Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Annual report and accounts 2015/16

Making a difference together

Tees, Esk and Wear Valleys NHS Foundation Trust

Annual report and accounts 2015/16

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

Foreword by the Chairman and Chief Executive

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Reviewing the past

It has been a busy and eventful year for the Trust and there have been a number of significant highlights and achievements. Everyone involved with the Trust from our staff and the people who use our services to our partner organisations and commissioners have contributed to our success and we would like to thank them for their support.

In May 2015 we received official confirmation from the Care Quality Commission (CQC) that we had been given an overall rating of 'Good' for our services. We were rated outstanding or good in 52 of the 60 areas inspected and none of our services were rated as inadequate. Our leadership was rated as outstanding.

Last summer we were awarded the contract to provide mental health and learning disability services in the Vale of York and we took over responsibility for these services on 1 October 2015. The transfer of services took place at a difficult time, following the sudden closure of Bootham Park Hospital in York at the end of September, as a result of a CQC inspection. Since then we have been doing all we can to support service users, their families and staff as well as developing and implementing plans to bring services back to York (more information in 'The year in brief' section). Everyone involved has worked incredibly hard to minimise the impact and to make sure that service users continue to receive the care and support they need.

At the beginning of March 2016 we joined a growing number of trusts that have become totally smoke-free. This was a really important move and one that will ultimately improve the health and wellbeing of service users. Although implementing the new policy has been a challenge and there is still work to do, most staff and service users have responded positively to the change and we continue to work with and support them to remain smoke-free.

Partnership working continues to be at the heart of everything we do. Over the last year we have worked with a wide range of public, private and voluntary sector organisations and agencies, as well as with the people who use our services and their carers to develop and modernise services. This has included working with the police to make sure the most vulnerable people are getting timely access to mental health services.

Developing services that enable us to support people in their home environment whenever possible has remained a key priority for us. We have continued to reduce the amount of time that individuals need to spend in hospital, making sure they get the care and treatment they need, when and where they need it.

For those people who are admitted to hospital, the quality of the environment is extremely important. TEWV has some of the best inpatient facilities in the country and work to modernise our facilities continues. For instance, we have just completed the final phase of the £13.8 million development of West Lane Hospital in Middlesbrough, providing state of the art facilities for young people.

We have made great progress against our goals but there have been challenges. In some areas people have been waiting longer than they should for treatment and we have had to admit more people to hospitals outside their local area than we would like. However, teams have been working hard to address these issues and we are starting to see some improvements.

Our staff are committed to providing the best possible services and it's therefore important that the Trust supports them in their roles. Our staff survey results remain consistently very positive, placing us among the best NHS employers in the country. We continue to use the feedback we receive from this and from our staff friends and family tests to continue to improve the working lives of our staff.

We have achieved a great deal over the last 12 months. This has been recognised at a national level and there are some excellent examples of this and other highlights in 'The year in brief' section of this report.

Looking to the future

We look forward to 2016/17 with a new chief executive at the helm. Colin Martin took over responsibility on 1 May 2016 after Martin Barkley's retirement from the Trust.

A key priority for the Trust over the coming months is to work with staff in York and Selby to continue to improve mental health and learning disability services for local people. An important step will be to bring adult inpatient services back to York. We are

looking forward to re-opening Peppermill Court in York in July as an adult inpatient assessment and treatment unit. Currently people are being admitted to hospitals in Middlesbrough and other areas of the Trust and although we are doing all we can to support families to visit we recognise this is far from ideal.

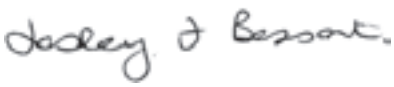
Alongside this we are involving local people in plans for a new hospital for York, due to open in 2019. We are also awaiting planning permission for a preferred site for the new hospital in Harrogate and will be progressing plans for the new unit over the coming months.

We will continue to embed the recovery approach in all areas of the Trust. At the end of last year we launched a new initiative to help us deliver purposeful and productive community services. Our aim is to make sure that our community teams use all of their resources to support the people we serve to meet their personal recovery goals. Over the coming year this work will be led by localities and will involve using the tools of our quality improvement system (TEWV QIS) to help identify and eliminate waste and redesign processes that add greater value to service users' recovery journeys.

Making sure the people who need our services get the best possible care and treatment, at the right time remains a key priority for TEWV. Next year this includes working with clinical teams to implement the new national standards for services.

Over the next 12 months we will continue to play a role in working with partner organisations and commissioners to plan and develop local services.

This is a challenging time for the NHS and for TEWV but we are confident that with the support of staff, service users, carers, volunteers, partner organisations, commissioners and Governors we can continue to improve and provide high quality services.



Lesley Bessant
Chairman

Colin Martin
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.

The year in brief

The year in brief

TEWV is committed to achieving its vision of being a recognised centre of excellence with high quality staff providing high quality services that exceed people's expectation.

Our staff are passionate about promoting recovery and wellbeing, supporting service users to achieve the goals they have set themselves. They strive to eliminate waste wherever it exists in the organisation so that they can focus on what's important – improving the lives of the people who use our services.

We work hard to develop and modernise our services and to make sure that people are getting the care and treatment they need, when and where they need it. Much of this work is done in partnership and we continue to strengthen relationships with service users and carers and a wide range of organisations and groups.

The following pages provide a brief overview of the year's highlights.

Developing excellent services

Help in a crisis

For adults

The crisis assessment suite is officially opened

A new crisis assessment suite opened at Roseberry Park in Middlesbrough last year and is now an integral part of the Teeswide crisis service.

The new unit is open twenty four hours a day, seven days a week and aims to make sure adults with urgent mental health needs get the care and treatment they need as quickly as possible.

People who are experiencing mental health crisis and attend the accident and emergency department, or call for an ambulance are now brought to the assessment suite. The unit is also a 'place of safety' for people detained by the police under Section 136 of the Mental Health Act.

The crisis assessment suite was set up in response to the Government's mental health crisis care concordat and is an excellent example of TEWV working closely with colleagues in the acute trust, ambulance service and police to improve services and support for people with mental ill health.

The unit also supports our crisis team, enabling them to offer a more responsive service and more intensive home treatment.

For young people

A new crisis and liaison service opened on Teesside in July 2015, providing quick support to children and young people who are in a mental health or emotional crisis.

The service is available 24 hours a day, seven days a week and follows on from the success of County Durham and Darlington CAMHS crisis and liaison service.

The team offers assessment and treatment to children and young people with mental ill health or learning disability crisis at the earliest point possible, so they receive the care and support they need promptly.

Staff from the new Teesside CAMHS crisis team

Representatives of the new team

New community perinatal service

A community perinatal service is now available for mums and mums to be on Teesside.

The specialist service was set up in June 2015 and supports women experiencing serious mental health conditions who are planning a pregnancy, are already pregnant or during the first year following a child's birth.

The community team works across Middlesbrough, Redcar and Cleveland, Hartlepool and Stockton-on-Tees to promote the mental wellbeing of both mother and infant.

By giving support and treatment they help mums with mental ill health to remain in their own home and with their families. Partners and families are actively encouraged to be involved in the care of mum and her recovery.

The team work very closely with midwives and health visitors at South Tees and North Tees and Hartlepool Hospitals NHS Foundation Trusts, as well as the specialist perinatal inpatient unit in Morpeth, which is commissioned for the Northern region. They also provide support and advice to a range of health and social care professionals.

The service is funded by NHS South Tees Clinical Commissioning Group and Hartlepool and Stockton-on-Tees Clinical Commissioning Group.

Homes not hospitals

As part of the 'Transforming Care' initiative we are developing services that will help support more people with learning disabilities in their own homes rather than in hospital.

This national initiative has two key features – reducing inpatient beds and enhancing community services to reduce the need for hospital admission.

The work involves helping prepare people who are currently inpatients to move on to live meaningful lives as part of the community.

White Horse View, a rehabilitation inpatient unit set up in Easingwold in 2011 to provide rehabilitation services nearer to home for adults with learning disabilities has achieved its objective of preparing individuals to lead more independent lives.

The closure of the unit is also freeing up money to reinvest in York and Selby, primarily to develop the existing assessment and treatment unit at Oak Rise in Acomb and strengthen community learning disability services.

Going smoke free

In March 2015 all Trust premises, including in-patient gardens and courtyards become totally smoke free, meaning service users, staff and visitors are no longer able to smoke tobacco on any Trust premises.

The decision to go smoke free was made in a bid to improve the health and life expectancy of service users. On average people with a serious mental illness die 15-20 years earlier than the rest of the population and smoking is responsible for over half of this difference. By reducing smoking levels TEWV hopes to see a positive improvement in service user's overall health.

The Trust has worked carefully to put measures in place to support current inpatients, as well as anyone admitted in the future. Patient information literature has been created to inform service users, their carers and families of what to expect and staff have undergone training in order to support, advise and carry out assessments to provide a range of nicotine replacement options. Support to stop smoking is also available, not only for service users, but for staff working for the Trust.

Embedding the recovery approach

The recovery project team with speakers from the conference

We held a **recovery conference** in March 2016, where over 170 staff, service users, carers and supporters came together to celebrate the achievements of recovery related projects and practice.

In a mix of presentations, workshops and experts by experience stories, the event explored what recovery means and how the Trust is supporting people to lead a fulfilling and meaningful life, irrespective of symptoms and diagnosis.

Following on from the success of the staff retreats, TEWV held its first **retreat for service users** and staff in May. The retreat was offered through ARCH Recovery College in Durham and the uptake was overwhelming.

Many who attended the 48 hour course were initially apprehensive, but soon realised how positive the experience would be. People were able to take time out to self-reflect on their lives in order to move forward more positively. This was achieved through a variety of ways including the use of light meditation and reflective art making

TEWV has been embedding its recovery programme across the Trust since 2013, transforming our culture to look beyond symptoms and helping people to work towards their personal life goals and dreams. We now provide more opportunities for those with lived mental health experience to work at the Trust, have established ARCH Recovery College in Durham and are making sure our risk procedures promote, rather than hinder, recovery. Plans are also in place to launch an online Virtual Recovery College in 2016/17.

Representatives from the partner organisations

New place of safety opened

A new Section 136 place of safety assessment suite opened at Harrogate District Hospital last year.

A Section 136 Place of Safety suite is somewhere a person can be detained for up to 72 hours if they are in mental health crisis and the police believe them to be in immediate need of care for their own sake or another person's safety. It is the third such service to be opened in North Yorkshire with other place of safety suites already successfully operating in Northallerton and Scarborough.

The suite, run by TEWV, has been made possible through a partnership with NHS Harrogate and Rural District CCG (which is funding the service), North Yorkshire Police, North Yorkshire County Council and North Yorkshire Air Ambulance Service.

The service allows officers to continue with their duties, but also significantly reduces the likelihood of individuals with mental health conditions in the Harrogate area being unnecessarily detained in custody. Previously people would have often been detained in a police custody suite, with the stigma that comes with that often adding to the distress they were experiencing.

Improving rehabilitation services

In County Durham and Darlington work has continued to improve rehabilitation services for adults and to help people develop the skills they need to lead as independent and socially inclusive life as possible.

Our aim is to make sure that people are not staying in hospital for longer than necessary and that they get the care and specialist input they need as quickly as possible. In particular the focus has been on providing the appropriate community services so that we can support people in their home environment wherever possible.

There has been a reduction in the need for bed based services, as more people move on to more appropriate accommodation. By the end of the 2015/16 occupancy at our two units in Darlington, providing complex and challenging rehabilitation services, had reduced by around 50%. Earlston House closed in early April 2016, reducing bed numbers from 30 to 15.

Improving the environment

Most people will receive the care and support they need in their home environment. However, when people need to spend time in hospital it's important that we can offer them a modern, fit-for-purpose environment.

West Lane Hospital

West Lane Hospital

The final phase in the building development at West Lane Hospital, Middlesbrough has been completed.

The hospital, which is home to the Trust's inpatient facilities for children and young people, has undergone a £13.8 million refurbishment over the last three years including:

- Westwood Centre, a state-of-the art 12 bed unit for young people who need to be cared for in a low secure environment. The Westwood Centre offers 24 hour support, seven days a week to young people who may have been in conflict with the law or present a significant risk to themselves or others.
- Newberry Centre, which provides 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. This unit has been extensively refurbished to provide much improved accommodation for inpatient assessment and treatment services.
- Evergreen Centre, part of the Northern Centre for Eating Disorders (NCED) has been expanded to include additional bedrooms and bigger indoor and outdoor spaces.

The last phase of the multi-million pound refurbishment, The Glades, was handed back to the Trust at the end of February 2016 and provides a new purpose built building that will house education facilities, meeting space, therapy and consulting rooms and a multi faith room, as well as being home to the community eating disorder service.

The Orchards

The Trust's new specialist inpatient rehabilitation and recovery unit, The Orchards in Ripon, opened in August 2015.

The totally refurbished unit provides a much improved facility and increased space for service users and staff, who were previously based at Abdale House in Harrogate. The unit includes nine en-suite bedrooms, a single bedsit style apartment and a range of modern facilities to assist with daily living skills, as well as group rooms and visitor accommodation.

Staff at The Orchards provide assessment, care planning, treatment and recovery in a warm, safe and homely environment. They help prepare our service users for community integration and ultimately to them leading a more independent life.

The Orchards also offers consulting space, to help provide services as locally as possible, and is a dedicated community service base for the area's early intervention in psychosis team and North Yorkshire County Council's local community

New contracts

Vale of York

Following a competitive tendering process, TEWV took over responsibility for mental health and learning disability services for the population of the Vale of York on 1 October 2015. The transfer took place immediately after patient services were moved from Bootham Park Hospital in York following notification by the Care Quality Commission (CQC) that the hospital was not fit for purpose.

Since then adult inpatients have been admitted to our hospitals outside of York, primarily Roseberry Park in Middlesbrough. We have strengthened community services to provide more support to people at home and reduce the need for admission to hospital. However, this is far from ideal and since October TEWV has been doing everything it can to bring services back to York.

The 136 suite (place of safety) re-opened at Bootham Park Hospital in December 2015 and we started to move outpatient clinics back to the hospital in February 2016.

Our focus now is on bringing adult inpatient services back to York as quickly as possible. Work is well underway at Peppermill Court in York to adapt it for this purpose and plans are on track to open this unit in July 2016.

Liaison and diversion service

Middlesbrough liaison and diversion team with Barry Coppinger (right), Cleveland police and crime commissioner

After a successful tendering process mental health and learning disability services are now delivered by TEWV in police custody suites and courts within Cleveland Constabulary and Durham Police areas.

Mental health nurses and other professionals work in partnership with local police to help assess offender's mental ill health and learning difficulties to make sure they get the right treatment at the earliest possible stage.

The all age liaison and diversion service has already been provided into Cleveland Police since January 2014 following a successful pilot funded by the Department of Health. TEWV staff have been working in Durham Police stations since April 2015 and the service has now been extended to cover the whole of County Durham and Darlington.

Prison services

Mental health and learning disability services in seven prisons are now being delivered by TEWV.

Since April 2015 the services have been provided under a new partnership, the North East Prison Cluster (NEPC) Healthcare Community. The new model, including the sub-contract of mental health wellbeing services to Rethink, has been successfully implemented and we have held two improvement events to remove waste from processes reduce waiting lists and increase contacts.

NEPC Healthcare Community
North East Prison Cluster

"I was impressed with the teams approach to the care and treatment review process. More importantly the patient was clearly at the centre of the process and the positive relationship between staff and service user was evident throughout the review."

from a commissioner

National recognition

Ward 15 at The Friarage Hospital in Northallerton scooped the coveted winner's award for psychiatric team of the year for working age adults at the annual **Royal College of Psychiatrist's Awards** ceremony in November 2015. The team was presented with the award for their work with service users, their families and the local community.

Mental health services for older people in Harrogate, together with NHS Harrogate and Rural District clinical commissioning group (CCG), has been awarded **Yorkshire and Humber Dementia Quality Award**. The award recognised how the two organisations worked with local GP practices to streamline the way patients with Alzheimer's disease and dementia receive their routine reviews. Instead of having duplicate appointments at the memory clinic and GP practice twice a year, care is now shared and patients are seen alternately by their GP and memory clinic every six months.

County Durham and Darlington child and adolescent mental health service (CAMHS) crisis and liaison team won the accolade for child and adolescent services at the **Nursing Times Awards** 2015 in November. This special award is presented to nurses who provide care in partnership with families and need to be able to develop trusting relationships. The same team also picked up the award for innovation in child, adolescent and young people's mental health at the **Positive Practice in Mental Health Awards**.

TEWV scooped two accolades at the **NHS England Friends and Family Test awards**, set up to recognise NHS providers who are going the extra mile in their work to listen to both patients and staff. **Kerry Jones, staff experience project manager** and our **patient and carer experience team** were both presented with awards from over 100 shortlisted entries. Kerry took the winner's award for 'Best staff Friends and Family Test initiative' following her work with staff to improve their work experience. Highly commended at the awards was our patient and carer experience team for putting a Trustwide system in place for the collection, analysis and circulation of patient and carer experience feedback.

Amy Colling, clinical lead, ward 15 at the Friarage Hospital in Northallerton was honoured at the **NHS North East Leadership Academy (NELA)** awards in November by being chosen as the NHS inspirational leader of the year. The award was presented in recognition of her work to inspire others to achieve great things, placing quality at the heart of everything she does and mentoring the next generation of leaders.

Our **Darlington and Teesdale mental health team for older people** was part of a multidisciplinary team that won the Best Integration Project of the Year award in the **North East and Cumbria commissioning awards**. The awards acknowledge the work in commissioning (planning and buying) health care services by the region's NHS groups, as well as social care partners and teams from North East Commissioning Support (NECS).

Talking Changes in County Durham and Darlington won the award for partnership working at the **Positive Practice in Mental Health Awards**. They were presented with the award for their work in improving access to psychological therapies (IAPT). This service is a joint venture between TEWV, County Durham and Darlington NHS Foundation Trust and Mental Health Matters.

The performance report

An overview

It has been challenging year but despite pressures on our services we met all our national requirements and Monitor targets. We were rated as green for governance and four for financial sustainability in our risk ratings and the Trust continues to be a going concern. The main issues that have challenged us over the last 12 months have been waiting times, out of area admissions, nurse recruitment and the expansion into York and Selby, particularly the unexpected closure of Bootham Park Hospital. We continue to work hard to address these issues. There is more information in the Foreword and Year in Brief sections of this report.

Colin Martin
Chief Executive
24th May 2016

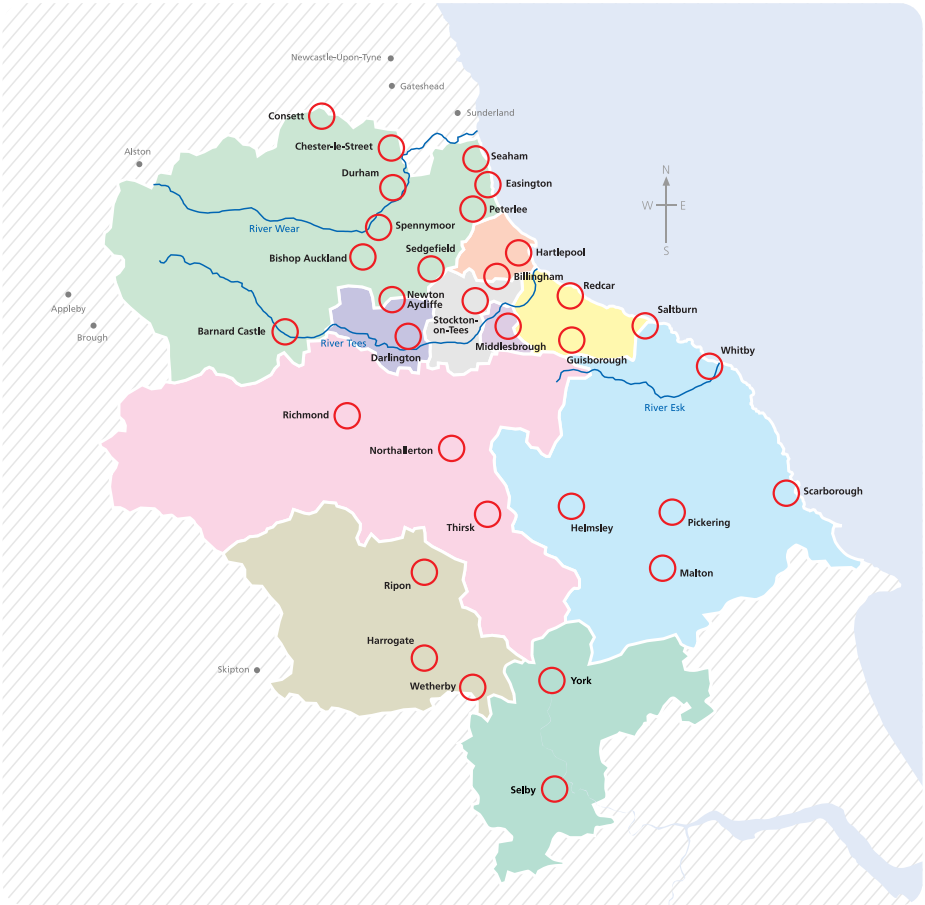
TEWV at a glance

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 achieved foundation trust status under the NHS Act 2006. Since then we have won two major contracts to provide mental health and learning disability services - since June 2011 we have had responsibility for services in Harrogate, Hambleton and Richmondshire and in October 2015 we took over the contract for the Vale of York.

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 and learning disability services for approximately 2.0 million people of all ages living in County Durham and Darlington, Teesside and most of North Yorkshire as well as the Wetherby area of West Yorkshire. We also provide community learning disability services to Craven District. Our specialist services also serve patients from other local health economies, particularly Cumbria, Tyne and Wear and Northumberland. With around 6500 staff and an annual operating income of approximately £312 million we deliver our services by working in partnership with local authorities and clinical commissioning groups, a wide range of other providers from the public, private and voluntary sector, as well as service users, their carers and the public.

The area we serve



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 the "Year in Brief" section for examples)
- respond better to market opportunities (see examples in the "Year in Brief" section)
- continue to invest in capital developments such as West Lane Hospital in Middlesbrough.

The TEWV approach

Our mission

To minimise the impact that mental illness or a learning disability has on people's lives.

Our vision

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

We will achieve our vision and mission through progressing our five strategic goals (see below).

Our values

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

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

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

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

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

Our goals

Strategic Goal 1
To provide excellent services, working with the individual users of our services and their carers to promote recovery and well being

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

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

Strategic Goal 4
To have effective partnerships with local, national and international organisations for the benefit of the communities we serve

Strategic Goal 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

Our Services

We provide a wide range of community mental health and learning disability services for people of all ages. Our services' role is to provide therapeutic and pharmacological treatments and other support to keep patients safe and to help them to achieve the recovery goals that they set for themselves.

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

- Durham and Darlington
- Tees
- North Yorkshire
- York and Selby

There is a fifth 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

"I'd like to thank you for the kindness and professionalism that you have shown to my mum over the last few difficult months of her life. I feel confident that she received the best care available and that due to this she was able to retain her dignity to the end."

from a service user's family

Key issues and risks which could impact on the achievement of the strategic direction

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 in the accountability report.

We consider that, at present, the key issues and risks which could impact on the achievement of our strategic direction are as follows:

Potential changes to service models and the provider landscape

In its "Five Year Forward View", published in October 2014, NHS England set out its vision for the future of the NHS. This has been built upon in further guidance/publications including Future in Mind (FiM), the Mental Health Task Force Report and the Transforming Care for People with a Learning Disability guidance.

These documents highlight the importance of the following:

- the need to have parity of esteem for mental health
- the importance of prompt access to services
- greater integration of services which break down barriers in how care is provided and they describe new models for achieving this
- a reduction in the over reliance on inpatient services with more people being supported in the community.

From our perspective the vision created via these documents has both significant risks and uncertainties as well as opportunities.

The need to ensure parity of esteem nationally is welcome, as is the additional resource that has been identified to support the delivery of the task force report and FiM. However there is a risk that the workforce required to implement the ambitions within the various pieces of guidance is not available or that it leads to a reduction in the workforce in 'core' services as staff are attracted to 'new cutting edge services'.

The drive to improve access to services is also welcome and indeed the Trust has prioritised access to services for a significant number of years. However there is a risk that the national targets set do not reflect the starting points of services and are not achievable due to a shortage in staff with appropriate skills. This could result in the Trust not meeting the governance requirement of NHS Improvement's Risk Assessment Framework.

The drive for integration of services and the implementation of the new care models, if appropriate, is a matter of local choice. This flexibility creates risks that different approaches will emerge across our localities and, as a result, there is significant uncertainty about the impact of any changes, including the potential development of new organisational structures, on our services. However, it will also allow the local areas to test different models and learn from these which could be an opportunity to test innovative ways to provide mental health care alongside physical health care for the benefits of the population. By learning from these models it may be possible to spread greater improvement over the larger populations to which the Trust provides services.

The integration of services also creates risks that mental health and learning disability services might suffer due to the focus being prioritised on other health services. However, it may also provide opportunity to ensure that people's mental health is considered alongside their physical health problems,

particularly in terms of people with long term conditions which often have a psychological impact.

Whilst the Trust is supportive of the need to ensure that there is not an over reliance on the use of inpatient beds there is a risk that the number of beds are reduced prior to appropriate alternatives being available in the community. This is a significant risk in terms of our learning disability services where in order to discharge patients often significant care packages are required in the community. In addition there is a risk that the remaining beds become financially unsustainable.

In response to the above risks and uncertainties:

- The Board has considered the implications of the Five Year Forward View for the Trust and received updates in terms of the Task Force Report and the Learning Disability Transforming Care agenda.
- The Trust is actively seeking to engage with commissioners and emerging GP federations to understand and influence the development of new models of care and to ensure that, if implemented, they have a positive impact on the mental health and well-being of the population they serve.
- The Trust is actively seeking to be engaged with the development of the Sustainability and Transformation Plans (STP) in the three footprints it operates within in order to ensure that the STPs reflect the key direction of travel outlines in the national policies.
- The Trust continues to engage with commissioners on the development of services outlined in the policy documents.
- The Trust has active engagement in the North East Transforming Care Board and is working with its local commissioners on the development of a robust learning disability community model that will allow more individuals to be cared for in the community whilst also ensuring that the required number of inpatients beds can be provided in a financially sustainable way.

The Financial Challenge

The successful delivery and development of the services we provide depends on us maintaining our strong financial performance.

In its Spending Review and Autumn Statement 2015 and 2016 Budget the Government announced a number of measures which could impact on our financial well-being:

- Whilst funding for NHS services has been ring-fenced, this is not the case for our partners e.g. local authorities. The savings they are required to make will create financial pressures for us going forward.
- In the Autumn Statement the Government announced that by 2020 additional funding of £10 billion more a year, in real terms, would be provided to the NHS compared to 2014-15. However, as reported by Monitor, the deficit of the NHS in England rose to £1.6bn in the first half of 2015/16, mainly as a result of the financial performance of acute Trusts. There are risks that the new funding provided will be focussed on reducing the deficit of the acute sector at the expense of mental health and learning disability services.
- Training monies have been excluded from the NHS ring-fence; compounding the impact of recent reductions in training funding which we access from Health Education North East eg Tier 2 continuing professional development funding is expected to reduce by £50,000 during 2016/17.

The introduction of the apprenticeship levy from April 2017 will represent both a significant cost pressure and an opportunity for the Trust.

To seek to mitigate these risks we will:

- continue to improve the productivity of our services using our well established quality improvement system
- continue to work with partners to seek to develop ways of providing services which meet the needs of each organisation whilst maintaining service quality
- continue to assess and monitor the impact of proposals for efficiency savings to ensure that they do not impact, adversely, on the quality of our services.
- with regard to training:
  - develop a revised approach to how our Training Needs Analysis is compiled and monitor its effectiveness to ensure that we obtain maximum value for money from our investment in training activities
  - pay constant attention to how we secure vocational training at the lowest cost whilst ensuring that we provide access to good quality training for non-registered staff
  - develop a Trust approach to making the most of opportunities afforded by the introduction of the apprenticeship levy.

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

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

Recruitment

The Trust has previously been able to successfully recruit staff across all disciplines and localities albeit with some degree of variation.

During the last year, however, in common with many other providers, there has been increasing evidence of more significant recruitment difficulties being experienced particularly with regard to the recruitment of registered nursing staff. We now consider that our ability to access the right number and quality of registered nurses is the key workforce risk for the Trust.

We also believe that the level of risk may increase given the age profile of the registered nurse workforce, which is expected to result in an increase in the number of Trust nurses retiring on age grounds over the next four years.

In response to concerns about registered nurse recruitment, in particular, the Trust:

- has identified the development and implementation of a Trust-wide recruitment plan as a priority for 2016/17
- has begun identifying and implementing revised and innovative recruitment processes and incentives
- is undertaking earlier and more effective engagement with student nurses within the Trust's boundaries
- has identified measures to improving the ability of the Trust Central Nurse Bank to provide registered nurses
- is developing new roles and career paths within the Trust.

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 have strengthened our governance arrangements and undertake regular self-assessments to ensure that, when shortcomings are identified, they are dealt with.

Going concern

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

The 2016-17 annual plan provides for a surplus of £6.1m (1.9% of turnover) and reflects a significant level of non-recurrent expenditure. The planned financial surplus for 2017-18 maintains this level of surplus. 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".

Performance analysis

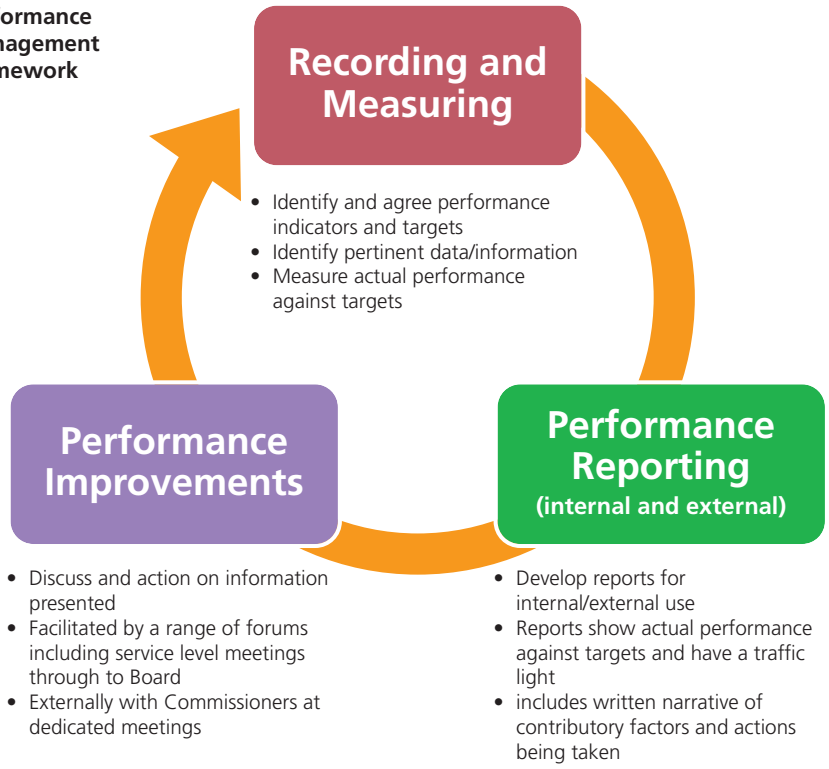
Each year the Board of Directors set a number of stretching targets (key performance indicators) for the Trust to work towards as part of its commitment to year-on-year improvement. This is undertaken as part of the annual business planning framework where members of the Board, Executive Management Team and Senior Clinical Directors discuss the key performance indicators for the following year.

The key performance indicators are reported within a "dashboard" which provides a high level overview of operational delivery throughout the financial year. This report is produced monthly specifically for our Board of Directors to give them assurance that the Trust is continuing to deliver operationally. We also make it available to our service users, wider public and commissioners and it is presented and discussed with our Council of Governors once a quarter. It should be noted that in setting the targets within this dashboard the Board of Directors is deliberately aspirational and stretching in recognition of our vision to provide excellent services that exceed people's expectations. For example Monitor's target for the percentage of service users having CPA reviews within 12 months is 95% but the Board has set our internal target at 98%.

The Board of Directors discusses the "Trust dashboard" each month in terms of areas of good practice but also areas where improvement is needed. If there are any areas where the Trust is significantly underperforming the Board may request further analysis and/or an action plan if they feel this is necessary.

It is important to note that we use a number of other performance dashboards widely throughout the organisation, and the "Trust dashboard" is an example of one of these. We believe that whilst a performance dashboard is critical in monitoring performance, it is only one part of an overarching performance management framework that supports performance and service improvement. Other examples where we use performance dashboards include the "strategic direction performance report" where we measure progress against the strategic goals we have set and our "commissioner reports" which measure progress against the key performance indicators agreed in the contract. Therefore we use performance dashboards to manage and continuously improve our performance and service delivery as part of our integrated performance management framework which forms a continuous cycle of performance improvement, as shown above.

Performance Management Framework



Given the importance that the Trust attaches to performance dashboards, it has invested significantly in a trust-wide integrated information centre (IIC). The IIC is a data warehouse which integrates data from a wide range of source systems e.g. patient information, finance, workforce and incidents. It is used to produce performance information for both internal and external use in the form of static monthly assurance reports and interactive reports which are updated daily via electronic feeds from the source systems allowing interrogation of the most up to date performance 24/7.

There are a number of benefits to having this tool which include:

- the availability of 'real time data' for use by the clinical services for clinical and business purposes. Staff are able to access the IIC at any time of day and can interact with the information it contains
- the availability of information from different source systems in one integrated system
- the ability to drill down to the lowest

level of data available (according to access rights). This means that managers can drill down from service level reports into individual patient or staff information
- the ability of the IIC to send prompts to staff that an area of performance is about to breach built-in standards
- it allows our approach on performance management to move from a "reactive" to a more "proactive" one, both in the way we manage performance data in our team and in the way we engage with clinical services.

Performance against key targets

The Trust met all its national requirements and Monitor targets during 2015/16. 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 below is the Trust's dashboard of key performance indicators for 2015/16.

Note: *This excludes York and Selby locality which transferred to the Trust on 1 October 2015.*

The Board received a monthly performance report during 2015/16 which contained performance against a range of indicators linked to the Trust's strategic goals as well as national requirements.

Scorecard

1. Users of Our Services	2015/16 Actual	2015/16 Target	2014/15 Actual	Change on 14/15*	Comment on 2015/16
Percentage of patients who have not waited longer than four weeks for a first appointment	82.65%	98.00%	83.73%	↓	
Percentage of patients who have not waited longer than four weeks following an internal referral	83.96%	98.00%	85.79%	↓	
Percentage of people experiencing a first episode of psychosis that were treated with a NICE approved care package within 2 weeks of referral	74.12%	50.00%	New National Indicator for 2015/16		Performance shown is not currently calculated using the national definition. Using the national definition the position is 60%
Percentage of people referred to the IAPT programme that were treated within 6 weeks of referral	84.77%	75.00%	New National Indicator for 2015/16		
Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral	94.78%	95.00%	New National Indicator for 2015/16		
Access to psychological therapies adult IAPT – percentage of people that enter treatment against the level of need in the general population (Durham and Darlington & North Yorkshire localities only)	13.57%	15.00%	11.82%	↑	
Recovery rate adult IAPT – percentage of people who complete treatment who are moving to recovery	46.07%	50.00%	47.63%	↓	
Percentage of admissions to inpatient services that had access to crisis resolution home treatment teams prior to admission (AMH only) Post Validated	97.18%	95.00%	98.42%	↓	
Percentage CPA 7 day follow up (AMH only) – Post Validated	97.75%	95.00%	97.42%	↑	
Percentage of CPA patients having a formal review documented within 12 months (AMH only)	98.85%	98.00%	97.75%	↑	Snapshot as at 31st March 16
Percentage of community patients who state they have been involved in the development of their care plan (AMH, MHSOP and LD)	90.19%	85.00%	90.58%	↓	

** Arrows indicate improvement (↑) or deterioration (↓) on previous year*

2. Quality	2015/16 Actual	2015/16 Target	2014/15 Actual	Change on 14/15*	Comment on 2015/16
The percentage of out of locality admissions to assessment and treatment wards (AMH & MHSOP) – Post-validated	17.01%	15%	Indicator changed to % for 2015/16		
Percentage of people re-admitted to assessment and treatment wards within 30 days (AMH & MHSOP)	24.16%	15%	19.89%	↓	
Number of patients who have 3 or more admissions in a year (AMH & MHSOP)	279	191	219	↓	
Median number of days from when a patient is discharged as an inpatient to their next admission as an inpatient (AMH and mental health services for older people - MHSOP - only)	104	146	139	↓	
Percentage of appointments cancelled by the Trust	1.10%	0.67%	1.33%	↑	
Number of unexpected deaths classed as a serious incident per 10,000 open cases	14.68	11.00	12.16	↓	
Percentage of wards who have scored greater than 80% satisfaction in patient survey	75.28%	75.00%	73.17%	↑	

3. Workforce	2015/16 Actual	2015/16 Target	2014/15 Actual	Change on 14/15*	Comment on 2015/16
Percentage of staff in post more than 12 months with a current appraisal	81.32%	95.00%	89.37%	↓	Snapshot as at 31st March16
Percentage compliance with mandatory and statutory training	87.48%	95.00%	88.11%	↓	Snapshot as at 31st March16
Percentage sickness absence rate	4.62%	4.50%	5.12%	↑	Snapshot as at 31st March16

5. Excellent and well Governed Trust	2015/16 Actual	2015/16 Target	2014/15 Actual	Change on 14/15*	Comment on 2015/16
Number of reds on CQC action plans (including MHA action plans)	0	0	0	↔	
Number of external referrals into Trust services	77,262	69,931	69,920	↑	
Delivery of our financial plan (I&E)	297,000	-4,784,000			

** Arrows indicate improvement (↑) or deterioration (↓) on previous year*

Notes

- **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 82.65%. However, it should be noted that the number of referrals received by the Trust increased by 6% during 2015/16 compared to 2014/15.
- **Percentage of patients who have not waited longer than four weeks following an internal referral** - The Trust has consistently failed to achieve the 98% target throughout the year, reporting an annual position of 83.96%; there has been a 9.08% increase in internal referrals during 2015/16 compared to 2014/15.
- **Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral** – The Trust has just failed to achieve the target of 95% with a performance of 94.78%. All localities are achieving the target with the exception of Teesside. The services in all localities are continuing to look at ways to reduce waiting times for treatment.
- **Access to psychological therapies adult IAPT** – percentage of people that enter treatment against the level of need in the general population – this indicator only relates to County Durham and Darlington and North Yorkshire Services. We have consistently under-performed against the Trust target throughout the year, but have achieved a significant improvement on the position reported in 2014/15. The services continue to work to increase referral numbers and address issues regarding patients accessing treatment.
- **Recovery rate adult IAPT** – percentage of people who complete treatment who are moving to recovery – Performance for 2015/16 has not achieved the annual target and is slightly worse than performance in 2014/15 by 1.75%. The services continue to review every patient who has not moved to recovery to ascertain the reasons why and work continues to look at patient engagement and how this can be improved.
- **The percentage 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 underperformed against the 15% target with an outturn of 17.01%.

- **Percentage of people re-admitted to assessment and treatment wards within 30 days (AMH & MHSOP)** - The Trust has underperformed against a target of 15% with performance of 24.16%. The circumstances of the readmissions have been investigated on a monthly basis and all were attributable to the severity of the symptoms and personal circumstances of the patients concerned.

- **Number of patients who have 3 or more admissions in a year (AMH & MHSOP)** - The Trust have underperformed against a target of 191 with performance of 279. The circumstances of the readmissions have been investigated on a monthly basis and all were attributable to the severity of the symptoms and personal circumstances of the patients concerned.

- **Median number of days from when a patient is discharged as an inpatient to their next admission as an inpatient (AMH and mental health services for older people - MHSOP - only)** – The Trust has failed to achieve the target of 146 days throughout the year, reporting a median period of 104 days from discharge to admission for any readmitted patient in adult mental health and older peoples services. Performance for 2015/16 has deteriorated compared to 2014/15.

- **Percentage of appointments cancelled by the Trust** – The trust have failed to achieve the target of 0.67% with a performance of 1.10%. It has been identified that some of these cancellations are due to how clinics are managed and investigations have been coordinated by the Data Quality Working Group. The information service managers in all localities are continuing to address data quality issues within this area and work is underway to identify any further areas of concern.

- **Number of unexpected deaths classed as a serious incident per 10,000 open cases** – The Trust has failed to achieve the target of 11 unexpected deaths per 10,000 open cases. This equates to 79 unexpected deaths, 19 more than was reported last year. The data was continuously monitored throughout the year and no patterns or trends have been identified. Performance for 2015/16 is worse than for 2014/15.

- **Percentage 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 81.32% in March 16. This is deterioration on the 89.37% achieved in 2014/15. 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 87.48% in March 16; however this is a slight deterioration on the outturn of 88.11% for 14/15. Regular monthly compliance reports are closely monitored at various levels and forums throughout the Trust.

- **Percentage sickness absence rate** – The Trust has under-performed against the 4.50% target with an outturn of 4.62% in March 16 but shows an improvement in performance compared to the 2014/15 outturn position of 5.12%. The Operational HR team continue to proactively support line managers to manage staff to facilitate a speedy return to work for staff.

Reducing our carbon footprint

The Trust has an approved sustainable development management plan (SDMP) which is incorporated within the estates and facilities management framework 2014 - 2017, and is based on a strong existing programme of environmental responsibility.

The Trust has developed a realistic action plan linked to the Good Corporate Citizenship (GCC) model with strategic themes that have been developed to address our environmental management responsibility.

Having recently undertaken our 2015/16 assessment against the GCC model, we are ahead of target making improvements from a baseline figure of 21% in November 2009 to 66% in March 2016.

The Trust has established an environmental steering group which will oversee the implementation of the SDMP and will be monitored through the bi-annual review of the GCC, and reported to the Board of Directors on an annual basis, through the Trust's annual report.

The Trust is a national leader in utilising renewable technology in an effort to assist the reduction in our carbon footprint and has adopted every possible available form of these technologies where cost effective across its portfolio of properties.

In a recent Government energy certification exercise rating of our buildings (A to G with D being above average) of the 33 properties surveyed, 28 were rated D and above with only 5 properties failing to achieve the average.

In going forward the Trust is embarking on a number of feasibility studies looking at extending the use of large scale solar photovoltaics and also generating our own power through the use of combined heat and power.

The Trust is preparing a bid for funding to increase the number of electric vehicle charging points at Trust sites in an effort to encourage greater take up of electric vehicles.

Responding to the external environment

TEWV serves patients across a large geographical area that includes:

- a number of industrial and / or coastal towns with high deprivation levels
- areas of former coal mining and iron ore mining which combine semi-rurality with high deprivation levels
- sparsely populated, isolated rural areas
- relatively affluent agricultural areas
- pockets of urban and suburban affluence
- the largest concentration of armed forces personnel in the UK (Catterick Garrison).

Challenges for TEWV as a provider include 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 with different financial pressures
- Manage the changing demand for our services
- respond to new national policy and guidance
- make best use of new medical and information technology which opens up additional ways of delivering services.

The Trust has a three year strategy, which sets out our continuing commitment to embed equality, diversity and human rights into everything we do. 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.

The accountability report

The accountability report

In the accountability report we provide information on our governance arrangements, staffing and the remuneration of directors and senior managers in order to demonstrate how we comply with best practice and key rules and requirements.

Colin Martin
Chief Executive
24th May 2016

The directors' report

The chairman, deputy chairman, chief executive and other board members as at 31 March 2016

Lesley Bessant

Chairman

Lesley 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 chair of Northumbria Probation Service Board.

Qualifications: BA Economics

Principal Skills & Expertise: Strategic leadership, strategic planning, performance management, corporate governance and risk management.

Term of office:
1 April 2014 to 31 March 2017

Date of Initial appointment:
1 April 2014

Jim Tucker

Deputy Chairman 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 2014 to 31 August 2017*

Date of Initial appointment:
1st September 2008

Dr Hugh Griffiths

Non-Executive Director and Chairman of the Quality Assurance Committee (from 1st September 2015)

Hugh was a consultant psychiatrist from 1988 and for eight years was an NHS trust medical director. In 2000 he also became medical director of the Northern Centre for Mental Health. He was director of policy and knowledge management for the NHS Clinical Governance Support Team in 2003/2004 and from then until 2010 was deputy national clinical director for Mental Health (England) at the Department of Health. Thereafter he was the National Clinical Director for Mental Health (England), leading the development of the Government's mental health strategy 'No Health Without Mental Health'. He retired in March 2013.

Qualifications: MB BS, FRCPsych

Principal Skills & Expertise: Service improvement, policy development, clinical leadership and management.

Term of Office:
1 April 2015 to 31 March 2018

Date of Initial appointment:
1st April 2015 (prior to his appointment Hugh served as an Associate Non-Executive Director of the Trust (non-voting) between 1st September 2014 and 31st March 2015).

Mr David Jennings

Non-Executive Director

David is a qualified accountant and worked for the Audit Commission for 26 years, including as acting head of operations. He set up his own business in 2011 and led the creation of a shared service between Redcar and Cleveland and Middlesbrough Councils' internal audit functions. He also acted as a consultant to a consortium of eight national accountancy firms seeking entry to the post-Audit Commission market. He is currently financial services manager and deputy Section 151 officer (Chief Finance Officer) at Redcar and Cleveland Borough Council.

Qualifications: Chartered Institute of Public Finance and Accountancy (CIPFA)

Principal Skills & Expertise: Expertise primarily in areas associated with finance, performance, and governance and skills in governance, auditing, business planning, the public sector, local government, performance improvement, shared services, business process improvement, performance management, change management, strategy, accounting, management and leadership.

Term of office:
1 September 2014 to 31 August 2017

Date of Initial appointment:
1st September 2014

Mr Marcus Hawthorn

Non-Executive Director, Chairman of the Audit Committee and Senior Independent Director (from 1st October 2015)

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, past 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 is a political assistant working for the City of York Council. She has previously worked both in private practice and as a company lawyer in engineering, construction and procurement law concentrating on international process plant development and the petrol-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 Richard Simpson

Non-Executive Director and Chairman of the Mental Health Legislation Committee

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. Richard is also a trustee of Age UK 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

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 (Mr. Barkley retired from the Trust on 28th April 2016).

