Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Annual report and financial statements 2011/12

Making a difference together

Tees, Esk and Wear Valleys NHS Foundation Trust

Annual report and financial statements 2011/12

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

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Introduction

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Reviewing the past

Since becoming a foundation trust in 2008 we have worked extremely hard to be recognised as a centre of excellence, with our skilled and committed staff providing high quality services that exceed people's expectations.

We have already gone a long way towards realising our vision and this was recognised last year when we won three nationally acclaimed awards, including the prestigious Mental Health Service Provider of the Year award from the Royal College of Psychiatrists (see page 23). This was an important milestone on our journey to excellence through continuous improvement and a reflection of our commitment to quality.

As a non-teaching trust, winning the Health Service Journal's first ever award for research and development (see page 23) was also a tremendous achievement and demonstrated our commitment to embedding clinical research across the organisation.

Our quality improvement system (TEWV QIS) is fundamental to our success and staff from all levels and professions across the organisation are being empowered to use the tools to bring about change and improve services. This was also acknowledged by the judges of the Health Service Journal awards who presented us with the Innovation in Mental Health award (see page 23).

These are challenging times for the NHS and for TEWV but we have continued to maintain a clear focus on the reason we are here – to improve people's lives by minimising the impact that their mental ill health or learning disability has on them.

This has been reflected in the feedback we have received from service users, carers, staff and external assessors. The results of the two annual patient surveys were very positive although there are areas where we need to improve (see page 20); staff who responded to the annual NHS staff survey continue to recommend TEWV as a great place to work or receive treatment (see page 24) and we have received glowing reports from external assessors such as the University of Teesside's Excellence in Practice Accreditation Scheme (see page 22).

We have gone through a significant amount of change over the last twelve months. In June 2011 we were given the privilege and responsibility for mental health and learning disability service provision in Harrogate, Hambleton and Richmondshire, welcoming service users and over 500 staff from this area to TEWV (see page 29). We have also successfully implemented a number of other new contracts which we secured in 2010/11 including the region-wide specialist inpatient eating disorder service (see page 21) and the provision of mental health services into eight regional prisons (sub-contracted by Care UK).

We have continued to develop and strengthen services that enable more people to remain at home for longer and reduce the amount of time they need to spend in hospital. The improvements to older people's services in Stockton (see page 23) have

"The Trust demonstrated improvements in quality over a wide range of services through innovative practice."

The Royal College of Psychiatrists

dramatically reduced our reliance on inpatient beds and developments in hospital and nursing home liaison services (see page 26) are also reducing admissions to mental health hospitals.

Despite the shift towards caring for people at home we are committed to providing first class inpatient accommodation for those who need to spend time in hospital and we have some of the best facilities in the country. Our latest development at Cross Lane Hospital in Scarborough (see page 20) is an excellent example of this.

I am delighted with the progress we have made this year and achieving such excellent results in the context of so much change is a huge achievement. The highlights section of this report contains some examples of the work we have done over the last twelve months towards achieving our strategic goals.

None of this would have been possible without the continued commitment of our staff and the support of our partner organisations, our service users and their carers, our governors and members and our volunteers. On behalf of the Board I would like to thank everyone who has contributed to our success.

Looking to the future

As we celebrate the achievements of 2011/12 we are already looking forward and planning for the future.

Health and social care is changing and it is important that we continue to increase our understanding of what our 'customers' (our commissioners, GPs, service users and carers) need and expect from us and respond accordingly. This will include preparing for the introduction of 'any qualified providers' for the provision of some psychological therapy services in the Tees area.

Our drive to continuously improve the quality and value of what we do is of fundamental importance – improving quality and reducing costs at the same time. Our TEWV Quality Improvement System is so effective in helping us achieve these twin aims.

We will continue to work hard to reduce waiting times and improve access for service users and to monitor and improve the outcomes and experiences of the people who use our services.

We are also investing in new services and facilities and our new £12 million scheme to provide an additional 51 forensic beds at Roseberry Park will open towards the end of 2012. We have started work on long term plans to develop West Lane Hospital in Middlesbrough to significantly improve the inpatient environment for young people and we are awaiting planning permission to develop a new facility for older people with complex mental health needs in Malton.

Since taking over responsibility for services in Harrogate, Hambleton and Richmondshire last year we have been getting to know and reviewing these services. Over the coming year we will continue to work with staff, service users and carers as well as our commissioners and partner organisations to build on and improve services so that local people have access to the right care, at the right time in the right place.

We have much to look forward to over the next twelve months but there are also many challenges ahead. However, with the support of our staff, service users and carers, partner organisations and commissioners, governors and members I know we can continue to make a positive difference.

Martin Barkley
Chief Executive

Directors' report

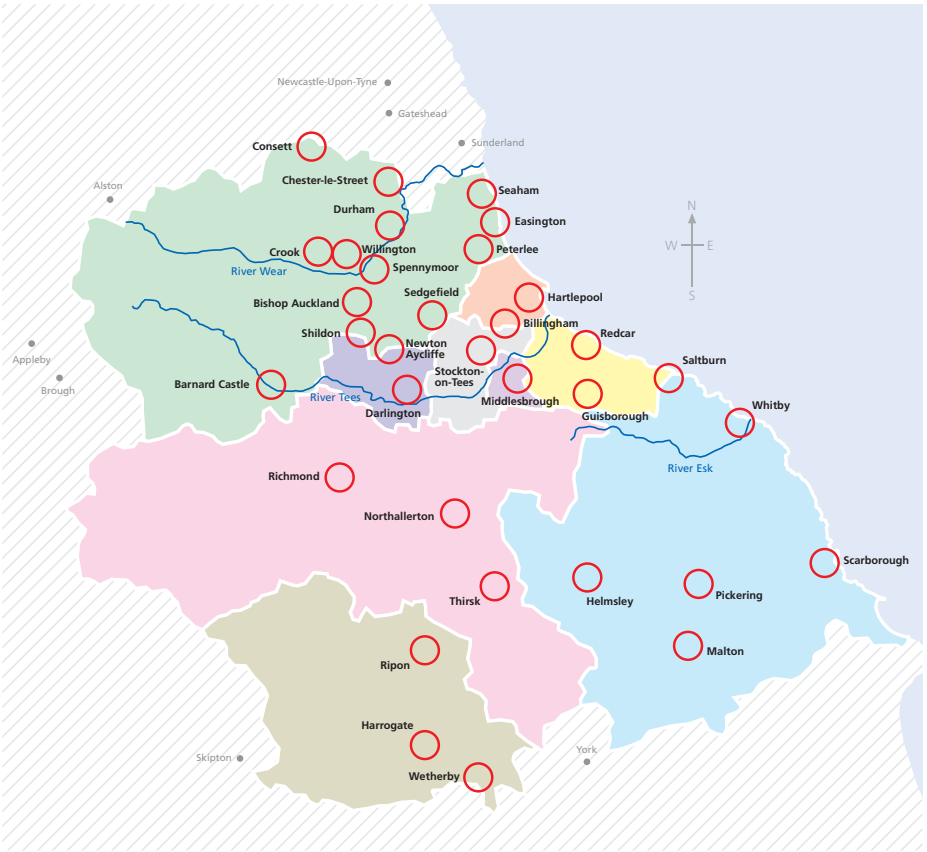
TEWV at a glance

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. In June 2011 we took over the contract to provide mental health, learning disability and substance misuse services to the people of Harrogate, Hambleton and Richmondshire.

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.

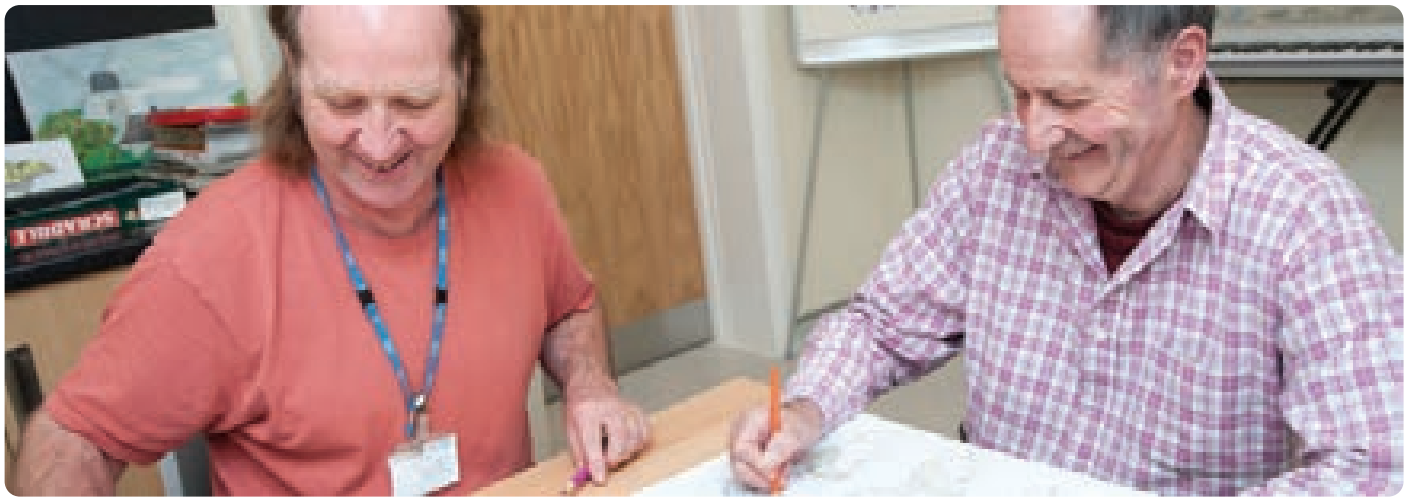
We provide a range of mental health, learning disability and substance misuse services for the 1.6 million people living in County Durham and Darlington, the Tees Valley, most of North Yorkshire (Scarborough, Whitby Ryedale, Harrogate, Hambleton and Richmondshire) as well as Wetherby in West Yorkshire. With over 5,800 staff and an annual income of £270 million we deliver our services by working in partnership with seven local authorities and primary care trusts, a wide range of other providers including voluntary organisations and the private sector, as well as service users, their carers and the public.

The services are spread over a wide geographical area which includes coastal, rural and industrial areas.



Being a foundation trust is helping us:

- build on and improve positive relationships with service users, carers, staff, partners and local people and give greater accountability to local people
- strengthen our internal process and systems to meet the challenges of modern health services
- develop locally based specialist services (see examples of some of the services we have developed on pages 20-29)
- respond better to market opportunities (for example see page 28)
- invest in capital developments such as Cross Lane Hospital on page 20



Our mission

To improve people's 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 safe and high quality services.
- We will safeguard those at risk of harm.
- Users of our services and their carers believe they have had positive experiences and outcomes.
- We continuously improve our position in local and national patient surveys.
- Users of our services are seen when they need to be seen, at a time convenient to them, have no unnecessary transfers and no delays in starting treatment.
- Users of our services are offered choices of personalised care and treatment and kept informed of their agreed treatment plan and options.
- Our service users and their carers believe we are responsive to their needs and concerns.

2.

To continuously improve the quality and value of our work

This means that…

- We continually improve patient safety throughout the organisation.
- We are accredited and known nationally and internationally for our high quality services and continuous improvement.
- All parts of the Trust have a culture of continuous improvement, with customers at the heart of our clinical and business decision-making.
- Quality indicators and outcome measures underpin our proactive performance management framework and high quality services.
- The TEWV Quality Improvement System is embedded throughout the Trust to deliver continuous improvement in the quality and value of our services.
- The Trust and its staff only do things that add value to our customers.

3.

To recruit, develop and retain a skilled and motivated workforce

This means that…

- We continuously improve our position in local and national staff surveys.
- Our staff feel supported and valued at work.
- Our staff have well defined job roles which add value.
- Our staff work both productively and flexibly.
- We promote and support the wellbeing of our staff.
- We engage all our staff through effective communication and involvement.
- Our staff are motivated to support and help patients at every opportunity.
- We proactively support all clinical staff to be involved in the leadership and management of the Trust.

4.

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

This means that…

- The Trust supports its commissioners to effectively commission mental health, learning disability, substance misuse and other specialist services.
- We engage with the NHS Commissioning Board at a local, regional and national and local level.
- We work in partnership with people who use our services to help them advocate their needs and views to commissioners, local and national organisations and local communities.
- We work with our Local Authority partners to support the delivery of a seamless service for our users and carers.
- We seek to influence each Health and Wellbeing Board either through membership or networking.

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 the population we serve and all potential commissioners because of our excellent quality and value.
- Our Council of Governors is fit for purpose and actively engaged in our strategic 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 clinically and cost effective using national benchmarks and outcomes data.
- We have a reputation for transparency by proactively publishing accurate, timely and comprehensive data and information about the Trust's performance.

• We work with commissioners to address gaps in local services. • We deliver services in accessible high quality environments and have much of our services close to where people live. • We continually seek and respond to feedback about the services we provide from our service users and carers, and take appropriate action where necessary.	• We have a reputation for excellence amongst the people who currently use our services and those who commission them. • We provide good quality information for patients, carers and GPs who want to know more about mental health, treatments and the services that are available from TEWV and how to access them.	• Service users consider that they have been helped and supported to achieve a self-determined and functioning lifestyle. • We deliver service models which are effective, responsive and supportive of the whole care pathway. • We work at a local, national and international level to minimise the stigma of mental health and learning disabilities experienced by our service users.
• We deliver services that are evidence-based and clinically cost-effective. • We have an active programme of research and development to improve the services we provide. • We actively seek out and report good practice and successfully disseminate it throughout the organisation. • We do what we say we are going to do.	• We promote a culture of actively challenging and reporting unsafe practice and quickly learn from our experience. • We use high quality pathways of care to support standardised work and deliver consistent good outcomes across the Trust. • We have consistently high standards implemented across the Trust.	• We are responsive to, but recognise differences in, local commissioner's intentions and resourcing decisions.
• We align the competencies of our staff to our clinical pathways through recruiting the right staff and targeted education and training. • All our staff consistently demonstrate behaviours consistent with the Trust's values. • The Trust and its staff understand and follow the Trust Compact.	• Our staff access appropriate education, training and development opportunities to achieve their full potential. • We provide effective placements for students throughout the organisation. • We welcome diversity and the Trust has a diverse workforce that is representative of the communities we serve. • We have the right staff with the right skills, competencies and attitudes to provide excellent services.	• We recruit and retain high quality staff, with the attitudes needed by our business, and manage succession through effective selection and development strategies.
• We have close and supportive working relationships with our local Directors of Public Health to promote good mental health. • We work closely with all GPs in our area to help them provide effective care for their patients with mental health, learning disability or substance misuse needs and access our services appropriately.	• We engage with universities and education providers to develop and increase our research and training capacity. • We have a range of formal and informal partnerships with providers and agencies across the public, private and voluntary sectors for the benefit of our communities.	• We engage with national and local organisations which represent the needs and views of service users and carers. • We engage with partners to improve value for money through shared services / facilities / approaches. • We fully contribute to the effectiveness of the local Education and Training Board.
• We proactively identify and manage risks to the Trust business. • The Trust identifies and eliminates waste while improving quality standards. • The Trust embraces technology to improve quality and efficiency and support innovation. • We are an environmentally friendly and socially responsible organisation.	• We lead and influence national and international policy and systems development. • We actively promote our successes to develop our reputation and brand to all stakeholders. • We continuously develop new business opportunities which are consistent with our Trust vision.	• We develop and continuously deliver our Trust business plan which is dynamic, flexible and responsive to the changing environment. • Effective financial contingency planning ensures our Trust is sustainable. • We have robust and regularly tested emergency and business continuity plans.

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 minimise any activity that does not add value or is wasteful.

To help us improve the quality of what we do we have developed a quality improvement system, which is based on and supported by Virginia Mason Medical Centre in Seattle. 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).

In 2011 we received the Health Service Journal Award for Innovation in Mental Health for our quality improvement system (see page 23).

Our services

In 2011 we moved to a locality based approach to managing services. This was to reflect the additional services from North Yorkshire becoming part of the Trust and to help us strengthen our links with local communities.

We have three localities:
- Durham and Darlington
- Tees
- North Yorkshire

As well as a directorate for forensic services.

We have four clinical divisions which span the localities:
- adult mental health services (including substance misuse services)
- mental health services for older people
- children and young people's services (including child and adolescent mental health services and children's learning disability services)
- adult learning disability services

Adult mental health services

We provide mental health services for adults of working age in partnership with social care and a wide range of voluntary and independent service providers, including:
- a wide range of community based assessment and treatment services including primary care, liaison, crisis intervention, assertive outreach, community affective disorders and psychosis teams and eating disorders. The Trust also provides community mental health and deafness services and adult attention deficit hyperactivity disorder (ADHD) across Teesside, County Durham and Darlington
- 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 (working with partners) in Durham, Darlington and Teesside
- the region's specialist inpatient eating disorder service (for the North East and North Cumbria)

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. The Trust also has wards within the Friarage in Northallerton and Harrogate District Hospital.

Substance misuse services

We provide community substance misuse assessment and treatment services for people aged 18 years and above. Services are provided in County Durham, Middlesbrough, Redcar and Cleveland, Scarborough, Whitby and Ryedale, Hambleton and Richmondshire and Harrogate. These services are funded primarily through drug and alcohol action teams and the specific nature of each service varies by locality.

Mental health services older people

We provide mental health services for older people working in partnership with social care and a wide range of voluntary and independent service providers. The services we provide include:
- a wide range of community based services include community mental health teams, acute liaison, care home liaison, day services 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, Cross Lane Hospital in Scarborough and wards within the Friarage in Northallerton and Harrogate District Hospital.

Children and young people's service

This service includes all child and adolescent mental health services and early intervention in psychosis services for the people of County Durham, Darlington, Teesside and North Yorkshire. Services for children with learning disabilities are also provided in County Durham, Darlington and Teesside. Most services are provided in the community with inpatient services being located on the West Lane Hospital site in Middlesbrough where we also opened a new specialist regional inpatient eating disorder service in July 2011.

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, units within Lanchester Road Hospital in Durham and the Dales in Stockton-on-Tees. The Trust also provides learning disability services for the people of Craven from the services based in Harrogate.

Forensic mental health and learning disabilities forensic services

Forensic services are specialist services which provide secure accommodation for people with mental health needs and learning disabilities predominantly within the criminal justice system.

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 also provide community forensic services including criminal justice liaison services that work across the whole offending behaviour pathway.

Our performance 2011/12

The following scorecard outlines our key performance indicators for 2011/12.

The Board received a monthly performance dashboard during 2011/2012 which contained performance against a range of indicators linked to the Trust's strategic goals as well as national requirements. The table shows the 2011/2012 annual position.

Scorecard

1. Users of Our Services	Value	Target	Comment
Percentage of patients, seen in the month, who have not waited longer than 4 weeks for a first appointment	94.92%	100.00%	Incremental target of 100% by December 2011, therefore March 2012 position detailed rather than the 2011/12 outturn
Percentage of patients, seen in the month, who have not waited longer than 9 weeks following internal referral	98.21%	100.00%	
Percentage of patients, seen in the month, who have not waited longer than 9 weeks for treatment	99.30%	100.00%	
Percentage of complaints satisfactorily resolved by the Trust	74.80%	90.00%	2011/12 position
Percentage CPA 7 day follow up*	98.56%	95.00%	2011/12 position
Percentage of CPA patients, where they have spent at least 12 months on CPA, having a formal review documented within 12 months (snapshot)*	97.25%	95.00%	Snapshot
Percentage of admissions to inpatient services that had access to crisis resolution home treatment teams prior to admission*	96.03%	90.00%	2011/12 position
Median number of days from when a patient is discharged as an inpatient to their next admission as an inpatient	109.00	69.00	2011/12 position

2. Quality	Value	Target	Comment
Number of reported outbreaks healthcare associated infections: MRSA Bacteraemia & Clostridium Difficile	0	0	2011/12 position
Data completeness: outcomes (Snapshot)*	97.30%	90.00%	Snapshot
Data completeness: identifiers (Snapshot)*	99.74%	99.00%	Snapshot
Self certification against compliance with requirements regarding access to healthcare for people with a learning disability*	100.00%	75.00%	Snapshot
Percentage of non acute patients (aged 18 and over) whose transfer of care was delayed, summed across the period (Paris Monitoring)*	1.55%	<7.50%	2011/12 position
Percentage of non acute patients (aged 18 and over) whose transfer of care was delayed, summed across the period (health and social care)- Trust Total	1.96%	<7.50%	2011/12 position
Number of people under 18 admitted to adult inpatient wards	9	14	2011/12 position
Total number of unexpected deaths reported - Trust position	47	33	2011/12 position

3. Workforce	Value	Target	Comment
% Sickness Absence Rate	5.3%	5.00%	Incremental target of 5.0% by March 2012 therefore the position detailed is the month of March, rather than 2011/12 position.
Assessment of current establishment (target is 98-100% but is shown as 99% with a 1% threshold on either side)	101.07%	99.00%	2011/12 position
Percentage of staff in post more than 12 months with a current appraisal	89.08%	95.00%	2011/12 position
Percentage compliance with mandatory and statutory training	83.35%	90.00%	2011/12 position
Percentage of all disciplinary cases where hearings are held that fall within 3 months of the decision to pursue a disciplinary	48.33%	75.00%	2011/12 position
Total number of RIDDOR incidents - Trust position	65	46	2011/12 position

4. Partnerships	Value	Target	Comment
Number of new cases of psychosis served by early intervention teams (cumulative from start of financial year)*	479	230	2011/12 position
Number of home treatment episodes by crisis home treatment services	5965	2978	2011/12 position

5. Sustainable Organisation	Value	Target	Comment
% of CQUIN indicators achieved	99.24%	90.00%	The quarter 4 CQUIN has been reported to commissioners but no confirmation of payments has been received, therefore this quarter 3 position is detailed
Number of GP Referrals into Trust services	24802	25411	2011/12 position
Finance Risk Rating (Trust Level Only)	4	4	Snapshot
CRES Delivery	104.00%	100.00%	Snapshot

Notes on our performance

It should be noted that the dashboard covers all services with the exception of Harrogate, Hambleton and Richmond which the Trust took over in June 2011. The Trust has been developing systems and processes in relation to a robust information infrastructure since this date which will enable it to fully embed the performance management framework for 2012/13.

The Trust has been able to collect performance information in relation to the requirements by the healthcare regulator, Monitor, and all key targets have been achieved for 2011/12. These targets are illustrated in the table by an asterix (*).

- **Percentage of patients, seen in the month, who have not waited longer than 4 weeks for a first appointment** – Whilst we failed to meet the target of 100%, we have continued to improve our performance throughout year from 85.05% in April 2011 to 95% in March 2011. This reflects the work that has been undertaken by services to improve access to services.

- **Percentage of patients, seen in the month, who have not waited longer than 9 weeks following internal referral** - Again whilst we have not delivered the target for the whole year we have maintained above 96% between April 2011 and March 2012; which again is reflective of the work undertaken.

- **Percentage of patients, seen in the month, who have not waited longer than 9 weeks for treatment** - Whilst we have not achieved the target of 100%, we have improved our performance from 97% in April 2010 to 99% in March 2012. We have performed at over 96% of patients being treated within 9 weeks throughout the year.

- **Percentage of complaints satisfactorily resolved by the Trust** - The Trust has fallen short of the annual target however the majority of complaints have been satisfactorily resolved. 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.

- **Total number of unexpected deaths reported** - Trust position – The National Patient Safety Agency has produced guidance which requires that unexpected deaths, where natural causes are not suspected, be reported. Of the 47 unexpected deaths, we are awaiting confirmation on 38.

- **Percentage sickness absence rate** - The March 2012 position is 5.3% 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 101%; however, this does not give cause for concern. This is mainly attributable to an increased use of bank and agency to cover vacancies, sickness and enhanced observations.

- **Percentage of staff in post more than 12 months with a current appraisal** – Whilst we have not achieved the target of 95%; a significant amount of work has been undertaken to validate reports with services to continuously improve compliance rates.

- **Percentage compliance with mandatory and statutory training** – The Trust has fallen short of the target of 90%; however, similarly to appraisals, a significant amount of work has been undertaken to validate reports with services to continuously improve compliance rates.

- **Percentage of all disciplinary cases where hearings are held that fall within 3 months of the decision to pursue a disciplinary** - Performance against the target over the last 12 months has consistently improved from 25% in May 2011. EMT receives a monthly update detailing progress made in relation to disciplinary investigations and hearings against the target of 3 months. The Head of Operational Human Resources Services regularly attends OMT to discuss employee relations issues.

- **Number of RIDDOR Incidents** – The Trust has reported 65 RIDDOR Incidents during 2011/12 which is significantly higher than the target of 46. The Health and Safety team investigate all the RIDDOR incidents and there are no underlying trends or lessons to be learnt from them. Analysis of the categories of RIDDOR incidents indicates that the highest proportions are physical assaults and control and restraint injures sustained by staff (60%). 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.

- **Number of GP referrals into Trust Services** – The Trust set itself a target of 25,000 referrals, which it has fallen marginally short of; however the Trust averages 2067 referrals a month and has reported above each monthly target in five months this financial year.

Working with our commissioners to improve performance

The Trust provides regular performance information to its commissioners as part of the mental health contract covering activity, key performance indicators and measures of quality. The Trust's commitment to contract performance management is evidenced through monthly contract meetings, and sub groups with commissioners which are regularly attended and have full participation of senior staff, including a number of Board members. These meetings/groups focus on areas such as service quality, service development and finance.

Two key commissioners' targets were identified and included in the dashboard KPIs for 2011/2012 under the strategic goal partnerships. The Trust overall achieved the requisite number of '**new cases of psychosis served by early intervention teams**' and the number of '**home treatment episodes by crisis home treatment teams**'. All key commissioner targets were also included in the relevant clinical locality performance reports throughout 2011/12 and monitored routinely.

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.

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 examples of how we are achieving our goal.

Patients give us their views

We received some positive feedback from the two annual national patient surveys. The Care Quality Commission's survey focussed on community mental health services and over 17,000 people across the country aged 16 years and over took part. Across County Durham and Darlington, Teesside, Scarborough, Whitby and Ryedale we were in the top 20% of trusts in 12 of the areas covered. Services in Harrogate, Hambleton and Richmondshire were included in the results for North Yorkshire and York and these services scored better than most other trusts in four of the eight categories.

TEWV was also one of 26 mental health trusts to voluntarily take part in the inpatient survey. We scored significantly better than the other trusts in 20 of the areas covered although results were lower than last year. These surveys provide valuable feedback from patients and help us focus on areas where we need to improve.

We use the feedback from these surveys to further improve our services and have made a number of changes to the way we work including auditing care plans, helping people to make informed choices about medication and the introduction of the carers' strategy (see page 28).

Major development in Scarborough

By the end of 2011/12 we were well on the way to completing our £10.4 million development at Cross Lane Hospital in Scarborough.

The new specialist mental health unit for older people opened in July 2011. The light, spacious accommodation replaced the outdated Rowan Lea building and is helping staff to provide more individualised care for people with different needs such as dementia or depression.

It has 20 single, en-suite bedrooms and service users, carers and staff were heavily involved in planning the new unit. Artwork chosen with the help of patient groups is a prominent feature in the new build and photographs featuring local people are an aid to recognition for patients with dementia, such as photographs of harvesting and cooking along the corridor leading to the dining area.

Phase two of the redevelopment, which is to fully refurbish the inpatient unit for working age adults (Ayckbourn), is well underway. The refurbished Danby ward now has full en-suite single rooms and increased therapeutic space, including a large activity room, a group room and a quiet room. Similar improvements to Esk ward were also nearing completion at the end of the year and the final phase (an extension to the unit) will be completed in late 2012.

New regional service for eating disorders

Staff welcome visitors at the open days for the Northern Centre for Eating Disorders

In 2011 we opened the first region-wide specialist centre for adults and children with eating disorders.

The Northern Centre for Eating Disorders provides inpatient services for the whole of the North East and North Cumbria. Highly trained specialist teams including physicians, nurses, dieticians and therapists work closely together to make sure inpatients get the mental and physical support and treatment they need. Dedicated chefs and kitchen facilities where patients can plan and prepare food are also key elements of these services.

The adult inpatient unit is based at West Park Hospital in Darlington and was the first in the country to adopt a fully integrated team approach to providing physical and mental health care. As well as 15 single en-suite bedrooms, each with its own entertainment system, the unit also has two high dependency beds for nasogastric feeding and medical interventions.

The unit for children and young people is located at West Lane Hospital in Middlesbrough. Evergreen has 12 single en-suite bedrooms and provides young people up to the age of 18 with a safe, comfortable and calm environment. Patients were consulted at every step of planning this new centre, even choosing the bright and funky décor.

Improving services for older people

Following a public consultation in South Durham, which concluded in early 2011, we were able to further improve services for older people. We reduced the number of inpatient beds and strengthened our community services so that more people could be cared for in their home environment.

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

As a result we created separate wards for the people of South Durham and Darlington. Our specialist functional inpatient centre is based at West Park Hospital in Darlington and we have a specialist organic assessment and treatment ward at Auckland Park Hospital in Bishop Auckland.

We have also reduced the time that people have to wait for diagnosis and treatment and developed more individualised support for people in their own homes.

In addition we established a dedicated challenging behaviour service at Auckland Park Hospital with a specialist inpatient unit and a new community team for the people of South Durham and Darlington.

Giving service users a voice

We work hard to ensure that the people who use our services are able to have their say in the way we provide and develop services.

We have established staff champions across our **child and adolescent mental health services** who help young people to get involved. Over the last year this has included a conference which was planned and delivered by young people. Our efforts have been recognised in Hartlepool and Redcar by gaining Department of Health's accreditation against the quality criteria for young people friendly health services – known as 'You're welcome'. Several teams have also gained Investing in Children accreditation.

The ForUs group, which is made up entirely of service users from our **forensic learning disability service** has had significant success over the last year. They are supported by our staff and provide valuable input into the development of services. Their achievements have included advising commissioners on service development , leading on national initiatives and presenting at international conferences.

Staff who support the ForUs group

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

Our aim was to embed a culture of continuous improvement across the Trust. To help us to this we developed a quality improvement system (TEWV QIS), which is based on a system developed by the Virginia Mason Medical Centre in Seattle. TEWV QIS is helping us reduce waste whilst continuing to deliver high quality services which are appropriate, effective and make a positive difference to people's lives.

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 42.

Our psychiatric intensive care unit (PICU) at West Park Hospital in Darlington became only the fourth PICU to achieve level 1(excellent) status against the nationally recognised Accreditation for Inpatient Mental Health Services standards (AIMS). They are one of only 12 mental health services nationally to be recognised at this level by the Royal College of Psychiatrists.

Excellence in practice

Staff from County Durham and Darlington celebrate their accreditation

Our mental health services for older people (MHSOP) were praised by the University of Teesside for their high standards. Between July and December 2011 the reviewers of the Excellence in Practice Accreditation Scheme (EPAS) reaccredited Durham and Darlington MHSOP and completed final accreditation for:

- Stockton inpatients and community mental health team (CMHT)
- Tees-wide young onset dementia team
- Easington and Hartlepool inpatient and CMHT
- Middlesbrough and Redcar & Cleveland inpatient and CMHT

All of the above teams achieved the highest rating of five stars which has only been awarded to two others teams in the nine years since EPAS was established. Middlesbrough and Redcar & Cleveland teams were also awarded the maximum possible scores for 'continuous quality improvement' and 'measuring efficiency and effectiveness'.

Improving patient safety

Last year our pharmacy team introduced a new mechanism for recording lithium test results, which is improving patient safety.

There are a number or risks associated with lithium, which is predominantly used for the treatment of bipolar disorder. As patients often remain on treatment for a number of years, it is crucial that they are well managed throughout their treatment. The lithium register is used to record patient test results and provides a systematic and reliable tool for communicating up-to-date information to clinical staff, helping them identify and address problems at an early stage.

"It is the first time I feel that I have really moved on with my life and know how to deal with my feelings and problems. I am who I want to be."

A service user

Hospitality assured

The Trust was once again recognised for its high hospitality standards in a nationally recognised scheme.

We received the top healthcare score in 'Hospitality Assured', a national quality standard from the Institute of Hospitality. This is the fifth year we have received the award and our third year at the top of the healthcare sector category.

Assessors visited four Trust sites to look at business and operational planning, performance, training, development and customer satisfaction.

Embedding TEWV QIS

Training is key to embedding our quality improvement system and ensuring it becomes 'the way we do things at TEWV'. To date we have 51 certified leaders who are helping us do this and we have also developed an abridged version of the training programme, QIS for leaders and a programme for medics. By the end of 2011/12 over 70 leaders and 160 medics had completed these programmes and are using the TEWV QIS to reduce waste and improve services.

We have also developed an initiative – the share and spread programme – which is helping us make sure we are able to successfully replicate best practice in all areas of the Trust. (see page 42 of the quality report for more examples).

National recognition

In November 2011 we won four prestigious national awards. This was a major accomplishment for the Trust and reflects our commitment to continuous improvement.

The awards included the prestigious **Mental Health Service Provider of the Year** award from the **Royal College of Psychiatrists**, which recognised our drive for excellence and quality improvement.

One of our senior clinical directors, Dr Angus Bell, was also named **Medical Manager/Leader of the Year** by the Royal College who were impressed with his commitment to our quality improvement system and to using it to improve patient care.
We were also successful in two categories in the **Health Service Journal Awards**.

Our quality improvement system (TEWV QIS) received the **Innovation in Mental Health award** for improving services and driving out waste. The judges were particularly impressed with our 'board to ward' engagement.

