Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Annual report and accounts 2016/17

Making a difference together

Tees, Esk and Wear Valleys NHS Foundation Trust

Annual report and accounts 2016/17

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

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Foreword by the Chairman and Chief Executive

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Reviewing the past
These are challenging times for the NHS and for our Trust. However, despite the pressures of the last twelve months, staff have worked extremely hard and we've maintained, and in some cases improved, performance against our targets. We're making good progress against waiting times, despite seeing an increase in referrals to the Trust, and we've met all of our financial targets.

Our overriding purpose is to minimise the impact that mental illness or learning disability has on a person's life. Our staff are passionate about promoting recovery and wellbeing, and that means supporting service users to achieve the goals they've set themselves.

Delivering TEWV's **recovery strategy** over the next three years is one of our most important priorities. The strategy was first approved in 2014 and in 2016/17 the Board of Directors approved phase two which builds on the work we've done to date. The development of the **Recovery College Online** is a key part of this strategy and the new website went live at the end of the year.

The **Discovery Hub**, a partnership project between the Trust and York St John University in York, was also officially launched in June 2016 following a successful pilot. People aged 18 and over who are currently using community mental health or affective services in York can access the Hub and receive one-to-one help from peer support workers (people with lived experience of mental ill health). This work has been done in partnership with Converge at York St John University.

We remain committed to achieving our vision of being a recognised centre of excellence with high quality staff providing high quality services that exceed people's expectation. Our staff strive to continually improve the services they provide by eliminating waste wherever it exists so that they can focus on what's important – improving the lives of the people who use our services.

Our **purposeful and productive community services (PPCS) programme** is the largest and most significant initiative the Trust has attempted in recent years. Changing the way we work in community services is supporting our recovery work and helping us continue to improve the quality of the care we provide.

Phase one of the programme was launched in 2016 and this included introducing a number of different ways of working in community teams. By the end of 2016/17 these 'products' had been implemented across the organisation. There were challenges along the way but we are starting to see the benefits of the new ways of working.

Key to its success is the use of our quality improvement system (TEWV QIS) which empowers and supports staff to improve services. It also challenges us to see the service through the eyes of patients and carers.

Phase two of the programme is now underway, focussing on the clinical services we provide and the systems we have in place to support them. This includes developing clinical pathways (standard, evidenced-based assessment and treatment plans) and

then making sure we have the right staff with the right skills to deliver these pathways.

The success achieved in child and adolescent mental health services in County Durham and Darlington is an excellent example of how PPCS can dramatically improve services.

Before introducing PPCS the teams had huge problems with waiting times. PPCS gave the team an opportunity to do things differently and to introduce **a single point of access**. There is now more transparency and staff are able to react quickly to increases in referrals and respond to problems as they arise. Waiting times reduced significantly and since September 2016 the teams have consistently met their targets.

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're able to provide a modern, fit-for-purpose environment.

Bringing adult inpatient services back to York was a priority for the Trust (following the sudden closure of Bootham Park Hospital a few days before we took over responsibility for services on 1 October 2015).

We reopened **Peppermill Court** on 1 October 2016 as a 24-bed adult inpatient assessment and treatment unit for the people of York and Selby. The £1.2 million project took just eight months to complete and the refurbished unit is modern, light and airy. The male and female wards each have 12 single bedrooms and direct access to gardens.

Our next priority is **a new hospital for the people of York and Selby** and the Trust remains committed to completing the development by the end of 2019. Last year the Vale of York CCG led a public consultation about potential sites and the proposed configuration and number of beds. We expect to make an announcement about the preferred location of the new hospital in June 2017.

Middlesbrough's adult community services also moved into purpose-designed accommodation in 2016. We invested over £2 million to develop the new **Parkside mental health resource centre (MHRC)**, which brings the four community teams together under one roof.

It's been a busy year and we've achieved a great deal. Our success has been recognised at a national level in a number of prestigious awards, which are detailed in the quality report.

Our achievements would not have been possible without the support of staff, service users, carers, volunteers, governors, partner organisations and commissioners. We are, as ever, very grateful for their commitment to the Trust.

Looking to the future

The Trust welcomes the development of the *5 Year Forward View for Mental Health* and we fully support these national priorities. As a Board we remain committed to improving the quality of our services and increasing the value that we provide to our stakeholders and commissioners.

Over the coming year our focus will continue to be on promoting recovery. We have made great progress although there is still much to do. Our aim is to make sure that inpatient and community services across the Trust are underpinned by a recovery based approach and that we have infrastructures in place that support a model of 'co-production'.

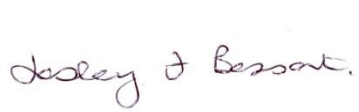
Alongside this we remain committed to improving the quality of our services and to making sure they are purposeful and productive – that we are making a positive difference to the lives of the people who use our services. We also have a duty to make the most of tax payers' money and to use our resources to get the best outcomes for people. The best way to do this is through focussing on improving quality.

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 will continue to work with service users and carers and a wide range of organisations and groups to plan and develop local services.

Over the coming year we will work with local people to finalise plans for the new hospital in York and continue to strengthen our community services to make sure that wherever possible people can get the care and treatment they need in their home environment.

Last year we started to have conversations with people in Hambleton and Richmondshire about how we could improve adult and older people's mental health services in the area. We will continue to work with the local CCG to consolidate the feedback and use it to develop options for the development of services for local people. We expect to carry out a formal public consultation in the Summer.

We remain passionate about improving mental health and learning disability services for the people we serve and we're looking forward to another purposeful and productive year.



Lesley Bessant
Chairman
23rd May 2017

Colin Martin
Chief Executive
23rd May 2017

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

The performance report

The performance report

Overview of performance

Purpose

The purpose of the performance report is to provide an overview of the Foundation Trust, our purpose, our strategic direction, including our vision, mission and strategic goals, the key risks to achieving them and information on how we have performed during the year.

Statement from the Chief Executive

Overall our performance for the year was good, despite the pressures and challenges facing the organisation. We met our financial targets and continued to improve against a number of key performance targets such as waiting times and appraisals.

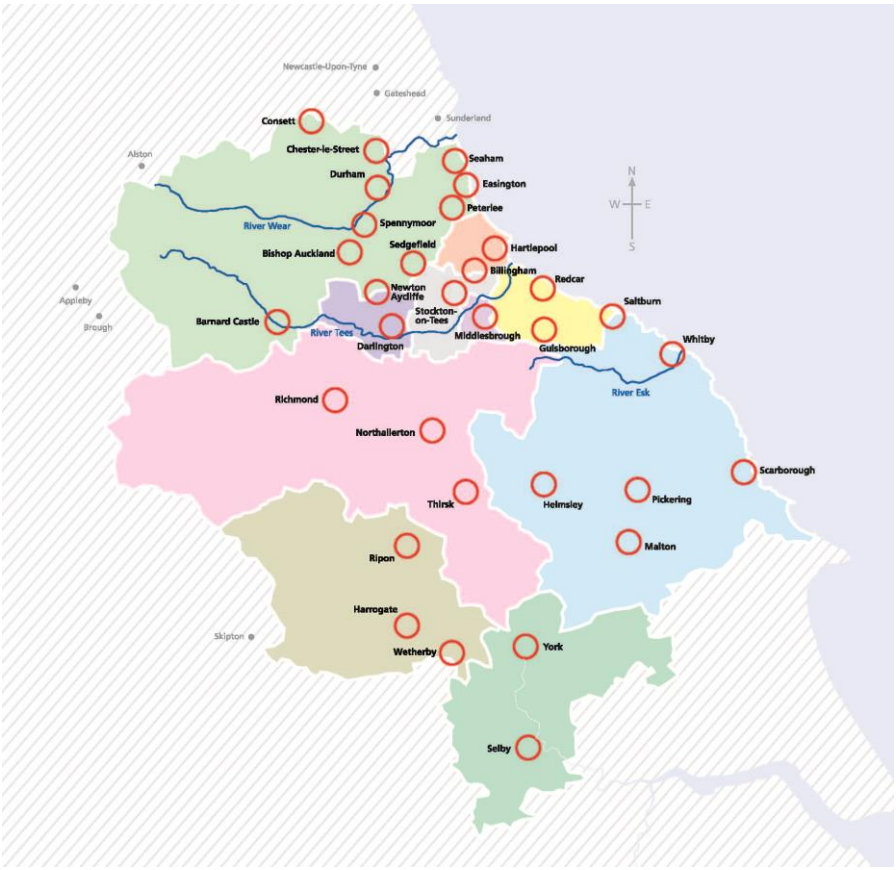
TEWV at a glance

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 NHS Improvement, 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, the City of York 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 6,400 staff and an annual operating income of approximately £345 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
- respond better to market opportunities
- continue to invest in capital developments such as Parkside mental health resource centre

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

We have five strategic 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

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 Five Year Forward View 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
- the greater integration of services and how this can be achieved through new models of care
- 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 Mental Health 5 Year Forward View and FiM. However there are two risks associated with this. The first being that the CCGs do not allocate resources to mental health that meet the national Investment Standard therefore making it difficult to deliver the additional services required. The second 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 are risks that the national targets set do not reflect the starting points of services, that the national construction of the targets is not in line with local service models and the national targets 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 Single Oversight 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 continues to be 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 key external environmental drivers such as the Five Year Forward View, the Mental Health 5 Year Forward View and the learning disability Transforming Care agenda and taken them into consideration in developing its annual operational/business plan.
- The Trust is actively seeking to engage with commissioners and 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. In County Durham, Darlington and Teesside the Trust is working closely with the CCGs and local authorities on the development of an accountable care partnership approach to commissioning and delivery of learning disability services.
- The Trust is actively engaging with the development and delivery of the Sustainability and Transformation Plans (STP) in the four footprints it operates within in order to ensure that the STPs reflect the key priorities of meeting the needs of people with mental health problems and learning disabilities as outlined 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 and Yorkshire and Humber Transforming Care Boards 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 Trust continues to work with commissioners to ensure that they meet the national mental health investment standard and has agreed a ring fence approach to the total mental health and learning disability commissioning budget with a number of CCGs.

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 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.

- 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 NHS Improvement, the forecast 2016/17 deficit for NHS Providers is expected to be around £800m mainly as a result of the financial performance of acute Trusts. This position includes the £1.6m Sustainability and Transformation funding.

  There continues to be 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.

  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 and Retention of Staff

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

During the last three years, 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, medical staff and allied health professional staff . We now consider that our ability to

access the right number and quality of clinical staff is the key workforce risk for the Trust.

We also believe that the level of risk may increase given the age profile of clinical staff, which is expected to result in an increase in the number of retirements on age grounds over the next three years.

In response to concerns about clinical staff recruitment and retention, the Trust:

- has developed, agreed and commenced implementation of a recruitment and retention action plan
- 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 and elsewhere
- has identified measures to improve the Trust's temporary staffing service
- is developing new roles and career paths within the Trust.

Although the full impact of Brexit is not yet clear, now that Article 50 has been triggered, the Board will be keeping this under close scrutiny, particularly in terms of its possible effect on our ability to recruit staff.

Demography and Demand risks

Demographic change, and changes in demand are risks for the Trust because:

- the block payment nature of our contracts means that our income does not automatically rise as activity increases
- changes in the pattern of demand might result in the current pattern and location of resources (such as staff or beds) becoming misaligned with need.

The Trust includes predicted changes in referrals among the information used in developing the Trust's business plan. We have, therefore, factored in the likely increase in the number of Under 18s and over 65s in the coming years, alongside a static 18-65 population into our plans.

However, referral patterns can also change due to changes in GP practice, economic shocks and changes in public attitudes to mental health (i.e. decline of stigma). Sudden increases in referrals can lead to pressures on community staff and to increased waiting times. Waiting time data is carefully monitored, but the Trust recognises that we need to improve the visibility and timeliness of data on referrals to assist the Trust as a whole to move resources to where they are most needed. We are therefore currently developing new processes and reports for referrals to enable a more effective response to meet localised pressures.

We also maintain positive relationships with our commissioners so that increases in referrals can be considered during contract negotiations.

Regulatory requirements

We fully support the NHS providing high quality healthcare. It is both what 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 2017-18 annual plan provides for a surplus of £10.1m (3.1% of turnover) and reflects a significant level of non-recurrent expenditure

The Board's view is that the Trust is a going concern and the disclosure, as recommended by the accounting standards board, can be made 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".

Colin Martin
Chief Executive **23rd May 2017**

Performance analysis

Key developments during 2016/17

During 2016/17 the Trust has supported the development of new models of care at a variety of levels. As one of NHS England's two pilots for provider management of specialist CAMHS budgets, we have worked with them to develop new processes and a plan to increase the crisis and intensive home treatment services for children across the whole of the area served by TEWV, so that admissions to inpatient beds reduce.

The Trust also continued its work to address the estate, access and quality issues which it inherited when we became the provider of mental health and learning disability services in York and Selby.

Other developments during 16/17 included the roll out of community CAMHS eating disorder services, a reconfiguration of our Durham and Darlington older people's wards to provide single-sex environments and a separation of functional and organic care, the opening of a new adult mental health community base in Middlesbrough, and the successful piloting of all all-age single point of access for community services in Scarborough.

There has also been significant "behind the scenes" work to rationalise and improve our patient pathways. We have done this as part of a long-term plan to reduce unwarranted variation in the quality of community-based mental health and learning disability services. Our next step towards achieving more purposeful and productive community teams is to identify the workforce skills and capacity required to implement our pathways effectively.

How we measure our performance

Each year the Board of Directors sets 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.