Mr 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. He is the vice-chair (and the Trust's appointed director) of the Achieving Real Change in Communities CIC Ltd, the Durham and Tees Valley Community Rehabilitation Company.

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 He chairs the Northern School of Psychiatry's workforce sub-committee and the HENE Mental Health Workforce Planning Group. He is also a member of the General Synod of the Church of England.

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 30 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

Mr Martin became the Trust's Chief Executive on 1st May 2016.

Elizabeth Moody

Director of Nursing and Governance

Elizabeth, who took up post as director of nursing and governance in July 2015, has over 25 years' experience in the NHS having registered as an RMN in 1991. She has held a variety of clinical and managerial roles having worked as a senior nurse at Northumberland, Tyne and Wear NHS FT for approximately 10 years. Prior to joining the Trust she worked as a deputy director of nursing, group nurse director for inpatient services and prior to appointment group nurse director for community services, leading on the community redesign of pathways of care and service improvement. Elizabeth has also worked nationally on programmes related to patient safety, governance and assurance.

Qualifications: RMN, PGDip Professional practice

Principal Skills & Expertise: Psychiatric nursing skills, project management, service improvement, managerial and leadership skills, patient and carer experience, patient safety, quality and assurance

Appointed:
August 2015

Notes:
* *indicates that the individual has been reappointed as a Board Member of the Foundation Trust.*

Other Directors of the Trust during 2015/16

Mr John Robinson

Chairman of the Quality Assurance Committee and Senior Independent Director, until 31st August 2015.

Mrs Chris Stanbury

Director of Nursing and Governance until 31st July 2015

Registers of interests

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.

Financial disclosures

The Trust is required to provide statements on

- its compliance with the cost allocation and charging guidance issued by HM Treasury
- better payment practice code
- income.

These are provided in the financial review.

Quality assurance

Overview of arrangements in place to govern service quality

The Trust has implemented its quality strategy, launched in 2014, which describes the arrangements for the governance of quality across the organisation. Those arrangements include the clinical governance systems for the Trust services together with the clinical assurance systems that detail how the corporate governance teams and Trustwide assurance groups manage the relevant assurance processes. The quality strategy is being delivered through frameworks for patient safety, patient experience and clinical effectiveness together with the Trust workforce strategy.

Delivery of the quality strategy is reported through a strategic scorecard with key performance indicators for each framework, reported monthly to the Quality Assurance Committee, a sub-group of the Board of Directors. The scorecard will be thoroughly evaluated during 2016 and revisions made to any key performance indicators as appropriate.

Each clinical directorate, in the five operational localities of the Trust, has a quality assurance group (QuAG) that reviews the performance against quality indicators of their clinical teams. Those groups manage their clinical directorate quality improvement plan, monitoring quality data and the local risk register providing assurance and escalating risk where necessary to the five locality management and governance boards (LMGB). These boards provide exception reports monthly to the Quality Assurance Committee with a regular bi-monthly assurance report on service quality. A set of standardised quality reports for the quality assurance groups, locality management and governance boards, Trustwide quality assurance groups, Quality Assurance Committee and commissioners has been developed in year.

The corporate quality governance teams manage the operational systems to provide quality performance information for the service and Trustwide quality assurance groups, boards and committee. These include, for example, the complaints and PALS teams, patient safety incident team, clinical audit team, quality data team and patient and carer experience team. The regulatory compliance team implements a programme of peer and service user inspections across Trust services to monitor the quality of service delivery against the regulatory fundamental standards. All corporate teams then also monitor quality improvement action plans developed from the performance deficits and risks identified and report into the Trustwide assurance groups and the Quality Assurance Committee. Key information on the CQC ratings for the Trust along with data on complaints and incidents can be found within the quality report section of this report.

The Trustwide quality assurance groups track the performance against the quality strategy scorecard and other Trustwide key performance indicators related to the key elements of quality – safety, effectiveness, experience, safeguarding, infection control, physical health, equality, diversity and human rights and medicines management. These groups also develop responses to national quality and best practice directives on a Trustwide basis and report on a regular reporting schedule to the quality assurance committee.

The Quality Assurance Committee provides an assurance and exception report to the Board of Directors on a monthly basis.

In addition to the implementation of the quality strategy, the Trust monitors and reports on performance against the national and local quality indicators in the commissioned contracts. Monthly quality reports are produced for all the service contracts and reviewed by commissioners with the locality operational management teams, corporate performance and quality governance teams. Each locality management team therefore has oversight of their service performance against the internal strategic quality targets and against their contractual quality indicators. More information relating to contractual performance metrics can be found in the quality report.

Quality governance

The Trust has embedded the quality governance framework in the quality strategy as well as in the vision of the Trust and the five strategic goals. In the reporting against the delivery of the quality strategy, the Board of Directors receive regular exception reports to ensure clear sight on potential risks to quality as well as using the Board risk register to monitor and manage risk.

The implementation of the quality strategy supported by the Trust's quality improvement system (TEWV QIS) ensures that the Board is promoting a quality focussed culture and the Board can then utilise the monitoring of both the strategy implementation and QIS activity within the overall evaluation performance.

The Trust uses quality information as a basis for monitoring the performance against the quality strategy targets, external quality and regulatory standards and contractual quality indicators. The systems for collection, analysis and reporting of quality data have been improved this year with the expansion of the electronic risk reporting system. This has increased the robustness of the quality information and reports used for the Board assurance framework and evaluation of quality performance.

There has been further consolidation and improvement in the quality governance systems within the Trust, with a robust programme of internal audit of several of the corporate governance teams and their processes. The levels of assurance provided by those audit processes have also been taken into account in the evaluation.

The new position of director of quality governance has been appointed to. This is an executive management team role, reporting to the executive director of nursing and governance to give additional expertise and clarity to the leadership of quality governance management. In addition to this, the new locality heads of nursing are now in place to support professional and clinical governance systems in each area.

A summary of action plans to improve quality governance

- A project plan for the quality assurance and Datix expansion concentrating on incident reporting, complaints and claims recording which is intended to improve the systems for the reporting, collection and analysis of quality governance information. This has included the establishment of a central approval team for all incidents reported to ensure a robust and consistent approach to incident reporting.
- Learning lessons – enhancing the systems and processes for disseminating lessons derived from the analysis and review of incidents, claims, complaints, safeguarding and external inspections – developing the learning culture of the Trust and improving the systems for action plan monitoring and testing of action effectiveness.
- Implementation of trust wide staff training regarding the Duty of Candour to ensure staff are aware of their roles and responsibilities within the new Duty of Candour regulations and are confident in engaging patients, families and carers in this work.
- Re-design of corporate patient safety incident management teams and processes in response to the new national serious incident framework recommendations.

Arrangements for monitoring improvements to the quality of healthcare

The quality strategy scorecard provides monthly monitoring data to the localities to enable focus on quality improvement planning. Efficacy of those improvement plans would be monitored through the scorecard reports. The clinical directorate quality assurance groups monitor their local quality improvement programmes as well as action plans resulting from quality information feedback and review of incidents, complaints and audits. This information is reported to the Quality Assurance Committee and to the Board of Directors.

Improvement planned through TEWV QIS is monitored through a 30, 60, 90 and 365 day follow-up process, reported within localities and monthly to the Executive Management Team.

The Trust project management framework is used to support the delivery of the majority of Trustwide quality improvements. The framework includes monthly reporting summarised to the executive management team with individual exception reporting on failing project targets and project changes. Significant Trustwide quality improvement programmes are reported to the Board of Directors quarterly.

The quality report (account) identifies four specific quality improvement priorities that are monitored monthly and reported quarterly to the Trust Quality Assurance Committee and published annually in the quality report (account). The planned quality improvements within the CQuIN programme agreed with commissioners are also monitored monthly and reported quarterly.

Additional quality issues

During 2015/16 we have:

- provided a new "place of safety" (also known as Section 136 Suites) in Harrogate resulting in their being a place of safety in each locality served by the Trust
- opened a crisis assessment suite (CAS) at Roseberry Park Hospital on Teesside
- opened a new rehabilitation service in North Yorkshire at The Orchards in Ripon
- completed the transformation of West Lane Hospital, our children and young people's inpatient site, resulting in the facility providing a modern therapeutic environment
- expanded our child and adolescent mental health services (CAMHS), using additional funding from commissioners to implement a 24/7 crisis service for under 18s in Teesside (in addition to the Durham service that commenced in 2014/15)
- implemented a peri-natal service in Teesside
- introduced an enhanced community learning disability service in Teesside that is available seven days a week from 8am until 8pm
- reduced the variation in practice among our community psychosis and early intervention in psychosis (EIP) teams, ensuring that patients receive the same quality of intervention wherever they live across the area served by the Trust
- developed our "unified affective disorders pathway" and are rolling this out across the Trust following a successful pilot
- improved processes in Durham and Darlington MHSOP, which have released nurse time for direct patient contact and improving recovery
- reduced the time taken for Scarborough memory service patients to receive a diagnosis and also increased capacity to deal with an increase in referrals for memory services
- developed a protocol to enable service users within low secure services have access to and use of mobile phones whilst within the ward environment
- replicated the successful "For Us" forensic learning disability service user group in forensic mental health.

Involving local people

Patient and public involvement

In November 2015 the Council of Governors approved an involvement and engagement framework which outlined the Trust's intentions to involve and engage with service users and carers in the development and delivery of our services through recognising the critical importance of working in partnership with the users of our services and their carers to design and deliver high quality person centred services which promote recovery.

Some of the valuable work undertaken through involvement activities has included:

- recruiting staff including medical and nursing positions with in excess of 50 interview panels including a service user or carer
- training a range of nursing students, doctors and those staff undertaking NVQ qualifications
- participating in a range of inspections of wards and working environments under Patient Led Assessment of the Care Environment (PLACE) and internal inspections against the Care Quality commission (CQC) Fundamental Standards
- participating in service user and advocate leadership training which provides a mechanism for self-development and confidence building
- assisting in the planning and delivery of conferences, sharing experiences and views
- assisting the Trust with plans to become smoke free
- joining a number of formal meeting groups contributing to the assurance of quality and safety of services
- significant work in looking at force reduction with service users using their own experiences to change culture and approaches
- a number of service users joining the experts by experience programme and assisting the Trust to embed recovery principles in all aspects of work
- employment of two expert by experience coordinators (previous attendees of the experts by experience programme)
- development of 14 involvement peer roles within the organisations working alongside staff in the delivery of care and support.

In 2015 Pam Elliott was nominated and successfully shortlisted by the Royal College of Psychiatrists for Carer of the Year for her work not only championing the role of carers within the Trust but through her personal community support carer work.

Consulting with local people

The Trust supported the three CCGs in County Durham and Darlington to carry out a public consultation on proposed changes to hospital inpatient services for older people with dementia. The consultation on the future configuration and location of inpatient beds ran from 4 January to 28 March 2016.

There are currently two 10-bed wards at Auckland Park Hospital in Bishop Auckland and one 10-bed ward at the Bowes Lyon Unit, Lanchester Road Hospital in Durham. The Trust will maintain 30 beds but plans to reduce the number of wards from three to two.

The local NHS clinical commissioning groups (Darlington CCG, Durham Dales, Easington and Sedgefield CCG and North Durham CCG) consulted on three possible options.

- Option 1 was to locate both wards (one male and one female) at Auckland Park Hospital at Bishop Auckland and close Picktree Ward in Durham.
- Option 2 was to provide separate male and female wards on separate sites (one ward at Bishop Auckland and one ward at Durham and close one of the wards at Bishop Auckland).
- Option 3 was to provide a mixed sex ward at Bishop Auckland and a mixed sex ward in Durham and close one of the wards at Bishop Auckland.

The preferred option of mental health professionals at TEWV was to have separate male and female wards at Bishop Auckland. The clinicians firmly believe that having separate wards for men and women is highly beneficial.

We held four public meetings as well as open meetings for service users, carers and staff and attended other meetings when requested. We received 66 written responses to the consultation. The report on the consultation is being considered by the Board of Governors of the three CCGs, who will make a decision on which option to implement.

Statement as to disclosure to Auditors

Each of the directors, holding office on 31st March 2016, confirms 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.

Staff report

At the end of March 2016 we employed just over 6,500 (headcount) staff:

The average numbers of employees for the 12 months ended 31 March 2016 are set out in the following table.

	Total (Number)	Permanently Employed (Number)	Other (Number)
Medical and dental	312	302	10
Administration and estates	1,097	1,060	37
Healthcare assistants and other support staff	283	272	11
Nursing, midwifery and health visiting staff	3,288	3,267	21
Scientific, therapeutic and technical staff	687	675	12
Social care staff	25	0	25
Agency and contract staff	120	0	120
Bank staff	257	0	257
Total	**6,069**	**5,576**	**493**
of which			
Number of Employees (WTE) engaged on capital projects	7	7	0

Our 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 (i.e. members of the Board of Directors and Executive Management Team) is 15 male and seven female.

Sickness absence figures (January to December 2015)

Average full time equivalent (FTE) staff in post	Adjusted FTE Sick days	FTE days available	FTE days lost to sickness absence*	Average sick days per FTE
5,460	58,633	1,992,923	95,116	10.7

** This figure is based on a calculation of actual working days available.*

"The staff never gave up on me despite my complicated and complex needs, for that I am very grateful. They have given me hope for the future again, I am now looking for a part time job and have recently just completed my GCSE's all thanks to the help I received from the ward."

from a service user

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 Trust sickness absence procedure contains a provision for disability leave so that staff with a disability, who require regular treatment to maintain their health and attendance at work can do so within an agreed number of days leave.
- The recruitment and selection policy is based upon national recruitment standards and as part of the Department of Employment 'Two Ticks' symbol we guarantee to interview all applicants who declare they have a disability and who meet the minimum requirements for the post. The Trust will provide all reasonable adjustments to enable people with a disability to attend for interview. This applies not only to staff applying for their first post with the Trust but also to staff seeking promotion.
- The redeployment process provides the opportunity for staff who are no longer able to carry out their job either on health grounds or because of organisational change to secure suitable alternative employment with the Trust. This can involve a period of shadowing, training and a trial period to widen the suitable opportunities available.
- The Trust's staff development policy recognises that people learn in different ways and that a positive learning environment that endeavours to meet people's needs is likely to impact positively on the level of knowledge retained. Reasonable adjustments work positively in a learning environment as they remove barriers to learning. Staff are far less likely to learn and retain knowledge if they are worried or anxious. Everyone is different, so this could be something that impacts directly on a person within the learning environment or it could be that another factor outside the learning environment is having a detrimental impact on their ability to learn of participate in the training. Managers and staff are encouraged to contact the education and training department to discuss how the Trust can best meet the needs of people from protected groups whilst they are participating in education and training.

Communicating and engaging with our staff

Our staff are our most important asset and we will only achieve our mission of improving the health of people with mental health or learning disability conditions if different groups of staff communicate well with each other and feel engaged with the organisation.

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
- Visits to services and teams by directors
- Quarterly leadership and management groups which give direct access to the Chief Executive
- An anonymous electronic mechanism for raising concerns which are responded to through ebulletin and posted on the intranet.

We are also developing a knowledge management solution (KMS) which will give us a fully integrated intranet, website, extranet and document management solution. The KMS will improve the way staff are able to communicate and engage with each other as well as share information and knowledge.

Staff involvement and engagement is also key to the success of our quality improvement system. TEWV QIS empowers staff to identify and remove waste and streamline processes which enables them to focus on doing things that add value for the people who use our services.

Consultations about proposed organisational changes, changes to workforce policies and procedures and terms and conditions issues have taken place at both a Trust and individual service level. This two way flow of information has helped to inform and improve decisions made.

Trust wide consultation takes place with staff side representatives via the bi-monthly joint consultative committee, with locality consultative committees taking place in the intervening months for issues specific to each locality. A number of groups have staff side representatives as members such as the health and wellbeing group, policy working group and health and safety committee. In addition staff side representatives are usually invited to join specific working groups when it is anticipated that there may be implications for staff.

Staff survey

Our results were compared with 29 other mental health trusts* and were extremely positive. We received the best scores in the country in 14 of the 32 areas covered by the survey and we were above average in all but three of the 32 areas.

Our top four ranking scores were:

- Percentage of staff suffering work related stress in the last 12 months (28% compared to a national average of 39%) **KF17**
- Staff satisfaction with level of responsibility and involvement (4.05 compared to a national average of 3.84, out of a possible 5) **KF8**
- Staff satisfaction with resourcing and support (3.6 compared to a national average of 3.31, out of a possible 5) **KF14**
- Support from immediate managers (4.03 compared to a national average of 3.85, out of a possible 5) **KF10**

Summary of staff survey results

	2014/15		2015/16		
	Trust	National Average	Trust	National Average	Trust improvement / Deterioration
Response Rate					
	57%	44%	55%	46%	2% decrease
Top 4 Ranking Scores					
KF17	38%	42%	28%	39%	10% decrease (improvement)
KF8	4.00	Not known	4.05	3.84	0.05 increase (scale from 1-5)
KF14	Not available	Not available	3.60	3.31	No comparable information
KF10	3.92	3.81	4.03	3.85	0.11 increase (scale from 1-5)
Bottom 3 Ranking Scores					
KF27	49%	Not known	17%	49%	32% decrease
KF22	22%	18%	23%	21%	1% decrease
KF29	94%	92%	90%	91%	4% decrease

Our bottom three ranking scores were:

- Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse (17% compared to a national average of 49%) **KF27**
- Percentage of staff experiencing physical violence from patients, relatives or public in the last 12 months (23% compared to a national average of 21%) **KF22**
- Percentage of staff reporting errors, near misses or incidents witnessed in the last month (90% compared to a national average of 91%). **KF29**

* This does not include mental health trusts that now also manage community services

Suggested areas for action

We use the feedback from the survey to develop action plans and the areas we intend focussing on are:

- encouraging more staff to report harassment, bullying or abuse
- reducing the number of staff experiencing violence from patients, relatives or the public
- increasing the proportion of staff who report errors, near misses or incidents that they witness.

A Trust composite action plan is currently under development to support suggested areas for improvement. This will be taken to the Board of Directors in May for consideration. Directorates are also considering their own results and forming their own local action plans to support local improvement. Quarterly monitoring takes place via the Investors in People link representatives and biannual updates are provided to the Trust Board.

Health, safety, security, emergency planning and business continuity

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.

Successes in the year include:

- introduction of the health, safety and security workbook as an e-document as a follow up to a two day QIS review in 2014/15
- provision of roadshows and support sessions held for the health, safety and security workbook champions around the Trust
- an audit programme of the health, safety and security e-workbook took place during the year in the following areas:
  - Confirmation that the e-workbook has been implemented by teams
  - Completion of general generic risk assessments
  - Number of first aiders identified in assessments for buildings
- Carrying out a live exercise 'Exercise Three Cathedrals' to test our business continuity plans in conjunction with Cleveland emergency Planning Unit. This exercise was held to test our plans for dealing with hazardous materials, communications with other emergency services and operation of the Trust's Command and Control management arrangements and once again demonstrated resilience in dealing with the events which may impact on our critical services.

Occupational health

Occupational health is provided by North Tees and Hartlepool NHS Foundation Trust. The contract was awarded following a competitive tendering process and includes general occupational health as well as fast track physiotherapy service for staff.

The occupational health service has continued to provide both a responsive and strategic service. They attend the fortnightly sickness case management meetings, coordinate the Trust's annual flu campaign and are active members of Trust groups such as the Health and Wellbeing Strategy Group and the Mindful Employer Group.

A key development during the year was the extension of the service to cover the staff who joined us from York and Selby. The transfer of the service took place on 1 October and arrangements have taken place to ensure that a comprehensive service is provided across the Trust.

Fraud policies and procedures

The Trust has an established anti-fraud and corruption policy which 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.

Staff and consultancy costs

In this annual report we are required to provide certain information about staff costs as follows:

- **Expenditure on consultancy** *(see note 3 to the accounts)*
  Consultancy is defined as "The provision to management of objective advice and assistance relating to strategy, structure, management or operations of an organisation in pursuit of its purposes and objectives."

  Trust expenditure on consultancy in 2015/16 was £472,000.

- **Off-payroll engagements.**
  The required information is set out in the following tables:

Table 1:
For all off-payroll engagements as of 31 March 2016, for more than £220 per day and that last for longer than six months

No. of existing engagements as of 31 March 2016	8
Of which...	
No. that have existed for less than one year at time of reporting.	4
No. that have existed for between one and two years at time of reporting.	0
No. that have existed for between two and three years at time of reporting.	3
No. that have existed for between three and four years at time of reporting.	0
No. that have existed for four or more years at time of reporting.	1

The Trust confirms that all existing off-payroll engagements, outlined above, have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

Table 2:
For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016, for more than £220 per day and that last for longer than six months

No. of new engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016	8
No. of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and National Insurance obligations	8
No. for whom assurance has been requested	8
Of which...	
No. for whom assurance has been received	0
No. for whom assurance has not been received	8
No. that have been terminated as a result of assurance not being received.	0

Table 3:
For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2015 and 31 March 2016

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	8
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure **must** include both off-payroll and on-payroll engagements.	29

- **Exit packages (see notes 4.5 and 4.6 to the Accounts)**

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	1	0	1
£10,000– £25,000	0	0	0
£25,001 – £50,000	0	0	0
£50,001 – £100,000	2	0	2
£100,000 – £150,000	1	0	1
£150,001 – £200,000	0	0	0
Total number of exit packages by type	4	0	4
Total resource cost ('000)	231	0	231

No non-compulsory departure payments were made during the financial year.

- **Fair Pay** *(see the Remuneration Report)*

The median remuneration of all staff	£27,361
The mid-point of the banded remuneration of the highest paid director	£182,500
The ratio between the median remuneration of the reporting entity's staff and the highest paid director figure	6.7

Details of the salaries and allowances and pension benefits of present and past senior managers are included in the Remuneration Report.

"You are a truly amazing team of people. My son is so very lucky to have had your care and valuable support over the years. Don't know how we would have managed without all your input."

from a service user's mother

Remuneration report

Statement from the Chairman of the Board's Nomination & Remuneration Committee

Information on the Board's Nomination and Remuneration Committee is provided in the section on Governance in the Accountability Report.

In 2014/15 the committee agreed an Executive Management Team (EMT) Pay Framework. Details of this policy are set out below.

This Framework does not cover the remuneration of:

- The Chief Executive
- The Medical Director
- Senior Clinical Director for the Kaizen Promotion Office (KPO)
- Those members of the Executive Management Team employed at the time of its introduction who have chosen to remain employed under national Agenda for Change terms and conditions; however they have the option to move under the Framework at any time.

During 2015/16 the committee made a 1% cost of living award to those senior managers covered by the EMT Pay Framework. This award was comparable to the cost of living increase covering most NHS staff on Agenda for Change and national medical and dental terms and conditions of service.

No substantial changes to senior managers' remuneration were made during the year.

Details of the salaries and allowances and pension benefits of senior managers in 2015/16 and payments made to past senior managers are provided in the tables in this section.

Senior managers' remuneration policy

The key features of the Executive Management Team (EMT) Pay Framework and pay arrangements for those senior managers not covered by it, except for those employed under national Agenda for Change and national medical and dental terms and conditions of service are set out in the following table:

Basic pay	The EMT Pay Framework is based on job evaluation point scores provided by Capita using an independent job evaluation system and agreed job descriptions. The pay levels are equivalent to the mid-point of the pay ranges proposed by Capita and are based upon the upper quartile market pay level for Executive Directors in Mental Health and Learning Disabilities NHS Trusts. The maximum amount which could be paid, in total, under the Framework is £1,342,345 The basic pay arrangements support the short and long term strategic objectives of the Trust by enabling it to recruit and retain talented individuals who undertake key leadership roles using levels of remuneration that represent value for money and which are comparable to those of other similar organisations.
Performance related components	In general, the EMT Pay Framework has no performance related components; however, starting salaries of less than the full (spot) amount (typically 7.5%) have been used for new post holders. In these circumstances the full amount becomes payable subject to the post-holder demonstrating good performance in their first year in office taking into account the achievement of objectives and the outcome of their appraisals.
Recruitment and retention premia (RRP)	The Nomination and Remuneration Committee has the option of paying Recruitment and Retention Premia but these should only be paid where there is clear evidence that the payments can be justified. No members of the EMT were paid a RRP during 2015/16.
Allowances	A Directors' Travel Allowance of £5,444 is included within the basic pay.
Provisions for the recovery of sums paid to Directors or for withholding payments of sums to senior managers	There is contractual provision for making appropriate deductions from notice period payments. Entitlement to pay progression is subject to confirmation from the individual's line manager that their performance over the preceding 12 months period has been rated as being good.

The salary of the Chief Executive (including steps taken by the committee to satisfy itself that it is reasonable)	The Chief Executive salary range that is used was determined following consideration of a series of independent reports about NHS foundation trust chief executive basic pay information including the latest report that was produced in January 2016. The January 2016 report identified an average mental health trust chief executive salary of £166,613 based upon an average revenue of £200m and an average workforce of 3,612. TEWV has revenue in excess of £300m and a workforce of 6,700. In addition the complexity of managing TEWV compared to other mental health trusts is increased by the unusually large number of partner organisations within the trust area including eight upper tier local authorities and nine CCGs. The Nomination and Remuneration Committee concluded that given this independent information, and an appreciation of the challenges that the scale and configuration of the trust, meant that to attract and retain a chief executive of appropriate quality would mean offering a salary of more than £142,500.
The Medical Director's allowance	The Medical Director's Allowance was, initially, based on a proportion of the incumbent's remuneration as a consultant but has been increased over time to reflect cost of living awards.
The salary of the Senior Clinical Director of the KPO	The salary of the Senior Clinical Director of the KPO is made up of basic pay as a medical consultant, together with any clinical excellence awards agreed, provided pro rata for contracted hours.

Notes:

- *For 2015/16:*
  - *No new components were introduced into the EMT Pay Framework.*
  - *No changes were made to the existing components of the EMT Pay Framework.*
- *The Trust's policy on senior manager remuneration and the Trust's general policy on employee remuneration are set out in the Pay and Reward Policy Statement which is available on the Trust's website.*

Other Policy Disclosures

- Service Contract Obligations
  Not applicable
- Policy on Payment for Loss of Office
  Senior managers, under the EMT Pay Framework:
  - *Have a contractual entitlement to three months' notice, other than in the case of summary dismissal.*
  - *An entitlement, where eligible, to a redundancy payment in accordance with Section 16 of the National Terms and Conditions of Service.*
- Statement of consideration of employment conditions elsewhere in the Foundation Trust
  A combination of an independent job evaluation scheme, to establish respective job weights, and independently gathered and reported information about Very Senior Manager remuneration levels in comparable trusts were used to establish the EMT Pay Framework.

  CAPITA undertook the job evaluation exercise and provided information about remuneration levels of equivalent posts within comparable organisations. This information has been used by the Nomination and Remuneration Committee to establish and operate the Executive Management Team Pay Framework since 2014 including consideration of updated independent remuneration reports.

  Individual employees directly affected by the Executive Management Team Pay Framework were consulted about the approach being taken and given the opportunity to retain their existing terms and conditions of employment should they wish to do so.

  Consultation about the Trust's Pay and Reward Policy Statement provided an opportunity to help raise awareness amongst other Trust staff and staff representatives of the approach being taken toward Very Senior Manager remuneration.

  In making cost of living awards under the EMT Pay Framework, the Nomination and Remuneration Committee takes into account national cost of living awards to other staff employed by the Trust.

Non-Executive Director Remuneration:

Basic Remuneration	The basic fees payable to the Chairman and Non-Executive Directors have been set by the Council of Governors taking into account information provided by Capita on fees payable by other Foundation Trusts. The Non-Executive Directors have not received an increase in their remuneration since 2013/14.
Additional fees paid for other duties	Additional fees are payable to the Chairman of the Audit Committee and the Senior Independent Director.
Allowances	The Chairman and Non-Executive Directors are able to claim reimbursement of expenses (e.g. travel) in line with Trust policy.

Colin Martin
Chief Executive
24th May 2016

"We were struggling to support one of our clients to maintain good health and wellbeing due to his low mood and lack of motivation. You have provided ideas, support and guidance to us as a team, to enable us to work with him more effectively. The outcome being that his quality of life is so much better. He's happy, healthy and much more motivated."

from the manager of a care provider

Senior managers' remuneration

Name and title	2015-16					
	Salary	Other Remuneration	Benefits in Kind *	Pension related benefits	Total Remuneration	Expenses Paid
	(bands of £5000) £000	(bands of £5000) £000	Rounded to the nearest £100	(bands of £2500) £000	(bands of £5000) £000	Rounded to the nearest £100
Mr Martin Barkley, *Chief Executive*	180-185	0	0	0	180-185	2,300
Mr Colin Martin, *Director of Finance*	120-125	0	9,200	42.5-45.0	175-180	1,300
Mr Brent Kilmurray, *Chief Operating Officer*	120-125	0	0	42.5-45.0	165-170	1,900
Dr Nick Land, *Medical Director* **	35-40	165-170	5,900	132.5-135.0	345-350	2,000
Mr David Levy, *Director of Human Resources and Organisational Development*	105-110	0	0	50.0-52.5	155-160	1,300
Mrs Chris Stanbury, *Director of Nursing and Governance - left 31 July 2015*	40-45	0	800	0	40-45	900
Mrs Elizabeth Moody, *Director of Nursing and Governance - started 01 July 2015*	75-80	0	3,400	162.5-165.0	240-245	1,300
Mrs Jennifer Illingworth, *Director of Quality Governance - started 18 May 2015*	75-80	0	3,100	130.0-132.5	210-215	1,200
Mr Chris Parsons, *Director of Estates and Facilities***** - left 7 April 2015*	0	0	0	0	0	0
Mrs Sharon Pickering, *Director of Planning, Performance and Communications*	95-100	0	6,100	67.5-70.0	170-175	1,600
Dr Ruth Briel, *Senior Clinical Director, Kaizen Promotion Office* ***	65-70	20-25	0	25.0-27.5	110-115	4,000
Mr Paul Newton, *Director of Operations - County Durham and Darlington - (seconded from 07 June 2015 and retired on 02 February 2016)*	25-30	0	800	0	25-30	100
Ms Jo Dawson, *Acting Director of Operations - County Durham and Darlington - started 08 June 2015 to 31 January 2016*	55-60	0	1,200	25.0-27.5	80-85	800
Mr Patrick Scott, *Director of Operations - County Durham and Darlington - started 01 February 2016*	15-20	0	300	7.5-10.0	25-30	400
Mr David Brown, *Director of Operations – Teesside*	100-105	0	4,300	17.5-20.0	120-125	700
Mr Levi Buckley, *Director of Operations – Forensic Services*	95-100	0	0	32.5-35.0	125-130	400
Mrs Adele Coulthard, *Director of Operations – North Yorkshire*	95-100	0	1,400	77.5-80.0	175-180	1,300
Mr Phil Bellas, *Trust Secretary*****	80-85	0	0	47.5-50.0	130-135	0
Mr Rob Cowell, *Director of Operations - Estates and Facilities Management*	90-95	0	2,700	130.0-132.5	225-230	2,300
Mrs Ruth Hill, *Project Director (01 October 2014 - 30 September 2015) and Director of Operations - York and Selby started 1 September 2015*	90-95	0	0	52.5-55.0	145-150	800
Mrs Jo Turnbull, *Chairman - left 31 March 2014*	0	0	0	0	0	0
Mrs Lesley Bessant, *Chairman*	50-55	0	0	0	50-55	4,400
Mrs Barbara Matthews, *Non-Executive Director*	10-15	0	0	0	10-15	2,700
Mr Mike Newell, *Non-Executive Director - left 31 March 2015*	0	0	0	0	0	400
Mr John Robinson, *Non-Executive Director - left 31 August 2015*	5-10	0	0	0	5-10	700
Mr Jim Tucker, *Non-Executive Director*	10-15	0	0	0	10-15	3,900
Mr Richard Simpson, *Non-Executive Director*	10-15	0	0	0	10-15	3,600
Mr Marcus Hawthorn, *Non-Executive Director (Senior Independent Director from 01 September 2015)*	15-20	0	0	0	15-20	100
Mr David Jennings, *Non Executive Director - started 1 September 2014*	10-15	0	0	0	10-15	1,300
Dr Hugh Griffiths, *Non-Executive Director - started 1 April 2015 (Associate Non Executive Director from 1 September 2014 to 31st March 2015)*	10-15	0	0	0	10-15	1,700

Band of highest paid directors total remuneration (£000) ****	180-185
Median of total remuneration	27,361
Ratio (Director to Median)	6.7

The above table shows the remuneration for time worked as a senior manager only. Where this was for part year (dates shown in table) the table reflects this.

* 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 2015-16 (£29k for 2014-15) & Clinical Excellence award

*** Other remuneration includes Additional Clinical Programmed Activity worked during the reported period (For which £5k was paid during 2015-16, £6k for 2014-15) & 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.

***** Trust Secretary role was added to Senior Manager status 01 January 2015

****** restated following additional guidance

Expenses of Governors

At 31 March 2016 the Trust had 46 Governors (2014-15, 43), with 23 receiving reimbursement of expenses (2014-15, 28). The total amount reimbursed as expenses was £6,856, (£9,548 in 2014-15)

Pay Terms and Conditions

Colin Martin
Chief Executive
24th May 2016

2014-15					
Salary	**Other Remuneration**	**Benefits in Kind ***	**Pension related benefits**	**Total Remuneration**	**Expenses Paid**
(bands of £5000) £000	**(bands of £5000) £000**	**Rounded to the nearest £100**	**(bands of £2500) £000**	**(bands of £5000) £000**	**Rounded to the nearest £100**
180-185	0	0	0	180-185	2,600
120-125	0	8,900	57.5-60.0	190-195	1,300
120-125	0	0	22.5-25.0	145-150	5,900
35-40	170-175	7,800	55.0-57.5	270-275	2,600
105-110	0	0	15.0-17.5	120-125	300
105-110	0	2,900	0	110-115	2,300
0	0	0	0	0	0
0	0	0	0	0	0
0-5	0	0	0	0-5	400
90-95	0	5,600	45.0-47.5	145-150	1,300
65-70	15-20	0	60.0-62.5	140-145	4,400
100-105	0	600	0	100-105	1,700
0	0	0	0	0	0
0	0	0	0	0	0
100-105	0	2,100	12.5-15.0	115-120	200
90-95	0	0	40.0-42.5	130-135	200
90-95	0	900	40.0-42.5	130-135	0
15-20	0	0	15.0-17.5	35-40	0
85-90	0	2,000	65.0-67.5	150-155	1,400
40-45	0	500	37.5-40.0	80-85	400
0	0	0	0	0	800
50-55	0	0	0	50-55	4,200
10-15	0	0	0	10-15	2,900
10-15	0	0	0	10-15	1,200
15-20	0	0	0	15-20	1,600
10-15	0	0	0	10-15	5,100
10-15	0	0	0	10-15	3,300
15-20	0	0	0	15-20	200
5-10	0	0	0	5-10	400
5-10	0	0	0	5-10	500

Band of highest paid directors total remuneration (£000) ****	180-185
Median of total remuneration	26,139
Ratio (Director to Median)******	7.0

"I cannot express enough my gratitude and thanks for all the support and flexibility that your team has shown to safer custody matters at the prison. The support I have received from your team has been excellent, and the best example of inter-disciplinary working. I have no doubt in my mind that this has saved lives."

from a HM prison manager

Senior managers' pension benefits

Name and title	Real increase in pension at retirement age for time in post (bands of £2500) £000	Real increase in pension lump sum at retirement age for time in post (bands of £2500) £000	Total accrued pension at retirement age at 31 March 2016 (bands of £5000) £000	Lump sum at retirement age related to accrued pension at 31 March 2016 (bands of £5000) £000
Mr Martin Barkley*, *Chief Executive*	0	0	0	0
Mr Colin Martin, *Director of Finance*	0.0-2.5	5.0-7.5	45-50	140-145
Mr Brent Kilmurray, *Chief Operating Officer*	0.0-2.5	(0.0-2.5)	30-35	85-90
Dr Nick Land, *Medical Director*	5.0-7.5	17.5-20.0	80-85	245-250
Mrs Chris Stanbury, *Director of Nursing and Governance - left 31 July 2015*	0	0	0	0
Mrs Elizabeth Moody, *Director of Nursing and Governance - started 01 July 2015*	5.0-7.5	20.0-22.5	35-40	110-115
Mrs Jennifer Illingworth, *Director of Quality Governance - started 18 May 2015*	5.0-7.5	12.5-15.0	20-25	65-70
Mrs Sharon Pickering, *Director of Planning, Performance and Communications*	2.5-5.0	2.5-5.0	30-35	95-100
Mr David Levy, *Director of Human Resources and Organisational Development*	0.0-2.5	5.0-7.5	25-30	75-80
Dr Ruth Briel, *Director of Kaizan*	0.0-2.5	2.5-5.0	35-40	105-110
Mr Phillip Bellas, *Trust Secretary*	0.0-2.5	0.0-2.5	10-15	25-30
Mr Rob Cowell, *Director of Estates - started 01 April 2014*	5.0-7.5	15.0-17.5	35-40	115-120
Mrs Ruth Hill, *Project Director - started 01 October 2014*	2.5-5.0	2.5-5.0	25-30	70-75
Mr Paul Newton, *Director of Operations - County Durham and Darlington - (seconded from 07 June 2015 and retired on 02 February 2016)*	0	0	0	0
Ms Jo Dawson, *Acting Director of Operations - County Durham and Darlington - started 08 June 2015 to 31 January 2016*	0.0-2.5	0.0-2.5	15-20	50-55
Mr Patrick Scott, *Director of Operations - County Durham and Darlington - started 01 February 2016*	0.0-2.5	0.0-2.5	20-25	65-70
Mr David Brown, *Director of Operations – Teesside*	0.0-2.5	0.0-2.5	35-40	110-115
Mr Levi Buckley, *Director of Operations – Forensic Services*	2.5-5.0	(30.0-32.5)	25-30	30-35
Mrs Adele Coulthard, *Director of Operations – North Yorkshire*	2.5-5.0	5.0-7.5	30-35	85-89

* Martin Barkley opted out of the NHS Pension Scheme 01 March 2014

Cash Equivalent Transfer Value at 31 March 2016	Cash Equivalent Transfer Value at 31 March 2015	Real Increase in Cash Equivalent Transfer Value for time in post
£000	£000	£000
0	2,170	(2,170)
856	818	38
462	440	22
1,646	1,519	127
0	1,097	(1,097)
611	446	124
379	270	94
564	517	47
532	483	49
659	631	28
162	133	29
760	643	117
392	360	32
0	1,032	(1,032)
249	223	16
360	314	7
766	744	22
273	327	(54)
541	484	57

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.

On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0% to 2.8%. This rate affects the calculation of CETV figures in this report. Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension scheme are based on the previous discount rate and have not been recalculated.

The reason for the negative increase in pension and lump sum for two senior managers is due to the inflation factor used (1.2%) being higher than the percentage growth in benefits.

Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Real increases are shown pro rata for the period employees were working as a senior manager for the Trust. If an employee left post, or started a role midway through the year.

Colin Martin
Chief Executive
24th May 2016

Governance including the Foundation Trust Code of Governance Disclosures

In this section we give details of our governance structure. We explain who sits on the Board of Directors and Council of Governors, how they operate and the areas they have focussed on during the year. We also report on the work of the Board's committees.

On 1st April 2016 the health sector regulator, Monitor, combined with the Trust Development Authority to form NHS Improvement. For ease of reference the name of the new regulator has been used in this section.

The Foundation Trust Code of Governance including the Statement on the Application of the Code

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

Tees, Esk and Wear Valleys NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

Under the Code of Governance 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.	54
A.1.1	A statement on how disagreements between the Council of Governors and Board of Directors should be resolved	54 - 55
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	35 - 36, 59, 62 & 68
A.1.2	The number of meetings of the Board of Directors and the Audit, Remuneration and Nominations Committees and individual attendance by directors	56, 59, 62 & 68
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.	66 - 67
A.5.3	The name of the Lead Governor.	64
B.1.1	The names of the non-executive directors whom the Board determines to be independent, with reasons where necessary.	35 - 36 & 55
B.1.4	A description of each director's skills, expertise and experience.	35 - 36
B.1.4	A statement about the Board of Directors' balance, completeness and appropriateness to the requirements of the NHS foundation trust.	55
B.2.10	A description of the work of the Nominations Committee(s) including the process used in relation to board appointments.	62 & 68
B.3.1	The other significant commitments of the Chairman and any changes to them during the year.	35 & 55
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.	69
B.6.1	A statement on how the performance evaluation of the board, its committees and its directors, including the Chairman, has been conducted.	57
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.	Not applicable
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.	55
C.1.1	A statement from the External Auditors about their reporting responsibilities	124 - 125
C.1.1	An explanation from the directors of their approach to quality governance in the annual governance statement.	72 - 75
C.2.1	A report that the Board has conducted a review of the effectiveness of the Trust's system of internal controls.	54
C.2.2	Information on how the internal audit function is structured and the role it performs.	60 - 61
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.	Not applicable
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.	60 - 61
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.	Not applicable
E.1.4	Contact procedures for members who wish to communicate with governors and/or directors.	69
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.	57
E.1.6	A report on the representativeness of Trust's membership and the level and effectiveness of member engagement.	69

The latest version of the code of governance is available on NHS Improvement's website: www.improvement.nhs.uk

"When I first met the team I was a person in the dark. I was someone who would not even get out of bed to set the children out to school, all I did was sleep. Now I am a mother, wife, a positive person who believes that tomorrow will be here for me and I'm ready and waiting."

from a service user

How the Trust is governed

The governance arrangements of foundations trusts, as public benefit corporations, are set out in Schedule 7 of the National Health Service Act 2006, as amended. Under this Act the Trust must have:

- a legally binding constitution
- a non-executive Chairman
- a Board of Directors comprising Non-Executive and Executive Directors
- A Council of Governors comprising elected public and staff governors and governors appointed by key stakeholder organisations
- A public and staff membership.

The Chairman of the Trust leads both 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 NHS Improvement 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 a panel established by NHS Improvement 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 and task and finish groups. including the Council of Governors' Nomination and Remuneration Committee support this work.

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
- 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.

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

A process has been established for the resolution of disputes between the Board and the 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 NHS Improvement or the Care Quality Commission of relevant concerns.

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

The Board of Directors

Under our Constitution our Board of Directors comprises:

- a Non-Executive Chairman
- five to seven Non-Executive Directors
- five Executive Directors which must include the Chief Executive (as the accounting officer), the Finance Director, a registered medical practitioner (the Medical Director) and a registered nurse (the Director of Nursing and Governance).

Information on the Board Members as at 31 March 2016, including details of their skills and expertise, is provided in the Accountability Report.

The Trust's Corporate Directors, the Director of Planning, Performance and Communications and the Director of Human Resources and Organisational Development, attend meetings of the Board in a non-voting capacity.

The Board considers that, as at 31 March 2016:

- its composition meets the requirements of the National Health Service Act 2006 and the constitution and is appropriate for the organisation
- all its members are "fit and proper" persons to be directors of the Trust in accordance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- there is an appropriate balance and breadth of skills, knowledge and experience amongst the Non-Executive Directors
- all the Non-Executive Directors meet the independence criteria set out in the Foundation Trust Code of Governance.

The Chairman had no other significant commitments and this position did not change during 2015/16.

Statement on the directors' responsibility for preparing the annual report and accounts

The Directors are required under the National Health Service Act 2006, and as directed by NHS Improvement, to prepare accounts for each financial year.

NHS Improvement, 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. NHS Improvement further directs that the accounts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual that is in force for the relevant financial year, which shall be agreed with HM Treasury.

In preparing these accounts, the Directors are required to apply on a consistent basis, for all items considered material in relation to the accounts, accounting policies contained in the NHS Foundation Trust Annual Reporting Manual issued by NHS Improvement 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.

Each of the directors, holding office on 31st March 2016, confirms that 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.

Attendance at Board meetings

The following table provides details of the attendance at the 14 meetings of the Board of Directors held during 2015/16:

Board Member	Position	No. of Board Meetings attended*
Lesley Bessant	• Chairman of the Trust • Chairman of the Board's Nomination and Remuneration Committee • Chairman of the Council of Governor's Nomination and Remuneration Committee • Chairman of the Commercial Oversight Committee	14
Martin Barkley	• Chief Executive	13
Jim Tucker	• Non-Executive Director • Deputy Chairman • Chairman of the Investment Committee	14
John Robinson	• Non-Executive Director • Chairman of the Quality Assurance Committee • Senior Independent Director	4 (6)
Marcus Hawthorn	• Non-Executive Director • Chairman of the Audit Committee • Senior Independent Director (from 1/10/15)	12
Hugh Griffiths	• Non-Executive Director • Chairman of the Quality Assurance Committee	13
David Jennings	• Non-Executive Director	10
Barbara Matthews	• Non-Executive Director	12
Richard Simpson	• Non-Executive Director • Chairman of the Mental Health Legislation Committee	14
Brent Kilmurray	• Chief Operating Officer	11
Nick Land	• Medical Director	13
Colin Martin	• Director of Finance and Information • Deputy Chief Executive	13
Chris Stanbury	• Director of Nursing and Governance (to 31/7/15)	3 (5)
Elizabeth Moody	• Director of Nursing & Governance (from 1/8/15)	8 (9)
David Levy*	• Director of Human Resources and Organisational Development	12
Sharon Pickering*	• Director of Planning, Performance and Communications	12

Notes:

1 ** Indicates that the Director holds a non-voting position on the Board of Directors*

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

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
- updates provided by the Chairman and Directors at Board meetings
- attendance by Governors at Directors' visits to services (bi-monthly)
- governors are encouraged to attend public meetings of the Board of Directors
- attendance at Governor development days.

Marcus Hawthorn, 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.

In general, with regard to attendance at meetings of the Council of Governors:

- the Chairman attends all meetings
- there is a standing invitation for the Non-Executive Directors to attend meetings
- Executive and Corporate Directors attend meetings if required, for example to deliver reports, or as observers.

The Council of Governors also has powers to require attendance of a Director at any of its meetings, under paragraph 26 (2) (aa) of Schedule 7 of the National Health Service Act 2006, for the purpose of obtaining information on the Foundation Trust's performance of its functions or the directors' performance of their duties. The Council of Governors did not exercise these powers during 2015/16.