Staff receive award for research culture

We were also awarded the first ever award for **Research Culture** in recognition of our contribution to worldwide mental health research. We were applauded for our "impressive work in a challenging field and across a wide geographical area."

Improving older people's services

In early 2011 staff at Lustrum Vale (our 22 bed inpatient unit for older people in Stockton) transformed the way they worked to improve patient care and reduce the time individuals need to spend in hospital.

By speeding up their assessment and treatment processes staff made sure that patients received the care they needed promptly and were able to return home quickly. Patients started receiving more support in their home environment and bed occupancy on the ward decreased dramatically.

At the end of June 2011 we temporarily closed the inpatient ward and since then patients have been admitted to Roseberry Park in Middlesbrough.

We closely monitored and reviewed the impact of this change on the people of Stockton-on-Tees and the results were very positive. In February 2012 we launched a public consultation proposing to make this change permanent (see page 32). This will not only allow us to make best use of a modern, purpose-built inpatient facility, but also enable us to reinvest money to support people in their own homes, in care homes and in the acute hospital.

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 34).

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.

A great place to work

Staff continue to recommend TEWV as a great place to work or receive treatment according to the results of the 2011 NHS national staff survey which were announced in March 2012. This is viewed as the single most important indicator in the annual survey and staff responses continue to place us in the top 20% of mental health/learning disabilities trusts in the country. TEWV was among the best performing trusts in over half of the 38 areas which were reviewed in the survey (see page 36 for more detailed information).

Annual staff awards

Staff from across the Trust were once against recognised through our fifth annual Making a Difference awards programme. The awards grow in popularity year on year as people realise they are an excellent way of showing staff that they are valued for the work they do. Over 220 teams and individuals were nominated by colleagues, managers, service users, carers and partner organisations. Forty teams and individuals were shortlisted for ten awards and the winners were invited to a special awards evening.

Living the Trust's values

The first winners of the Living the Values award (Harrogate's assertive outreach team) receive their award

Towards the end of last year we introduced a new bi-monthly award to recognise staff for making a difference to the experience of others by living the Trust's values.

It's not just what we do but the way we do things that's important and people tell us every day how staff from across the organisation are making a huge positive impact on their lives.

These staff are working according to our values (see page 13) - the guiding principles for how we want our staff to behave and this award reflects the importance we place on these values.

We also introduced a three day senior leadership programme which was attended by over 200 managers as well as a series of open workshops and team development sessions, all aimed at embedding the Trust's values and behaviours across the organisation. We have received excellent feedback from staff and are planning additional sessions.

Commitment to quality
Teamwork
Living the values
Involvement Wellbeing
Respect

Outstanding service recognised

Russell Maguire, a storekeeper based at Roseberry Park in Middlesbrough is celebrating being awarded the prestigious High Sheriff's Award for his long and outstanding service with the NHS.

The certificate, awarded to local people who have made a significant contribution to their community was presented by Mrs Alexandra Holford, High Sheriff of North Yorkshire. Russell has worked for the NHS for more than 40 years.

Awards success

Staff receive award for innovation in mental health

In addition to our outstanding success at the Health Service Journal and Royal College of Psychiatrists' awards (see page 23) many other staff have been recognised for their achievements at a national and local level.

Nursing Times awards

- Our early intervention in psychosis team in South Durham were highly commended in the Team of the Year award
- The learning disability forensic service 'ForUs group' reached the final of the learning disabilities nursing award

Royal Institute of British Architects

Roseberry Park won two awards:

- The Gold award for its design and
- North East project of the year

NHS Library and Knowledge Services

- Our library and information service was commended in the Sally Hernando Award for Innovation

Safer Care North East Patient Safety Summit

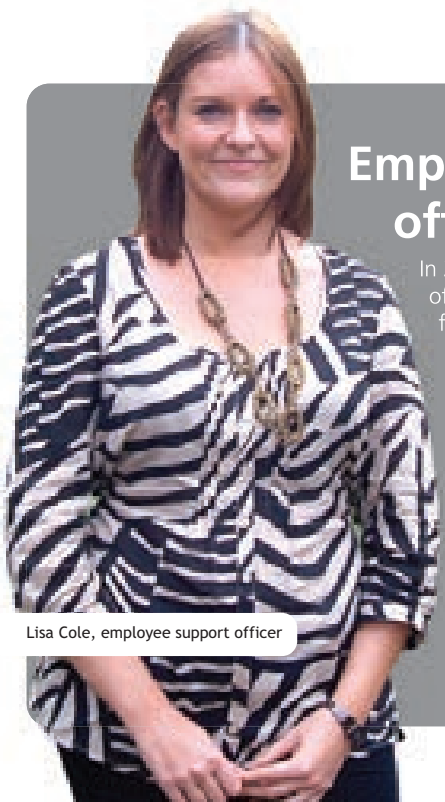
- We were involved in a collaborative venture, which won the safer care clinical theme award

Best of Darlington

- The Darlington Dementia Collaborative won the Putting Darlington on the Map award.

Equality North East Equality Awards

- Our equality and diversity team were shortlisted for a good practice award.



Lisa Cole, employee support officer

Employee support officer

In 2011 we appointed an employee support officer to help us promote a culture and create a framework of support for staff who experience mental health issues.

Our aim is to reduce the amount of sickness absence through mental ill health and this appointment is helping us make progress towards meeting the six pledges of the Mindful Employer Charter that we signed in 2009.

The support officer provides practical advice and signposting as well as more tailored support for staff.

Developing our workforce

Over the course of the year we have continued to develop new roles across all of our services and teams, which are helping us provide improved patient care. For example:

- physical care practitioners on adult mental health wards are helping support people with physical health problems
- we have continued to increased the number of non-medical prescribers, particularly in our substance misuse services and mental health services for older people
- we now have clinical nurse specialist roles in most of our child and adolescent mental health teams
- we have continued to develop associate practitioner roles in our learning disability community teams

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.

New clinical pathways for children and young people

We work closely with our partners to make sure that children and young people have quick access to excellent care and last year this included developing new clinical pathways.

In 2011/12 we developed a new challenging behaviour pathway for children with learning disabilities which is now being piloted. The aim of this new clinical pathway is to support staff to deliver evidenced based assessment and treatment and to help them meet the needs of children and young people with challenging behaviour.

In Redcar and Cleveland we worked alongside partner organisations to develop pathways for children and young people. The aim is to make sure they have easy access to the services they need to meet their mental health needs

Improving liaison services

We have continued to work closely with our partners in the acute trusts and with nursing homes to improve services for older people.

After a successful year long trial we received confirmation that funding for a service to increase specialist mental health support for older people in South Tees care homes would continue.

The South Tees care home liaison team works with care homes in Middlesbrough, Redcar and Cleveland to help their staff recognise different mental health issues and learn new ways to manage the symptoms.

The service is already having a huge positive impact on care home residents. The number of people who are admitted to mental health hospitals has more than halved and the use of medication has significantly reduced. 20% of care home residents who had previously been prescribed anti-psychotic medication for challenging behaviour have had their medication reduced or stopped and care home staff are implementing more non-medical approaches to managing challenging behaviour in people with dementia.

The South Tees mental health liaison team

Our acute hospitals liaison service now includes designated psychiatrist sessions and waiting time from referral to assessment has been reduced from an average of five days to two days, with urgent referrals seen within 24 hours. We are also providing a bespoke mental health skills development package to ward staff.

TEWV hosts international festival

In September 2011 over 190 delegates from across Europe took part in the region's first international mental health festival, passionate about mental health.

The 13th annual Europsy Festival gave attendees the opportunity to share their experiences of mental illness and mental health care and to raise awareness about the stigma that surrounds it.

Following a lively opening ceremony where participants broke down a 'stigma wall' (see photo) there was a packed programme of workshops. These ranged from creating a graffiti mural and making traditional North East 'clippy mats' to gardening in Durham's Botanic Gardens. There were also sessions where service users, carers and professionals got together to share their expertise and experience to learn from each other.

Europsy Rehabilitation is a European organisation, which is directed by mental health professionals and users of services. Its mission is to stand up for the rights of people with mental disabilities.

"I found working with the team an amazing experience. They worked with our care home and gave staff more confidence and knowledge of the activities that helped to stimulate the residents."

A care home activities co-ordinator

Developing the dementia pathway

We have continued to develop our dementia pathway, following the publication of NICE guidance.

In Teesside we have worked with South Tees Hospitals NHS Foundation Trust to reduce waiting times for CT scans, a key part of the diagnostic process. Scans are now carried out within six days of the first appointment with the memory clinic.

In Durham Dales we are part of the Durham Dales Integrated Care Organisation (IC) which is a national pilot. We have provided training to improve early recognition of dementia in primary care and offered memory screening to people attending for a flu jab.

Open access

Over the last twelve months our substance misuse services in Stockton have worked closely with partner agencies to successfully implement an open access referral system in line with the national drug strategy.

The aim is to improve access and, ultimately, outcomes for people with drug and alcohol problems. A duty system was set up in each of the organisations involved so that service users have access to all the services they need on the day of referral. We have also set up on-site multi-agency recovery meetings immediately following assessment and all agencies are involved in care planning and review discussions with service users and their families.

This holistic approach, which has received very positive feedback, has improved the quality of care planning, information sharing and family involvement.

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

Our vision is to be recognised as a centre of excellence for mental health, learning disability and substance misuse services and to have a reputation for providing high quality services that exceed people's expectation.

We are keen to lead and influence national and international policy and systems development as well as to make a difference locally for the people who need our services.

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 implementing a number of contracts that are consistent with our vision and which reflect the high standard and cost effectiveness of our services. These include:

- the regional centre for inpatient eating disorders (see page 21)
- talking changes (improving access to talking therapies service for County Durham and Darlington)
- the sub-contract to provide mental health care into the eight regional prisons

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

Some of the people involved in the spirituality conference

Spirituality and mental health

The Trust is leading the way in recognising the importance of spirituality in mental health.

Over 60 people attended our inaugural spirituality conference. This highly successful event attracted speakers and participants from across the UK, Australia and the USA and gave them the opportunity to share good practice and learn more about the importance of spirituality in mental health.

We have also developed what we believe is the first ever spirituality pathway which ensures patients' spiritual needs are incorporated into their care and treatment. The pathway provides structure to ensure that everyone receives the same standard of spiritual care and that consistent, dignified care is delivered. Although there is increasing evidence to support the importance of spiritual care, there are no examples of incorporating it into treatment plans in this structured way.

Caring for carers

The Trust's governors played a key role in the development of our new carers strategy which was launched in October 2011.

Written with the help of carers and governors, the aim of the strategy is to improve carers' lives by making sure that their needs are recognised and that services are developed to meet those needs.

A carer can be anyone - adult or young person, parent or child - and many people do not see themselves as carers, for them it is simply part of normal everyday life.

Carers of all ages told us that they want to be involved and informed but also want us to recognise that their caring role can have an impact on their own health and wellbeing.

Some of the carers and governors involved in developing the strategy

Retaining a local focus

Following our success in winning the tender to provide mental health and learning disability services in Harrogate, Hambleton and Richmondshire, these services transferred to TEWV in June 2011.

To reflect the additional services becoming part of the Trust and to help us strengthen our links with local communities we introduced new management and leadership arrangements across the organisation.

We established four operational directorates, one for each of our localities (Tees, County Durham and Darlington and North Yorkshire) and a separate forensic directorate. In each of the localities we set up four clinical directorates:

- adult mental health and substance misuse
- mental health services for older people
- children and young people's services
- learning disability services

A senior clinical director for each speciality ensures that speciality wide issues such as clinical governance and best practice standards are addressed Trust wide.

95%
of patients had their first appointment within four weeks of referral

99%
of patients received treatment within nine weeks of referral

99%
of quality targets (CQUIN) achieved

Principal risks and uncertainties

Our business plan, which supports the achievement of our strategic direction, recognises the changes to the environment and the 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 Annual Goverance Statement describes the systems and processes through which risks are identified, managed and mitigated. This can be found on page 93.

Reform of the NHS

The structural changes to the NHS arising from the Health and Social Care Act will, inevitably, create risks for the Trust.

Our relationships with commissioners, built over many years, will be disrupted by the abolition of the primary care trusts.

To mitigate these risks we will continue to seek to build relationships with the emerging clinical commissioning groups, health and wellbeing boards and healthwatch.

Regulatory Changes

The findings of the Mid Staffordshire NHS Foundation Trust Public Inquiry are due to be published during 2012/13.

These are likely to have significant implications for the way healthcare providers are regulated.

In addition, the implications of the changing role of Monitor and the introduction of the new licensing regime are, at present, unknown.

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.

We recognise that competition will increase as new organisations enter the market and as efficiencies are sought through commissioning arrangements.

We have already seen increased competition for the provision of substance misuse services.

The introduction of the "any qualified provider model" also creates risks to our future income levels.

We will, therefore, need to work harder and be second to none in terms of quality and value.

Meeting efficiency targets

We have an excellent record in achieving the efficiency targets placed on us. However, this is becoming increasingly hard.

We must ensure that efficiencies are not detrimental to our patients but maintain and, if possible, enhance the quality of our services.

Implications arising from reductions in public expenditure

Although the NHS budget has increased in 2012/13 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.

Payment by results

We recognise that there are risks to our income levels during the transition from block contracts to payment by results.

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

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*:
- an 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 governance 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 governance risk rating in quarter 3 2011/12 was due to the Care Quality Commission reporting moderate concerns and imposing compliance actions following its visit to learning disability forensic services at the Ridgeway Unit, Roseberry Park Hospital .

Following a further inspection in March 2012 the Care Quality Commission found that the Trust had addressed these concerns and compliance actions and that Roseberry Park was meeting all the essential standards of quality and safety.

Regulatory interventions

Monitor did not use its formal powers of intervention against the Trust in 2010/11 and 2011/12.

Further information

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

Risk rating performance 2010/11 and 2011/12

	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	Green	Green	Green	Green	Green

	Annual Plan 2011/12	Q1 2011/12	Q2 2011/12	Q3 2011/12	Q4 2011/12
Financial risk rating	4	4	4	4	4
Governance risk rating	Green	Green	Green	Amber-red	Green

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 as they can influence the way our services are delivered and improved. We have developed 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 carer support strategy was launched in 2011 with an action plan to raise awareness and support carers with what they had told us was important to them when caring for a relative using our services.

These are a few examples of how service users and carers have been helping us to continually improve our services:

- attending meetings with Trust staff such as the Mental Health Act committee, pharmacy, psychological therapies, patient and carer information and essential standards reference groups
- involvement in research projects, eg Advance Project study to evaluate the impact on service users, carers and staff on moving to a new psychiatric inpatient facility
- visiting our wards with PALS staff to talk to patients about their experiences of quality and safety standards on the wards
- helping with the recruitment of new staff
- working alongside staff in quality service improvement events
- visiting wards as part of the patient environment action teams to check the cleanliness of our wards
- helping to train student nurses, giving their personal experiences of living with mental health conditions and using our services
- taking part in the medical development programme, helping to train and recruit doctors
- reviewing new patient and carer information as part of a readers panel
- being part of learning disability reference groups supported by advocacy involved in the recruitment of staff, a programme of staff training and clinical research.

Public consultations

The Trust worked closely with NHS Tees on proposals to change the way we provide services for older people in Stockton-on-Tees and we held a formal public consultation which ran from 9 February to 9 May 2012. A final decision is expected at the end of May.

In July 2011, following a dramatic reduction in bed occupancy, the Trust temporarily closed the 22 bed inpatient unit at Lustrum Vale in Stockton-on-Tees (see page 23). Since then patients have been admitted to Roseberry Park in Middlesbrough. The proposal was to make this change permanent, enabling us to not only save money but also, more importantly, to further improve mental health services for the people of Stockton-on-Tees. We will continue to invest in our community teams and make the best use of this modern, purpose-built inpatient unit (rehabilitation inpatient services have already moved into Lustrum Vale).

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.

The LINks have continued to provide valuable feedback on our services through survey work and by attending focussed meetings. The Trust has also worked with some of our LINKs colleagues to jointly run events in different locations to share information.

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 services. People contact PALS using the free phone, send messages to the PALS mobile, send emails and write letters raising concerns or comments about the services. Between 1 April 2011 and 31 March 2012, 1,126 contacts were recorded and responded to by PALS (this was an increase of 33 contacts from 2010 – 11 when 1,093 contacts were made).

Formal complaints

In 2011 -12 we received 141 written complaints (this was an increase of 16 complaints compared to the 125 complaints received in 2010 -11).

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 four times by the Ombudsman concerning requests for information relating to Trust complaints, they decided not to investigate three of the complaints further. At the end of the year there was one outstanding case 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** - staff were reminded of the need to keep updated on all issues related to children and young persons' needs by regularly reviewing care documents with parents and carers. Staff were also reminded to remain in contact when in the community by carrying a mobile phone with them.
- **children's and adolescent mental health service** – improving the information and guidance provided to parents of service users who are discharged from the service and who may have a change in their treatment as a result of their discharge; procedures for transfer of care between Trust services to be reviewed to ensure future care is appropriately planned and coordinated.
- **adult mental health services** – improving communication between community mental health teams and in-patient units in relation to hospital transfers and keeping service users updated.
- **forensic learning disability services** – review of the Trust's child visiting policy and documentation to ensure compliance with the policy; staff to ensure families using the child visiting facility to be given an explanation of the facilities available.
- **forensic services** – improving the induction process for all staff, including student nurses in relation to the importance of confidentiality and upholding information governance principles.
- **mental health services for older people** – improving care coordination for service users, agreeing with families how frequently to seek their views, sharing care plans and risk assessments where consent has been gained, ensuring the care coordinator attends all reviews and agreeing specifically which professional will take the lead when more than one organisation is involved in providing care.
- **adult learning disabilities** – to improve care plans to ensure that they formally identify if families have been consulted about medication and that their wishes are documented.

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 the report.

Supporting our staff

At the end of 2011/12 we employed around 5,900 staff (compared to 5,200 at the end of the previous year) including over:

- 240 doctors
- 3,500 nurses
- 550 psychologists and allied health professionals
- 1,000 admin and estates staff

Our workforce is primarily white (94%), which is broadly in line with our local population, and is made up of 75% female and 25% male staff.

Health and wellbeing

The health and wellbeing of our staff continues to be a priority and we are working with our occupational health provider to support staff. Over the last year joint working has improved and this has included the introduction of a revised pre-employment screening process. The annual influenza vaccination campaign also proved successful with more Trust staff being vaccinated than ever before.

In 2011/12 the occupational health service provider took on responsibility for supporting an additional 550 staff from North Yorkshire and this transition was well handled. The number of missed appointments and late cancellations continue to be a concern and further joint work is underway to address these concerns.

Sickness absence figures for 2011 (calendar year)

(statistics produced by Department of Health Information Centre)

Average of 12 months (Jan-Dec 2011)	Average full time equivalent (FTE) staff in post	FTE days available	FTE days lost to sickness absence	Average sick days per FTE
5.5%	4,785	1,076,625	59,289	12.4

Reducing the level of sickness absence within the Trust to 5% remains a challenging target for us and the at end of March 2012 our rate was 5.3%

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. In 2011 we reviewed our communications strategy and gathered views from staff who, in general, felt we communicate well.

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

- team briefing system
- Trust magazine (insight)
- intranet
- weekly e-bulletin
- informal visits by directors and formal board visits

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 74% of staff said they

regularly attended team meetings which included core and/or directorate briefings and 88% of those found the meetings useful. Our intranet (inTouch) is also a vital communication tool and source of information for staff.

Monthly meetings have been held throughout the year between Trust and local staff representatives to ensure that meaningful consultation about key workforce and service issues takes place. Consultations about proposed organisational changes, changes to workforce policies and procedures and terms and conditions issues have taken place during the last year. Such consultations have taken place at both Trust and individual service level. This two-way flow of information has helped to inform and improve decisions made.

The Trust's quality improvement system is based upon employee participation and throughout the year numerous quality improvement events, directly involving hundreds of employees, of all levels and types, have taken place across the Trust. A Trust-wide ideas scheme has been introduced that encourages and recognises those staff who suggest ways of improving any aspect of what we do.

We continue to use a range of ways such as project groups, team meetings, and focus groups to involve staff in Trust wide and local developments that impact directly on them.

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 became disabled. It also included guidance on mental wellbeing in the workplace and provides a framework for addressing issues concerning disability. The policy was part of the Trust's commitment to ensuring that all employees receive, and can access, appropriate support and guidance to help them remain and perform well at work. Improvements to the health at work policy were made toward the end of 2011/12 resulting in a new management of sickness absence procedure being produced that will be implemented during 2012/13.

- The recruitment and selection policy aims to ensure that full and fair consideration is given to all applications for employment including those made by people with a disability or other protected characteristics described by the Equality Act 2010. The policy is based upon national recruitment standards including NHS Employers employment check standards and the Department of Health good practice guidance on the National Health Service (appointment of consultants) regulations 1996. In addition, the policy and Trust practice comply with the Department of Employment 'two ticks' symbol by providing a number of public commitments to disabled people, including a guarantee to interview all applicants with a disability who meet the minimum criteria for a job vacancy and to consider them on their merits.

- 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 policy promotes equity of access and fairness by demonstrating that education, training and access to learning and library/knowledge resources is available on an equitable and increasingly flexible basis to all staff groups in accordance with need and without discrimination.

- The equality and diversity policy aims to ensure that we meet the Equality Act 2010 aims of eliminating discrimination, harassment and victimisation along with fostering good relationships between people who share a relevant protected characteristic under the Act and those who do not. Our seven equality objectives include reducing by 50% the number of indicators in the staff survey where staff who have long term health conditions have statistically significantly less favourable responses.

Staff survey

TEWV was among the best performing trusts in over half of the areas which were reviewed in the annual NHS staff survey, which was carried out towards the end of 2011.

Our response rate was 64% which is the same response rate as last year and means, once again, that our return rate was among the highest in the country.

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

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

- Perceptions of effective action from the employer towards violence and harassment (3.75 on a scale of 1-5 compared to 3.56 nationally) **KF27**
- Percentage of staff having equality and diversity training in the last 12 months (83% compared to 53% nationally) **KF36**
- Percentage of staff feeling there are good opportunities to develop their potential at work (55% compared to 42% nationally) **KF10**
- Staff intention to leave (2.38 on a scale of 1-5 compared to 2.61 nationally) **KF33**

Involving and engaging with staff is key to improving patient care and it was therefore particularly pleasing to see that our staff gave us an overall result on staff engagement that placed us in the top 20% of similar type trusts.

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

- Percentage of staff suffering work-related injury in the last 12 months (9% compared with 8% nationally). Our result remained the same as last year. **KF17**
- Percentage of staff receiving experiencing physical violence from patients, relatives or the public in the last 12 months (16% compared with 12% nationally). This is, however, an area that is improving year on year and we have moved out of the worst 20% of trusts for this indicator. **KF23**

The other two bottom ranking scores were:

- Effective team working (3.81 on a scale of 1-5 which was the national average score for this area). **KF6**
- Percentage of staff appraised in last 12 months (83% which was the national average score for this area) **KF12**

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. The results show that there has been improvement in this area although there is still more to do. Our commitment to reducing the incidence of violence and aggression is also reflected in this survey with staff telling us that we are taking effective action.

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. An example of a recent development in this area is the introduction of the employee support officer role (see page 25).

We are currently developing Trust wide and directorate action plans to address areas where we need to improve. The key priorities for next year are likely to be:

- continuing to reduce the levels of violence and aggression against staff
- helping teams to work more effectively
- providing more opportunities for staff to develop their potential at work
- enhancing the ability of immediate managers to support their staff
- improving communication between senior management and other staff
- continuing to improve the experiences at work of disabled and black and minority ethnic staff.

Progress against the local plans is regularly reviewed by directorate management teams. Trust wide actions are included within the workforce development plan and progress is reviewed by the Board of Directors on a quarterly basis.

Summary of Staff Survey Results

	2010-11		2011-12		
	Trust	National Average	Trust	National Average	Trust improvement / Deterioration
Response Rate					
	64%	54%	64%	54%	No change
Top 4 Ranking Scores					
KF27	3.68	3.58	3.75	3.56	Improvement
KF36	63%	47%	83%	53%	Improvement
KF10	55%	45%	55%	42%	No change
KF33	2.46	2.55	2.38	2.61	No change
Bottom 4 Ranking Scores					
KF23	18%	14%	16%	12%	Improvement - decrease in % points
KF17	8%	8%	9%	8%	No change
KF6	3.88	3.80	3.81	3.81	No change
KF12	80%	82%	83%	83%	No change

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 have completed the 2nd year of audits on health, safety and security workbooks (the Trust's health and safety management system) as part of a three year rolling programme across the Trust. The workbooks have now been rolled out, along with training and support, to our new sites and teams in North Yorkshire.

We also ran a business continuity plan exercise and review programme and carried out table top exercises to test and improve the resilience of these plans.

Reducing our carbon footprint

We are 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 52% in March 2012.

The Trust in partnership with our new waste and recycling service providers are committed to eradicating waste to landfill by increasing recycling and the converting of general waste to RDF refuse derived fuels for incineration by renewable power plants.

"You have really been a great support to me through the toughest year of my life."

A service user

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 North East Specialised 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 have been sub-contracted by Care UK for mental health services in prisons in the North East commissioned by the North East Specialist Commissioning Team.

We have continued our joint venture with Mental Health Matters and MIND for Tees IAPT services. We are also lead provider of the joint venture to provide IAPT services in County Durham and Darlington, working with Mental Health Matters and County Durham and Darlington Hospitals NHS Foundation Trust.

We are part of a consortium led by South Staffordshire and Shropshire NHS Foundation Trust to provide 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)

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 13). The strategy reflects the ten key statements of the Monitor quality governance framework.

Following an assessment the Board considers that the Trust meets the best practice set out in the 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 (QuAC) (see page 78). The committee is supported with a network of quality assurance groups in clinical divisions across the service localities and with a number of specialist assurance groups such as safeguarding or infection prevention control.

Improving quality governance

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

- We have established a programme of clinical team inspections using the judgement framework of the Care Quality Commission to monitor compliance with the Essential Standards and validate the evidence clinical staff present to assure quality and safety of clinical care. This is complemented by a series of service user led inspections which focus on patient experience and opinion of the service – this ensures the users of our services are measuring the quality of our services.
- We carried out a robust quality assurance review of the new services we are providing in North Yorkshire and have worked on the resultant development plan to effective conclusion in March 2012. There has been an ongoing quality improvement plan put in place to build on the achievements to date.
- The regular collection of patient views on their experience of care has increased across 50% more areas including community teams. The surveys rate experience against a 'top ten' of quality indicators developed by service users and the information is used to develop actions to improve services.
- We have redesigned and further developed the processes for investigating both incidents and complaints and for planning improvement actions. We have set up systems to monitor progress of improvements following incidents and complaints and achieved 95% completion of change actions this year.
- All clinical divisions complete two quality service reviews across all localities and present findings to the QUAC for debate. The reviews use the CQC outcomes and the quality assurance strategy - the findings from the governance performance data is analysed and put together with the related service developments and improvements. The reviews give the opportunity to present assurance evidence, highlight good practice and present the plans to mitigate any risks and manage challenges to quality and safety.
- The Productive Mental Health Ward programme has been implemented on a wide range of in-patient areas to give a focus to monitoring service delivery and performance of standard work. This promotes clinical effectiveness and consistency of positive practice.
- We have worked with our commissioners to establish quarterly reviews of quality indicators through a structured Clinical Quality Review process at locality level. This facilitates the analysis of the quality information we collect and gives the opportunity to look behind the data, relate data to more qualitative descriptions of care delivery and combine data to present a more comprehensive view of service quality.
- We have focused further improvement on the information governance sequences and raised the outcome scores despite the senior risk owner structures needing to be re-designed. 95% of staff completed the national training programme and a significant number of service record systems reviews have been implemented to improve the quality assurance of clinical records.
- Our safeguarding teams have implemented performance monitoring systems to ensure assurance information is available that means we can review concerns raised and understand any patterns or trends. In addition a rapid process improvement workshop resulted in a new system of reporting and progressing vulnerable adult concerns. This will be 'rolled out' across other localities once testing complete.
- The clinical audit team and all their operational process have been realigned to ensure the audit resources are focused in the areas to monitor the mitigation of risk and assure clinical effectiveness.

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

Research and development

Our aim is to improve the quality of care we deliver through research and we have continued over the last year to rapidly increase our participation in large scale clinical research. In addition, our strategic shift towards leading novel research has resulted in collaboration on an increasing number of successful major research bids.

We are now supporting a significant portfolio of national scale research and have built on collaborative partnerships with the Mental Health Research Network and other National Institute of Health Research networks. This collaboration has enabled us to embed a culture of a research across all our localities and divisions, including within Harrogate, Hambleton and Richmondshire.

As external recognition of recent progress, the Trust won the first ever National HSJ Research Culture award (see page 23). The judges commended the integrated working of our R&D staff with clinical research networks, success in the challenging circumstances of embedding across dispersed sites of a wide geography, the senior level commitment to making research core business and the resulting growth in research activity within a short time. This success, representative of the firm commitment placed on making research core business within the Trust, has reached a wide audience and is presenting ongoing collaborative opportunity for the Trust.

The growing participation in clinical research through 2011/12, which includes several multi-site large scale trials of a higher degree of complexity, reflects the Trust's firm commitment to improving the quality of care we provide as well as to contributing to the broader goals of mental health research. National Institute for Health Research (NIHR) research studies currently active within the Trust span psychosis and attention deficit hyperactivity disorder (ADHD), addictions, drug safety, genetics and mental ill health, forensic mental health, with a substantial involvement in affective disorder and mental health services research. A significant milestone of 2011/12 has been our first ever recruitment of Trust patients to an industry sponsored study. The research study of a complex injectable antipsychotic treatment involved development of a research pharmacy facility and early success has consolidated plans for further collaboration with pharmaceutical industry to address key areas of unmet need for our service users.

Over 500 participants from the Trust have been engaged in national research this year across 40 large scale multi-site studies, more than double the number of studies and a 20% increase in participants reported for the preceding year. This is clear evidence of our commitment to contributing to the evidence base for improving outcomes for the people who use our services.

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. This approach is exemplified by a study run in partnership with Durham University which has conducted a comprehensive evaluation of staff, user and carer experience of the move to the new Roseberry Park in Middlesbrough, funded by the NIHR Physical Environment Programme. The resulting new knowledge, fully informed by user and carers, is of significance across the Trust and broader NHS organisation in informing decisions which influence future in-patient facility development.

Our collaborative partnership with Durham University continues to develop, with research progress reported across a number of areas of shared interest such as primary care mental health, evaluation of psychological interventions in young people and prescribing quality and safety and genetics of mental ill health. From this collaboration, three major external grant successes have been achieved during 2011/12 which will fund the study of the use of Lamotrigine in borderline personality disorder, brief interventions for primary care depression in older people and effectiveness of naltrexone implants for heroin addiction.

Our clinicians have published articles this year in a range of high quality journals, amongst them 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.

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

There were no reportable SUIs involving data loss or confidentiality breach's in 2011/12 (categories 3-5).

The table opposite shows a summary of other personal data related incidents in 2011/12 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	0
IV	Unauthorised disclosure (fax sent to incorrect address)	1
V	Other	3

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 2011/12. This is the fourth Quality Report we have produced and it tells you what we have done about improving the quality of services in 2011/12 and how we intend to further improve the quality of our services in 2012/13.

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 we provide excellent services, working with the individual users of our services and their carers to promote recovery and wellbeing*, by:

- delivering services that are safe, effective and responsive
- ensuring our service users and their carers believe they have had a good experience and feel better
- offering our service users choices of personalised care and treatment, with no unnecessary transfers and delays, and ensuring service users are kept informed of their agreed treatment plan and options
- helping and supporting our service users to achieve a self-determined and functioning lifestyle

In doing so, we aim *to continuously improve the quality and value of our work*, by:

- using the TEWV quality improvement system (QIS) throughout the Trust to deliver continuous improvement in the quality and value of our services
- ensuring the Trust and its staff only do things that add value for our customers
- delivering services that are evidence-based and clinically cost-effective
- promoting a culture of actively challenging and reporting unsafe practice and quickly learning when we get it wrong; thus improving patient safety throughout the organisation
- making best use of quality indicators and outcome measures

These commitments and aspirations are embedded within the Trust's mission, vision and strategic goals.

During 2011/12 we have continued to make good progress on improving the quality of services that we provide. This was recognised externally during the year when we won a number of prestigious awards, in particular:

- We were named **Mental Health Services Provider of the Year 2011 by the Royal College of Psychiatrists**. The judges said:

  "The Trust demonstrated improvement in quality over a wide range of services through innovative practice. We were particularly impressed by their promotion of mental health awareness and meaningful service user involvement at all levels of the organisation."

- We received a **Health Service Journal (HSJ) Award for Innovation in Mental Health for our Quality Improvement System (TEWV QIS)**. This award recognised the Trust's success in embedding a culture of continuous improvement enabling staff to reduce waste whilst continuing to deliver high quality services.
- The Trust received a **Health Service Journal (HSJ) Award for Research Culture**. This award recognised the Trust's work to contribute to worldwide mental health research and further improve the quality of its own services and care locally.
- Dr Angus Bell, our Senior Clinical Director for adult services, was named **Medical Manager / Leader of the Year 2011 by the Royal College of Psychiatrists**. The judges said:

  "Dr Bell has demonstrated the implementation of management theory into practice, resulting in clearly evidenced improvements in service quality and efficiency. His approach includes the innovative use of models from outside healthcare. The inpatient pathway has dramatically improved through increased frequency of patient reviews, resulting in shorter admissions and fewer violent incidents."