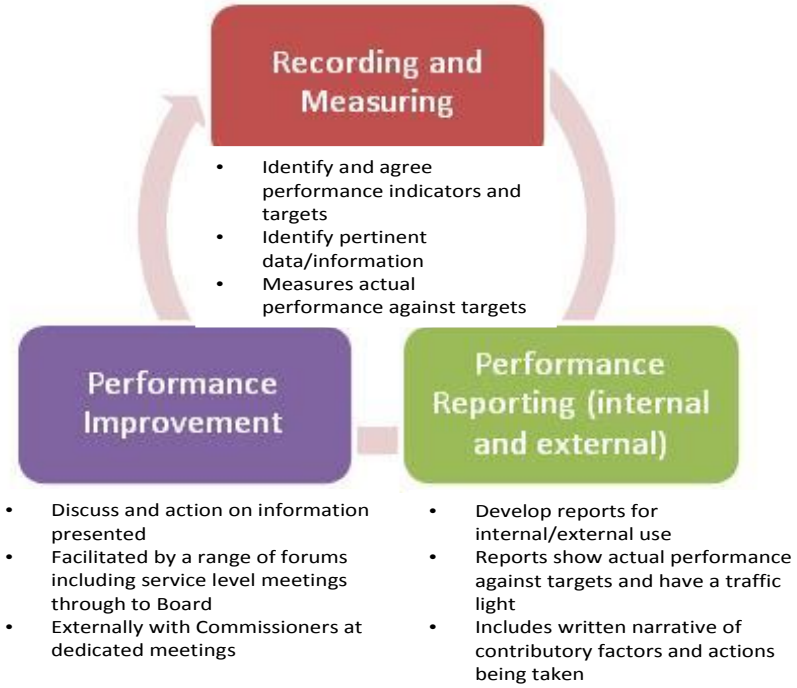
The key performance indicators are reported within a "dashboard" which provides a high level overview of operational delivery throughout the financial year. This report is produced monthly specifically for our Board of Directors to give it assurance that the Trust is continuing to deliver operationally. 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.

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 of Directors may request further analysis and/or an action plan if it feels 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" where we 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 below.

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
- allowing 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.

How we performed

Performance against key health care targets

The Trust monitors a range of key health care targets which include those set internally by the Board of Directors, those set externally as part of the mental health contracts with Commissioners and the national ones within NHS Improvement's (NHSI) Single Oversight Framework (SOF). This section will focus on the national ones within the NHSI SOF as the former two are covered already within this Annual Report (see "Overview of Performance" and further below "Progress towards targets as agreed with local commissioners".

There are 10 operational metrics within the SOF which came into effect from 1st October 2016; replacing the previous regulatory framework (Risk Assessment Framework). The Trust monitors progress against each of the operational metrics and provides an update to the Board of Directors within its monthly performance report. Between October 2016 and March 2017, the Trust achieved 9 of the 10 metrics each month with the exception of 1 metrics which was achieved in the month of March 2017.

Progress towards targets as agreed with local Commissioners, together with details of other key quality improvements

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

There were two operational standards and three national quality requirements included within the 16/17 mental health contract which were:

- number of episodes of mixed sex accommodation – sleeping
- percentage CPA 7 day follow up (adult services)
- duty of Candour (failure to notify)
- data completeness - NHS number
- data completeness – ethnicity doding

The majority of targets were achieved for the 16/17 financial year for the nine core CCGs. The only target not achieved was "Data completeness – Ethnicity Coding" for the Vale of York CCG where they achieved 89% against the target of 90%. There had been a sudden increase in referrals during the last quarter and the service identified a review was needed of referral forms to ensure all required data is captured at point of referral and time is given to address gaps in patient information.

During 2016/17 the Trust improved patient care through various quality improvements. For example, we:

- continued to embed the Trust's focus recovery and launched the Recovery College Online which provides a range of online educational courses and resources to people who might be struggling with mental health issues
- revised our quality strategy and its scorecard, which has an increased focus on patient reported outcome measures based on what is important to them
- reviewed the harm minimisation and risk management practice across the Trust which included the development of harm minimisation principles
- worked with our partners to support service user needs at all levels, for example, with the creation of 'York Connects'
- refreshed our Purposeful Inpatient Admissions (PIPA) process
- developed plans to improve the productivity of our community teams
- further embedded our commitment to be a 'smokefree' mental health Trust
- implemented an approach to improve the service user experience in times of transition from child to adult services
- continued to improve our estate to meet the needs of service users.

Performance against key targets

The scorecard below is the Trust's dashboard of key performance indicators for 2016/17. The Board received a monthly performance report during 2016/17 which contained performance against this range of indicators.

The Trust became responsible for the provision of mental health services in York and Selby from October 2015 however data to reflect this is not included in the 2015/16 performance position. Therefore it is not possible to draw direct comparison from 2015/16 and 2016/17 data.

1.Activity	2016/17 Actual	2016/17 Target	2015/16 Actual	Change on 15/16*	Comment on 2016/17
Total number of external referrals into Trust services test	100,109	91,759	80,348	↑	
Caseload Turnover	2.39%	1.99%	1.88%	↓	
Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	93.03%	85.00%	88.83%	↓	
Number of patients with a length of stay (admission to discharge) of greater than 90 days (A&T wards)	355	277	272	↓	
Percentage of people re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) Rolling 3 months	7.61%	15.00%	24.16%	↑	15/16 KPI not based on rolling 3 months
Number of instances where a patient has had 3 or more admissions in the past year to Assessment & Treatment wards (AMH and MHSOP) Rolling 3 months	291.66	237.00	279	↓	15/16 KPI not based on rolling 3 months

2.Quality	2016/17 Actual	2016/17 Target	2015/16 Actual	Change on 15/16*	Comment on 2016/17
Percentage of patients who were seen within 4 weeks for a first appointment following an external referral	85.65%	90.00%	82.65%	↑	
Percentage of appointments cancelled by the Trust	0.71%	0.67%	1.10%	↑	
The percentage of Out of Locality Admissions to assessment and treatment wards (AMH & MHSOP) – Post-validated	23.07%	15.00%	17.01%	↓	
Percentage of patients surveyed reporting their overall experience as excellent or good (month behind)	92.45%	91.44%	n/a	N/A	New KPI for 2016/17
Number of unexpected deaths classed as a serious incident per 10,000 open cases – post validated	8.59	12.00	14.68	↑	
3.Workforce	**2016/17 Actual**	**2016/17 Target**	**2015/16 Actual**	**Change on 15/16***	**Comment on 2016/17**
Actual number of workforce in month (Establishment 95%-100%)	93.74%	100%	98.60%	↓	
Percentage of registered healthcare professional jobs that are advertised two or more times	17.39%	15.00%	n/a	N/A	New KPI for 2016/17
Percentage of staff in post more than 12 months with a current appraisal	92.88%	95.00%	81.32%	↑	Snapshot as at 31st March 17
Percentage compliance with mandatory and statutory training	89.18%	95.00%	87.48%	↑	Snapshot as at 31st March 17
Percentage sickness absence rate (month behind)	5.00%	4.50%	4.62%	↓	
4. Money	**2016/17 Actual**	**2016/17 Target**	**2015/16 Actual**	**Change on 15/16***	**Comment on 2016/17**
Delivery of our financial plan (I and E)	-19,222,000	-8,057,087	-269,000	N/A	
CRES delivery	6,734,472	6,610,251	7,885,000	N/A	
Cash against plan	57,845,000	49,036,000	54,148,000	N/A	

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

Notes

- **Total number of external referrals into Trust services** – The Trust has exceeded the annual target of 100,109 by 8,350. This is an increase on the outturn of 80,348 recorded in 2015/16. However data including the York and Selby locality only started to be collected from April 2016. If this data is excluded, the position for 2016/17 shows an increase when compared to 2015/16.

- **Caseload Turnover** - The Trust has not achieved target in 2016/17, reporting 2.39% for the financial year against a target of 1.99%. A deteriorating performance trend has been seen since September 2016 and performance for 2016/17 is worse than that for 2015/16. Work is ongoing to improve caseload management via the purposeful and productive community services program. The increase in the number of referrals received by the Trust is also likely to be contributing to this position.

- **Bed Occupancy –** The Trust has not achieved the target in 2016/17, reporting 93.03% for the financial year against a target of 85.00% with all localities reporting above target. However an improving performance trend has been seen since November 2016 although performance for the financial year 2016/17 is worse than that for 2015/16. A key factor that contributed to this high level of occupancy was the lack of adult mental health inpatient beds in York and Selby until October 2016. This resulted in the placement of York adult mental health patients requiring inpatient care into beds in other localities within the Trust. The adult mental health beds re opened in York in October 2016 and levels of occupancy moved closer to the target set. However it is recognised that there continues to be pressures in some localities.

- **Length of stay greater than 90 days** - The Trust has failed to achieve the target in 2016/17, reporting 355 which has exceeded the annual target of 277 and is greater than the annual outturn for 2015/16. The service continually reviews patients with a long length of stay to ensure appropriate plans are in place and concerns addressed promptly.

- **Percentage of people re-admitted to assessment & treatment wards within 30 days (AMH & MHSOP) -** The Trust position for the financial year is 7.61% which has met the annual target of 15%. This is an improvement on the annual outturn for 2015/16 which was 24.16%. The circumstances of the readmissions have been investigated 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 237 with performance of 291. This is a deterioration on the annual outturn for 2015/16. The circumstances of the readmissions have been investigated and all were attributable to the severity of the symptoms and personal circumstances of the patients concerned.

- **Percentage of patients seen within 4 weeks following external referral -** the Trust position for the financial year is 85.65% which has not met the annual target of 90.00%. This is an improvement on the annual outturn for 2015/16 which was 82.65% and the best performance in the previous 3 years. Work is ongoing to address areas of concern.

- **Percentage of appointments cancelled by the Trust –** The Trust has failed to achieve the target of 0.67% with a performance of 0.71%. However this is an improvement compared to the 2015/16 outturn of 1.10% and the best year end position in the previous 3 years.

- **The percentage of Out of Locality Admissions to assessment and treatment wards (AMH & MHSOP) – Post-validated** – 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 23.07%, which is also a deterioration on the annual outturn for 2015/16 of 17.01% and the poorest

performance over the past 3 years. The lack of inpatient beds in York has contributed to this position.

- **Percentage of patients surveyed reporting their overall experience as excellent or good** – The Trust has met the target of 91.44% with a position of 92.45%. Comparable data for 15/16 outturn is not available as this is the first year this data has been captured.

- **Number of unexpected deaths classed as a serious incident per 10,000 open cases –** The number shown is the maximum level of unexpected deaths that we would expect to see rather than a target number we are trying to achieve.

- **Actual number of workforce in month (Establishment 95% - 100%)** - The Trust position for the financial year is 93.74% which has not met the annual target, and is a deterioration on the 2015/16 outturn. The Trust has invested in holding recruitment fairs to improve recruitment opportunities which have proved a success, particularly in relation to attracting student nurses from university.

- **Percentage of registered healthcare professional jobs that are advertised two or more times** - The Trust position for the financial year is 17.39%, which is 2.39% over the annual target. Comparative data for 2015/16 is not available as this is the first year this data has been captured. The success of the aforementioned recruitment fairs will have a positive impact on this indicator.

- **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 92.88% in March 2017. This is an improvement on the 81.32% achieved in 2015/16 and the best position in both the financial year to date and the previous 3 years. The use of operational management huddles is now embedded across the Trust which includes discussions on appraisal compliance levels; this has had a positive impact on performance levels being achieved.

- **Percentage compliance with mandatory and statutory training** – The Trust has under-performed against the 95% target with an outturn of 89.18% in March 17; however this is an improvement on the outturn of 87.48% for 15/16 and 14/15 also. This indicator is monitored through the report out process to address non-compliance.

- **Percentage sickness absence rate** – The Trust has under-performed against the 4.50% target with an outturn of 5.00% in March 17. This is a deterioration in performance compared to the 2015/16 outturn position. The Operational HR team continue to proactively support line managers to manage staff to facilitate a speedy return to work for staff.

- **Delivery of our financial plan (I and E) -** The comprehensive income outturn for the period ending 31 March 2017 is a surplus of £19,222k, representing 5.6% of the Trust's turnover. The Trust is ahead of plan largely due to contract variations with commissioners, a refund of historic National Insurance payments linked to widening access trainees, and vacancies. Recruitment to posts is ongoing.

- **CRES Delivery (snapshot) - Total** CRES delivery by the Trust for 31 March 2017 is £590,459. Identified Cash Releasing Efficiency Savings at 31 March 2017 was ahead of plan and recurrent plans were fully implemented at the year end with no issues anticipated into 2017/18 financial year.

- **Cash against plan -** Total cash at 31 March 2017 is £57,845k and is ahead of plan largely due to planned delays in the capital programme and the Trust's surplus position. Capital expenditure is behind plan due to scheme delays, though schemes are progressing.

Reducing our carbon footprint

The Trust has a five year sustainable development management plan (SDMP), which supports the NHS Sustainable Development Unit's view that a sustainable healthcare system must do more than focus on carbon – it must also consider how to minimise the impact of other negative environmental impacts, such as waste or water, and also to maximise opportunities to support the local economy and community.

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.

Going forward, the Trust has embarked on an in depth and extensive survey of the three largest Trust facilities in an effort to reduce their carbon footprint using new technologies, after which consideration will be given to the report's recommendations. Large scale solar photovoltaics and also generating our own electric through the use of combined heat and power are two schemes which could help the Trust achieve its obligation in meeting our carbon reduction target of 34% by 2020.

In the annual Government energy certification exercise rating of our buildings (A to G with D being typical) of the 31 qualifying properties surveyed, more than half of the buildings were rated C and above with only six properties failing to achieve the typical G and D ratings.

Using assisted funding provided by The Workplace Charging Scheme, we have increased the availability of electric vehicle charging points strategically across the Trust. Current locations now offering EV charging to staff and visiting members of the public include Lanchester Road Hospital, Parkside MHRC, Cross Lane Hospital, Flatts Lane Centre and West Park Hospital. The scheme also responds to a recent staff survey on attitudes to electric vehicles and the need for a charging post infrastructure to encourage greater take up of electric vehicles.

Whilst the Trust has embarked on many successful recycling initiatives, further improvements can be achieved by segregating and recycling our general waste.