In total the Council of Governors held seven meetings (including the annual general meeting) during 2015/16. However, only Mrs. Bessant attended one of these as it was a special meeting to approve the appointment of the Chief Executive.

Attendance by Board Members at the Council of Governors meetings held in 2015/16 was as follows:

Name	Attended
Lesley Bessant	7
Dr Hugh Griffiths	4
Marcus Hawthorn	4
David Jennings	2
Barbara Matthews	4
John Robinson	1 (3)
Richard Simpson	5
Jim Tucker	5
Martin Barkley	5
Brent Kilmurray	5
Nick Land	2
David Levy	5
Colin Martin	4
Elizabeth Moody	2 (4)
Sharon Pickering	6
Chris Stanbury	2(3)

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

Evaluating Board performance

The Board's performance is evaluated using a scheme initially developed by Deloitte LLP.

In 2015/16 this included assessments of the performance of:

- the Chairman by all other Board Members
- the Chairman by a focus group of Governors on those aspects of her role which relate to the Council of Governors.
- each Board Member by the Chairman and two Non-Executive Directors and two Executive Board Members drawn at random
- the Board of Directors by all Board Members
- the Audit Committee, the Investment Committee, the Mental Health Legislation Committee and the Quality Assurance Committee by the members of those committees.

The outcomes of the individual performance evaluations are used to inform the appraisals of Board Members.

The outcomes of the collective Board assessment and those of its committees are reviewed by the Board to identity any developmental requirements.

The evaluation built upon the independent external review conducted by Deloitte LLP in 2013/14; however, no external consultancy was engaged to support the Board performance evaluation in 2015/16.

Terms of Office of the Chairman and Non-Executive Directors and how their appointments can be terminated

The terms of office for the Chairman and Non-Executive Directors are usually for three years. They will be appointed for a second term of office, without the need for external competition, unless they fail to meet performance, independence or regulatory requirements or the skills and experience required on the Board have changed since their initial appointment. They may also be appointed to serve for more than six years (two three year terms) if it is in the Trust's interest for them to do so and the reasons for this must be approved by the Council of Governors.

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
- if they cease to be a fit and proper person to be a Director of the Trust in accordance with the Licence, the Constitution or the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Reports of the Board's Committees

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

Each committee has terms of reference, including reporting requirements, which have been approved by the Board. Copies of the terms of reference are available in our Integrated Governance Framework which is published 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 overarching responsibility for providing assurance to the Board on the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

The responsibilities of the Audit Committee also include:

- reviewing the adequacy of all risk and control disclosure statements (e.g. the annual governance statement) prior to endorsement by the Board
- ensuring the internal audit function is effective, meets mandatory NHS internal audit standards and provides appropriate independent assurance
- making recommendations to the Council of Governors on the appointment, re-appointment or removal of the external auditor
- making recommendations to the Council of Governors on the terms of engagement of the external auditor and reviewing and monitoring the performance, independence and objectivity of the external auditor
- reviewing the work and findings of the external auditor and considering the implications and management responses to their work
- reviewing the findings of other assurance functions, both internal and external to the organisation (e.g. the Care Quality Commission, NHS Improvement, etc.) and considering the implications for the governance of the Trust
- reviewing and monitoring the integrity of any financial statements including any financial judgements contained in them and ensuring the completeness and accuracy of information provided to the Board
- reviewing arrangements by which staff may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters (the whistleblowing policy).
- overseeing counter fraud activities and monitoring compliance with the Bribery Act 2010
- commissioning value for money studies.

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:

Marcus Hawthorn (Chairman)	5
Hugh Griffiths	4
David Jennings	3
Richard Simpson	5

The Director of Finance, the External Auditors and representatives of the Head of Internal Audit generally attend all meetings of the committee. The Trust Secretary is the secretary to the committee.

At least once a year, members of the committee are required to meet privately with the external and internal auditors without management being present.

"I have thoroughly enjoyed this placement; it gave me the opportunity to learn things not taught from a text book. You taught me valuable skills and showed me the meaning of commitment, hard work and dedication."

from a student

"It was your personal and very gentle and respectful approach to my diagnosis and subsequent therapeutic interventions that helped me so much. You made me aware of my condition and what it would mean to me in the future and worked with me to help me to develop the skills I need."

from a service user

The work of the Audit Committee in discharging its responsibilities

A key role of the committee is to monitor, oversee and provide assurance to the Board on the conduct of the audit of the Annual Report and Accounts.

For the year ended 31st March 2016 the committee has:

- reviewed the terms of engagement with the External Auditors; these were subsequently approved by the Council of Governors on the recommendation of the committee.
- approved the External Auditors' Audit Strategy Memorandum and Strategic Audit Plan and received progress reports on the conduct of the audit
- approved the Protocol for Liaison between the Internal and External Auditors including those areas of Internal Audit's work of specific interest to the External Auditors for reliance
- reviewed and assured the Board that the Trust is, and is expected to remain, a "going concern" and that the Accounts should be prepared on that basis
- approved the schedule of losses and special payments as part of the Annual Accounts process
- received the Annual Report of the Head of Internal Audit and considered its findings in relation to the Annual Governance Statement
- reviewed and commented on the Annual Governance Statement.

In its review of the Annual Report and Accounts the committee took into account the External Auditors' findings arising from the audit and the limited (scope) review of the Quality Account. In doing so the committee paid particular attention to:

- the audit conclusions in relation to the significant risks and key areas of management judgement outlined in the Audit Strategy Memorandum
- internal control issues identified from the transfer of staff from the York and Selby area and management's response to them
- property valuation, noting that the impairments in 2015/16 had been reported and explained to the Board.

During the 2015/16 financial year the committee has also:

- sought and gained assurance on the development, coverage and resources available to deliver the clinical audit programme and received half yearly progress reports on its implementation
- considered and commented on the draft Raising Concerns/Whistleblowing Procedure, taking into account the recommendations of the national report "Freedom to Speak Up" by Sir Robert Francis QC
- reviewed and provided assurance to the Board on its ability to sign off certificates and the statements required by NHS Improvement both in relation to the annual plan and the York and Selby transaction
- reviewed the strategic and operational internal audit plans ensuring that these were aligned to the principal risks facing the Trust and could be adequately resourced
- 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. The committee has drawn the Board's attention to those matters which it considers have implications for the Trust's assurance framework
- 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 and put in place arrangements for the induction and development of members of the committee
- considered corporate governance and accounting developments
- considered, in conjunction with representatives of the Council of Governors, the performance of, and the future contractual relationship with, the External Auditors.

The external auditors

Mazars LLP was appointed by the Council of Governors, on the recommendation of a working group comprising the Audit Committee and Governors, as the Trust's External Auditors in 2013 for three years following competitive tendering.

During 2015/16, a working group comprising Members of the Committee and representatives of the Council of Governors, considered whether the contract with Mazars LLP should be extended for a further two years (as allowed) or retendered. Taking into account the satisfactory performance of the firm, following a review against criteria developed from the contract specification, the working group recommended to the Council of Governors that the contract with Mazars LLP for the provision of external audit services should be extended for two years i.e. until the completion of the 2017/18 audit. The working group's recommendation was subsequently approved by the Council of Governors.

The cost of providing external audit services during 2015/16 was £40,000 excluding VAT. This included the cost of the statutory audit, the review of the quality account, the independent review of the accounts of the charitable funds and the whole Government accounting return.

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 Stuart Fallowfield ACCA, 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.

The Nomination and Remuneration Committee of the Board

The Nomination and Remuneration Committee is responsible for overseeing the appointment of Executive Directors and directors who report directly to the Chief Executive and is responsible for deciding their terms and conditions of service (where these are not determined nationally). The committee is also responsible for authorising applications to NHS Improvement and HM Treasury for permission to make special severance payments to an employee or former employee.

The membership of the committee comprises the Chairman of the Trust and all the Non-Executive Directors. The Chief Executive is also an ex officio member of the committee in relation to all matters pertaining to the appointment of those Director positions which fall within its remit.

Advice and/or services were provided to the committee by David Levy, Director of Human Resources and Organisational Development and Phil Bellas, Trust Secretary. No external advice or support was commissioned by the committee during 2015/16.

During 2015/16 the Nomination and Remuneration Committee

- Approved applications to Monitor to make severance payments in two cases
- Agreed the recruitment process for the appointment of the new Chief Executive
- Approved changes to the terms and conditions of service for certain directors in accordance with the Executive Pay Framework and applicable national guidance
- Approved the Trust Process for the Fit and Proper Persons Test
- Approved the annual uplift to be applied to the remuneration of the Executive and other relevant Directors.

The committee met 4 times during the year. Attendance by each member was as follows:

Name	Attended
Lesley Bessant	7
Hugh Griffiths	4
Marcus Hawthorn	4
David Jennings	2
Barbara Matthews	3
John Robinson	1 (1)
Richard Simpson	4
Jim Tucker	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

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 and ensuring their alignment to the business development strategy
- considering and providing assurance to the Board on the appropriateness and robustness of the medium term financial strategy, the estates and facilities management framework and the information strategy
- monitoring the implementation of the business development strategy
- undertaking in-year monitoring of capital expenditure
- reviewing proposals (including evaluating risks) for major business cases and their respective funding sources
- reviewing the management and administration of Charitable Funds held by the Trust
- monitoring progress towards the achievement of the "upside" scenarios included in the business plan.

As at 31 March 2016 the membership of the committee comprised:

- Jim Tucker, Non-Executive Director (Chairman of the Committee)
- Lesley Bessant, Chairman of the Trust
- Marcus Hawthorn, Non-Executive Director
- Barbara Matthews, Non-Executive Director
- Martin Barkley, Chief Executive
- Brent Kilmurray, Chief Operating Officer
- Colin Martin, Director of Finance and Information
- Sharon Pickering, Director of Planning, Performance and Communications

The committee met seven times during the year.

During 2015/16 the committee:

- monitored and provided assurance to the Board on the Trust's capital expenditure and business development and tendering activities
- reviewed the Trust's financial strategy and capital funding options
- reviewed and recommended the following developments to the Board:
  - the outline business case for the further development of the PARIS Electronic Care Record system which aimed to improve clinical record keeping and increase the time available for face to face care with patients
  - the outline business case for the further development of the Integrated Information Centre
  - the outline and full business cases for the re-provision of inpatient accommodation in Harrogate
  - the full business case for the reprovision of CMHT accommodation at Parkside in Middlesbrough
  - the business case to upgrade the Trust's Community of Interest Network (COIN)
- received assurance and made a recommendation to the Board in relation to the transfer of the Durham PCT Charitable Funds to the County Durham Community Foundation
- approved the establishment of a limited liability company, "North East Transformation System Limited" to be jointly owned with Gateshead Health NHS Foundation Trust.

Mental Health Legislation Committee (MHLC)

The duties of the committee are:

- to provide assurance to the Board on the Trust's compliance with the Mental Health Act 1983 and the Mental Capacity Act 2005, including any statutory Codes of Practice relating thereto, by:
  a. reviewing activity and performance with appropriate comparisons and trends; and
  b. identifying common themes arising from the findings of the Care Quality Commission following visits to the Trust's services and to escalate risk and propose mitigating actions to the Board where assurance is lacking *(NOTE: Oversight and monitoring of actions in response to recommendations received from the Care Quality Commission falls within the remit of the Quality Assurance Committee)*
- to consider the implications of any changes to statute, including statutory Codes of Practice, or case law relating to the Trust's responsibilities as a provider of mental health services and to make recommendations, as required, for changes to the Trust's policies, procedures and practice
- to ensure appropriate arrangements are in place for the appointment and appraisal of associate managers and oversee managers' hearings
- to consider other matters at the request of the Board of Directors.

During the year MHLC met in April 2015, July 2015, October 2015 and January 2016.

As at 31 March 2016 the membership of the committee comprised:

- Richard Simpson, Non-Executive Director (Chairman of the Committee)
- Hugh Griffiths, Non-Executive Director
- Lesley Bessant, Trust Chairman
- Nick Land, Medical Director
- Brent Kilmurray, Chief Operating Officer
- Elizabeth Moody, Director of Nursing and Governance
- Two Public Governors (as representatives of service users and carers)

The Quality Assurance Committee

The Quality Assurance Committee (QuAC) is the principal provider of assurance to the Board on quality, in particular, to ensure compliance with the fundamental standards prescribed in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The committee receives regular assurance reports from the Locality Management and Governance Boards and the corporate assurance groups in accordance with the Trust's quality governance arrangements.

(Further information on the Trust's quality governance arrangements is provided in the Directors' Report.)

As at 31 March 2016 the membership of the committee comprised:

- Hugh Griffiths, Non-Executive Director (Chairman of the Committee)
- Lesley Bessant, Chairman of the Trust
- David Jennings, Non-Executive Director
- Barbara Matthews, Non-Executive Director
- Richard Simpson, Non-Executive Director
- Jim Tucker, Non-Executive Director
- Martin Barkley, Chief Executive
- Brent Kilmurray, Chief Operating Officer
- Nick Land, Medical Director
- Elizabeth Moody, Director of Nursing and Governance
- Jennifer Illingworth, Director of Quality Governance

The Directors of Operations and Deputy Medical Directors attend, for the whole meeting, when the reports of their Locality Management and Governance Boards are considered by the committee.

The committee met 10 times during 2015/16.

Information on the Trust's progress against its quality priorities is included in the Quality Account.

The Commercial Oversight Committee

The Board established the Commercial Oversight Committee to oversee and provide assurance to the Board on the operation of the Trust's subsidiaries and trading vehicles.

The committee comprises:

- Lesley Bessant, Chairman of the Trust (Chairman of the Committee)
- Marcus Hawthorn, Chairman of the Audit Committee
- Jim Tucker, Chairman of the Investment Committee
- Nick Land, Medical Director

During 2015/16 the committee met three times to monitor the development of the Trust's subsidiary, Positive Independent Proactive Support Ltd.

Council of Governors

Report of the Lead Governor

The lead governor has a role to play in facilitating direct communication between NHS Improvement and the NHS foundation trust's council of governors. This will be in a limited number of circumstances and, in particular, where it may not be appropriate to communicate through the normal channels, which in most cases will be via the chairperson or the trust secretary.

Further details on this role are set out in Appendix B to the Code of Governance.

The Lead Governor of the Trust is Cllr Ann McCoy.

Report from the lead governor on the work of the Council of Governors during 2015/16

As lead Governor I have responsibilities to Monitor and the Care Quality Commission. As I have been able to report since this post was created, there have been no concerns with any aspects of the appointment process in the Trust or non-compliance with the constitution, and there have been no concerns about the capability of the Chair.

Following a review of the sub- committee system we now have task and finish groups and the Trust working groups. The work of these groups is to look at issues that the Council of Governors has prioritised and these are proving to be more targeted, focused and efficient. Projects are

- member and stakeholder representation and engagement
- spirituality
- workforce and development
- patient experience
- equality and diversity
- environmental strategy.

All the groups regularly report to the Council of Governors to ensure all Governors are aware of the issues being reviewed and are given the opportunity to question or comment on the reports.

Governors continue to enhance their skills and knowledge through training and development sessions, some of which are mandatory, to enable them to exercise their role effectively and efficiently. Governors have also undertaken visits to some of the in-patient establishments.

Governors also continue to ask questions of either concern or that require explanation and information at Council of Governors' meetings and we appreciate the Trust being open and honest in the responses we receive.

The Council of Governors understands and appreciates that this has been another challenging year due once again to funding issues and changes to legislation, but the Trust has a robust financial system in place which is presented to Governors at every meeting.

There has been added pressure with the Trust's expansion into York and Selby and the sudden closure of Bootham Park Hospital, but we recognise the commitment and dedication of staff and the Board to continue to provide services of the highest standard for patients and carers.

Finally on behalf of the Council of Governors I would like to record our thanks to the outgoing Chief Executive, Martin Barkley, for his commitment and dedication during his time with the Trust and wish him well for the future.

We would also like to congratulate Colin Martin on his appointment as the new Chief Executive. The Council of Governors had the opportunity to be part of the appointment process and we look forward to working with him in his new role.

The Composition of the Council of Governors as at 31st March 2016

Membership of the Council of Governors during 2015/16

The terms of office of Governors and their attendance at the seven meetings (including the Annual General Meeting) held during 2015/16 was as follows:

Public Governors (Elected)

Name	Constituency	Term of Office From	To	Total Attended
Andrea Goldie	Darlington	01/07/2014	30/06/2017	7
Dennis Haithwaite	Darlington	12/11/2014	30/06/2017	3
Mary Booth	Middlesbrough	01/07/2014	30/06/2017	6
Catherine Haigh	Middlesbrough	01/07/2013	30/06/2016	7
Judith Webster	Scarborough and Ryedale	01/07/2014	30/06/2017	4
Keith Marsden	Scarborough and Ryedale	01/07/2013	30/06/2016	3 (4)
Richard Thompson	Scarborough and Ryedale	01/07/2014	30/06/2017	2
Claire Farrell	Redcar and Cleveland	01/07/2014	30/06/2017	0 (4)
Vanessa Wildon	Redcar and Cleveland	15/07/2013	30/06/2016	7
Gillian Restall	Stockton-on-Tees	01/07/2014	30/06/2017	7
Paul Emerson-Wardle	Stockton-on-Tees	12/11/2014	30/06/2017	4
Gary Emerson	Stockton-on-Tees	01/07/2013	30/06/2016	6
Janice Clark	Durham	01/07/2014	30/06/2016	6
Betty Gibson	Durham	01/07/2014	30/06/2017	6
Sarah Talbot-Landon	Durham	12/11/2014	30/06/2016	4 (5)
Cliff Allison	Durham	01/07/2014	30/06/2017	6
Vince Crosby	Durham	01/07/2013	01/02/2016	4
Mark Williams	Durham	01/07/2013	30/06/2016	5
Zoe Sherry	Hartlepool	01/07/2014	30/06/2017	4
Jean Rayment	Hartlepool	01/07/2013	30/06/2016	7
Angela Stirk	Hambleton and Richmondshire	01/07/2014	30/06/2017	3
Colin Wilkie	Hambleton and Richmondshire	01/07/2014	30/06/2017	7
Hilary Dixon	Harrogate and Wetherby	01/07/2013	30/06/2016	6
Chris Gibson	Harrogate and Wetherby	01/07/2013	30/06/2016	4
Sandy Taylor	Harrogate and Wetherby	01/07/2013	30/06/2016	7
Mina Shreekant Bobdey	Rest of England	19/02/2016	30/06/2018	0 (0)

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

Staff Governors (Elected)

Name	Constituency	Term of Office From	To	Total Attended
Judith Hurst	Corporate	01/07/2014	30/06/2017	6
Simon Hughes	Teesside	01/07/2014	30/06/2017	6
Wendy Pedley	North Yorkshire	10/10/2014	30/06/2017	0
Jacqui Dyson	County Durham and Darlington	10/10/2014	30/06/2017	1
Glenda Goodwin	Forensic	10/10/2014	30/06/2017	7
Gary Matfin	York and Selby	09/02/2016	30/06/2018	1 (1)

** 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

Name	Constituency	Date appointed	Total Attended
Debbie Newton	Hambleton, Richmondshire and Whitby Clinical Commissioning Group / Scarborough and Ryedale Clinical Commissioning Group / Harrogate Clinical Commissioning Group / Vale of York Commissioning Group	11/04/2013	2
John Drury	Hartlepool and Stockton-on-Tees Clinical Commissioning Group / NHS South Tees Clinical Commissioning Group	01/07/2014	2
David Smart	North Durham Clinical Commissioning Group / Durham Dales, Easington and Sedgefield Clinical Commissioning Group / Darlington Clinical Commissioning Group	25/09/2014	4
Marion Grieves	University of Teesside	29/04/2015	4
Prof Pali Hungin	Durham University	01/07/2014	5
Richenda Broad	Middlesbrough Council	01/07/2014	1
Cllr Ann McCoy	Stockton Borough Council	08/07/2014	7
Cllr Stephen Akers-Belcher	Hartlepool Borough Council	15/08/2014	0
Kevin Kelly	Darlington Borough Council	13/08/2015	1 (3)
Lesley Jeavons	Durham County Council	01/07/2014	1
Cllr Tony Hall	North Yorkshire County Council	01/07/2014 (to 23/3/16)	4
Prof Ian Watt	The University of York	01/07/2014	0
Helen Douglas	York City Council	29/03/2016	0 (0)

The maximum number of meetings to be attended for those Governors who held office during parts of the year is shown in brackets.

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 2015/16

Constituency Name	Date of Election	No. of Seats	No. of Candidates	No. of Votes Cast	No. of eligible voters	Turnout (%)
County Durham	24/03/16	1	0	-	-	-
York	24/03/16	3	4	38	330	11%
Selby	24/03/16	2	0	-	-	-
Rest of England	19/02/16	1	1	n/a	n/a	n/a
York & Selby (Staff)	19/02/16	1	1	n/a	n/a	n/a

All elections to the Council of Governors have been administered and overseen by Electoral Reform Services to ensure independence and compliance with the election rules contained within the Trust's Constitution.

Report of the Council of Governors' 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 2015/16 the committee:

- provided assurance to the Council of Governors on the performance of the Non-Executive Directors
- reviewed the Council of Governors' approach to the remuneration of the Chairman and Non-Executive Directors
- approved a policy statement on the appointment and terms of office of the Chairman and Non-Executive Directors
- agreed the arrangements for the appointment of Non-Executive Directors during 2016/17.

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 two meetings during 2015/16, was as follows:

Lesley Bessant	Chairman of the Trust	2
Martin Barkley	Chief Executive	0
Betty Gibson	Public Governor	2
Lesley Jeavons	Appointed Governor	0 (1)
Sandy Taylor	Public Governor	2
Colin Wilkie	Public Governor	1
Judith Hurst	Staff Governor	0 (1)

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

Advice and services were provided to the committee by Phil Bellas, Trust Secretary. No external advice or support was commissioned by the committee during the year.

Membership Report

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

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

- **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.

As at 31 March 2016 the Trust's membership was as follows:
- Public Members – 8,762
- Staff Members – 6,467

The above information includes the membership of the new public and staff constituencies for York and Selby which were established in 2015/16.

The table above provides an analysis of our public membership compared to the population covered by the Trust:

Public constituency	Number of members	Eligible membership
Age (years):		
0-16	53	375,413
17-21	748	126,959
22+	7,476	1,491,460
Ethnicity:		
White	7,987	1,897,919
Mixed	48	17,513
Asian or Asian British	153	40,256
Black or Black British	52	7,935
Other	15	2,744
Socio-economic groupings*:		
AB	1,932	116,754
C1	2,402	176,896
C2	1,971	136,350
DE	2,368	175,232
Gender:		
Male	3,064	980,149
Female	5,675	1,013,680

Note: The above analysis excludes:
- *485 members who did not provide their dates of birth*
- *507 members who did not state their ethnicity*
- *23 members who did not state their gender*

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
- brought together staff in our member and patient and public involvement teams to ensure involvement and engagement activities were more effective and co-ordinated
- produced a membership charter setting out what members can expect from the Trust in terms of communication, engagement and consultation.

In 2015/16 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 member engagement events in their localities - during the year we held events in Teesside and County Durham and Darlington
- communication to relevant constituencies to promote awareness of elections
- meeting members at promotional stands at a variety of events
- website forum for members' information
- membership cards including unique membership number and contact details
- expanded use of social media.

As part of the development of the business plan, a briefing is provided to the Council of Governors on the Board's drafts priorities. This enables Governors to engage with their membership and to provide feedback to Board of Directors during the formal approval process.

Out of 25 responses received from Governors to a survey, as part of the annual performance evaluation, 19 "agreed" and 5 "slightly agreed" that the Council of Governors was successful in influencing the Trust's business plan.

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

The Council of Governors has established a task and finish group to review its representational role which is due to report in 2016/17.

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.

Regulatory Ratings

In accordance with the Health and Social Care Act 2012 we must remain licenced with NHS Improvement to provide healthcare services.

The licence, which was introduced on 1 October 2013, created a number of obligations which we must meet including being financially sustainable and having robust governance arrangements.

NHS Improvement, through its "Risk Assessment Framework", uses risk ratings to assess compliance with the continuity of service and governance conditions of the licence.

During Quarter 2 2015/16 the Continuity of Service Risk Rating was replaced by a new Financial Sustainability Risk Rating.

The key change was that, in addition to assessing performance on liquidity and capital service coverage, the new risk rating also focussed on income and expenditure margin and variance from plan.

Although the measures changed, the descriptions of the risk ratings remained 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)

The governance risk rating is based upon performance against selected national access and outcomes standards; the outcome of CQC inspections and assessments; information received from third parties; a selection of information chosen to reflect organisational health; and the assessment of risks relating to financial sustainability, governance and efficiency.

The governance risk ratings are described as follows:

- "green" (no evident concerns)
- "under review" (including a description of the issues)
- "red" (regulatory action being taken).

Risk rating performance 2014/15 and 2015/16

2015/16	Annual Plan	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Continuity of Service/ Financial Sustainability rating	3	3	4	4	4
Governance rating	Green	Green	Green	Green	Green

2014/15	Annual Plan	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Continuity of service rating	4	4	4	4	4
Governance rating	Green	Green	Green	Green	Green

(Notes: The increase in the Continuity of Service/Financial Sustainability Risk Rating from Quarter 2, 2015/16 arose from the changes made to the metrics used in its calculation).

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 168 responsibilities set out in Monitor's *NHS Foundation Trust Accounting Officer Memorandum*.

Colin Martin
Chief Executive
24th May 2016

Annual Governance Statement

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

The purpose of the system of internal control
The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Tees, Esk and Wear Valleys NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Tees, Esk and Wear Valleys NHS Foundation Trust for the year ended 31 March 2016 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 Training programme.

The risk and control framework
The Trust's approach to Risk Management is contained in the Integrated Governance Framework which 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, serious incident investigations, complaints management, litigation, staff surveys, task groups, Trust risk register, clinical audit and internal and external audit.

The embedding of risk management can be demonstrated 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 reporting arrangements on serious investigations and complaints
- Framework for assessing and managing clinical risk and harm minimisation
- 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 and evaluation of services
- The Trust maintains close links with social services departments to ensure the delivery of integrated care and treatment

In addition an Assurance Framework was in place at 31 March 2016 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 I.T. systems to support the organisation's objectives including data quality, the lack of agreed currencies, and quality and outcome measures for the Trust's patient care contracts.

In all cases 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 recognises the importance of gaining independent assurance that controls are operating effectively and action plans are successfully implemented. To do this the Trust takes increasing account of information it receives from other organisations and has put in place a process to ensure that this is timely, accurate and recorded. The assurances it receives from third parties are assessed and actions are developed and implemented to improve their robustness and usefulness to the Trust. This ensures 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 89% against the Information Governance Toolkit requirement in 2015/16 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 has an established anti-fraud and corruption policy which 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.

The Trust was fully compliant with the registration requirements the Care Quality Commission at the conclusion of 2015/16.

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 this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

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

- Agreeing a rolling 3 year annual financial strategy and plan
- A rigorous process of setting annual budgets and a detailed cost improvement programme including a Quality Impact Assessment (QIA).
- Annual review of Standing Financial Instructions and Schemes of Delegation
- The formalisation of a treasury management policy
- Robust performance management arrangements
- A programme of supporting directorates to better understand and manage their relative profitability
- Breaking the trust's overall reference cost indicator down to Specialty / directorate
- Levering efficiencies through internal and collaborative procurement initiatives
- Using benchmarking and nationally published performance metrics to inform plans for improved bed and community service efficiency
- Rationalising the estate
- Improving workforce productivity
- Benchmarking management costs
- Commissioning external consultancy where the Trust believes economy and efficiency can be improved
- Embedding the Quality Improvement Systems (QIS) methodology to review how the Trust operates, maximising efficiency and minimising waste
- Values based recruitment process
- Supporting staff to raise issues through whistleblowing and no blame culture

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

Information Governance

There were five incidents reported on the IG Toolkit during this period of which all were responded to by the ICO. Of the responses received by the ICO none required the Trust to take further action. Each incident occurred because of unauthorised access to the patient record and all staff involved received the appropriate sanction for this type of Information Breach

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. 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:
  - Data quality policy
  - Minimum standards for record keeping
  - Policy and procedure for PARIS (Electronic patient record / information system)
  - Care programme approach (CPA) policy
  - Information governance policy
  - Information systems business continuity policy
  - Data protection policy

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

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, Audit Committee, Quality 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 2015/16, 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.

Colin Martin
Chief Executive

"Having personally witnessed staff going over and above their duty to support two elderly patients to return home over the weekend, and having seen the significant positive impact the liaison service has had upon our services we wish to thank them for their help."

from an accident and emergency department


TEWV NHS Foundation

The 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 Valleys NHS Foundation Trust's (TEWV) quality report for 2015/16. This is the 8th quality report we have produced and it tells you what we have done to improve the quality of our services in 2015/16 and how we intend to make further improvements in 2016/17.

Our mission, vision and strategy

The purpose of the Trust is:

'To minimise the impact that mental illness or a learning disability has on people's lives'

and our vision is:

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

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

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

It is also supported by our quality strategy 2014-2019. This outlines what the Trust expects from all staff as we work towards our vision of delivering high quality services that exceed people's expectations.

In delivering quality we believe our services must:

- provide the perfect experience
- be appropriate
- be effective
- reduce waste
- build upon the standards set by the Care Quality Commission (CQC).

We monitor our progress against these goals via our quality strategy scorecard which is considered on a quarterly basis by the Quality Assurance Committee (a sub-committee of the Board).

On 1 October 2015 TEWV took over responsibility for providing mental health and learning disabilities for the whole of the Vale of York CCG area. Since then we have undertaken work to understand these services better and to identify where quality is high and where we believe we can improve this further. The majority of the information provided in this report for 2015/16 therefore does not include the services in the Vale of York but where we can we have provided this and made this clear. The priorities identified for 2016/17 will apply across the organisation, including services serving the Vale of York.

TEWV's 2015 Community Mental Health Survey results led to CQC highlighting the Trust as one of five across the country performing better than expected when compared to other Trusts.

There were four areas the Trust was significantly better than most other Trusts, these were:

- organising care
- planning care
- reviewing care
- crisis care.

Areas where our performance was similar to other trusts and which we will focus improvement on were:

- providing help with finding support for financial advice or benefits and finding or keeping work
- support in taking part in an activity locally
- giving information about getting support from people with experience of the same mental health needs.

These types of support are amongst those that will be improved by our recovery improvement priority (see **Part 2, 2016/17 priorities for improvement section**).

What we have achieved in 2015/16

We have continued to work with our commissioners to deliver new services to meet the needs of those who use our services. For example we have:

- Provided a new "place of safety" (also known as Section 136 suite) in Harrogate resulting in their now being a place of safety in each locality served by the Trust. This means that police forces can avoid using police station cells for people arrested due to behavour triggered by a

mental health crisis across the whole Trust area.
- Opened a crisis assessment suite (CAS) at Roseberry Park Hospital on Teesside. For patients and carers, the CAS has meant a reduction in the time they wait for assessments to commence as the facility is staffed on a 24/7 basis. In addition, the project has enabled a more sensitive and suitable environment to be provided for both patients and families. Overall patient experience has improved. There have also been benefits for our partners such as Cleveland Police and accident and emergency departments.
- Opened a new rehabilitation service in North Yorkshire at The Orchards in Ripon. This provides a modern, fit-for-purpose therapeutic environment that will assist patients' recovery and reduce readmissions to acute assessment and treatment beds.

In the 2015 national NHS Staff Survey, the Trust remained the top mental health and learning disability provider. It scored the best score in **14** of the **32** areas covered by the staff survey.

- Completed the transformation of West Lane Hospital, our children and young people's inpatient site, resulting in the facility providing a modern therapeutic environment.
- Expanded our child and adolescent mental health services (CAMHS), using additional funding from commissioners to implement a 24/7 crisis service for under 18s in Teesside (in addition to the Durham service that commenced in 2014/15).
- Implemented a peri-natal service in Teesside with clinics established at North Tees & Hartlepool NHS Foundation Trust and South Tees NHS Foundation Trust sites and an agreed training plan for midwives and health visitsors.
- Introduced an enhanced community learning disability service in Teesside that is available seven days a week from 8am until 8pm. This has resulted in capacity and flexibility to meet the needs of people with complex needs and behaviours that challenge, prevented unnecessary admissions and facilitated effective timely discharge.

We have also worked to improve our quality through staff training, communication and process improvement. For example we have:

- Agreed a learning culture framework and implemented processes for learning from reportable incidents (RIDDOR), safeguarding, serious incidents, complaints, claims and quality reviews. We have also disseminated learning lessons bulletins to staff about these topics and received positive feedback about the impact of these on front-line-staff and their practice.
- Improved the way that we record, collate and report quality-related information and statistics.
- Established a group that feeds into the learning disability services quality board in North Yorkshire, where people who use our services give us meaningful feedback and clear actions for future improvement.

The Trust has had the highest number of Friends and Family responses for a mental health Trust for ten of the eleven months between December 2015 and January 2016.

In January the number of respondents who would recommend the Trust's services was **86%**.

- Piloted the "Safewards" model in ten forensic wards and are now extending this to our remaining forensic wards given the evidence from the pilot that incidents have decreased.
- Facilitatated secure wards' service user attendance at the regional forensic recovery and outcomes meeting in Wakefield (quarterly). In July 2015, five service users attended the national service user conference in Birmingham. One service user has also attended two national recovery and outcomes steering group meetings in Birmingham.
- Improved the way we manage complaints from patients and carers. This enables us to acknowledge and investigate complaints more effectively, including reviewing clinical records and Trust policies, consulting with clinical staff involved in the complaint, seeking expert clinical advice as required, and producing a response.

In addition we have worked with our partners to improve services. For example we have:

- Extended access to the ARCH Recovery College in Durham by developing on-line access for people that cannot physically attend the courses (including patients being treated in secure settings). These courses help service users develop strategies to help them live the life that they want to live.
- Established York and Selby Mental Health Connects which provides a platform that enables TEWV to build on existing relationships with third sector organisations and to develop new relationships that promote improved service quality and enables all partners to jointly work toward increasing investment in mental health services within York and Selby.

TEWV scored the **4th** highest out of all 230 NHS acute, mental health and community Trusts in the Learning from Mistakes league table published by Monitor in March 2016.

- Extended our pilot of locating mental health services for older people (MHSOP) community staff in GP surgeries from the

initial site at Blackhall, County Durham more widely across Durham Dales, Easington and Sedgefield (DDES) CCG area. The aim of this is to simplify the referral process so that people registered with the GP practice can access mental health services quickly and conveniently.
- Worked with Middlesbrough and Stockton MIND to make advice and signposting sessions available to inpatients at Roseberry Park and their carers.

As well as the examples above, we have also continued to drive improvements in the quality of our services through using the TEWV Quality Improvement System (QIS). This is the Trust's approach to continuous quality improvement and uses tried and tested techniques to improve the way services are delivered. Some notable examples of what we have achieved in 2015/16 are that we have:

- Reduced the variation in practice among our community psychosis and early intervention in psychosis (EIP) teams, ensuring that patients receive the same quality of intervention wherever they live across the area served by the Trust.
- Developed our "unified affective disorders pathway" and are rolling this out across the Trust following a successful pilot. We have also developed a new pathway for MHSOP service users with a "functional" illness (i.e. an illness not related to dementia or other degenerative brain changes).

In 2015/16 the Trust received **200** complaints. During 2015/16 **79%** of complaints were resolved satisfactorily.

As a result of these complaints **59** action plans to learn the lessons were generated. At the end of March 2016, the Trust had no action plans that were outstanding more than one month beyond their originally agreed timescale.

- Improved processes in Durham and Darlington MHSOP, which have released nurse time for direct patient contact and improving recovery.
- Reduced the time taken for Scarborough memory service patients to receive a diagnosis and also increased capacity to deal with an increase in referrals for memory services.
- Developed a protocol to enable service users within low secure services to be able to use mobile phones whilst within the ward environment.
- Replicated the successful "For Us" forensic learning disability service user group in forensic mental health.

In 2015/16 the Trust was also recognised externally in a number of national awards where we were shortlisted and / or won. Awards won by TEWV teams or staff members are shown in the table below:

Awarding Body	Name / Category of Award	Team/individual
NHS Friends and Family Test (FFT) Awards 2016	Best Staff Friends and Family Test Initiative award	Kerry Jones, Staff Experience Project Manager
	Awarded highly commended at these awards for best FFT initiative in any other NHS-funded service. The team was recognised for putting a Trustwide system in place for the collection, analysis and dissemination of patient and carer experience feedback.	Patient and carer team
Nursing Times Awards	Child and Adolescent Mental Health Services (CAMHS)	Durham and Darlington CAMHS crisis team (for person centred care planning for young people with emerging personality disorders)
Royal College of Psychiatrists	Psychiatric team of the year: working age adults	Ward 15, Friarage Hospital
North East Leadership Academy	NHS Inspirational Leader of the Year	Amy Colling
Positive practice in Mental Health	Innovation in Child, Adolescent and Young Peoples Mental Health	CAMHS crisis team
	Partnership working	Talking Changes (Durham and Darlington)

Awards where TEWV or one of its teams / staff were shortlisted for an award but did not win that award in 2015/16 were:

Awarding Body	Name / Category of Award	Team/individual
Nursing Times Awards	Child and Adolescent Mental Health Services (CAMHS) Team of the year	CAMHS Scarborough, Ryedale and Whitby for working with young people to develop videos about services
Patient Safety Awards	Clinical Leadership (highly commended)	Karen Atkinson for improving quality/efficiency in the patient safety department
	Mental Health category	Durham CAMHS crisis and liaison team for person centre care planning for young people with emerging personality disorder
		Eating disorders services
Royal College of Psychiatrists	Psychiatric trainer of the year	Dr Mani Santhanakrishnan
	SAS doctor of the year	Dr Sagrika Nag
	Carer contributor of the year	Pam Elliott
Health Service Journal Awards	Staff engagement	Whole organisation
	Board leadership	Whole organisation
North East Leadership Academy	NHS Development Champion of the year	Sarah Dexter-Smith and Jenny Oddy

Structure of this quality report document

The structure of this quality 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 2015/16, the required statements of assurance from the Board and our priorities for improvement in 2016/17.
- **Section 3** – Further information on how we have performed in 2015/16 against our key quality metrics and national targets and the national quality agenda.

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

A full statement of Directors' responsibilities in respect of the quality report is included at the end of the quality report. This is further supported by the signed limited assurance report provided by our external auditors on the content of the 2015/16 quality report.

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 quality report please do let us know by e-mailing Sharon Pickering (Director of Planning, Performance and Communications) at sharon.pickering1@nhs.net or Elizabeth Moody (Director of Nursing and Governance) elizabeth.moody@nhs.net.

Colin Martin
Chief Executive

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

Update on 2014/15 quality priorities

In last year's quality report we reported on our progress with our quality priorities for 2014/15. Within this we also noted some further actions for 2015/16. In some cases, these actions were to be included within the quality priorities for 2015/16, and therefore, are reported within this quality report. In other cases, these quality priorities were discontinued in the quality report but remained a priority for the Trust. The following is a brief summary of our progress with the quality priorities that were not continued in the quality report priorities for 2015/16.

To have more staff trained in specialist suicide prevention and intervention	During 2015/16 the Trust realised that in order to support this priority in the long term we needed to take a wider approach. This means that we needed to incorporate all aspects of harm minimisation that could impact on a service user's life. A fundamental part of this is suicide presentation and intervention. Due to this, our suicide prevention project was closed and a new harm minimisation and risk management project was opened. This has now become a quality priority within the Trust and is included within this document. Further information can be found in **Part 2, 2016/17 Priorities for Improvement section**.
To implement the recommendations of the Care Programme Approach (CPA) review, including, **- Improving communication between staff, patients and other professionals** **- Treating people as individuals**	The recovery focused care planning training that commenced in 2014/15 continued during 2015/16 and we achieved the following targets at the end of March 2016. • All Trust psychosis and EIP teams to have received recovery focused care planning training (100% achieved). • 95% of staff attending training reporting an improved information / knowledge of recovery focused care planning (82% achieved) – i.e. more than 8 out of 10 people who have attended this training have improved their knowledge. • 95% of staff attending training report they are clear about intended action to take to improve care planning (91% achieved). • 95% of staff satisfied with the recovery focused care planning training (92% achieved). • 95% of staff would recommend this training to staff, patients and carers (95% achieved). Further work continued in 2015/16 to streamline all recording and documentation relating to CPA and standard care on the Trusts electronic patient record (Paris). Alongside this, there has been joint work with the new harm minimisation framework and risk assessment process to ensure this is incorporated into CPA and care planning. Training will continue through harm minimisation, recovery, relevant mandatory training and our new staff induction in 2016/17.
To manage the pressure on acute inpatient beds	During 2015/16 a crisis team training package was devised and piloted with team members from every crisis team. In addition to this, a crisis team manager support event was held resulting in an established network for the crisis leadership team. The crisis training was evaluated, and an appraisal of options for future training has been sent to the crisis network and acute care forum for consideration. Crisis / contingency plans were reviewed and tested as part of an improvement event. The format has since been used in redesigning shaping this element of service users electronic care record. We will continue to understand relationships between community care teams and crisis and intensive home treatment, to maximise opportunities for viable alternatives to hospital admission. This will be discussed/ planned through the crisis network and the acute care forum.

2015/16 Priorities for improvement – how did we do

As part of our 2014/15 quality report following consultation with our stakeholders, the Board of Directors agreed four quality priorities to be addressed during 2015/16.

Priority 1: Delivery of the recovery project in line with the agreed plan. .

Priority 2: to embed the recovery approach (in conjunction with CPA).

Priority 3: Expand the use of positive behavioural support in our learning disabilities services.

Priority 4: Implementation of age appropriate risk assessments and care plans for children and young people services.

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

It is important to note that the achievement of these 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.

Priority 1:
Delivery of the recovery project in line with the agreed plan

Why is this important:
This is a continuation of the priority identified in 2014/15 and recognises that delivery of recovery focused services is critical but will take a number of years. Our stakeholders and Board therefore agreed it was important that this remained a key priority in 2015/16.

The three year recovery strategy within TEWV aims to embed recovery values and principles in services for adults and older adults and ensure we are delivering care that is in line with service users' and carers' needs.

The 2014 national community patient survey shows that TEWV's scores for providing health and advice to patients about their physical health needs, financial / benefit advice and support for staying in or finding work, or taking part in a local activity are all relatively low (between 4.7 and 5.2 out of 10) compared to other groups of questions in the survey. While these are in line with the scores achieved by other mental health trusts, they do demonstrate the need for a long term commitment to moving to recovery-oriented services.

The benefits / outcomes we aimed to deliver were:

- care designed to support service users to achieve their own goals
- staff genuinely believing that service users can lead fulfilling lives
- service users genuinely feeling listened to, heard and validated
- views and personal expertise by experience of service users and carers being valued
- staff working in partnership with service users and carers at every level of service delivery
- service users being supported to take charge of their lives, promoting choice and self-management.

What we did in 2015/16:
The following is a summary of the key actions we have completed in 2015/16:

What we said we would do	What we did
Expand the number of experts by experience to 24 within TEWV by quarter 2 2015/16.	The recovery programme has now trained four cohorts of experts by experience. Each cohort provided a five day training programme led by Jacqui Dillon, an international consultant on lived experience and the chair of the UK's Hearing Voices Network alongside the Trusts Recovery Programme Clinical Lead. The training prepares individuals to use their own personal lived experience in recovery/service development projects within TEWV. We currently have 31 experts by experience.
Develop and deliver peer training to 10 potential peers by quarter 3 2015/16.	We have run two introductory peer training courses for a total of 10 people. Additional funding from Health Education North has been used to procure Sutton Mental Health Foundation as a provider to deliver accredited peer training which commenced in Q4 2015/16 and will be completed in June/July 2016/17 – 14 people are taking part, seven of which took part in the introductory course, seven are new.
Develop 6 new peer roles within TEWV by quarter 4 2015/16.	Over the last year 14 new peer roles have been established in the Trust with an increasing recognition of the value of these roles within teams.
Expand the number of Recovery College courses delivered to 28 and identify options for roll out into other areas by quarter 3 2015/16.	The ARCH recovery college in Durham* has continued to expand its provision with more students signing up and attending courses. We were able to exceed our expectations being able to deliver 40 courses in comparison to the planned 28 courses. As at the end of March 2016 the number of new people enrolled at the Recovery College stood at 188. In addition, TEWV is now developing a Virtual Recovery College to allow all service users and carers across the Trust's geography to have access to self-management training and education.
Roll out recovery training to a further 250 TEWV staff and embed recovery principles into core mandatory training by quarter 4 2015/16.	In the last year the recovery project team have delivered a substantial amount of recovery related training across the Trust, with 531 attendances from Trust staff. This includes: adult mental health teams involved in a Trust-wide quality improvement work-stream, children's and young people's services, mental health services for older people, the Trust induction programme and training designed to help those diagnosed with a personality disorder. A Trust recovery conference was held in March 2016.
Work with the Health Foundation and using their methodology to embed shared decision making principles within the recovery programme by quarter 4 2015/16.	Recovery principles have been embedded in much of TEWV's mandatory training and work continues to embed it within the remaining mandatory training courses. We have continued to work with the Health Foundation throughout 2015/16 to ensure the principles of shared decision making are integrated with other recovery related training including harm minimisation.

* *Only patients resident within County Durham are served by the ARCH recovery college because it is commissioned by Durham Dales, Easington and Sedgefield (DDES) and North Durham CCGs. However there are other recovery colleges in Teesside and York provided by other organisations, and TEWV co-operates with these.*

How we know we have made a difference:
The following table shows how we have performed against the targets we set ourselves for this priority:

Indicator	Target	Actual	Timescale
Number of courses delivered at ARCH Recovery College.	28	40	Q3 2015/16
Number of individuals receiving peer support training.	10	10	Q3 2015/16
Number of new peer roles established in TEWV.	6	14	Q4 2015/16
Number of TEWV staff receiving recovery related training.	250	531*	Q4 2015/16

** total number of people receiving training, some people could be duplicated if attended more than one session/conference.*

What we plan to do in 2016/17:
This will continue to be an improvement priority for us. Our plans for 2016/17 are set out in **Part 2, 2016/17 priorities for improvement section.**

Priority 2:
Nicotine management and smoking cessation

Why this is important:
Research suggests that people with severe mental illness die 15-20 years earlier than the general population. A significant contributor to this is that people with mental health problems also have poorer physical health, with many more smoking when compared to the average population.