We continue to drive improvements in the quality of our services through using the TEWV QIS and by changing the way we deliver services. Some examples of what we have achieved during 2011/12 are:

- An improvement workshop held across adult mental health inpatient, crisis and community teams in Scarborough, Whitby and Ryedale has led to the introduction of a range of standard ways of working and the elimination of many

"I will endeavour to emulate the values which have been demonstrated by the team. They are caring, compassionate and respectful to patients and workers alike, motivated and committed to their occupation and it was both a pleasure and privilege to work with them."

A student nurse

activities which did not add value to the patient. By improving our assessment, caseload management and communication, the service has reduced lengths of inpatient stays, reduced the time people wait for a first and second appointment with the community teams and improved access to crisis services.

- We have improved the processes for assessment, care planning and discharge for community psychosis services for adults in Redcar & Cleveland. In particular, waiting times from referral to first contact have reduced from 16 to 4 days; the number of patients waiting to be given a first appointment date has reduced from 103 to 0; and the proportion of people who do not attend their appointments, impacting both on the effectiveness and efficiency of care we provide, has reduced from 4% to 0%.
- Community mental health teams for older people in Stockton have reduced the average time from referral to first face to face contact to 4 days and the average time from referral to assessment from 24 days to 8.4 days. As a result, the team is now able to offer next day appointments. This practice is currently being shared across South Tees where an average waiting time of 8 days is currently being achieved.
- A new role of physical care practitioner has been created in adult mental health inpatient services. Physical care practitioners are staff dedicated to addressing physical health needs and promoting healthy lifestyles. This new role will deliver evidence-based physical health interventions and health promotion as well as supporting the service in the overall planning of care.
- In South Durham mental health inpatient services for older people have been reconfigured to enable us to provide specialist inpatient care to those patients with a functional illness and those with an organic illness. This is supported by an enhanced community service. This change has reduced waiting times, reduced the time from referral to diagnosis and treatment, and enabled services to provide tailored levels of support for people in their own homes. In Teesside, using the learning from South Durham, we have improved admission and discharge processes and reduced the number of people staying in hospital longer than they need to.
- We have enhanced our liaison with acute hospitals and now provide designated psychiatrist sessions to the acute hospitals with waiting times from referral to assessment reduced from an average of 5 days to 2 days. Urgent referrals are now assessed within 24 working hours.
- We have completed a pilot in South Tees to increase specialist mental health support for older people in care homes. This has halved the number of mental health admissions to hospital from care homes and reduced by 20% the number of care home residents prescribed anti-psychotic medication for challenging behaviour. Due to the success of the pilot future funding has been agreed to continue this work.

- We have continued the development of the dementia pathway which follows the published NICE guidance. In Teesside joint work with the South Tees Hospitals NHS Foundation Trust now means computerised tomography (CT) scanning, a key part of the diagnostic process, can take as little as six days from first appointment with the memory clinic.

It is always pleasing to have the quality of our services recognised by external assessments and some examples of this in 2011/12 include:

- Our assessment and treatment wards in adult mental health services have received accreditation from the Royal College of Psychiatrists Accreditation for Acute Wards.
- Our electro-convulsive treatment (ECT) suites in adult mental health services in Tees have received accreditation from the Royal College of Psychiatrists Accreditation of Electro-Convulsive Treatment Suites.
- We have received recognition from the National Patient Safety Agency regarding our work on falls by service users which has resulted in significant improvements. In mental health services for older people in 2011, falls resulting in a fractured neck of femur reduced by two-thirds, and the overall falls rate was reduced by one-half.
- Our mental health services for older people achieved the Excellence in Practice Accreditation Scheme. This scheme assessed the service over six categories: working in organisations; collaborative working; user focused care; performance management; measuring efficiency and effectiveness; continuous quality improvement. All inpatient and community teams in County Durham, Darlington and Tees achieved the maximum 5 stars.
- The early intervention in psychosis team in South Durham was highly commended in the Nursing Times Team of the Year Awards.

However, we know that we do not always get it right for all of our service users and their carers. For example, the Care Quality Commission (CQC) inspections of our learning disability services in 2011/12 highlighted a number of concerns. These concerns relate mainly to specific policy and procedures that may impact on the experience of our service users and carers rather than highlighting any significant risk to the safety of patients or the effectiveness of the care they receive. We know we cannot afford to be complacent and we recognise that we need to remain focused on driving up standards across the whole Trust. That is why we continue to listen, to learn and 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:

- Section 2 – information on how we have improved in the areas of quality we identified as important for 2011/12, the required statements of assurance from the Board and our priorities for improvement in 2012/13.
- Section 3 – further information on how we have performed in 2011/12 against our key quality metrics and national targets.

It should be noted that the content of this Report refers to services within County Durham, Darlington, Teesside, Scarborough, Whitby and Ryedale only and does not cover the Trust's services in Hambleton, Richmondshire and Harrogate. The is because the consultation and selection of quality priorities and indicators for 2011/12 preceded the Trust's acquisition of services in Hambleton, Richmondshire and Harrogate which began on the 1st June 2011. However, our new areas in North Yorkshire were involved in the process to agree the quality priorities and indictors for 2012/13, and hence, our Quality Report for 2012/13 will be inclusive of Hambleton, Richmondshire and Harrogate.

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 in on page 66. This is further supported by the signed limited assurance report provided by our external auditors on the content of the 2011/12 Quality Report which is included on page 67.

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 e-mailing either myself at martinbarkley@nhs.net, or Sharon Pickering (Director of Planning & Performance) at sharon.pickering1@nhs.net

Martin Barkley
Chief Executive

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

2011/12 Priorities for improvement – how did we do?

As part of our 2010/11 Quality Report the Board of Directors agreed five quality priorities to be addressed in 2011/12.

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

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

Priority 3: To implement lessons learnt from serious untoward incidents and complaints.

Priority 4: To improve the quality of the crisis services including service user satisfaction.

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

Progress has been made against these five priorities and the following section provides details. It is important to note that the achievement of our aims should not be seen as the end point. These aims are often a key milestone in a journey of quality improvement and further work will continue to embed good practice and deliver real improvements in experience and outcomes for our service users. The green boxes throughout this section are examples of the impact on our service users of what we have done.

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 31st March 2012.

In Redcar & Cleveland and Darlington our service users and carers said …'we don't get copies of our care plans'.

In response….we have improved our systems so everyone gets a copy of their care plan after an initial assessment and any subsequent review.

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 the start of 2011/12, we did 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 changes to make their experience better.

What we have achieved in 2011/12:
We are pleased to report this aim has been **fully** met.

We have increased the number of service users who have responded to our request for feedback on their experience from **1,147** in 2010/11 to **3,054** in 2011/12. This is an increase of **1,907** responses.

We have therefore increased the number of service users who were asked about their experience by 166% by 31st March 2012 compared to the target of 50%.

In forensic services our service users and carers said …'we want more opportunity to take leave'

In response….we have developed a standard process for taking leave and as a direct result four patients from the forensic learning disability service have had unescorted leave within the secure perimeter of the hospital – the first time this has happened since the move to Roseberry Park in 2010.

What we did in 2011/12 to achieve our aim:

- We identified and published a baseline of the numbers of service users who were asked about their experience and the methodologies we used in 2010/11.
- We identified and agreed the methodologies to be piloted to capture service user experience in community services and began to pilot these.
- We developed a menu of all the different ways used to capture service user experience appropriate for use with different groups of service users.
- We developed a regular reporting structure to ensure survey response rates and the results of service user experience surveys are being monitored.

In Oak and Elm Wards at West Park and Stockdale Ward at Roseberry Park our service users and carers said.... 'there is not enough to do'

In response…. we asked service users what they want and we purchased X-Box and Wii games consoles and board games. Occupational therapists are regularly attending the ward community meeting, including where possible at weekends. An improvement event is planned for 2012/13 with service users to look into developing and improving opportunities for meaningful activities on inpatient units.

- We ensured service user views that are gathered are fed back to staff on wards and in teams quickly so that they can address any issues that have been raised.
- We completed the roll out of the electronic system used to collect service user experience across all adult mental health, functional mental health services for older people and forensic service inpatient areas in Durham, Darlington and Tees.
- We have produced an annual evaluation report on the findings from the service user experience surveys and uptake numbers.
- We evaluated the community pilot project and through the annual business planning process have developed recommendations for next steps to be taken in 2012/13.

What we plan to do in 2012/13:
Whilst we have met our aim for this priority and have made real progress in 2011/12 we know there is still more that we need to do. This theme has, therefore, been chosen again as a quality priority for our Quality Report for 2012/13 (see priority 2 for 2012/13).

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 31st March 2012.

Why this is important:
We know that when someone is transferred from one service to another or from one team to another the service user is at greater risk. 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. In 2011/12 we wanted to build on what we did in 2010/11 and expand this to all transfers of care, not just discharges from inpatient services. This would ensure all service users are transferred in a safe and effective way.

What we have achieved in 2011/12:
We are pleased to report this aim has been **fully** met.

In 2010/11, the number of serious untoward incidents with actions for improving transfers of care was 10.

Following our action….no serious untoward incidents in 2011/12 identified transfers of care as a contributing factor to the incident

In September 2011 and March 2012 we audited our transfers of care. In September 2011, for the 372 audit lines across a sample of 30 cases, **34%** (126) met the agreed quality standards. In March 2012, for the 227 audit lines across a sample of 20 cases, **67%** (151) met the agreed quality standards.

We have therefore:
Improved our compliance against the agreed quality standards by **33%** against the target of **10%**.

What we did in 2011/12 to achieve our aim:

- We developed a regular reporting mechanism to report on the number of Care Programme Approach reviews held prior to transfer and used this to identify the baseline.
- We agreed a set of quality standards to apply to the Care Programme Approach reviews and care plans completed when there is a transfer of care.
- We checked the baseline quality of Care Programme Approach reviews and care plans at transfer by undertaking an audit of reviews and care plans against the agreed quality standards. This included the involvement of service users, carers and all relevant professionals.
- In response to the results of the audit, we developed an action plan to address key findings and started the implementation of the action plans.
- We evaluated the impact of the implementation of the action plan by further spot checks.

The four agreed quality standards that were routinely not met in the initial audit, but as a result of the actions implemented were routinely met in the re-audit and contributed to the 52% improvement, were:

- transfers of care to be preceded by a meeting / discussion
- full involvement of service users and relevant teams/agencies in transfers
- the outcome to be recorded on the care plan review document on PARIS, the Trust's electronic patient record

- documentary evidence that the service user and carers were aware of their new care co-ordinator/lead professional and their contact details prior to the transfer

What we plan to do in 2012/13:
We recognise that when our services users transfer from one team to another this can be a difficult time. It is important that it is done appropriately and we have, therefore, carried forward this theme as a quality priority for our Quality Report for 2012/13 (see Priority 3 for 2012/13).

Priority 3: Implementing lessons learnt from serious untoward incidents and complaints

Our aim:
To ensure 90% of the actions agreed in response to the reviews of serious untoward incidents and complaints are implemented on time by 31st 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 strive 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 have achieved in 2011/12:
We are pleased to report this aim has been **fully** met.

In 2011/12, 90.3% (430) of planned actions in response to reviews of serious untoward incidents and 95.8% (46) of planned actions in response to complaints were delivered within their agreed deadline against the target of 90%.

This is a significant improvement on what was achieved in 2010/11.

A key lesson learnt from our complaints in adult mental health in 2011/12 is…

In response to feedback about service users' access to telephones on inpatient wards and their ability to communicate easily and safely with their carers, family and friends, procedures have been reviewed and staff made aware of the options service users on in-patient wards have for making and receiving telephone calls.

What we did in 2011/12 to achieve our aim:
- We tested the safety systems developed in 2010/11 for the most serious incident reporting, investigations and complaints in Teesside, Durham and Darlington. This included incidents such as:
  - serious untoward incidents, e.g. deaths or permanent damage or significant 'near misses'
  - 'near misses' and reversible harm
- We identified what would be required to extend the implementation of safety systems for less serious incidents.

A key lesson learnt from our serious untoward incidents in 2011/12 is…

As a result of staffs' access to timely clinical information being identified as a contributing factor to incidents, the Trust has implemented and embedded its electronic patient record (PARIS), and as a consequence serious untoward incidents due to clinical record keeping have reduced.

- We implemented the agreed safety systems in Teesside, Durham and Darlington.
- We developed a system where we can analyse the issues being highlighted in complaints, claims and incidents and identify common themes that need to be addressed.
- We developed and tested a system for collating and disseminating lessons learnt on a monthly basis including the use of 'stories' and scenarios about incidents and complaints.
- We reviewed outcomes using a consistent model which will be included in our future audit programme for 2012/13.
- We established a quarterly patient safety team report to the Trust's quality and assurance committee (QuAC) with feedback provided to clinical services.
- We explored existing patient safety systems in North Yorkshire and identified the work required to ensure consistency with existing arrangements in Durham, Darlington and Teesside.
- We implemented safety systems in North Yorkshire services.

What we plan to do in 2012/13:
This theme has not been chosen as a quality priority in our Quality Report for 2012/13. However, we will continue to embed our culture and systems for recognising, acting on and learning from serious untoward incidents and complaints. This will remain a key issue for the Trust and will be routinely monitored by the Trust's QuAC.

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 31st March 2012.

Why this is important:

Our review of serious untoward incidents, complaints and feedback from service users, carers, GPs and Local Involvement Networks (LINks) in 2010/11 indicated that we did not have consistent quality across our crisis services. 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, therefore, essential.

What we did in 2011/12:

In 2011/12, the Trust carried out a baseline satisfaction survey of people using its crisis services.

The results of this survey were:

	Baseline*
Satisfied	33% (5)
Satisfied with suggestions for improvement	20% (3)
Dissatisfied	40% (6)
Not possible to determine	7% (1)

** Performed Aug 2011; Number of Surveys Returned =15*

Although over half of service users surveyed (**53%**) were 'satisfied' or 'satisfied with suggestions for improvement', there is a significant proportion (**40%**) who were dissatisfied with their experience. The results of the survey, and further findings from the Trust's GP survey, local staff focus groups, a MIND review and Local Involvement Networks reports identified some important feedback.

In summary, our service users, carers and partner organisations said that:

- contact was sometimes too late and that mental distress could have been averted or reduced by earlier/speedier contact
- staff can appear to be unhelpful or unresponsive to concerns expressed by service users, carers, and staff from other organisations
- there appears to be gaps between what services users and carers expect and what the service can realistically provide
- there is a perception that the service may be under-resourced to cope with peaks in demand and operating 24/7
- there is a perception that some crisis teams will support service users with 'other crises' which are not mental health related and perhaps not 'urgent', whereas other teams will prioritise on urgent mental health crisis. This perceived inconsistency can lead to disappointment by service users

The key issues that our service users, carers and partner organisations said we should address were:

- crisis teams need to have a single point of contact / helpline
- we need to improve how crisis services communicate with services users, carers and our partner organisations

In 2010/11, the number of issues raised by service users and carers with the Trusts' patient advice and liaison service (PALS) and the number of complaints regarding crisis services was 45.

Following our action….the number in 2011/12 fell to 28.

- we need to communicate better to our service users, carers and partner organisations what our crisis teams do and how they support people in crisis
- our community services need to provide more early intervention and prevention, e.g. Mental Health First Aid, building resilience training, to help avoid crises
- we need to improve our crisis out of hours cover with teams visiting, where appropriate, more people in their homes
- we need to consider more access to 'safe-house' facilities / crisis beds

When we started to address this priority it became clear from our initial investigations that more fundamental and urgent change was required rather than that originally planned in our 2010/11 Quality Report. The aim to improve satisfaction by 10% is still

relevant. However, we recognised that delivering this would not be enough. We decided to undertake a comprehensive review of our crisis services led by the Trust's Chief Operating Officer. Given the increased scope of the review we decided that we needed to extend the timescales, and therefore, we revised the original plan. The revised plan was to complete the review and implement the resulting actions over two years rather than one.

The following actions were delivered in 2011/12, which is now year one of this two-year programme of change:

- We collated and analysed a wide range of performance data relating to all the crisis teams including feedback and opinion.
- We undertook improvement workshops with crisis services in Durham and Redcar & Cleveland. This led to the introduction of a 'shift coordinator' role, a range of standard processes and the elimination of many processes which did not add value for the patient.
- In Durham, for example, the average time from referral to assessment was reduced from 5 hours 36 minutes to 4 hours.
- In Redcar & Cleveland the team increased the percentage of crisis episodes resolved in 14 days from 56% to 82% which has created capacity within the team to respond to more people in crisis.
- We have started to develop a profile of an 'optimal' crisis team and a standard service model.
- We have started to develop a standard operating policy.
- We reviewed our shift patterns and are developing standard working arrangements to ensure staff availability matches referral / demand.
- We reviewed our 'out of hours' provision and are developing a model for new joint working arrangements across the teams in County Durham & Darlington and Tees.

What we have achieved in 2011/12:
At the end of 2011/12, we undertook a further assessment of satisfaction of service users and carers.

The results of this survey were:

	Baseline*	Re-Survey**
Satisfied	33% (5)	80% (4)
Satisfied with suggestions for improvement	20% (3)	20% (1)
Dissatisfied	40% (6)	0% (0)
Not possible to determine	7% (1)	0% (0)

** Performed Aug 2011; Number of Surveys Returned =15*
*** Performed March 2012; Number of Surveys Returned =5*

The re-survey in March 2012 shows an improvement with those 'satisfied' or 'satisfied with suggestions for improvement' increasing from **53%** to **100%**. However, this result is not reflected in the actual numbers satisfied due to the small sample of only 5 responses that were returned.

What we plan to do in 2012/13:
In the second year of the review we plan to further embed these changes. In 2012/13 we will:

- launch the new service model and standard operating policy across the Trust which will include standard working arrangements, revised shift patterns, increased access to medical cover, new arrangements for 'out of hours' provision, risk management, skill mix, core competencies and training
- develop and launch an 'out of hours' telephone helpline and telephone triage service to release staff out of hours to focus on crisis work
- consider the implementation of the Rapid Assessment Interface & Discharge (RAID) model developed in Birmingham where psychiatric liaison teams address crisis in A&E Departments. This will enable crisis teams to withdraw from A&E in normal working hours (i.e. 9am-10pm) and to provide more home based treatment
- increase crisis team links with the community, working with regular forums and Local Involvement Networks / Local HealthWatch to develop the role of all community organisations in avoiding / addressing crisis
- increase the awareness of the Trust's crisis services with our stakeholders.
- revise the geographic locations of the crisis teams, particularly in North Durham

Whilst the second year of this review has not been identified as a priority in the Quality Report for 2012/13, it is contained within Trust business plan for 2012/15. Progress against the actions will be monitored by the Trust's Executive Management Team and the Trust Board on a quarterly basis.

"A great place to work or receive treatment."

2011 National NHS staff survey

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 31st 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 together with 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 have achieved in 2011/12:

During March 2012 we audited our clinical risk assessments. Of the 253 cases sampled for the audit, **92%** of the agreed expected standards were met. Whilst this does not meet the aim of 100%, it does represent an improvement of **11%** compared to the position in September 2011.

The chart above shows that all services made an improvement during 2011/12. Both substance misuse services and forensic services met **100%** of the standards by March 2012. The lowest performance was in adult learning disabilities who achieved 82% of the standards in March 2012. However, this service did make the greatest improvement, **19%**, during the year.

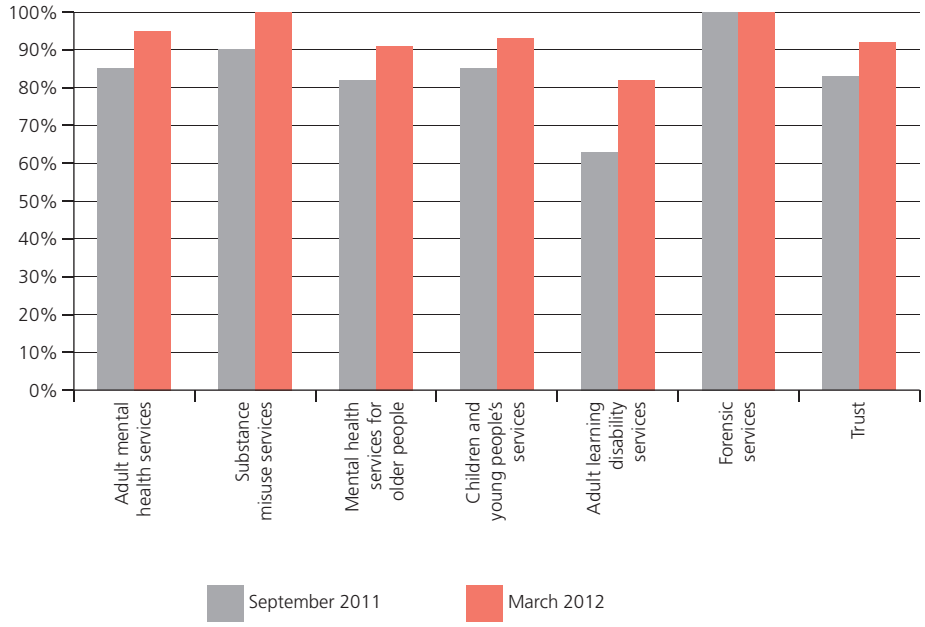
The next chart also shows that we scored between **91%** and **94%** for 6 of the 7 standards in March 2012. For standard 4, 'all sources of information for the clinical risk assessment to be identified', we achieved **87%**. However, this was the standard that we made the greatest improvement in with an increase of **19%** compared to the September 2011 position.

What we did in 2011/12:

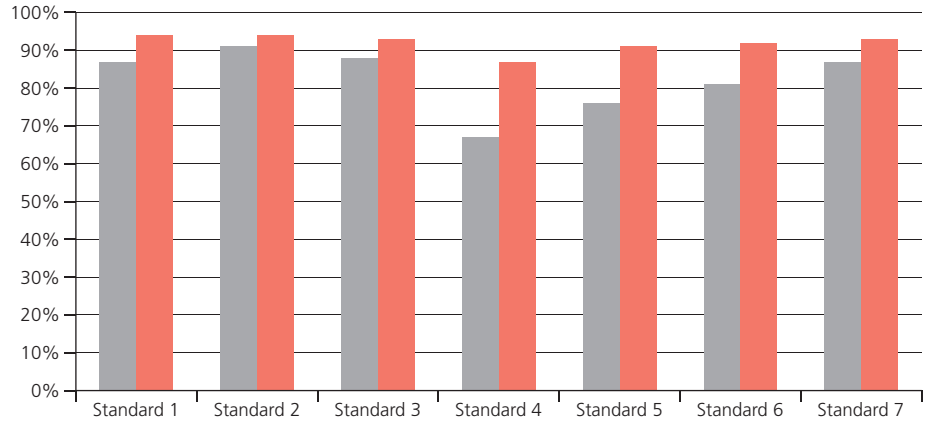
In working towards this aim:

- We agreed acceptable standards for the completion of clinical risk assessments, to include quality and timescales for completion.
- We undertook an audit to establish a baseline position against those standards and identify issues which required action.
- We established a monthly monitoring process to check completion within the agreed timescales.

Percentage of Standards Achieved by Services



Percentage Achieved in each Standard across the Trust



Standard 1.	A risk assessment has been undertaken and documented at the most recent Care Programme Approach/standard care review meeting or critical point in the service user's journey.
Standard 2.	The appropriate registered assessment document been used.
Standard 3.	The risk assessment documents historical and current risk factors.
Standard 4.	All sources of information are identified.
Standard 5.	The risk assessment is up to date, signed and authorised.
Standard 6.	The clinical risk assessment includes a risk summary which reflects the information and risks identified in the assessment.
Standard 7.	If a risk summary is included, the risk summary informs the care / intervention plan.

"Under sometimes very distressing circumstances the ward gave me an impression of warmth, kindness and security. Each and every member of staff, including domestic and ancillary seem to play a part in creating this success."

A service user's daughter

- We developed and implemented an action plan to address any areas of non compliance. Some of the key actions implemented were:
  - We addressed training needs using a new e-learning package and have recently expanded this into services in North Yorkshire
  - We established continuous monitoring and action planning in response to compliance issues.
- We carried out a re-audit to determine if we had 100% compliance against the agreed standards.

What we plan to do in 2012/13:
Although the aim for this priority was not fully met in 2011/12, significant improvements were made both at a Trust level and notably in some services. This theme has not been chosen as a quality priority in our Quality Report for 2012/13, however, the Trust will continue to improve its clinical risk management practices towards achieving the 100% target to ensure we are providing excellent services.

In 2012/13 we will:

- use root cause analysis techniques to identify any further issues from the re-audit
- implement an extensive training programme for risk assessment and management and the use of specialist risk assessment tools
- ensure that the actions from 2011/12 and 2012/13 are embedded in everyday practice using PARIS, the Trust's electronic patient record

Further improvement work will ensure that all services achieve all the agreed standards with additional effort in those areas where performance is lower e.g. adult learning disabilities and Trust-wide performance against standard 4.

Statements of Assurance from the Board 2011/12

The Department of Health and Monitor require us to include our position against a number of mandated statements to provide assurance from the Board of Directors on progress made on key areas of quality in 2011/12. In some cases additional information is supplied and where this is the case this is provided in italic.

Review of services

During 2011/12 TEWV provided and/or sub-contracted **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 2011/12 represents **97** per cent of the total income generated from the provision of NHS services by TEWV for 2011/12.

The review of services is undertaken by the Quality and Assurance Committee (QuAC) and includes a quarterly report from each clinical service. This report includes information on:

- *patient safety – including information on incidents, SUIs, levels of violence and aggression, medication incidents, implementation of safety alerts*
- *clinical effectiveness – including information on the implementation of NICE guidance and the results of clinical audits*
- *patient experience – including information on complaints, claims, and PALs contacts*
- *compliance with the Care Quality Commission Essential Standards of Safety and Quality*

In addition to the formal report, the services deliver a presentation on any particular areas of work that have been undertaken to improve quality or invite a service user to talk to the QuAC on the experience they have had and what they think we could do to improve.

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.

Each service also has a 'Performance Dashboard' which contains a 'balanced' overview of the performance of the service. This 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.

Finally, on a quarterly basis, all the services review their quality and clinical assurance performance and report to the relevant commissioners either through a clinical quality review process or a written assurance pack. The information collated includes:

- *patient safety – a thematic analysis of serious incidents, actions taken for improvement, safety alerts, infection prevention and control audit and incident data, medicines management review, safeguarding audits and an action plan update for children and adults*
- *Care Quality Commission compliance – details of monthly quality risk profile reports and feedback from CQC inspections and reviews*
- *patient experience – details of lessons learned from complaints, patient feedback / surveys and patient reported outcomes*
- *clinical audit and evidence based practice information*

Participation in clinical audits and national confidential inquiries

During 2011/12, **seven** national clinical audits and **one** national confidential inquiry covered NHS services that TEWV provides.

During 2011/12, TEWV participated in **57%** of national clinical audits and **100%** of 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 was eligible to participate in during 2011/12 are as follows:

- POMH UK Topic 1 - prescribing high dose and combined antipsychotics on adult acute and psychiatric intensive care wards.
- POMH UK Topic 3 - prescribing high dose and combined antipsychotics on forensic

wards.
- POMH UK Topic 6 - assessment of side effects of depot antipsychotic medication
- POMH UK Topic 7 - monitoring of patients prescribed lithium
- POMH UK Topic 10 - use of antipsychotic medicine in CAMHS
- POMH UK Topic 11 - prescribing of antipsychotics for people with dementia
- National Audit of Schizophrenia (NAS)
- 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 2011/12 are as follows:

- POMH UK Topic 7 - monitoring of patients prescribed lithium
- POMH UK Topic 10 - use of antipsychotic medicine in CAMHS
- POMH UK Topic 11 - prescribing antipsychotic medication for people with dementia
- National Audit of Schizophrenia (NAS)
- National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH)

For POMH UK Topics 1 and 3, the Trust has adopted a local audit approach. The Trust did not participate in POMH UK Topic 6, instead choosing to focus resources and effort on the five national clinical audits and national confidential inquiries above.

The national clinical audits and national confidential inquiries that TEWV participated in, and for which data collection was completed during 2011/12, are listed below alongside the number of cases submitted to each audit or inquiry as a percentage of the number of registered cases required by the terms of the national audit or inquiry.

Audit Title	Cases Submitted	% of the number of registered cases required
POMH UK Topic 7c - monitoring of patients prescribed lithium	862	100%
POMH UK Topic 11 - prescribing antipsychotics for people with dementia	43	100%
National Audit of Schizophrenia (NAS)	100	100%
POMH UK Topic 10 - use of antipsychotic medicine in CAMHS	47	100%
National Confidential Inquiry into Suicide & Homicide by People with Mental Illness	n/k*	98%**

* *Cases are submitted confidentially and directly by individual consultants, and therefore, the number of cases submitted is not known.*

** *Extract from NCI Annual Report July 2011: For the final year of the suicide and homicide analysis we therefore estimate the final number of cases based on data completeness in previous years. Projected figures are based on the average annual return of Inquiry questionnaires, i.e. adjusted to an assumed final figure of 98% for both suicide and homicide. For homicide in Wales, numbers are too small to calculate projected figures. For sudden unexplained deaths, actual figures are shown, including those in the final year. Page 6 Para 2 NCI*

The reports of **four** national clinical audits were reviewed by the provider in 2011/12 and TEVW intends to take the following actions to improve the quality of healthcare provided:

- POMH UK Topic 7c - monitoring of patients prescribed lithium

  Actions:
  - to present a full report to clinical directors and the Chief Operating Officer
  - to produce a summary report and disseminate to all divisions
  - divisions to identify any deficits and implement remedial action
  - to share results with safe medication practice group and drug and therapeutics committee

- POMH Topic 9 - the use of antipsychotic medication in people with learning disabilities

  Actions:
  - to ensure all relevant service users receive blood pressure and electro-physiology monitoring, and where patient's refused blood pressure monitoring, this is to be documented

- POMH UK Topic 11 - prescribing antipsychotics for people with dementia

  Actions:
  - to have a clearly documented indication for treatment
  - to have a documented risk/benefit analysis
  - to ensure that service users and carers are consulted on the risks and benefits
  - to ensure that service users are reviewed for their response to treatment

- National Audit for Psychological Therapies - MHSOP

  Actions:
  - teams to be restructured to address waiting time issues
  - to review reasons for why outcomes measures at pre- and post- therapy have not been undertaken routinely

The reports of **43** local clinical audits were reviewed by the provider in 2011/12 and TEWV intends to take the following actions to improve the quality of healthcare provided. The actions for these are included in **Appendix 1**.

*In addition to those local clinical audits reviewed (i.e. those that were reviewed by the Trust's QuAC), the Trust undertook a further **174** local clinical audits in 2011/12. These clinical audits were led by the services for reasons of service improvement and professional development and were reviewed through the service / professional group governance arrangements.*

Participation in clinical research

The number of patients receiving NHS services provided or subcontracted by TEWV in 2011/12 that were recruited during the period to participate in research approved by a research ethics committee was **1357**.

*Of the 1357, **433** were recruited to National Institute for Health Research portfolio studies. This compares with 374 patients involved as participants in research studies during 2010/11 and 106 in 2009/10. This is a key indicator of the Trust's rapidly increasing involvement with large scale, often complex, national research (e.g. psychosis, attention deficit hyperactivity disorder, addictions, drug safety, forensic mental health, affective disorders and mental health services research).*

The Trust's growing participation in clinical research through 2011/12 reflects our firm commitment to improving the quality of care we provide, as well as contributing to the broader goals of mental health research.

Examples of how we have expanded our participation in clinical research include:

- *In 2011/12 we saw our first ever collaboration in an industry sponsored study of a complex injectable antipsychotic treatment.*
- *We were involved in conducting **83** clinical research studies during 2011/12, completing 23 within the agreed time (and to the agreed recruitment targets.) This compares with 59 and 15 respectively in 2010/11. 38 of these studies were supported by the National Institute for Health Research through its research networks.*
- ***76** members of our clinical staff participated as researchers in studies approved by a Research Ethics Committee, with 22 of these in the role of Principal Investigator for National Institute for Health Research supported studies.*
- ***29** researchers from outside the organisation were granted access under the national Research Passport scheme to perform research with us compared to 13 in 2010/11.*
- *We have continued to develop collaborative partnerships with the Mental Health Research Network and other National Institute of Health Research networks. This collaboration has enabled us to embed the culture of research across all our localities and divisions, including within Harrogate, Hambleton and Richmondshire.*
- *We have continued to build our collaborative partnership with Durham University. We have made progress in a number of areas of shared interest (e.g. primary care mental health, evaluation of psychological interventions in young people and prescribing quality and safety and genetics of mental ill health). From this collaboration, three major external grant successes have been achieved during 2011/12 which will fund the study of the use of Lamotrigine in borderline personality disorder, brief interventions for primary care depression in older people and the effectiveness of Naltrexone implants for heroin addiction.*

We have developed processes to ensure research has led to improvements in quality of care. This has been achieved by ensuring that the design, delivery and findings of research are communicated and discussed by research interest groups, who in turn use the results to influence practice within the Trust. An example of how research has influenced practice and led to improvements in the quality of care is:

- *The Trust has worked with the Mental Health Research Network and other clinical research networks to encourage its service users and carers to participate in research studies. Our aim is to have active involvement in all areas of research from design through to sharing the results. This approach is exemplified by a study run with Durham University which evaluated the service user, carer and staff experience of the move to the new Roseberry Park facility in Middlesbrough. The findings of this study have helped the Trust to better understand what it is about a building, an in-patient ward and a move from one facility to another that influences the experience of service users, carers and staff.*

*In recognition of our work this year the Trust received a **Health Service Journal (HSJ) Award for Research Culture**.*

Goals agreed with commissioners

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

A proportion of TEWV's income in 2011/12 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 2011/12 are available online at www.tewv.nhs.uk/qualitypayments

An overall total of £3,747,316 was available for CQUIN to TEWV in 2011/12 conditional upon achieving quality improvement and innovation goals across all of its CQUINs, and a total of £3,744,990 was received for the associated payment on 2011/12 (nb: subject to final confirmation from commissioners). This compares to £3,254,877 available and £3,069,478 received in 2010/11.

