Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Annual report and financial statements 2012/13

Making a difference together

Tees, Esk and Wear Valleys NHS Foundation Trust

Annual report and financial statements 2012/13

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

Introduction

Directors' report

Quality report

Governance and financial review

Financial statements

Introduction

Foreword by the Chief Executive

Reviewing the past

Looking back over the last year has given me the opportunity to take stock and reflect on all that we have achieved in 2012/13.

It has been a busy and challenging year during a period of significant change in the NHS but our staff have risen to the challenges and worked hard to maintain a focus on doing what's important – improving the lives of the people who use our services. We achieved over 90% of our business plan objectives and all of the CQUIN (quality) targets set by our primary care trusts, thereby maximising the possible income to the Trust, enabling us to protect jobs and invest in making improvements.

We are proud of being part of the NHS and of working with our partners to provide some of the best mental health care in the country. This was recognised in the nationally acclaimed Health Service Journal awards where we were shortlisted for Provider of the Year.

We have continued to be at the forefront of developing innovative services such as Recovery Injectable Opioid (RIO) (page 29) and specialist eating disorder services (page 20). We have also maintained our focus on strengthening and improving existing services, using the tools of the TEWV Quality Improvement System (TEWV QIS) to help us (page 23).

We have some of the best inpatient facilities in the country and over the last year have continued to modernise our estate. Bankfields Court in Normanby, Cross Lane Hospital in Scarborough and the extension to the forensic unit at Roseberry Park have all been successfully completed whilst work is underway on Springwood in Malton and West Lane Hospital in Middlesbrough (page 20).

Effective partnership working is key to our success and to improving services for people with mental ill health or a learning disability. Last summer we carried out our biennial survey of GPs to obtain their feedback on how we can work better with them in their roles as vital partners in the care of people who use our services. Furthermore, the work we are doing with our colleagues in acute trusts is making a huge positive difference to people who have both physical and mental health needs (page 26). We have also worked with partners to improve services for veterans (page 26) and with the police to help people with mental ill health access the appropriate services (page 26).

We should not underestimate some of the challenges we have faced during 2012/13 such as adapting to providing talking therapy services on Teesside as part of the new 'Any Qualified Provider' process, the significant expansion of our forensic inpatient services on Teesside and, for our colleagues in Harrogate, Hambleton and Richmondshire, becoming more fully integrated into TEWV. This included the successful completion of a major project to move these services onto the Trust's electronic patient record system (PARIS). There have also been occasions when things have not happened as they should and we strive to do everything we can to learn lessons from incidents and complaints to minimise the likelihood of something similar happening again.

However, the feedback we have received suggests that we are making excellent progress towards our vision of being a recognised centre of excellence with high quality staff providing high quality services that exceed people's expectations.

We were delighted with the fantastic results of the annual NHS staff survey, which confirmed us as being one of the best NHS employers in the country. TEWV was rated best mental health and learning disability trust in the country in five of the 28 areas covered in the survey and was in the top 20% in a further 15 areas (see page 36). Shortly after the year ended we also achieved the Investors in People standard, demonstrating significant progress since our earlier accreditation three years ago and giving us further evidence that our efforts to be an exemplary employer are paying off.

The results from the GP and patient surveys both showed that we have made improvements to services although we know there is still work to do. We were also delighted to retain NHS Litigation Authority (NHSLA) level 2 in 2012. This was excellent news for the Trust, not only because it meant a reduction to our 'insurance charges' but, and perhaps more importantly, because it showed we could demonstrate lower levels of risk.

We could not possibly achieve what we do without the support of our staff, our partner organisations and commissioners, our service users and carers, our governors, members and last, but not least, our volunteers. On behalf of the Board I would like to thank everyone for their continued commitment to TEWV and the people who benefit from our services.

Looking to the future

Our focus for the coming year will be on delivering exceptional quality, making sure that we are doing all we can to provide the best quality care for the people who use our services and to meet the requirements of our commissioners.

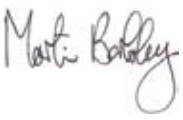
We will continually strive for better outcomes and better experiences for our service users and carers. This means making sure that people not only have a positive experience with the Trust, but also a positive outcome from their treatment. We can only do this effectively by listening to what our service users and carers are saying about their needs and expectations as well as how well we are doing and using that feedback to improve services. We are already learning a lot from the wealth of feedback we are gathering from our inpatient services and we intend extending this work to include our community patients.

The lessons we learn from the report of the Mid Staffordshire NHS Foundation Trust public inquiry will also play an important part in our drive to continually improve the quality of our services.

A key challenge for the Trust in achieving better outcomes for service users, is moving towards having a real focus on recovery across the organisation. 'Recovery' is a word commonly used by people with mental health problems to describe their struggles to live meaningful and satisfying lives. Our aim is to design and provide services that support recovery to help people reach their self determined goals. If adopted successfully this can transform services and unlock the potential of people experiencing mental distress.

The ongoing financial constraints on the public sector mean it is even more important that we continue to improve quality whilst reducing costs. To do this we need to invest in our people and although I was delighted with the positive results of the last staff survey and our IIP assessment we must continue to use the feedback from staff to make further improvements. Central to this will be our work to create a working environment that promotes good health and wellbeing.

With the changing landscape of NHS organisations, not least of which are the new Clinical Commissioning Groups, NHS England and Health and Wellbeing Boards, it is important that we take time to build effective relationships with our new colleagues. There are challenges ahead but we have a wealth of experience and expertise in TEWV and, crucially, great staff, which makes me confident that we can overcome these challenges and continue to improve and develop excellent services. I am looking forward to continuing to work with our staff, service users and carers, partner organisations and commissioners, Governors and members to make a positive difference to the people who need our services.



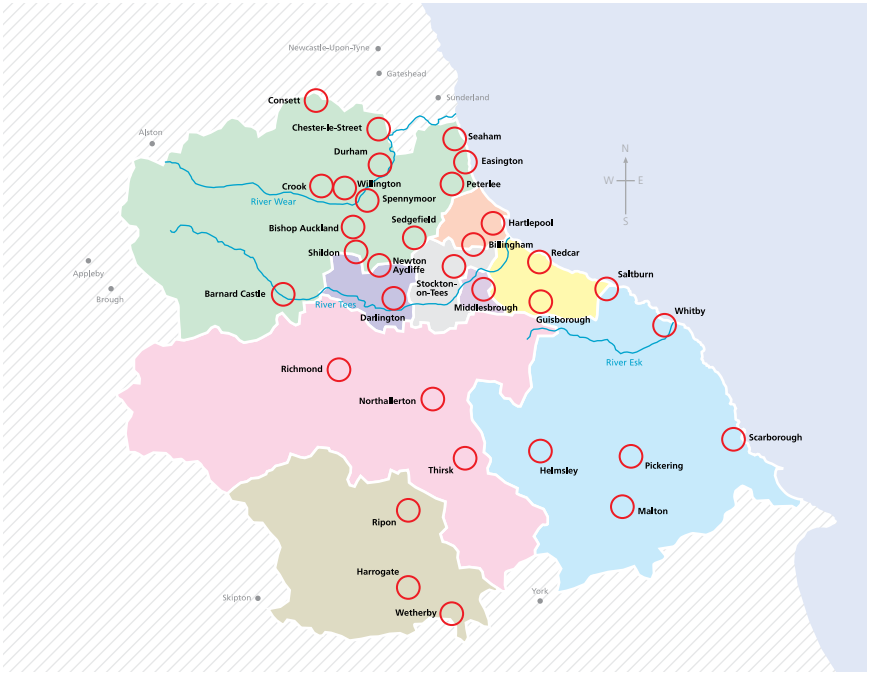
Martin Barkley
Chief Executive

❝ There is an air of quiet calmness which is refreshing. It is a hospital the NHS can be proud of ❞
A service user's sister

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.

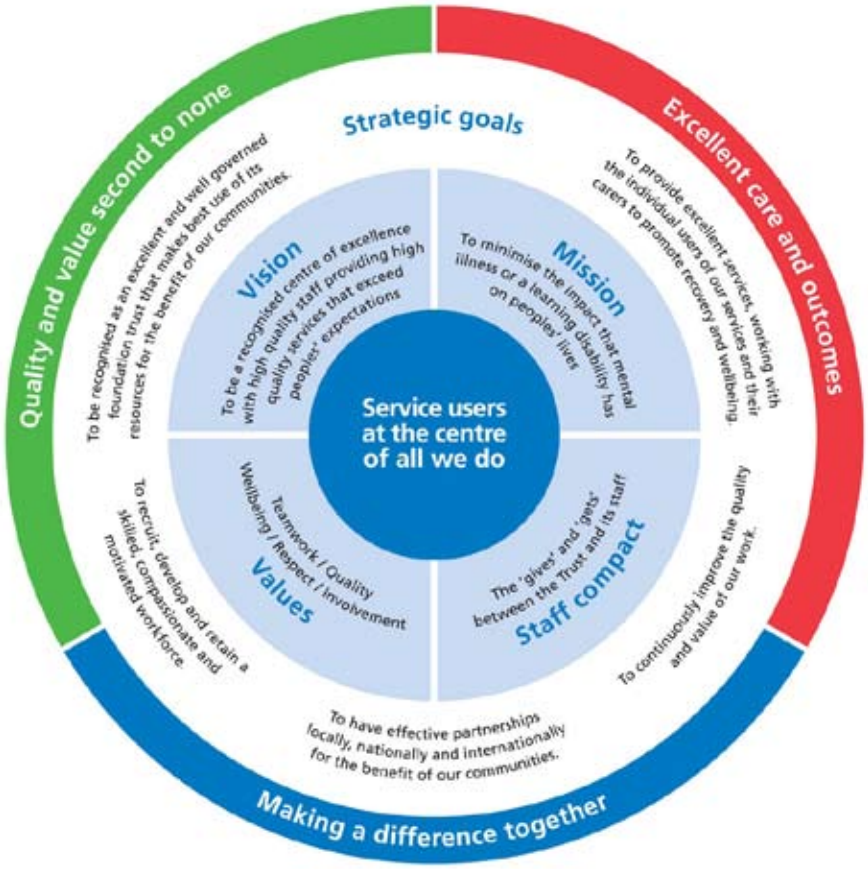
We provide a range of mental health, learning disability and substance misuse services for the 1.6 million people living in County Durham and Darlington, the Tees Valley, most of North Yorkshire (Scarborough, Whitby, Ryedale, Harrogate, Hambleton and Richmondshire) as well as Wetherby in West Yorkshire. With over 6000 staff and an annual income of £293 million we deliver our services by working in partnership with eight local authorities and clinical commissioning groups, 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 be more accountable to local people
- Strengthen our internal process and systems to meet the challenges of modern health services
- Develop locally based specialist services (see pages 20 – 29 for examples)
- Respond better to market opportunities (see examples on pages 20 – 29)
- Continue to invest in capital developments such as West Lane Hospital in Middlesbrough

The TEWV approach



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 the individual users of our services and their carers to promote recovery and well being**	**This means that…** • We deliver safe and high quality services. • We safeguard those at risk of harm. • Users of our services and their carers have positive experiences and outcomes.	• Users of our services are seen when they need to be, 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 as part of their agreed treatment plan. • We support commissioners to identify and address gaps and inequalities in local services.
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 locally, 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 and aligned to other systems 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, compassionate and motivated workforce.**	**This means that…** • We continuously improve our position in 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 compassionate and motivated to help patients and carers 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…** • We support our commissioners to effectively commission mental health, learning disability, substance misuse and other specialist services. • We engage with the NHS Commissioning Board locally, regionally and nationally.	• 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 work with our local authority partners to support the delivery of a seamless service for our users and carers.
5 **To be recognised as an excellent and well governed foundation trust that makes best use of its resources for the benefit of our communities.**	**This means that…** • Our Council of Governors is fit for purpose and actively engaged in our strategic development. • We utilise the membership of the Trust in our governance arrangements of the organisation. • Our governance arrangements satisfy commissioners and external regulators.	• Trust services regularly use benchmark and outcomes data to deliver improvements in quality and value. • We publish accurate, timely and comprehensive data and information about the Trust's performance. • We proactively identify and manage risks to the Trust business.

	• We deliver services in accessible, high quality environments. • We treat people as near to where they live as possible. • We continually seek and respond to feedback about the services we provide from our service users and carers, and take action if appropriate.	• We have a reputation for excellence. • We provide high quality accessible information on how people can access our services. • We work with our service users and carers to enable them 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 to minimise the stigma of mental health and learning disabilities.
	• We deliver services that are evidence-based and clinically cost-effective. • We have an active programme of funded 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 promote a culture of actively challenging and reporting unsafe practice, quickly learning from our experience and embedding lessons learned. • We use high quality pathways of care to support standardised work and deliver consistently good outcomes. • We are responsive to, but recognise differences in, commissioners' intentions and resourcing decisions.	• We have consistently high standards implemented. • We use efficient and effective systems of data management to monitor and improve services. • We are the provider of choice for the population we serve and all potential commissioners because of our excellent quality and value.
	• We align the competencies of our staff to our clinical pathways through recruiting the right staff and targeted education and training. • We 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. • We provide high quality placements for students throughout the organisation. • The Trust and its staff respect and embrace the human rights and diversity of our workforce, patients and carers.	• We have the right staff with the right skills, competencies and attitudes to provide excellent services. • We have effective workforce and succession planning in place. • All of our staff understand the value of their 'Total Reward Statement'. • We fully contribute to the effectiveness of the Local Education and Training Board.
	• We influence and contribute to each health and wellbeing board. • We are the provider of choice for universities and colleges for medical, nursing, psychology, allied health professional and other mental health and learning disability training.	• 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 have a growing portfolio of funded research and development in the Trust which we use to improve the quality of our services.	• We have partnership arrangements with every acute foundation trust in our area.
	• The Trust supports staff and services to improve productivity through use of the best available tools and technologies / methodologies. • We seek to reduce the impact of our business on the environment. • We influence national and international policy and systems development.	• We actively promote our successes to develop our reputation and brand to all stakeholders. • We develop new business opportunities which are consistent with our Trust vision. • We deliver a Trust Business Plan which is dynamic, flexible and responsive to the changing environment.	• Effective financial contingency planning ensures we manage known emerging risks. • We have robust and regularly tested emergency and business continuity plans which manage known emerging risks. • We work with other organisations and play our part in improving the health of the populations we serve

TEWV Quality Improvement System (QIS)

Our aim is to deliver high quality services which

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

To help us improve the quality of what we do we have developed a quality improvement system, which is based on and supported by Virginia Mason Medical Centre in Seattle. TEWV QIS is about improving the ways we do things within the Trust by identifying and removing wasteful activities and focusing on those that add value to our customers (our service users, their carers and the people who commission our services).

❝ We were very impressed with how successfully your organisation has strategically implemented a whole system approach to Lean methodology. The positive impact of this was observed by us at a clinical level ❞

An NHS foundation trust assistant director

Our services

Our purpose is to improve people's lives by minimising the impact of mental health or a learning disability. Our service models emphasise the importance of this and of community services focusing on enabling people who have mental ill health or a learning disability to be active citizens leading self-determined lives in their local community, with admission to hospital being the true exception rather than the norm.

The Trust's services are organised primarily on a locality-basis:

- County Durham and Darlington
- Tees
- North Yorkshire

with a fourth directorate covering forensic services.

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

- 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

The following paragraphs give more detail on the services we provide.

Adult mental health services (AMH)

We provide community and inpatient mental health services for adults of working age in partnership with social care and a wide range of voluntary and independent service providers for the people of County Durham, Darlington, Teesside and North Yorkshire.

We treat patients with psychotic illnesses (such as schizophrenia), and also those with affective illnesses (such as depression, anxiety and compulsive disorders).

Services include:

- 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; we also provide mental health services for people with a sensory impairment (deafness) and Attention Deficit Hyperactivity Disorder (ADHD)
- inpatient assessment and treatment services, including acute, intensive care, challenging behaviour and rehabilitation services
- primary care psychological therapies in County Durham and Darlington (working with partners) and as one of several qualified providers on Teesside (we do not provide this service in North Yorkshire as Leeds and York Partnership Foundation Trust are contracted to deliver this across the whole county)
- the specialist regional North East and North Cumbria eating disorder inpatient services for adults, with "step up" and "step down" day hospital services for Teesside, County Durham and Darlington patients
- inpatient services to serving military personnel as part of a national consortium and community based services to military veterans

Our main hospitals are Lanchester Road Hospital in Durham, West Park Hospital in Darlington, Roseberry Park Hospital in Middlesbrough, Sandwell Park in Hartlepool, Cross Lane Hospital in Scarborough and wards within The Friarage in Northallerton and Harrogate District Hospital.

Substance misuse services (SMS)

We provide community substance misuse assessment and treatment services for people aged 18 years and above. Services are provided in County Durham, Middlesbrough, Stockton, Scarborough, Whitby and Ryedale, Hambleton and Richmondshire, and Harrogate. Funding for these services has now passed to local authorities as part of their new public health statutory duties. The specific nature of each service (ie drug misuse, alcohol misuse, or both) varies by locality.

Mental health services for older people (MHSOP)

We provide mental health services for older people working in partnership with social care and a wide range of voluntary and independent service providers for the people of County Durham, Darlington, Teesside and North Yorkshire.

We treat people with 'functional' illnesses, that is similar illnesses to those treated by our adult services but where the physical frailty of our patients requires a specialist approach. We also treat people with "organic" illnesses, such as dementia.

The services we provide include:

- A wide range of community based services including memory clinics, acute liaison, care home liaison, day services and specialist treatment for patients with early onset dementia
- Inpatient assessment and treatment services, including acute and challenging behaviour services

Our main inpatient services for MHSOP are provided at the Bowes Lyon Unit on the Lanchester Road Hospital site in Durham, West Park Hospital in Darlington, Roseberry Park Hospital 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 (CYP)

This service includes all child and adolescent mental health services (including learning disabilities) and early intervention in psychosis services for the people of County Durham, Darlington, Teesside and North Yorkshire.

Most services are provided in the community with inpatient assessment and treatment and low secure services being provided at West Lane Hospital in Middlesbrough. Our hospital at West Lane is also the base for our specialist regional North East and North Cumbria eating disorder inpatient service for children and young people.

Adult learning disabilities (LD)

We provide community and inpatient specialist assessment and treatment services to people with learning disabilities and mental health problems, autism, epilepsy and challenging behaviour in County Durham, Darlington, Teesside and North Yorkshire.

Our main sites are at Bankfields Court in Middlesbrough, Lanchester Road Hospital in Durham and The Dales in Stockton-on-Tees. The Trust also provides community learning disability services for the people of Craven from the services based in Harrogate.

Forensic mental health (FMH) and forensic learning disabilities (FLD) services

Forensic services are specialist services which treat patients referred to us by the criminal justice system because of mental health or learning disabilities conditions which have been a factor driving their offending.

We provide community, inpatient and rehabilitation forensic services for people with mental health problems and learning disabilities.

Our inpatient services, including medium and low secure environments, are based at Roseberry Park in Middlesbrough with step down units in Lanchester Road Hospital in Durham and community rehabilitation services for people with learning disabilities at Oakwood in Middlesbrough.

We also provide community forensic services including criminal justice liaison services that work across the whole offending behaviour pathway, for example street triage in Middlesbrough and the mental health service within all seven North East prisons.

Our performance 2012/13

Performance against key targets

The Trust met all its national requirements and Monitor targets. In addition to these, each year the Board of Directors set a number of stretching targets (performance indicators) for the Trust to work towards as part of its commitment to year-on-year improvement. The scorecard below is the Trust's dashboard of key performance indicators for 2012/13.

The Board received a monthly performance report during 2012/13 which contained performance against a range of indicators linked to the Trust's strategic goals as well as national requirements. That report incorporated separate dashboards for Trust services prior to June 2011 and that for Harrogate, Hambleton & Richmond (due to separate reporting mechanisms in year). The following table shows the 2012/13 year to date combined position for Tees, Esk and Wear Valleys NHS Foundation Trust.

1. Users of Our Services	2012/13 Value	2012/13 Target	Comment
Percentage of patients who have not waited longer than 4 weeks for a first appointment	**89.08%**	**98.00%**	2012/13 position
Percentage of patients who have not waited longer than 6 weeks following an internal referral	**93.30%**	**98% by Dec 2012**	Incremental target of 98% by December 2012. the traffic light is based on the 98% target.
Percentage of patients receiving treatment within 6 weeks of external referral date	**90.56%**	**98% by Dec 2012**	
Percentage of complaints satisfactorily resolved by the Trust	**76.36%**	**90.00%**	2012/13 position
Percentage CPA 7 day follow up (adult services only) - validated	**97.14%**	**95.00%**	2012/13 position
Percentage of CPA Patients having a formal review documented within 12 months (adult services only) - Cumulative snapshot	**96.90%**	**95.00%**	Cumulative snapshot
Percentage of admissions to Inpatient Services that had access to Crisis Resolution Home Treatment Teams prior to admission (adult services only) - validated	**97.35%**	**95.00%**	2012/13 position
Median number of days from when a patient is discharged as an inpatient to their next admission as an inpatient	**140**	**118**	2012/13 position
2. Quality	**2012/13 Value**	**2012/13 Target**	
Number of admissions of 16-18 year olds onto Adult Mental Health Wards	**8**	**12**	2012/13 position
Percentage of non acute patients whose transfer of care was delayed	**2.07%**	**7.50%**	2012/13 position
Number of unexpected deaths classed as a serious incident per 10000 open cases	**15.91**	**12**	2012/13 position
Outcomes for patients on CPA (from MHMDS)	**96.73%**	**90.00%**	Snapshot
Data Completeness: Identifiers	**99.18%**	**99.00%**	Snapshot
Self certification against compliance with requirements regarding access to healthcare for people with a learning disability (snapshot)	**100.00%**	**75.00%**	Snapshot
The number of "out of locality" admissions	**680**	**299**	2012/13 position
3. Workforce	**2012/13 Value**	**2012/13 Target**	
Number of RIDDOR Incidents per 100000 occupied bed days	**15.36**	**18**	2012/13 position
Percentage of staff in post more than 12 months with a current appraisal (snapshot)	**86.93%**	**95.00%**	Snapshot
Percentage compliance with mandatory and statutory training (snapshot)	**87.13%**	**90.00%**	Snapshot
Percentage Sickness Absence Rate (month behind)	**5.26%**		Decremental target to 5.0% by March 2013. This indicator is always reported a month behind, the data shown is the financial year to date position as at the end of February 2013.
Assessment of current establishment (including Bank Agency and Overtime)	**98.67%**	**98-100%**	Snapshot
Percentage of all disciplinary cases where hearings are held in the month that fall within 3 months of the decision to pursue a disciplinary investigation	**58.49%**	**90.00%**	2012/13 position
4. Partnerships	**2012/13 Value**	**2012/13 Target**	
Number of Early Intervention Teams (EIP) new cases	**599**	**259**	2012/13 position
Number of Crisis Home Treatment Episodes	**6152**	**3383**	2012/13 position
Access to Psychological Therapies - Adult IAPT: The proportion of people that enter treatment against the level of need in the general population	**8.68%**	**15.00%**	2012/13 position
Recovery Rate - Adult IAPT: The proportion of people who complete treatment who are moving to recovery	**45.11%**	**50.00%**	2012/13 position
5. Sustainable Organisation	**2012/13 Value**	**2012/13 Target**	
Number of GP Referrals into Trust Services	**34484**	**30631**	2012/13 position
CRES delivery (snapshot)	**99.15%**	**100.00%**	Snapshot

Commentary on Performance

● **Percentage of patients who have not waited longer than 4 weeks for a first appointment** – The Trust has consistently failed to achieve the 98% target throughout the year, reporting a monthly average position of 89%; this is reflected in the annual position of 89%. The forensic directorate has generally reported above target throughout the year, with most months reporting 100%. The remaining locality directorates have consistently reported below target. The Trust position has been largely affected by the Harrogate, Hambleton & Richmond services, which have reported a monthly average position of 65%. These services transferred onto PARIS during the year, which had a negative impact on performance; data continues to be cleansed as part of the transfer.

● **Percentage of patients who have not waited longer than 6 weeks following an internal referral** - Whilst we did not meet the target, performance has remained consistent throughout the year reporting between 91% and 95%. The financial year to date position reports 93%. The forensic directorate has generally reported above target throughout the year, but the locality directorates have only reported above target occasionally during the year, this has not been consistently maintained. Again, the Trust position has been largely affected by the Harrogate, Hambleton & Richmond services, which have reported a monthly average position of 79%. As mentioned above the data continues to be cleansed as part of the transfer onto PARIS.

● **Percentage of patients receiving treatment within 6 weeks of external referral date** - Again we have not met the target of 98%. Performance has fluctuated throughout the year reporting between 85% and 94%. The financial year to date position reports 91%. Whilst the forensics directorate reported above target at the beginning of the year, it has reported below target since January. The locality directorates have reported consistently below target since October. Again, the Trust position has been largely affected by the Harrogate, Hambleton & Richmond services, which have reported a monthly average position of 74%. As mentioned above the data continues to be cleansed as part of the transfer onto PARIS.

● **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. Throughout 2012/13, 39 complainants indicated that they were not happy with the response received in relation to their complaint; this accounts for 23.6% of a total of 165 resolutions letters sent. Complaints are monitored by the Quality and Assurance Committee and are thoroughly investigated. Both the patient experience department and patient advice and liaison services (PALS) strived to resolve as many concerns/complaints as possible informally.

● **Number of unexpected deaths per 10,000 open cases that meet the serious untoward incident criteria** – The National Patient Safety Agency has produced guidance which requires that unexpected deaths, where natural causes are not suspected, be reported. Of the 77 unexpected deaths within 2012/13 we are currently awaiting confirmation from the coroner on 46. Each reported serious untoward incident is reviewed to identify whether there are any care related factors which contributed towards the death, and where any such issues are identified improvements are made to prevent repetition. This work is in addition to proactive work to seek and resolve care delivery issues.

● **The number of "out of locality" admissions** – The Trust has consistently reported above the monthly target of 25 out of locality admissions. During 2012/13 we reported 680 'out of locality' patients against a target of 299. Durham & Darlington have consistently reported over target throughout the year and have implemented a comprehensive action plan. Locality reports have been developed to enable validation within the services and these are monitored closely within the locality directorate and are focused on within their monthly performance meetings. It should be noted that some of the out of locality bed days were due to people needing specific environments, or not being able to be admitted to what would have been their home unit for a range of legitimate clinical reasons.

● **Percentage of staff in post more than 12 months with a current appraisal** – The Trust has under-performed against the 95% target throughout the year. Regular monthly compliance reports are sent out to heads of service who have performance management processes operating to robustly monitor and manage compliance rates. The Trust has recently introduced a conditional pay progression procedure which begun implementation from 1 October 2012 for those staff due an increment in January 2013. Work is still ongoing to validate the end of year figure by allowing operational services to confirm the staff records showing as non-compliant are accurate. It should be noted the figure is to be revised.

● **Percentage compliance with mandatory and statutory training** – Whilst we have reported below target throughout the year, the Trust has reported an improvement. The reported figure of 87.13% includes staff employed on a bank contract. The compliance figure increases to 91.80% when bank staff are excluded. A significant amount of work was undertaken by both operational clinical services and education and training team to ensure the records are accurate. Regular reports are produced and distributed on a monthly basis through the heads of service and robust performance management processes are operating to monitor and manage non compliance of individuals.

● **Percentage sickness absence rate** – The Trust has reported below target since November showing a general downward trend. Absence for the financial year to date ending February 2013 was 5.26%; compared to 5.6% for February 2012. The Trust continues to manage sickness absence in line with the health at work policy.

● **Percentage of all disciplinary cases where hearings are held in the month that falls within 3 months of the decision to pursue a disciplinary investigation** – The Trust has under-performed against the 90% target throughout the year. The figures all exclude cases that were delayed due to sickness absence. Reasons for delays have been examined and reported to the Executive Management Team, and the human resources directorate has also contributed to a paper presented by the Director of Nursing and Governance into the difficulties experienced in the completion of all types of investigations. Meetings have been held with individuals, their companions, commissioning managers and investigating officers at the three month stage to explain the delays. The Head of Operational Human Resources Services also regularly attends the operational management team meetings to discuss employee relations issues.

● **Access to psychological therapies** - adult IAPT: The proportion of people that enter treatment against the level of need in the general population – Whilst this indicator applied to both County Durham and Teesside Locality Directorates for the first six months of 2012/13, it only relates to County Durham and Darlington Service from October 12. We have consistently under-performed against the Trust target throughout the year. Durham and Darlington has been affected by staff vacancies and recruitment delays (predominantly Durham) and staff undertaking training linked to two randomised studies with Durham University - Casper (collaborative care with elderly people) and Cobra (cost effectiveness with behavioural activation). The service has developed an action plan to look at ways to improve performance, which is being monitored on a monthly basis and reported to commissioners. This was also an issue within Teesside; decreases were also attributable to the preparation for the close of the contract.

● **Recovery rate** - adult IAPT: The proportion of people who complete treatment who are moving to recovery – Again we have consistently under-performed against the Trust target throughout the year. As mentioned above, County Durham and Darlington has been affected by staff vacancies and training. Work is continuing on the case management system to improve the flow of cases and individual caseloads are being monitored through supervision and performance reports. Analysis is being undertaken to identify trends and to understand why patients are not moving to recovery. The Teesside service started in September; validation work has been undertaken and actions are being developed to improve the recording of recovery information. This includes contacting patients who do not attend prior to discharge, asking them to complete a rating scale to demonstrate recovery and the establishment of an operational group to undertake some dedicated work with patients who drop out of groups in order to identify reasons for this.

● **CRES delivery** – The Trust has reported below the 100% target since October 2012; however an improvement was achieved for December reporting 0.85% below target and this has been maintained for the final three months of the financial year. As previously reported CRES is marginally behind plan due to the reconfiguration of the forensic services expansion at Roseberry Park Hospital.

Highlights

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

We are passionate about promoting recovery and wellbeing, supporting our service users to achieve their individual goals.

We listen and respond to feedback and do all we can to provide local people with the individualised care and treatment they need, when and where they need it.

We work hard to help our service users remain as independent as possible and to enable them to be active citizens in their local community.

Hospital admissions have become the exception rather than the norm for people with mental ill health or a learning disability. However, we have also continued to modernise our inpatient units so that those people who need to spend time in hospital have access to some of the best facilities in the country.

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

Start on site at West Lane Hospital

First class facilities

Work got underway last year on the £13.8 million development of **West Lane Hospital in Middlesbrough**. The work, which will create a centre of excellence for children and young people, will be completed in stages over the next four years. It will include a new, state-of-the-art mental health unit for young people who need to be cared for in a low secure environment, an extensive refurbishment and redesign of existing premises for inpatient assessment and treatment services and improvements to the Evergreen Centre, part of the Northern Centre for Eating Disorders.

A £3.9 million development on the **Springwood Hospital site in Malton** is also progressing well. The new inpatient facility, which is expected to open towards the end of 2013, will provide a purpose-designed specialist unit for older people with complex mental health needs for the whole of North Yorkshire.

We completed the extension to our **forensic facilities at Roseberry Park** (see page 28) and the final stage of the £10.4 million development of **Cross Lane Hospital in Scarborough** was completed last year. This included the refurbishment and extension of the adult inpatient unit (Ayckbourn). This excellent development was highly commended in the Building Better Healthcare Awards in the patient environment best external or landscaping project category.

Last year the Trust also approved plans to develop a new £1.3 million community base for **child and adolescent mental health services in Scarborough**. The new facility will open in July 2013, replacing the outdated Beck House and providing much improved accommodation for patients and staff.

Information standard

Last year we achieved the nationally recognised Information Standard accreditation for the high quality of our patient and carer information.

The Information Standard
Certified member

We are one of only four mental health trusts nationally to achieve this exacting standard, which involves a rigorous assessment to ensure that our information is accurate, impartial, balanced, evidence-based, accessible and well written.

The Information Standard helps people quickly identify reliable sources of information through the use of an easily recognised quality mark, which is now displayed on patient and carer information and on our website.

Specialist services

Last year we extended our adult eating disorder service to provide specialist 'step-up/step-down' support for people across Teesside, County Durham and Darlington.

The service is available to patients who are living at home but still need support in their recovery. The specialist team offer a two step approach as an alternative to inpatient or residential programme. 'Stepping up' caters for patients who may require further support to prevent admission to hospital as well as help for those awaiting admission. 'Stepping down' is for patients following discharge from hospital and aims to help prevent relapse and encourage recovery.

The 12 – 18 week programme is similar to a residential programme – highly structured with an intense focus on learning skills for recovery. But it is has the advantage of allowing patients to continue to live at home.

Staff and service users outside the new unit

Home cooked meals

Acting on feedback from patients we have revolutionised the way food is prepared in our learning disability units. Instead of serving up traditional hospital food, patients and staff now work together to prepare home cooked meals.

Food was previously bought either frozen or chilled, heated up on individual wards and served to patients. Now staff, patients and dieticians create menus and recipe cards that are healthy, nutritious and easy to understand.

At each mealtime staff work with patients to cook the food that they have planned. This self catering model also helps promote a sense of independence on the wards and gives patients the confidence to be able to cater for themselves when they leave the unit.

Following a very successful three month pilot at Lanchester Road Hospital in Durham the idea was adopted by Bankfields Court in Middlesbrough and the Dales in Stockton.

Preparing food in one of the units

Improving dementia services

Andrew Jones, MP, (centre) with staff from memory service

In June 2012 we launched a dedicated memory management service for the people of Harrogate and Ripon, which is giving local people quick access to good quality assessment, diagnosis and treatment of dementia.

People are living longer and the number of people with dementia is increasing. This is particularly significant in the Harrogate area where 20% of the population is over the age of 65 (compared to a national average of 16%).

Evidence shows that early diagnosis and treatment of people with dementia helps people remain independent for longer and prevents unnecessary admissions into hospital care. We are now able to give people with dementia and their carers the treatment, information, advice and support they need quickly to help them continue to have the best possible quality of life.

The team, which also offers an outreach service to rural areas and to patients who are physically frail and unable to travel, has already dramatically reduced waiting times from 10 to four weeks.

Strengthening community services

Effective community services are vital to supporting people to live at home and we continued to develop these services over the last year. For example:

- We developed an **intensive community liaison service for older people** living in the **Teesside** area, both in their own homes and in care homes. The aim is to support people who have acute mental health difficulties and challenging behaviour. The team offer prompt assessment and treatment and also provide support for carers and families.
- We have developed new ways of working across our **community learning disability teams** in **Teesside** to provide a more client centred approach.

Highlights

Our goal:
To continuously improve the quality and value of our work

We are totally committed to continually improving the quality of our services, ensuring the needs of the people who receive services from the Trust are our central focus.

We strive to eliminate waste wherever it exists in the organisation so that our staff can focus on what's important – improving the lives of the people who use our services.

We are well on the way to embedding a culture of continuous improvement across the Trust and our quality improvement system (TEWV QIS) is fundamental to achieving this goal. TEWV QIS is not just a set of tools, it's the way we do things at TEWV to empower staff to eliminate waste and improve quality.

This section contains examples of how we are achieving our goal as well as evidence of our success.

Transforming services for people with dementia

Building on our previous success with the dementia collaborative in Darlington we have been working with health and social care partners in Harrogate and Teesside to improve services for people with dementia.

A two year project is well underway in **Harrogate** where we are working with Harrogate District NHS Foundation Trust, North Yorkshire County Council and Harrogate CCG to improve services by, for instance, reducing waiting times, introducing a single assessment process and improving the environment.

In **Teesside** we are working with North Tees and Hartlepool NHS Foundation Trust, the two local authorities and the two clinical commissioning groups.

We have already seen some significant improvements in preventing unnecessary admissions to accident and emergency departments from care homes. Three care homes are piloting the changes which have resulted in a 33% reduction in 999 calls from the homes.

Quality design

Our state-of-the-art specialist inpatient unit on Teesside for people with learning disabilities was designed using the tools of the Trust's Quality Improvement System.

The new Bankfields Court development near Middlesbrough, which opened in 2012, has two six-bedded inpatient assessment and treatment units and six individual rehabilitation flats.

Staff and clients were involved in the project from concept to completion and used TEWV QIS to develop the design requirements.

The £5.3 million facility is a significant improvement on the former accommodation on the Bankfields Court site. The new facilities offer clients personal space within modern, homely surroundings, whilst creating a therapeutic environment to aid recovery.

National accreditation

Staff from the Newberry Centre

Willow Ward at West Park Hospital in Darlington is one of only seven rehabilitation wards nationally to achieve an 'excellent' rating against the Accreditation for Inpatient Mental Health Services (AIMS) standards from the Royal College of Psychiatrists.

The team received the accreditation in 2012 following an assessment which covered areas such as ward environment, therapies and activities on the unit, the admission process and patient safety.

Achieving this national accreditation is recognition of the work that the team does with service users with some of the most challenging and complex behaviours.

The Newberry Centre at West Lane Hospital in Middlesbrough was named one of the top child and adolescent mental health inpatient units in the country by the Royal College of Psychiatry.

The unit was accredited by the College's Quality Network for Inpatient Child and Adolescent Mental Health Services (QNIC). Accreditation is for three years with a peer review taking place at the end of the second year.

Staff from Willow Ward celebrate their achievement

Embedding TEWV QIS

We have continued to work hard to embed our quality improvement system so that it becomes 'the way we do things at TEWV'.

Week long rapid process improvement workshops (RPIWs) remain fundamental to empowering staff to bring about change, eliminate waste and make improvements to services. Last year we held 28 RPIWs across the organisation along with three workshop to develop clinical pathways and seven 3P (production, preparation and process) events to bring about radical, rather than incremental, change. (See page 42 in the quality report for examples).

As the momentum builds and more and more people from across the organisation learn how the tools can help them improve their services, we are seeing the impact of this at a local level.

Last year leaders from all areas of the Trust completed over 200 improvement projects linked to the QIS for leaders training programme and over 90 administrative staff completed projects linked to the 'QIS for admin' training. Over 200 consultants and specialist doctors also signed up for our QIS for medics programme and 60 of those have already completed their training.

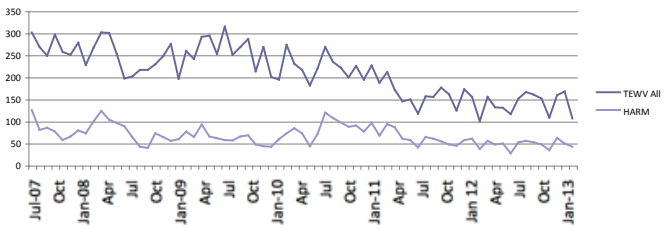
Our success in embedding our quality improvement system was recognised nationally when we were shortlisted for two Lean awards - Lean Champion of the Year Award and Improving Services through Training and Development.

Reducing incidences of violence and aggression

Over the last year we have continued to see a year-on-year reduction in the number of incidents of violence and aggression towards patients and staff by patients.

Reducing the number of incidents, and particularly those causing physical harm, has been a key priority for the Trust over the last few years (it was one of the priorities in our first Quality Report). At the end of 2012/13 (compared to 2007/2008) we reported a 58% reduction and although this remains a priority for us we are pleased that these figures continue to fall.

A number of initiatives, led and supported by the Board of Directors, have been instrumental in achieving this ongoing reduction in incidents. These have included the implementation of a challenging behaviour pathway, more robust supervision and training, improved processes and tools for managing and monitoring patients' behaviour and risk.



Incidents of physical assaults (all and those leading to harm) by patients to patients and staff.

This work was recognised in the national Patient Safety Awards where we were shortlisted in the patient safety in mental health category. It was also acknowledged by staff in the national staff survey who said they believed we take effective action towards violence and harassment.