Of the 14,290 tonne of waste produced across the Trust in 2015/2016, only 17% of this waste was recycled at source and separated out for recycling here at TEWV. Any recycling material mixed in with general rubbish is separated out by our waste contractor and sent off to be recycled – this includes tins, paper, cardboard, glass and plastics, Very little of our waste ends up going to land fill; our waste contractor achieves almost 100% recycling from the waste that the trust produces. In addition, the Trust is currently undertaking a review of internal recycling into the segregation and recycling of waste with a view to rolling this out Trust-wide.

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.

Human rights

The Trust has worked with the British Institute of Human Rights to develop a human rights training package for use by TEWV early intervention in psychosis services staff that can also be accessed by staff in other NHS trusts. The training is part of efforts to empower staff to better understand and use human rights in their day to day work to improve decision making and assist with adopting a more person-centred approach to engaging with service users and carers. Evaluation of the training project has identified that 86% of practitioners believe that they now have enough or a good understanding of how to use a human rights approach in practice compared to pre-training feedback that 71% of practitioners had little or no understanding of how to use a human rights approach in practice.

Important events since end of financial year

At the time of writing this report there were no events which have materially affected the Trust.

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 **23rd May 2017**

The Directors' Report

The Chairman, Deputy Chairman, Chief Executive and other Board Members as at 31st March 2017

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 2017 to 31 March 2020*
Date of Initial appointment: 1 April 2014
(Note: The Chairman has no other material commitments and this position did not change during the year)

Jim Tucker, Deputy Chairman and Chairman of the Resources 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
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).

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

Marcus Hawthorn, Non-Executive Director, Chairman of the Audit Committee and Senior Independent Director
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 2016 to 31 August 2019*
Date of Initial appointment: 1 September 2013

Paul Murphy, Non-Executive Director
Paul has had a broad range of experiences at a senior level in public and private (not-for-profit) sectors, as well as central and local government, including spells as a ministerial private secretary and an assistant director at City of York Council. He is now a freelance consultant, with an interest in particular in mental health, wellbeing, and in services for children and young people.
Qualifications: BA (Hons) English & Related Literature

Principal skills and expertise: Strategic planning, operational management, change management, human resources, communications, education, and articulating the service user voice.
Term of office: 1 September 2016 to 31 August 2019
Date of Initial appointment: 1 September 2016

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 Charity, an enterprise charity based in the West End of Newcastle.
Qualifications: BA (Hons) Sociology and Social Anthropology; Advanced Diploma in Leadership and Development Coaching.
Principal Skills & Expertise: Communications, marketing, stakeholder engagement, crisis management, executive coaching, training, organisational development.
Term of office: 1 September 2016 to 31 August 2019*
Date of Initial appointment: 1 September 2013

Shirley Richardson, Non-Executive Director
Shirley was the Board Nurse Director at Gateshead Health NHS Foundation Trust for 17 years prior to her retirement in 2010.
She is a registered nurse and has leadership experience in acute, elderly, mental health, learning disability and paediatrics, across both hospital and community.
Since 2011 she has been chairman of Carers Together Foundation, a charity providing information, advice and support to carers in Middlesbrough, Redcar and East Cleveland.
Principal skills and experience: Transformational leadership, strategic planning, coaching and mentoring, service redesign, performance improvement, quality and safety systems, governance and risk management, research and development.
Qualifications: MBA, RN, Diploma of Chartered Institute of Marketing
Term of office: 1 September 2016 to 31 August 2019
Date of Initial appointment: 1 September 2016

(Note: * indicates that the individual has been reappointed as a Board member of the Foundation Trust.)

Colin Martin, 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 a Director of North East Transformation System Ltd, a joint venture between the Trust and Gateshead Health NHS Foundation Trust.
Qualifications: Qualified accountant, FCCA.
Principal Skills & Expertise: Programme and project management, systems development, PFI finance, information analysis, performance management and service development
Appointed: 1 May 2016 (prior to his appointment Mr. Martin was the Trust's Director of Finance and Information)

Brent Kilmurray, Chief Operating Officer and Deputy Chief Executive
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.
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

Drew Kendall, Interim Director of Finance and Information
Drew has extensive financial experience having worked in NHS Acute and Mental Health services for over 27 years and was previously Associate Director of Finance with the Trust since 2009. He is a member of the National HFMA (Healthcare Financial Management Faculty) Mental Health Faculty and HFMA Policy group. Drew is also a Board member of the AuditOne NHS Audit consortium.
Qualifications: Qualified accountant, FCCA
Principal Skills & Expertise: Financial management and costing, programme and project management, foundation trust regime and application process, information and systems development.
Appointed: (Interim) June 2016

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 chairs the Northern School of Psychiatry's workforce sub-committee and is the mental health representative on the Humber Coast and Vale Local Workforce Action Board. 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

Elizabeth Moody, Director of Nursing and Governance
Elizabeth took up post as director of nursing and governance in July 2015. Elizabeth 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 and Expertise: Psychiatric nursing skills, project management, service improvement, managerial and leadership skills, patient and carer experience, patient safety, quality and assurance
Appointed: August 2015

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

Other Directors of the Trust during 2016/17

- Mr. Martin Barkley, Chief Executive, to 28th April 2016.
- Mrs. Barbara Matthews, Non-Executive Director, to 31st August 2016.

Accounting guidance

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

Better Payment Practice Code

The Better Payment Practice code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. Performance for the financial year 2016-17 was as follows:

	2016-17	
	Number of Invoices	Value of invoices £000s
NHS Creditors		
Total bills paid	1,857	30,395
Total bills paid within target	950	23,603
Percentage of bills paid within target	51.16%	77.66%
Non-NHS Creditors		
Total bills paid	55,105	109,099
Total bills paid within target	53,589	106,598
Percentage of bills paid within target	97.25%	97.71%

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.

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. The strategy has been refreshed in consultation with service users, carers and staff and the revised version was ratified by the Board of Directors in December 2016.

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.

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 were developed last year and have continued to be refined during 2016/17.

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 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 activity and 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 expansion of the electronic risk reporting system and the success of the central approval team in managing the incident reporting process has meant that the systems for collection, analysis and reporting of quality data have been improved this year. The robustness of our quality information and reports used for the Board assurance framework and evaluation of quality performance has increased with these developments.

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.

A summary of action plans to improve quality governance:

- We have continued to embed a robust and consistent approach to incident reporting across the Trust through the development of our central approval team.
- To further promote a learning culture in the Trust we have enhanced our arrangements for analysing and reviewing incidents, claims, complaints, safeguarding and external inspections and improved our systems and processes for monitoring and providing assurance on the effectiveness of action plans.
- We have amalgamated our patient safety, complaints, legal and claims functions into a single department to ensure greater emphasis is placed on shared learning and the triangulation of information.
- We plan to further embed the Duty of Candour to ensure staff are fully aware of their roles and responsibilities under the regulations and are confident in engaging with patients, families and carers.
- The implementation of our new patient experience system will allow us to be more flexible and responsive in the way we collect and report service user feedback.
- We have responded to recommendations and feedback from the Care Quality Commission inspections in a proactive and timely manner.

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.

Involving local people

Involvement and Engagement

The Trust continues to build upon its agreed framework to involve and engage service users and carers with an extensive involvement programme largely devolved to service level but supported by the involvement and engagement team.

Involvement undertaken by service users and carers ranges from consultation right through to co-production with a primary focus of improving the delivery of high quality person centred services that promote recovery. Just under 400 service users and carers were formally registered for involvement last year.

Involvement over the last 12 months has included:

- Service user and carer participation in over 135 interview panels to ensure staff with the right skills, values and behaviours are appointed. A staff member speaking about a service user said "*Her wild card question totally put the service user at the forefront which did throw some light on our recruitment decision making*."
- Provision of training to a range of staff, doctors in training and nurse students through the use of personal experience stories and sharing clinical histories.
- Inspection of wards and premises under Patient Led Assessment of the Care Environment (PLACE) and the Care Quality Commission's (CQC) Fundamental Standards.
- Membership of steering groups, committees and local governance groups to contribute to the provision, design and build of planned new premises and those premises refurbished to accommodate inpatient areas and to review the quality, safety and performance of the Trust.
- Consultation with young people to agree appropriate payment mechanisms for involvement with a competition to design a voucher wallet.
- Co-production and delivery of public consultation sessions by a service user group in Northallerton (The Phoenix Group).
- Attendance and co-delivery of an Involvement, Engagement and Recovery conference for County Durham and Darlington to design new ways of working to involve service users and carers.
- Participation in service improvement events utilising the Trust Quality Improvement System's methodology.

- A continuation of the development programmes; Leadership for Advocates and Service Users, Expert by Experience Programme for Adult Mental Health Services.
- Co-delivery of training programmes at ARCH Recovery College and the co-production of content hosted on the Trust's Recovery College online.

In 2016 our Experts by Experience Programme won the Royal College of Psychiatrists' "Service User/Patient Contributor of the Year" award for its work, in partnership with Trust staff, to influence the design of new policies, processes and projects in order to develop better service user experience and outcomes.

Consulting with local people

During 16/17 we engaged extensively with local people across York and Selby about the development of a new hospital. This culminated in a public consultation, led by the Vale of York CCG. We sought views on the location of the new hospital (from three possible sites) and the proposed number and configuration of beds. A final decision about the preferred location of the new hospital is expected in June 2017.

In the second half of the year we started to work with Hambleton, Richmondshire and Whitby CCG to gather feedback from local people about transforming mental health services for people in Hambleton and Richmondshire. The feedback from local people will be used to develop options for a formal public consultation, which is expected to start in June 2017.

We fully involve overview and scrutiny committees, Healthwatch and our governors in the development of our quality account, and in reporting on our progress in delivering it. Our locality-based structure also facilitates meaningful discussions with local authorities at both overview and scrutiny and Health and Wellbeing Board levels.

Improving services as a result of feedback

Responding to feedback from the Care Quality Commission (CQC)
We have made a number of improvements following inspections by the CQC:

- We re-provided adult mental health services in an improved environment in York and Selby
- We transferred inpatient services for older people from Worsley Court in Selby to refurbished unit at Acomb Garth in York.
- We introduced an enhanced training programme for inpatient clinical staff on the management of patient leave (time away from the ward).
- We focussed on reducing medication omissions to improve patient safety
- We finalised our updated recovery strategy which was approved by the Board of Directors.
- We improved reporting systems for mandatory training compliance to provide oversight of performance from the executive team to team manager level.

Service Improvements as a result of patient surveys

We gain important feedback from patient surveys, which enable us to focus improvements on specific wards and services. For instance:

- Some service users reported that they were not given a choice of location for their appointments – appointment letters are now clear about choice of venue.

- Some carers had not been given information about how to raise concerns or make complaints - carers are now sent a copy of a leaflet about how to raise concerns or complaints. We also enclose this information with every CPA meeting invitation.

Complaints Process
Complaints are managed following national guidance and we endeavour to respond to all of our formal complaints within 60 days. We have a complaints manager aligned to each locality area of the Trust who works with the relevant operational staff member, service user and/or carer to resolve the issue that has been raised.

Our role as a foundation trust
The role of governors is central to the governance of foundation trusts. At TEWV our governors are involved throughout the development of our business plan / operational plan and quality account and provide a useful sense-check on our plans and a conduit for engagement with communities and partners. Governors are also involved in mock inspections, where their perspective can help us understand the viewpoint of both patients and inspectors.

Foundation Trust status also allows the Trust to plan for the long term, and to reinvest the surpluses we make into capital investment. This is why we have been able to continue improving or replacing community bases that do not fully support modern mental health and learning disability services, and put in place credible, self-funded plans for the building of the proposed new mental health hospital in York.

Partnership working

The Trust works closely with the acute trusts that cover the area we serve. This is particularly the case around liaison teams who are based in acute hospitals, but also for the Tees perinatal community team. These services are funded by the relevant CCGs for each hospital.

Our prison mental health service works closely with Rethink (a voluntary sector organisation) and Northumberland Tyne and Wear (NTW) FT so that service uses can benefit from the different strengths of the three organisations (their participation is as subcontractors, with the TEWV contract funded by NHS England).

During 16/17 the Trust subcontracted provision of early intervention in psychosis work to a 3rd sector organisation, and the provision of community mental health care in Pocklington to Humber Foundation Trust. At the end of 16/17 we have served notice on both contracts as we believe that alternative arrangements will provide better value for money and allow national standards to be more effectively met.

TEWV's quality improvement system (TEWQV QIS) remains at the heart of our organisation. To help us continually improve our use of the techniques, and to ensure we maintain a proactive culture of improvement we retain an arrangement with the Virginia Mason Institute who periodically visit the trust to observe how we are conducting quality improvement and to offer advice and guidance.

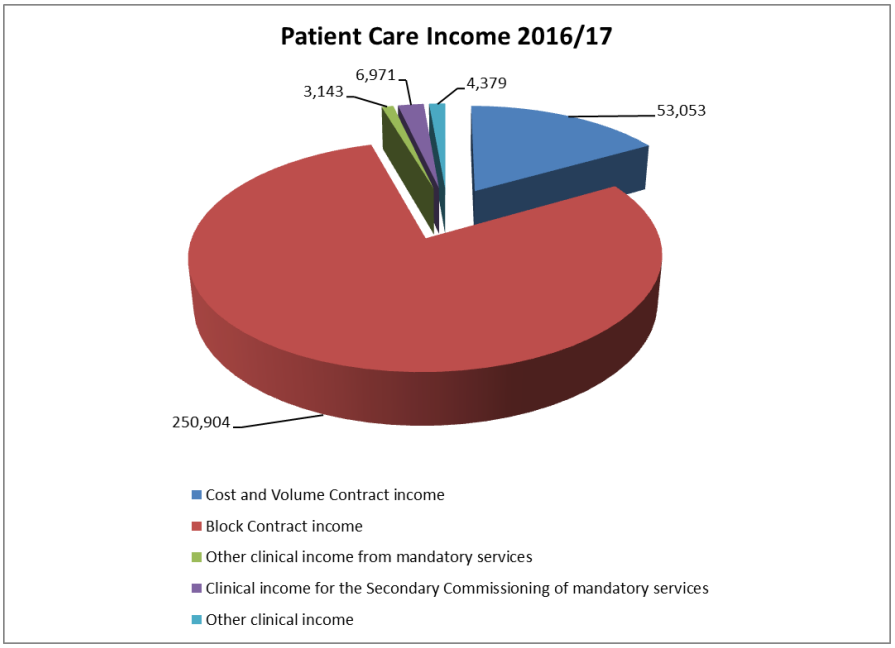
We supported the development of the Harrogate vanguard's work on redesigning how health care for elderly people is provided and worked with GPs in many parts of County Durham and in Catterick to embed mental health practitioners within GP

surgeries. We support CCG and local authority commissioning work by providing data to assist their planning and decision making.