As part of the development and agreement of the 2011/12 mental health contract, discussions were held between the Trust 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.

"You gave me the tools I needed and how to use them so I can get my life back on track. I can honestly say I have never in my life felt so good and in control."

A service user

What others say about the Trust

Registration with the Care Quality Commission (CQC) and periodic / special reviews
TEWV is required to register with the Care Quality Commission and its current registration status is **registered to provide services with no conditions attached**.

The Care Quality Commission has **not taken** enforcement action against TEWV during 1st April 2011 to 31st March 2012.

TEWV has participated in five special reviews or investigations by the Care Quality Commission relating the following areas during 2011/12:

- Lanchester Road Hospital, Durham (included four units with 26 beds for a mix of learning disabilities assessment and treatment and forensic inpatient rehabilitation services).
- 163 Durham Road, Stockton (included three units with 13 beds for a mix of learning disabilities assessment and treatment and short term care services).
- Bankfields Court, Middlesbrough (included six units with 28 beds for a mix of learning disabilities assessment and treatment and short term care services).
- Roseberry Park, Middlesbrough (included five units with 51 beds for learning disability forensic inpatient assessment and treatment and rehabilitation services).
- Church View, Kirkleatham, Redcar (included one unit with eight beds for learning disability long stay / challenging behaviour services).

These special reviews / investigations were all part of the CQC's targeted programme of 150 unannounced inspections of hospitals and care homes that care for people with learning disabilities.

The reports following these special reviews / investigations highlighted three services that meet full compliance requirements. Two services, however, were identified as requiring action.

- *Roseberry Park, Middlesbrough – moderate concerns impacting on compliance.*
- *Church View, Stockton – minor concern which required an improvement action.*

The concerns relate mainly to specific policy and procedures that may impact on the experience of our service users and carers but did not highlight any significant risk to the safety of patients or the effectiveness of the care they receive.

TEWV intends to take the following actions to address the conclusions or requirements reported by the Care Quality Commission. TEWV has made the following progress by 31 March 2012 in taking such actions.

Roseberry Park, Middlesbrough

Outcome 4: care and welfare of people who use services – person centred care.
Concern: essential standard not met – cancellation of service user leave due to staff sickness and vacancies.

Actions:
To consider the issue of leave using an improvement workshop. This will address:
- How leave is monitored and why leave is not occurring.
- How to prioritise leave in light of other urgent client-led needs.
- The development of a standardised processes to ensure alternative arrangements for family leave are established if leave is cancelled due to staff sickness / vacancies.
- A review of our staffing levels to enable leave.

Progress:
- An improvement workshop has been completed on leave. As a result, service users have had unescorted leave within the secure perimeter of the hospital for the first time since the move to Roseberry Park in 2010.
- A leave compact & patient information have been developed and individual wards are monitoring the use of this routinely.
- Guidance has been developed to staff for use when re-arranging family visits.
- A review of our staffing levels to enable leave has been completed

Outcome 4: care and welfare of people who use services – person centred care.
Concern: essential standard not met – monitoring of service users telephone calls.

Actions:
- To review all current risk plans relating to the use and supervision of telecommunication technology.
- All ward managers and responsible clinicians to be instructed that telephone contact is unsupervised unless risks are identified.
- To undertake a spot check of telephone contact arrangements.
- To develop and ratify the policy, assessment, standard process and regular review of individual patients and the use of tele-communications technology.

Progress:
- All current risk plans relating to the use and supervision of telecommunication technology have been reviewed.
- Guidance (including risk assessment) has been developed and disseminated to all wards.
- All ward managers and responsible clinicians have been instructed that telephone contact is unsupervised unless risks are identified.
- Initial checks on telephone arrangements have been completed and a further audit of risk assessments is to be completed.
- A policy, assessment, standard process and regular review for individual patients and the use of tele-communications technology has been developed.

Outcome 4: care and welfare of people who use services – person centred care.

Concern: essential standard not met – the use of punitive approaches and restrictive practices.

Actions:
- To review the approaches taken to inform behavioural interventions to ensure the framework is individualised, non-punitive, non-restrictive and socially enabling.
- To review the mechanisms that promote the inclusion of patients in the design, delivery and review of their care (and how this is recorded).
- To ensure that there are standard processes across the entire service to improve the consistency of practice and effectiveness.

Progress:
- A review of the approaches taken to inform behavioural interventions to ensure the framework is individualised, non-punitive, non-restrictive and socially enabling is currently being undertaken together with an audit of intervention plans.
- A standard of best practice on intervention planning is being developed, to promote user involvement, the availability of accessible information, plans that are non-punitive, non-restrictive and socially enabling.
- The CQUIN target on Care Programme Approach standards are being implemented allowing for greater involvement of service users.
- A quality improvement system project is currently looking at the effectiveness of intervention plans.

Outcome 4: care and welfare of people who use services – person centred care.
Concern: essential standard not met – access to activities and occupational therapist.

Actions:
- To review the level of occupational therapy resources within the service.
- The functioning of the activity centre, including the provision of occupational therapy services, to be the subject of a quality improvement system event.

Progress:
- A review of occupational therapy resources within the service has been completed.
- Occupational therapy representation was included in the improvement event for the Ridgeway activity centre.
- Service user representative attended and participated in the five day quality improvement system event regarding the Ridgeway activity centre.
- The review has increased access to the Ridgeway activity centre.

Outcome 7: safeguarding people who use services from abuse and welfare of people who use services – person centred care.
Concern: essential standard not met – the provider did not have policies and procedures in place to safeguard patients when segregation was used to manage a person's care and treatment.

Actions:
- To update the challenging behaviour policy regarding the use of segregation and seclusion.
- To disseminate the changes, distribute the policy to all clinical areas, and on the Trust's staff intranet (inTouch).
- To audit awareness of amended policy across learning disability forensic services.
- To ensure contact numbers for the internal safeguarding team and the Local Authority are clearly visible to staff, service users and carers.
- To devise a flow chart for the reporting process for safeguarding concerns and display within all areas.
- To ensure ward visits by the Trust adult safeguarding lead to discuss safeguarding issues with staff.
- To undertake a re-audit of staff awareness of the challenging behaviour policy, followed by action plans based on the findings.
- To review the challenging behaviour pathway.

Progress:
- An audit on staff awareness of the challenging behaviour policy including the seclusion procedure has been completed. The audit report has been circulated and training issues for staff were identified within the audit and changes highlighted on the intranet (inTouch).
- A spot check audit was carried out and showed an improvement on safeguarding information being available on wards.
- A flow chart has been devised to show the reporting process for safeguarding concerns and this will be made available to all wards once finalised by safeguarding lead.
- A dedicated member of staff has been identified for the forensic services specifically to address any safeguarding issues.
- A review of the challenging behaviour pathway has commenced.
- A re-audit of staff awareness of the challenging behaviour policy is planned for 2012/13.

Outcome 13: people should be safe and their health and welfare needs met by sufficient numbers of appropriate staff.
Concern: essential standard not met – the provider did not have sufficient numbers of suitably qualified, skilled and experienced staff employed to meet the needs of patients at all times.

Actions:
- To review the advertisement and recruitment processes for staff within the service, to demonstrate a commitment to sustaining staffing levels (registered and health care assistant) to support access to activities and leave.
- To increase flexibility of the nurse bank as part of contingency plans to meet acute variations in service need.
- To recruit a patient involvement support worker to increase the establishment and enhance patient involvement and experience within the service.
- To re-profile the current staffing and recruitment to ensure the service can maintain full establishment levels, allowing for anticipated vacancies, sickness and training needs.
- To performance manage absence due to illness robustly using the health at work policy, and regular monitoring of sickness levels at corporate and service levels.
- To review the ward establishments and skill mix to ensure ability to comply on ongoing basis with outcome 13.

Progress:
- All qualified nursing posts are now fully established. The number of vacancies is minimal at present.
- A rolling recruitment program is in place within the service.
- A visual control board has been developed to monitor trends regarding sickness, vacancies and recruitment. Analysis of retention and attrition rates are being calculated
- A post has been recruited to for a dedicated qualified member of nursing staff to take the lead on implementing the health at work policy.
- An additional post has been recruited to the nurse bank to meet acute variations in service need.
- A Trust-wide review of establishments is to be undertaken by Nursing & Governance.

Church View, Kirkleatham, Redcar

Outcome 4: care and welfare of people who use services – person centred care.
Concern: essential standard met but to maintain this people should have person centred care plans that are reviewed and evaluated.

Actions:
- To establish systems to ensure effective and regular care plan evaluation and reviews are undertaken with the involvement of patients or their representatives.
- To introduce a patient friendly care plan format for all patients.
- To deliver in-house training and clinical supervision systems.
- To undertake a care plan review audit on a monthly basis.
- To ensure the key worker, key worker group and primary nurse are responsible for the timely evaluation and review of individual care plans.
- To ensure the charge nurse and deputy charge nurse oversee all improvement measures.

Progress:

- All service users, carers, and where appropriate family, are involved in the care plan evaluation process with Care Programme Approach (CPA).
- All clients now have a patient friendly care plan.
- In house training and clinical supervision systems are in place.
- All key workers and primary nurses are responsible for the timely evaluation and review of individual care plans and this is monitored through a care plan review / audit which is being undertaken by the Modern Matron on a monthly basis. The first audit showed significant improvement.
- The Charge nurse and Deputy Charge Nurse, along with the Modern Matron, oversee all improvement measures.

Following the initial inspection by the CQC and the Trust's response outlined above, the CQC carried out another unannounced inspection of Roseberry Park on 12th and 13th March 2012. The services the CQC inspected were adult mental health and forensics services (including forensic learning disability services). The CQC reported that the Trust had developed and was implementing an action plan to address the concerns raised at the original visit to Roseberry Park (i.e. staffing and the facilitation of leave) and is now fully compliant with all the CQC standards across the whole of Roseberry Park, including the forensic learning disability services.

The CQC also carried out one planned review at Sandwell Park, Hartlepool during May 2011 where it agreed that Sandwell Park was fully compliant with the required standards.

Quality of data

TEWV submitted records during 2011/12 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: **99.4%** for admitted patient care; **99.9%** for outpatient care.
- Which included the patient's valid General Practitioner Registration Code was **96.14%** for admitted patient care; **97.59%** for outpatient care.

The Trust will be taking the following actions to improve data quality:

- *We have 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, staff, financial and risk 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.*
- *These regular reports 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 between the services and the Chief Operating Officer, the Director of Finance and Information and the Director of Planning and Performance.*
- *Data Quality is discussed each month at an Executive Management Team meeting dedicated to Performance.*

Information governance toolkit attainment levels

TEWV Information Governance Assessment Report score overall score for 2011/12 was **84%** and was graded **satisfactory**.

Payment by results clinical coding audit

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

The Trust does however arrange an independent audit of its clinical coding accuracy by an external auditor as required within the Information Governance Toolkit. In 2011/12, the results for completeness were:

- ***93%** for primary diagnosis*
- ***84%** for secondary diagnosis*

*The results mean that the Trust will post a **level 3** achievement for accuracy.*

TEWV has also been leading the way with the Northern Cluster on the development of Payment by Results. As at the 31st December 2011, the percentages of patients on the inpatient and community caseloads who have been assessed using the cluster tool and received a cluster category are:

	Adult Mental Health	Mental Health Services for Older People
NHS County Durham & Darlington	97.10%	95.90%
NHS Tees	97.10%	95.70%
NHS North Yorkshire & York (Scarborough, Whitby & Ryedale locality only)	95%	100%

2012/13 Priorities for Improvement

The quality and assurance committee (QuAC) is responsible, on behalf of the Board of Directors, for ensuring 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 2012/13 involved a number of stakeholders such as GPs, local authority leads, overview and scrutiny committees, local involvement networks, governors and PCTs. The process was as follows:

- An internal review was undertaken on the findings of serious untoward incidents, other incidents, complaints, patient advice and liaison service contacts and audit findings to identify common themes in terms of where quality needs to be improved.
- An event was held in July 2011 to share these issues with a wide range of stakeholders, including staff, and to get feedback on where they think the quality of services needs to be improved.
- Stakeholders from the following agencies were invited to attend:
  - Overview & Scrutiny Committees (x7)
  - Directors of Adult Social Services (x7)
  - Directors of Children's Social Services (x7)
  - PCT clusters (x3)
  - GP Commissioning Consortia (x16)
  - Local Involvement Networks (LINKs) (x7)
  - Trust Governors – Public (x27)
  - Trust Governors – Appointed (x15) (this included staff governors)

- 29 stakeholders representing 13 agencies attended the event.
- From this workshop ten key quality themes were identified and these were presented to the Board of Directors in October 2011 as part of the identification of the Trust's business planning priorities for 2012/13.
- At its formal meeting in November, the Board of Directors agreed the four quality priorities (from the ten themes identified at the stakeholder workshop) for 2012/13 to be included in the Quality Report. The remaining themes identified by the stakeholders were fed into the business planning process and are included within the Trust's business plan for 2012/15.
- Key responsible leads within the Trust were identified for each priority and an overarching target and detailed actions were then developed.
- A further stakeholder workshop, with the same invitees as shown above, was held in February 2012 where the proposed indicators and actions were shared. The stakeholders gave comments on these which were captured and taken into account in finalising the aims and final action plans for each priority as described below.

Our four priorities for 2012/13 are:

Priority 1: To undertake a comprehensive review of the Care Programme Approach (CPA), care co-ordination process and care planning.
Priority 2: To improve how we gain feedback from patients on their experience and improve our services and the feedback we receive.
Priority 3: To sustain an improvement in all transfers of care with standard work practices and improved communication between professionals implemented.
Priority 4: To develop broader liaison arrangements with acute trusts around physical health needs of mental health patients.

Priority 1: To undertake a comprehensive review of the Care Programme Approach, care co-ordination process and care planning

Our aim:
To improve the Care Programme Approach, care coordination and care planning by improving our compliance against agreed best practice standards by 31st March 2013.

Why this is important:
The Care Programme Approach, care coordination and care planning is critical to the quality of care our patients receive. In 2011/12, our stakeholders fed back that the quality of our current systems is variable and that our processes do not necessarily provide the best outcomes and experience of care. We take this feedback very seriously and agree that to improve the quality of our care we must ensure that our Care Programme Approach, care coordination and care planning is evidenced-based and best practice is used across the whole Trust.

What we will do
We will:
- establish a steering group and working groups with involvement from the nursing and governance directorate, the information department, clinical services, service user and carers, and local authority partners by Q1 12/13
- design a review methodology and produce a project scope and a structure for the working groups by Q1 12/13
- agree a procedure to approve the recommendations, manage the changes and monitor improvement with the services and lead clinicians by Q1 12/13
- establish a baseline position against agreed best practice standards by Q2 12/13
- develop a project plan and a business case, including consultation and engagement strategy, by Q2 12/13
- deliver the project plan, implementing and embedding changes by Q3 12/13
- establish a post-review position against agreed best practice standards by Q4 12/13

Priority 2: To improve how we gain feedback from patients on their experience and improve our services and the feedback we receive

Our aim:
To maintain the number of service users and carers who are asked about their care at 2011/12 levels and demonstrate improvements in the feedback we receive on their experience of care by 31st March 2013.

Why this is important:
As identified in our quality priorities for 2011/12, a key element of our approach to quality is to ensure that the experience of people who use our services is excellent. We have made significant improvements in gathering feedback in 2011/12, however, much of this work has been within specific projects and pilots. Our aim in 2012/13 is not just to ask more people but to ensure we ask service users and carers across all our services and show that we are listening by making changes that improve their experience of our services.

What we will do
We will:
- embed the electronic feedback system across inpatient areas in adult mental health and functional areas of mental health service for older people by Q1 12/13
- be routinely reviewing feedback from inpatient areas in adult mental health and functional areas of mental health service for older people and taking action from Q2 12/13
- undertake a scoping exercise, in consultation with our stakeholders, for capturing the experience of service users and carers in community services by Q2 12/13
- identify options for capturing the experience of service users and carers in community services by Q3 12/13
- propose a solution for capturing the experience of service users and carers in community services by Q4 12/13
- undertake a scoping exercise for gathering feedback using a wide range of approaches from children and young people and people with learning disabilities and their carers / families by Q3 12/13
- report on plans for gathering feedback from children and young people and people with learning disabilities and their carers / families to the Trust's patient experience group by Q4 12/13
- fully implement a system to use patient experience feedback to improve services by Q4 12/13

Priority 3: To sustain an improvement in all transfers of care with standard work practices and improved communication between professionals implemented

Our aim:
To ensure all transfers of care meet our agreed set of best practice standards by 31st March 2013.

Why this is important:
As identified in our quality priorities for 2011/12, we recognised the additional risk to patients when they are transferred between services and staff. In 2010/11, we improved the discharge process from our inpatient wards as this is the transfer with the highest risk. In 2011/12, we expanded this to start making improvements in all transfers of care. In 2012/13, we aim to embed this work Trust-wide to ensure that all service users are transferred to the most appropriate service and team in a safe and effective way.

What we will do
We will:
- establish a project group to review, develop and improve our approach to transfers of care by Q1 12/13
- review our progress with the plans derived from audit reports in Q4 11/12 and update accordingly by Q1 12/13
- review our compliance with agreed best practice standards for the transfer of historical information and devise action plans with our services to improve this by Q1 12/13
- identify issues and devise action plans with our services to sustain improvements in transfers in care and implement further recommendations by Q2 12/13
- undertake a repeat audit of our compliance against our agreed best practice standards, including our progress with delivering our action plans, by Q3 12/13
- produce a report on the outstanding key issues for improving and sustaining transfers of care, including action plans agreed with the services, by Q4 12/13.
- review our compliance with agreed best practice standards by Q4 12/13

Priority 4: To develop broader liaison arrangements with acute trusts around physical health needs of mental health patients

Our aim:
To increase the number of service users whose care is managed within an agreed shared care / joint care pathway by 31st March 2013.

Why this is important:
It is universally acknowledged that people with mental health needs and learning disabilities have poorer long term health outcomes compared to the wider population. It is known, through experience, that the management of physical health care of people with certain mental health conditions (e.g. dementia) is more complex and challenging for acute trusts. We therefore think it is important that we support our colleagues in acute trusts, where possible, enabling them to provide high quality care for people with mental health and learning disability problems.

What we will do
We will:

- establish a steering group to co-ordinate this work by Q1 12/13
- identify existing communication and partnership groups between the Trust and local Acute Trusts by Q1 12/13
- establish a baseline for the implementation of current liaison arrangements with acute trusts for deliberate self harm pathways, green gight groups, psychiatric liaison teams, health facilitation services, the dementia collaborative by Q1 12/13
- map all the current interfaces with Acute Trusts, numbers of transfers, observational/escort support required, specialist referrals by Q2 12/13
- identify the gaps and agree an improvement plan with each Acute Trust by Q2 12/13
- plan quality improvement and business development work to address gaps and unmet needs by Q3 12/13
- implement quality improvement and business development work and ensure a wider liaison framework is in place by Q4 12/13

Monitoring Progress

We will monitor formally our progress against all of the above priorities on a quarterly basis. A quarterly quality report performance report, outlining performance against the overall aims, progress with the delivery of our planned actions and any corrective action required, will be shared with the Trust's Executive Management Team, Quality and Assurance Committee and Council of Governors.

A key way for delivering the priorities for 2012/13 will be the use of the various tools within the Trust's quality improvement system. As outlined earlier the Trust's quality improvement system is the Trust's framework and approach to continuous quality improvement and has within it standardised processes for monitoring progress and improvement.

In addition to this, we will be reviewing other evidence to show what impact our actions have had on our service users and carers and those organisations we work with. For example, we will be looking for evidence of:

- a reduction in serious untoward incidents, incidents and 'near misses' (i.e. incidents that are avoided through action but could have resulted in an incident) where failure to comply with agreed best practice standards for the Care Planning Approach, care coordination and care planning was a contributing factor
- an increase in the number of compliments we receive from service users and carers who have had a good experience following action we have taken in response to negative feedback we have received
- a reduction in complaints and negative feedback to our patient advice and liaison service from service users and carers who are dissatisfied with their transfer of care
- an improvement in responses to the questions in the national service user survey and our local surveys about how service users feel their physical health needs have been met

Part 3:
Other information on quality performance 2011/12

Our performance against our quality metrics in 2011/12

The following table provides details of our performance against our set of agreed quality metrics for 2011/12. These metrics are the same as those we reported against in our Quality Report 2008/09, 2009/10 and 2010/11 which allows us to monitor progress.

	2011/12		2010/11	2009/10	2008/09	2007/08
Quality Metrics	**Target**	**Actual**	**Actual**	**Actual**	**Actual**	**Actual**
Patient Safety Measures						
1 Number of Unexpected Deaths	<33	**47**	28	32	40	38
2 Number of outbreaks of Healthcare Associated Infections	0	**0**	0	0	0	0
3 Patient Falls per 100,000 OBDs from 11/12**	<105	**91**	105	89	96	139
Clinical Effectiveness Measures						
4 CPA 7 day follow up	>95.0%	**98.08%**	98.5%	97.5%	97.3%	99.0%
5 Implementation of NICE Guidance	100%	**95.2%**	66.7%	75.0%	75.0%	26.5%
6 Average length of stay for patients in AMH & MHSOP Assessment & Treatment Wards	<39	**37**	39	47	47	45
Patient Experience Measures						
7 Delayed Transfers of Care	<7.5%	**1.6%**	1.6%	2.9%	4.8%	N/A
8 Complaints per 100,000 patients from 11/12**	<412	**404**	368	315	n/k	n/k
9 **National Patient Survey**						
Number of questions where our score was within the top 20% of Mental Health Trusts	Improvement on 2010/11 survey	**12 (32%)**	18 (47%)	16 (42%)	18 (49%)	7 (19%)
Number of questions where our score was within the middle 60% of Mental Health Trusts		**23 (61%)**	14 (37%)	22 (58%)	17 (46%)	30 (81%)
Number of questions where our score was within the lowest 20% of Mental Health Trusts		**3 (8%)**	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.

** In 2011/12 we identified that in order to make comparisons with previous years valid we need to use a rate as the way we set the target and measure the actual. This is because the Trust has changed in size over the years and has therefore increased the number of service users it is providing care to. For example we opened an additional 60 forensic beds in 2009/10. The comparison data for 2007/08 to 2010/11 has been adjusted where possible to be measured as a rate, and therefore, is different from the figures reported in the 2010/11 Quality Report.

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.*
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.*

"Thank you very much for the event you held. It gave us a really constructive way of moving forward with issues we have within the service."

An NHS trust about TEWV QIS

Comments on Areas of Under-Performance

Metric 1:
Of the **47** unexpected deaths (i.e. a death that is not expected due to a terminal medical condition or physical illness), the coroner has informed the Trust on the outcome of nine inquests. The verdicts give by the coroner were that one was an accidental death, two were natural causes and six were suicides. We are awaiting confirmation on the remaining 38 cases.

In response to this, the highest number of unexpected deaths in the last five years, the Trust has implemented an improved review process. This has enabled a greater understanding of common factors influencing unexpected deaths. The Trust has also agreed a quality priority for 2012/13 to improve its care programme approach, care coordination and care planning which includes clinical risk management procedures.

Metric 5:
The position for 2011/12 is 95.2%. The main reasons for completion rates being below the target of 100% is that although the work has been performed, clinical audits are not reported as 'complete' until action plans have been agreed and submitted to the Clinical Audit Team. Several projects were also expanded in scope during 2011/12, and therefore, timescales were extended into 2012/13 to ensure the work could be fully completed. Furthermore, it should be noted that whilst we did not achieve the target set, the percentage of audits of NICE guidelines that we have completed so far this financial year is at the highest level since 2007/08.

Our performance against national targets and regulatory requirements in 2011/12

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.

	2011/12		2010/11	2009/10	2008/09	2007/08
Quality Metrics	**Target**	**Actual**	**Actual**	**Actual**	**Actual**	**Actual**
a The Trust has registered with the CQC with no conditions	**Yes**	**Yes**	Fully met	Fully met	Fully met	Fully met
b Number of occupied bed days of under 18s admitted to adult wards	**0**	**83**	70	173	104	79
c Retention rate substance misuse (rolling 12 months and reported 3 months behind)	**>89.0%**	**90.3%**	84.4%	89.7%	87.8%	82.6%
d Number of early intervention in psychosis new cases (cumulative position)	**>230**	**479**	455	407	301	236
e Number of crisis resolution home treatment episodes	**>2978**	**5965**	5751	5191	3944	3865
f Percentage of admissions to inpatient services that had access to crisis resolution home treatment teams	**>90.0%**	**96.0%**	97.0%	97.2%	94.5%	N/A
g Care Programme Approach 7 day follow up	**>95.0%**	**98.6%**	98.5%	97.5%	97.3%	99.0%
h Maintain level of crisis resolution teams set out in 2003/06 planning round	**Maintain**	**Maintained**	Maintained	Maintained	Maintained	Maintained

Notes on national targets and regulatory requirements

a) Information shown between 2007/08 and 2009/10 is compliance with Healthcare Commission Core Standards; however these are no longer applicable and have been replaced by registration with the Care Quality Commission from 2010/11.

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

c) Retention rate - the information shown for 2010/11 has been updated since the Quality Report 2010/11 was published. This is due to a 3-month delay in reporting which meant the final out-turn position was not available at the time of publishing the 2010/11 Quality Report. The forecast data for 2011/12 is to the end September 2011, and the data in the final Quality Report for 2011/12 will be as at end December 2011. Again, this is due to the 3-month delay in reporting.

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 **83** occupied bed days for under-18s admitted to adult wards in 2011/12 which relates to 9 patients that were admitted. However, all of these admissions were clinically appropriate. Furthermore, these admissions were of children aged 16-18 who were admitted to the two specific adult mental health wards where we have ensured that the staff has received additional training to manage people aged 16-18 should this be appropriate. There were no admissions onto adult wards of children and young people under 16 years of age.

External Audit

The two mandated indicators to be included in the nationally required external audit of the Quality Report 2011/12 are:

- Care Programme Approach 7 day follow up
- Percentage of admissions to inpatient services that had access to crisis resolution home treatment teams

The full definitions for these indicators are contained in **appendix 4**.

The additional quality metric selected by the Council of Governors to be included in the audit is:

- Average length of stay for patients in adult mental health and mental health services for older people assessment and treatment wards. This is measured by taking the total length of stay of all discharged patients from these wards for the reporting period and dividing it the number of discharges.

Quality metrics, national targets and regulatory requirements for 2012/13

In reviewing the metrics to be used in the Quality Report 2012/13, the Board of Directors have agreed that it would be appropriate to change three of the metrics to make them more meaningful. The changes to the quality metrics for 2012/13 identified by the Board of Directors are:

- The number of unexpected deaths (Quality Metric 1) has been changed to the 'number of unexpected deaths classed as a serious incident per 10,000 open cases'. This is because the Trust can influence the number of unexpected deaths classed as a serious incident but has less influence on the number of all unexpected deaths given that some of these are as a result of natural causes. In addition using a rate is also more valid for comparison purposes across the years as activity has increased.
- The number of patient falls per 100,000 occupied bed days (Quality Metric 3) has been changed to the 'number of patient falls per 1,000 admissions' as experience has shown this indicator is more closely linked to new admissions rather than occupied bed days.
- The number of complaints per 100,000 patients (Quality Metric 8) has been changed to the 'percentage of complaints satisfactorily resolved' as experience has shown that it is more important to measure the satisfaction of our response to complaints as opposed to the absolute number of complaints. The latter we encourage as important feedback to the Trust on the quality of our services.

The Quality Report: Reporting Requirements for 2011/12 and Planned Changes for 2012/13 (Department of Health, Gateway 17240) published in February 2012 sets out potential changes to the Quality Report, and in particular, the requirement to report on some additional of quality indicators recommended by the National Quality Board in 2012/13. Reporting against these indicators is not mandatory for 2011/12, and not all indicators are relevant to a Mental Health Trust. However, the following sets out the position for 2011/12 and a comparison with 2010/11 where data is available. These indicators will be adopted for the Quality Report 2012/13.

Domain 4: Ensuring that people have a positive experience of care.
Indicator: Percentage of staff who would recommend the provider to family or friends needing care.

KEY FINDING 34. Staff recommendation of the Trust as a place to work or receive treatment.

	2009	2010	2011
Trust score	3.60	3.62 (top 20%)	3.73 (top 20%)
National Average Score for all Mental Health Trusts	-	3.49	3.42
Best Score for all Mental Health Trusts	-	4.14	3.94

NB: a higher score is a better performance Source: TEWV Staff Survey 2011

The Trust's score improves each year and, although not the best, is in the top 20% of all mental health Trusts in England in 2010 and 2011.

Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm.
Indicator: Rate of patient safety incidents and percentage resulting severe harm or death.

Timeframe	Patient safety incident rate per 1000 bed days *(median & range compared to 57 other mental health Trusts)*	Percentage of patient safety incidents resulting in severe harm or death *(% for all mental health Trusts)*
1st October 2010 to 31st March 2011	20.24 (median 18.6) (50th percentile mid range 12.5 - 24.0)	0.00% (0.8%)
1st April 2011 to 30th September 2011	18.50 (median 21.1) (50th percentile mid range 16.5 - 27.0)	0.19% (0.8%)

Source: Organisation Patient Safety Workbooks Sept 2011 & March 2012. National Patient Safety Agency

Our stakeholders' views

The Trust recognises the importance of the views of our stakeholders as part of our assessment of the quality of the services we provide and to help us drive change and improvement. How we involve and listen to what our stakeholders say about us is critical to this process. In producing the Quality Report 2011/12, we have tried to improve how we involved our stakeholders in assessing our quality in 2011/12.

The following are some positive comments from our stakeholders at the events in 2011/12:

- *An opportunity for group discussion, to share real examples, experiences and perspectives.*
- *A good mix of stakeholders and good discussion.*
- *Genuine public 'meaningful' engagement.*
- *Useful to see how areas are targeted.*
- *Learnt a lot – moving forward together.*
- *An enjoyable interactive session.*

The following are the comments on things we could do better in our Quality Report:

- *The Trust needs to explain in more detail why some of the priorities were chosen.*
- *The use of 'story boards' could help describe experiences better.*
- *The Trust could provide more proposals for measurements*

In line with national guidance, we have circulated our draft Quality Report for 2011/12 to the following stakeholders:

- PCTs
- Local Involvement Networks (LINks)
- Local Authority Overview & Scrutiny Committees

We also circulated the Quality Report to our shadow Clinical Commissioning Group Chairs.

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

The following are the key themes received from stakeholders in reviewing our Quality Report for 2011/12.

- Our stakeholders reported that the Quality Report 2011/12 was *well-written* and *presented* in a *readable format*. The Report is *clear, accurate, open and positive* and a *fair reflection* of the Trust's quality. In addition we received a number of helpful suggestions for improving the Report which we will take into account next year.
- Our stakeholders welcomed the opportunity to be involved in the process of developing our quality priorities and the Report in 2011/12. As a consequence, our stakeholders were universally supportive of the priorities indentified for 2012/13. Our stakeholders are keen to see the Trust fully involving its service users, carers and partner organisations in the work to deliver these priorities and to receive quarterly updates on our progress during the forthcoming year.
- Our stakeholders recognised the progress we have made in improving quality in 2011/12 reflected also in the achievement of awards and positive external assessments. It was also recognised that the Trust has been open about where a priority had not been fully met and could show progress in 2011/12 and commitment to further improvement.
- One concern was raised regarding the number of occupied bed days of under 18s admitted to adult wards. Whilst it was recognised that these admissions were clinically appropriate and staff on the adult wards concerned receive additional training, this remains a key quality issue for the Trust.
- A further concern highlighted was that there were a higher number of unexpected deaths in 2011/12 compared to the target and these did not seem to be reflected within the priorities for 2012/13. It should be noted that as one of nine quality metrics, this will remain a priority for the Trust in 2012/13.
- Finally, in recognition of the new and emerging structures across the health and social care system, our stakeholders have recommended the Trust needs to reflect in its Quality Account how it will work with Clinical Commissioning Groups, Health and Wellbeing Boards, local HealthWatch and third sector organisations to improve health, wellbeing and quality across the whole system of care whilst working alongside existing stakeholders such as GP practices and the acute Trusts.

2011/12 Statement of Directors' responsibilities in respect of the Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, Directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2011/12;
- 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 2011 to June 2012;
  - Papers relating to Quality reported to the Board over the period April 2011 to June 2012;
  - Feedback from the commissioners dated May 2012;
  - Feedback from governors dated 26th March & 11th April 2012;
  - Feedback from LINks dated May 2012;
  - Feedback from Overview and Scrutiny Committees dated May 2012;
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 29th May 2012
  - The latest national patient survey published on 9th August 2011;
  - The latest national staff survey published on 20th March 2012;
  - The Head of Internal Audit's annual opinion over the Trust's control environment dated 24th May 2012;
  - Care Quality Commission quality and risk profiles dated 10th April 2012.
- 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;
- 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

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 Tees, Esk and Wear Valleys NHS Foundation Trust's Quality Report for the year ended 31 March 2012 (the "Quality Report") and certain performance indicators contained therein.