Highlights

Our goal:
To recruit, develop and retain a skilled, compassionate and motivated workforce.

We want to be the best employer we can be and this means creating a culture where staff feel valued and supported to work according to the Trust's values.

Our aim is to make sure that

- Staff have clear roles and are able to acquire the skills and expertise they need to perform them well
- We provide opportunities for staff to learn and develop effectively
- Staff are able to get involved and contribute to decision making within the Trust
- We promote and support the health and wellbeing of our staff
- We give staff the opportunity to develop as effective leaders

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

Thumbs up from staff

Results of the annual NHS staff survey confirmed TEWV as being one of the best NHS employers in the country.

Our staff gave us the best score in five of the 28 areas covered and put us in the top 20% in a further 15 areas, compared to other mental health and learning disability trusts. (See page 36 for more information about the results of the survey).

New career framework for healthcare assistants

In April 2012 we introduced an innovative new career framework for our healthcare assistants (HCAs) to enable them to progress through Agenda for Change pay band 3.

The framework, which is for existing and new staff, gives individuals the opportunity to acquire the skills and competencies they need to carry out their role more effectively and to further develop their own career. Ultimately, and perhaps most importantly, it is enabling us to support our staff to provide the best possible quality of care to our service users.

The training programme includes a Diploma in Health and Social Care level 3 and in the first year over 180 HCAs have enrolled on the course, which is paid for by the Trust.

Valuing our staff

A winning team at at the Making a Difference Awards

Excellent staff are our greatest asset and our Board of Directors take every opportunity to recognise them for their dedication and commitment.

Our annual **Making a Difference awards** programme has gone from strength to strength and the sixth awards ceremony was a huge success. Forty teams and individuals from across the Trust were shortlisted from around 200 nominations for ten awards. We received excellent feedback from staff about these awards, which are a great way of showing staff they are valued for what they do.

We also recognise staff for their **long service** to the NHS, presenting those with over 25 years service with a certificate and high street vouchers. Last year our Chairman and Chief Executive welcomed over 30 people from across the Trust at a special ceremony to mark this important milestone.

Our values provide the guiding principles for how we want our staff to behave and to reflect the importance we place on these the Chairman presents a bi-monthly **Living the Values award**. Seven teams and individuals have received this award since it was introduced in early 2012. In addition, since the end of 2012 the Executive Management Team have chosen a Team of the Week to recognise those that have gone that extra mile to achieve great outcomes.

Commitment Teamwork to quality
Living the values
Involvement Wellbeing
Respect

Developing leaders

TEWV staff secured two of only 60 places on a well respected national leadership programme – the **NHS Vanguard for Emerging Leaders programme**.

This intensive 26 week leadership development programme was developed by the NHS Institute in partnership with the Emerging Leaders Network. They used a range of tools and approaches to develop individuals' ability to lead large scale change and bring about quality improvement.

Our own **leadership and management programme** (LAMD) has also been an excellent stepping stone for staff to complete degrees.

Last year seven staff achieved their BSc (Hons) degree in Practice Innovation after completing the accredited two year LAMD programme.

Staff celebrate completing their degrees

Students at the summer school

Summer school

We introduced a new summer school for medical students in 2012 (one of only three in the country).

19 students from medical schools all over the UK attended the three day programme, which gave them the opportunity to find out what it's like to be a psychiatrist and a chance to experience elements of psychiatry not necessarily in the curricula.

The school was a great success, with excellent feedback from participants, and will be repeated in 2013.

Better training, better care

We were one of just 16 trusts in the country to be chosen to take part in a pilot scheme to revolutionise early supervision arrangements for junior doctors.

Our focus is on training and support for foundation trainees and first year core trainees in psychiatry and the project has been designed to support the various training stages in their first few weeks.

Our junior doctors wear green lanyards to help colleagues quickly identify they are new to the workplace, before moving onto blue in the advance training phase after their initial induction.

It is part of the national 'Better Training Better Care' programme and aims to improve the quality of training and learning in our adult and older people's mental health services as well as provide improved safety and quality care for patients.

Junior doctors taking part in the pilot

Highlights

Our goal:
To have effective partnerships locally, nationally and internationally for the benefit of our communities.

We are proud of being part of the NHS and of working with our partners to provide some of the best mental health care in the country.

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 all our partners so that we can continuously improve our services and achieve sustainable success.

Over the past year we have continued to work with our existing partners and to develop new relationships so that the people who need our services get the best possible care.

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

Working with acute hospitals

Over the last year we have been working with and supporting colleagues in acute hospitals across Teesside, County Durham and Darlington to improve services for people with both physical and mental health needs.

Our commissioners have been great in giving us a very positive challenge. They have made a big investment in very significantly expanding our mental health liaison services. There was evidence from Birmingham that effectively resourced liaison services save the NHS money as well as improve outcomes for patients. We have been given two years to test out this evidence in Durham, Darlington and Teesside.

In **County Durham and Darlington** a two-year project is underway to develop the acute hospital liaison mental health services at Bishop Auckland General Hospital, Darlington Memorial Hospital and the University Hospital of North Durham. Last year we merged the existing adult and older people's liaison teams, recruited additional staff and extended the hours that this new service is available. We have also set up an enhanced liaison service into community hospitals and referrals to this service have doubled over the last year.

Staff from the acute liaison service at University Hospital of South Tees

A new round the clock acute liaison service is available across hospitals in **Teesside**. Adult and older people's services have come together into a single team, with a single point of contact, to provide services 24 hours a day. Staff are working with colleagues at South Tees NHS Foundation Trust and North Tees and Hartlepool NHS Foundation Trust to assess patients with mental health problems and help them access the services they need.

Streets ahead

In 2012 we launched a pilot project in Teesside to help give people with mental ill health who come into contact with the Police access to the appropriate services.

The street triage service is available daily from 4pm until midnight and is already having a positive impact on reducing the number of detentions made under the Mental Health Act.

Police officers can call out the street triage team if they attend an incident and consider someone may have mental ill health, a learning disability or problems with substance misuse. The team carries out an assessment and helps identify if people need to be detained for care and treatment.

Nurses from the street triage team are also providing mental health awareness training to Cleveland Police officers, to further equip them with a wider knowledge and understanding of mental illness.

Caring for veterans

The Veterans' Wellbeing Assessment and Liaison Service (VWALS) is a partnership between TEWV, Northumberland, Tyne and Wear NHS Foundation Trust and the charity Combat Stress. They also work with the Royal British Legion to address other concerns such as housing, employment or welfare issues.

As well as helping veterans, VWALS provides a wellbeing group for their families and carers to help them better understand and cope with the issues often faced by those who have served in the armed forces.

Healthcare staff in acute hospital and community settings can also use VWALS when treating patients who have served in the armed forces and who they think may benefit from mental health support.

A perfect day

Over the last year the team from the Orchard day service in Middlesbrough (an integrated health and social care service for people with complex learning difficulties and/or physical needs) have made huge improvements to their services.

Staff from TEWV and Middlesbrough Council used the tools of the Trust's quality improvement system to create a 'perfect day' for their clients. This joint ownership of what they were trying to achieve was key to their success.

As a result they introduced news way of working, timetabling and organised individual and group activities both at the Orchard and in the local community.

Feedback was extremely positive with excellent examples of positive changes for individuals.

Caring in care homes

Our care home liaison teams continue to have a huge positive impact on the quality of life of older people.

Mental health nurses across the Trust work closely with care home staff to make sure that residents with dementia get the care and treatment they need in their home environment.

As well as assessing and treating patients they also help care home staff gain a better understanding of dementia and develop the skills they need to care for people with challenging behaviour. They also help focus on reducing the need for medication to help people with challenging behaviour.

Last year we

- Set up a new team in Hambleton and Richmondshire to support 17 residential and nursing homes.
- Developed services in County Durham and Darlington to include an advanced nurse practitioner, occupational therapist and clinical psychologist. The team also helps care home staff identify which activities will best engage each resident.
- Strengthened services in Harrogate and Ripon by establishing a new team to work alongside community and on-call teams to provide services seven days a week.

Members of the Harrogate and Ripon care home liaison team

Highlights

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

Our local communities are at the heart of everything we do and we are committed to working with our governors and members to meet the needs of local people. We are also keen to lead and influence national and international policy and systems development.

We have continued to use our extensive experience, expertise and sound financial management for the benefit of our communities. We were one of just six NHS organisations to be shortlisted for the prestigious Provider of the Year Award by the Health Service Journal and our Chief Executive was also shortlisted for the Chief Executive of the Year Award.

Over the last year we have secured a number of contracts that are consistent with our vision and which reflect the high standard and cost effectiveness of our services. We were disappointed, however, not to be awarded the substance misuse contract for Redcar and Cleveland.

Our Reference Costs are the second lowest in the NHS and we retained our 'green' governance rating with Monitor.

This section includes information about our new contracts as well as other examples of how we are achieving our goal.

The performance of the Board of Directors as a whole and individually is evaluated each year, leading to the formulation of a development plan, which has been implemented.

MOD contract renewed

Our contract to provide acute mental health inpatient services for serving military personnel was renewed at the end of December.

We are one of eight NHS mental health trusts across the country involved in the Joining Forces Network, which is led by South Staffordshire and Shropshire Healthcare NHS Foundation Trust.

We first secured the contract in 2009 and over the last three years have provided inpatient care for Armed Forces personnel at West Park Hospital in Darlington.

The new contract includes some exciting innovations, including a mental health 'app' specially developed to offer mental health information to personnel from the army, navy and air force, which will be rolled out in 2013/14.

We provide highly specialised secure services and over the last year we have continued to develop and strengthen these services to meet people's needs. We opened an extension to our inpatient services at Ridgeway, Roseberry Park in Middlesbrough. The new facility includes a unit which provides highly specialist, medium secure inpatient services for people with autism as well as inpatient services for women with severe disorders.

We have also expanded our adult autism team into Darlington and Teesside and staff work alongside colleagues in other mental health, learning disability and forensic services to offer a complete autism care pathway.

New talking therapies service launched

Staff from the new talking therapies service

In 2012 we launched a new psychological therapies service on Teesside as part of 'Any Qualified Provider' to support the thousands of people struggling to cope because they are feeling low, stressed or worried.

TalkingTherapies@tewv is open to anyone over the age of 16 who lives in the Teesside area. We offer a range of NHS approved therapies to cater for the different needs and wishes of those who need help.

Support is available in groups, online, over the phone or face-to-face. This includes wellbeing courses where people learn techniques for overcoming their problems, access to online talking therapies and self help material (with support from a therapist) and one-to-one help from a qualified therapist.

People can contact the service directly or through their family doctor and assessments are offered on the same day a referral is received.

Improving talking therapies for young people

Last year TEWV was successful in its bid to become a partner in one of two new learning collaboratives set up by the Government to improve access to psychological therapies for children and young people.

The project in the North East supports children, young people and their families living in the Redcar and Cleveland, Stockton on Tees, Durham, Darlington and Northallerton areas, who need specialist therapies.

The aim is to increase and widen access to therapies including CBT (cognitive behavioural therapy) for children and young people who suffer with anxiety or depression. It will also offer parenting skills training for parents of children aged 3-10 years with behavioural problems.

A specialist nine month training programme is a key part of the North East, Yorkshire and Humber Learning Collaborative. Mental health nurses, social workers and an occupational therapist are undertaking the training and will pioneer the improved service which will offer a wider choice of where, when and how children, young people and their families can be seen.

Our partners in the collaborative are Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH) and Northumbria University with Investing in Children supporting young people, their parents and carers.

Staff taking part on the training programme

New service for people with chronic heroin addiction

TEWV was one of three trusts nationally to secure a contract to provide injectable opioid treatment. The new service, which was launched in 2012, is available to people in the Easington district.

Recovery injectable opioid (RIO) aims to help patients stop injecting heroin and it works by structuring the patient's day and providing intensive support and therapy.

Patients are prescribed injectable diamorphine (pharmaceutical heroin) in a strictly supervised clinic, which they attend once or twice every day. They do not take injectable opioid medication away with them.

Research has shown that prescribing injectable opioids in a tightly controlled environment can reduce the use of street heroin and associated crime. This type of treatment can improve the patients' health and quality of life and give them the stability they need to help them recover from their heroin addiction.

RIO has been funded by the Department of Health until March 2015.

Principal risks and uncertainties

Our business plan, which supports the achievement of our strategic direction, recognises that the environment in which we operate and the needs of our stakeholders are constantly changing.

The Board continues 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 95.

Increasing competition

Over the last few years competition for the services we provide has increased particularly for substance misuse services and as a result of the introduction of the "any qualified provider model" for increasing access to psychological therapies in Teesside.

We expect this trend to continue as new organisations enter the market and as efficiencies are sought through commissioning arrangements.

We recognise that to retain services we must be second to none in terms of quality and value. However, we must also assure ourselves that, in tendering for contracts, the services we provide will be safe and sustainable.

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

We do not operate in isolation from other providers of public services. Many of our services are provided through integrated management arrangements with local authorities.

If, as a result of reductions in public sector expenditure, our partners decide to withdraw from these arrangements it could result in inefficiencies, poor service to our patients and their carers and difficulties in meeting our contractual obligations.

We will continue to support and work with our partners highlighting the benefits of integrated working for all concerned.

Payment by results

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

We are in a relatively strong position to respond to this change due to our excellent reference costs; the significant investment we have made in developing our clinical information systems; the development of systems and processes to support the introduction and operation of PbR; and the significant input we have made, at a national level, into its development.

Board Sustainability

Over the next few years we expect there to be a number of significant changes to the membership of our Board of Directors.

In 2013/14 the Chairman and one Non-Executive Director will be retiring. Other Non-Executive Directors and certain Executive Directors have also indicated that they will retire over the next three years.

There are risks that this will disrupt the leadership of the Trust and may act as a distraction from our focus on delivering high quality services.

In response to these risks we have worked with the Nomination and Remuneration Committee of our Council of Governors to ensure robust processes are in place for the appointment of the Chairman and Non-Executive Directors and the terms of office of the Non-Executive Directors are staggered so that vacancies are spread over a number of years. We have also appointed external recruitment consultants to assist us attract high calibre candidates for appointment.

The compliance framework and the risk ratings

Monitor, the independent regulator of foundation trusts, has developed a 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 two areas based on the following criteria:

- finance – *achievement of plan, underlying performance, financial efficiency and liquidity*
- governance – *legality of the constitution, growing a representative membership, appropriate board roles and structures, service performance (targets and national standards), clinical quality and patient safety, effective risk and performance management, co-operation with NHS bodies and local authorities*

The risk ratings are expressed as:

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

Risk rating performance 2011/12 and 2012/13

	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
	Annual Plan 2012/13	**Q1 2012/13**	**Q2 2012/13**	**Q3 2012/13**	**Q4 2012/13**
Financial risk rating	4	4	4	4	5
Governance risk rating	Green	Green	Green	Green	Green

Regulatory interventions

Monitor did not use its formal powers of intervention against the Trust in 2011/12 and 2012/13.

A new system of regulation

In April 2013 Monitor will become the sector regulator for health.

Under the Health and Social Care Act 2012 the Trust's authorisation as a foundation trust will be replaced by a new provider licence.

All providers of NHS services will be required to hold a licence unless they are exempt under regulations made by the Department of Health.

Provider licences set out obligations for providers of NHS services including specific requirements for NHS foundation trusts.

The licence will be supported by a risk assessment framework which will supersede the compliance framework.

All foundation trusts will be licensed automatically in April 2013.

Further information

Further information about the compliance framework and provider licences is available on Monitor's website www.monitor-nhsft.gov.uk

Involving and listening

Patient and public involvement

It is important that we involve service users, their carers, families and the wider community in our work as they can influence the way our services are delivered and improved. The patient experience and involvement strategy gives continued commitment to involving and learning from people's experiences and the carer support strategy commits us to involving and supporting carers.

These are a few examples of the types of activities that service users and carers have been involved with across the Trust over the past year:

- participation in the service users, carers and advocates leadership programme, which gives people skills and confidence to get involved and make a difference
- attending regular meetings with Trust staff such as the Mental Health Act committee and pharmacy, psychological therapies, patient and carer information and essential standards reference groups
- visiting many of our wards with patient advice and liaison service (PALS) staff to talk to patients about their experiences of quality and safety standards on the wards, identifying areas for improvement
- helping with the recruitment of new staff
- attending focus groups to give expert opinions on a variety of topics, including care pathways, care planning and service changes
- 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
- speaking to Trust members, governors and staff at events about how they have been getting involved
- giving their personal stories of recovery both verbally at events and in writing to educate staff and to give hope and reassurance to others
- reviewing new patient and carer information as part of a readers panel
- being part of learning disability reference groups, supported by advocacy, that are involved in the recruitment of staff, a programme of staff training and clinical research

Public engagement

The Trust worked closely with Harrogate and Rural District Clinical Commissioning Group (CCG) on proposals to improve the way we provide services for older people in the Harrogate area.

Alexander House in Knaresborough and the Rowan Ward at Harrogate District Hospital had 32 beds between them. National guidance says a population the size of the Harrogate area needs around 15 – 16 assessment and treatment beds for older people.

As community services have strengthened, people are spending less time in hospital and less than half of the beds were in use at any one time.

In order to continue to modernise dementia services and make good use of taxpayers' money we proposed reducing the number of beds to the recommended number of 16.

Following an extensive engagement exercise with local people, which included a number of workshop style events, the CCG and the local Overview and Scrutiny Committee approved plans to provide inpatient services at the Rowan Ward in Harrogate District Hospital, freeing up Alexander House to be used as a community focused mental health resource centre.

> ***"Thanks to all who have cared for my husband. I thank you for the patience you have shown and I am grateful to those of you who showed me equal patience and were ready to discuss my fears and anxieties"***
>
> *A service user's wife*

Involvement with local networks

We continued to have positive working relationships with **Local Involvement Networks (LINks)** from seven local authority areas. We held regular meetings with representatives to share information and held several joint events. LINks members also undertook 'enter and view visits' at a number of our sites and we responded to their reports and specific requests for information. In July 2010, as part of health care reforms, the Government announced plans to set up an independent champion for health and social care consumers called Healthwatch England to replace LINKs.

Healthwatch England was established on 1 October 2012 with local Healthwatch organisations starting on 1 April 2013. The primary task of local Healthwatch organisations will be to gather evidence from the views and experiences of patients, service users and the public about their local health and care services and to provide feedback to organisations based on that evidence. The Trust is committed to engaging with the public, patients and the public and looks forward to working with Healthwatch to identify any areas for improvement.

Patient advice and liaison service (PALS)

PALS has continued to visit wards across the Trust, 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 2012 and 31 March 2013, 1,103 contacts were recorded and responded to by PALS (this was a small reduction of 23 contacts from 2011 – 12 when 1,126 contacts were made).

Formal complaints

In 2012-13 we received 177 written complaints (this was an increase of 36 complaints compared to the 141 complaints received in 2011 -12).

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 eleven times by the Ombudsman concerning requests for information relating to Trust complaints, they decided not to investigate eight of the complaints further. At the end of the year there were three outstanding cases with the Ombudsman.

Listening and learning

We continue to learn valuable lessons from complaints and concerns raised with PALS from service users and their carers. Improvements identified over the last year included:

- **children's learning disability services** – service areas were asked to ensure that multi-agency care/support plans are in place to identify service users' needs and how they are most appropriately met.
- **children's and adolescent mental health service (CAMHS)** – we recognised the need to ensure more seamless transition processes between CAMHS and adult mental health services for service users and earlier identification of care co-ordinators in adult services.
- **adult mental health services** – crisis teams were reminded that, where possible, when reviewing medication there should be a clear discussion/ appointment with the consultant psychiatrist and every attempt should be made to involve the family in this prior to any decision being reached.
- **forensic learning disability services** – staff were reminded that service users should receive a copy of an information sheet about leave from the ward; inpatient staff were asked to review how information is fed back to service users from the ward round and to continually seek the views of service users and carers so that appropriate improvements can made.
- **forensic services** – to explore training opportunities for staff relating to self awareness, dealing with people and difficult situations (eg de-escalation and customer service skills). The protocol for service users to retain their own property on the ward to be reviewed and staff to be reminded of Trust procedures relating to service users' property.
- **mental health services for older people** – it was recommended that pertinent financial and housing arrangements for service users are discussed in ward formulation and care programme approach (CPA) meetings with accurate records made on the trust's electronic care records system, PARIS. Staff to be reminded that all service users should have relevant, evidence based intervention plans relating to their care needs.
- **adult learning disabilities** - service areas to be reminded that reference should be made in care plans regarding service users' needs around personal hygiene.

The Trust also receives hundreds 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 March 2013 we employed just over 6,000 staff (compared to 5,900 at the end of March 2012) including around:

- 250 doctors
- 2,040 qualified nurses
- 1,650 clinical support staff
- 620 qualified psychologists, allied health professionals and pharmacists
- 1,500 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.

Communicating and engaging with our staff

We employ approximately 6000 staff, working at over 170 sites, across 3600 square miles, which means the Trust has to make additional efforts to communicate effectively.

We have a number of key corporate mechanisms for communicating and engaging with staff and these include:

- Team briefing system
- Trust magazine (insight)
- Intranet
- Weekly e-bulletin
- Informal visits by directors and formal board visits

Last year, in response to feedback from staff who wanted to hear more about what was going on at director level we introduced two new features in our weekly e-bulletin – a round up of discussions at the Executive Management Team (EMT) meetings and a weekly message from the Chief Executive, Martin Barkley (Chief Executives' reflections).

We also strengthened arrangements for consulting with staff about our business plans.

Monthly meetings were held throughout the year between the Trust and local staff representatives to ensure that meaningful consultation about key workforce and service issues takes place. We are discussing revised consultation arrangements with staff representatives that will include formal locality consultation arrangements for the first time. We anticipate that the new arrangements will be in place during 2013/14.

Consultations about proposed organisational changes, changes to workforce polices and procedures and terms and conditions issues have taken place during the last year. Such consultations have taken place both at Trust and individual service level. This two way flow of information has helped to inform and improve decisions made.

Our quality improvement system continues to be a key way of involving staff and this was backed up by the results of our staff

" I can honestly say during my time spent on the ward, every single member of staff I have encountered has demonstrated professionalism in their actions and has been generous with both their knowledge and skills to support my practical placement "

An occupational therapy student

Health and wellbeing

The health and wellbeing of our staff remains a priority and we continue to work very closely with our external occupational health provider to support our staff. Over the last year joint partnership working has resulted in over 300 more flu vaccinations being administered than the previous year. An occupational health physician now attends case reviews and has received excellent feedback. Counselling and physiotherapy services also continue to provide rapid access to treatment and rehabilitation services. The number of missed appointments and late cancellations, however, remains a concern and a joint approach to identify possible solutions is underway. The occupational health service will go through the tendering process in 2013/14.

The introduction of our internal Employee Support Officer has also received excellent feedback as an effective support to staff who experience mental ill health as well as their managers.

Sickness absence figures for 2012 (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
5.1%	6,235	1,950,650	99,605	16

Our work to reduce sickness absence rates across the Trust is paying off and at the end of March 2013 we had achieved our target of 5%. The cumulative rate was 4.98%.

survey which said that the numbers of staff who felt able to contribute towards improvements at work had risen from 67% to 79%.

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 sickness absence management procedure is used to help ensure that a fair and effective approach to the management of sickness absence is adopted throughout the Trust. The Trust takes all reasonable measures to support employees where there are problems and has developed a 'guide to good health and wellbeing' that can be accessed on the Trust's intranet.
- 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 were in the top 20% of mental health and learning disability Trusts in 20 of the 28 areas reviewed and received the best score in the country in five of those areas. Our response rate was 62%.

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

We scored the best scores of all mental health and learning disability Trusts in the following areas:

- Percentage of staff having well structured appraisals (54% compared to 41% nationally) **KF8**
- Percentage of staff saying hand washing materials are always available (64% compared to 55% nationally) **KF12**
- Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months (15% compared to 21% nationally) **KF19**
- Percentage of staff being able to contribute towards improvements at work (79% compared to 71% nationally) **KF22**
- Percentage of staff having equality and diversity training in the last 12 months (85% compared to 59% nationally) **KF26**

We were particularly pleased to see that such a high percentage of staff feel able to contribute towards improvements. Involving staff is key to improving services and fundamental to the success of our quality improvement system.

There was only one area where we scored below average, compared to other Trusts:

- Percentage of staff experiencing physical violence from patients, relatives or the public (23% compared to 20% nationally). **KF16**

This continues to be an area of concern for the Trust and tackling this issue remains a high priority for us.

There have been improvements in a number of key areas since the previous year's survey:

- Percentage of staff able to contribute towards improvements at work (increased to 79% from 67%)
- Job satisfaction (increased to 3.77, on scale of 1-5, from 3.66)
- Percentage of staff appraised (increased to 93% from 84%)
- Percentage of staff having well structured appraisals (increased to 54% from 46%)
- Fairness and effectiveness of incident reporting procedures (increased to 3.67, on a scale of 1-5, from 3.6)

It was great to see that the percentage of staff receiving appraisals had risen from 84% to 93%. We now need to concentrate on the quality of the appraisals. Although the percentage of staff having well structured appraisals had increased and we are the highest of mental health Trusts in this area, there is still plenty of room for improvement.

There were two areas where staff experiences had deteriorated since last year:

- Percentage of staff suffering work-related stress (increased to 42% from 28%) **KF11**
- Percentage of staff working extra hours (increased to 69% from 61%) **KF5**

These figures are concerning and will be the focus of more detailed analysis so that we can take action to address them.

Another of our bottom ranking scores was the numbers of staff experiencing harassment, bullying or abuse from patients, relatives or the public where we scored the national average of 30%. **(KF18)**

We also included a number of local questions in the staff survey. The results on the whole were very positive and the key findings were:

- 77% of staff attended core team brief and/or directorate briefings and 89% of those found them useful
- 86% of staff were aware of the staff compact and 90% of those believed their managers adhered to it and 81% believed that the Trust adheres to it
- 89% of staff were aware of the Trust's values and behaviours statements and 90% of those believed their colleagues work by them, 92% believed that their managers work by them and 85% believed that their senior managers work by them
- 64% of staff believed that senior managers are visible in the workplace, 69% think that their senior managers were accessible and 76% felt able to approach senior managers about an issue. Of those who did, 87% received feedback from the senior manager.

The responses given to all of these questions were more positive than the responses given a year ago.

Over the last year we have worked hard to address the issues highlighted in the previous staff survey. We have continued to raise awareness and understanding of the Trust compact and the Trust values. Regular sessions have taken place across the Trust for staff and they form a key part of the Embedding the Values Programme for managers (page 13). The programme has recently been extended to include band 6 managers. The Employee Support Officer role is also receiving some very positive feedback.

Previous staff survey results showed a difference in scores between disabled and non disabled staff. We wanted to better understand why this was so, so we commissioned the Percy Hedley Foundation to undertake independent research with staff with long term health conditions. Staff told us that they were sometimes having difficulty accessing workplace adjustments. As a result of this feedback improvements have been made which have been recognised in this year's survey results. It is recognised that more work in this area is needed and an action plan has been developed to progress the findings of the independent research.

We are currently working on an action plan to address the findings of this year's staff survey. The expected priority areas are:

- reducing the number of our staff suffering physical violence and verbal abuse from patients/relatives
- reducing work related stress
- reducing the number of additional hours worked by staff
- raising the quality of appraisals
- improving the experiences of our BME and disabled staff
- improving communication between senior managers and staff.

Summary of Staff Survey Results

	2011/12		2012/13		Trust Improvement/ Deterioration
Response rate	Trust	National Average	Trust	National Average	
	64%	54%	62%		*deterioration*

	2011/12		2012/13		
Top 4 Ranking Scores	Trust	National Average	Trust	National Average	Trust Improvement/ Deterioration
KF26	83%	53%	85%	59%	Improvement
KF12	62%	59%	64%	55%	Improvement
KF8	46%	39%	54%	41%	Improvement
KF22	67%	66%	79%	71%	Improvement

	2011/12		2012/13		
Bottom 4 Ranking Scores	Trust	National Average	Trust	National Average	Trust Improvement/ Deterioration
KF16	N/A	N/A	23%	20%	
KF11	28%	33%	42%	41%	deterioration
KF18	N/A	N/A	30%	30%	
KF5	61%	65%	69%	70%	deterioration

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 third year of audits of the health, safety and security workbook (the Trust's health and safety management system) as part of a three year rolling programme across the Trust.

We have continued to run a programme of table-top exercises to test our business continuity plans. Lessons learnt from these exercises have been used to 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 54% in March 2013.

We have introduced a four bay charging facility for electric vehicles at West Park Hospital in Darlington. We have also installed apparatus at Flatts Lane Centre in Normanby to reduce and stabilise the incoming voltage which will save money, reduce carbon emissions by 12% and extend the life expectancy of all electrical equipment.

Contractual relationships

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

Our services are commissioned by:

- North Durham Clinical Commissioning Group
- Durham Dales, Easington and Sedgefield Clinical Commissioning Group
- Darlington Clinical Commissioning Group
- Hartlepool and Stockton Clinical Commissioning Group
- South Tees Clinical Commissioning Group
- Scarborough and Ryedale Clinical Commissioning Group
- Hambleton, Richmondshire and Whitby Clinical Commissioning Group
- Harrogate and Rural District Clinical Commissioning Group
- Vale of York Clinical Commissioning Group
- The North East Specialised Commissioning Group
- Yorkshire and the Humber Specialised Commissioning Group
- The Ministry of Defence
- The Ministry of Justice
- 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 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 are sub-contracted by Care UK to provide mental health services in prisons in the North East, commissioned by the North East Specialist Commissioning Team.

We continue to be the 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. The contract is with the Ministry of Defence (MOD).

We work in partnership with Northumberland, Tyne and Wear NHS Foundation Trust, the charity Combat Stress and the Royal British Legion to provide the Veterans' Wellbeing Assessment and Liaison Service (VWALS), a new mental health and wellbeing service for veterans and their families in the North East.

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 and 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 and Assurance Committee (QuAC) (see page 82).

The committee is supported with a network of Quality Assurance Groups in clinical divisions across the service localities and by thirteen specialist assurance groups such as patient experience, safeguarding or infection prevention control.

Improving quality governance

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

- We have implemented a comprehensive programme of review visits of the wards, involving the PALS team and service users, which focus on the patient's experience and opinion of the service – this ensures the users of our services are measuring the quality of our services. We ask the ward managers to develop improvement plans based on the feedback from the review and then revisit those areas to see if there has been change. We also follow up a number of those review visits with an unannounced inspection by our own internal compliance team who test out the evidence the staff have of how they meet the Care Quality Commission Essential Standards of Quality and Safety.
- We have continued to grow and develop our systems for gathering patient and carer feedback, now covering all assessment and treatment wards and a wide range of community teams. The reports are collated by an external company so we can have a true picture of what our service users think about our services. We ask the wards to display their results and show what has changed on a ward or department as a result of the service user feedback.
- We have been reviewing all the clinical assurance evidence we had about compliance with the NICE guidelines and developing systems to monitor that compliance. The NICE information provides benchmarks of best practice for our service delivery and provides a good measure to see how our services are performing against that best practice.
- The project work continued this year on reducing incidents of aggression and challenging behaviour on our wards. We have been implementing some specific new methods of monitoring and dealing with challenging behaviour and have developed a challenging behaviour pathway. The work has resulted in a significant reduction in those incidents and an improvement in the staff survey of how many staff are experiencing aggression in the workplace.
- The work on learning lessons from incidents, complaints, safeguarding and claims has progressed further this year. We have developed a framework for all the recommended changes to be logged and tracked with plans for next year to measure the impact and effect of action plans. This work will give us more robust systems in the future to help reduce the likelihood of recurrent themes of omissions or errors.
- Through the work on gathering data for the measurement of quality indicator achievement agreed with our commissioners we have developed audits for monitoring specialist safeguarding supervision and the compliance with supervision polices. This has added to our assurance information about the implementation of safeguarding practice. We have reviewed the safeguarding teams for both children and adults to ensure the right level of support is available to support staff in the protection of our most vulnerable service users.
- Across the Trust in adult, older people and learning disability services we have implemented a national initiative called the Patient Safety Thermometer that is aimed at eliminating any physical harm that our service users may suffer. This includes taking a sample of all the patients seen by Trust staff on a certain day and examining them for one of four possible physical harms that may have happened – falls, pressure sore, catheter infections and thrombosis (venous thrombolytic embolism). This work is being continued next year with an emphasis on reducing risk of falls.
- The Trust was successful in achieving the National Health Service Litigation Authority Assessment at Level 2. This is a test of the systems we have in place to manage risks in the organisation and looks at how we support staff to implement and follow the policies and procedures we have in place for that risk mitigation and learning to prevent a risky situation re-occurring. The Trust staff were able to demonstrate that they knew how to implement all the required procedures and policies and that the Trust systems were robust.
- The Productive Mental Health Ward programme has now been implemented on a wide range of in-patient areas and been introduced into the newer services in North Yorkshire to give a focus to monitoring service delivery and performance of standard work. This promotes clinical effectiveness and consistency of positive practice.

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 quality of our services is regulated by the Care Quality Commission (CQC). The outcome of planned and responsive reviews undertaken by the CQC and actions taken where it raised concerns are also detailed in the quality account (page 41)

The report can also be downloaded from the Trust's website.

Research and development

We see research as essential work for the Trust, both contributing to our quality of care, and the broader evidence base in mental health.

We are now participating in a significant portfolio of large scale research and have continued to develop collaborative partnerships with the Mental Health Research Network (MHRN), Dementia and Neurodegenerative Diseases Research Network (DeNDRoN) and other National Institute of Health Research networks. 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.

Collaboration within the NIHR infrastructure has enabled us to embed a culture of a research across all our localities and divisions. We have made notable progress in embedding research within Harrogate, Hambleton and Richmondshire, where service users have had the opportunity to participate in two important NIHR portfolio studies for the first time. ARITMO studies the effects of current antipsychotic drug treatment on the electrocardiogram and has provided safety monitoring for participants beyond that routinely received. Psycho-education with problem solving (PEPS) therapy for adults with personality disorder has given access to a novel, and otherwise unavailable, intervention. Over 70 participants in the Harrogate region have had involvement in these important research studies which will inform the broader evidence base for improved mental health treatments of the future.

Other NIHR studies currently active within the Trust span psychosis, attention deficit hyperactivity disorder (ADHD), addictions, drug safety and forensic mental health, with a growing portfolio of personality disorder research. The LABILE (lamotrigine and borderline personality disorder: investigating clinical effectiveness) study has been funded this year. People with borderline personality disorder have poor mental health and may experience sudden and distressing changes in mood and treatment options are currently limited. The study will address an important gap in the evidence and establish whether adding lamotrigine to usual treatment for people with borderline personality disorder improves mental health and is a cost-effective use of resources.

In addition, 2012/13 saw a rapid growth in Trust support of large scale dementia research. In response to national drivers including the Prime Minister's Challenge on Dementia, the Trust has doubled its proportion of research in older people's services, from 10% to 20% of total research portfolio. This has been driven through the creation of strong divisional research leadership and in collaboration with the DeNDRoN network. In addition, development of a research pharmacy capability has consolidated plans for further collaboration with the pharmaceutical industry in dementia research, with the aim of addressing key areas of unmet need for our service users.

Over 550 participants from the Trust have been engaged in national research this year across 42 large scale multi-site studies. The growing capability of the Trust to support more complex research activity relevant to the needs of our service users is reflected in the component of interventional studies within the research portfolio. This proportion, previously around 10%, has grown to one third of all studies. This is clear evidence of our commitment to contributing to the evidence base for improving outcomes for the people who use our services.

Our MeHRY (Mental Health Research for the Young) collaboration with Durham University continues to grow, with a focus on youth mental health and primary care mental health. Two senior lecturers and three postdoctoral research associates have been appointed in the last year. Our clinicians have published articles this year in a range of high quality journals including British Medical Journal , Journal of Psychiatric and Mental Health Nursing, and Early Intervention in Psychiatry.

Serious untoward incidents

involving data loss or confidentiality breach

There were no reportable SUIs involving data loss or confidentiality breach's in 2012/13 (categories 3-5).

The table below shows a summary of other personal data related incidents in 2012/13 at category 1-2.

SUMMARY OF OTHER PERSONAL DATA RELATED INCIDENTS IN 2011-12 at LEVEL 1-2		
Category	Nature of Incident	**Total**
I	Loss/theft of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	**6**
II	Loss/theft of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	**0**
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	**0**
IV	Unauthorised disclosure (fax sent to incorrect address)	**3**
V	Other	**1**

Quality report

Chief Executive's Report

I am pleased to be able to present Tees, Esk and Wear Valleys NHS Foundation Trust's (TEWV) quality report for 2012/13. This is the fifth quality report we have produced and it tells you what we have done about improving the quality of services in 2012/13, and how we intend to further improve the quality of our services in 2013/14.

At TEWV we are fully committed to continually improve 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."

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 (see page 14).

To achieve this, we aim to continuously improve the quality and value of our work (see page 14).

These commitments are embedded within the Trust's strategic direction – the TEWV approach (see page 13).

During 2012/13 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 were shortlisted for a number of prestigious awards, in particular:

- In 2012 we were one of just six NHS organisations to be shortlisted as finalists for the prestigious **Provider of the Year award** by the **Health Service Journal**.
- We were once again recognised by the **Royal College of Psychiatrists** who shortlisted our staff and a service user and a carer in five categories of their annual awards:
  - **Core Psychiatrist of the Year**
  - **Academic/Research of the Year**
  - **Service User Contributor of the Year**
  - **Carer Contributor of the Year**
  - **Psychiatrist of the Year**
- One of our student nurses in Craven was awarded the **Nursing Times Student Nurse of the Year – Learning Disabilities Award** in 2012.
- We have the best mental health inpatient facilities in the country and this was acknowledged by the Royal Institute of British Architects who gave our flagship development, Roseberry Park in Middlesbrough, one of their national awards. The Trust was one of only two organisations to receive the award in the North East and the only mental health trust to receive an award.
- Cross Lane Hospital in Scarborough was highly commended in the **Building Better Healthcare Awards** in the patient environment best external or landscaping project category.

The positive feedback we received from our external assessors is further proof of the high standard of our services. For example:

- **Monitor**, the independent regulator of foundation trusts, gave the Trust positive feedback following its assessment of our business plan, our approach to quality and sound financial management.
- We achieved level 2 in the **NHS Litigation Authority (NHSLA) Scheme** and the NHSLA assessors were extremely complimentary about our staff and services.
- In 2012 the Trust was certified as a provider of high quality health and social care information by the **Information Standard Scheme**.
- We maintained our **Hospitality Assured Accreditation** for the Trust-wide estates and facilities hotel services team (housekeeping, porters, reception staff), retaining our position as top healthcare facility assessed across the UK.
- The medium secure inpatient facility at Roseberry Park, Middlesbrough was commended by the **Quality Network for Forensic Mental Health Services** when reviewed in 2013 against the Department of Health Best Practice Guidance for Adult Medium Secure Services.

We also continued to drive improvements in the quality of our services through using the TEWV Quality Improvement System (QIS) and by changing the way we deliver services. Some examples of what we achieved during 2012/13 are:

County Durham & Darlington

- A review within the **adult mental health community teams** resulted in the introduction of a standard duty rota and the streamlining of performance management data processes which released **484** hours of administrative staff time per year. This 'released time' was first invested in a review of clinical correspondence and then in reducing the time for clinical correspondence to be sent to GPs from **7 days to 4 hours**.
- By centralising and improving the way in which the ordering of clinical items are managed on the **West Park Hospital site**, there has been a **40%** reduction in the number of orders being placed and a **23%** reduction in expenditure. This is now in the process of being rolled out to all Trust in-patient areas. So far by streamlining and standardising the number of stationery items available across the Trust, the Trust has saved on average **£20,000** per quarter in the first year, and **£179,000** on printing costs. All of these initiatives have been implemented successfully without reducing the quality of care that we provide to our services users and carers.

