Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Annual report and summary financial statements 2013/14

Making a difference together

Tees, Esk and Wear Valleys NHS Foundation Trust

Annual report and financial statements 2013/14

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

A copy of the full accounts is available on our website www.tewv.nhs.uk



The excellent artwork showcased in this report was part of the TEWV Arts exhibition (see page 19).

Strategic and directors' report

Quality report

Governance and financial review

Directors' remuneration report and statutory statements

Financial statements



Strategic and Directors' Report



Foreword by the Chief Executive

Reviewing the past

Over the last twelve months our focus has been on our ambition to provide exceptional quality services, making sure that we are doing all we can to provide the best possible care for the people who use our services and to meet the requirements of our commissioners.

Last year we achieved all the targets set by Monitor and virtually all of the CQUIN (quality) targets set by our clinical commissioning groups.

Improving quality whilst reducing costs is a challenge but our staff have shown great determination, innovation and commitment and have continued to reduce waste wherever it exists and provide effective, high quality services.

Their achievements have once again been recognised at a national level. Last year our staff won eight prestigious national awards and were shortlisted for a further five. This is a tremendous and well deserved accolade and you will find more information about their success throughout this report.

We are passionate about promoting recovery and supporting our service users to achieve their individual goals. In 2013/14 we launched a programme which will fundamentally change our approach to recovery. This important piece of work aims to design and provide services that help people live meaningful and satisfying lives within the limits of their mental illness (see page 118). Supporting this work is the model line programme which also got underway last year and is helping our community teams to become more effective and recovery focussed (see page 21).

We have continued to make the best use of our resources for the benefit of local communities. This has included modernising our existing buildings and developing new facilities for our patients and staff. The West Lane development in Middlesbrough and Springwood in Malton (see page 19) are excellent examples of this.

Good partnership working is essential to making sure people get the care and support they need. This is particularly important for some of the most vulnerable people in our society such as those with a mental health problem who come into contact with the police. A number of new initiatives were introduced last year which will make sure that people get appropriate support quickly (see pages 24 and 25).

The wellbeing of our service users is our main priority but by trying to protect patients from harm there's a risk that we limit their freedom. Last year we received a warning notice from the Care Quality Commission (CQC), which was subsequently lifted in August 2013 (see page 26). Although there were no concerns about the quality of care or patient safety, the CQC inspectors said we were making assumptions about individual's capacity to make decisions, which was limiting their independence. This was an important lesson for us and has helped us adapt our approach to the management of risk.

Overall the feedback we've received from external organisations such as the CQC has been extremely positive (see page 50 of the quality report for more information on CQC reports). We also received national accreditation for a number of our services during 2013/14 (see page 21).

I was delighted that the annual staff survey results once again rated us as being one of the best NHS trusts in the country. TEWV was rated best mental health and learning disability trust in five of the 28 areas covered and was in the top 20% in a further 14 areas.

These reports and accreditations provide further assurance that we're making good 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 are passionate about promoting recovery and supporting our service users to achieve their individual goals."

Looking to the future

An important priority for the Trust is to achieve the priorities set out in our new quality strategy which has four key components:

- perfect patient experience
- great outcomes for people who use our services
- ensuring our services do no harm and
- staff engagement.

The implementation of this strategy is central to our quest of continuing to improve the quality and value of the work that we do. Another element is to improve productivity through innovation.

During the next 12 months it is likely that the Trust will be subject to one of the new style inspections, which were established by the CQC in 2013.

We are going to progress our plans to replace the outdated inpatient wards in the Harrogate, Hambleton and Richmondshire localities. These remain our only inpatient wards with shared bedroom facilities including a number of three and four bedded bays.

Of crucial importance are our staff and the Trust will continue to invest in the development of their skills and expertise. There is international evidence of the link between an engaged and motivated workforce and the quality of service provided and we will strive to maintain our first place position in the national NHS staff survey results and also achieve the Gold Standard in Investors in People accreditation.

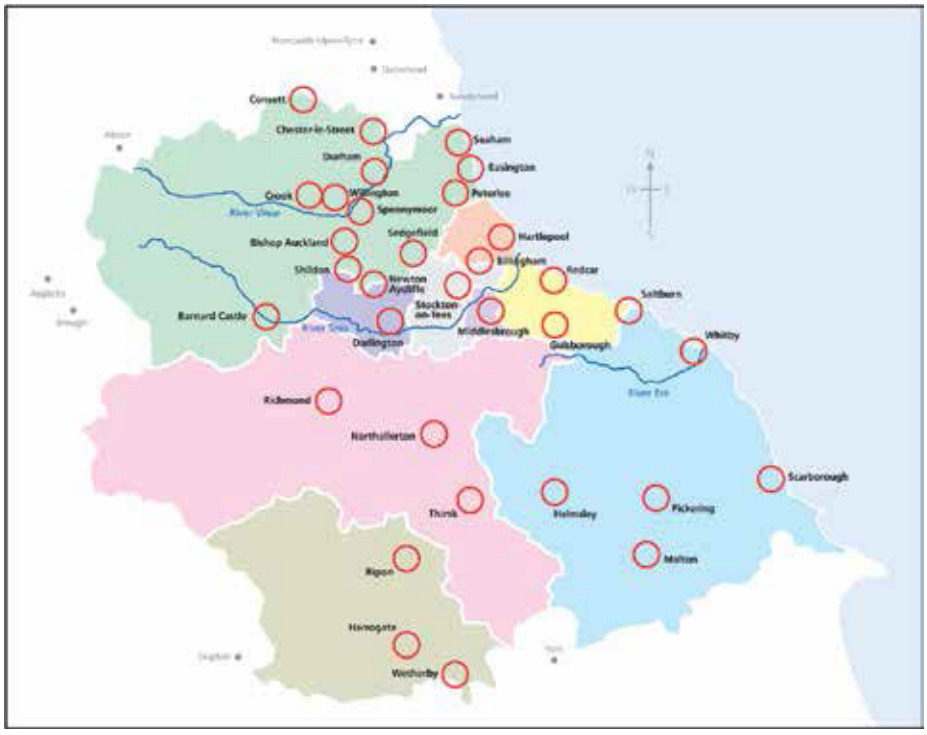
It's a privilege to be chief executive of one of the best mental health trusts in the country and to be supported by such excellent staff, partner organisations, commissioners, service users, carers, governors, members and volunteers. I would like to thank them for their continued commitment to the Trust. Together we really do make a difference.

Martin Barkley
Chief Executive

This annual report, including the annual accounts, has been prepared under a direction issued by Monitor under the National Health Service Act 2006.



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 health sector regulator.

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 operating income of £291 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.

TEWV serves patients across a large geographical area that includes:

- a number of industrial and / or coastal towns with high deprivation levels (eg Hartlepool, Middlesbrough, Scarborough)
- areas of former coal mining (Durham) and iron ore mining (Redcar and Cleveland) which combine semi-rurality with high deprivation levels
- sparsely populated, isolated rural areas (often with "hidden" deprivation) in the Durham and Yorkshire Dales, and North Yorks Moors
- relatively affluent agricultural areas (Hambleton, Ryedale)
- pockets of urban and suburban affluence in parts of Durham City, Stockton, Darlington and Harrogate (all of which also have pockets of deprivation)
- the largest concentration of armed forces personnel in the UK (Catterick Garrison).

There is, however, variation across the areas the Trust serves and challenges for TEWV as a provider are how to:

- balance the different needs and priorities of commissioners while providing a consistent level of quality across the Trust
- manage resources so that we can deliver effectively in urban and rural areas.

Some of the social issues that impact the Trust include:

- the impact of changes in society, and in particular the fragmentation of communities and breakdown of families which increase the prevalence of mental health conditions among the population
- levels of unemployment, which have been increasing in much of our area but which may now have peaked
- the growth in use of social media, which can be both positive and negative for the mental health of social media users
- reduction in the stigma associated with mental illness, and heightened awareness of the symptoms of some conditions (eg dementia) which can lead to earlier presentation and diagnosis

The Trust has developed a three year strategy, which sets out our continuing commitment to embed equality, diversity and human rights into everything we do. The implementation of this strategy is overseen by a cross-directorate working group including a Non-Executive Director chairman. All initiatives are assessed for compliance against equality, diversity and human rights issues.

In 2013/14 the Trust received no judgements from a tribunal or court under the Human Rights Act 1998 or the Equality Act 2010. We will continue to work with commissioners to ensure our ongoing compliance the Acts.

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 18-27 for examples)
- respond better to market opportunities
- continue to invest in capital developments such as West Lane Hospital in Middlesbrough (see page 19)

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 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.

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

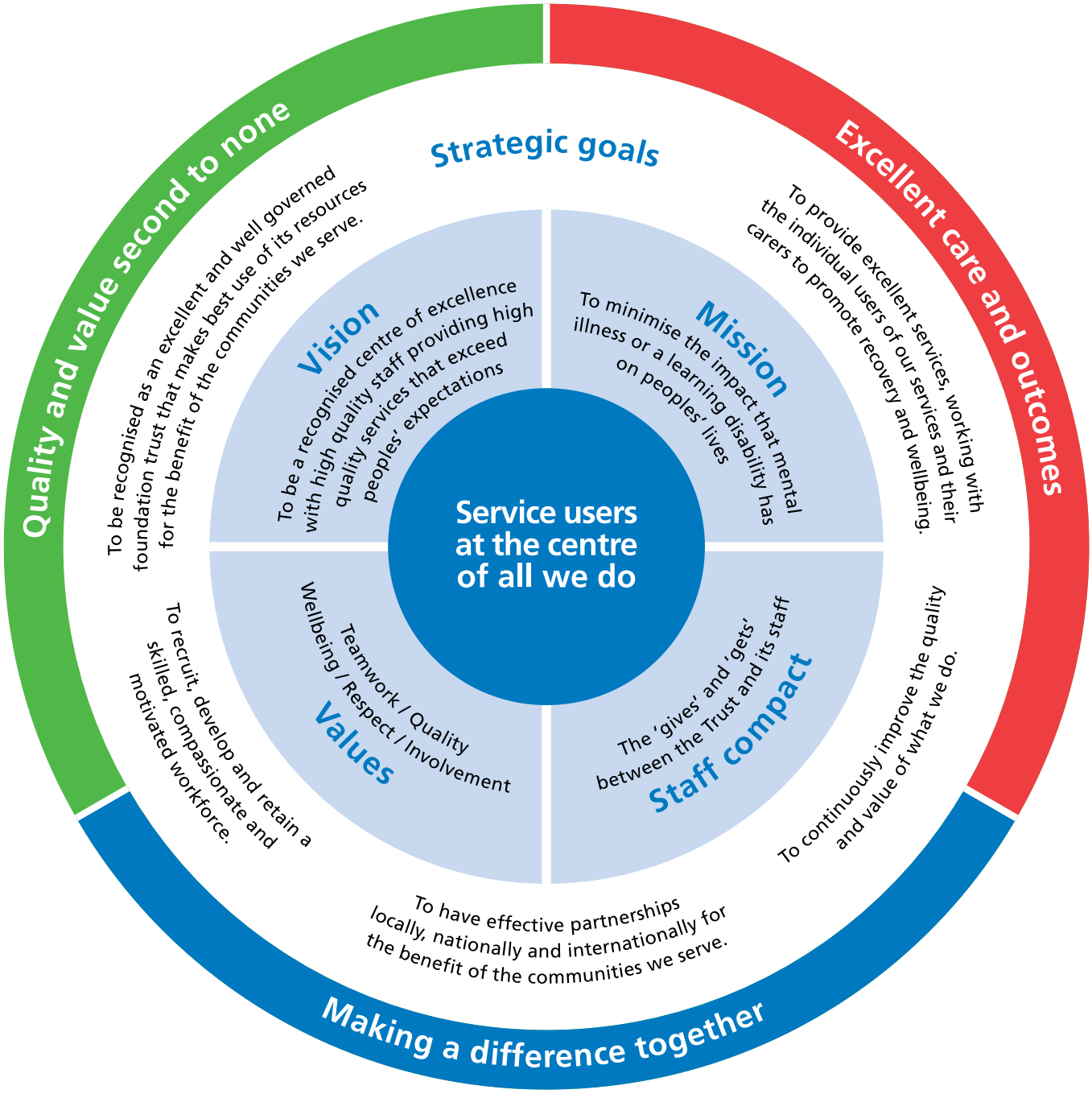
We have five strategic goals

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 which improve the health and wellbeing of our users and their carers. • 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, with no unnecessary transfers or delays in starting treatment.
2 **To continuously improve the quality and value of our work.**	**This means that…** • We deliver consistently good outcomes supported by effective pathways of care and standard work. • We are accredited and known locally, nationally and internationally for our high quality services and continuous improvement. • The quality of our services is demonstrated through real time patient experience and outcome measures	• The TEWV Quality Improvement System is embedded and aligned throughout the Trust to deliver continuous improvement in the quality, and value of our services. • The Trust and its staff only do things that add value to our customers.
3 **To recruit, develop and retain a skilled, compassionate and motivated workforce.**	**This means that…** • We continuously improve our staff survey results and are in the top 10% performing mental health trusts nationally. • Our staff feel supported and valued at work. • Our staff have well defined job roles which add value.	• Our staff work productively, flexibly and with compassion. • We promote and support the wellbeing of our staff. • We engage all our staff through effective communication and involvement. • We proactively support 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 the communities we serve.**	**This means that…** • We support all our commissioners to effectively commission mental health, learning disability, substance misuse and other specialist services. • We engage with NHS England locally, regionally and nationally	• We work closely with all GPs in our area to ensure they can access our services appropriately and provide effective care for patients with mental health, learning disability or substance misuse needs. • We work in partnership with local authorities 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 the communities we serve.**	**This means that…** • Our Council of Governors is fit for purpose and actively engaged in our strategic development. • We maintain the highest rating of regulatory compliance and maintain the level of transparency and candour required.	• We engage the membership of the Trust in the governance arrangements of the organisation. • We regularly use benchmark and outcomes data to deliver improvements in quality and value.

• Users of our services are fully involved in the development and delivery of their care plan. • All of our estate is of high quality.	• We continually seek and act upon feedback, from our service users and carers, on the services we provide. • We provide high quality accessible information about our services and how people can access them.	• We work with our service users and carers to enable them to achieve their recovery goals. • We minimise harm occurring to the users of our services
• The Trust promotes a culture that encourages and enables staff to identify and eliminate waste. • We deliver services that are evidence-based and clinically cost-effective	• We have an active applied programme of funded research and development to improve the services we provide. • We identify good practice and embed it throughout the organisation.	• We promote a culture of actively challenging and reporting unsafe practice, quickly learning from our experience and embedding lessons learned. • The relevant information to improve services and optimise patient experience and outcomes is readily available to staff
• 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, development and leadership 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, users and their carers. • We have the right staff with the right skills, competencies and attitudes to provide excellent services that deliver our care pathways.	• 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 Health Education North East (HENE).
• We influence and contribute to each Health and Wellbeing Board in the communities we serve. • We are the partner of choice for the training of health and social care professionals	• We have a range of formal and informal partnerships with organisations across the public, private and voluntary sectors for the benefit of the communities we serve. • We have a growing portfolio of funded research and development which we use to improve the quality of our services	• We have effective working arrangements with every acute foundation trust in our area. • We have effective working arrangements with all elements of the criminal justice system
• The Trust supports staff and services to improve productivity through use of the best available tools and technologies / methodologies. • We reduce the impact of our business on the environment.	• We actively promote our successes to develop our reputation and brand to all stakeholders and are regarded as the provider of choice. • We deliver a Trust Business Plan which is dynamic, flexible and responsive to the changing environment.	• The Trust is rated in the top 10% for patient outcomes, experience and cost efficiency. • The information we produce is accurate, timely and of high quality.



The TEWV approach



"When my father needed care you were marvellous at sorting out our problems. You have continued to give our family amazing support overcoming insurmountable problems with ease. You have shown great skill, kindness and compassion towards myself and my father."

From a service user's daughter

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:

- Durham and Darlington
- Tees
- North Yorkshire

with a fourth directorate covering forensic services.

Clinical leadership is aligned through the clinical directors across four specialities 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 Durham and Darlington (working with partners) and as one of several qualified providers on Teesside (we do not currently 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, 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 and North Yorkshire. The Trust also runs one of three national pilots testing the prescribing of injectable opiates.

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, 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. West Lane Hospital is in the middle of a major modernisation project to improve the accommodation (see page 19)

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 learning disabilities forensic services (LDFS)

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 behind 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 Hospital 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 and the mental health service within all seven North East prisons.



Our performance 2013/14

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 (key performance indicators) for the Trust to work towards as part of its commitment to year-on-year improvement.

The scorecard opposite is the Trust's dashboard of key performance indicators for 2013/14.

The Board received a monthly performance report during 2013/14 which contained performance against a range of indicators linked to the Trust's strategic goals as well as national requirements.

Commentary on under-performance

- **Percentage of patients who have not waited longer than four weeks for a first appointment –** The Trust has failed to achieve the 98% target throughout the year, reporting an annual position of 86.24%. However, it should be noted that the number of referrals received by the Trust increased by nearly 10% during 2013/14 compared to 2012/13.
- **Percentage of patients who have not waited longer than four weeks following an internal referral -** Whilst we did not meet the target, the Board did set itself a more stretching target compared to last year's target of six weeks. The annual outturn was 88.33% with a target to achieve 98% by December 2013.
- **Percentage of complaints satisfactorily resolved by the Trust –** The Trust has failed to achieve the 90% target throughout the year, reporting an annual position of 65.77%. However, the majority of complaints have been satisfactorily resolved. Throughout 2013/14, 51 complainants (out of 149 resolution letters sent) indicated that they were not happy with the response received in relation to their complaint. Complaints are monitored by the Quality 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.
- **Data completeness: Identifiers –** The target of 99% was set internally by the Trust; however the Monitor target is 97%. The final outturn position was 98.73% which is just below the Trust target but above the Monitor one. There are a number of areas where improvement is required and there is focused work on these which is being monitored by the data quality group.
- **The number of "out of locality" admissions –** This indicator measures the number of times a patient is admitted to a hospital within the Trust that is not the one we would expect them to be admitted to. The Trust has consistently reported above the monthly target of 25 out of locality admissions. During 2013/14 we reported 512 'out of locality' patients against a target of 299. Whilst the position for 2013/14 is significantly above the target that the Board set it should be noted that the overall position for 2013/14 is significantly better than the 2012/13 performance. In 2013/14 there were a total of 512 out of locality admissions in the year compared to 680 in 2012/13 which is almost a 25% improvement. Locality reports have been developed to enable us to understand the position within each of the services and these are monitored closely within the localities. 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 the expected unit for a range of legitimate clinical reasons. Furthermore it is extremely rare that a patient needs to be admitted to a different provider due to lack of capacity within the Trust.
- P**ercentage of staff in post more than 12 months with a current appraisal –** The Trust has under-performed against the 95% target with an outturn of 89% in March 14. However, this is an improvement on the outturn of 86.93% for March 13. Regular monthly compliance reports are closely monitored at various levels and forums throughout the Trust.
- **Percentage compliance with mandatory and statutory training –** The Trust has under-performed against the 95% target with an outturn of 91.45% in March 14; however this is an improvement on the outturn of 87.13% for March 13. Regular monthly compliance reports are closely monitored at various levels and forums throughout the Trust.
- **Percentage of all disciplinary cases completed within eight weeks –** The Trust has under-performed against the 90% target throughout the year. Further work is on going to raise the importance of concluding investigations within the eight week period.
- **Access to psychological therapies -** Adult IAPT: The proportion of people that enter treatment against the level of need in the general population – this indicator only relates to County Durham and Darlington Service. We have consistently under-performed against the Trust target throughout the year. We have developed an action plan to address this underperformance and this continues to be implemented.
- **Recovery rate –** Adult IAPT: The proportion of people who complete treatment who are moving to recovery – Whilst performance for 2013/14 has not achieved the annual target it has improved compared to the position for 2012/13. The services continue to review every patient who has not moved to recovery to ascertain the reasons why and actions are taken where feasible to improve this position.

1. Users of our services	2013/14 Actual	2013/14 Target	2012/13 Actual	Change on 12/13	Comment on 2013/14
Percentage of patients who have not waited longer than four weeks for a first appointment	86.24%	98%	89.08%	↓	2013/14 full year position
Percentage of patients who have not waited longer than four weeks following an internal referral	88.33%	98%*	n/a		Target was 98% by December 2013
Percentage of complaints satisfactorily resolved by the Trust	65.77%	90%	76.36%	↓	2013/14 full year position
Percentage CPA 7 day follow up (AMH only) (validated position)	97.86%	95%	97.14%	↑	2013/14 full year position
Percentage of CPA patients having a formal review documented within 12 months (AMH only)*	96.56%	95%	n/a		Snapshot as at 31 March 14
Percentage of admissions to inpatient services that had access to crisis resolution home treatment teams prior to admission (AMH only) (validated position)	97.58%	95%	97.35%	↑	2013/14 full year position
Median number of days from when a patient is discharged as an inpatient to their next admission as an inpatient (AMH and MHSOP only)	171	140	140	↑	2013/14 full year position
Percentage of those patients surveyed that expressed they were 'satisfied' with their overall experience (month behind)	90.72%	90%	n/a		April 13 – Feb 14 as data is reported one month behind
2. Quality	**2013/14 Actual**	**2013/14 Target**	**2012/13 Actual**	**Change on 12/13**	**Comment on 2013/14**
Number of clinically inappropriate admissions of children aged less than 18 onto AMH Wards	0	0	n/a		2013/14 full year position
Percentage of non-acute patients whose transfer of care was delayed	1.89%	7.50%	2.07%	2013/14 full year position	2013/14 full year position
Number of unexpected deaths classed as a serious incident per 10,000 open cases	11.88	12	15.91	2013/14 full year position	2013/14 full year position
Data completeness: outcomes	96.68%	90%	n/a		Snapshot as at 31 March 14
Data completeness: identifiers	98.73%	99%	99.18%	↓	Snapshot as at 31 March 14
The number of 'out of locality' admissions	512	299	680	↑	2013/14 full year position
Percentage of CROMs that have improved: affective and psychosis superclass	38.12%	No target	n/a		2013/14 full year position
Percentage of CROMs that have improved: organic superclass	24.96%	No target	n/a		2013/14 full year position
3. Workforce	**2013/14 Actual**	**2013/14 Target**	**2012/13 Actual**	**Change on 12/13**	**Comment on 2013/14**
Number of RIDDOR incidents per 100,000 occupied bed days	12.78	15	15.36	↑	2013/14 position
Percentage of staff in post more than 12 months with a current appraisal**	89%	95%	86.93%	↑	Snapshot as at 31 March 14
Percentage compliance with mandatory and statutory training**	91.45%	95%	87.13%	↑	Snapshot as at 31 March 14
Percentage sickness absence rate**	4.8%	5%	5.26%	↑	2013/14 position
Percentage of disciplinary investigations completed within 8 weeks	33.67%	90%	n/a		2013/14 full year position
Percentage of medical staff who have gone through revalidation	100%	100%	n/a		2013/14 full year position
4. Partnerships	**2013/14 Actual**	**2013/14 Target**	**2012/13 Actual**	**Change on 12/13**	**Comment on 2013/14**
Number of EIP new cases	619	259	599	↑	2013/14 full year position
Number of crisis resolution/home treatment episodes	3725	3383	n/a		2013/14 full year position
Access to psychological therapies adult IAPT – percentage of people that enter treatment against the level of need in the general population (Durham and Darlington locality only)	8.24%	15%	n/a		2013/14 full year position
Recovery rate adult IAPT – percentage of people who complete treatment who are moving to recovery	48.78%	50%	45.11%	↑	2013/14 full year position
5. Sustainable organisation	**2013/14 Actual**	**2013/14 Target**	**2012/13 Actual**	**Change on 12/13**	**Comment on 2013/14**
Number of GP referrals into the Trust services	37,879	31,244	34,484	↑	2013/14 full year position
Trust cluster price < 95 against the national publication	90	95	n/a		Snapshot as at 31 March 14

**Please note the actual shown will differ from the Trust dashboard report as validation exercises were undertaken during April and the final figures reported in the quarterly workforce report to be presented to Trust Board in April.



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. Our recovery programme (see below) demonstrates our commitment to this.

We continually review and modernise our services and facilities to make sure that the people who use them are getting the care they need, when and where they need it, and that we're making good use of our resources.

Most people are able (and want) to receive care and treatment within their own homes and we have continued to develop our community teams so that they can support them.

Those who need to spend time in hospital deserve to be cared for in the best possible environment. Our inpatient facilities are some of the best in the country and over the last year we have continued to invest in our estate.

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

Improving rehabilitation services

Over the last twelve months we have made a number of improvements to our adult rehabilitation services. Our aim is to work with individual services users to maximize their quality of life. This means helping them develop the skills they need to lead as independent and socially inclusive lives as possible, with appropriate support.

We have reduced the time that services users are spending in hospital by making sure they get the care and specialist input they need quickly and that we start to plan for their discharge as soon as they are admitted to hospital.

Last year the remaining residents moved out of Victoria Road in Hartlepool. The unit had provided 'slow stream' recovery services and patients were staying for over two years. These service users are now living in more appropriate accommodation (see page 30 for more detail on the public engagement).

We also approved plans to develop a specialist inpatient rehabilitation unit for the people of Harrogate, Hambleton and Richmondshire at the Orchards in Ripon to replace outdated accommodation in Harrogate. This work is due to start in May 2014 and the rehabilitation service will move from Abdale House in Harrogate in 2015. The extensively refurbished accommodation will contain nine en-suite bedrooms as well as a single 'bedsit' style apartment.

Working towards recovery

Members of the recovery programme steering group

In 2013/14 we launched the 'recovery programme' which aims to embed the ethos of recovery into all of our services.

Unlike traditional ideas of clinical recovery, which focus on removing symptoms and getting back to normal, personal recovery is much broader. Personal recovery means different things to different people and should be defined by the person experiencing mental illness. However, for many people it means a way of living a satisfying and meaningful life within the limits of mental illness.

Helping someone to recover can include assisting them to find a job, getting somewhere safe to live and supporting them to develop relationships.

Our recovery programme has four aims:

- develop a culture where recovery principles are completely embedded in policy and practice
- establish a recovery college which is co-designed and delivered with staff, service users and partner organisations. Attending a recovery college can give people the confidence and skills to take control over their lives and pursue their aspirations
- increase opportunities for people with lived experience of mental health to be involved in our work
- transform the way we approach risk assessment and risk management.

TEWV arts

In October 2013 TEWV Arts held its first exhibition in a public gallery. This initiative is an excellent example of a recovery based approach. Service users and staff worked together, using art, to tackle the stigma associated with mental illness.

The occupational therapy team worked with a small group of service users and held an exhibition in a Middlesbrough art gallery called '1 in 4 journeys', reflecting the number of people estimated to have mental health issues at some point during their life.

They also held workshops and performances to raise public awareness of mental illness and break down barriers. This was a hugely successful event, which showcased and celebrated service user talents and highlighted the benefits of art and creativity.

You will see examples of the artwork throughout the annual report

Building for the Future

The dining room at the new Westwood Centre

One of the wander pathways at Springwood

The first phase of the £13.8 million development of West Lane Hospital in Middlesbrough was completed in early 2014. **The Westwood Centre** offers a safe environment for young people, aged 12 to 18, from across the country to be assessed and treated for a range of complex mental health needs.

The Westwood Centre offers 24 hour support, seven days a week to young people who may have been in conflict with the law and need to be legally detained under the Mental Health Act because they present a significant risk to themselves or others.

The newly rebuilt centre offers a wide range of treatments and therapies and has a fantastic range of facilities to aid recovery including 12 ensuite bedrooms, education rooms, a music room, a gym and sports facilities and family visiting areas.

In December 2013 we opened a new, state of the art, specialist inpatient unit for older people with dementia and complex needs in Malton, North Yorkshire.

The £3.9m purpose-designed **Springwood** replaced outdated accommodation that had been well established on the Malton Hospital site for a number of years.

The new Springwood offers patients from North Yorkshire 24-hour care within modern, homely surroundings. The new spacious and contemporary building provides 14 single en-suite bedrooms, one of which is equipped as a high dependency suite.

New to the unit are internal and external wander pathways which offer patients with dementia, who can become anxious or agitated, the space to wander in a safe and secure environment.



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 and the value of what we do so that the people who use our services have the best possible experience and outcome.

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.

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.

Our award-winning staff

National recognition for Trust teams

A number of our high quality services received recognition at national awards.

A project devised to help keep vulnerable people safe online won one of the prestigious Nursing Times awards in 2013. **The internet risk awareness group** is for people with learning disabilities. Internet risks such as being a victim of crime or cyber-bullying are increased for people with a learning disability. Additionally for those with a forensic background, there is an added risk of offending online.

This 10 session programme helps service users understand the benefits and risks of the internet, to help them to make informed choices and minimise the chance of being a victim of crime or distress. Sessions also outline legal aspects around using the internet, tackling behaviours such as stalking.

A partnership between **mental health staff in Harrogate** and the charity **Dementia Forward**, were also awarded a Nursing Times award for nursing in mental health.

This was for the work they've done to improve day services for people under the age of 65 with early onset dementia. Previously day care had been provided on a hospital ward. Now the 'Time out Together' group provides a range of community based activities including walking, bowling and visiting places of interest.

Learning disability services in Durham won the innovation in mental health award at the Health Service Journal awards for their self-catering project which encourages people with learning disabilities to choose and prepare their own meals.

National accreditation

Child and adolescent mental health services in Northallerton became the first service in North Yorkshire to achieve national **Investing in Children** membership status in recognition of the way they have increased participation with its young people.

The Harrogate memory management service (who also received one of this year's staff awards – see photo) received accreditation with excellence from the Memory Services National Accreditation Programme (MSNAP). The award assures staff, service users and carers, commissioners and regulators of the quality of the service we provide.

The Evergreen Centre, part of our **Regional Centre for Eating Disorders**, became the first eating disorders centre for children and young people to be awarded excellence by the Quality Eating Disorders Network. It is also one of five with excellent accreditation by the Quality Network for Inpatient Child and Adolescent Mental Health services.

The way we do things at TEWV

Teams across the Trust are now routinely using the TEWV QIS tools and methods to drive up quality, eradicate waste and improve services.

An excellent example of this is the Trust's finance team who were named 'team of the year' at the Healthcare Financial Management Association (HFMA) Northern Branch Awards for their use of TEWV QIS to significantly reduce lead times for processing invoices and producing budget reports.

Over the last 12 months TEWV held 28 rapid process improvement workshops (RPIW). These week long events empower staff to bring about change, eliminate waste and make improvements to services. We also held a number of other improvement (Kaizen) events such as 3P (production, preparation and process) events to bring about radical, rather than incremental, change; and rapid pathway development workshops (RPDWs).

We also continued to train our staff to use the TEWV QIS tools to make improvements at a local level.

In 2013/14

- 90 consultants and specialist doctors completed the QIS for medics programme
- 43 managers completed the QIS for leaders programme and
- 60 administrative staff completed the QIS for admin programme.

Finance team of the year

Using TEWV QIS for radical redesign

Last year we launched the model line programme which is supporting our community teams to become recovery focussed.

Teams are using the tools of our quality improvement system to look in depth at all aspects of a service and radically redesign the entire process.

The patient centred pathways that have been developed using the QIS methodology describe **what** needs to happen to deliver high quality care. The model line allows teams the time and resources to work out **how** this can be done in the least wasteful way.

A model line looks at the entire pathway through the patient's perspective and makes sure that each step adds value to the patient experience and outcome.

The first service to run a model line is psychosis. The aim is to make sure patients receive personalised care at a pace and level that is suitable to them from first onset of symptoms to a meaningful recovery.



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 are able to get involved and contribute to decision making within the Trust
- We give staff the opportunity to develop as effective leaders and managers
- We provide effective training and development opportunities for staff
- We make sure that every role counts and that we only ask staff to do things that add value
- We promote and support the health and wellbeing of our staff

Over the last year our staff and external assessors have told us that TEWV is a great place to work. At the start of the year we achieved Investors in People standard, having made significant progress since our previous accreditation.

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

Thumbs up from staff

The results of the 2013 annual NHS staff survey confirmed TEWV as being one of the best NHS employers in the country.

The Trust was rated best mental health and learning disability trust in the country in five of the 28 areas covered and was in the top 20% in a further 14 areas.

TEWV was in the top 20% of trusts recommended by their staff as a place to work or receive treatment. It was also among the best performing Trusts for engaging with its staff.

The trust also received the best score for staff being able to contribute towards improvements at work, overall job satisfaction and staff feeling satisfied with the quality of work and patient care they are able to provide.

(See page 35 for more detailed results of the survey).

Leading the way

Excellent leaders and managers have a direct impact on the care we deliver to service users and carers. People at all levels act as an inspiration to others by developing services and implementing change in a way that motivates and engages those around them.

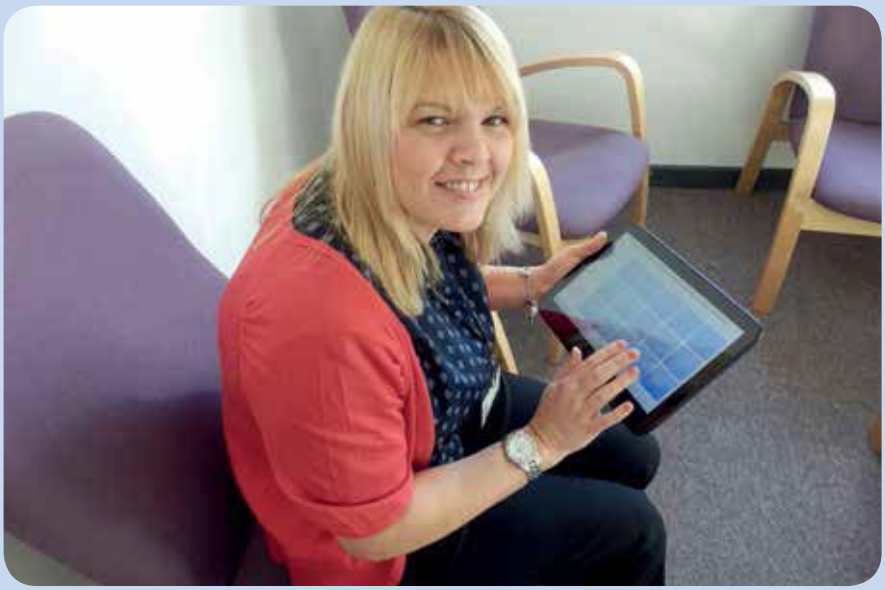
A number of our staff have received national and regional recognition for their exceptional leadership skills.

Derek Benn, modern matron in learning disabilities, was named the NHS Leadership Academy's national Leader of Patient Inclusivity for his work with service users and their families making sure patients have the best experience. Derek was also shortlisted for Nurse Leader of the Year in the Nursing Times awards. Regional recognition went to Dr Suresh Babu, consultant psychiatrist who was named NHS Inspirational Leader and Kaye Wilson, clinical team manager who won the NHS Leadership Development champion of the Year award.