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 2012, to enable the Council of Governors to demonstrate that it has discharged its governance responsibilities by commissioning an independent assurance report in connection with the indicators. 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
The indicators for the year ended 31 March 2012 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- 7 Day Follow-up; and
- Crisis Resolution Team Contacts.

We refer to these national priority indicators collectively as the "indicators".

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* 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 Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Foundation Trust Annual Reporting Manual; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports*.

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.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with those documents listed below:

- Board minutes for the period April 2011 to June 2012;
- Papers relating to Quality reported to the Board over the period April 2011 to June 2012;
- Feedback from the Commissioners dated May 2012;
- Feedback from LINks dated May 2012;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 3 May 2012;
- The 2012 national patient survey;
- The 2012 national staff survey;
- Care Quality Commission quality and risk profiles dated 6 March 2012; and
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 29 May 2012;

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

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

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:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- Making enquiries of management;
- Testing key management controls;
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- 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
Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*.

The nature, form and content required of Quality Reports are determined by Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Tees, Esk and Wear Valleys NHS Foundation Trust.

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 2012:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*;
- the Quality Report is not consistent in all material respects with the sources specified in *Foundation Trust Annual Reporting Manual*; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports*.

Deloitte LLP
Chartered Accountants
Newcastle Office
29 May 2012

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 85).

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

Our Board of Directors has retained certain decisions to itself including the definition of the Trust's strategic goals and objectives, the approval of the business 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 committees are exercised on behalf of the Board by our Chief Executive.

The Board, through its audit committee, conducts a review on the effectiveness of internal control annually based on the findings of the Head of Internal Audit (see page 77).

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.

Statement of Compliance with the Code of Governance:

In 2011/12 we complied with all the provisions of the code of governance with the following exceptions:

- **Provision C.2.2 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-executive directors have terms of office of over three years:
  - Mr Jim Tucker (four years)
  - Mr Andrew Lombard (three years and two months)
  - Mrs Barbara Matthews (three years and two months)
  - Mr Douglas Taylor (three years and six 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.

- **Provision C.2.3 states that:** *"The names of governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to take an informed decision on their election. This should include prior performance information such as attendance records at governor meetings and other relevant events organised by the NHS foundation trust for governors."*

  The Trust does not provide details of attendance records in election papers. This is because all candidates are able to provide their own election statements and it is considered that the provision of this information might unduly affect the outcome of an election.

Code of Governance Disclosures

The Code requires us to disclose the following information in our Annual Report:

Code ref:	Disclosure	Page(s)
A.1.1	A statement either confirming compliance with each of the provisions of the code or, where appropriate, an explanation in each case why the trust has departed from the code.	71
A.1.2	The names of: - The Chairman - The Deputy Chairman - The Chief Executive - The Senior Independent Director - The chairman and members of the nominations committee - The chairman and members of the audit committee - The chairman and members of the remuneration committees	74 and 75
A.1.2	The number of meetings of the Board of Directors and those committees and individual attendance by directors.	76 - 79
A.3.1	The names of the non-executive directors whom the Board determines to be independent, with reasons where necessary.	73
A.3.4	A description of each directors expertise and experience.	74 and 75
A.3.4	A clear statement about the Board of Directors' balance, completeness and appropriateness.	73
B.1.3	The names of the governors and details on their constituency, whether they are elected or appointed and the duration of their appointments, together with details of the nominated lead governor.	82 - 83
B.1.3	The number of meetings of the Board of Governors and individual attendance by governors and directors.	82 - 83
C.1.7	The other significant commitments of the Chairman and any changes to them during the year.	74
C.1.14	A separate section describing the work of the nominations committee, including the process it has used in relation to Board appointments and an explanation if neither external search consultancy nor open advertising has been used in the appointment of a chairman or non-executive director.	85
D.2	How performance evaluation of the Board of Directors, its committees and its directors has been conducted.	76
E.1.3	As part of the remuneration disclosures of the annual report, where an executive director serves as a non-executive director elsewhere, whether or not the director will retain such earnings.	108
F.1.1	An explanation from the directors of their responsibility for preparing the accounts and a statement by the auditors abouttheir reporting responsibilities.	92 and 96
F.1.2	A statement from the Directors that the business is a going concern, with supporting assumptions or qualifications as necessary.	91
F.2.1	A report that the Board has conducted a review of the effectiveness of the Trust's system of internal controls.	71 and 93
F.3.3	A separate section describing the work of the audit committee in discharging its responsibilities.	77
F.3.5	Where the Council of Governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, a statement from the audit committee explaining the reasons recommendation and the why the Council of Governors has taken a different position.	77
F.3.8	An explanation of how, if the auditor provides non-audit services, auditor objectivity and independence is safeguarded.	77
G.1.4	Contact procedures for members who wish to communicate with governors and/or directors.	86
G.1.5	The steps the Board has taken to ensure that members of the Board, and in particular the non-executive directors, develop an understanding of the views of governors and members about their NHS foundation trust.	76

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

"I really feel that without your help I might not have made it. I have always felt that you have respected me, cared about me and done everything in your power to help me."

A service user

The Board of Directors

Our Board of Directors comprises:
- 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.

There were no changes to the membership of the Board during 2011/12.

The Chairman has no other significant commitments than shown overleaf. These did not change during 2011/12.

Membership of the Board
as at 31 March 2012

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 and a 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 and computing and a post graduate diploma in numerical analysis

Term of office:
1 July 2010 – 31 August 2013*

Mr Douglas Taylor
Non-executive Director and chairman of the audit committee

Douglas is a former Director of Finance in a development corporation and a major NHS teaching hospital trust. He was also most recently Chief Executive of a Newcastle based regional housing association and is a consultant to the housing sector.

Qualifications: Qualified accountant, CPFA

Term of office:
1 March 2011 to 31 August 2014*

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 1994 (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 18 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 for over 25 years and was previously the Director of Finance for Tees and North East Yorkshire NHS Trust.

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

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 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 the University of Essex.

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:
1 September 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.teww.nhs.uk.

Note: (*) 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 usually 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, risks and assurance reports from its principal committees.

Prior to January 2012 meetings of the Board were held in public at least once each quarter with the remaining meetings being held in private.

From January 2012, in preparation for the requirements of Health and Social Care Act 2012, the Board decided to hold all its meetings in public.

Most meetings are held in West Park Hospital, Darlington; however, to support visibility and accountability, one meeting each quarter is held elsewhere in the Trust's area.

During 2011/12 meetings were held in Durham, Stockton on Tees, Middlesbrough and Scarborough.

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

The attendance of directors at meetings during 2011/12 is set out in the table below:

Attendance at board meetings

The Board met 13 times during 2011/12: 10 ordinary meetings and 3 special meetings. The number of these meetings attended by individual directors was as follows:

	No. of Board Meetings attended
Mrs Jo Turnbull	13
Mr Andrew Lombard	11
Mrs Barbara Matthews	12
Mr Graham Neave	7
Mr Michael Newell	11
Mr John Robinson	9
Mr Douglas Taylor	12
Mr Jim Tucker	12
Mr Martin Barkley	13
Dr Nick Land	12
Mr Colin Martin	11
Mr Les Morgan	12
Mrs Chris Stanbury	11
Mr David Levy	11
Mr Chris Parsons	9
Mrs Sharon Pickering	8

The Trust Secretary attends every Board meeting in accordance with the requirements of the constitution.

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 directors.

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

Under the scheme:

- The collective performance of the Board is evaluated by each Board member, the staff governors and a selection of senior managers and clinicians. The Board agrees a development plan based on the outcome of the evaluation.
- The performance of the Chairman is evaluated by self assessment, assessments by each Board member and by a governor focus group facilitated by the Senior Independent Director.
- The performance of each 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 non-executive directors.
- 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.

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 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
- attendance at governor development days

Andrew Lombard, as the Senior Independent Director, is also available to governors if they have concerns regarding any issues which have not been addressed by the Chairman, Chief Executive or Director of Finance.

With regard to attendance at meetings of the Council of Governors:

- 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 2011/12, including the Annual General Meeting was as follows:

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

Committees of the Board

The Board has standing audit, investment, quality and assurance, mental health act and remuneration committees.

Each committee has terms of reference which has 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 sections.

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 annual governance statement) prior to endorsement by the Board
- ensuring the internal audit function is effective, meets mandatory NHS internal audit standards and provides appropriate independent assurance
- making recommendations to the Council of Governors on the appointment, re-appointment or removal of the external auditor
- 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 (e.g. the Care Quality Commission, Monitor, etc) and considering the implications for the governance of the Trust
- reviewing and monitoring the integrity of any financial statements including any financial judgements contained in them and ensuring the completeness and accuracy of information provided to the Board
- reviewing arrangements by which staff may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters (the whistleblowing policy)

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

- its work in support of the annual governance statement 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.

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

The committee met five times during the year. Attendance by each member was as follows:

Mr Douglas Taylor (chairman)	5
Mr Andrew Lombard	4
Mr Michael Newell	4
Mrs Barbara Matthews	5

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 2011/12, 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 2010/11 annual report including the annual financial statements and quality report based on the findings of the external auditors' reports to those charged with governance (ISA 260) and external review of the quality account
- provided assurance to the Board on the fairness and accuracy of the 2010/11 annual report and financial statements of charitable trust funds
- considered the recommendations and the management response arising from a review of how the training needs of staff are identified and addressed, commissioned from Deloitte LLP
- reviewed and gained assurance on development of clinical audit including ensuring the coverage of principal risks within the clinical audit programme and the alignment of processes in the new areas of North Yorkshire
- monitored and received assurances on the progress of the reforming community teams project which was introduced following a report commissioned by the committee from Deloitte LLP in 2009
- reviewed and provided assurances which enabled the Board to sign off the annual statements required by Monitor under its compliance framework
- reviewed operational and contractual issues relating to Roseberry Park

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 2011/12 Deloitte LLP, the external auditors, was commissioned to undertake a review of strategic training needs analysis.

Deloitte LLP also provided advice the Trust on the treatment of potential tax liabilities arising from the Ridgeway Café and Shop.

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 appointed Deloitte LLP as the Trust's external auditors until the completion of the 2012/13 audit.

The cost of providing external audit services during 2011/12 was £71,500 excluding VAT. This includes the cost of the statutory audit, the review of the quality account required by Monitor, the independent regulator of foundation trusts, the review of the accounts of the charitable funds and the whole Government accounting return.

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 FT terms of authorisation
- considering the Trust's medium-term financial strategy, in relation to both revenue and capital
- reviewing proposals (including evaluating risks) for major business cases and their respective funding sources prior to submission to the Board
- reviewing the management and administration of charitable funds held by the Trust
- reviewing progress on the "upside" scenarios included in the business plan.

The membership of the committee comprises:

- a non-executive director chairman - Mr Jim Tucker
- three other non-executive directors – Mr Andrew Lombard, Mr Michael Newell and Mr Douglas Taylor
- the Chief Executive, Finance Director, Chief Operating Officer and Director of Planning and Performance.

The committee met 6 times during the year.

During 2011/12 the committee reviewed and recommended to the Board:

- the full business case for the expansion of forensic services at Roseberry Park Hospital
- the business case for the e-rostering project
- revisions to the PARIS system contract
- revisions to the West Lane Hospital site development control plan
- the outline business cases for the following developments:
  - the reconfiguration of MHSOP inpatient beds in south Durham and Darlington
  - the development of MHSOP complex care services at Springwood on the Malton Hospital site

Quality assurance committee (QAC)

This committee oversees the assurance processes and clinical governance systems to enable monitoring of the quality and safety of clinical services delivered by the Trust. As part of that monitoring the committee receives assurance reports from a number of working groups and clinical division quality and assurance groups, enabling regular checking of the compliance evidence with the Care Quality Commission Essential Standards of safety and quality.

The committee manages the development and production of the annual Quality Account and monitors performance of achievement 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, internal and external reviews, to identify lessons to be learned by the Trust and actions required.

This year the committee has received six monthly divisional quality and assurance reports as well as three monthly reports from the working groups. These have been analysed by the compliance panel as part of the committee's work together with reviewing reports from other committees and groups responsible for Mental Health Act legislation, equality and diversity, workforce development and estates and facilities management.

The committee has also heard a number of 'patient stories' from individual service users, carers, families and service user forums. These have provided insight into both positive and critical views and experiences of the users of our clinical services, and have enabled the committee to debate issues of good practice and areas for further development. There have also been a number of clinical case issues presented for discussion, as well as several examples of quality and assurance improvements and projects.

To ensure that the Board of Directors maintain a focus on the quality of services, a monthly report is provided together with quarterly reports detailing issues raised through complaints and PALS and the performance against the patient experience quality indicators.

Membership

- Mr John Robinson, Non-executive Director chairs the committee with support from Mrs Chris Stanbury, the Director of Nursing and Governance.

Other members are:
- Non-executive Directors – Mr Jim Tucker, Mr Graham Neave and Mr Mike Newell
- Dr Nick Land, Medical Director
- Mr Les Morgan, Chief Operating Officer
- Mrs Sharon Pickering, Director of Planning and Performance
- Mr Stephen Scorer, Deputy Director of Nursing and Patient Safety
- Ms Christine McCann, Associate Director of Nursing and Clinical Assurance
- Mrs Joan Breckon, Associate Director of Nursing and Patient Experience
- Mrs Lesley Mawson, Associate Director of Nursing and Compliance
- Directors of Operations – Mrs Adele Coulthard, Mr Paul Newton, Mr David Brown and Mr Levi Buckley
- Senior Clinical Directors – Dr Ruth Briel, Dr Chandi Siriwardana, Dr Ahmad Khouja, Dr Angus Bell, Professor Joe Reilly, Dr Soraya Mayet and Dr Lennon Swart
- Mrs Sue Hunter, Chief Pharmacist/Associate Director of Pharmacy
- Service Development Managers – Ms Mandy Barrett, Ms Donna Sweet, Mrs Susan Sirrell, Ms Jill Jefferson and Mr David Kerr

The Committee held 12 meetings during 2011/12.

Mental Health Act committee

The Mental Health Act committee is a sub committee of the Board of Directors that is accountable for the safe and efficient management of mental health legislation and the overseeing of mental health act administration activity and performance. This Committee's responsibilities are:
- To ensure appropriate arrangements are in place for the appointment of associate managers and oversee managers' hearings
- To receive information and review, if necessary, the number of patients subject to 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 Mental Health Act 1983 and make proposals for changes to the Board
- Receive regular reports from the Mental Health Act Operational Groups
  - To scrutinise CQC Mental Health Act Commission Visit Reports and Management Responses and monitor the implementation of Action Plans
  - To review annually the Trust's compliance with the statutory requirements of the Mental Health Act 1983 and the Mental Capacity Act 2005
  - To consider other topics as defined by the Board

The committee meets quarterly, is chaired by Mr Andrew Lombard, Non-executive Director, with support from Mrs Chris Stanbury, Director of Nursing and Governance who is responsible for the Mental Health Act administration department. The committee has met four times between April 2011 and March 2012. The members currently are:

- two Non-Executive Directors, Mr Andrew Lombard and Mrs Barbara Matthews
- the Director of Nursing and Governance
- the Medical Director
- the Director of Estates and Facilities Management (or his nominated deputy)
- a service user representative
- a carer representative

However, membership was reviewed in January 2012 and it was recommended that:
- there was an increase in the number of non-executive directors on the committee from two to three
- the Chief Operating Officer (or nominated deputy) was included as a member of the committee
- the Director of Nursing and Governance to be able to appoint a nominated deputy to attend meetings as a full member on her behalf
- the quorum of the Committee to be three members with at least one being a non-executive director and one being an executive director or nominated deputy

In addition, the committee has regular staff who attend but are not full members. These include the Trust Mental Health Act Legislation Lead, Mental Health Act Officer and the Associate Director for Nursing and Compliance.

The committee has a standing agenda which includes the performance reports against the mental health legislation activity as well as the review reports from all the Care Quality Commission Mental Health Act Commissioner inspections.

The committee reviews performance issues and themes of activity and then monitors the progress against actions recommended by the Care Quality Commission to improve the care and services for detained patients.

The committee presents a quarterly report to the Board of Directors.

The committee had four meetings in April, July, October 2011 and January 2012.

Remuneration committee

The remuneration committee comprises the Chairman and all non-executive directors. The Chief Executive attends meetings of the committee but is not present when items concerning his own remuneration or conditions of service are considered. The Director Human Resources and Organisational Development undertakes the role of secretary to the remuneration committee.

During 2011/12 there was one meeting of the remuneration committee which was held on 6th March 2012. The attendees at this meeting were as follows:

- Mrs Jo Turnbull
- Mr Andrew Lombard
- Mr Douglas Taylor
- Mr John Robinson
- Mrs Barbara Matthews
- Mr Jim Tucker

The Director of Human Resources and Organisational Development provided advice and information to the committee during 2011/12 on Executive and Corporate Directors remuneration and terms of service. This was based upon information previously provided to the Trust by Income Data Services Ltd and Capita Surveys and Research.

A director's performance evaluation scheme is used. Individual executive and corporate directors objectives are related to the Trust's strategic goals and progress toward achievement of these objectives is reviewed and recorded at least twice a year by the Chief Executive and subsequently reported to non-executive directors.

The Trust does not operate an annual performance-related pay scheme for directors and there is no provision for compensation in respect of early termination with the exception of redundancy. Entitlement to payments arising from early termination of employment by reason of redundancy is in accordance with NHS redundancy terms and conditions and the NHS pension scheme.

There were no significant awards made to past senior managers.

The remuneration report can be found on page 108.

The Council of Governors

Changes to the composition of the Council of Governors, to reflect the expansion of the Trust in North Yorkshire and the introduction of new management and leadership arrangements, came into effect on 1st July 2011.

During 2011/12 the Council of Governors comprised:

- The Chairman of the Trust as Chairman of the Council of Governors
- Governors elected by the public members of the following constituencies

Constituency	No. of Governors to 30/6/11	No. of Governors from 1/7/11
Darlington	2	2
Durham	10	8
Hambleton & Richmondshire	-	2
Harrogate and Wetherby	-	3
Hartlepool	2	2
Middlesbrough	3	2
Redcar & Cleveland	3	2
Scarborough & Ryedale (formerly North East Yorkshire)	4	3
Stockton	4	3
Total	**28**	**27**

- Governors elected by staff members of the following classes:

Class	No. of Governors to 30/6/11	No. of Governors from 1/7/11
Nursing	1	-
Medical	1	-
Allied health professionals	1	-
Corporate services	1	1
Psychology	1	-
Learning disability and forensic directorate	1	-
Children and young people's services, older people's mental health services, substance misuse and North East Yorkshire directorate	1	-
Adult mental health directorate	1	-
County Durham and Darlington	-	1
Forensic	-	1
North Yorkshire	-	1
Teesside	-	1
Total	**8**	**5**

- Governors appointed by the following stakeholder and partner organisations:

	No. of Governors to 30/6/11	No. of Governors from 1/7/11
NHS County Durham and Darlington	1	1
NHS Tees	1	1
NHS North Yorkshire & York	1	1
North East Mental Health and Learning Disability Commissioning Directorate	1	-
Durham County Council	1	1
Darlington Borough Council	1	1
Hartlepool Borough Council	1	1
Stockton-on-Tees Borough Council	1	1
Middlesbrough Borough Council	1	1
Redcar & Cleveland Borough Council	1	1
North Yorkshire County Council	1	1
University of Teesside	1	1
Durham University	1	1
North Tees and Hartlepool NHS Foundation Trust South Tees Hospitals NHS Foundation Trust County Durham and Darlington NHS Foundation Trust Scarborough and North East Yorkshire Healthcare NHS Trust	1	-
North East Prisons Directorate	1	1
Voluntary Organisations Network North East Ryedale Voluntary Action	2	-
University of York	-	1
Northern Specialist Commissioning Group	-	1
Total	**17**	**15**

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 2011/12 was 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	01/07/08	01/07/11	1 (1)
Andrea Goldie	Darlington	18/12/11	30/06/14	1 (1)
Dennis Haithwaite	Darlington	18/12/11 (re-elected)	30/06/14	3 (5)
Catherine Haigh	Middlesbrough	29/10/09	30/06/11	1 (1)
Ann Tucker	Middlesbrough	01/07/11 (re-elected)	30/06/14	3 (5)
Michael Taylor	Middlesbrough	01/07/10 (re-elected)	30/06/13	3 (5)
Richard Thompson	Scarborough & Ryedale (formerly North East Yorkshire)	01/07/08	30/06/11	1 (1)
Judith Webster	Scarborough & Ryedale (formerly North East Yorkshire)	01/07/11	30/06/14	4 (4)
Keith Marsden	Scarborough & Ryedale (formerly North East Yorkshire)	01/07/10 (re-elected)	30/06/13	4 (5)
Andrea Darrington	Scarborough & Ryedale (formerly North East Yorkshire)	17/02/12 (re-elected)	30/06/14	4 (5)
Jayne Mitchell	Redcar & Cleveland	01/07/08 18/12/11	30/06/11 30/06/14	1 (1) 1 (1)
Caroline Parnell	Redcar & Cleveland	18/12/08	17/12/11	1 (4)
Vivienne Trenchard	Redcar & Cleveland	01/07/10 (re-elected)	30/06/13	4 (5)
Rita Clark	Stockton	01/07/08	30/06/11	0 (1)
Cllr Ray McCall	Stockton	18/12/11 (re-elected)	17/12/14	3 (5)
Paul Emerson	Stockton	01/07/10	30/06/13	5 (5)
Gareth Rees	Stockton	01/07/08	30/06/11	0(1)
Terry Winfield	Stockton	01/07/11	30/06/14	3 (4)
Maggie Bosanquet	Durham	29/10/09	30/06/11	0 (1)
Dr Rachel Mitchell	Durham	01/07/08	30/06/11	0 (1)
Simon Carey	Durham	18/12/08	03/08/11	0 (2)
Betty Gibson	Durham	01/07/11 (re-elected)	30/06/14	5 (5)
Christopher Wheeler	Durham	01/07/11 (re-elected)	30/06/14	3 (5)
Dr Nadja Reissland	Durham	01/07/10	30/06/13	2 (5)
Cliff Allison	Durham	18/12/11	30/06/14	1 (1)
Drew Terry	Durham	18/12/11	30/06/14	1 (1)
Andrew Everett	Durham	01/07/10 (re-elected)	30/06/13	3 (5)
Vince Crosby	Durham	01/07/10 (re-elected)	30/06/13	3 (5)
John Doyle	Durham	01/07/10 (re-elected)	30/06/13	4 (5)
Andrew Forcer	Hartlepool	01/07/11	30/06/14	0 (4)
Paul Williams	Hartlepool	01/07/10 (re-elected)	30/06/13	4 (5)
Colin Wilkie	Hambleton and Richmondshire	18/12/11	30/06/14	1 (1)
Susan Heathcote	Hambleton and Richmondshire	18/12/11	30/06/14	1 (1)

Maximum possible number of meetings to be attended shown in brackets
No governors held office for the Harrogate and Wetherby Constituency as there were insufficient members to enable elections to be held
Mr Karl Banzyni was elected as a Governor on 24 June 2011 for Durham but did not take up office.

Staff Governors (Elected)

Name	Class		Term of Office		No. of Council of Governor meetings attended (inc the AGM)
	To 30/6/11	From 1/7/11	From	To	
Simon Hughes	Allied Health Professionals	-	1/7/08	30/6/11	1(1)
	-	Teesside	01/07/11	30/06/14	3 (4)
Giles Hallam	Nursing	-	1/7/08	30/6/11	1(1)
Nigel Cooke	LD& Forensic	-	1/7/08	30/6/11	1(1)
Jill Jefferson	MHSOP, C&YP, SM, NEY	-	1/7/08	30/6/11	1(1)
Clare Beighton	Adult Mental Health	-	16/7/08	30/6/11	0(1)
Doug Wardle	-	County Durham & Darlington	01/07/11	30/06/14	4 (4)
Judith Hurst	Corporate	-	25/01/10	30/06/11	1(1)
Stuart Johnson	-	Corporate	01/07/11	30/06/14	4 (4)
Lisa Taylor	-	Forensic	17/02/12	30/06/14	0 (1)
Jacqueline Howe	-	North Yorkshire	18/12/11	30/06/14	0 (1)

Maximum possible number of meetings to be attended shown in brackets

Appointed Governors

Name	Class		Term of Office		No. of Council of Governor meetings attended (inc the AGM)
	To 30/6/11	From 1/7/11	From	To	
Melanie Bradbury	NHS North Yorkshire and York		01/07/11 (re-appointed)	30/06/14	2 (3) she was on sabbatical from 01.10.11
Malcolm Cook	NHS County Durham and Darlington		01/07/11 (re-appointed)	30/06/14	0 (5)
Cath Siddle	Acute Trusts	-	01/07/08	30/06/11	0 (1)
Clare Hunter	NHS Tees		01/07/11 (re-appointed)	30/06/14	4 (5)
Prof Cliff Hardcastle	Teesside University		26/11/09	30/06/11	0 (1)
Prof Paul Keane OBE	Teesside University		01/07/11	30/06/14	3 (4)
Mike Hill	Voluntary sector		01/07/08	30/06/11	1 (1)
Prof Pali Hungin	Durham University		01/07/11 (re-appointed)	30/06/14	1 (5)
Matt Spencer	North East Prisons		01/07/11 (re-appointed)	14/10/11	0 (3)
Ruth Hicks	Middlesbrough Borough Council		01/07/11	23/11/11	1 (4)
Tony Parkinson	Middlesbrough Borough Council		24/11/11	30/06/14	0 (1)
Cllr Tristan Learoyd	Redcar & Cleveland Borough Council		01/07/11	23/02/12	1 (4)
Cllr Ann McCoy	Stockton Borough Council		01/07/11 (re-appointed)	30/06/14	3 (5)
Jill Harrison	Hartlepool Borough Council		01/07/11 (re-appointed)	30/06/14	2 (5)
Pauline Mitchell	Darlington Borough Council		01/07/11 (re-appointed)	30/06/14	3 (5)
Lesley Jeavons	Durham County Council		01/07/11 (re-appointed)	30/06/14	5 (5)
Cllr Tony Hall	North Yorkshire County Council		01/07/11	30/06/14	4 (4)
Prof Ian Watt	The University of York		01/07/11	30/06/14	2 (4)

Maximum possible number of meetings to be attended shown in brackets
No appointment was made during 2011/12 by the Northern Specialist Commissioning Group

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 2011/12

Constituency	Date	Seats	No. of Candidates	No. of eligible voters	Turnout (%)
Middlesbrough	24/06/11	1	4	985	10.4
Scarborough and Ryedale	24/06/11	1	3	267	12.4
Stockton on Tees	24/06/11	1	3	948	10
Durham	24/06/11	3	3	N/A	N/A
Hartlepool	24/06/11	1	1	N/A	N/A
Coprorate Staff	24/06/11	1	3	959	25.2
Teesside Staff	24/06/11	1	1	N/A	N/A
County Durham and Darlington Staff	24/06/11	1	1	N/A	N/A
Darlington	07/12/11	2	6	616	6.5
Durham	07/12/11	2	7	1442	10.3
Hambleton and Richmondshire	07/12/11	2	4	120	23.3
Stockton on Tees	07/12/11	1	1	N/A	N/A
Redcar and Cleveland	07/12/11	1	2	677	7.7
North Yorkshire Staff	07/12/11	1	2	795	14.2
Scarborough & Ryedale	08/02/12	1	2	382	15.4%
Forensic Staff	08/02/12	1	1	N/A	N/A

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 2011/12

During 2011/12 the Council of Governors:

- held our Annual General Meeting based on the theme of dementia
- further developed its arrangements for engaging with members (see below)
- assisted with the development of a carer survey within older people's services and monitored the resultant action plan
- developed a carers strategy for the Trust
- assisted with the development of the patient experience and involvement strategy for Trust
- received briefings on the expansion of the Trust into areas of North Yorkshire and subsequent options for the improvement of delivery of services
- assured itself on our financial and operational performance
- assured itself on progress on the priorities included in the quality account for 2011/12 and approved the local indicator for external assurance
- assisted with the development of the Trust's business plan
- contributed to the development of our annual report
- assured itself on the performance of the Board, the Chairman and the Non Executive Directors
- approved the training and development plan for Governors
- received briefings on learning disability services following the Panorama expose of Winterbourne View, Bristol along with the outcomes of the National Patient Survey, National Staff Survey and the implications of the Health and Social Care Bill

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 thematic committees
The following issues were progressed by the four thematic committees during 2011/12:

Improving the experience of carers committee (Chairman: Ann Tucker)
- assisted in the development of an implementation plan for the carers Strategy and agreed its subsequent monitoring
- developed a carers leaflet and handbook
- supported the delivery of the "triangle of care" within the Trust

Improving the experience of service users committee (Chairman: Keith Marsden)
- considered the implications for service users of delays in the reinstatement of benefit payments
- discussed the implementation of service user feedback technologies

Promoting social inclusion committee (Chairman: Vivienne Trenchard)
- received briefings on the delivery of the connecting communities project to further social inclusion
- considered how the Trust was meeting the needs of staff employed through the Mindful Employer Initiative and the subsequent appointment of a employee support worker
- received briefings and regular updates on the appointment and subsequent work of the Trust's advanced specialist in vocational rehabilitation worker
- agreed the winner and highly commended nominations of the 'making a difference award' for tackling stigma and promoting social inclusion

Making the most of membership committee (Chairman: Paul Emerson)
- monitored the progress on the implementation of the membership plan
- agreed the external events diary for the recruitment of members for 2011
- developed the membership strategy and plan for 2012
- reviewed the evaluations of the positive practice public engagement events and approved the delivery of future events during 2012
- agreed the format of the Annual General meeting
- developed the member charter and membership levels for introduction during 2012

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 2011/12 the committee:
- assured the Council of Governors regarding the performance of the Chairman and non-executive directors
- reviewed the remuneration of the Chairman and Non-executive Directors

Meetings of the committee are chaired by the Chairman of the Trust except that the Senior Independent Director becomes a member of and chairs the committee for the matters relating to the appraisal and appointment of the Chairman.

The membership of the committee and attendance at its 2 meetings during 2010/11 was as follows:

Mrs Jo Turnbull	Chairman of the Trust	2
Mr Martin Barkley	Chief Executive	0
Mrs Clare Hunter	Appointed Governor	1 (1)
Mr Mike Hill	Appointed Governor	1 (1)
Mrs Melanie Bradbury	Appointed Governor	0 (0)
Mrs Andrea Darrington	Public Governor	1 (1)
Mrs Betty Gibson	Public Governor	1 (1)
Dr Nadja Reissland	Public Governor	1
Mr Colin Wilkie*	Public Governor	0 (0)

Maximum possible number of meetings to be attended shown in brackets
Mr. Wilkie attended a meeting of the committee on 23/2/12 as a co-opted member. His appointment as a full member was subsequently ratified by the Council of Governors

Mr 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

In addition to the above committees the following working groups have been established:

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.

Training and development

Each year the Council of Governors reviews its operation in accordance with the code of governance. The review is based on self assessment and focus group discussions. A development plan is produced 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.

During 2011/12 the Council of Governors held two development days. These events:
- provided governors with networking opportunities.
- enabled discussions with directors of operation on issues and developments within their constituencies
- receive briefings on national issues including the health and social care bill and the development of local healthwatch

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 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.

In our membership strategy 2011 we set ourselves the following objectives:
- to recruit an additional 350 (nett) public members
- to recruit at least 100 members in each of the new constituencies in North Yorkshire to enable elections of governors.

We exceeded our target in terms of recruiting new members overall (822) and recruited sufficient members to hold elections in Hambleton and Richmondshire.

Unfortunately we did not recruit sufficient members in Harrogate and Wetherby to be able to hold elections. To address this, we have commissioned external support to enable us to recruit sufficient members in that area to be able to hold elections in July 2012.

We consider that, except in the new areas of North Yorkshire, our membership is broadly representative in terms of age, gender and ethnicity.

Members wishing to contact governors and/or directors of the Trust can do so via the trust secretary's department on 01325 552314, email ft.membership@tewv.nhs.uk or visit our website www.tewv.nhs.uk.

Please also use these contact details or visit our website, www.tewv.nhs.uk if you would like to become a member.

Membership recruitment

Activities to support member recruitment during 2011/12 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 e.g. Middlesbrough MELA, Guisborough Town Fair, Scalby Fair, Scarborough Superpride and "fun days" at Ripon and Thirsk race courses,
- 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
- continuing to build on links with stakeholders to promote membership
- direct targeting of key groups
- 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 2011/12 the size and movements in public membership were as follows:

Public members as at 1/4/11	5311
New public members during 2011/12	909
Public members leaving during 2011/12	87
Public members as at 31/3/12	6133

The number of members for each of the public constituencies on 31st March 2012 was as follows:

Public constituencies	
Darlington	627
Durham	1489
Hambleton & Richmondshire	137
Hartlepool	721
Harrogate and Wetherby	54
Middlesbrough	1052
Redcar & Cleveland	672
Scarborough & Ryedale	385
Stockton	996

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

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

Our staff membership as it 31 March 2012 was as follows:

Staff constituencies	
County Durham and Darlington	1562
Corporate	975
Forensic	737
North Yorkshire	804
Teesside	1861

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
  - the official opening of new premises.
- visiting promotional stands at a variety of events

Our public 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 2011/12 we held the following public meetings for our members:

Date	Constituency	Focus	Number of Attendees
01/05/2011	Stockton and Hartlepool	**Positive Practice event:** - Care planning at Lustrum Vale - Involvement - Non-pharmacological interventions in dementia - Carers and staff working together - Introduction to the Triangle of Care - Patient experience and involvement strategy	56
05/07/2011	Scarborough and Ryedale	**Positive Practice event:** - Involvement - Personalisation agenda - Work placements reducing stigma - Carer support - Introduction to the Triangle of Care - How relationships may change when caring for someone	60
22/09/2011	Durham	**Positive Practice event:** - Service user and carer leadership programme - Durham Countrywide Forum - New ways of working in mental health - a consultant's perspective - Workshops as part of the Europsy event	52
28/03/2012	Teesside	**Positive Practice event:** - Advance Project, Middlesbrough - How service users and carers have benefitted from Involvement activities and undertaking a leadership programme - How the Trust is working with carers - The TEWV brand - New ways of working in mental health - A consultant's perspective - Consultation on improving mental health services for older people in Stockton-on-Tees	63

Financial report

Financial review 2011/12

Summary of financial performance

In 2011-12 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 2011-12 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 £5.5m for the financial year and achieved £5.6m.