Tees

- Improvements in the transition process from **tier 4 children's services to adult services in the South Tees** area has resulted in a significant reduction in the time taken to agree the transition plan from an average of **175 days to 28 days** (an **84%** improvement). Developing and agreeing the plan more quickly and implementing the plan earlier will increase the success rate of the transition and provide a better experience for service users, carers and all staff involved.

- The **Orchard day service in Middlesbrough** undertook improvement work to create 'the perfect day' for its service users. Following the event the percentage of planned activities delivered increased from **23%** to **95%**, and planned physiotherapy activities increased from **18%** to **100%**. In the spirit of continuous improvement, staff have continued to develop the service and have introduced daily work plans, individually tailored service user activity plans developed with carers, a standard procedure for handover between carers and staff and a 'pick and mix' activity menu of activities to suit seasonal and weather conditions.
- The **North Tees Dementia Collaborative** held an improvement event to look at the continuing healthcare process. The workshop involved staff from the Trust and four other organisations that make up the collaborative: Tees PCT; North Tees and Hartlepool NHS Foundation Trust; Stockton Borough Council; Hartlepool Borough Council and carers. Initial testing of the new process indicates a saving of **50 minutes** for each assessment completed (a **55%** improvement) and a saving of **15 minutes** for each multidisciplinary decision-making meeting (an average saving of **45 minutes** of staff time per meeting). The time saved has enabled the Trust to see more service users, more quickly. One carer commented that 'if this had been in place before it would have made a very difficult process much easier and clearer'.

North Yorkshire

- The **Harrogate and Rural community mental health services for older people** team developed a new process to speed up our response to referrals. This has enabled the time from receipt of all referrals to allocation of a first appointment with the community team to be reduced from **3 days** to the **same day** (a **66%** improvement), the response time from receipt of an urgent referral to the service user being seen reduced from **7 days** to **1 day** (an **85%** improvement) and the response time for service users to be seen by the memory service from **74 days** to **28 days** (a **62%** improvement).

Forensic services

- A **ward in forensic mental health services** introduced a daily report out process to replace the traditional ward round. This enabled all staff to have more frequent access to expert advice and support from the multi-disciplinary team and an opportunity for health care assistants to actively contribute to discussions on the day-to-day management and improvement of care. As a result there was a **67%** reduction in incidents of violence and aggression, a **15%** reduction in staff time spent on observations, an increase in time available for staff to spend with patients and an increase in patient's attendance at the resource centre. Patients reported a clear preference to see staff on a one-to-one basis rather than in a ward round, felt they now had more time with staff, that their requests were dealt with more promptly and that staff were more knowledgeable and consistent with their care. An improvement event is now planned for 2013/14 to consolidate the learning from the pilot and plan a safe roll-out to the other wards in forensic services.

We know, however, that the NHS can get it very wrong. The recent reports on Winterbourne View and Mid Staffordshire NHS Foundation Trust (the 'Francis 2 Report') are very important and we are considering these carefully to see what lessons we can learn from these events. In 2013/14 the Trust will be doing a number of workshops with its staff and Governors (which includes service users and carers and stakeholder representatives) and positive practice events for the wider public on the themes highlighted in Francis 2. The output of these events, including the views of the Trust and our stakeholders, the implications for the Trust and proposed actions will form part of the Trust's formal response. This will be approved by the Board by quarter 2 2013/14.

In 2012/13 we received 177 complaints. 165 of these complaints have been investigated and 76.4% (126) were satisfactorily resolved with the complainant. 39 complainants indicated some level of dissatisfaction with the Trust's response. 5 of these were referred to the Ombudsman with 4 resulting in no further action and 1 still outstanding.

In 2012/13, there were 92 serious untoward incidents. For 19 of these incidents it was determined that the Trust's actions or inactions were a factor in the occurrence of the incident.

In 2012/13, there were 1,651 incidents reported involving service users which led to harm compared to 1,824 in 2011/12.

A key part of our drive for continuous improvement is actively seeking out the views of our service users and their carers, the GPs who refer into our services and our staff. In addition to the feedback we receive through our daily interaction with service users and carers, from complaints, from contact with our patient advice and liaison (PALS) team and the use of surveys, in 2012/13 the Trust also performed **61** service user and carer–led validation visits. These are visits to inpatient wards by a small group of service users and carers, supported by our PALS team, to ask people about their experiences of being on the ward. The findings of these visits are discussed and actions agreed. Follow-up visits to the ward focus on understanding if service users' experiences have improved as a result of the actions we have taken.

We know, however, that when we make mistakes and get it wrong this can have devastating consequences. Therefore we are determined to make best use of all our knowledge and resources to detect problems early, to act promptly and decisively, and ensure that what we do to address these problems improves the care we provide and the outcome and experience for our service users and carers.

We encourage the reporting of all incidents and 'near-misses' and analyse patterns to identify common themes. For serious untoward incidents we perform a rigorous analysis to identify the root cause. Although we seek to reduce the harm associated with serious untoward incidents, we believe that a high number of reported incidents is also an indication of a good culture of openness and reporting within the Trust.

The following are some examples of the lessons we have learnt and improvements made in 2012/13 as a consequence of the feedback we received from our service users, carers, staff and partner providers.

- The national service user survey highlighted issues regarding the explanation of medications, side effects and the care plan. Specific questions on these issues were added to the Trust's local surveys which enabled regular feedback at a team level. The act of adding these questions to our local surveys focussed the minds of our wards and teams on these issues, and as a result, feedback from our service users improved. We learned that the survey was in itself a powerful improvement tool.
- Feedback from complaints highlighted that staff, service users and carers were not always clear as to who had been invited to attend care review meetings. The resulting miscommunication meant that sometimes the care review meeting was felt to be unsuccessful due to the absence of key personnel. It was agreed that all people invited to a care review meeting would receive an invitation, and where the meeting was called at short notice each person would be telephoned. A record of written / telephoned invitations would be added to the electronic patient record and audited.

To further embed quality throughout the Trust, our key developmental plans for 2012/13 include:

- ensuring all patients are managed within evidence-based clinical care pathways and supported to achieve long term recovery
- improving patient experience and outcomes by using the data to challenge and improve practice
- building our capacity to deliver continuously improving services using the Trust's quality improvement system
- further developing our approach to research and development to improve patient care
- implementing the information strategy to improve our ability to analyse and improve quality, and predict and manage risks to quality

The structure of this quality report is in line with guidance that has been published by both the Department of Health 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 2012/13, 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 2012/13 against our key quality metrics and national targets.

The information contained within this report is accurate, to the best of my knowledge.

A full statement of Directors' responsibilities in respect of the quality report is included on page 71). This is further supported by the signed limited assurance report provided by our external auditors on the content of the 2012/13 quality report which is included in on page 72.

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, Chris Stanbury (Director of Nursing and Governance at chris.stanbury@nhs.net or Sharon Pickering (Director of Planning and Performance) at sharon.pickering1@nhs.net

Martin Barkley
Chief Executive

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

2012/13 Priorities for improvement – how did we do

As part of our 2011/12 quality report the Board of Directors agreed four quality priorities to be addressed in 2012/13.

Priority 1:	**To undertake a comprehensive review of the implementation of the Care Programme Approach, the care co-ordination process and care planning across the Trust**
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.**
Priority 4:	**To develop broader liaison arrangements with acute trusts around physical health needs of mental health patients**

Progress has been made against these four priorities and the following section provides details.

It is important to note that the achievement of priorities should not be seen as the end point. These priorities 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 blue boxes throughout this section provide examples of improvement and are in addition to the main text which provides a more balanced view of achievements and areas for further improvement.

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

Why this is important:
How we implement the Care Programme Approach, care coordination and care planning is critical to the quality of care many of our service users receive. On 31 March 2013, there were **9,674** people whose care and treatment is delivered using the Care Programme Approach. 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 took this feedback very seriously and agreed that to improve the quality of our care we must ensure that our care coordination and care planning is evidenced-based and best practice is used across the whole Trust.

Our aim:
Following the publication of the quality report 2011/12, the steering group concluded that delivering the recommendations of the review was likely to require a complex implementation plan. It was agreed that to attempt to complete the multi-agency review, fully involving service users and carers and embedding the changes within a nine month project plan, may not result in the best outcomes for the project and safe, high quality patient care. As a result, the Board agreed that in 2012/13 this priority should be limited to completing the review and identifying recommendations, with the implementation of the recommendations starting in 2013/14 and continuing through to 2014/15.

The review aims for 2012/13 were to:

- clearly define and quantify problematic issues with the implementation of the Care Programme Approach, care coordination and care planning
- determine the fundamental cause of these issues
- identify recommendations for improvement, agreed jointly with partner agencies and service users

What we have achieved in 2012/13:
The comprehensive review of the Care Programme Approach has been completed.

*In March 2012, **69%** (n=84) of respondents stated that they had been given/offered a copy of their care plan. By November 2012 this had increased to **75%** (n=88). There are, however, variations across the Trust. In Auckland Park, for example, service users within community mental health services for older people reported an increase from **40%** to **100%** over the same time period.*

What we did in 2012/13:

- We established a steering group and working groups with involvement from our clinical services, service user and carers and local authority partners.
- We designed a review methodology and produced a project scope and a structure for the working groups.
- The themes of the review were:
  - organisational working arrangements in community teams
  - transfers of care
  - key performance indicators requiring data from the Care Programme Approach processes
  - internal and external requirements / demands on the Care Programme Approach process and the care coordinator
  - service user and carer engagement.
  - professional and support roles in implementation of the Care Programme Approach
  - assessment and care planning
  - quality and process improvements and outputs which relate to the Care Programme Approach processes and role of the care coordinator
  - Care Programme Approach policy content
  - impact of issues with regards to Section 117 aftercare entitlement – the statutory duty to provide health and social care to service users following discharge from inpatient care
- The review included:
  - consultation with staff groups across all disciplines and agencies, including our seven partner local authorities, through focus group and interview
  - extensive consultation with service users and carers across all localities and divisions (ie adult mental health, mental health services for older people, children's and young people's services)

  - a Care Programme Approach documentation review
  - a Care Programme Approach strategy and policy review
  - the collation of audit and survey data. (for example, the results of the audit in 2010 which reviewed **537**, approximately **5%** of all people on the Care Programme Approach)
  - the collation of previous changes and developments
  - research of relevant national development and best practice
- We agreed a procedure to approve the recommendations, manage the changes and monitor improvement with the services and lead clinicians.
- We established a baseline position against agreed best practice standards.
- We developed and delivered the project plan, including consultation and engagement strategy, and developed recommendations with the operational group by quarter 4 12/13.

The following is a summary of the key findings of the review:

- The quality of assessment and care planning is variable across the Trust.
- Care coordinators spend a significant amount of time on the administration of the Care Programme Approach and other processes related to internal and external initiatives. This reduces the time available to spend with service users and carers, to listen and to talk, and to deliver recovery focused interventions.
- There is a lack of clarity and agreed processes regarding the management of section 117 – the statutory duty to provide health and social care to service users following discharge from inpatient care.
- Some service users and carers believe they are removed from, and not fully involved in, the care planning process or their treatment.
- Some service users and carers report that the care documentation that is shared with them is not always clear and fully understandable.

What we plan to do in 2013/14:
The implementation of a number of the recommendations of the Care Programme Approach review relating to improving care planning and communications between patients and staff are described in quality priorities 1 & 2 for 2013/14 (see page 63). Some key themes in addition to these that will form part of the implementation plan are:

- further improving transfers of care
- making effective use of data and efficient data collection to monitor performance
- ensuring risk management is embedded within the Care Programme Approach
- embedding the values and principles of care co-ordination and the recovery approach

The implementation plan will also include establishing a post-review position against agreed best practice standards following a given period of time after the recommendations have been delivered to ensure best practice has been embedded throughout the Trust.

Psychosis team, Middlesbrough
*Following feedback from carers about how they were involved in the decisions and treatment of the person they cared for, the team implemented a standard approach for involving carers at all points of the care planning, review and discharge process. As a result, the percentage reporting they were well informed increased from **50%** in May 2012 to **100%** in December 2012.*

❝ Your patience, understanding and guidance has enabled me to move from a very dark place towards a future full of light, laughter and love ❞
A service user

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

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 was to not just 'ask' more people but to extend our approach across all our services and show that we are listening by making changes that improve their experience within our services.

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

What we have achieved in 2012/13:
We are pleased to report this aim has been met.

The following service users and carers have been asked about their experiences in 2012/13.

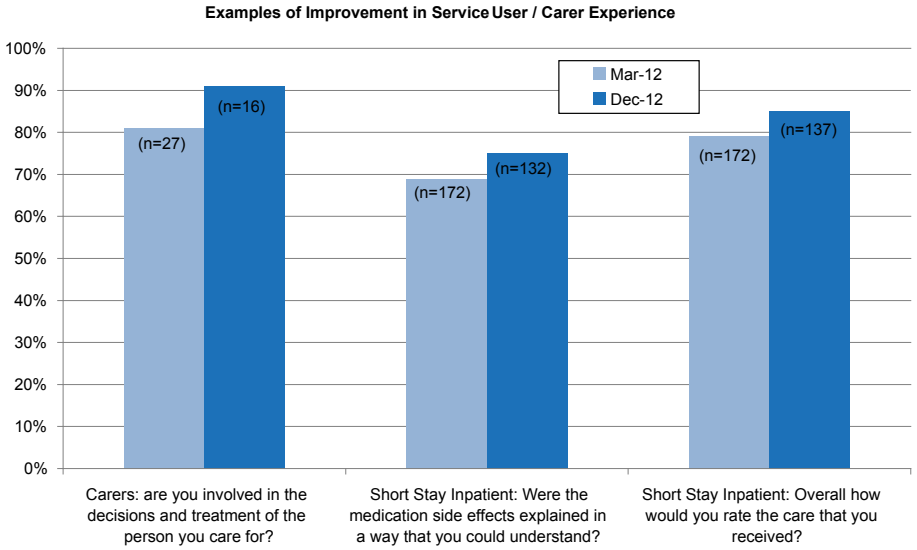
Table 1: Service users and carers surveyed

Service / Locality		Number of responses - inpatients	Number of responses - community	Number of responses - total
Adult mental health	County Durham & Darlington	967	129	1,096
	Tees	800	328	1,128
	North Yorkshire	441	90	531
Mental health services for older people	County Durham & Darlington	164	227	391
	Tees	112	108	220
	North Yorkshire	79	17	96
Substance misuse	Trust-wide	n/a	68	68
Children and young people	Trust-wide	0	27	27
Forensic	Trust-wide	205	58	263
Number of Responses - Total		2,768	1,052	3,820

Compared to 2011/12, the number of service users and carers who responded to our surveys in 2012/13 increased by **25%**, from 3,054 to **3,820**. The number of responses for all North Yorkshire services are half that of the other localities because the services are smaller and the system to seek service user views was implemented at a later date during 2012/13. The 3,820 service users and carers who responded represents **8.6%** of the total number of people seen by the Trust in 2012/13.

The following are examples of where we have improved the experience of our service users and carers in 2012/13:

Esk Ward, Scarborough
*The percentage score to the question 'overall, how would you rate the care that you have received increased from **75%** in April 2012 to **93%** in December 2012.*



Other aspects have remained unchanged but good. For example, in March 2012 and December 2012, **97%** (n=33) of service users reported that they were treated with dignity and respect.

However, we still have work to do. There are aspects of care that our service users and carers say through our surveys that we need to improve. For example, satisfaction scores with care plans in community mental health services for older people vary between **45%** and **88%**. Further work has identified that service users and carers sometimes do not value the care plan as they do not easily recognise it within their documentation. This is an issue particularly when working with people in the early stages of dementia. The teams are looking at developing formats of care plans that are more visual. This is also relevant to quality priority 1 for 2012/13, the Care Programme Approach review, in that care coordinators recognise the need to spend less time on the administration of the Care Programme Approach and invest more time explaining the care plan in a way tailored to the needs and understanding of individuals.

What we did in 2012/13:
We now routinely survey **72** clinical areas using **44** portable electronic devices and **two** static kiosks, one in the community adult mental health service in Parkside, Middlesbrough, and one in the community mental health services for older people in Auckland Park, Bishop Auckland.

To achieve our aim, we:

- embedded the electronic feedback system across inpatient areas in adult mental health and functional areas of mental health service for older people
- routinely reviewed feedback from inpatient areas in adult mental health and functional areas of mental health service for older people and took action
- undertook a scoping exercise, in consultation with our stakeholders, for capturing the experience of service users and carers in community services
- identified options for capturing the experience of service users and carers in community services
- proposed a solution for capturing the experience of service users and carers in community services
- undertook 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
- reported 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.

What we plan to do in 2013/14:
Further to a review of the initial work stream plan using the lessons learned from work to date and the practical work needing to be undertaken, it was identified that the final implementation stage in children and young people's services and learning disability services will extend into Q1 2013/14.

This priority on patient experience has not been selected as a priority for the quality report in 2013/14. However, improving the patient experience remains central to quality improvement strategy within the Trust. To enable the Trust to continue to deliver this strategy, the patient experience team has been established and funded.

Bowes Lyon Unit, Durham
Following feedback from older people's service users that medication side effects were not always explained to them, action was taken by the ward to make sure service users had the opportunity to ask. As a result, the percentage reporting that they were well informed increased from **50%** *in October 2012 to* **88%** *in December 2012.*

Elm Ward, Darlington
On this adult mental health ward the figure for understanding medication side effects increased from **69%** *to* **92%**. *This improvement was achieved by raising awareness of the issue with staff, ensuring service users and carers understood their right to ask and increasing the frequency of pharmacy visits.*

> ***❝ Prior to coming here I was planning to train as a GP, but the longer I am here and see how phenomenal the service you provide is, the more I am thinking that psychiatry may be a career option for me ❞***
> *A fourth year medical student*

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

Why this is important:
We recognise the additional risk to service users when they are transferred between services and staff. In 2012/13, there were:

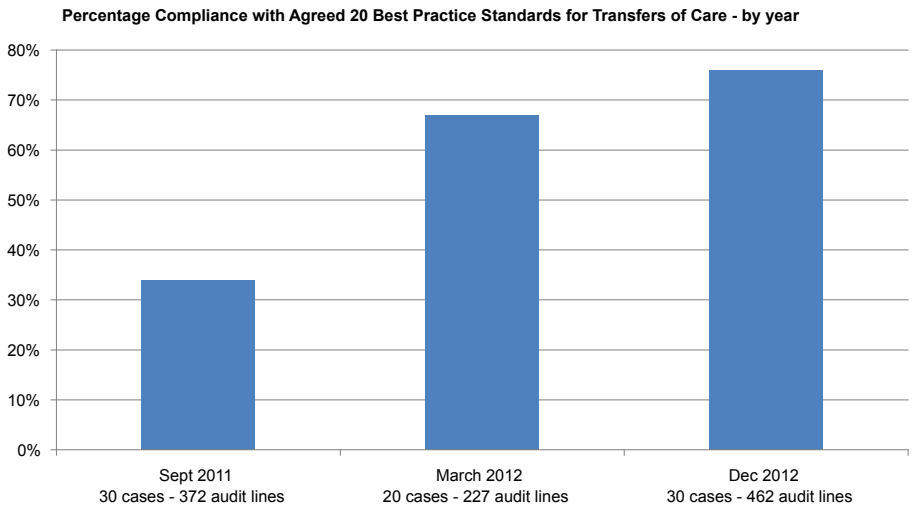
- **6,482** transfers of care from community teams to inpatient care
- **6,492** transfers of care from inpatient care to community teams
- **480** transfers of care between community teams

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 aimed to ensure that all service users Trust-wide are transferred to the most appropriate service and team in a safe and effective way.

Our aim:
Our aim was to ensure all transfers of care meet our agreed set of 20 best practice standards by 31st March 2013. A list of the 20 best practice standards is in **appendix 4**.

What we have achieved in 2012/13:
We have continued to make positive improvements towards this aim.

The most recent audit in December 2012 has shown an improvement in our compliance with our agreed 20 best practice standards.

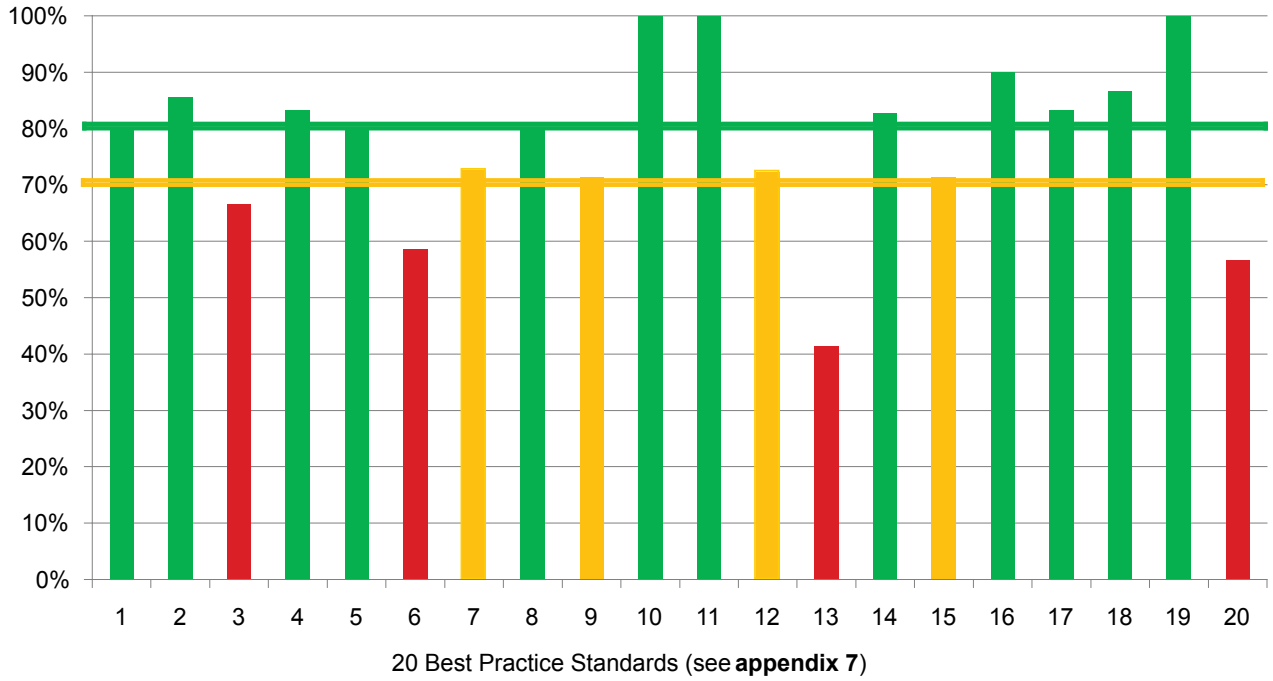


NB: the number of audit lines is the total number of standards that were audited in all applicable cases.

Although overall compliance has improved, compliance against the individual standards is variable with some key areas for further improvement.

*The overall audit result in adult mental health was **85%**. **15** of the **20** best practice standards audited in adult mental health scored over **80%**.*

Percentage Compliance with Agreed 20 Best Practice Standards for Transfers of Care - by standard



The following key was used for the purposes of categorising our performance:

>80% **70-80%** **<70%**

The best practice standards for further improvement that are less than 70% are:

- **Standard 3:** Has the outcome of the meeting/discussion been documented in the review and care plan documents on electronic patient record (PARIS) as required by the Care Programme Approach policy?
- **Standard 6:** If the outcome not on PARIS, is the medical history documented elsewhere (eg case notes/activity recording)?
- **Standard 13:** Are the timescales for the formal handover of care co-ordinator / lead professional responsibilities documented in the care plan?
- **Standard 20:** Was all contemporary care documentation (assessment, care plans, reviews and up to date risk assessment) completed and accessible to the receiving team?

What we did in 2012/13:

To achieve our aim, we:

- established a project group to review, develop and improve our approach to transfers of care; whilst this group did not involve service users and carers directly, the project group for the Care Programme Approach review *(see quality priority 1 2011/12 – pages 45-46)* also addressed transfers of care and included extensive service user involvement
- reviewed our progress with the plans derived from audit reports in quarter 4 2011/12 and update accordingly
- reviewed our compliance with agreed best practice standards for the transfer of historical information and devised action plans to improve this
- identified issues and devised action plans to sustain improvements in transfers in care and implement further recommendations
- undertook a repeat audit of our compliance against our agreed best practice standards, including our progress with delivering our action plans
- produced a report on the outstanding key issues for improving and sustaining transfers of care, including action plans agreed with the services

What we plan to do in 2013/14:

Further to the review of the initial work stream plan, it was identified that allowing a six month period for the implementation of the action plans resulting from an audit would be required to give an opportunity for improvement to be embedded. It was intended that a re-audit would be carried out in quarter 4 2012/13; however, this has been postponed to 2013/14 to provide more time for the actions from the audit in quarter 3 2012/13 to be fully implemented.

This theme has not been chosen specifically as a quality priority for 2013/14 because improvement in transfers of care was addressed in the Care Programme Approach review in 2012/13 and will form part of the implementation plan in 2013/14. So far, a standard process for transfers of care has been developed that embraces all the best practice standards which will be implemented and monitored Trust-wide in 2013/14.

Durham and Darlington
In the three months from the new service starting on the 1 November 2013, the number of referrals received by the enhanced liaison service for people aged over 65 years was ***566****. This is a* **95%** *increase on the same period in 2011/12.*

During the same three-months, the number of face-to-face contacts with service users aged over 65 years was **2,178***, a more than* **four-fold** *increase on the same time period in 2011/12.*

The evidence suggests that the new service is improving access to the service and addressing an unmet need of both service users and the acute trust.

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

Why this is important:
It is universally acknowledged that people with mental health needs and/or learning disabilities have poorer long term physical 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 (eg dementia) is more complex and challenging for acute trusts. We, therefore, think it is important that we support our colleagues in acute trusts, and where possible, enable them to provide high quality physical health care for people with mental health needs and learning disabilities.

Our aim:
Our initial aim was to deliver a Trust-wide initiative. However, following agreement of two key service developments by commissioners, the scope of this priority was changed to focus on the areas of County Durham and Darlington and Tees only, with service improvement driven through two locality-led projects for enhancing acute liaison services in these areas.

In County Durham and Darlington, a two-year project was commissioned to develop the acute hospital liaison mental health service. In Tees, the Trust has received additional funding for the development of an acute liaison service.

In both cases, the new model builds upon existing proven service models. The new investment is being used to merge the current acute liaison teams in adult mental health and mental health services for older people. With this combined capacity, and a remit to provide services to people aged 18 years and over, the new services will provide enhanced liaison, assessment and intervention services for people with physical and mental health needs in acute trusts. This will:

- ensure that a person's mental health needs are met when they are in an acute hospital for treatment for their physical health needs, thus removing one of the potential barriers to provision of good physical health care
- increase the early detection and treatment of depression, dementia and delirium, and therefore, reduce the number of people with an undetected mental illness within an acute hospital setting
- improve the patient and carer experience / satisfaction
- enable acute trusts to manage patients with mental health needs more easily and with dignity and respect
- reduce 'frequent attendees' at accident and emergency units (A&E), urgent care centres and medical assessment units and admissions, investigations and outpatient attendances for those with medically unexplained physical symptoms
- reduce 'repeat' self harm presentations to A&E and urgent care centres and subsequent admissions
- reduce admissions from A&E into acute hospitals for those with a mental health disorder
- reduced re-admissions to acute hospitals for those with a mental health disorder
- reduce the length of in-patient stay at acute hospitals (includes community hospitals in County Durham and Darlington)
- increase proportion of patients returning to their usual place of residence (with consequent reduced health and social care community costs)
- reduce the overall cost to the local health economy ascribed to service users with mental health and substance misuse needs currently accessing acute hospitals

What we have achieved in 2012/13:
We can confirm that the two projects in County Durham and Darlington and Tees have been fully implemented in line with the plans outlined below.

What we did in 2012/13:
In County Durham and Darlington we:

- developed and implemented a communication and engagement plan with our acute trust partner
- developed an accommodation implementation plan (including access to information technology) for the new service to be based within the acute trust environment
- fully recruited to new service
- established the new enhanced liaison service in community hospitals
- extended the hours of the self harm function of the new service
- extended the ward liaison for mental health services for older people function of the new service
- established the medically unexplained physical symptoms function of the new service
- established the post discharge function of the new service

In Tees we:

- established project leadership and developed an implementation plan
- established engagement arrangements with acute trust and commissioners
- established core data sets and baselines from which to perform future evaluation
- recruited core team and work is ongoing to establish accommodation for the team within the acute trust
- provided training and development for all recruited staff
- undertook a three-day service improvement event to develop the service model, operational policy and standard procedures
- implemented extended hours provision in February 2013 and 24/7 provision in March 2013
- commenced data capture systems and implement information sharing arrangements with acute trusts

What we plan to do in 2013/14:
This theme has not been chosen specifically as a quality priority for 2013/14. However, both projects will be formally evaluated in 2013/14 and action plans developed to respond to any further issues. The Trust has contracted with external agencies to support this review. The review will include an evaluation on the following themes: economic, process, patient experience and environmental outcomes. The evaluation in County Durham and Darlington is due to be performed and reported by quarter three 2013/14. The evaluation for the Tees service will take place in quarter four 2013/14.

In 2012/13 this priority has focussed on County Durham, Darlington and Tees. In 2013/14, the Trust will continue to explore with commissioners and the acute trusts in North Yorkshire ways to address the physical health needs of people with mental health needs and learning disabilities. The Trust also intends to develop a physical health strategy which will be Trust-wide.

Statement of assurances from the Board 2012/13

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 2012/13.

Review of services

During 2012/13 TEWV provided and/or sub-contracted seven relevant health services.

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

The income generated by the relevant health services reviewed in 2012/13 represents 100% per cent of the total income generated from the provision of the relevant health services by TEWV for 2012/13.

Our seven services are:
- adult mental health services
- mental health services for older people
- children and young people's mental health and learning disability services
- adult learning disability services
- forensic mental health services
- forensic learning disabilities services
- substance misuse services

The review of services is undertaken by the quality and assurance committee and includes a six-monthly report from each clinical division. This report includes information on:
- patient safety – including information on incidents, serious untoward incidents, levels of violence and aggression, medication incidents, implementation of safety alerts
- clinical effectiveness – including information on the implementation of National Institute for Clinical Excellence (NICE) guidance and the results of clinical audits
- patient experience – including information on complaints, claims, contacts with the Trust's PALS, results from the service user surveys and visits from the service user and carer led teams.
- Care Quality Commission – compliance with the Essential Standards of Safety and Quality and any risks to compliance or the quality of services.

In addition to the formal report, the services deliver a presentation on any particular areas of work that have been undertaken to improve quality and invite service users and carers to talk to the Trust's quality and assurance committee 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 quality and assurance committee recognises that some of the data is more available and robust than others. The data on standard clinical outcomes in mental health is still limited.

The Board also undertakes monthly visits, and the Executive Management Team bi-monthly visits, to our wards and teams across the Trust to listen to what our staff say and feel about the services they provide for our service users and carers. A key part of the Board 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. 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 Care Quality Commission 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 2012/13 five national clinical audits and one national confidential inquiry covered the relevant health services that TEWV provides.

During 2012/13 TEWV participated in **60%** 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 2012/13 are as follows:
- Prescribing Observatory in Mental Health (POMH) UK Topic 4 – Prescribing Anti-Dementia Drugs.
- POMH UK Topic 11b – Prescribing of Antipsychotics for People with Dementia.
- POMH UK Topic 12 – Prescribing for People with Personality Disorder.
- POMH UK Topic 13 – Prescribing for Attention Deficit Hyperactivity Disorder.
- National Audit of Psychological Therapies in Adult Mental Health.
- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness.

The national clinical audits and national confidential inquiries that TEWV participated in during 2012/13 are as follows:
- POMH UK Topic 11b – Prescribing of Antipsychotics for People with Dementia.
- POMH UK Topic 12 – Prescribing for People with Personality Disorder.
- National Audit of Psychological Therapies in Adult Mental Health.
- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness.

NB: For POMH UK Topics 4 and 13 the Trust has adopted a local audit approach.

The national clinical audits and national confidential inquiries that TEWV participated in, and for which data collection was completed during 2012/13, are listed opposite 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 12 – Prescribing for People with Personality Disorder	43	100%
National Confidential Inquiry into Suicide & Homicide by People with Mental Illness	n/k*	97%**
National Audit of Psychological Therapies in Adult Mental Health	4,313	100%
POMH UK Topic 11 – Prescribing of Antipsychotics for People with Dementia	86	100%

*** Cases are submitted confidentially and directly by individual consultants, and therefore, the number of cases submitted is not known.**
**** Extract from National Confidential Inquiry Annual Report July 2012: 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, ie adjusted to an assumed final figure of 97% for England and 98% for Wales, and for homicide in England 98%. For homicide in Wales, numbers are too small to calculate projected figures. For sudden unexplained death, actual figures are shown, including those in the final year. Page 10 Para 2 National Confidential Inquiry.**

The reports of **one** national clinical audit was reviewed by the provider in 2012/13 and TEWV intends to take the following actions to improve the quality of healthcare provided:

- POMH UK Topic 12 – Prescribing for People with Personality Disorder

Actions:

- to sample caseloads regarding the number of service users with possible diagnosis of borderline personality disorder to verify our reporting systems
- to circulate the report to all teams to note concerns raised, recommendations and discussion/action
- to circulate and discuss at the locality quality and assurance groups
- to circulate 'unhelpful behaviour patterns diagram' from dialectic behavioural training to encourage teams to re-look at diagnosis, prompt recognition of service users on caseload and rationale for treatment options

The reports of **69** local clinical audits (**138** individual audits) were reviewed by the provider in 2012/13 and TEWV intends to take the following actions to improve the quality of healthcare provided. NB: 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 quality and assurance committee), the Trust undertook a further **69** clinical audits in 2012/13. 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 2012/13 that were recruited during the period.

to participate in research approved by a research ethics committee was **958**. Of the **958**, **536** were recruited to National Institute for Health Research (NIHR) portfolio studies. This compares with 433 patients involved as participants in NIHR research studies during 2011/12 and 374 in 2010/11. This is a key indicator of the Trust's rapidly increasing involvement with large scale, often complex, national research (eg psychosis, attention deficit hyperactivity disorder, addictions, drug safety, forensic mental health, affective disorders, personality disorder and mental health services research).

The Trust's growing participation in clinical research through 2012/13 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:

- We were involved in conducting 104 clinical research studies during 2012/13. This compares with 83 in 2011/12. 68 of these studies were supported by the National Institute for Health Research through its networks and 16 new studies approved through its coordinated research approval process.
- 80 members of our clinical staff participated as researchers in studies approved by a Research Ethics Committee, with 33 of these in the role of Principal Investigator for National Institute for Health Research supported studies.
- Nine researchers from outside the organisation were granted access under the National Research Passport Scheme to perform research with us compared to 29 in 2011/12.
- 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 ensure the culture of research across all our localities and divisions, with progress particularly notable within Harrogate, Hambleton and Richmondshire where 70 participants were recruited to important large scale research studies. ARITMO studies which consider the effects of current antipsychotic drug treatment on the electrocardiogram has provided safety monitoring for participants beyond that routinely received. Psycho-education with problem solving therapy for adults with personality disorder has given access to a novel and otherwise unavailable intervention.
- We have continued to build our collaborative partnership with Durham University. We have made progress in a number of areas of shared interest including primary care mental health, evaluation of psychological interventions in young people and prescribing quality and safety. From this collaboration, four major external grant successes have been achieved which have funded the study of the use of Lamotrigine in borderline personality disorder, brief interventions for primary care depression in older people, clinical (and cost) effectiveness of behavioural activation therapy versus cognitive behavioural therapy and Naltrexone implants for heroin addiction. Other significant grant applications addressing areas of unmet need for our service users have been submitted in the year and for those funded in 2012/13 teams have been established and research is either in set-up or actively recruiting participants.
- In addition, 2012/13 saw a rapid growth in Trust support of large scale dementia research. In response to national drivers including the Prime Minister's Challenge on Dementia, the Trust has doubled its proportion of research in older people's services, from 10% to 20% of the total research portfolio. This has been driven through the creation of strong divisional research leadership and in collaboration with the National Institute of Health Research. In addition, development of a research pharmacy capability has consolidated plans for further collaboration with pharmaceutical industry in dementia research.

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. We also support and nurture lead researchers within clinical specialties in order that the research and development activity is aligned with the skills and knowledge needs articulated by the services.

Goals agreed with commissioners

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

A proportion of TEWV's income in 2012/13 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 relevant health services, through the Commissioning for Quality and Innovation Payment Framework (CQUIN). Further details of the agreed goals for 2012/13 are available online at: http://www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275

As part of the development and agreement of the 2012/13 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. These are monitored at meetings every quarter with our commissioners.

An overall total of **£5,938,580** was available for CQUIN to TEWV in 2012/13 conditional upon achieving quality improvement and innovation goals across all of its CQUINs, and a total of **£5,938,580 (100%)** was received for the associated payment on 2012/13. This compares to £3,747,316 available and £3,744,990 received in 2011/12.

> ***❝ Thank you and well done to everyone who has supported this patient in what has been very positive progress in very challenging circumstances ❞***
> ***HMYOI Governor***

Some examples of CQUIN indicators which the Trust made progress with in 2012/13 were:

- The percentage of older people having a physical assessment within seven days of admission: An audit in County Durham and Darlington in 2011/12 identified that **83%** of patients received a physical assessment within 12 hours of using the agreed assessment tool. Of these only **68%** had this assessment recorded within their electronic patient record. Similar results were reflected across the Trust. By quarter four 2012/13, the figure was **100%** within seven days across the whole Trust.
- To ensure that transitions from children and young people's services to adult mental health or learning disability services are managed appropriately: At quarter 1 2012/13, less than **13%** of children had a transition plan in place at the agreed time prior to their 18th birthday. By quarter four 2012/13, the figure was **100%**.

However, we did not always make such good progress throughout the whole year.

- The percentage of people with learning disabilities to have a health action plan generated directly from an annual health assessment, and those admitted to an acute trust to have a hospital passport in place. An audit in quarter 1 identified that localities (County Durham, Darlington and Tees only) varied from **39%** to **66%** for a health action plan and less than **9%** for a hospital passport. Following the introduction of joint clinics between learning disability health facilitators and GP practices, the percentage increased by quarter three to between **50%** and **80%** across the different localities for both measures. This was a significant improvement for these service users, however, still short of the trajectory for quarter three and expectation for quarter four of 90%. By quarter four, all localities achieved between **90.9%** and **99.3%**.

What others say about the provider

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 attache**d.

The Care Quality Commission has **not taken** enforcement action against TEWV during 2012/13.