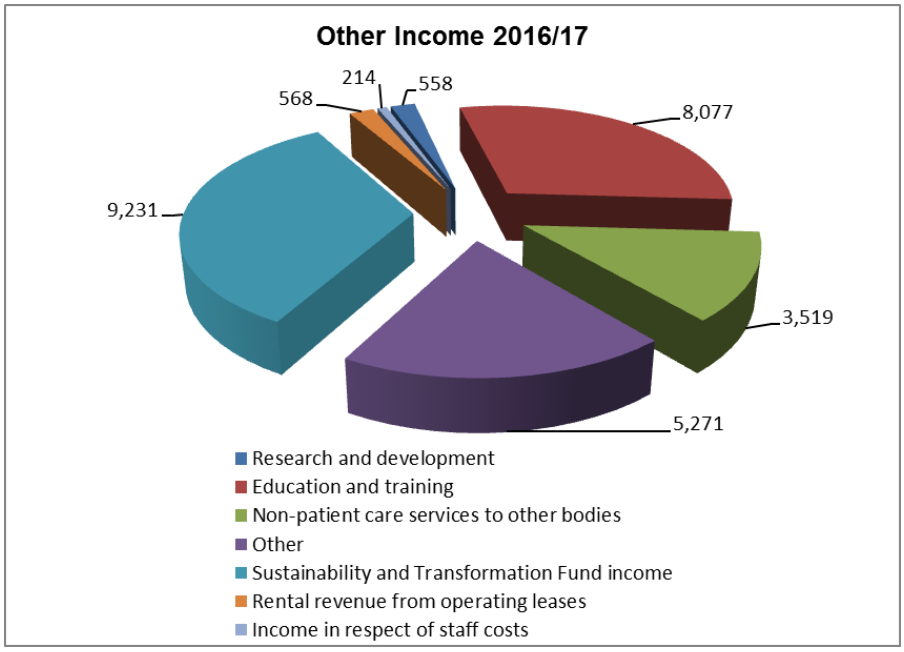
In York and Selby we have set up York and Selby Connects, which is a grant pool for the local voluntary community organisations to bid into to fund mental health and learning disability related initiatives.

Income Generation

During 2016-17, income generated was £345.9m from a range of activities; 92.1% from direct patient care. Patient care income came from the following areas:



There was a further £27.4m from sustainability and transformation funding, education, 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

Statement as to disclosure to Auditors

Each of the directors, holding office on 31st March 2017, 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.

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.

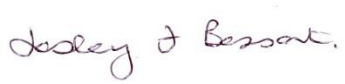
This Framework does not cover the remuneration of:

- 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 2016/17 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.

With the exception of the retirement and return to work on a part-time basis of the Medical Director there were no substantial changes to senior managers' remuneration made during the year.

Details of the salaries and allowances and pension benefits of senior managers in 2016/17 and payments made to past senior managers are provided in the tables in this section.



Lesley Bessant
Chairman of the Board's Nomination and Remuneration Committee

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 table overleaf:

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 under the Framework is £1,352,934 Through these arrangements the Trust has satisfied itself that senior managers' remuneration is reasonable. The basic pay arrangements support the short and long term strategic objectives of the Trust by enabling the Trust 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 amount (typically 7.5%) have been used for new post holders. The full amount becomes payable subject to the post-holder demonstrating good performance in their first year in office taking into account 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 2016/17.
Allowances	A Directors' Travel Allowance of £5,444 is included within 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, where applicable, is subject to confirmation from the individuals line manager that their performance over the preceding 12 months period has been rated as being good.
The Medical Director's Allowance	£10,588 (up to 31st July 2016)
The salary of the Senior Clinical Director of the KPO	£67,773

Other Policy Disclosures

- Service Contract Obligations:
  None identified

- Policy on Payment for Loss of Office:
  A contractual entitlement to three months' notice, other than in the case of summary dismissal. Where eligible an entitlement 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 Executive Management Team 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..

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 **23rd May 2017**

Senior managers' remuneration

Name and Title	2016-17						2015-16					
	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Benefits in Kind * Rounded to the nearest £100	Pension related benefits (bands of £2500) £000	Total Remuneration (bands of £5000) £000	Expenses Paid Rounded to the nearest £100	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Benefits in Kind * Rounded to the nearest £100	Pension related benefits (bands of £2500) £000	Total Remuneration (bands of £5000) £000	Expenses Paid Rounded to the nearest £100
Mr Martin Barkley, Chief Executive - left 28 April 2016	10-15	0	0	0	10-15	300	180-185	0	0	0	180-185	2,300
Mr Colin Martin, Chief Executive *****	155-160	0	11,800	285.0-287.5	455-460	1,100	120-125	0	9,200	22.5-25.0	155-160	1,300
Mr Drew Kendall, Director of Finance and Information - started 01 May 2016	95-100	0	2,100	167.5-170.0	265-270	1,100	0	0	0	0	0	0
Mr Brent Kilmurray, Chief Operating Officer / Deputy Chief Executive	120-125	0	0	35.0-37.5	155-160	1,700	120-125	0	0	25.0-27.5	150-155	1,900
Dr Nick Land, Medical Director **	70-75	55-60	6,200	65.0-67.5	200-205	1,800	35-40	165-170	5,900	107.5-110.0	320-325	2,000
Mr David Levy, Director of Human Resources and Organisational Development	105-110	0	0	17.5-20.0	125-130	600	105-110	0	0	35.0-37.5	140-145	1,300
Mrs Chris Stanbury, Director of Nursing and Governance - left 31 July 2015	0	0	0	0	0	0	40-45	0	800	0	40-45	900
Mrs Elizabeth Moody, Director of Nursing and Governance - started 01 July 2015	105-110	0	9,600	110.0-112.5	230-235	1,400	75-80	0	3,400	152.5-155.0	235-240	1,300
Mrs Jennifer Illingworth, Director of Quality Governance - started 18 May 2015	95-100	0	4,000	80.0-82.5	180-185	1,400	75-80	0	3,100	122.5-125.0	200-205	1,200
Mrs Sharon Pickering, Director of Planning, Performance and Communications	95-100	0	7,300	20.0-22.5	125-130	1,600	95-100	0	6,100	55.0-57.5	155-160	1,600
Dr Ruth Briel, Senior Clinical Director, Kaizen Promotion Office ***	65-70	15-20	0	25.0-27.5	110-115	3,700	65-70	20-25	0	12.5-15.0	95-100	4,000
Mr Paul Newton, Director of Operations - County Durham and Darlington - (seconded from 07June 2015 and retired on 02 February 2016)	0	0	0	0	0	0	25-30	0	800	0	25-30	100
Ms Joanna Dawson, Acting Director of Operations - County Durham and Darlington - started 08 June 2015 to 31 January 2016	0	0	0	0	0	0	55-60	0	1,200	17.5-20.0	75-80	800
Mr Patrick Scott, Director of Operations - County Durham and Darlington - started 01 February 2016	95-100	0	1,700	395.0-397.5	495-500	2,600	15-20	0	300	7.5-10.0	20-25	400
Mr David Brown, Director of Operations – Teesside	100-105	0	4,900	22.5-25.0	130-135	3,200	100-105	0	4,300	5.0-7.5	110-115	700
Mr Levi Buckley, Director of Operations – Forensic Services	95-100	0	0	30.0-32.5	125-130	900	95-100	0	0	20.0-22.5	115-120	400
Mrs Adele Coulthard, Director of Operations – North Yorkshire	95-100	0	2,500	30.0-32.5	130-135	0	95-100	0	1,400	65.0-67.5	160-165	1,300
Mrs Elizabeth Herring, Director of Operations - North Yorkshire - started 14 November 2016, left 02 January 2017	10-15	0	600	0.0-2.5	10-15	100	0	0	0	0	0	0
Mr Phil Bellas, Trust Secretary	80-85	0	0	20.0-22.5	105-110	0	80-85	0	0	35.0-37.5	120-125	0
Mr Robert Cowell, Director of Operations - Estates and Facilities Management	95-100	0	2,500	30.0-32.5	130-135	1,100	90-95	0	2,700	115.0-117.5	210-215	2,300
Mrs Ruth Hill, Project Director (01 October 2014 - 30 September 2015) and Director of Operations - York and Selby started 1 September 2015	95-100	0	1,500	50.0-52.5	145-150	1,500	90-95	0	0	40.0-42.5	130-135	800
Mrs Lesley Bessant , Chairman	50-55	0	0	0	50-55	4,000	50-55	0	0	0	50-55	4,400
Mrs Barbara Matthews, Non-Executive Director - left 31 August 2016	5-10	0	0	0	5-10	1,000	10-15	0	0	0	10-15	2,700
Mr John Robinson, Non-Executive Director - left 31 August 2015	0	0	0	0	0	0	5-10	0	0	0	5-10	700
Mr Jim Tucker, Non-Executive Director	10-15	0	0	0	10-15	2,600	10-15	0	0	0	10-15	3,900
Mr Richard Simpson, Non-Executive Director	10-15	0	0	0	10-15	2,700	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	0	15-20	0	0	0	15-20	100
Mr David Jennings, Non Executive Director	10-15	0	0	0	10-15	1,100	10-15	0	0	0	10-15	1,300
Dr Hugh Griffiths, Non-Executive Director	10-15	0	0	0	10-15	2,500	10-15	0	0	0	10-15	1,700
Mrs Shirley Richardson, Non-Executive Director started 01 September 2016	5-10	0	0	0	5-10	900	0	0	0	0	0	0
Mr Paul Murphy, Non-Executive Director started 01 September 2016	5-10	0	0	0	5-10	1,100	0	0	0	0	0	0

Band of highest paid directors total remuneration (£000) ****	155-160	**Band of highest paid directors total remuneration (£000) ********	180-185
Median of total remuneration	27,361	**Median of total remuneration**	27,361
Ratio (Director to Median)	5.8	**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

** From 02 August 2016 Dr Land ceased all work categorised as other remuneration and worked solely as a Trust director. 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 £9k was paid during 2016-17 (£28k for 2015-16) & Clinical Excellence award relating to the period 01April 2016 to 02 August 2016.

*** Other remuneration includes Additional Clinical Programmed Activity worked during the reported period (For which £5k was paid during 2016-17, £5k for 2015-16) & 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.

***** Colin Martin was promoted to Chief Executive on 01 May 2016. Previously he acted as Director of Finance and Information - the remuneration table is presented as such.

Expenses of Governors

At 31 March 2017 the Trust had 45 Governors (2015-16, 46), with 35 receiving reimbursement of expenses (2015-16, 23). The total amount reimbursed as expenses was £8,763, (£6,856 in 2015-16)

Pay Terms and Conditions

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

The Remuneration Committee is responsible for Executive Directors pay.

Colin Martin
Chief Executive 23 May 2017

Membership:

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

Senior managers' pension benefits

Name and title	Real increase in pension at retirement age for time in post	Real increase in pension lump sum at retirement age for time in post	Total accrued pension at retirement age at 31 March 2017	Lump sum at retirement age related to accrued pension at 31 March 2017	Cash Equivalent Transfer Value at 31 March 2017	Cash Equivalent Transfer Value at 31 March 2016	Real Increase in Cash Equivalent Transfer Value for time in post
	(bands of £2500) £000	(bands of £2500) £000	(bands of £5000) £000	(bands of £5000) £000	£000	£000	£000
Mr Colin Martin, Chief Executive	12.5-15.0	40.0-42.5	60-65	180-185	1,166	856	310
Mr Drew Kendall, Director of Finance and Information started 01 May 2016	7.5-10.0	15.0-17.5	30-35	90-95	523	408	105
Mr Brent Kilmurray, Chief Operating Officer	2.5-5.0	0.0-2.5	30-35	85-90	501	462	39
Dr Nick Land, Medical Director *	0	0	0	0	0	1,646	(1,646)
Mrs Elizabeth Moody, Director of Nursing and Governance	5.0-7.5	15.0-17.5	40-45	125-130	721	611	110
Mrs Jennifer Illingworth, Director of Quality Governance	2.5-5.0	7.5-10.0	25-30	70-75	450	379	71
Mrs Sharon Pickering, Director of Planning, Performance and Communications	0.0-2.5	(0.0-2.5)	35-40	95-100	598	564	34
Mr David Levy, Director of Human Resources and Organisational Development	0.0-2.5	2.5-5.0	25-30	80-85	576	532	44
Dr Ruth Briel, Director of Kaizan	0.0-2.5	2.5-5.0	35-40	110-115	730	659	71
Mr Phillip Bellas, Trust Secretary	0.0-2.5	0.0-2.5	10-15	25-30	186	162	24
Mr Robert Cowell, Director of Estates	0.0-2.5	5.0-7.5	40-45	120-125	822	760	62
Mrs Ruth Hill, Senior Clinical Director, Kaizen Promotion Office	2.5-5.0	2.5-5.0	25-30	75-80	439	392	47
Mr Patrick Scott, Director of Operations - County Durham and Darlington	17.5-20.0	47.5-50.0	40-45	115-120	643	360	283
Mr David Brown, Director of Operations – Teesside	0.0-2.5	2.5-5.0	35-40	115-120	824	766	58
Mr Levi Buckley, Director of Operations – Forensic Services	0.0-2.5	0.0-2.5	25-30	30-35	301	273	28
Mrs Adele Coulthard, Director of Operations – North Yorkshire	0.0-2.5	0.0-2.5	30-35	90-95	582	541	41
Mrs Elizabeth Herring, Director of Operations - North Yorkshire - started 14 November 2016, left 02 January 2017	0.0-2.5	0.0-2.5	30-35	90-95	543	495	6

* Dr Land claimed his pension during 2016-17

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.