Corinne Walsh, a service development worker in mental health services for older people was named Best Dementia Care inspiring Leader at the National Dementia Care Awards.

National recognition

Tracking staff experiences



In 2013 we launched an innovative new project to use handheld electronic devices to gather the views of staff.

Staff answer a short questionnaire, which is based on the patient experience 'friends and family test', and aims to find out what it's really like to work for TEWV. The Trust will use the feedback to improve services and demonstrate the link between positive staff and patient experience.

Following a successful pilot on four wards the project was rolled out to all adult and older people's inpatient areas.

Investing in behaviours

Our forensic services are part of a national programme aimed at creating a culture within the NHS where high quality, compassionate care thrives.

The national Investing in Behaviours programme, supported by the Kirkpatrick Partnership recognises that there is no point measuring quality without developing quality enhancing behaviours.

Following a cultural assessment the service identified the types of behaviours they wanted staff to display and what they needed to do to provide a supportive environment where staff are able to provide compassionate care.

Over the past year the service has developed and is piloting a new local induction programme for staff. The focus is on having a good balance between essential security training and making sure new staff have a clear understanding of the service's person centre, compassionate and recovery focussed approach.

Forensic services

Initial feedback has been extremely positive and the new programme will now be implemented.

TEWV's got talent...

A more proactive approach to help staff reach their full potential was launched by TEWV last year.

We set up a 'Talent Board' of executive management team members and a 'Talent Forum' with representatives from all directorates to develop our approach to talent management. (Talent management is the overall term that describes the processes used by organisations to make sure they have the correct number of staff with the right skills to enable them to be successful.)

Initially our focus will be the staff in leadership and management roles and those who aspire to these roles. But, as we learn more about implementing talent management, we will extend the approach to other staff groups.



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.

Over the past year we have continued to work closely with our existing partners to develop new initiatives and improve existing services.

We have also established links with a range of new organisations and are working with them to implement new services.

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

Reducing reoffending

Members of the IOM unit

One of our mental health nurses is playing a vital role in County Durham's Integrated Offender Management (IOM) unit.

This specialist unit, which was set up to work with offenders who cause the most harm to local communities, has seen record results in reduced reoffending over the past year (58% in County Durham and 64% in Darlington).

IOM units are made up of representatives from a range of local agencies. They work closely with repeat offenders, supporting them and their families, to reduce the likelihood of reoffending. Many of the offenders have mental health problems and live chaotic lives. Our mental health nurse is helping to make sure they get the support and treatment they need.

Following a successful six month pilot as part of the Big Diversion Project, the offender health commissioners funded the full time post for a further year.

Improving services for children and young people

TEWV is involved in two new partnerships which will improve mental health services for children and young people.

In 2013 the partnerships secured £830k to extend involvement in the national Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) project.

The aim of the programme is to transform services for young people with mental health problems by giving them and their families a greater say, both in their individual care and in how services are developed.

One partnership will cover Easington, Hartlepool and Middlesbrough and the second spans Harrogate, Scarborough, Whitby and Ryedale. Our partners are Investing in Children and, in the Hartlepool area, Alliance Psychological Services. They join four existing partnerships, which were set up in 2012, meaning that the whole of the Trust is now involved in this important initiative.

Improving dementia services

Over the past year we have continued to work with health and social care partners in Harrogate, Stockton and Hartlepool to improve services for people with dementia.

A two year project came to a close at the end of 2013/14. The **Harrogate Dementia Collaborative** brought together experts and those living with dementia from TEWV, Harrogate and District Foundation Trust, North Yorkshire County Council and the Harrogate and Rural District Clinical Commissioning Group (CCG).

Thanks to the work of the collaborative a number of new measures have been adopted including specialist dementia care training in hospital and in other care settings, preventing unnecessary accident and emergency admissions, more streamlined referral processes, enhancing communication on the wards and speeding up the process of diagnosis and improving capacity of local services.

Members of the North Tees dementia collaborative

The **North Tees Collaborative** has a growing membership including TEWV, North Tees and Hartlepool NHS Foundation Trust, Stockton and Hartlepool Clinical Commissioning Group, Stockton and Hartlepool Borough Councils.

A successful pilot with three care homes, which reduced the number of unnecessary admissions to hospital for care home residents by a third is now being rolled out across all the care homes in Stockton and Hartlepool. Key to this has been the regular physical health monitoring by trained care staff.

Other areas of improvement include using the All about Me document to share more person centred information with providers. This document is now being widely used in acute hospital care, care homes and domiciliary care.

The team were also highly commended in the Trust's annual awards (see photo).

Working with the police

Two initiatives were launched last year in Scarborough to make sure that people with mental health problems who are identified by the police get the care and support they need quickly.

A new assessment suite at Cross Lane Hospital provides a Place of Safety for vulnerable adults detained by the police under Section 136 of the Mental Health Act.

Previously the police had no option but take people in this situation to a custody suite, even though they may not have committed an offence.

While detained in the Place of Safety, medical assessments take place and arrangements are made for treatment and care.

A street triage project has also been rolled out in Scarborough to help reduce the number of people detained under the Mental Health Act (MHA).

When police attend an incident and believe that an individual has a mental illness they contact the street triage team of mental health nurses to carry out an immediate assessment.

It means those people who do need care and treatment receive the right services quickly, and that those who don't are not unnecessarily detained. The project builds on the success of a similar project in Cleveland.

Landmark personality disorder trial

A major two year study got underway in 2013 into drug therapy for personality disorders.

We were one of five NHS Trusts across the country chosen to host the LABILE (lamotrigine and borderline personality disorder: investigating long term effectiveness) trial. The study aims to establish whether lamotrigine, a mood stabiliser, is a worthwhile and useful treatment for borderline personality disorder.

People diagnosed with borderline personality disorder experience a range of problems which affect their everyday lives, including emotional distress, negative feelings about themselves, and problems in relationships. There are currently no medicines licensed for the treatment of borderline personality disorder, which affects between 0.5% and 2% of the population.

Service users in the affective disorder teams in Stockton, Middlesbrough and Redcar were invited to take part, and over the two years of the study, recruitment will move to Harrogate and other areas of the Trust.



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.

The Statutory Powers of the Council of Governors were strengthened following the introduction of the Health and Social Care Act 2012. In order to ensure that our Governors understood their new powers, a significant number of them attended national and local training events. Some of the training undertaken has included how, as a Council, Governors can collectively and effectively hold to account the non-executive directors for the performance of the Board.

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.

Over the last year TEWV has continued to use its extensive experience, expertise and sound financial management for the benefit of our communities.

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

Governors appoint new chairman

TEWV's Council of Governors appointed a new chairman in February 2014.

Lesley Bessant joined the Trust on 1 April, 2014, replacing Jo Turnbull whose term of office came to an end on 31 March 2014.

Mrs Bessant had a long and successful career in local government until her retirement from Gateshead Council in 2005.

Since then she has held a number of non-executive roles including Pro Chancellor on the Board of Governors for Northumbria University and she is currently Chair of Northumbria Probation Trust.

Foundation trust chairmen are appointed by trust governors and Mrs Bessant's initial term of office is three years.

Hospital given all clear by regulators

Staff from Auckland Park

Auckland Park Hospital in Bishop Auckland, which provides services for older people with advanced dementia, was given the all clear by the Care Quality Commission (CQC) in August 2013. This followed a warning notice received from the CQC in June 2013 for failing to meet two of their standards.

Although the concerns raised in June 2013 were not about the quality of care or patient safety, the CQC said that staff were making assumptions about individuals' capacity to make decisions, which was limiting their independence. The motives of staff had been to protect patients from harm but standard restrictions meant they were limiting patients' freedom.

Staff quickly realised that by doing things differently they could give patients more choice, independence and freedom. Patients now have unrestricted access to the gardens and can choose whether their bedroom doors are open or locked during the day.

Staff are using more creative, visual ways of communicating with patients who are less able to understand so that they can choose what they want to do or eat. They have also introduced clear and easy to understand signage, pictures and landmarks to help patients find their way around.

Running a regional service

In 2013/14 the Department of Health appointed TEWV to manage the North of England (Mental Health Act) Approval Panel (NEAP).

Under the Mental Health Act, all decisions to detain someone in hospital are agreed by at least one specially trained doctor who is 'approved' by an expert panel. Once detained people must have a responsible clinical who must also be 'approved'.

NEAP manages the approval function process and registers for the North of England. Our NEAP team will also provide advice and guidance for professionals applying to become approved clinicians or Section 12 doctors, making sure they meet all appropriate requirements.

The NEAP team

Using technology to improve clinical services

In 2013/14 we secured more than £880,000 funding to help us use technology to provide better mental health services.

The money came from the national 'Safer Hospitals Safer Wards' scheme and the Nursing Technology Fund. It is being used in three main ways:

- Digital dictation project – to ensure dictation is done using digital devices which will improve the security of information, staff productivity and communication with patients, GPs and other agencies. It will also reduce printing costs and improve the quality of record keeping.
- Electronic transfer of information such as e-discharge letters and GP correspondence – to allow GP's computer systems to integrate with the Trust's systems so information can be more easily shared.
- 500 laptops for nurses – to equip nursing staff with Wi-Fi enabled laptops so they can securely access Trust systems initially from Trust premises and potentially from other locations in the future. This will mean clinical records will be more quickly updated ensuring accurate and safer record keeping.

Governance arrangements strengthened

In October 2013 we implemented revised governance arrangements, which provide more clearly defined assurance processes and structures as well as greater clarity about roles and responsibilities.

The new arrangements were introduced following a planned review of our locality based leadership and management arrangements, which were introduced in 2011.

Our aim is to make sure we maintain a strong locality focus whilst continuing to develop our five major specialities Trust wide.

The new structure provides clear and more direct lines of accountability within our directorates as well as improved assurance processes for our Board of Directors (see page 37 for more information).



Principal risks and uncertainties

Like all organisations, we are affected by, and must manage, risks and uncertainties that can impact on our ability to deliver our strategic direction.

The annual governance statement describes the systems and processes through which risks are identified, managed and mitigated. This can be found on page 106.

We consider that the present principal risks and uncertainties facing the Trust are as follows:

Implications arising from reductions in public expenditure

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

In response we will continue to improve the productivity of our services using our well established quality improvement system and work with partners to seek to develop ways of providing services which meet the needs of each organisation whilst maintaining service quality.

Payment by results

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

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

Waiting times

During 2013/14 our performance on waiting times has deteriorated.

In 2012/13 the percentage of patients seen in month who have not waited longer than four weeks was 94.92%. For 2013/14 this had reduced to 86.24%.

We are committed to taking action to ensure we achieve our targets; however, there is a risk that this might not be achieved if the trend of increasing referrals continues.

Regulatory requirements

We fully support the NHS providing high quality healthcare. It is what both we expect of ourselves as well as what patients and carers expect from us. Nevertheless there is a risk that we might not achieve the standards set by the Care Quality Commission in all services all of the time.

To address this risk we undertake regular self assessments of services and in 2013/14 we have strengthened our governance arrangements to ensure that, when shortcomings are identified, they are dealt with.

Legal requirements

The Supreme Court in its ruling on what has become known as the "Cheshire West case", set a precedent that anyone who meets a new legal test will be considered to be deprived of their liberty and subject to a protective care regime. This means that people who lack mental capacity to made decisions for themselves, whether as a result of dementia, learning disabilities or mental health problems should have the benefit of regular independent reviews to ensure that their placement and any restrictions on their movement are still in their best interests. Although we have always placed great emphasis on ensuring compliance with the Deprivation of Liberty Safeguards (DoLS) in the Mental Capacity Act 2005 there is uncertainty about the implications of the ruling on workloads and overheads.

Monitor risk ratings

The Health and Social Care Act 2012 made changes to the way providers of NHS services are regulated.

Under the Act:

- the role of Monitor changed from being the independent regulator of foundation trusts to become the sector regulator for health services in England
- a new licensing system was introduced which contains obligations for providers of NHS services. This allows Monitor to fulfil its new duties as well as enabling the regulator to continue to oversee the way foundation trusts are governed.

The Compliance Framework

Prior to the implementation of the new provider licences foundation trusts were required to meet the requirements of their "Authorisations".

Monitor developed a regulatory framework to assess a foundation trust's compliance with the terms of its Authorisation, "The Compliance Framework".

The three main components of the Compliance Framework were:

- an annual risk assessment based on an evaluation of a foundation trust's annual plan
- in-year monitoring usually through quarterly submissions
- intervention.

Risk ratings were assigned by Monitor 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.

These risk ratings were expressed as:

- financial risk rating:
  1 (highest risk) to 5 (lowest risk)
- governance risk rating:
  - green (no material concerns)
  - amber-green (limited concerns surrounding Authorisation)
  - amber – red (material concerns surrounding Authorisation)
  - red (potential or actual significant breach of Authorisation)

The Risk Assessment Framework

In October 2013, in response to the introduction of provider licences, Monitor replaced the Compliance Framework with a new Risk Assessment Framework.

Under the Risk Assessment Framework:

- The financial risk rating has been replaced with a continuity of services risk rating.

  This new risk rating aims to identify whether the financial situation of a provider could place key NHS services at risk. It incorporates two common measures of financial robustness: liquidity and capital servicing capacity.

  The continuity of services risk ratings are as follows:
  - 4 (no evident concerns)
  - 3 (emerging or minor concern potentially requiring scrutiny)
  - 2* (level of risk material but stable)
  - 2 (material risk)
  - 1 (significant risk)

- A governance risk rating has been retained; however:
  - its components have been aligned to the requirements of the new provider licence
  - The risk ratings have been changed to be as follows:
    - green (no evident concerns)
    - narrative risk rating (potential material causes for concern) setting out the description of the issue and the steps (formal or informal) being taken to address it
    - red (regulatory action being taken).

Risk rating performance 2012/13 and 2013/14	Annual Plan 2013/14	Q1 2013/14	Q2 2013/14	Q3 2013/14	Q4 2013/14
Under the Compliance Framework					
Financial risk rating	4	4	4		
Governance risk rating	Green	Red	Red		
Under the Risk Assessment Framework					
Continuity of service risk rating				4	4
Governance risk rating				Green*	Green
*Note: On the introduction of the Risk Assessment Framework (1 October 2013) the Trust was assigned a narrative governance risk rating of "Monitor is investigating governance concerns at the Trust, triggered by a CQC inspection"(see below). Monitor concluded its investigation in quarter 3 2013/14 and assigned a green governance risk rating.					
	Annual Plan 2012/13	Q1 2012/13	Q2 2012/13	Q3 2012/13	Q4 2012/13
Under the Compliance Framework					
Financial risk rating	4	4	4	4	5
Governance risk rating	Green	Green	Green	Green	Green

Variation from plan and regulatory interventions

On 20 June 2013, Monitor commenced a formal investigation into potential breaches by the Trust of its Provider Licence. Monitor took this action due to quality governance concerns arising as a result of a Warning Notice being issued to the Trust by the Care Quality Commission (CQC) in relation to Regulation 17 ('Respecting and involving service users') of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The Warning Notice was issued by the CQC following the Trust's failure to address concerns it had originally raised in August 2012. (Further details of the CQC investigation are provided in page 54 of the Quality Report)

During the course of its investigation, Monitor reviewed evidence obtained from a number of sources including:

- The Warning Notice published by the CQC on 17 June 2013
- The findings of an independent investigation of the Trust's policies and procedures for planning and implementing actions in response to the 2012 CQC compliance failure
- The findings of an independent review into the circumstances of the deaths of four service users of the Derwentside Affective Disorder service during February 2013
- The findings of a review of the Trust's quality governance arrangements against Monitor's Quality Governance Framework by Deloitte LLP.
- A meeting held with the Trust on 13 December 2013, which discussed the evidence provided during the investigation.

As a result of progress made in responding to the governance concerns and based on assurances from the CQC that its previous recommendations had been actioned and the required standards met, Monitor notified the Trust on 21st January 2014 that it had concluded its investigation and returned the Trust's governance risk rating to green.

In doing so the regulator also set out its expectations that remaining recommendations from the Deloitte LLP and other reviews, both already undertaken and planned, should be carried out effectively and at pace.

Deloitte LLP has been commissioned to undertake a follow up review of progress against its recommendations on quality governance in early 2014.



Involving and listening

Service user and carer involvement

We involve service users and carers in many different aspects of our services to learn from their experiences.

Over the past year they have, for example:

- participated in the service users, carers and advocates leadership programme, which gives people skills and confidence to get involved and make a difference
- attended a number of focus groups with Trust staff to give expert opinions on a variety of topics such as the Mental Health Act, the Care Programme Approach, forensic patient experience, pharmacy and how the Trust handles information
- visited many of our wards with the quality assurance team and PALS staff to talk to patients about their experiences of quality and safety standards on the wards, identifying any areas for improvement
- took part in the patient led assessments of the care environment programme (PLACE) carrying out ward inspections of non-clinical aspects of care such as the environment, food and hydration, and privacy and dignity
- worked with governance staff to inspect wards and teams in the internal programme to monitor compliance with the Care Quality Commission standards
- helped with the recruitment of new staff through interview panels and workshops
- gave presentations at Trust conferences, staff training sessions and a variety of workshops, including assisting with the development of a recovery strategy
- participated in quality improvement workshops and events to improve and develop services
- supported other service users in a peer support group for those with emotional and psychological distress and substance misuse problems
- took part in food tasting and menu planning to assist with decisions relating to the trust catering contract (including choices, preferences and quality)
- gave ideas and opinions for our building redesigns, refurbishments and decoration including Abdale House in Harrogate, Westwood Centre in Middlesbrough, Lake House in Scarborough, Rowan Ward in Harrogate, Ward 14 at the Friarage Hospital Northalleton and a forensic ward at Roseberry Park
- assisted with the research strategy for mental health services for older people
- took part in the medical development programme, helping to train and recruit doctors

- participated in positive practice events sharing experiences with Trust members, governors and staff
- supported by advocacy to participate in a learning disability reference group, helping to recruit staff, training staff and a clinical research programme.

Trust Involvement with local networks

Healthwatch England was established on 1 October 2012 with local Healthwatch organisations starting on 1 April 2013 replacing the Local Involvement Networks (LINks). Healthwatch is an independent consumer champion that gathers and represents the public's views on health and social care services in England. The Trust liaises with a number of local Healthwatch organisations in County Durham, Darlington, Hartlepool, Tees and North Yorkshire, sharing information and responding to requests.

Public engagement

In 2013/14 the Trust worked closely with Hartlepool and Stockton Clinical Commissioning Group (CCG) on proposals to improve rehabilitation services on Teesside and the proposed closure of Victoria Road in Hartlepool.

The Victoria Road facility provided continuing care and slow stream rehabilitation and included accommodation for nine patients.

As rehabilitation services have developed over recent years, more support has been made available in the community and residents are moving to more suitable accommodation.

The accommodation at Victoria Road was in a good condition but rooms did not have en-suite facilities, which is a key requirement of modern mental health care units.

The number of residents at Victoria Road had been reducing over the last two years. At the end of September 2013 there were no residents and the facility was temporarily closed.

Following an engagement exercise with key stakeholders to understand their views and gain feedback about the proposals the CCG approved our plans to close Victoria Road.

Patient advice and liaison service (PALS)

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 2013 and 31 March 2014, 1173 contacts were recorded and responded to by PALS this was an increase of 154 contacts from 2012/13 when 1,103 contacts were made.

Formal complaints

In 2013/14 we received 150 written complaints. This was a decrease of 27 complaints compared to the 177 complaints received in 2012/13.

The Parliamentary and Health Service Ombudsman (PHSO) is responsible for operating the second stage (independent review) of the NHS complaints regulations process. In 2013 the PHSO changed its arrangements for managing complaints and is now investigating more complaints about NHS and social care organisations.

In 2013/14 there were 17 contacts from the PHSO about complaints made to the Trust. The Trust has received seven decisions about the way the Trust managed the complaints. One decision upheld the complainant's allegations and one was required to implement further action.

Listening and learning

We continue to learn valuable lessons from complaints and concerns from service users and their carers. We identified a number of improvements over the last year including:

Child and adolescent mental health service (CAMHS)
The pharmacy bulletin was used to highlight the importance of discussing side effects with patients and carers when initiating or changing medication. Additional reminders were made to clinicians about directing patients and carers to the Choice and Medication website containing details of medication and side effects.

Adult mental health service
Access teams now discuss the option of directing a referral to the talking therapies services where this is a more appropriate and direct treatment option.

Forensic learning disability service
Staff reviewed their systems for storing patients' personal property to reduce the risk of misplacement. Information leaflets are being developed for patients to explain why property needs to be stored and what type of items have to remain in storage for security purposes.

Forensic service
The level and frequency of drug and alcohol screening was reviewed and will be monitored by the multi-disciplinary team bi-weekly. Staff are also to increase the re-testing of drug and alcohol screening to ensure accurate results.

Mental health service for older people
Awareness of staff was raised about the impact on the patient and their family of review meetings being held with many professional staff present. Staff have developed alternative ways to involve professionals to improve the experience of review meetings for the patient.

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 2014 we employed just over 6,000 staff:

- 250 doctors
- 1990 qualified nurses
- 1,600 clinical support staff
- 660 qualified psychologists, allied health professionals and pharmacists
- 1,500 administrative and estates staff

Workforce is primarily white (95%), which is broadly in line with our local population and is made up of 76% female and 24% male staff.

The number of male and female directors and senior managers (ie members of the Board of Directors and Executive Management Team) is as follows: 14 male and six female.

Health and wellbeing

The health and wellbeing of our staff remains a high priority for the Trust and we have continued to work with our occupational health provider to support our staff.

There was a significant improvement in performance by our occupational health provider during 2013/14. Activity trends and levels were within agreed targets although waiting time for a first appointment with an occupational health nurse remains a challenge. Plans have also been developed to further improve pre-employment checks through the use of an on-line screening system.

A range of improvements were put in place and embedded during 2013/14 including the use of template reports, text reminders and the involvement of the occupational health physician in regular Trust case management review meetings.

The Trusts occupational health service provider, North Tees and Hartlepool NHS Foundation Trust, achieved accreditation against the Safe, Effective, Quality Occupational Health Service (SEQOHS) standards during 2013/14 and, following a competitive tendering process, was awarded the Trust's new occupational health service contract commencing April 2014.

Sickness absence figures for 2013 (calendar year)
(statistics produced by Department of Health Information Centre)

Average of 12 months (Jan-Dec 2013)	Average full time equivalent (FTE) staff in post	FTE days available	FTE days lost to sickness absence	Average sick days per FTE
4.7%	5,515	1,240,813	58,643	10.6

Our work to reduce sickness absence rates across the Trust and improve the health and wellbeing of our staff is paying off and at the end of March 2014 our rate was 4.8%, below our target of 5%.

Communicating and engaging with our staff

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 which includes a round-up of discussions at the Executive Management Team meetings and a weekly message from the Chief Executive. We also include a monthly Board round up following the public Board of Directors meeting
- Informal visits by directors and formal board visits

The final report from the public inquiry into Mid Staffordshire NHS Foundation Trust by Robert Francis QC was released in February 2013. In early 2013/14 we held 15 engagement events to gather views and ideas from staff, governors and members on the actions we needed to take to address the recommendations of the report. We are implementing a number of suggestions including the introduction of an anonymous on-line feedback form to make it easier for staff to raise concerns and a 'you said, we did' page on the Trust intranet that we use to let staff know how we've used feedback to improve services.

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. In September 2013 we introduced new arrangements to support more local consultation. Four locality consultative committees (LCCs) were established, chaired by the director of operations and attended by local staff representatives. These committees meet bi-monthly (alternating with the main joint consultative committee (JCC), which now also meets bi-monthly). The LCCs address local issues but can escalate to the JCC if required. This new arrangement frees up the JCC to focus on Trust-wide issues.

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 survey which said that 79% of staff felt able to contribute towards improvements at work.

Valuing our staff

Our staff are our most important asset and recognising their excellent work and the vital contributions they make to patient care is very important. This can range from a simple 'thank you' in our weekly e-bulletin to nominating teams and individuals for one of our annual staff awards.

Last year 40 teams or individuals were shortlisted for our seventh **Making a Difference Awards** and invited to a special awards ceremony. The Trust's awards programme is extremely popular and last year received almost 200 nominations.

The quarterly **Living the Values Award**, which is publicised in the Trust's magazine, recognises staff who have clearly demonstrated the Trust's values in their day to day work. In addition, the Executive Management Team names a weekly team or individual of the week for those who have gone that extra mile to achieve great outcomes.

We also held our annual **long service awards** ceremony for staff with over 25 years services in the NHS, presenting them with a certificate and high street vouchers.

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.



The Trust's policy on pay

During 2013/14 the Trust confirmed its support for national pay and terms and conditions of service but also clarified its belief that changes are needed to help ensure that Agenda for Change and medical staff pay and conditions arrangements, designed more than ten years ago, are consistent with present day circumstances.

During 2013/14 the Trust implemented changes agreed by the NHS Staff Council to occupational sick pay arrangements and developed revised appraisal arrangements that are to be tested during 2014/15. These changes are intended to improve performance by optimising use of the relevant Agenda for Change terms and conditions. As part of this commitment during 2013/14 the Trust revised its local pay progression procedure, which links annual pay progression to completion of core mandatory training and appraisal, to improve its effectiveness.

The Trust is committed to the principle of equal pay for work of equal value and carried out an Equal Pay Audit that was shared with the Board of Directors and staff representatives during 2013/14. The audit did not highlight any significant concerns. The Board of Directors agreed that a written statement of intent regarding the Trust's future approach to pay and reward would be developed by June 2014 to complement the Trust's workforce strategy.

Staff survey

The Trust was in the top 20% of mental health and learning disability trusts in 19 of the 28 areas reviewed and received the best score in the country in five of those areas. Our response rate was 60%. We were also in the top 20% of trusts for staff engagement, which is based on three indicators:

- ability of staff to contribute towards improvements at work
- staff recommending the Trust as a place to work or receive treatment and
- staff motivation at work.

Details of our top and bottom ranking scores are included in the table on page 35 (see KF reference below)

Our top five ranking scores were:

- work pressure felt by staff (2.80, on a scale of 1–5, compared to 3.07 nationally – the lower the score the better) **KF3**
- staff job satisfaction (3.85, on a scale of 1-5, compared to 3.67 nationally) **KF23**
- percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver (83% compared to 77% nationally) **KF1**
- percentage of staff able to contribute towards improvements at work (79% compared to 72% nationally) **KF22**
- fairness and effectiveness of incident reporting procedures (3.68, on a scale of 1-5, compared to 3.52 nationally) **KF15**.

Our bottom five ranking scores were:

- percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months (23% compared to 19% nationally) **KF16**
- percentage of staff receiving job- relevant training, learning or development in the last 12 months (80% compared to 82% nationally) **KF6**
- percentage of staff experiencing physical violence from staff in the last 12 months (4% compared to 4% nationally) **KF17**
- percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months (30% compared to 30% nationally) **KF18**
- effective team working (3.84 on a scale of 1-5, compared to 3.83 nationally - the higher the score the better) ***KF4***.

Overall we have maintained our scores since last year, which is good news although it does mean we haven't made any significant improvements since 2012. For instance, it is disappointing that there was no change in the numbers of staff experiencing physical violence. Reducing this figure remains a high priority for the Trust.

Over the last year we have worked hard to address the issues highlighted in the previous staff survey. Local action plans have been developed and implemented and in addition some examples of work that has taken place are:

- We've continued to look at ways of improving the health and wellbeing of our staff. This included trying to gain a better understanding of the causes of stress and we included additional local questions in this year's survey. Stress assessment tools have also been considered and several staff engagement workshops have taken place in both adult mental health services at Roseberry Park and learning disability forensic services.
- We've reviewed and updated the challenging behaviour policy which has been renamed 'Positive approaches to supporting people whose behaviour is described as challenging'.
- We've introduced more ways of anonymously reporting concerns to the Executive Management Team. Staff can use the form on Intouch or leave a message on the concerns line.

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

- percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months
- percentage of staff receiving job-relevant training, learning or development in the last 12 months
- percentage of staff experiencing physical violence from staff in the last 12 months
- percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months
- effective team working
- quality of appraisal
- disabled and BME staff experiences
- communication between senior management and staff
- whistle-blowing awareness raising and the quality of responses
- staff compact review/awareness raising.

Summary of Staff Survey Results

	2012/13		2013/14		Trust Improvement/ Deterioration
Response rate	Trust	National Average	Trust	National Average	
	62%	51%	60%	50%	deterioration

	2012/13		2013/14		Trust Improvement/ Deterioration
Top 5 Ranking Scores	Trust	National Average	Trust	National Average	
KF3	2.83	3.02	2.80	3.07	Improvement
KF23	3.78	3.66	3.85	3.67	Improvement
KF1	80%	78%	83%	77%	Improvement
KF22	79%	71%	79%	72%	No change
KF15	3.67	3.52	3.68	3.52	Improvement

	2012/13		2013/14		Trust Improvement/ Deterioration
Bottom 5 Ranking Scores	Trust	National Average	Trust	National Average	
KF16	22%	20%	23%	19%	deterioration
KF6	85%	82%	80%	82%	deterioration
KF17	3%	4%	4%	4%	deterioration
KF18	29%	30%	30%	30%	deterioration
KF4	3.89	3.83	3.84	3.83	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, emergency planning and business continuity issues.

Achievements have included:

- the introduction of health, safety and security champions and a programme of training to support them
- the introduction of a health, safety and security newsletter
- completion of an audit programme which covered all of the health, safety and security workbooks (the Trust's health and safety management system) and
- a programme of table top business continuity exercises to test our business continuity plans culminating in Exercise Three Rivers, a live exercise organised by the Trust in conjunction with Cleveland Emergency Planning Unit.

Reducing our carbon footprint

We are committed to reducing our carbon footprint and have an environmental strategy and implementation plan. 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. A further evaluation of our performance, environmental strategy and carbon management plan is to be carried out in 2014.

The Trust now generates energy from every renewable resource – wind, photovoltaics, solar thermal, ground and air source heat pumps and biomass. Roseberry Park's Northdale Centre has our largest roof array of photovoltaics capable of generating a 50 kilowatt peak (kWp) and, over its life expectancy, saving the Trust in excess of 500 tonnes of carbon emissions. There is currently a feasibility study underway to expand the use of photovoltaics at Roseberry Park to a system capable of delivering an additional 200 kWp.



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 (lead commissioner for mental health & learning disability services in County Durham & Darlington)
- 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 (for services in parts of Ryedale only)
- Leeds North Clinical Commissioning Group (for services in Wetherby Town only)
- Airedale, Wharfedale and Craven Clinical Commissioning Group (for learning disability services in Craven only)
- NHS England (for forensic services, tier 4 children and adolescent services, and adult eating disorder service, some offender health service e.g. street triage)
- The Ministry of Defence
- The Ministry of Justice
- National Offender Management Service
- Darlington Borough Council
- Durham County Council
- Hartlepool Borough Council
- Middlesbrough Council
- Stockton-on-Tees Borough Council
- Redcar and Cleveland Borough Council
- North Yorkshire County Council

Contract for services in Harrogate, Hambleton and Richmondshire
Last year Harrogate and Rural District CCG and Hambleton, Richmondshire and Whitby CCG agreed not to re-tender the mental health and learning disability services in Harrogate, Hambleton and Richmondshire, currently provided by TEWV. The contract with TEWV will change to a standard national contract.

We provide some 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 NHS England.

We are working with Durham Tees Valley Probation Trust in a joint venture to provide community services for offenders with a personality disorder across Durham and Teesside. This service is commissioned by the National Offender Management Service and the Ministry of Justice.

We are part of a joint venture, ARCC, for a number of organisations across County Durham and Tees Valley to come together to seek opportunities for providing services for local communities. This approach is being organised through a community interest company including the Trust and two local authorities, an employment/skills/training employer, a faith sector provider, a housing provider, a charity, and a probation service. Although not presently commissioned to provide services, ARCC will consider new tenders for probation and offender health services.

We continue to be lead provider in a joint venture to provide Improving Access to Psychological Therapies (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.

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. This is a mental health and wellbeing service for veterans and their families in the North East and is commissioned by NHS England.

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

We are working in partnership with local charities Dementia Forward and Red Cross in North Yorkshire to develop opportunities for older people with dementia to engage in meaningful activities and make social connections outside the hospital setting.

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

- Carillion Services (Roseberry Park Hospital)
- The Grosvenor House Group (Lanchester Road Hospital)
- Integral Ltd (West Park Hospital and other properties in North Yorkshire)
- South Tees Hospitals NHS FT (Friarage Hospital)
- Harrogate District Hospitals NHS FT (Briary Unit, Harrogate)

Quality Assurance

Overview of arrangements in place to govern service quality

This year the Board of Directors approved new arrangements to govern service quality that were implemented in October 2013. These arrangements are based on the directorate and locality structures in the Trust and align the governance and management of service delivery. The governance arrangements consist of both clinical and corporate governance structures and processes and are monitored through the sub-committee to the Board of Directors, the Quality and Assurance Committee.

The clinical governance structures ensure there is clinical engagement and ownership throughout the Trust in the assurance of quality for services.

- There are clear lines of accountability from the service clinical teams to their directorate quality and assurance groups (QuAGs) , to their locality management and governance boards (LMGB) then to the Quality and Assurance Committee and to the Board of Directors. The arrangements give a direct line of governance from 'ward to board' to act as controls for quality and provide the system for escalation and management of risk.

Our clinical governance house

- The speciality development groups are Trustwide and are based on the functional groupings within the Trust, such as adult mental health. These groups lead the development of clinical standards, through the design of clinical pathways based on NICE guidelines and other evidence. This facilitates the learning and adoption of best practice from and between different parts of the Trust. This helps mitigate and control the risks of ineffective or inappropriate care through geographical variation.

The clinical governance structures are described in our clinical governance house (see above). There are agreed information flows of quality indicator information that are collected from service monitoring and reporting systems, collated and analysed and then fed back up through the directorate QuAGs and LMGBs. Those groups add operational context to the information and assess the levels of risk to the quality of services. The groups can escalate the information and agree actions to manage and mitigate the risks to patient care.

The Trustwide governance groups and corporate teams provide control to the risk of poor quality care by the management of the policies, procedures and work programmes they are responsible for. The data they collate and information they produce, for feedback to the clinical services, acts as a further control enabling services to reflect on their performance, highlight and manage potential risks and secure improvement. The Trustwide governance groups are supported by the corporate governance teams and report directly to the Quality and Assurance Committee.

- Controls to risks are also Trust policies, procedures and standard work, supported by training, to enable the workforce to deliver the agreed standards of care and treatment. Training and education, staffing profiles, clear job roles data systems, the project framework and improvement plans all mitigate against risk and prevent risks impacting on delivery of direct care and Trust services.
- The Trust governance groups and corporate teams have key performance indicators through which systems can be monitored. Compliance with policy is checked by audit programmes.
- The assurance and escalation framework outlines the steps required to set controls, develop mitigation plans and what is to be done if risks change, or controls and mitigation fails.

Both the LMGB and the Trustwide governance groups produce regular assurance and exception reports for the Quality and Assurance Committee that include their risk register scores. These together with mitigation and improvement work progress are used to produce the monthly reports that go to the Board of Directors.