TEWV has participated in six special reviews or investigations by the Care Quality Commission relating to the following areas during 2012/13:

- **Auckland Park, Bishop Auckland** – a purpose-built unit providing care and treatment for older people's mental health inpatient care, day care and outreach services. There are three wards on site, which have 12 beds each.
- **Roseberry Park, Ridgeway – learning disability services** – care is provided in units of between 4 and 20 beds for a mix of learning disability forensic inpatient assessment and treatment and rehabilitation services.
- **Trust Headquarters, West Park – clozapine and lithium clinics** – for the Care Quality Commission (CQC) purposes, Trust Headquarters is registered as the central location for the main community services of the Trust. In line with CQC's guidance on locations, there are a number of clinical services associated with this location, most of which are based in the community. The CQC visited a sample of four outpatient clinics – Ellis Centre (Scarborough), West Park Hospital (Darlington), Wessex House (Stockton) and Ideal House (Stockton)
- **Victoria Road, Hartlepool** – provides nine beds for rehabilitation of people with continuing health care needs. There are also an additional four crisis beds.
- **Alexander House, Knaresborough** – a ten bedded unit providing care for older people with complex needs living in the North Yorkshire area. The purpose of Alexander House changed at the end of September 2012 when the Springwood Unit in Malton closed. The services previously provided at Springwood temporarily transferred to Alexander House whilst new premises are built at the Malton site.
- **Church View, Kirkleatham, Redcar** – one unit with eight beds for learning disability long stay / challenging behaviour services.
- NB: there was one review for **HMP Frankland, Durham** for which the Trust is sub-contracted to provide specialist mental health care by the lead contractor Care UK. As such, the outcome of this review is within the quality report for Care UK.

The reports following these inspections highlighted that four services met full compliance requirements. Two services, however, were identified as requiring action.

- Auckland Park, Bishop Auckland – one moderate concern and one minor concern impacting on compliance and requiring improvement actions.
- Trust Headquarters, West Park – Clozapine and Lithium Clinics – a moderate concern which required an improvement action.

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 31st March 2013 in taking such actions.

Auckland Park, Bishop Auckland

Outcome 1 (Regulation 17): Respecting and involving people who use services. Moderate Concern: essential standard not met – the provider had not provided appropriate opportunities, encouragement and support to people who used the service in relation to their autonomy and independence.

Actions and Progress

- Development of a standard process to ensure carers and relatives receive a copy of the 'how to make comments, compliments and complaints' leaflet on admission and to record this in the case notes. *Progress to date: evidence of standard process in place; positive feedback from carers*.
- All service users to be offered hand washing facilities prior to meals. If this is not possible, then individual wipes to be available. However on the challenging behaviour wards, if this would cause distress to the service user, an intervention plan to be in place to ensure infection control standards are met. 'Have you washed your hands' signs to be placed in all dining rooms. *Progress to date: implemented*.
- Individual intervention plans to be in place for all service users where the doors need to be locked because of patient needs and safety. Assessment wards to offer service users keys to their rooms as standard practice and to be documented in the clinical record if, due to clinical reasons, this is not the case. Issues around locking of doors to be explained in the information leaflet. *Progress to date: significant progress made towards achieving planned outcomes and clinical services have implemented changes.*
- Improve access to cognitive stimulation boxes and outside space. Individual risk assessments and intervention plans to clearly articulate strategies to manage this. Signs to be placed on doors to identify to service users and carers when and how to access risk assessments and intervention plans as they contain very personal information for each service user. General rummage boxes to be placed around the wards for patients' general use. Use of sensory panels to be explored for the walls in all three wards. Signage to be placed on the garden door regarding access to the outside garden. Patient advice and liaison service assessment tool to be used to help identify which person centred activities would be most appropriate for the individual patient. *Progress to date: wards are in the process of acquiring rummage boxes; signs indicating access to garden and cognitive stimulation boxes in place; assessment tool implemented across wards; intervention plans now linked to outcome of assessment tool*.
- Snacks are always available, however, due to the nature of the illness of some patients it is difficult to leave hot food and snacks lying around the ward. Notice boards with pictures are to be placed around the ward and used as prompts for patients and carers to obtain drinks and snacks whenever they want. Individual intervention plans to identify issues with diet/nutrition. *Progress to date: signage for snacks in place; involvement of dietetics services to help identify issues with diet/nutrition*.
- Interventions plans to ensure that five key areas of care are addressed:
  – risk
  – physical care
  – carers liaison
  – medication
  – condition related treatments
  – therapeutic activity

All interventions to reflect a person centred approach. Progress to date: service improvement event facilitated; five main areas of 'must have's' within intervention plans identified; a standard approach to capturing the patient's presentation including adherence to the person centred interventions recorded in the case notes.

- if viewing panels are required to be left opened whilst patients are in the rooms, individual care plans to be devised. *Progress to date: implemented*.
- Body Mass Index (BMI) to be recorded for every patient on admission within physical examination form. Evidence of ongoing monitoring to be held in case notes whenever intervention plan requires this measure to be undertaken. Intervention plan to articulate frequency of BMI testing. *Progress to date: implemented.*

Outcome 21 (Regulation 20): Records ***Minor Concern:*** essential standard not met – the provider had not maintained an accurate record in respect of the care and treatment provided to each person.

Actions and Progress

- Risk assessments, detailed care plans or other evaluations to support restrictive practices to be recorded in care record. *Progress to date: completed with ongoing implementation*.
- Individual risk assessments and intervention plans to reflect patients' nutritional needs. An approved risk tool to be used to help identify patients at risk. *Progress to date: awaiting training for tool – to be implemented in 2013/14*.

Trust Headquarters, West Park – Clozapine and Lithium Clinics

Outcome 9 (Regulation 13): Management of Medicines
Moderate Concern: essential standard not met – people were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to safely manage them.

All the following actions are to be implemented by the 31st August 2013 using the Trust's project management framework.

- Implement standardised and documented processes in all clozapine clinics which clearly identify staff roles in relation to prescribing, monitoring and dispensing. *Specific actions to implement: unified processes in all clinics; sharing best practice; increase efficiencies in the dispensing process; increase collaboration across the dispensing / monitoring / prescribing activities.*
- Nominate a responsible consultant for each clozapine clinic. *Specific actions to implement: clear leadership for managing clozapine patients.*
- Implement electronic visual control boards for each clinic. *Specific actions to implement: show monitoring and dispensing status for each patient which can be accessed and updated by nursing and pharmacy staff so that outstanding monitoring or supplies can be quickly and easily be identified; ensure sustainability.*
- Implement a process for producing repeat prescriptions from an electronic template together with standard work for notification of doses changes. *Specific actions to implement: reduce the potential for transcription errors; ensure there is an auditable record of dose changes; reduce medical time required to write prescriptions*.

Quality of data

TEWV submitted records during 2012/13 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: **99.20%** for admitted patient care; **99.80%** for outpatient care.
- Which included the patient's valid General Practitioner Registration Code was **92.02%** for admitted patient care; **96.54%** for outpatient care.

TEWV Information Governance Assessment Report score overall score for 2012/13 was 85% and was graded satisfactory.

The Information Governance Toolkit measures the information security and Caldicott functions of the Trust.

It is important to the Trust because it is used by Monitor and the Care Quality Commission as one of the measures that we are carrying out our legal duties under the Data Protection Act 1998, Freedom of Information Act 2000 and aspects of the Human Rights Act.

It is important to patients because it demonstrates that the Trust has safe and secure processes in place to protect the sensitive personal information that we process. It also demonstrates that our staff have robust training in areas such as confidentiality. A successful and high performing Trust is saying that it takes its responsibilities seriously in regard to patient information and safety.

85% (satisfactory) means that we achieved the minimum level 2 on all elements of the toolkit; however, in a significant number of elements we met level 3 (the highest score). This is an improvement on the 2011/12 score of 84%. In comparison to other local mental health trusts, 69%, 71% and 79%, the Trust compares well.

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

The Department of Health at the end of 2012 issued draft guidance for the coming financial year. This requires organisations to implement outcome measurement as a key requirement of developing Mental Health Payment by Results. The areas for development are:

- **Clinically Reported Outcome Measure (CROM)**: This will be the Health of the Nation Outcome Score (HoNOS) and reported via the Mental Health Minimum Data Set.
- **Patient Reported Outcome Measure (PROM)**: There are a number of options of PROM tools available. The Trust is still deciding on the best option.

- **Patient Reported Experience Measure (PREM)**: This will be the Friends and Family Test *(Mental Health Guidance for PbR: 2012/13: section 7.1)*. Specifically, the percentage of service users surveyed during the reporting period who would recommend the Trust as a provider of care to their family or friends.

In response to this, the Trust is developing its approach to recording and reporting these measures. The testing of these measures will form part of the Payment by Results contract with commissioners in 2013/14 as a step towards future mandated requirements.

The Trust has and continues to play a significant national role in these developments. We are undertaking national work on behalf of the Department of Health to analyse pilot data on HoNOS and a potential PROM.

At this point due to the infancy of these measures, there are currently issues around the quality of the data, and therefore, the current measurement of outcomes is not reliable. However, significant work to resolve this is underway within the Trust.

At quarter 3 2012/13:

- 94.3% of service users on the adult mental health and mental health services for older people caseload were clustered with a HoNOS score.
- 87% of service users on the adult mental health and mental health services for older people caseload were reviewed within the guideline timeframe.

At the time of publication, there is no national benchmarking data to compare against the Trust reported figures.

Further work for 2013/14 includes:

- the clinical audit of outcome scoring
- further training and support for staff
- measurement of the developmental process using data quality reporting
- the inclusion of key Payment by Results development metrics as part of routine performance management
- development of an integrated information centre to assist reporting of Payment by Results data

TEWV 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.
- The Trust is introducing an Integrated Information Centre. Within this there is a tool that will enable services and teams to assess and improve in real time the quality of their data.

" You made a pretty scary situation far more bearable and manageable. My mother is now happy and settled, thanks to your help and care "

The family of a service user

Mandatory quality indicators

The following are the mandatory quality indicators relevant to mental health Trusts, issued jointly by the Department of Health and Monitor and effective from February 2013. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127382/130129-QAs-Letter-Gateway-18690.pdf.pdf

For each quality indicator we have presented a mandatory statement and the data on the NHS Information Centre (NHSIC) for the most recent and the previous reporting period available.

Care Programme Approach seven day follow-up

TEWV considers that this data is as described for the following reasons:

- The discrepancy between the Trust final reported figure and the figure reported to Monitor is due to the fact the Trust final figure is refreshed throughout the year to reflect a validated position as data quality issues are resolved. The figure reported to Monitor is the position at quarter end and is not refreshed after submission. The discrepancy between the figure reported to Monitor and the NHSIC figure is due to the fact the NHSIC data is submitted at a Primary Care Trust (PCT) level, and therefore, excludes data for patients from PCTs outside the Trust area or where the PCT is unspecified in the patient record.
- The few actual breaches were a result of services users not attending the follow-up appointment despite efforts of the service to contact the patient and failure in the communication between the discharging ward and the community team.

TEWV **has taken** the following actions to improve this percentage, and so the quality of its services:

- This is a key performance indicator within the Trust's performance framework and is monitored via the Trust dashboard at service and Board level on a monthly basis.
- Through the performance management framework, all breaches are validated with the relevant service and discussed at director-level and service-level performance meetings.
- Reviewing how the services maintain contact with the patient in the days following discharge to eliminate non-attendance at the follow-up appointment.
- Where there is a greater risk of non-attendance at follow-up (eg homelessness), the services are proactive in contacting other agencies with whom the patient is in contact.
- Implementing a standard process to ensure patients discharged to other services (eg 24 hour care unit) are not overlooked.
- Reminding staff regarding procedures for follow-up when patient on leave from the ward or the care coordinator on leave from work.
- Continuous raising of awareness and reminders to staff by ward / team managers at ward / team meetings of the national requirement, the need to follow the standard procedure and the need to record data accurately.

Below is presented, in a table format, the percentage for at least the last two reporting periods.

Prescribed Information	Related NHS Outcomes Framework Domain	TEWV Actual Quarter 4 2012/13	TEWV Actual Quarter 3 2012/13	* National Benchmarks in Quarter 3 2012/13	TEWV Actual Quarter 2 2012/13	TEWV Actual Quarter 1 2012/13
The data made available by the Health and Social Care Information Centre (NHSIC) with regard to the **percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care** during the reporting period.	1: Preventing People from dying prematurely 2: Enhancing quality of life for people with long-term conditions **All trusts providing mental health services**	Trust Final Reported: **96.4%** Trust Reported to Monitor: **96.4%**	Trust Final Reported: **96.6%** Trust Reported to Monitor: **96.5%** NHSIC Reported: **97.1%**	NHSIC Reported: National Average MH Trust = **97.6%** Highest/Best MH Trust = **100%** Lowest/Worst MH Trust = **92.5%**	Trust Final Reported: **97.6%** Trust Reported to Monitor: **97.4%**	Trust Final Reported: **97.8%** Trust Reported to Monitor: 97.5%
* latest benchmark data available on NHSIC at quarters 3 2012/13						

Crisis resolution home treatment team acted as a gatekeeper

TEWV considers that this data is as described for the following reasons:

- The discrepancy between the Trust final reported figure and the figure reported to Monitor is due to the fact the Trust final figure is refreshed throughout the year to reflect a validated position as data quality issues are resolved. The figure reported to Monitor is the position at quarter end and is not refreshed after submission. The discrepancy between the figure reported to Monitor and the NHSIC figure is due to the fact the NHSIC data is submitted at a Primary Care Trust (PCT) level, and therefore, excludes data for patients from PCTs outside the Trust area or where the PCT is unspecified in the patient record.
- The discrepancy between the NHSIC and the Trust / Monitor figure is due to the fact the NHSIC data is submitted at a primary care trust (PCT) level, and therefore, excludes data for patients from PCTs outside the Trust area or where the PCT is unspecified in the patient record.
- The few actual breaches were a result of failure to follow the standard procedure.

TEWV **has taken** the following actions to improve this percentage, and so the quality of its services:

- This is a key performance indicator within the Trust's performance framework and is monitored via the Trust dashboard at service and Board level on a monthly basis.
- Through the performance management framework, all breaches are validated with the relevant service and discussed at director-level and service-level performance meetings.
- A Trust-wide review of crisis services in 2012/13 acknowledged the lessons from breaches and built these lessons into standard work to be implemented across all crisis services in 2013/14.
- Continuous raising of awareness and reminders to staff by ward / team managers at ward / team meetings of the national requirement, the need to follow the standard procedure and the need to record data accurately.

Below is presented, in a table format, the percentage for at least the last two reporting periods.

Prescribed Information	Related NHS Outcomes Framework Domain	TEWV Actual Quarter 4 2012/13	TEWV Actual Quarter 3 2012/13	* National Benchmarks in Quarter 3 2012/13	TEWV Actual Quarter 2 2012/13	TEWV Actual Quarter 1 2012/13
The data made available by the Health and Social Care Information Centre (NHSIC) with regard to the **percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper** during the reporting period.	2: Enhancing quality of life for people with long-term conditions **All trusts providing mental health services**	Trust Final Reported: **97.2%** Trust Reported to Monitor: **97.2%**	Trust Final Reported: **97.4%** Trust Reported to Monitor: **97.4%** NHSIC Reported: **97.7%**	NHSIC Reported: National Average MH Trust = **98.4%** Highest/Best MH Trust = **100%** Lowest/Worst MH Trust = **90.7%**	Trust Final Reported: **98.3%** Trust Reported to Monitor: **98.0%**	Trust Final Reported: **96.6%** Trust Reported to Monitor: **96.2%**
* latest benchmark data available on NHSIC at quarters 3 2012/13						

Staff, friends and family test

TEWV considers that this data is as described for the following reasons:

- The 2012 result, **76.4%**, is better than the national average and a small but significant improvement on the 2011 result – a result of the actions outlined below.

TEWV **has taken** the following actions to improve this percentage, and so the quality of its services:

- Annual Trust and team level action plans developed in response to the NHS Staff Survey. Some areas for improvement work in 2012/13 were:
  - reduced the number of staff experiencing physical violence, harassment, bullying or abuse from service users or relatives by improving the challenging behaviour pathway, the post incident review process and the offer of support for staff following an incident
  - increased the number of staff experiencing effective team working by ensuring all teams have team briefing and have access to bespoke team development
  - increased the proportion of staff contributing to the improvement of the Trust via the Trust's quality improvement system, business planning cycle and leadership and management development network
  - improved line manager support and reduced the number of staff experiencing pressure at work by ensuring all staff have regular and effective supervision and appraisal, implementing 'stress' assessments and support at a team and individual level and providing training for all staff to embed the Trust values: teamwork, quality, wellbeing, respect, involvement

Below is presented, in a table format, the percentage for at least the last two reporting periods.

Prescribed Information	Related NHS Outcomes Framework Domain	TEWV Actual 2012	National Benchmarks in 2012	TEWV Actual 2011
The data made available by the Health and Social Care Information Centre (NHSIC) with regard to the **percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.**	4: Ensuring that people have a positive experience of care **All trusts**	NHS Staff Survey Reported: **76.4%**	NHS Staff Survey Reported: National Average MH Trust = **70.8%** Highest/Best MH Trust = **81.2%** Lowest/Worst MH Trust = **n/k**	NHS Staff Survey Reported: **75.2%**

Patient's experience of contact with a health or social care worker

TEWV considers that this data is as described for the following reasons:

- The 2012 result, **88.42**, is better than the national average and a small but significant improvement on the 2011 result – a result of the actions outlined below.

TEWV **has taken** the following actions to improve this percentage, and so the quality of its services:

- Annual Trust and team level action plans developed in response to the NHS service user survey for community services. However, a key part of our approach to improvement was the comprehensive review of the Care Programme Approach outlined in the 2012/13 quality priority 1 (see pages 45-46), and specifically, the recommendations for implementation outlined in 2013/14 quality priorities 1 and 2 (see page 60). A benefit expected from the actions in 2013/14 will be a reduction in staff time spent on administrative tasks and more face to face time to listen to, to understand and gain the confidence of service users and carers.
- In addition to the feedback from the national survey, the Trust's local surveys include the questions used to derive this indicator. In 2012/13, 1,052 service users were surveyed locally on these questions. As a result, the Trust receives feedback at a community team level and responds as appropriate.

Below is presented, in a table format, the number for at least the last two reporting periods.

Prescribed Information	Related NHS Outcomes Framework Domain	TEWV Actual 2012	National Benchmarks in 2012	TEWV Actual 2011
The data made available by the Health and Social Care Information Centre (NHSIC) with regard to the **Trust's "Patient experience of community mental health services" indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period.**	2: Enhancing quality of life for people with long-term conditions 4: Ensuring that people have a positive experience of care **All trusts providing mental health services**	NHSIC Reported: **88.42**	NHSIC Reported: National Average MH Trust = **86.64** Highest/Best MH Trust = **91.77** Lowest/Worst MH Trust = **82.59**	NHSIC Reported: **87.35**

Notes on metric
This indicator is a composite measure, calculated by the average weighted (by age and sex) score of four survey questions from the community mental health survey. The four questions were:
Thinking about the last time you saw this NHS health worker or social care worker for your mental health condition…
…Did this person listen carefully to you?
…Did this person take your views into account?
…Did you have trust and confidence in this person?
…Did this person treat you respect and dignity?

Patient safety incidents including incidents resulting in severe harm or death

TEWV considers that this data is as described for the following reasons:

- The Trust reported and National Reporting & Learning System (NRLS) reported data for 2012/13 differ because the Trust's definition of a patient safety incident is wider than that of the NRLS.
- There is not a nationally established and regulated approach to reporting and categorising patient safety incidents. Different Trusts may choose to apply different approaches and guidance to reporting, categorisation and validation of patient safety incidents. The approach taken to determine the classification of each incident, such as those 'resulting in severe harm or death', will often rely on clinical judgement. This judgement may, acceptably, differ between professionals. In addition, the classification of the impact of an incident may be subject to a potentially lengthy investigation which may result in the classification being changed. This change may not be reported externally and the data held by a Trust may not be the same as that held by the NRLS. Therefore, it may be difficult to explain the differences between the data reported by Trust and data reported by the NRLS as this may not be comparable
- The number of incidents reported by TEWV to the NRLS for quarters 1 and 2 2012/13 is above the national average. The percentage resulting in severe harm or death is lower than the national average. However, it is not possible to use this data to comment of the Trust's culture of incident reporting or the occurrence of incidents. The absolute numbers of incidents reported is a factor of the relative size of Trusts and the complexity of their case-mix. Similarly, the percentage of incidents reported as severe harm or death is a factor of the different methodologies used by Trusts to identify incidents and categorise their severity and therefore comparisons across Trusts are inconclusive. We can say, however:
  - the reporting of patient safety incidents in the Trust is increasing year on year
  - amongst the most common themes are disruptive / aggressive behaviour, accidents (including falls) and self harming behaviours which account for three-quarters of all incidents leading to harm
  - there is evidence of learning lessons from incidents. For example, between 2007/08 and 2012/13 the Trust, through its monitoring and action, has reduced incidents of violence and aggression by **58%**.

TEWV **has taken** the following actions to improve this number / percentage, and so the quality of its services, by:

- an analysis of all patient safety incidents are reported and reviewed by the Trust's Quality and Assurance Committee via the quarterly Patient Safety Report and the six-monthly review of services, and with commissioners via the Clinical Quality Review Process
- introducing a web-based reporting system that enables timely and service-specific analysis and a transparent corporate overview
- analysing areas of low reporting and trends in high risk incident categories. These are reviewed monthly by the responsible service with action plans developed and monitored as appropriate to address warning signs
- all serious untoward incidents (i.e. those resulting in sever harm or death) are subject to a 'root cause analysis' This is a robust and rigorous approach to understanding how and why each incident has happened, to identify any causal factors and to implement any lessons for the future
- raising awareness of staff through clinical team leads the importance and value of reporting and reviewing 'near misses'

Below is presented, in a table format, the rate for at least the last two reporting periods.

Prescribed Information	Related NHS Outcomes Framework Domain	TEWV Actual Quarters 3&4 2012/13	TEWV Actual Quarters 1&2 2012/13	* National Benchmarks in Quarters 1&2 2012/13
The data made available by the Health and Social Care Information Centre (NHSIC) with regard to the number of patient safety incidents, and percentage resulting in severe harm or death, reported within the trust during the reporting period.	5: Treating and caring for people in a safe environment and protecting them from avoidable harm **All trusts**	Trust Reported to NRLS: **3,027** incidents reported with **41 (1.4%)** resulted in severe harm or death	Trust Reported to NRLS: **2,919** incidents reported with **41 (1.4%)** resulted in severe harm or death NRLS Reported: **2,911** incidents reported with **41 (1.4%)** resulted in severe harm or death	NRLS Reported: National Average MH Trusts: **2,044** incidents reported with **32 (1.6%)** resulting in severe harm or death Lowest MH Trust: **22** incidents reported with **0 (0%)** resulting in severe harm or death Highest MH Trusts: **6,903** incidents reported with **102 (1.4%)** resulting in severe harm or death **3,541** incidents reported with **334 (9.4%)** resulting in severe harm or death
* latest benchmark data available on NRLS at quarters 1 & 2 2012/13				

2013/14 priorities for improvement

The Trust's Quality and Assurance Committee 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 2013/14 involved a number of our stakeholders. The process was as follows:

- An internal review was undertaken on the findings of serious untoward incidents, other incidents / 'near misses', complaints, PALS contacts and audit findings to identify common themes for improving quality.
- An event was held in July 2012 to share these issues with our stakeholders and get feedback on where they think the quality of our services needs to be improved.
- Stakeholders from the following agencies were invited to attend:
  - Primary Care Trusts (x3)
  - Clinical Commissioning Groups (x9)
  - Directors of Adult Social Services (x7)
  - Directors of Children's Social Services (x7)
  - Overview and Scrutiny Committees (x7)
  - Local Involvement Networks (LINKs) (x7)
  - Trust Governors – public (x27)
  - Trust Governors – appointed (x15)
  - Trust Governors – staff (x5)
- **28** stakeholders representing **16** agencies and **seven** of our Governors attended this event.
- From this workshop seven key quality themes were identified and these were presented to the Board of Directors.
- At its formal meeting in November, the Board of Directors agreed the four quality priorities for 2013/14 to be included in the 2012/13 quality report from the seven key quality themes identified by our stakeholders. The remaining themes identified by the stakeholders were fed into the business planning process and are included within the Trust's Business Plan for 2013/16.
- For each quality priority the Trust identified a Lead Director and high level action plan.
- A second stakeholder workshop, with the same invitees as shown above, was held in February 2013 where our four quality priorities and proposed plans to deliver these were shared.
- **18** stakeholders representing **11** agencies and **12** of our Governors attended this event.
- The stakeholders gave comments on our plans and were asked to consider what benefits / outcomes they would expect for our service users and carers from these priorities. Their ideas were captured and taken into account in finalising our final action plans for each priority as described below.

Our four priorities for 2013/14 are:

Priority 1: To implement the recommendations of the Care Programme Approach review relating to improving care planning

Priority 2: To implement the recommendations of the Care Programme Approach review relating to improving communications between patients and staff

Priority 3: To improve the delivery of crisis services through implementation of the crisis review's recommendations

Priority 4: To further improve clinical communication with GPs

Priority 1: Implement the recommendations of the Care Programme Approach review relating to improving care planning

Why this is important:
In 2012/13, the Trust performed a comprehensive review of the implementation of the Care Programme Approach. Some key findings of this review relevant to care planning were:

- The quality of assessment and care planning is variable across the Trust.
- Care coordinators spend a significant amount of time on the administration of the Care Programme Approach and other processes related to internal and external initiatives. This reduces the time available to spend with service users and carers to deliver recovery focused interventions.
- There is a lack of clarity and agreed processes regarding the management of section 117 – the statutory duty to provide health and social care to some service users following discharge from in-patient care.

The Care Programme Approach and care planning is critical to the quality of care our service users receive, and therefore, addressing these issues for service users, carers, staff and all agencies with whom we work with is a clear priority for improving quality within the Trust.

What benefits / outcomes our service users and carers should expect:
It is anticipated that when we deliver this priority, our service users and carers, our partners in care and our staff will see an improvement in their experience of the care planning process. For example:

- An improved standard of patient focussed care planning across the Trust.
- A reduction in staff time spent on administrative tasks and more face to face treatment time with service users and carers.

What we will do in 2013/14:
We will:

- develop a detailed implementation plan during quarter one 2013/14
- commence the delivery of the agreed implementation plan for the areas relating to care planning during quarter two 2013/14

Some key themes relating to care planning that will form part of the implementation plan are:

- reduce the administrative burden and documentation for people on standard care and reinvest time on more patient focussed care planning
- ensure that the all service users are correctly allocated to and managed on either the Care Programme Approach or standard care
- consider how care is planned in a way that service users understand. For example, start with 'what does the service user want as an outcome' and end with 'what actions do we need to deliver this outcome'
- review the process for assessing and managing risk and ensure it fully supports the aim of high quality, safe and recovery focussed care
- clarify with our partners in care the expectations for all health and social care professionals working with the Care Programme Approach
- consolidate our experience of tried and tested improvements in care planning and spread best practice across the Trust
- clarify arrangements for Section 117 aftercare, specifically, policy, case management, review and monitoring

Priority 2: Implement recommendations of the Care Programme Approach review relating to improving communications between patients and staff.

Why this is important:
Within the comprehensive review of the Care Programme Approach, the Trust identified issues relating to communications between patients and staff. The following are some of the findings from this review relevant to communications between patients and staff.

- Care coordinators spend a significant amount of time on the administration of the Care Programme Approach and other related processes. This reduces the time available to spend with service users and carers to listen and talk.
- Some service users and carers believe they are removed from, and not fully involved in, the care planning process or their treatment.
- Some service users and carers report that the care documentation that is shared with them is not always clear and fully understandable.

The full involvement and participation of service users and carers within care planning is associated with improved outcomes and the experience of care. Addressing these issues is a clear priority for improving quality within the Trust.

What benefits / outcomes our service users and carers should expect:
It is anticipated that when we deliver this priority, our service users and carers, our partners in care and our staff will see an improvement in their experience of the care planning process. For example:

- service users and carers reporting that their care plans are meaningful (ie clear and fully understood, personalised to them and will help them achieve their goals)
- service users and carers reporting that they are fully involved in their care, empowered by the support they receive from our services and able to make decisions with the care staff on the future of their care

What we will do in 2013/14:
We will:

- develop a detailed implementation plan by quarter one 2013/14
- commence the delivery of the agreed implementation plan for the areas relating to communications between patients and staff by quarter two 2013/14

Some key themes relating to care planning that will form part of the implementation plan are:

- reduce the administrative burden and documentation for people on standard care and reinvest time in communicating with service users and carers
- make best use of time to communicate with service users and carers to increase service user and carer involvement in their care, such that they experience care that is personal, relevant, meets their expectations and assists their recovery
- implement 'My Shared Pathway' across all divisions (this is a practical tool developed within the Trust that helps service users and carers to clarify for themselves and our staff what they want for their life and their care and how this should happen)
- develop a standard approach for a care plan that is meaningful to individual service users and carers (ie flexible, personal, avoids technical language / jargon and acronyms)

To deliver these recommendations the Trust will seek significant involvement from service users and carers (including young carers) as an expert partner in care.

Priority 3: To improve the delivery of crisis services through implementation of the crisis review's recommendations

Why this is important:
Access to and the response from the crisis team is central to the safety and effectiveness of the care received by service users. The provision of this type of intervention at a time of great need can have a significant impact on service users' continued recovery as well as avoiding unnecessary admissions to inpatient care. Ensuring a consistent quality of crisis care across the Trust and at any time of day is, therefore, essential.

In 2011/12, the Trust identified improving crisis services as a quality priority in response to feedback from service users, carers and staff and the occurrence of incidents and complaints. A review was completed and a number of recommendations of this review were implemented in 2012/13:

- a new / revised operational policy – to ensure consistency across the Trust
- new out of hours / night time arrangements – to ensure the crisis service is available for service users 24 hours a day, seven days a week
- new day shift arrangements – to ensure that staff are deployed to match the highs and lows in demand for crisis services
- a new role of shift coordinator – to ensure crisis staff can focus on responding quickly to people in crisis, whilst also protecting time for intensive home treatment to prevent further escalation of need
- better working with the wards – to enable the crisis team to be more proactive, working with the inpatient wards to facilitate safe and supported discharge
- training needs assessment – to ensure the crisis teams have the right numbers and skill mix to perform the full range of leadership, management, care and treatment

Whilst the primary aim of the review in 2012/13 was to improve the quality of the services provided by crisis services through a reduction in variance across the teams with regard to effectiveness, establishment, skill mix, staffing levels and activity, the aim for 2013/14 is to embed these changes to maximise the quality of service our service users and carers receive.

What benefits / outcomes our service users and carers should expect:

- a standard of high quality crisis and home treatment services across the Trust
- continued avoidance of unnecessary admissions to inpatient care and more care closer to home
- service users and carers reporting an improvement in their experience of crisis services

What we will do in 2013/14:
We will:

- implement recommendations from the crisis review by quarter one 2013/14
- perform a service user survey by quarter three 2013/14 – ensuring time for the 2012/13 changes to be fully embedded
- monitor the implementation of the crisis review recommendations by quarter three 2013/14
- implement the training plan by quarter three 2013/14
- establish an internal collaborative / clinical network to provide a forum for crisis staff to meet to share good practice, discuss real issues and potential solutions, and for professional development eg clinical supervision, peer support, action learning sets by quarter three 2013/14
- demonstrate improved performance for community crisis services by quarter four 2013/14

Although the majority of the work to review the service and implement recommendations occurred in 2012/13, our stakeholders at the quality report stakeholder event in February 2013 made the following additional suggestions which we will address in our improvement plans for 2013/14:

- to ensure that all agencies that come into contact with people with mental health needs are aware of what the service provides and when they should be involved
- to ensure that a crisis / relapse plan is agreed as part of a person's overall care plan

It was also suggested that crisis services should be available for all people, including those under 18 years and over 65 years. The Trust is currently commissioned to provide crisis services for people aged 18 to 64 years, and is also available to people aged 17 and 65 years and over with a functional mental illness if clinically appropriate. The service is not currently commissioned to provide for all people under 18 years or people over 65 years with an organic illness (ie dementia). However, a project has been funded in County Durham and Darlington to assess the need for crisis services for people over 65 years with an organic illness, the results of which may influence future commissioning intentions.

Priority 4: To further improve clinical communication with GPs

Why this is important:
The Trust and the GPs within its area are partners in care. During the lifetime of a person with mental health needs and/or learning disabilities their needs change. Service users and carers will require monitoring and interventions from primary care, sometimes secondary / specialist care, and sometimes to address physical needs often associated with mental ill-health and learning disabilities. The pathway of care of an individual is complex and unique to them.

As partners in care, the Trust and its local GPs must work together to maximise our combined efforts. How effectively we communicate our roles, our actions and what we expect of each other is critical to this partnership, and ultimately the outcome and experience of service users and carers.

Our current view of our communication with GPs is that there is no common approach across the Trust and we do not always focus on what the GP and service user and carer needs to know. This conclusion was borne out by the feedback we received from GPs in our GP Survey in 2012.

What benefits / outcomes our service users and carers should expect:

- a standard of high quality communication with GPs across the Trust
- GPs reporting that the Trust's communication regarding the care of service users is timely, focussed and highlights what they need to know (eg diagnosis, key points in care plan, medication and changes, actions for the GP, contact details of the care coordinator)
- service users and carers reporting that they are offered copies of communications between the Trust and the GP

What we will do in 2013/14:
We will:

- agree a standard template and complete project scope by quarter one 2013/14
- agree a business case for the implementation of standard templates by quarter two 2013/14
- create a standard front sheet and free text template for all written communication on the patient electronic record (PARIS) for use Trust wide for all written clinical communication with GP's building on existing work and GP feedback by quarter three 2013/14
- ensure electronic template(s) function effectively within clinical situation by quarter three 2013/14
- establish Trust wide use of template(s) via senior clinical directors and directors of operations by quarter four 2013/14
- develop a standard process for telephone and email access for clinical advice by quarter three 2013/14 and pilot in quarter four 2013/14
- establish lines of communication most effective for GP practices - eg emailing 'letters' by quarter four 2013/14
- pilot of standard process for access to clinical advice and expertise with selected teams by quarter four 2013/14

Further actions to be addressed in our implementation plan for 2013/14 that our stakeholders at the quality report stakeholder event in February 2013 raised are:

- consider, with GPs, a standard for ensuring a minimum six-monthly update is provided to GPs for service users with long-term conditions

Monitoring progress

We will monitor formally our progress against all of the above priorities on a quarterly basis. A quarterly quality 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.

In November 2013, we will also share the quarter two 2013/14 report with all our stakeholders as a mid-year report to facilitate our stakeholder's review of our quality report at year end.

A key way for delivering the priorities for 2013/14 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' (ie incidents that are avoided through action but could have resulted in an incident) where failure to comply with agreed best practice standards (eg 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 lessons we have learnt
- a reduction in complaints and negative feedback to our PALS
- an improvement in responses to the questions in the national service user survey and our local surveys about how service users feel about their care
- specific positive comments from service users' experience feedback

Part 3: Other information on quality performance 2012/13

Our performance against our quality metrics

The following table provides details of our performance against our set of agreed quality metrics for 2012/13.

These metrics are similar to those we reported against in our quality report 2008/09, 2009/10 and 2010/11 which allow us to monitor progress. However, in some cases, the exact definition in 2012/13 has changed as we have learned lessons on what is more meaningful to quality. These are:

- The 'number of unexpected deaths' reported in 2008/11 (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' reported in 2008/11 (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' reported in 2008/11 (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.

Table 2: Quality Metrics

Quality Metrics		2012 /13		2011/12	2010/11	2009/10
		Target	Actual	Actual	Actual	Actual
Patient Safety Measures						
1	Number of unexpected deaths classed as a serious incident per 10,000 open cases	< 12.00*	15.91	12.00		
2	Number of outbreaks of healthcare associated infections	0	0	0	0	0
3	Patient falls per 1000 admissions	< 37.44	34.09	37.44		
Clinical Effectiveness Measures						
4	Percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care (validated)	> 95.00%	97.14%	98.08%	98.50%	97.50%
5	Percentage of clinical audits of NICE Guidance completed	100%	89.47%	95.20%	66.70%	75.00%
6	Average length of stay for patients in adult mental health and mental health services for older people assessment and treatment wards	< 37	35	37	39	47
Patient Experience Measures						
7	Delayed transfers of care	< 7.50%	2.07%	1.60%	1.60%	2.90%
8	Percentage of complaints satisfactorily resolved	> 90.00%	76.36%			
National Patient Survey						
9	Number of questions where our score was within 5% of the highest scored mental health trusts	n/a	11 (29%)	12 (32%)	18 (47%)	16 (42%)
	Number of questions where our score was within the middle 90% of scored mental health trusts		27 (71%)	23 (61%)	14 (37%)	22 (58%)
	Number of questions where our score was within 5% of the lowest scored mental health trusts		0 (0%)	3 (8%)	6 (16%)	0 (0%)

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

Notes on selected metrics

1.Data for this metric is taken from incident reports which are then reported via the National Strategic Executive Information System. The number of unexpected deaths has been changed to the 'number of unexpected deaths classed as a serious incident per 10,000 open cases' for 2012/13. 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.

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. The number of patient falls per 100,000 occupied bed days has been changed to the 'number of patient falls per 1,000 admissions' for 2012/13 as experience has shown this indicator is more closely linked to new admissions rather than occupied bed days.

4.Although the title of this metric has changed from 'Care Programme Approach 7 day follow up' in 2011/12 to the 'percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care', the data the metric is based on remains unchanged. This change was made for clarity purposes only and consistency with the mandatory indicator on page 58. Data for this metric is taken from the Trust's patient systems and is aligned to the national definition.

5.Although the title of this metric has changed from 'implementation of NICE Guidance' in 2011/12 to the 'percentage of clinical audits of NICE Guidance completed', the data the metric is based on remains unchanged. This change was made for clarity purposes only. 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 systems.

7.Delayed transfers of care are 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 systems.

8.Complaints data is compiled from the number of written complaints received by the Trust and is reported annually to the Department of Health. The number of complaints per 100,000 patients has been changed to the 'percentage of complaints satisfactorily resolved' for 2012/13 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.

9.The National Patient Survey for 2012/13 is not directly comparable to previous community surveys. Also the National Patient Survey for 2009/10 is an inpatient survey which is not directly comparable to the community surveys. The metrics previously reported previously were categorised as follows:

- **a.** number of questions where our score was within the top 20% of mental health trusts
- **b.** number of questions where our score was within the middle 60% of mental health trusts
- **c.** number of questions where our score was within the lowest 20% of mental health trusts

" You have all helped me through an extremely difficult time in my life. I'll never forget the amazing work you have done for me "
A service user

Comments on areas of under-performance

Metric 1: Number of unexpected deaths classed as a serious incident per 10,000 open cases

There have been **15.91** unexpected deaths per **10,000** open cases (ie a death that is not expected due to a terminal medical condition or physical illness) in 2012/13 against a target of **12.00**. This accounts for **77** unexpected deaths.

From the total of **77** unexpected deaths in 2012/13: 55 were in the community; five took place in hospital; 4 were inpatients but the death took place away from the hospital; 13 were no longer in contact with the service.

So far, **31** cases have been reported by the Coroner of which 18 were confirmed suicides and four were accidental death. We are awaiting confirmation from the coroner on the remaining 46 deaths reported this year.

The Trust has a robust process for reviewing all unexpected deaths as a result of a serious untoward incident. This process includes a 'root cause analysis', a robust and rigorous approach to understanding how and why each unexpected death has happened and to identify any common factors that may have influenced the death where the Trust learn lessons for the future.

Metric 5: Implementation of National Institute for Clinical Excellence (NICE) Guidance

The projections for NICE audits to be completed in 2012/13 have changed during the year. **30** clinical audits were planned to take place in 2012/13, however, **11** of these were not undertaken.

- **7** were suspended due to NICE publication delays or NICE advising the guidance was not relevant for mental health Trusts.
- **3** were suspended as a new clinical care pathway is to be developed to replace the NICE Guidance.
- **1** clinical audit on Borderline Personality Disorders was replaced by a quality improvement project which was completed in 2012/13.