Total CRES achieved at 31 March 2012 was £7.8m and was marginally ahead of plan, mainly as a result of the early implementation of schemes identified for 2012-13. Total CRES achieved was recurrent and the Trust is making good progress with future years plans.

Income growth
The Trust experienced significant growth in income mainly due to the successful tender to provide mental health and learning disability services into Craven, Harrogate and Hambleton & Richmondshire localities. In addition the Trust was also awarded the regional contract to provide specialist inpatient services for adults and children with eating disorders.

Underlying performance against Monitor's compliance regime – financial metrics

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

Financial metrics

	Performance	Rating
EBITDA margin	8.4%	3
EBIDTA % achieved	106.4%	5
Return on assets	9.5%	5
I & E surplus margin	4.2%	5
Liquidity days	33.8 days	4
Overall rating		4

2011/12 objectives

Objectives	Outcomes
Delivering a £5.5m financial surplus	**Financial surplus of £5.7m achieved**
Achieving a Monitor risk rating of 4	**Calculated risk rating of 4 achieved**
Delivery of £7.5m cash releasing efficiency savings	**Delivery of £7.8m cash releasing efficiency savings**
EBITDA margin of 8.0%	**EBITDA margin of 8.5% 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, £7.8m of our cost base was saved through a variety of ongoing 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 2011-12, £24.5m was invested in capital assets.

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

	2011 -12 £
Investment in fixed assets	24.5m
Disposal of unprotected asset	1.2m

The Trust has a borrowing limit of £89.9m 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 committed working capital facility of £18m, which was increased in December 2011 to £20.5m. This was not required during the year as the Trust had strong liquidity which improved further 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 (2011-12) 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 2012-13 annual plan provides for a surplus of £5.9m (2% of turnover).The financial plans for 2013-14 and 2014-15 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 2011-12

Accounting policies for pensions and other retirement benefits are set out in page 102 and 105 in the accounts and details of senior employees' remuneration can be found in page 108.

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

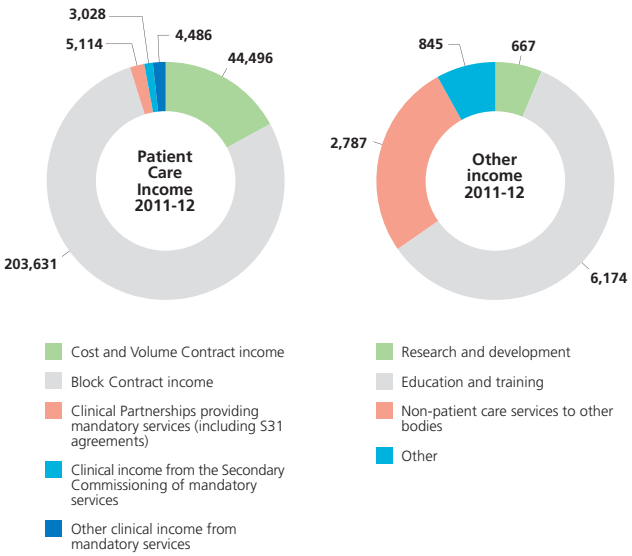
The Better Payment Practice code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. Performance for the financial year 2011-12 is as follows:

	Year to date	
	Number of invoices	Value of invoices £000s
NHS creditors		
Total bills paid	930	14,181
Total bills paid within target	654	10,801
Percentage of bills paid within target	70.32%	76.16%
Non-NHS Creditors		
Total bills paid	51,653	76,727
Total bills paid within target	48,599	74,381
Percentage of bills paid within target	94.09%	96.94%

Income generation

During 2011-12, income generated was £271.2m from a range of activities; 96.1% from direct patient care. Patient care income came from the following areas:

There is a further £10.5m from education and other non-patient care services.



Senior managers' remuneration & pension
Details of senior manager's remuneration and pension can be found on pages 108 and 109 of the financial statements.

Management costs
In line with best practice the trust continues to monitor expenditure on management costs in accordance with Department of Health definitions. In 2011-12, 4.93% of our total income was incurred on management costs.

Martin Barkley
Chief Executive

29th May 2012

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

29th May 2012

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 Annual 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 Annual 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

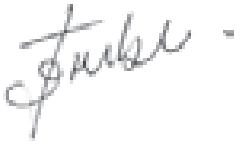
The Directors are responsible for keeping proper accounting records which disclose, with reasonable accuracy, at any time the financial position of the Trust. This is to ensure proper financial procedures are followed, and that accounting records are maintained in a form suited to the requirements of 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 are required to confirm that:

- as far as they are aware, there is no relevant information of which the Trust's auditor is unaware and
- that they have taken all steps they ought to have taken as a director in order to make themselves aware of any such information and to establish that the Auditor is aware of that information.

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



Jo Turnbull
Chairman on behalf of the Board of Directors

29th May 2012

Annual Governance Statement 2011-12

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 2012 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 internal and external mechanisms including; NHSLA, Care Quality Commission, complaints management, litigation, staff surveys, task groups, clinical audit and internal and external audit.

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 2012 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.

Within 2011-12 the Trust has strengthened and further imbedded both its training provision and monitoring controls within its devolved information risk management framework.

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 prior years in the development of

a robust workforce performance management framework and the further development of the Trust's I.T. systems to support the organisation's 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 3rd party assurances through the development of a system which records and validates the form and frequency of assurances received. This system will allow the Trust to assess the level of assurance that can be taken and what actions are necessary to improve the benefit of all 3rd party assurances. This will ensure that governance processes continue to become more dynamic in the pursuit of effectiveness and efficiency.

The Trust has confirmed its commitment to ensure ongoing compliance with the requirements of the Department of Health Information Governance Assurance Programme. The Trust achieved an overall score of 84% against the Information Governance Toolkit requirement in 2011/12 with all sequences achieving at least level 2. This was an improvement on last year as in 2010/11 two criteria did not achieve level 2. 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 a SIRO network, which in turn has increased Information Governance awareness, training and understanding through delegation of responsibility to information asset owners and information asset administrators. The network has been supported by an Information Governance Campaign to deliver information and training.

The Trust is fully registered with the Care Quality Commission.

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 projections, to ensure that the obligations of Tees, Esk & Wear Valleys NHS Foundation Trust under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Within the financial year 2011-12 the Trust suffered a financial loss of £262k due to a fraud. This resulted from an action to change a current supplier's bank account details, the request for the bank account change subsequently having been found to be fraudulent and the funds moved overseas. The police and local counter fraud specialists were informed, and have advised the Trust that at this point they are unable to recover the loss. The Trust has therefore accounted for the loss in 2011-12.

Since the incident a full and complete review of all financial procedures was completed with co-operation from Counter Fraud and Internal Audit to ensure that the risk of any future fraudulent activity is minimised.

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 and 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 and Council of Governors.
- The Director of Finance and Information is the corporate lead for data quality and chairs an internal group which has the responsibility for ensuring data quality within the Trust. The Executive Management team considers data quality on a monthly basis as part of a dedicated meeting to review 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 Board of Directors is responsible for setting the strategic direction of the organisation and monitoring the progress of the organisation against targets. The Board also receives minutes and reports from its sub committees.
- 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 Board of Directors all clinical governance activity including a review of the clinical audit processes and programme.
- Internal Audit provides an independent and objective opinion on the degree to which risk management, control and governance support the achievement of the Trust's objectives. The Head of Internal Audit opinion provided significant assurance for this area.
- 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

29th May 2012

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 2012 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 2012 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 part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the National Health Service Act 2006; and
- 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 Audit Code for NHS Foundation Trusts requires us to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading or inconsistent with information of which we are aware from our audit. We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls;
- 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, CF
(Senior Statutory Auditor)
For and on behalf of Deloitte LLP
Chartered Accountants and Statutory Auditor
Newcastle, UK
Date:

Statement of comprehensive income for 12 months ended 31 March 2012

	Note	12 months ended 31 March 2012 £000	12 months ended 31 March 2011 Including WPH voluntary termination of PFI ** As restated * £000	WPH voluntary termination of PFI ** As restated * £000	Excluding WPH voluntary termination of PFI ** As restated * £000
Revenue:					
Income from activities	2	260,755	237,099	0	237,099
Other operating income	2	10,473	9,597	0	9,597
Total operating income		**271,228**	**246,696**	**0**	**246,696**
Operating expenses	3	(257,912)	(227,946)	(224)	(227,722)
Operating surplus/(deficit)		**13,316**	**18,750**	**(224)**	**18,974**
Finance costs:					
Finance income	8	357	387	0	387
Finance expense - financial liabilities	9	(5,035)	(10,233)	(5,709)	(4,524)
Finance expense - unwinding of discount on provisions		(19)	(24)	0	(24)
PDC dividends payable		(2,927)	(2,518)	0	(2,518)
Net Finance Costs		**(7,624)**	**(12,388)**	**(5,709)**	**(6,679)**
surplus/(deficit) for the year		**5,692**	**6,362**	**(5,933)**	**12,295**
Other comprehensive income					
Impairments - property, plant and equipment		0	0	0	0
Revaluation gains - property, plant and equipment		0	68	0	68
Other reserve movements		0	0	0	0
Total comprehensive income/(expense) for the year		**5,692**	**6,430**	**(5,933)**	**12,363**

* The restated figures reflect the change in accounting policy for the treatment of donated assets. Foundation trusts are required to apply the change in accounting policy retrospectively through a prior period adjustment. Details of the change is given in notes to the accounts starting on page 101 - Prior year restatement.

** 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.

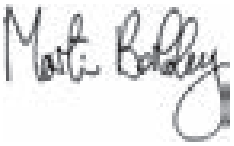
Statement of financial position as at 31 March 2012

	Note	31 March 2012 £000	31 March 2011 As restated* £000	1 April 2010 As restated* £000
Non-current assets				
Property, plant and equipment	12	198.493	183,698	179,151
Trade and other receivables	22	59	61	369
Total non-current assets		**198,552**	**183,759**	**179,520**
Current assets				
Inventories	21	174	223	223
Trade and other receivables	22	4,641	4,354	5,670
Non current assets for sale and assets in disposal groups	18	3,180	4,225	5,055
Cash and cash equivalents	25	30,065	31,578	41,594
Total current assets		**38,060**	**40,380**	**52,542**
Current liabilities				
Trade and other payables	26	(24,157)	(18,369)	(18,132)
Borrowings	27	(2,125)	(2,085)	(1,992)
Provisions	31	(693)	(556)	(667)
Other liabilities	29	(4,788)	(4,632)	(2,348)
Total current liabilities		**(31,763)**	**(25,642)**	**(23,139)**
Total assets less current liabilities		**204,849**	**198,497**	**208,923**
Non-current liabilities				
Borrowings	27	(86,173)	(85,555)	(102,309)
Provisions	31	(960)	(918)	(1,020)
Total non-current liabilities		**(87,133)**	**(86,473)**	**(103,329)**
Total assets employed		**117,716**	**112,024**	**105,594**
Financed by taxpayers' equity				
Public dividend capital		143,821	143,821	143,821
Revaluation reserve	33	11,729	11,787	12,382
Statement of comprehensive income reserve		(37,834)	(43,584)	(50,609)
Total Taxpayers' Equity		**117,716**	**112,024**	**105,594**

* The restated figures reflect the change in accounting policy for the treatment of donated assets. Foundation trusts are required to apply the change in accounting policy retrospectively through a prior period adjustment. Details of the change is given in notes to the accounts starting on page 101 - Prior year restatement.

The notes 1-44 form part of these financial statements.

The financial statements on pages 97 - 118 were approved by the Board and signed on its behalf by:

Signed:  (Chief Executive) Date: 29 May 2012

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 2011	**112,024**	**143,821**	**11,787**	**0**	(43,584)
Surplus for the year	**5,692**	0	0	0	5,692
Transfers between reserves	**0**	0	(58)	0	58
Taxpayers' Equity at 31 March 2012	**117,716**	**143,821**	**11,729**	**0**	**(37,834)**
Taxpayers' Equity as 1 April 2010 - as previously stated	**105,594**	143,821	12,382	282	(50,891)
Prior Period Adjustment *	**0**	0	0	(282)	282
Taxpayers' Equity at 1 April 2010	**105,594**	**143,821**	**12,382**	**0**	**(50,609)**
Surplus for the year	**6,362**	0	0	0	6,362
Transfers between reserves	**0**	0	(663)	0	663
Revaluations	**68**	0	68	0	0
Taxpayers' Equity at 31 March 2011	**112,024**	**143,821**	**11,787**	**0**	**(43,584)**

* In 2011-12 there was a change in accounting policy for the treatment of donated assets. Foundation trusts are required to apply the change in accounting policy retrospectively through a prior period adjustment. Details of the change is given in notes to the accounts starting on page 101 - Prior year restatement.

Statement of cash flows for 12 months ended 31 March 2012

	Note	12 months ended 31 March 2012 £000	12 months ended 31 March 2011 £000
Cash flows from operating activities			
Operating surplus from continuing operations		13,316	18,750
Operating surplus		**13,316**	**18,750**
Non-cash income and expense:			
Depreciation and amortisation		3,999	5,518
Impairments		5,668	2,496
Loss on disposal of PPE		175	200
Loss on sale of assets held for sale		70	0
Profit on sale of assets held for sale		(73)	(132)
(Increase) / Decrease in trade and other receivables		(186)	1,563
Decrease in inventories		49	0
Increase/(Decrease) in trade and other payables		3,853	(341)
Increase in other liabilities		156	2,509
Increase / (Decrease) in provisions		137	(213)
Other movements in operating cash flows		0	119
Net cash generated from operations		**27,164**	**30,469**
Cash flows from investing activities			
Interest received		372	387
Purchase of property, plant and equipment		(19,971)	(12,144)
Sales of property, plant and equipment		938	532
Net cash generated used in investing activities		**(18,661)**	**(11,225)**
Cash flows from financing activities			
Capital element of Private Finance Initiative obligations		(2,053)	(16,682)
Interest element of Private Finance Initiative obligations		(4,972)	(5,215)
PDC dividend paid		(2,955)	(2,457)
Cash flows from (used in) other financing activities		0	(4,927)
Net cash generated used in financing activities		**(9,980)**	**(29,281)**
Decrease in cash and cash equivalents	25	**(1,477)**	**(10,037)**
Cash and cash equivalents at 1 April	25	**31,542**	**41,579**
Cash and cash equivalents at 31 March	25	**30,065**	**31,542**

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 2011-12 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.

Prior year restatement

Donated assets

Donated property, plant and equipment assets are capitalised at their fair value on receipt. The donation is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met. The donated assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

In Accounts prepared prior to 2011-12 the following treatment was adhered to for 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.

Per the ARM 2011-12, foundation trusts are required to apply the change in accounting policy retrospectively, through a prior period adjustment, in accordance with IAS 8 Accounting Policies, Changes in Accounting Estimates and Errors.

The effect of the prior period adjustment to the 2011-12 financial statements is summarised below:

SOCITE Donated asset reserve	As previously reported £000	Prior year restatement £000	Restated £000
Taxpayers equity at 1 April 2010	282	(282)	0
Transfer to the SOCI	(10)	10	0
Taxpayers equity at 31 March 2011	272	(272)	0
Statement of comprehensive income reserve			
Taxpayers equity at 1 April 2010	(50,891)	282	(50,609)
Surplus for the year	6,372	(10)	6,362
Other reserve movements	663	0	663
Taxpayers equity at 31 March 2011	(43,856)	272	(43,584)
SOCI			
Surplus for the year	6,372	(10)	6,362

Government grant funded assets

Government grants are grants from government bodies other than revenue from NHS bodies for the provision of services. Where a grant has been used to fund revenue expenditure it is taken to the Statement of Comprehensive income to match that expenditure.

Grant income relating to assets is recognised within income when the foundation trust becomes entitled to it, unless the grantor imposes acondition that the future economic benefits embodied in the grant are to be consumed as specified by the grantor and if it is not, the grant must be returned to the grantor, e.g. a grant that is conditional on the construction of an asset.

In Accounts prepared prior to 2011-12 capital grants were 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 were valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations and impairments were taken to the government grant reserve and, each year, an amount equal to the depreciation charge on the asset was released from the government grant reserve to offset the expenditure.

The Trust has received no capital government grants in either the current or prior year therefore no restatement was necessary.

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.

The Trust has identified the valuation of the Trust estate and the valuation of Provisions as critical accounting judgements and key sources of uncertainty. DTZ Ltd provide third party assurance of the value of the estate. Provisions are, in the main, injury benefits provision which are valued using actuarial tables.

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

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

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 property, plant and equipment assets are capitalised at their fair value on receipt. The donation is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met. The donated assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Government grants
Government grants are grants from government bodies other than revenue from NHS bodies for the provision of services. Where a grant has been used to fund revenue expenditure it is taken to the Statement of Comprehensive income to match that expenditure.

Grant income relating to assets is recognised within income when the foundation trust becomes entitled to it, unless the grantor imposes acondition that the future economic benefits embodied in the grant are to be consumed as specified by the grantor and if it is not, the grant must be returned to the grantor, e.g. a grant that is conditional on the construction of an asset.

Non-current assets held for sale
Non-current assets are classified as held for sale 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
Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the Trust's Statement of Financial Position.

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

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

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

Provisions
Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate. The discount rate has decreased from 2.9% to 2.8% in real terms resulting in an increase 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 2012. 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 has entered into a joint operation with Mental Health Matters and County Durham & Darlington NHS Foundation Trust to provide services to improve access to psychological therapies (IAPT services). The Trust is the host organisation and only the Trust's share of of the income and expenditure; gains and losses; assets and liabilities; and cash flows are recognised in the accounts.

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 2012. 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)

Income from activities	12 months ended 31 March 2012 £000	12 months ended 31 March 2011 As restated £000
Cost and volume contract income	44,496	38,195
Block contract income	203,631	188,948
Clinical partnerships providing mandatory services (including S31 agreements)	5,114	3,577
Clinical income for the secondary commissioning of mandatory services	3,028	1,787
Other clinical income from mandatory services	4,486	4,592
Total income from activities	**260,755**	**237,099**
Other operating income		
Research and development	667	623
Education and training	6,174	5,534
Transfers from donated asset reserve in respect of depreciation on donated assets	0	0
Non patient care services to other bodies	2,787	2,751
Other revenue	273	557
Profit on disposal of land and buildings	0	132
Profit on disposal of other tangible fixed assets	73	0
Income in respect of staff costs where accounted on gross basis	499	0
Total other operating income	**10,473**	**9,597**
Total operating income	**271,228**	**246,696**

Note 2.2
Private patient income

The Trust has no private patient income (2010-11, £nil)

Note 2.3
Operating lease income

The Trust has no operating lease income (2010-11, £nil)

Note 2.4
Operating income (by type)

	12 months ended 31 March 2012 £000	12 months ended 31 March 2011 As restated £000
Income from activities		
NHS Foundation Trusts	705	807
NHS Trusts	158	132
Strategic Health Authorities	67	59
Primary Care Trusts	252,892	230,508
Local Authorities	3,377	3,578
Department of Health - other	4	132
NHS Other	156	236
Non NHS Other	3,396	1,647
Total income from activities	**260,755**	**237,099**
Other operating income		
Research & development	667	623
Education and training	6,174	5,534
Non-patient care services to other bodies	2,787	2,751
Other	273	557
Profit on disposal of land & buildings	0	132
Profit on disposal of other tangible fixed assets	73	0
Income in respect of staff costs where accounted on gross basis	499	0
Total other operating income	**10,473**	**9,597**
Total operating income	**271,228**	**246,696**
Analysis of income from activities - non NHS other		
Other government departments and agencies	553	598
Other	2,843	1,049
	3,396	**1,647**
Analysis of other operating income - other		
Estates recharges	0	89
Catering	27	242
Rental income	100	101
Other	146	125
	273	**557**

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 2012 £000	12 months ended 31 March 2011 As restated £000
Services from NHS Foundation Trusts	3,709	1,065
Services from NHS Trusts	436	423
Services from PCTs	630	121
Purchase of healthcare from non NHS bodies	1,760	1,736
Executive directors costs	1,385	1,434
Non-executive directors costs	152	153
Staff costs	198,646	175,995
Drug costs	4,069	3,676
Supplies and services - clinical (excluding drug costs)	1,511	1,314
Supplies and services - general	3,311	4,095
Establishment	7,484	6,278
Research and development	508	274
Transport	3,267	3,513
Premises	16,006	15,092
Increase in bad debt provision	28	189
Depreciation on property, plant and equipment	3,999	5,518
Impairments of property, plant and equipment	5,558	1,166
Impairments of assets held for sale	110	1,330
Audit fees		
audit services - statutory audit	66	66
audit services - regulatory reporting	18	18
non audit services	26	21
Other auditors remuneration		
further assurance services	218	218
Clinical negligence	499	390
Loss on disposal of other property, plant and equipment	175	200
Loss on disposal of assets held for sale	70	0
Legal fees	584	287
Consultancy costs	689	866
Training courses and conferences	1,244	1,215
Patient travel	66	61
Redundancy	269	177
Hospitality	169	148
Insurance	70	38
Losses, ex-gratia & special payments	492	157
Other	688	712
Total operating expenses	**257,912**	**227,946**
Analysis of operating expenses - other		
Services from local authorities	228	114
Other patients' expenses	243	336
National QC and accreditation fees	90	0
Miscellaneous	127	262
	688	**712**

Note 3.1
Other audit remuneration

Other audit remuneration in 2011-12 for £218,000 (2010-11, £218,000) is for internal audit services.

Note 4.1
Employee expenses

	12 months ended 31 March 2012			12 months ended 31 March 2011		
	Total £000	Permanently Employed £000	Other £000	Total £000	Permanently Employed £000	Other £000
Salaries and wages	160,977	155,734	5,243	145,647	139,124	6,523
Social security costs	11,899	11,061	838	10,349	9,633	716
Pension costs - defined contribution plans						
Employers contributions to NHS Pensions	19,621	18,448	1,173	17,467	16,464	1,003
Termination benefits	269	269	0	177	177	0
Agency/contract staff	8,099	0	8,099	4,908	0	4,908
Gross employee expenses	**200,865**	**185,512**	**15,353**	**178,548**	**165,398**	**13,150**
less income in respect of salaries and wages where netted off expenditure	(271)	(271)	0	(624)	(624)	0
Total employee expenses	**200,594**	**185,241**	**15,353**	**177,924**	**164,774**	**13,150**
of which:						
Costs capitalised as part of assets	294	294	0	318	318	0
Total employee expenses exc. capitalised costs	**200,300**	**184,947**	**15,353**	**177,606**	**164,456**	**13,150**

The salary costs of the capital development team are capitalised over the full costs of the Trust's capital schemes which in 2011-12 were predominantly Roseberry Park hospital, Cross Lane hospital and Bankfields Court.

Note 4.2
Average number of employees (WTE Basis)

	12 months ended 31 March 2012			12 months ended 31 March 2011		
	Total Number	Permanently Employed Number	Other Number	Total Number	Permanently Employed Number	Other Number
Medical and dental	273	253	20	238	223	15
Administration and estates	940	890	50	872	831	41
Healthcare assistants and other support staff	290	282	8	293	288	5
Nursing, midwifery and health visiting staff	3,140	3,090	50	2,857	2,809	48
Scientific, therapeutic and technical staff	540	471	69	457	388	69
Social care staff	43	0	43	40	0	40
Bank and agency staff	283	0	283	231	0	231
Total	**5,509**	**4,987**	**522**	**4,988**	**4,539**	**449**

Note 4.3
Employee benefits
There were no employee benefits paid in the twelve months ended 31 March 2012 (twelve months to 31 March 2011, nil).

Note 4.4
Early retirements due to ill health
During the period to 31 March 2012 there were 14 (2010-11, 9) early retirements from the Trust on the grounds of ill-health. The estimated additional pension liabilities of the ill-health retirement will be £998,347 (2010-11, £642,757). The cost of this ill-health retirement will be borne by the NHS Business Services Authority - Pension Division.

Note 4.5
Analysis of termination benefits
There were 6 payments for termination benefits valuing £269,000 during the period to March 2012 (2010-11, 6 payments valuing £177,000)

Note 4.6
Cost of exit packages
During the period to 31 March 2012 there were 7 (2010-11,2) exit packages costing £269,00 (2010-11, £176,000). These packages were non compulsory.

Note 4.7
Senior managers' remuneration

	2011-12				2010-11			
	Salary	Other Remuneration	Benefits in Kind*	Total Remuneration	Salary	Other Remuneration	Benefits in Kind*	Total Remuneration
Name and Title	(bands of £5000) £000	(bands of £5000) £000	Rounded to the nearest £100	(bands of £5000) £000	(bands of £5000) £000	(bands of £5000) £000	Rounded to the nearest £100	(bands of £5000) £000
Mr Martin Barkley, *Chief Executive*	150-155	0	0	150-155	145-150	0	0	145-150
Mr Colin Martin, *Director of Finance and Information*	115-120	0	8,000	125-130	110-115	0	7,600	120-125
Dr Nick Land, *Medical Director*	35-40	160-165 **	3,100	195-200	30-35	155-160 **	3,100	190-195
Mr David Levy, *Director of HR & OD*	100-105	0	0	100-105	100-105	0	0	100-105
Mrs Chris Stanbury, *Director or Nursing and Governance*	105-110	0	2,200	105-110	95-100	0	1,900	95-100
Mr Chris Parsons, *Director of Estates and Facilities*	90-95	0	3,500	85-90	85-90	0	3,200	95-100
Mrs Sharon Pickering, *Director of Planning and Performance*	90-95	0	4,600	95-100	90-95	0	3,600	90-95
Mr Les Morgan, *Chief Operating Officer*	110-115	0	100	110-115	100-105	0	5,600	105-110
Mr Paul Newton, *Director Of Operations - County Durham & Darlington*	85-90	0	6,600	95-100	75-80	0	6,800	85-90
Mr David Brown, *Director Of Operations - Teesside*	85-90	0	2,900	90-95	80-85	0	4,000	80-85
Mrs Lesley Ann Crawford, *Service Director - Adult Services left 31st May 2011*	10-15	0	200	10-15	80-85	0	1,600	80-85
Mr Levi Buckley, *Director Of Operations - Forensic Services started 1st June 2011*	60-65	0	0	60-65	0	0	0	0
Mrs Adele Coulthard, *Director Of Operations - North Yorkshire started 1st October 2011*	35-40	0	0	35-40	0	0	0	0
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 (Left June 10)*	0	0	0	0	00-05	0	0	00-05
Mrs Barbara Matthews, *Non Executive Director (Started July 10)*	10-15	0	0	10-15	05-10	0	0	05-10
Mr Mike 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 Graham 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

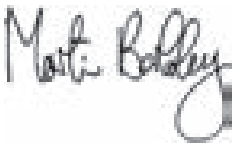
Band of highest paid directors total remuneration (£000) ***	150-155	Band of highest paid directors total remuneration (£000) ***	145-150
Median of total remuneration	25,528	Median of total remuneration	24,457
Ratio (Director to Median)	6.0	Ratio (Director to Median)	6.0

* Benefits in kind are the provision of lease cars
** Other remuneration includes the full time salary for the role as a consultant psychiatrist plus an additional 2 Additional Clinical Programmed Activities worked during the reported period (For which £27k was paid during 2011-12 (£26k for 2010-11) & Clinical Excellence award
*** The Chief Executive is shown as the highest paid director, as the Medical Director has a substantive post as a Consultant Psychiatrist as well as Director responsibilities - including this would not show a true and fair ratio.

Pay Terms and Conditions
With the exception of directors, non-executives and medical staffing the workforce are covered by Agenda for Change. All inflationary uplifts for staff employed under national terms and conditions have been in accordance with nationally determined pay arrangements. All executive directors are on a permanent contract and have a notice period of 6 months.

The Remuneration Committee is responsible for Executive Directors pay.

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

Signed:  Chief Executive Date: 29 May 2012

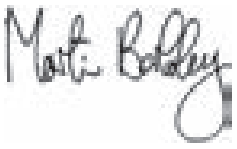
Note 4.8
Senior managers' pension benefits

Name and Title	Real increase in pension at age 60 (bands of £2500) £000	Real increase in pension lump sum at age 60 (bands of £2500) £000	Total accrued pension at age 60 at 31 March 2012 (bands of £5000) £000	Lump sum at age 60 related to accrued pension at 31 March 2012 (bands of £5000) £000	Cash Equivalent Transfer Value at 31 March 2012 £000	Cash Equivalent Transfer Value at 31 March 2011 £000	Real Increase in Cash Equivalent Transfer Value £000	Employers Contribution to Stakeholder Pension To nearest £100
Mr Martin Barkley, *Chief Executive*	0.0-2.5	0.0-2.5	70-75	220-225	1,627	1,554	73	100
Mr Colin Martin, *Director of Finance and Information*	0.0-2.5	0.0-2.5	35-40	110-115	627	543	84	100
Dr Nick Land, *Medical Director*	2.5-5.0	5.0-7.5	60-65	180-185	1,100	960	140	100
Mr Les Morgan, *Chief Operating Officer*	2.5-5.0	10.0-12.5	45-50	145-150	942	813	128	100
Mrs Chris Stanbury, *Director or Nursing and Governance*	0.0-2.5	2.5-5.0	45-50	145-150	942	851	91	100
Mr David Levy, *Director of HR & OD*	0.0-2.5	0.0-2.5	15-20	55-60	365	324	41	-
Mrs Sharon Pickering, *Director of Planning and Performance*	0.0-2.5	0.0-2.5	25-30	75-80	390	324	65	100
Mr Chris Parsons, *Director of Estates and Facilities*	0.0-2.5	2.5-5.0	15-20	55-60	432	398	34	-
Mr Paul Newton, *Director Of Operations - County Durham & Darlington*	2.5-5.0	7.5-10.0	40-45	130-135	820	694	126	100
Mr David Brown, *Director Of Operations - Teesside*	0.0-2.5	5.0-7.5	25-30	85-90	533	461	72	100
Mrs Lesley Ann Crawford, *Service Director - Adult Services left 31st May 2011*	0.0-2.5	0.0-2.5	30-35	90-95	615	574	7	-
Mr Levi Buckley, *Director Of Operations - Forensic Services started 1st June 2011*	0.0-2.5	2.5-5.0	15-20	45-50	210	150	45	-
Mrs Adele Coulthard, *Director Of Operations - North Yorkshire started 1st October 2011*	0.0-2.5	0.0-2.5	20-25	65-70	354	326	14	-

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.

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.

Signed:  Chief Executive Date: 29 May 2012

Note 5.1
Operating leases

	12 months ended 31 March 2012 £000	12 months ended 31 March 2011 £000
Minimum lease payments	6,079	4,599
Total	**6,079**	**4,599**

Note 5.2
Arrangements containing an operating lease

	12 months ended 31 March 2012 £000	12 months ended 31 March 2011 £000
Future minimum lease payments due:		
not later than one year	5,265	4,465
later than one year and not later than five years	7,650	6,056
later than five years	3,131	2,983
Total	**16,046**	**13,504**

The Trust operating leases includes leased vehicles for staff, property rental and telephony rental.

Management have identified an error in the calculation of the prior year note which has resulted in a restatement.

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 2012 (31 March 2011, £nil).

Note 7
Corporation tax
The Trust has no Corporation Tax liability or asset at 31 March 2012 (31 March 2011, £nil).

Note 8
Finance income

	12 months ended 31 March 2012 £000	12 months ended 31 March 2011 £000
Bank deposits	357	387
Total	**357**	**387**

Note 9
Finance costs - interest expense

	12 months ended 31 March 2012 £000	12 months ended 31 March 2011 £000
Other	23	4,784
Finance costs in PFI obligations		
Main finance cost	5,012	5,449
Total	**5,035**	**10,233**

Other finance costs for 2011-12 are the change in discount rate of provisions (£23,000). For 2010-11 other finance costs are the 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).

Note 10
Impairment of assets

	12 months ended 31 March 2012 £000	12 months ended 31 March 2011 £000
Re-statement of assets to open market value of assets held for sale	0	456
Impairment of completed assets (previously classified as assets under construction)	0	710
Changes in market price	5,668	1,330
Total impairments	**5,668**	**2,496**

Note 11
Intangible assets
The Trust has no intangible assets as at 31 March 2012 (31 March 2011, £nil).