Improving quality governance

Early in 2013, the Board of Directors undertook a self assessment against the Monitor Quality Governance Framework (QGF) and identified those areas that required further development. This assessment was built upon with the results of the planned audit of the Trust quality governance performance by the internal auditors which, although gave significant assurance regarding the Trust performance, made a number of recommendations to improve the quality governance arrangements.

The improvement plan resulted in the redesign of the Trust governance arrangements, the development of the clinical assurance framework and the review of the quality and assurance strategy.



Further to the warning notice issued to the Trust by the Care Quality Commission in May 2013 the Trust commissioned a further governance review. This was carried out by Deloitte and assessed the Trust governance arrangements directly against the standards of the quality governance framework. The resulting action plan aims to increase consistent compliance with the QGF and ensure improvement in performance of the governance systems and processes.

To achieve this, the Quality and Assurance Committee, that reports directly on governance and quality to the Board of Directors has been reviewed and redesigned. This is to improve the monitoring of assurance and escalation of risk, separating the quality assurance and quality improvement reporting. All the governance structures and processes have been reviewed and redesigned resulting the new arrangements for both clinical and Trustwide governance groups. These have been established with standardised agendas and reporting processes to enable robust systems.

There are improvement projects in place to enhance the quality of the information and dataflow systems. These are to ensure the monitoring and risk management of the standards of clinical care is based on the best quality information and data. Processes are now in place to version control documents, reports and minutes of meetings. The quality and assurance strategy has been reviewed and the new quality strategy includes a new clinical assurance framework and now includes clear strategic objectives for the improvement of clinical quality. These will be monitored, using a strategic quality scorecard, from ward to Board level.

Arrangements for monitoring improvement to the quality of healthcare

There are a number of systems in place to monitor quality improvement in clinical health services:

Clinically reported outcomes (CROMs) and patient reported outcomes – with the introduction of Payment by Results the tracking of outcome measures before and after a planned quality improvement can be used to monitor direct impact on the service users and the quality of their care.

Patient reported experience measures – as one of the Trust's ambitions for quality is to provide the perfect patient experience, a central system in the Trust to monitor quality improvement of services is by collecting data from patients about their experiences.

Clinical audit – the outcomes of improvement programmes and actions are audited against the required standards and the aims of the improvement action. These are usually random subject selection audits and can involve single cycle or continuous testing approaches.

Complaints and incidents – before and after monitoring of these quality indicators, when quality improvements are planned, can track the impact on the delivery of care.

TEWV QIS – the preparation for the key improvement events TEWV QIS involves numerical and experiential data collection with target metrics. Re-measure of these target metrics after the event at 30, 60, 90 and 365 days enables monitoring the impact on quality of the QIS improvement events.

Scorecards – agreeing the end objectives for improvement and the metrics that will demonstrate the achievement of those objectives enable a scorecard approach to be used that then enables close monitoring of progress toward the improvement objective.

There are no material inconsistencies between the Annual Governance Statement (page 106), annual Board statements and CQC reports/ action plans (see quality report page 54).

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 Trust has had a range of CQC reviews that include planned but unannounced compliance inspections and Mental Health Act reviews. Two of the planned compliance inspections were re-visits to check for compliance in units where previous compliance or enforcement action was required. All action plans are now completed that were put in place to address compliance issues.

In addition one locality was subject to an interagency planned thematic review of the mental health emergency services, including Section 136 arrangements. A further locality was involved in a multi-agency planned thematic review of children's services and safeguarding. These action plans are currently ongoing and on track.

The summary of reports and action plans is included in the quality report (page 54).

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

Additional quality issues not covered in the quality report.

In addition to the quality priorities that are reported in the quality report there have been a number of other quality improvements, including:

- The expansion to the systems for the collection of patient reported experience data has continued. Patients now have a regular opportunity to feed back their levels of satisfaction in learning disability and children's services as well as in a range of community team settings.
- The programme of improvement to the clinical environment has continued with the refurbishment of in-patient areas in Northallerton and in Harrogate. A new older person's unit has been built in Malton and the first phase of the new children's in-patient accommodation is complete (see page 19).
- A number of improvement events reduced waiting times and streamlined processes resulting in less bureaucracy for patients being referred into services.
- The memory services in North Yorkshire have implemented new pathways, working in partnership with third sector services to develop award winning services (see page 21).
- The transition from child to adult services in mental health has been enhanced with greater shared care arrangements and joint working. This improves the experience for the young adult and their family.
- All the Clozapine prescribing, dispensing and monitoring services have been standardised and simplified. This has significantly reduced the risk of errors in the Clozapine clinics as well as improving the patient experience.
- Security practices in forensic services have been improved to increase the amount of personal choice and autonomy, decreasing blanket restrictive practice wherever possible within the medium secure environment.

Research and development

We are committed to supporting and promoting research across all our services and localities. The more research-active we are as a Trust, the better care we will provide. Our involvement in large-scale clinical trials gives service users and carers access to treatments at the forefront of knowledge. In our work with the National Institute of Health Research and our collaboration with national and international academic partners, we contribute to the worldwide evidence base for mental health care. We seek to create a culture of enquiry within our services which welcomes innovation and challenge.

- The full involvement of people with experience of mental health problems and their carers is essential to ensure the quality and relevance of our research, in the development of ideas, study design and conduct, and in getting the results to those who can use them to improve care. Our Mental Health in the Young (MeHRY) collaboration with Durham University has established a young peoples' research involvement group, YouthSpeak, which is already influencing and improving our work. They made a superb workshop contribution to our annual research and development (R&D) conference. Our LABILE clinical trial of lamotrigine in borderline personality disorder is overseen locally by a study steering group whose composition includes two service users, to ensure that all study governance and delivery is properly informed from a patient perspective.
- Our work in clinical trials has shown we can successfully make these important studies available to service users across the Trust's wide geography. This year the COBRA trial has given access to behavioural activation therapy in a research setting for people with depression in primary care in County Durham, recruiting 150 participants. The Three Shires Study of oral health intervention recruited 684 participants from our early intervention in psychosis services in all our localities. 2013/14 also saw a rapid growth in Trust support of large scale dementia research. Over 80 participants have been recruited this year to dementia studies which included recognition of the Trust as the highest performer nationally in recruiting to a study of visual impairment in dementia.
- This has been our most successful year yet in recruiting participants to National Institute of Health Research (NIHR) portfolio studies. We more than doubled our activity from the previous year, reaching a total of 1218 participants within our secondary care services. We also helped to recruit more than 300 participants to primary care mental health studies, with a focus on trials which increase access to evidence-based psychological interventions. We have sought to increase our involvement in commercially-sponsored research as a high priority for government, our network funders and our Trust R&D growth strategy. This year we exceeded our recruitment target to a commercial study involving people with schizophrenia treated with injectable antipsychotics. Our strong partnerships within NIHR clinical research networks have been essential in delivering these successes. We are an active and committed partner in the establishment of the new North East and North Cumbria Clinical Research Network launched on 1 April 2014.
- Research conducted in the Trust is producing results of international significance. Three Trust staff were co-authors on a February 2014 paper in the Lancet medical journal, showing evidence that cognitive behavioural therapy may be a viable alternative for people with psychosis who do not take antipsychotic medication. Our Durham University Mental Health Research Group has published more than 20 research articles in many other high-quality journals including Schizophrenia Bulletin, Psychiatric Bulletin, Early Intervention in Psychiatry, BMC Medical Education, and Journal of Research in Nursing.
- The Trust's clinical academic partnership with Durham University is developing substantial new directions of research with a strong focus on benefit to service users. At our first joint annual mental health R&D conference with the University in March 2014, progress was presented on themes spanning the effect of childhood trauma on mental health, the opportunities and challenges in the use of 'big data' for mental health research, and the potential for wider access to psychosocial interventions in primary care settings. The NIHR Clinical Research Network Chief Executive Jonathan Sheffield gave the keynote address on the importance of using research networks in delivering evidence to improve patient care.

Serious untoward incidents

involving data loss or confidentiality breach

There were no reportable SUIs involving data loss or confidentiality breach's in 2013/14 (categories 3-5)

The table below shows a summary of other personal data related incidents in 2013/14 at category 1-2.

Type of Incident	No
Lost in Transit	**2**
Lost or stolen paperwork	**5**
Disclosed in error	**11**
Unauthorised access/disclosure	**3**
Other	**2**
Total category 1-2	**23**

Quality report



PART 1:
Statement on quality from the Chief Executive of the Trust

I am pleased to be able to present Tees, Esk and Wear Valley NHS Foundation Trust's (TEWV) quality account / report for 2013/14. This is the sixth quality account / report we have produced and it tells you a lot of what we have done to improve the quality of our services in 2013/14 and how we intend to make further improvements in 2014/15.

Please note: for the purposes of publication in the Trust's annual report, the quality account is termed the quality report, and therefore, is termed as both of these throughout this document.

In the 2013 NHS service user survey of community services, the Trust scored **7.5 out of 10** (sample size of 217) for 'overall care'. This was a similar score to other mental health Trusts in the survey.

In the Trust's own surveys in 2013/14, **91%** (sample size of 6,135) of service users reporting 'excellent' or 'good' to the question 'overall how would you rate the services you have received'

In 2013/14, in the Friends and Family Test, the Trust scored **45** on a scale between -100 and +100 (sample size of 1,293).

This means that to the question 'would you recommend the Trust as a place to receive treatment', **87%** of patients reported 'extremely likely' or 'likely', and **5% (68 patients)** reported 'unlikely' or 'extremely unlikely'.

Our commitment to delivering high quality services is supported by our second strategic goal:

'To continuously improve the quality and value of our work'

This commitment is embedded within the TEWV approach (page 14).

Our starting point in delivering this strategic goal was to understand what quality means to the Trust and all our stakeholders. In order to be able to demonstrate that we are delivering quality we believe our services must:

- **Provide the perfect experience –** this means that the people who use our services consider that the way we work with them ensures that they are listened to, engaged with and treated with compassion, respect and dignity.
- **Be appropriate –** this means that treatment and care should be safe, 'does no harm', be evidence-based and relevant to the needs of the individual.
- **Be effective –** this means that what we do, delivers the outcomes that we and our service users and carers expect, and makes a positive difference to people's lives.
- **Reduce waste –** this means that we should remove or minimise any activity that does not add value to people who use our services, our staff and our other stakeholders.
- **Be built upon** the standards set by the Care Quality Commission and the other regulators we are accountable to.

To support the delivery of our vision, the Trust has developed a quality strategy which sets out our ambition for quality:

'To ensure safe, patient centred and effective high quality clinical care and treatment, delivered by valued individuals and teams'

To deliver this we have identified a number of priorities to be addressed in 2014/15. Section two of the quality account / report sets out four quality priorities for 2014/15 that were developed and agreed with our stakeholders. Within the Trust's business plan there are additional priorities for 2014/15 and beyond which also have a focus on improving quality.

What we have achieved in 2013/14

Section two of the quality account / report also sets out our progress on our four quality priorities for 2013/14. However, these quality priorities are not the only ways we have improved the quality of our services in 2013/14. The following are other notable examples of quality improvements within our services / localities in 2013/14:

- We have continued to invest in ensuring our buildings provide appropriate and therapeutic environments. In 2013/14 we saw the completion of a brand new complex care ward at Springwood in Malton, the opening of a purpose built low secure ward for children and young people at the West Lane site in Middlesbrough, the upgrade of the lodge at Bankfields Court to support an individual package of care, and the development of a new community team

base at Windsor House in Harrogate.

- We have continued to work with our commissioners to deliver new services to meet the needs of those who use our services. For example:
  - A new section 136 suite and a street triaige service in Scarborough
  - A crisis and recovery house in Shildon, County Durham.
- We have worked with our partners to improve services. For example:
  - We have worked with Dementia Forward and the Red Cross in Harrogate to develop additional activities for those with dementia outside hospital.
  - We have provided training to care home staff to promote the use of evidence-based practice.
  - We have continued to develop our liaison services to support the acute Trusts in our area to provide improved experiences for theit patients who also have mental health problems.

In addition to these examples above, we have continued to drive improvements in the quality of our services through using the TEWV Quality Improvement System (TEWV QIS). This is the Trust's framework and approach to continuous quality improvement and uses tried and tested techniques to improve the way services are delivered.

Some notable examples of what we achieved within our services in 2013/14 are:

- The time taken from referral to the specialist eating disorders team and acceptance for treatment by the specialist team has reduced from 43 days to **6** days.
- **100%** of service users who leave adult mental health inpatient wards in North Yorkshire now leave with a summary of their care and their discharge plan which includes their medications. This avoids the risk of duplication with multiple prescriptions.
- Harrogate dementia collaborative ran an improvement event to reduce attendance of people with dementia to the emergency department at Harrogate District Hospital. Outcomes included:
  - Creating a 'best practice' file for service users to support care homes manage their care including clear, visual representations of key support information.
  - Developing a system to support communication and action for care homes to address a deterioration of a service user's health.
- We have significantly reduced the time it takes for children to transfer to adult services when they are 18 years old.
- We have redesigned the care planning process on our low secure forensic learning disability wards which has resulted in patients experience ratings improving form 6 out of 10 to **8 out of 10**.

In 2013/14 the Trust was also recognised externally when we won or were shortlisted for a number of prestigious awards, in particular:

Eight Awards Won:	Six Awards Shortlisted:
Nursing Times Awards 2013: • Nursing in Mental Health • Nursing in Learning Disabilities National Dementia Care Awards: Best Inspiring Leader HSJ Awards 2013 Innovation in Mental Health: Learning Disability Inpatient Service in Durham NHS Leadership Awards 2013: NHS Leader of Patient Inclusivity of the Year National Service User Achievement: Service User Led Initiative for My Shared Pathway in Forensic Services Hospitality Assured Business Excellence Team of the Year Award 2013: Hotel Service Team HFMA: Finance Director of the Year	Royal College of Psychiatrists Psychiatric Team of the Year for Older Adults 2013 Nursing Times Awards 2013: • Nurse Leader • Nurse of the Year National Leadership Awards: • NHS Inspirational Leader of the Year • NHS Leadership Development Champion of the Year A carer who works with our Trust was shortlisted for the Royal College of Psychiatrists Carer Contributor of the Year Award 2013

In the 2013 NHS Staff Survey, the Trust scored **3.89 out of 5.00** (sample size of 492) for the question 'would recommend the Trust as a place to work and receive treatment'.

This was an **improvement on 2012** and within the **top 20%** of all mental health Trusts who participated in the survey.

Overall in 2013 TEWV was ranked **1st out of 57** mental health Trusts for the NHS Staff Survey

In the Trust's own surveys in 2013/14, **77%** (sample size of 1,109) of carers replied 'yes, always' to the question 'do you feel that you are actively involved in decisions about the person you care for'

In the Trust's own surveys in 2013/14, **77%** (sample size of 3,000) of service users reporting 'yes always' to the question 'did you feel safe on the ward'.

The majority who felt they did not always feel safe were in wards where behaviours that challenge are more prevalent.



In 2013/14 the Trust reported 83 serious untoward incidents. Of these 60 resulted in the death of a patient or alleged homicide.

As a result of the root cause analysis of these incidents in 2013/14, 269 action points were generated. At March 2014, 4 of these action points were outstanding more than one month beyond their originally agreed timescale.

In 2013/14 the Trust received 150 complaints. During 13/14 65% of complaints were resolved satisfactorily.

As a result of these complaints 78 action plans to learn the lessons were generated. At March 2014, 13 of these action plans were outstanding more than one month beyond their originally agreed timescale.

What we have learnt in 2013/14

Of course we know we do not always get it right. The Trust is working hard to develop a culture of openness and honesty to help improve its quality. The systems of complaints, incident reporting, surveying and regulation are critical to this.

During the year we have listened to our service users and carers, staff, partner organisations and regulators. The following are some examples of the lessons we have learnt and improvements made in 2013/14:

- Improvement has been made to clinical risk assessment and management as a result of root cause analyses of serious untoward incidents.
- The Trust developed a workbook to help qualified nursing staff manage service users' physical care following concerns raised by clinical staff regarding their knowledge and skills.
- Greater effort is being made to explain the purpose of medication and assess side effects following feedback from patient surveys that this was not always done well.
- In response to feedback from carers that they were not always involved in decisions about treatment and care, in some of our services, we have committed to contacting carers on a regular basis and providing drop-in sessions for carers.
- Feedback from patient surveys on an adult learning disabilities ward specifically requested a cinema room. A room was re-decorated, blinds and a projector installed and the room now operates as a cinema room.

The structure of this quality account / report is in accordance 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 2013/14, the required statements of assurance from the Board and our priorities for improvement in 2013/14.
- Section 3 – Further information on how we have performed in 2013/14 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 account / report is included on page 74. This is further supported by the signed limited assurance report provided by our external auditors on the content of the 2013/14 quality account / report which is included on page 75.

I hope you find this report interesting and informative. If you would like to know more about any of the examples of quality improvement we have highlighted in this report, or have any feedback or suggestions on how we could improve our 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

2013/14 Priorities for improvement – how did we do

As part of our 2012/13 quality account / report the Board of Directors agreed four quality priorities to be addressed in 2013/14.

Priority 1 & 2	**Implement the recommendations of the Care Programme Approach review relating to:** **– improving care planning.** **– 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**

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 further improvements in experience and outcomes for our service users.

Priorities 1 & 2: Implement the recommendations of the Care Programme Approach (CPA) review relating to: – improving care planning, – improving communications between patients and staff.

Why this is important:
We are two years into a complex and significant four year programme to improve the use of the CPA across the Trust. CPA is the approach we use to assess patients, plan and coordinate care, and review progress with patients who require secondary mental health services and have complex needs.

In 2012/13, the Trust performed a comprehensive review of its use of the CPA. Some key findings of this review relevant to care planning and communication 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 CPA and other processes related to internal and external initiatives. This reduces the time available to spend with service users and carers to listen and discuss concerns and deliver recovery focused interventions.
- 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 understandable.
- There is a lack of clarity and agreed processes regarding the management of section 117 of the Mental Health Act – the statutory duty to provide health and social care to some service users following discharge from in-patient care.

In 2013/14 the focus of this priority was to develop a plan to implement the recommendations of the review and commence the implementation of this plan via the CPA project.



CPA and care planning is critical to the quality of care our service users receive. The full involvement and participation of service users and carers within care planning is associated with improved outcomes and the experience of care. Addressing the issues above for service users, carers, staff and all agencies with whom we work with was a clear priority for improving the quality of the services the Trust delivers.

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

As the recommendations of the review are fully implemented in 2014/15 and 2015/16, our service users and carers, partners in care and staff should expect to see:

- a standard of high quality care planning across the Trust
- service users and carers reporting that they feel listened to and understood, that they understand and are involved in the development of their care plan and subsequent care reviews, and that their care plan will help them achieve their goals
- a reduction in staff time spent on administrative tasks associated with care planning and more face to face treatment time with service users and carers.

What we did in 2013/14:

The following is a summary of the key things we have done in 2013/14:

Developed a detailed implementation plan.	• The development of the detailed implementation plan was deferred by the Board to quarter 3 2013/14 to allow time to recruit a project manager and agree a methodology for implementation. • The CPA project commenced with appointment of a project manager on the 1st October 2013. • The detailed implementation plan was agreed in November 2013.	**Achieved**
Commence the delivery of the detailed implementation plan.	• We have established the project governance arrangements with representation from each locality / speciality and two service users. • We have established links with other co-dependent Trust projects eg recovery, model lines (a project to develop model teams and a model way of working to provide best practice care), how we communicate with GPs, payment by results (the national project to link payment for service to outcomes delivered for patients), PARIS (the electronic patient record). A significant part of the CPA project will be delivered through these projects. • We are establishing communication links with each Local Authority via existing joint meetings and partnership boards. • We have reviewed the current CPA policy to ensure it is consistent with our plans. • We are in the process of re-issuing to every service user on CPA a copy of their care plan on yellow paper with clear instructions on how to raise concerns, a briefing note on the CPA project and an invitation to be involved in the project. At March 2014, around 2,000 service users out of a total of 10,359 people on CPA have been re-issued with a copy of their care plan. In 2014/15 all service users on CPA within all services will be re-issued with a copy of their care plan • We have further developed our service user information folder which includes: a new information leaflet about CPA and care coordination; appointment information; community team and contact information; mental health / service fact sheet; recovery diary. The Trust is considering a proposal to send a folder to all service users on CPA in 2014/15.	**Achieved**

What we plan to do in 2014/15:

The next steps are reflected in quality priorities 2 & 3 for 2014/15 (see page 65).

"I was anxious when I arrived on Christmas Day but staff made me very welcome and were so kind to me I was soon put at my ease. I know that if I need help it's just a phone call away….I hope my experience gives hope to anyone afraid of hospitals."

From a patient

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 teams are central to the safety and effectiveness of the care received by service users when they are experiencing a crisis. The provision of this type of intervention at a time of great need can have a significant impact on service users' 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.

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

Through the delivery of this priority, our service users and carers, our partners in care and our staff should expect to see:

- A standard of high quality crisis and home treatment services across the Trust.
- 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 did in 2013/14:

Two projects in County Durham and Darlington and Tees were used to implement the recommendations of the crisis review in 2013/14. This priority did not include North Yorkshire as the organisational review in 2012/13 was limited to County Durham and Darlington and Tees. There has been, however, a review of community mental health teams including crisis services in North Yorkshire during 2013/14.This work has taken the recommendations of the crisis review in County Durham and Darlington and Tees and developed a model of care suited to the North Yorkshire locality. It is expected that the revised model for crisis services in North Yorkshire will be implemented alongside the recommendations for the wider community mental health services in 2014/15.

The following is a summary of the key things we have done in County Durham and Darlington and Tees in 2013/14:

Implement recommendations from the crisis review – for both County Durham and Darlington and Tees	• We have implemented a consistent operational policy. • We have developed new shift patterns to match staff numbers with peaks and troughs in demand. • We have introduced a new role of shift coordinator to release front-line staff to focus on delivering care. This has ensured a quick response to crisis intervention whilst also protecting time for intensive home treatment. During the day each team has a shift coordinator. Out of hours the teams within each locality come together with one shift coordinator covering each locality. • We have developed better joint working with inpatient wards resulting in crisis staff spending more time on wards to facilitate safe, prompt and supported discharge. • We have established a Trust crisis team collaborative / network for staff to share issues, solutions and best practice. The first formal meeting of the group will be in April 2014.	**Achieved**
Implement recommendations from the crisis review – specifically in County Durham and Darlington	• We have reviewed medical staffing to ensure all crisis teams have equal access to appropriate medical input. • We are implementing a standard operating protocol for handovers of patients between crisis services and other Trust inpatient and community services. • We have developed and implemented a model for a crisis / recovery house in Shildon, County Durham. • We have reviewed all staff skills and developed a training plan for '14/15.	**Achieved**
Implement recommendations from the crisis review – specifically in Tees	• We are piloting a centralised s136 suite at Roseberry Park – formal arrangements will be agreed based on success of pilot. • We have assessed the levels of staff stress within the crisis teams and taken action where required.	**Achieved**

What we plan to do in 2014/15:

The crisis services have not been chosen specifically as a priority for 2014/15. However, the quality priority for 2014/15 on managing the pressure on inpatient beds (page 66) will involve crisis services.



Priority 4: To further improve clinical communication with GPs

Why this is important:
The needs of an individual with mental ill-health and/or a learning disability are always unique and often complex. As partners in care, the Trust and its local GPs must work together to maximise our combined efforts to meet these needs. 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 view of our communication with GPs was that it was variable approach across the Trust and we did not always focus on providing what GPs and service users and carers needed to know. This conclusion was borne out by the feedback we received from GPs.

What benefits / outcomes our service users and carers should expect:
Through the delivery of this priority, our service users and carers, our partners in care and our staff should expect to see:

- 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.
- Service users and carers reporting that they are offered copies of communications between the Trust and the GP

What we did in 2013/14:
The following is a summary of the key things we have done in 2013/14:

Agree a draft standard template for clinical communications with GPs (eg discharge plans).	• A draft standard template was approved by the Trust in June 2013.	**Achieved**
Agree a business case for the implementation of the standard template.	• A business case for the implementation of the standard template was approved by the Trust in September 2013.	**Achieved**
Create a standard patient information / front sheet and free text template for clinical communications with GPs on PARIS.	• A key challenge was to ensure that the standard electronic template was compatible with historical and new versions of the Care Programme Approach (CPA) documentation and could be generated electronically on PARIS (the electronic patient record). • This issue created a delay and a revised project plan was agreed by the Trust in December 2013 to defer this action from quarter 2 to quarter 4 2013/14. • A final standard electronic template for clinical communications with GPs was agreed by the Trust in February 2014.	**Achieved**
Ensure the electronic version of the standard template on PARIS functions effectively within clinical situations.	• Given the delay in agreeing the final standard template, testing the template on PARIS did not commence until quarter 4 2013/14. • The Trust agreed in the revised project plan to defer this action to be completed by quarter 2 2014/15. • Testing is now in progress and is on track for completion by quarter 2 2014/15, however, this is outside the originally reported timeframe of 2013/14.	**Not Achieved in '13/14 but on track for revised deadline of Q2 '14/15**

"You provided every item of equipment and all the skills necessary to nurse my partner in comfort, safety and dignity"
From a patient's partner

Establish Trust wide use of the standard template for clinical communications with GPs.	• Given completing the testing of the final standard electronic template on PARIS was deferred to quarter 2 2014/15, implementing the template Trust-wide will not happen until this time. • The Trust agreed in the revised project plan to defer implementation to quarter 2 2014/15, however, this is outside the originally reported timeframe of '13/14. • In the meantime each locality is on track to develop a training and roll out plan which will support the implementation of the standard template Trust-wide by quarter 2 2014/15.	**Not Achieved in '13/14 but on track for revised deadline of Q2 '14/15**



Update on 2012/13 quality priorities

In last year's Quality Account / Report we reported on our progress with our quality priorities for 2012/13. Within this we also noted some further actions for 2013/14. In some cases, these actions were to be embodied within the quality priorities for 2013/14, and therefore, are reported within this quality account / report. In other cases, these quality priorities were discontinued in the quality account / report but remained a priority for the Trust. The following is a brief summary of our progress with the quality priorities that were discontinued.

To improve how we gain feedback from patients on their experience and improve our services and the feedback we receive	• In 2013/14 we extended our survey work into children and young people's services and services for adults with learning disabilities • In 2013/14 we received responses from 6,135 service users about their experience compared to 3,820 in 2012/13. This is a 61% increase on the previous year and shows we are continuing to seek feedback on the experience of care within all our services.
To sustain an improvement in all transfers of care with standard work practices and improved communication between professionals	• A re-audit of services in 2013/14 rated the Trust AMBER (ie compliant for 50% to 79% of transfers). As a result service-level action plans have been agreed and are being implemented.
To develop broader liaison arrangements with acute Trusts around physical health needs of mental health patients.	• In 2012/13 the Trust reported that the two projects to extend acute liaison services to older people in County Durham and Darlington and Tees had been completed. It was noted that in 2013/14 a full evaluation of the projects would be performed. It was also noted that work would continue in North Yorkshire with commissioners to explore opportunities for establishing acute liaison. • In County Durham and Darlington the high visibility of the service within the hospitals has resulted in a significant increase in the number people being supported during the period of their admission, and with a reduction in urgent referrals. Over the 12 month period from October 2012 to September 2013 the service received 2,211 referrals for patients aged over 65. This is more than double the previous year, with face-to-face contacts for this period increasing by over 400%. The average length of stay for older people in acute wards was between 0.9 and 3.2 days shorter than before the service was extended. The total number of acute hospital bed-days saved is estimated at between 1,990 and 7,075 in a full year. The economic evaluation suggested that the £2m per annum. invested in the service is more than outweighed by the cost of bed days in acute hospital care and continuing social care provision that was required prior to the service being in place. • In Tees, the service was not operational until April 2013, and therefore, the 12-month evaluation is not expected until quarter 1 2014/15. • In North Yorkshire, the Trust has worked with its commissioners to develop opportunities for mental health liaison including input into acute trusts. Business cases for three services in Scarborough, Northallerton and Harrogate have been agreed. It is anticipated that these services will commence in 2014/15.

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 2013/14. These statements are contained within the blue boxes. In some cases additional information is supplied and where

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 2013/14.

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 patient advice and liaison service, 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. They listen to what service users, carers and staff think and feel about the services we provide. 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.

On a monthly 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.

On a quarterly basis we have clinical quality and risk governance meetings with commissioners.

Participation in clinical audits and national confidential inquiries

During 2013/14, **six** national clinical audits and **one** national confidential inquiry covered the relevant health services that TEWV provides.

During 2013/14, TEWV participated in **100%** 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, and did participate in, during 2013/14 are as follows:

- National Audit of Schizophrenia.
- Prescribing Observatory in Mental Health (POMH) UK topic 13a – prescribing for attention deficit hyperactivity disorder (ADHD).
- POMH UK topic 7d – monitoring of patients prescribed lithium.
- POMH UK topic 4b – prescribing anti-dementia drugs.
- POMH UK topic 10c – use of antipsychotic medicine in children and young people's mental health services (CAMHS).
- National Audit of Psychological Therapies (NAPT) in adult mental health.
- National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH).

NB: For POMH UK Topics 13a, 7d, 4b and 10c above 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 2013/14, are listed below alongside the number of cases submitted to each audit or inquiry as a percentage of the number of registered cases required by the terms of the national audit or inquiry.



Audit Title	Cases	% of the number of registered cases required
National Audit of Schizophrenia	100	100%
POMH UK topic 13a – prescribing for ADHD	35	100%
POMH UK topic 7d – monitoring of patients prescribed lithium	868	100%
POMH UK topic 4b – prescribing anti-dementia drugs	***	100%
POMH UK topic 10c – use of antipsychotic medicine in CAMHS	***	100%
National Audit of Psychological Therapies (NAPT) in adult mental health		100%
National Confidential Inquiry into Suicide & Homicide by People with Mental Illness	n/k*	97%**

* 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 2013: for the final year of the patient suicide and homicide analysis we estimated the final number of cases based on data completeness in previous years. Projected figures are based on the average annual return of inquiry questionnaires in England, ie for suicide 97% and for homicide 98%. Page 11 Para 2 National Confidential Inquiry.
*** POMH Topic 4b and Topic 10c are currently underway and the reports are anticipated by the end of March 2014 and July 2014 respectively. It should be noted that there has been a delay in the publication of the national report for POMH topic 4b by POMH-UK.
**** The NAPT clinical audit is a retrospective case record audit of people who completed therapy between 1st July 2012 and 31st October 2012.

The reports of **three** national clinical audits were reviewed by the provider in 2013/14 and TEWV intends to take the following actions to improve the quality of healthcare provided:

- POMH UK topic 13a – prescribing for attention deficit hyperactivity disorder (ADHD).
  Actions:
  - The physical healthcare group to consider access to percentile and growth charts via the electronic patient record system.
  - The clinical audit report to be presented to the children's and adult mental health services development groups and distributed to all relevant teams.
  - The clinical audit report to be presented to the drug and therapeutics committee
- POMH UK topic 7d – monitoring of patients prescribed lithium.
  Actions:
  - To disseminate the clinical audit results to clinical directors, heads of service, team managers and lithium register designated links.
  - Action plans for ensuring pre-treatment checks are performed to be requested from the Chester-le-Street, Ripon and Whitby adult mental health teams.
  - Action plans for ensuring annual weight/BMI/waist circumference are recorded to be requested from all teams.
  - To share the clinical audit results with the Drug and Therapeutics Committee.
  - To set up three monthly exception reporting of pre-treatment checks.
- National Audit of Psychological Therapies (NAPT) in Adult Mental Health.
  Actions:
  - The localities to review their local reports, develop and implement action plans to improve clinical practice where identified as necessary.
  - To look at attrition rates across the speciality and identify any potential improvements to address this area which was below the national average.

The reports of **81** local clinical audits (**186** individual audits) were reviewed by the provider in 2013/14 and TEWV intends to take the following actions to improve the quality of healthcare provided. **Appendix 2** includes a selection of **nine** key themes from these local clinical audits reviewed in 2013/14.

In addition to those local clinical audits reviewed (ie those that were reviewed by the Trust's Quality and Assurance Committee), the Trust undertook a further 65 clinical audits in 2013/14.

All the clinical audits referenced above were included in the annual internal forward audit programme for reasons of quality assurance, service improvement or professional development. The forward audit programme is agreed every year with the clinical services to include 'must do' national or Trust-wide audits and those requested by services as part of their quality assurance or quality improvement plans. The audits vary in focus – some monitor compliance against an internal policy or procedure and others measure the variance of current practice against national standards, such as NICE guidance. A number are designed to provide evidence of the outcomes from a service initiatives or new practice, particularly the quality improvement initiatives agreed as CQUINs.

The findings from these audits are reported to the Trust Quality and Assurance Committee, with any risks from findings escalated through the management systems. Any learning and recommendations from the audit results are expressed as actions for the services to implement to achieve further improvement. Many of the actions are simply to prompt and remind staff about existing guidance and some result in change to processes and systems. Audit findings are regularly used in other quality improvement projects to plan where to focus change and development.

The delivery of actions is monitored through the Trust governance systems and delays in achievement are escalated. At the end of March 2014 there were **28** action points that were overdue beyond their originally agreed timescales. Topics are re-audited to monitor that improvement actions have been effective.

Participation in clinical research

The number of patients receiving NHS services provided or subcontracted by TEWV in 2013/14 that were recruited during the period to participate in research approved by a research ethics committee was **1,411**.

Of the **1,411**, **1,049** were recruited to National Institute for Health Research (NIHR) portfolio studies. This compares with **536** patients involved as participants in NIHR research studies during 2012/13 and **433** in 2011/12. This is a key indicator of the Trust's rapidly increasing involvement with large scale, often complex, national research across clinical disciplines such as psychosis, attention deficit hyperactivity disorder, addictions, drug safety, forensic mental health, dementia, affective disorders and personality disorder.