The reason for the negative increase in pension and lump sum for two senior managers is due to the inflation factor used (0.0%) 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
23 May 2017

Staff Report

Average staff costs and number of employees

Employee expenses	12 months ended 31 March 2017			12 months ended 31 March 16 (Restated)		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
	£000	£000	£000	£000	£000	£000
Salaries and wages	198,641	190,858	7,783	189,093	180,866	8,227
Social security costs	16,541	15,843	698	12,994	12,317	677
Pension costs – defined contributions plans (Employers contributions to NHS Pensions)	24,170	23,192	978	22,635	21,687	948
Pension Cost – other contributions	15	15	0	11	11	0
Other Post employment benefits	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0
External Bank	0	0	0	0	0	0
Agency/contract staff	5,780	0	5,780	4,971	0	4,971
NHS Charitable funds staff	0	0	0	0	0	0
Gross employee expenses	**245,147**	**229,908**	**15,239**	**229,704**	**214,881**	**14,823**
Less income in respect of salaries and wages where netted off expenditure	(11)	(11)	0	(170)	(170)	0
Total employee expenses	**245,136**	**229,897**	**15,239**	**229,534**	**214,711**	**14,823**
of which:						
Costs capitalised as part of assets	228	228		338	338	0
Analysed onto Operating Expenditure:						
Employee Expenses - Staff	243,318	228,148	15,170	227,258	212,552	14,706
Employee Expenses – Executive directors	1,081	1,081	0	1,194	1,194	0
Research & development	509	440	69	744	627	117
Redundancy	0	0	0	0	0	0
Internal audit costs	0	0	0	0	0	0
Early retirements	0	0	0	0	0	0
Special Payments	0	0	0	0	0	0
NHS Charitable funds: Employee expenses	0	0	0	0	0	0
Total employee expenses excluding capitalised costs	**244,908**	**229,669**	**15,239**	**229,196**	**214,373**	**14,823**

The salary costs of the capital development team are capitalised over the full costs of the Trust's capital schemes, of which in 2016-17 the largest completed scheme was Parkside.

Average number of employees (WTE Basis)	12 months ended 31 March 2017			12 months ended 31 March 16 (Restated)		
	Total Number	Permanently Employed Number	Other Number	Total Number	Permanently Employed Number	Other Number
Medical and dental	324	311	13	312	302	10
Ambulance staff	0	0	0	0	0	0
Administration and estates	1,129	1,095	34	1,097	1,060	37
Healthcare assistants and other support staff	305	295	10	283	272	11
Nursing, midwifery and health visiting staff	3,466	3,458	8	3,288	3,267	21
Nursing, midwifery and health visiting learners	0	0	0	0	0	0
Scientific, therapeutic and technical staff	719	699	20	687	675	12
Healthcare science staff	10	10	0	0	0	0
Social care staff	24	0	24	25	0	25
Agency and contract staff	158	0	158	120	0	120
Bank staff	268	0	268	257	0	257
Other	0	0	0	0	0	0
Total	**6,403**	**5,868**	**535**	**6,069**	**5,576**	**493**
of which						
Number of employees (WTE) engaged on capital projects	6	6	0	7	7	0

Demographic Information

Our workforce is primarily white, broadly in line with our local population and at the end of March 2017 there were 5,102 female members of staff (77%) and 1,483 male (23%).

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 eight female.

Sickness absence figures (January to December 2016)

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
5,886	65,609	2,148,385	106,432	11.1

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

Our average sickness absence rate was 4.95%

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 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.

In 2016/17 we made efforts to improve the training needs analysis by the greater involvement of services in speciality based training needs identification and planning activities.

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.
- Establishment and appointment of a Trust freedom to speak up guardian

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. We remain committed to improving the way we use of the staff friends and family test to engage with the workforce.

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 27 other mental health trusts and were positive. We received the best scores in the country in four of the key findings covered by the survey.

Our top five ranking scores were:

- Staff satisfied with level of responsibility and involvement (3.98 compared to a national average of 3.8, out of a possible 5)
- Percentage of staff believing that the organisation provides equal opportunities for career progression (94% compared to a national average of 87%)
- Percentage of staff feeling unwell due to work related stress in the last 12 months (33% compared to a national average 41%)
- Effective use of patient/service user feedback (3.84 compared to a national average 3.70, out of a possible 5)
- Staff satisfaction with resourcing and support (3.51 compared to a national average of 3.36, out of a possible 5)

Our bottom five ranking scores were:

- Percentage of staff/colleagues reporting most recent experience of violence (92% compared to a national average of 93%)
- Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves (59% compared to a national average of 55%)
- Percentage of staff/colleagues reporting most recent experience of harassment bullying and abuse (57% compared to a national average of 60%)
- Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months (22% compared to a national average of 21%)
- Percentage of staff reporting errors, near misses or incidents witnessed in the last month (91% compared to a national average of 92%).

	2015/16		**2016/17**		**Trust improvement/ deterioration**
Response rate	Trust	National	Trust	National	
	55%	41%	49%	44%	6% decrease

	2015/16		**2016/17**		**Trust improvement/ deterioration**
Top 5 ranking scores	Trust	National Average	Trust	National Average	
KF8	4.05	3.84	3.98	3.87	Decrease 0.9
KF21	92%	84%	94%	87%	Increase 2%

KF17	28%	39%	33%	41%	Increase 5% (negative)
KF32	3.89	3.68	3.84	3.70	Increase 0.5
KF14	3.60	3.31	3.51	3.36	Decrease 0.9
Bottom 5 ranking scores	Trust	National Average	Trust	National Average	
KF24	90%	84%	92%	92%	Increase 2%
KF18	53%	55%	59%	55%	Increase 6% (negative)
KF27	35%	49%	57%	60%	Increase 22%
KF22	23%	21%	22%	21%	Decrease 1% (positive)
KF29	90%	91%	91%	92%	Increase 1% (positive)

Despite the number of changes to the key finding scores, only seven were statistically significant.

Suggested areas for action
The feedback from the survey will be used to develop action plans. The areas we intend focussing on are:

- Introducing a bespoke anti-bullying and harassment procedure to try and further encourage staff to report harassment, bullying or abuse.
- Increase staff engagement and develop clearer mechanisms to process and feedback intelligence that is provided from staff regarding sensitive issues.
- Identify the reasons why staff are attending work despite feeling unwell and attempt to reduce this figures.
- Increasing the percentage of staff who report errors, near misses or incidents that they witness.

A Trust composite action plan is currently under development and is due to be approved in June. Localities and corporate directorates are also considering their own results and forming their own local action plans to support local improvement. Quarterly monitoring takes place and bi-annual 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:

- Launch of the new e-workbook by the health and safety team providing training sessions to staff which has included the introduction of webinar sessions, allowing delegates to telephone in to a 30 minute presentation.

This option of training has been well received by those who have attended and has resulted in a cost saving in travel and time of both the health and safety team and the attendees.

- 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 building
- Completed a one day kaizen event in relation to completing the e-workbook which has identified an action plan.
- Completed investigations and reported RIDDOR incidents to HSE and EMT which identified agreed action plans by Service.
- Maintained and managed the process for the Trustwide suicide environmental surveys.
- Completed disability access audits for in-patient units across the Trust and completed the introduction of portable hearing loops which will be distributed to main sites and out-patient units for patient and staff use.
- Developed and videoed a 'how to set up your display screen equipment' in conjunction with education and training department which will be made available shortly on ESR and Intouch.

Occupational health

The 2016/17 staff flu campaign was the most successful to date with 55.43% of frontline health care workers receiving a flu vaccination (an increase of 16% over the previous year). Physiotherapy and counselling referral activity continued to be strong during 2016 and pre-employment screening activity increased in line with a growth in Trust recruitment. The Trust adopts a partnership approach to working with its occupational health service provider that includes the provider being regularly involved in Trust sickness absence team meetings, the infection and prevention & control committee, the health, safety, security & fire committee, the health and wellbeing group and the mindful employer group.

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.

Exit Packages

Early retirement due to ill health

During the period to 31 March 2017 there were 11 (2015-16, 5) early retirements from the Trust on the grounds of ill-health. The estimated additional pension liabilities of ill-health retirement will be £927,379 (2015-16, £384,305). The cost of this ill-health retirement will be borne by the NHS Business Service Authority – Pension Division.

Analysis of termination benefits

There were 11 payments for termination benefits valuing £368,000 during the period to March 2017, relating to redundancy (2015-16, 4 payments valuing £231,000).

Cost of exit packages

	12 months ended 31 March 2017			12 months ended 31 March 2016		
Exit Package Costs	**Total Number**	**Compulsory Redundancies Number**	**Other Departures Number**	**Total Number**	**Compulsory Redundancies Number**	**Other Departures Number**
<10,000	1	1	0	1	1	0
£10,001 - £25,000	4	4	0	0	0	0
£25,001 - £50,000	5	5	0	0	0	0
£50,001 - £100,000	0	0	0	2	2	0
£100,001 - £150,000	1	1	0	1	1	0
£150,001 - £200,000	0	0	0	0	0	0
>£200,001	0	0	0	0	0	0
Total number of exit packages	**11**	**11**	**0**	**4**	**4**	**0**
Total resource cost (£000's)	**368**	**368**	**0**	**231**	**231**	**0**

Exit packages: other non compulsory

There were no other non compulsory exit packages between 01 April 2016 and 31 March 2017, (2015-16, nil)

Consultancy costs

Consultancy costs for 2016/17 were £684k, compared to £472K in 2015/16. Further details are provided in note 3 to the accounts.

Off payroll arrangements

Table 4B: For all off-payroll engagements as of 31 March 2017, for more than £220 per day and that last for longer than six months	2016/17 Number of Engagements
No. of existing engagements as of 31 March 2017	14
Of which:	
Number that have existed for less than one year at the time of reporting	7
Number that have existed for between one and two years at the time of reporting	4
Number that have existed for between two and three years at the time of reporting	1
Number that have existed for between three and four years at the time of reporting	2
Number that have existed for four or more years at the time of reporting	0
Conformation	
Please confirm 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.	No

Table 4C: For all new off-payroll engagements, or those that reached six months in duration, between 01 April 2016 and 31 March 2017, for more than £220 per day and that last for longer than six months	2016/17 Number of Engagements
Number of new engagements, or those that reached six months in duration between 01 Apr and 31 Mar 2017	7
Number of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and national insurance obligations	7
Number for whom assurance has been requested	7
Of which:	
Number for whom assurance has been received	7
Number for whom assurance has not been received	0
Number that have been terminated as a result of assurance not been received	0

In any case where, exceptionally: - the trust has engaged without including contractual clauses allowing the trust to seek assurance as to their tax obligations or - where assurance has been requested and not received, without a contract termination Please specify the reason for this	Not applicable

Table 4D: For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2016 and 31 March 2017	2016/17 Number of Engagements
Number of off-payroll engagements of board members, and/or, senior officials with significant responsibility, during the financial year.	0
Number of individuals that have been deemed “board members, and/or, senior officials with significant responsibility”. This figure should include both off-payroll and on-payroll engagements.	27

In any case where individuals are included within the first row of this table, please set out:	
Details of the exceptional circumstances that led to each of these engagements	There have been no off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year
Details of the length of time each of these exceptional engagements lasted	

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.

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.	53
A.1.1	A statement on how disagreements between the Council of Governors and Board of Directors should be resolved.	54
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	 25 25 27 26 62 & 70 60 62 & 70
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, 60, 62 & 70
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 – 68

A.5.3	The name of the Lead Governor.	65
B.1.1	The names of the non-executive directors whom the Board determines to be independent, with reasons where necessary.	25 – 27 & 55
B.1.4	A description of each director's skills, expertise and experience.	25 – 28
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 & 70
B.3.1	The other significant commitments of the Chairman and any changes to them during the year.	25
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.	71
B.6.1	A statement on how the performance evaluation of the board, its committees and its directors, including the Chairman, has been conducted.	58
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	199
C.1.1	An explanation from the directors of their approach to quality governance in the annual governance statement.	76
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.	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.	73
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.	72

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

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 a committee 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, the Trust Secretary and the Senior Clinical Director for the Kaizen Promotion Office) 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 31st March 2017, 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 31st March 2017:

- 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.

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 Department of Health Group Accounting 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 Department of Health Group Accounting Manual, 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 2017, 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 ten ordinary meetings and three special meetings of the Board of Directors held during 2016/17:

Board Member	Position	No of Board meetings attended
Lesley Bessant	▪ Chairman of the Trust ▪ Chairman of the Board Nomination and Remuneration Committee ▪ Chairman of the Council of Governor's Nomination and Remuneration Committee ▪ Chairman of the Commercial Oversight Committee	13
Martin Barkley	▪ Chief Executive (to 28th April 2016)	0 (1)
Colin Martin	▪ Chief Executive (from 1st April 2016) ▪ Chairman of the Executive Management Team ▪ Director of Finance and Information and Deputy Chief Executive (to 30th April 2016	13
Jim Tucker	▪ Non-Executive Director ▪ Deputy Chairman ▪ Chairman of the Resources Committee	13
Marcus Hawthorn	▪ Non-Executive Director ▪ Senior Independent Director ▪ Chairman of the Audit Committee	11
Hugh Griffiths	▪ Non-Executive Director ▪ Chairman of the Quality Assurance Committee	11
David Jennings	▪ Non-Executive Director	10
Barbara Matthews	▪ Non-Executive Director (to 31st August 2016)	4 (4)
Paul Murphy	▪ Non-Executive Director (from 1st September 2016)	6 (9)
Shirley Richardson	▪ Non-Executive Director (from 1st September 2016)	7 (9)
Richard Simpson	▪ Non-Executive Director ▪ Chairman of the Mental Health Legislation Committee	13
Drew Kendall	▪ Interim Director of Finance and Information (from June 2016)	10 (12)
Brent Kilmurray	▪ Chief Operating Officer and Deputy Chief Executive	12
Nick Land	▪ Medical Director	13
Elizabeth Moody	▪ Director of Nursing & Governance	12
David Levy*	▪ Director of Human Resources and Organisational Development	13
Sharon Pickering*	▪ Director of Planning, Performance and Communications	11

(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:

- Regular private meetings between the Chairman and governors.
- 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 2016/17.