Of the **19** which remained on the Trust's programme for clinical audits of NICE Guidance in 2012/13, **89.5% (17)** were completed in 2012/13. Of the **2** that were not completed in 2012/13, one on Delirium and one on End of Life Care, both were performed but will not be fully completed until quarter 1 2013/14.

It is important to note that this metric measures the Trust's ability to evidence that NICE Guidance has been implemented. The Trust systematically implements evidence-based practice, including that from NICE Guidance, and at quarter 4 2012/13 there were no outstanding actions relating to NICE Guidance awaiting implementation.

Metric 8: Percentage of complaints satisfactorily resolved

There have been **177** complaints received during 2012/13 and **165** resolution letters sent following investigation. At the 31st March 2013, **76.36% (126)** have been satisfactorily resolved. **39** complainants have given an indication that they their complaint was not satisfactorily resolved.

Of the **39** complaints not satisfactorily resolved, only **5** of these were referred to the Ombudsman with no further actions on **4** complaints and **1** still outstanding.

Table 3 below shows the resolution rate by service:

Table 3: Complaints Resolution

Service	Locality	Total number of resolution letters sent	Percentage (numbers) satisfactorily resolved
Adult Mental Health	Durham & Darlington	40	62.5% (25)
	Tees	39	76.9% (30)
	North Yorkshire	28	71.4% (20)
Mental Health Services for Older People	Durham & Darlington	8	87.5% (7)
	Tees	3	100% (3)
	North Yorkshire	10	60% (6)
Children's & Young Peoples Services Mental Health & Learning Disabilities	Durham & Darlington	5	60% (3)
	Tees	6	100% (6)
	North Yorkshire	4	100% (4)
Adult Learning Disabilities	Durham & Darlington	2	100% (2)
	Tees	1	100% (1)
	North Yorkshire	3	100% (3)
Forensic Services	Trust-wide	14	100% (14)
Nursing & Governance	Corporate	2	100% (2)
Total		**165**	**76.36% (126)**

Complaints are monitored by the quality assurance committee and are thoroughly investigated. Both the patient experience department and PALS strived to resolve as many concerns/complaints as possible informally.

Our performance against national targets and regulatory requirements

The following table demonstrates how we have performed against a wide range of targets set for us by the Department of Health, our regulator Monitor and our commissioners.

Table 4: National targets and regulatory requirements

Quality Metrics		2012/13		2011/12	2010/11	2009/10
		Target	Actual	Actual	Actual	Actual
a	The Trust has registered with CQC with no conditions	Fully met	Fully met	Fully met	Fully met	Fully met
b	Number of occupied bed days of under 18s admitted to adult wards	0	64	83	70	173
c	Retention rate substance misuse (rolling 12 months and reported 3 months behind)	=/> 89.90%	89.91%	89.90%	84.40%	89.70%
d	Number of early intervention in psychosis new cases (cumulative position)	> 130	599	479	455	407
e	Number of crisis resolution home treatment episodes (cumulative position)	> 1,692	6,152	5,965	5,751	5,191
f	Percentage of admissions to acute wards for which the crisis resolution home treatment team acted as a gatekeeper (validated)	> 95.00%	97.35%	96.00%	97.00%	97.20%
g	Percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care (validated)	> 95.00%	97.14%	98.08%	98.50%	97.50%
h	Maintain level of crisis resolution teams set out in 2003/06 planning round	Maintain	Maintained	Maintained	Maintained	Maintained

Notes on national targets and regulatory requirements

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

c) Retention rate - the information is subject to a 3-month delay in reporting, therefore the figure shown is the position reported in the February 2013 report which covers October 2011 to November 2012.

f) Although the title of this metric has changed from 'percentage of admissions to inpatient services that had access to crisis resolution home treatment teams' in 2011/12 to the 'percentage of admissions to acute wards for which the crisis resolution home treatment team acted as a gatekeeper', the data the metric is based on remains unchanged. This change was made for clarity purposes only and consistency with the mandatory indicator on page 59.

g) Although the title of this metric has changed from 'Care Programme Approach 7 day follow up' in 2011/12 to the 'percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care', the data the metric is based on remains unchanged. This change was made for clarity purposes only and consistency with the mandatory indicator on page 58.

Comments on areas of under-performance

Indicator b: Number of occupied bed days of under 18s admitted to adult wards

There were **64** occupied bed days for the 'under 18s admitted to adult wards' in 2012/13. This relates to eight patients staying between one and 24 days on adult mental health wards across the Trust.

It is important to note that all of these admissions were clinically appropriate. For example, an admission of an adolescent aged 17 years and 10 months for a stay that is likely to last more than two months avoids an unnecessary transition to adult mental health later. Or, where the clinical need of the service user would be best met on an adult ward

External audit

For 2012/13, auditors have provide a limited assurance report on whether two mandated indicators included in the quality report have been reasonably stated in all material respects. The three indicators for the Trust in the quality report 2012/13 are:

- The percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care.
- The percentage of admissions to acute wards for which the crisis resolution home treatment team acted as a gatekeeper.
- Number of patient safety incidents and percentage resulting in severe harm or death.

In 2012/13 NHS foundation trusts are also required to report the number of patient safety incidents that occurred, and the percentage of such incidents that resulted in severe harm or death.

The full definitions for these indicators are contained in **appendix 3**.

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 2012/13, we have tried to improve how we involved our stakeholders in assessing our quality in 2012/13.

The following are some positive comments from our stakeholders at the events in 2012/13:

- *fantastic – informative – thank you for time and efforts*
- *excellent opportunity to contribute*
- *feedback brilliant and workshop very informative*
- *interesting and blue sky thinking*
- *it is important and positive to feel actively involved in decision making. TEWV are very good at this*
- *good debate and dialogue*
- *good to discuss Care Programme Approach and crisis*
- *good opportunity to influence the quality report*
- *good opportunity to ask questions and receive responses*
- *good presentations and explanations on why, what and how. Useful in stimulating discussion*
- *meaningful involvement of stakeholders*
- *good mix of stakeholders on the table*
- *good to meet people from different agencies and different areas*

The following are the comments on things we could do better in our quality report stakeholder events:

- *lack of representation from local authorities, GPs and clinical commissioning groups across whole patch*
- *could have spent longer on the priorities for next year and less on a review of last year and the issues and concerns*
- *the Trust needs to explain in more detail why some of the priorities were chosen*
- *would have valued some background information to give a more informed contribution*
- *need a dedicated facilitator for each table*
- *avoid using abbreviations which can be confusing*

In addition to these, our stakeholders also noted:

- *A lack of representation from local authorities, GPs and clinical commissioning groups across whole patch.*

In response the Trust will continue to make the quality report an open and transparent process and encourage participation through its stakeholder events and systems for reporting quality and assurance to its stakeholders.

In line with national guidance, we have circulated our draft quality report for 2012/13 to the following stakeholders:

- NHS England – Area Teams (x2)
- Clinical Commissioning Groups (x9)
- Local Authority Overview & Scrutiny Committees (x7)
- Local HealthWatch (x7)

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

The following are the general themes received from stakeholders in reviewing our Quality Account for 2012/13:

- Although some stakeholders said the document was easy to read, one Healthwatch did note that the document still contained management jargon.
- All stakeholders recognised the efforts of the Trust to involve and engage them in the process of the Quality Account, and in particular, stakeholders welcomed the opportunity to discuss the Trust's quality and contribute to setting quality priorities at the two Quality Account Stakeholder Events in July and February each year.
- Stakeholders acknowledged the progress the Trust made with its quality priorities for 2012/13 and encouraged the Trust to continue making improvements in these areas in the following years.
- There was board support for the quality priorities for 2013/14. Stakeholders made a number of suggestions for the Trust to consider, in particular, the need to ensure service users and carer involvement in the implementation and evaluation of these priorities in 2013/14.

Our stakeholders did raise a number of points of clarity and, where possible, these have been addressed in the document before publication. However, the Trust will write to each stakeholder addressing each comment made following publication of the Quality Account 2012/13 and as part of an annual lessons learnt exercise in preparation for the Quality Account 2013/14.

In response to many stakeholders' requests, the Trust has agreed to continue providing all stakeholders with a half-year update in November 2013 on the Trust's progress with delivering its quality priorities and metrics for 2013/14.

2012/13 Statement of Directors' responsibilities in respect of the quality report

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

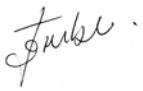
In preparing the quality report, Directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2012/13;
- 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 2012 to June 2013;
  - Papers relating to Quality reported to the Board over the period April 2012 to June 2013;
  - Feedback from the commissioners dated May 2013;
  - Feedback from Governors dated 12 March and 16 April 2012;
  - Feedback from Local Healthwatch organisations dated May 2013;
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 2 May 2013
  - The latest national patient survey published on 13 September 2012;
  - The latest national staff survey published on 28 February 2013;
  - The Head of Internal Audit's annual opinion over the Trust's control environment received by the Audit Committee on 16 May 2013;
  - Care Quality Commission quality and risk profiles dated 4 April 2013.
- 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/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275)

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
28 May 2013

Martin Barkley
Chief Executive
28 May 2013

2012/13 Limited assurance report on the content of the quality report and mandated performance indicators

Independent Auditor's Assurance Report to the Board of Governors of Tees, Esk and Wear Valleys NHS Foundation Trust on the Quality Report

We have been engaged by the Board 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 2013 (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 2013, to enable the Council of Governors to demonstrate they have discharged their 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 2013 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- CPA 7 Day Follow Up; and
- Access to Crisis Resolution Team indicators;

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 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 below; 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 consider whether it addresses the content requirements of the *NHS Foundation Trust Annual Reporting Manual*, and consider the implications for our report if we become aware of any material omissions.

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

- Board minutes for the period April 2012 to 28 May 2013;
- Papers relating to Quality reported to the Board over the period April 2012 to 28 May 2013;
- Feedback from the Commissioners dated May 2013;
- Feedback from local Healthwatch organisations dated May 2013;
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 for the period April 2012 to March 2013;
- The 2012 national patient survey;
- The 2012 national staff survey;
- Care Quality Commission quality and risk profiles dated 31 March 2013.
- The Head of Internal Audit's annual opinion over the trust's control environment dated 16th May 2013.

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.
- Reading the documents.

A limited assurance engagement is smaller 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 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 2013:

- 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 *Detailed Guidance for External Assurance on Quality Reports*; 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*.

Deloitte LLP
Chartered Accountants
Newcastle upon Tyne
29 May 2013

Governance and financial review

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 (licence).

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 receive the annual accounts and annual report
- to appoint or remove the Trust's external auditor
- to determine proposals to increase the proportion of the Trust's income earned from non-NHS sources by 5% or more in any financial year
- to inform the Board whether or not it considers that any proposals to provide non-NHS services will interfere, to a significant extent, with the provision of NHS services

A number of committees including the Nomination and Remuneration Committee support this work (see page 88).

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

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

Any powers which the Board has not reserved to itself or delegated to sub-committees are exercised on behalf of the Board by our Chief Executive.

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.

Under the leadership of our Chief Executive, the Executive Management Team (which comprises the executive, corporate and operational 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.

During 2012/13 we have complied with the pledges of the National Health Service Constitution.

On 1 October 2012 we amended our constitution to reflect the provisions of the Health and Social Care Act 2012 with regard to foundation trusts' ability to earn income from non-NHS sources.

The amount of income a foundation trust may earn from non-NHS sources is limited to 49% of its total income.

Proposals to increase the proportion of a foundation trust's income derived from non-NHS sources by 5% or more in any one year must now be determined by the Council of Governors.

In addition, each year, the Council of Governors must inform the Board whether or not it considers that the amount of income earned from non-NHS sources will have a detrimental effect on the provision of NHS services.

Changes to our governance arrangements

During 2012/13 a working group of the Board and Council of Governors reviewed our constitution to ensure, amongst other matters, it complied with the requirements of the Health and Social Care Act 2012.

The changes to the constitution have been approved by the Board and Council of Governors and came into force on 1 April 2013. These include:

- New duties for the Board of Directors and individual Directors requiring them to act with a view to promoting the success of the Trust so as to maximise the benefits for its members and the public.
- The establishment of statutory duties for the Council of Governors; to hold the Board, and individual Directors, to account and to represent the interests of the members of the Trust as a whole and the public.
- Changes to the powers of the Council of Governors. The consent of the Governors will be required to:
  - amend the Trust's constitution.
  - enter into "significant transactions" (as defined in the constitution).
- The introduction of annual members' meetings to receive the annual report and accounts and to enable members to vote on any changes to the Constitution which affect the powers and duties of the Council of Governors. The meetings will be combined with the annual general meetings of the Trust.
- Increased transparency. Individual Directors can be required to attend meetings of the Council of Governors to explain their own or the Board's performance; and the agendas and minutes of meetings of the Board must be provided to Governors.
- Amendments to the composition of the Council of Governors eg the removal of seats for primary care trusts.
- Changes to reflect the new role of Monitor as the regulator of the health sector and the introduction of licences for providers of NHS services.
- The introduction of a new public constituency enabling anyone resident in England and also otherwise eligible to become a member of the Trust.
- Changes to the criteria on whether a person can become and remain a Governor.

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, 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 2012/13 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:

- Andrew Lombard (three years and two months)
- Mrs Barbara Matthews (three years and two months)
- 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.	**75**
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 Committee	**78, 88, 81, 83**
A.1.2	The number of meetings of the Board of Directors and those committees and individual attendance by Directors.	**80**
A.3.1	The names of the Non-Executive Directors whom the Board determines to be independent, with reasons where necessary	**77**
A.3.4	A description of each Director's expertise and experience	**78**
A.3.4	A clear statement about the Board of Directors' balance, completeness and appropriateness.	**77**
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	**85-86**
B.1.3	The number of meetings of the Council of Governors and individual attendance by Governors and Directors	**85-86, 80**
C.1.7	The other significant commitments of the Chairman and any changes to them during the year	**77-78**
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 a Non-Executive Director	**88**
D.2	How performance evaluation of the Board of Directors, its committees and its Directors has been conducted	**80**
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	**N/A**
F.1.1	An explanation from the Directors of their responsibility for preparing the accounts and a statement by the auditors about their reporting responsibilities	**94,98**
F.1.2	A statement from the Directors that the business is a going concern, with supporting assumptions or qualifications as necessary	**93**
F.2.1	A report that the Board has conducted a review of the effectiveness of the Trust's system of internal controls	**95**
F.3.3	A separate section describing the work of the audit committee in discharging its responsibilities	**81**
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 recommendation and the reasons why the Council of Governors has taken a different position	**N/A**
F.3.8	An explanation of how, if the auditor provides non-audit services, auditor objectivity and independence is safeguarded	**81**
G.1.4	Contact procedures for members who wish to communicate with Governors and/or Directors	**89**
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	**80**

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

The Board of Directors

Our Board of Directors comprises:

- a Non-Executive Chairman
- seven Non-Executive Directors
- five Executive Directors

In accordance with the constitution the Executive Directors must include the Chief Executive (as the accounting officer), the Finance Director, a registered medical practitioner and a registered nurse.

All members of the Board are equally responsible for scrutinising the performance of the Trust 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.

The Chairman has no other significant commitments than shown overleaf. These did not change during 2012/13.

The Board of Directors

The membership of the Board as at 31 March 2013:

Mrs Jo Turnbull, Chairman

1 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 2013 to 31 March 2014*
Date of Initial appointment: 1 July 2008**

Mr John Robinson, Deputy Chairman and Chairman of the Quality and Assurance Committee (until October 2012)

2 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 County Durham and Darlington and member of Durham and Darlington Fire Authority.
Qualifications: RMN and RGN, CPN Certificate, Further Education Teaching Certificate, Diploma in Management Studies
Term of office: 1 September 2012 – 31 August 2015*
Date of Initial appointment: 1July 2008**

Mr Andrew Lombard, Non-Executive Director, Senior Independent Director and Chairman of the Mental Health Act Committee

3 Andrew is a former Non-Executive Director for Tees and North East Yorkshire NHS Trust. He was previously Head of Information and Communications Technology with Cleveland Police and was for many years chairman of a charity for people with disabilities.
Qualifications: HNC maths, stats, computing and a post graduate diploma in numerical analysis
Term of office: 1 July 2010 – 31 August 2013*
Date of Initial appointment: 1 July 2008**

Mr Douglas Taylor, Non-Executive Director and Chairman of the Audit Committee

4 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*
Date of Initial appointment: 1 July 2008**

Mrs Barbara Matthews, Non-Executive Director

5 Barbara is a qualified lawyer and currently works part time for the City of York Council. She has previously worked as a lawyer in the petro-chemical engineering industry.
Qualifications: BA hons, JD (law)
Term of office: 1 July 2010 to 31 August 2013
Date of Initial appointment: 1st July 2010

Mr Mike Newell, OBE, Non-Executive Director and Chairman of the Quality and Assurance Committee from October 2012

6 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 a research consultant with the International Centre for Prison Studies.
Qualifications: BA Engineering, post graduate diploma in management studies
Term of office: 1 September 2012 – 31 August 2015*
Date of Initial appointment: 1 July 2008**

Mr Graham Neave, Non-Executive Director

7 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*
Date of Initial appointment: 1st September 2008

Mr Jim Tucker, Non-Executive Director and Chairman of the Investment Committee

8 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: 1 September 2012 to 31 August 2014*
Date of Initial appointment: 1 September 2008

Mr Martin Barkley, Chief Executive

9 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

Mr Brent Kilmurray, Chief Operating Officer

10 Brent has been an NHS Executive Director since 2005, having previously worked at City Hospitals Sunderland, NHS South of Tyne and Wear and South Tyneside NHS Foundation Trust. Prior to that he worked in Local Government. Brent is also a Parent Governor at his local first school.
Qualifications: BA (Hons), MA
Appointed: February 2013

Dr Nick Land, Medical Director

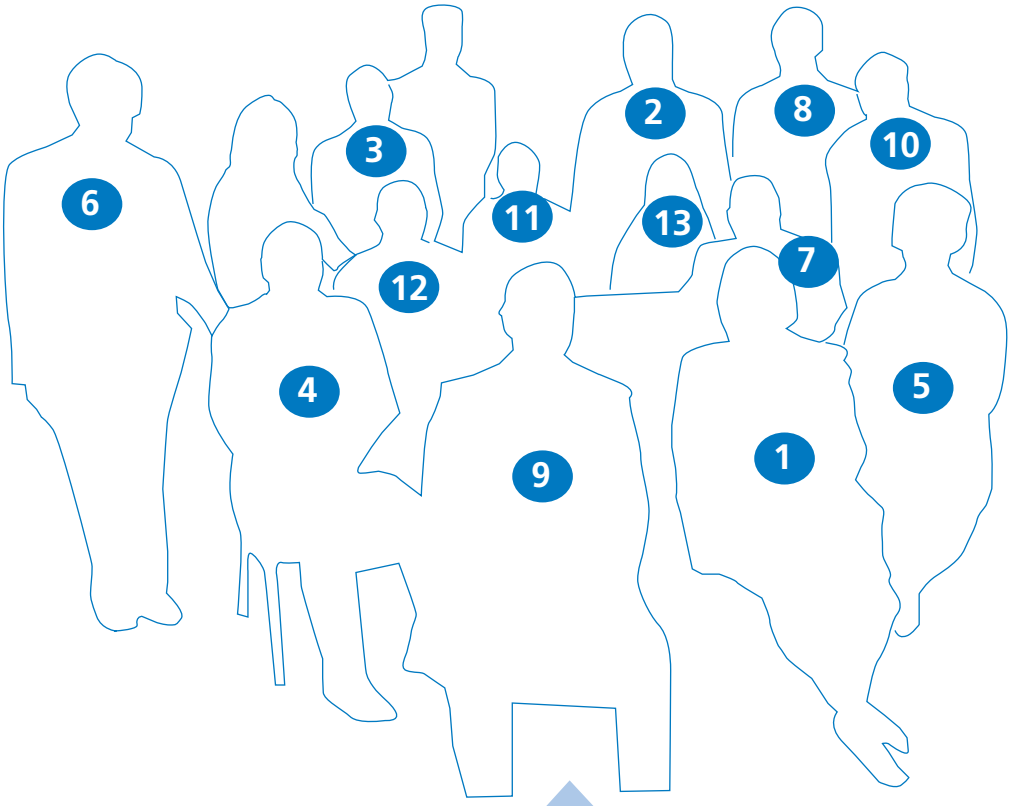
11 Nick has been a Consultant Psychiatrist for people with learning disabilities for 19 years. Prior to becoming the Medical Director he was Clinical Director for Learning Disability and Forensic Services at the Trust. Interests include service development and medical education. He is on the executive of the NHS Confederation Mental Health Network and a member of the Monitor mental health Medical Advisory Group. He chairs the Northern School of Psychiatry's workforce sub-committee and sits on the Northern LETB council.
Qualifications: MA, MBBS, FRCPsych
Appointed: January 2010

Mr Colin Martin, Director of Finance and Deputy Chief Executive

12 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. He is the Chair of the Audit North NHS audit consortium.
Qualifications: Qualified accountant, FCCA
Appointed: April 2006

Mrs Chris Stanbury, Director of Nursing and Governance

13 Chris joined the NHS in 1980 as a psychology graduate and registered as an RMN in 1985. She has held a variety of clinical, managerial and educational roles, gaining further registrations 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



(Note:
(*) indicates that the individual has been reappointed as a Board Member of the Foundation Trust.
(**) The Chairman and Non-Executive Directors of the predecessor NHS Trust were appointed to those offices of the Foundation Trust on its Authorisation on 1 July 2008).

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.

Changes in Board Membership during 2012/13

There were the following changes to the membership of the Board of Directors during 2012/13:

- Mr Les Morgan resigned from his position as the Chief Operating Officer in July 2012.
- Dr Ruth Briel acted as the Interim Chief Operating Officer for the period July 2012 to February 2013.
- Mr Brent Kilmurray was appointed as the Chief Operating Officer from February 2013.

Board Meetings

The Board formally meets at least ten times a year. Special meetings are also usually held in August and December. Further special meetings are held as and when necessary to consider 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.

All meetings of the Board are held 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 2012/13 meetings were held in Durham, Harrogate, Middlesbrough and Scarborough.

The Chairman holds meetings with the Non-Executive Directors without the Executive Directors present each month.

The attendance of Directors at meetings during 2012/13 is set out in the table below:

Attendance at Board meetings

The Board met 12 times during 2012/13: 10 ordinary meetings and 2 special meetings. The number of these meetings attended by individual Directors was as follows:

Mrs Jo Turnbull	12
Mr Andrew Lombard	11
Mrs Barbara Matthews	11
Mr Graham Neave	5
Mr Mike Newell	9
Mr John Robinson	9
Mr Douglas Taylor	12
Mr Jim Tucker	12
Mr Martin Barkley	11
Dr Ruth Briel	7 (7)
Mr Brent Kilmurray	2 (2)
Dr Nick Land	10
Mr Colin Martin	11
Mr Les Morgan	3 (3)
Mrs Chris Stanbury	11
Mr David Levy**	11
Mr Chris Parsons***	9 (10)
Mrs Sharon Pickering**	11

(*The maximum number of meetings to be attended for those Board Members who held office during part of the year is shown in brackets
**The corporate directors attend meetings in a non-voting capacity.
*** From 1 February 2013 it was agreed that Mr Parsons, Corporate Director for Estates and Facilities Management, should not attend Board meetings except for specific purposes as part of his flexible retirement arrangements.)

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

Keeping informed of the views of Governors and members

Our Board of Directors ensures it is kept informed of the views of Governors and members in a number of ways, including:

- attendance at Council of Governors meetings
- receiving reports on the outcome of consultations with Governors, for example on the business plan
- Non-Executive Directors 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 other usual business arrangements.

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 ordinary meetings and one special meeting of the Council of Governors during 2012/13, including the Annual General Meeting, was as follows:

Mrs Jo Turnbull	6
Mr Andrew Lombard	6
Mrs Barbara Matthews	3
Mr Graham Neave	2
Mr Mike Newell	5
Mr John Robinson	3
Mr Douglas Taylor	6
Mr Jim Tucker	4
Mr Martin Barkley	5
Dr Ruth Briel	3 (3)
Mr Brent Kilmurray	1 (1)
Dr Nick Land	1
Mr Colin Martin	4
Mr Les Morgan	1 (1)
Mrs Chris Stanbury	3

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 Non-Executive Director is evaluated by self assessment and assessments by the Chairman and a sample of both Non-executive and Executive Directors.
- Detailed consideration of the results of the performance evaluation of the Chairman and Non-Executive Directors is undertaken by the Nomination and Remuneration Committee of the Council of Governors. A report from the committee is made to a general meeting of the Council of Governors.
- The appraisal of the performance of Executive Directors is carried out by the Chief Executive, whose performance is appraised by the Chairman. The outcomes of the appraisals are reported to the Remuneration Committee of the Board.
- Personal development plans are completed by the Chairman and Board members and monitored during the year.
- The performance of the Board's committee is evaluated by self assessment. The results are considered by each committee and the Board.

❝ Since transferring to the new autism specific centre he has made life changing progress and we feel very fortunate that he has had the opportunity to benefit from the autism specific expertise now available to him ❞
The parents of a service user

Committees of the Board

The Board has standing Audit, Investment, Quality and Assurance, Mental Health Act (from 1 April Mental Health Legislation Committee) and Remuneration Committees.

Each committee has terms of reference which have been approved by the Board and include 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.

The Audit Committee

Role and Responsibilities

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

The responsibilities of the Audit Committee also include:

- reviewing the adequacy of all risk and control disclosure statements (e.g. 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 to the governance of the Trust
- reviewing and monitoring the integrity of any financial statements including any financial judgements contained in them and ensuring the completeness and accuracy of information provided to the Board
- reviewing arrangements by which staff may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters (the whistleblowing policy)

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

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

Membership of the Committee

The Committee comprises not less than four members all of whom must be independent Non-Executive Directors. There is also a standing invitation for all other Non-Executive Directors to attend meetings of the Committee and participate in discussions but not to vote.

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 four times during the year. Attendance by each member was as follows:

Mr Douglas Taylor (Chairman)	4
Mr Andrew Lombard	4
Mr Mike Newell	4
Mrs Barbara Matthews	4

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 2012/13, 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 2011/12 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 2011/12 annual report and financial statements of charitable trust funds
- monitored and gained assurance on the implementation of the action plan developed in response to the review of how the training needs of staff are identified and addressed, commissioned from Deloitte LLP
- gained assurance on the coverage of the clinical audit programme and monitored progress on its implementation.
- 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
- reviewed the Trust's integrated governance strategy including risk management arrangements
- assured itself that the proper arrangements were in place for combating fraud
- supported the Council of Governors in its tendering of external audit services

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

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
Deloitte LLP was the Trust's external auditor for 2012/13.

The cost of providing external audit services during 2012/13 was £61,500 excluding VAT. This includes the cost of the statutory audit, the review of the quality account required by Monitor, 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 (licence)
- 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 Chairman – Mr Jim Tucker
- four other Non-Executive Directors – Mrs Barbara Matthews, Mr Andrew Lombard, Mr Mike Newell and Mr Douglas Taylor
- the Chief Executive, Finance Director, Chief Operating Officer and Director of Planning and Performance

The Committee met six times during the year.

During 2012/13 the committee reviewed and recommended the following capital developments to the Board:

- the development of MHSOP complex care services at Springwood, Malton
- the development of West Lane Hospital, Middlesbrough
- the reprovision of accommodation for the Scarborough, Whitby and Ryedale CAMHS team from Beck House to Manor Court, Scarborough
- the provision of a new perimeter fence to block 15 at Roseberry Park to ensure compliance with government guidance for medium secure services
- the reconfiguration of forensic and secure services estate at Roseberry Park
- phase 2 of the service improvement and space utilisation project
- the refurbishment of Shildon CECU to provide crisis beds
- the refurbishment of The Orchards, Ripon to provide rehabilitation services for North Yorkshire and to create a local base for the delivery of community services
- the development of the Harrogate Resource Centre

The Quality and Assurance Committee (QuAC)
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 Quality and Safety.

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.

The Committee receives a monthly position statement in respect of the Trust's Care Quality Commission (CQC) registration. Assurance is provided with regard to the Trust's compliance with the Essential Standards of Quality and Safety. This includes monitoring and analysis of the CQC's Quality and Risk Profile when published.

This year the Committee has received six monthly divisional quality and assurance reports as well as scheduled 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 and families. 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.

The Committee ensures balance with quality development and assurance items on the planned agenda but leaves space for flexibility allowing debate for clinical quality and safety issues and exception reporting.

To ensure that the Board of Directors maintains 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 Mike Newell, Non-Executive Director chairs the committee with support from Chris Stanbury, the Director of Nursing and Governance.

Other members are:

- Nominated Non-Executive Directors – Mr John Robinson, Mr Jim Tucker, Mr Graham Neave
- Dr Nick Land, Medical Director
- Mr Brent Kilmurray, 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, Mr Levi Buckley
- Senior Clinical Directors – Dr Ruth Briel, Dr Julian Whaley, Dr Ahmad Khouja, Dr Angus Bell, Professor Joe Reilly, Dr Soraya Mayet, 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 Sharon Tufnell, Ms Heather Corlett

The Committee held 12 meetings during 2012/13

Mental Health Act Committee (from 1 April 2013 Mental Health Legislation Committee)

The Mental Health Act Committee is a Committee of the Board that is accountable for the safe and efficient management of mental health legislation, specifically the Mental Health Act and the Mental Capacity Act including the Deprivation of Liberty Safeguards (DoLS) and the overseeing of Mental Health Act administration activity and performance.

This Committee's duties are:

- to ensure appropriate arrangements are in place for the appointment of Associate Hospital Managers and overseeing Manager's hearings.
- to receive and review activity and performance information in respect of the use of each section of the Mental Health Act 1983 and Mental Capacity Act 2005 with appropriate comparisons and trends.
- to consider matters of good practice, and in particular, the implication of the Codes of Practice: Mental Health Act 1983 and Mental Capacity Act 2005 and make proposals for change to the Board.
- receive regular reports from the Mental Health Policy Groups.
- to scrutinise CQC Mental Health Act Commission Visit Reports and management responses and monitor the implementation of action plans.
- to review at least annually the Trust's compliance with 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 Andrew Lombard, Non-Executive Director, with support from Chris Stanbury, Director of Nursing and Governance who is responsible for the Mental Health Act administration service. The Committee has met four times between April 2012 and March 2013. The members currently are:

- Mr Andrew Lombard, Non-Executive Director
- Mr John Robinson, Non-Executive Director
- Mr Douglas Taylor, Non-Executive Director
- Mrs Chris Stanbury, Director of Nursing and Governance
- Dr Nick Land, Medical Director
- Mr Brent Kilmurray, Chief Operating Officer
- Mr Chris Parsons, Director of Estates and Facilities Management
- Two service user representatives
- A carer representative

The Executive and Corporate Director Members of the Committee may nominate deputies (with voting rights) to attend meetings on their behalf.

In addition, there are staff who regularly attend meetings but are not members. These include the Trust Head of Mental Health Legislation, Mental Health Act Advisor and the Associate Director of Nursing and Compliance.

The Committee has a standing agenda which includes the performance reports against the Mental Health Act 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 2012 and January 2013

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 of Human Resources and Organisational Development undertakes the role of secretary to the Remuneration Committee.

During 2012/13 there was one meeting of the Remuneration Committee which was held on 26 June 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 Remuneration Committee received advice from The Director of Human Resources and Organisational Development and information from Capita Business Services Ltd.

A Directors performance evaluation scheme is used. Individual Executive and Corporate Director 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.

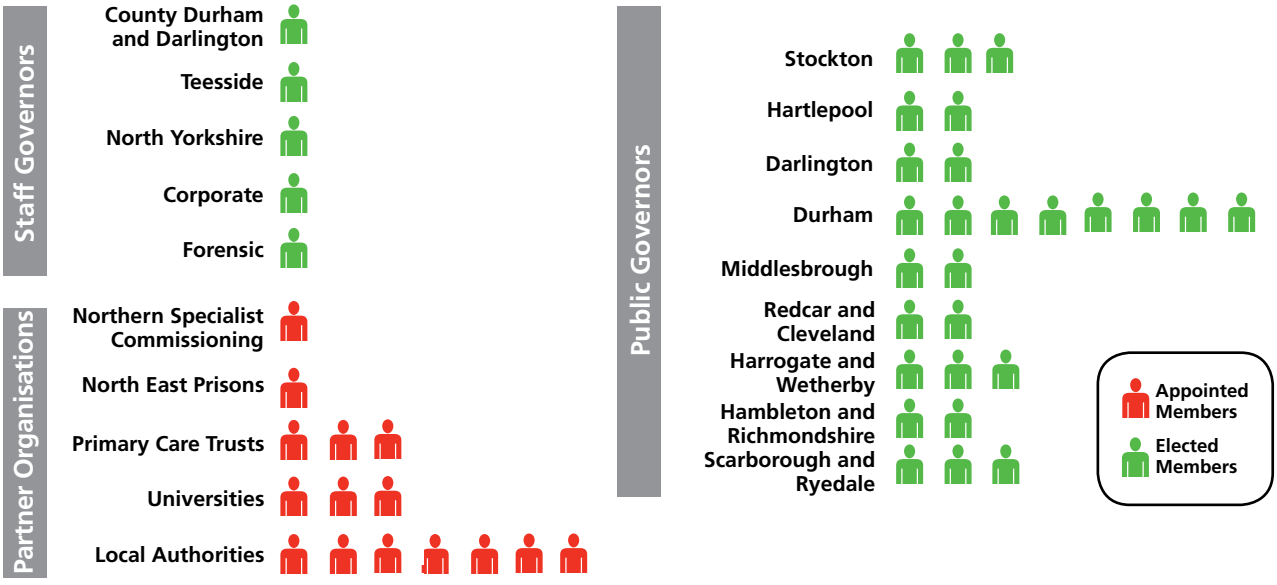
The Trust does not operate an annual performance-related pay scheme for Directors and there is no provision for compensation in respect of early termination with the exception of redundancy. Entitlement to payments arising from early termination of employment by reason of redundancy is in accordance 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 112.

The Council of Governors

Composition of the Council of Governors during 2012/13



Membership of the Council of Governors during 2012/13

The terms of office of Governors and their attendance at the five ordinary meetings and one special meeting of the Council of Governors held during 2012/13 was as follows:

Public Governors (Elected)				
		Term of Office		
Name	**Constituency**	**From**	**To**	**Total Attended***
Andrea Goldie	Darlington	18/12/2011	30/06/2014	5
Dennis Haithwaite	Darlington	18/12/2011	30/06/2014	2
Betty Gibson	Durham	01/07/2011	30/06/2014	6
Christopher Wheeler	Durham	01/07/2011	30/06/2014	4
Dr Nadja Reissland	Durham	01/07/2010	30/06/2013	4
Cliff Allison	Durham	18/12/2011	30/06/2014	6
Drew Terry	Durham	18/12/2011	31/03/2013	5
Andrew Everett	Durham	01/07/2010	30/06/2013	4
Vince Crosby	Durham	01/07/2010	30/06/2013	5
John Doyle	Durham	01/07/2010	30/06/2013	6
Colin Wilkie	Hambleton and Richmondshire	18/12/2011	30/06/2014	4
Susan Heathcote	Hambleton and Richmondshire	18/12/2011	24/01/2013	3 (4)
Dr John Fairfield	Harrogate and Wetherby	01/07/2012	30/03/2013	1 (5)
Keith Thompson	Harrogate and Wetherby	18/02/2013	26/03/2013	0 (1)
Shirley Burniston	Harrogate and Wetherby	01/07/2012	09/11/2012	1 (2)
Andrew Forcer	Hartlepool	01/07/2011	10/12/2012	0 (4)
Paul Williams	Hartlepool	01/07/2010	30/06/2013	5
Zoe Sherry	Hartlepool	21/03/2013	30/06/2014	0 (1)
Ann Tucker	Middlesbrough	01/07/2011	30/06/2014	5
Michael Taylor	Middlesbrough	01/07/2010	30/06/2013	3
Jayne Mitchell	Redcar and Cleveland	18/12/2011	30/06/2014	6
Vivienne Trenchard	Redcar and Cleveland	01/07/2010	30/06/2013	5
Judith Webster	Scarborough and Ryedale	01/07/2011	30/06/2014	4
Keith Marsden	Scarborough and Ryedale	01/07/2010	30/06/2013	4
Andrea Darrington	Scarborough and Ryedale	17/02/2012	30/06/2014	6
Cllr Ray McCall	Stockton	18/12/2011	30/06/2014	2
Paul Emerson-Wardle	Stockton	01/07/2010	30/06/2013	5
Gareth Rees	Stockton	18/02/2013	30/06/2014	1 (2)
Terry Winfield	Stockton	01/07/2011	02/01/2013	2 (4)

(*The maximum number of meetings to be attended for those Governors who held office during part of the year is shown in brackets)

Staff Governors (Elected)

		Term of Office		
Name	Constituency	From	To	Total Attended*
Simon Hughes	Teesside	01/07/2011	30/06/2014	6
Doug Wardle	County Durham and Darlington	01/07/2011	30/06/2014	2
Stuart Johnson	Corporate	01/07/2011	30/06/2014	1
John Kelly	North Yorkshire	21/03/2013	30/06/2014	0 (1)
Lisa Taylor	Forensic	17/02/2012	30/06/2014	2
Jacqueline Howe	North Yorkshire	18/12/2011	15/01/2013	0 (4)

(*The maximum number of meetings to be attended for those Governors who held office during part of the year is shown in brackets)

Appointed Governors

		Term of Office		
Name	Constituency	From	To	Total Attended*
Melanie Bradbury**	NHS North Yorkshire and York	01/07/2011	31/03/2013	0 (0)
Malcolm Cook**	NHS County Durham and Darlington	01/07/2011	31/03/2013	0
Clare Hunter**	NHS Tees	01/07/2011	31/03/2013	3
Prof Paul Keane	University of Teesside	01/07/2011	30/06/2014	5
Prof Pali Hungin	Durham University	01/07/2011	30/06/2014	3
Tony Parkinson	Middlesbrough Borough Council	24/11/2011	30/06/2014	0
Cllr Ann McCoy	Stockton Borough Council	01/07/2011	30/06/2014	5
Jill Harrison	Hartlepool Borough Council	01/07/2011	30/06/2014	0
Pauline Mitchell	Darlington Borough Council	01/07/2011	11/07/2012	0 (1)
Ann Workman	Darlington Borough Council	11/07/2012	30/06/2014	1 (5)
Lesley Jeavons	Durham County Council	01/07/2011	30/06/2014	2
Cllr Tony Hall	North Yorkshire County Council	01/07/2011	30/06/2014	3
Prof Ian Watt	The University of York	01/07/2011	30/06/2014	0

(* The maximum number of meetings to be attended for those Governors who held office during parts of the year is shown in brackets.
** On 1st April 2013 primary care trusts were abolished under the Health and Social Care Act 2012. Seats on the Council of Governors have been allocated to clinical commissioning groups – one for each locality.
- During 2012/13 Redcar and Cleveland Borough Council, the North East Prisons Directorate and the Northern Specialist Commissioning Group did not appoint Governors to the seats allocated to them on the Council of Governors.)

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.

The Lead Governor

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.