The Trust's growing participation in clinical research through 2013/14 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 continued our participation in clinical research include:

- We were involved in conducting **92** clinical research studies during 2013/14. This compares with **104** in 2012/13. **46** of these studies were supported by the NIHR through its networks and **22** new studies approved through its coordinated research approval process.
- **73** members of our clinical staff participated as researchers in studies approved by a research ethics committee, with **42** of these in the role of principal investigator for NIHR supported studies.
- **19** researchers from outside the organisation were granted access under the National Research Passport Scheme to perform research with us compared to 9 in 2012/13.
- We have continued to develop our collaborative partnership with Durham University across a number of areas of shared interest including primary care mental health, evaluation of psychological interventions in young people and prescribing quality and safety. This year we celebrated five years of this partnership. Of more than **20** high impact publications resulting from this collaboration, findings from a study involving people with schizophrenia who can't or won't take antipsychotic drug treatment were published in the Lancet. This ground breaking research involving Trust participants suggests that cognitive therapy without medication could be safe and effective in reducing psychotic symptoms.
- 2013/14 saw a rapid growth in Trust support of large scale dementia research. In response to the Prime Minister's Challenge on Dementia, the Trust is scoping development of a research pharmacy capability, consolidating plans for further collaboration with pharmaceutical industry in dementia research. Over **80** participants have been recruited this year to dementia studies which included recognition of the Trust as the highest performer nationally in recruiting to a study of the prevalence of visual impairment in dementia.
- The Trust is one of five NHS Trusts across the UK hosting a trial which aims to establish whether lamotrigine, a mood stabiliser, is an effective treatment for borderline personality disorder. There are currently no medicines licensed for the treatment of borderline personality disorder, which affects between 0.5% and 2% of the population. So far over **20** participants have been randomised to the trial across a spread of services including those from Harrogate and Ripon. The study delivery is overseen locally by a study steering group whose composition includes two users of services to ensure that all study governance and delivery is properly informed from patient perspective.
- An important study of an oral health intervention for people with serious mental illness has been undertaken, successfully engaging all Trust early intervention in psychosis teams.
- Commercially sponsored research remains a priority for government, our network funders and our Trust's research and development growth strategy. This year we submitted a number of expressions of interest for participation in pharmaceutical company sponsored research. Notable was a Lundbeck sponsored observational study involving patients with schizophrenia treated with anti psychotic injections. Recruitment targets have been exceeded with agreement of the sponsor.

We have also 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 2013/14 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).

As part of the development and agreement of the 2013/14 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 £5,819,018 was available for CQUIN to TEWV in 2013/14 conditional upon achieving quality improvement and innovation goals across all of its CQUINs, and a total of £5,777,218 (99.28%) is estimated to be received for the associated payment on 2013/14. This compares to £5,938,580 (100%) and £3,744,990 (99.9%) received in 2012/13 and 2011/12 respectively. (The estimate for 2013/14 has been agreed with commissioners however this has not gone through all the required governance processes for full approval)

Some examples of CQUIN indicators which the Trust made progress with in 2013/14 were:

- To improve access to support for service users and carers from the point of diagnosis of dementia to support them in coming to terms with the impact of the condition and the losses they experience. In quarter 4 2012/13 the Trust reported that between 3% and 15% of service users surveyed had received the relevant information leaflets on diagnosis, medication, support of carers, etc. By quarter 4 2013/14 this had increased to between 73% and 98% depending on leaflet and locality and above the target set by commissioners of 20%.
- To deliver improvement in the level of falls using data from NHS Safety Thermometer. In quarter 3 2013/14, 70% of mental health services for older people inpatient staff and 97% of community learning disabilities staff were trained in the falls pathway against a year-end target of 60% and 80% respectively. An audit has confirmed that all older people admitted to inpatient care and all people with learning disabilities open to caseload are now screened for their risk of falls with all those at high risk receiving a falls intervention plan.
- Patients with a learning disability and epilepsy who experience prolonged or serial seizures have an epilepsy rescue medication protocol in place. At quarter 3 2013/14 it was reported that across County Durham, Darlington and Tees 80% of people identified had a rescue plan in place against a year end target of 75%.
- 100% of all children and adolescent mental health service patients have a transition care plan in place by the age of 17.5 years.

However, we did not always make such good progress throughout the whole year. Delays have meant that the following CQUINs were not on track in 2013/14.

- To improve the implementation of the pathway of care in A&E services by improving the implementation of the borderline personality disorder integrated care pathway. Progress with the plan has been delayed, in particular, with gaining service user involvement and joint working with the emergency departments within acute Trusts.
- To have achieved a minimum agreed response rate for uptake of the inpatient survey ensuring data is maintained of those who refuse to participate. Although progress has been made in most areas, response rates in several services and localities (for example North Yorkshire adult mental health 77%; Durham mental health services for older people 79%) are below the target of 80%.

What others say about the provider

Registration with the Care Quality Commission (CQC) and periodic / special reviews

TEWV is required to register with the CQC and its current registration status is **registered to provide services with no conditions attached**.

The CQC has **taken one** enforcement action and raised **one moderate concern** and **one minor concern** against TEWV during 2013/14.

TEWV has participated in **13** special reviews or compliance inspections by the CQC relating to the following areas during 2013/14:

- Two inspections at **Auckland Park, Bishop Auckland** – a 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.
- **Tunstall Ward, Lanchester Road Hospital, Durham** – a 20 bed acute admission ward for female patients only and accommodates patients both detained under sections of the Mental Health Act 1983 (MHA) and informal patients who are not detained under the Act.
- **West Lane, Middlesbrough** – an inpatient service with three wards for young people. One ward provides assessment and treatment, one ward is a low secure facility, and the third ward is an inpatient eating disorder service.
- **Dental Suite Ridgeway, Roseberry Park, Middlesbrough** – this service is provided within the Health Centre at Roseberry Park Hospital. It provides services to patients within the low and medium secure wards at the hospital. The provider uses the facilities of the health centre which are maintained by the Trust. The management of appointments is maintained by staff working within the health centre.
- **Trust Headquarters, West Park – two community teams** – for the CQC purposes, Trust Headquarters is registered as the central location for the main community services of the Trust. CQC visited a sample of two community teams. This included teams delivering support for those with psychosis and affective disorder.
- **Trust Headquarters, West Park – clozapine and lithium clinics** – the CQC visited a sample of outpatient clinics for this inspection. At a previous inspection in 2012/13, CQC found concerns with the Trust's arrangements for medicines. CQC carried out this inspection to check whether action had been taken to address these concerns. They found that improvements had been made.
- **Bankfields Court, Middlesbrough** – Bankfields Court provides an assessment and treatment, rehabilitation and respite service for adults with learning disabilities from the Teesside area who also have associated mental health problems, challenging behaviour or severe epilepsy. There are two units with six beds each and a converted house with one bed for assessment and treatment; six rehabilitation flats and eight respite beds.
- **Thornaby Road, Middlesbrough** – a small home providing personal and nursing care for five people with learning disabilities and additional support needs.
- **Lanchester Road Hospital, Durham** – five learning disability and forensic learning disability assessment and treatment wards.
- **163 Durham Road, Stockton** – two five-bedded assessment and treatment wards providing services for adults with a learning disability and associated

challenging behaviours, autism, and epilepsy, and a respite service for adults with a learning disability who can have complex needs or present with challenging behaviours.

- **Ridgeway, Roseberry Park, Middlesbrough** – forensic learning disability wards – although the CQC visited these wards in 2013/14 the published report on these visits was not available at the time of producing the quality account.
- There was one review for **HMP Holme House** 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 account / report for Care UK.

The CQC also undertook a review of health services for looked after children and safeguarding operating in the areas of the Trust served by Stockton Borough Council. A recommendation for TEWV as a result of this inspection was to ensure that practitioners are assessing and describing the risk to children and families when making referrals to children's social care to enable social workers to make informed decision. A further recommendation was to assess the training requirements of practitioners working in a supporting role to ensure that they are accessing safeguarding training at a level commensurate with their duties

TEWV has also participated in **38** Mental Health Act inspections by the Care Quality Commission to the following ward areas during 2013/14:

Ward	Service Type	Locality
Abdale House	Adult mental health rehab	Harrogate
Bankfields	Learning disabilities assessment and treatment	Middlesbrough
Bedale	Adult mental health psychiatric intensive care	Middlesbrough
Bek	Learning disabilities assessment and treatment	Durham
Bilsdale	Adult mental health assessment and treatment	Middlesbrough
Binchester	Older people's mental health challenging behaviour	Bishop Auckland
Birch	Adult mental health assessment and treatment	Darlington
Bransdale	Adult mental health assessment and treatment	Middlesbrough
Cedar	Adult mental health assessment and treatment	Harrogate
Ceddesfeld	Older people's mental health challenging behaviour	Bishop Auckland
Danby	Adult mental health assessment and treatment	Scarborough
Earlston House	Adult mental health 24 hour nursed care	Durham
Evergreen	Children's eating disorders	Middlesbrough
Farnham	Adult mental health assessment and treatment	Durham
Fulmar	Non forensic mental health low secure	Middlesbrough
Kirkdale	Non forensic mental health low secure	Middlesbrough
Langley	Forensic learning disabilities	Durham
Lincoln	Adult mental health assessment and treatment	Hartlepool
Lustrum Vale	Adult mental health 24 hour nursed care	Stockton
Mandarin	Forensic mental health low secure	Middlesbrough

Ward	Service Type	Locality
Maple	Adult mental health assessment and treatment	Darlington
Merlin	Forensic mental health medium secure	Middlesbrough
Mulberry House	Adult mental health 24 hour nursed care	Easington
Newberry	Children's mental health assessment and treatment	Middlesbrough
Oakwood	Forensic learning disabilities rehab	Middlesbrough
Picktree	Older people's mental health assessment and treatment	Durham
Primrose Lodge	Adult mental health 24 hour nursed care	Chester-le-Street
Ramsey	Learning disabilities assessment and treatment	Durham
Roseberry	Older people's mental health assessment and treatment	Durham
Rowan	Older people's mental health assessment and treatment	Harrogate
Springwood	Older people's mental health continuing care	Malton
Talbot	Learning disabilities assessment and treatment	Durham
The Dales	Learning disabilities assessment and treatment	Stockton
Tunstall	Adult mental health assessment and treatment	Durham
Ward 14	Older people's mental health assessment and treatment	Northallerton
Ward 15	Adult mental health assessment and treatment	Northallerton
Westerdale (S)	Older people's mental health assessment and treatment	Middlesbrough
Westwood	Children's mental health low secure	Middlesbrough

The CQC Mental Health Act Commissioners also undertook an inspection to look at the arrangements for assessment and application for detention that operate in the areas of the Trust served by Durham County Council Social Services and Darlington Borough Council. The primary action was for the two local authorities to address conveyance / transport issues. However the Trust was requested to identify and progress action to reduce the time that police are waiting at Section 136 suites.



The reports following these inspections highlighted that all but two services met full compliance requirements. The following outlines the two services which required action.

Auckland Park, Bishop Auckland: during August 2012, the CQC raised one moderate concern and one minor concern impacting on compliance and requiring improvement actions. Following a further inspection in April 2013 an enforcement action and moderate concern was raised. Whilst the CQC did not indicate that there were any issues in terms of the quality of the care provided at Auckland Park, they did find that some processes on the ward were not tailored to meet individual assessments of the needs of the patients.

TEWV took the following actions to address the conclusions or requirements reported by the Care Quality Commission. TEWV has made the following progress by 31st March 2014 in taking such actions.

Auckland Park, Bishop Auckland

Outcome 1 (Regulation 17): respecting and involving people who use services.
Enforcement action: 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

- Bedroom and en-suite doors are now not locked unless there are:
  - unmanageable risk issues identified in the individual intervention plans that describe the risk management, or
  - documented patient / carer wishes for the doors to be locked.
- Staff ensure individual views are considered and risks assessed relating to autonomy and independence and document the assessment outcomes giving a rationale for the decisions made. Outcomes of assessments are recorded in the electronic patient record (PARIS).
- All staff have participated in retraining and a discussion on the principles of regulation 17, the related patient outcome, and positive risk taking approaches developed for Auckland Park.
- Capacity to make decisions about care and treatment for every individual is assumed unless there is evidence to indicate that there is compromise to their level of capacity to make those decisions. Individual capacity assessments are carried out when patients are involved in decisions about their care.
- When patients have been assessed to have a reduced capacity to make decisions about their care, then families, carers and advocates are involved to represent the patient's view. Referral requests for an Independent Mental Capacity Advocate and notes from involvement discussions are recorded in the PARIS record.
- Staff assess individual views and risks and document the assessment outcomes to give the rationale for the risk management plan agreed and decisions made.
- On admission / transfer to the ward, patients and carers are advised that bedrooms and en-suite bathrooms are usually left unlocked. Their wishes in relation to this and the plan agreed are recorded in the case note section of the PARIS record. An information leaflet and standard process checklist has been developed for this process.
- Health records include decisions to give patients individual bedroom keys and take account of individual patients' capacity, best interests, risks and wishes. A standard process checklist has been developed for this process.
- Decisions about the need to lock bedrooms are reviewed on a weekly basis as a minimum, at the time the intervention plan is reviewed and a case note entry is made to reflect this.
- Doors leading to Ceddsfield Ward and Hamsterley Ward gardens are unlocked during daylight hours.
- Changes to signage recommended by the Stirling audit (a tool for assessing the environment within which people with dementia are cared for) have been implemented eg:
  - signs have been placed at low height
  - black/blue font on yellow background is used
  - pictorial and word content are both used.
- A range of communication strategies for those who no longer are able to understand the written word have been developed. These include sharing best practice from other services.
- A standard care plan has been implemented for all patients on admission to Auckland Park that identifies the essentials required for person centred care within a positive risk framework. The care plan describes the specific individual needs and wishes of the individual patient.

Outcome 2 (Regulation 18) : consent to care and treatment
Moderate Concern: essential standard not met – the provider had not suitable arrangements in place to obtain and act in accordance with the consent of people who used the service.

Actions and Progress

- The Trust's policy for controlling access to in-patient areas (including the locking of ward doors) has been implemented. Individual intervention detailing risk assessment and risk management plans identifies the ward egress and access level for each patient.
- Where it is assessed that an informal patient should not be allowed to leave the ward unaccompanied for reasons relating to risk, the team consider whether a liberty has been deprived. It is then considered how that deprivation should be authorised, either via the Mental Health Act or Mental Capacity Act, and then follow the appropriate policy and document in the patient's notes.
- An individually meaningful picture that assists a patient in distinguishing their room is used on bedroom doors as well as the person's name.
- There are clear procedures and guidelines in place for the use of mental capacity assessments. These are being implemented appropriately.
- All staff are up to date with Mental Capacity Act and deprivation of liberty training and are competent in the application of the legislation.
- Ward managers have agreed suitable environmental improvements with advice from staff trained in implementing the recommendations of the Stirling audit. Environmental improvements consider the needs and abilities of patients and are culturally and generationally appropriate.
- Cognitive stimulation boxes are available for all patients and stored appropriately following discussion with the patient and their carers and in accordance with their capacity, risks and wishes.
- Where patients cannot manage free access, cognitive stimulation boxes are accessible as described in the individual intervention plan to promote positive therapeutic access.
- Training in the use of the Malnutrition

"Not only was my partner looked after in a most wonderful way but the caring encompassed me and our son. We were supported in every possible way and kept informed at each stage of his admission – there was always someone to talk to us"
From a service user's partner

Universal Screening Tool (MUST) has been provided to each of the wards and the tool has been implemented for every patient on all wards at Auckland Park.

163 Durham Road, Stockton

Outcome 4: care and welfare of people who use the service.
Minor concern: people should get safe and appropriate care that meets their needs and supports their rights.

Actions and Progress
Although the inspection was completed in March 2014, the report was received on the 15 April 2014. The following actions have been identified to address the concern raised:

- Training will be provided to the inpatient staff in the implementation of a positive behavioural support (PBS) model which includes proactive interventions to support the development of independence and autonomy.
- Specialist ongoing coaching and supervision in implementing the PBS model will be provided to the inpatient staff by qualified behavioural practitioners.
- Audits of care plans and observation of inpatient staff will take place to:
  - ensure care plans include intervention plans that promote and maintain independence
  - ensure inpatient staff are always supporting and promoting the independence and autonomy of service users.
- A specific improvement event will be undertaken to ensure standard processes are in place that ensure there are clear links between different areas of care planning activity.
- Health action plans for all inpatients will be reviewed to ensure they clearly outline the actions needed to maintain or improve the health of the person.

The enforcement action and moderate concern raised for Auckland Park was removed following a further re-inspection in August 2013.

During this inspection the CQC found that:

- the Trust had fully implemented the improvement plans, and had achieved compliance in both essential standards
- the improvements meant Auckland Park Hospital had in place appropriate opportunities, encouragement and support to people who used the service in relation to their autonomy and independence
- before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes
- where people did not have the capacity to consent, the Trust had acted in accordance with legal requirements.

The family members that the CQC spoke with were extremely complimentary about the service and staff. They told the CQC that this was the best service their relatives had used and that all the staff were extremely skilled and competent.

Comments from relatives included:

"I have absolutely no complaints about the hospital and staff. All the staff are absolutely marvellous and the care is second to none. I don't know why anyone would not consider the service to be first class.", and

"The service is excellent. It really is marvellous."



Quality of data

TEWV submitted records during 2013/14 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: **99.50%** for admitted patient care; **99.90%** for outpatient care
- which included the patient's valid General Medical Practice Code was **91.89%** for admitted patient care; **97.19%** for outpatient care.

TEWV Information Governance Assessment Report overall score for 2013/14 was **88%** and was graded **satisfactory**.

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

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 demonstrates that our staff have robust training in areas such as confidentiality and the Trust carries out its legal duties under the Data Protection Act 1998, Freedom of Information Act 2000 and aspects of the Human Rights Act.

88% (satisfactory) means that we achieved at least the level 2 standard on all elements of the toolkit, however, in a significant number of elements we met the level 3 (the highest score). This is an improvement on the 2012/13 score of **85%.**

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

Monitor, the regulator of Foundation Trusts, at the end of 2013 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)**: the Trust is currently testing as part of a scale pilot a patient reported wellbeing measure, the Warwick-Edinburgh Mental Well-being Scale (WEMWBS), as recommended in the Monitor 2014/15 currency and tariff development guidance
- **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 guidance, 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 2014/15 and will be 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 in relation to the PROM and PREM developments.

At end of March 2014:

- **94.5%** of service users on the adult mental health and mental health services for older people caseload were assessed using the mental health clustering tool. The clustering tool is the nationally agreed approach for categorising patients' needs and is the basis for payment by result.
- **88.1%** 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 limited national benchmarking data to compare against the Trust reported figures.

Further work for 2014/15 includes:

- the inclusion of key payment by results development metrics as part of routine performance management
- embedding the new metrics into clinical services
- further development of the Integrated Information Centre within the Trust 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 a data quality strategy and scorecard to monitor improvement. The strategy aims to:
  - maximise the accuracy, timeliness and quality of all our data wherever and however it is recorded
  - ensure that every member of our staff understands that data quality is the responsibility of everyone and an integral part of their role
  - ensure we achieve compliance with all our statutory and regulatory obligations.
- 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.
- In 2014/15, the Trust is continuing to implement an Integrated Information Centre. Within this there is a data quality engine that will enable services and teams to assess and improve the quality of their data in real time.
- 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.

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 (CPA) seven day follow-up

The data made available by the Health and Social Care Information Centre (NHSIC) with regard to the percentage of patients on CPA who were followed up within seven days after discharge from psychiatric in-patient care during the reporting period.

TEWV Actual Quarter 4 2013/14	***National Benchmarks in Quarter 4 2013/14***	***TEWV Actual Quarter 3 2013/14***	***TEWV Actual Quarter 2 2013/14***	***TEWV Actual Quarter 1 2013/14***
Trust final reported and figure reported to Monitor: **97.11%** NHSIC reported: **98.6%**	NHSIC reported: National average mental health (MH) Trust = **97.4%** Highest/best MH Trust = **100%** Lowest/worst MH Trust = **93.3%**	Trust final reported and figure reported to Monitor: **97.95%** NHSIC reported: **98.20%**	Trust final reported figure: **98.64%** Figure reported to Monitor: **98.62%**	Trust final reported and figure reported to Monitor: **97.68%**

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 in quarter 2 2013/14 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 NHSIC and the Trust / Monitor figure is due to the fact the NHSIC data is submitted at a Clinical Commissioning Group (CCG) level, and therefore, excludes data for patients from CCGs outside the Trust area or where the CCG is unspecified in the patient record.
- The few actual breaches, **44** in total in 2013/14, were a result of:
  - services users not attending the follow-up appointment despite efforts of the service to contact the patient, and
  - failure in 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, by:

- monitoring this key performance indicator via the Trust's dashboard at service and board level on a monthly basis
- investigating all breaches and identifying lessons learnt at director 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
- proactively contacting other agencies with whom the patient is in contact where there is a greater risk of non-attendance at follow-up (eg homelessness)
- 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 patients are on leave from the ward or the care coordinator is on annual leave / holiday
- continuously raising awareness and reminding staff at ward / team meetings of this national requirement, the need to follow the standard procedure and the need to record data accurately.



Crisis resolution home treatment team acted as a gatekeeper

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.

TEWV Actual Quarter 4 2013/14	***National Benchmarks in Quarter 4 2013/14***	***TEWV Actual Quarter 3 2013/14***	***TEWV Actual Quarter 2 2013/14***	***TEWV Actual Quarter 1 2013/14***
Trust final reported and figure reported to Monitor: **98.11%** NHSIC reported: **98.1%**	NHSIC Reported: National average MH Trust = **98.30%** Highest/best MH Trust = **100%** Lowest/worst MH Trust = **75.20%**	Trust final reported and figure reported to Monitor: **97.67%** NHSIC Reported: **98.3%**	Trust final reported and figure reported to Monitor: **97.84%**	Trust final reported and figure reported to Monitor: **96.63%**

* latest benchmark data available on NHSIC at quarters 3 2013/14

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

- The discrepancy between the NHSIC and the Trust / Monitor figures is due to the fact the NHSIC data is submitted at a CCG level, and therefore, excludes data for patients from CCGs outside the Trust area or where the CCG is unspecified in the patient record.
- The few actual breaches, **39** in total in 2013/14, 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, by:

- monitoring this key performance indicator via the Trust's dashboard at service and board level on a monthly basis
- investigating all breaches and identifying lessons learnt at director and service level performance meetings
- reviewing crisis services in 2012/13, acknowledged the lessons from breaches and building these lessons into standard work which was implemented across all crisis services in 2013/14
- continuously raising awareness and reminding staff at ward / team meetings of this national requirement, the need to follow the standard procedure and the need to record data accurately

"Thank you for not giving up on me - I know it's your job but I wouldn't be here without all of your support"
From a service user

Staff Friends and Family Test

The data made available by the 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.

TEWV Actual 2013	***National Benchmarks in 2013***	***TEWV Actual 2012***	***TEWV Actual 2011***
3.89 out of 5.00 (sample size of 492)	National Average MH Trust = **3.55 out of 5.00** Highest/Best MH Trust = **4.04 out of 5.00**	**3.83 out of 5.00** (sample size of 519)	**3.73 out of 5.00** (sample size of 536)

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

- The figure is derived from the NHS staff survey.
- The 2013 result, **3.89 out of 5.00**, is a small improvement on the 2012 and 2011 results and is in the top 20% of all mental health trusts.
- This improvement is linked to the five areas in the 2013 survey that the Trust achieved its best scores, four of which were the best score for all mental health Trusts in England.
  - Work pressure felt by staff: **2.80 out of 5.00** compared to national average of **3.07** (NB: lower better).
  - Staff job satisfaction: **3.85 out of 5.00** compared to national average of **3.67**.
  - The percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver: **83%** compared to national average of **77%**.
  - The percentage of staff feeling they are able to contribute towards improvements at work: **79%** compared to national average of **72%**.
  - Fairness and effectiveness of incident reporting procedures: **3.68 out of 5.00** compared to national average of **3.52**.

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

- Annual Trust and directorate level action plans are developed in response to the NHS Staff Survey. Some areas for improvement work in 2013/14 were:
  - Continuation of the work to try to improve the health and wellbeing of the Trust's staff. This included trying to gain a better understanding of the causes of stress. Stress assessment tools have been considered and several staff engagement workshops have taken place in both adult mental health services at Roseberry Park and learning disability forensic services.
  - The Trust reviewed and updated its policy for positive approaches to supporting people whose behaviour is described as challenging.
  - The Trust introduced more ways of anonymously reporting concerns. Staff can now use a form on the intranet or leave a message on the concerns line.



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

The data made available by the 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.

TEWV Actual 2013	***National Benchmarks in 2013***	***TEWV Actual 2012***	***TEWV Actual 2011***
NHSIC Reported: **89.40** (sample size of 217)	NHSIC Reported: National Average MH Trust = **85.80** Highest/Best MH Trust = **90.90** Lowest/Worst MH Trust = **80.90**	NHSIC Reported: **88.42** (sample size of 230)	NHSIC Reported: **87.35** (sample size of 223)

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?

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

- The figure is derived from the NHS service user survey.
- The Trust's score for 2013 was **89.4.** The Trust's score in 2013 is an improvement on 2012 and 2011 and is closer to the best mental health Trust score of **90.9** compared to 2012.
- The individual scores that this figure is based on were:
  - Did this person listen carefully to you?: **9.1 out of 10**, and better than the national average.
  - Did this person take your views into account?: **8.7 out of 10**, and better than the national average.
  - Did you have trust and confidence in this person?: **8.5 out of 10**, similar to the national average.
  - Did this person treat you with respect and dignity?: **8.7 out of 10**, and better than the national average.

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

- Annual Trust and directorate level action plans were developed and implemented in response to the NHS Service User Survey for community services. However, a key part of our approach to improvement was the implementation of the recommendations of the review of the Care Programme Approach outlined in the quality priorities for 2013/14 and 2014/15. A benefit expected from these priorities will be a reduction in staff time spent on administrative tasks and more face to face time to listen 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 similar to those used nationally. In 2013/14, **6,135** service users were surveyed locally on these questions. It is the act of continuously surveying the experience of service users and responding to the feedback which ensures that the Trust continuously improves on this metric.

Patient safety incidents including incidents resulting in severe harm or death

The data made available by the 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.

TEWV Actual Quarters 3&4 2013/14	***TEWV Actual Quarters 1&2 2013/14***	****National Benchmarks in Quarters 1&2 2013/14***	***TEWV Actual Quarters 3&4 2012/13***
Trust Reported to NRLS: **3,143** incidents reported of which **25** (**0.79%**) resulted in severe harm or death NB: NRLS reported figure not available until 2014/15	Trust Reported to NRLS: **3,285** incidents reported of which **36** (**1.10%**) resulted in severe harm or death NRLS Reported: **3264** incidents reported of which **35 (1.07%)** resulted in severe harm or death	NRLS Reported: National Average MH Trusts: **2,228** incidents reported of which **28** (**1.26%**) resulted in severe harm or death **Lowest MH Trust: **655** incidents reported of which **18 (2.75%)** resulted in severe harm or death Highest MH Trusts: **6,609** incidents reported of which **94** (**1.42%**) resulted in severe harm or death	Trust Reported to NRLS: **3,027** incidents reported of which **41** (**1.4%**) resulted in severe harm or death NRLS Reported: **3,048** incidents reported of which **41** (**1.4%**) resulted in severe harm or death

* latest benchmark data available on NRLS
** One Trust reported zero incidents but this has been discounted

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

- The Trust reported and National Reporting & Learning System (NRLS) reported data for 2013/14 differ because the Trust's definition of a patient safety incident is wider than that of the NRLS.
- There is currently no nationally agreed or regulated approach to reporting, categorising and validating patient safety incidents. Different Trusts may choose to apply different approaches. For example, the approach taken to determine a classification such as those 'resulting in severe harm' will often rely on clinical judgement which may, acceptably, differ between professionals. The classification of an incident may also be subject to a potentially lengthy investigation which may result in the classification being changed. The change may not be reported externally and the data held by a Trust may not be the same as that held by the NRLS.
- The number of incidents reported by TEWV to the NRLS for quarters 3 and 4 2012/13 is above the national average. The percentage resulting in severe harm or death is similar to the national average. However, it is not possible to use this data to comment on 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 between 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.

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

- analysing all patient safety incidents - these 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
- subjecting all serious untoward incidents (ie those resulting in severe harm or death) 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, of the importance and value of reporting and reviewing 'near misses



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 2014/15 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, patient advice and liaison service contacts and audit findings to identify common themes for improving quality.
- These were discussed with the Trust's Quality and Assurance Committee, and together with the views of the other locality and specialty-specific quality groups across the Trust, a set of key themes for improving quality were developed.
- An event was held in July 2013 where these findings and key themes were shared with our stakeholders to get feedback on where they think the quality of our services needs to be improved.
- Representatives from the following stakeholders agencies were invited to attend:
  - clinical commissioning groups (x9)
  - local authority overview and scrutiny committees and directors of social services (x7)
  - Healthwatch (x7)
  - Trust governors – public (x33)
  - Trust governors – elected (x14)
- From this workshop **13** key quality themes were selected and these were presented to the Board of Directors in October 2013.
- At its formal meeting in November, the Board of Directors agreed the **four** quality priorities for 2014/15 from the **13** 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 2014/17.
- For each quality priority a lead director was identified who developed the key actions that would be taken to address the priority in 2014/15.
- A second stakeholder workshop, with the same invitees as shown above, was held in February 2014 where our four quality priorities and proposed plans to deliver these were shared.
- 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 our final action plans for each priority as described below.

Our four priorities for 2014/15 are:

Priority 1: To have more staff trained in specialist suicide prevention and intervention.

Priority 2: Implement recommendations of CPA review, including, improving communication between staff, patients and other professionals treating people as individual

Priority 3: Embed the recovery approach (in conjunction with CPA).

Priority 4: Managing pressure on acute inpatient beds.

Priority 1: To have more staff trained in specialist suicide prevention and intervention

Why this is important:
From 1981 to 2007, age-standardised suicide rates in the North East of England reduced year on year to a low in 2007 of 10.5 per 100,000 of the population. This was significantly higher than the rate for England in 2007 of 9.5. Since 2007 the rate in the North East of England has increased and was 12.0 per 100,000 of the population in 2012 and similar to levels seen in the first few years of the decade.

Again the rate in the North East of England in 2012 remained significantly higher than the rate for England of 10.4. It is therefore a priority that the recent upward trend is reversed and the gap between the North East of England and the rest of England is reduced. However, it is recognised that the suicide rate is influenced by many social and economic factors which are beyond the control of the Trust. The Trust, therefore, aims to play its part by improving how staff recognise the warning signs and intervene early to prevent avoidable suicides.

What benefits / outcomes our service users and carers should expect:
- The number of staff trained in specialist suicide prevention and intervention will have increased.
- Staff who have received specialist training will be confident in suicide prevention and intervention.
- Care will be provided in a way that manages risk whilst promoting recovery and keeping our service users safe.

What we will do in 2014/15:

We will:
- approve the project scope by quarter 1 2014/15
- recruit the project team and establish the project group to take this forward by quarter 1 2014/15
- review current practice within the Trust by quarter 1 2014/15.
- develop a suicide prevention framework and training and implementation plan that describes
- what training is required, who will provide it and what other support is necessary for staff to provide effective suicide prevention and intervention by quarter 2 2014/15
- develop a training needs assessment and training plan which will describe who will receive training and how this will be rolled out across the Trust by quarter 3 2014/15
- commence training for priority staff (e.g. crisis teams) by quarter 4 2014/15 (to be completed for all relevant staff in 2015/16)

Priority 2: Implement recommendations of the Care Programme Approach (CPA), including:

- Improving communication between staff, patients and other professionals
- Treating people as individuals

Why this is important:
The CPA and care planning is critical to the quality of care our service users receive. 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 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:
- improved service user experience, choice and involvement in their personal recovery
- services that are personal and meaningful to service users
- carers will feel recognised, valued and supported.

What we will do in 2014/15:

We will:
- implement actions relating to CPA from model lines pilot team by quarter 2 2014/15
- by quarter 4 2014/15, redesign CPA processes and documentation to ensure they fulfil the following:
  - meeting mandatory requirements whilst reducing unnecessary burden on staff
  - ensuring the requirements of the Mental Health Act are met whilst reducing unnecessary burden on staff
  - development of standard work regarding section 117 of the Mental Health Act – the statutory duty to provide health and ocial care to some service users following discharge from in-patient care.
- implement regular audit and case management / supervision systems to include monitoring of transfer processes within PARIS (the electronic patient record) by quarter 4 2014/15

It is anticipated that further work to fully implement the recommendation of the CPA review will continue into 2015/16. In 2015/16 the following actions will be delivered:
- implement core competency frameworks to identify the competencies needed by staff to implement the revised CPA processes and documentation
- implement a work based competency tool to assess competency and appraises' / supervisors' performance of assessment and care planning skills
- implement systems and standards for training, supervision and case management of care co-ordinators and lead professionals
- start the development of a revised Trust / multi-agency CPA policy



Priority 3: Embed the recovery approach (in conjunction with CPA)

Why this is important:

Many people who have experienced mental health related problems have shown us that it is possible to maintain or re-establish their wellbeing, meaning, value and purpose in life. But, despite advances in mental health care, too often people are still left feeling disconnected from themselves, from friends and family, from the communities in which they live, and from meaning and purpose in life. Clearly this can have a devastating and long-term life changing effect. It is, therefore, important that the services we provide do not just focus on alleviating the symptoms of mental ill-health, but also are provided within a culture that in every way promotes recovery where recovery is defined as:

'A deeply personal, unique process of changing one's attitudes, values, feelings and goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life within the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness. Recovery from mental illness involves much more than recovery from the illness itself'.

Recovery from mental illness: the guiding vision of the mental health system in the 1990s (Anthony), Psychosocial Rehabilitation Journal, 16(4), April 1993, 11-23.

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

- recovery focussed practice across all Trust services
- increased opportunities for people with 'lived experience' of mental illness to co-produce services across the Trust
- the Trust promoting a culture of harm minimisation, actively working to help service users develop resilience, control, choice, hope and empowerment.

What we will do in 2013/14:

We will:

- develop a programme of work to ensure the principles of recovery are embedded within all key programmes eg CPA, model lines, risk assessment and management (ongoing)
- establish the current position on recovery action planning and devise an implementation plan by quarter 2 2014/15
- increase the opportunities for volunteering by quarter 4 2014/15
- establish a cohort of service user / carer trainers to co-design and co-deliver recovery training by quarter 4 2014/15
- investigate the role of peer support workers (staff with 'lived experience' providing care and support) by quarter 4 2014/15
- establish recovery leads in all localities, specialities and pilot teams by quarter 4 2014/15
- establish a recovery college and courses by quarter 2 2014/15.

Priority 4: Managing pressure on acute inpatient beds

Why this is important:

Wherever possible we try to help people to receive care close to home so they do not need to be admitted into a hospital bed. However, sometimes, people do need to spend time in hospital. When this is necessary it is important that they are admitted to the ward that has been identified as serving that community, unless they choose to go to a different unit, or there are clinical reasons to support this. This is important as it means that service users receive their inpatient care close to home and their families and carers and also it helps ensure better engagement from the community team that will support them when they leave the ward. Currently 22% of patients do not receive care at their 'local' inpatient unit.

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

- In 2014/15 we are aiming for 85% of patients being treated close to home increasing to 90% in 2015/16 and beyond.