Note 12.1
Property, plant and equipment 2011-12

	Total £000	Land £000	Buildings exc. dwellings £000	Dwellings £000	Assets under construction £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000
Cost or valuation at 1 April 2011	289,919	49,827	217,202	196	10,800	2,696	293	6,589	2,316
prior period adjustments	0	0	0	0	0	0	0	0	0
Restated cost or valuation at 1 April 2011	**289,919**	**49,827**	**217,202**	**196**	**10,800**	**2,696**	**293**	**6,589**	**2,316**
Additions purchased	24,529	0	11,111	0	13,356	0	34	28	0
Reclassifications	0	0	9,719	0	(9,719)	0	0	0	0
Disposals	(177)	0	(177)	0	0	0	0	0	0
Cost or valuation at 31 March 2012	**314,271**	**49,827**	**237,855**	**196**	**14,437**	**2,696**	**327**	**6,617**	**2,316**
Accumulated depreciation at 1 April 2011	106,221	35,997	59,452	196	0	2,437	250	6,096	1,793
prior period adjustments	0	0	0	0	0	0	0	0	0
Restated accumulated depreciation at 1 April 2011	**106,221**	**35,997**	**59,452**	**196**	**0**	**2,437**	**250**	**6,096**	**1,793**
Provided during year	3,999	0	3,555	0	0	78	7	198	161
Impairments	5,558	0	5,558	0	0	0	0	0	0
Accumulated depreciation at 31 March 2012	**115,778**	**35,997**	**68,565**	**196**	**0**	**2,515**	**257**	**6,294**	**1,954**

Note 12.2
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 as previously stated	99,613	35,457	53,905	196	0	2,348	243	5,848	1,616
prior period adjustments	0	0	0	0	0	0	0	0	0
Restated accumulated depreciation at 1 April 2010	**99,613**	**35,457**	**53,905**	**196**	**0**	**2,348**	**243**	**5,848**	**1,616**
Provided during year	5,518	0	4,997	0	0	89	7	248	177
Impairments	1,166	540	626	0	0	0	0	0	0
Reclassifications	(76)	0	(76)	0	0	0	0	0	0
Accumulated depreciation at 31 March 2011	**106,221**	**35,997**	**59,452**	**196**	**0**	**2,437**	**250**	**6,096**	**1,793**

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 2012									
Owned	104,556	13,830	84,985	0	4,807	179	70	323	362
PFI	93,685	0	84,055	0	9,630	0	0	0	0
Donated	252	0	250	0	0	2	0	0	0
Net book value total at 31 March 2012	**198,493**	**13,830**	**169,290**	**0**	**14,437**	**181**	**70**	**323**	**362**
Net book value - 31 March 2011									
Owned	100,297	13,830	74,862	0	10,291	255	43	493	523
PFI	83,129	0	82,620	0	509	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 - 1 April 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 1 April 2010	**179,151**	**14,370**	**160,100**	**0**	**3,152**	**266**	**50**	**532**	**681**

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
Buildings excluding dwellings	1	88
Assets under Construction & POA	10	90
Plant & Machinery	1	8
Transport Equipment	1	5
Information Technology	1	4
Furniture & Fittings	1	6

Note 15.1
Analysis of property, plant and equipment - 1 April 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 1 April 2010	**179,151**	**14,370**	**160,100**	**0**	**3,152**	**266**	**50**	**532**	**681**

Note 15.2
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 15.3
Analysis of property, plant and equipment - 31 March 2012

	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	**179,368**	13,790	165,578	0	0	0	0	0	0
NBV - Unprotected assets	**19,125**	40	3,712	0	14,437	181	70	323	362
Total at 31 March 2012	**198,493**	**13,830**	**169,290**	**0**	**14,437**	**181**	**70**	**323**	**362**

Note 15.4
NBV of property, plant and equipment in the Revaluation Reserve as at 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
as at 1 April 2010	**12,382**	1,102	11,280	0	0	0	0	0	0
movement in year	**(595)**	206	(801)	0	0	0	0	0	0
as at 31 March 2011	**11,787**	**1,308**	**10,479**	**0**	**0**	**0**	**0**	**0**	**0**

Note 15.5
NBV of property, plant and equipment in the Revaluation Reserve as at 31 March 2012

	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
as at 1 April 2011	**11,787**	1,308	10,479	0	0	0	0	0	0
movement in year	**(58)**	0	(58)	0	0	0	0	0	0
as at 31 March 2012	**11,729**	**1,308**	**10,421**	**0**	**0**	**0**	**0**	**0**	**0**

Note 16
Investments
The Trust holds no investments as at 31 March 2012 (31 March 2011, £nil).

Note 17
Associate and jointly controlled operations
The Trust has no investments in associate (and joined controlled operations) as at 31 March 2012 (31 March 2011, £nil).

Note 18.1
Non current assets for sale and assets in disposal groups 2011-12

	Total £000	Property, Plant & Equipment £000
NBV of non-current assets for sale and assets in disposal groups at 31 March 2011	4,225	4,225
Less assets sold in year	(935)	(935)
Less impairment of assets held for sale	(110)	(110)
NBV of non-current assets for sale and assets in disposal groups at 31 March 2012	**3,180**	**3,180**

Note 18.2
Non current assets for sale and assets in disposal groups 2010-11

	Total £000	Property, Plant & Equipment £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 18.3
Liabilities disposal groups
The Trust has no liabilities in disposal groups as at 31 March 2012 (31 March 2011, £nil).

Note 19
Other assets
The Trust has no other assets as at 31 March 2012 (31 March 2011, £nil).

Note 20
Other financial assets
The Trust has no other financial assets as at 31 March 2012 (31 March 2011, £nil).

Note 21.1
Inventories

	31 March 2012 £000	31 March 2011 £000
Materials	174	223
Total Inventories	**174**	**223**

Note 21.2
Inventories recognised in expenses

	31 March 2012 £000	31 March 2011 £000
Inventories recognised in expenses	223	223
Total Inventories recognised in expenses	**223**	**223**

Note 22
Trade receivables and other receivables

	31 March 2012 £000	31 March 2011 £000
Current		
NHS receivables	1,239	2,123
Other receivables with related parties	440	298
Provision for impaired receivables	(159)	(339)
Prepayments	1,913	1,553
PFI Prepayments		
Prepayments - lifecycle replacements	110	25
Accrued income	151	19
PDC dividend receivable	66	38
VAT receivable	546	375
Other trade receivables	335	262
Total current trade and other receivables	**4,641**	**4,354**
Non Current		
Other trade receivables	59	61
Total non current trade and other receivables	**59**	**61**

Note 23.1
Provision for impairment of receivables

	31 March 2012 £000	31 March 2011 £000
At 1 April	339	149
Increase in provision	152	244
Amounts utilised	(208)	0
Unused amounts reversed	(124)	(55)
At 31 March	**159**	**339**

Note 23.2
Analysis of impaired receivables

	31 March 2012 £000	31 March 2012 £000	31 March 2011 £000	31 March 2011 £000
Ageing of impaired receivables	**Trade receivables**	**Other receivables**	**Trade receivables**	**Other receivables**
0 - 30 days	40	0	49	0
30 - 60 Days	21	0	51	0
60 - 90 days	18	0	45	0
90 - 180 days	41	0	43	0
over 180 days	39	0	131	19
Total	**159**	**0**	**319**	**19**
Ageing of non-impaired receivables past their due date				
0 - 30 days	430	201	1,584	28
30 - 60 Days	130	1	295	7
60 - 90 days	71	3	98	39
90 - 180 days	200	6	169	3
over 180 days	57	33	147	80
Total	**888**	**244**	**2,293**	**157**

Note 24
Finance leases

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

Note 25
Cash and cash equivalents

	31 March 2012 £000	31 March 2011 £000
At 1 April	31,542	41,579
Net change in year	(1,477)	(10,037)
At 31 March	**30,065**	**31,542**
Broken down into:		
Commercial banks and cash in hand	95	34
Cash with Government Banking Service	29,970	31,544
Cash and cash equivalents as in SoFP	**30,065**	**31,578**
Bank overdraft	0	(36)
Cash and cash equivalents as in SoCF	**30,065**	**31,542**

Note 26.1
Trade and other payables

	31 March 2012 £000	31 March 2011 £000
NHS payables	3,267	413
Amounts due to other related parties - revenue	2,524	2,224
Other trade payables – capital	3,402	1,506
Other trade payables – revenue	3,835	3,188
Social Security costs	2,038	1,719
VAT payable	31	25
Other taxes payable	2,126	1,894
Other payables	2	30
Accruals	6,932	7,370
Total current trade and other payables	**24,157**	**18,369**

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 2012 (2010-11, £nil).

Note 27
Borrowings

	31 March 2012 £000	31 March 2011 £000
Current		
Bank overdrafts	0	36
Obligations under Private Finance Initiative contracts	2,125	2,049
Total current borrowings	**2,125**	**2,085**
Non current		
Obligations under Private Finance Initiative contracts	86,173	85,555
Total other non-current liabilities	**86,173**	**85,555**

PFI borrowings are in relation to Lanchester Road Hospital and Roseberry Park Hospital which all operate under a standard form PFI contract i.e. unitary payments are payable from the date construction completion and are not subject to re-pricing. Inflation linked to RPI is applied annually. Final settlements are expected in May 2038 and March 2040 respectively.

Note 28.1
Prudential borrowing limit

	31 March 2012 £000	31 March 2011 £000
Total long term borrowing limit set by Monitor	89,900	106,100
Working capital facility agreed by Monitor	20,500	18,000
Total prudential borrowing limit	**110,400**	**124,100**
Long term borrowing available at 1 April	106,100	107,100
Net actual repayment borrowing in year - long term	(16,200)	(1,000)
Long term borrowing available at 31 March	**89,900**	**106,100**
Working capital borrowing available at 1 April	18,000	17,000
Net actual borrowing in year - working capital	2,500	1,000
Working capital borrowing available at 31 March	**20,500**	**18,000**

Note 28.2
Prudential borrowing limit ratios

	Threshold	31 March 2012
Minimum dividend cover	>1x	6.2x
Minimum interest cover	>2x	4.6x
Minimum debt service cover	>1.5x	3.3x
Maximum debt service to revenue	<10%	2.60%

The NHS foundation trust is required to comply and remain within a prudential borrowing limit. This is made up of two elements:

- the maximum cumulative amount of long-term borrowing. This is set by reference to the four ratio tests set out in the Prudential Borrowing Code for NHS foundation trusts. The financial risk rating set under Monitor's Compliance Framework determines one of the ratios and therefore can impact on the long term borrowing limit; and
- the amount of any working capital facility approved by Monitor.

Further information on the Prudential Borrowing Code for NHS foundation trusts and Compliance Framework can be found on Monitor's website.

Note 29
Other liabilities

	31 March 2012 £000	31 March 2011 £000
Current		
Deferred income	4,788	4,632
Total other current liabilities	**4,788**	**4,632**

Note 30
Other financial liabilities

The Trust has no other financial liabilities at 31 March 2012 (31 March 2010-11, £nil).

Note 31.1
Provisions for liabilities and charges - 2011-12

	Total £000	Pensions - other staff £000	Legal claims £000	Restruct-uring £000	Other £000
At 1 April 2011	1,474	963	349	162	0
Change in the discount rate	22	22	0	0	0
Arising during the year	813	124	314	200	175
Utilised during the year	(614)	(120)	(277)	(217)	0
Reversed unused	(61)	0	(61)	0	0
Unwinding of discount	19	19	0	0	0
At 31 March 2012	**1,653**	**1,008**	**325**	**145**	**175**
Expected timing of cash flows:					
not later than one year	693	48	325	145	175
Current	**693**	**48**	**325**	**145**	**175**
later than one year and not later than five years	193	193	0	0	0
later than five years	767	767	0	0	0
Non Current	**960**	**960**	**0**	**0**	**0**
TOTAL	**1,653**	**1,008**	**325**	**145**	**175**

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 - £50,000 (2010-11, £131,000), employer / public liability claims notified by the NHS Litigation Authority £200,200 (2010-11, £154,000), and the provision for employment law £74,822 (2010-11, £64,000).

Included in the 'restructuring' category and arising during the period is a provision for organisational change. Other provisions include a provision for the costs of transferring equipment from North Yorkshire PCT.

Note 31.2
Provisions for liabilities and charges - 2010-11

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

Note 31.3
NHSLA provisions for liabilities and charges

£3,246,000 (2010-11, £1,724,000) is included in the provisions of the NHS Litigation Authority at 31 March 2012 in respect of clinical negligence liabilities of the NHS Foundation Trust.

Note 32.1
Contingent liabilities

	31 March 2012 £000	31 March 2011 £000
Gross value of contingent liabilities	135	120
Net value of contingent liabilities	**135**	**120**

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

Note 32.2
Contingent assets

The Trust has no contingent assets at 31 March 2012 (31 March 2011, £nil)

Note 33
Revaluation reserve

	31 March 2012 £000	31 March 2011 £000
Revaluation reserve at 1 April	11,787	12,382
Revaluations	0	68
Transfers to other reserves	(58)	(663)
Revaluation reserve at 31 March	**11,729**	**11,787**

Note 34.1
Related Party Transactions

	Income £000	Expenditure £000
2011-12		
Value of transactions (other than salary) with board members in 2011/12	0	0
Value of transactions (other than salary) with key staff members in 2011/12	0	0
Value of transactions (other than salary) with other related parties in 2011/12		
Department of Health	152	1,488
Other NHS Bodies	262,957	7,491
Other	4,436	44,870
Total	**267,545**	**53,849**
2010-11		
Value of transactions with board members in 2010/11	0	0
Value of transactions with key staff members in 2010/11	0	0
Value of transactions with other related parties in 2010/11		
Department of Health	195	956
Other NHS Bodies	239,757	6,285
Other	4,597	39,554
Total	**244,549**	**46,795**

Note 34.2
Related Party Balances

	Receivables £000	Payables £000
2011-2012		
Value of balances (other than salary) with board members at 31 March 2012	0	0
Value of balances (other than salary) with key staff members at 31 March 2012	0	0
Value of balances (other than salary) with related parties in relation to doubtful debts at 31 March 2012	159	0
Value of balances with other related parties at 31 March 2012		
Department of Health	48	47
Other NHS Bodies	1,240	7,063
Other	1,042	7,970
Total	**2,489**	**15,080**
2010-11		
Value of balances (other than salary) with board members at 31 March 2011	0	0
Value of balances (other than salary) with key staff members at 31 March 2011	0	0
Value of balances (other than salary) with related parties in relation to doubtful debts at 31 March 2011	320	0
Value of balances with other related parties at 31 March 2011		
Department of Health	14	234
Other NHS Bodies	2,109	4,350
Other	674	6,740
Total	**3,117**	**11,324**

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
Airedale Foundation Trust
Central Manchester Universities Foundation Trust
Harrogate And District NHS Foundation Trust
Humber NHS Foundation Trust
Kings College Hospital NHS Foundation Trust
Leeds Partnership NHS Foundation Trust
Northumbria Healthcare NHS Foundation Trust
Tavistock And Portman NHS Foundation Trust
York Hospitals NHS Foundation Trust
Leicester Partnership NHS Trust
NE Ambulance Service NHS Trust
Nottinghamshire Healthcare NHS Trust
Scarborough and North Yorkshire Healthcare NHS Trust
Central London Community Healthcare NHS Trust
Northumberland Care 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
Nottinghamshire County Teaching PCT
Redcar & Cleveland PCT
Sheffield PCT
South Tyneside PCT
Stockton-on-Tees Teaching PCT
Suffolk PCT
Birmingham East And North PCT
Bradford And Airedale Teaching PCT
Camden PCT
Hull Teaching PCT
Manchester PCT
Newcastle PCT
Redbridge 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:

Durham County Council
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 2012 £000	31 March 2011 £000
Property, plant and equipment	4,108	8,290
Total as at 31 March	**4,108**	**8,290**

Note 35.2
Other Financial Commitments

The Trust has no other financial commitments as at 31 March 2012 (31 March 2011, £nil).

Note 36
Finance lease obligations

The Trust has no finance obligations as at 31 March 2012 (31 March 2011, £nil).

Note 37.1
PFI obligations (on Statement of Financial Position)

	31 March 2012 £000	31 March 2011 £000
Gross PFI liabilities	227,627	231,934
of which liabilities are due		
not later than one year	7,271	7,049
later than one year and not than five years	30,078	29,552
later than five years	190,278	195,333
Finance charges allocated to future periods	(139,329)	(144,330)
Net PFI liabilities	**88,298**	**87,604**
not later than one year	2,126	2,049
later than one year and not later than five years	8,996	8,691
later than five years	77,176	76,864
	88,298	**87,604**

Management have identified an error in the calculation of the prior year note which has resulted in a restatement.

Note 37.2
On SoFP PFI commitments

	31 March 2012 Total £000	31 March 2012 Lanchester Rd PFI £000	31 March 2012 Roseberry Park PFI £000	31 March 2011 Total £000
Commitments				
Within one year	2,157	321	1,836	2,068
2nd to 5th years (inclusive)	9,314	1,365	7,949	8,933
Later than 5 years	81,490	10,426	71,064	83,098
Total	**92,961**	**12,112**	**80,849**	**94,099**

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

There were no events after the reporting period for 2011-12.

Note 40.1
Financial assets by category

	Total £000	Loans and receivables £000
Assets as per SoFP		
NHS Trade and other receivables excluding non financial assets (at 31 March 2012)	2,611	2,611
Cash and cash equivalents at bank and in hand (at 31 March 2012)	30,065	30,065
Total at 31 March 2012	**32,676**	**32,676**
NHS 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**

Note 40.2
Financial liabilities by category

	Total £000	Other financial liabilities £000
NHS Trade and other payables excluding non financial assets (at 31 March 2012)	19,993	19,993
Provisions under contract (at 31 March 2012)	1,653	1,653
Total at 31 March 2012	**21,646**	**21,646**
NHS Trade and other payables excluding non financial assets (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**

Note 40.3
Fair values of financial assets at 31 March 2012

	Book Value £000	Fair Value £000
Non current trade and other receivables excluding non financial assets	59	59
Other	30,065	30,065
Total	**30,124**	**30,124**

Note 40.4
Fair values of financial liabilities at 31 March 2012

	Book Value £000	Fair Value £000
Provisions under contract	1,653	1,653
Total	**1,653**	**1,653**

Note 40.5
Maturity of Financial liabilities

	31 March 2012 £000	31 March 2011 £000
In one year or less	20,686	15,313
In more than one year but not more than two years	48	45
In more than two years but not more than five years	144	135
In more than five years	768	737
Total	**21,646**	**16,230**

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 43 cases in the twelve months to the 31 March 2012 at a value of £265,000 (2010-11, 59 cases, value £12,000).

Note 43
Third party assets and liabilities
The Trust held £1,259,000 cash at bank and in hand at 31 March 2012 (31 March 2011, £1,252,000) 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 held £300,000 cash at bank and in hand at 31 March 2012 (31 March 2011, £239,000) which related to monies held by the Trust for a staff savings scheme. This has been excluded from the cash at bank and in hand figure reported in the accounts.

Note 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 £20,500,000, unused at 31 March 2012.

Appendices

Appendix 1
Summary of the actions in response to 43 clinical audits reviewed in 2011/12

1 Clinical Audit of Safeguarding Children Policy Implementation

Summary of Planned Actions
- The safeguarding lead to include within safeguarding training:
  - Recording whether or not consent has been obtained for a referral to children's services.
  - Recording the outcome of referral within clinical records.

2 Clinical Audit of NICE CG25 - Violence

Summary of Planned Actions
- Staff will document whether preferred strategies in the event of a disturbed/violent incident have been discussed and document these in the intervention plan or reasons why not discussed documented in the patient record.
- Staff will be trained in the use of the post incident standard procedures as part of Leading Improvement in Patient Safety (LIPS) violence reduction project.
- The children's tier 4 service will perform a clinical audit of NICE Clinical Guideline 25 – Violence.

3 Clinical Audit Person Centred Pathway of Care for Challenging Behaviour in Children with Learning Disabilities (3 month evaluation)

Summary of Planned Actions
- The wording of clinical standards will be reviewed to improve clarity for staff.
- Standard work to support the use of assessment tools will be established and circulated to all pilot sites.
- Further training will be provided for all pilot sites around use of the assessment tools within the pathway.
- The pathway will be audited again at the 6 month point. In order to better assess the impact of the alterations made, this has been amended to 7 months.

4 Clinical Audit of Schizophrenia NICE Clinical Guideline 82

Summary of Planned Actions
- The results of audit will be reviewed within clinical teams.
- Written information about psychosis will always be offered where appropriate to service users.
- We will identify who the report is to be presented to at the CAMHS Directorate Management Team.
- All service users will have a physical health review at least every 12 months which is documented in the Trust's electronic patient record (PARIS).
- Consideration will be given for the use of psychological/alternative therapies.
- For service users who have not responded to pharmacological or psychological therapies, a medical review will be undertaken and consideration be given to psychological treatment in accordance with NICE guidance and/or commencement of Clozapine documented.

5 Clinical Audit of Rapid Tranquillisation Annual Report

Summary of Planned Actions
- The audit tool will be adapted giving further clarity around the baseline observations required.
- The results of the audit will be communicated to services via the Safe Medicines Practice Group, Modern Matron meeting and other appropriate fora. Emphasis will be placed on risk levels related to non compliance around monitoring respiration and documenting on Early Warning Scorecard (EWSC).
- The training package will ensure more emphasis is placed on why the EWSC needs to be completed in a timely fashion and the risk areas it identifies. This will be achieved through further roll out of the e-learning package.
- We will monitor uptake of the e-learning package to ensure all grades of clinical nursing staff complete the mandatory training requirements related to rapid tranquillisation. Adherence to mandatory training requirements will be monitored via the training and education department's systems and managers of service.
- The audit cycle will continue to be completed annually using the same process, and timely auditing of the children and young people's service alongside the four areas previously audited this year.

6 How well informed patients are to enable them to recognise the signs and symptoms of toxicity during treatment with Lithium

Summary of Planned Actions
- All patients prescribed Lithium will be reminded of the signs and symptoms of Lithium toxicity at 3 monthly intervals.
- All patients prescribed Lithium will have received the National Patient Safety Authority Lithium Therapy important information for patients leaflet.

7 Crisis Resolution Home Treatment Teams Functional Analysis of Care Environments (FACE) Audit

Summary of Planned Actions
- All patients referred to crisis will have a Functional Analysis of Care Environments (FACE) Risk Profile completed at time of assessment, on discharge, and at any time during their home treatment period should their situation change.
- Team managers will monitor any non compliance with completion of FACE documentation.
- Staff will be reminded to input the correct time the patient was seen into the Trust's electronic patient record (PARIS).

8 Re-audit of NICE CG25 – Violence

Summary of Planned Actions
- The results will be discussed and shared within local governance forums.
- All service users will have a Red Border Risk Assessment performed on admission.
- Service user's feelings during and after the incident will be documented in the post-incident review.
- The service user will always be involved in care planning and have their preferences taken into consideration as to preferred strategies in the event of a disturbed / violent incident and documented in the care plan.

9 Person Centred Pathway of Care for Challenging Behaviour in Children with Learning Disabilities (6 month review)

Summary of Planned Actions
- The content and format of the pathway will be reviewed in light of findings from the audit.
- If the information contained within the referral is inadequate, the receiving team will request more information from the referrer.
- A re-audit when patients are further down the pathway to monitor the quality of the patient's journey at later stages will identify any variances.

10 Audit of Use of Interpreters

Summary of Planned Actions
- Discussion will to be undertaken on the use of interpreters to translate appointment letters or having standard letters for appointments in different languages within the Trust's electronic patient record (PARIS).
- If the patient has been asked and refused to state their ethnicity, this refusal will be recorded on PARIS.
- If a patient refuses an interpreter the reason for this will be documented.
- The use of telephone interpretation will be considered more within inpatient areas.

11 Clinical Audit of NICE CG43 – Obesity

Summary of Planned Actions
- A risk assessment and guidance will be completed for measuring waist circumference.
- There will be continued access to a range of healthy foods.
- All staff will be trained in nutritional screening, including screening for overweight and obesity.
- A Trust-wide 'weight management pathway' will be piloted in two forensic learning disability services wards before being rolled out across the whole service and Trust-wide.
- There will be improved access to written information and leaflets on healthy lifestyle, healthy eating and physical activity.
- Where the service user does not have motivation to change their lifestyle and this is linked to lack of capacity, this will be documented in patient's care records.
- Re-audit of obesity.

12 Audit of Use of Hypnotics

Summary of Planned Actions
- The audit results will be sent to the adult mental health clinical governance committee and action plan agreed.
- The audit results will be sent to the drug and therapeutics committee.
- The audit tools will be reviewed.
- Re-audit annually.

13 Clinical audit of training needs of staff providing treatment for children and young people with post-traumatic stress disorder (PTSD)

Summary of Planned Actions
- The results of the audit will be shared with workforce planning and psychological therapies groups.
- Specific training in trauma focussed psychological therapies will be offered and delivered to all staff, not just those who identify a training need.

14 Clinical Audit of Rapid Tranquillisation (Durham & Darlington

Summary of Planned Actions
- All staff will receive feedback from the audit via the management structure to reiterate policy requirements.
- The lead nurse in medicines management will develop and circulate a briefing sheet related to post rapid tranquilisation (RT) observations, more specifically around respiration.
- A process will be formulated to enable patients to write their account of the situation in their notes.
- Managers will ensure the completion of mandatory RT training by all clinical staff.
- The lead nurse in medicines management will review the audit tool for re-audit to give clearer guidelines on purpose and requirements.

15 T2 and T3 Audit in Learning Disability Inpatient Areas in Durham

Summary of Planned Actions
- The service leadership team will ensure the Trust policy is consistently implemented.
- A re-audit in 12 months will complete audit cycle.

16 GP referrals to Mental Health Service

Summary of Planned Actions
- Communication with primary care regarding standards of referrals will be improved.
- Inputting of GP letter content onto the Trust's electronic patient record (PARIS) will be improved.
- There will be faster allocation of the referral to the appropriate team member.
- Re audit in 6 months time.

17 Monitoring of Mood Stabilisers

Summary of Planned Actions
- Monitoring forms have been produced for Valproate and Carbamazepine and will be put in place.
- Re-audit in a year's time.

18 Clinical Audit of 'Management of Hyperprolactinemia in Patients on Antipsychotic Medication

Summary of Planned Actions
- The results will be discussed at the drug and therapeutics committee to simplify / modify the existing guideline.
- The findings will be discussed at the audit meeting in postgraduate teaching programme.
- The report/findings will be circulated to the psychosis team consultants/team mangers to discuss in team meetings.

19 Clinical Audit of Record keeping standards of reports prepared for Mental Health Review Tribunals and Hospital Managers Review Meetings regarding patients receiving supervised community treatment (SCT)

Summary of Planned Actions
- The recommendations will be circulated widely to clinicians in the Trust.
- Re-audit in 12 months.

20 Care Programme Approach Audit 2010 – Adult Forensic Mental Health Services

Summary of Planned Actions
- All open cases will have a comprehensive assessment on the Trust's electronic patient record (PARIS).
- All assessments for new referrals will be completed within 28 days of acceptance of the referral.
- Care Programme Approach (CPA) / standard care will be identified for all service users.
- All care plans will contain a review date.
- Carer identification will be documented on PARIS.
- A physical health examination will be conducted within 12 hours of admission to hospital.
- Service users and carers, where appropriate, will be involved in care planning.
- Service users, GPs and other involved agencies will receive a copy of the care plan.
- A mental capacity test will be carried out where appropriate.

21 Audit on the Monitoring of Side Effects of Antipsychotic Medication in Darlington Community Psychosis Team

Summary of Planned Actions

- Documentation regarding presence/ absence of side effects will be improved.
- The new outpatient letter template will include a subheading of side effects to prompt clinicians to assess and record this information.
- The letter template for clinics will be modified.
- At least once a year, Liverpool University Neuroleptic Side Effects Rating Scale (LUNSERS) score will be documented. This will be done at the same time as Care Programme Approach (CPA) review and score recorded on the Trust's electronic patient record (PARIS) CPA review document.
- Training will be provided in the use of LUNSERS tool (to elicit side effects systematically).
- The results of audit will be disseminated to the whole team to raise awareness and improve practice.
- The audit will be repeated in 9-12 months (August/December 2012) to measure change in practice and to complete the audit cycle.

22 Prescribing Practice in Patients with Personality Disorder

Summary of Planned Actions

- The NICE prescribing guidelines will be followed. Any deviations from NICE guidelines will be documented and justified.
- For patients who lack capacity to consent it will be documented that the treatment is given under appropriate legislation.
- Re-audit will be performed to complete the cycle.

23 Use of Antipsychotics amongst Patients with a Diagnosis of Dementia: A Clinical Audit

Summary of Planned Actions

- We will encourage the psychological/non-pharmacological approach prior to starting antipsychotic medications.
- We will clearly document in patient's record a statement of "risk benefit has been considered" when starting the medication.
- All patients will have documented capacity assessment before starting antipsychotic medications.
- When patients lack capacity, the medication and their side effect profile will be discussed with the patient's carers / relatives and documented in patient's notes.
- A standard format/check list will be created that can be attached to patient's case record before starting antipsychotic medications.

24 Consent to Treatment and Capacity Assessment of Detained

Summary of Planned Actions

- The results will be disseminated to directorate governance fora for local action plans to be agreed.
- The results will be discussed with the Mental Health Act office.
- The results will be discussed at the safe medication practice group.

25 Audit on Assessment of Standards set for Formative and Summative Monitoring of Early Psychiatric Trainees

Summary of Planned Actions

- A more effective communication processes for assessment will be established.
- A flow chart re-design will be undertaken to make it more user friendly which will ensure easy readability and will enhance familiarity with its contents.

26 Mental State Examinations (MSEs) performed by Junior Doctors as Part of their Training

Summary of Planned Actions

- Consultants will inform junior doctors when they commence their rotation that Mental State Examinations (MSEs) must be completed on all patient
- The reasons an MSE is not completed will be documented.
- F2 junior doctors will take on some of the senior house officers responsibilities so senior house officers have further time to perform MSEs
- Senior house officers will have 1 hour of protected time per week for MSE.
- Senior house officers will organise time during the week and allocate tasks to others if needed.

27 Person Centred Pathway – Falls

Summary of Planned Actions

- Review pathway again in 6 months from last audit to monitor ongoing impact and support continuous improvement.

28 Non Prescription Products and Psychotropic Medications: An Audit of Professional Practice

Summary of Planned Actions

- To improve documentation, we will consider introducing a prompt will be developed for non prescription products in Kardex and in care documents in the Trust's electronic patient record (PARIS).
- Information will be passed on to the PARIS department and to discuss with the lead pharmacist.
- If the clinician becomes aware of the use of non prescription products in their patients, this will be discussed with the pharmacist.
- The audit result will be emailed to all the doctors in the Trust through email and orally presented in January local teaching session in Roseberry Park.
- The pharmacist will give a talk on common non prescription products and their interaction with psychotropic medications in the local Trust teaching session.

29 Monitoring and Treatment of Urinary Tract Infections (UTIs) in Psychiatry Patients

Summary of Planned Actions

- Every time an antibiotic is prescribed, the name, dose and duration will be recorded in the notes.
- All mid stream urine collections sent off will have a result recorded in the notes.
- Local guidelines will be reviewed and modifications to local practice recommended if appropriate.
- Re-audit to include formal recording of number of asymptomatic Urinary Tract Infections (UTIs), in which formal urology investigation required, and possibly number of chronic UTIs.

30 Dietary Fibre Content in Hospital Food

Summary of Planned Actions

- A copy of the audit will be provided to dieticians to review.
- A copy of the audit will be provided to hotel services to consider reviewing the menu.

31 Central Clinical Audit of Transfers of Care

Summary of Planned Actions

- The audit report will be cascaded to all relevant inpatient and community teams to review and address areas for improvement.
- Ward and team managers will monitor areas for improvement quarterly via the Clinical Reporting System (CRS) / Purposeful In-Patient Admission (PIPA) process and use supervision to address any individual issues with staff.
- A re-audit will be undertaken in the same pilot areas (Feb 2012).
- Areas identified for improvement will be considered during the Care Programme Approach (CPA) policy review with particular consideration given to the responsibility for completion of care documents at point of discharge.
- The results of the audit will be discussed and monitored in locality and adult mental health governance forums to ensure all actions are implemented.
- A Root Cause Analysis (RCA) (including direct observation) will be performed on findings with relevant staff.
- Findings of the RCA will be used by the nursing and governance directorate and clinical divisions to inform future planning.

32 Capacity and Consent in In-Patients

Summary of Planned Actions
- The ward boards will include colour coded information of capacious / incapacious for each admitted patient.
- The documentation of treatment in the Mental Capacity Act (MCA) of Capacity and Consent will state that the plan of treatment is outlined in the care plan or in the continuation of the same paragraph.
- The formulation meeting documentation plan will include a separate section that ensures the MCA 1 form is completed by the responsible clinician by the end of the formulation meeting.
- The formulation resource box available on the wards will include the MCA 1 Form.

33 CQuIN Indicator – to Improve the Quality of Discharge Planning and Communication from Inpatient Adult Wards

Summary of Planned Actions
- The audit report will be cascaded to all inpatient and community teams to review and address any areas for improvement.
- Ward and team managers will monitor areas for improvement quarterly via the Clinical Reporting System (CRS) / Purposeful In-Patient Admission (PIPA) process and supervision to address areas of poor compliance with individual staff.
- A re-audit will be undertaken in the same pilot areas.
- Areas identified for improvement will be considered during the Care Programme Approach (CPA) policy review with particular consideration to be given to the responsibility for completion of care documents at point of discharge.
- The results of the audit will be discussed and monitored in locality and adult mental health governance forums to ensure all actions are implemented.
- Root Cause Analysis (RCA) (including direct observation) will be performed.

34 Is DVLA Guidance on Fitness to Drive Routinely Implemented Alongside Discharge Planning from an Acute Mental Health Ward?