Elections held during 2012/13

Constituency	Date	Seats	No. of Candidates	No. of eligible voters	Turnout (%)
Harrogate & Wetherby	8/06/2012	3	2	N/A	N/A
Stockton-on-Tees	21/03/2013	1	1	N/A	N/A
Hartlepool	21/03/2013	1	2	723	8.57%
Harrogate & Wetherby	21/03/2013	2	1	N/A	N/A
North Yorkshire Staff	21/03/2013	1	4	802	16.08%

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 2012/13

During 2012/13 the Council of Governors:

- held our Annual General Meeting based on the theme of Learning Disabilities
- assured itself on our financial and operational performance
- 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
- contributed to the development of the Trust's Business Development Strategy
- approved changes to the Trust's Constitution taking into account requirements under the Health and Social Care Act 2012
- approved appointments of Non-Executive Directors
- reviewed the remuneration of the Chairman and Non-Executive Directors
- considered future working of its four thematic Committees
- received briefings on service changes, Staff and Patient Surveys and the outcomes of Care Quality Commission Inspections to the Trust's hospitals
- attended Development Days to enhance Governors' skills and knowledge
- received reports on the outcomes of Care Quality Commission inspections of the Trust's services and assured itself of actions being taken to address any concerns
- approved the appointment of the Trust's external auditors from 2013/14
- assured itself on the Trust's responses to the Department of Health's review of Winterbourne View and the recommendations of the public inquiry into Mid Staffordshire NHS Foundation Trust.

❝ Anxiety is such a crippling thing and that is how I feel when I have an attack. You have been patient with me when I was unable to move, you have given me reassurance when I was unsettled by noises and people. You have got me to a place I never thought possible with my mental health and for that I thank you ❞
A service user

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 2012/13:

Improving the Experience of Carers (Chairman: Ann Tucker)
- Monitored the implementation of the Carers' Support Strategy
- Developed a combined carers leaflet across services
- Monitored carer feedback
- Considered the roll out of carer link workers and the role of care co-ordinators
- Monitored the implementation of the Care Programme Approach project
- Supported the delivery and further roll out of the Triangle of Care

Improving the Experience of Service Users (Chairman: Keith Marsden)
- Explored actions that had been taken following a patient story highlighting poor service user experience
- Received an update on the Trust's PALs service
- Considered how the Trust monitors and meets the dietary requirements of service users
- Monitored food provision in inpatient areas and contributed to the development of the food contract specification
- Considered the implications for the Trust following the Coroner's report into the death of Baby Q.
- Monitored the implementation of the Service User Experience and Involvement Strategy
- Received information on the changes implemented to Crisis Resolution and Home Treatment services

Promoting Social Inclusion (Chairman: Vivienne Trenchard)
- Monitored the implementation of the Connecting Communities project
- Participated in the development of the recovery model in the Trust
- Received updates on the achievements of the Trust's Advanced Specialist in Vocational Rehabilitation Work
- Explored the use of personal budgets
- Assisted in the development of the Trust's Park Art event supporting World Mental Health Day
- Received information on a pilot peer support worker in the Early Intervention in Psychosis service
- Received a briefing on the use of Community Treatment Orders
- 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 (Chairman: Paul Emerson-Wardle)
- Developed the Membership Strategy and Plan 2013/14 and monitored the progress of the Membership Strategy and Plan 2012
- Reviewed the delivery and evaluation of four Celebrating Positive Practice public engagement events in 2012/13 and approved the delivery of events for 2013/14
- Agreed the format of the Annual General Meeting and agreed the theme for 2013
- Developed the external events diary for the recruitment of members in 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 2012/13 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
- Recommended the re-appointment of the Chairman of the Trust and three Non-Executive Directors.

In accordance with procedures adopted by the Council of Governors:
- Two of the Non-Executive Directors, Mike Newell and John Robinson, were re-appointed following external competition. The Committee was supported by NRG Executive during this process.
- Jim Tucker, Non-Executive Director, was re-appointed without external competition as he had completed only one term of office.

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 9 meetings during 2012/13 was as follows:

Mrs Jo Turnbull	Chairman of the Trust	**8**
Mr Andrew Lombard	Senior Independent Director	**6 (6)**
Mr Martin Barkley	Chief Executive	**2**
Mrs Andrea Darrington	Public Governor	**8**
Mrs Betty Gibson	Public Governor	**9**
Dr Nadja Reissland	Public Governor	**7**
Mr Colin Wilkie	Public Governor	**8**

As the Senior Independent Director, Mr. Lombard attends only those meetings at which the appointment, performance and remuneration of the Chairman is being considered.

During 2012/13 the Committee received independent advice on the remuneration of the Chairman and Non-Executive Directors from Capita Business Services Ltd.

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 Monitor
- 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:

Quality Account Task Group
This task group of Governors assists the Trust in the development of the annual Quality Report (see page 41).

Business Plan Workshops
Governors have the opportunity to attend workshops to assist the Trust in the development of the Business Plan.

Constitutional Working Group
This working group, which included representatives of both the Board and Council of Governors, reviewed the Trust's Constitution to ensure it complies with the Health and Social Care Act 2012.

External Audit Working Group
This group comprising Governors and members of the Audit Committee oversaw the tendering of external audit services for the Trust.

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.

Various other ad hoc briefing and training events are held for Governors throughout the year to ensure Governors are skilled and understand the initiatives undertaken by the Trust.

Training and development

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

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

A training and development plan has been approved based on a needs assessment and issues arising from the annual review of the operation of the Council of Governors.

All Governors must undertake the following mandatory training:

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

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

During 2012/13 the Council of Governors held two development days. These events enable Governors to receive briefings on and to discuss national and local issues and provide networking opportunities.

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 2012 we set ourselves the following objectives:

- to recruit an additional 511 (nett) public members
- to ensure that there were sufficient public members in the Harrogate and Wetherby Constituency to hold elections in July 2012
- To focus recruitment activity on North Yorkshire and Durham Constituencies whilst maintaining membership levels in other areas
- Seek to improve the demographic profile of our membership to ensure it remains broadly representative of the local population.

We achieved our objectives recruiting an additional 838 (nett) public members by 31 December 2012.

Members wishing to contact Governors and/or Directors of the Trust can do so via the Trust Secretary's department on 01325 552314, email tewv.ftmembership@nhs.net 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

The key recruitment methods employed by the Trust are:

- Trust website
- attendance at public meetings and events held by the Trust
- attendance at events held by other organisations
- advertising in a range of public venues and in the local press
- promotional stands in organisations, shopping centres, leisure centres, libraries, Trust premises etc
- activities promoting the Time to Change anti-stigma campaign
- involvement of Governors in activities outside of the Trust
- employing an external recruitment agency

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 2012/13 the size and movements in public membership were as follows:

Public members as at 1/4/12	**6,113**
New members during 2012/13	**1,072**
Members leaving during 2012/13	**253**
Public members as at 31/3/13	**6,952**

The number of members for each of the public constituencies on 31st March 2013 was as follows:

Public constituencies	
Darlington	**679**
Durham	**1,626**
Hambleton & Richmondshire	**371**
Harrogate and Wetherby	**354**
Hartlepool	**723**
Middlesbrough	**1,093**
Redcar & Cleveland	**699**
Scarborough & Ryedale	**396**
Stockton	**1,011**

Staff membership

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

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

Our staff membership up to 31 March 2013 was as follows:

Staff constituencies	
County Durham and Darlington	1,557
Corporate	924
Forensic	781
North Yorkshire	759
Teesside	1,678

Member Engagement

As well as growing a representative membership the Trust is committed to ensuring accountability through developing member engagement.

Over the last 12 months we have introduced:

- four levels of membership (support member, informed member, active member and involved member) enabling members to choose the communication and engagement activities appropriate for them
- a membership Charter setting out what members can expect from the Trust in terms of communication, engagement and consultation

In 2012/13 engagement with members was undertaken via the following:

- a welcome pack for new members
- annual General Meeting
- bi-monthly publication of 'Insight' which includes a member page
- personal invitations to attend events celebrating positive practice in their localities
- communication to relevant Constituencies to promote awareness of elections
- meeting members at promotional stands at a variety of events
- involvement in public consultations affecting the delivery of Trust services
- website forum for members' information.
- membership Cards including unique membership number and contact details
- use of social media

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 2012/13 we held the following public meetings for our members:

Date	Constituency	Focus	Number of Attendees
03/05/2012	**Scarborough and Ryedale**	• How service users and carers have benefitted from involvement activities and undertaking a leadership programme • How the Trust is listening to carers • New ways of working in mental health - a consultant's perspective • Re-development of Springwood Unit at Malton Hospital providing complex care for older people's services • The 'TEWV' brand – What does TEWV mean to you?	**46**
04/07/2012	**Hambleton and Richmondshire**	• Patient Advice and Liaison Service (PALs) • Involvement – What is it? • How the Trust gains valuable feedback from service users and carer • Your local public Governors • Adult mental health community team • Learning disability services – role of health facilitation • Children and adolescent mental health services (CAMHS) • Mental health services for older people • What it means to become a carer	**54**
08/11/2012	**County Durham and Darlington**	• Expansion of the psychiatric liaison service in Durham and Darlington hospitals for older people and working age adults • How service users and carers have benefitted from Involvement activities • Early intervention into psychosis service • Your local Governors	**79**
21/03/2013	**Teesside**	• The psychiatric liaison service in Teesside working in the acute hospitals, people's own homes and residential care homes • Service users and carers inspecting our hospitals against the Essential Standards of Care developed by the Care Quality Commission • The Trust gaining feedback on its services from service users and carers and what this is telling us • Mental health professionals and the police delivering 'street triage' to deliver timely intervention for mental ill health • Improvements being made to ensure children and young people and their families gain easier access to services at the time that they need it • Gaining access to our self referral service 'TalkingTherapies@ TEWV' and how psychological therapies can help	**86**
All engagement activity is monitored through the Making the Most of Membership Committee.			

Financial Review 2012-13

Summary of Financial Performance

In 2012-13 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 2012-13 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 £5.6m for the financial year and achieved £6.0m.

Total CRES achieved at 31 March 2013 was £8.7m and was in line with plan, all CRES achieved was recurrent and the Trust is making good progress with future years plans.

Income Growth
The Trust's growth in income was mainly due to gains on the revaluation of buildings, and the full year effect of providing mental health and LD services into Craven, Harrogate and Hambleton & Richmondshire localities. In addition the Trust expanded its forensic service, opening additional capacity throughout quarters 3 and 4 of 2012-13.

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	9.6%	4
EBIDTA % achieved	128.3%	5
Return on assets	6.9%	5
I & E surplus margin	5.2%	5
Liquidity days	36.5 days	4
Overall rating		5

2012-13 objectives

Objectives	Outcomes
Delivering a £5.6m financial surplus	**Financial surplus of £6.0m achieved**
Achieving a Monitor risk rating of 4	**Calculated risk rating of 5 achieved**
Delivery of £8.7m cash releasing efficiency savings	**Delivery of £8.7m cash releasing efficiency savings**
EBITDA margin of 7.7%	**EBITDA margin of 9.6% 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, £8.7m 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 2012-13, £15.4m was invested in capital assets.

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

	2012-13 £m
Investment in fixed assets	15.4
Disposal of unprotected assets	0.9

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.

Modern Equivalent Asset (MEA) Valuation
The Trust's land and buildings were subject to a revaluation 31 March 2013, which resulted in impairments as follows:

	2012-13 £m
Impairment losses	16.3
Impairment reversals	7.6
Total expense realised in SoCI	8.7

The impairment losses are recognised as expenditure, with reversals of prior impairments recognised as income.

Working Capital
Throughout the year the Trust had access to a committed working capital facility of £20.5m. This was not required during the year as the Trust had strong liquidity which improved further to 36.5 days 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 (2012-13) 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 2013-14 annual plan provides for a surplus of £3.5m (1.3% of turnover) and reflects a significant level of non-recurrent expenditure. The planned financial surplus for 2014-15 and 2015-16 improves as non-recurrent expenditure reduces. 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 Monitor's Code of Audit Practice. As far as the directors are aware, all relevant audit information has been fully disclosed to the auditor and no relevant audit information has been withheld or made unavailable. Nor have any undisclosed post balance sheet events occurred.

No political or charitable donations were made by the Trust during 2012-13.

Accounting policies for pensions and other retirement benefits are set out in page108 in the accounts and details of senior employees' remuneration can be found in page 112.

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

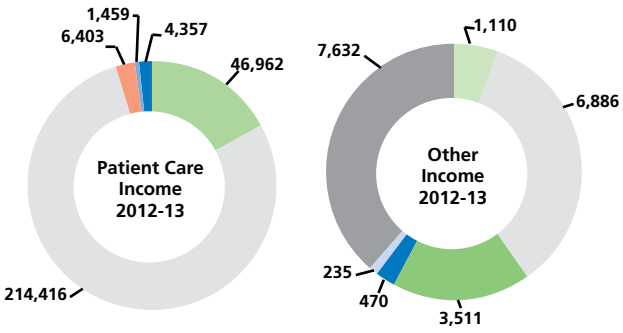
Better Payment Practice Code
The Better Payment Practice code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. Performance for the financial year 2012-13 was as follows:

	Year to Date	
	Number of Invoices	Value of invoices £000s
NHS Creditors		
Total bills paid	1215	15,458
Total bills paid within target	598	11,436
Percentage of bills paid within target	49.22%	73.99%
Non-NHS Creditors		
Total bills paid	57,225	77,833
Total bills paid within target	55,003	75,797
Percentage of bills paid within target	96.12%	97.38%

Income Generation
During 2012-13, income generated was £293.4m from a range of activities; 93.2% from direct patient care. Patient care income came from the following areas:

There is a further £19.8m from education, reversal of impairments and other non-patient care services.

As shown above, the Trust's income from the provision of goods and services for the purposes of the health service in the UK was greater than its income from the provision of goods and services for any other purposes.



Senior managers' remuneration & pension
Details of senior managers' remuneration and pension can be found on page 112 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 2012-13 4.89% of our total income was incurred on management costs, a reduction on 4.93% in 2011-12.

Martin Barkley
Chief Executive
28 May 2013

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 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
28 May 2013

Responsibilities of Directors for preparing the accounts

The Directors are required under the National Health Service Act 2006, and as directed by Monitor, 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 requirement in preparing the accounts.

Jo Turnbull
Chairman on behalf of the Board of Directors
28 May 2013

Annual Governance Statement 2012-13

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 on-going 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 2013 and up to the date of approval of the annual report and accounts.

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 and Assurance Committee (a 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
- To identify a 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; NHS Litigation Authority, Care Quality Commission, complaints management, litigation, staff surveys, task groups, Trust risk register, 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 risk standards prescribed by NHS Litigation Authority and has retained its level 2 status. In addition an Assurance Framework was in place at 31 March 2013 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:

In anticipation of the publication of the public inquiry into Mid Staffordshire NHS Foundation Trust the Trust implemented a process of Quality Impact Assessments (QIA). These are designed to assess and approve all CRES schemes for the impact they have on clinical performance, and ultimately, patient care.

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 2012-13 the Trust has strengthened and further embedded both its training provision and monitoring controls within its devolved information risk management framework.

A further review was completed during 2012-13 to improve the effectiveness of project management frameworks, ensuring all relevant information flows are captured.

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 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 on-going compliance with the requirements of the Department of Health Information Governance Assurance Programme. The Trust achieved an overall score of 85% (up from 84%) against the Information Governance Toolkit requirement in 2012/13 with all sequences achieving at least level 2. The Director of Nursing and Governance is the senior information risk owner (SIRO) at Board level. The Trust operates 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 is supported by an Information Governance Campaign to deliver information and training.

The Trust is fully registered with the Care Quality Commission.

As an employer with staff entitled to membership of the NHS Pension scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

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

The Foundation Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that the obligations of Tees, Esk & Wear Valleys NHS Foundation Trust under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

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

- Agreeing a rolling 3 year annual financial strategy and plan
- A rigorous process of setting annual budgets and a detailed cost improvement programme including a Quality Impact Assessment (QIA).
- 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 trust's 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
- Embedding the Quality Improvement Systems (QIS) methodology to review how the Trust operates, maximising efficiency and minimising waste.

The Board plays an active role by:

- Determining the level of financial performance it requires and the consequent implications (including QIA)
- Reviewing in detail each month financial performance, financial risk and delivery against the detailed Cost Improvement Programme
- Agreeing the Integrated Business Plan, Annual Plan, Quality Report 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 reports

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare a Quality Account 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 Account presents a balanced and accurate view:

- The Quality and Assurance Committee is responsible for producing the Quality Account with the Director of Nursing and Governance and the Director of Planning and Performance being lead directors. The Quality and Assurance Committee has received reports throughout the year regarding the development of the Quality Account, including an early draft.
- Priorities for improvement have been identified from an analysis of serious untoward incidents, complaints, as well as feedback from users and other stakeholders. These priorities have been shared with wider stakeholders for comment and were approved by the 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 responsibility for ensuring data quality within the Trust. The Executive Management team considers data quality on a monthly basis as part of a dedicated meeting concerned with performance. Furthermore data quality is also discussed at monthly performance meetings between the Director of Finance, Director of Planning and Performance and the Chief Operating Officer with each clinical directorate.
- Data quality is included within the corporate risk register which is used by the Board of Directors to monitor the risk of incomplete and inaccurate data.
- Significant assurance was provided by internal audit on the processes in place to accurately report the three performance indicators mandated by Monitor to be contained within the Quality Account.
- 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, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, Audit Committee, Quality and Assurance Committee and Mental Health Act (Legislation) Committee; and a plan to address weaknesses and ensure continuous improvement of the system is in place.

My review is also informed by

- The Care Quality Commission
- 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.
- It is the Council of Governors duty to hold the non-executive directors to account for the performance the Board of Directors, and to represent the interests of the public.
- The Audit 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 including reviewing and commentating on the clinical governance programme.
- The Quality and Assurance Committee oversees on behalf of the Board all clinical governance activity including a review of the clinical audit processes and programme.
- Internal Audit provides an independent and objective opinion on the degree to which risk management, control and governance support the achievement of the Trust's objectives. The Head of Internal Audit opinion provided significant assurance for this area, and all issues raised have been considered appropriately.
- 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 and Governance 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
28 May 2013

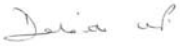
Independent auditors' report to Tees, Esk and Wear Valleys NHS Foundation Trust on the NHS Foundation Trust consolidation schedules

We have examined the NHS Foundation Trust consolidation schedules (FTCs) numbered 1 to 38 and 40 of Tees, Esk and Wear Valleys NHS Foundation Trust for the year ended 31 March 2013, which have been prepared by the Director of Finance and acknowledged by the Chief Executive.

This report is made solely to the Board of Tees, Esk and Wear Valleys NHS Foundation Trust in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006 (the Act) and for no other purpose. Our audit work has been undertaken so that we might state to the Board 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, in giving our opinion, accept or assume responsibility to anyone other than the Trust and the Board, as a body, for this report, or for the opinions we have formed.

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

As agreed with Monitor, in forming our opinion on whether the consolidation schedules are consistent with the statutory financial statements, we have not considered inconsistencies below the clearly trivial threshold of £250,000.

Signature: 

Date: 28 May 2013

Name of auditor/firm: Deloitte LLP
Address: Newcastle, UK

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 Tees, Esk and Wear Valleys NHS Foundation Trust for the year ended 31 March 2013 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Cash Flow Statement, 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.

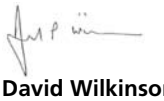
Scope of the audit of the financial statements
An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes 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 2013 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
28 May 2013

Financial statements

Statement of comprehensive income for 12 months ended 31 March 2013

	Note	12 months ended 31 March 2013	12 months ended 31 March 2012
		£000	£000
Revenue			
Income from activities	2	273,597	260,755
Other operating income	2	19,844	10,473
Total operating income		**293,441**	**271,228**
Operating expenses	3	(279,042)	(257,912)
Operating surplus		**14,399**	**13,316**
Finance costs:			
Finance income	8	329	357
Finance expense - financial liabilities	9	(5,223)	(5,035)
Finance expense - unwinding of discount on provisions		(21)	(19)
PDC dividends payable		(3,465)	(2,927)
Net Finance Costs		**(8,380)**	**(7,624)**
Surplus for the year		**6,019**	**5,692**
Other comprehensive income			
Impairments - property, plant and equipment		(350)	0
Revaluation gains - property, plant and equipment		10,339	0
Other reserve movements		0	0
Total comprehensive income for the year		**16,008**	**5,692**

Statement of financial position as at 31 March 2013

	Note	31 March 2013 £000	31 March 2012 £000
Non-current assets			
Property, plant and equipment	12	210,222	198,493
Trade and other receivables	22	56	59
Total non-current assets		**210,278**	**198,552**
Current assets			
Inventories	21	208	174
Trade and other receivables	22	4,029	4,641
Non current assets for sale and assets in disposal groups	18	3,000	3,180
Cash and cash equivalents	25	23,460	30,065
Total current assets		**30,697**	**38,060**
Current liabilities			
Trade and other payables	26	(18,976)	(24,157)
Borrowings	27	(2,109)	(2,125)
Provisions	31	(451)	(693)
Other liabilities	29	(560)	(4,788)
Total current liabilities		**(22,096)**	**(31,763)**
Total assets less current liabilities		**218,879**	**204,849**
Non-current liabilities			
Borrowings	27	(84,068)	(86,173)
Provisions	31	(1,068)	(960)
Total non-current liabilities		**(85,136)**	**(87,133)**
Total assets employed		**133,743**	**117,716**
Financed by taxpayers' equity			
Public dividend capital		143,840	143,821
Revaluation reserve	33	21,387	11,729
Statement of comprehensive income reserve		(31,484)	(37,834)
Total Taxpayers' Equity		**133,743**	**117,716**

The notes 1-44 form part of these financial statements.
The financial statements on pages 99-122 were approved by the Board and signed on its behalf by:

Martin Barkley
Chief Executive
28 May 2013

Statement of changes in taxpayers' equity

	Total	Public Dividend Capital (PDC)	Revaluation Reserve	Statement of Comprehensive Income Reserve
	£000	£000	£000	£000
Taxpayers' Equity at 1 April 2012	**117,716**	**143,821**	**11,729**	**(37,834)**
Surplus for the year	**6,019**	**0**	**0**	**6,019**
Transfers between reserves	**0**	0	(331)	331
Impairments	**(350)**	0	(350)	0
Revaluations	**10,339**	0	10,339	0
Public Dividend Capital received	**19**	19	0	0
Taxpayers' Equity at 31 March 2013	**133,743**	**143,840**	**21,387**	**(31,484)**

Taxpayers' Equity at 1 April 2011	**112,024**	**143,821**	**11,787**	**(43,584)**
Surplus for the year	**5,692**	**0**	**0**	**5,692**
Transfers between reserves	**0**	0	(58)	58
Other reserve movements	**117,716**	143,821	11,729	(37,834)

Statement of cash flows for 12 months ended 31 March 2013

	Note	12 months ended 31 March 2013 £000	12 months ended 31 March 2012 £000
Cash flows from operating activities			
Operating surplus from continuing operations		14,399	13,316
Operating surplus		**14,399**	**13,316**
Non-cash income and expense:			
Depreciation and amortisation		4,128	3,999
Impairments		16,385	5,668
Reversals of impairments		(7,632)	0
Loss on disposal of PPE		187	175
Loss on sale of assets held for sale		40	70
Profit on sale of assets held for sale		(235)	(73)
(Increase) / Decrease in trade and other receivables		637	(186)
(Increase) / Decrease in inventories		(34)	49
Increase/(Decrease) in trade and other payables		(3,058)	3,853
Increase / (Decrease) in other liabilities		(4,228)	156
Increase / (Decrease) in provisions		(155)	137
Net cash generated from operations		**20,434**	**27,164**
Cash flows from investing activities			
Interest received		329	372
Purchase of property, plant and equipment		(17,660)	(19,971)
Sales of property, plant and equipment		935	938
Net cash generated used in investing activities		**(16,396)**	**(18,661)**
Cash flows from financing activities			
Public dividend capital received		19	0
Capital element of Private Finance Initiative obligations		(2,121)	(2,053)
Interest element of Private Finance Initiative obligations		(5,217)	(4,972)
PDC dividend paid		(3,324)	(2,955)
Net cash generated used in financing activities		**(10,643)**	**(9,980)**
Decrease in cash and cash equivalents	**25**	**(6,605)**	**(1,477)**
Cash and cash equivalents at 1 April	**25**	**30,065**	**31,542**
Cash and cash equivalents at 31 March	**25**	**23,460**	**30,065**

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, which has been agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2012-13 NHS Foundation Trust Annual Reporting Manual issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

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

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

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

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 provisions 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.

A full MEA valuation was carried out on the Trusts land and buildings 31 March 2013, and the assets have been treat as prescribed in the FT Annual Reporting Manual (ARM). Accumulated depreciation on these assets has been written to zero, and the cost or valuation at 31 March 2013 amended to the MEA values to reflect this.

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 a condition 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.

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 2.8% to 2.2% 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 on-going 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 2013. 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 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, GP 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.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

(a) Accounting valuation
A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period.

Actuarial assessments are undertaken in intervening years between formal valuations using updated membership data and are accepted as providing suitably robust figures for financial reporting purposes.

The valuation of the scheme liability as at 31 March 2013 is based on the valuation data as 31 March 2012, updated to 31 March 2013 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

(b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

The Scheme Regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next formal valuation to be used for funding purposes will be carried out at as at March 2012 and will be used to inform the contribution rates to be used from 1 April 2015.

Scheme provisions
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. From 2011-12 the Consumer Price Index (CPI) will be used to replace the Retail Prices Index (RPI).

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

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

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 the employer."

Additional Voluntary Contributions (AVCs)
Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's 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 year's service they can preserve their accrued NHS pension for payment when they reach retirement age.

Operating segments
The Trust has no elements that require segmental analysis for the period ended 31 March 2013. The chief operating decision maker has been identified as the Executive Director Chief Operating Officer post within the Trust; and on this basis the Trust has identified healthcare as the single operating segment.

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

Note 2.1 Operating income (by classification)

	12 months ended 31 March 2013	12 months ended 31 March 2012
Income from activities	**£000**	**£000**
Cost and Volume Contract income	46,962	44,496
Block Contract income	214,416	203,631
Clinical Partnerships providing mandatory services (including S31 agreements)	6,403	5,114
Clinical income for the Secondary Commissioning of mandatory services	1,459	3,028
Other clinical income from mandatory services	4,357	4,486
Total income from activities	**273,597**	**260,755**
Other operating income		
Research and development	1,110	667
Education and training	6,886	6,174
Non patient care services to other bodies	3,275	2,787
Other revenue	470	273
Profit on disposal of assets held for sale	235	0
Profit on disposal of other tangible fixed assets	0	73
Reversal of impairments of property, plant and equipment	7,632	0
Income in respect of staff costs where accounted on gross basis	236	499
Total other operating income	**19,844**	**10,473**
Total operating income	**293,441**	**271,228**

Note 2.2 Private patient income
The Trust had no private patient income (2011-12, £nil)
The private patient income cap on NHS Foundation trusts was removed from 1 October 2012 by the Health & Social Care Act, and disclosures made in prior years are no longer required.
Note 2.3 Operating lease income
The Trust had no operating lease income (2011-12, £nil)
Note 2.4 Non NHS income
The Trust had Non NHS income totalling £16,313k (2011-12, £8,119k)

Note 2.5 Operating income (by type)

	12 months ended 31 March 2013 £000	12 months ended 31 March 2012 £000
Income from activities		
NHS Foundation Trusts	758	783
NHS Trusts	22	80
Strategic Health Authorities	229	67
Primary Care Trusts	264,931	252,892
Local Authorities	3,392	3,377
Department of Health - other	33	4
NHS Other	492	156
Non NHS Other	3,740	3,396
Total income from activities	**273,597**	**260,755**
Other operating income		
Research & Development	1,110	667
Education and training	6,886	6,174
Non-patient care services to other bodies	3,275	2,787
Other	470	273
Profit on disposal of assets held for sale	235	0
Profit on disposal of other tangible fixed assets	0	73
Reversal of impairments of property, plant and equipment	7,632	0
Income in respect of staff costs where accounted on gross basis	236	499
Total other operating income	**19,844**	**10,473**
Total operating income	**293,441**	**271,228**
Analysis of income from activities - non NHS other		
Other government departments and agencies	538	553
Other	3,202	2,843
	3,740	3,396
Analysis of other operating income - other		
Catering	123	27
Rental income	100	100
Other	247	146
	470	273

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 2013	12 months ended 31 March 2012 As restated
	£000	£000
Services from NHS Foundation Trusts	4,351	4,104
Services from NHS Trusts	0	41
Services from PCTs	377	630
Purchase of healthcare from non NHS bodies	1,844	1,760
Executive directors costs	1,331	1,385
Non-executive directors costs	163	152
Staff costs	208,217	198,202
Supplies and services - clinical (excluding drug costs)	1,627	1,511
Supplies and services - general	3,485	3,311
Establishment	7,110	7,062
Research and development - (Not included in employee expenses)	600	508
Research and development - (Included in employee expenses)	716	444
Transport	432	546
Premises	13,608	12,847
Increase in bad debt provision	126	28
Drug costs	3,565	4,069
Inventories consumed (excluding drugs)	174	223
Rentals under operating leases - minimum lease receipts	5,568	6,079
Depreciation on property, plant and equipment	4,128	3,999
Impairments of property, plant and equipment	16,345	5,558
Impairments of assets held for sale	40	110
Audit fees		
audit services - statutory audit	74	66
audit services - regulatory reporting	0	18
Clinical negligence	557	499
Loss on disposal of other property, plant and equipment	187	245
Loss on disposal of assets held for sale	40	0
Legal fees	556	584
Consultancy costs	881	689
Training courses and conferences	1,598	1,244
Patient travel	65	66
Redundancy - (Not included in employee expenses)	167	269
Redundancy - (Reversal of unused provision)	(139)	0
Hospitality	138	169
Insurance	108	70
Other services, eg external payroll	225	218
Losses, ex gratia & special payments- (Not included in employee expenses)	142	492
Other	636	714
Total operating expenses	**279,042**	**257,912**

Analysis of operating expenses - other

Services from local authorities	232	228
Other patients' expenses	224	243
CQC and accreditation fees	85	90
Miscellaneous	95	153
	636	**714**

Note 4.1 Employee expenses

	12 months ended 31 March 2013			12 months ended 31 March 2012		
	Total	Permanently Employed	Other			
	£000	£000	£000	£000	£000	£000
Salaries and wages	173,416	162,114	11,302	166,017	155,734	10,283
Social security costs	13,239	12,302	937	11,899	11,061	838
Pension costs - defined contribution plans (Employers contributions to NHS Pensions)	20,579	19,268	1,311	19,621	18,448	1,173
Agency/contract staff	3,969	0	3,969	3,058	0	3,058
Gross employee expenses	**211,203**	**193,684**	**17,519**	**200,595**	**185,243**	**15,352**
less income in respect of salaries and wages where netted off expenditure	(650)	(650)	0	(271)	(271)	0
Total employee expenses	**210,553**	**193,034**	**17,519**	**200,324**	**184,972**	**15,352**
of which:						
Costs capitalised as part of assets	289	289	0	294	294	0
Analysed into Operating Expenditure:						
Employee Expenses - Staff	208,217	190,896	17,321	198,201	183,043	15,158
Employee Expenses - Executive directors	1,331	1,331	0	1,385	1,385	0
Research & development	716	518	198	444	250	194
Total employee expenses exc.capitalised costs	**210,264**	**192,745**	**17,519**	**200,030**	**184,678**	**15,352**

The salary costs of the capital development team are capitalised over the full costs of the Trust's capital schemes, of which in 2012-13 the largest was Roseberry Park hospital. 2011/12 employee expenses has been amended to better reflect the nature of staff costs incurred, with £5,041k moving from agency/contract to salaries and wages relating to bank and social care staff

Note 4.2 Average number of employees (WTE Basis)

	12 months ended 31 March 2013			12 months ended 31 March 2012		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
	Number	Number	Number	Number	Number	Number
Medical and dental	279	254	25	273	253	20
Administration and estates	991	928	63	940	890	50
Healthcare assistants and other support staff	281	277	4	290	282	8
Nursing, midwifery and health visiting staff	3,270	3,211	59	3,140	3,091	49
Scientific, therapeutic and technical staff	593	521	72	540	471	69
Social care staff	39	0	39	43	0	43
Bank and agency staff	310	0	310	283	0	283
Total	**5,763**	**5,191**	**572**	**5,509**	**4,987**	**522**

Note 4.3 Early retirements due to ill health

During the period to 31 March 2013 there were 22 (2011-12,14) early retirements from the Trust on the grounds of ill-health. The estimated additional pension liabilities of the ill-health retirement will be £1,335,184 (2011-12, £998,347). The cost of this ill-health retirement will be borne by the NHS Business Services Authority - Pension Division.

Note 4.4 Analysis of termination benefits

There were 3 payments for termination benefits valuing £167,000 during the period to March 2013, all relating to redundancy (2011-12, 6 payments valuing £269,000)

Note 4.5 Cost of exit packages

	12 months ended 31 March 2013			12 months ended 31 March 2012		
Exit Package Cost	**Total number**	**Compulsory Redundancies number**	**Other Departures number**	**Total number**	**Compulsory Redundancies number**	**Other Departures number**
<10,000	1	1	0	1	0	1
£10,001 - £25,000	1	1	0	1	0	1
£25,001 - 50,000	0	0	0	1	0	1
£50,001 - £100,000	0	0	0	4	0	4
£100,001 - £150,000	1	1	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0
Total number of exit packages	3	3	0	7	0	7
Total resource cost (£000's)	**167**	**167**	**0**	**269**	**0**	**269**

Note 4.6 Analysis of off-payroll engagements

There were no off-payroll engagements at a cost of over £58,200 per annum that were in place as at 31 January 2012

There were no new off-payroll engagements between 23 August 2012 and 31 March 2013, for more than £220 per day and more than 6 months.

Note 4.7 Senior managers' remuneration

	2012-13					2011-12				
	Salary	Other Remuneration	Benefits in Kind *	Total Remuneration	Expenses Paid	Salary	Other Remuneration	Benefits in Kind *	Total Remuneration	Expenses Paid
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	(bands of £5000) £000	Rounded to the nearest £100	(bands of £5000) £000	(bands of £5000) £000
Mr Martin Barkley, Chief Executive	180-185	0	0	180-185	4,100	150-155	0	0	150-155	3,100
Mr Colin Martin, Director of Finance	120-125	0	8,900	125-130	0	115-120	0	8,000	125-130	0
Dr Nick Land, Medical Director	35-40	165-170 **	7,100	205-210	300	35-40	160-165 **	3,100	195-200	2,000
Mr David Levy, Director of Human Resources and Organisational Development	105-110	0	0	105-110	500	100-105	0	0	100-105	1,500
Mrs Chris Stanbury, Director of Nursing and Governance	105-110	0	2,100	110-115	300	105-110	0	2,200	105-110	100
Mr Chris Parsons, Director of Estates and Facilities – left 28 February 2013	80-85	0	3,100	85-90	0	90-95	0	3,500	95-100	200
Mrs Sharon Pickering, Director of Planning and Performance	90-95	0	4,900	95-100	0	90-95	0	4,600	95-100	0
Mr Les Morgan, Chief Operating Officer – left 1 July 2012	25-30	0	0	25-30	300	110-115	0	100	110-115	700
Dr Ruth Briel, Acting Chief Operating Officer – started 1 June 2012, left 11 March 2013; now Senior Clinical Director KPO – started 12 March 2013	70-75	15-20***	0	90-95	4,400	0	0	0	0	0
Mr Brent Kilmurray, Chief Operating Officer – started 11 February 2013	15-20	0	0	15-20	0	0	0	0	0	0
Mr Paul Newton, Director of Operations - County Durham and Darlington	90-95	0	1,100	95-100	400	85-90	0	6,600	95-100	0
Mr David Brown, Director of Operations – Teesside	90-95	0	1,800	95-100	0	85-90	0	2,900	90-95	1,800
Mrs Lesley Crawford, Service Director Adult Services – left 31 May 2011	0	0	0	0	0	10-15	0	200	10-15	0
Mr Levi Buckley, Director of Operations – Forensic Services – started 1 June 2011	75-80	0	0	75-80	600	60-65	0	0	60-65	4,200
Mrs Adele Coulthard, Director of Operations – North Yorkshire – started 1 October 2011	80-85	0	0	80-85	3,000	35-40	0	0	35-40	0
Mrs Jo Turnbull, Chairman	40-45	0	0	40-45	7,000	40-45	0	0	40-45	6,600
Mr Andrew Lombard, Non-Executive Director	15-20	0	0	15-20	3,000	15-20	0	0	15-20	3,400
Mrs Barbara Matthews, Non-Executive Director	10-15	0	0	10-15	2,100	10-15	0	0	10-15	2,800
Mr Mike Newell, Non-Executive Director	10-15	0	0	10-15	1,300	10-15	0	0	10-15	1,600
Mr John Robinson, Non-Executive Director	10-15	0	0	10-15	2,100	10-15	0	0	10-15	2,100
Mr Graham Neave, Non-Executive Director	10-15	0	0	10-15	0	10-15	0	0	10-15	0
Mr Jim Tucker, Non-Executive Director	10-15	0	0	10-15	2,800	10-15	0	0	10-15	2,100
Mr Douglas Taylor, Non-Executive Director	15-20	0	0	15-20	4,400	15-20	0	0	15-20	3,500
	Band of highest paid directors total remuneration (£000) ****				180-185	Band of highest paid directors total remuneration (£000) ***				150-155
	Median of total remuneration				25,784	Median of total remuneration				25,528
	Ratio (Director to Median)				6.8	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 (including on-call) plus an additional 2 Additional Clinical Programmed Activities worked during the reported period (For which £28k was paid during 2012-13 (£27k for 2011-12) & Clinical Excellence award

*** Other remuneration includes an Additional Clinical Programmed Activity worked during the reported period (For which £6k was paid during 2012-13) & 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.

Expenses of Governors

The total amount reimbursed in 2012-13 as expenses to Governors was £9,411, (£5,635 in 2011-12)

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

Martin Barkley
Chief Executive
28 May 2013

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 2013 (bands of £5000) £000	Lump sum at age 60 related to accrued pension at 31 March 2013 (bands of £5000) £000	Cash Equivalent Transfer Value at 31 March 2013 £000	Cash Equivalent Transfer Value at 31 March 2012 £000	Real Increase in Cash Equivalent Transfer Value £000
Mr Martin Barkley, Chief Executive	10.0-12.5	30.0-32.5	85-90	265-270	2,003	1,686	317
Mr Colin Martin, Director of Finance	(0.0-2.5)	(0.0-2.5)	35-40	115-120	669	660	9
Dr Nick Land, Medical Director	2.5-5.0	7.5-10.0	65-70	200-205	1,249	1,157	92
Mr Les Morgan, Chief Operating Officer – left 1 July 2012	2.5-5.0	10.0-12.5	55-60	165-170	1,099	991	108
Dr Ruth Briel, Acting Chief Operating Officer – started 1 June 2012, left 11 March 2013; now Senior Clinical Director KPO – started 12 March 2013	2.5-5.0	12.5-15.0	25-30	85-90	513	415	98
Mr Brent Kilmurray, Chief Operating Officer – started 11 February 2013	0.0-2.5	0.0-2.5	20-25	70-75	339	329	1
Mrs Chris Stanbury, Director of Nursing and Governanc	(0.0-2.5)	(2.5-5.0)	50-55	150-155	1,004	991	13
Mr David Levy, Director of Human Resources and Organisational Development	0.0-2.5	0.0-2.5	20-25	60-65	399	384	15
Mrs Sharon Pickering, Director of Planning and Performance	(0.0-2.5)	(0.0-2.5)	25-30	80-85	418	410	8
Mr Chris Parsons, Director of Estates and Facilities – retired 28 February 2013	-	-	-	-	0	454	(454)
Mr Paul Newton, Director of Operations - County Durham and Darlington	0.0-2.5	0.0-2.5	45-50	140-145	894	862	32
Mr David Brown, Director of Operations – Teesside	0.0-2.5	0.0-2.5	30-35	90-95	600	561	39
Mr Levi Buckley, Director of Operations – Forensic Services	0.0-2.5	2.5-5.0	15-20	50-55	242	221	21
Mrs Adele Coulthard, Director of Operations – North Yorkshire	0.0-2.5	0.0-2.5	20-25	70-75	386	372	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.