People who smoke and have mental health problems are no less likely to want to quit smoking than those without, but it is suggested that they are more likely to be heavily addicted to smoking and anticipate difficulty quitting smoking, and be less likely to succeed. However, as in the general population, smokers with mental health problems are more likely to quit if they are provided with behavioural support and alternatives.

The benefits / outcomes we aimed to deliver:
- encouragement to commit to giving up smoking for both service users and staff
- effective support to give up smoking including access to nicotine replacement therapy (NRT) for both service users and staff
- access to trained staff able to provide advice around smoking cessation for service users
- improved physical health in the longer term and life expectancy (for both staff and service users)
- reduced exposure to smoke for staff, which will improve their wellbeing.

What we did in 2015/16:

What we said we would do	What we did
Appoint a project manager for the nicotine management and smoking cessation project by quarter 1 2015/16.	We appointed a project manager in April 2015 (Quarter 1) to lead the Trust's project in order to implement the plans to go smokefree on 9 March 2016.
Develop a communications plan to inform staff and service users of the Trust's plans to implement its policy on nicotine management and smoking cessation by quarter 1 2015/16.	A detailed communications plan was developed in Quarter 1 2015/16 to ensure service users, carers and staff were kept informed on the progress of the project. A key part embedded within the communications plan was to ensure service users and staff were informed of the developments of the nicotine management and smoking cessation project including the revised policy which ultimately details the Trust's smokefree standards.
Identify potential/available alternatives to smoking/nicotine and understand mechanisms for prescribing by quarter 1 2015/16.	A 'Pharmacy' group was developed in Quarter 1 to look at all available products to support a smoker to become smokefree inclusive of the prescribing pathway. This group also looked at the options for temporary abstinence and also the options available should the service user wish to set a quit date. Additional behavioural support and advice was made available to staff who set themselves a quit date. This was provided following a comprehensive assessment by a Level 2 trained member of staff. Such staff also received a direct referral to community stop smoking services at the end of the Trust's own support.
Have used the baseline assessment tool (identified within the NICE Public Health guidance 48 (PH48) on smoking cessation) to ensure that the Trust's practice is in line with recommended NICE guidance by quarter 1 2015/16.	The baseline assessment tool was used to ensure all areas of Trust clinical practice, as identified by NICE nicotine management and smoking cessation guidelines were introduced as common practice within every day service user care for those that smoke.
Complete a benchmarking exercise to understand the number of staff smokers in order to set targets for reduction by quarter 2 2015/16 and then monitor performance against those targets in future quarters.	A benchmarking exercise was undertaken to identify the numbers of staff who currently smoke across the Trust (not including York and Selby). This showed that various percentages of staff identified themselves as a smoker at any given time. This has made it difficult to set a target; however, the Trust has maintained that they will continue to support Trust staff in their efforts to stop smoking.
Work with our local authority smoking cessation services to host clinics at key Trust localities (such as Roseberry Park or Lanchester Road) by quarter 2 2015/16.	A 'Local Authority Commissioners' group was set up to look at the provision of services for staff across Trust premises. Lloyds Pharmacies at Lanchester Road Hospital, West Park Hospital and Roseberry Park have been commissioned to provide support to staff wishing to stop smoking from 9 March 2016. Other smoking cessation services will also be contacted as the project continues into 2016/17 to look at the possibility of providing drop-ins for staff within other areas of the Trust such as Scarborough and York.

What we said we would do	What we did
Advertise, promote and maximise the opportunity provided by Stoptober 2015 by quarter 3 2015/16.	Multiple Stoptober events were held across the Trust to advertise the support available for those wishing to stop smoking.
Review our no smoking policy to incorporate nicotine management and smoking cessation by quarter 3 2015/16.	A full policy review took place and the newly ratified nicotine management policy is now available Trustwide for staff to access.
Develop an implementation plan to support staff to stop smoking by quarter 3 2015/16.	An implementation plan was developed by the human resources department to support staff to stop smoking.
Have sufficient staff trained in nicotine management and smoking cessation pilot sites in each of our localities to sustain the delivery of our smoke free agenda within the pilot sites by quarter 4 2015/16.	Over 1300 frontline staff have been trained to level 1 (very brief advice) to ensure service users are identified as smokers/non-smokers on admission and offered nicotine management support for temporary abstinence or to set a quit date. 200 staff have completed a more advanced level 2 practitioner training which allows them to provide a detailed assessment of a smoker and then offer nicotine replacement products and behavioural support. Training of staff will continue into 2016/17 to ensure the Trusts standards are embedded throughout the organisation.
Implement the Trust's standards on nicotine management and smoking cessation as per the new / revised approved policy by quarter 4 2015/16.	The newly revised policy has been ratified and approved which sets out the Trust's smokefree standards, which were implemented on the 9 March 2016. These standards will be further embedded as the project continues into 2016/17.

How we know we have made a difference:
The following table shows how we have performed against the targets we set ourselves for this priority:

Indicator	Target	Actual	Timescale
Proportion of inpatient units that are smoke free.	75%	100%	Q4 2015/16
Proportion of locally identified clinical staff that have been trained to smoking cessation level 2.	75%	95%	Q4 2015/16
Delivered reduction in staff smoking in line with target agreed in quarter 2 2015/16.	90%	N/A	Q4 2015/16

A clinical audit of smoking prevalence within all Trust services was carried out in December 2015. The audit highlighted the following key points:

- 56% of all inpatients on the 28 December across the Trust are non-smokers;
- On the 28 December 2015 all specialities (except forensic mental health (FMH)) reported having more patients who are non-smokers than patients who currently smoke;
- 43% of all inpatients on the 28 December across the Trust currently smoke;
- Smoking rates are noticeably higher amongst inpatients (on the 28 December) within FMH (68%) in comparison to other specialities.

Please note that these improvements have also been delivered in York and Selby inpatient units, which also went smokefree on 9 March along with other Trust hospitals.

What we plan to do in 2016/17:
This will continue to be an improvement priority for us. Our plans for 2016/17 are set out in **Part 2, 2016/17 priorities for improvement section**. A further audit will be conducted in December 2016 to review the smoking status of the service users within the Trust to highlight the impact of change since going fully smokefree within Trust inpatient sites on the 9 March 2016.

Priority 3:
Expand the use of positive behavioural support (PBS) in our learning disabilities services

Why this is important:
Behaviour can be defined as "the actions or reactions of a person in response to external or internal stimuli" and can be:

- anything a person says or does
- voluntary or involuntary
- good, bad, desirable or undesirable
- judged along degrees of 'appropriateness.

The factors that determine behaviour are highly complex and much behaviour has multiple causes. Positive behavioural approaches are focused on **illumination** (understanding the meanings and purposes of the behaviour from the individual's point of view) rather than on **elimination**. Therefore, rather than seeking ways to control people (in the name of treatment and/or intervention), this approach seeks ways to better understand the person and the stimuli for their behaviour, to communicate with them, and to work with them toward achieving fulfilling lives.

There is a considerable evidence base which shows the clear benefits of positive behavioural support as a strategy in terms of enhancing the quality of life of service users and also reducing behavioural challenges. It is widely recognised that positive behavioural support offers the most ethically stringent, evidence-based intervention option for people with learning disabilities and challenging needs and that its use is key to the reduction of restraint and other restrictive practices (including physical, chemical, mechanical restraint and seclusion) in all health and social care settings.

The benefits / outcomes we aimed to deliver:

- a values led based, person centred approach
- improved quality of life, happiness and well-being
- service users being given the skills and coping capacities to be able to deal with the demands of everyday living
- a reduction in restrictive practice including control and restraint and use of 'as-required' medication
- an improved support structure in place for people whose behaviour is described as challenging.

What we did in 2015/16:

What we said we would do	What we did
Ensure by quarter 4 2015/16 that all people who are referred to the learning disabilities service receive an initial screening and if behavioural challenges are considered to need a functional assessment, place the person onto Tier 1 of the positive behavioural support pathway. The brief behavioural assessment tool (BBAT) is a core component of Tier 1 therefore everyone who is placed onto Tier 1 automatically undergoes a brief behavioural assessment.	Analysis of the use of the pathway demonstrates we have achieved all our targets. We have also achieved a reduction in intensity and frequency of concerning behaviours for 63% of the people in quarter 1 on the pathway and 20% of the people in quarter 2 on the pathway – 15 people having been successfully discharged with a PBS plan in place. Of those remaining, they continue on the pathway. **Examples of quality of life improvements reported:** Service user 1 – is now noticeably smiling more and observed to appear happy and content; now goes out every day somewhere he chooses, voluntarily links arms with others companiably – intensity of one of the priority behaviours of concern has gone from 'severe' to 'minor'. Service user 2 – intensity / frequency of one of priority behaviours of concern has gone from 'major / hourly' to 'negligible / less (than weekly)' following the implementation of the PBS intervention plans. Service user 3 – All priority behaviours of concern have reduced following PBS intervention plans and the person has been discharged from the pathway – this service user has since been found to be terminally ill and is on an end of life pathway. The reduction of the impact of their behaviours on their quality of life surely has contributed to a more peaceful and dignified end.
Ensure appropriate training is available in order to increase the number of community staff who are trained in positive behavioural support by quarter 4 2015/16.	Training has continually been made available to staff which has enabled the achievement to meet and go above the target of 95%. This will continue into 2016/17 to ensure staff can receive the training they need to embed the positive behavioural support approach.
Maintain a register of all inpatient staff that have completed the positive behavioural support training (including new employees) and ensure regular positive behavioural support training sessions are provided for inpatient staff to ensure service remains at 95% by quarter 4 2015/16.	At the end of quarter 4 the service achieved 96% of staff trained. Training sessions will continue to be provided and the register maintained during 2016/17 to ensure the current target is met on an ongoing basis.

How we know we have made a difference:
The following table shows how we have performed against the targets we set ourselves for this priority. This data does not include York and Selby:

Indicator	Target	Actual	Timescale
Percentage of people (of those identified as suitable from initial screening) placed onto the positive behavioural support pathway and underwent a brief behavioural assessment tool (BBAT) assessment.	100%	100%	Q4 2015/16
Percentage increase in staff training within community teams from 60% to 95%.	75%	95%	Q4 2015/16
Percentage of staff training maintained in inpatient areas.	95%	96%	Q4 2015/16

Evidence has shown a reduction in restrictive practice that has been implemented across the service through the use of the PBS approach. It shows that there has been a clear reduction in behaviours of concern and very clear evidence of improvements of quality of life in all cases. These improvements in themselves demonstrate reductions in restrictive practice because if this had not been the case such positive outcomes would not have been achieved.

Less frequent and intense behaviour scores mean there has been less need to intervene and therefore adopt more restrictive practices.

Increased quality of life again means more positive practice is happening for people; this again implies very clearly that there is reduced need to intervene in more restrictive ways.

What we plan to do in 2016/17:
We will continue to use the PBS approach across the adult LD service. In 2016/17 we plan to purchase the person centred active support (PCAS) training which is an additional but integral part of the PBS approach. This will be delivered as a train the trainers approach across the service over the coming 2-3 years.

In addition to expanding the use of positive behavioural support across our learning disabilities service we are also implementing it across our other specialities. This work will take place as part of a project within the Trust that will:

- conduct person-centred behavioural support training within adult mental health services and mental health services for older people pilot sites
- Develop a behavioural support plan template and debriefing tool for inpatients areas
- review the Trust's policies on behaviours that challenge
- revise current management of violence and aggression training so that it includes positive behavioural support.

"Thank you for the kindness and humanity that you persistently demonstrated to my good friend while he was in your care. I was always comforted to see how much care and patience he was shown as well as the kindness and professionalism given to myself during my visits."

from a service user's friend

Priority 4:
Implementation of developmental age appropriate risk assessments and care plans for children and young people's services

Why this is important:
Children and young people's services (CYPS) assess and treat children at different ages and development stages of their life. There is a vast difference between the verbal, cognitive and social interaction skills of a four year old child and a 17 year old adolescent. There are also different risks associated with different age groups or developmental stages.

The historic system for undertaking risk assessments and producing care plans in CYPS does not reflect the different risks and issues identified at each developmental stage and age group a child presents in. This can result in an ineffective use of staff time which affects the experience of service users and carers in a negative way.

The benefits / outcomes we aimed to deliver:
By creating age, and developmental, appropriate risk assessments and care plans, CYPS will be able to co-produce risk assessments and risk management plans with the young person and their family, which are responsive to their age, development and need. Children, young people and their carers will therefore:

- be at the centre of care with an agreement in place on the identified risks
- have a shared care plan and risk assessment which will include a summary of the identified risks and interventions
- have more meaningful risk assessments and care plans based on needs, and less unnecessary documentation
- have a shorter wait for assessment and treatment because staff will have more time available for patient contacts (due to more focused assessments and care planning)
- feel that the process is more tailored to the individual needs of the child / young person and more supportive to their wellbeing, safety and recovery
- experience a consistent high standard of practice across CYPS in assessing and managing risk.

What we did in 2015/16:

What we said we would do	What we did
Draft age appropriate risk assessment and care plans for the revised risk management documentation created by quarter 1 2015/16.	Whilst the documentation was in development feedback was received from staff within the children's hubs (such as school nurses, health visitors, senior educational needs co-ordinators (SENCO)) requesting that we align our revised documentation with the children's assessment framework (CAF). The first sections of the revised documentation now match that of the CAF with the aim of supporting patient care and improve communication when linking with our partners whilst also saving Trust staff time. The draft documentation has been piloted across two Trust teams, one in North Durham and the other in Stockton. Feedback from staff taking part in the pilot teams was positive with relevant suggested changes made.
Gather service user feedback on the revised risk management documentation and process by quarter 2 2015/16.	A questionnaire was developed to gather service user views on the revised documentation. Feedback from the questionnaire showed that no changes to the revised documentation were required.
Ensure approval of the revised risk management documentation and process from relevant Trust governance groups including those involving patients and carers by quarter 2 2015/16.	The draft documentation was reviewed and approved within the Trust's speciality development group for children's services.
Complete revisions to our risk management documentation and process based on feedback received from Trust governance groups by quarter 3 2015/16.	As no changes were required when reviewed by service users and the Trust's children's speciality development group, no revisions were completed. Following the upload of the documentation to Paris (our electronic patient record system), service user and speciality development group views will be gathered with any requested changes being added to Paris to ensure the documentation reflects what is needed and required by our service users.
Upload the approved documents on to Paris (our electronic patient record system) by quarter 4 2015/16.	The Paris system has been updated to make the system more user friendly. This means that the flow of how documentation is used on the system differs from when the risk assessments and care plans were originally revised. Currently the basic principles of the revised documentation have been uploaded within Paris. Further development is ongoing to adapt the documentation to flow in the same way as the updated version of Paris.

What we said we would do	What we did
Complete staff training on the new documentation and process by quarter 4 2015/16.	During January to March 2016 staff received training to enable them to seamlessly use the updated version of Paris. This training will continue during the ongoing developmental work being carried out on Paris as mentioned above.
Ensure the revised risk management process is implemented across all teams by quarter 4 2015/16.	Whilst the staff training was taking place, the revised risk management process was implemented across all teams in preparation for the revised documentation being uploaded on to Paris.

How we know we have made a difference:
The following table shows how we have performed against the targets we set ourselves for this priority (please note, this data does not include York and Selby):

Indicator	Target	Actual	Timescale
Percentage of children offered a paper copy of their completed risk assessment.	100%	100%	Q4 2015/16
Percentage of all staff trained on new documentation (inpatient and community).	100%	100%	Q4 2015/16
Reduction in staff time inputting risk management documentation in to Paris.	50%	Will be reported during 2016/17	Q1 2016/17
Percentage of staff training maintained in inpatient areas.	95%	96%	Q1 2016/17

Staff have received training on the revised documentation and how to use the updated version of Paris. Training will continue across the Trust into 2016/17 as Paris is updated.

What we plan to do in 2016/17:
During 2016/17 we will continue to use the revised risk assessments and care plans that have been uploaded on to Paris. The documentation will be reviewed at regular intervals to ensure they are meeting the needs of our service users, with any amendments being made when necessary.

York and Selby services will be able to access the TEWV version of Paris in 2016/17. However, they already use age appropriate risk assessments and care plans. Work will commence to review the strengths of both sets of forms which will lead to further improvement in the future.

We will monitor the impact that the changes have on time staff spend inputting risk management documentation into PARIS, and continue to gather the views of patients and their carers to ensure that our new arrangements are have the intended impact.

Statement of Assurances from the Board 2015/16

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 2015/16. In some cases additional information is supplied and where this is the case this is provided in *italic*.

Review of services

During **2015/16** TEWV provided and/or sub-contracted **20** relevant health services.

TEWV has reviewed all the data available to them on the quality of care in **20** of these relevant health services.

The income generated by the relevant health services reviewed in 2015/16 represents **100%** per cent of the total income generated from the provision of the relevant health services by TEWV for 2015/16.

In line with our clinical assurance framework the review of data and information relating to our services is undertaken monthly by the relevant Quality Assurance Group (QuAG) for each service. A monthly report is produced for each QuAG which includes information on:

- ***patient safety** – including information on incidents, serious untoward incidents, levels of violence and aggression, infection prevention and control and health and safety*
- ***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 patient satisfaction; carer satisfaction; the Friends and Family Test; complaints; and contacts with the Trust's patient advice and liaison service*
- ***Care Quality Commission (CQC)** – compliance with the essential standards of safety and quality, and the Mental Health Act.*

Following discussion at the QuAG any areas of concern are escalated to the relevant Locality Management and Governance Board (LMGB) and from there to the Quality and Assurance Committee (QuAC) the sub-committee of the Board which has responsibility for Quality Assurance. The QuAC receives formal reports from each of the Locality Management and Governance Boards on a two monthly basis.

We also undertake an internal inspection programme, the content of which is based on the Fundamental Standards of Quality and Safety published by the CQC. These inspections cover all services and the inspection team includes members of our compliance Team, service user and carer representatives from our fundamental standards group and peers from other services. In advance of the visit the inspection team review a range of information on the quality of the service being inspected, for example: incident data, PALS / complaints data, CQC compliance reports and Mental Health Act visit reports, and any whistleblowing information. At the end of the internal inspection verbal feedback is given to the ward/team manager and any issues are escalated to the head of service, head of nursing and the director of nursing and governance. An action plan is produced and implementation is assured via the QuAGs, LMGBs and Quality Assurance Committee (QuAC), as described above, and in line with the Trust's clinical assurance framework.

Each month the Board of Directors also undertakes a minimum of seven 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.

In addition to the above the Trust has introduced an integrated information centre (IIC) which is a data warehouse which integrates information from a wide range of source systems eg patient information, finance, workforce and incidents. The information within the IIC is updated regularly from the source systems and allows for the interrogation of the most up to date positions at any time of the day. This allows clinical staff and managers to access the information on their service at any time of day (or night) and to be able to 'drill' down to the lowest level of the data available (according to access rights). The IIC also sends prompts to staff which helps to improve the care and experience of our service users. For example, the IIC sends prompts to care coordinators on a weekly basis listing those patients whose care plan reviews are due in the next week, two weeks and one month. This ensures that staff can be proactive about ensuring these patients have review appointments scheduled in a timely manner thus improving patient safety.

Finally, in addition to the internal review of data / information we undertake as outlined above, we also regularly provide our commissioners with information on the quality of our services. We hold regular clinical quality review meetings with commissioners where they review all the information on quality that we provide them, with a particular emphasis on trends and the narrative behind the data. At these meetings we also provide information to our commissioners on any thematic analysis or quality improvement activities we have undertaken and on our responses to national reports that have been published.

The increase in services reported above compared to that reported in 2014/15 relates to the Trust becoming the provider of services in the Vale of York on the 1 October 2015. Since October we have replicated the governance processes, outlined above, within our York and Selby locality and they have commenced the review of available data. It is expected that this will become further embedded during 2016/17.

Participation in clinical audits and national confidential inquiries

During 2015/16, **three** national clinical audits and **one** national confidential inquiry covered the relevant health services that TEWV provides.

During 2015/16, 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** during 2015/16 are as follows:

- National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH);
- POMH UK Topic 13b: Prescribing for ADHD in Children, Adolescents and Adults;
- POMH UK Topic 14b: Prescribing for substance misuse – alcohol detoxification;
- POMH UK Topic 15a: Prescribing valproate for bipolar disorder.

The national clinical audits and national confidential inquiries that TEWV **participated in** during 2015/16 are as follows:

- National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH);
- POMH UK Topic 13b: Prescribing for ADHD in Children, Adolescents and Adults;
- POMH UK Topic 14b: Prescribing for substance misuse – alcohol detoxification;
- POMH UK Topic 15a: Prescribing valproate for bipolar disorder.

A further internal Trust re-audit of POMH UK Topic 10c: Prescribing antipsychotics for children and adolescents was undertaken.

The national clinical audits and national confidential inquiries that TEWV participated in, and for which data collection was completed during 2015/16, are listed in the table above alongside the number of cases submitted to each audit or inquiry as a percentage of the number of registered cases required by the terms of the national audit or inquiry.

Audit Title	Cases Submitted	% of the number of registered cases required
POMH UK Topic 13b: Prescribing for ADHD in Children, Adolescents and Adults.	99	Not applicable
POMH UK Topic 14b: Prescribing for substance misuse – alcohol detoxification.	27	Not applicable
POMH UK Topic 15a: Prescribing valproate for bipolar disorder.	197	Not applicable
National Confidential Inquiry into Suicide & Homicide by People with Mental Illness.	n/k*	99%

** Cases are submitted confidentially and directly by individual consultants, and therefore, the number of cases submitted is unknown.*

The report of **one** national clinical audit was reviewed by the provider in 2015/16 and TEWV intends to take the following actions to improve the quality of healthcare provided:

- POMH UK Topic 13b: Prescribing for ADHD in Children, Adolescents and Adults

Actions:

- Present audit report to drugs and therapeutics committee, CYPS, LD and AMH clinical audit subgroups.
- Disseminate audit report to relevant team managers and consultants.
- Work by CAMHS / LD CAMHS consultants to find out about access arrangements to centile charts.
- Identify a source of pulse centile charts and make them available to CAMHS / LD CAMHS teams.
- Project lead to liaise with adult ADHD and CAMHS teams to introduce standardised rating scales for use in reviews for patients prescribed medication for ADHD.

The reports of **161** local clinical audits were reviewed by the provider in 2015/16 and TEWV intends to take actions to improve the quality of healthcare provided. **Appendix 2** includes the actions we are planning to take against the **eight** key themes from these local clinical audits reviewed in 2015/16.

*In addition to those local clinical audits reviewed (i.e. those that were reviewed by our Quality Assurance Committee and Clinical Effectiveness Group), the Trust undertook a further **66** clinical audits in 2015/16. These clinical audits were led by the services and individual members of staff for reasons of service improvement and professional development and were reviewed by the specialty clinical audit subgroups.*

Participation in clinical research

The number of patients receiving NHS services provided or subcontracted by TEWV in 2014/15 that were recruited during that period to participate in research approved by a research ethics committee was **260**.

*Of the **331**, **314** were recruited to **22** National Institute for Health Research (NIHR) portfolio studies. This compares with **265** patients involved as participants in NIHR research studies during 2014/15.*

Recruitment into research has increased this year due to a number of higher recruiting studies including the REQUOL (mental health) study which recruited 84 participants and the IDEAL (Dementia) study which recruited 60 participants. The Trust contributes to the overall Clinical Research Network: North East and North Cumbria targets for recruitment and the Mental Health, DeNDRoN and Health Service Delivery specialties that we contribute to have all exceeded recruitment targets for this year.

We continue to be involved with large scale national research across a variety of clinical disciplines such as psychosis, drug safety, forensic mental health, dementia, learning disabilities, personality disorder and children and young people services. Our ongoing participation in clinical research through 2015/16 reflects our firm commitment to improving the quality of care we provide, as well as contributing to the broader goals of mental health, learning disability and dementia research. The Trust has also supported national research into the implications of later retirement ages in the NHS.

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

- *We were involved in conducting **61** clinical research studies during 2015/16. **27** of these studies were supported by the NIHR through its networks and **17** new studies approved through its coordinated research approval process.*
- ***28** members of our clinical staff participated as researchers in studies approved by a research ethics committee, with **16** of these in the role of principal investigator for NIHR supported studies.*
- ***875** members of our staff were also recruited as participants to both NIHR portfolio and non-portfolio studies that were undertaken within TEWV.*
- ***76** researchers from outside the organisation were granted access under the National Research Passport Scheme to perform research with us compared to 33 in 2014/15. This increased number was due to issuing 37 letters of access for research teams to access research participants in the York and Selby region which became part of our Trust in October 2015.*
- *We have a new 5 year R&D strategy with a strong focus on PPI engagement and academic collaborations which provide us with the aim of becoming a lead research site with further opportunities for research involvement for our service users. We continue to be co-applicants on large scale grant applications in collaboration with our university partners.*
- *We have setup a clinical trials pharmacy department which will provide the infrastructure to enable us to participate in future CTIMP studies.*
- *We have research champions embedded across all of our memory services which provides a link to ensure equality of access to research opportunities across the Trust. Our research champions promote the national Join Dementia Research system and we have been a pilot site for a 'JDR' on prescription scheme in collaboration with the Alzheimer's Society.*

Goals agreed with commissioners

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

A proportion of TEWV's income in 2015/16 was conditional on 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.

Further details of the agreed goals for 2015/16 and for the following 12 month period are available electronically at http://www.tewv.nhs.uk/site/about/how-well-are-we-doing.

As part of the development and agreement of the 2015/16 mental health contract, discussions were held between the Trust and each of its commissioners to agree a set of goals and indicators that all parties felt were appropriate and relevant to local and national strategies. Indicators linked to physical healthcare, positive behaviour support and family support were key to both provider and commissioners. These are monitored at meetings every quarter with our commissioners.

An overall total of £6,509,603 was available for CQUIN to TEWV in 2015/16 conditional upon achieving quality improvement and innovation goals across all of its CQUINs, and a total of £6,459,439 (99.2% from the TEWV CQUIN prior to the Vale of York contract and 100% from the Vale of York CQUIN) is estimated to be received for the associated payment in 2015/16. This compares to £5,765,066 (98.02%) received in 2014/15, £5,777,218 (99.28%) in 2013/14 and £5,938,580 (100%) in 2012/13 (the estimate for 2015/16 has still to go through all the required governance processes for full approval). The Vale of York CQUIN consisted of a 1.57% scheme which was included within the contract in relation to services post October 2015.

Some examples of CQUIN indicators which the Trust made progress with in 2015/16 were:

- *Improved response time for urgent assessments to North Yorkshire acute trust emergency departments, children's wards, adult crisis teams and community services. Baseline data for March – May 2015 showed that 25% of urgent referrals within Scarborough were seen by a suitably trained practitioner within four hours of referral, 22% in Northallerton and 92% in Harrogate. As at quarter 4, all areas reported **100%**.*
- *To support parent/carers, young carers and siblings of young people in service, an evaluation of family support has been undertaken. Peer mentoring groups are being offered in Durham & Darlington and Teesside.*
- *Expanded peer worker roles throughout the Trust. The Trust exceeded the targets for the agreed metrics with commissioners. **14** involvement peers and **two** paid expert coordinator posts have been introduced. There are now **50** regular positions on steering and working groups for service users with lived experience and there are a further threeTrust groups that are attended by an average number of **31** individuals with lived experience. **79** volunteering opportunities have been offered to individuals with lived experience.*
- *Improved care pathway journeys within CAMHS to ensure compliance with admission and discharge standard process descriptions. At quarter 1 60% of admissions were completed in line with the standard process description and 79% of discharges. As at quarter 4, **95%** of admissions and **100%** of discharges were completed in line.*

What others say about the provider

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

TEWV is required to register with the Care Quality Commission (CQC) and its current registration status is **registered to provide services with no conditions attached**. The Care Quality Commission has not taken enforcement action against TEWV during 2015/16.

During 2015/16 TEWV were subject to one CQC Compliance inspection at Ridgeway, Roseberry Park but has not yet received formal feedback.

The Trust has had one social care inspection during 2015/16 at 367 Thornaby Road and a draft report has been received. The draft report states that 367 Thornaby Road is good overall and no action plan was required.

CQC's rating for each key area for 367 Thornaby Road was:

Key area	Rating
Are services caring?	Good
Are services safe?	Good
Are services effective?	Good
Are services responsive?	Good
Are services well-led?	Good

The Trust has also had one joint CQC and HMPI 2015/16 inspection but are waiting for formal feedback.

The CQC also undertook a review of health services for Looked After Children and Safeguarding in the Middlesbrough, from 8 June to 15 June 2015. A recommendation for TEWV and the CCG was to ensure that early help services for children who require access to Tier One and Two services for emotional health and well-being are strengthened.

There has also been a Looked After Children and Safeguarding review in Hartlepool; however the final report is awaited.

York and Selby Service

In the mobilisation period leading up to the transfer of York and Selby services from Leeds and York Partnership Foundation Trust (LYPFT) to TEWV, a CQC Inspection was carried out at Bootham Park Hospital (BPH) on 8 and 9 September 2015. This was a follow up to the Trustwide CQC Inspection of LYPFT in October 2014 where compliance actions were raised.

During this inspection of BPH, the CQC identified specific concerns about the environment and in particular the fixture and fittings that posed potential ligature risk of suicide or serious harm for patients; LYPFT were not able to remove the fixtures and fittings because of BPH status as a listed building. As well as the ligature risk there was a problem with the water temperature and patients were believed to be at risk of scalding from high water temperatures.

On the two adult admission inpatient wards CQC Inspectors found that nursing staff were unable to observe all parts of the wards due to the layout, that there was a lack of call alarms for patients, there was poor hygiene and infection control as well as insufficient staffing levels.

On the 24 September 2015 LYPFT were given notice by CQC that they were to de-register BPH and formally served them notice under Section 64 of the Health and Social Care Act 2014. CQC stated that they required for no regulated activities to be carried on at the location BPH by midnight 30 September 2015.

On the 1 October 2015 the York and Selby services transferred to TEWV and a Notice of Decision to vary the conditions of TEWV Registration by CQC was received. This confirmed that they had registered all services with the exception of BPH. Since the Notice of Decision was made CQC have allowed TEWV to reopen Bootham Park for outpatient services and the Section 136 Suite only.

The following requirements were found by CQC following their LYPFT inspection in September 2015 at Bootham Park Hospital and the actions taken by TEWV since the 1 October 2016 to address these issues raised by CQC are:

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Fundamental standards were not met as the provider (LYPFT) did not:

- take appropriate steps to ensure wards were safe to use for their intended purpose and were used in a safe way;
- assess the risk of infection and prevent and control the spread of infection;
- assess the risks to the health and safety of service users of receiving care or treatment. They did not include arrangements to respond appropriately and in good time to people's changing needs;
- have risk assessments that contained plans for managing risks;
- do all that was reasonably practicable to mitigate risk. The Trust (LYPFT) did not make the required adjustments to premises, process and practices to ensure the safety of people who used the service.

Actions and Progress by TEWV

- Inpatient wards have moved from Bootham Park Hospital. Peppermill Court and Acomb Garth are undergoing refurbishment. This will ensure that all York and Selby patients in beds within that locality will be in wards / units that meet the safe care and treatment standards.
- Peppermill Court environmental risk assessment to be reviewed once refurbishment completed.
- Review all environmental risk assessments in line with TEWV policies. On completion of review of environmental risk assessments, consider unsafe areas and ensure doors locked where appropriate.
- A Trustwide review of ligature risk was undertaken in March 2016. Estates work identified will be completed.
- All Ward environments will be EMSA compliant following refurbishment.
- New risk assessment framework and new Paris (our electronic patient record system) training will be implemented together. FACE risk assessment and SAMP (Safety, Assessment Management Plan) will be discontinued by end of March 2016.
- The multi-disciplinary team will ensure all patients will be involved in planning their care and treatment, including the observation and engagement care plan. This will be recorded daily in the clinical record and include the patients' views.
- Infection prevention and control (IPC) audits to be undertaken in all inpatient wards in York and Selby locality.

Regulation 18 HSCA (RA) Regulations 2014 Staffing
Fundamental standards were not met as the provider did not:

- ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in order to make sure they could meet people's care and treatment needs.

Actions and Progress by TEWV

- Ongoing programme of recruitment alongside management of change process.
- Process to manage staff in MHSOP and AMH service through business continuity and management of change process to support establishment of staff across both services.
- Review of shift systems and establishments and introduction of e-roster meetings across all wards and services.

The following requirements were found by CQC following their LYPFT inspection in October 2014 across York and Selby services. Below are the actions TEWV have identified to be taken and their progress against breaches and compliance issues raised by CQC which are not covered by the actions raised in the September 2015 actions listed above.

Regulation 19 HSCA 2008 (Regulated Activities)
Regulations 2010 Complaints
The systems for identifying, handling and responding to complaints made by service users were not effective across the Trust (LYPFT).

This is because the systems currently in place did not identify, handle and record complaints being resolved at local resolution or ward level, complaints were stored and handled within patient care records contrary to published guidance and it was not clear that complaints were fully investigated.

Actions and Progress by TEWV

- Complaints are recorded and managed centrally by the complaints department. Staff in York and Selby now adhere to TEWV complaints policy. Lessons learnt following complaints are shared in the York and Selby locality QuAGs. TEWV complaints manager has attended Quality Assurance groups in York and Selby to discuss process for managing complaints. When complaints have been received discussions have taken place with relevant service managers and other clinical staff to enable responses to be provided.

Regulation 23 HSCA 2008 (Regulated Activities)
Regulations 2010 Supporting staff
The Trust (LYPFT) did not ensure that staff received mandatory training including Mental Capacity Act (MCA) and Deprivation Of Liberty Safeguards (DoLS), complaints training and Mental Health Act training. The Trust did not ensure all staff received appropriate training, supervision and appraisal.

Actions and Progress by TEWV

- Monitoring of mandatory training is undertaken by the education and training department and reported to ward managers, the York and Selby locality management and governance board and the Trust Board. Ward managers ensure staff complete mandatory training as well as supervision and appraisal.

Regulation 18 HSCA 2008 (Regulated Activities)
Regulations 2010 Consent to care and treatment
The registered provider (LYPFT) did not have suitable arrangements in place for obtaining and acting in accordance with, the consent of patients in relation to the care and treatment provided to them at Bootham Park Hospital ward 2 and the Becklin Centre ward 4 and 5 in accordance with the Mental Health Act (MHA), Code of Practice, Regulation 18.

Actions and Progress by TEWV

- The rolling programme of MHA training now includes the York and Selby locality. The programme has six modules ranging from an introduction to the MHA and MCA to modules including consent and capacity, MHA / DoLS interface. All of these modules are available to York and Selby staff of all levels and disciplines.
- TEWV have also provided specific training to each ward and unit around the MHA and MCA including TEWV policies, all of which have been implemented across York and Selby which reflect the requirements of both the MHA and MCA Codes of Practice.

Regulation 20 HSCA 2008 (Regulated Activities)
Regulations 2010 Records
The patients were not protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of an accurate record in respect of each service user which should include appropriate information and documentation in relation to their care and treatment.

Actions and Progress by TEWV

- Immediate review of care record documentation was reported as undertaken by LYPFT and improvements made.
- Physical health assessment on admission will be monitored as part of the audit on admission paperwork and care plan audit.

Regulation 13 HSCA 2008 (Regulated Activities)
Regulations 2010 Management of medicines
At Worsley Court the Trust (LYPFT) must ensure that there are no delays to the administration of patients' medication.

Actions and Progress by TEWV

- Registered nurses now check all drug cards following medication rounds.
- Posters requesting non-interruption of medication rounds are now placed on the ward for visitors and staff.
- A meeting has taken place to look at improving systems and process around the management of medicines at all MHSOP services in York and Selby.
- Medication round observations are now undertaken within York MSHOP services and reported on by the lead nurse for medicines management.

TEWV has also participated in **43** Mental Health Act inspections by the Care Quality Commission to the following ward areas during 2015/16:

Ward	Service type	Locality
Acomb Garth	Adult Mental Health Rehab	York
Bankfields Court	Learning Disabilities Assessment & Treatment	Middlesbrough
Bedale	Adult Mental Health Assessment & Treatment	Middlesbrough
Bek	Learning Disabilities Assessment & Treatment	Durham
Bilsdale	Adult Mental Health Assessment & Treatment	Middlesbrough
Birch	Adult Eating Disorders	Darlington
Brambling	Forensic Mental Health Low Secure	Middlesbrough
Bransdale	Adult Mental Health Assessment & Treatment	Middlesbrough
Cedar	Adult Mental Health Assessment & Treatment	Darlington
Ceddesfeld	Older People's Mental Health Assessment & Treatment	Bishop Auckland
Cherry Trees	Older People's Mental Health Assessment & Treatment	York
Danby	Adult Mental Health Assessment & Treatment	Scarborough
Eagle	Forensic Learning Disability Low Secure	Middlesbrough
Earlston House	Adult Mental Health Rehab	Darlington
Farnham	Adult Mental Health Assessment & Treatment	Durham
Harland	Forensic Learning Disability Low Secure	Durham
Harrier	Forensic Learning Disability Low Secure	Middlesbrough
Ivy/Clover	Forensic Learning Disability Low Secure	Middlesbrough
Jay	Forensic Mental Health Low Secure	Middlesbrough
Kirkdale	Low Secure Rehabilitation	Middlesbrough
Langley	Forensic Learning Disability Low Secure	Durham
Lark	Forensic Mental Health Low Secure	Middlesbrough
Lincoln	Adult Mental Health Assessment & Treatment	Hartlepool
Lustrum Vale	Adult Mental Health Rehabilitation	Middlesbrough
Mandarin	Forensic Mental Health Medium Secure	Middlesbrough
Maple	Adult Mental Health Assessment & Treatment	Darlington
Meadowfields	Older People's Mental Health Assessment & Treatment	York
Merlin Ward	Forensic Mental Health Low Secure	Middlesbrough
Newberry Centre	Child and Adolescent Service Assessment & Treatment	Middlesbrough
Oak Rise	Learning Disabilities Assessment & Treatment	York
Orchards	Adult Mental Health Rehabilitation	North Yorkshire
Park House	Adult Mental Health Rehabilitation	Middlesbrough
Primrose Lodge	Adult Mental Health Rehabilitation	Chester le Street
Robin	Forensic Learning Disability Low Secure	Middlesbrough
Roseberry	Older People's Mental Health Assessment & Treatment	Darlington
Sandpiper	Forensic Mental Health Medium Secure	Middlesbrough
Springwood	Older People's Mental Health Assessment & Treatment	North Yorkshire
Westerdale North	Older People's Mental Health Assessment & Treatment	Middlesbrough
Westerdale South	Older People's Mental Health Assessment & Treatment	Middlesbrough
Westwood Centre	Child and Adolescent Service Low Secure	Middlesbrough
White Horse View	Learning Disabilities Rehabilitation	Easingwold
Willow	Adult Mental Health Rehabilitation	Darlington
Worsley Court	Older People's Mental Health Assessment & Treatment	Selby

Quality of data

TEWV submitted records during 2015/16 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: 99.99% for admitted patient care.
- Which included the patient's valid General Medical Practice Code was 99.98% for admitted patient care.

TEWV information governance assessment report overall score for 2015/16 was 89% and was granted as **satisfactory***.

**The colour green represents the information governance toolkit rating of satisfactory.*

The information governance toolkit measures performance in the following areas:

- information governance management
- confidentiality and data protection
- information security assurance
- clinical information security assurance
- secondary use assurance
- corporate information assurance.

A satisfactory score in the toolkit is important to patients as 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 completed training in areas such as confidentiality and information security. It also shows the Trust carries out its legal duties under the Data Protection Act 1998 and Freedom of Information Act 2000.

89% *(**satisfactory**) means that we have achieved at least level 2 on all of the 45 requirements of the toolkit, however, in a significant number of elements we attained level 3 (the highest score).*

TEWV was **not** subject to the Payment by Results clinical coding audit during 2015/16 by the Audit Commission.

Monitor, issued draft guidance at the end of 2014 for the 2015/16 financial year. This required organisations to share with commissioner's outcome measurements as a key requirement of developing the Mental Health Currency and Tariff. The areas for development are:

- ***Clinically Reported Outcome Measure (CROM)****: this is the Health of the Nation Outcome Score (HoNOS) and reported via the Mental Health Minimum Data Set (MHMDS). The reporting of this is now available to all clinicians and managers on their desktops via the IIC. The outcome reports are also routinely provided to commissioners. These reports are automatically generated by the IIC, other than in York and Selby, where moving data recording onto the electronic patient record system used in the rest of the Trust has to be completed first (this move will be taking place in 2016/17 Q1).*
- ***Patient Reported Outcome Measure (PROM)****: the Trust has implemented the use of the patient reported wellbeing measure, the short version of the Warwick-Edinburgh Mental Well-being Scale (SWEMWBS). The reporting of this is now available to all clinicians and managers on their desktops via the IIC, other than in York and Selby (see above).*

A training programme has been provided to clinical staff on the use and understanding of the outcome tools in day to day practice and how to access and interpret the IIC data in relation to PROMS and CROMS.

At the end of March 2016, excluding York and Selby:

- ***97%*** *of service users on the adult mental health (AMH) and 99% of services users on the mental health services for older people (MHSOP) caseloads were assessed using the mental health clustering tool.*
- ***91%*** *of service users on the adult mental health (AMH) and 91% of services users mental health services for older people (MHSOP) caseloads were reviewed within the guideline timeframes.*

Further work for 2016/17 includes:
- *The testing of a currency model in forensic mental health services and children and young people's services.*

TEWV will be taking the following actions to improve data quality:
- We have a data quality 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.
  - To ensure that every member of our staff understands that data quality is the responsibility of everyone and an integral part of their role.
  - To ensure we achieve compliance with all our statutory and regulatory obligations.
- A data quality working group (formed in late 2014/15) continues to identify areas of poor data quality, develop locality specific action plans in relation to data quality, and provide advice, support and education to teams. This group reports into the Trust data quality group.
- 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.
- We report on data quality to the Board as part of our strategic direction scorecard reports.
- 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, Performance and Communication.
- We have agreed data quality improvement plans (DQIPs) with our commissioners for key indicators, particularly those that require new data recording or collection systems to be put in place.

"She has not only supported my husband but also me - his wife and carer. It means a lot to us that she takes the time to talk us through problems and queries with such patience and empathy. I know that she is at the other end of the phone whenever needed and is so approachable."

from a service user's husband

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 7 day follow-up

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

Note the data for quarter 3 and Quarter 4 2015/16 does include York & Selby services which joined the Trust on the 1 October 2015 (see table below).

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 4 2015/16 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 in quarters 2 and 3 is due to the fact the NHSIC data is submitted at a Clinical Commissioning Group (CCG) level, and therefore, excludes data where the CCG is unspecified in the patient record
- the few actual breaches, **50** in total in 2015/16, were a result of:
  - difficulty in engaging with the service user despite efforts of the service to contact the patient; and
  - breakdown in processes.

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

- monitoring this key performance indicator via the Trust's dashboard at team, service and Board level on a monthly basis
- investigating all breaches and identifying lessons to be learned at directorate and service level performance meetings
- undertaking a quality improvement system session to review the monitoring and validation process
- adhering to a standard process to ensure patients discharged to other services (e.g. 24 hour care unit) are not overlooked, including the introduction of visual control boards
- 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.

TEWV Actual Quarter 4 2015/16	National Benchmarks in Quarter 3 2015/16	TEWV Actual Quarter 3 2015/16	TEWV Actual Quarter 2 2015/16	TEWV Actual Quarter 1 2015/16
Trust final reported figure: **97.75%**	NHSIC reported: Highest/best MH Trust = **100%**	Trust final reported figure: **97.8%**	Trust final reported figure: **97.5%**	Trust final reported figure: **98.1%**
Figure reported to Monitor: **98.76%**	National average MH Trust = **96.9%**	Figure reported to Monitor: **97.55%**	Figure reported to Monitor: **97.57%**	Figure reported to Monitor: **98.07%**
NHSIC reported: **97.8%**	Lowest/worst MH Trust = **50%**	NHSIC reported: **97.5%**	NHSIC reported: **97.6%**	NHSIC reported: **98.1%**

** latest benchmark data available on NHSIC at quarters 3 2015/16*

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.

Note the data for Quarter 3 and Quarter 4 2015/16 does include York & Selby services which joined the Trust on the 1 October 2015 (see table below).

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 Clinical Commissioning Group (CCG) level, and therefore, excludes data where the CCG is unspecified in the patient record
- the few actual breaches, **49** in total in 2015/16, 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 team, service and Board level on a monthly basis
- investigating all breaches and identifying lessons learnt at director and service level performance meetings
- undertaking a quality improvement event session to review the monitoring and validation process
- 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.

TEWV Actual Quarter 4 2015/16	National Benchmarks in Quarter 3 2015/16	TEWV Actual Quarter 3 2015/16	TEWV Actual Quarter 2 2015/16	TEWV Actual Quarter 1 2015/16
Trust final reported figure: **97.18%**	NHSIC Reported: National average MH Trust = **97.4%**	Trust final reported figure: **96.6%**	Trust final reported figure: **97.2%**	Trust final reported figure: **97.9%**
Figure reported to Monitor: **96.74%**	Highest/best MH Trust = **100%**	Figure reported to Monitor: **96.57%**	Figure reported to Monitor: **97.24%**	Figure reported to Monitor: **98.13%**
NHSIC Reported: **96.7%**	Lowest/worst MH Trust = **61.9%**	NHSIC Reported: **96.5%**	NHSIC Reported: **97.0%**	NHSIC reported: **98.1%**

** latest benchmark data available on NHSIC at quarters 3 2015/16*

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

The data made available by the Health and Social Care Information Centre (NHSIC) with regard to the Trust's "patient experience of community mental health services" indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period. The figures we have included are from the CQC website but at the time of writing comparative figures were not available on the NHSCIC.

TEWV Actual 2015	National Benchmarks in 2015	TEWV Actual 2014	TEWV Actual 2013
Overall section score: **8.0** (sample size 239)	Highest/Best MH Trust = **8.2** Lowest/Worst MH Trust = **6.8**	NHSIC Reported: **8.1*** (sample size of 188)	NHSIC Reported: **89.40** (sample size of 217)

**not directly comparable with 2013 data*

An overall Trust score is not provided, due to the nature of the survey, therefore it is not possible to compare Trusts overall. For 2015, we have reported the section score which compiles the results from the questions used from the survey detailed in the notes on metric.