Summary of Planned Actions
- The audit will be presented at postgraduate teaching for locality at next available session.
- The report will be forwarded to consultants to action recommendations at a ward level.
- All patient records will include documentation on whether they received advice to contact Driving Vehicle & Licensing Authority regarding inpatient stay and discharge documentation will include driving status.
- The report will be forwarded to clinical governance lead and clinical assurance and registration department.
- Re-audit will take place in 2012.

35 Clinical Audit of NICE CG9 - Eating Disorders

Summary of Planned Actions
- On referral, the results of all physical assessments undertaken by GP or paediatrics will be documented within Trust's electronic patient record (PARIS) documentation by the allocated professional.
- Advice given regarding dental checkups (if vomiting) will be documented on PARIS.
- Information on self help groups and support groups, when given, will be documented within the PARIS record.
- The information on likely side effects of medication will be given to patients, and this conversation will be documented within the PARIS record.

36 Care Programme Approach (CPA) Audit (to include risk assessment process - C&YPS

Summary of Planned Actions
- All service users will have an identified care co-ordinator / lead professional by the care planning stage.
- All care plans will contain a review date.
- Service users and carers, where applicable, will be involved in developing the care plan.
- Service users will be given a copy of the care plan.
- GPs will be sent a copy of the care plan (this may be in the form of a letter).
- Service users will be invited to reviews and encouraged to express their views.
- Side effect monitoring tools will be used where indicated.

37 Care Programme Approach (CPA) Audit (to include risk assessment process – Learning Disability Forensics Services

Summary of Planned Actions
- Care Programme Approach (CPA) training will be developed specifically looking at the completion of CPA on the Trust's electronic patient record (PARIS). Following development this will be rolled out to all parts of the service.
- An aide memoire will be produced to facilitate the completion of the Samurai Risk Assessment on PARIS.
- An annual Samurai Risk Assessment competency tool will be completed by all registered nurses involved in using this assessment tool.
- Implementation of the CPA standards devised with the help of the For Us User Group.
- All Staff will complete e-learning CPA modules.

38 MHSOP, LD and Forensics - Clinical Audit of Quality Report Priority 5: Clinical Risk Assessment and Management Quality Standards

Summary of Planned Actions
- The report and findings of this audit will be reviewed by the service development managers and divisional quality and assurance groups.
- The report and findings of this audit will be disseminated to participating clinical teams.
- A Root Cause Analysis (RCA) will be undertaken for those criteria where standards of compliance require improvement.
- Any identified practice changes following consideration / root cause analysis will be communicated to all clinical teams for implementation as appropriate.
- Re-audit February 2012.

39 MHSOP Audit into Antipsychotic Use in Dementia – Trainee Doctor

Summary of Planned Actions
- We will continue to use the paper form.
- The audit cycle will be completed to monitor performance.

40 AMH Level of Child Safeguarding Training (Roseberry Park) – Trainee Doctor

Summary of Planned Actions
- We will clarify whether training is transferable from other Trusts.
- Individuals will liaise with education and training team if they are unsure of training level requirements.

41 MHSOP Quality of Primary Care referrals to Memory Clinic Re-audit – Trainee Doctor

Summary of Planned Actions
- The results will be shared with Redcar & Cleveland memory clinic team.
- A referral form will be circulated to local GP surgeries by Redcar & Cleveland memory clinic team.
- Guidance on how to assess capacity and when to refer patients will be provided by the team to the GP surgeries.

42 AMH The use of PRN Antipsychotics and Anticholinergic Medication in Adult Wards – Trainee Doctor

Summary of Planned Actions
- Disseminate results
- Re-audit

43 AMH Clinical Audit of Benzodiazepine Prescribing in Adult Community Mental Health Team Outpatients - Trainee Doctor

Summary of Planned Actions
- We will raise awareness further of the NICE guidelines by circulating e-mails to relevant healthcare professionals and by posters.
- E-mails will include recommendations for improvement and requesting feedback for any additional suggestions.
- Any new suggestions will be incorporated into the action plan.
- Re-audit in 12 months.

Apendix 2
Feedback from our stakeholders

NHS
County Durham and Darlington

Our Reference YC/JCM/corres/120516 – TEWV quality account
Your Reference None

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16 May 2012

Martin Barkley
Chief Executive
Tees, Esk and Wear Valleys NHS Foundation Trust
West Park Hospital
Edward Pease Way
Darlington
County Durham DL2 2TS

Dear Martin

Quality account 2011/12

Many thanks for sharing your quality account for 2011/ 12. Overall we felt the document was well written and presented and would like to offer the following commentary that has been compiled from the relevant parties. We will be monitoring the progress throughout the coming year via the clinical quality review group.

NHS County Durham and Darlington is pleased to have the opportunity to review and comment on Tees, Esk and Wear Valley NHS Foundation Trust's (TEWV) quality account for 2011/12.

As a commissioner we meet with the trust on a regular basis to monitor, review and discuss quality issues with the trust. We also visit inpatient facilities this allows us to gain insight into care delivered by observing speaking and engaging with patients, carers and staff.

The trust must be commended on its achievements in particular the external assessments and awards. The Trust has made good progress against the priorities set to improve the quality of patient care and experience. We acknowledge that not all priorities met the targets expected but the work undertaken cannot be dismissed, and the achievements gained are a credit to all involved.

Your quality account provides a clear, accurate, open and positive reflection of the quality of patient care provided. Clinicians and management alike have played a wide role in influencing the agenda around quality and this is evident from the comprehensive examples given of actions that are being undertaken following the results of several clinical audits. All of these actions continue to provide the reassurance that the three domains of quality, (patient safety, clinical effectiveness and patient experience) are actively being driven forward.

NHS County Durham and Darlington can confirm that TEWV achieved completion of all the schemes included in the CQUIN framework and the efforts of staff in this attainment should be commended.

It is pleasing to see the priorities from 2011/12 being built upon and stretched, as well as new priorities which indicate aspirations for continuous improvement of services for your patients.

We look forward to continuing to work closely with you and your team.

Yours sincerely

Yasmin Chaudhry
Chief Executive

Cc Debbie Edwards, Board Nurse and Clinical Quality Lead, NHSCDD
Richard Harker, Clinical Quality Lead, Darlington SCCG
Liz Herring, Deputy Director of Nursing and Clinical Quality, NHSCDD
Neil O'Brien, Clinical Quality Lead, North Durham SCCG
Sharon Pickering, Director of Planning and Performance, TEWV
Dinah Roy, Clinical Quality Lead, DDES SCCG
Chris Stanbury, Director of Nursing and Governance, TEWV

Durham County Council Adults Wellbeing and Health Overview and Scrutiny Committee

Comments on the Tees, Esk and Wear Valleys NHS Foundation Trust Quality Account for 2011/12

The Committee welcomes Tees, Esk and Wear Valley's NHS Foundation Trust's Quality Accounts and the opportunity to provide comment on it. This is the third year the Committee has provided comment and acknowledge progress by the Trust towards delivery of their priority areas for 2011/12.

Durham County Council's Adults Wellbeing and Health OSC Chair and lead Scrutiny officer have attended both stakeholder workshops in July 2011 and February 2012. To this end we welcome the early opportunity to examine key issues identified during 2011/12 and also consideration of draft priorities for 2012/13.

In considering the priorities for 2012/13, the Committee particularly welcomes Priority 1 that a root and branch review of the Care Programme approach be undertaken. The Care Programme approach has been referenced in a number of representations made to the Adults Wellbeing and Health OSC by service users and carers particularly in instances of service review. Bearing this in mind, the Committee would wish to see service users and carers/families actively engaged in this process.

The Committee also welcomes proposals "to develop broader liaison arrangements with Acute Trusts around physical health needs of mental health patients" and has asked County Durham and Darlington NHS Foundation Trust to support this.

One comment which was noted at the last meeting of the Committee but does need emphasising, with quality accounts and their complexity and size, stakeholder involvement should be at a early stage. To do properly and organise quality comment needs sufficient time to organise and implement. A suggested way forward would be to have stakeholder engagement/development sessions early in the Quality Account production process.

The Committee would also refer to the recent NHS Reforms introduced by the Government and place on record its desire to further develop its relationships with the Foundation Trust and continue the track record of co-operation and collaborative working.

To conclude, the Committee agree that from the information received from the Trust, the identified priorities for 2012/13 are a fair reflection of healthcare services provided by the Trust and note the progress made against the 2011/12 priorities. In addition, the Committee request to receive a six monthly progress report on delivery of 2012/13 targets.

Health and Partnerships Scrutiny Committee comments on Tees, Esk and Wear Valleys NHS Foundation Trust – Draft Quality Account 2011/12

Given the change in remit, the Health and Partnerships Scrutiny Committee does not solely scrutinise the services of the Trust, this falls to the Adults and Housing Scrutiny Committee, however, the responsibility to comment on the Quality Account falls to the Health and Partnerships Scrutiny Committee given their Scrutiny of health powers.

Therefore, Members of the Health and Partnerships Scrutiny Committee have considered the draft Quality Account 2011/12 for Tees, Esk and Wear Valleys NHS Foundation Trust and agreed that the presentation of the document has greatly improved from previous years and thought on a whole the document was user friendly and readable.

In respect of the Quality Improvement Priorities for 2011/12, Members have the following comments:-

To proactively seek feedback from service users and cares on a day to day basis and act on this – Members are pleased to note that the Trust has engaged with considerably more services users and as a result more systems have improved, i.e. copies of care plans are available after an initial assessments and subsequent reviews.

To improve transfers of care, including improving communication between professionals – Members are delighted that following action against this priority no serious untoward incidents in 2011/12 identified transfers of care as a contributing factor to the incident.

To implement lessons learnt from serious untoward incidents and complaints – Members are pleased note significant improvement against this priority and welcome the application of agreed safety systems in Teesside, Darlington and Durham being rolled out in North Yorkshire.

To improve the quality of the crisis services including service user satisfaction – Members are pleased the Trust is working closely with LINks and hope this will continue as they morph into Healthwatch and they welcome the marked increase in patients statistics.

To review and monitor clinical risk assessments to ensure they comply with expected standards and outcomes – Members believe this to be a high target and understand why it has not been fully met, but note the significant improvements which have been made and hope the Trust will continue to strive for 100% compliance against this priority.

In respect of 2012/13 Priorities for Improvement, Members have the following comments:-

To undertake a comprehensive review of the Care Programme Approach (CPA), care co-ordination process and care planning – Members welcome the reasoning for choosing this priority and look forward to receiving future assurance that improvement to the quality of care through the Care Programme Approach is achievable.

To improve how we gain feedback from patients on their experience and improve our services and the feedback we receive – Members appreciate why this has remained a priority and note it is the Trust's aim to ask more service users and carers from across all of the services for feedback.

To sustain an improvement in all transfers of care with standard work practices and improved communication between professionals implemented – Members appreciate why this has remained a priority and welcome the aim to continue to strive to ensure that all service users are transferred to the most appropriate service and team in a safe and effective way.

To develop broader liaison arrangements with Acute Trusts around physical health needs of mental health patients – Members are currently undertaking a piece of work in respect of long term conditions and will monitor this priority with interest.

Overall, Members welcome the Quality Accounts and are pleased with the Trusts progress against the chosen priorities. Members would like to receive quarterly reports on the progress being made, to enable them to provide a more detailed and valuable contribution to the Quality Accounts in the future and wish to continue to be invited to Stakeholders events.

Darlington LINk have welcomed and enjoyed the opportunity to be involved with the Quality Accounts over the last twelve months and benefit from partnership working with Tees, Esk and Wear Valley NHS Trust. The Trust actively involves and engages with LINk members and we believe fully embraces the ethos of a patient being at the centre of their care.

Darlington LINk agree with all of the priorities set out in the 2012-2013 Quality Account and look forward to working with TEWV to help achieve those objectives. LINk members are pleased to see work to improve the Crisis Team continues and are happy to say that joint working and information sharing is already taking place. This has and will continue to greatly benefit the people of Darlington.

Darlington LINk look forward to some further partnership working over the next year and thank the Trust for their continued help and support.

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23rd May 2012

Chris Stanbury
Director of Nursing and Governance
Tees and Esk Wear Valley NHS Foundation Trust
Lanchester Road Hospital
Lanchester Road
Durham
DH1 5RD

Dear Chris

Re Tees Esk and Wear Valley NHS Foundation Trust Quality Accounts 2011/12

I am delighted to provide you with a commissioner narrative as requested for your Quality Accounts. The narrative has been jointly approved by NHS Tees, NHS Hartlepool and Stockton-On-Tees Clinical Commissioning Group and NHS South Tees Clinical Commissioning Group.

"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 has actively engaged the nascent Clinical Commissioning Groups (CCGs) on the quality agenda and welcomes the opportunity to submit a joint statement on the Annual Quality Account for Tees, Esk and Wear Valleys NHS Foundation Trust.

NHS Tees and NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group and NHS South Tees Clinical Commissioning Group 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 2011/12.

During 2011/12 we have continued to provide joint robust challenge through our Clinical Quality Review Groups (CQRGs) to drive improvements in the quality of services and outcomes for patients. The CQRGs involve key stakeholders who focus on a significant range of topics including all aspects of safety, clinical effectiveness and patient experience. Tees, Esk and Wear Valleys NHS Foundation Trust have been open and transparent in their approach to working with commissioners and have responded positively to constructive clinical challenge.

During 2011/12, clinical members of NHS Tees were invited to attend a number of key committees in relation to the patient safety agenda, including the Directors' Panel which scrutinises serious incident reports, and ensures lessons learned are identified and disseminated and the Adult Safeguarding Committee.

The Trust has worked extremely hard at driving forward innovation in public engagement and improving patient experience. They have a well embedded culture of patient participation and engage in a variety of methods to capture patient experience from a wide range of services including Children's, Adults, Older people and people with a learning disability.

NHS Tees and CCG representatives have collaborated with other commissioners to work with the Trust in agreeing, implementing and delivering the Commissioning for Quality and Innovation (CQUIN) scheme in 2011/12. This approach will be maintained in 2012/13.

NHS Tees and CCGs will continue to work very closely with relevant key staff groups during the transition period to facilitate a seamless handover of commissioner responsibilities at the end of March 2013. As Commissioners we look forward to continuing to work in partnership with Tees, Esk and Wear Valleys NHS Foundation Trust during 2012/13 to further improve the quality of services that the Trust provides for the people of Teesside".

Yours sincerely

Bev Reilly
Associate Director/Board Nurse
Patient Safety, Quality and Safeguarding
NHS Tees

cc: C Willis, Chief Executive, NHS Tees
Dr B Posmyk, Interim Chair, NHS Hartlepool and Stockton on Tees Clinical Commissioning Group
A Wilson, Interim Chief Operating Officer, NHS Hartlepool and Stockton on Tees Clinical Commissioning Group
Dr Henry Waters, Interim Chair, NHS South Tees Clinical Commissioning Group
A Hume, Interim Chief Operating Officer, NHS South Tees Clinical Commissioning Group

Hartlepool LINk

TEWV Quality Account 2011/12

- As an introduction it would be good to have a Trust Boundary map including the constituent parts / areas to show the relative sizes and relationship to each other
- The map could be colour coded and show the percentage of service users to the population of each area.
- Where research has been carried out, what are the outcomes? How does this research benefit patients / service users?
- Where surveys have been sent out and the returned surveys counted and collated. It would help if this also included the numbers of surveys sent out.
- All statistics being presented could be broken down into their individual areas within the trust to be able to compare and contrast each area. As well as an overview of the whole trust.
- All areas do not seem to have the same inputs / services so it is hard to see how one area may be more advanced or specialist than others.
- CQC – The inspections highlighted concerns around compliance. There were progress reports, but no clear indication of how closely they would be monitored, how often, or who by, other than their own senior staff. The time scale was vague - 12/13. Nor was it evident what course would be taken if not fully compliant at that time.
- Appendix No 16. G.P. referrals .It was good to see standards of referrals being addressed and also to be re audited.

Zoe Sherry 16.05.12

Stockton-on-Tees LINk

Stockton-on-Tees LINk comment re: Tees Esk and Wear Valleys NHS Foundation Trust Quality Account

Stockton-on-Tees LINk welcomes the opportunity to comment on the TEWV Quality Account.

Comments from 2011/12 priorities

Stockton-on-Tees commend the Trust on their progress towards achieving the 2011/12 quality account priorities particularly in relation to improving the capture of patient experience and bringing risk analysis in line with service users personal needs.

The LINk welcome the robust review of the crisis team service across the area and understand that although not included as a quality account priority for 2012/13 the review and progress will be monitored as part of the Trusts Business Plan. The LINk expect to see regular updates regarding the progress made available in the public domain in an accessible format as this continues to be an important aspect of service provision for service users, carers and other professionals alike. The LINk would particularly like to see this review reflect and consider the needs of people who are not registered with a GP e.g. those who recently moved into the area and particularly those who may be more vulnerable due to addictions.

2012/13 Priorities

Priority 1: Stockton-on-Tees LINk was pleased to see a comprehensive review of care co-ordination and care planning was highlighted as the first priority as this is a consistent concern of both service users and carers. The LINk has been told of the need to ensure care plans are developed in a way that gives service users ownership of the document in terms of language, readability and possession of a physical copy.

The LINk would strongly encourage the Trust to ensure that carers are fully included in this review including the input of young carers within the home.

Priority 2: The LINk was pleased to see a significant improvement in the volume of patient experience collection and support the Trusts priority to make improvements based on this feedback. The LINk would like to see regular updates regarding the progress of improvements to stakeholders, service users and carers to demonstrate that the Trust has listened and acted on experiences given.

Priority 3: Stockton-on-Tees LINk supports the drive to sustain improvement and ensure transfers of care meet your agreed set of best practice standards. The LINk feel this would be further strengthened if service users and carers could be involved in the ongoing development of best practice standards to highlight what these standards mean for patient experience.

The LINk would also request that the Trust shares summary reports on any outstanding key issues during key points of the year.

Priority 4: The LINk strongly supports effective communication and liaison arrangements with Acute Trusts around the physical health needs of mental health patients. However, as it

is acknowledged that people with mental health needs and learning disabilities have poorer long term health outcomes than the wider population the LINk would like to see the Trust work with North Tees and Hartlepool NHS Foundation Trust to resolve the lack of an acute liaison nurse focused on learning disabilities in this area. The lack of an acute liaison nurse is potentially putting residents with a learning disability in Stockton-on-Tees and Hartlepool at an even greater disadvantage than other areas of the region.

Additional comments

The LINk noted that there were a higher number of actual unexpected deaths in 2011/12 compared to the target, within the patient safety measures yet these did not seem to be reflected within the priorities for 2012/13.

The LINk felt that there should be an increased focus/commentary within the Quality Account on how the Trust will be working with new and emerging health and wellbeing structures, including Clinical Commissioning Groups, Health and Wellbeing Boards, local HealthWatch and third sector organisations. This needs to be carried out alongside the development and strengthening of relationships with existing stakeholders such as GP practices and the acute trusts. These relationships are vital in terms of education, signposting, delivery of well thought out pathways and prevention/ maintaining wellbeing for many service users.

Finally, the LINk hope to see both the quality account and other regular updates suitable for the public made available in an accessible easy to understand format.

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21st May 2012

Tees Esk and Wear Valleys NHS Foundation Trust
Quality Account 2011 – 2012
Response from Middlesbrough LINk

All the LINks were pleased to see that Tees Esk and Wear Valleys Trust has made significant improvements over the last 12 months and that plans and initiatives are in place to continue striving for further improvements over the next 12 months.
Regular meetings between the host team and the Trust have continued throughout the year. These meetings have enabled any concerns and issues to be raised and discussed are felt to be a positive way of engaging and working together. The LINk values the good working relationship with the Trust and the opportunity to take part in activities including contributing to setting priorities for and commenting on the Quality Account. In addition TEWV Trust has cooperated with the LINk Mental Health Working Group whenever requested.

LINk would recommend that the final version is in a suitable format and font size for ease of reading and versions available for all sections of the public.

Quality Account 2011 – 12

Part Two – Priorities for Improvement 2012/2013

Priority 1 – To undertake a comprehensive review of the Care Programme Approach, care co-ordination and care planning

- Members were pleased to see care planning made a priority. They were particularly reassured to note the involvement of service users and carers in the review as they are the experts at what it is like to experience a high standard of care.

Priority 2 – To improve how we gain feedback from patients on their experience and improve our services and the feedback we receive

- We welcome the continuing emphasis the Trust places on gaining service user and carer feedback and acting on it promptly. Members hope that there is a similar continuing dedication to service user and carer involvement in service improvement, including by Rapid Process Improvement Workshop (RPIW), and all times engagement would prove useful.

Priority 3 – To sustain an improvement in all transfers of care with standard work practices and improved communication between professionals

- Members were pleased that the Trust recognises the importance of improving transfers of care and hope that this includes transfers between clinicians within teams or services.

Priority 4 – To develop broader liaison arrangements with Acute Trusts around physical health needs of mental health patients

- Members appreciate TEWV's commitment to improving the physical health of their service users. It is hoped that this work will also have some impact on the stigma that mental health and learning disability service users' face.

The LINk did not identify any significant omissions of concern.

Yours sincerely

Catherine Haigh
Chair Middlesbrough LINk

Tees, Esk and Wear Valley NHS Foundation Trust Quality Account 2011 – 2012

Response from Redcar and Cleveland LINk

The LINk was pleased to see that the Trust has made significant improvements over the last 12 months and that plans and initiatives are in place to continue striving for further improvements over the next 12 months.

The LINk was, however, concerned to see that a number of under 18 year olds were still being admitted to adult wards in spite of the target set at zero by the Department of Health for 2011/12.

Whilst we appreciate that these admissions were clinically appropriate and that staff received additional training to meet the needs of the patients, it remains a concern and the LINk supports to work of the Trust to meet this target over the coming year.

Regular meetings between the LINk host team and the Trust have continued throughout the year. These meetings have enabled any concerns and issues to be raised and discussed and are felt to be a positive way of engaging and working together. The LINk values the good working relationship with the Trust and the opportunity to work in partnership, including being invited to offer an opinion on the Equality Delivery System, commenting on the Quality Account and gathering patient experience of using the Crisis Team service to help inform the review.

Upon reviewing the EDS, the LINk was pleased to see that the Trust had written an honest account of its progress made towards the self assessment, and that plans were in place for continued improvement.

The LINk also fully supported the decision to review the Crisis Team service as it demonstrates another good example of how the Trust use patient experience to improve services.

The LINk looks forward to continuing to work in partnership with the Trust over the coming months and welcomes regular updates on the progress made with the priorities to enable this information to be shared with its members.

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Tees, Esk and Wear Valleys NHS
Foundation Trust

2012

To whom it may concern

Re: Tees Esk and Wear Valleys NHS Foundation Trust Quality Account Statement 2012

As a Commissioner, NHS North Yorkshire and York are pleased to be able to review and comment on Tees, Esk and Wear Valleys NHS Foundation Trust Quality Account for 2011/12.

Over the past 12 months we have worked hard together as Commissioner and Provider to improve the quality of mental health services for the residents of North Yorkshire. Through the contract management process the Trust has provided assurance to us as Commissioners, by sharing a range of data and quality metrics which have assured us of the quality of patient services.

The Quality Account for Tees, Esk and Wear Valleys NHS Foundation Trust is a very informative and extremely honest account of both successes and failures throughout the year and provides a clear, accurate, and open story of the quality of patient care provided. The TEWV Quality Improvement System (QIS) and the improvements it has achieved is to be commended and has been recognised by TEWV receiving the Health Service Journal Award for Innovation in Mental Health as a result. We are also especially pleased to note the following achievements:-

- TEWV were named the Mental Health Services Provider of the Year 2011 by the Royal College of Psychiatrists
- TEWV received a Health Service Journal Award for Research Culture
- Dr. Angus Bell (TEWV's clinical director for Adult services) being named as Medical Manager / Leader of Year 2011 by the Royal College of Psychiatrists.

Tees, Esk and Wear Valleys NHS Foundation Trust has also demonstrated significant improvements across the CQUIN indicators for 2011/12. Indicators for 2012/13 are currently being agreed.

The priorities identified in the Quality Account for 2012/13 reflect those identified by NHS North Yorkshire and York, namely:

- A comprehensive review of the CPA, care co-ordination and care planning
- To improve patients experience
- To sustain an improvement in ALL transfers of care
- To improve the physical health needs of mental health patients

As a commissioner we commend this Quality Account for its accuracy, honesty, and openness. We recognise that Tees, Esk and Wear Valleys NHS Foundation Trust strives to deliver good quality patient care, and we look forward to working with the Trust to bring about further improvements in quality during 2012/13.

Yours sincerely

Julie Bolus
Director of Nursing
NHS North Yorkshire and York

North Yorkshire County Council
Chief Executive's Group

County Councillor Jim Clark
(Harrogate/Harlow Division)

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21 May 2012

Sharon Pickering
Director of Planning & Performance
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Dear Sharon

Quality Accounts

Thank you for inviting the North Yorkshire Scrutiny of Health Committee to contribute to your Trust's Quality Account (QA) for 2011/12.

I would be grateful if you would include the following comments from the Committee in the final version of your QA:

> On the basis of the Committee's long standing involvement with the Trust and the stakeholder workshops I attended in July 2011 and in February 2012, on behalf of the Committee, I am confident that the Trust's Quality Account is representative and comprehensive in terms of the services provided.
>
> The priorities for 2012/13 are clearly informed by an-going engagement process with patients and the public. This on-going approach is supplemented by specific events/workshops including all stakeholders.
>
> I fully support the 4 priorities for 2012/13.
>
> Over the last year the Martin Barkley, Chief Executive, has demonstrated his personal commitment and willingness to engage with the Scrutiny of Health Committee by attending a number of informal and formal meetings. This has been primarily to brief the Committee on the Trust's plans for moving care from in-patient settings into community settings and supporting people to live independently in their own homes. This is consistent with national policy and with recommendations in North Yorkshire Review of Health Services 2011.

Cont/d ...

Key to the success of that transition will be greater integration of health and social care. Services provided by the borough/district councils, particularly housing, also need to be factored into the transition.

As we move forward into an era of Health and Wellbeing Boards, integration of care will be increasingly important. Looking forward to 2013/14, the Trust may want to consider including a specific priority around the integration of care and partnership working.

Finally, the way in which the QA openly highlights areas of under performance against quality metrics and how improvements will be taken forward as part of the priorities for 2012/13 is reassuring. There is clearly a commitment to sharing information in an open and honest way and towards continuous improvement in the Trust.

County Councillor Jim Clark
Chairman – North Yorkshire Scrutiny of Health Committee

Please send Bryon Hunter (contact details below) a copy of your Quality Accoun when it is available.

If you need to discuss this matter further or any other issue relating to the work of the Scrutiny of Health Committee, please do not hesitate to contact Bryon or myself.

I hope this is helpful.

Yours sincerely

County Councillor Jim Clark
Chairman – North Yorkshire County Council Scrutiny of Health Committee

Bryon Hunter's Contact Details:

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Noth Yorkshire LINk

North Yorkshire LINk response to the Tees Esk and Wear Valley Quality Accounts 2011 – 2012

North Yorkshire LINk are pleased to comment on the Tess Esk and Wear Valley Quality Account for 2011-2012 (TEWV QA 2011-2012). This is a very extensive and comprehensive report and the Trust has generally done well against the priorities laid out in the TEWV QA 2011-2012.

The LINk are pleased to see that all the priorities for 11/12 were achieved to some degree with a good increase in percentages, especially the increase of more than 90% on the implementation of lessons learnt from serious untoward incidents and complaints. There seems to be an assurance that these priorities are continuing to be built upon and improved through the aims given alongside the priorities.

The LINk continues to progress with the priorities laid out in TEWV QA 2011-2012 for the Quality Accounts for 2012-2013 requesting that patient and public experience feedback to be a continuing theme along with sustaining the improvement in all transfers of care and improving the communication between professionals.

There is still a concern regarding the use of jargon and large bodies of text. The LINk would suggest that the use of diagrams would break up texts and hold people's attention. The LINk also feels more explanation is needed in certain areas of the Quality Accounts around the need to undertake clinical audits. It is also felt that definitions and descriptions could be included as footnotes.

It has been recognised that the Quality Account improves year on year and the LINk hopes that the concerns detailed above continue to be worked on.

The LINk would like to thank Tees Esk and Wear Valley NHS Trust for the opportunity to comment on the Quality Accounts.

Although it is not yet a requirement to consult our Clinical Commissioning Groups on the Quality Report 2011/12, we did share the report with the CCG Chairs and Accountable Officers. We received one response:

- 'I found your document straight forward and easy to read' – Dr Kate Bidwell, GP, CCG Chair North Durham

The following stakeholders were given the opportunity to comment on our draft Quality Report for 2011/12 and responded that they had no specific comments to make:

- Tees Joint Health Overview & Scrutiny Committee.
- Hartlepool Health Overview & Scrutiny Committee

Apendix 3
Mandatory quality performance indicator definitions

100% enhanced Care Programme Approach (CPA) patients receive follow up contact within seven days of discharge from hospital

Detailed descriptor:
The proportion of those patients on Care Programme Approach (CPA) discharged from inpatient care who are followed up within 7 days.

Data definition:
All patients discharged to their place of residence, care home, residential accommodation, or to non psychiatric care must be followed up within 7 days of discharge. All avenues need to be exploited to ensure patients are followed up within 7 days of discharge. Where a patient has been discharged to prison, contact should be made via the prison in-reach team.

Exemptions:
- Patients who die within 7 days of discharge may be excluded.
- Where legal precedence has forced the removal of the patient from the country.
- Patients transferred to NHS psychiatric inpatient ward.
- CAMHS (children and adolescent mental health services) are not included.

The 7 day period should be measured in days not hours and should start on the day after discharge.

Accountability:
Achieving at least 95% rate of patients followed up after discharge each quarter.

Admissions to inpatient services had access to crisis resolution home treatment teams

Detailed descriptor:
The proportion of inpatient admissions gate-kept by the crisis resolution home treatment teams.

Data definition:
Gate-keeping: in order to prevent hospital admission and give support to informal carers, crisis resolution home treatment teams are required to gate-keep all admission to psychiatric inpatient wards and facilitate early discharge of service users. An admission has been gate-kept by a crisis resolution team if they have assessed6 the service user before admission and if the crisis resolution team was involved in the decision making-process, which resulted in an admission.

Total exemption from crisis resolution home treatment teams gate-keeping:

- Patients recalled on community Treatment Order.
- Patients transferred from another NHS hospital for psychiatric treatment.
- Internal transfers of service users between wards in the Trust for psychiatry treatment.
- Patients on leave under Section 17 of the Mental Health Act.
- Planned admission for psychiatric care from specialist units such as eating disorder unit are excluded.

Partial exemption:
Admissions from out of the trust area where the patient was seen by the local crisis team (out of area) and only admitted to this trust because they had no available beds in the local areas. Crisis resolution home treatment teams should assure themselves that gate-keeping was carried out. This can be recorded as gate-kept by crisis resolution home treatment teams.

Apendix 4
Glossary

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.

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.

Clinical Reporting System (CRS): the current Trust system for extracting, analysing and reporting clinical activity within the Trust.

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.

Divisions: services in TEWV are organised around six Divisions: Adult Metal Health Services, Substance Misuse Services, Mental Health Services for Older People, Adult Learning Disability Services, Children & Young Peoples Services, Forensics – see also Localities.

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.

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.

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.

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.

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.

Localities: services in TEWV are organised around three Localities (i.e. County Durham & Darlington, Tees, North Yorkshire) and one Directorate (i.e. Forensics) – see also Divisions.

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 by a national programme of audit.

National Patient Safety Agency (NPSA): is an arm's length body of the Department of Health who aim to reduce risks to patients receiving NHS care and improve safety by informing, supporting and influencing organisations and people working in the health sector. The agency also supports the resolution of concerns about the performance of individual clinical practitioners to help ensure their practice is safe and valued.

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.

Near Misses: an event or circumstance that could have resulted in unnecessary damage, loss or harm such as physical or mental injury to a patient, staff, visitors or members of the public which was averted through intended or unintended action.

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 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.

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.

Clinical Commissioning Groups (CCGs): the local commissioning structure envisaged by the White Paper: Liberating the NHS for the transfer of 80% of the commissioning of local health services to GPs.

Psychiatric Liaison: the branch of psychiatry that specialises in the interface between medicine and psychiatry often taking place in acute hospital settings.

Quality and 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).

Red Border Risk Assessment: red border refers to the colour of the physical document which is of such importance that the document with its red borders can be easily seen within a set of notes.

Root Cause Analysis (RCA): a technique employed during an investigation that systematically considers the factors that may have contributed to the incident and seeks to understand the underlying causal factors.

Safety Alert Broadcast System (SABs): an national electronic web based system accessed by NHS Trusts, which brings together all safety alerts from the National Patient Safety Agency (NPSA), Medicines and Healthcare Products Regulatory Agency (MHRA) and NHS Estates, which holds copies of all alert notices together with statistics on responses from NHS Trusts and Strategic Health Authorities.

Samurai: a clinical risk assessment tool used to assess the needs for equipment, physical needs, risk of self harm and assessment of behaviours of children and young people with learning disabilities.

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.

Unexpected Death: a death that is not expected due to a terminal medical condition or physical illness.

Urinary Tract Infection (UTI): is a bacterial infection that affects part of the urinary tract - the organ system that produces, stores, and eliminates urine.

Visual Control Boards: a technique for improving quality within the overall TEWV Quality Improvement System (QIS).

If you would like additional copies of this report please contact:

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www.tewv.nhs.uk

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