What we will do in 2013/14:

We will:

- reduce the percentage of people on community team caseloads that are admitted to inpatient care by quarter 4 2014/15
- reduce the readmission rates to inpatient care following discharge by quarter 4 2014/15
- continue to improve the skills and effectiveness of the crisis teams as gatekeepers to inpatient care by quarter 4 2014/15

In addition to these key actions, there are a number of other projects aimed at improving services that will impact indirectly on the Trust's ability to manage pressure of beds. For example:

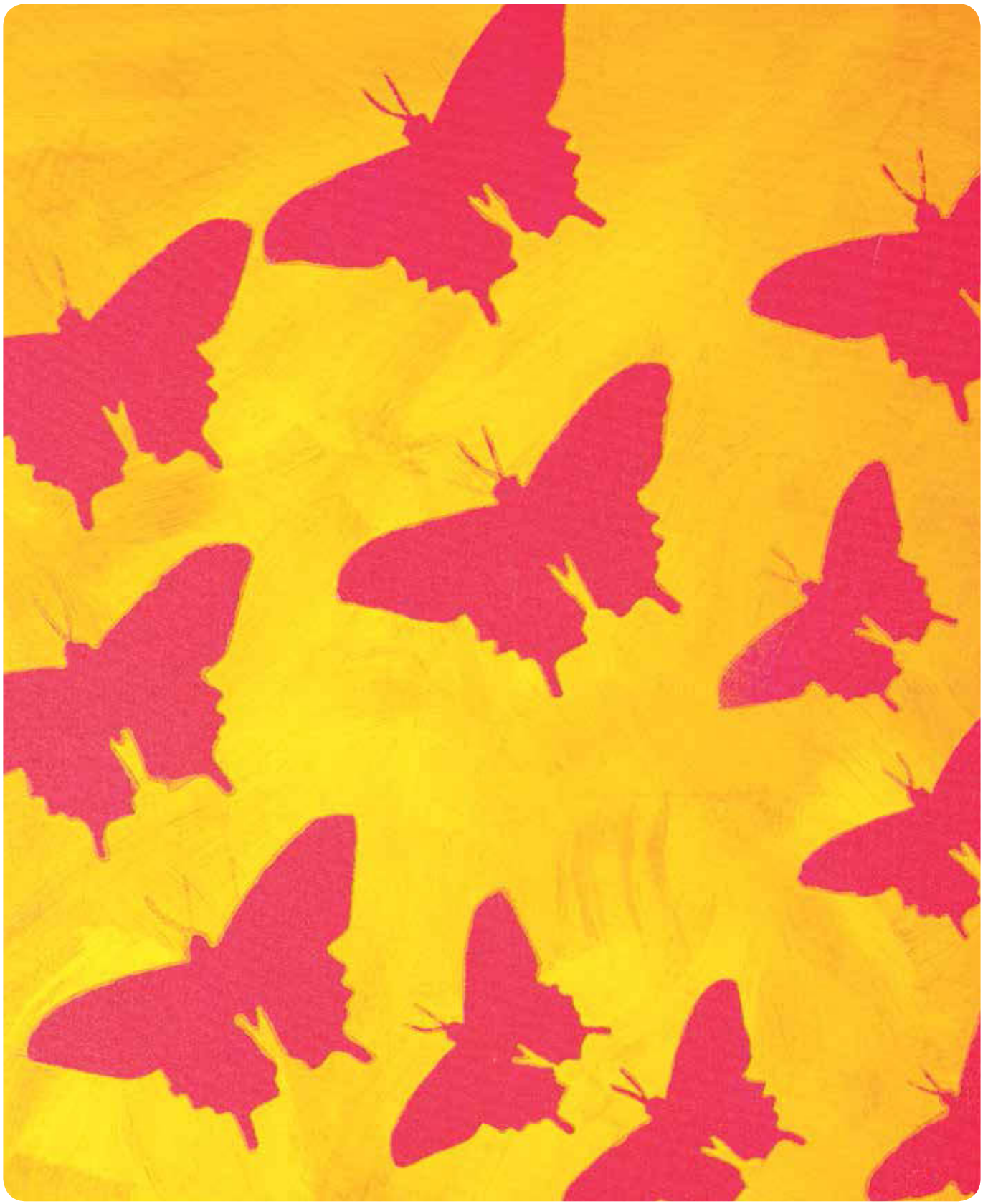
- work with community mental health teams to improve the quality of home treatment, crisis and care planning
- building on the work of rapid process improvement workshops in 2013/14 to improve the quality and efficiency of discharge planning
- evaluating the opportunity for using rehabilitation as a step-up facility from home treatment as well as a step-down facility from acute inpatient care
- working with commissioners to develop new services that prevent admissions and shorten lengths of stay when inpatient care is necessary eg street triage, crisis beds, GP liaison services

Monitoring progress

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

In November 2014, we will also share the quarter 2 2014/15 update report with all our stakeholders as a mid-year report to facilitate our stakeholder's review of our quality account / report at year end.

A key way for delivering the priorities for 2014/15 will be the use of the various tools within the Trust's quality improvement system (TEWV QIS). As outlined earlier, TEWV QIS is the Trust's framework and approach to continuous quality improvement and has within it standardised processes for monitoring progress and improvement.





Part 3: Other information on quality performance 2013/14

Our performance against our quality metrics

The following table provides details of our performance against our set of agreed quality metrics for 2013/14.

These metrics are the same as those we reported against in our quality account / report, 2012/13 which allow us to monitor progress. However, in some cases, the exact definitions in 2012/13 and 2013/14 have changed from 2009/10 and 2010/11 as we have learned lessons on what is more meaningful to quality.

These are:

- The 'number of unexpected deaths' reported in 2009/11 (metric 1) was changed in 2012/13 to the 'number of unexpected deaths classed as a serious incident per 10,000 open cases'. This is because using a rate is a valid approach for making comparisons across the years even if activity within the Trust increases.
- The 'number of patient falls per 100,000 occupied bed days' reported in 2009/11 (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 2009/11 (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		2013/14		2012/13	2011/12	2010/11	2009/10
		Target	Actual	Actual	Actual	Actual	Actual
Patient Safety Measures							
1	Number of unexpected deaths classed as a serious incident per 10,000 open cases	< 12.00*	**11.88**	15.91	12.00		
2	Number of outbreaks of Healthcare Associated Infections	0	**0**	0	0	0	0
3	Patient Falls per 1,000 admissions	< 31.04	**35.99**	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%	**97.86%**	97.14%	98.08%	98.50%	97.50%
5	Percentage of clinical audits of NICE guidance completed	100%	**97%**	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 & treatment wards	AMH <33 MHSOP <52	**AMH: 31.72**	35	37	39	47
Patient Experience Measures							
7	Delayed transfers of care	< 7.50%	**1.89%**	2.07%	1.60%	1.60%	2.90%
8	Percentage of complaints satisfactorily resolved	> 90.00%	**65.77%**	76.36%			
National Patient Survey							
9	Number of questions where our score was within 5% of the highest scored mental health trusts		**12 (32%)**	11 (29%)	12 (32%)	18 (47%)	16 (42%)
	Number of questions where our score was within the middle 90% of scored mental health trusts		**26 (68%)**	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%)**	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

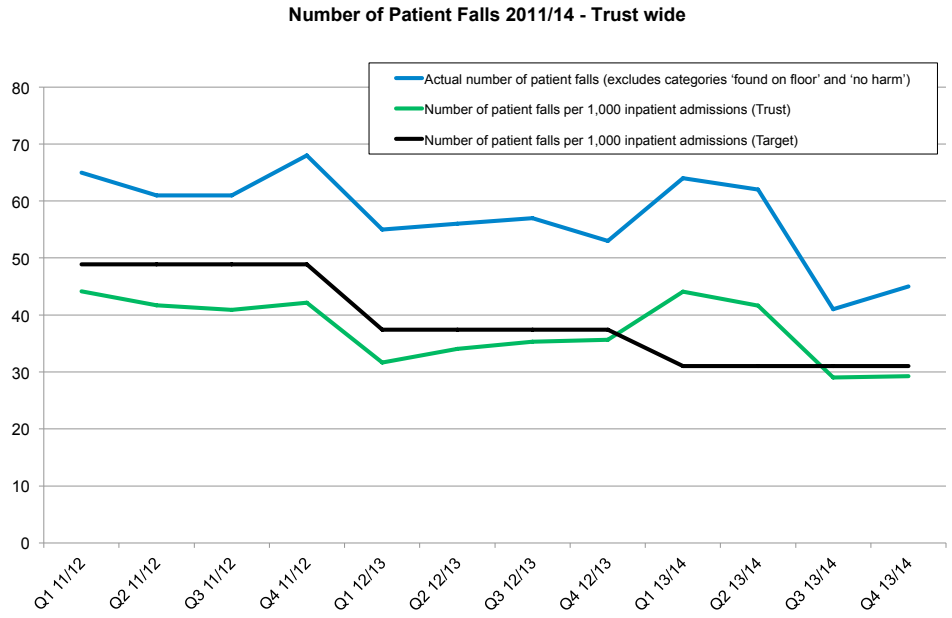
1. Data for this metric is taken from incident reports which are then reported via the National Strategic Executive Information System (STEIS).
2. Outbreaks of healthcare associated infections relates to those of MRSA bacteraemia and C Difficile. The infection prevention and control team would be notified of any outbreaks direct by the ward and that would then be recorded on an 'outbreak' form before being reported externally.
3. Patient falls excludes the categories 'found on floor' and 'no harm'. Data for this metric is taken from incident reports which are then reported via the Trust's risk management system, DATIX.
4. Data for CPA 7 day follow up is taken from the Trust's patient systems and is aligned to the national definition.
5. The percentage of clinical audits of NICE guidance completed is based on the number of audits of NICE guidelines completed against the number of audits of NICE guidelines planned. 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. The percentage of complaints satisfactorily resolved is based on the number of complaints where the complainant did not report dissatisfaction with the Trust's response expressed as a percentage of the total number of resolution letters sent out. Please note, if the complainant did not respond to the resolution letter it was assumed that the complainant was satisfied with the Trust's response.
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



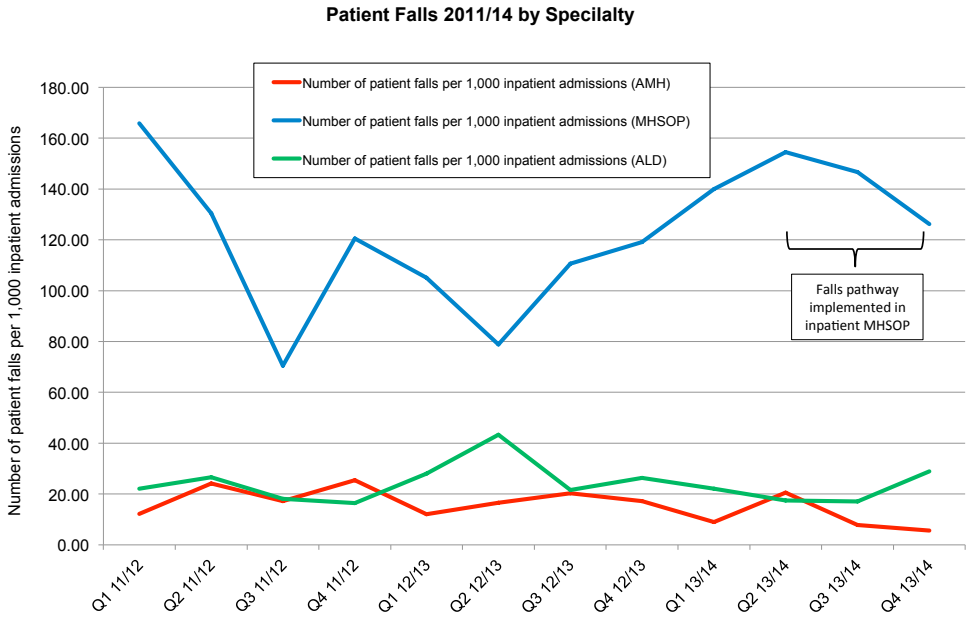
Comments on areas of under-performance

Metric 3: Patient falls per 1,000 admissions

The number of falls reduced significantly in quarters 3 and 4 2013/14 to **29.02** and **29.26** per 1,000 admissions respectively against a target of **< 31.04** and was the lowest quarterly rate in two years. However, overall for 2013/14 the rate was **35.99** and above target due to higher falls rates in quarters 1 and 2 2013/14. The following graph shows the rate by quarter over the last two years:



Further analysis shows that the increase in 2013/14 was influenced mostly by an increase in falls in mental health services for older people services. The reduction in quarter 3 2013/14 reflects the implementation of the revised falls pathway in older people's inpatient services. It is expected, therefore, the rate will continue to fall in 2014/15 as the falls pathway is further implemented within older people's community services.



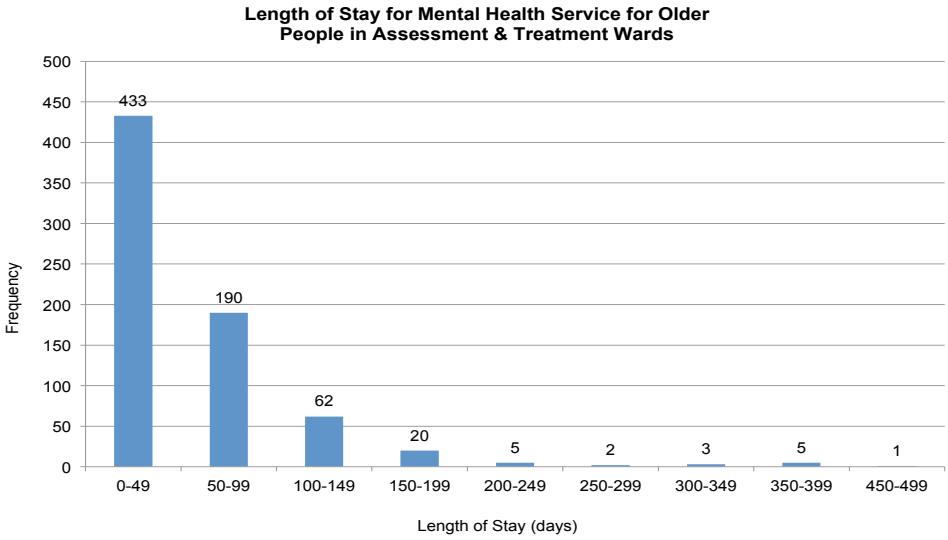
Metric 5: Percentage of clinical audits of NICE Guidance completed

In 2013/14, **97%** (35 out of 36) of NICE clinical audits planned for completion in 2013/14 were completed. The remaining one NICE clinical audit that was planned for completion but not completed in 2013/14 was undertaken and the action plan is awaiting final sign-off in quarter 1 2014/15.

Metric 6: Average length of stay for patients in adult mental health and mental health services for older people assessment and treatment wards

The average length of stay for adults has remained steady and below the target for 2013/14 and is therefore GREEN. The average length of stay for older people was within target for quarters 1 and 2 but increased from 50/51 days to **56** days in quarter 3 2013/14 which is above the target of < 52 days, and therefore RED.

The following table shows the actual lengths of stay for **722** older people discharged in 2013/14. Whilst the average length of stay for patients on mental health services for older people assessment and treatment wards was **54** days, the average was skewed by a few long stay patients. In fact **16** patients in 2013/14 had stays over 200 days. If the stays of these **16** patients were capped at 200 days, the average length of stay would be **51.9** days and within the target of < 52 days.



Metric 8: Percentage of complaints satisfactorily resolved

Complaints are monitored by the Quality Assurance Committee and are thoroughly investigated. Both the patient experience department and patient advice and liaison services (PALS) strive to resolve as many concerns/complaints as possible informally.

Table 3 below shows the resolution rate of complaints by service.

Table 3: Complaints Resolution

Service	Locality	Total number of complaints resolution letters sent	Percentage (numbers) satisfactorily resolved*
Adult mental health	Durham & Darlington	43	60.4% (26)
	Tees	34	61.7% (21)
	North Yorkshire	22	77.2% (17)
Mental health services for older people	Durham & Darlington	7	57.1% (4)
	Tees	8	37.5% (3)
	North Yorkshire	2	50% (1)
Children's and young people's services mental health and learning disabilities	Durham & Darlington	1	100% (1)
	Tees	5	100% (5)
	North Yorkshire	1	100%(1)
Adult learning disabilities	Durham & Darlington	2	50% (1)
	Tees	2	100% (2)
	North Yorkshire	2	50% (1)
Forensic services	Trust-wide	19	73.68% (14)
Other	Trust-wide	1	100% (1)
	Total	**149**	**65.77% (98)**

* The percentage of complaints satisfactorily resolved is based on the number of complaints where the complainant did not report dissatisfaction with the Trust's response expressed as a percentage of the total number of resolution letters sent out. Please note, if the complainant did not respond to the resolution letter it was assumed that the complainant was satisfied with the Trust's response.



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 & Regulatory Requirements

Indicators		2013/14		2012/13	2011/12	2010/11	2009/10
		Target	Actual	Actual	Actual	Actual	Actual
a	The Trust has registered with CQC with no conditions	Fully met	**Fully met**	Fully met	Fully met	Fully met	Fully met
b	Number of occupied bed days of under 18s admitted to adult wards	0	**48**	64	83	70	173
c	Retention rate substance misuse (rolling 12 months and reported 3 months behind)	=/> 92.90%	**92.45%**	89.91%	89.90%	84.40%	89.70%
d	Number of early intervention in psychosis new cases (cumulative position)	> 259	**619**	599	479	455	407
e	Number of crisis resolution home treatment episodes (cumulative position)	> 3,338	**3,725**	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%	**97.58%**	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%	**97.86%**	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	Maintained

Notes on national targets and regulatory requirements

b) Retention rate is the percentage of people who misuse substances who stay within treatment for the duration of the course of treatment. The information is subject to a three month delay in reporting, therefore, the figure shown is the position reported in the January 2013 report which covers November 2012 to October 2013.
e) The number of crisis home treatment episodes in 2013/14 is significantly less than previous years. This is due to a change in the definition of the indicator where multiple linked contacts are now counted as a single episode rather than individual episodes.

"Thank you for helping me with transition into civilian life from the army. You sat and listened to my stories while I've cried and you remained professional and supportive, helping me come to terms with things and realise things are actually ok."
From a staff member and former army personnel

Comments on areas of under-performance

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

There were **48** occupied bed days for the 'under 18s admitted to adult wards' in 2012/13. This relates to **10** patients.

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 an episode 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.

Indicator c: Retention rate substance misuse (rolling 12 months and reported three months behind)

The percentage of people who misuse substances and stay within treatment for the duration of the course of treatment is **92.49%** at Oct 2013 and below the target of **92.90%.**

External audit

For 2013/14, our external auditors have to provide a limited assurance report on whether two mandated indicators included in the quality account / report have been reasonably stated in all material respects. In addition the Council of Governors have the option to choose one further local indicator for external assurance. The three indicators which have been included in the external assurance of the quality account / report 2013/14 are:

- The percentage of patients on CPA who were followed up within seven 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.
- Percentage of complaints satisfactorily resolved.

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 account / report 2013/14, we have tried to improve how we involved our stakeholders in assessing our quality in 2013/14.

The following are some positive comments we received from our stakeholders following the two events we held in July 2013 and February 2014:

- *honest and open with data presented – as always*
- *good to have an opportunity to discuss the issues*
- *group work was useful and wide ranging*
- *no facilitation and leading on issues – good listening*
- *good quality discussion*
- *very positive attitude to create progress*
- *good pre-event reading / informative material (ie information pack)*
- *mix of ideas and participants*
- *good to be part of the development of the quality account / report and see where our work fits in*

The following are the comments from our stakeholders on things we could do better in our quality account / report:

- *try to increase attendance and encourage wider participation eg GPs, people with direct patient contact*
- *try running two events to avoid peak holiday time*
- *no chance to network as work groups stayed the same*
- *a long afternoon – could have been done in less time if presentations shorter*
- *get views from people not in the room – websites, twitter, facebook*

In response the Trust will continue to make the production of the quality account / 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 account / report for 2013/14 to the following stakeholders:

- NHS England – area reams (x2)
- clinical commissioning groups (x9)
- health and wellbeing boards (x7)
- local authority overview and scrutiny committees (x7)
- local HealthWatch (x7)

All the comments we have received from our stakeholders are included verbatim in **Appendix 1**.

The following are the general themes received from stakeholders in reviewing our quality account / report for 2013/14:

- The Trust has undertaken meaningful engagement of stakeholders in the development of the 2013/14 quality account
- The content was representative of the Trust's overall approach to quality
- There was overall support for the priorities identified for 2014/15 although some stakeholders have identified other areas they would like the Trust to address.
- The majority of stakeholders felt the document was well presented and readable although some thought the production of a summary would be helpful.
- Some stakeholders felt the quality account would have been stronger if additional information had been included notably:
  - information about the work the Trust has undertaken on learning lessons from serious incidents and complaints
  - assurance on actions undertaken by the Trust in reviewing service risks against the recommendations of the Francis and Mid Staffordshire Trust Inquiry and Berwick review
  - the action that is being taken to address the metrics/indicators that are not achieving the expected levels.

The Trust will write to each stakeholder addressing each comment made following publication of the quality account / report 2013/14 and as part of an annual lessons learnt exercise in preparation for the quality account / report 2014/15.

In response to many stakeholders' requests, the Trust has agreed to continue providing all stakeholders with a half-year update in November 2014 on the Trust's progress with delivering its quality priorities and metrics for 2014/15.



2013/14 Statement of Directors' responsibilities in respect of the quality account / report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Account) Regulations 2010 to prepare quality accounts / report for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality account / report (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 account / report.

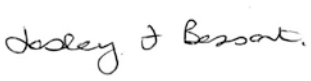
In preparing the quality account / report, Directors are required to take steps to satisfy themselves that:

- the content of the quality account / report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2013/14
- the content of the quality account / report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2013 to June 2014
  - papers relating to quality reported to the Board over the period April 2013 to June 2014
  - feedback from the commissioners dated May 2014
  - feedback from Governors dated 19 March, 7 April and 22 May 2014
  - feedback from local Healthwatch organisations dated May 2014
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, May 2014
  - the latest national patient survey published on 17 September 2013
  - the latest national staff survey published on 25 February 2014
  - The Head of Internal Audit's annual opinion over the Trust's control environment received by the Audit Committee on 15 May 2014
  - Care Quality Commission quality and risk profiles dated 8 April 2014
- the quality account / report presents a balanced picture of the NHS Foundation Trust's performance over the period covered
- the performance information reported in the quality account / report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality account / 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 account / report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the quality account / report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the quality account / report regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the quality account / 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 account / report.

By order of the Board



Chairman
27 May 2014

Chief Executive
27 May 2014

Independent auditor's report to the Council of Governors of Tees, Esk and Wear Valleys NHS Foundation Trust on the quality report

We have been engaged by the Council of Governors of Tees, Esk and Wear Valleys NHS Foundation Trust to perform an independent assurance engagement in respect of Tees, Esk and Wear Valleys NHS Foundation Trust's quality report for the year ended 31 March 2014 (the "quality report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2014 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- 100% enhanced Care Programme Approach (CPA) patients receiving follow-up contact within seven days of discharge from hospital; and
- Admissions to inpatient services had access to crisis resolution home treatment teams.

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 in section 2.1 of Monitor's *2013/14 Detailed Guidance for External Assurance on Quality Reports*; 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 considered the implications for our report if we became aware of any material omissions.

We read the other information contained in the quality report and consider whether it is materially inconsistent with:

- Board minutes for the period April 2013 to April 2014
- papers relating to quality reported to the Board over the period April 2013 to April 2014
- feedback from the commissioners, dated 19 May 2014 and 20 May 2014
- feedback from local Healthwatch organisations received on 19 May 2014
- the Trust's complaints report published under regulation 18 of the local authority social services and NHS Complaints Regulations 2009, covering the period April 2013 to March 2014
- the 2013 national patient survey
- the 2013 national NHS staff survey
- Care Quality Commission quality and risk profiles dated 31 March 2014
- the Head of Internal Audit's annual opinion over the trust's control environment for the period April 2013 to March 2014 and
- any other information included in our review.

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 Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

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 2014, to enable the Council of Governors to demonstrate that it has discharged its governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Tees, Esk and Wear Valleys NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators
- making enquiries of management
- testing key management controls
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation
- comparing the content requirements of the NHS Foundation Trust *Annual Reporting Manual* to the categories reported in the quality report and
- reading the documents.

A limited assurance engagement is 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 2014:

- 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 section 2.1 Monitor's *2013/14 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*.

Cameron Waddell CPFA for and on behalf of Mazars LLP, Chartered Accountants and Statutory Auditor, Rivergreen Centre, Aykley Heads, Durham, DH1 5TS

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.

The statutory duties of our Council of Governors are:

- to hold the Non-Executive Directors individually and collectively to account for the performance of the Board
- to represent the interests of the members of the Trust as a whole and the interests of the public.

It has specific responsibilities:

- 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
- to determine (in conjunction with the Board of Directors) any proposed changes to the Trust's Constitution
- to determine (in conjunction with the Board of Directors) any questions on mergers, acquisitions or separation of the Trust
- to determine (in conjunction with the Board of Directors) whether the Trust should be dissolved
- to determine any significant transactions (as defined in the Constitution) proposed by the Board of Directors
- to consider any matters raised by the Care Quality Commission or Monitor which might affect the Trust's compliance with the terms of its Licence or its registration of services
- to determine whether any matter should be referred to Monitor's Panel on whether the Trust has failed or is failing to act in accordance with its Constitution, or to act in accordance with Chapter 5 of the NHS Act 2006.

A number of committees including the Nomination and Remuneration Committee support this work (see page 95).

The Council of Governors has the power to require a Director of the Trust to attend a meeting in order to obtain information about the Trust's performance of its functions or the Director's performance of his/her duties.

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.

The general statutory duty of our Board, and each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the corporation as a whole and for the public.

Our Board of Directors:

- exercises certain functions in conjunction with our Council of Governors (see above)
- 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 our constitution.

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

The Board, through its Audit Committee, conducts a review on the effectiveness of internal control annually based on the findings of the Head of Internal Audit (see page 85).

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
- the provision of appropriate and accurate information to our Board of Directors.

Resolution of disputes between the Board and Council of Governors

A process has been established for the resolution of disputes between the Board and Council of Governors.

Led by the Chairman or Deputy Chairman and supported by the Senior Independent Director the process is based on a number of steps by which the matters in dispute are formally stated, considered and responded to.

If resolution cannot be achieved the view of the Board will prevail unless the issue falls within the Council of Governors' statutory powers.

Nothing within the process restricts the Council of Governors from informing Monitor, Monitor's Panel or the Care Quality Commission of relevant concerns.

Further details of the dispute resolution procedure are included in annex 9 of our constitution.

The Foundation Trust Code of Governance

The Foundation Trust Code of Governance, published by Monitor provides an overarching framework for corporate governance and complements the statutory and regulatory obligations placed on foundation trusts.

A revised version of the Code came into effect on 1 January 2014. This took into account regulatory changes as a result of the Health and Social Care Act 2012 and built upon the significant update to the UK Corporate Governance Code which was issued in 2012 by the Financial Reporting Council.

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.

Statement of compliance with the Code of Governance:

In 2013/14 the Trust complied with all relevant requirements of the Code with the exception of provision A.1.9 on having a single code of conduct for Board Members.

Although the Trust does not have a single code, the conduct of Board Members is governed by their terms and conditions of office and contracts of employment as appropriate.

In addition all Board Members have given an undertaking to abide by the Professional Standards for NHS Boards published by the Professional Standards Council.



Governance Disclosures

Under the Code of Governance and the Foundation Trust Annual Reporting Manual (published by Monitor) the Trust is required to disclose the following information on its governance arrangements:

Code ref:	Summary of Disclosure Requirement	Page(s)
A.1.1	A schedule of matters or a summary statement of how the Board of Directors and the Council of Governors operate, including the types of decisions to be taken by each body and which are delegated to the Executive Management Team on behalf of the Board of Directors.	78
A.1.1	A statement on how disagreements between the Council of Governors and Board of Directors should be resolved.	78
A.1.2	The names of: • The Chairman • The Deputy Chairman • The Chief Executive • The Senior Independent Director • The chairmen and members of the Nominations Committee • The chairmen and members of the Audit Committee • The chairman and members of the Remuneration Committees	82-83
A.1.2	The number of meetings of the Board of Directors and the Audit, Remuneration and Nominations Committees and individual attendance by directors	84-85 88 & 95
A.5.3	The names of members of the Council of Governors, whether they are elected or appointed, the constituency or organisations they represent and the duration of their appointments.	92-93
A.5.3	The name of the Lead Governor.	90
FT ARM	The number of meetings of the Council of Governors and individual attendance by governors and directors.	92-93
B.1.1	The names of the non-executive directors whom the Board determines to be independent, with reasons where necessary.	82
B.1.4	A description of each director's skills, expertise and experience.	82-83
B.1.4	A statement about the Board of Directors' balance, completeness and appropriateness to the requirements of the NHS foundation trust.	82
FT ARM	A brief description of the length of appointments of the non-executive directors and how they may be terminated.	82 & 95
B.2.10	A description of the work of the Nominations Committee(s) including the process used in relation to board appointments.	95
FT ARM	Information on the work of the nominations committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or non-executive director.	95
B.3.1	The other significant commitments of the Chairman and any changes to them during the year.	82
B.5.6.	A statement on how the governors have undertaken and satisfied the requirement to canvass the opinion of the trust's members and the public (and for appointed governors the body they represent) on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and communicate their views to the Board of Directors.	96
FT ARM	Information on whether the Council of Governors has used its power to require one or more directors to attend a governors' meeting for the purpose of obtaining information on the foundation trust's performance of its functions or the directors' performance of their duties under paragraph 26(2)(aa) of Schedule 7 of the National Health Service Act 2006.	84

Code ref:	Summary of Disclosure Requirement	Page(s)
B.6.1	A statement on how the performance evaluation of the board, its committees and its directors, including the Chairman, has been conducted.	85
B.6.2	The identity of any external facilitator who supported the performance evaluation of the board and whether they have any other connection with the trust.	85
C.1.1	An explanation from the directors of their responsibility for preparing the annual report and accounts. A statement that they consider the annual report and accounts, taken as a whole, are fair, balanced and reasonable and providing the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy.	110
C.1.1	An explanation from the directors of their approach to quality governance in the annual governance statement.	106
C.1.1	A statement from the directors that the business is a going concern, with supporting assumptions or qualifications as necessary.	98
C.2.1	A report that the Board has conducted a review of the effectiveness of the Trust's system of internal controls.	78
C.2.2	Information on how the internal audit function is structured and the role it performs.	86
C.3.5	A statement from the Audit Committee, if applicable, explaining its recommendation on the appointment/reappointment of the external audit and the reasons why it was not accepted by the Council of Governors.	N/A
C.3.9	A description of the work of the Audit Committee in discharging its responsibilities including: • the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; • an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and • if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	85
D.1.3	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	N/A
E.1.4	Contact procedures for members who wish to communicate with governors and/or directors.	Back cover
E.1.5	A statement on how the Board of Directors, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust.	84
FT ARM	Information on membership of the foundation trust including: • a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership; • information on the number of members and the number of members in each constituency; and • a summary of the membership strategy • an assessment of the membership and a description of any steps taken during the year to ensure a representative membership including progress towards any recruitment targets for members.	96
FT ARM	Information on how members of the public can access the registers of interests of the Board of Directors and Council of Governors.	83 & 93
The latest version of the code of governance is available on Monitor's website: www.monitor-nhsft.gov.uk		



The Board of Directors

Our Board of Directors comprises:

- a Non-Executive Chairman
- five to 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.

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 considers that, as at 31st March 2014:

- Its composition meets the requirements of the National Health Service Act 2006 and the constitution
- Its size is sufficient and appropriate to meet the requirements of the organisation
- The Chairman and all the Non-Executive Directors are independent in accordance with the criteria set out in the foundation trust code of governance

However, it is recognised that, following the resignation of Douglas Taylor on 28 February 2014, there is a need to increase the independent financial expertise and experience available to the Board.

The other significant commitments of the Chairman in 2013/14 are shown below. These did not change during the year.

The membership of the Board as at 31 March 2014 was as follows:

Mrs Jo Turnbull, Chairman
Jo is a former Chairman of County Durham and Darlington Priority Services NHS Trust and a former Non-Executive Director of County Durham and Darlington Health Authority. She is a non-practicing solicitor and a Justice of the Peace.
Qualifications: LLB Newcastle University
Principal Skills & Expertise: Strategic leadership, risk management, legal skills / expertise, service change, stakeholder engagement and partnership working
Term of office: 1 April 2013 to 31 March 2014*
Date of Initial appointment: 1 July 2008**

Mr Jim Tucker, Deputy Chairman (from 1st December 2013) and Chairman of the Investment Committee
Jim is a former senior executive with Nike. He spent over 20 years working for Nike in a number of roles in the UK, over 10 of these as General Manager, and before retiring from Nike was General Manager for the developing markets in Eastern Europe, the Middle East and Africa.
Qualifications: BSc Chemical Engineering, Certified Diploma in Finance, Diploma in Management Studies
Principal Skills & Expertise: Strategic leadership, change management, executive selection and team building, mentoring and financial acumen.
Term of Office: 1 September 2012 to 31 August 2014*
Date of Initial appointment: 1st September 2008

Mr Marcus Hawthorn Non-Executive Director and Chairman of the Audit Committee (from 1st March 2014)
Marcus is a former Colonel in the British Army with extensive command and operations experience. His 30 years' service culminated in a number of senior programme and change management roles in the Ministry of Defence and the Home Office. Since then he was most recently the Head of Group Risk and Compliance at Age UK and he is now Northern Area Manager for the Royal British Legion.
Qualifications: BEng(Hons) Chemical Engineering, MSc Design of Information Systems, Postgraduate Diploma in Law. Also, Fellow of the Chartered Management Institute.
Principal Skills & Expertise: Risk, compliance and audit management, program management, operations, resilience and business continuity, systems development, change management, stakeholder engagement and partnership working, influence and strategic communications, human resource management, public and third sector focus and logistics.
Term of office: 1 September 2013 to 31 August 2016
Date of Initial appointment: 1 September 2013

Mrs Barbara Matthews, Non-Executive Director
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)
Principal Skills & Expertise: Risk management, public policy development, legal skills/expertise, commercial focus, contract negotiation and tender development skills.
Term of office: 1 September 2013 to 31 August 2016*
Date of Initial appointment: 1 July 2010

Mr Mike Newell, OBE, Non-Executive Director and Chairman of the Quality and Assurance Committee
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
Principal Skills & Expertise: Risk management, commercial mediation (CEDR trained), industrial relations (former National Trade Union leader), performance management, human rights in criminal justice settings, change management and international engagement and partnership working.
Term of office: 1 September 2012 to 31 August 2015*
Date of Initial appointment: 1 July 2008**

Mr John Robinson, Non-Executive Director and Senior Independent Director from 1 September 2013 (Deputy Chairman until 1 December 2013)
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
Principal Skills & Expertise: Clinical skills and expertise, strategic leadership, legal awareness, communication and stakeholder engagement, human resource management, training skills, partnership working, performance management and patient focus.
Term of office: 1 September 2012 to 31 August 2015*
Date of Initial appointment: 1 July 2008**

Mr Richard Simpson, Non-Executive Director and Chairman of the Mental Health Legislation Committee (from 1 December 2013)
Richard runs his own business delivering coaching, training and public relations consultancy. He has previous experience as a Non-Executive Director in the NHS and is a Trustee of The Millin Centre, an enterprise charity based in the West End of Newcastle.
Qualifications: BA (Hons) Sociology and Social Anthropology; Advanced Diploma in Leadership and Development Coaching.