Note the data in the above table does not include York and Selby services which joined the Trust on the 1 October 2015, which was after the survey was carried out.

Notes on metric

Prior to 2014, this indicator was 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?

However the CQC (who design and collate the results of the survey) no longer provide a single overall rating for each NHS Trust. Therefore, for 2014 onwards, the following questions replaced those previously asked around contact with a NHS health worker or social care worker:

…Did the person or people listen carefully to you?
…Were you given enough time to discuss your needs and treatment?
…Did the person or people you saw understand how your mental health needs affect other areas of your life?

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

- The figures are derived from the NHS Patient survey report.
- The individual scores that this figure is based on were:
  - Did this person listen carefully to you: TEWV mean score of **8.4**. The lowest national mean was 7.6 and the highest 8.7.
  - Were you given enough time to discuss your needs and treatment: TEWV mean score of **7.7**. The lowest national mean was 6.8 and the highest 8.0.
  - Did the person or people you saw understand how your mental health needs affect other areas of your life: TEWV mean score of **7.7**. The lowest national mean was 6.0 and the highest 7.8.

To determine how the Trust is performing, a banding of better/worse/about the same was allocated to each Trust for each question, using a statistic called the 'expected range' which takes into account the number of respondents from each Trust as well as the scores for all other Trusts. Of the 33 questions rated, the CQC categorisation of TEWV result compared to other mental health Trusts was "Better" for 5 questions and "About the Same" for 28.

The CQC has published detailed scores for TEWV which can be found at http://www.cqc.org.uk/provider/RX3/survey/6#undefined.

TEWV is taking the following actions to improve patient experience through:

- further staff training on positive behavioural support. Full implementation of this approach should improve the experience for inpatients due to reduced use of restraint
- increasing the amount of time available for clinical staff to spend in direct contact with patients through improvements to other processes that they are involved with (including reducing the time taken to input essential information into our electronic care record)
- the Quality Improvement priorities set out in section 3, particularly the further development of a Recovery Approach, Harm Minimisation and Transitions should have a positive impact upon community patient experience
- continuing to carry out our local inpatient and community surveys with established mechanisms in place for action plan development and feedback.

The Trust continues to carry out regular patient experience surveys across all services which includes the Friends and Family Test. Between April 2015 and January 2016 the Trust received feedback from 11,916 patients of which 86% would be extremely likely or likely to recommend the service and 5% would be unlikely or very unlikely to recommend.

Patient safety incidents including incidents resulting in severe harm or death

The data made available by the Health and Social Care Information Centre (HSCIC) 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. The next reporting period is March 2016.

Note the data below includes York and Selby from the 1 October 2015 when these services which joined the Trust.

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

- The Trust reported and National Reporting & Learning System (NRLS) reported data for quarters 3 and 4 2014/15 showed a variance of 642 incidents. In considering the information it is acknowledged that at that time there was sometimes an identified delay in uploading incidents to NRLS which would account for the figures reported. Incidents are now uploaded to NRLS on a weekly basis. In Q1 and Q2 of 2015/16 there is a discrepancy of 172 incidents which relates to a data quality issue following a system upgrade in the reporting period.
- The number of incidents reported by TEWV to the NRLS for Quarters 1 and 2 2015/16 was just below the national average. However, it is not possible to use the NRLS data to comment on a 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 a Trust and the complexity of their case-mix. We have noted that:
  - the reporting of patient safety incidents in the Trust was largely consistent when comparing quarters 1 and 2 2015/16 with quarters 3 and 4 2014/15
  - amongst the most common themes reported are self-harming behaviour, patient accident, disruptive, aggressive behaviour and medication which account for three-quarters of all incidents leading to harm
  - during 2015/16 TEWV reported 119 incidents as serious Incidents, of which 80 were deaths due to unexpected causes.

Ongoing work in TEWV continues to improve our reporting culture and the quality of our services through:

- analysis of all patient safety incidents. These are reported and reviewed by the patient safety group and sub group of the Trust's Quality Assurance Committee. A monthly report is circulated to the QuAC. Safety incidents are reported to commissioners via the clinical quality review process
- the implementation of an enhanced web-based reporting system that enables timely and service-specific analysis and a transparent corporate overview including proactive identification of areas of risk, trends and themes across the whole of the Trust
- a dedicated central approval team is in place to ensure consistent grading of incidents and to improve the overall quality of reporting
- analysis of 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
- ensuring all serious incidents (ie those resulting in severe harm or death) are subject to a serious incident review. This is a robust and rigorous approach to understand how and why each incident has happened, to identify any causal factors and to identify and share any lessons for the future. Raising awareness of the importance and value of reporting and reviewing 'near misses'
- implementation of a revised policy in line with the NHS England Serious Incident Framework (2015). This new approach will promote an increased opportunity for learning lessons and improving the quality of services.

TEWV Actual Quarters 3&4 2015/16	*National Benchmarks in Quarters 3&4 2014/15	TEWV Actual Quarters 1&2 2015/16	TEWV Actual Quarters 3&4 2014/15
Trust Reported to NRLS: *as at 31st March 2016 **3789** incidents reported of which **110 (2.9%)** resulted in severe harm or death	NRLS Reported: National Average MH Trusts: incidents reported of which resulted in severe harm or death **Lowest MH Trust: **840** incidents reported of which **0** resulted in severe harm and **11 (1.3%)** in death Highest MH Trusts: **6723** incidents reported of which **74 (1.1%)** resulted in severe harm and 0 in death. The highest reported rate of deaths as a proportion of overall incidents was reported by two MH Trusts at 3.2%.	Trust Reported to NRLS: **3,827** incidents reported of which 72 (1.88%) resulted in severe harm or death* NRLS reported: **3,827** incidents reported of which **72 (1.88%)** resulted in severe harm or death *17 Severe Harm and 55 Death	Trust Reported to NRLS: **3,279** incidents reported of which **27 (0.8%)** resulted in severe harm or death NRLS reported: **3921** incidents of which **31 (0.8%)** resulted in severe harm or death

*** One Trust reported 8 incidents with 0 incidents of severe harm or death*

2016/17 Priorities for Improvement

During 2015/16 we held two events inviting our stakeholders to take part in our process of identifying quality priorities for 2016/17 to be included in the quality report. These events took place in July 2015 and February 2016: further information can be found in **Part 3, our stakeholders' views section**. In addition to the quality priorities identified by our stakeholders, we have a number of additional priorities to improve quality included within the Trusts 2016/17 – 2018/19 Business Plan; details can be found in **appendix 3**.

Our four agreed 2016/17 priorities for inclusion in the quality report are:

Priority 1: Continue to develop and implement recovery focused services

Priority 2: Implement and embed the revised harm minimisation and risk management approach

Priority 3: Further implementation of the nicotine replacement programme and smoking cessation project

Priority 4: Improve the clinical effectiveness and patient experience at times of transition

Priority 1: Continue to develop and implement recovery focused services

Why this is important:
Service users and carers continue to make it clear that they want services to go beyond reducing the symptoms of mental health. They want support to live meaningful and fulfilling lives irrespective of whether or not they experience a reduction in symptoms.

This is a continuation of the priority originally identified in 2014/15 and it recognises that while cultural change is occurring, it will require ongoing work for a number of years to embed the recovery approach meaningfully. An extension of work in this area is essential for ensuring recovery orientated care is available across all Trust areas including the York and Selby locality and corporate services. In addition we need to ensure that recovery principles are embedded within other key strategic projects

Our stakeholders and Board therefore agreed it was important that this remains a key priority in 2016/17.

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

- the care they receive to be designed to support and achieve their own personal goals
- they feel really listened to and heard
- their views and personal expertise by experience are valued
- they are supported to take charge of their lives, promoting choice and self-management
- our staff to work in partnership with them at every level of service delivery; genuinely believe that service users will benefit from an improved quality of life and reflect this in care plans.

What we will do in 2016/17:

We will:

- ensure recovery principles are embedded within the Trust's harm minimisation project by including them within the training being implemented by the project by Q2 2016/17
- expand peer involvement within the Trust, having six new peer roles by Q3 2016/17
- continue to implement phase 1 of the recovery project with an interim evaluation report presented to the executive management team providing an update on progress to date by Q3 2016/17
- develop a business case for phase 2 of the recovery project and submit for approval by Q3 2016/17
- deliver recovery training to 84% of new Trust staff as part of their induction by Q4 2016/17
- develop and consolidate the experts by experience group ensuring their input into key Trust developments by Q4 2016/17
- design and establish the Virtual Recovery College so that it available to access by Q4 2016/17
- complete implementation of phase 1 of the recovery project with a final evaluation report presented to the executive management team by Q1 2017/18
- if approved, implement phase 2 of the recovery project in line with agreed project plan.

How will we know we are making a difference?
In order to demonstrate that we are making progress against this priority we will measure and report on the following metrics:

Indicator	Target	Timescale
Percentage of new Trust staff receiving recovery training as part of their Trust induction.	84%	Q4 2016/17
To introduce new lived experience/ peer roles into the organisation.	6	Q4 2016/17
Number of self-management pages available on Virtual Recovery College.	30	Q4 2016/17
Number of new opportunities for individuals with lived experience to take part in service development / improvement initiatives.	20	Q4 2016/17

Priority 2:
Implement and embed the revised harm minimisation and risk management approach

Why this is important:
Harm minimisation is an approach to proactively identifying, assessing, evaluating, reducing and communicating risk in order to maximise safety for all parties involved in the care and treatment of our service users and carers. Clinical risk assessment and management in practice provides a protective process within which to promote the principles of recovery. Best Practice in Managing Risk (Department of Health June 2007) states that: "*Safety is at the centre of all good health care, this is particularly important in mental health, but it is also more sensitive and challenging'. Furthermore, "Patient autonomy has to be considered alongside public safety. A good therapeutic relationship must include both sympathetic support and objective assessment of risk and an understanding of the benefits of positive risk taking*".

Traditionally, approaches to risk management for people within mental health and learning disability services have been concerned with protecting individuals and those around them from danger and reducing harm. A recent review of our risk management practices identified that within TEWV there was evidence that risk identification had become a 'tick box' exercise leading to poor risk identification and management. Little analysis of risks, lack of bringing together supporting information from different sources and minimal engagement of service users in their own assessment were regular findings of incident reviews. There was also an emerging picture of disconnection with identification of risk and subsequent development of a plan to mitigate and manage the risk.

A cultural shift is therefore required towards recovery focused harm minimisation and safety planning based on shared decision making and the joint development of personal safety plans. This presents an approach which respects service users' needs, while recognising everyone's responsibilities – service users, professionals, family, and friends – to behave in ways which will maintain personal and public safety. This recovery-orientated approach to harm minimisation is concerned with the development of hope, facilitation of a sense of control, choice, autonomy and personal growth, and the provision of opportunities for the service user rather than risk averse practice which may be detrimental to the service users recovery and rehabilitation.

The benefits / outcomes our service users and carers should expect:
- an increase in personal risk and safety plans that demonstrate clear formulation of risk and show direct correlation to the care and intervention plan
- an increase in the number of current risk assessments which show evidence of *formulation*
- an increase in the number of personal risk and safety plans that demonstrate co-production with service users, their families and/or carers
- a reduction in the occurrence of inadequate risk management practice as a root or contributory finding in the review of serious incidents from the baseline
- an agreed set of practice standards for the initiation, maintenance and termination of engagement and observation procedures based on the principles of harm minimisation intervention.

This project also supports delivery of the recovery project and priority 1.

What we will do in 2016/17:

We will:
- complete a review of the current harm minimisation and risk management practice across the Trust by Q1 2016/17
- develop and agree harm minimisation principles including engagement guidelines by Q1 2016/17
- develop and complete harm minimisation training materials and training plan which will include a recovery focused approach by Q2 2016/17
- commence face to face training which includes expert by experience input / delivery by Q2 2016/17
- develop an e-learning package which will include a competency framework by Q3 2016/17
- have sufficient staff trained in priority areas by Q4 2016/17.
- evaluate the project and develop options for future delivery by Q4 2016/17.

How will we know we are making a difference?
In order to demonstrate that we are making progress against this priority we will measure and report on the following metrics:

Indicator	Target	Timescale
Face to face training to be developed and delivered alongside experts by experience. This will support recovery orientated harm minimisation practice which focuses on narrative formulation and co-production of recovery / safety plans.	65% of all clinical staff received face to face training	Q4 2016/17
Set of outcome measures to be developed in conjunction with experts by experience/service users/ carers.	Quantitative and qualitative measures developed and implemented	Q2 2016/17
A measured increase in the number of current risk assessments which show evidence of formulation and a narrative from baseline.	To be confirmed as part of review of current harm minimisation practice taking place in Q1 2016/17	Q4 2016/17
An increase in personal risk and safety plans that demonstrate clear formulation of risk and show direct correlation to the care and/or intervention plan.		Q4 2016/17
An increase in the number of personal risk and safety plans that demonstrate co-production with service users, their families and/or carers.		Q4 2016/17

Priority 3:
Further implementation of the nicotine replacement programme and smoking cessation project

Why this is important:
This is a continuation of the priority identified in 2014/15 and recognises that delivery of the smokefree agenda is critical to improving the life expectancy and health of our service users and staff. Our stakeholders and Board therefore agreed it was important that this remained a key priority in 2015/16.

The work undertaken in 2015/16 enabled the Trust's inpatient areas to go smokefree on 9 March 2016. The aim of the extension of the priority is to embed the work completed to date (within inpatient services and with staff) and to implement further within the Trust's community teams – to support patients in a community setting to stop smoking.

In addition within the prison population, smoking rates are very high, at around 70-80% of prisoners, and a high proportion of these smokers have an identified mental health condition. By reducing smoking rates within the prisons population both prisoners and staff will benefit from the available nicotine management and smoking cessation services support, ultimately leading to improved physical health in the long term.

The benefits / outcomes our service users and carers should expect:
- encouragement to commit to giving up smoking
- effective support to give up smoking including access to nicotine replacement therapy (NRT)
- access to trained staff able to provide advice around smoking cessation
- improved physical health in the longer term
- the provision of voluntary smoke free wings in prisons in the North East for prisoners and staff eventually leading to a completely smoke free estate.

What we will do in 2016/17:

We will:
- develop a communication plan for the prison services by Q1 2016/17
- further embed the Trust's policy on being smoke free within inpatient sites by conducting an audit to show if levels of nicotine replacement / management products have increasingly been prescribed across inpatient sites by Q2 2016/17
- further embed the Trust's policy on being smoke free within inpatient sites by reviewing levels (and maintenance) of staff trained in nicotine management and smoking cessation by Q2 2016/17
- following the above audit and review of training, if necessary, identify inpatient sites that require additional support and provide training / one to one visits by Q2 2016/17
- nicotine management policy and information leaflets developed for prison services by Q3 2016/17
- medication options identified inclusive of the use of disposable e-cigarettes for prison services by Q3 2016/17
- continue to monitor the implementation plan developed to support staff to stop smoking by Q3 2016/17
- implement nicotine management and smoking cessation training across Trust community teams by Q4 2016/17
- support staff to ensure a seamless pathway of support on admission / discharge for service users undertaking smoking cessation by Q4 2016/17
- support prison services with their plans to go smoke free by identifying prison trainers to deliver level 1 and level 2 smoking cessation and nicotine management training by Q4 2016/17.

In addition, a clinical audit will be conducted in December 2016 to review the smoking status of the service users within the Trust to highlight the impact of change since going fully smokefree within Trust inpatient sites on the 9 March 2016.

How will we know we are making a difference:
In order to demonstrate that we are making progress against this priority we will measure and report on the following metrics:

Indicator	Target	Timescale
Proportion of community staff trained to level 1 (NCSCT) and brief intervention.	75%	Q4 2016/17
Proportion of relevant community staff that have been trained to smoking cessation level 2.	75%	Q4 2016/17
Following a review of adequate numbers of trained staff for in-patient units, the appropriate number of additional staff to be trained to Level 2.	75%	Q4 2016/17
Proportion of prisons providing smoke free wings for prisoners and staff to access/work within.	85%	Q3 2016/17

As mentioned above, an audit will be conducted during December 2016 to review the change in inpatient service user smoking levels since going smokefree on 9 March 2016.

Priority 4:
Improve the clinical effectiveness and patient experience at times of Transition

Why this is important:
Feedback we have received from stakeholders both internally and externally identified transitions as an area that should be focused on as a priority. This is due to service users highlighting issues at various points of transitions such as when a service user is moving from an inpatient unit where care is provided 24/7 to a community setting where care is provided less intensively or from CAMHS to adult services. Examples of issues that have faced patients were a feeling of "falling off a cliff" and finding it difficult to access clinical staff for advice in "sub-crisis" situations.

The various points of transition can be distressing with increased risk of harm for our service users and carers which we would like to minimise as much as possible. By focusing on a specific area of concern we will influence quality, improve patient safety risks and experience for the area of concern in order to sustain high levels of support for patients during times of transition. The area of concern we will be focusing on is CAMHS transitions to adult services. This type of transition has been highlighted as an issue via audits completed, feedback from stakeholders and through our commissioners providing a CQUIN target on CAMHS transitions.

The benefits / outcomes our service users and carers should expect:
By creating age, and developmental, appropriate risk assessments and care plans, CYPS will be able to co-produce risk assessments and risk management plans with the young person and their family, which are responsive to their age, development and need. Children, young people and their carers will therefore:

- have positive experience at points of transition
- be at the centre of their transition plan development and implementation
- be able to learn from and be supported by people with lived experience of the transition phase
- be able to become an expert in their own plan / developing their own solutions
- experience effective joint working and good information transfer by the services involved with each other and with the service users and their carer(s)
- have continuity of care post transition.

What we will do in 2016/17:

We will:

- baseline the current experiences of service users through a review of transition in CAMHS which includes service user and carer experience feedback by Q1 2016/17
- review and develop a safe transition and discharge protocol for CAMHS by Q1 2016/17
- implement the safe transitions and discharge protocol by Q2 2016/17
- undertake an audit of the protocols to include a further collection of service user and carer experience feedback by Q3 2016/17
- review the outcome of the audit with the aim to develop and implement an action plan by Q4 2016/17.

What we will do in 2017/18:

- using the audit action plan, further embed the safe transitions and discharge protocol by monitoring the agreed actions and timescales by Q2 2017/18
- undertake an additional audit of the protocols to include further collection of service user and carer experience feedback by Q2 2017/18
- review outcome of the audit, updating current action plan by Q3 2017/18
- complete an evaluation report on the effectiveness of implementation of the new protocol and feedback to relevant stakeholders by Q4 2017/18.

How will we know we are making a difference?
In order to demonstrate that we are making progress against this priority we will measure and report on the following metrics:

Indicator	Target	Timescale
Implement new transitions protocol across CAMHS teams.	100%	Q3 2016/17
An improvement in the experience of service users going through transitions in CAMHS.	90%	Q3 2017/18

Monitoring Progress

The Trust will monitor its progress in implementing these priorities at the end of each quarter and report on this to the Quality Assurance Committee and Council of Governors.

We will also send a six monthly update to all of our stakeholders, and provide a further update of the position as of 31 December at our February 2016 quality account stakeholder workshop.

Part 3: Other information on quality performance 2015/16

Our performance against our quality metrics

The following table provides details of our performance against our set of agreed quality metrics for 2015/16.

Note: *the data in this section does not include York and Selby services which joined the Trust on 1 October 2015 unless stated in the "Notes on selected metrics".*

These metrics are the same as those we reported against in our quality report, 2014/15 and since 2011/12. This allows us to monitor progress over time. However, in some cases we have needed to change our metrics:

- The 'number of unexpected deaths' reported in 2011/12 (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 more valid approach for making comparisons across the years as it allows for changes in activity within the Trust.
- The 'number of patient falls per 100,000 occupied bed days' reported in 2011/12 and 2012/13 (metric 3) was changed in 2013/14 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 2011/12 and 2012/13 (metric 8) was changed in 2013/14 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.

Please also note the National Patient Survey for 2015/16 is not directly comparable to previous surveys therefore the historical data has been moved from the tables below to the "notes on selected metrics".

During 2016/17 we will be reviewing our Trust's quality strategy. As part of this work we will be agreeing a set of Trust quality metrics. It is likely that future quality reports will contain some of the most important of these revised quality metrics rather than those in this quality report.

Quality Metrics

Quality Metrics	2015/16 Target	2015/16 Actual	2014/15 Actual	2013/14 Actual	2012/13 Actual	2011/12 Actual
Patient Safety Measures						
1 Number of unexpected deaths classed as a serious incident per 10,000 open cases	<12.00*	**14.68**	12.16	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	<27.79	**46.69**	44.54	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	> 95.00%	**97.75%**	97.42%	97.86%	97.14%	98.08%
5 Percentage of clinical audits of NICE guidance completed	100%	**100.0%**	100%	97%	89.47%	95.20%
6 Average length of stay for patients in adult mental health and mental health services for older people assessment & treatment wards	AMH <30.2 MHSOP <52	**26.81** **62.67**	26.67 62.18	AMH 31.72 MHSOP 54.08	35	37
Patient Experience Measures						
7 Delayed Transfers of Care	<7.50%	**1.69%**	2.11%	1.89%	2.07%	1.60%
8 Percentage of complaints satisfactorily resolved	> 90.00%	**79.00%**	75.38%	65.77%	76.36%	
9 **National Patient Survey**						
Number of questions where our mean score was within 5% of the highest mean scored mental health trusts	Improvement on previous year	**16**	10			
Number of questions where our mean score was within the middle 90% of mean scored mental health trusts		**17**	23			
Number of questions where our mean score was within 5% of the lowest mean scored mental health trusts		**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. **Note** this data does include York and Selby services.*
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 2015/16 is not directly comparable to previous Community Surveys, although a comparative positon for 2014/15 has been provided. Also the National Patient Survey for 2009/10 is an inpatient survey which is not directly comparable to the community surveys.*

National Patient Survey historical performance

National Patient Survey	2013/14	2012/13	2011/12
Number of questions where our score was within 5% of the highest scored mental health trusts	12 (32%)	11 (29%)	12 (32%)
Number of questions where our score was within the middle 90% of scored mental health trusts	26 (68%)	27 (71%)	23 (61%)
Number of questions where our score was within 5% of the lowest scored mental health trusts	0 (0%)	0 (0%)	3 (8%)

Comments on Areas of Under-Performance

Metric 1:

Number of unexpected deaths classed as a serious incident per 10,000 open cases.

The Trust position in 2015/16 is **14.68** which is 2.68 above the target of 12.00. The total number of unexpected deaths reported was **83** in 2015/16 compared to **61** unexpected deaths in 2014/15.

The definition of an unexpected death is one where 'natural causes are not suspected.' The table (above right) shows the number of unexpected deaths formally reported during 2015/16. Of the 83 reported deaths many are still awaiting a formal coroner's verdict, however 70 deaths would appear to be due to suicide related causes and 5 were definitely found to be from physical health related causes. These numbers are subject to change as more information is received from the coroner. Data from York and Selby relates to the period 1 October 2015 - 31 March 2016 only which is when the services were formally transferred to the Trust.

All unexpected deaths are robustly reviewed as Serious Incidents and reported externally to our commissioners. Family members and carers are included within the review process in keeping with the principles of Duty of Candour (being open and honest). An action plan of learning points is developed from each investigation and these are monitored until they are satisfactorily closed.

The 36 Serious Incidents reported which did not result in the death of a service user were mainly due to incidents of significant self-harm (including overdoses) and fractures relating to patient falls. These incidents are investigated with the same level of scrutiny as described above.

Metric 3:

Patient falls per 1,000 admissions.

The number of falls reported in 2015/16 is **46.69** per 1,000 admissions, which is significantly above the target of <27.79.

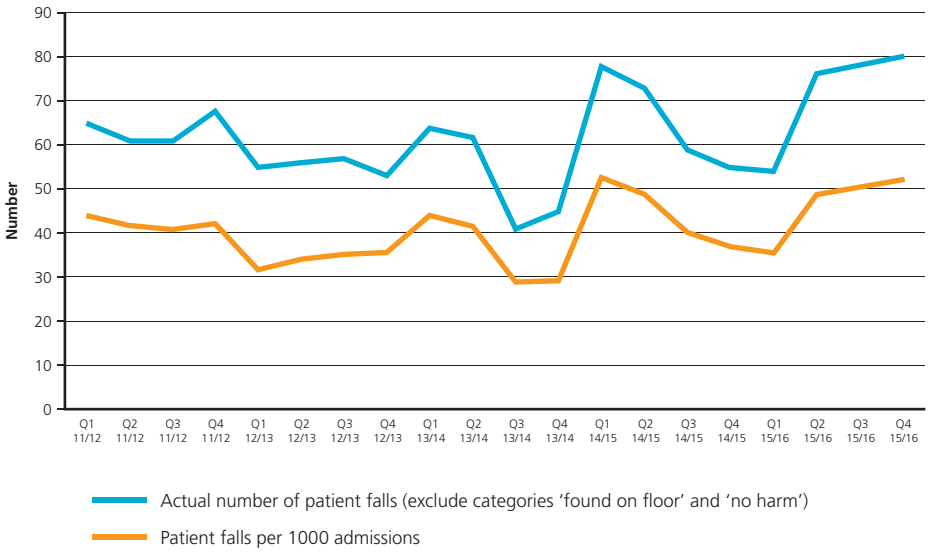
This relates to 288 falls this financial year to date: 88 (30.56%) in Durham and Darlington, 93 (32.30%) in Teesside, 59 (20.49%) in Forensics, 47 (16.32%) in North Yorkshire and 1 (0.35%) other. Of the falls reported, 231 (80.21%) were classified low with minimal harm, 51 (17.71%) were reported as moderate short term harm, 5 (1.74%) were reported as severe. The 5 falls resulting in severe harm occurred on different wards. No patterns have been identified.

The graphs to the right shows that the downwards trend between 2011/12 and the end of 2013/14 have been replaced by an upwards trend during 2014/15 and 2015/16.

Unexpected Deaths 2015/16

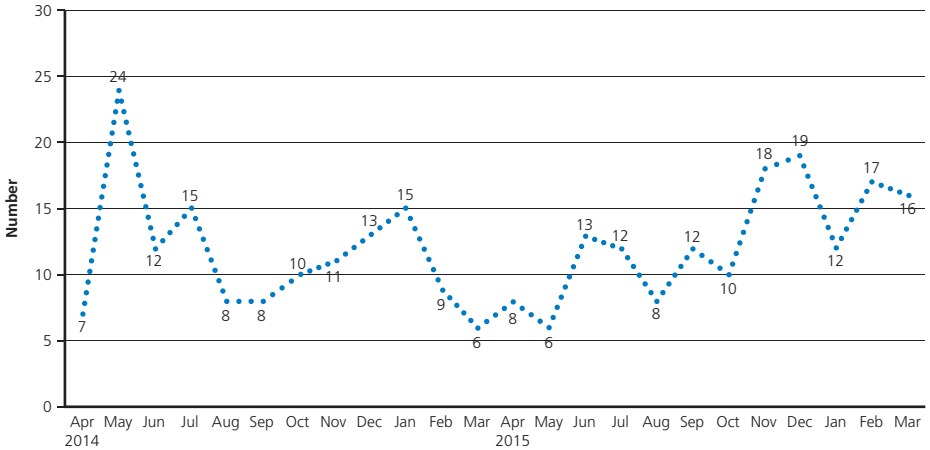
	Serious Incidents classed as unexpected deaths	Serious Incidents which did not result in death
Durham & Darlington	32	10
Teesside	25	11
North Yorkshire	17	7
Forensics	4	2
York & Selby	4	4
Out of Trust Area	1	2
Total	**83***	**36**

Patient Falls - Trust wide 2011/12 to 2015/16



Of the 288 falls, 151 (52.43%) were reported within mental health services for older people. This is comparable to the 132 reported at the same point during 2014/15.

Actual number of patient falls (MHSOP)



The Trust 'falls executive group' was reintroduced in 2015/16 and steers and monitors Trust falls management, reporting into the patient safety group. Data on falls is now also available on the IIC.

Whilst the Group is still determining what regular data reports they and services require to facilitate ongoing monitoring, the group approved an audit tool for use in 2015/16, the use of the audit tool by each clinical speciality is as follows:

- MHSOP – the audit has been undertaken, using the audit tool. The results of the audit have led to (1) the production of guidance for junior doctors regarding falls assessment and management; (2) pain assessment and management training has been fully rolled out and (3) a pain medication algorithm has been developed. A review of ward level action plans was undertaken during March 2016 and a sleep hygiene share and spread event is planned for June 2016.
- Adult LD – the audit has been undertaken and the audit report has been compiled and is awaiting ratification. This will be included on the agenda of the May 2016 falls executive meeting.
- Forensics MH & LD – The audit has been undertaken, an initial report has been drafted and will be included on the agenda for the May 2016 fall executive meeting.
- Adult MH – the audit has been undertaken and a set of draft proposals produced. In addition, the specialty is currently reviewing the visual control boards supporting the PIpA (Purposeful Inpatient Admission) process in relation to physical health; actions to embed the decision tool will be part of this work. It is proposed that AMH wards will have a formalised input from pharmacists in relation to the potential impact of medication on risk of falls, and it was agreed at the March acute care forum that localities would share falls information to identify any issues and trends across the specialty.

All services are currently completing a skills gap analysis with the intention to commission targeted training. A report from this work was delivered at the March 2015 meeting of the falls executive group.

Metric 6:

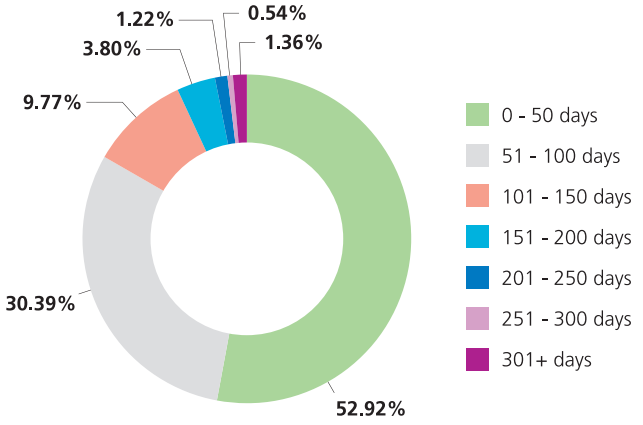
Average length of stay for patients in adult mental health and mental health services for older people assessment and treatment wards.

The average length of stay for adults has remained steady throughout 2015/16, only reporting above target for two months. The average length of stay for older people has been above target since Q3 2013/14, with the exception of one month, reporting 62.67 days for 2015/16. This is 10.67 above target. The pie chart below shows the breakdown for the various lengths of stay during 2015/16.

The median length of stay was 48 days, which is better than the target of 52 days and demonstrates that the small number of patients that have very long lengths of stay have a significant impact on the mean figures reported.

The length of stay of patients is closely monitored by all services within the Trust. The reasons for the increase in the average length of stay for patients are due to a small number of patients with a very long length of stay, which has skewed the overall average. 52.92% of lengths of stay were between 0-50 days, with 30.39% between 51 – 100 days. 23 patients had a length of stay greater than 200 days; the majority were attributable to the complex needs of the patients (such as co-morbidity with physical health problems).

Length of Stay for Mental Health Services for Older People in A&T Wards FYDT 2015/16



Metric 8:
Percentage of complaints satisfactorily resolved.

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. If the complainant did not respond to the resolution letter indicating dissatisfaction it is assumed that the complainant was satisfied with the Trust's response.

The percentage of complaints satisfactorily resolved in 2015/16 was 79.00%, which is below the target of 98% but an improvement on 2014/15 and 2013/14. This relates to 158 complaints being satisfactorily resolved. Complaints are monitored by the Quality Assurance Committee and each is thoroughly investigated.

There were 42 people who were not satisfied with our response to their complaint since April 2015 and as at 31 March, there was one still open awaiting a further response. The subject of complaints or those that expressed dissatisfaction are varied but predominately are about clinical care, which covers a number of different subjects including ineffective treatment and care, medication and discharge/Transfer/continuity of care. Trust wide there were no specific trends or patterns identified in the reasons given for dissatisfaction.

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

Complaints Resolution 2015/16

	FYTD		
	Number of complaints resolution letters sent	**Number of dissatified responses recieved**	**Percentage satisfactorily resolved***
Durham & Darlington	**73**	**9**	**88%**
Adult mental health	53	6	89%
Mental health services for older people	4	0	100%
Children and young people's services	14	3	79%
Learning disabilities	2	0	100%
Tees	**52**	**16**	**69%**
Adult mental health	37	10	73%
Mental health services for older people	8	3	63%
Children and young people's services	6	3	50%
Learning disabilities	1	0	100%
North Yorkshire	**54**	**14**	**74%**
Adult mental health	43	11	74%
Mental health services for older people	7	2	71%
Children and young people's services	4	1	75%
Learning disabilities	0	0	N/A
Forensics	**21**	**3**	**86%**
Forensic learning disabilities	12	2	83%
Forensic mental health	8	1	88%
Forensic offender health	1	0	100%

Our performance against the risk assessment framework targets and indicators

The following table demonstrates how we have performed against the relevant indicators and performance thresholds set out in appendix A of the risk assessment framework.

Risk assessment framework

Indicators		2015/16 Threshold	2015/16 Actual	2014/15 Actual	2013/14 Actual	2012/13 Actual
a Care Programme Approach (CPA) patients having formal review within 12 months	TEWV Inc Y&S for 15/16	95%	**98.76%**	97.75%	96.56%	96.90%
b Admissions to inpatients services had access to Crisis resolution/home treatment teams		95%	**96.74%**	98.42%	98.58%	97.35%
c Meeting commitment to serve new psychosis cases by early intervention teams		95%	**265%**	254%	239%	231%
e Mental health data completeness: identifiers		97%	**99.61%**	99.61%	98.73%	99.18%
f Mental health data completeness: outcomes for patients on CPA		50%	**90.22%**	94.09%	96.68%	96.73%
g Certification against compliance with requirements regarding access to health care for people with a learning disability		**Compliant**	**Compliant**	Compliant	Compliant	Compliant
h Percentage of people experiencing a first episode of psychosis that were treated with a NICE approved care package within two weeks of referral		50%	**55.91%**			
i Percentage of people referred to the IAPT programme that were treated within 6 weeks of referral		75%	**84.01%**			
j Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral		95%	**95.93%**			

** 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 risk assessment framework targets and indicators

The figure reported for percentage of people experiencing a first episode of psychosis that were treated with a NICE approved care package within two weeks of referral reflects the quarter 4 position. In quarter 3 the Trust reported 68.10% to Monitor; however this was based on a proxy indicator as the definition for this key performance indicator was not released until January.

There are an additional two indicators contained within appendix A of the risk assessment framework that are relevant however these have been reported in the quality metrics table:

- *Care programme approach (CPA) patients receiving follow-up contact within seven days of discharge.*
- *Minimising mental health delayed transfers of care.*

There are three new indicators that have been reported from quarter 3 (as at the 31 December) 2015/16:

- *Percentage of people experiencing a first episode of psychosis that were treated with a NICE approved care package within two weeks of referral.*
- *Percentage of people referred to the IAPT programme that were treated within 6 weeks of referral.*
- *Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral.*

Where available the historic information shown for 2013/14 has been taken from the Board dashboard report at year end. The 2012/13 information has been taken from the "combined" Board dashboard report at year end which included the Harrogate, Hambleton and Richmond services.

External Audit

For 2015/16, our external auditors have to provide a limited assurance report on whether two mandated indicators included in the quality report have been reasonably stated in all material respects. In addition the Council of Governors (CoG) 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 report 2015/16 are:

- the percentage of patients on care programme approach 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
- complaints satisfactorily resolved (the local indicator chosen by the Council of Governors).

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

The information below provides details on a number of additional areas relating to quality and quality improvement:

Local improvement plans

Duty of Candour

Since Regulation 20: Duty of Candour of the Health and Social Care Act 2008 (amended 2015) has been enforced, TEWV has developed a Duty of Candour register in line with the recommendations, which is managed and monitored by the Director of Quality Governance.

Additionally, TEWV have developed a draft Duty of Candour Policy: *Being Open, Honest and Transparent*, which outlines the legal responsibility to inform a patient and carer should anything go wrong that causes or has potential to cause harm and distress. This underpins the culture of candour. Briefing and consultation sessions on the draft policy have been held in Quarter 4 across the Trust in readiness for full implementation and embedding in practice of the policy in 2016/17.

Training in "delivering difficult messages" is also in the process of being developed and will be rolled out in 2016/17 to ensure staff have the necessary level of skills and confidence to undertake this process.

Sign Up To Safety

Sign up to Safety is a three year national patient safety programme launched on 24 June 2014 with the mission being to strengthen patient safety in the NHS and make it the safest healthcare system in the world.

What we have done:
A Trust safety improvement plan was submitted based on the guidance provided by the Sign up to Safety campaign office. The plan comprises the Trust quality strategy with driver diagrams identifying the three areas of patient safety (harm minimisation, force reduction and learning lessons) which the Trust will focus on as part of the campaign. The National Sign Up To Safety Lead Suzette Woodward stated that it was one of the best she had seen.

Information roadshows have been completed throughout the Trust and presentations made to directorate QuAGs and LMGBs, Speciality development groups (SDGs), leadership and network groups, modern matrons, medics conference, health and safety team, North of England Mental Health Development Unit Suicide Prevention Conference.

A communication strategy has also been developed and information is regularly provided via the Trust internal e-communications, linking to a Sign Up To Safety intranet page which includes links to the national campaign webinars and information. Posters have been circulated to all wards and teams and two main reception areas of the Trust

Service users and carers have been approached to identify what safety means to them. Suicide/harm minimisation update training which was initially developed for adult services Darlington and Durham has now been opened up to all services and includes a Sign up to Safety element.

The initial implementation of the force reduction project demonstrates positive assurance with regard to continued reductions in the use of restrictive interventions, notably prone restraint.

What we will be doing:
The learning lessons, force reduction and harm minimisation projects and metrics are the focus of the implementation plan. 90 day plans have been developed and will continue to be updated. Learning lessons bulletins have been produced monthly since October. Due to the close alignment between the principles of force reduction and harm minimisation an alliance between the two projects has been made to optimise skills/knowledge and resources. As such the two teams will be co-developing and co-delivering with experts by experience both recovery orientated harm minimisation, and positive behavioural support training supporting the reduction of restrictive practice. This will enable the Trust to achieve the cultural change required to move toward recovery orientated harm minimisation which focuses on narrative formulation and co-production of recovery / safety plans.

NHS Staff Survey Results

The NHS recognises that the percentage of staff reporting that they have been harassed, bullied or abused by managers / colleagues and the percentage reporting that they believe the organisation provides equal opportunities for career progression and promotion are important indicators that correlate with high quality patient care.

The 2015 NHS Staff Survey was distributed to randomly selected Trust staff before York and Selby services came into TEWV. Therefore the results do not include York and Selby staff. The results for these two indicators were:

- 16% of staff reported experiencing harassment, bullying or abuse from staff in the last 12 months. This was the lowest (best) score of any of the 29 NHS organisations that are solely focussed on mental health services.
- 92% of staff stated that they believed that the Trust provides equal opportunities for career progression. This is one of the best scores reported by a mental health Trust.

CQC Rating

As reported in the 2014/15 quality report, TEWV participated in one Trustwide inspection during January 2015 under the Care Quality Commission's new approach to inspections. This was before the Trust expanded to cover York and Selby. The overall findings during the inspection were rated as **GOOD**.

CQC's rating for each key area was:

Key area	Rating
Are services caring?	Good
Are services safe?	Requires Improvement
Are services effective?	Good
Are services responsive?	Good
Are services well-led?	Outstanding

The Trust received a rating of "requires improvement" for the key area "Are services safe". The Trust has addressed the majority of the improvement actions required to meet the CQC Fundamental Standards where the inspectors found non-compliance with regulations.

1. **To meet the 2014 Regulation 10 requirements, for Dignity and Respect: All the actions have been completed as follows:**
   - The en-suite female bedrooms have been relocated, that were adjacent to the male corridor in Earlston House, to create a new female zone upstairs.
   - A new clinic room has been created just off the main hall in Earlston House, away from both female and male bedroom areas.
   - The Trust Privacy and Dignity policy has been reviewed, clarifying the zoning advice and re-issued, with staff briefings, through the matron group.
   - All in-patient areas have been reassessed against the Regulation 10 requirements and guidance has been given to each ward regarding implementation of the zoning protocol.

2. **To meet the 2014 Regulation 12 requirements, for Safe Care and Treatment: All the actions have been completed as follows:**
   - The two cases on Hamsterley and Ceddesfeld wards have been reviewed and the required safeguarding processes regarding covert medication have been put into place.
   - The covert medication procedure has been reviewed and improved.
   - The nurse who was observed to make an administration error was suspended until competency was achieved further to a retraining programme. A personal statement and learning plan was actioned.
   - All the actions were completed and evidence submitted before the end of the inspection period.
   - Learning lessons information is distributed across all MHSOP and monitoring of administration will continue with observation, audit and sampling.

3. **To meet the 2014 Regulation 9 requirements, for Person Centred Care:**
   - The clinical risk management systems and processes have been reviewed on Ward 15, and plans have been put in place for both environmental and process improvements.
   - The discharge planning processes for those inpatients in learning disability Assessment and Treatment units have been reviewed, through an improvement event with partners and we will implement a more commissioning specification approach to the formulation of discharge plans.

All actions have been completed with the exception of the improvement plans for the environment on Ward 15 at Friarage Hospital. An options appraisal is currently in development to determine timescales and a way forward to complete the plans for ward 15.

4. **To meet the 2014 Regulation 12 requirements, for Safe Care and Treatment: All actions have been completed as follows:**
   - A parabolic mirror in the seclusion room at Ward 15 has been installed to ensure there are no blind spots where patients cannot be observed.
   - The estates escalation processes for inpatient staff, in hosted environments, has been reviewed to ensure the TEWV Director of Estates and Facilities Management can resolve delays in environmental maintenance and improvement actions. We have briefed the matron and ward managers of those wards about the escalation process.
   - The TEWV Director of Estates and Facilities Management has a quality monitoring process in place with partner NHS Trusts where estate services are provided by these organisations.

All actions have been completed.

Southern Health Report

This national report[1] is an independent review into practice at Southern Health NHS Foundation Trust regarding the preventable death of a patient, who had a learning disability, in 2013. The review covered all deaths of patients who had received care from their mental health and learning disability (MH & LD) services between April 2011 and March 2015

The key findings of this report were:

- lack of leadership, focus and sufficient time spent on carefully reporting and investigating unexpected deaths of MH&LD service users
- inadequate serious incident reporting

[1] https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2015/12/mazars-rep.pdf

processes and standards of investigation;
- Timeliness of those incidents that were investigated – average completion time of 10 months
- involvement of families and carers was very limited
- that Southern Health Trust could not demonstrate a comprehensive, systematic approach to learning from deaths
- that other service providers were not included in investigations when it would have been appropriate
- that Southern Health Trust failed to use the data it had available to effectively understand mortality and issues relating to deaths of its service users.

We have reviewed the 23 recommendations and as a result is:
- considering the scope and terms of reference of a mortality review process (to include reporting to the open Trust Board)
- revising patient safety information reporting to ensure all patient groups can be easily identified, for example those patients with a learning disability
- hosting a region wide event with Mazars (the authors of the report) on 21 April 2016 to discuss the wider implications of the report and agree a consistent response.

Force reduction

The Trust's force reduction project is aimed at reducing the use of restrictive interventions across the Trust, encouraging a recovery focussed culture that is committed to developing therapeutic environments where physical interventions are only used as a last resort

In recent years a number of reports have focused on the use, or abuse, of restrictive interventions in health and care services. In 2012 the Department of Health published Transforming Care: A national response to Winterbourne View Hospital which outlined the actions to be taken to avoid any repeat of the abuse and illegal practices witnessed at Winterbourne View Hospital. A subsequent CQC inspection of over 150 learning disability services found some services having an over-reliance on the use of 'restraint' rather than on preventative approaches to 'challenging behaviour'. Analysis of the MIND report Physical Restraint in Crisis (2013) raised concerns about the Trust's levels of prone (Face down) restraint.

Key areas of focus of the project include:
- **Data collection, analysis and reporting** – more transparent and focussed analysis of information on restrictive interventions which is reported to the trust Quality and Assurance Committee on a quarterly basis.

- **Development and use of behavioural support plans** – a standard template has been produced to ensure that aspects of the person's environment that they find challenging are identified and addressed, that quality of life is enhanced and that wherever possible people are supported to develop alternative strategies by which they can better meet their own needs.

- **Implementation of the safewards model** – The safewards model promotes a new set of interventions to staff teams which have been proved to reduce conflict and levels of containment within inpatient settings .Implementation across inpatient sites is now complete with plans in place to train other ward areas across 2016.

- **Use of debrief tools following use of restrictive intervention** – The project team have created and facilitated a working group to develop a debrief tool for both patients and staff to complete for the use of restrictive interventions. If effective, debrief training will be developed to support the pilot areas which could potentially be incorporated within the existing Trust management of violence and aggression (MOVA) training programme as recommended within the recent changes to NICE guidance.

- **Management of violence and aggression training (MOVA)** – Training in the management of violence and aggression is a pivotal intervention within the force reduction framework. Whilst this training cannot be categorised as a strategy to reduce the use of restrictive intervention, the context in which it is taught, monitored and clinically lead will require significant consideration long term as the organisation implements its restraint reduction plan.

- **Use of Medication in the management of behaviours that challenge** – A working group has been set up that includes representation from service users and staff. The group are currently exploring how we may define the use of 'Rapid tranquilisation' and the context of its use. A policy review to reflect changes to NICE guidance and the force reduction framework is nearly complete.

- **Use of Seclusion and Mechanical Restraint in the management of behaviours that challenge** – The project team are currently engaging with all services with allocated seclusion rooms to better understand staff perceptions of its use and how this may be incorporated in a wider preventive model of behaviour support. Training in the use of seclusion is emerging as a key theme within this work stream.