In total the Council of Governors held five ordinary meetings and an annual general meeting during 2016/17. Board Member attendance at these meetings was as follows:

Name	Attended
Lesley Bessant	6
Dr Hugh Griffiths	6
Marcus Hawthorn	6
David Jennings	5
Barbara Matthews	2 (3)
Paul Murphy	3 (3)
Shirley Richardson	3 (3)
Richard Simpson	6
Jim Tucker	5
Martin Barkley	0 (0)
Colin Martin	6
Drew Kendall	4
Brent Kilmurray	3
Dr Nick Land	0
Elizabeth Moody	4
David Levy	2
Sharon Pickering	5

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

In addition, the Council of Governors held a special meeting in October 2016 to consider a significant transaction. Of the Board members, only Jim Tucker, Marcus Hawthorn, Drew Kendall and Brent Kilmurray attended this meeting.

Evaluating Board performance

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

In 2016/17 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 (Resources) 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.

No external consultancy was engaged to support the Board performance evaluation in 2016/17.

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
Dr. Hugh Griffiths	5
David Jennings	5
Paul Murphy	2 (2)
Richard Simpson	3 (3)

(The maximum number of meetings to be attended by those committee members appointed for part of the year is shown in brackets)

The Director of Finance and Information, 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.

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.

In relation to the annual audit for the year ended 31st March 2017 the committee has:

- reviewed the terms of engagement with the external auditors and recommended them to the Council of Governors.
- 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 scale of, and reasons for, the increase in consultancy costs compared to the previous year.
- The treatment of the Trust's subsidiary, Positive Independent Support Ltd, in the accounts and the appropriateness of management's judgement that group accounts should not be prepared.
- The financial surplus reported for the year, including the receipt of NHS Improvement incentive funding for good financial performance, noting that the normalised surplus position, excluding non-recurrent items, remained relatively consistent with previous years.
- Off-payroll arrangements including the scale of payments and longevity in certain cases.

During the 2016/17 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
- reviewed and provided assurance to the Board on its ability to sign off certificates and the statements required by NHS Improvement in relation to the annual plan
- 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 regular reports from the Local Counter Fraud Specialist noting action taken on increasing fraud awareness and in response to alleged cases of fraud in the Trust
- reviewed the Trust's position against NHS Protect's self review toolkit and sought assurances that local counter fraud arrangements covered all dimensions of fraud.
- proposed arrangements to improve understanding of the role and performance of the external auditors by the Council of Governors which were subsequently adopted by that body.
- reviewed and gained assurance on the robustness of new processes to improve action plan monitoring for complaints and serious incidents.
- reviewed and provided assurance to the Board on the Trust's submission to NHS England on compliance with the Core Standards for emergency preparedness, resilience and response.
- considered corporate governance and accounting developments
- received briefings on quality accounts and the move the greater transparency and on changes to the home care market and their implications for the Trust.

The external auditors

Mazars LLP are the Trust's external auditors.

The firm was appointed by the Council of Governors in 2013 for three years and, following a review by the Audit Committee and Governors, the contract was extended for a further two years (as allowed) i.e. until the completion of the 2017/18 audit.

The cost of providing external audit services during 2016/17 was £47,520 including VAT. This includes 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.

Details of the external audit fees, split between the statutory audit fees and other auditor remuneration, are provided in notes 3 and 5.5 to the accounts.

The internal auditors

Internal audit services are provided by Audit One; a not-for-profit provider of internal audit, technology risk assurance and courter fraud services to the public sector in the North of England.

Mr Stuart Fallowfield ACCA, the Director of Internal Audit at Audit One, 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 Mr David Levy, Director of Human Resources and Organisational Development and Mr Phil Bellas, Trust Secretary.

No external advice or support was commissioned by the committee during 2016/17.

The Committee met once during 2016/17 to:

- Approve the annual uplift to be applied to the remuneration of the executive and other relevant directors
- Approved arrangements in relation to the position of Director of Finance and Information following Mr. Martin's appointment as the Chief Executive of the Trust.

The members of the committee present at this meeting were: Lesley Bessant, Jim Tucker, Marcus Hawthorn and Colin Martin (for the latter item).

The annual statement from the Chairman of the Nomination and Remuneration Committee is provided in the remuneration report.

Resources Committee

The Resources Committee was established in December 2016 and met twice during the financial year.

The committee replaced the Investment Committee and, in addition to undertaking the latter committee's functions of reviewing major business cases and investments and overseeing the management and administration of the charitable funds, has a broader remit encompassing reviewing and providing assurance to the Board on the following matters:

- The appropriateness of the resources available to the Trust, both financial and non-financial (e.g. workforce, IT and estates) to deliver its Operational/Business Plan.
- The robustness and alignment of relevant strategies and plans and progress towards their delivery.
- Changes to the external environment in the medium to longer term.

As at 31st March 2017 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
- David Jennings, Non-Executive Director
- Paul Murphy, Non-Executive Director
- Colin Martin, Chief Executive
- Brent Kilmurray, Chief Operating Officer
- Drew Kendall, Interim Director of Finance and Information*
- Sharon Pickering, Director of Planning, Performance and Communications*
- David Levy, Director of HR and Operational Development*

(Note: These members are only expected to attend meetings when matters within their portfolios are being considered).

(Note: the Investment Committee met six times during the year).

Mental Health Legislation Committee (MHLC)

The role of the committee is:

- 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 them:
- 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

The committee met four times during the year.

As at 31st March 2017 the membership of the committee comprised:

- Richard Simpson, Non-Executive Director (Chairman of the Committee)
- Lesley Bessant, Trust Chairman
- Paul Murphy, Non-Executive Director
- Shirley Richardson, Non-Executive Director
- Dr 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)

Quality Assurance Committee

The Quality Assurance Committee (QuAC) is the principal provider of assurance to the Board on quality, in particular, 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 31st March 2017 the membership of the committee comprised:

- Dr. Hugh Griffiths, Non-Executive Director (Chairman of the Committee)
- Lesley Bessant, Chairman of the Trust
- Richard Simpson, Non-Executive Director
- Jim Tucker, Non-Executive Director
- Shirley Richardson, Non-Executive Director
- Colin Martin, Chief Executive
- Brent Kilmurray, Chief Operating Officer
- Dr. 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 2016/17.

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 Resources Committee
- Dr Nick Land, Medical Director

The committee met five times during 2016/17.

The 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.

As Lead Governor I have responsibilities to NHS Improvement and the Care Quality Commission (CQC). I am able to report again that there have been no issues of concern with any aspects of the appointment process in the Trust or non-compliance with the Constitution.

The Trust kept me fully informed when the CQC raised some concerns about a few aspects of care in York and Selby. The Trust responded quickly and appropriately to the concerns raised and kept myself and the Council of Governors fully informed so therefore no action was required by myself in my role as Lead Governor.

The Task and Finish Groups are now well established and continue to review many of the aspects of the Trust's work both with patients and carers.

Training and development sessions remain a priority for governors to ensure they have the skills and knowledge to enable them to monitor, challenge and ask appropriate questions on the information presented to the Council of Governors.
Training has included Equality and Diversity, Adult and Children's Safeguarding and Improvement Systems.

Recovery is a very positive aspect of the Trust's values and vision. The development of the Recovery College has proven to be an important part of some patients' pathways to achieving confidence and independence.

Recently I, together with other governors attended the launch of the Virtual Recovery College. This is an exciting new development that will give many more patient and carers the chance to experience and know what opportunities there are for them to enhance their lives.

The Council of Governors appreciate that this has been another challenging year due to the funding issues of both the Trust and its partners, such as Local Authorities and the Clinical Commissioning Groups. It will be important that the Trust continues to work closely with all its partners to ensure the continued provision of high quality services.

Finally, on behalf of the Council of Governors I would like to say that we appreciate the commitment and dedication of the staff in their endeavours to provide the best services possible to the patients and carers.

The Composition of the Council of Governors as at 31st March 2017

Membership of the Council of Governors during 2016/17

The terms of office of governors and their attendance at the 7 meetings (including the Annual General Meeting) held during 2016/17 was as follows:

Public Governors (Elected)

Name	Constituency	Term of office From	To	Total Attended
Andrea Goldie	Darlington	01/07/2014	30/06/2017	4
Dennis Haithwaite	Darlington	12/11/2014	30/06/2017	3
Mary Booth	Middlesbrough	01/07/2014	30/06/2017	5
Catherine Haigh	Middlesbrough	07/07/2016	30/06/2019	5
Judith Webster	Scarborough and Ryedale	01/07/2014	30/06/2017	3
Liz Forbes-Browne	Scarborough and Ryedale	01/07/2016	30/06/2019	1 (6)
Keith Marsden	Scarborough and Ryedale	01/07/2013	30/06/2016	1 (1)
Richard Thompson	Scarborough and Ryedale	01/07/2014	30/06/2017	2
Claire Farrell	Redcar and Cleveland	01/07/2014	30/06/2017	0
Vanessa Wildon	Redcar and Cleveland	07/07/2016	30/06/2019	6
Gillian Restall	Stockton-on-Tees	01/07/2014	30/06/2017	7
Paul Emerson-Wardle	Stockton-on-Tees	12/11/2014	30/06/2017	1 (5)
Gary Emerson	Stockton-on-Tees	01/07/2016	30/06/2019	5

Janice Clark	Durham	01/07/2014	30/06/2017	4 (6)
Betty Gibson	Durham	01/07/2014	30/06/2017	1 (1)
Sarah Talbot-Landon	Durham	01/07/2016	30/06/2019	6
Anthony Heslop	Durham	01/07/2016	30/06/2017	5 (6)
Cliff Allison	Durham	01/07/2014	30/06/2017	6
Dr Lakkur Murthy	Durham	01/07/2016	30/06/2019	4 (6)
Keith Mollon	Durham	01/07/2016	30/06/2019	6 (6)
Peter Burgess	Durham	01/07/2016	08/03/2017	5 (6)
Mark Williams	Durham	01/07/2013	30/06/2016	0 (1)
Zoe Sherry	Hartlepool	01/07/2014	30/06/2017	4
Jean Rayment	Hartlepool	01/07/2016	30/06/2019	7
Angela Stirk	Hambleton and Richmondshire	01/07/2014	30/06/2017	1 (5)
Colin Wilkie	Hambleton and Richmondshire	01/07/2014	30/06/2017	5 (6)
Hilary Dixon	Harrogate and Wetherby	01/07/2016	30/06/2019	5
Hazel Griffiths	Harrogate and Wetherby	01/07/2016	30/06/2019	5 (6)
Chris Gibson	Harrogate and Wetherby	01/07/2016	30/06/2019	3
Sandy Taylor	Harrogate and Wetherby	01/07/2013	30/06/2016	1 (1)
Dr Mina Shreekant Bobdey	Rest of England	19/02/2016	26/01/2017	0 (6)
Dr Martin Combs	York	23/03/2016	30/06/2018	6
Dr Peter Harrison	York	23/03/2016	30/06/2018	5
Nathaniel Drake	York	23/03/2016	30/06/2018	0 (4)

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

Staff Governors (Elected)

Name	**Constituency**	**Term of office From**	**To**	**Total Attended**
Dr Judith Hurst	Corporate	01/07/2014	30/06/2017	5
Simon Hughes	Teesside	01/07/2014	30/06/2017	7
Wendy Pedley	North Yorkshire	10/10/2014	30/06/2017	1 (2)
Jacqui Dyson	County Durham and Darlington	10/10/2014	15/08/2016	1 (1)
Glenda Goodwin	Forensic	10/10/2014	30/06/2017	7
Gary Matfin	York and Selby	09/02/2016	30/06/2018	6

*(*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	Term of office From	To	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	31/10/2016	3 (5)
Lisa Pope	Hambleton, Richmondshire and Whitby Clinical Commissioning Group / Scarborough and Ryedale Clinical Commissioning Group / Harrogate Clinical Commissioning Group / Vale of York Commissioning Group	01/11/2016	-	0 (2)
Dr John Drury	Hartlepool and Stockton-on-Tees Clinical Commissioning Group / NHS South Tees Clinical Commissioning Group	01/07/2014	-	2
Dr David Smart	North Durham Clinical Commissioning Group / Durham Dales, Easington and Sedgefield Clinical Commissioning Group / Darlington Clinical Commissioning Group	25/09/2014	-	3
Marion Grieves	University of Teesside	29/04/2015	-	3
Prof Pali Hungin	Durham University	01/07/2014	-	2
Richenda Broad	Middlesbrough Council	16/10/2014	30/09/2016	0 (1)
Cllr Ann McCoy	Stockton Borough Council	08/07/2014	-	6
Cllr Stephen Akers-Belcher	Hartlepool Borough Council	15/08/2014	24/05/2016	0 (1)
Kevin Kelly	Darlington Borough Council	13/08/2015	-	0
Lesley Jeavons	Durham County Council	01/07/2014	16/12/2016	1 (6)
Lee Alexander	Durham County Council	30/01/2017	-	0 (1)
Cllr Helen Swiers	North Yorkshire County Council	24/05/2016	-	6 (6)
Prof Ian Watt	The University of York	01/07/2014	26/01/2017	0 (6)
Prof Angela Simpson	The University of York	27/01/2017	-	0 (1)
Cllr Ashley Mason	York City Council	28/06/2016	-	0 (6)
Helen Douglas	York City Council	29/03/2016	23/05/2016	0 (1)

(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 document is available for inspection on our website.