Chris Parsons retired and claimed pension in February 2013 before returning to work - this is the reason increases and acrrued amounts are shown as zero

The reason for the negative increase in pension and lump sum for three of the senior managers is due to the inflation factor used (5.2%) being higher than the percentage growth in benefits. The negative increase in CETV is because this director has flexibly retired 28th February, though returned to work 1st April 2013.

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.

Brent Killmurrays real increase in CETV is adjusted to reflect his starting date with the trust.

Martin Barkley
Chief Executive
28 May 2013

Note 5.1 Operating leases

	12 months ended 31 March 2013 £000	12 months ended 31 March 2012 £000
Minimum lease payments	5,568	6,079
Total	**5,568**	**6,079**

Note 5.2 Arrangements containing an operating lease

	12 months ended 31 March 2013 £000	12 months ended 31 March 2012 £000
Future minimum lease payments due:		
not later than one year	4,626	5,265
later than one year and not later than five years	4,853	7,650
later than five years	1,963	3,131
Total	**11,442**	**16,046**

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

Note 5.3 Limitation on auditor's liability

There is no specified limitation stated in the engagement letter of the Trust's auditors.

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

Note 6 Discontinued operations
The Trust has no discontinued operations at 31 March 2013 (31 March 2012, £nil).

Note 7 Corporation tax
The Trust has no Corporation Tax liability or asset at 31 March 2013 (31 March 2012, £nil).

Note 8 Finance income

	12 months ended 31 March 2013	12 months ended 31 March 2012
	£000	£000
Bank deposits	329	357
Total	**329**	**357**

Note 9 Finance costs - interest expense

	12 months ended 31 March 2013	12 months ended 31 March 2012
	£000	**£000**
Other	88	23
Finance costs in PFI obligations		
Main finance cost	5,135	5,012
Total	**5,223**	**5,035**

Other finance costs for 2012-13 are £88,000 relating to a change in the discount rate of provisions, in 2011-12 this was £23,000.

Note 10 Impairment of assets

	12 months ended 31 March 2013	12 months ended 31 March 2012
	£000	**£000**
Changes in market price	16,735	5,668
Reversal of impairments	(7,632)	0
Total impairments	**9,103**	**5,668**

Note 11 Intangible assets
The Trust has no intangible assets as at 31 March 2013 (31 March 2012, £nil).

Note 12.1 Property, plant and equipment 2012-13

	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 2012	**314,271**	**49,827**	**237,855**	**196**	**14,437**	**2,696**	**327**	**6,617**	**2,316**
Additions purchased	15,368	0	11,120	0	4,100	148	0	0	0
Impairments	(350)	(294)	(56)	0	0	0	0	0	0
Reclassifications	0	0	13,798	0	(13,798)	0	0	0	0
Revaluations	(106,911)	(38,098)	(68,617)	(196)	0	0	0	0	0
Transfers to/from assets held for sale and assets in disposal groups	(600)	0	(600)	0	0	0	0	0	0
Disposals	(187)	0	(187)	0	0	0	0	0	0
Cost or valuation at 31 March 2013	**221,591**	**11,435**	**193,313**	**0**	**4,739**	**2,844**	**327**	**6,617**	**2,316**
Accumulated depreciation at 1 April 2012	**115,778**	**35,997**	**68,565**	**196**	**0**	**2,515**	**257**	**6,294**	**1,954**
Provided during the year	4,128	0	3,779	0	0	74	12	123	140
Impairments	16,345	2,119	14,226	0	0	0	0	0	0
Reversal of impairments	(7,632)	(18)	(7,614)	0	0	0	0	0	0
Revaluations	(117,250)	(38,098)	(78,956)	(196)	0	0	0	0	0
Accumulated depreciation at 31 March 2013	**11,369**	**0**	**0**	**0**	**0**	**2,589**	**269**	**6,417**	**2,094**

Note 12.2 Property, plant and equipment 2011-12

	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 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**
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 12.3 Property, plant and equipment financing

Net book value - 31 March 2013	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
Owned	111,873	11,435	94,964	0	4,739	255	58	200	222
PFI	98,107	0	98,107	0	0	0	0	0	0
Donated	242	0	242	0	0	0	0	0	0
Net book value total at 31 March 2013	**210,222**	**11,435**	**193,313**	**0**	**4,739**	**255**	**58**	**200**	**222**
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**

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 - 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 15.2 Analysis of property, plant and equipment - 31 March 2013

	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	200,614	11,395	189,219	0	0	0	0	0	0
NBV - Unprotected assets	9,608	40	4,094	0	4,739	255	58	200	222
Total at 31 March 2013	**210,222**	**11,435**	**193,313**	**0**	**4,739**	**255**	**58**	**200**	**222**

Note 15.3 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 15.4 NBV of property, plant and equipment in the Revaluation Reserve as at 31 March 2013

	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 2012	11,729	1,308	10,421	0	0	0	0	0	0
movement in year	9,658	(375)	10,033	0	0	0	0	0	0
as at 31 March 2013	**21,387**	**933**	**20,454**	**0**	**0**	**0**	**0**	**0**	**0**

Note 16 Investments
The Trust holds no investments as at 31 March 2013 (31 March 2012, £nil).

Note 17 Associate and jointly controlled operations
The Trust has no investments in associate (and joined controlled operations) as at 31 March 2013 (31 March 2012, £nil).

Note 18.1 Non current assets for sale and assets in disposal groups 2012-13

	Total	Property, Plant & Equipment
	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 31 March 2012	3,180	3,180
Plus assets classified as available for sale in the year	600	600
Less assets sold in year	(740)	(740)
Less impairment of assets held for sale	(40)	(40)
NBV of non-current assets for sale and assets in disposal groups at 31 March 2013	**3,000**	**3,000**

Assets Held for Sale

Note 18.2 Non current assets for sale and assets in disposal groups 2011-12

	Total	Property, Plant & Equipment
	£000	£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 18.3 Liabilities disposal groups
The Trust has no liabilities in disposal groups as at 31 March 2013 (31 March 2012, £nil).

Note 19 Other assets
The Trust has no other assets as at 31 March 2013 (31 March 2012, £nil).

Note 20 Other financial assets
The Trust has no other financial assets as at 31 March 2013 (31 March 2012, £nil).

Note 21.1 Inventories

	31 March 2013	31 March 2012
	£000	£000
Carrying Value at 1 April	174	223
Additions	208	174
Inventories recognised in expenses	(174)	(223)
Carrying Value at 31 March 2013	**208**	**174**

Note 22 Trade receivables and other receivables

	31 March 2013	31 March 2012
	£000	£000
Current		
NHS receivables	788	1,239
Other receivables with related parties	310	440
Provision for impaired receivables	(197)	(159)
Prepayments	1,941	1,913
PFI Prepayments		
Prepayments - lifecycle replacements	198	110
Accrued income	25	151
PDC dividend receivable	0	66
VAT receivable	591	546
Other trade receivables	373	335
Total current trade and other receivables	**4,029**	**4,641**
Non Current		
Other trade receivables	56	59
Total non current trade and other receivables	**56**	**59**

Note 23.1 Provision for impairment of receivables

	31 March 2013	31 March 2012
	£000	£000
At 1 April	159	339
Increase in provision	196	152
Amounts utilised	(88)	(208)
Unused amounts reversed	(70)	(124)
At 31 March	**197**	**159**

Note 23.2 Analysis of impaired receivables

	31 March 2013	31 March 2013	31 March 2012	31 March 2012
	£000	£000	£000	£000
Ageing of impaired receivables	**Trade receivables**	**Other receivables**	**Trade receivables**	**Other receivables**
0 - 30 days	63	0	40	0
30-60 Days	0	0	21	0
60-90 days	0	0	18	0
90- 180 days	26	0	41	0
over 180 days	108	0	39	0
Total	**197**	**0**	**159**	**0**
Ageing of non-impaired receivables past their due date				
0 - 30 days	587	208	430	201
30-60 Days	170	3	130	1
60-90 days	54	2	71	3
90- 180 days	40	82	200	6
over 180 days	13	19	57	33
Total	**864**	**314**	**888**	**244**

Note 24 Finance leases
The Trust does have any finance lease obligations other than PFI commitments.

Note 25.1 Cash and cash equivalents

	31 March 2013	31 March 2012
	£000	£000
At 1 April	30,065	31,542
Net change in year	(6,605)	(1,477)
At March	**23,460**	**30,065**
Broken down into:		
Commercial banks and cash in hand	10	95
Cash with Government Banking Service	23,450	29,970
Cash and cash equivalents as in SoFP	**23,460**	**30,065**
Bank overdraft	0	0
Cash and cash equivalents as in SoCF	**23,460**	**30,065**

Note 25.2 Third party assets held

	31 March 2013	31 March 2012
	£000	£000
At 1 April	**1,560**	**1,490**
Gross inflows	3,018	2,898
Gross Outflows	(2,909)	(2,828)
At 31 Mar / 31 Mar	**1,669**	**1,560**

Note 26.1 Trade and other payables

	31 March 2013	31 March 2012
Current	**£000**	**£000**
NHS payables	295	3,267
Amounts due to other related parties - revenue	2,924	2,524
Other trade payables - capital	1,198	3,402
Other trade payables - revenue	3,028	3,836
Social Security costs	2,110	2,038
VAT payable	47	31
Other taxes payable	2,095	2,126
Other payables	7	2
Accruals	7,197	6,931
PDC dividend payable	75	0
Total current trade and other payables	**18,976**	**24,157**

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 2013 (2011-12, £nil).

Note 27 Borrowings

	31 March 2013	31 March 2012
Current	**£000**	**£000**
Obligations under Private Finance Initiative contracts	2,109	2,125
Total current borrowings	**2,109**	**2,125**
Non current		
Obligations under Private Finance Initiative contracts	84,068	86,173
Total other non-current liabilities	**84,068**	**86,173**

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 2013	31 March 2012
	£000	£000
Long term borrowing limit set by Monitor as at 1 April	89,900	89,900
Net change in long term borrowing limit agreed by Monitor in year	0	0
Long term borrowing limit set by Monitor as at 31 Dec	**89,900**	**89,900**
Working Capital Facilty limit set by Monitor as at 1 April	20,500	20,500
Net change in working capital factility limit agreed by Monitor in year	0	0
Working Capital Factilty limit set by Monitor as at 31 Dec	**20,500**	**20,500**
Total Prudential Borrowing Limit	**110,400**	**110,400**
Borrowing (as defined in the Prudential Borrowing Code) at 1 April	88,298	87,640
Net actual borrowing/(repayment) in year	(2,121)	658
Long term borrowing at 31 March	**86,177**	**88,298**
Working capital borrowing at 1 April	0	0
Net actual borrowing/(repayment) in year - working capital	0	0
Working Capital borrowing at 31 March	**0**	**0**

Note 28.2 Prudential borrowing limit ratios

	Threshold	31 March 2013
Minimum dividend cover	>1x	6.4x
Minimum interest cover	>2x	5.2x
Minimum debt service cover	>1.5x	3.8x
Maximum debt service to revenue	<10%	2.54%

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 2013	31 March 2012
	£000	£000
Current		
Deferred income	560	4,788
Total other current liabilities	**560**	**4,788**

Note 30 Other financial liabilities
The Trust has no other financial liabilities at 31 March 2013 (31 March 2011-31 March 2012, £nil).

Note 31.1 Provisions for liabilities and charges - 2012-13

	Total	Pensions other staff	Legal claims	Restructuring	Other
	£000	£000	£000	£000	£000
At 1 April 2012	**1,653**	**1,008**	**325**	**145**	**175**
Change in the discount rate	88	88	0	0	0
Arising during the year	459	134	186	139	0
Utilised during the year	(495)	(129)	(191)	0	(175)
Reversed unused	(207)	0	(68)	(139)	0
Unwinding of discount	21	21	0	0	0
At 31 March 2013	**1,519**	**1,122**	**252**	**145**	**0**
Expected timing of cash flows:					
not later than one year	451	54	252	145	0
Current	**451**	**54**	**252**	**145**	**0**
later than one year and not later than five years	214	214	0	0	0
later than five years	854	854	0	0	0
Non Current	**1,068**	**1,068**	**0**	**0**	**0**
TOTAL	**1,519**	**1,122**	**252**	**145**	**0**

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 - £10,000 (2011-12, £50,000), employer / public liability claims notified by the NHS Litigation Authority £206,693 (2011-12, £200,200), and the provision for employment law £35,000 (2011-12, £74,822).

Included in the 'restructuring' category and arising during the period is a provision for organisational change, 'other' provisions utilised during the year related to the transfer of equipment.

Note 31.2 Provisions for liabilities and charges - 2011-12

	Total	Pensions other staff	Legal claims	Restructuring	Other
	£000	£000	£000	£000	£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 Expected timing of cash flows: 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**

Note 31.3 NHSLA provisions for liabilities and charges
£2,454,000 (2011-12, £3,246,000) is included in the provisions of the NHS Litigation Authority at 31 March 2013 in respect of clinical negligence liabilities of the NHS Foundation Trust.

Note 32.1 Contingent liabilities

	31 March 2013	31 March 2012
	£000	£000
Gross value of contingent liabilities	162	135
Net value of contingent liabilities	**162**	**135**

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 2013 (31 March 2012, £nil)

Note 33 Revaluation reserve

	31 March 2013	31 March 2012
	£000	£000
Revaluation reserve at 1 April	**11,729**	**11,787**
Impairments	(350)	0
Revaluations	10,339	0
Transfers to other reserves	(331)	(58)
Revaluation reserve at 31 March	**21,387**	**11,729**

Note 34.1 Related Party Transactions

	Income	Expenditure
2012-2013	**£000**	**£000**
Value of transactions with board members in 2012-2013	0	0
Value of transactions with key staff members in 2012-2013	0	0
Value of transactions with other related parties in 2012-2013		
Department of Health	582	0
Other NHS Bodies	276,545	7,600
Other	4,328	38,854
Total	**281,455**	**46,454**
2011-2012		
Value of transactions with board members in 2011-2012	0	0
Value of transactions with key staff members in 2011-2012	0	0
Value of transactions with other related parties in 2011-2012		
Department of Health	152	1,488
Other NHS Bodies	262,957	7,491
Other	4,436	44,652
Total	**267,545**	**53,631**

Note 34.2 Related Party Balances

	Receivables	Payables
2012-2013	**£000**	**£000**
Value of balances (other than salary) with board members in 2012-2013	0	0
Value of balances (other than salary) with key staff members in 2012-2013	0	0
Value of balances (other than salary) with related parties in relation to doubtful debts at 31 March 2013	177	0
Value of balances with other related parties at 31 March 2013		
Department of Health	0	75
Other NHS Bodies	626	470
Other	710	8,316
Total	**1,513**	**8,861**
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	114	47
Other NHS Bodies	1,240	7,063
Other	883	7,970
Total	**2,396**	**15,080**

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 (total transactions greater than £30k) with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

South Tees Hospitals NHS Foundation Trust
County Durham And Darlington NHS Foundation Trust
Harrogate And District NHS Foundation Trust
North Tees And Hartlepool NHS Foundation Trust
North East Ambulance Service NHS Foundation Trust
Northumberland, Tyne And Wear NHS Foundation Trust
York Hospitals NHS Foundation Trust
Leeds Partnership NHS Foundation Trust
South Staffordshire Healthcare NHS Foundation Trust
South London And Maudsley NHS Foundation Trust
Nottinghamshire Healthcare NHS Trust
Scarborough And North East Yorkshire NHS Trust
Northumbria Healthcare NHS Foundation Trust
Newcastle Upon Tyne Hospitals NHS Foundation Trust
Airedale NHS Foundation Trust
County Durham PCT
North Tyneside PCT
North Yorkshire And York PCT
Middlesbrough PCT
Redcar And Cleveland PCT
Stockton-On-Tees Teaching PCT
Darlington PCT
Hartlepool PCT
Barnsley PCT
Leeds PCT
Sunderland Teaching PCT
South Tyneside PCT
Western Cheshire PCT
Gateshead PCT
East Lancashire Teaching PCT
Brighton And Hove City Teaching PCT
Derbyshire County PCT
Newcastle PCT
North East Strategic Health Authority
Yorkshire and The Humber Strategic Health Authority
NHS Business Services Authority
NHS Litigation Authority
National Treatment Agency
Department of Health

There were another 56 organisations for which the Department is regarded as the parent Department that Tees, Esk and Wear Valleys NHS Foundation Trust had transaction with, which do not meet the materiality threshold.

In addition, the Trust has had a number of material transactions (total transactions greater than £30k) with other Government Departments and other central and local Government bodies. These transactions have been with:

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

There were another 10 other Government Departments and other central and local Government bodies that Tees, Esk and Wear Valleys NHS Foundation Trust had transaction with, which do not meet the materiality threshold.

Note 35 Contractual capital commitments

	31 March 2013	31 March 2012
	£000	£000
Property, plant and equipment	9,205	4,108
Total as at 31 March	**9,205**	**4,108**

Note 35.2 Other Financial Commitments

The Trust has no other financial commitments as at 31 March 2013 (31 March 2012, £nil).

Note 36 Finance lease obligations
The Trust has no finance obligations as at 31 March 2013 (31 March 2012, £nil).

Note 37.1 PFI obligations (on Statement of Financial Position)

	31 March 2013 Total	31 March 2013 Lanchester Rd PFI	31 March 2013 Roseberry Park PFI	31 March 2012 Total
	£000	£000	£000	£000
Gross PFI liabilities	**222,070**	**44,216**	**177,854**	**227,627**
of which liabilities are due				
not later than one year	7,343	1,437	5,906	7,271
later than one year and not later than five years	30,872	5,944	24,928	30,078
later than five years	183,855	36,835	147,020	190,278
Finance charges allocated to future periods	(135,893)	(27,674)	(108,219)	(139,329)
Net PFI liabilities	**86,177**	**16,542**	**69,635**	**88,298**
not later than one year	2,109	450	1,659	2,126
later than one year and not later than five years	9,355	1,896	7,459	8,996
later than five years	74,713	14,196	60,517	77,176
	86,177	**16,542**	**69,635**	**88,298**

Note 37.2 On SoFP PFI commitments

	31 March 2013 Total	31 March 2013 Lanchester Rd PFI	31 March 2013 Roseberry Park PFI	31 March 2012 Total
Commitments	**£000**	**£000**	**£000**	**£000**
Within one year	2,238	331	1,907	2,157
2nd to 5th years (inclusive)	9,665	1,409	8,256	9,314
Later than 5 years	79,435	10,133	69,302	81,490
Total	**91,338**	**11,873**	**79,465**	**92,961**

Note 38 Off-SoFP PFIs commitments
The Trust has no off-SoFP PFIs as at 31 March 2013 (31 March 2012, £nil).

Note 39 Events after the reporting period

The Trust is expecting to complete the transfer of assets from PCT's with an estimated value of £5,385k. The transfer is not yet complete due to national delays, though is expected to be actioned with effect 01 April 2013 (2011/2012, none).

Note 40.1 Financial assets by category

	Total	Loans and receivables
Assets as per SoFP	**£000**	**£000**
NHS Trade and other receivables excluding non financial assets (at 31 March 2013)	1,982	1,982
Cash and cash equivalents at bank and in hand (at 31 March 2013)	23,460	23,460
Total at 31 March 2013	**25,442**	**25,442**
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**

Note 40.2 Financial liabilities by category

	Total	Other financial liabilities
	£000	**£000**
NHS Trade and other payables excluding non financial assets (at 31 March 2013)	14,418	14,418
Provisions under contract (at 31 March 2013)	1,519	1,519
Total at 31 March 2013	**15,937**	**15,937**
NHS Trade and other payables excluding non financial assets (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**

Note 40.3 Fair values of financial assets at 31 March 2013

	Book Value	Fair Value
	£000	**£000**
Non current trade and other receivables excluding non financial assets	56	56
Total	**56**	**56**

Note 40.4 Fair values of financial liabilities at 31 March 2013

	Book Value	Fair Value
	£000	**£000**
Provisions under contract	1,068	1,068
Total	**1,068**	**1,068**

Note 40.5 Maturity of Financial liabilities

	31 March 2013	31 March 2012
	£000	**£000**
In one year or less	14,870	20,685
In more than one year but not more than two years	53	48
In more than two years but not more than five years	160	145
In more than five years	854	768
Total	**15,937**	**21,646**

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 60 cases in the twelve months to the 31 March 2013 at a value of £5,000 (2011-12, 43 cases, value £265,000). The 2011-12 total includes 1 incident of fraud value £261k.

Note 43 Third party assets and liabilities

The Trust held £1,293,000 cash at bank and in hand at 31 March 2013 (31 March 2012, £1,260,000) 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 £376,000 cash at bank and in hand at 31 March 2013 (31 March 2012, £300,000) 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 2013.

Appendix 1: Summary of the actions in response to 69 local clinical audits (138 individual audits in total) reviewed in 2012/13

1 Infection Prevention And Control Audits (NB: 64 Individual Audits Completed)

Summary of Planned Actions

- All infection prevention and control audits are continuously monitored by the infection prevention and control team and required actions are implemented collaboratively by the clinical staff and infection prevention and control team.

2 Case File Audit In Respect Of Safeguarding

Summary of Planned Actions

- Attendance at child protection conferences and core groups to be documented in case file records and minutes from these meetings to be stored in case file.
- Assessments to be reviewed following the child becoming subject to Child Protection Plan.
- Detailed action plans to be developed following assessment, which:
- Enable other clinicians to work with the child/young person.
- Identify clear outcomes for the child/young person.
- Evidence the impact upon the child/young person of the work undertaken and any improvements.

3 'Did Not Attend' Policy Audit (I.E. Service Users Not Attending Clinical Appointments Without Prior Notification To Cancel)

Summary of Planned Actions

- E-bulletin reminder for staff regarding criteria and standards from the 'did not attend' policy and inclusion of standards letters on the electronic patient record implemented.
- A cross divisional task and finish group of senior staff to be established to ensure a comprehensive policy review and implementation is achieved.
- Rapid re-audit planned for six months following implementation of new policy amendments and new policy lead been appointed.

4 CQUIN Target 7 - Increasing Numbers Of Patients On Care Programme Approach With A Vocational Assessment And Action In The Care Plan

Summary of Planned Actions

- To feedback results of audit to heads of service and team manager via email with a request that team manager's action as a matter of priority.
- Team managers to be provided with a list of cases included in the audit and to be informed of their responsibility to monitor this with team members.
- Teams to be sent a standard description process relating to vocational assessment and care planning and this target.
- Current results and issues to be raised at the Divisional Quality and Assurance Groups and locality performance meetings in October.
- Teams to be offered a further session with an advanced vocational specialist. This has already been offered/ provided but will be made again.

5 Clinical Record Keeping Ward 14 Friarage Hospital, Northallerton

Summary of Planned Actions

- Information packs to be assembled to provide to patients and carers.
- Staff to be reminded about record keeping standards.
- Weekly audit of three clinical records to be undertaken by senior ward staff.
- Medical team to meet to discuss and implement standards for record keeping protocol, use of electronic record keeping as per Trust policy.
- Leading Improvement in patient safety audits to be completed for all patients monthly as part as management supervision.

6 Waste Management Audit

Summary of Planned Actions

- Audit report to be disseminated to all modern matrons to implement all recommendations.
- All sharps boxes should be ordered via Cardea using the standardised sharps boxes on Medical Device Template 2: Clinical Waste and Decontamination.
- Guidance/procedures for the safe use and disposal of sharps should be clearly displayed in all settings used by community staff (posters are available).

7 Clinical Re-Audit Of Clinical Risk Assessment And Management (Children & Young Peoples Service)

Summary of Planned Actions

- No action plan required as high standards of practice were demonstrated.

8 Sustained Improvements In Transfer Of Care

Summary of Planned Actions

- Implement standard process for transfers of care.
- Embed visual control board initiative to include targets for completion /quality of care documents on electronic patient record.
- Care Programme Approach Review to include recommendation to follow national guidance in respect of service users supported by standard care.
- Results of this audit to be discussed and monitored in governance groups to ensure actions are completed.
- Divisional action plans to be discussed and monitored in their respective governance groups.

9 Clinical Audit Of High Dose Antipsychotic Prescribing

Summary of Planned Actions

- Disseminate results to divisions.
- Standard process for recording medication reviews on electronic patient record to be agreed within each psychosis team.

10 Serious Untoward Incidents Lessons Learnt

Summary of Planned Actions
- Patient Safety / Clinical Effectiveness Group to review the action plans from the suicide prevention audit.
- Patient Safety / Clinical Effectiveness Group to receive an update on the risk management actions from the annual plan.
- Details of annual plan framework to be reported within project management forms to the Executive Management Team.

11 Re-Audit Of Manual Handling Of People (Cycle 2)

Summary of Planned Actions
- Ward managers to raise awareness of the patient handling risk assessment on electronic patient record, and complete appropriately for all applicable service users.
- The methodology of audit to be reviewed which enables audit to assess more clinical practice.
- All staff practicing patient handling must complete mandatory training.

12 Provision Of Information To Patients Regarding Their Condition And Treatment

Summary of Planned Actions
- All staff to be made aware of the policy and the importance of its implementation.
- Audit findings to be shared with all locality Quality and Assurance Groups.
- A standard operating procedure to be produced to guide staff as to where to document that key information has been provided to patients.

13 CQUIN Target 7 - Increasing Numbers Of Patients On Care Programme Approach With A Vocational Assessment And Action Plan In Their Care Plan

Summary of Planned Actions
- To set level of improvement and action plan to implement improvements.
- To feedback results of baseline to locality managers, team managers and clinical teams to raise awareness.

14 Clinical Record Keeping - Cedar Ward, Harrogate

Summary of Planned Actions
- All staff must be reminded to complete paper records in accordance with Trust policy.
- Ward managers to arrange for nursing and medical records to be placed in Trust approved folders.
- All staff must ensure allergies/no allergies are recorded in service user's care records.
- Ward manager to ensure that all information given to service users is recorded.

15 Clinical Audit Of Prescribing Practice (Hartlepool Children & Young Peoples Services)

Summary of Planned Actions
- Present audit and report to Teesside locality and Children & Young Peoples Quality and Assurance Groups for consideration and approval.
- Recommendations to be disseminated to all prescribers within children & young people's service

16 Clinical Risk Assessment And Management - Cedar Ward, Harrogate

Summary of Planned Actions
- Report and findings of this audit to be reviewed by the Adult Mental Health Service Development Group and divisional Quality and Assurance Group.
- Report and findings to be disseminated to participating clinical team.
- Ward to undertake root cause analysis for those criteria where standards of compliance require improvement.
- Any identified practice changes following consideration / root cause analysis to be communicated to all ward teams for implementation as appropriate.

17 Clinical Audit Of Internal Discharge Summaries From Mental Health Services For Older People Trainee Psychologists - Timing

Summary of Planned Actions
- As part of any end of placement review, clinical supervisors confirm with Trainees that all outstanding paperwork and electronic patient record records are completed, up to date and that discharge and/or ongoing care arrangements have been formally communicated to all parties including the referrer.
- Develop an end of placement checklist in which the above can be confirmed.

18 Clinical Re-Audit Of Clinical Risk Assessment & Management Quality Standards – Adult Mental Health

Summary of Planned Actions
- To disseminate to all teams for discussion and ensure lessons learnt. Teams to prepare local action plans to be signed off by team managers.
- Report to be presented and discussed at Adult Mental Health Clinical Audit Group. Summary and minutes to disseminate to locality Quality and Assurance Groups.
- Review of clinical risk and management policy re clarity of the timescales for review of assessments.

19 Clinical Audit Of Emergency Equipment - Resuscitation

Summary of Planned Actions
- Resuscitation group to discuss methodology for next year's audit.
- Up to date emergency equipment checklist and visual aid (developed as a component of the audit) to be incorporated into the renewed policy.
- Ward managers to ensure checks are conducted across all shifts to ensure that all nursing staff are familiar with the emergency equipment available.
- Signs identifying the location of the emergency backpack should be clearly visible.
- All spare equipment should be stored centrally in clearly labelled boxes/cupboards.
- A robust ordering system should be introduced to ensure out of date/used equipment is replacement immediately.
- Resuscitation team to produce a detailed and informative update on all developments and improvements implemented through the audit and to make it available via e-bulletin and in-touch.

20 Clinical Audit Of Safer Lithium Therapy Alert Card And Booklet

Summary of Planned Actions
- A visual aid to be produced which can be easily displayed in homes of patients/carers and families which details the signs and symptoms of lithium toxicity.
- Health professionals who are caring for patients prescribed lithium need to remind and encourage them to always bring their Lithium Therapy Record Books to their appointments.
- Health professionals who are caring for patients prescribed lithium need to discuss the Lithium Alert Cards with patients and explain the importance of patients carrying them at all times.

21 Clinical Audit Of Trust Seclusion Policy (Learning Disabilities)

Summary of Planned Actions
- Seclusion recording document to be incorporated into electronic patient record.
- Seclusion policy to be reviewed.
- Standard Process Flowcharts, Standard Process Descriptions and Standard Operating Procedures should be developed for seclusion episodes.
- Provide training for inpatient staff involved in seclusion episodes.

22 Clinical Audit Of Adherence To NICE Clinical Guidelines In The Management Of Borderline Personality Disorder Inpatients At The Westwood Centre

Summary of Planned Actions
- Dissemination of findings in Westwood multi-disciplinary team meeting and in Tier 4 Quality and Assurance Groups Meeting.

23 Clinical Audit Of Trust Seclusion Policy (Forensic Services)

Summary of Planned Actions
- Seclusion template to be incorporated into electronic patient record.
- Seclusion policy to be reviewed.
- Seclusion flow chart to be reviewed in line with current policy and displayed in seclusion suites.

24 Clinical Audit Of Physical Healthcare Assessment And Examination Of Service Users (Admission, Annual And Ongoing)

Summary of Planned Actions
- Update and issue all ward based staff with the standard process for completion of physical assessment on admission to hospital.
- All medical staff to be issued with the standard process for completion of physical assessment on admission to hospital.
- Meet with consultants and current medical staff to discuss standard process and highlight findings.
- Physical Nurse Practitioners to attend medical staff induction programme to promote the standard process for completion of physical assessment.
- Physical examination to be added to the named nurse audit.
- Monitor compliance as part of multi-disciplinary team 24 hour report out.
- Include physical assessment within 24 hour report handover sheets.

25 Clinical Audit Of Pregnant Service Users

Summary of Planned Actions
- Improve links with contraception and sexual health service and document contraception provided.
- All staff members to revisit contraception at minimum of 3 monthly, to be discussed within team meetings.
- Literature will be readily available within the centre including contact numbers for contraception and sexual health service and service opening times.
- Training to be delivered to staff to enable discussion and information be provided to clients around basic contraception.
- Develop care plan as guide to support pathway delivery to include all multi-disciplinary team reviews, attendance, agencies involved in care.
- To share new care plan within team meeting.
- Request template of care plan on main care record.
- Continue to actively work with midwives in ensuring information is shared in relation to discharge of mother from maternity department.

26 Fractured Neck Of Femur Case Review

Summary of Planned Actions
- Quality and Assurance Committee to consider the recommendation that all fractured neck of femurs sustained following a fall/found on floor should be investigated by the mental health services for older people falls team only.
- Quality and Assurance Group to consider a rolling programme for the physical care training for all inpatient mental health services for older people staff.
- Monitoring of falls assessment: effective use of the electronic visual display boards in relation to falls to ensure effective daily monitoring
- Mental health services for older people falls governance group to review the data captured by DATIX for falls/found on floor
- Mental health services for older people falls governance group to review the data required by the patient safety thermometer, CQUIN, NHSLA and RRR essential care after an inpatient fall and ensure DATIX captures same.
- Mental health services for older people falls governance team to develop a standard process description for the approvers and reviewers of DATIX for falls and found on floor.

27 NICE CG137 - The Epilepsies: Pharmacological Treatment By Seizure Type

Summary of Planned Actions
- The results of this audit are to be shared with the learning disability medical group.
- Current levels of good practice should be maintained.
- To make the learning disability medical group aware of the potential for some antiepileptic drugs to exacerbate other co-existing seizure types.

28 Clinical Audit Of Safer Lithium Therapy (Section 3) Therapeutics And Monitoring

Summary of Planned Actions
- To share evidence of good practice throughout the Trust and encourage engagement with local GP practices.
- To ensure the quality of record keeping is maintained with possible support for lead nurse in the completion of paperwork and visits for newly referred patients.
- Education session to be provided within the Trust on the shared care agreement.
- More information on the role of the lithium nurse to be provided to patients so they have a better understanding of the care they will/ will not receive.

29 Clinical Audit Of Assessment Of Anxiety As A Psychiatric Co-Morbidity In Children Diagnosed With Attention Deficit Hyperactivity Disorder In Easington Children & Adolescent Mental Health Team

Summary of Planned Actions
- Presentation at relevant forum.
- Attempt publication in peer reviewed journal.

30 Safeguarding Adults Audit -Supervision Baseline

Summary of Planned Actions
- Safeguarding team to continue to prompt staff to complete a DATIX form at each contact.
- Safeguarding team to record advice given on the electronic patient record system.
- Future audits will assess the standard of the referral form as part of the audit.
- Staff to document the safeguarding process on the patient's primary care electronic patient record records.
- Flow chart within the Trust protocol to be updated to provide more clarification for staff on the information required by the Safeguarding Adults Team.
- Lessons learnt to be shared across the organisation following a serious case review via the SBARD template.
- Team to develop a format/form to agree contract and recording of clinical supervision for the more complex cases.

31 Safeguarding Adults Audit

Summary of Planned Actions
- Further training to be provided within the forensic service on MAPPA re: the use of the new protocol and documentation.
- MAPPA procedure is to be held on the Trust internet to aid staff with the completion of the correct forms as per the MAPPA procedure.
- Teams are to discuss the visual display boards and improve the information around patients who are subject to MAPPA linking with the minutes of the daily report out meetings.
- Staff to be provided with clarification around the storage of the MAPPA information.

32 Safeguarding Children -Supervision Baseline

Summary of Planned Actions
- To record the supervision tool used and to change the documentation to prompt the recording of tool used.
- To ensure that the pre-supervision documentation is completed prior to the session by the supervisee. Supervision documentation to be e-mailed to the supervisee a week before the supervision session.
- To record details of why a safeguarding supervision was delayed to enable further review of this. Change supervision template to record these details.

33 Nice CG78: Emerging Personality Disorder

Summary of Planned Actions
- Disseminate audit report to Quality and Assurance Groups to share findings and lessons learnt.
- Children & young people's service pharmacist to review medication regimes for complex patients with emerging personality disorder within inpatient services.
- Development of a clinical excellence group to agree standards for management, supervision arrangement and pre-work for emerging personality disorder pathway.
- Development of personality disorder pathway within the children & young people's service.

34 Lips Risk Assessment/Care Planning Audit

Summary of Planned Actions
- Internal alert to be produced highlighting importance of involving families/carers.
- Audit tool to be brought into line with clinical risk assessment and management and a central audit to be conducted centrally.
- Findings to inform the Care Programme Approach review.

35 Psychosis With Co-Existing Substance Misuse NICE CG:120 (Forensic Services)

Summary of Planned Actions
- To circulate NICE Clinical Guidance 120, Psychosis with Coexisting Substance Misuse to all team managers.
- To arrange a meeting to discuss the findings of the Clinical Audit of NICE CG120 – Psychosis with Coexisting Substance Misuse and to identify specific actions that need to be taken within the forensic services.
- (Following the above meeting) For all wards to review the findings of the Clinical Audit of NICE CG 120 – Psychosis with Coexisting Substance Misuse and implement any changes in their own clinical area as necessary.
- To carry out a re-audit of NICE CG 120 – Psychosis with Coexisting Substance Misuse.

36 Risk Assessment

Summary of Planned Actions
- Patient safety / clinical effectiveness group to receive an update on the risk management actions from the annual plan.
- Details of annual plan framework to be reported within project management forms to the Executive Management Team.

37 Re-Audit Of Trust Seclusion Policy

Summary of Planned Actions
- Review paper based seclusion documentation against policy requirements (and reissue new format if required).
- Develop a seclusion template on electronic patient record to electronically record episodes of seclusion
- Communicate the results of the audit to clinical teams involved.

38 Psychosis With Co-Existing Substance Misuse NICE CG 120 – Adult Mental Health And Substance Misuse Services (NB: 2 Individual Audits Completed)

Summary of Planned Actions
- Guideline to be made available to all clinical areas.
- Pursue implementation of the FACE risk assessment for substance misuse.
- Consolidate all dual diagnosis audits to allow meaningful data collection and analysis.
- Audit findings to be shared with all clinical teams involved.

39 Re-Audit Of NICE CG:38 Bipolar Disorder

Summary of Planned Actions
- Dissemination of audit results at the appropriate forum of clinical governance / clinicians.
- Explore reasons for limited response rate to audit.
- Annual review of high-risk patients to assess for under-diagnosis of bipolar disorder.

40 Clinical Audit Of Suicide Prevention

Summary of Planned Actions

- All operational managers and service development managers to be sent a copy of locality audit reports with action plan to complete and return.
- Clinical Audit Department to receive and format action plans.
- Trust-wide report and action plan to be taken to Quality and Assurance Committee and Patient Safety Group.
- Update on action plan to be requested from operational managers (beginning of August 2012).
- Time limited group to examine the national in-patient and new community toolkits to revise and ensure fit for purpose for next audit programmed for October 2012.
- A multidisciplinary review undertaken within two weeks of the suicide or serious suicide attempt. This will be achieved through continual improvements to the review process.
- Information and support will be provided for those patients/ carers affected by an incident. This will be achieved through improvements to the family liaison process described in the patient safety team's annual plan.
- Information and support will be provided for those staff affected by an incident through planned. improvements described in the patient safety team's annual plan.

41 Safe And Secure Medicines In Crisis Teams

Summary of Planned Actions

- Review and amend audit tool and process guidelines based on feedback from auditors and update information re delivery modes.
- Communicate results to all members of crisis teams.
- Incorporate audit results into training to improve practices and adherence to standards.
- All team managers should attend the training to ensure understanding of registered nurse role related to and legal parameters.
- Team managers to complete a local audit on a quarterly basis to encourage improvement in practice via regular feedback.

42 Audit Of Policy "The Care And Management Of Dual Diagnosis"

Summary of Planned Actions

- Audit findings to be shared with all locality Quality and Assurance Groups to discuss findings and recommendations.
- Draft substance misuse risk assessment (aide-memoir) tool to be presented to relevant groups for consideration.
- All staff to be reminded of the importance of completing intervention/care plans.
- Dual diagnosis leads to monitor staff compliance to the policy.
- Local arrangements to be reviewed to improve the attendance of substance misuse staff at service users care planning meetings and Care Programme Approach reviews.

43 NICE PHG 24: Alcohol Use Disorders: Preventing The Development Of Hazardous And Harmful Drinking

Summary of Planned Actions

- To use standardised screening tools.
- To ensure that alcohol review is carried at all appointments within specialist substance misuse services.
- To ensure all staff are trained in the use of audit tools, delivery of structured brief advice and extended brief interventions.
- To circulate clinical audit report to all teams Trust wide.