Whilst a number of the above approaches remain within the pilot phase, there have been significant reductions evident across the Trust. Available data at Q3 2015/16 in comparison to Q3 2014/15 highlighted that there had been an 81% reduction in Prone restraint across the trust. In order to understand whether prone restraint was being substituted for other restrictive interventions, analysis of other restrictive interventions such as seclusion (the supervised confinement of a person in a room which may be locked), supine (face up) restraint and rapid tranquilisation (administration of medicine to help quickly calm people) has also taken place. The results below highlight that the trust has seen a corresponding reduction across all types of restrictive interventions.

- 890 incidents involving restrictive interventions occurred during the quarter. Q3 14/15 highlighted 1114 incidents suggesting a **21% decrease**
- 33 prone restraints during Q3 suggest an **81% decrease** based on the 173 that occurred during the same period in 14/15
- 197 supine restraints suggest a **41% percent reduction** from the 329 incidents that occurred during the same period in 14/15
- Q3 14/15 identified 37 uses of seclusion. Q3 of the current financial year identified 32 uses, highlighting a **14% decrease**
- 115 administrations of rapid tranquilisation highlighting a **21% reduction** from the same time last year.

Tier 4 CAMHS services remains an outlier within the data, however reductions since training was delivered in Positive Behaviour Support and Safewards shows promise. Use of prone restraint has also significantly reduced.

Our stakeholders' views

The Trust recognises the importance of the views of our stakeholders as part of our assessment of the quality of the services we provide and to help us drive change and improvement.

How we involve and listen to what our stakeholders say about us is critical to this process. In producing the quality report 2015/16, we have tried to improve how we involved our stakeholders in assessing our quality in 2015/16.

Our stakeholder engagement events were held in a location central to the Trust's area, and included a mixture of presentations on current progress against quality priorities and collective discussion among stakeholders about the focus of future quality improvement priorities. We achieved a balanced participation both geographically and between different types of stakeholders (e.g. Trust Governors, CCGs, Local Authorities and Healthwatch). Staff engagement is through staff governors' involvement in the stakeholder event, and also the engagement the Trust carries out with staff on our business plan, which includes our proposed quality priorities.

The positive feedback we have received was mostly within the following themes

- chance to talk to leads of all four quality improvement priorities and find out about services
- well facilitated session, where a clear quality story was presented and participants were not drowned in huge amounts of data and had sufficient time for discussions
- good mix of participants from Trust governors and voluntary, commissioning and local government sectors

However, some participants felt more time was needed to interact with the improvement leads, that we needed to keep the event within the parameters of the quality report, and that we need to amplify all presenters at the event.

Participants also wished that more of their colleagues from similar organisations would attend to further improve the representation from all sectors and geographies within the Trust.

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

In line with national guidance, we have circulated our draft quality report for 2015/16 to the following stakeholders:

- NHS England;
- North East Commissioning Support;
- Clinical Commissioning Groups (x9);
- Health & Wellbeing Boards (x8);
- Local Authority Overview & Scrutiny Committees (x8);
- Local HealthWatch (x8).

All the comments we have received from our stakeholders are included verbatim in **appendix 5**.

The following are the general themes received from stakeholders in reviewing our quality report for 2015/16:

- the quality report stakeholder events are well attended and enable meaning full audience participation
- pleased with the progress made against the 2015/16 quality priorities and agree with the plans for the 2016/17 quality priorities
- note the missed targets against the quality metrics but accept the plans to mitigate any issues going forward
- keen to see the suicide prevention work carried out as part of the harm minimisation and risk management approach
- congratulates the Trust on the results of survey results, its transparent approach and comparative position with other organisations
- the majority felt the quality report is a true and fair reflection of the quality of the Trust

The Trust will write to each stakeholder addressing each comment made following publication of the quality report 2015/16 and use the feedback as part of an annual lessons learnt exercise in preparation for the quality report 2016/17. In our commitment to listen to our stakeholders and learn from their feedback, we are developing a summary version of the 2015/16 quality report which will be published on Trust's website.

In response to many stakeholders' requests, the Trust has agreed to continue providing all stakeholders with a half-year update in November 2016 on the Trust's progress with delivering its quality priorities and metrics for 2016/17

2015/16 Statement of Directors' responsibilities in respect of the quality report

The Directors are required under the Health Act 2009 and the National Health Service (Quality report) Regulations 2010 to prepare Quality reports / Report for each financial year.

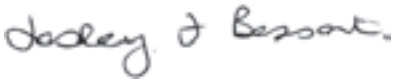
Monitor has issued guidance to NHS foundation Trust boards on the form and content of annual quality report (which incorporate the above legal requirements) and on the arrangements that NHS foundation Trust boards should put in place to support the data quality for the preparation of the quality report.

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

- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2015/16 and supporting guidance;
- the content of the quality report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2015 to May 2016;
  - Papers relating to quality reported to the Board over the period April 2015 to May 2016;
  - Feedback from the Commissioners dated 29 April, 5 May and 19 May 2016;
  - Feedback from Governors dated 16 March, 13 April and 19 May 2016;
  - Feedback from Local Healthwatch organisations dated 13 May 2016;
  - Feedback from Overview and Scrutiny Committees dated 11 May, 12 May and 13 May 2016;
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 17 May 2016;
  - The latest national patient survey published 21 October 2015;
  - The latest national staff survey published 24 February 2016;
  - The Head of Internal Audit's annual opinion over the Trust's control environment dated 12 May 2016;
  - CQC Intelligent Monitoring Reports dated June 2015 and February 2016.
- the quality report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;
- the performance information reported in the quality report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review;
- the quality report has been prepared in accordance with Monitor's annual reporting manual and supporting guidance (which incorporates the quality reports regulations) as well as the standards to support data quality for the preparation of the quality report.

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

By order of the Board



Lesley Bessant
Chairman
24th May 2016

Colin Martin
Chief Executive
24th May 2016

2015/16 Limited assurance report on the content of the quality reports and mandated performance indicators

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 2016 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter
The indicators for the year ended 31 March 2016 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 and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in Monitor's Detailed Guidance for External Assurance on Quality Reports 2015/16; 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 supporting guidance 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 2015 to April 2016;
- Papers relating to quality reported to the Board over the period April 2015 to April 2016;
- Feedback from Commissioners, dated 5 May 2016, 19 May 2016 and 29 April 2016;
- Feedback from governors;
- Feedback from local Healthwatch organisations, Healthwatch Darlingon (undated), Healthwatch North Yorkshire (undated), and Heathwatch York (undated);
- Feedback from Overview and scrutiny committee, Darlington Borough Council (undated) and Durham County Council (dated 11 May 2016);
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, for the period 1 April 2015 to 31 March 2016;
- The 2015 national patient survey;
- The 2015 national NHS staff survey;
- Care Quality Commission Intelligent Monitoring Reports, dated June 2015 and February 2016;
- The Head of Internal Audit's annual opinion over the trust's control environment for the period April 2015 to March 2016; 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 2016, 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 Valley NHS Foundation Trust for our work or this report, except 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 of these criteria, 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 2016:

- 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 and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in Monitor's Detailed Guidance for External Assurance on Quality Reports 2015/16; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance.

Cameron Waddell (CPFA) Engagement Lead,
for and on behalf of Mazars LLP

Chartered Accountants and Statutory Auditor
Rivergreen Centre,
Aykley Heads,
Durham, DH1 5TS

24 May 2016


Teesside University
Student Nurse
TEWV NHS Foundation Trust

The External Auditor's Report and Opinion

The External Auditor's Report and Opinion 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 2016 under the Local Audit and Accountability Act 2014. The financial statements comprise the Statement of Comprehensive Net Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2015-16 Government Financial Reporting Manual (the 2015-16 FReM) and Monitor's NHS foundation trust annual reporting manual 2015/16.

We have also audited the information in the Remuneration and Staff Report that is subject to audit, being:

- the table of salaries and allowances of senior managers and related narrative notes;
- the table of pension benefits of senior managers and related narrative notes;
- the table of exit packages and related notes;
- analysis of staff numbers; and
- the table of pay multiples and related narrative notes.

This report is made solely to the Governors of Tees, Esk and Wear Valleys NHS Foundation Trust in accordance with part 5 of the Local Audit and Accountability Act 2014 and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the 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.

The Chief Executive as accounting officer is also responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the Trust's use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Our assessment of the risks of material misstatement
During the course of the audit we identified the following risks that had the greatest effect on our overall audit strategy:

- the risk of management override of controls. The ISAs mandate that this risk is deemed to be significant on all audits;
- income and expenditure recognition; and
- property valuation.

Our assessment and application of materiality
We apply the concept of materiality both in planning and performing our audit, and in evaluating the effect of misstatements on the financial statements and our audit. Materiality is used so we can plan and perform our audit to obtain reasonable, rather than absolute, assurance about whether the financial statements are free from material misstatement. The level of materiality we set is based on our assessment of the magnitude of misstatements that individually or in aggregate, could reasonably be expected to have influence on the economic decisions the users of the financial statements may take based on the information included in the financial statements. The overall materiality level we set for the Tees, Esk and Wear Valleys NHS Foundation Trust financial statements was £3.034 million, which is approximately 1% of expenditure.

We agreed with the Audit Committee that we would report to the Committee all audit differences in excess of £91,000, as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds.

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.

We scoped our audit approach in response to the risks outlined above, see table opposite.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources
We have undertaken our review in accordance with the Code of Audit Practice prepared by the Comptroller and Auditor General (C&AG), having regard to the guidance on the specified criterion issued by the C&AG in November 2015, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The C&AG determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Risk	Audit approach
Management override of controls In all entities, management at various levels within an organisation are in a unique position to perpetrate fraud because of their ability to manipulate accounting records and prepare fraudulent financial statements by overriding controls that otherwise appear to be operating effectively. Due to the unpredictable way in which such override could occur, we consider there to be a risk of material misstatement due to fraud and thus a significant risk on all audits.	Our approach involved: • testing the appropriateness of journal entries and other adjustments made in preparing the financial statements; • reviewing the key areas within the financial statements where management has used judgement and applied estimation techniques; and • reviewing significant transactions outside the normal course of business or that otherwise appear to be highly unusual.
Revenue and Expenditure recognition There is a risk of fraud in the financial reporting relating to revenue and expenditure recognition due to the potential to inappropriately record revenue and expenditure in the wrong period. Due to there being a risk of fraud in revenue and expenditure recognition we consider it to be a significant risk on all audits.	Our approach involved evaluating the design and implementation of controls to mitigate these risks and undertaking a range of substantive procedures including: • testing of material income and expenditure including tests to ensure transactions are recognised in the correct year; • testing material year end receivables, payables, accruals and provisions; • reviewing intra-NHS reconciliations and data matches; • reviewing management oversight of material accounting estimates and any changes to accounting policies; • reviewing judgements about whether the criteria for recognising provisions were satisfied; and • testing of material adjustment journals.
Property valuation Land and buildings are the Trust's highest value assets. Management engage an expert, to assist in determining the fair value of property to be included in the financial statements. Changes in the value of property may impact on the Statement of Comprehensive Income depending on the circumstances and the specific accounting requirements of the Annual Reporting Manual.	Our approach involved: • updating our understanding on the approach taken by the Trust in its valuation of land and buildings; • reviewing the scope and terms of the engagement with the valuer and how management used the valuation report to value land and buildings in the financial statements; • obtaining information on the methodology and the valuer's procedures to ensure objectivity and quality; and • considering evidence of regional valuation trends.

Opinion on financial statements
In our opinion the financial statements:
- give a true and fair view of the state of Tees, Esk and Wear Valleys NHS Foundation Trust's affairs as at 31 March 2016 and of its income and expenditure for the year then ended;
- have been prepared properly in accordance with the accounting policies directed by Monitor; and
- have been properly prepared in accordance with the requirements of the National Health Service Act 2006.

Opinion on other matters
In our opinion:
- the part of the Remuneration and Staff Report subject to audit has been prepared properly in accordance with the requirements directed by Monitor with the consent of the Treasury as relevant to NHS Foundation Trusts; and
- the information given in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we report by exception
We report to you if:
- in our opinion the governance statement does not comply with Monitor's guidance;
- we refer the matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have a reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency;
- we issue a report in the public interest under Section 24, Schedule 7 of the Local Audit and Accountability Act 2014; or
- the Trust has not put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

In particular we are required to consider whether we have identified any inconsistencies between our knowledge acquired during the audit and the directors' statement that they consider the annual report is fair, balanced and understandable and whether the annual report appropriately discloses those matters that we communicated to the audit committee which we consider should have been disclosed.

We are also required to report to you if, in our opinion, the governance statement 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 governance statement or that risks are satisfactorily addressed by internal controls. We have nothing to report in these respects.

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 the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Cameron Waddell,
CPFA for and on behalf of Mazars LLP

Chartered Accountants and Statutory Auditor
Rivergreen Centre, Aykley Heads, Durham, DH1 5TS
24 May 2016


CHANGE
CLEAR GOALS
DSHIP

The financial review and the annual accounts 2015/16

Financial review and foreword to the annual accounts 2015/16

The annual accounts

The annual accounts are prepared in accordance with paragraphs 24 and 25 of Schedule 7 to the NHS Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

Summary of financial performance

In 2015-16 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 2015-16 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 £4.8m for the financial year and realised a surplus of £0.3m. The surplus was less than planned mainly due to fixed asset impairments as part of the Trust's three yearly revaluation of its estate.

The Trust's revenue streams have increased from 2014/15 due to the commencement of the contract to provide mental health and learning disabilities services to York and Selby in October 2015.

Excluding the impact of impairments being greater than planned, the Trust would have reported a surplus £6.5m in excess of plan, which was largely due to additional contract income for clinical services.

Total CRES achieved at 31 March 2016 was £8.5m and was in line with plan. All CRES achieved was recurrent and the Trust is making good progress with future years plans.

2015/16 objectives

Objectives	Outcomes
Delivering a £4.8m financial surplus	**Financial surplus of £0.3m realised**
Delivering an EBITDA of £20.0m	**EBITDA of £25.8m delivered**
Achieving a Monitor risk rating of 4	**Calculated risk rating of 4 achieved**
Delivery of £8.5m cash releasing efficiency savings	**Delivery of £8.5m cash releasing efficiency savings**
EBITDA margin of 7.0%	**EBITDA margin of 8.3% achieved**

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
Capital service cover	1.83x	3
Liquidity	37.7 days	4
I&E margin	4.18%	4
I&E margin variance from plan	1.75%	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, £8.5m 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 2015-16, £9.6m was invested in capital assets.

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

	2015-16 £m
Investment in fixed assets	9.6
Disposal of unprotected assets	0.4

Modern equivalent asset (MEA) valuation

The Trust's land and buildings were subject to revaluations during the financial year ended 31 March 2016, which resulted in impairments as follows:

	2015-16 £m	
	Realised in surplus	Realised in reserves
Impairments	-15.4	-4.3
Reversal of impairments	2.3	0.0
Revaluation gains	0.0	3.5
Total loss realised	**-13.1**	**-0.8**

When realised in the surplus, impairment losses are recognised as expenditure, and reversals of prior impairments recognised as income.

Working Capital

The Trust had strong liquidity which improved to 37.7 days due to the operational surplus.

Accounting policies

The Trust prepared the financial statements in accordance with the NHS Foundation Trust Annual Reporting Manual (2015-16) 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.

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 2015-16.

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

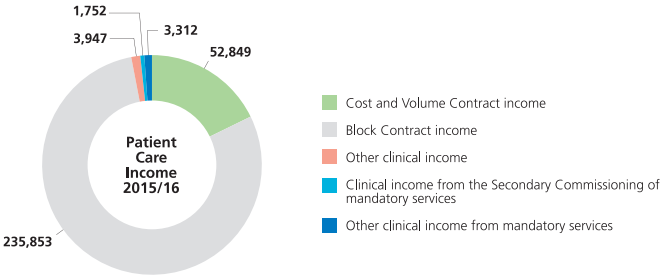
The Trust had complied with the cost allocation and charging requirements as set out in HM Treasury and Office of Public Sector Information guidance.

Ill health retirements

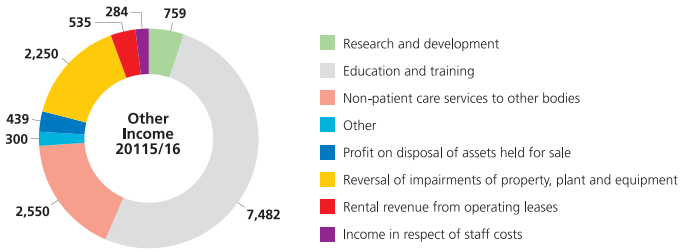
During 2015-16 the Trust had five employees retire early on the grounds of ill health; the value of these early retirements (from NHS Pensions) is £0.4m.

Income generation

During 2015-16, income generated was £312.3m from a range of activities; 95.3% from direct patient care. Patient care income came from the following areas:



There was a further £14.6m from education, reversal of impairments and other non-patient care services.



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

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 2015-16 was as follows:

	2015-16	
	Number of invoices	**Value of invoices £000s**
NHS Creditors		
Total bills paid	1,018	22,392
Total bills paid within target	768	29,622
Percentage of bills paid within target	75.44%	87,63%
Non-NHS Creditors		
Total bills paid	50,448	93,067
Total bills paid within target	49,117	91,361
Percentage of bills paid within target	97.63%	98.17%

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.

Management costs

In line with best practice the Trust continues to monitor expenditure on management costs in accordance with Department of Health definitions. In 2015-16, 4.80% of the Trust's total income was incurred on management costs, a decrease on the 4.82% reported in 2014-15.

Colin Martin
Chief Executive
24th May 2016

Statement of Comprehensive Income for 12 months ended 31 March 2016

	Note	12 months ended 31 March 2016 £000	12 months ended 31 March 2015 £000
Revenue			
Income from activities	2	297,713	278,021
Other operating income	2	14,599	16,561
Total operating income		**312,312**	**294,582**
Operating expenses	3	(303,312)	(281,129)
Operating surplus		**9,000**	**13,453**
Finance costs			
Finance income	8	202	151
Finance expense - financial liabilities	9	(5,422)	(5,396)
Finance expense - unwinding of discount on provisions		(17)	(12)
PDC dividends payable		(3,494)	(4,076)
Net Finance Costs		**(8,731)**	**(9,333)**
Surplus for the year		**269**	**4,120**
Other comprehensive income			
Will not be reclassified to income and expenditure			
Impairments - property, plant and equipment		(4,379)	(15,596)
Revaluations		3,541	3,960
Total comprehensive income for the year		**(569)**	**(7,516)**

Statement of Financial Position as at 31 March 2016

	Note	31 March 2016 £000	31 March 2015 £000
Non-current assets			
Property, plant and equipment	12	210,388	218,924
Investments in associates (and joint arrangements)	16	80	0
Trade and other receivables	22	47	50
Total non-current assets		**210,515**	**218,974**
Current assets			
Inventories	21	181	171
Trade and other receivables	22	6,873	6,566
Cash and cash equivalents	25	54,148	47,147
Total current assets		**61,202**	**53,884**
Current liabilities			
Trade and other payables	26	(24,360)	(20,242)
Borrowings	27	(5,429)	(5,319)
Provisions	30	(650)	(337)
Other liabilities	28	(299)	(385)
Total current liabilities		**(30,738)**	**(26,283)**
Total assets less current liabilities		**240,979**	**246,575**
Non-current liabilities			
Borrowings	27	(86,181)	(91,610)
Provisions	30	(1,106)	(1,074)
Total non-current liabilities		**(87,287)**	**(92,684)**
Total assets employed		**153,692**	**153,891**
Financed by taxpayers' equity			
Public dividend capital		145,053	144,683
Revaluation reserve	32	18,641	19,606
Income and expenditure reserve		(10,002)	(10,398)
Total taxpayers' equity		**153,692**	**153,891**

The notes 1-43 form part of these financial statements.

The financial statements on pages 130 to 133 were approved by the Board and signed on its behalf by:

Colin Martin
Chief Executive
24th May 2016

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 2015	**153,891**	**144,683**	**19,606**	**(10,398)**
Surplus for the year	**269**	0	0	269
Impairments	**(4,379)**	0	(4,379)	0
Revaluations - property, plant and equipment	**3,541**	0	3,541	0
Transfer to retained earnings on disposal of assets	**0**	0	(127)	127
Public dividend capital received	**370**	370	0	0
Taxpayers' Equity at 31 March 2016	**153,692**	**145,053**	**18,641**	**(10,002)**
Taxpayers' Equity at 1 April 2014	**161,377**	**144,653**	**31,242**	**(14,518)**
Surplus for the year	**4,120**	0	0	4,120
Impairments	**(15,596)**	0	(15,596)	0
Revaluations	**3,960**	0	3,960	0
Public Dividend Capital received	**30**	30	0	0
Taxpayers' Equity at 31 March 2015	**153,891**	**144,683**	**19,606**	**(10,398)**

Statement of Cash Flows for 12 months ended 31 March 2016

	Note	12 months ended 31 March 2016 £000	*Restated 12 months ended 31 March 2015 £000
Cash flows from operating activities			
Operating surplus		**9,000**	**13,453**
Non-cash income and expense:			
Depreciation and amortisation	3	4,150	4,247
Impairments	3	15,368	12,560
Reversals of impairments	2	(2,250)	(5,506)
Gain on disposal of PPE	2	(434)	(62)
Increase in trade and other receivables		(304)	(1,114)
(Increase) / Decrease in inventories		(10)	11
Increase in trade and other payables		3,403	3,139
Increase / (Decrease) in other liabilities		(86)	186
Increase in provisions		328	41
Net cash generated from operations		**29,165**	**26,955**
Cash flows from investing activities			
Interest received		202	151
Purchase of property, plant and equipment		(9,299)	(7,957)
Sales of property, plant and equipment		875	199
Cash from acquisitions of business units and subsidiaries		(80)	0
Net cash generated used in investing activities		**(8,302)**	**(7,607)**
Cash flows from financing activities			
Public dividend capital received		370	30
Loans received from the Department of Health		0	15,000
Loans repaid to the Department of Health		(3,000)	0
Capital element of Private Finance Initiative obligations		(2,319)	(2,138)
Interest paid		(196)	0
Interest element of Private Finance Initiative obligations		(5,258)	(5,286)
PDC dividend paid		(3,459)	(4,149)
Net cash generated / (used) in financing activities		**(13,862)**	**3,457**
Increase in cash and cash equivalents	25	**7,001**	**22,805**
Cash and cash equivalents at 1 April	25	**47,147**	**24,342**
Cash and cash equivalents at 31 March	25	**54,148**	**47,147**

**restated following additional guidance*

Notes to the accounts

Note 1.

Accounting Policies

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual, which has been agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2015-16 NHS Foundation Trust Annual Reporting Manual issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

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

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

IFRS 9	Financial instruments
IFRS 10 (amendment) & IAS 28 (amendment)	Sale or contribution of assets
IFRS 10 (amendment) & IAS 28 (amendment)	Investment entities applying the consolidation exception
IFRS 11 (amendment)	Acquisition of an interest in a joint operation
IFRS 15	Revenue from contracts with customers
IAS 1 (amendment)	Disclosure initiative
IAS 16 (amendment) & IAS 38 (amendment)	Depreciation and amortisation
IAS 16 (amendment) & IAS 41 (amendment)	Bearer plants
IAS 27 (amendment)	Equity method in separate financial statements
Annual improvements 2012-2015 cycle	n/a

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

The Trust has identified the valuation of the Trust estate and the valuation of Provisions as critical accounting judgements and key sources of uncertainty. Cushman and Wakefield (previously DTZ Ltd) provide third party assurance of the value of the estate completing a full modern equivalent valuation exercise every 3 years. Provisions are, in the main, injury benefits provisions which are valued using actuarial tables.

The Trust has not consolidated its charitable fund within the main accounts on the grounds of materiality as per guidance within the annual reporting manual. The Trust has not consolidated its Joint Associate for the provision of improving access to psychological therapies (IAPT) services within the main accounts on the grounds of materiality as per guidance within the annual reporting manual. The Trust has not consolidated its subsidiary for the provision of Positive Individual Proactive Support (PIPS) services within the main accounts on the grounds of materiality as per guidance within the annual reporting manual.

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

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

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

Expenditure on employee benefits

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

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

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

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

Property, plant and equipment

Recognition
Property, plant and equipment is capitalised if:

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

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

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

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

Each piece of new equipment has its useful economic life assessed prior to capitalisation; however, the range of useful lives is shown below:

- IT Equipment is depreciated over 5 years
- Furniture and Equipment and other Equipment are depreciated between 5 and 10 years
- Plant aligned to buildings is depreciated between 15 and 30 years

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

- Land and non-specialised buildings – market value for existing use
- Specialised Buildings – Depreciated Replacement Cost

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

A full MEA valuation was carried out on the Trusts land and buildings 31 March 2016, and the assets have been treated as prescribed in the FT Annual Reporting Manual (ARM). Accumulated depreciation on these assets has been written to zero, and the cost or valuation at 31 March 2016 amended to the MEA values to reflect this. All of the Trusts MEA valuations have been completed by Cushman and Wakefield Inc. (independent qualified valuer).

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

A non current asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IFRS 5.

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

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

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

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

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

The Trust does not recognise any intangible assets.

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

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

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

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

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

Legacy Transfers
For property plant and equipment assets that have been transferred to the Trust from another NHS body, the assets transferred are recognised in the accounts as at the date of transfer. The cost and accumulated depreciation balances from the transferring entity's accounts are preserved on recognition in the Trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the Trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

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

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

Non-current assets held for sale
Non-current assets are classified as held for sale when the following conditions are met:

1. The asset is available for immediate sale in its present condition
2. The sale must be highly probable i.e.:
   - management are committed to a plan to sell the asset
   - an active programme has begun to find a buyer and to complete the sale
   - the asset is being actively marketed at a reasonable price
   - the sale is expected to be completed within 12 months of the date of classification as "Held for Sale"
   - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

	2015/16	2014/15
Short term (<5 years)	-1.55%	-1.50%
Medium term (5-10 years)	-1.00%	-1.05%
Long term	-0.80%	2.20%
Pensions rate	1.37%	1.30%

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

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

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

Clinical negligence costs
The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 30.3.

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

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

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

The Trust has no contingent assets.

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

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

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

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

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

Leases
Operating leases are lease agreements where the Trust is not exposed to the risks and rewards of ownership of a leased asset. Rentals are charged to operating expenses on a straight-line basis over the term of the lease.

Corporation tax
Foundation Trusts are exempt from corporation tax on their principle health care income under section 519A Income and Corporation Taxes Act 1988. In determining whether other income may be taxable, a full review of the Trust's activities has been carried out in accordance with guidance published by HM Revenue and Customs to establish any activities that are subject to Corporation Tax. Based on this review there is no corporation tax liability in the period ended 31st March 2016.

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

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

Foreign currencies
The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March 2012. Resulting exchange gains and losses for either of these are recognised in the Trust's surplus/deficit in the period in which they arise.

Third party assets
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in Note 42 to the accounts.

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

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as PDC dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities, except for donated assets and daily average cash balances with the Office of the Paymaster General. The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets. The dividend payable is based on the average relevant net assets for the year.

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

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

Joint operations
Joint operations are activities undertaken by the Trust in conjunction with one or more other parties but which are not performed through a separate entity.

The Trust has entered into a joint operation with Mental Health Matters and County Durham & Darlington NHS Foundation Trust to provide services to improve access to psychological therapies (IAPT services). The Trust is the host organisation and only the Trusts share of the income and expenditure; gains and losses; assets and liabilities; and cash flows are recognised in the accounts. The Trust has not consolidated the joint operation on the grounds of materiality.

The Trust is also Trustee for the "Tees Esk and Wear Valleys NHS Trust General Charitable Fund", the balances of which are not consolidated with the Trusts accounts on the grounds of materiality.

The Trust is a shareholder in the newly established company "Positive Individualised Proactive Support Limited", however this has not traded in 2015/16, so has no entries consolidated into the 2015/16 Financial Statements.

Pension costs

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

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

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

(a) Accounting valuationAccounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period.

This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes.

The valuation of scheme liability as at 31 March 2016, is based on valuation data as 31 March 2015, updated to 31 March 2016 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

(b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

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

Annual Pensions
From 01 April 2015 the 1995 and 2008 final salary based schemes were replaced with a career average scheme. Annual pensions are accrued at a rate of 1/54th of pensionable pay each year of membership. All employees without pension scheme protection ended their 1995 / 2008 scheme and started in the 2015 scheme. Upon retirement employees may get 2 pensions, their 2015 scheme pension and any 1995/2008 scheme pension held.

The 1995 and 2008 schemes are "final salary" schemes. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service. From 01 April 2015 only members with pension scheme protection can continue to accrue additional years in these schemes.

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

Pensions Indexation
Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) replaced the Retail Prices Index (RPI).

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

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

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

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

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

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

Auto-Enrolment
To comply with auto-enrolment the Trust has opened a second pension scheme, for employees not eligible to be enrolled in the NHS Pension Scheme. The NHS Scheme will always be the default selection, however employees not eligible for membership are entered into the National Employment Savings Trust (NEST) scheme. This is a defined contribution scheme, and as such the cost to the NHS Body of participating in the scheme is equal to the contributions payable to the scheme for the accounting period.

Operating segments
The Trust has no elements that require segmental analysis for the period ended 31 March 2016. The chief operating decision maker has been identified as the Executive Director Chief Operating Officer post within the Trust; and on this basis the Trust has identified healthcare as the single operating segment.

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

Note 2.1
Operating income (by classification)

Income from activities	12 months ended 31 March 2016 £000	*Restated 12 months ended 31 March 2015 £000
Cost and Volume Contract income	52,849	53,887
Block Contract income	235,853	212,332
Clinical income for the Secondary Commissioning of mandatory services	1,752	1,316
Other clinical income from mandatory services	3,312	3,478
Other clinical income	3,947	7,008
Total income from activities	**297,713**	**278,021**
*restated following additional guidance		
Other operating income		
Research and development	759	843
Education and training	7,482	7,235
Non patient care services to other bodies	2,550	2,344
Other revenue	300	273
Profit on disposal of assets held for sale	439	62
Reversal of impairments of property, plant and equipment	2,250	5,506
Rental revenue from operating leases	535	179
Income in respect of staff costs where accounted on gross basis	284	119
Total other operating income	**14,599**	**16,561**
Total operating income	**312,312**	**294,582**

Note 2.2
Operating lease income

	12 months ended 31 March 2016 £000	*Restated 12 months ended 31 March 2015 £000
Rental revenue from operating leases	535	179
Future minimum lease receipts		
not later than one year;	507	96
later than one year and not later than five years;	12	68
later than five years.	24	0
Total future minimum lease receipts	**543**	**164**

Note 2.3
Non NHS income
The Trust had Non NHS income totalling £8,810k (2014-15, £15,140k)

Note 2.4
Operating income (by type)

	12 months ended 31 March 2016 £000	12 months ended 31 March 2015 £000
Income from activities		
NHS Foundation Trusts	880	872
NHS Trusts	0	12
CCGs and NHS England	292,346	268,478
Local Authorities	2,003	4,444
NHS Other	430	1,193
Non NHS Other	2,054	3,022
Total income from activities	**297,713**	**278,021**
Other operating income		
Research & Development	759	843
Education and training	7,482	7,235
Non-patient care services to other bodies	2,550	2,344
Other	300	273
Profit on disposal of assets held for sale	439	62
Reversal of impairments of property, plant and equipment	2,250	5,506
Rental revenue from operating leases - minimum lease receipts	535	179
Income in respect of staff costs where accounted on gross basis	284	119
Total other operating income	**14,599**	**16,561**
Total operating income	**312,312**	**294,582**
Analysis of income from activities - non NHS other	595	525
Other government departments and agencies	1,459	2,497
Other*	**2,054**	**3,022**

*Other income is mainly from the Trusts Lifeline Project contract (£1,321k), (2014-15, £nil). In 2014/15 the Trust received £1,879k from Care Uk ltd, but this contract ended 31 March 2015.

Analysis of other operating income - other		
Catering	115	134
Other	185	139
	300	**273**

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

Commissioner requested services		
Income from activities from commissioner requested	292,799	268,555
Income from activities from non-commissioner requested services	19,513	26,027
	312,312	**294,582**

Note 3
Operating expenses (by type)

	12 months ended 31 March 2016 £000	*Restated 12 months ended 31 March 2015 £000
Services from NHS Foundation Trusts	4,795	3,787
Services from NHS Trusts	3	0
Purchase of healthcare from non NHS bodies	4,073	1,512
Purchase of social care (under s.75 or other integrated care arrangements)	711	639
Executive directors costs	1,194	1,144
Non-executive directors costs	157	168
Staff costs	226,547	212,892
Supplies and services - clinical (excluding drug costs)	2,359	1,665
Supplies and services - general	3,027	2,854
Establishment	3,911	4,117
Research and development - (Not included in employee expenses)	34	220
Research and development - (Included in employee expenses)	744	765
Transport (Business travel only)	2,712	2,716
Transport (other)	1,095	988
Premises - business rates payable to local authorities	1,277	1,155
Premises - other	15,059	14,190
Increase in bad debt provision	66	423
Change in provisions discount rate(s)	(57)	229
Drug costs	3,562	3,290
Inventories consumed (excluding drugs)	171	182
Rentals under operating leases - minimum lease receipts	6,727	5,710
Depreciation on property, plant and equipment	4,150	4,247
Impairments of property, plant and equipment	15,368	12,560
Audit fees - statutory audit	47	47
Clinical negligence - amounts payable to the NHSLA (premiums)	902	665
Loss on disposal of land and buildings	5	0
Legal fees	917	635
Consultancy costs	472	1,538
Internal audit costs - (not included in employee expenses)	222	231
Training courses and conferences	1,448	1,370
Patient travel	45	62
Redundancy - (Not included in employee expenses)	231	71
Early retirements - (Not included in employee expenses)	0	82
Hospitality	131	145
Insurance	64	90
Losses, ex gratia & special payments- (Not included in employee expenses)	591	156
Other	552	584
Total operating expenses	**303,312**	**281,129**

*Additional classifications for internal audit costs have resulted in restatements of prior year comparatives.

Analysis of operating expenses - other		
Services from local authorities	38	67
Other patients' expenses	185	239
CQC and accreditation fees	94	87
Miscellaneous	235	191
	552	**584**

Note 4.1
Employee expenses

	12 months ended 31 March 2016			12 months ended 31 March 2015		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
	£000	£000	£000	£000	£000	£000
Salaries and wages	188,382	180,866	7,516	176,668	168,819	7,849
Social security costs	12,994	12,317	677	12,707	11,969	738
Pension costs - defined contribution plans (Employers contributions to NHS Pensions)	22,635	21,687	948	21,240	20,206	1,034
Pension Cost - other contributions	11	11	0	9	9	0
Agency/contract staff	4,971	0	4,971	4,375	0	4,375
Gross employee expenses	**228,993**	**214,881**	**14,112**	**214,999**	**201,003**	**13,996**
less income in respect of salaries and wages where netted off expenditure	(170)	(170)	0	127	127	0
Total employee expenses	**228,823**	**214,711**	**14,112**	**215,126**	**201,130**	**13,996**
of which:						
Costs capitalised as part of assets	338	338	0	325	325	0
Analysed into Operating Expenditure (page 14):						
Employee Expenses - Staff	226,547	212,552	13,995	212,892	199,066	13,826
Employee Expenses - Executive directors	1,194	1,194	0	1,144	1,144	0
Research & development	744	627	117	765	595	170
Total employee expenses exc. capitalised costs	**228,485**	**214,373**	**14,112**	**214,801**	**200,805**	**13,996**

The salary costs of the capital development team are capitalised over the full costs of the Trust's capital schemes, of which in 2015-16 the largest were West Lane Hospital, The Orchards and Alexander House.

Note 4.2
Average number of employees (WTE Basis)

	12 months ended 31 March 2016			12 months ended 31 March 2015		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
	Number	Number	Number	Number	Number	Number
Medical and dental	312	302	10	285	274	11
Administration and estates	1,097	1,060	37	1,039	995	44
Healthcare assistants and other support staff	283	272	11	310	289	21
Nursing, midwifery and health visiting staff	3,288	3,267	21	3,167	3,143	24
Scientific, therapeutic and technical staff	687	675	12	643	637	6
Social care staff	25	0	25	27	0	27
Agency and contract staff	120	0	120	115	0	115
Bank staff	257	0	257	273	0	273
Total	**6,069**	**5,576**	**493**	**5,859**	**5,338**	**521**
of which:						
Number of Employees (WTE) engaged on capital projects	7	7	0	7	7	0

Note 4.3
Early retirements due to ill health

During the period to 31 March 2016 there were 5 (2014-15, 16) early retirements from the Trust on the grounds of ill-health. The estimated additional pension liabilities of the ill-health retirement will be £384,305 (2014-15, £827,272). The cost of this ill-health retirement will be borne by the NHS Business Services Authority - Pension Division.

Note 4.4
Analysis of termination benefits

There were 4 payments for termination benefits valuing £231,000 during the period to March 2016, relating to redundancy (2014-15, 7 payments valuing £188,000).

Note 4.5
Cost of exit packages

	12 months ended 31 March 2016			12 months ended 31 March 2015		
Exit Package Cost	**Total number**	**Compulsory Redundancies number**	**Other Departures number**	**Total number**	**Compulsory Redundancies number**	**Other Departures number**
<10,000	1	1	0	3	3	0
£10,001 - £25,000	0	0	0	2	2	0
£50,001 - £100,000	2	2	0	2	1	1
£100,001 - £150,000	1	1	0	0	0	0
Total number of exit packages	**4**	**4**	**0**	**7**	**6**	**1**
Total resource cost (£000's)	**231**	231	0	**188**	106	231

Note 4.6
Exit packages: other non compulsory

There were no other non compulsory exit packages between 01 April 2015 and 31 March 2016, (2014-15, nil)

Note 4.7
Directors' remuneration and other benefits

The aggregate annual amounts payable to directors were:

	12 months ended 31 March 2016 £000	12 months ended 31 March 2015 £000
Salary	1,739	1,535
Other Remuneration	189	186
Taxable benefits	39	31
Employer's pension contributions	198	193
Total	**2,165**	**1,945**

Further details of directors' remuneration can be found in the remuneration report.

Note 5.1
Operating leases

	12 months ended 31 March 2016 £000	12 months ended 31 March 2015 £000
Minimum lease payments	6,727	5,710
Total	**6,727**	**5,710**

Note 5.2
Arrangements containing an operating lease

	12 months ended 31 March 2016 £000	12 months ended 31 March 2015 £000
Future minimum lease payments due:		
not later than one year	4,971	4,703
later than one year and not later than five years	5,894	6,166
later than five years	2,404	3,365
Total	**13,269**	**14,234**

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

Note 5.3
Limitation on auditor's liability

There is no specified limitation stated in the engagement letter of the Trust's auditors (no specified limitation 2014/15).

Note 5.4
The late payment of commercial debts (interest) Act 1998

The Trust did not pay any interest payable arising from claims or pay compensation to cover debt recovery costs under this legislation (2014-15, £nil).

Note 5.5
Other audit remuneration

The Trust did not pay external auditors any additional remuneration during 31 March 2016 (31 March 2015, £nil). Auditors remuneration for statutory audit is shown in note 3.

Note 6
Discontinued operations

The Trust has no discontinued operations at 31 March 2016 (31 March 2015, £nil).

Note 7
Corporation tax

The Trust has no Corporation Tax liability or asset at 31 March 2016 (31 March 2015, £nil).

Note 8
Finance income

	12 months ended 31 March 2016 £000	12 months ended 31 March 2015 £000
Interest on bank accounts	202	151
Total	**202**	**151**

Note 9
Finance income

	12 months ended 31 March 2016 £000	*Restated 12 months ended 31 March 2015 £000
Capital loans from the Department of Health	164	105
Finance costs in PFI obligations		
Main finance cost	3,999	4,108
Contingent finance cost	1,259	1,183
Total	**5,422**	**5,396**

* restated following additional guidance

Note 10
Impairment of assets

	12 months ended 31 March 2016 £000	12 months ended 31 March 2015 £000
Changes in market price	15,368	12,560
Reversal of impairments	(2,250)	(5,506)
Total Impairments charged to operating surplus	**13,118**	**7,054**
Impairments charged to the revaluation reserve	4,379	15,596
Total Impairments	**17,497**	**22,650**

Note 11
Intangible assets
The Trust has no intangible assets as at 31 March 2016 (31 March 2015, £nil).

Note 12.1
Property, plant and equipment 2015-16

	Total £000	Land £000	Buildings exc. Dwellings £000	Assets under construction £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000
Cost or valuation at 1 April 2015	**223,494**	**11,916**	**205,064**	**3,620**	**610**	**84**	**853**	**1,347**
Transfers by absorption - NORMAL	535	0	0	0	0	0	535	0
Additions purchased	9,635	0	8,405	1,170	60	0	0	0
Impairments charged to operating expenses	(15,368)	(189)	(15,179)	0	0	0	0	0
Impairments charged to the revaluation reserve	(4,379)	(1)	(4,378)	0	0	0	0	0
Reversal of impairments credited to operating income	2,250	233	2,017	0	0	0	0	0
Reclassifications	0	0	3,485	(3,485)	0	0	0	0
Revaluations	3,541	942	2,599	0	0	0	0	0
Transfers to/from assets held for sale and assets in disposal groups	(449)	(130)	(319)	0	0	0	0	0
Disposals / Derecognition *	(5,944)	0	(5,936)	0	(8)	0	0	0
Cost or valuation at 31 March 2016	**213,315**	**12,771**	**195,758**	**1,305**	**662**	**84**	**1,388**	**1,347**
Accumulated depreciation at 1 April 2015	**4,570**	**0**	**2,360**	**0**	**379**	**50**	**438**	**1,343**
Transfers by absorption - NORMAL	159	0	0	0	0	0	159	0
Provided during the year	4,150	0	3,589	0	45	12	500	4
Transfers to/from assets held for sale and assets in disposal groups	(13)	0	(13)	0	0	0	0	0
Disposals / Derecognition *	(5,939)	0	(5,936)	0	(3)	0	0	0
Accumulated depreciation at 31 March 2016	**2,927**	**0**	**0**	**0**	**421**	**62**	**1,097**	**1,347**

* Derecognition of valuation and accumulated depreciation is due to a modern equivalent asset valuation.

Note 12.2
Property, plant and equipment 2014-15

	Total	Land	Buildings exc. Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2014	**237,120**	**11,916**	**221,983**	**735**	**523**	**84**	**532**	**1,347**
Additions purchased	7,951	0	4,250	3,293	87	0	321	0
Impairments charged to operating expenses	(12,560)	0	(12,560)	0	0	0	0	0
Impairments charged to the revaluation reserve	(15,596)	0	(15,596)	0	0	0	0	0
Reversal of impairments credited to operating income	5,506	0	5,506	0	0	0	0	0
Reclassifications	0	0	408	(408)	0	0	0	0
Revaluations	3,960	0	3,960	0	0	0	0	0
Transfers to/from assets held for sale and assets in disposal groups	(2,887)	0	(2,887)	0	0	0	0	0
Cost or valuation at 31 March 2015	**223,494**	**11,916**	**205,064**	**3,620**	**610**	**84**	**853**	**1,347**
Accumulated depreciation at 1 April 2014	**3,208**	**0**	**1,231**	**0**	**318**	**38**	**355**	**1,266**
Provided during the year	4,247	0	4,014	0	61	12	83	77
Derecognition *	(2,885)	0	(2,885)	0	0	0	0	0
Accumulated depreciation at 31 March 2015	**4,570**	**0**	**2,360**	**0**	**379**	**50**	**438**	**1,343**

Note 12.3
Property, plant and equipment financing

Net book value - 31 March 2016	Total	Land	Buildings exc. Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000
Owned	123,106	12,771	108,476	1,305	241	22	291	0
PFI	87,282	0	87,282	0	0	0	0	0
Net book value total at 31 March 2016	**210,388**	**12,771**	**195,758**	**1,305**	**241**	**22**	**291**	**0**
Net book value - 31 March 2015								
Owned	126,327	11,916	110,107	3,620	231	34	415	4
PFI	92,597	0	92,597	0	0	0	0	0
Net book value total at 31 March 2015	**218,924**	**11,916**	**202,704**	**3,620**	**231**	**34**	**415**	**4**

Note 13
Non current assets acquired by government grant
The Trust has no assets acquired by government grant (2014-15, nil).

Note 14
Economic life of property, plant and equipment

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

Note 15.1

Land and buildings disposed previously used to provide commissioner requested services

	Total	Land	Buildings exc. Dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value of assets disposed	**(436)**	0	(436)	0	0	0	0	0	0
Sale proceeds*	**900**	0	900	0	0	0	0	0	0
Expenditure associated with sale	**(30)**	0	(30)	0	0	0	0	0	0
Profit on sale	**434**	**0**	**434**	**0**	**0**	**0**	**0**	**0**	**0**

* The sale of these assets does not impact on the Trusts ability to meet its obligation to provide commissioner requested services as no sales are authorised without full consideration of the impact on service provision. Services previously provided in these buildings are now delivered within existing Trust estate, or the service has transferred to another provider.

Note 15.2

NBV of property, plant and equipment in the Revaluation Reserve as at 31 March 2016

	Total	Land	Buildings exc. Dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
as at 1 April 2015	**19,606**	964	18,642	0	0	0	0	0	0
movement in year	**(967)**	900	(1,867)	0	0	0	0	0	0
as at 31 March 2016	**18,639**	**1,864**	**16,775**	**0**	**0**	**0**	**0**	**0**	**0**

Note 15.3

NBV of property, plant and equipment in the Revaluation Reserve as at 31 March 2015

	Total	Land	Buildings exc. Dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
as at 1 April 2014	**31,242**	964	30,278	0	0	0	0	0	0
movement in year	**(11,636)**	0	(11,636)	0	0	0	0	0	0
as at 31 March 2015	**19,606**	**964**	**18,642**	**0**	**0**	**0**	**0**	**0**	**0**

Note 16

Investments

	12 months ended 31 March 2016 £000	12 months ended 31 March 2015 £000
as at 1 April	0	0
additions	80	0
as at 31 March	**80**	**0**

Note 17

Associate and jointly controlled operations

The Trust has no investments in associates or joined controlled operations consolidated in these accounts as at 31 March 2016 (31 March 2015, £nil) on the basis of materiality (as disclosed in note 1).