Principal Skills & Expertise:
Communications, marketing, stakeholder engagement, crisis management, executive coaching, training, organisational development.
Term of office: 1 September 2013 to 31 August 2016
Date of Initial appointment: 1 September 2013

(Notes:
(*) 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).

Mr Martin Barkley, Chief Executive
Martin joined the NHS in 1972 as a trainee hospital administrator and has been a senior manager in mental health and learning disability services since 1986. He has served as Chief Executive at three trusts since 1994 (East Surrey, Nottingham and Hampshire) before joining this trust in April 2008.
Qualifications: Dip IHM, DMS, MBA (Henley/Brunel)
Principal Skills & Expertise: Service modernisation and organisational development
Appointed: April 2008

Brent Kilmurray, Chief Operating Officer
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
Principal Skills & Expertise: Operational service leadership, performance management, strategy development, service change, risk management, programme and project management.
Appointed: February 2013

Dr Nick Land, Medical Director
Nick has been a consultant psychiatrist for people with learning disabilities for 20 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
Principal Skills & Expertise: Strategic leadership, public policy development, clinical skills/expertise, performance management and service change
Appointed: January 2010

Mr Colin Martin, Director of Finance and Deputy Chief Executive
Colin has worked in local government and the NHS for over 25 years and was previously the Director of Finance for Tees and North East Yorkshire NHS Trust. He is the Chair of the Audit North NHS audit consortium.
Qualifications: Qualified accountant, FCCA
Principal Skills & Expertise: Programme and project management, systems development, PFI finance, information analysis, performance management and service development
Appointed: April 2006

Mrs Chris Stanbury, Director of Nursing and Governance
Chris joined the NHS in 1980 as a psychology graduate and registered as an RMN in 1985. She has held a variety of 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.
Principal Skills & Expertise: Psychiatric nursing skills, psychodynamic psychotherapy, project management, managerial and leadership, teaching, coaching and mentorship
Appointed: February 2009

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



Changes to Board Membership 2013/14

The following changes to the membership of the Board of Directors occurred during 2013/14:

- Mr Andrew Lombard (Senior Independent Director and Chairman of the Mental Health Legislation Committee) retired from the Board on 31 August 2013.
- Mr Graham Neave (Non-Executive Director) resigned on 31 August 2013.
- Mr Marcus Hawthorn and Mr Richard Simpson were appointed as Non-Executive Directors from 1st September 2013 (see above)
- Mr Douglas Taylor (Non-Executive Director and Chairman of the Audit Committee) resigned on 28 February 2014.

Board Meetings

The Board formally meets twelve times a year including special meetings 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; however, the Board may, by resolution, exclude members of the public from parts of its meetings for special reasons.

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 2013/14 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.

Attendance at Board meetings
The number of these meetings attended by individual Directors was as follows:

	No. of Board Meetings attended*
Jo Turnbull	12
Martin Barkley	10
Andrew Lombard	4 (5)
John Robinson	9
Barbara Matthews	11
Graham Neave	2 (5)
Mike Newell	10
Douglas Taylor	11 (11)
Jim Tucker	12
Brent Kilmurray	11
Dr Nick Land	11
Colin Martin	11
Chris Stanbury	11
Richard Simpson	7 (7)
Marcus Hawthorn	7 (7)
David Levy**	9
Sharon Pickering **	10

*(*The maximum number of meetings to be attended by 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).*

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 and Directors 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.

John Robinson, 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 of the Council of Governors during 2013/14, including the Annual General Meeting was as follows:

Jo Turnbull	5
Marcus Hawthorn	3 (3)
Andrew Lombard	2 (2)
Barbara Matthews	5
Graham Neave	0 (2)
Mike Newell	3
John Robinson	5
Richard Simpson	3 (3)
Douglas Taylor	2
Jim Tucker	4
Martin Barkley	3
Brent Kilmurray	5
Dr Nick Land	1
Colin Martin	4
Chris Stanbury	4
David Levy	3
Sharon Pickering	4

(The maximum number of meetings to be attended by those Board Members who held office during part of the year is shown in brackets)

During 2013/14 the Council of Governors did not exercise its powers under paragraph 26 (2) (aa) of Schedule 7 of the National Health Service Act 2006 to require the attendance of a Director at any of its meetings for the purpose of obtaining information on the Foundation Trust's performance of its functions or the directors' performance of their duties.

"(The Trust demonstrated) a very focussed approach to ensuring difficult cases have discharge options explored. It is very easy to allow those with complex presentations to drift through years of inpatient care"

From a mental health case manager, specialised commissioning team

Evaluating Board performance

In 2013/14 the Trust commissioned Deloitte LLP to undertake an external review of the Board's performance.

This review comprised:

- surveys of Board members and staff
- interviews with Board members
- interviews with a sample of senior managers
- interviews with the Trust Secretary's department
- interviews with external stakeholders
- focus groups with Governors, service users and staff
- Observations of meetings of the Board and the Audit and Investment Committees
- a review against the Department of Health's "Board Governance Assurance Framework".

In 2013/14 Deloitte LLP were:

- the Trust's External Auditors until the completion of the 2012/13 audit
- commissioned to undertake a review against Monitor's Quality Governance Framework as part of the investigation being undertaken by Monitor.

The Trust has no other connections with the firm.

Committees of the Board

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

Each committee has terms of reference which have been approved by the Board and includes its reporting requirements. Details of the terms of reference are 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 (eg the annual governance statement) prior to endorsement by the Board
- ensuring the internal audit function is effective, meets mandatory NHS internal audit standards and provides appropriate independent assurance
- making recommendations to the Council of Governors on the appointment, re-appointment or removal of the external auditor
- approving the remuneration and terms of engagement of the external auditor and reviewing and monitoring the independence and objectivity of the external auditor
- reviewing the work and findings of the external auditor and considering the implications and management responses to their work
- reviewing the findings of other assurance functions, both internal and external to the organisation (eg the Care Quality Commission, Monitor, etc) and considering the implications to the governance of the Trust
- reviewing and monitoring the integrity of any financial statements including any financial judgements contained in them and ensuring the completeness and accuracy of information provided to the Board
- reviewing arrangements by which staff may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters (the whistleblowing policy).

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

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

Membership of the committee

The committee comprises 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.

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

Douglas Taylor (Chairman to 28/2/14)	4(4)
Marcus Hawthorn (Chairman from 1/3/14)	2 (2)
Andrew Lombard	1 (2)
Mike Newell	2
Barbara Matthews	3 (3)
John Robinson	3 (4)
Richard Simpson	2 (2)

(The maximum number of meetings to be attended by those Non-Executive Directors who were members of the committee for part of the year is shown in brackets)

The Director of Finance, Head of Internal Audit and the External Audit Partner 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.

The work of the Audit Committee in discharging its responsibilities

During the year, the committee:

- reviewed the development and coverage of the clinical audit programme and received half yearly progress reports
- reviewed and challenged the external and internal audit plans and the counter fraud plan to gauge whether they were appropriately focussed. The internal audit plan was subsequently reviewed mid-year, in the light of the Monitor investigation, to ensure it would be able to provide the assurances required to enable the annual governance statement and corporate



governance statements to be signed off
- reviewed progress, at each meeting, against the internal audit plan and considered the outcome of reviews undertaken in the context of the Trust's controls and risk environment
- considered quarterly reports from the Local Counter Fraud Specialist noting action taken on increasing fraud awareness and in response to alleged cases of fraud in the Trust
- reviewed the assurances supporting the corporate governance statement 2013/14 and recommended its signing off to the Board
- considered and approved the letters of engagement with the external auditors including the audit fees
- reviewed the Trust's revised whistleblowing policy and was subsequently assured that its proposed amendments had been incorporated in the document
- approved the external audit/internal audit protocol for liaison report year ended 31 March 2014 - there were no issues arising
- approved the External Audit Strategy Memorandum 2013/14
- considered corporate governance and accounting developments
- considered and was assured that the Trust remained a "going concern" and that the annual accounts for 2013/14 could be prepared on that basis
- reviewed the annual report and financial statements for 2013/14 taking into account the external auditors' findings that:
  - their work on significant risks and key areas of management judgement had provided the assurance they sought and had not highlighted any material issues to bring to the committee's attention.
  - a single misstatement identified in the accounts had been adjusted
  - disclosure issues highlighted during the audit, with regard to the presentation of the accounts, had been amended
  - the Trust had proper arrangements for securing economy, efficiency and effectiveness
  - the annual report, including the quality report (see page 41) and financial statements (see page 113) had been prepared in accordance with the Foundation Trust Annual Reporting Manual 2013/14 and the financial statements provided a true and fair view of the state of the Trust's affairs as at 31/3/14 and of its income and expenditure for the year then ended.

  The only significant issue considered by the committee was the risk of misstatement arising from the Accounting Officer's decision not to prepare group accounts ie to consolidate the charitable funds into the Trust's accounts.

  The committee, taking into account the nature and value of the charitable funds and the external auditors' view that the approach taken was reasonable, concurred with the Accounting Officer's judgment on this matter.
- reviewed the quality account and the outcome of the limited (scope) review undertaken by the external auditors.

The external auditors
Mazars LLP was appointed as the Trust's external auditors in 2013 for three years following competitive tendering.

In making the appointment the Council of Governors accepted the recommendations of a joint working party comprising members of the Audit Committee and representatives of the Council of Governors.

The cost of providing external audit services during 2013/14 was £45,000 including 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.

The Trust also participated in a national benchmarking process on nursing staff deployment levels in mental health Trusts undertaken by Mazars LLP. There were no additional fees paid to the firm for this support.

The internal auditors
Internal audit services are provided by Audit North; a not-for-profit provider of audit, information systems, assurance and investigation services serving the public sector in the North of England.

Mr John Whitehouse CIPFA, the Director of Audit at Audit North, is the Trust's Head of Internal Audit.

Each year the Audit Committee agrees an internal audit plan which sets out the reviews to be undertaken during the year which is aligned to the principal risks identified by the Trust.

Progress reports are provided by the internal auditors to each meeting of the committee and contribute to the Head of Internal Audit's annual opinion on the Trust's system of internal control, which is used to inform the annual governance statement.

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.

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 Provider 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 – Jim Tucker
- four other Non-Executive Directors.

  For 2013/14 the Non-Executive Director members of the committee were:
  - Marcus Hawthorn (from 1 December 2013)
  - Andrew Lombard (to 31 August 2013)
  - Barbara Matthews
  - Mike Newell (to 30 November 2013)
  - Douglas Taylor (to 28 February 2014)
  - Richard Simpson (from 1 December 2013)

- the Chief Executive, Finance Director, Chief Operating Officer and Director of Planning and Performance.

The committee met 6 times during the year.

During 2013/14 the committee reviewed and recommended the following developments to the Board:

- the development of digital input enabling voice recordings to be uploaded directly to a central server
- the Trust's revised telephony contract
- the Harrogate Community Resource Centre (Windsor House)
- the refurbishment/reconfiguration of The Orchards, Ripon for provision of rehabilitation beds for North Yorkshire and a local 'spoke' for the delivery of community services in the Ripon area
- the re-provision of Middlesbrough CAMHS community team accommodation at the West Lane Hospital site, Middlesbrough.

The Quality 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. The committee receives assurance reports from a number of established corporate assurance working groups of the committee and the locality management and governance boards, which provide assurance that the organisation is discharging its duty of quality and safety in compliance with the Health and Social Care Act 2008.

The Committee provides assurance to the Board of Directors that the Trust is compliant with the regulator's standards of quality and safety as set out in the Health and Social Care Act 2008 (Registration requirements) Regulations 2009.

The committee commissions and monitors projects/programmes of work to assist the Trust to maintain CQC registration and/or discharge its duty of quality and safety.

The committee receives a monthly position statement in respect of the Trust's 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 received six monthly directorate quality and assurance reports. From November 2013 the committee received monthly assurance exception reports from locality management governance boards as well as scheduled reports from the working groups. This provided the committee with a regular opportunity to critically review areas of practice, patient experience, clinical safety and effectiveness, service development, improvement and governance to assure quality standards are being maintained.

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.

The committee is responsible for making recommendations about priorities in the annual quality account (for the following year) and for noting assurance on the delivery of the quality account priorities.

The committee works to promote a quality focussed culture throughout the Trust which is open and inclusive, which values learning from and participation by staff, reacts to problems positively, encourages questioning and lessons learned. To ensure that the Board of Directors maintain a focus on the quality of services, a monthly report is provided together with quarterly reports detailing issues raised through complaints and PALS and the performance against the patient experience quality indicators.

The committee held 12 meetings during 2013/14.

Members are:

- Mr Mike Newell, Non-Executive Director and Committee
- Mr John Robinson, Non-Executive Director
- Mr Jim Tucker, Non-Executive Director
- Mrs Barbara Matthews, Non-Executive Director
- Mrs Chris Stanbury, Director of Nursing and Governance
- Dr Nick Land, Medical Director
- Dr Ahmad Khouja, Deputy Medical Director and Clinical Director - forensic service
- Dr Lennon Swart, Senior Clinical Director - children and young people's service
- Dr Angus Bell, Senior Clinical Director - AMH and Clinical Director - AMH (Tees)
- Dr Kirsty Passmore, Senior Clinical Director - LD
- Dr Tolulope Olusoga, Senior Clinical Director - MHSOP
- Mr Brent Kilmurray, Chief Operating Officer
- Mr Stephen Scorer, Deputy Director of Nursing and Governance
- Ms Christine McCann, Associate Director of Nursing and Governance
- Mrs Lesley Mawson, Associate Director of Nursing and Governance
- Mrs Joan Breckon, Associate Director of Nursing and Governance
- Mrs Sharon Pickering, Director of Planning and Performance
- Mr Levi Buckley, Director of Operations – Forensic Services
- Mrs Adele Coulthard, Director of Operations -North Yorkshire
- Mr Paul Newton, Director of Operations - Durham and Darlington
- Mr David Brown, Director of Operations - Teesside
- Dr Neil Mayfield, Deputy Medical Director - North Yorkshire
- Dr Lenny Cornwall, Deputy Medical Director - Teesside
- Dr Ingrid Whitton, Deputy Medical Director - Durham and Darlington



Mental Health Legislation Committee

The duties of the committee are:

- to ensure appropriate arrangements are in place for the appointment of associate managers and oversee 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 implications of the Code of Practice (Revised): Mental Health Act 1983 and Mental Capacity Act 2005 and make proposals for change to the Board
- receive regular reports from the Mental Health Act operational groups
- to scrutinise CQC Mental Health Act visit reports and management of 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.

Four meetings were held during 2013/14.

Membership of the committee:

- Mr Richard Simpson, Non-Executive Director and Chair
- Mr John Robinson, Non-Executive Director
- Mr Jim Tucker, Non-Executive Director
- Mr Douglas Taylor, Non-Executive Director (until Feb 2014)
- Dr Nick Land, Medical Director
- Mrs Chris Stanbury, Director of Nursing and Governance
- Mr Brent Kilmurray, Chief Operating Officer (also attends as Director with responsibility for estates and facilities management)
- a carer representative
- a service user representative (stood down in January 2014)

Remuneration Committee

Membership of the Remuneration Committee during 2013/14 comprised the Trust Chairman, who also chaired the committee, all Non-Executive Directors and the Chief Executive. The Director of Human Resources and Organisational Development provides secretarial support to the Remuneration Committee.

Three meetings were held during 2014/15

Date	Attendance
24/9/13	Mrs Jo Turnbull, Chairman Mr Martin Barkley, Chief Executive Mrs Barbara Matthews, Non-Executive Director Mr Mike Newell, Non-Executive Director Mr Jim Tucker, Non-Executive Director Mr John Robinson, Non-Executive Director Mr Douglas Taylor, Non-Executive Director Mr Marcus Hawthorn, Non-Executive Director Mr Richard Simpson, Non-Executive Director Mr David Levy, Director of HR & OD (in attendance)
29/1/14	Mrs Jo Turnbull, Chairman Mr Colin Martin, Director of Finance and Information Mr Mike Newell, Non-Executive Director Mr Jim Tucker, Non-Executive Director Mr John Robinson, Non-Executive Director Mr Douglas Taylor, Non-Executive Director Mr Richard Simpson, Non-Executive Director Mr David Levy, Director of HR & OD (in attendance)
25/3/14	Mrs Jo Turnbull, Chairman Mr Martin Barkley, Chief Executive Mrs Barbara Matthews, Non-Executive Director Mr Jim Tucker, Non-Executive Director Mr John Robinson, Non-Executive Director Mr Marcus Hawthorn, Non-Executive Director Mr Richard Simpson, Non-Executive Director Mr David Levy, Director of HR & OD (in attendance)

Advice and/or services were provided by Mr David Levy, Director of Human Resources and Organisational Development and Mr David Evans of Capita.

During 2013/14 the Remuneration Committee considered information and made decisions about proposals to make two severance payment recommendations to Monitor. The Remuneration Committee made a decision to award a 1% cost of living basic pay increase to Executive and Corporate Directors for 2013/14. The Remuneration Committee also approved the 2013 Employer Based Clinical Excellence Awards recommendations made by a Trust panel and commissioned an independent job evaluation exercise concerning posts within the Trust Executive Management Team to be undertaken by Capita.



The Council of Governors

Report from Councillor Ann McCoy, Lead Governor on the work of the Council of Governors during 2013/14

As Lead Governor I am the point of contact for Monitor and the CQC. Examples would be Monitor wishing to understand the view of Governors about the capability of the Chairman, or be investigating some aspect of an appointment process or decision which may not have complied with the constitution, or likewise CQC in their role of inspection. I am happy to report that it has never happened.

As Lead Governor I receive full reports following the CQC inspections, this allows me to ask any questions of concern or clarification at the Council of Governors meetings. There have been occasions when I have submitted questions and the Trust's officers have made timely and satisfactory responses.

The powers and responsibilities of Governors have been strengthened and to ensure the Council of Governors exercise these new Powers in an appropriate way a task and finish group has been set up of which I am a member. The 'holding the Non-Executive Directors to account for performance of the Board' task and finish group will produce a report to be submitted to the Council of Governors with recommendations as to how the powers will be used.

A suggestion that came from a training event that I attended on the new powers was that Governors could meet with me before the start of the Council of Governors meetings to raise any issues they have on the Trust Board's agenda or minutes. How this might be implemented is being looked at.

The sub committees continue to review policies and procedures to ensure service users and carers receive the highest quality treatment and support from the Trust.

Projects have included

- the carers strategy
- membership and the re-launch of the Insight magazine
- hospital food and the outcome of the food tendering contract
- the work of volunteers
- the regulations and procedures for associate hospital managers and tribunals reviewing patients in hospital on sections and community treatment orders.

All the sub committees submit reports to the Council of Governors meetings to ensure all Governors are aware of the issues being reviewed.

Governors continue to enhance their skills and knowledge through training and development to enable them to exercise their role effectively. The training has included.

- finance and business planning
- equality and diversity
- TEWV QIS
- Mental Health Act and Capacity Act legislation
- Governors development day
- Participation in the national Governwell training programme

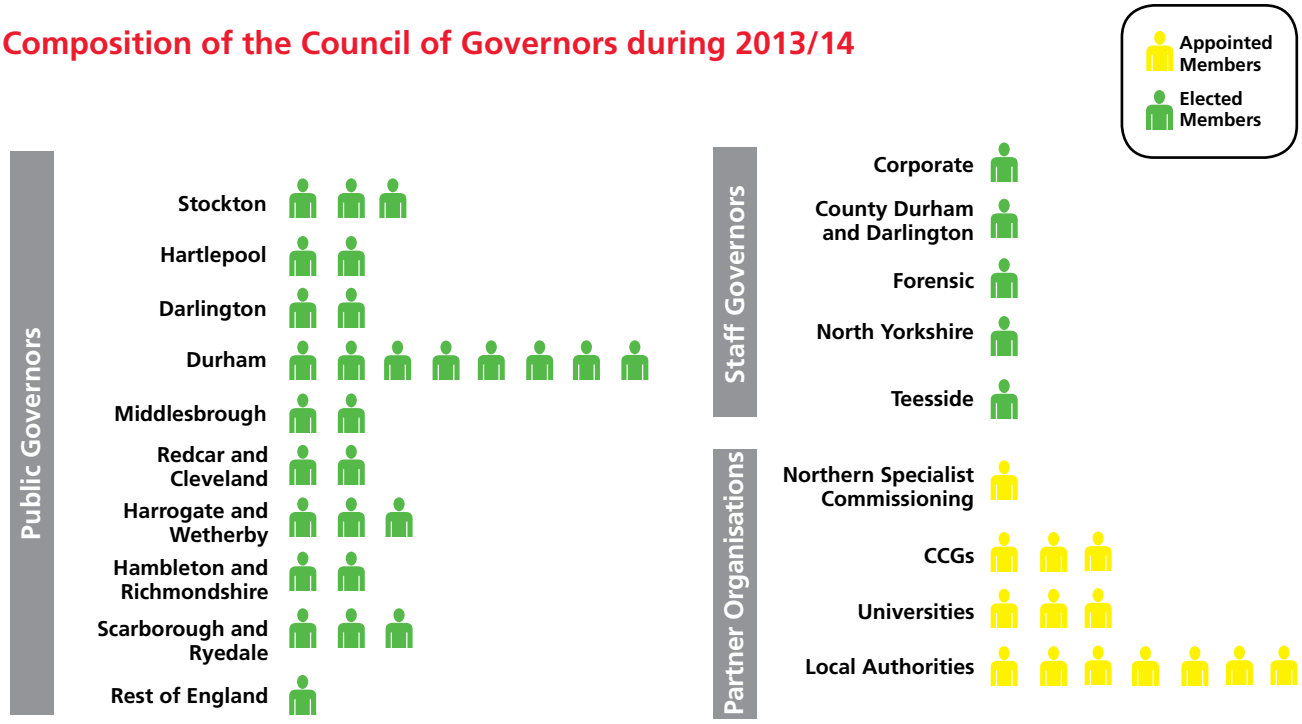
This year has been interesting and challenging with changes in CQC inspections and the transfer of responsibility for Health commissioning to the CCGs, Local Authorities and reduced funding.

The Council of Governors is aware of the enormous pressure this has put on the Trust and recognises the commitment and dedication of staff and the Board to ensure the services to patients and carers provided remain of the highest standard.

I know I speak for all the Governors when I say that we will miss the Chairman Jo Turnbull, she has been an outstanding Chairman who has made the Council of Governors understand the importance of their role and the contribution we make to her vision for TEWV. We wish her well.

We all look forward to working with the new Chair, Lesley Bessant.

Composition of the Council of Governors during 2013/14





Membership of the Council of Governors during 2013/14

The terms of office of Governors and their attendance at the five ordinary meetings (including the Annual General Meeting) held during 2013/14 was as follows:

Public Governors (Elected)

Public Governors (Elected)		Term of Office		
Name	Constituency	From	To	Total attended
Andrea Goldie	Darlington	18/12/2011	30/06/2014	4
Dennis Haithwaite	Darlington	18/12/2011	30/06/2014	2
Ann Tucker	Middlesbrough	01/07/2011	30/06/2014	4
Catherine Haigh	Middlesbrough	01/07/2013	30/06/2016	3 (4)
Michael Taylor	Middlesbrough	01/07/2010	30/06/2013	1 (2)
Judith Webster	Scarborough and Ryedale	01/07/2011	30/06/2014	4
Keith Marsden	Scarborough and Ryedale	01/07/2013	30/06/2016	2 (4)
Andrea Darrington	Scarborough and Ryedale	17/02/2012	30/06/2014	5
Jayne Mitchell	Redcar & Cleveland	18/12/2011	30/06/2014	5
Vanessa Wildon	Redcar & Cleveland	15/07/2013	30/06/2016	4 (4)
Vivienne Trenchard	Redcar & Cleveland	01/07/2010	30/06/2013	0 (1)
Cllr Ray McCall	Stockton-on-Tees	18/12/2011	30/06/2014	3
Gary Emerson	Stockton-on-Tees	01/07/2013	30/06/2016	4 (4)
Gareth Rees	Stockton-on-Tees	18/02/2013	24/02/2014	2 (4)
Paul Emerson-Wardle	Stockton-on-Tees	01/07/2010	30/06/2013	1 (1)
Betty Gibson	Durham	01/07/2011	30/06/2014	5
Chris Wheeler	Durham	01/07/2011	30/06/2014	3
Dr Nadja Reissland	Durham	01/07/2013	30/06/2016	4
Cliff Allison	Durham	18/12/2011	30/06/2014	5
Andrew Everett	Durham	01/07/2013	30/06/2016	5
Vince Crosby	Durham	01/07/2013	30/06/2016	4
David Lawson	Durham	01/07/2013	30/06/2014	1 (4)
Mark Williams	Durham	01/07/2013	30/06/2016	4 (4)
Drew Terry	Durham	18/12/2011	03/04/2013	0 (0)
John Doyle	Durham	01/07/2010	30/06/2013	1 (1)
Zoe Sherry	Hartlepool	21/03/2013	30/06/2014	4
Jean Rayment	Hartlepool	01/07/2013	30/06/2016	3 (4)
Paul Williams	Hartlepool	01/07/2010	30/06/2013	1 (1)
Dr Matthew Kiernan	Hambleton and Richmondshire	01/07/2013	30/06/2014	3 (4)
Colin Wilkie	Hambleton and Richmondshire	18/12/2011	30/06/2014	5
Hilary Dixon	Harrogate and Wetherby	01/07/2013	30/06/2016	3 (4)
Chris Gibson	Harrogate and Wetherby	01/07/2013	30/06/2016	3 (4)
Sandy Taylor	Harrogate and Wetherby	01/07/2013	30/06/2016	4 (4)

(Notes:
**The maximum number of meetings to be attended for those Governors who held office during part of the year is shown in brackets*
No Governor held office for the Rest of England Constituency during the year as there were insufficient members to hold an election)

Staff Governors (Elected)

Staff Governors (Elected)		Term of Office		
Name	Constituency	From	To	Total attended
Dr John Kelly	North Yorkshire	31/03/2013	30/06/2014	5
Simon Hughes	Teesside	01/07/2011	30/06/2014	5
Doug Wardle	County Durham and Darlington	01/07/2011	08/03/2014	2 (5)
Stuart Johnson	Corporate	01/07/2011	25/02/2014	0 (4)
Lisa Taylor	Forensic	17/02/2012	30/06/2014	0 (5)

*(*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
Prof Paul Keane OBE	University of Teesside	01/07/2011	30/06/2014	1 (5)
Prof Pali Hungin	Durham University	01/07/2011	30/06/2014	3 (5)
Gill Alexander	Hartlepool Borough Council	21/10/2013	20/10/2016	0 (2)
Jill Harrison	Hartlepool Borough Council	01/07/2011	02/07/2013	0 (1)
Debbie Newton	Hambleton, Richmondshire and Whitby Clinical Commissioning Group / Scarborough and Ryedale Clinical Commissioning Group / Harrogate Clinical Commissioning Group	11/04/2013	10/04/2016	1 (5)
Dr Kate Bidwell	North Durham Clinical Commissioning Group / Durham Dales, Easington and Sedgefield Clinical Commissioning Group / Darlington Clinical Commissioning Group	01/04/2013	31/03/2016	5
Cllr Ann McCoy	Stockton Borough Council	01/07/2011	30/05/2015***	4
Ann Workman	Darlington Borough Council	11/07/2012	10/07/2015	1
Lesley Jeavons	Durham County Council	01/07/2011	30/06/2014	2
Cllr Tony Hall	North Yorkshire County Council	31/07/2013	31/05/2017	2 (4)
Heather Moorhouse	North Yorkshire County Council	03/06/2013	13/07/2013	0 (1)
Prof Ian Watt	The University of York	01/07/2011	30/06/2014	0
Tony Parkinson	Middlesbrough Borough Council	24/11/2011	04/09/2013	0 (2)

(* The maximum number of meetings to be attended for those Governors who held office during parts of the year is shown in brackets.
** During 2013/14 the Northern Specialist Commissioning Group and the Hartlepool and Stockton and South of Tees Clinical Commissioning Groups did not appoint Governors to the seats allocated to them on the Council of Governors.
*** Cllr McCoy's terms of office was extended by Stockton Borough Council during the year).

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



Elections held during 2013/14

Constituency	Date	Seats	No. of Candidates	No. of eligible voters	No. of Actual Voters	Turnout %
Scarborough and Ryedale	21/06/2013	1	4	408	56	13.70%
Stockton-on-Tees	21/06/2013	1	3	1005	90	9.00%
Redcar and Cleveland	21/06/2013	1	2	693	52	7.50%
Middlesbrough	21/06/2013	1	3	1083	78	7.20%
Harrogate and Wetherby	21/06/2013	3	4	354	60	16.90%
Hambleton and Richmondshire	21/06/2013	1	2	370	64	17.30%
Hartlepool	21/06/2013	1	2	720	58	8.10%
Durham	21/06/2013	5	8	1628	127	7.80%

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.

Committees of the Council of Governors

The Council of Governors has established four thematic committees and the Nomination and Remuneration Committee to support its work.

Thematic committees

The following issues were progressed by the four thematic committees during 2013/14:

Improving the experience of carers

Chairmen: Ann Tucker (to September 2013) / Vanessa Wildon (from September 2013)

- monitored the carers' support strategy implementation plan - this was signed off during the year
- considered the delivery of carer awareness training to staff in support of the Triangle of Care
- received briefings on the care programme approach project
- discussed the pilot project for service user information packs
- considered the use of carer stories in the Trust
- reviewed the use of electronic devices for obtaining carer feedback
- received briefings on the development of pilot information packs in Derwentside and Scarborough
- raised concerns about the provision of transport for service users and carers

Improving the experience of service users

Chairmen: Keith Marsden (to September 2013) and Catherine Haigh (from September 2013)

- received a briefing on the work of the pharmacy team
- kept an overview of progress on the tendering of the patients' food contract
- considered deaf awareness and the pilot project for the provision of portable hearing loops
- raised concerns about access to Lanchester Road Hospital
- reviewed the results of patient surveys
- considered the provision and availability of statutory advocacy support
- reviewed patient feedback standards and reporting arrangements
- considered the involvement of service users in CQC inspections

Promoting social inclusion and recovery

Chairmen: Vivienne Trenchard (to July 2013) and Chris Wheeler (from September 2013)

- monitored the implementation of the connecting communities project in Murton
- discussed volunteering in the Trust including the review of the volunteer strategy
- received updates on and considered the development and implementation of the recovery strategy
- received a briefing on a project examining the impact of parental mental health on children
- discussed the potential effects that funding for the 'Better Care Fund' would have on the Trust
- 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

Chairmen: Paul Emerson-Wardle (to July 2013) and Sandy Taylor (from September 2013)

- monitored the implementation of the membership strategy and plan 2013/14 and identified key priority areas for 2014/15
- reviewed the delivery and evaluation of the Annual General Meeting/Annual Members' Meeting 2013 and the Celebrating Positive Practice events held during the year
- commenced preparations for the 2014 Annual General Meeting/Annual Members' Meeting
- agreed the membership pages in the "Insight" magazine
- agreed the piloting of information drop in events
- developed proposals (subsequently approved by the Council of Governors) for recruitment incentive drives in Hambleton and Richmondshire and Harrogate and Wetherby

Reports on the work of the thematic committees are provided to each meeting of the Council of Governors and to the Annual General Meeting/Annual Members' Meeting.

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 2013/14 the Committee:

- Provided assurance to the Council of Governors on the performance of the Chairman and Non-Executive Directors
- Reviewed the remuneration of the Chairman and Non-Executive Directors
- Recommended:
  - The appointment of a new Chairman of the Trust and two Non-Executive Directors following open competition.
  - The re-appointment of a Non-Executive Director.

In accordance with the procedures adopted by the Council of Governors, Mrs. Matthews was re-appointed without external competition as she had performed satisfactorily in the role and 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 11 meetings during 2013/14 was as follows:

Jo Turnbull	Chairman of the Trust	6*
Andrew Lombard	Senior Independent Director (to 31/8/13)	4**
John Robinson	Senior Independent Director (from 1/9/13)	4**+
Martin Barkley	Chief Executive	2***
Andrea Darrington	Public Governor	8 (8)
Betty Gibson	Public Governor	10
Lesley Jeavons	Appointed Governor	3 (3)
Dr Nadja Reissland	Public Governor	2 (8)
Sandy Taylor	Public Governor	3 (3)
Colin Wilkie	Public Governor	10

Notes:
* Mrs Turnbull did not attend meetings which were exclusively related to discussions on the appointment of the new Chairman.
** As the Senior Independent Director, Mr Lombard and Mr Robinson only attended those meetings at which the appointment, performance and remuneration of the Chairman was considered.
*** In accordance with the Trust's procedure for the Appointment of the Chairman and Non-Executive Directors the Chief Executive is ineligible from attending those meetings of the committee to agree shortlists or when it is acting as an Appointment Panel.
+ Mr Robinson also attended one meeting as the shadow Senior Independent Director
The maximum number of meetings which could be attended by the members of the committee, including those who held office during part of the year, is shown in brackets.

During 2013/14 the committee received independent advice and support on the recruitment of the Chairman and two Non-Executive Directors from the Northern Recruitment Group plc.

Mrs. Angela Greatley, Chairman of Tavistock and Portman NHS Foundation Trust was the independent assessor for the appointment of the Chairman.

The appointments of the Chairman and the Non-Executive Directors can be terminated for the following reasons:

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



Other Governor groups and meetings

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
Workshops are held annually to brief and consult Governors on the draft business plan.

This process enables the views of members to be fed into the business planning process.

The Council of Governors is formally consulted on the final draft of the business plan and its comments are reported to, and considered by, the Board as part of the approvals process.

Whilst the Board has considered that this process has been appropriate for the approval of the two year business plan it recognises more formalised engagement with members and stakeholders might be required following the introduction of year strategic planning by Monitor.

Task and finish groups
The Council of Governors is piloting the use of task and finish groups based on the topic of how Governors should hold the Non-Executive Directors to account for the performance of the Board; one of their new duties under the Health and Social Care Act 2012.

These project based groups are intended to enable the Governors to focus on issues which fall between its thematic committees and enable the Trust to make best use of their skills, experience and knowledge.

The Council of Governors is also represented on key operational groups within the Trust and attend various other ad hoc briefing and training events.

Performance Appraisal

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.

Training and development
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.

The plan incorporates both the national "Governwell" programme run by the Foundation Trust Network (introduced in 2013) and locally provided courses.

All Governors must undertake the following mandatory training:

- Introduction
- Governwell – core skills
- Role of a Governor
- Financial and business performance and planning
- Equality and diversity
- TEWV Quality Improvement System
- Mental Health Act and Mental Capacity Act Legislation
- Safeguarding

The training and development plan also provides opportunities for Governors to undertake self development with a range of optional training courses available including access to other modules of the Governwell scheme.

During 2013/14 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.

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 2013/14 we set ourselves the following objectives:

- to achieve a public membership of 7,524
- to increase public membership in the Harrogate and Wetherby, Hambleton and Richmondshire, Scarborough and Ryedale, and County Durham Constituencies
- to maintain, at least, the number of members in the other Constituencies
- to focus recruitment activities on increasing the number of members from under-represented groups.