Elections held during 2016/17

Constituency Name	Date of Election	No of Seats	No. of candidates	No. of Votes cast	No. of eligible voters	Turnout (%)
Durham	29/06/2016	5	8	176	1877	9
Harrogate and Wetherby	29/06/2016	3	3	-	-	-
Hartlepool	29/06/2016	1	1	-	-	-
Middlesbrough	29/06/2016	1	3	92	1129	8
Redcar and Cleveland	29/06/2016	1	1	-	-	-

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.

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.

During the year the committee:

- Considered applications received for appointment as a non-executive director of the Trust.
- Received assurance on the conduct and outcomes of the appraisals of the Chairman and non-executive directors.
- Recommended Mrs. Bessant's re-appointment as the Chairman of the Trust to the Council of Governors.
- Developed a policy and procedure for the management of complaints alleging misconduct by the Chairman and non-executive directors.

The membership of the committee, and attendance at its two meetings during 2016/17, was as follows:

Lesley Bessant	Chairman of the Trust	2
Marcus Hawthorn	Senior Independent Director	1 (1)
Betty Gibson	Public Governor	0 (2)
Sandy Taylor	Public Governor	1 (1)
Colin Wilkie	Public Governor	2
Mary Booth	Public Governor	1 (1)
Dr. Judith Hurst	Staff Governor	2

(The maximum number of meetings to be attended by members of the committee during the year is shown in brackets)

Advice and services were provided to the committee by Phil Bellas, Trust Secretary.

The committee also received advice and support from Dixon Walter Ltd in relation to the recruitment of two non-executive directors.

Training and Development

The Trust has a duty under National Health Service Act 2006 to ensure that governors are equipped with the skills and knowledge they require to undertake their role.

To meet this requirement the Council of Governors has agreed a training and development programme based on the national "Governwell" programme and local opportunities including four governor development days per year.

The programme is reviewed annually.

Assurance on the effectiveness of these arrangements is sought through the annual performance evaluation of the Council of Governors. Of those governors responding to the survey:

- 83% of governors appointed in the last 18 months considered that the Trust provided an adequate induction programme
- 88% agreed that relevant training was provided on an ongoing and timely basis and appropriate briefings were provided in relation to key topics being discussed.
- 88% considered that the governor development days and ad hoc briefings had assisted them develop their wider knowledge and understanding of their role and the Trust.

Governor participation in the development of the Operational and Business Plan

Governors, as representatives of the members of the Trust and the public, have a key role in the development of our operational/business plan through the business planning framework.

In 2016/17 the Council of Governors:
- held a workshop to support the identification of future priorities, the outcome of which was presented to the Board at its annual business planning event in October.
- considered and provided comments on the draft business plan during the course of its development

These arrangements enabled governors to engage with their members and partner organisations at key stages during the preparation of the operational/business plan.

Of those governors responding to the annual performance evaluation, 72% agreed with the statement that the Council of Governors was successful in influencing the Trust's business plan/strategy.

Further information on the involvement and engagement with members is provided in the Membership Report.

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 31st March 2017 the Trust's membership was as follows:
- Public members – 9,236
- Staff members – 6,482

The following table 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	46	370,890
17-21	728	122,684
22+	7,963	1,475,581
Ethnicity:		
White	8,433	1,866,509
Mixed	51	17,281
Asian or Asian British	153	40,009
Black or Black British	55	7,824
Other	15	5,407
Socio-economic groupings*:		
AB	2,040	114,195
C1	2,544	173,962
C2	2.088	134,131
DE	2,508	173,618
Gender:		
Male	3,172	966,883
Female	6,026	1,002,269

(Note: The above analysis excludes:
- 499 members who did not provide their dates of birth
- 523 members who did not state their ethnicity
- 38 members who did not state their gender).

Member engagement

The focus of the Trust is to grow a representative membership to ensure accountability through engaging with its members.

A range of activities and actions have been taken to support member engagement:

- Choice of level of membership (support, informed, active and involved member) to better align the aspirations of members against the types of engagement available within the Trust.
- Successful amalgamation of the patient and public involvement team and those staff responsible for membership in order that a better, more coordinated appropriate signposting and discussions are held with the public about the range of involvement and engagement available.
- Development of a handbook for service and carers to inform them about involvement activities.

Over the last 12 months specific engagement with the membership of the Trust has included:
- Welcome packs issued to every new public member with a unique membership card and number, welcome letters and details of staff governors issued to all new staff members.

- Issue of the insight magazine to all members signed up as an informed member and above which includes articles written by governors and service users and carers within the members' page.
- Personal invitations to attend member engagement events held in County Durham and Darlington, Teesside, and Hambleton and Richmondshire.
- Communications and drop in events to support the awareness of governor elections.
- Annual General and Members' Meeting
- Website forum and increased use of social media
- A number of social / community events attended such as Durham Pride, World Mental Health Day events in Redcar, Hartlepool and Harrogate
- Attendance at College Fresher and wellbeing days.
- Consultation on the business plan priorities including seeking views of the public and formal consultation with the Council of Governors to enable them to engage with their membership.
- Invitations to formal public consultations held within York and Selby on the provision of inpatient services.

All involvement and engagement activity is monitored through the Council of Governors Involvement and Engagement Committee.

The Council of Governors approved recommendations from its Task and finish Groups on:
- Holding the non-executive directors to account for the performance of the Board of Directors
- Member and stakeholder engagement and representation

Governors have also established of a new task and finish group review involvement which is due to report in early 2018/19.

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.ftmemberhsip@nhs.et or visit our website www.tewv.nhs.uk

Please also use these contact details if you would like to become a member.

NHS Improvement's Single Oversight Framework

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

The Single Oversight Framework applied from Quarter 3 of 2016/17. Prior to this, Monitor's *Risk Assessment Framework* (RAF) was in place. Information for the prior year and first two quarters relating to the RAF has not been presented as the basis of accountability was different. This is in line with NHS Improvement's guidance for annual reports.

NHS Improvement has placed the Trust in segment 1 (maximum autonomy).

This segmentation information is the Trust's position as at 31st March 2017. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the trust disclosed above might not be the same as the overall finance score here.

Area	**Metric**	**2016/17 Q3 score**	**2016/17 Q4 score**
Financial sustainability	Capital service capacity	2	2
	Liquidity	1	1
Financial efficiency	I&E margin	1	1
Financial controls	Distance from financial plan	1	1
	Agency spend	1	1
Overall scoring		**1**	**1**

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 NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require 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 required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of [name] 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 Department of Health Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by ***NHS Improvement***, 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* **(*and the Department of Health Group Accounting Manual*)** have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance and
- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Colin Martin
Chief Executive **23rd May 2017**

Annual Governance Statement 2016/17

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 2017 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.

Oversight and assurance to the Board on the operation of the Trust's risk management arrangements (both clinical and non-clinical) are provided by the Audit Committee. The Quality Assurance Committee also approves the clinical audit programme and monitors its delivery. The terms of reference of these committees ensures that there is a co-ordinated and complementary approach to risk management.

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; NHS Litigation Authority (NHSLA), Care Quality Commission (CQC), 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.
- The development of an action plan to further strengthen risk management and Board Assurance Framework processes as outlined in the Head of Audit Opinion.

Public stakeholders are involved in identifying risks and providing assurance that they are mitigated 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 2017 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 Cash Releasing Efficiency Savings (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.

Plans are also in place to further develop the Trust's I.T. systems to support the organisation's objectives (including data quality, the implementation of mental health currencies including quality and outcome measures) and the Trust's approach to managing counter fraud.

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 its controls are operating effectively and that its action plans to strengthen controls are successfully implemented. To do this the Trust uses information received from other organisations which is timely, accurate and recorded. . This supports robust governance processes that provide assurance that the Trust is compliant with the provisions of the licence

The Trust is committed to meeting the requirements of the Department of Health's Information Governance Assurance Programme. An overall score of 88% was achieved against the Information Governance Toolkit in 2016/17 with all sequences achieving, at least, level 2 compliance. The Director of Finance and Information is the senior information risk owner (SIRO) at Board level. The Trust operates a SIRO network (information asset owners and administrators), which has increased Information Governance awareness, training and understanding of standards. The network is supported by an Information Governance Campaign to delivery of these activities.

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 foundation trust is fully compliant with the registration requirements of the Care Quality Commission.

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

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

The foundation trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that 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 CRES
- Agreeing the integrated Business Plan, Quality Report and Self Certification submitted to NHS Improvement.
- Considering plans for all major capital investment and disinvestment

The Trust's Audit Committee has a key role on behalf of the Board in reviewing assurance through its audit programme on the effective use of resources. The Trust also gains assurance from:

- Internal audit reports, including review of CRES
- External audit reports on specific areas of interest
- The Care Quality Commission reports

Information Governance

There were four incidents reported on the Information Governance Toolkit during this period of which all were responded to by the Information Commissioner's Office (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. NHS Improvement (in exercise of the powers conferred on 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, the 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 governance issues including reviewing commenting on the clinical audit 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 good 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 2016/17, 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 **23rd May 2017**

Quality Report
(subject to independent review)

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 Account for 2016/17. This is the 9th Quality Account we have produced and it tells you what we have done to improve the quality of our services in 2016/17 and how we intend to make further improvements in 2017/18.

TEWV primarily serves the populations of:

- County Durham;
- Darlington;
- North Yorkshire (not including Craven district);
- Selby;
- Teesside (the boroughs of Hartlepool, Middlesbrough, Redcar & Cleveland and Stockton);
- Wetherby town;
- York.

Our specialist services such as Child and Adolescent Mental Health Services (CAMHS) inpatient wards, Adult Eating Disorder wards and Forensic Secure Adult wards serve patients from elsewhere in the North East, Cumbria, Yorkshire and the Humber and further afield.

The improvement priorities and metrics in this plan apply to the whole of the area served by TEWV.

Our Mission, Vision & Strategy

The purpose of the Trust is:

'To minimise the impact that mental illness or a learning disability has on peoples' 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** 2017-2020. This outlines our quality vision for the future, which is that:

- We will provide care which is patient, carer and staff co-produced, recovery-focused and meets agreed expectations.
- We will provide care which is sensitive to the distress and needs of patients, carers and staff. Staff will respond with kind, intelligent and wise action to enable the person to flourish.
- Care will be flexible and proactive to clinical need and provided by skilled and compassionate staff with the time to care.
- Care will be consistent with best practice, delivered efficiently and where possible, integrated with the other agencies with whom we work.
- We will support staff to deliver high-quality care and will provide therapeutic environments which maintain safety and dignity.

The Quality Strategy contains 3 Goals which are:

- Patients, carers and staff will feel listened to and heard, engaged and empowered and treated with kindness, respect and dignity.
- We will enhance safety and minimise harm.
- We will support people to achieve personal recovery as reported by patients, carers and clinicians.

TEWV's 2016 Community Mental Health Survey *results.*

There were 4 questions the Trust scored better than most other Trusts, these were:

- Were you given enough time to discuss your needs and treatments?
- Were you involved as much as you wanted to be in agreeing what care you will receive?
- Were you involved as much as you wanted to be in decisions about which medicines you receive?
- Were you given information about new medicines(s) in a way that you were able to understand?

The section with the lowest overall scores for TEWV was in relation to the support and wellbeing section, particularly in relation to the following questions:

- 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.

Each Goal has high-level measures which the Trust will monitor for assurance that the Trust's vision for quality is being delivered. These measures will be scrutinised by our Quality Assurance Committee and Board (QuAC). In addition, we have identified a number of supporting actions, established and new, which will each be monitored.

What we have achieved in 2016/17

- 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:
  - Re-established Adult Mental Health (AMH) beds in York following the closure of Bootham Park Hospital (prior to TEWV commencing as the main provider in York in October 2015). A temporary 24 bed facility, Peppermill Court opened in October 2016. Our plan is to develop a new, fit-for-purpose adult and older people's mental health hospital within York. During 2016/17 we assisted the

Vale of York Clinical Commissioning Group (CCG) to carry out a significant engagment programme on the future of mental health inpatient services in York.

- Brought together all of our Middlesbrough adult community mental health teams into one new, purpose built location (Parkside) which offers an improved patient experience.
- Introduced an option for children and their parents to choose a telephone referral rather than face to face referral in our Durham and Darlington CAMHS service. This has proved very popular and has also helped us to reduce waiting times.
- Been chosen by NHS England as one of two national pilots where providers manage how specialist CAMHS budgets are spent. This went live on 1st April 2017 This will mean that more children will be able to receive care close to their home.

In the 2016 national NHS Staff Survey, the Trust had a response rate of 49% (2891 of 5952 eligible staff), the average response rate for Mental Health and Learning Disability Trusts.

The Trust scored better than average on **22** of the **32** areas covered by the staff survey, **4** of which were the best score for Mental Health.

- Developed a multidisciplinary physical health team that works within our Forensic Secure Adult wards at Roseberry Park which includes doctors, nurses and physiotherapy. This has enabled delivery of general primary care initiatives including national screening programmes, vaccination programmes and long term condition management.
- Developed and delivered nurse education programmes which focused specifically on improving the skill set in relation to providing physical health care to patients in our Forensic Secure Adult wards (many of whom will be a resident on our secure wards for several years).

- We have also worked to improve our quality through staff training and, communication. For example we have:
  - Revised our processes for reviewing action plans from serious incidents to ensure a greater focus is placed upon ensuring key findings are acted upon and lessons are learnt across the organisation. This improved process will also be adopted for complaints during 2017/18.
  - Completed a review of the current harm minimisation and risk management practice across the Trust which included the development of harm minimisation principles which are reflected in the new policy. This work is built upon a recovery-orientated approach to clinical risk assessment and management and we have employed 3 Experts by Experience to co-produce and co-deliver face to face harm minimisation training to clinical staff.
  - Established a Trustwide workstream which aims to respond to the recent National Quality Board 2016 Safe Staffing guidance and supplementary publications. This work is to be expanded as part of next year's Business Plan and is included within this Quality Account as one of its five priorities for 2017/18.