Note 18.1
Non current assets for sale and assets in disposal groups 2015-16

	Total	PPE: Land	Property, Plant & Equipment
	£000	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 31 March 2015	**0**	0	0
Plus assets classified as available for sale in the year	**436**	130	130
Less assets sold in year	**(436)**	(130)	(130
NBV of non-current assets for sale and assets in disposal groups at 31 March 2016	**0**	**0**	**0**

Note 18.2
Non current assets for sale and assets in disposal groups 2014-15

	Total	PPE: Land	Property, Plant & Equipment
	£000	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 31 March 2014	**135**	130	130
Less assets sold in yearLess assets sold in year	**(135)**	(130)	(130
NBV of non-current assets for sale and assets in disposal groups at 31 March 2015	**0**	**0**	**0**

Note 18.3
Liabilities disposal groups
The Trust has no liabilities in disposal groups as at 31 March 2016 (31 March 2015, £nil).

Note 19
Other assets
The Trust has no other assets as at 31 March 2016 (31 March 2015, £nil).

Note 20
Other financial assets
The Trust has no other financial assets as at 31 March 2016 (31 March 2015, £nil).

Note 21
Inventories

	12 months ended 31 March 2016 £000	12 months ended 31 March 2015 £000
Carrying Value at 1 April	171	182
Additions	181	171
Inventories recognised in expenses	(171)	(182)
Carrying Value at 31 March	**181**	**171**

Note 22
Trade receivables and other receivables

	31 March 2016 £000	31 March 2015 £000
Current		
NHS receivables	2,371	2,394
Other receivables with related parties	553	497
Provision for impaired receivables	(86)	(542)
Prepayments	3,093	2,784
PFI Prepayments		
Prepayments - lifecycle replacements	0	555
Accrued income	47	60
VAT receivable	564	577
Other trade receivables	331	241
Total current trade and other receivables	**6,873**	**6,566**
Non Current		
Other trade receivables	47	50
Total non current trade and other receivables	**47**	**50**

Note 23.1
Provision for impairment of receivables

	31 March 2016 £000	31 March 2015 £000
At 1 April	542	230
Increase in provision	86	542
Amounts utilised	(522)	(111)
Unused amounts reversed	(20)	(119)
At 31 March	**86**	**542**

Note 23.2
Analysis of impaired receivables

	31 March 2016 £000	31 March 2016 £000	31 March 2015 £000	31 March 2015 £000
Ageing of impaired receivables	**Trade receivables**	**Other receivables**	**Trade receivables**	**Other receivables**
0 - 30 days	1	0	457	0
30 - 60 Days	1	0	85	0
60 - 90 days	38	0	0	0
90 - 180 days	3	0	0	0
over 180 days	43	0	0	0
Total	**86**	**0**	**542**	**0**
Ageing of non-impaired receivables past their due date				
0 - 30 days	1,515	324	1,187	35
30 - 60 Days	170	20	101	22
60 - 90 days	126	4	1	8
90 - 180 days	134	9	68	53
over 180 days	46	31	11	9
Total	**1,991**	**388**	**1,368**	**127**

Note 24
Finance leases

The Trust does not have any finance lease obligations other than PFI commitments (2014-15, nil).

Note 25.1
Cash and cash equivalents

	12 months ended 31 March 2016 £000	12 months ended 31 March 2015 £000
At 1 April	47,147	24,342
Net change in year	7,001	22,805
At 31 March	**54,148**	**47,147**
Broken down into:		
Commercial banks and cash in hand	133	278
Cash with Government Banking Service	54,015	46,869
Cash and cash equivalents as in SoFP	**54,148**	**47,147**
Bank overdraft	0	0
Cash and cash equivalents as in SoCF	**54,148**	**47,147**

Note 25.2
Third party assets held

	12 months ended 31 March 2016 £000	12 months ended 31 March 2015 £000
At 1 April	1,180	1,400
Gross inflows	3,297	3,069
Gross Outflows	(3,061)	(3,289)
At 31 March	**1,416**	**1,180**

Note 26.1
Trade and other payables

	31 March 2016 £000	31 March 2015 £000
NHS payables - capital	376	0
NHS payables	1,807	459
Amounts due to other related parties - revenue	3,766	2,950
Other trade payables - capital	1,197	861
Other trade payables - revenue	2,300	3,181
Social Security costs	2,291	2,096
VAT payable	73	39
Other taxes payable	2,159	2,020
Other payables	2	34
Accruals	10,302	8,550
PDC dividend payable	87	52
Total current trade and other payables	**24,360**	**20,242**

Non current
The Trust has no non current trade and other payables

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

Note 26.2

Early retirements detail included in NHS payables above

There There were no early retirement costs in the NHS payables balance at 31 March 2016 (2014-15, £nil).

Note 27

Borrowings

Current	31 March 2016 £000	*restated 31 March 2015 £000
Capital loans from Department of Health	3,000	3,000
Obligations under Private Finance Initiative contracts	2,429	2,319
Total current borrowings	**5,429**	**5,319**
Non current		
Capital loans from Department of Health	9,000	12,000
Obligations under Private Finance Initiative contracts	77,181	79,610
Total other non-current liabilities	**86,181**	**91,610**

* restated following additional guidance

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

During 2014-15 the Trust received a £15,000k loan repayable over 5 years from the Department of Health, which was used to support the Trust's capital programme

Note 28

Other liabilities

	31 March 2016 £000	31 March 2015 £000
Current		
Deferred income - goods and services	299	385
Total other current liabilities	**299**	**385**

Note 29

Other financial liabilities

The Trust has no other financial liabilities at 31 March 2016 (31 March 2015, £nil).

Note 30.1

Provisions for liabilities and charges 2015-16

	Total £000	Pensions - other staff £000	Legal claims £000	Other £000
At 1 April 2015	1,474	1,129	274	8
Change in the discount rate	22	(57)	0	0
Arising during the year	813	225	341	168
Utilised during the year - accruals	(614)	(157)	(133)	0
Reversed unused	(61)	0	(51)	(8)
Unwinding of discount	19	17	0	0
At 31 March 2016	**1,653**	**1,157**	**431**	**168**
Expected timing of cash flows:				
not later than one year	693	51	431	168
Current	**693**	**51**	**431**	**168**
later than one year and not later than five years	193	206	0	0
later than five years	767	900	0	0
Non Current	**960**	**1,106**	**0**	**0**
Total	**1,653**	**1,157**	**431**	**168**

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

Legal claims relate to the following; employer / public liability claims notified by the NHS Litigation Authority £125,651 (2014-15, £114,550), and the provision for employment law £305,000 (2014-15, £159,145).

Note 30.2

Provisions for liabilities and charges 2014-15

	Total £000	Pensions - other staff £000	Legal claims £000	Other £000
At 1 April 2014	1,358	1,099	259	0
Change in the discount rate	229	229	0	0
Arising during the year	213	0	205	8
Utilised during the year - accruals	(284)	(158)	(126)	0
Reversed unused	(117)	(53)	(64)	0
Unwinding of discount	12	12	0	0
At 31 March 2015	**1,411**	1,129	274	8
Expected timing of cash flows:				
not later than one year	337	55	274	8
Current	**337**	**55**	**274**	**8**
later than one year and not later than five years	222	222	0	0
later than five years	852	852	0	0
Non Current	**1,074**	**1,074**	**0**	**0**
Total	**1,411**	**1,129**	**274**	**8**

Note 30.3

Clinical negligence liabilities

£525,202 (2014-15, £589,225) is included in the provisions of the NHS Litigation Authority at 31 March 2016 in respect of clinical negligence liabilities of the NHS Foundation Trust.

Note 31.1
Contingent liabilities

	31 March 2016 £000	31 March 2015 £000
Gross value of contingent liabilities	(182)	(118)
Net value of contingent liabilities	**(182)**	**(118)**

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

Note 31.2
Contingent assets

The Trust is currently involved in a contractual legal dispute which may result in future economic benefits relating to past events. No income has been recognised in the financial statements due to uncertainty around the amount of these economic benefits, and because an appeals process is available following the outcome, (31 March 2015, £nil).

Note 32
Revaluation reserve

	31 March 2016 £000	31 March 2015 £000
Revaluation reserve at 1 April	**19,606**	**31,242**
Impairments	(4,379)	(15,596)
Revaluations	3,541	3,960
Asset disposals	(127)	0
Revaluation reserve at 31 March	**18,641**	**19,606**

Note 33.1
Related Party Transactions

	Income £000	Expenditure £000
2015-2016		
Value of transactions with board members in 2015-2016	0	0
Value of transactions with key staff members in 2015-2016	0	0
Value of transactions with other related parties in 2015-2016		
Department of Health	240	0
Other NHS Bodies	303,262	9,283
Subsidiaries / Associates / Joint Ventures	1,346	0
Other	3,372	38,681
Total	**308,220**	**47,964**
2014-2015		
Value of transactions with board members in 2014-2015	0	0
Value of transactions with key staff members in 2014-2015	0	0
Value of transactions with other related parties in 2014-2015		
Department of Health	260	4
Other NHS Bodies	279,182	6,824
Subsidiaries / Associates / Joint Ventures	1,879	350
Other	5,946	36,910
Total	**287,267**	**44,088**

Note 33.2
Related Party Balances

	Receivables £000	Payables £000
2015-2016		
Value of balances (other than salary) with board members in 2015-2016	0	0
Value of balances (other than salary) with key staff members in 2015-2016	0	0
Value of balances (other than salary) with related parties in relation to doubtful debts at 31 March 2016	(86)	0
Value of balances (other than salary) with related parties in respect of doubtful debts written off in year at 31 March 2016	0	0
Value of balances with other related parties at 31 March 2016		
Department of Health	0	160
Other NHS Bodies	2,253	3,208
Subsidiaries / Associates / Joint Ventures	110	0
Other	1,090	8,830
Total	**3,367**	**12,198**
2014-2015		
Value of balances (other than salary) with board members at 31 March 2015	0	0
Value of balances (other than salary) with key staff members at 31 March 2015	0	0
Value of balances (other than salary) with related parties in relation to doubtful debts at 31 March 2015	(522)	0
Value of balances (other than salary) with related parties in respect of doubtful debts written off in year at 31 March 2015	0	0
Value of balances with other related parties at 31 March 2015		
Department of Health	1	52
Other NHS Bodies	1,854	911
Subsidiaries / Associates / Joint Ventures	157	0
Other	972	7,570
Total	**2,462**	**8,533**

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

Note 33.3
Related Party Transactions

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

The Department of Health is regarded as a related party. During the period Tees, Esk and Wear Valleys NHS Foundation Trust has had a significant number of material transactions (total transactions greater than £1,000k) with the Department, and with other entities for which the Department is regarded as the parent department, or a related party. These entities are detailed in the table below (income and expenditure totals are for the accounting period, receivables and payables balances are at 31 March 2016):

Entity	Income £000	Expenditure £000	Receivables £000	Payables £000
NHS England - North East Commissioning Hub	48,983	0	353	0
NHS Durham Dales, Easington and Sedgefield CCG	46,516	0	87	13
NHS South Tees CCG	42,111	48	145	0
NHS North Durham CCG	37,135	0	68	18
NHS Hartlepool and Stockton-on-Tees CCG	34,394	6	23	15
NHS Vale of York CCG	19,124	0	1	0
NHS Hambleton, Richmondshire and Whitby CCG	14,933	0	306	0
NHS Harrogate and Rural District CCG	14,201	22	139	0
NHS Scarborough and Ryedale CCG	13,868	0	86	0
NHS Darlington CCG	12,990	0	16	640
Health Education England	7,446	5	180	5
NHS England - Cumbria and North East Local Office	5,121	0	3	0
NHS Leeds North CCG	1,045	0	5	0
NHS Property Services	248	1,432	209	892
South Tees Hospitals NHS Foundation Trust	195	1,402	11	124
Leeds and York Partnership NHS Foundation Trust	392	1,030	97	838
Other DH Group	4,800	5,338	524	823

In addition, the Trust has had a number of material transactions (total transactions greater than £1,000k) with other Government Departments and other central and local Government bodies. These are detailed in the table below:

Entity	Income £000	Expenditure £000	Receivables £000	Payables £000
NHS Pension Scheme	0	22,635	0	3,224
HM Revenue & Customs	0	12,994	0	4,450
Other Government Bodies	3,372	3,042	1,090	1,156

Note 34.1
Contractual capital commitments

	31 March 2016 £000	31 March 2015 £000
Property, plant and equipment	2,397	6,913
Total as at 31 March	**2,397**	**6,913**

Note 34.2
Other Financial Commitments

The Trust has no other financial commitments as at 31 March 2016 (31 March 2015, £nil).

Note 35
Finance lease obligations

The Trust has no finance lease obligations as at 31 March 2016 (31 March 2015, £nil).

Note 36.1
On SoFP PFI obligations (finance lease element)

	31 March 2016 Total £000	31 March 2016 Lanchester Rd PFI £000	31 March 2016 Roseberry Park PFI £000	31 March 2015 Total £000
Gross PFI liabilities	**194,043**	**38,816**	**155,227**	**204,237**
of which liabilities are due				
not later than one year	7,651	1,462	6,189	7,577
later than one year and not later than five years	31,350	5,952	25,398	31,265
later than five years	155,042	31,402	123,640	165,395
Finance charges allocated to future periods	(114,433)	(23,692)	(90,741)	(122,308)
Net PFI liabilities	**79,610**	**15,124**	**64,486**	**81,929**
not later than one year	2,429	481	1,948	2,319
later than one year and not later than five years	10,204	1,926	8,278	9,874
later than five years	66,977	12,717	54,260	69,736
	79,610	**15,124**	**64,486**	**81,929**

Note 36.2
On SoFP PFI service concession commitments

	31 March 2016 Total £000	31 March 2016 Lanchester Rd PFI £000	31 March 2016 Roseberry Park PFI £000	*Restated 31 March 2015 Total £000
Commitments				
not later than one year	10,584	1,969	8,615	10,444
later than one year and not later than five years	45,056	8,377	36,679	44,463
later than five years	280,714	47,258	233,456	295,801
Total	**336,354**	**57,604**	**278,750**	**350,708**

* Restated following additional guidance

Note 36.3
On SoFP PFI unitary payments

	31 March 2016 Total £000	31 March 2016 Lanchester Rd PFI £000	31 March 2016 Roseberry Park PFI £000	31 March 2015 Total £000
Unitary payment	**10,604**	**1,942**	**8,662**	**10,481**
Consisting of:				
Interest charge	3,999	730	3,269	4,108
Repayment of finance lease liability	2,319	486	1,833	2,138
Service element	2,723	411	2,312	2,661
Capital lifecycle maintenance	304	54	250	391
Contingent Rent	1,259	261	998	1,183
Total	**10,604**	**1,942**	**8,662**	**10,481**

The Trust have full control of clinical services provided from PFI funded hospitals, and full access and use of the buildings, which are maintained by the PFI project companies as part of the PFI procurement contract.

PFI project companies provide services for "hard" facilities management including building maintenance and life cycle replacement programmes. A contractual commitment exists for the PFI project companies to maintain the building at "category b" status for the contract life (30 years from commencement for Lanchester Road and 30 years from financial close for Roseberry Park).

The contract can be terminated within the 30 year contract period if contractual obligations for service delivery (maintenance) and building availability are not met. This is controlled by a points based payment deduction methodology within the standard PFI contract. The Trust have the right to cease the contract early, subject to payment of a financial penalty.

Note 37
Off-SoFP PFIs commitments
The Trust has no off-SoFP PFIs as at 31 March 2016 (31 March 2015, £nil).

Note 38
Events after the reporting period
The Trust has no events after the reporting period.

Note 39.1
Financial assets by category

	Total	Loans and receivables
Assets as per SoFP	**£000**	**£000**
NHS Trade and other receivables excluding non financial assets (at 31 March 2016)	3,263	3,263
Cash and cash equivalents at bank and in hand (at 31 March 2016)	54,148	54,148
Total at 31 March 2016	**57,411**	**57,411**

	Total	Loans and receivables
	£000	**£000**
NHS Trade and other receivables excluding non financial assets (at 31 March 2015)	2,700	2,700
Cash and cash equivalents at bank and in hand (at 31 March 2015)	47,147	47,147
Total at 31 March 2015	**49,847**	**49,847**

Note 39.2
Financial liabilities by category

	Total	Other financial liabilities
	£000	**£000**
Borrowings excluding finance lease and PFI liabilities (at 31 March 2016)	12,000	12,000
Obligations under PFI, LIFT and other service concession contracts (at 31 March 2016)	79,610	79,610
Trade and other payables excluding non financial liabilities (at 31 March 2016)	19,750	19,750
Provisions under contract (at 31 March 2016)	126	126
Total at 31 March 2016	**111,486**	**111,486**

	Total	Other financial liabilities
	£000	**£000**
Borrowings excluding Finance lease and PFI liabilities (at 31 March 2015)	15,000	15,000
Obligations under PFI, LIFT and other service concession contracts (at 31 March 2015)	81,929	81,929
NHS Trade and other payables excluding non financial assets (at 31 March 2015)	16,035	16,035
Provisions under contract (at 31 March 2015)	115	115
Total at 31 March 2015	**113,079**	**113,079**

Note 39.3
Fair values of financial assets at 31 March 2016

	Book Value	Fair Value
	£000	**£000**
Non current trade and other receivables	47	47
Other investments	80	80
Total	**127**	**127**

Note 39.4
Fair values of financial liabilities at 31 March 2016

	Book Value	Fair Value
	£000	**£000**
Loans	9,000	9,000
Total	**9,000**	**9,000**

Note 39.5
Maturity of Financial liabilities

	31 March 2016	31 March 2015
	£000	**£000**
In one year or less	25,305	21,469
In more than one year but not more than two years	5,469	5,429
In more than two years but not more than five years	13,735	16,445
In more than five years	66,977	69,736
Total	**111,486**	**113,079**

Note 40
On SoFP pension schemes

The Trust does not operate an on-statement of financial position pension scheme. Refer to note 1 for details.

Note 41
Losses and special payments

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

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

These amounts are reported on an accruals basis, but exclude provisions for future losses.

A breakdown of losses and special payments recognised by the trust is below:

At 31 March 2016	Number of cases	Value £000
Losses		
Cash losses	1	0
Special payments		
Ex gratia payments	23	8
Total at 31 March 2016	**24**	**8**

At 31 March 2015	Number of cases	Value £000
Losses		
Cash losses	0	0
Special Payments		
Ex gratia payments	58	15
Total at 31 March 2015	**58**	**15**

Note 42
Third party assets and liabilities

The Trust held £906k cash at bank and in hand at 31 March 2016 (31 March 2015, £715k) which related to monies held by the NHS Trust on behalf of patients. This has been excluded from cash at bank and in hand figure reported in the accounts.

The Trust held £510k cash at bank and in hand at 31 March 2016 (31 March 2015, £465k) which related to monies held by the Trust for a staff savings scheme. This has been excluded from the cash at bank and in hand figure reported in the accounts.

Note 43
Financial risk management

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

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

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

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

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

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

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

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

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

Appendices

Apendix 1
Glossary

Adult Mental Health Service (AMH): Services provided for people between 18 and 64 – known in some other parts of the country as "working-age services". These services included inpatient and community mental health services. In practice, some patients younger than 64 may be treated in older people's services if they are physically frail or if they have Early Onset Dementia. Early Intervention in Psychosis teams (EIP) may treat patients younger than 18 years old as well as those over that age.

Alcohol Detoxification Pathway: This is the standard set of assessments that we use to identify alcohol dependency and a set of consequent interventions we use to address this.

ARCH (aspiration, recovery, confidence, hope): This is the name of our Durham Recovery College, and it reflects the impact that we intend our recovery work to have on our service users' lives.

Audit Commission: This was the national body responsible for appointing external auditors to many public bodies. It also ran counter-fraud work and produced national value for money studies. Government re-assigned its roles to other bodies and the Commission was closed on 31 March 2015.

Audit North: This is an Audit Consortium covering many health, local government and other bodies in the North East, Yorkshire, East Midlands and Cumbria. Audit North provider TEWV's internal audit service (the Trust's external auditors are Mazars).

Autism Services / 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 behaviours and interests, and in some cases, cognitive delays.

Behavioural Activation: As a treatment for depression and other mood disorders, behavioural activation is based on the theory that, as individuals become depressed, they tend to engage in increasing avoidance and isolation, which serves to maintain or worsen their symptoms. The goal of treatment, therefore, is to work with depressed individuals to gradually decrease their avoidance and isolation and increase their engagement in activities that have been shown to improve mood. Many times, this includes activities that they enjoyed before becoming depressed, activities related to their values or even everyday items that get pushed aside.

Benchmarking: This is where data on how the same service / team performs clinically, financially or otherwise is compared against other similar services / teams in other places. Often this comparison will be against the average, median, upper or lower quartile position, which is worked out by ranking all of the services / teams. Benchmarking may be "internal" (comparing teams across TEWV) or "external" (comparing across the country).

Board / Board of Directors: The Trust is run by the Board of Directors made up of the Chairman, Chief Executive, Executive and Non-Executive Directors. The Board is responsible for ensuring accountability to the public for the services it manages. It also:

- Ensures effective dialogue between the Trust and the communities it serves;
- Monitors and ensures high quality services;
- Is responsible for the Trust's financial viability;
- Sets general policy direction;
- Appoints and appraises the Trust's executive management team. It is overseen by a Council of Governors and regulated by Monitor.

C Difficile: a species of bacteria of the genus Clostridium that causes severe diarrhoea and other intestinal disease when competing bacteria in the gut flora have been wiped out by antibiotics.

CAMHS: Children and Young People's Mental Health services (see Children and Young People's Services).

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 Programme Approach (CPA) Policy: the Trusts policy on the Care Programme Approach.

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.

Care UK: A major provider of NHS and private sector healthcare services, which until March 2015 held the contract for health services in the prisons in North East England, subcontracting the mental health elements of the contract to TEWV.

Children and Young People Service (CYPS): Services for people under 18 years old. These include community mental health services and inpatient services. In Durham, Darlington and Teesside TEWV also provides services to children and young people with learning disability related mental health needs.

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.

Clinical Research Network (CRN): This is part of the National Institute for Health Research which provides the infrastructure to allow high quality research to take place within the NHS, so patients can benefit from new and better treatments.

Clinical Trials of Investigational Medicinal Products (CTIMPs): These are studies which determine the safety and/or efficacy of medicines in humans.

CLiP (Clinical Link Pathway): Completed on the Trust's electronic patient record (Paris) for Falls allowing them to be monitored effectively.

Clywd / Hart Review: A review of the complaints systems and the use of complaints data carried out by Rt Hon Ann Clwyd (MP for the Cynon Valley) and Professor Tricia Hart, (chief executive, South Tees Hospitals NHS Foundation Trust) who were commissioned by the Secretary of State for Health to lead the review. It came as part of a response to the Francis report, which highlighted that complaints are a warning sign of problems in a hospital.

COBRA (cost and outcome of behavioural activation versus cognitive behaviour therapy for depression): is a research study comparing 2 psychological interventions for the treatment of depression in adults. The study aims to determine both the clinical and cost effectiveness of Behavioural Activation compared to Cognitive Behavioural Therapy for depression in adults within primary care.

Cognitive Behavioural Therapy (CBT): CBT is a "talking therapy." The therapist will talk with the patient about how they think about themselves, the world and other people and how what they do affects their thoughts and feelings. CBT can help patients change how they think ('Cognitive') and what they do ('Behaviour'). These changes can help the patient to feel better. Unlike some of the other talking treatments, it focuses on the 'here and now' problems and difficulties. Instead of focusing on the causes of your distress or symptoms in the past, it looks for ways to improve the patient's state of mind now.

Commissioners: The organisations that have responsibility for buying health services on behalf of the population of the area work for.

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.

Confidential Enquiry Report: A national scheme that interviews clinicians anonymously to find out ways of improving care by gathering information about which factors contributed to the inability of the NHS to prevent each suicide of a patient within its care. National reports and recommendations are then produced.

Coproduction: This is an approach where a policy, and approach or other initiative / action is designed jointly by TEWV and a service user / service users.

Council of Governors: the Council of Governors is made up of elected public and staff members, and also includes non-elected members, such as the Prison Service, Voluntary Sector, Acute Trusts, Universities, Primary Care Trusts and Local Authorities. The Council has an advisory, guardianship and strategic role including developing the Trust's membership, appointments and remuneration of the Non-Executive Directors including Chairman and Deputy Chairman, responding to matters of consultation from the Trust Board, and appointing the Trust's auditors.

Crisis Care Concordat: The Mental Health Crisis Care Concordat is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis.

Culture of Candour: This relates to an open culture where things that go wrong are not kept secret but rather kept in the open so that people can understand and learn from what went on without blame or shame being allocated to individuals.

Dashboard: A report that uses data on a number of measures to help managers build up a picture of operational (day to day) performance or long term strategic outcomes.

Data Protection Act 1998: The law that regulates storage of and access to data about individual people.

Data Quality Improvement Plans: A plan to improve the reliability / accuracy of data collected on a particular subject – often used where data has not been collected in the past and new systems to do this need to be set up.

DATIX: TEWV's electronic system for collecting data about clinical, health and safety and information governance incidents.

Department of Health: The government department responsible for Health Policy.

Directorate(s): TEWV's corporate services are organised into a number of directorates: Human Resources and Organisational Development; Finance and Information; Nursing and Governance; Planning, Performance and Communications; Estates and Facilities Management. In the past our clinical specialities were called clinical directorates. The Specialities are Adult Mental Health services, Mental Health Services for Older People, Children and Young People's Services and Adult Learning Disability Services.

Drug and Therapeutics Committee: This is a subcommittee of the Quality Assurance Committee. It's role is to provide assurance to the Board of Directors, through the monitoring of quality and performance indicator data, planned work streams, guideline development and system implementation that the use of medicines throughout the Trust is safe, evidence-based, clinically and cost effective.

Duty of Candour: From 27 November 2014 all NHS bodies are legally required to meet the Duty of Candour. This requires healthcare providers to be open and transparent with those who use their services in relation to their care and treatment, and specifically when things go wrong.

Early Intervention in Psychosis (EIP): Early intervention in psychosis is a clinical approach to those experiencing symptoms of psychosis for the first time. It forms part of a new prevention paradigm for psychiatry and is leading to reform of mental health services especially in the United Kingdom. This approach centres on the early detection and treatment of early symptoms of psychosis during the formative years of the psychotic condition. The first three to five years are believed by some to be a critical period. The aim is to reduce the usual delays to treatment for those in their first episode of psychosis. The provision of optimal treatments in these early years is thought to prevent relapses and reduce the long-term impact of the condition.

Electroconvulsive Therapy (ECT): ECT is a treatment for a small number of severe mental illnesses. It was developed in the 1930s and was used widely during the 1950s and 1960s for a variety of conditions. It is now only used for fewer, more serious conditions. An electrical current is passed through the brain to produce an epileptic fit – hence the name, electro-convulsive. No-one is certain how ECT works. We do know that it can change patterns of blood flow through the brain and change the metabolism of areas of the brain which may be affected by depression. There is evidence that severe depression is caused by problems with certain brain chemicals. It is thought that ECT causes the release of these chemicals and, probably more importantly, makes the chemicals more likely to work and so help recovery.

Equality Champions: Staff within TEWV who have been appointed to promote good practice in equalities within their service and who attend the Trust-wide Equalities group.

Experts by Experience: experts by experience have been trained to work alongside the recovery team to develop and deliver recovery related training in supporting staff and service development in recovery related practice. Experts by experience work with Trust staff, they do not work with service users and carers (ie they are not acting in a peer role). These roles are managed via our Patient and Public Involvement process.

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.

Formulation: This is where clinicians use information obtained from their assessment of a patient to provide an explanation or hypothesis about the cause and nature of the presenting problems. This helps in developing the most suitable treatment approach.

Freedom of Information Act 2000: A law that outlines the rights that the public have to request information from public bodies (other than personal information covered by the Data Protection Act), the timescales they can expect to receive the information, and the exemptions that can be used by public bodies to deny access to the requested information.

Friends and Family Test: A survey question put to patients, carers or staff that asks whether they would recommend a hospital / community service to a friend of family member if they needed that kind of treatment.

Functional (MHSOP): Older people with a decreased mental function which is not due to a medical or physical condition.

General Medical Practice Code: is the organisation code of the GP Practice that the patient is registered with. This is used to make sure that our patients' GP practice is recorded correctly.

Health and Social Care Information Centre (HSCIC): The Health and Social Care Information Centre (HSCIC) was set up as an executive non-departmental public body in April 2013, sponsored by the Department of Health. It is the national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care.

Health and Wellbeing Boards: The Health and Social Care Act 2012 established health and wellbeing boards as a forum where key leaders from the health and care system would work together to improve the health and wellbeing of their local population and reduce health inequalities. Health and wellbeing board members collaborate to understand their local community's needs, agree priorities and encourage commissioners to work in a more joined-up way.

Health Education North East: The Health and Social Care Act 2012 established Health Education England which is supported by 13 local education and training boards (LETBs) spread across the country. HENE is the LETB that covers the North East of England, north Cumbria and Richmondshire / Hambleton area of North Yorkshire. It is responsible for the education and training of the whole NHS north east workforce. The professions range from medics, dentists, nurses, dental nurses, allied health professionals and healthcare scientists, to a variety of support staff such as healthcare and nursing assistants, therapists and technical staff.

Health of the Nation Outcome Score (HoNOS): A way of measuring patients' health and wellbeing. It is made up of 12 simple scales on which service users with severe mental illness are rated by clinical staff. The idea is that these ratings are stored, and then repeated- say after a course of treatment or some other intervention- and then compared. If the ratings show a difference, then that might mean that the service user's health or social status has changed. They are therefore designed for repeated use, as their name implies, as clinical outcomes measures.

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.

Health Technology Assessment (HTA): The HTA Programme is the largest of the National Institute for Health Research programmes. We fund independent research about the effectiveness, costs and broader impact of healthcare treatments and tests for those who plan, provide or receive care in the NHS. We fund our studies via a number of routes including commissioned and researcher-led workstreams.

Her Majesties Prison Inspectorate (HMPI): The inspectorate reporting on the treatment and conditions for those in prison and other types of custody in England and Wales.

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.

Human Resources: This phrase is either shorthand for all the staff working for TEWV, or the corporate service within TEWV responsible for ensuring that we have policies, procedures and professional advice that help us to recruit and retain suitably qualified, skilled and motivated workers in our full range of jobs (in other organisations this might be known as the Personnel Department).

IAPT (also known as 'Talking Therapies'): IAPT stands for "Increasing Access to Psychological Therapies" and was introduced in the last.

Infection Prevention and Control Team: The prevention of health care associated infections (HCAI), both in patients and staff, is an integral part of the professional responsibility of all health care workers. TEWV's infection prevention and control team for the trust consists of 2 senior infection prevention and control and physical healthcare nurse (IPCNs), 2infection prevention and control and physical healthcare nurses. The role of Director of Infection Prevention and Control (DIPC) is undertaken by the Director of Nursing and Governance for the Trust who is accountable directly to the board and chairs the Trust Infection Prevention and Control Committee.

Information Governance Toolkit & Assessment Report: is a national approach that provides a framework and assessment for assuring information quality against national definitions for all information that is entered onto computerised systems whether centrally or locally maintained.

Integrated Information Centre: TEWV's system for taking data from the patient record (Paris) and enabling it to be analysed to aid operational decision making and business planning.

Join Dementia Research (JDR): is a new national system which allows anyone, with or without dementia, to register their interest in becoming involved in dementia research. People can register online, by phone or by post and the system aims to match people to studies they may be able to take part in.

Learning Disabilities Service: Services for people with a learning disability and mental health needs. TEWV has Adult Learning Disability (ALD) service in each of its 3 Localities and also specific wards for Forensic LD patients. TEWV provides Child LD services in Durham, Darlington and Teesside but not in North Yorkshire.

Lived Experience: A member of the public or staff who has been treated for MH issues in the past and so has special insight into the patient perspective of having a mental illness and receiving treatment.

Local Authority Overview and Scrutiny Committee: All "upper-tier" and "unitary" local authorities are responsible for scrutinising health services in their area, and most have a Health Overview and Scrutiny Committee (OSC). Darlington, Hartlepool, Middlesbrough, Stockton and Redcar & Cleveland Councils have formed a joint Tees Valley OSC.

Localities: services in TEWV are organised around three Localities (ie County Durham & Darlington, Tees, North Yorkshire). Our Forensic services are not organised as a geographical basis, but are often referred to a fourth "Locality" within TEWV.

Locality Management and Governance Board (LMGB): A monthly meeting held in each of our Localities (see above) that involves senior managers and clinical leaders who work in that Locality which takes key decisions that relate to that Locality.

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 Act: The Mental Health Act (1983) is the main piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder. In most cases, when people are treated in hospital or another mental health facility they have agreed or volunteered to be there. However, there are cases when a person can be detained (also known as sectioned) under the Mental Health Act (1983) and treated without their agreement. People detained under the Mental Health Act need urgent treatment for a mental health disorder and are at risk of harm to themselves or others.

Mental Health and Learning Disabilities Data Set (MHLDDS): This contains data about the care of adults and older people using secondary mental health, learning disabilities or autism spectrum disorder services. Data is submitted by all providers of NHS funded services (doing so is a contractual requirement). This used to be referred to as the Mental Health Minimum Data Set (MHMDS).

Mental Health Foundation: A UK mental health research, policy and service improvement charity.

Mental Health Minimum Data Set (MHMDS): see Mental Health and Learning Disabilities Data Set (MHLDDS) above.

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.

Mental Health Services for Older People (MHSOP): Services provided for people over 65 years old. These can be to treat 'functional' illness, such as depression, psychosis or anxiety, or to treat 'organic' mental illness (conditions usually associated with memory loss and cognitive impairment), such as dementia. The MHSOP service sometimes treats people younger than 65 with organic conditions such as early-onset dementia.

Model Lines: A TEWV programme to support community teams to become recovery focused by using the quality improvement system philosophy and tools to maximise the time staff have available to work with patients, their families and carers. It also seeks to standardise the approach taken by different staff within a team, and across the Trust as a whole.

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.

Multi-agency: this means that more than one provider of services is involved in a decision or a process.

Multi-disciplinary: this means that more than one type of professional is involved – for example: psychiatrists, psychologists, occupational therapists, behavioural therapists, nurses, pharmacist all working together in a Multi-Disciplinary Team (MDT).

My Shared Pathway: My Shared Pathway is used in our Forensic (Adult Secure) wards. It focusses on recovery, identifying and achieving outcomes and streamlining the pathway for service users within secure settings. This way of working ensures that service users are treated as individuals by looking at each person's needs. They are encouraged to find new ways of meeting their needs by looking at the whole pathway through secure care, from the very start.

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. This is supported by a national programme of audit.

National Reporting and Learning System (NRLS): The National Reporting and Learning System (NRLS) is a central (national) database of patient safety incident reports. All information submitted is analysed to identify hazards, risks and opportunities to continuously improve the safety of patient care.

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 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.

NHS England Commissioners: The part of NHS England responsible for commissioning specialist mental health services – e.g. Adult Secure (Forensic), CAMHS Inpatients and Inpatient adult and CYP Eating Disorders.

NHS England – Area Teams: The teams with NHS England responsible for commissioning specialised services and monitoring our performance against our specialist services contracts.

NHS Service User Survey: the annual survey of service users' experience of care and treatment received by NHS Trusts. In different years has focused both on inpatient and community service users.

NHS Staff Survey: an annual survey of staffs' experience of working within NHS Trusts.

Opting in to Clinical Research (OptiC): This has recently been incorporated within our local electronic patient records system. Systems like this, which are embedded in NHS records, allow service-users to express an interest (or otherwise) in participating in clinical research and have the potential to enhance and streamline the recruitment of patients to studies.

Organic (MHSOP): Older people with a decreased mental function which is due to a medical or physical condition. This includes dementia-related conditions.

Out of Locality Action Plan: The Trust wants all inpatients to be admitted to the normal hospital for the place where they live for their condition, unless they express a choice to be treated elsewhere. Sometimes we are unable to do that when there are no beds available in their local hospital in which case the patient would be admitted to another TEWV hospital, further away from where the patient lives. We have an action plan to reduce the number of times this happens.

Overview & Scrutiny Committees (OSCs): These are statutory committees of each Local Authority which scrutinise the development and progress of strategic and operational plans of multiple agencies within the Local Authority area. All local authorities have an OSC that focussed on Health, although Darlington, Middlesbrough, Stockton, Hartlepool and Redcar & Cleveland Councils have a joint Tees Valley Health OSC that performs this function.

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.

Paris Programme: Ongoing improvement of the Paris system to adapt it to TEWV's service delivery models and pathways.

Patient Advice & Liaison Team (PALs): The Patient Advice and Liaison Service (PALS) offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers. TEWV has its own PALS service as do all other NHS providers.

Patient Safety Group: The group monitors on a monthly basis the number of incidents reported, any thematic analysis and seeks assurances from operational services that we are learning from incidents. We monitor within the group any patient safety specific projects that are on-going to ensure milestones are achieved and benefits to service users are realised.

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.

Peer Trainer: someone who is trained and recruited as a paid employee within the Trust in a specifically designed job to actively use their lived experience and to deliver training courses to other service users and carers. They work within the Recovery College.

Peer Volunteer: someone who gives their time freely to the Trust in a specifically defined unpaid role to actively use their lived experience (as a service user or carer) to support other carers and service users. They work alongside and support paid staff as well as providing support to specific groups / tasks.

Peer Worker: someone who is trained and recruited as a paid employee within the Trust in a specifically designed job, to actively use their lived experience (as a service user or carer) to support other service users, in line with the Recovery Approach.

Pharmacotherapies: in smoking cessation aims to reduce the symptoms of nicotine withdrawal, thereby making it easier for a smoker to stop the use of cigarettes. Pharmacotherapies can also refer to the replacement of a person's drug of choice with a legally prescribed and dispensed substitute. As well as for those experiencing difficulties with a range of medical conditions.

PPI: Patient and Public Involvement.

Prescribing Observatory in Mental Health (POMH): a national agency, led by the Royal College of Psychiatrists, which aims to help specialist mental health services improve prescribing practice via clinical audit and quality improvement interventions.

Prime Minister's Challenge on Dementia: David Cameron's government's five year vision for the future of dementia care, support and research, which was launched in 2012 and updated in 2015. The overall ambition set by the vision is by 2020 for England to be:

- The best country in the world for dementia care and support and for people with dementia, their carers and families to live; and
- The best place in the world to undertake research into dementia and other neurodegenerative diseases.

Project: A one-off, time limited piece of work that will produce a product (such as a new building, a change in a service or a new strategy / policy) that will bring benefits to relevant stakeholders. In TEWV projects will go through a Scoping phase, and then a Business Case phase before they are implemented, evaluated and closed down. All projects will have a project plan, and a project manager.

Purposeful Inpatient Admission and Treatment: This is TEWV's method for ensuring that all patients receive assessments and treatments as quickly as possible so that their length of stay is kept as short as possible.

Quality report: A Quality report is a report about the quality of services by an NHS healthcare provider. The reports are published annually by each provider.

Quality Assurance Committee (QuAC): sub-committee of the Trust Board responsible for quality and assurance.

Quality Assurance Groups (QuAG): Locality / divisional groups within the Trust responsible for quality assurance.

Quality Goals: (see Quality Strategy, below).

Quality Governance Framework (Monitor): Monitor's approach to making sure NHS foundation Trusts are well run and can continue to provide good quality services for patients.

Quality Strategy: This is a TEWV strategy. The current strategy covers 2014 – 2019, but will be refreshed during 2016/17. It sets a clear direction and outlines what the Trust expects from its staff to work towards our vision of providing excellent quality care. It helps TEWV continue to improve the quality and value of our work, whilst making sure that it remains clinically and financially sustainable.

Quality Strategy Scorecard: A set of numerical indicators related to all aspects of Quality, reported to Trust Board four times per year, that helps the Board ascertain whether the actions being taken to support the Quality Strategy are having the expected positive impact.

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.

Recovery Approach: This is a new approach in mental health care that goes beyond the past focus on the medical treatment of symptoms, and getting back to a "normal" state. Personal recovery is much broader and for many people it means finding / achieving a way of living a satisfying and meaningful life within the limits of mental illness. Putting recovery into action means focusing care on what is personally important and meaningful, looking at the person's life goals beyond their symptoms. Helping someone to recover can include assisting them to find a job, getting somewhere safe to live and supporting them to develop relationships.

Recovery College: A recovery college is a learning centre, where service users, carers and staff enrol as students to attend courses based on recovery principles. Our recovery college, called ARCH, opened in September 2014 in Durham. This exciting resource is available to TEWV service users, carers and staff in the Durham area. Courses aim to equip students with the skills and knowledge they need to manage their recovery, have hope and gain more control over their lives. All courses are developed and delivered in co-production with people who have lived experience of mental health issues.

Recovery Strategy: TEWV's long term plan for moving services towards the recovery approach (see above).

Research for Patient Benefit (RfPB): provides funding for high quality research, inspired by patients and practice, for the benefit of users of the NHS in England. Its main purpose is to realise, through evidence, the huge potential for improving, expanding and strengthening the way that healthcare is delivered for patients, the public and the NHS.

Resilience: Resilience in the context of this Quality report is the extent to which patients can cope, and maintain their own well-being when they can feel their mental health worsening. We work with patients to build up their resilience as part of the recovery approach, and often develop Resilience Plans with them.

RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations): is the reporting requirement for work-related deaths and injuries. This requires deaths and injuries to be reported when there has been an accident which caused the injury, the accident was work-related and / or when the injury is of a type which is reportable.

Ridgeway: The part of Roseberry Park Hospital that houses our Adult Low Secure and Medium Secure wards (also known as Forensic wards).

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.

Safeguarding Adults / Children: Safeguarding means protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect. It is fundamental to creating high-quality health and social care.

Safewards: is a set of interventions proven to reduce conflict within inpatient settings.

Section 117 of the Mental Health Act: This part of the Act provides for aftercare to be given to some people discharged from mental health inpatient beds to help them avoid readmission to hospital. The duty applies both to the NHS and to Social Services.

Section 136 of the Mental Health Act: 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.

Section 136 Suite: A "place of safety" where people displaying behaviours that are a risk to themselves or to the public can be taken by the Police pending a formal mental health assessment. This procedure is contained within Section 136 of the Mental Health Act.

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 delivery of services, absconding from secure care.

Service User Focus Groups: a discussion group made up of people who either are, or have been users of our services. The outputs from these groups inform management decisions.

STEIS: National system for reporting serious incidents.

Stoptober: This is a Public Health England initiative held in October each year. It is a programme designed to help people quit smoking based on evidence that if you quit for 28 days you are five times more likely to quit for good.

Specialities: The new term that TEWV uses to describe the different types of clinical services that we provide (previously known as "Directorates"). The Specialities are Adult Mental Health services, Mental Health Services for Older People, Children and Young People's Services and Adult Learning Disability Services.

SWEMWBS: The shortened version of WEMWBS (see below).

TEWV: see 'The Trust'.

TEWV Quality Improvement System (QIS): the Trust's framework and approach to continuous quality improvement based on Kaizen / Toyota principles.

Trust Board: See 'Board / Board of Directors'.

The Health Foundation: is an independent national charity working to improve the quality of healthcare in the UK. The Health Foundation supports people working in health care practice and policy to make lasting improvements to health services. They carry out research and in-depth policy analysis, run improvement programmes to put ideas into practice in the NHS, support and develop leaders and share evidence to encourage wider change. Each year they give grants in the region of £18m to fund health care research, fellowships and improvement projects across the UK – all with the aim of improving health care quality.

The Trust: Tees, Esk and Wear Valleys NHS Foundation Trust.

Trustwide: This means across the whole geographical area served by the Trust's 3 Localities.

Unexpected Death: a death that is not expected due to a terminal medical condition or physical illness.

Values Based Recruitment Project: This is a recruitment method that does not just focus on the skills and experience but also on the values and likely behaviours of job applicants.

Virtual Recovery College: This is an initiative that would allow people to access recovery college materials and peer-support on-line.

Visual Control Boards: a technique for improving quality within the overall TEWV Quality Improvement System (QIS).

Warwick-Edinburgh Mental Well-Being Scale (WEMWBS): The Warwick-Edinburgh Mental Well-being Scale (WEMWBS) is a scale of 14 positively worded items, with five response categories, for assessing mental wellbeing. There is also a "short" version of this scale – where this is used it is called SWEMWBS.

Youth Speak: is a young people's group which aims to give young people a voice and skills in mental health research; reducing mental health stigma for young people through research; and shaping research to influence mental health services for young people.

Apendix 2
Key themes from 161 local clinical audits reviewed in 2015/16

Audit Theme	Summary of Actions
NICE	• The Self-Harm Pathway was piloted in a CAMHS community team prior to its planned roll out across the Trust. A clinical audit was undertaken to assess the compliance of the pilot team to the CYPS Self-Harm Pathway. Results indicated that further work is required to be undertaken to improve practice prior to further roll out to ensure all parameters of the pathway are delivered consistently, in particular: - Recording frequency of past self-harm, immediate risks and access to family/carers medications in the comprehensive assessment; - Identifying steps to achieve goals in the care plan; - Having formulation meetings; - Reviewing the risk assessment at discharge; - Giving the patient their discharge plan. • The Attention Deficit Hyperactivity Disorder (ADHD) Pathway was implemented across CAMHS and a clinical audit was undertaken to establish whether improvements were identified following initial baseline audit within the 2 community pilot sites in January 2015. • There have been several clinical audits which ascertained that the number of patients with Learning Disabilities on each Pathway, those who have completed a Pathway and those who are suitable to be placed on a Pathway but currently are not. • The Dementia Care Pathway aims to deliver person-centred services based on the most up to date evidence for delivering high standards of care. Early assessment and diagnosis are the key components of the Trust Pathway which was reviewed in June 2014. A clinical audit was undertaken in MHSOP memory and community teams involved in the diagnosis of patients with dementia. Results indicated that 91% of cases the comprehensive assessment was started on the date of the first face-to-face contact and in 85% of cases were completed within 28 days of starting it. In 84% the risk assessment was started on the date of the first face-to-face contact. Further work is required around the standard relating to the GP being sent a letter about the diagnosis within 5 days of the diagnostic meeting. • The clinical audit of POMH-UK Topic 13b – Prescribing for Attention Deficit Hyperactivity Disorder (ADHD) in Children, Adolescents and Adults showed that 100% of applicable patients on medication for ADHD had blood pressure, heart rate and weight/BMI (and height for under 16s) documented at baseline and within 3 months of starting medication for ADHD. 100% had a documented medication review in the last year. Improvements were required with the recording of monitoring parameters on centile charts in CAMHS / LD CAMHS services. Recording on centile charts enables clinicians to assess the risk:benefit ratio on ongoing treatment, and underpins safe and effective shared care of patients between specialist and primary care services. If recorded on the charts in the patient-held medication record, it provides assurance to both parties that required monitoring has been completed prior to prescriptions being issued. In adult services, recording of physical health parameters are being addressed as part of the Physical Healthcare Team's work on the implementation of the Lester Tool. Standardised rating scales for use in reviews for patients prescribed medication for ADHD will be introduced as a component of the pathway for adults with ADHD.
Physical Healthcare	• Current work programmes to drive forward improvements in physical healthcare include: - CQUIN 1 – Physical Health Care and Health Promotion for Service Users with psychosis. - National CQUIN 4 – Improving Physical Healthcare to Reduce Premature Mortality in People with Severe Mental Illness (Implementation of the Lester Tool reported via Royal College of Psychiatrists). - NHSIQ funded project/audit in 2 pilot sites in TEWV to improve the cardiovascular health of patients with a serious mental illness. • Audit activities supported CQUIN 1 and 4 which demonstrated significant improvements from the previous years' results. • These work programmes are currently led by the Physical Health/SMI Team and also link into other Trust initiatives including: - Kaizen work which has recently commenced to implement the physical health/monitoring of antipsychotic medication requirements of the NICE Guidance for Schizophrenia and Psychosis, 2014.