As shown below although we fell 37 new members short of our annual target, we did achieve increases in our key areas.

We consider that the public membership of the Trust is broadly representative of our local population.

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 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

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

During 2013/14 the size and movements in public membership were as follows:

Public members as at 1/4/13	6952
New members during 2013/14	674
Members leaving during 2013/14	139
Public members as at 31/3/14	7487

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

Public constituencies Total	
Darlington	703
Durham	1719
Hambleton & Richmondshire	381
Harrogate and Wetherby	369
Hartlepool	725
Middlesbrough	1147
Redcar & Cleveland	824
Scarborough & Ryedale	457
Stockton	1066
Rest of England	96

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	1550
Corporate	945
Forensic	804
North Yorkshire	795
Teesside	1,579

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

To support member engagement 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 2013/14 engagement with members was undertaken via the following:

- a welcome pack for new members
- Annual General Meeting/Annual Members' Meeting
- inclusion of a members page in our 'Insight' magazine
- 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 2013/14 we held the following positive practice events for our members:

Date	Constituencies	Focus	No. of Attendees
09/05/2013	Scarborough, Whitby and Ryedale	• how the Trust obtains and acts on feedback from service users and carers • Care Programme Approach documentation developed by the learning disability reference group • community service pathways for adults • the pilot to improve the pathway of service users with bi polar disorder • the re-development of the Springwood Unit in Malton for older people • the transfer of services from Beck House to Manor Court in Scarborough • an update from local public Governor, Keith Marsden	62
19/09/2013	County Durham and Darlington	• how service users and carers are assisting the Trust recruit staff • changes to the crisis resolution and home treatment service including the provision of new crisis beds in Shildon • how service users with substance misuse issues are supported • the impact of the psychiatric liaison service in its first year of operation • how the Trust obtains and acts on feedback from service users and carers • the support and treatments available for people with a learning disability who may have a dementia • new developments in accessing psychological therapies for children and young people	76

All engagement activity is monitored through the Making the Most of Membership Committee.



Financial review 2013-14

Summary of Financial Performance

In 2013-14 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 2013-14 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, both planned and achieved, are shown in the table opposite:

The Trust planned an operating surplus of £3.5m for the financial year and achieved £12.2m. The surplus is higher than planned largely as a result of valuation gains from an independent property review (£5.4m), slippage on projects planned for 13-14 which will now take place in 14-15 (£2.1m) and a non-recurrent reduction in the PFI unitary payment at Roseberry Park Hospital (£1.5m).

Total CRES achieved at 31 March 2014 was £9.8m and was ahead of plan, all CRES achieved was recurrent and the Trust is making good progress with future years plans.

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*
Debt service cover	2.18x	3
Liquidity	13.7 days	4
Overall rating		4

Improving efficiency and ensuring value for money
The Trust is continuously striving to improve efficiency in its use of resources by reviewing systems and pressures, evaluating skill mix, optimising the use of capacity and ensuring best value through robust procurement practices. In year, £9.8m of our cost base was saved through a variety of ongoing schemes.

Capital Investment
The Trust has utilised its freedoms as a foundation trust to improve the infrastructure and ensure the most modern equipment and technology is available for patient care. Over the last twelve months we have reinvested surpluses with the aim of providing the best possible environment. As a foundation trust during 2013-14, £13.3m was invested in capital assets.

2013-14 objectives

Objectives	Outcomes
Delivering a £3.5m financial surplus	**Financial surplus of £12.2m achieved**
Achieving a Monitor risk rating of 4	**Calculated risk rating of 4 achieved**
Delivery of £9.4m cash releasing efficiency savings	**Delivery of £9.8m cash releasing efficiency savings**
EBITDA margin of 7.2%	**EBITDA margin of 8.8% achieved**

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

	2013-14
	£m
Investment in fixed assets	13.3
Disposal of unprotected assets	3.2

Modern equivalent asset (MEA) valuation
The Trust's land and buildings were subject to a revaluation 31 March 2014, which resulted in impairments as follows:

	2013-14 £m	
	Realised in surplus	Realised in reserves
Impairment reversals	5.4	0.0
Revaluation gains	0.0	9.1
Total gain realised	5.4	9.1

When realised in the surplus, 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 to 13.7 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 (2013-14) 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 2014-15 annual plan provides for a surplus of £4.5m (1.7% of turnover) and reflects a significant level of non-recurrent expenditure. The planned financial surplus for 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 Mazars LLP as external auditors in accordance with the National Health Service Act 2006 and Monitors Code of Audit Practice. As far as the directors are aware, all relevant audit information has been fully disclosed to the auditor and that no relevant audit information has been withheld or made unavailable. Nor have any undisclosed post balance sheet events occurred.

No political or charitable donations were made by the Trust during 2013-14.

Accounting policies for pensions and other retirement benefits are set out in the full accounts and details of senior managers remuneration can be found on page 102 of the remuneration report.

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

Counter fraud
The Trust has an established fraud and corruption policy that was reviewed and approved at the Trust's Audit Committee in July 2013. This policy aims to minimise the risk of fraud, bribery or corruption by detailing the key roles and responsibilities of employees and related parties; as well as promoting an anti-fraud culture throughout the Trust.

The policy and related materials are available on the Trust's intranet and counter-fraud information is prominently displayed both on the Trust's intranet and throughout the Trust's premises.

The Trust's Local Counter-Fraud Specialist (LCFS) reports to the Audit Committee quarterly and performs a programme of work designed to provide assurance to the Board with regard to fraud and corruption. The LCFS provides regular fraud awareness sessions to the Trust's staff, investigates concerns reported by staff and liaises with the police. If any issues are substantiated, the Trust takes appropriate criminal, civil or disciplinary measures.

Ill Health Retirements
During 2013-14 the Trust had 12 employees retire early on the grounds of ill health; the value of these early retirements (from NHS Pensions) is £1.0m.

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 2013-14 was as follows:

2013-14	Number of Invoices	Value of invoices £000s
NHS Creditors		
Total bills paid	1,148	22,645
Total bills paid within target	601	18,747
Percentage of bills paid within target	52.35%	82.79%
Non-NHS Creditors		
Total bills paid	53,268	91,105
Total bills paid within target	51,505	88,731
Percentage of bills paid within target	96.69%	97.39%

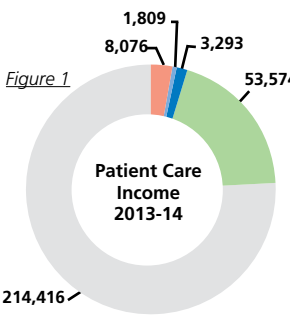
It is Trust policy to pay all creditors as they fall due, unless extenuating circumstances are apparent, e.g. a dispute in the amount being charged, or the service / goods provided.

Income Generation
During 2013-14, income generated was £291.0m from a range of activities; 94.5% from direct patient care. Patient care income came from the areas highlighted in *Figure 1*:

There is a further £16.0m from education, reversal of impairments and other non-patient care services - see *Figure 2*.

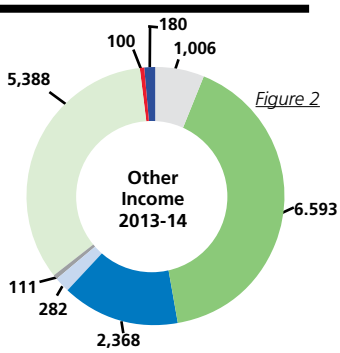
As shown, the Trust's income from the provision of goods and services for the purposes of the health service in the UK was greater than its income from the provision of goods and services for any other purposes. This income has had no negative impact on the provision of health services.

Figure 1



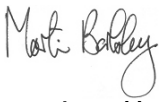
- Cost and volume contract income
- Block contract income
- Clinical partnerships providing mandatory services (including S31 agreements)
- Clinical income from the Secondary Commisioning of mandatory services
- Other clinical income from mandatory services

Figure 2

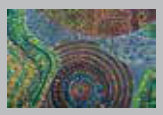


- Research and development
- Education and training
- Non-patient care services to other bodies
- Other
- Profit on disposal of assets held for sale
- Reversal of impairments of property, plant and equipment
- Rental revenue from operating leases
- Income in respect of staff costs

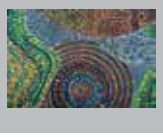
Management costs
In line with best practice the Trust continues to monitor expenditure on management costs in accordance with Department of Health definitions. In 2013-14, 4.78% of the Trust's total income was incurred on management costs, a reduction on 4.89% reported in 2012-13.



Martin Barkley
Chief Executive
27 May 2014



Directors' remuneration report and statutory statements



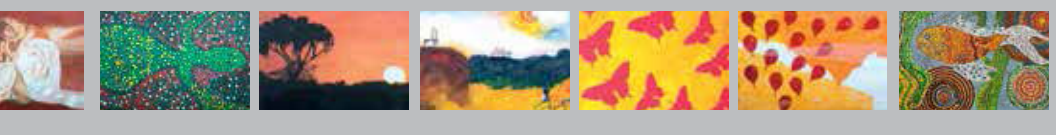
Directors' Remuneration Report

Senior managers' remuneration

Name and Title	2013-14						
	Salary (bands of £5000)	Other Remuneration (bands of £5000)	Benefits in Kind Rounded to the nearest £100	Pension related benefits (bands of £2500)	Total Remuneration (bands of £5000)	Expenses Paid Rounded to the nearest £100	
	£000	£000		£000	£000		
Mr Martin Barkley, Chief Executive	180-185	0	0	2.5-5.0	180-185	3,100	
Mr Colin Martin, Director of Finance	120-125	0	9,700	20.0-22.5	150-155	300	
Dr Nick Land, Medical Director	35-40	165-170	8,900	72.5-75.0	285-290	300	
Mr David Levy, Director of Human Resources and Organisational Development	105-110	0	0	22.5-25.0	125-130	1,900	
Mrs Chris Stanbury, Director of Nursing and Governance	105-110	0	3,700	(7.5-10.0)	105-110	200	
Mr Chris Parsons, Director of Estates and Facilities*****	60-65	0	2,600	0	60-65	200	
Mrs Sharon Pickering, Director of Planning and Performance	90-95	0	5,700	17.5-20.0	115-120	100	
Mr Les Morgan, Chief Operating Officer left 1 July 2012	0	0	0	0	0	0	
Dr Ruth Briel, Senior Clinical Director, Kaizen Promotion Office	65-70	10-15	0	7.5-10.0	85-90	3,300	
Mr Brent Kilmurray, Chief Operating Officer	120-125	0	0	62.5-65.0	180-185	6,000	
Mr Paul Newton, Director of Operations - County Durham and Darlington	100-105	0	2,100	50.0-52.5	150-155	200	
Mr David Brown, Director of Operations – Teesside	100-105	0	2,300	60.0-62.5	165-170	100	
Mr Levi Buckley, Director of Operations – Forensic Services	80-85	0	0	42.5-45.0	125-130	1,100	
Mrs Adele Coulthard, Director of Operations – North Yorkshire	80-85	0	0	22.5-25.0	105-110	1,100	
Mrs Jo Turnbull, Chairman - left 31 March 2014	50-55	0	0	0	50-55	8,900	
Mr Andrew Lombard, Non-Executive Director - left 31 August 2013	5-10	0	0	0	5-10	1,600	
Mrs Barbara Matthews, Non-Executive Director	10-15	0	0	0	10-15	2,500	
Mr Mike Newell, Non-Executive Director	10-15	0	0	0	10-15	1,800	
Mr John Robinson, Non-Executive Director	15-20	0	0	0	15-20	2,100	
Mr Graham Neave, Non-Executive Director - left 31 August 2013	5-10	0	0	0	5-10	0	
Mr Jim Tucker, Non-Executive Director	10-15	0	0	0	10-15	4,200	
Mr Richard Simpson, Non-Executive Director - started 1 September 2013	5-10	0	0	0	5-10	1,500	
Mr Marcus Hawthorn, Non-Executive Director - started 1 September 2013	5-10	0	0	0	5-10	600	
Mr Douglas Taylor, Non-Executive Director - left 28 February 2014	15-20	0	0	0	15-20	4,000	
	Band of highest paid directors total remuneration (£000) **** 180-185						
	Median of total remuneration 25,894						
	Ratio (Director to Median) 6.8						

* 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 2013-14 (£28k for 2012-13) & Clinical Excellence award
*** Other remuneration includes Additional Clinical Programmed Activity worked during the reported period (For which £2k was paid during 2013-14, £6k for 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. Pension related benefits have also been excluded from this calculation, as they are not known for all staff.
***** Christopher Hugh Parsons took flexible retirement 28th February 2013, returning 1st April 2013 on reduced hours equating to 0.60 wte

Expenses of Governors
At 31 March 2014 the Trust has 40 Governors (2012-13, 36), with 26 Receiving reimbursement of expenses (2012-13, 22). The total amount reimbursed as expenses was £10,445, (£9,411 in 2012-13)



	2012-13					
	Salary (bands of £5000)	Other Remuneration (bands of £5000)	Benefits in Kind Rounded to the nearest £100	Pension related benefits (bands of £2500)	Total Remuneration (bands of £5000)	Expenses Paid Rounded to the nearest £100
	£000	£000		£000	£000	
	180-185	0	0	242.5-245.0	420-425	4,100
	120-125	0	8,900	(10.0-12.5)	115-120	0
	35-40	165-170 **	7,100	72.5-75.0	280-285	300
	105-110	0	0	5.0-7.5	110-115	500
	105-110	0	2,100	(22.5-25.0)	85-90	300
	80-85	0	3,100	10.0-12.5	95-100	0
	90-95	0	4,900	(2.5-5.0)	90-95	0
	25-30	0	0	90.0-92.5	115-120	300
	70-75	15-20***	0	112.5-115.0	205-210	4,400
	15-20	0	0	0.0-2.5	15-20	0
	90-95	0	1,100	7.5-10.0	100-105	400
	90-95	0	1,800	27.5-30.0	120-125	0
	75-80	0	0	25.0-27.5	100-105	600
	80-85	0	0	2.5-5.0	85-90	3,000
	40-45	0	0	0	40-45	7,000
	15-20	0	0	0	15-20	3,000
	10-15	0	0	0	10-15	2,100
	10-15	0	0	0	10-15	1,300
	10-15	0	0	0	10-15	2,100
	10-15	0	0	0	10-15	0
	10-15	0	0	0	10-15	2,800
	0	0	0	0	0	0
	0	0	0	0	0	0
	15-20	0	0	0	15-20	4,400
	Band of highest paid directors total remuneration (£000) **** 180-185					
	Median of total remuneration 25,784					
	Ratio (Director to Median) 6.8					

Notes:
1 Information on the membership and work of the Remuneration Committee is provided on page 88.

2 The following disclosures for each senior manager who served during the year are subject to audit:

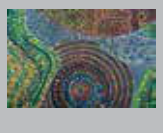
- Salary and fees (in bands of £5,000)
- All taxable benefits (total to the nearest £100)
- Annual performance-related bonuses (in bands of £5,000)
- Long-term performance-related bonuses
- Pension–related benefits

- Any other items in the nature of remuneration - but excluding payments to former senior managers.
- The total of the above items.
- Prior year comparatives for each of the amounts.

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 Lesley Bessant - Chairman
All Non-Executive Directors of the Trust Board

Martin Barkley,
Chief Executive,
27 May 2014



Senior managers' pension benefits

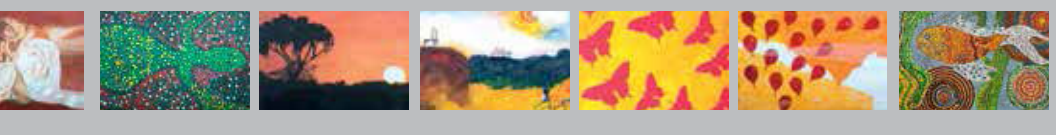
Name and title	Real increase in pension at age 60 (bands of £2500)	Real increase in pension lump sum at age 60 (bands of £2500)	Total accrued pension at age 60 at 1 March 2014 (bands of £5000)	
	£000	£000	£000	
Mr Martin Barkley, Chief Executive	0.0-2.5	0.0-2.5	90-95	
Mr Colin Martin, Director of Finance	0.0-2.5	2.5-5.0	40-45	
Dr Nick Land, Medical Director	2.5-5.0	7.5-10.0	70-75	
Dr Ruth Briel, Director of Kaizan	0.0-2.5	0.0-2.5	30-35	
Mr Brent Kilmurray, Chief Operating Officer	2.5-5.0	7.5-10.0	25-30	
Mrs Chris Stanbury, Director of Nursing and Governance	(0.0-2.5)	(0.0-2.5)	50-55	
Mr David Levy, Director of Human Resources and Organisational Development	0.0-2.5	2.5-5.0	20-25	
Mrs Sharon Pickering, Director of Planning and Performance	0.0-2.5	0.0-2.5	25-30	
Mr Chris Parsons, Director of Estates and Facilities*				
Mr Paul Newton, Director of Operations - County Durham and Darlington	0.0-2.5	5.0-7.5	50-55	
Mr David Brown, Director of Operations – Teesside	2.5-5.0	7.5-10.0	30-35	
Mr Levi Buckley, Director of Operations – Forensic Services	0.0-2.5	5.0-7.5	15-20	
Mrs Adele Coulthard, Director ofOperations – North Yorkshire	0.0-2.5	2.5-5.0	25-30	

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

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004-05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

*Christopher Hugh Parsons retired and claimed pension in February 2013 before returning to work - this is the reason increases and acrrued amounts are shown as zero

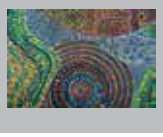
Martin Barkley
Chief Executive
27 May 2014



	Lump sum at age 60 related to accrued pension at 31 March 2014 "bands of £5000)	Cash Equivalent Transfer Value at 31 March 2014	Cash Equivalent Transfer Value at 31 March 2013	Real Increase in Cash Equivalent Transfer Value
	£000	£000	£000	£000
	270-275	2,113	2,047	66
	120-125	721	684	37
	215-220	1,373	1,277	96
	90-95	545	524	21
	80-85	397	346	51
	155-160	1,050	1,026	24
	65-70	440	408	32
	80-85	452	428	24
	150-155	984	914	70
	100-105	684	613	71
	55-60	281	247	34
	75-80	423	394	29

"Thank you for the first class treatment I received, the standards of care were extremely high. The gentle, sympathetic and sensitive way the staff treated their patients was wonderful and rarely have I heard or witnessed such excellence anywhere in the area of psychology and medicine before."

From a service user



Statements

Annual governance statement 2013-14

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 2014 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 Assurance Committee (a sub-committee of the Board) has delegated authority to oversee and manage the risk management programme as it relates to clinical risk. The Audit Committee has delegated authority to oversee and manage the risk management programme as it relates to non-clinical risk.

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

The risk and control framework
The Trust's risk management strategy contained in the integrated governance strategy is subject to regular review. The principal risks to compliance with the NHS foundation trust condition 4 (FT governance) and actions identified to mitigate these risks are detailed below.

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; NHSLA, 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.

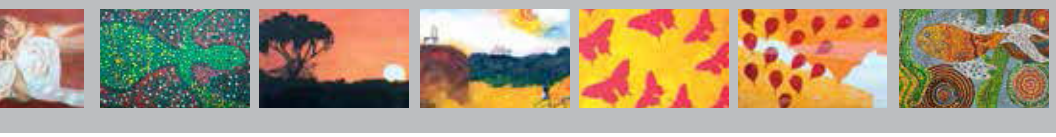
The Trust has been formally assessed against risk standards prescribed by NHSLA and has retained its level 2 status. In addition an assurance framework was in place at 31 March 2014 and remains in place up to the date of approval of the annual report and accounts.

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 is improving the control and management of some of the risks in the following areas:

- The Trust continues to use a process of quality impact assessments (QIA) which 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 and additional resources have been deployed to increase clinical audit capacity. Action plans are in place to further strengthen and embed clinical audit procedures.

- The Trust has continued to strengthen and further embed both its training provision and monitoring controls within its devolved information risk management framework.



- 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 IT systems to support the organisations objectives including data quality, the lack of agreed currencies, and quality and outcome measures for the Trust's patient care contracts.

In all cases mitigation plans are in place to ensure that these gaps are removed as soon as is practicable. This process is managed by the Trust Board's sub committees and reported to the Board.

The Trust has identified that it needs to improve the level of reliance it can place on assurances it gains that controls are operating and action plans are implemented effectively. This will be achieved by an increasing reliance on validated third party assurances through the development of a system which records and validates the form and frequency of assurances received. This system will allow the Trust to assess the level of assurance that can be taken and what actions are necessary to improve the benefit of all third party assurances. This will ensure that governance processes continue to become more dynamic in the pursuit of effectiveness and efficiency, and enables the Trust to assure itself of the validity of its Corporate Governance Statement, required under NHS foundation trust condition 4(8)(b).

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%against the Information Governance Toolkit requirement in 2013/14 with all sequences achieving at least level 2. The Director of Finance and Information 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 was fully compliant with the registration requirements the Care Quality Commission at the conclusion of 2013/14. However, in June 2013 the Trust received a Warning Notice from the CQC in connection with non-compliance with 2 standards at Auckland Park Hospital in County Durham. The CQC revisited the unit in August 2013 and reported that following actions taken by the Trust, the unit was now compliant with the standards. In June 2013 Monitor opened an investigation in to the Trust to examine whether the Trust was or had been in breach of the terms of its licence as a result of receiving the warning notice. The Trust engaged Deloitte LLP to undertake an independent Quality Governance Review of the Trust to identify areas for improvement and to also inform the investigation being undertaken by Monitor. The Trust has used the final Quality Governance Review report to inform a number of improvements to its governance structures and processes. Monitor closed its investigation in to the Trust in January 2014.

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 and Wear Valleys NHS Foundation Trust under the Climate Change Act and the Adaptation Reporting requirements are complied with.

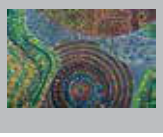
Review of economy, efficiency and effectiveness of the use of resources

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

- agreeing a rolling five 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 trusts overall reference cost indicator down to specialty / directorate
- levering efficiencies through internal and collaborative procurement initiatives
- using benchmarking and nationally published performance metrics to inform plans for improved bed and community service efficiency
- rationalising the estate
- improving workforce productivity
- benchmarking management costs
- commissioning external consultancy where the Trust believes economy and efficiency can be improved
- embedding the TEWV 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 CIP
- agreeing the IBP, 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 quality accounts for each financial year. Monitor has issued guidance to NHS Foundation Trust boards on the form and content of annual quality reports which incorporate the above legal requirements in the *NHS Foundation Trust Annual Reporting Manual*.

The following steps have been put in place to ensure that the quality accounts present a balanced and accurate view:

- The Quality Assurance Committee is responsible for producing the quality accounts with the Director of Nursing and Governance and the Director of Planning and Performance being lead directors. The Quality Assurance Committee has received reports throughout the year regarding the development of the quality accounts, including an early draft of the accounts.
- Priorities for improvement have been identified from an analysis of serious untoward incidents, complaints, as well as feedback from users and other stakeholders. Theses priorities have been shared with wider stakeholders for comment and were approved by the Quality Assurance Committee before final sign off by the Board of Directors and Council of Governors.
- The Director of Finance and Information is the corporate lead for data quality and chairs an internal group which has the responsibility for ensuring data quality within the Trust. The Executive Management Team considers data quality on a monthly basis as part of a dedicated meeting 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. The Trust has also developed a data quality strategy which provides a framework for improvements in this important area. A data quality strategy scorecard is also in place to enable the Board of Directors to track progress.
- The Trust has the following policies linked to data quality:
  - o data quality policy
  - o minimum standards for record keeping
  - o policy and procedure for PARIS (Electronic patient record / information system)
  - o Care Programme Approach (CPA) policy
  - o information governance policy
  - o information systems business continuity policy
  - o 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 Assurance Committee and Mental Health 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;

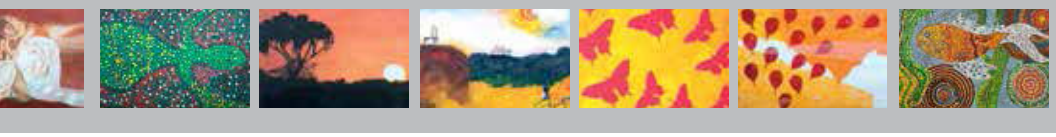
- The Board of Directors is responsible for setting the strategic direction of the organisation and monitoring the progress of the organisation against targets. The Board also receives minutes and reports from its sub committees.
- It is the Council of Governors duty to hold the non-executive directors 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 Assurance Committee oversees on behalf of the Board of Directors all clinical governance activity including a review of the clinical audit processes and programme.
- Internal Audit provides an independent and objective opinion on the degree to which risk management, control and governance support the achievement of the Trust's objectives. The Head of Internal Audit opinion provided significant assurance for this area, 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 not identified any significant internal control issues within 2013-14, and 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

27 May 2014



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.

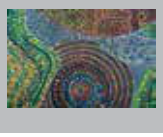
In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

- 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
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance 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
27 May 2014



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 Financial Reporting Manual that is in force for the relevant financial year, which shall be agreed with HM Treasury.

In preparing these accounts, the Directors are required to:

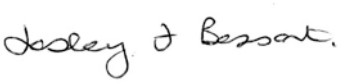
- apply on a consistent basis, for all items considered material in relation to the accounts, accounting policies contained in the NHS Foundation Trust Financial Reporting Manual issued by Monitor
- make judgements and estimates which are reasonable and prudent; and ensure the application of all relevant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

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

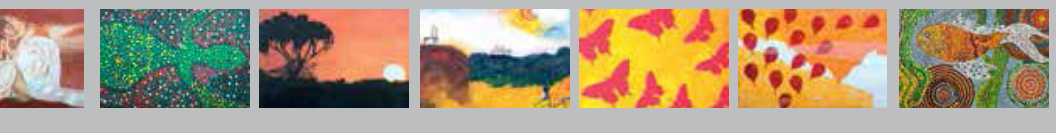
The Directors are also responsible for safeguarding all the assets of the Trust, including taking reasonable steps for the prevention and detection of fraud and other irregularities.

The Directors confirm that:

- as far as they are aware, there is no relevant information of which the Trust's auditor is unaware
- 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 annual report and accounts, taken as a whole, are fair, balanced and reasonable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy and
- the Trust is a going concern.



Lesley Bessant
Chairman on behalf of the Board of Directors
27 May 2014



Independent Auditor's report to the Council of Governors of Tees, Esk and Wear Valleys NHS Foundation Trust

We have audited the financial statements of Tees, Esk and Wear Valleys NHS Foundation Trust for the year ended 31 March 2014 under the National Health Service Act 2006. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. These financial statements have been prepared under applicable law and the accounting policies set out in the Statement of Accounting Policies.

We have also audited the information in the Remuneration Report that is described as having been audited.

This report is made solely to the Council of Governors of Tees, Esk and Wear Valleys NHS Foundation Trust in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, 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 Council of Governors of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of the accounting officer and the auditor
As described more fully in the Statement of Accounting Officer's Responsibilities, the accounting officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practice's 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:
l give a true and fair view of the state of Tees, Esk and Wear Valleys NHS Foundation Trust's affairs as at 31 March 2014 and of its income and expenditure for the year then ended;

- have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2013/14; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts
In our opinion:

- the part of the Remuneration Report to be audited has been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts; and
- the information given in the Directors Report and Strategic 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 where under the Audit Code for NHS Foundation Trusts we are required to report to you if, in our opinion, the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements. We are not required to assess, nor have we assessed, whether all risks and controls have been addressed by the Annual Governance Statement or that risks are satisfactorily addressed by internal controls.

Certificate
We certify that we have completed the audit of the accounts of Tees, Esk and Wear Valleys NHS Foundation Trust 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 issued by Monitor.

Cameron Waddell (CPFA) Engagement Lead, for and on behalf of Mazars LLP Chartered Accountants and Statutory Auditor
Rivergreen Centre, Aykley Heads, Durham, DH1 5TS
27 May 2014



Financial statements

Summary financial statements 2013/14

The summary financial statements have been approved by the Board of Directors.

Martin Barkley
Chief Executive
27 May 2014

Statement of comprehensive income for 12 months ended 31 March 2014

	12 months ended 31 March 2014	Restated* 12 months ended 31 March 2013
	£000	£000
Revenue		
Income from activities	274,946	273,597
Other operating income	16,028	19,844
Total operating income	**290,974**	**293,441**
Operating expenses	(269,538)	(279,130)
Operating surplus	**21,436**	**14,311**
Finance costs		
Finance income	84	329
Finance expense - financial liabilities	(5,232)	(5,135)
Finance expense - unwinding of discount on provisions	(22)	(21)
PDC dividends payable	(4,054)	(3,465)
Net Finance Costs	**(9,224)**	**(8,292)**
Surplus for the year	**12,212**	**6,019**
Other comprehensive income		
Will not be reclassified to income and expenditure		
Gain/(loss) from transfer by absorption from demising bodies	7,042	0
Impairments - property, plant and equipment	(1,523)	(350)
Revaluations	9,090	10,339
Total comprehensive income for the year	**26,821**	**16,008**

Statement of financial position as at 31 March 2014

	31 March 2014 £000	31 March 2013 £000
Non-current assets		
Property, plant and equipment	233,912	210,222
Trade and other receivables	53	56
Total non-current assets	**233,965**	**210,278**
Current assets		
Inventories	182	208
Trade and other receivables	5,449	4,029
Non-current assets for sale and assets in disposal groups	135	3,000
Cash and cash equivalents	24,342	23,460
Total current assets	**30,108**	**30,697**
Current liabilities		
Trade and other payables	(17,072)	(18,976)
Borrowings	(2,138)	(2,109)
Provisions	(313)	(451)
Other liabilities	(199)	(560)
Total current liabilities	**(19,722)**	**(22,096)**
Total assets less current liabilities	**244,351**	**218,879**
Non-current liabilities		
Borrowings	(81,929)	(84,068)
Provisions	(1,045)	(1,068)
Total non-current liabilities	**(82,974)**	**(85,136)**
Total assets employed	**161,377**	**133,743**
Financed by taxpayers' equity		
Public dividend capital	144,653	143,840
Revaluation reserve	31,242	21,387
Income and expenditure reserve	(14,518)	(31,484)
Total taxpayers' equity	161,377	133,743

The financial statements on pages 114 - 117 were approved by the Board and signed on its behalf by:

Martin Barkley
Chief Executive
27 May 2014

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 2013	**133,743**	**143,840**	**21,387**	**(31,484)**
Surplus for the year	**12,212**	0	0	12,212
Transfers by MODIFIED absorption: Gains/(losses) on 1 April transfers from demising bodies.	**7,042**	0	0	7,042
Transfers by MODIFIED absorption: transfers between reserves	**0**	0	2,439	(2,439)
Transfers between reserves	**0**	0	(151)	151
Impairments	**(1,523)**	0	(1,523)	0
Revaluations	**9,090**	0	9,090	0
Public Dividend Capital received	**889**	889	0	0
PDC adjustment for cash impact of receivables transferred from legacy teams	**(76)**	(76)	0	0
Taxpayers' Equity at 31 March 2014	**161,377**	144,653	31,242	(14,518)

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)

Statement of cash flows for 12 months ended 31 March 2014

	12 months ended 31 March 2014	Restated* 12 months ended 31 March 2013
	£000	£000
Cash flows from operating activities		
Operating surplus	**21,436**	**14,311**
Non-cash income and expense:		
Depreciation and amortisation	4,254	4,128
Impairments	4,888	16,385
Reversals of impairments	(5,388)	(7,632)
(Gain) / Loss on disposal of PPE	(106)	(8)
(Increase) / Decrease in trade and other receivables	(1,261)	637
(Increase) / Decrease in inventories	26	(34)
Increase/(Decrease) in trade and other payables	(1,623)	(3,058)
Increase / (Decrease) in other liabilities	(361)	(4,228)
Increase / (Decrease) in provisions	(183)	(155)
Other movements in operating cash flows	(128)	0
Net cash generated from operations	**21,554**	**20,346**
Cash flows from investing activities		
Interest received	84	329
Purchase of property, plant and equipment	(13,536)	(17,572)
Sales of property, plant and equipment	3,306	935
Net cash generated used in investing activities	**(10,146)**	**(16,308)**
Cash flows from financing activities		
Public dividend capital received	889	19
Public dividend capital repaid	(76)	0
Capital element of Private Finance Initiative obligations	(2,110)	(2,121)
Interest element of Private Finance Initiative obligations	(5,225)	(5,217)
PDC dividend paid	(4,004)	(3,324)
Net cash generated / (used) in financing activities	**(10,526)**	**(10,643)**
Increase / (Decrease) in cash and cash equivalents	**882**	**(6,605)**
Cash and cash equivalents at 1 April	**23,460**	**30,065**
Cash and cash equivalents at 31 March	**24,342**	**23,460**

*restated to reflect changes detailed in SoCI

Appendix 1:
Feedback from our stakeholders

The following responses to our stakeholders were received from our stakeholders (in alphabetical order):

Darlington Borough Council Health and Partnerships Scrutiny Committee

DARLINGTON
BOROUGH COUNCIL

Tees, Esk and Wear Valleys NHS Foundation Trust – Draft Quality Account 2013/14

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.

Members of the Health and Partnerships Scrutiny Committee have considered the draft Quality Account 2013/14 for Tees, Esk and Wear Valleys NHS Foundation Trust. Members attended both Stakeholder events during the past year and acknowledge that the structured of the events enabled meaningful audience participation and an opportunity for a free exchange of views.

Members agreed that the presentation of the document was user friendly and readable.

In respect of the Quality Improvement Priorities for 2013/14, Members have the following comments to make:

To implement recommendations of the Care Programme Approach (CPA) Review relating to improving care planning and communication between staff and patients – Members note that the Trust is half-way through a complex process of improving the CPA and its application. The aim of both these priorities is to improve service users and carers' experience of the care planning process, improve the standard of service user focussed care planning, minimise the time staff require to complete administrative tasks resulting in maximising face to face contact with service user. Members welcome the emphasis on the promotion of recovery within the CPA as an important element for the service user.

Members welcome the governance arrangements, which have representation from each locality and speciality, including service users. The introduction to provide the CPA for all service users is a positive move towards a consistent approach. As an

evolving plan the CPA process should adapt to the individual's needs and provide the best outcome for the service user. It should also be a useful communication tool involving all staff and professionals involved in the care of the service user. At the time of the draft document being submitted Members note that approximately one fifth of the total of services users' plans have been completed. It is obviously a considerable task for staff, however, Members conclude that it is essential that it is completed as soon as possible for the benefit of all service users.

The development of a service user information folder to include the new CPA information, appointment details, community team details and contact arrangements, mental health service fact sheet and recovery diary appears to be a valuable resource for service users, family members and carers alike. Members hope that the Trust will consider that all service users will be provided with this pack in the future.
To improve the delivery of crisis services through implementation of the Crisis Review recommendations – Members are advised that the aim of this Priority is to provide a high quality home treatment service across the Trust for service users in crisis. The impact of this service should reduce unnecessary admissions to inpatient care and provide valuable care closer to home.