44 NICE CG 115: Alcohol Use Disorders - Diagnosis, Assessment And Management Of Harmful Drinking And Alcohol Dependence

Summary of Planned Actions

- To expand the guidance provided with the audit tool to ensure auditors are clear on the different sections and the relevant questions to answer.
- To ensure all service users who have a community detoxification are monitored daily for at least 4 days.
- To ensure 100% of service users prescribed a drug treatment receive a comprehensive assessment.

45 Inpatient Physical Assessment Acute Patients, And Annual Patients (NB: 2 Individual Audits Completed)

Summary of Planned Actions

- All services will be asked to monitor the results of this audit and provide an action plan for their own divisions.
- This action plan will be submitted to the Clinical Assurance and Registration Department and the Physical Healthcare Group, to ensure that all staff are aware of this audit, the results and recommendations.
- The results of the audit will be discussed at the Physical Healthcare Group.
- The audit findings and recommendations will be presented to the relevant Quality and Assurance Groups.
- The audit findings and recommendations will be presented to the Quality and Assurance Committee.
- The audit findings will be utilised as evidence for the NHS Litigation Authority Physical Healthcare Standard.

46 Clinical Audit Of NICE CG90: Depression

Summary of Planned Actions

- The low rate of mild to moderate patients with depression receiving cognitive behavioural therapy needs to be investigated to see if there is a need as it is unclear from the audit data whether there is provision of short term psychodynamic psychotherapy.
- The low rate of mild to moderate service users receiving couples therapy needs to be investigated to see if there is a need as it is unclear from the audit data whether there is provision of short term psychodynamic psychotherapy.
- Further investigation into the low rate of mild to moderate patients with depression receiving individual cognitive behavioural therapy, to establish if this may be due to mild to moderate patients with depression. being in secondary care and not accessing Improving Access to Psychological Therapies services.
- The low rates for cognitive behavioural therapy noted need to be investigated to see if there is currently sufficient capacity to deliver individual cognitive behavioural therapy as the first line treatment in primary and secondary care. It may be necessary to review activity against numbers of patients with depression and see how many staff are available to provide these therapies.

47 The VIPS Framework Quality Assurance Tool For Person Centred Dementia Services

Summary of Planned Actions
- Person centred care will be described in ward operational policies and written information for patients and their carers provided.
- Audit inpatient areas using University of Stirling Design for people with dementia audit tool.
- Identify an appropriate tool to audit the social environment for people with dementia.
- Care and intervention plans will include information on an individual's strengths, abilities, activities and personal history.
- Where additional tools such as the pool activity level or a personal profile have been completed this information will be integrated into individuals care and intervention plans.
- Activity and occupation on inpatient areas to be addressed via productive ward module.
- All staff providing care to people with dementia will receive training in person centred care.

48 Pilot Of The National Audit Of Falls In Care Settings (Royal College Of Physicians)

Summary of Planned Actions
- Pilot test data submission on behalf of the Royal College of Physicians.
- Clinical audit undertaken to inform the development of the national audit tool – no actions to be identified for Trust.

49 Trust's Adherence To NICE Clinical Guideline 113: (Generalised Anxiety Disorder And Panic Disorder)

Summary of Planned Actions
- Revise audit tool and re-audit.
- Information Department support regarding identification of patients with a diagnosis of generalised anxiety disorder as their primary diagnosis from electronic records.
- Increase staff awareness around the importance of written information regarding treatment of generalised anxiety disorder and panic disorder.
- Increase staff awareness of written information regarding using medication in the treatment of generalised anxiety disorder.
- Information on local/national self-help organisations and support groups to be displayed in consulting areas.

50 Audit Of Transition From Child And Adolescent Mental Health Services

Summary of Planned Actions
- To create a checklist for transitions.
- Provide information about adult services to service user.
- Prepare a leaflet about adult services to give to young people at the stage of transfer.
- Information about the available support for young people other than adult mental health services.
- Disseminate the results of the audit.

51 Patient Environment Action Team (Peat)

Summary of Planned Actions
- Presentation of summary findings to Quality and Assurance Committee via Estates & Facilities Management update report.

52 Validation Of Self Audits For Health, Safety And Security Workbooks

Summary of Planned Actions
- All identified responsible persons for workbooks showing red are re-visited by the Health and Safety Team and given support to complete the workbooks.
- Identified responsible persons for workbooks showing as amber are given a deadline to complete the books and reminded of the requirement to advise the Health and Safety Team of completion to allow them to be recorded as green.
- Monthly reporting to directorate heads of service on status of workbooks issued.
- Repeat of self audit of 100% of workbooks to establish ongoing reviews.
- 30% of validation audits of all workbooks on quality of assessments completed.
- Report to clinical audit team on findings from audits.

53 Clinical Audit Of Suicide Prevention – Forensic Services, Adult Mental Health, Mental Health Service For Older People, Children & Young Peoples Services (NB: 5 Individual Audits Completed)

Summary of Planned Actions
- Heads of service to receive their service reports and action plan template.
- Action plans to be completed according to each service areas highlighted development in practice requirements and returned to the clinical audit team.
- The Trust wide action plan will be populated from the local action plans and progressed to improve standards which will be monitored via the Heads of Service and reported to the clinical audit team as specified in the action plan.

54 Rapid Tranquilisation - South

Summary of Planned Actions
- Informal feedback given to managers.
- Full review of policy initiated, including audit tool.
- Update briefing and communicate relevant changes to managers following policy review.

55 Review Of Local Induction Monitoring Of Permanent Staff

Summary of Planned Actions
- HR Manager appointed to lead update of engagement and use of temporary and self employed workers procedure.
- Organisational Development Team to receive monthly spreadsheet from Finance showing all invoices paid to agencies by department/ cost centre.
- 20% sample of above to be used to confirm that local induction checklist and monitoring form has been completed.

56 Clinical Audit Of Adherence To NICE CG:128 Autism

Summary of Planned Actions
- Results to be shared with divisional Quality and Assurance Groups and disseminated across the division.
- Results to be shared with autistic spectrum disorders leads across the division to influence development.
- Development of autistic spectrum disorders pathway to support consistent approach to the assessment, diagnosis and management of young people.
- Re-audit in April 2013 – audit tool will need to be amended to reflect actions from this report.

57 Clinical Audit Of Safeguarding Children Policy Implementation

Summary of Planned Actions
- Team managers to remind all staff of the importance to follow the Safeguarding Children Policy to ensure compliance with the requirement that all referrals followed up in writing within 48 hours.
- Team managers to remind all staff of the importance to follow the Safeguarding Children Policy to ensure compliance with the requirement that documentation within client records regarding whether consent was received for referral.
- Team managers to remind all staff of the importance to follow the Safeguarding Children Policy to ensure compliance with the requirement that a copy of the referral in client records.
- Team managers to remind all staff of the importance to follow the Safeguarding Children Policy to ensure compliance with the requirement that the outcome of referral is documented within client records.

58 Clinical Audit Of NICE CG 113 - Generalised Anxiety Disorder And Panic Disorder.

Summary of Planned Actions
- To add to Mental Health Services for Older People Quality and Assurance Group agenda for discussion and approval.
- Once approved through Quality and Assurance Group to be discussed in Mental Health Services for Older People governance groups and in Consultant meeting.
- Re-audit in line with Trust requirements.

59 Trust Seclusion Policy

Summary of Planned Actions
- Ensure all staff are made aware of the Trust's Challenging Behaviour Policy and the record keeping requirements.

60 Re-Audit Post Traumatic Stress Disorder NICE CG26

Summary of Planned Actions
- To share outcome of post traumatic stress disorder re-audit.
- To improve audit tool and sampling methods to address broader range and detail of questions and incidence.
- To include in future audit questions relating to emotional stabilisation work and multiple diagnostics.
- To share issues raised about prescribing practices with medical director for comment and possible pursuit.

61 CQUIN - To Improve The Quality Of Discharge Planning And Communication From Inpatient Adult Wards

Summary of Planned Actions
- This audit report to be cascaded to all adult mental health inpatient and community teams to review and address areas for improvement.
- Ward and team managers to monitor areas for improvement quarterly via clinical reporting system /PIPA process and supervision to address areas of poor compliance with individual staff
- Areas identified for improvement to be considered during the Care Programme Approach Policy review with particular consideration given to the responsibility for completion of care documents at point of discharge.
- The results of the clinical audit to be discussed and monitored in locality and Adult Mental Health Governance Groups to ensure all actions are completed.
- Standard work agreed at 7 day Kaizen event to be re-distributed across adult mental health teams.
- Admission pathway audit to be implemented across all adult mental health inpatient areas.
- Community staff discharge from inpatients requirements to be to be incorporated into the development of the adult mental health audit tool for case management.
- Discharge standards to be added to Care Programme Approach Policy as an appendix during review in 2012/13.

62 Clinical Audit Of Transfer Of Care

Summary of Planned Actions
- This audit report to be cascaded to all inpatient and community teams to review and address areas for improvement.
- Ward and team managers to monitor areas for improvement quarterly via clinical reporting system and supervision to address areas of poor compliance with individual staff.
- Transfer review meeting/discussion must be held prior to transfer going ahead and must include all relevant persons involved in the person's care.
- Areas identified for improvement to be considered during the Care Programme Approach Policy review.
- The results of the audit to be discussed and monitored in locality and governance forums to ensure all actions are completed.
- Reminder that timescales for formal hand over of responsibilities must be documented in the care plan.

63 Casefile Audit In Respect Of Safeguarding

Summary of Planned Actions
- To feedback the outcome to the Child & Adolescent Mental Health Services managers.
- If staff are experiencing difficulty in contacting a social worker, the team manager and the safeguarding children team to be alerted to ensure that this can be addressed.

64 Clinical Audit Of quality report Priority 5: Clinical Risk Assessment & Management Quality Standards, Learning Disabilities

Summary of Planned Actions
- Report and findings of this audit to be reviewed by the forensic service development managers and divisional Quality and Assurance Groups.
- Report and findings of this audit to be disseminated to participating clinical teams.
- Service Development Manager to undertake root cause analysis across the division.

65 Equality And Diversity Audit

Summary of Planned Actions
- Submit a business case for all clinical staff to receive cultural competency training.
- To organise training for clinical staff in relation to issues relating to the asylum seeker community.
- Develop a data collection system to collect demographics around gender re-assignment that complies with legislation.
- Provide training for staff in relation to the legalities around collecting data in relation to gender re-assignment.
- Carry out a clinical audit to assess referrals to the safeguarding team in relation to domestic violence and arranged marriage.

66 Re-Audit Of Documentation Of Driving Status

Summary of Planned Actions
- Discuss driving status document format with electronic patient record team.
- Present clinical audit findings to Mental Health Services for Older People Quality and Assurance Group, Consultants Group and locality governance groups to improve awareness of responsibility and liability.
- Remind all staff doing initial assessments and Care Programme Approach reviews of responsibilities for recording driving status and advice given.

67 Clinical Record Keeping 2011/2012 Substance Misuse

Summary of Planned Actions
- Each team who took part in the clinical audit must complete a clinical record keeping action plan to be monitored through Quality and Assurance Group.
- Clinical staff that are not professionally registered must be assessed for competency in clinical record keeping.
- Clinical teams must discuss the results of the audit in their team meetings and this must be minuted.
- Relevant line managers to follow up identified teams where audit returns were not submitted.

68 Psychological Therapy Skills In Children & Young Peoples Services

Summary of Planned Actions
- Team and service managers to ensure all clinical staff are in receipt of clinical supervision. Specific service and team reports of this clinical audit will assist in this.
- Clinical audit information to be used in workforce planning and training in psychological therapies.
- Clinical audit information to be considered in coding of activity on electronic patient record.
- An annual review date of audit to be set and conducted within each Children & Young Peoples team/service
- Audit to be presented to the divisional quality and assurance group.

69 Clinical Audit Of The Segregation Procedure

Summary of Planned Actions
- To communicate the results of this audit to the clinical teams involve.
- To re-circulate the Seclusion and Segregation briefing sheet to ward staff.
- To ensure that there are consistent and thorough systems in place to inform staff of revisions made to the Protocol for the Use of Seclusion and Segregation.

Appendix 2: Feedback from our stakeholders

Darlington Health and Partnerships Scrutiny Committee

DARLINGTON
BOROUGH COUNCIL

Tees, Esk and Wear Valleys NHS Foundation Trust – Draft Quality Account 2012/13

The Health and Partnerships Scrutiny Committee remit covers the Governance arrangements of the Trust and has the responsibility to comment on the Quality Accounts, in line with its Health Scrutiny Powers. The Adults and Housing Scrutiny Committee remit scrutinises the delivery and provision of mental health and learning disability services.

Members of the Health and Partnerships Scrutiny Committee have considered the draft Quality Account 201213 for Tees, Esk and Wear Valleys NHS Foundation Trust and attended both Stakeholder events over the past year. Members would like to acknowledge that the Stakeholder events are always well attended and informally structured to enable meaningful audience participation, with the opportunity for a free exchange of views.

In respect of the Quality Improvement Priorities for 2012/13, members have the following comments to make:

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 have looked forward to receiving assurance of improvement to the quality of care through the Care Programme Approach. Members are delighted that the comprehensive review of the Care Programme Approach has been achieved. Members believe that the key findings of the review in relation to improving care planning and communications between staff, service users and carers will have a large impact on the future Quality Priorities 1 and 2 for 2013/14.

To improve how we gain feedback from patients on their experience and improve our services and the feedback we receive – Members are pleased this aim has been met and surpassed, and increased by up to 25%. Members are satisfied that the Trust has acknowledged that there are aware that there are aspects of care that services users and carers have feedback through surveys that need to

be improved, for example. Community Mental Health Services for Older People and welcome the commitment to improve ethos. Although, this priority has not been selected for 2013/14, Members note that a Patient Experience Team has been established reflecting the importance the Trust regards patient feedback.

To sustain an improvement in all transfers of care with standard work practices and improved communication between professionals implemented – Members welcome that the Trust has made positive achievement towards this aim and that overall compliance has been achieved, while acknowledging that compliance against individual standards is variable with some key areas for improvement. It was noted that after a six month period of implementation of the Action Plan, an audit would be undertaken to assess the improvement made.

To develop broader liaison arrangements with Acute Trusts around physical health needs of mental health patients – Members believe that liaison with Acute Trusts is key to improving the services for patients with mental health and or learning disability issues and also improving relationships with the Acute Trusts. We are delighted that two projects in County Durham and Tees have been fully implemented and will be evaluated during 2013/14.

Quality Improvement Priorities for 2013/14 are and Members have the following comments

Implement the recommendations of the Care Programme Approach Review relating to improving care planning – Members are pleased that this priority has arisen following the success of the Care Programme Approach Review and support its inclusion. Driving up quality of services is essential and Members welcome the high quality of care service users and carers could potentially receive and look forward to receiving update about its progress.

Implement the recommendations of the Care Programme Approach review relating to improving communications between patients and staff – Members again, acknowledge that this priority has arisen following the success of the Care Programme Approach Review and support its inclusion. Members believe all forms of communications to be valuable and involvement of service users and carers in discussing care plans will only be a benefit to improving service delivery.

To improve the delivery of crisis services through implementation of the Crisis review's recommendations – Members are pleased that this priority has been chosen as they believe that effective Crisis Teams will result in reduced hospital admissions, a reduction of reliance on inpatient beds and ultimately result in efficiencies. Members hope that crisis support can be made available to adults over the age of 65 and look forward to receiving evaluation of County Durham and Darlington project which may influence future commissioning intentions. Although, Members do have concerns about the number of staff operating across a large geographical area and look forward to receiving innovative ways the Trust will achieve compliance.

To further improve clinical communication with GPs – Members welcome this priority and hope that communications can be improved between the Trust and GPs and wish the Trust every success in achieving this. It was noted that there is

currently not a uniform approach taken to communicating with GPs and Members hoped that a standard way of communicating across the two organisations can be achieved.

Overall, Members welcome the opportunity to comment of the Trust's Quality Accounts and are pleased with the Trusts progress against the chosen priorities, in a challenging year for all NHS organisations. Members would like to receive six monthly reports on the progress being made, to enable them to provide a more detailed and valuable contribution to the Quality Accounts in the future and wish to continue to be invited to Stakeholders events.

Councillor Wendy Newall
Chair, Health and Partnerships Scrutiny Committee

Darlington HealthWatch

Comments on Tees, Esk and Wear Valley Foundation Trusts Quality Account for 2012-13 from Darlington LINk. These comments are on behalf of the LINk Management Group and active members of the 'task and finish' groups.

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 Foundation 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 feel the Trust have meaningfully involved a wide and varied section of stakeholders and members of the public and have been pleased to be updated on patient engagement activity throughout the year. We are happy with all of the priorities set against the work which has been completed towards making improvements in these areas.

Darlington LINk agree with all of the priorities set out in the 2013-2014 Quality Account and will pass details and information gathered to Healthwatch Darlington to move forward with and work alongside TEWV to help achieve those objectives.

LINk members have enjoyed attending Quality Account meetings and have actively been involved in round table discussions to discuss objectives and to voice their opinions where appropriate.

Darlington LINk are particularly pleased to see the priority for improving communications with GP's as this has been an issue highlighted with the organisation and patient involvement groups for many years. Members look forward to seeing improvements within this area during their time with Healthwatch Darlington.

Darlington LINk would like to thank Tees, Esk and Wear Valley NHS FT for their continued engagement and support and LINk members look forward to some further partnership working over the next year with Healthwatch Darlington.

Kind Regards

healthwatch Darlington

Durham County Council Adults Wellbeing and Health Overview and Scrutiny Committee

Contact: Councillor Robin Todd
Direct Tel: 0191 383 3149
Fax:
email: robin.todd@durham.gov.uk
Your ref:
Our ref: RT

1 June 2013

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,

Tees Esk and Wear Valleys NHS Foundation Trust Draft Quality Accounts – Response from Durham County Council's Adults Wellbeing and Health Overview and Scrutiny Committee

At its meeting on 15 April 2013, Members of the Council's Adults, Wellbeing and Health Overview and Scrutiny Committee gave consideration to the Trust's Draft Quality Accounts.

The Committee welcome the opportunity to provide comment and attached is a response to the Trust's Draft Quality Accounts.

As Chairman of the Committee, I would like thank yourself and colleagues from the Trust for actively engaging with members of the Committee to develop this year's Quality Accounts report.

Yours sincerely,

Councillor Robin Todd,
Chair of the Adults, Wellbeing and Health Overview and Scrutiny Committee,
Durham County Council

DURHAM COUNTY COUNCIL ADULTS WELLBEING AND HEALTH OVERVIEW AND SCRUTINY COMMITTEE

COMMENTS ON TEES ESK AND WEAR VALLEY'S NHS FOUNDATION TRUST QUALITY ACCOUNT FOR 2012/13

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 fourth year the Committee has provided comment and acknowledge progress by the Trust towards delivery of their priority areas for 2012/13.

Durham County Council's Adults Wellbeing and Health OSC Chair and lead Scrutiny officer have attended stakeholder workshops during 2012/13 and engaged in the Quality Accounts process. To this end we welcome the early opportunity to examine key issues identified during 2012/13 and also consideration of draft priorities for 2013/14.

In considering the priorities for 2013/14, the Committee welcomes all of the identified priorities which seek to build on the work commenced by the Trust in reviewing its Care Programme approach, particularly those proposals to continue to engage with service users and carers/families. The Committee has previously emphasised the importance of service users and carers/families being actively engaged in this process, and it is encouraging that the way in which the Trust communicates services to these stakeholders remains a priority.

The Committee previously welcomed proposals "to develop broader liaison arrangements with Acute Trusts around physical health needs of mental health patients" and has would seek the continuance of this work.

One area of concern identified by the Committee for consideration as part of its 2013/14 work programme is the incidence of suicides within County Durham. Members have noted a key action identified within the Durham County Council Council Plan to "develop and Implement a multi-agency Public Mental Health and Suicide prevention strategy for County Durham" and see the Tees Esk and Wear Valley NHS Foundation Trust as a key partner in this activity.

To conclude, the Committee agree that from the information received from the Trust, the identified priorities for 2013/14 are a fair reflection of healthcare services provided by the Trust and note the progress made against the 2012/13 priorities. In addition, the Committee request to receive a six monthly progress report on delivery of 2013/14 targets.

North Durham Clinical Commissioning Group

The Rivergreen Centre
Aykley Heads
Durham City DH1 5TS

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Tel: 0191 605 3169

10 May 2013

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

Tees, Esk and Wear Valleys NHS Foundation Trust
Quality Account 2012/2013 Collaborative Statement

Thank you for sharing your quality account report for 2012/13.

North Durham, Durham Dales, Easington and Sedgefield and Darlington Clinical Commissioning Groups (CCGs) are pleased to have had the opportunity to review and comment on Tees, Esk and Wear Valleys NHS Foundation Trust's quality account for 2012/2013.

The CCGs would like to commend the trust on its achievements, in particular the external achievements and awards.

Overall the CCGs felt that the report was well written and presented and would like to offer the following commentary.

As commissioners, the CCGs meet on a regular basis with the trust to monitor, review and discuss quality issues, considering their quality and innovation programmes of work. We have also continued to conduct regular commissioner-led inspection visits into inpatient facilities to allow greater insight into the care being delivered to patients, by directly

observing and speaking with patients, carers and staff. Therefore, the CCGs feel that the document is an accurate representation of the services provided during 2012/13 within the trust.

We recognise that improvements are being made by Tees, Esk and Wear Valleys NHS Foundation Trust, including those relating to access of services and welcome the efforts made by the trust to engage stakeholders and service users in their well-established quality improvement programme.

It is disappointing that the number of unexpected deaths is reported as higher than the target. However, the CCGs recognise that Tees, Esk and Wear Valleys NHS Foundation Trust has reported the information promptly and has instigated an independent review of the services affected. The CCGs are happy to support this and will work with the trust to address any recommendations that might follow the investigation.

The CCGs were also concerned to observe following publication of the National Reporting and Learning system (NRLS) Organisational Patient Safety report in March 2013 that the organisation has noticeably fallen from the middle 50% of reporters to the lowest 25% percentile. The CCGs will look to address these concerns through the on-going quality review group process.

The CCGs acknowledge the progress made in improving access to services in the "out of hours" period and see this as a key area for development as outlined in the document. We are also pleased to see the improved working arrangements between Tees, Esk and Wear Valley NHS Foundation Trust and County Durham and Darlington NHS Foundation Trust.

The CCGs agree with the priorities outlined in the document for the coming year and are willing to work in partnership to achieve the common goals of improving access, experience and safety for all patients.

We look forward to working continuously with you and your team.

Yours sincerely

Dr Neil O'Brien
Clinical Chief Officer

North Yorkshire HealthWatch

Tees Esk and Wear Valley NHS Foundation Trust
Quality Account 2012- 2013
Healthwatch North Yorkshire Comments

Healthwatch North Yorkshire would like to thank Tees Esk and Wear Valley NHS Foundation Trust for the opportunity to comment on their Quality Accounts for the year 2012-2013.

Comments from Healthwatch North Yorkshire:

The Document:

The document contains evidence of:

- An overall statement of accountability for TEWVNHSFT from the Chief Executive
- Commentary on the activity/progress of the four priorities from 2012/13
- Statement of Assurances
- Confirmation of compliance with Monitor
- Confirmation that TEWVNHSFT participates in clinical audits and research
- Confirmation that a proportion of income is dependent on achieving CQUIN goals although not all have been achieved
- Confirmation of CQC registration
- Data quality
- Engagement with stakeholders
- The identification of four improvement priorities, the benefit to Service Users and Carers clearly stated, and implementation, monitoring and reporting arrangements to examine progress

The document is not so good at:

- Plain English
- Use of “management speak” terminology. Embed is just one example
- Describing if /when / how data from surveys will be used and feedback mechanisms

Some General Comments:

The document is well presented and easy to read.
Also,

Pg 87 - definition of CCG not with the rest of the Cs in Appendix 8.

Some Specific Concerns:

Chief Executive's Statement - Whilst it is of interest to read of external success of TEWVNHSFT, this is not relevant to the QA.

Pg 8 - The report states "The recent reports on Winterbourne View and Mid Staffordshire NHS Foundation Trust (the 'Francis 2 Report') are very important and we are considering these carefully to see what lessons we can learn from these events."

It would be more useful and engender confidence if a timeframe was provided for identifying and remedying any deficiencies and that TEWV engage in open and frank discussions with all stakeholders.

Pg 9 - Paragraph beginning "The national service user survey highlighted issues regarding."

There is no comment on the differences between the TEWV and NY+Y data (see table below) and how these would be addressed nor the poor response rate from TEWV. This is of concern c.f. Priority Two 2012/13.

Domain	Trust	
	NY+Y	TEWV
Health and social care workers	9.1 /10	8.7 /10
Medications	7.6 /10	7.1 /10
Talking Therapies	7.5 /10	6.9 /10
Care Coordinator	8.7 /10	8.7 /10
Care Plan	7.1 /10	7.0 /10
Care review	7.7 /10	7.9 /10
Crisis Care	5.9 /10	7.0 /10
Day to Day Living	6.2 /10	6.2 /10
Overall	7.2 /10	7.1 /10

Responses were received from 259 service users at North Yorkshire and York PCT.

Responses were received from 230 service users at Tees, Esk and Wear Valleys NHS Foundation Trust.

Pg 17- Table 1 Service Users and Carers Surveyed.

To make more sense of the data include patient totals and include percent of responses. Yes there has been an increase in responses but how does this measure up against the total number of patients seen per annum.

Pg 19 - Priority 3

This priority was not met and it is of some concern that this priority has not been rolled over to the next year as a **specific** priority.

Pg 22 - Priority 4

An explanation as to why this was not applied to North Yorkshire is required.

Pg 30 - Paragraph beginning “The percentage of people with learning disabilities to have a Health Action Plan ..”

The document does not say how TEWVNHSFT is going to achieve the expected 90% compliance.

Pg 31 et seq - With regard to the moderate concerns and improvement actions required to meet full CQC compliance requirements at Auckland Park and the Clinics, West Park, it would be sensible to audit the units periodically to ensure that the implemented actions are being fully complied with.

Pg 35 - At quarter 4 2012/13: *(as at end Feb 12/13 – to update at Q4)*

- **94.3%** of service users on the Adult Mental Health and Mental Health Services for Older People caseload were clustered with a HoNOS Score.
- **87%** of service users on the Adult Mental Health and Mental Health Services for Older People caseload were reviewed within the guideline timeframe.

The document does not say if these figures are good or bad, what the minimum standard is/will be. An explanation is needed.

Pg 35 - “Further work for 2013/14 includes:”

This does not appear to include any involvement of Service Users or Carers.

Pg 36 et seq - **Mandatory quality indicators**

It is confusing to have the reason(s) for the discrepancy before the data. Consider reversing the data boxes.

Pg 44 - Priority 1

- It is unclear where the unmet objectives from Priority 3 2012/13 are being addressed within this priority. Please clarify where and how this work will continue.
- It is here that some of the recommendations the Francis 2 report may be delivered. For example, taken from the handouts from the February 2013 Stakeholder Event, “embedding the values and principles of care coordination and compassionate care”.

Pg 45 - Priority 2 “It is anticipated that when we deliver this priority, our service users and carers should expect to see an improvement in how our staff communicate with them.”

Not a very positive statement – when / should - consider rewriting it.

Pg 47 - Priority 3 In “**What we will do in 2013/14:**”

Instead of establishing an internal collaborative / clinical network consider including Service Users and Carers to give "just in time" data.

Further comments from Healthwatch North Yorkshire include:

- Pleased to see the focus is continuing on CPA and Care co-ordination. It is obvious that this priority was going to take more than one year to make a difference and it was good to see this recognised. It is helpful to see that the plan builds on the work already done to ensure real and lasting changes are made to improve transfer of care and embed risk management.
- Concerned about the level of unexpected deaths. Pleased to see that root cause analysis is being undertaken but would be further reassured to see what actions have been taken as a result of the analysis to reduce the numbers of unexpected deaths.
- Concerned about the poor level of implementation of NICE guidance but pleased to see this has been recognised and action taken to address issues.
- Finally the stakeholder events have been very useful but, as recognised, not all areas are represented.

North Yorkshire County Council

County Councillor Jim Clark
(Harrogate/Harlow Division)

74 Green Lane
Harrogate
North Yorkshire
HG2 9LN

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15 May 2013

Sharon Pickering
Director of Planning & Performance
Central Resources
Lanchester Road Hospital
Durham
DH1 5RD

Dear Sharon

Quality Account – 2012/13

Thank you for inviting the North Yorkshire Scrutiny of Health Committee to contribute to the Tees, Esk and Wear Valleys NHS Foundation Trust Quality Account (QA) for 2012/13.

Please accept this letter as the comments from the Committee.

On the basis of the Committee's long standing involvement with the Trust I am confident that the Trust's QA is representative and comprehensive in terms of the services provided.

The priorities for 2013/14 are clearly informed by an on-going engagement process with patients and the public. This on-going approach is supplemented by specific events/workshops including all stakeholders.

Over the last year the Trust's Operations Director has demonstrated her 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 ensure the Committee was consulted on developments at Alexander House in Knaresborough which included plans for moving care from in-patient settings into community settings and supporting people to live independently in their own homes.

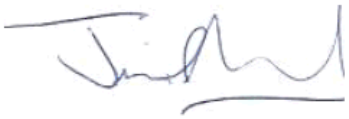
Cont/d …

Against this background I fully support the Trust's priorities for improvement in 2013/14.

Looking further into the future the Trust may want to consider including specific priorities around the integration of care and increased partnership working. The way in which the Trust is already working in partnership with the Harrogate and District NHS Foundation Trust, for instance, to develop the Harrogate Dementia Collaborative is an excellent example of partnership working to improve care for people with dementia. The QA could be used to give this work even more impetus.

Finally, the way in which the QA openly highlights areas of under performance against quality metrics and how improvements will be taken forward is reassuring. There is clearly a commitment to sharing information in an open and honest way and towards continuous improvement in the Trust.

Yours sincerely



County Councillor Jim Clark
Chairman – North Yorkshire County Council Scrutiny of Health Committee

The following stakeholders were given the opportunity to comment on our draft Quality Account for 2012/13 and made a short comment by email:

- Hambleton, Richmondshire & Whitby CCG responded that *'The document was looked and the following four points noted. The report is very comprehensive with a lot of positive aspects. As a CCG in coming year we want to look at issues local to Hambleton, Richmond and Whitby, discuss the outcome of the GP Survey undertaken by the Trust in 2012 and consider environmental standards in some units and how to improve.'*

The following stakeholders were given the opportunity to comment on our draft Quality Account for 2012/13 and responded that they had no specific comments to make:

- Durham Healthwatch: responded that given the Board was not fully in place Healthwatch was not able to make a comment this year.
- Hartlepool Health Overview & Scrutiny Committee: responded that the Quality Account had been circulated to all members and no comments had been raised
- NHS Commissioning Board – Local Area (Durham, Darlington & Tees): chose to defer to the CCGs as lead commissioners.
- Redcar & Cleveland Health Overview & Scrutiny Committee: responded that the 30 day consultation time sat in between their cycle of meetings, and therefore, the Committee would not have the opportunity to prepare a formal response.
- Stockton Health Overview & Scrutiny Committee: responded that the Quality Account had been presented to the Adult Services & Health Select Committee and no specific comments had been raised.
- The Healthwatch organisations in Stockton, Middlesbrough and Redcar & Cleveland responded separately but with the common statement: *'Healthwatch was launched on 1st April 2013 and we are currently in the process of recruiting our membership and from there a Board will be appointed. We therefore feel it would be inappropriate to make a comment on the Quality Accounts for 2012/13. However, we would welcome the opportunity to be involved in setting future priorities later in the year and making comment for 2013/14 when the Healthwatch Boards are in place.'*

The following stakeholders were given the opportunity to comment on our draft Quality Account for 2012/13 but chose not to offer comment:

- Harrogate & Rural District CCG
- Hartlepool HealthWatch Hartlepool & Stockton CCG
- Middlesbrough Health Overview & Scrutiny Committee
- Scarborough & Ryedale CCG
- South Tees CCG

Appendix 3: Mandatory quality performance indicator definitions

Percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care

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.
* Follow up may be face-to-face or telephone contact, this excludes text or phone messages

The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper*.

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 assessed** 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 a 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.

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.

* This indicator applies to patients in the age bracket 16-65 years and only applies to CAMHS patients where they have been admitted to an adult ward.

** An assessment should be recorded if there is direct contact between a member of the team and the referred patient, irrespective of the setting, and an assessment made. The assessment should be face-to-face and only by telephone where face-to-face is not appropriate or possible

Patient safety incidents reported to the National Reporting and Learning Service (NRLS).*

Indicator construction:
The number of incidents as described above. A patient safety incident is defined as 'any unintended or unexpected incident(s) that could or did lead to harm for one of more person(s) receiving NHS funded healthcare'.

Indicator format:
Whole number.

* Monitor has the removed the requirement to report this as a rate per 100,000 population

Patient safety incidents reported to the National Reporting and Learning Service (NRLS), where degree of harm is recorded as 'severe harm' or 'death', as a percentage of all patient safety incidents reported.*

Numerator:
The number of patient safety incidents recorded as causing severe harm /death as described above. The 'degree of harm' for patient safety incidents is defined as follows;
- 'severe' – the patient has been permanently harmed as a result of the patient safety incident, and
- 'death' – the PSI has resulted in the death of the patient.

Denominator:
The number of patient safety incidents reported to the National Reporting and Learning Service (NRLS).

Indicator format:
Standard percentage.

* Monitor has replaced the requirement to report this as a rate per 100,000 population with the requirement to report such incidents as a percentage of all patient safety incidents reported by the Trust.

Appendix 4: 20 Best practice standards for transfers of care

1	Is there evidence that a transfer review meeting was held prior to the transfer?
2	If it has not been possible to hold a transfer review meeting (e.g. unplanned/quick relocation etc) is there evidence that teams have communicated with regard to the service users needs/care?
3	Has the outcome of the meeting/discussion been documented in the Review and Care Plan documents on PARIS as required by the CPA policy?
4	If the documentation in 3) above has not been completed, is the transfer review and plan of care documented elsewhere (e.g. case notes/activity recording)
5	Psychiatric history
6	Medical history
7	Forensic history
8	Relationship/life/family history
9	If the historical information above has not been documented on the review document has a comprehensive assessment been completed and documented?
10	If yes to 9. above, is the psychiatric, medical, forensic and relationship/life/family history documented in the comprehensive assessment
11	If neither 9. or 10. Apply, have the relevant history sections (see 5 – 8 above) been documented in the central index under Service User History.
12	Are the timescales for the formal handover of care co-ordinator / lead professional responsibilities documented?
13	Are the timescales for the formal handover of care co-ordinator / lead professional responsibilities documented in the care plan?
14	Is there evidence of service user involvement in the transfer review meeting
15	Is there evidence of carer involvement in the transfer review meeting?
16	Is there evidence that all involved agencies/teams contribute to the transfer review meeting?
17	Was a new care co-ordinator/ lead professional identified from within the receiving team prior to the transfer?
18	Is there evidence that the service user and carer were aware of the new care co-ordinator/ lead professional and their contact details prior to the transfer?
19	Are details of first contact by receiving team documented?
20	Was all contemporary care documentation (assessment, care plans, reviews and up to date risk assessment) completed and accessible to the receiving team

Appendix 5: Glossary

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.

Antipsychotic Medication: an antipsychotic (or neuroleptic) is a psychiatric medication primarily used to manage psychosis (including delusions, hallucinations, or disordered thought), particularly in schizophrenia and bipolar disorder, and is increasingly being used in the management of non-psychotic disorders.

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).

Autistic Spectrum Disorders: describes a range of conditions including autism, Asperger syndrome, pervasive developmental disorder not otherwise specified (PDD-NOS), childhood disintegrative disorder, and Rett syndrome, although usually only the first three conditions are considered part of the autism spectrum. These disorders are typically characterized by social deficits, communication difficulties, stereotyped or repetitive behaviors and interests, and in some cases, cognitive delays.

C Difficile: a species of bacteria of the genus Clostridium that causes severe diarrhea and other intestinal disease when competing bacteria in the gut flora have been wiped out by antibiotics.

Cardea: the Trust's electronic system for purchasing goods.

Care Programme Approach (CARE PROGRAMME APPROACH) & 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): 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 Commissioning Groups (CCGs): NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England. CCGs are clinically led groups that include all of the GP groups in their geographical area. The aim of this is to give GPs and other clinicians the power to influence commissioning decisions for their patients. CCGs are overseen by NHS England.

Cognitive Behavioural Therapy: CBT is a form of talking therapy that combines cognitive therapy and behaviour therapy. It focuses on how you think about the things going on in your life – your thoughts, images, beliefs and attitudes (your cognitive processes) – and how this impacts on the way you behave and deal with emotional problems. It then looks at how you can change any negative patterns of thinking or behaviour that may be causing you difficulties. In turn, this can change the way you feel.

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.

Dialectic Behavioural Therapy: a psychological therapy for people with borderline personality disorder (BPD), especially those with self-harming behaviour or suicidal thoughts.

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, Forensic Services – see also Localities

FACE Risk Assessment: 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.

Forensic Services: forensic mental health and learning disability services work mainly with people who are mentally unwell or who have a learning disability and have been through the criminal justice system. The majority of people are transferred to secure hospital from prison or court, where their needs can be assessed and treated. These services are intended to see that people with severe mental illness or learning disability who enter the criminal justice system get the care they need.

Functional Mental Health Service for Older People: a term used to refer to patients with mental health needs which are non-organic (i.e. dementia) in nature.

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.

Healthwatch: 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. Forensic Services) – see also Divisions.

Multi-Agency Public Protection Arrangements (MAPPA): the name given to arrangements in England and Wales for the "responsible authorities" tasked with the management of registered sex offenders, violent and other types of sexual offenders, and offenders who pose a serious risk of harm to the public.

Mental Health Act: NHS Trust's compliance with the Sections of the Mental Health Act (1983) Amended (2007) regarding the care and treatment of people detained under Sections of the Act.

Mental Health Research Network (MHRN): is part of and funded by the National Institute for Health Research and provides the NHS infrastructure to support commercial and non-commercial large scale research in mental health including clinical trials.

Monitor: the independent economic regulator for NHS Foundation Trusts.

MRSA: is a bacterium responsible for several difficult-to-treat infections in humans. MRSA is especially troublesome in hospitals, prisons and nursing homes, where patients with open wounds, invasive devices, and weakened immune systems are at greater risk of infection than the general public.

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 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.

NHS 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.

NHS Staff Survey: an annual survey of staffs' experience of working within NHS Trusts.

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 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 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.

Personality Disorder: class of personality types and enduring behaviors associated with significant distress or disability, which appear to deviate from social expectations particularly in relating to other humans.

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.

Psychosis: is the term used to describe a type of mental health issue that seriously affects the way that a person thinks or feels and where the person can lose contact with reality.

Quality and Assurance Committee (QuAC): sub-committee of the Trust Board responsible for quality and assurance.

Quality and Assurance Groups (QuAG): Locality / divisional groups within the Trust responsible for quality and assurance.

Quality Risk Profile Reports: The Care Quality Commission's (CQC) tool for providers, commissioners and CQC staff to monitor provider's compliance with the essential standards of quality and safety.
Rapid Process Improvement Workshop (RPIW): a technique for improving quality within the overall TEWV Quality Improvement System (QIS)

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.

SBARD: a simple tool to help clinician's frame clinical conversations for action – situation; background; assessment; recommendation

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.

TEWV Quality Improvement System (QIS): the Trust's framework and approach to continuous quality improvement based on Kaizen / Toyota principles.

Tier 4 Children's Services: specialist inpatient and community services for children.

Unexpected Death: a death that is not expected due to a terminal medical condition or physical illness.

Visual Control Boards: a technique for improving quality within the overall TEWV Quality Improvement System (QIS).

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