- Model Lines and Purposeful and Productive Community Services work currently being implemented in Psychosis/Early Intervention in Psychosis (EIP) teams.
- Smoke Free project; all inpatient areas are smoke free from March 2016, and plans are in place to then enhance this work in community teams (including EIP Teams).
- TEWV Physical Health Project; the associated work will impact on the physical health knowledge and skills of clinical staff.
- Paris Programme work, including improvements to the recording mechanisms for physical health assessment and interventions following audit recommendations.
- AEIP National Audit. The audit results within this report demonstrate a significant improvement in comparison to those captured within the AEIP national audit report written in 2015. This may be attributable to the ongoing support and monitoring provided by the CQUIN project team (including Clinical Audit input).

• The Physical Healthcare Project Team has delivered bespoke training to implement the new Early Warning System (EWS) Procedure and Charts. Services that have been offered training, have been audited, identifying good practice points and areas for learning and improvement.

Medicines Management

• A process for debrief with patients after they have received As Needed (PRN) medication has been included in the Force Reduction Project work stream. The debriefing following rapid tranquilisation will be incorporated into the new debrief process which is currently in development.
• Medicine management training is mandatory for all registered nurses with clinical contact. There has been an expectation that all registered nurses will complete an annual assessment in practice of their skills related to administration of medicines as part of the Trusts appraisal process. Following the annual assessment tool being updated to ensure nurses are able to demonstrate knowledge of high risk medicines, a clinical audit was required to be conducted to ascertain the proportion of permanent registered nurses who completed the medicine management assessment in practice between 1 April 2014 and 31 March 2015. The new assessment document has been developed and launched and all inpatient areas now have access to this as a reminder to complete this mandatory assessment and has been made available on the Trust Intranet.
• An audit has been undertaken to evaluate supervision arrangements for Non-Medical Prescribers (NMP) against requirements set out in the Trust NMP Procedure to Practice. The availability of specialty supervision sessions is restricted in some areas. Planned restructuring of NMP supervision arrangements aims to promote and support improvements so that all NMPs can access supervision appropriately and a revised NMP Procedure to Practice has been launched.
• Patient Group Directions (PGDs) provide a legal framework for the supply and/or administration of medicines to groups of patients. An audit was undertaken to assess compliance with the Trust PGD guidance specifically covering the following medications and doses supplied to adults by Crisis Teams: Diazepam 2mg, Diazepam 5mg and Zopiclone 7.5mg. 100% compliance was maintained/achieved in all 4 of the criteria relating to PGD supplies and access. Improvements were required with the recording of patient date of birth/NHS number, weekly stock checks, recording the time PGDs were supplied/administered and recording requisition number.

Violence and Aggression / Suicide Prevention

• A range of audits have been undertaken which support the Trust Projects for Harm Minimisation and Force Reduction. Audits around violence and aggression, training includes Force Reduction, PBS, Safe Wards, reduction in prone restraint, development of debrief process.
• Clinical audits have informed the following developments:
• The Harm Minimisation Policy has been drafted which includes supportive engagement and observation. The policy links with recovery principles and will also inform future Management of Violence and Aggression (MOVA) training.
• Training package development. New training looks at being more proactive in the management of risk (suicide audits).
• The 3 sign up to safety projects: Harm Minimisation, Force Reduction, and Learning Lessons.
• Changes to the risk assessments on Paris.
• Revision of Suicide Prevention Training.

Positive Behavioural Support (PBS)	• The PBS project in adult learning disabilities was established in June 2013 and aimed to ensure that all service users whose behaviour is described as challenging receive evidence based and ethically sound assessment and intervention in line with nationally and internationally recognised best practice – positive behaviour support. The key elements of the PBS project include: - All senior managers and senior clinicians in adult learning disability services took part in sessions giving them an awareness and understanding of the principles and key characteristics of PBS to enable them to properly support frontline staff. - All frontline staff including senior clinicians where appropriate will be trained to gain the knowledge, skills and attitudes to deliver PBS practices across the adult learning disabilities service. • A PBS clinical pathway has been rolled out across the adult LD services and additional coaching and mentoring is also provided for frontline staff as part of the delivery of the PBS project from skilled and experienced behaviour practitioners. • Clinical audits have been undertaken to establish activity of the use of Functional Assessments and Formulations and their connection to PBS intervention plans, Environmental Adaption plans, Skills Teaching plans, Focussed Support Strategy and Reactive plans. Proactive interventions were also investigated which related to sensory interventions, community outings, skills teaching and meaningful in-house activity. All patients had evidence of functional assessment and baseline measures however improvements were required with documenting evidence of a formulation and PBS intervention plans linked to the outcome of functional assessment and formulation. Findings showed that the proactive and reactive interventions used by staff could be considered effective in avoiding episodes of behaviour escalating into an incident requiring a restrictive intervention.
Infection Prevention and Control (IPC)	• All Infection Prevention and Control Audits are continuously monitored by the IPC team and any required actions are rectified collaboratively with the IPC team and ward staff. Assurance of implementation of actions is monitored by the Clinical Audit and Effectiveness team via the clinical audit database. • A total of 91 IPC clinical audits were conducted during 2015/16 in inpatient areas in the Trust. 100% of clinical areas achieved standards between 80-100% compliance. • Clinical audits have been undertaken to assess compliance with Hand Hygiene standards and a monthly Essential Steps audit is completed in inpatient areas.
Supervision	• Clinical audit findings have informed the development of the new Trust Supervision policy and will also inform the training packages which support implementation. • There is an ongoing contract requirement which involves undertaking an audit for specialist services to establish the duration of clinical supervision which staff have achieved, with a target of a minimum of 2 hours. Results from the findings have informed the Trust Supervision Policy.
Records Management	• Clinical audit activities have assessed clinical record keeping and informed changes within the electronic patient record (Paris) for the Trust. • Examples of aspects which have been assessed against record keeping standards include physical health promotion documentation, physical examination documentation, and Trustwide compliance with the Minimum Standard in Clinical Record Keeping Trust policy.

Apendix 3
Trust business plan additional quality priorities

In addition to the four quality priorities for 2016/17 set out in this document, the Trust has also included additional quality priorities within our 2016/17-2018/19 business plan. These are shown below.

Priority	Actions and Timescales
Ensure our current approach to addressing the physical healthcare needs of our patients is embedded and developed further	• Integrate physical health monitoring, assessment and management into daily practice (inpatients) (Q1 2016/17). • Include Physical Health principles and standards in relevant policies, procedures and strategies (Q2 2016/17). • Develop Physical Health and Wellbeing Policy for Community Services and an action plan for each Locality (Q3 2016/17). • Implement electronic physical health incident reporting system (Q4 2016/17). • Identify clinical staff training needs to monitor and manage the physical health care needs of their patients (Inpatient and community) Medical, Nursing and AHP (Q2 2017/18). • Embed physical health across all community services (Q3 2017/18). • Develop implementation plan and hand over responsibility for implementation to Operational Services (Q4 2017/18).
Build on the existing Learning Lessons project to ensure the process for learning lessons and making improvements are embedded in everyday practice	• Conduct baseline assessment in pilot teams to identify the prevailing culture (Q1 2016/17). • Include learning lessons framework and processes n relevant policies and processes (Q2 2016/17). • Re-measure the prevailing culture in the pilot clinical teams and share learning (Q3 2016/17).
Implement a TEWV programme to further reduce restrictive practice and increase use of Positive Behavioural Support	• Review Trust policies on behaviours that challenge, rapid tranquilisation, seclusion and mechanical restraint (Q1 2016/17). • Complete Positive Behavioural Support training in all pilot sites (Q1 2016/17). • Develop a Behaviour Support Plan template and debriefing tool for inpatient areas (Q1 2016/17). • Complete Safe Wards 'Train the trainer' sessions in all inpatient areas (Q1 2016/17).
Review and refresh the Quality Strategy	• Engage with stakeholders on revised draft strategy and its metrics (Q1 2016/17). • Revise strategy following on from consultation (Q2 2016/17). • Strategy approved and ratified by Trust Board (Q2 2016/17). • Complete communication of new Strategy throughout the organisation (Q4 2016/17).
Respond to the national guidance on safe staffing	• Review national guidance when published. • Develop action plan within 3 months of publication.
Further embed the TEWV Quality Improvement System (QIS) - including developing methods for share and spread, maintenance of standard work and everyday lean management	• Deliver further QIS Training Programmes (ongoing). • Develop QIS Locality Boards in each Locality to encourage share and spread, maintenance of standard work and everyday lean management (Q1 2016/17). • Fully embed monthly Locality Report Outs in practice (Q4 2016/17). • Ensure all Certified Leads recertify in 2016/17 (Q4 2016/17). • Deliver the Kaizen Production Team's work programme, particularly the Affective Disorders Unified Pathway within Adult community teams (Q4 2016/17).

Develop a new system for identifying and discussing emerging clinical treatments that assists early adoption	• Undertake a review of the current process (Q1 2016/17). • Implement a streamlined approach (Q2 2016/17). • Review effectiveness of new system making appropriate changes if necessary (Q4 2016/17).
Respond to relevant recommendations of the report into SUI Investigations at Southern Health	• Identify priorities, good practice, positive approaches and areas best served by continued collaboration across the region (Q1 2016/17). • Establish mortality review group with monthly meetings (Q2 2016/17), and 6 month progress reports (Q4 2016/17). • Establish reporting mechanisms relating to mortality review group (Q2 2016/17). • Review reporting systems to ensure relevant data is being produced (Q3 2016/17).

In addition to these, many of the operational plans and the enabling priorities set out within our Business Plan underpin our quality improvement agenda. Our business plan can found on TEWV's website www.tewv.nhs.uk (About the trust/how we do it)

Apendix 4
Quality performance indicator definitions

The percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care

Data definition:
All patients discharged to their place of residence, care home, residential accommodation, or to non-psychiatric care must be followed up within 7 days of discharge. All avenues need to be exploited to ensure patients are followed up within 7 days of discharge*. Where a patient has been discharged to prison, contact should be made via the prison in-reach team.

Exemptions:
- Patients who die within 7 days of discharge may be excluded.
- Where legal precedence has forced the removal of the patient from the country.
- Patients transferred to NHS psychiatric inpatient ward.
- CYPS are not included.

The 7 day period should be measured in days not hours and should start on the day after discharge.

Accountability:
Achieving at least 95% rate of patients followed up after discharge each quarter.

** Follow up may be face-to-face or telephone contact, this excludes text or phone messages*

The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper

Data definition:
Gate-keeping: in order to prevent hospital admission and give support to informal carers, crisis resolution home treatment teams are required to gate-keep all admission to psychiatric inpatient wards and facilitate early discharge of service users. An admission has been gate-kept by a crisis resolution team if they have assessed** the service user before admission and if the crisis resolution team was involved in the decision making-process, which resulted in an admission.

Total exemption from crisis resolution home treatment teams gate-keeping:
- Patients recalled on a Community Treatment Order.
- Patients transferred from another NHS hospital for psychiatric treatment.
- Internal transfers of service users between wards in the Trust for psychiatry treatment.
- Patients on leave under Section 17 of the Mental Health Act.
- Planned admission for psychiatric care from specialist units such as eating disorder unit.

Partial exemption:
Admissions from out of the Trust area where the patient was seen by the local crisis team (out of area) and only admitted to this Trust because they had no available beds in the local areas. Crisis resolution home treatment teams should assure themselves that gate-keeping was carried out. This can be recorded as gate-kept by crisis resolution home treatment teams.

** This indicator applies to patients in the age bracket 16-65 years and only applies to CYPS 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.*

Complaints Satisfactorily Resolved

Numerator:
From the number of response letters sent during the month where there is no notification from the complainant that they are dissatisfied and requesting further action.

Denominator:
Number of resolution letters sent within the month.

Apendix 5
Feedback from our stakeholders

Darlington Overview and Scrutiny Committee

DARLINGTON
BOROUGH COUNCIL

Tees, Esk and Wear Valleys NHS Foundation Trust – Draft Quality report 2015/16

The Health and Partnerships Scrutiny Committee remit covers the Governance arrangements of the Trust and has the responsibility to comment on the Quality reports, in line with its Health Scrutiny Powers. The Adults and Housing Scrutiny Committee remit scrutinises the delivery and provision of mental health and learning disability services.

Members of the Health and Partnerships Scrutiny Committee have considered the draft Quality report 2015/16 for Tees, Esk and Wear Valleys NHS Foundation Trust and attended Stakeholder events over the past year. Members would like to acknowledge that the Stakeholder events are always well attended and informally structured to enable meaningful audience participation, with the opportunity for a free exchange of views.

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

In respect of the Quality Improvement Priorities for 2015/16, Members have the following comments to make:

Delivery of the Recovery Project in line with the agreed plan – Members recognised the continuation of this priority, identified in 2014/15, as service users wanted the service to go beyond reducing symptoms of mental health and required support to live meaningful and fulfilling lives whether or not there was improvement in symptoms.

Members welcomed the benefits and aims of this priority which included care designed to support service users to achieve their own goals; staff genuinely believe that service users can get their lives back; service users genuinely feel listened to, heard and validated; views and personal expertise by experience of service users and carers being valued; staff working in partnership with service users and carers at every level of service delivery; and service users being supported to take charge of their lives, promoting choice and self-management.

Scrutiny Members were pleased to see the key actions in relation to staff and training completed in 2015/16 which had resulted in the Trust surpassing its performance target and are delighted that the Trust has once again included this as a Priority Action for 2016/17.

To implement a Nicotine Management and Smoking Cessation Policy within the Trust – Members were extremely pleased to note that the Trust was now completely smoke free. Research suggests that people with severe mental illness die 15-20 years earlier than the general population and that there is a higher incidence of smoking compared to the average population. It is also recognised that many are heavily addicted to smoking and have difficulty in quitting.

Scrutiny Members welcomed the appointment of a Project Manager for the Nicotine Management and Smoking Cessation Project and the development of a communications plan to inform staff and users of the Trust's No Smoking Policy

It was also pleasing to note that the Trust had identified potential alternatives to nicotine and completed a benchmarking exercise to understand how many staff were also smokers. The clinical audit of smoking prevalence within all Trust services highlighted that 56 per cent of inpatients were non-smokers although rates were noticeably higher amongst Forensic Mental Health service users in comparison.

Members are delighted that The Trust is to maintain this priority for 2016/17 and look forward to receiving the results of the audit to be completed in December 2016.

Expand the Use of Positive Behavioural Support (PBS) in Learning Disabilities Services – Members welcomed the completion of the Positive Behavioural Support strategy which enhances the quality of life of learning disability service users whilst also reducing behavioural challenges.

Members noted the potential benefits and outcomes to service users including a values led based, person centred approach; improved quality of life, happiness and well-being; developing the skills and coping capacities to be able to deal with the demands of everyday living; reduction in restrictive practice including control and restraint and use of 'as-required' medication; and an improved support structure in place for people whose behaviour is described as challenging.

Members welcomed continued use of PBS approach across the Adult Learning Disabilities Service and the purchase of the Person Centred Advice Support training, an additional but integral part of the PBS approach to be delivered as a train the trainers approach across the service over the next two to three years.

Implementation of Age Appropriate Risk Assessments and Care Plans for Children and Young People Services – Members were delighted at the completion of this Priority as they recognised that there was a considerable difference between the verbal, cognitive and social interaction skills of a 4 year old child and a 17 year old adolescent.

Members noted that the development of age appropriate risk assessment and care plans would enable Children and Young Peoples Services to co-produce risk assessments and risk management plans with the young person and their family ensuring they are responsive to their age, development and need.

Scrutiny was pleased to note that the documentation uploaded onto Paris is to be reviewed, and amended where necessary, at regular intervals to ensure it meets the needs of the service users.

Quality Metrics – Missed Targets – Members noted the information from the Trust in relation to Quality Metrics around unexpected deaths, falls, length of stay in MHSOP and complaints received and in doing so accepted the explanation for each individual missed target and the actions to be taken to address the situation.

Quality Achievements and Improvements – Members were delighted to note that The Trust's Force Reduction Project had provided significant reductions across the Trust with 81 per cent reduction in Prone restraint and a corresponding reduction across all types of restrictive interventions being achieved. It was pleasing to note that the results of the NHS Staff Survey had revealed that TEWV was the top Mental Health Trust in England and a CQC Rating of Good had also been achieved. In relation to the Transparency and Openness league table Members were delighted to learn that TEWV as the fourth best Trust.

Members have the following comments to make on the Quality Improvement Priorities for 2016/17 –

Continue to Develop and Implement Recovery Focused Services – Members welcomed the continuation of this priority in order to continue to develop and implement recovery focused services, through delivery of the agreed project plan.

Implement and Embed the Revised Harm Minimisation and Risk Management Approach – Members look forward to the implementation of the revised harm minimisation and risk management approach as it provided links to recovery ensuring people were more self-sufficient and resilient.

Further Implementation of the Nicotine Replacement Programme and Smoking Cessation Project – Members welcomed the further work that the Trust was to do around Nicotine Replacement as the smoke free agenda was critical to improving the life expectancy and health of service users and staff. It was particularly pleasing to note that the Trust was also to support other Trusts and north east prisons, where 70 to 80 percent of prisoners had an identified mental health condition. Members look forward to receiving the data on the Nicotine Replacement Programme.

Improve the Clinical Effectiveness and Patient Experience at Times of Transition – Members noted that the Trust had highlighted this priority as a result of feedback from stakeholder events due to service users raising issues when moving from an inpatient unit to a community setting. Transition is particularly important when a child moves to adult services as care is provided in a different way. Members look forward to receiving six monthly updates at Stakeholder Events and an updated position at the February 2017 Quality report Stakeholder Event.

Overall, Health and Partnerships Scrutiny Committee welcomed the opportunity to comment on the Trust's Quality reports and are pleased with the Trusts progress against the chosen priorities, in a challenging year for all NHS organisations. Members would like to receive six monthly reports on the progress being made, to enable them to provide a more detailed and valuable contribution to the Quality reports in the future. They would also like to continue to be invited to Stakeholders events.

Councillor Wendy Newall
Chair, Health and Partnerships Scrutiny Committee

Durham County Council Adults Wellbeing and Health Overview and Scrutiny Committee

Contact: Cllr John Robinson
Direct Tel: 03000 268140
e-mail:
Your ref:
Our ref:

Colin Martin
Chief Executive
Tees, Esk and Wear Valleys NHS Foundation Trust,
West Park Hospital
Edward Pease Way
Darlington
DL2 2TS

11 May 2016

Dear Mr Martin,

Tees, Esk and Wear Valleys NHS Foundation Trust – Quality reports 2015/16

Following meetings of Durham County Council's Adults Wellbeing and Health Overview and Scrutiny Committee on 27 April and 9 May 2016 please find attached the Committee's response to your draft Quality reports for 2015/16.

The response provides commentary on the Trust's performance for 2015/16 as well as the identified priorities for 2016/17.

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 John Robinson
Chair of the Adults, Wellbeing and Health Overview and Scrutiny Committee

Members

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DURHAM COUNTY COUNCIL ADULTS WELLBEING AND HEALTH OVERVIEW AND SCRUTINY COMMITTEE

COMMENTS ON TEES ESK AND WEAR VALLEYS NHS FOUNDATION TRUST QUALITY REPORT FOR 2015/16

The Committee welcomes Tees Esk and Wear Valleys NHS Foundation Trust's Quality report 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 report process provides the Committee with one such mechanism.

The Committee has engaged with the Trust on a number of issues during the course of 2015/16 including the review of Inpatient Dementia Wards serving County Durham and Darlington; the North East and Cumbria learning disability fast track project and the Trust's Care Quality Commission inspection results and associated action plan.

The Committee considers that the Quality report is clearly set out and acknowledges up front that performance during 2015/16 has been challenging, set against a context of a considerable increase in demand for services. Progress made against 2015/16 is clearly identified and the Committee congratulates the Trust on achieving against all of its Quality report priorities for 2015/16 and delivering against targets for its Care Programme approach; Clinical Audits, Average length of stay for adult mental health services and delayed transfers of care.

In considering those quality metrics where the Trust has missed its target, the Committee are particularly concerned in respect of unexpected deaths, given that suicide prevention training was an identified priority for 2015/16. The Committee has identified mental health and suicides as a potential review topic within its 2016/17 work programme and would welcome the Trust's input into this work.

In respect of complaints handling, members noted that 78.8% complaints were satisfactorily resolved against a target of 90% which, whilst below target, is the best reported position since 2012/13. The Committee notes that performance in this respect across Durham and Darlington is even higher at 88%.

The Committee welcome all of the 2016/17 priorities identified within the draft Quality report and in respect of the nicotine replacement programme and smoking cessation service, members feel that the trust should ensure that this priority covers staff as well as service users, but note the difficulty experienced by the Trust in obtaining accurate baseline figures for staff smoking.

In summary, the Committee agree that from the information received from the Trust, the identified priorities for 2016/17 are a fair reflection of healthcare services provided by the Trust and note the progress made against the 2015/16 priorities.

Finally, in order to ensure that it continues to provide a robust Health scrutiny function and assurances in this respect to the residents of County Durham, the Committee would request a six monthly progress report on delivery of 2016/17 priorities and performance targets in October 2016.

Durham County Council Adults Wellbeing and Health Overview and Scrutiny Committee

Contact: Cllr Lucy Hovvels
Direct Tel: 03000 268728
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Your ref:
Our ref:

Durham County Council

Sharon Pickering
Director of Planning, Performance and Communications
Tees, Esk and Wear Valleys NHS Foundation Trust
Tarncroft
Lanchester Road Hospital
Durham
DH1 5RD

Friday, 13th May 2016

Dear Sharon

Re: Tees, Esk & Wear Valleys NHS Foundation Trust Quality Account 2015/16

Thank you for the opportunity to comment on the Tees Esk and Wear Valleys NHS Foundation Trust (TEWV) Quality Account 2015/16. The County Durham Health and Wellbeing Board appreciate this transparency and would like to provide the following comments on the document.

We commend you on your performance against your four priority areas of improvement over the last year which were:

Priority 1: Delivery of the recovery project in line with the agreed plan
Priority 2: Nicotine Management and Smoking Cassation
Priority 3: Expand the use of Positive Behavioural Support (PBS) in our Learning Disabilities Services
Priority 4: Implementation of developmental age appropriate risk assessments and care plans for Children and Young People Services.

These priorities align with the County Durham Joint Health and Wellbeing Strategy.

We also congratulate you on your Community Mental Health Survey results which we note led to the Care Quality Commission (CQC) highlighting the trust as one of five performing better than expected across the country compared to other Trusts.

It is important that the Quality Account aligns, where appropriate, to the County Durham Joint Health and Wellbeing Strategy, Clinical Commissioning Group Commissioning Intentions, Quality Premium Indicators and the Better Care Fund Plan which have been agreed through the County Durham Health and Wellbeing Board. The Quality Account should also align across the plans in the wider footprint of the Sustainability and Transformation Plan 2016/21.

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www.durham.gov.uk

Page 2 of 4

The Health and Wellbeing Board supports the Trust's 2016/17 priorities for improvement which align to the strategic objectives in the Joint Health and Wellbeing Strategy, as follows:

	TEWV - Priorities for improvement 2016/17	Joint Health and Wellbeing Strategy 2016-19 – Strategic Objectives
1	Continue to implement Recovery focussed services	Improve the mental and physical wellbeing of the population
2	Implement and embed the revised harm minimisation and risk management approach	Improve the mental and physical wellbeing of the population Protect vulnerable people from harm
3	Further implementation of the nicotine replacement programme and smoking cessation project	Reduce health inequalities and early deaths
4	Improve the clinical effectiveness and patient experience at times of Transition	Improve the quality of life, independence and care and support for people with long term conditions Improve the mental and physical wellbeing of the population Protect vulnerable people from harm

Work to develop the recovery approach, which has taken place by the Trust in 2015/16, including the expansion of the number of courses completed thorough the ARCH Recovery College in Durham, is welcomed and fully supported by the Health and Wellbeing Board. We commend you on exceeding your target for the numbers of courses completed and welcome the introduction of Virtual Recovery Colleges to allow service users and carers' greater access to self-management training and education. Recovery is included as part of the Joint Health and Wellbeing Strategy, the Better Care Fund Plan and the Clinical Commissioning Group's Commissioning Intentions.

We welcome the focus on implementing and embedding a revised harm minimisation and risk management approach. Evidence in the Joint Strategic Needs Assessment highlights the suicide rate for Durham as being significantly higher than the England average between 2012 and 2014. Actions to reduce self-harm and suicides rates and improve mental health for the population of County Durham have been included in the Joint Health and Wellbeing Strategy.

Crisis care continues to be a key priority for the Health and Wellbeing Board and actions are identified in the Joint Health and Wellbeing Strategy, County Durham No Health without Mental Health Implementation Plan and the local Mental Health Crisis Care Concordat action plan to ensure that we improve outcomes for people experiencing mental health crisis. It is recognised by the Mental Health Partnership Board (a sub group of the Health and Wellbeing Board) of which TEWV is a member, that crisis services across

County Durham need to respond to feedback by service users and providers. The Health and Wellbeing Board would appreciate feedback as to whether TEWV will be considering the development or remodelling mental health crisis services across County Durham to ensure future services are fit for purpose, sustainable and continue to have improved outcomes for those people who are in crisis.

Evidence in the Joint Strategic Needs Assessment highlights that smoking is the biggest single contributor to a shorter life expectancy and contributes substantially to the cancer burden. Smoking rates are higher within certain vulnerable groups, which include those with mental health problems. Actions to reduce smoking are reflected in the Joint Health and Wellbeing Strategy. The Health and Wellbeing Board supports the Trust in identifying nicotine management and smoking cessation as a priority for 2016/17.

Improving the clinical effectiveness and patient experience at times of transition is essential to ensure a seamless service for patients. The Health and Wellbeing Board has identified the transition between children and adults services as an area for inclusion in the Joint Health and Wellbeing Strategy 2016-19. This includes disability services and the development of a countywide team to ensure that the experience of children and their carers is positive and seamless.

We commend your progress in 2015/16 in relation to Person-Centred Behavioural Support (PBS) across your Learning Disabilities service and note, whilst this does not remain a priority area for TEWV for the next year, that you have identified a number of actions which will further embed your approach to supporting individuals accessing the Learning Disabilities Service. The Health and Wellbeing Board has received regular updates in relation to the Fast Track Plan – Transforming Care for People with a Learning Disability. It would be useful for the Health and Wellbeing Board to continue to receive updates in relation to the development of community Learning Disability services across County Durham and detailed plans in relation to hospital bed reduction to support these plans.

The Health and Wellbeing Board have also received regular updates in relation to the implementation of the Autism Act through the Local Autism Action Plan in order to support people with autism and would welcome the inclusion of activity in relation to autism diagnosis, particularly in relation to plans to increase capacity and plans for expanding post diagnosis support for people with autism.

Improving access to and availability of suitable accommodation and services to support recovery for people with a range of needs, including learning disabilities, mental health problems and autism, to enable them to live as independently as possible in the community is a priority identified in the Joint Health and Wellbeing strategy and the Trust may wish to reference this within the Quality Account.

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

Councillor Lucy Hovvels
Cabinet Portfolio Holder for Adult and Health Services

Hartlepool Audit and Governance Committee

Tees, Esk and Wear Valleys NHS Foundation Trust – Comments from Hartlepool's Audit and Governance Committee on the Quality Account

Members of Hartlepool's Audit and Governance Committee welcomed the opportunity to comment on the Tees, Esk and Wear Valleys NHS Foundation Trust's (TEWV) Quality Account. The Committee made the following comments.

The Committee queried why suicides were included in the unexpected deaths statistics and questioned if they should be recorded separately. In response to this query, TEWV were of the view that the statistics could be broken down; however, the recording of a death was the responsibility of the Coroner. While staff may informally know the cause of death, it was the Coroner's responsibility to declare it, which could take some time depending on the circumstances. The statistics relating to deaths recorded by TEWV referred to existing patients and anyone who had received a service from the Trust in the last six months.

Members discussed the work in relation to smoking cessation. There was an in-patient nurse responsible for promoting the campaign and offering nicotine replacement therapies. Members were informed that the use of e-cigarettes was allowed at inpatient facilities and smoking cessation services would also be extended to community mental health services. TEWV had also been approached by the prison service to undertake smoking cessation work with prisoners as the prison service had a national target of being smoke free by 2018. Members welcomed the work being carried out but recognised that it could be a challenge for some patients. TEWV recognise the challenge and are committed to the work being undertaken.

The time differential between the preparation of the Quality Account/approval and the financial year was questioned by Members. The Committee was informed that part of the Quality Account was backward looking so all the appropriate data sets needed to be available to produce the new targets. Members were informed that it was a challenge to produce all the information and to provide consultees with the required 30 days notice to provide their comments and feedback.

Healthwatch Darlington

Healthwatch Darlington

Comments on Tees, Esk and Wear Valley Foundation Trusts Quality report for 2015-16 from Healthwatch Darlington. These comments are on behalf of the Healthwatch Board and active members of the Healthwatch Networks.

Healthwatch Darlington have welcomed and enjoyed the opportunity to be involved with the Quality reports 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.

Priorities 2014/2015

- **To have more staff trained in specialist suicide prevention and intervention**
  Healthwatch Darlington are keen to follow the work of this priority moving forward into the harm minimisation project. Suicide prevention remains a priority for the Darlington Mental Health Network and concerns are shared amongst many groups in the town.
- **To implement the recommendations of the Care Plan Approach (CPA)**
  We are pleased to note that work again will continue via the harm minimisation project.
- **To manage the pressure on acute impatient beds**
  Again we are pleased to note that work will continue on this priority and particularly keen to see any work relating to crisis looked into for improvement.

Priorities 2015/2016

Priority 1: Delivery of the recovery project in line with the agreed plan.

Due to the nature of the Healthwatch network we are happy to see the number of trained experts by experience has increased to 31, well over the predicted 24, Q2 target. It is great to see training continuing with potential peers, and again that the number of peers trained exceeds the target number. Whilst the Recovery College has not been developed as a physical building in the Darlington area, we are still encouraged by the work the College is completing and look forward to the work expanding in a hub and spoke virtual model. The numbers of recovery trained staff are encouraging and shared decision making work moving forward will be vital.

Healthwatch Darlington are pleased to see all targets have been met or exceeded for priority 1.

Priority 2: Nicotine Management and Smoking Cessation.

Healthwatch Darlington are pleased to see most of the targets have been met and understand it may be difficult to quantify the change in staff behaviour. The organisation is pleased to note the continued support from the Trust to support both patients and staff to stop smoking.

Priority 3: Expand the use of Positive Behavioural Support in our Learning Disabilities Services.
Healthwatch Darlington support the use of Positive Behavioural Support in light of previous years and findings around the use of restraints and as an encouraging tool going forward. We are pleased to note all targets have been met and the examples of improvement have been very encouraging to read.
Priority 4: Implementation of age appropriate risk assessments and care plans for Children and Young People Services.
The organisation were pleased to note the use of service user involvement when developing questionnaires. We are also encouraged to note the development of PARIS to make the system more user friendly as it has been noted in the past that changes to the system are sometimes very lengthy.
We are pleased to note where figures are available that targets have been met and look forward to the remaining data being shared in 2016/17

Quality Indicators

We are pleased to see many of the Quality Indicators have been met, but acknowledge along with the Trust that areas are still to be improved. We are especially keen to see the continued progression of patient experience and patient safety.

Priorities for 2016-17

Priority 1: Continue to develop and implement Recovery focused services.
Priority 2: Implement and embed the revised harm minimisation and risk management approach.
Priority 3: Further implementation of the nicotine replacement programme and smoking cessation project.
Priority 4: Improve the clinical effectiveness and patient experience at times of Transition.
Healthwatch Darlington agree with the priorities set for 2016/2017 as all 4 are essential to patient experience and care.
Healthwatch Darlington participants have enjoyed attending Quality report meetings and have actively been involved in round table discussions to discuss objectives and to voice their opinions where appropriate. The group had noted the reduction in public Quality report meetings and have found commenting on the Quality report easier with the two meetings per year.
Healthwatch Darlington would like to thank Tees, Esk and Wear Valleys NHS Foundation Trust for their continued engagement and support and participants look forward to further partnership working over the next year.

Healthwatch North Yorkshire

TEWV Quality reports

The accounts propose a significant amount of training for staff to be undertaken however it is unclear how this will impact on the quality of service experienced by patients.

Welcome the brief inclusion of direct user voice as part of Priority 4 - Improve the clinical effectiveness and patient experience at times of Transition - however this should be further expanded and embedded throughout the document. The voice of carers is also absent.

Overall the format and presentation is not accessible to the general public. The document t is text havey and would benefit from use of simpler language and images..

Under Priority 1 - delivery of the recovery project in line with the agreed plan – it is noted that the results of the National Community Patients survey are poor. While welcoming the desire to improve this the report doesn't say exactly the actions taken will have an impact.

Priority 2 - Nicotine Management and Smoking Cessation – seems heavily focussed on support for staff and not clear enough on what is or has been done for service users

Regarding unexpected deaths it needs to be more explicit who is responsible for declaring actions plans satisfactorily closed.

Healthwatch York

Response from Healthwatch York to Tees, Esk and Wear Valleys NHS Foundation Trust Quality report 2016/16

Although TEWV have only had responsibility for services in York since October 2015, it feels as though a lot has been achieved in a relatively short period of time. Healthwatch York particularly welcomes TEWV's commitment to promoting and strengthening patient and public involvement. We have been very pleased to be able to support TEWV to engage with local service users, their carers and the wider community.

It is good to see that one of next years priorities is to continue to develop and implement recovery focused services. We are pleased to see that TEWV are committed to providing opportunities for people with lived experience to take part in service development and improvement initiatives.

Healthwatch York welcomes TEWV's commitment to involving more people in the future development of local mental health and learning disability services. We look forward to more opportunities for working together during the coming year to make sure that as many local people as possible have opportunities to get involved.

Joint Durham and Darlington CCGs

NHS
North Durham
Clinical Commissioning Group

Our Reference: 050516/ho/EM/QA2015
Your Reference:

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North Durham CCG
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05 May 2016

Elizabeth Moody
Director of Nursing and Governance
Tees Esk and Wear Valleys NHS Foundation Trust
Trust Headquarters
West Park Hospital
Edward Pease Way
Darlington
County Durham
DL2 2TS

Dear Elizabeth

RE: Tees, Esk and Wear Valleys NHS Foundation Trust (TEWVFT) Quality Account 2015/16

Corroborative statement from
NHS North Durham Clinical Commissioning Group (CCG), NHS Darlington CCG and NHS Durham Dales, Easington, Sedgefield CCG

As commissioners NHS North Durham CCG, NHS Durham Dales, Easington and Sedgefield CCG and NHS Darlington CCG are committed to ensuring that our residents receive safe, high quality services from Tees Esk and Wear Valleys NHS Foundation Trust (TEWVFT).

The clinical commissioning groups (CCGs) across County Durham and Darlington welcome the opportunity to review and comment on the trust's Quality Account for 2015/16 and would like to offer the following commentary:

The CCGs can confirm that to the best of their knowledge the information provided within the annual Quality Account is an accurate and fair reflection of the trust's performance for 2015/16.

The Quality Account is presented in the format required by NHS England and reflects a fair and accurate position of the trust's quality profile and we are pleased to see reference to the progress made against National Quality reports and issues such as the recommendations from the Southern Health NHS Foundation Trust independent report, Duty of Candour and safe staffing. The trust is also to be congratulated in scoring the 4th highest of all 230 NHS acute, mental health and community trusts in the "Learning from Mistakes" league table published by Monitor in March 2016. This supports the focus the trust has on making a difference to patients by being a learning organisation.

The CCGs would like to commend the trust on all their external achievements and are pleased to see the trust's positive results from the 2015 NHS staff survey and in the 2015 NHS community mental health services survey.

The report provides evidence of the governance structures in place within the trust which facilitate the reviewing and learning from patient safety issues, patient experience and the clinical effectiveness data. It was pleasing to see how this structure enables staff, service users and carers to share their views on the services provided by the trust via the Board of Directors programme of ward visits each month.

Throughout 2015/16 the CCGs have continued to hold monthly bi-monthly clinical quality meetings and monthly contract review meetings with TEWVFT. The CCGs had issued the trust with a formal performance notice during 2015/16 in relation to safeguarding training and this was subsequently lifted following the trust's achievement against all the requirements in the action plan. The organisation has been working with the CCGs to demonstrate transparency in relation to quality concerns and provide assurance that safe and effective care is being delivered and that the views and expectations of service users and the public are listened to and acted upon. To gain further insight and assurance of the quality of care being provided to patients we have continued throughout 2015/16 to conduct frequent commissioner led inspection visits to the trust. The visits have been supported by the trust and provided the CCGs with a valued opportunity to talk with staff and service users.

It was also pleasing to see that the trust has further embedded the Safewards project and made significant improvements to their complaints management processes.

It is commendable that the trust achieved a 100% participation rate with relevant national clinical audits and confidential inquiries as well as increasing participation in clinical research. The report provides evidence of the actions the organisation has implemented, such as research champions being embedded across all of the memory services.

The CCGs acknowledge that the trust has initiated appropriate actions in response to compliance against the key mandatory quality indicators in order to improve performance outcomes. Building on the suicide prevention initiatives undertaken during 2014/15 the trust have developed a more comprehensive 'Harm Minimisation' Project during 2015/16 providing greater emphasis on recovery focused harm minimisation and safety planning based on shared decision making with service users and carers. This is welcomed by the CCGs recognising that this will aid the reduction in service user safety incidents relating to self-harm and suicide.

The CCGs are encouraged to see the continuation of work from the 2014/15 quality priorities which the trust further embedded during 2015/16, such as the 100% achievement with the recovery focused care planning training across the Psychosis and the Early Interventions in Psychosis (EIP) teams.

The National Reporting and Learning System (NRLS) data for quarters 3 and 4 2014/15 demonstrated a variance in the incident data submitted to the National Reporting and Learning System. This was identified by the Trust as being due to delays in uploading the data. Remedial actions were put in place and the CCGs would like to acknowledge the improved position during quarters 1 and 2 in 2015/16 and increased confidence in the validity of these figures. The CCGs acknowledge the improvements made in the timeliness of reporting these incidents to the NRLS and we look forward to seeing further improvements when the next organisational patient safety reports are released.

The CCGs acknowledge the work the trust has done to improve patient access to mental health services quickly and conveniently through projects such as the online access to the Arch Recovery College in Durham and the extension of the community provision for Mental Health Services for Older People (MHSOP) sited in GP surgeries within the Durham Dales, Easington and Sedgefield CCG area.

NHS North Durham CCG, NHS Durham Dales, Easington and Sedgefield CCG and NHS Darlington CCG are supportive of the trust priorities for 2016/17 particularly the focus on implementation and embedding the revised harm minimisation and risk management approach which will continue to increase the safety for people using the trust's services.

The CCGs look forward to continuing to work in partnership with TEWVFT to assure the quality of services commissioned in 2016/17.

Yours sincerely

G Findley

Gillian Findley
Director of Nursing, Quality and Development
NHS North Durham Clinical Commissioning Group

Signed in consultation with:
NHS North Durham CCG,
NHS Durham Dales, Easington and Sedgefield CCG and
NHS Darlington CCG

3

Joint Partnership Commissioning Unit

"Care through partnership"

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Partnership Commissioning Unit
Commissioning services on behalf of:
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NHS Harrogate and Rural District CCG
NHS Scarborough and Ryedale CCG
NHS Vale of York CCG

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Unit 5 Kettlestring Lane
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19th May 2016

Dear Sharon,

Quality Report Statement 2014/15 for Tees, Esk and Wear Valley NHS Foundation Trust:

The Partnership Commissioning Unit (PCU) is pleased to be able to review and comment on the 2015/16 quality report, on behalf of NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group (CCG), NHS Harrogate and Rural District CCG, and NHS Scarborough and Ryedale CCG and NHS Vale of York Clinical CCG (from 1st October 2015)

Tees Esk and Wear Valley NHS Foundation Trust (TEWV) and the PCU have worked in close partnership to improve the quality of services for the population of North Yorkshire, and since 1st October 2015, the Vale of York. Monthly quality meetings have been held alongside monthly contract monitoring meetings over this period which has shown the Trust to be open and honest in its delivery of safe and effective services.

Through the contract management process, the Trust has provided assurance to the PCU as commissioners on behalf of the four CCGs, by sharing a range of data and quality metrics which have improved the quality of patient services. We are particularly pleased with the following achievements:

- Joint working on the implementation of the Crisis Care Concordat Plan
- The opening of the Harrogate Health Based Place of Safety (HBPoS) in August 2015.
- Enhanced Liaison Services in all North Yorkshire and York CCG areas to be open longer
- The piloting of street triaging services in York and Scarborough.

Working in partnership has been a key theme throughout the year and a particular example of this is the Transforming Care Agenda. Over the last six months TEWV has worked in partnership with the PCU and other key stakeholders to develop a direction and provide input towards the completion of the 'Building the Right Support' plan with a view to reducing inpatient placements for those with Learning Disabilities and/or autism and enhance community provision of these services to ensure people are cared for in their communities wherever possible.

Through clinical site visits and regular reporting we have been assured about the quality of care received in various clinical areas, further supported by the patient experience. Where concerns or incidents have arisen we have worked with TEWV to make sure root cause analyses are carried out and any lessons learned and embedded.

In addition, TEWV has been successful in achieving the milestones of a large majority of CQUIN targets for the year, and the national and local indicators for 2016/17 CQUIN scheme have been agreed with the Trust.

In conclusion the PCU on behalf of the CCGs commends this quality account for its accuracy and honesty. We recognise that TEWV delivers good quality and effective patient care and we look forward to continuing our close working partnership with the Trust in 2016/17.

Regards

Yours sincerely

Victoria Pilkington
Head of Partnership Commissioning Unit

Joint South Tees CCG and Hartlepool & Stockton CCG

NHS
Hartlepool and Stockton-on-Tees
Clinical Commissioning Group

Director of Nursing and Governance
06 MAY 2016

NHS
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Clinical Commissioning Group

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Date: 29th April 2016

Elizabeth Moody
Director of Nursing and Governance
Tees Esk and Wear Valleys NHS Foundation Trust
Trust Headquarters
West Park Hospital
Edward Pease Way
Darlington
County Durham
DL2 2TS

Dear Elizabeth

RE: Tees, Esk and Wear Valleys Quality Account 2015/16
Statement for NHS South Tees CCG and NHS Hartlepool and Stockton-On-Tees CCG

NHS South Tees Clinical Commissioning Group (ST CCG) and NHS Hartlepool and Stockton-On-Tees Clinical Commissioning Group (HAST CCG) commission healthcare services for the populations of Hartlepool, Stockton and South Tees. The CCGs welcome the opportunity to submit a statement on the annual Quality Account for Tees, Esk and Wear Valleys NHS Foundation Trust (TEWVFT).

The CCGs can confirm that to the best of their knowledge the information provided within the annual Quality Account is an accurate and fair reflection of the Trust's performance for 2015-16.

The Quality Account is clearly presented in the format required by NHS England and the information clearly represents the Trust quality profile.

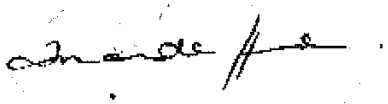
improving health together

It was previously noted that the NRLS data for quarters 3&4 2014/15 demonstrates a variance in the incident data submitted to the National Reporting and Learning System. This was identified by the Trust as being due to delays in uploading the data. Remedial actions were put in place and the CCGs would like to acknowledge the improved position of quarters 1&2 in 2015/16 and increased confidence in the validity of these figures. The CCGs will continue to work with the Trust to improve the timeliness of reporting and management of these incidents. Whilst acknowledging that work is underway to improve the position they would like see further improvement in the quality and timeliness of the management of serious incident investigations.

Following the initiatives on suicide prevention undertaken during 2014/15 the Trust and their stakeholders recognised the need to take a wider approach to support this priority. This resulted in the development of the more comprehensive 'Harm Minimisation' Project during 2015/16 facilitating the cultural shift towards recovery focused harm minimisation and safety planning based on shared decision making with patients, and the joint development of personal safety plans. This is welcomed by the CCGs recognising that this will aid the reduction in service user safety incidents relating to self-harm and suicide.

The CCGs are supportive of the Trust priorities for 2016/17 particularly the focus on implementation and embedding the revised harm minimisation and risk management approach which will continue to increase the safety of our service users.
The CCGs look forward to continuing to work in partnership with the Trust to assure the quality of services commissioned on behalf of their population in 2016/17.

Yours sincerely,



Mrs Amanda Hume
Chief Officer
South Tees CCG

On behalf of NHS South Tees Clinical Commissioning Group (ST CCG) and NHS Hartlepool and Stockton-On-Tees Clinical Commissioning Group (HAST CCG)

If you would like additional copies of this report please contact:

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Our Chairman, Directors and Governors can be contacted via the Trust Secretary's office at West Park Hospital (see above address).
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For more information about the Trust and how you can get involved visit our website

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