The new 'out of hours' arrangements are to facilitate 24/7 access for service users. Members note that changes to shift patterns have been implemented and a night shift co-ordinator employed to oversee all teams to match projected need. Members look forward to examining the results of this strategy in order to be reassured that the service meets demand.

Members understand that the Operational Policy for Durham and Darlington medical input has been standardised. Members welcome the development of a new model for service users in crisis and that the review of all staff skills and training for staff will ensure the best outcome for the individual. A Section136 Suite at Roseberry Park, Middlesbrough has been piloted and Members are looking forward to the benefits of this scheme.

To further improve clinical communication with GPs – Members welcome the approach to improve the sharing of appropriate data between Trust staff and GP's. High quality communication links are essential to ensure a service user is cared for in a holistic way. This approach should ensure timely intervention as physical health can impact dramatically on an individual's mental health and vice versa. Members also noted that service users would be offered a copy of any communication in relation to their care.

Members understand that a template for communication with GP's is being piloted, although further development work may be required to refine it, with a view to full roll out in 2014/15. This will include a process which will allow GP's to access expert advice via telephone and e mail.

Additional Comments

Members note that although there is a zero target for under eighteen year olds to be admitted onto an adult ward, the report identified 48 instances (relating to ten individuals) of this occurring. The report goes on to explain that the admissions were clinically appropriate, however, the Members seek assurance that there is sufficient

capacity within the Trust to care for service users under the age of eighteen in the most appropriate settings.

Members look forward to an update regarding the retention of people who misuse substances and remain engaged for the full term of their treatment. At the time of the draft report the percentage figures are slightly below target. As the information is subject to a three month delay Members hope that the updating will mean that the target has been met.

Quality Improvement Priorities for 2014/15 are and Members have the following comments

Suicide prevention with particular emphasis on increasing suicide prevention training – Members welcome the development of a suicide prevention framework and implementation plan understand the need for the development of a training needs assessment and training plan.

Implement recommendations of CPA review including improving communication between staff, patients and other professionals and treating people as individuals – Members again, acknowledge that this priority has arisen following the success of the Care Programme Approach Review and support its inclusion. Members believe that improved service user experience and involvement in personal recovery will be a huge benefit to improving service delivery. Members also recognise that services should be personal and meaningful and that carers should feel recognised, valued and supported.

Embed the recovery approach in conjunction with CPA – Members look forward to the development of an implementation plan to ensure the principles of recovery are embedded within all key programmes and welcome the development of an implementation plan to increase opportunities for co-production.

Managing pressure on acute inpatient beds – Members embrace this priority as it will ensure patients are treated close to home and within the unit that has been identified for their locality. It will also reduce 'out of locality' admissions to the Trust target. The actions to monitor the impact on patients and additional staff time associated with out of locality admissions and implementation of the agreed out of locality admissions action plan are welcomed.

Overall, Health and Partnerships Scrutiny Committee Members have welcomed the opportunity to examine and comment on the Trust's Quality Accounts. Members are pleased to note the progress made regarding the chosen priorities in the light of challenging times for NHS organisations. Members value the updates, not only the six monthly reports on progress, but also the contributions that staff from TEWV provide at the regular briefing sessions and the formal Scrutiny meetings in Darlington.

Councillor Wendy Newall
Chair, Health and Partnerships Scrutiny Committee

Healthwatch Darlington

Comments on Tees, Esk and Wear Valley Foundation Trusts Quality Account for 2013-14 from Healthwatch Darlington. These comments are on behalf of the Healthwatch Board and active members of the 'task and finish' groups.

Healthwatch Darlington 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 Healthwatch Darlington participants and we believe fully embraces the patient voice. Healthwatch Darlington feel the Trust have meaningfully involved a wide and varied section of stakeholders and members of the public and have been regularly updated on patient engagement activity throughout the year. The organisation is particularly pleased to note the high percentage of carers who are actively involved in decision making around the person they care for. We are happy with all of the priorities set against the work which has been completed towards making improvements in these areas.

Healthwatch Darlington agree with all of the priorities set out in the 2014-2015 Quality Account and will pass details and information gathered to the public. We are particularly pleased to hear of the formation of the Trust crisis team collaborative/network and hope this network will continue to improve crisis services provided by the Trust. Whilst 'Crisis services' are not highlighted as a priority for 14/15 we are happy to note crisis beds will be looked at under the managing the pressures on inpatient beds workstream.

Healthwatch Darlington participants 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.

Healthwatch Darlington have been concerned by the actions given to the Trust by CQC over the last twelve months but recognise and applaud the Trusts open and transparent measures for improvement. We believe the Trust have acted quickly and appropriately to any concerns raised and are confident for the upcoming year.

The organisation is pleased to note the positive comments of carers and family members in response to the reviewed areas.

The participants of Healthwatch Darlington are happy with the results from the staff survey and pleased to note the Trusts location in the top percentiles throughout the country.

For 2014/2015 Healthwatch Darlington look forward to seeing positive improvements around staff training in suicide prevention and intervention, as this is one of the concerns being looked at by our own Task and Finish group. We are also pleased to see the priority around reducing the pressures on inpatient beds as it has been noted as a concern of the organisation over the last 12 months.

Priorities 2 and 3 around the Care Plan Approach are welcomed and we are particularly pleased to hear of the development of the service user information folder. We are also happy to see the Recovery Approach adopted as we have in the past noted a lack of emphasis on recovery for mental health patients.

Healthwatch Darlington would like to thank Tees, Esk and Wear Valleys NHS FT for their continued engagement and support and participants look forward to further partnership working over the next year.

Kind Regards

Andrea Goldie
Community Participation and Engagement Officer

healthwatch Darlington

Healthwatch Darlington Limited; eVOLution Building, Church Row, Darlington, DL1 5QD

website www.healthwatchdarlington.co.uk

Healthwatch County Durham

19th May 2014

Tees, Esk and Wear Valleys NHS Foundation Trust Draft Quality Account 2013-2014

Healthwatch County Durham has received the draft Quality Account for 2013-14 and is grateful for the opportunity to respond to the report at this stage.

Members of the Healthwatch County Durham staff team and Board members have attended both of the Quality Account events held earlier this year. We would like to acknowledge that we welcomed the opportunity to engage so actively in the process, especially in the roundtable focussed discussions. Both events were well presented, very well attended and the agenda and content was inclusive for all. Healthwatch County Durham feels that the Trust have meaningfully involved a wide and varied section of stakeholders and members of the public and has been pleased to be updated on patient engagement activity throughout the year. We are satisfied with all of the priorities set and the work which has been completed towards making improvements in these areas.
With respect of the Draft Quality Accounts 2013-14, Healthwatch County Durham has the following comments:

Communication with service users
One of the four agreed priorities for 13/14 was 'improving communications between patients and staff' because in 12/13 'some service users and carers report that the care documentation that is shared with them is not always clear and understandable'. Progress is reported that at March 2014 around 2,000 service users out of 10,359 people on Care Programme Approach (CPA) have been re-issued with a copy of their care plan. We further note that 'improving communication between staff, patients and other professionals' is a priority for the forthcoming year, 14/15. Nevertheless:

1. Why is no comment made about the fact that only approximately 20% of users have received this new 'yellow paper' care plan copy?

2. What has been done to evaluate whether this new communication is addressing the priority - ie. that *it is* actually clearer and more understandable *from the perspective of the service users*?

3. Given the lack of information about post-implementation review, does the proposal to send a folder to all service users incorporate such evaluation?

4. The focus in 14/15 on redesigning CPA documentation seems to be more on compliance and the reduction of the burden on staff, rather than on improved effectiveness of the communication with service users.

5. The Quality Account report would be better received if it was broken down into a brief, easy-to-read summary; this could benefit the general public along with focussed service users. A full report could also be available on a website and through partner organisations.
6. Service user engagement regarding the layout of the report might also be considered in future.
7. Having a simple graphical flowchart, using text boxes, might be worth considering, to benefit members of the public with learning or reading difficulties.

On balance, Healthwatch County Durham is content to support the draft document once our comments have been noted. We have appreciated the opportunity to be involved throughout the process. We would like this involvement in the development of the quality accounts to continue in the future.

We have found the actions noted in the document to be realistic and the priorities are essential to help ensure quality improvements for patients. We look forward to working together in the future.

We hope that this response is clear; should you have any queries, please contact Joanne Scott, tel. 01325 375 960, email: j.scott@healthwatchcountydurham.co.uk.

Yours sincerely

Judith Mashiter and Paul Taylor
Joint Chairs Healthwatch County Durham

Durham County Council's Adults Wellbeing and Health OSC

Contact: Cllr Robin Todd
Direct Tel:
e-mail:
Your ref:
Our ref:

Martin Barkley
Chief Executive
West Park Hospital
Edward Pease Way
Darlington
DL2 2TS

15 May 2014

Dear Mr Barkley,

Tees, Esk and Wear Valleys NHS Foundation Trust – Quality Accounts 2013/14

Following meetings of Durham County Council's Adults Wellbeing and Health Overview and Scrutiny Committee on 22nd April and 12th May, 2014 please find attached the Committee's response to your draft Quality Accounts for 2013/14.

The response provides commentary on the Trust's performance for 2013/14 as well as the identified priorities for 2014/15.

I would like to thank the Trust for providing the opportunity for continued engagement of the Adults Wellbeing and Health Overview and Scrutiny Committee in the aforementioned process.

Yours sincerely,

Cllr Robin Todd
Chair of the Adults, Wellbeing and Health Overview and Scrutiny Committee

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 2013/14

The Committee welcomes Tees, Esk and Wear Valley's NHS Foundation Trust's Quality Account and the opportunity to provide comment on it.

The Committee are mindful of their statutory health scrutiny role and the need to demonstrate a robust mechanism for providing assurance to the residents of County Durham that health service provision is efficient and effective. The quality account process provides the Committee with one such mechanism.

The Committee has engaged with the Trust on a number of issues during the course of 2013/14 including inpatient and community adult mental health services, children and young people's mental health and mental health services for older people. Continued engagement on trust activity is welcomed.

In examining the Quality Accounts' priorities and the performance issues highlighted therein, the Committee noted national pressures in respect of inpatient beds and, in particular, the incidence of trusts securing such beds on an "out of area" basis. It is pleasing to note that TEWV has not needed to adopt this approach. The Committee also supports Priority 1 regarding suicide prevention training as members have already examined the development of a public mental health strategy which has strong linkages to suicide prevention.

The Committee noted the performance information in respect of patient safety incidents including incidents resulting in severe harm or death and would seek clarification from the Trust explaining how patient human rights and safeguarding issues are reflected in the Quality Account priorities.

Subject to the above, the Committee agree that from the information received from the Trust, the identified priorities for 2014/15 are a fair reflection of healthcare services provided by the Trust and note the progress made against the 2013/14 priorities. However, the Committee would also seek clarification and assurances from the Trust that the identified priorities are linked to the declared priorities of Clinical Commissioning groups.

Finally, the Committee has also reflected upon the implications of the Francis report arising from the Mid-Staffordshire enquiry for local authority health scrutiny and, in doing so, would request more regular access to performance overview information. To this end, the Committee request a six monthly progress report on delivery of 2014/15 priorities and performance targets.

County Durham Health and Wellbeing Board

Contact: Cllr Lucy Hovvels
Direct Tel: 03000 268728
Fax:
email: lucy.hovvels@durham.gov.uk

Sharon Pickering
Director of Planning and Performance
Tees, Esk and Wear Valley NHS Trust
Lanchester Road Hospital
Lanchester Road
Durham
DH1 5RD

19 May 2014

Dear Sharon

Re: TEWV Quality Account

Thank you for the opportunity to comment on your Trust's Quality Account. The County Durham Health and Wellbeing Board appreciate this transparency and would like to provide comments on the document.

It is important that the Quality Account aligns to the County Durham Joint Health and Wellbeing Strategy, Clinical Commissioning Group Commissioning Intentions and Quality Premium Indicators that have been agreed through the County Durham Health and Wellbeing Board, where appropriate.

If you require further information on the Joint Health and Wellbeing Strategy, Clinical Commissioning Group Commissioning Intentions and Quality Premium Indicators, please contact Andrea Petty, Strategic Manager – Policy, Planning & Partnerships on 03000 267312 or by email at andrea.petty@durham.gov.uk.

Yours sincerely

Cllr Lucy Hovvels
Chair, County Durham Health and Wellbeing Board

Joint Durham, Darlington and Teesside CCGs

NHS
North Durham
Clinical Commissioning Group

Our Reference	140519 Barkley TEWV	North Durham CCG
Your Reference	2013/14 quality account	The Rivergreen Centre
Direct line	None	Aykley Heads
Main number	0191 605 3169	Durham
E-mail	0191 605 3248	DH1 5TS
	neilobrien@nhs.net	

19 May 2014

Dear Martin

Corroborative statement from
NHS North Durham Clinical Commissioning Group (CCG),
NHS Durham Dales, Easington, Sedgefield CCG,
NHS Darlington CCG,
NHS South Tees CCG, and
NHS Hartlepool and Stockton-on-Tees CCG,
for Tees Esk and Wear Valleys NHS Foundation Trust's Quality Account 2013/14

The clinical commissioning groups (CCGs) welcome the opportunity to review and comment on the Quality Account for 2013/14 and would like to offer the following commentary:

As commissioners, North Durham CCG, Durham Dales, Easington and Sedgefield CCG, Darlington CCG, South Tees CCG and Hartlepool and Stockton-on-Tees CCG are committed to commissioning high quality services from Tees Esk and Wear Valleys NHS Foundation Trust (TEWVFT) and take seriously their responsibility to ensure that patients' needs are met by the provision of safe, high quality services and that the views and expectations of patients and the public are listened to and acted upon.

Firstly the CCGs would like to commend the trust on its external achievements and awards. In particular on the results of the 2013 NHS Staff survey, in which the trust overall was ranked 1st out of 57 mental health trusts.

The CCGs now hold bimonthly clinical quality review group (CQRG) meetings with the trust; these meetings are well attended and provide positive engagement for the monitoring, review and discussion of quality issues. The CCGs have also continued throughout 2013/14 to conduct regular commissioner inspection visits to TEWVFT sites in accordance with the commissioners' planned programme of work, to gain assurances and an insight into the quality of care being delivered to patients.

In so far as we have been able to check the factual details, the CCGs view is that the report is materially accurate. It is clearly presented in the format required by NHS England and the information it contains accurately represents the trust's quality profile, but disappointingly fails to provide assurance of the actions undertaken by the trust in

reviewing service risks against the recommendations of the Francis and Mid Staffordshire Trust Inquiry and Berwick review. The CCGs note the impact and response to the Care Quality Commission (CQC) enforcement notice and resultant change in the trust's Monitor rating during 2013/14; acknowledging the significant amount of work to realign their quality governance arrangements, the risk assessment and care given to patients. We look forward to seeing the full benefit of this work in 2014/15.

We also recognise that improvements that are being made to engage stakeholders and service users in the trust's quality improvement programme and note the detailed narrative the trust has provided in response to the CQC visits that have taken place throughout 2013/14. It's unfortunate that the trust has not included a more detailed summary to demonstrate the significant work being undertaken around organisational learning from serious incidents and complaints in order to prevent similar scenarios occurring across the trust.

The CCGs recognise the improvements and continued focus on safe lithium monitoring and expect that a re-audit of the POMH UK for lithium monitoring will demonstrate sustained improvement. The CQRG will continue to work with the trust on this matter as there are implications for primary care.

The CCGs acknowledge the work that the trust has achieved to date in the delivery of the 2012/13 priorities and in the ongoing delivery of the trust's quality metrics during 2013/14. South Tees CCG however, has noted that it would be helpful if CCG locality level data could be provided, recognising the challenges that this poses to the trust. It is noted in the account that the trust has not highlighted the actions which are being undertaken, across the organisation, to address patient falls, average length of stay and satisfactory resolution of complaints, which would provide readers with assurances that these areas are being addressed.

North Durham CCG, Durham Dales, Easington and Sedgefield CCG, Darlington CCG, South Tees CCG and Hartlepool and Stockton-on-Tees CCG welcome the specific priorities for 2014/15 highlighted in the report and feel that they are appropriate areas to target for continued improvement which link in with CCG commissioning priorities. Overall the report is well written and presented and is reflective of quality activity across the organisation and outlines the trust's aspirations for 2014/15.

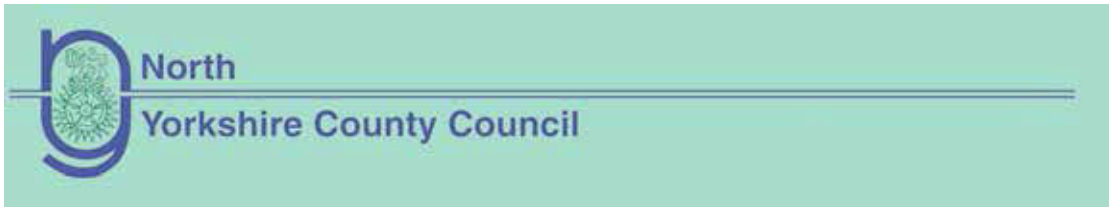
The CCGs look forward to continuing to work in partnership with the trust to assure the quality of services commissioned in 2014/15.

Yours sincerely

Dr Neil O' Brien
Clinical Chief Officer
NHS North Durham CCG

Signed in consultation with:
NHS North Durham CCG,
NHS Durham Dales, Easington, Sedgefield CCG,
NHS Darlington CCG,
NHS South Tees CCG, and
NHS Hartlepool and Stockton-on-Tees CCG

North Yorkshire County Council Scrutiny of Health Committee



(Harrogate/Harlow Division)

74 Green Lane
Harrogate
North Yorkshire
HG2 9LN
Tel: 01423 872822

E-mail: cllr.jim.clark@northyorks.gov.uk

15 May 2014

Sharon Pickering
Director of Planning and Performance
Central Resources
Lanchester Road Hospital
Durham
DH1 5RD

Dear Sharon

Draft Quality Account – 2013/14

Thank you for inviting the North Yorkshire Scrutiny of Health Committee to contribute to the Tees, Esk and Wear Valleys NHS Foundation Trust's Quality Account (QA) for 2013/14.

Please accept this letter as the comments from the Committee.

On the basis of our Committee's long standing involvement with the Trust I am confident that the QA is representative and comprehensive in terms of the services provided.

The priorities for 2014/15 have clearly informed by an on-going engagement process with patients and the public which has been supplemented by specific events/workshops including all stakeholders. We were represented and contributed at those events.

Throughout the year the Committee has been well briefed on developments at the Springwood Unit in Malton Hospital, on the refurbishment of the Rowan Ward at Harrogate Hospital and on the new memory clinic at Alexander House in Knaresborough.

Against this background we support the Trust's priorities for improvement in 2013/14, particularly Priority 4: Managing Pressure on acute inpatient beds. It is essential that people receive their inpatient care as close as possible to where they live and they are supported in the community when they are discharged.

As I highlighted in last year's QA, I do feel there is an opportunity for the Trust to include specific priorities around the integration of care and increased partnership working. With the advent of the Better Care Fund such an approach would be timely. I also feel that in Part 3 of the QA, with regard to "Performance against Quality Metrics" and Performance Against National Targets and Regulatory Requirements, there should be a greater explanation of how performance will be improved where targets have not been met.

I invite you to attend a Committee meeting during the next year to give an update on how this year's QA is progressing and to provide more information on the Metrics I have referred to above. Please contact Bryon Hunter to make the necessary arrangements. Bryon's contact details are shown below.

Yours sincerely

County Councillor Jim Clark
Chairman – North Yorkshire County Council Scrutiny of Health Committee

Bryon Hunter
Scrutiny Team Leader
North Yorkshire County Council
Tel. 01609/532898
Email: bryon.hunter@northyorks.gov.uk

Joint North Yorkshire CCGs

"Care through partnership"

NHS

Partnership Commissioning Unit
Commissioning services on behalf of:
NHS Hambleton, Richmondshire and Whitby CCG
NHS Harrogate and Rural District CCG
NHS Scarborough and Ryedale CCG
NHS Vale of York CCG

victoria.pilkington@nhs.net

Tel: 01904 694717

Sovereign House
Unit 5 Kettlestring Lane
Clifton Moor
York
YO30 4GQ

20 May 2014

Dear Sharon Pickering

Re: Tees, Esk and Wear Valley NHS FT Quality Account 2013/14

Having reviewed the document we feel it is a comprehensive and informative report which sets out clearly the positive commitment of the Trust to delivering year on year improvement in the delivery of Mental Health and Learning Disability Services.

The Chief Executive's Statement provides a useful strategic overview and summary of achievements and reflects the continued challenges of delivering excellence in an increasingly tough financial climate.

We commend the Trust on progress made in 2013/14 and in particularly the development of new services for patients and their carers in Harrogate and Scarborough; and new therapeutic facilities to improve services in North Yorkshire. The overall position of TEWV as number 1 in the NHS Staff Survey ranking is a reassuring indication of the Trusts commitment to improving staff morale, however there remain areas in which staff score the Trust significantly lower regarding the Family and Friends Test and we would be concerned that the Trust focusses attention on such areas to improve all areas, particularly in North Yorkshire to the level of the best.

The Trust has an impressive record of achievement in relation to external awards and is to be congratulated on the range of achievements reflecting the high level of leadership at all levels which is key to the organisations future success.

We support the Trusts' priorities for 2014/15 particularly the focus on suicide and the management of pressure on acute beds. We aim to work closely with the Trust to develop crisis services and care services closer to home and to deliver improvements in the IAPT service over the next 12 months to reduce demand for inpatient care.

Clinical communication with GPs has improved in the last 12 months however further work is required in ensuring timely and effective communication is developed and

maintained following patient discharge and we look forward to the implementation of electronic forms of communication.

Overall as a Commissioner we feel assured that Tees, Esk and Wear Valley NHS FT as a high performing and credible provider with whom we have developed an excellent commissioning relationship and we feel the report reflects a fair and accurate position in relation to the delivery of high quality Mental Health and Learning Disability Services.

Yours sincerely

Victoria Pilkington
Deputy Director of Partnership Commissioning

Tees Valley Joint Health Scrutiny Committee

Tees Valley Joint Health Scrutiny Committee

Statement for inclusion in TEWV Quality Account 2013-14

The Tees Valley Joint Health Committee was pleased to consider a presentation outlining the key issues for the Quality Account at a meeting on 3 March 2014. The Committee was also represented at the stakeholder event on 13 February.

The Committee considered progress against the priorities for 2013-14 and was pleased to see the progress on the improvements to the crisis service following its review. These included more intensive home treatment and preventative care.

This is a key service area and mental health crisis can lead to high levels of stress for patients, carers and staff. The Committee received assurances around the role of the crisis shift co-ordinator that had been introduced to increase the amount of time clinical staff spent with patients; the co-ordinator is not a clinical role but they have access to clinical support where necessary.

During 2013-14, the Joint Committee and some constituent local authorities raised concerns and issues in relation to the proposed closure of crisis beds at Victoria Road unit in Hartlepool. This proposal was confirmed in April. An effective community based crisis service will be crucial for these changes to work and as a certain amount of patients may continue to need inpatient care, the effect of the closure including the reduction in available beds and use of alternatives will need to be closely monitored.

The s.136 suite where patients are taken for assessment by police officers has also been centralised at Roseberry Park. This will also need closely monitoring, particularly to monitor the impact on the Hartlepool and north of Tees area.

The Committee was interested to see the work to improve communications between the Trust and GPs; this is a crucial relationship for the management of a patient's care.

Members noted that work to standardise templates for communication will be ongoing and appreciate that the Trust covers many GPs over a wide geographical area that may have differing needs. The creation of CCGs provides a further opportunity for general practice to shape mental health and learning disability services.

The Committee was concerned to learn that the number of suicides has increased nationally in recent years and that the area with the fastest increase was North East England.

The Committee therefore strongly support the inclusion of the priority for 2014-15 to have more staff trained in specialist suicide prevention and intervention. The suicide rate is affected by many factors and partners including local authorities will also have a role to play in prevention.

Priority three for 2014-15 should see the Trust further embedding the recovery approach across all its services. The Committee welcome the plans for increase training opportunities for staff, and particularly welcome the commitment to more closely involve service users in the joint production of training and services.

Members from Stockton-on-Tees considered the increased use of the recovery model as part of a local review of adult mental health social care in 2013-14 and appreciate the importance of this in order to maximise the chances of a patient's inclusion in the community.

The Trust also proposes to carry over priorities relating to the improvements to the Care Programme Approach (care planning and co-ordination) as part of the ongoing review which is clearly a wide ranging project.

It was noted both at the Tees Valley Committee and the Regional Health Scrutiny Committee in early 2014 that the Trust needs to reduce the numbers of patients admitted to inpatient beds outside of their locality (ie. beds still within the Trust area but not at the unit identified as serving the patient's community). Therefore priority 4 for 14-15– managing pressure on acute inpatient beds – is welcomed.

In terms of the key quality metrics, there is generally good performance but the Trust will need to monitor key indicators including number of patient falls, and percentage of complaints that are satisfactorily resolved, to ensure improvements are sustained. The Committee noted that the number of occupied beds days of under 18s admitted to adult wards was above target for the year, but that in some cases this was clinically appropriate (for example, a mature seventeen year old projected to stay in the unit beyond their 18th birthday).

In order to track progress over the longer term, it was useful to see the section in the draft Quality Account on the ongoing work on the 2012-13 quality priorities that had not been carried over into 2013-14.

The Committee would like to thank the Trust for the comprehensive range of information provided and the regular updates on performance and service developments that are provided throughout the year.

Appendix 2:
Key themes from 81 local clinical audits (186 individual audits) reviewed in 2013/14

Audit Theme	Summary of Actions
Infection Prevention and Control (IPC) audits (77 individual audits of ward / team areas)	• All infection prevention and control audits are continuously monitored by the IPC team and required actions are rectified collaboratively with the IPC team and ward staff.
Clinical audit of NICE guidance on autism (2 local clinical audits)	• The findings of the audit are to be used to inform an adult autism rapid process improvement workshop (RPIW) and rapid pathway development workshop (RPDW) scheduled in 2014/15. • The audit results are to be cascaded across adult mental health services to encourage participation in autism training in 2014/15.

Clinical audit of NICE guidance on bipolar disorder (2 local clinical audits)	• The findings will be highlighted in the audit bulletin to improve awareness of the specific requirements to:
	  • Consider alternative options if there has been no response to a combination of preventative medications.
	  • Further encourage patient involvement in relapse prevention and self help support groups.
	  • Further encourage family/carer involvement in support groups.
	• The results to be discussed in all consultant groups, specifically to:
	  • Increase awareness to ensure physical health checks are completed fully, routinely and recorded on PARIS (the electronic patient record).
	  • Further ensure that when medication is changed, a clear statement should be entered on PARIS of the factors considered including psychiatric factors, physical health and patient preference.
	  • Further ensure that a statement is entered on PARIS (at least annually) about the patient's views of their treatment.
	  • Further ensure the most appropriate referral route for obtaining a second opinion for people with treatment resistant bipolar disorder.
	  • Further ensure that the risk of suicide/self harm is documented regularly (at least at each review for stable low risk patients).
	• To be re-audited with new audit tool in 2014/15.

Clinical audits of supervision (local clinical audits across 4 service areas)	• Team / ward managers / clinical leads to ensure a high standard of supervision in line with the Trust's supervision policy, including:
	  • All staff to have identified their own clinical supervisor within one month of start date or change of supervisor
	  • A copy of all clinical supervision contracts to be retained in staff personal files
	  • Increasing the number of staff encouraged to participate in a minimum of eight one- hour clinical supervision sessions and four one-hour managerial supervision sessions per year
	  • Ensuring supervision logs are kept up-to-date.
	  • Ensuring supervision to address work pressures e.g. sickness absence, stress management, caseload management
	  • Where appropriate establish monthly peer group supervision sessions.

Clinical risk assessment and management audits (local clinical audits across 7 service areas)	• Audit results to be disseminated to teams and individuals highlighting key themes where further improvement can be made. • A key facts bulletin to be developed and published to all staff to encourage further improvement on risk assessment and management. • Feedback sessions to be held with the Team managers for the individual cases where data was not recorded sufficiently. • Refresher training to be provided to staff on specific areas including: the responsibilities of the 'lead professional' role; the use of SAMURAI risk assessment tool; recording risk assessments on PARIS; ensuring risk assessment information is linked to the care plan. • A re-audit of cases highlighted as not meeting the standard to be performed following refresher training. • Deputy medical directors to have discussion with clinical directors regarding sign off of risk assessments by consultants. • Ensure that risk assessment and management is routinely discussed as part of clinical supervision.

Audit Theme	Summary of Actions

Clinical audit of safer lithium monitoring audits (3 local clinical audits)	• Audit results to be shared with the safe medication practice group and fed back to prescribers in teams.
	• Key areas for further improvement to highlight:
	  • Ensuring lead professionals / care co-ordinators continue to document efforts made for monitoring and record outcome of discussion with patient on PARIS.
	  • Ensuring prescribers continue to discuss monitoring with patient, and if patient is not aware of this then letter to GP should reflect this.
	  • Ensure all patients are given/offered a lithium alert card and this is documented on PARIS.
	  • Ensuring staff continue to document PARIS what monitoring has been done / offered.
	• To explore possibility of reviewing lithium visual display boards to include key headings (e.g. BMI etc).

Suicide prevention audits (3 local clinical audits across 5 service areas)	• Individual inpatient ward and community team action plans were produced at the time of auditing. Action plans will be monitored via the appropriate locality governance routes. • The findings from the audit shall be used as evidence within the quality priority for 2014/15: to have more staff trained in specialist suicide prevention and intervention.

Transfers of care audits (local clinical audits across 5 service areas)	• The audit report will be shared with the relevant service governance groups and with care pathway work streams to build findings into standard operating procedures.
	• The audit report to be discussed with the Trust's CPA project lead to further embed standards of best practice into care coordination practice.
	• Key areas for services to further improve transfers include:
	  • Ensuring the staff record a narrative on forensic history including stating where no forensic history exists.
	  • Further ensuring that staff review care plans within one month of discharge and provide patients/carers with a written copy of their care plan.
	  • Ensuring that for patients who have transferred from mental health inpatients services, the receiving care coordinator documents the outcome of the 7 day follow-up, including FACE risk assessment.
	• Ward and team managers will randomly spot check at least two discharges per month and report findings to the relevant service governance groups.

Safeguarding children audits (3 local clinical audits)	• Audit lead to produce lessons learned briefing for all the safeguarding team and link professionals which includes a summary of the audit and identified areas for improvement. • Link professionals and safeguarding team to use the lessons learned bulletin to further support the training provided to staff with a focus on the improvement areas identified. • The senior nurse to remind safeguarding children supervisors of the importance of ensuring records identify the date and findings of when the child was last seen and, if appropriate, spoken to. • Clear explanations of consent for child protection, child in need and common assessment framework referrals to be included on Trust's webpage on safeguarding children and in safeguarding children training. • Perform a mapping exercise to look at who the current link professionals are, what areas they cover and where the gaps are. • Following identification of gaps, senior managers to be informed and asked to address this by identifying link professionals. • E-bulletin notice to inform staff of who their named nurse and doctor are for safeguarding children, and also the role of the safeguarding team and link professionals.

Appendix 3: Quality Performance Indicator Definitions

Percentage of patients on Care Programme Approach who were followed up within seven 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 seven days of discharge. All avenues need to be exploited to ensure patients are followed up within seven 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 seven 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 seven 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

Percentage of complaints satisfactorily resolved

Numerator:
From the number of resolution letters sent during the month the number where there is no indication that the complainant indicates they are not happy with the response and wants further action following receipt of the resolution letter.

Denominator:
Number of resolution letters sent within the month.

Indicator format:
Standard percentage.

Appendix 4: 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.

Bipolar disorder: is a mental illness typically classified as a mood disorder. It is characterized by episodes of an elevated or agitated mood known as mania, usually alternating with episodes of depression.

Body Mass Index (BMI): is a measure for human body shape based on an individual's mass and height

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.

Care Programme Approach (CPA): describes the approach used in specialist mental health care to assess, plan, review and co-ordinate the range of treatment care and support needs for people in contact with secondary mental health services who have complex characteristics. It is a called "an approach" rather than just a system because the way that these elements are carried out is as important as the actual tasks themselves. 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.

Clozapine: is an atypical antipsychotic medication used in the treatment of schizophrenia.

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, clinical commissioning groups 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.

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.

Health care associated infections (HCAIs): treatment-resistant infection contracted as a consequence of being in contact with healthcare services, predominantly MRSA and c-difficile.

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.

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 and 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.

Lithium: lithium carbonate is a medicine which is used in depression, mania, bipolar disorder, self-harming behaviour and treating aggressive behaviour.

Localities: services in TEWV are organised around three localities (ie County Durham & Darlington, Tees, North Yorkshire) and one directorate (ie forensic services) – see also specialities.

Mental Capacity Act: is a framework to provide protection for people who cannot make decisions for themselves. It contains provision for assessing whether people have the mental capacity to make decisions, procedures for making decisions on behalf of people who lack mental capacity and safeguards. The underlying philosophy of the MCA is that any decision made, or action taken, on behalf of someone who lacks the capacity to make the decision or act for themselves must be made in their best interests.

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.

NHS service usersurvey: 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 Reporting and Learning System (NRLS): an NHS led central database of information on patient safety incidents used to identify and tackle important patient safety issues at their root cause.

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 and 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 and 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 and 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 behaviours 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.

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.

Schizophrenia: is a mental disorder characterized by a breakdown in thinking and poor emotional responses.http://en.wikipedia.org/wiki/Schizophrenia - cite_note-1 Common symptoms include delusions, such as paranoia; hearing voices or noises that are not there; disorganized thinking; a lack of emotion and a lack of motivation.

Section 136 of the Mental Health Act: is the law which can be used to admit a person to hospital for assessment and/or treatment for a mental illness. The police can use section 136 of the Mental Health Act to take a person to a place of safety when they are in a public place. They can do this if they think the person has a mental illness and are in need of care. A place of safety can be a hospital or a police station. The police can keep the person under this section for up to 72 hours. During this time, mental health professionals can arrange for a Mental Health Act assessment.

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.

Specialities: services in TEWV are organised around six specialities: adult mental health services, substance misuse services, mental health services for older people, adult learning disability services, children and young people's services, forensic services – see also Localities

TEWV Quality Improvement System (QIS): the Trust's framework and approach to continuous quality improvement based on Kaizen / Toyota principles.

Unexpected death: a death that is not expected due to a terminal medical condition or physical illness.

Visual control boards: a technique for improving quality within the overall TEWV Quality Improvement System (QIS).

If you would like additional copies of this report or the full set of accounts please contact:

The communications team
Tees, Esk and Wear Valleys NHS Foundation Trust
West Park Hospital
Edward Pease Way
Darlington
DL2 2TS
Email: tewv.enquiries@nhs.net
Tel: 01325 552223

Our Chairman, Directors and Governors can be contacted via the Trust Secretary's office at West Park Hospital (see above address).
Tel: 01325 552314
Email: tewv.ftmembership@nhs.net

For more information about the Trust and how you can get involved visit our website

www.tewv.nhs.uk

Design:www.integraldesignmedia.co.uk