- In addition we have worked with our partners to improve services. For example we have:
  - Worked with James Cook Universtiy Hospital (JCUH) to develop a joint Parkinsons pathway.

- Worked with the Police, Acute Hospitals and others to address the issues which led some individuals to be “frequent attenders” in urgent care settings.
- Created “York Connects” – a grant resource for voluntary sector organisations to bid for that facilitates innovative, community level action to suppport mental illness prevention and recovery.
- Continued with work with Northumberland, Tyne and Wear NHS Foundation Trust (NTW) to improve the service offered to Adult Eating Disorders inpatients by making full use of our collective expertese.
- Involved a large number of Adult Learning Disabilities (ALD) patients, family members and carers in a co-production event aimed at advancing the use of Philosophies of Care across the Trust’s ALD services. The group has agreed two outcomes:
  - ‘Supporting people to live a life that makes their heart smile, in an individual way that is safe and flexible’ and;
  - ‘To provide the Right support, at the Right time, in the Right place, by the Right people, that leads to a meaningful, healthy and purposeful life.

  Work will now take place on delivering these outcomes.
- Improved the physical health care provision for patients treated in the Forensic Adult Secure wards at Rosebery Park by working with JCUH to bring their clinicians inside our secure perimeter. This includes holding a consultant led endocrinology clinic within Ridgeway every 6 months in addition to arranging individual assessments on site where appropriate. We have also developed and implemented a referral pathway to JCUH specialities.
- Held a co-production event to develop the Secure Outreach and Transitions Team. A carer co-facilitated this event.
- Worked with a large multi-disiplinary and multi-agency team from across the 7 prisons in North East England to hold a two day service improvement event – the outputs will improve transitions for the patient between each prison establishment or TEWV service (if appropriate).

Our Staff *Friends and Family Test (FFT)* results include:

- 81% are likely or highly likely to recommend treatment at TEWV.
- 72% would recommend TEWV as a place to work.
- 82% agree that they are able to make suggestions for improvement.

- 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 2016/17 are that we have:
  - Refreshed our Purposeful Inpatient Admission (PIPA) approach with patients to ensure that physical health care and other recent clinical developments are fully embedded into our day-to-day inpatient processes.
  - Redesigned crisis services in North Yorkshire so that they meet the needs of people of all ages.
  - Introduced new ways to manage the workload of our community teams more effectively, so that servics users get the treatment they need more quickly and more consistently than previously.
  - Simplified many of our clinical pathways (our guidance about the steps that take place during a course of community treatment).
  - Developed a new Mental Health Services for Older People (MHSOP) Functional Care pathway. This has been tested and is now being rolled out Trustwide. It provides a clear pathway of care for people with functional disorders (i.e. depression / psychosis). The pathway also includes clear guidance for physical health monitoring.
  - Developed four Clinical Link Pathways (CLiPs) – for Community Mental Health Teams (CMHTs), acute hospital liaison, care home liaison and inpatient services. These CLiPS are based on National Institute for Clinical Excellence (NICE) guidance and have been informed by the positive and safe programme.
  - Piloted and rolled-out a Positive Behaviour Support Pathway of Care in our Forensic Secure Adult wards and the Secure Outreach and Transitions Team.
  - Held a quality improvement event in December 2016 to develop a formal process between AMH and ALD / Forensic Learning Disability (FLD) services in relation to the AMH acute care pathway. The event involved staff from AMH, ALD and FLD services who developed standard work on collaborative working across the specialties to ensure appropriate timely responses for all patients accessing AMH acute services. The group had identified the need for all patients who could potentially access AMH services to have a robust crisis plan in place to ensure appropriate assessment and intervention at the point of crisis. A template for these plans was developed during the week. The teams were challenged to conduct a retrospective review of caseloads and ensure all identified patients had a robust crisis plan in place. This work is now well on the way to completion.

In 2016/17 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**
Positive Practice in Mental Health awards 2016	Mental Wellbeing of Staff	Staff Mindfulness Service
	The MINDset Quality Improvement Award	TEWV Quality Improvement System (QIS) teams in Hartlepool and Stockton
NHS Innovations North Bright Ideas in Health awards 2016	Service Improvement	The Recovery Focused Care Transfer (ReFleCT) service
Royal College of Psychiatry annual awards	Psychiatric Team of the Year – older age adults	The North Tees liaison psychiatry team part of a wider generic liaison team delivering care to patients presenting at the University Hospital of North Tees in Stockton
	Psychiatric Communicator of the Year	Dr Paul Blenkiron, consultant psychiatrist, AMH services, York
	Patient / Patient Contributor of the year	TEWV Experts by Experience Group
North East NHS Leadership Recognition awards 2016	Emerging leader	Thomas Hurst, ward manager, Overdale ward, Roseberry Park, Middlesbrough
	Inspirational leader	Mani Krishnan, consultant psychiatrist, MHSOP, Teesside
	Inclusive leader	Lisa Taylor, head of service, offender health
Northern Lights Awards Quality Improvement awards 2017	Delirium	Stockton team 'spot it, stop it' (TEWV, Stockton Borough Council and Stockton CCG)
UK Parkinson's Excellence Network Awards 2017	For their work in addressing complex symptoms of Parkinson's	Parkinson's Advanced Symptoms Unit (collaboration between South Tees NHS Trust and Tees, Esk and Wear Mental Health Trust)
National Autistic Society – professionalism in autism	Outstanding healthcare professional	Dr Helen Pearce, consultant psychiatrist, LD forensics, Roseberry Park, Middlesbrough
NHS England FFT awards (**Highly Commended**)	Best FFT Initiative in Other NHS Funder Services	Patient and carer experience team

Awards where TEWV or one of its teams / staff were shortlisted for an award but did not win that award in 2016/17 were:

Awarding Body	**Name / Category of Award**	**Team / individual**
Royal College of Nursing Nurse awards 2017 **(winners to be announced 05/05/2017)**	Mental health practice award	Matty Caine, mental health team manager, Integrated Mental Health Team, Her Majesty's Young Offenders Institute (HMP YOI) Low Newton, Durham
British Medical Journal (BMJ) 2017 **(winners to be announced 04/05/2017)**	Prevention Team	Suicide Prevention Training
Health Service Journal (HSJ) Value in Healthcare awards **(winners to be announced in May 2017)**	Improving the value of NHS support services	Workforce Development Team
Northern Lights Awards Quality Improvement awards 2017	Delirium	Health Education North East England (HENEE) for *icanpreventdelirium*
Patient Experience Network National awards (PENNA)	FFT and Patient Insight for Improvement	Kerry Jones, human resources manager
Patient Safety awards	Board Leadership	TEWV
	Best Organisation	TEWV
	Patient Safety in Mental Health	Force Reduction Team
		Physical Health Project Team
		Parkinson's Advanced Symptom Unit (PASU) (Parkinson's Unit – joint collaboration)
Health Service Journal (HSJ) awards	Provider of the Year	TEWV
Ripon Civic Society awards	Environment	The Orchards, Ripon
North East NHS Leadership Recognition awards 2016	Team outstanding achievement	Kaizen Promotion Office (KPO)
Royal College of Midwifery Annual awards	Slimming world partnership working	Psychological therapies (IAPT) team
The National Autistic Society – Autism Professional Awards 2017	Outstanding health services	Northdale Centre, Ridgeway, Roseberry Park, Middlesbrough
Student Nursing Times Awards 2016	Mentor of the year	Claire Baird, clinical nurse specialist, Child Learning Disabilities Service, Stockton

Structure of this Quality Account document

The structure of this Quality Account is in accordance with guidance that has been published by both the Department of Health and the Foundation Trust regulator, NHS Improvement and contains the following information:

- **Part 2** – Information on how we have improved in the areas of quality we identified as important for 2016/17, the required statements of assurance from the Board and our priorities for improvement in 2017/18.
- **Part 3** – Further information on how we have performed in 2016/17 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 Account is included in **appendix 1**. This is further supported by the signed limited assurance report provided by our external auditors on the content of the 2016/17 Quality Account which is included in **appendix 2**.

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 Account 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.

Mr. Colin Martin
Chief Executive
Tees, Esk and Wear Valleys NHS Foundation Trust

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

Update on 2015/16 quality priorities

In last year's Quality Account we reported on our progress with our quality priorities for 2015/16. Within this we also noted some further actions for 2016/17. In some cases, these actions were to be included within the quality priorities for 2016/17, and therefore, are reported within this Quality Account. In other cases, these quality priorities were discontinued in the Quality Account 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 Account priorities for 2016/17.

Expand the use of Positive Behavioural Support (PBS) in our Learning Disabilities Services	PBS awareness training has continued to be rolled out along with other key intensive training programmes. In addition to this, there have been staff trained in Person Centre Active Support (PCAS) which is a methodology that supports the PBS approach. The PBS pathway has been reviewed, and as a result of the review it was included as a CLiP to the new Learning Disabilities Core Pathway and continues to be promoted across all services. The Trust is in the process of recruiting an Associate Nurse Consultant for Learning Disabilities who will lead the continued roll out of PBS across all Adult Learning Disability services, expanding this further in the future.
Implementation of age appropriate risk assessments and care plans for CYPS	The revised age appropriate risk assessment for the CYPS service has now been embedded within the service. It is accessible on the Paris system (our electronic patient record) for all staff to use. Training has been completed across the whole service for use of the revised risk assessment. The age appropriate care plan has been developed to become the 'My Passport' and is child / young person focused. It was planned for this to be available on the Paris system for use across the CYPS service. A recent review of all Trust care plans across all services has delayed the My Passport from being uploaded to Paris – the paper version will continue to be filled in until the upload has been completed. The service will continue to liaise with the Paris team to ensure delays are kept to a minimum.

2016/17 Priorities for improvement – how did we do

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

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 patients.

Priority 1: Continue to develop and implement Recovery focused services

Why this is important:

Patients 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 has been 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 remained a key priority for 2016/17.

The benefits / outcomes we aimed to deliver were:

- The care patients receive would be designed to support and achieve their own personal goals.
- Patients and their carers would feel really listened to and heard.
- Patients and their carer's views and personal expertise by experience would be valued.
- Patients would feel supported to take charge of their lives, promoting choice and self-management.

- Our staff would work in partnership with patients and their carers at every level of service delivery; genuinely believing that patients will benefit from an improved quality of life and this would be reflected in care plans.

What we did in 2016/17:

The following is a summary of the key actions we have completed in 2016/17:

What we said we would do	What we did
• 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.	The central Recovery Programme team and the Harm Minimisation project team have worked in close partnership throughout the year to both review and set up a new Harm Minimisation Policy and to ensure that recovery and wellbeing values and principles have been embedded within both the face to face and e-learning training packages. The process has followed a co-production approach with individuals with lived experience co-designing the training packages throughout.
• Expand Peer involvement within the Trust, having 6 new peer roles by Q3 2016/17.	We have worked to expand both paid and unpaid lived experience roles during this financial year. This has included employing 3 paid Expert Trainers as part of the Harm Minimisation project, 1 Peer within the Outcomes teams and a further Peer Trainer to work within the development of the Recovery College Online. We have also registered 24 Involvement Peers with 20 new Involvement Peer roles being commenced. Throughout expanding developments we have identified that our Involvement Peer handbook can be enhanced. We are currently in the process of reviewing this. We have also identified, that not all Involvement Peers that initially register go on to actively engage in a role. This is for a variety of reasons such as moving into paid work, deciding this is not the right time for them to engage in this role and/or service changes. Evaluations of Peer roles both paid and unpaid indicate that they are highly valued by both staff and patients.
• Continue to implement Phase 1 of the Recovery Project with an interim evaluation report presented to the Executive Management team (EMT) providing an update on progress to date by Q3 2016/17.	In August 2016 we implemented a process to review both the Phase 1 Recovery and Wellbeing Strategy and the Recovery Programme business case. As part of the development of a new 2017- 2020 Recovery and Wellbeing strategy we completed an interim evaluation of Phase 1 achievements and this was submitted to the Board of Directors in January 2017. We have achieved the majority of our targets and actions that were set out in the initial strategy. The interim summary evaluation is available within the appendix of our new Recovery and Wellbeing strategy.

• Develop a business case for Phase 2 of the Recovery project and submit for approval by Q3 2016/17.	A new 3 year Recovery and Wellbeing Strategy and Business Case for Recovery and Wellbeing was developed. A Business Case was submitted and approved in November 2016.
• Deliver Recovery training to 84% of new Trust staff as part of their induction by Q4 2016/17.	We have delivered a recovery training slot at every Trust induction during 2016/17. This has been delivered by our Experts by Experience group. 100% of new staff to the Trust have therefore received an introduction to recovery principles as part of their induction process, including the opportunity to hear from individuals who have accessed services and the elements of support that can support or hinder recovery. This has always been rated the most highly of all of the induction training slots.
• Develop and consolidate the Experts by Experience group ensuring their input into key Trust developments by Q4 2016/17.	We have continued to consolidate and develop the adult services Expert by Experience group securing their input into a broader range of training and service developments. They now have input into higher level strategic developments and into the Trust business planning process. We now have lived experience positions on the Recovery Programme Board. The group were nominated and won the Royal College of Psychiatrist award for patient involvement for 2016 and received this award in November. One significant challenge over the year, has been the increasing demand for Expert by Experience input into service developments and availability to meet this demand.
• Design and establish the Virtual Recovery College so that it available to access by Q4 2016/17.	The Virtual Recovery College has now been renamed Recovery College Online. The Recovery College Online site has now been built with 28 self-management pages, 1 full course and a number of other courses in development. The Recovery College Online was launched on the 23rd March 2017. We have secured recurring funding to provide an ongoing service. Recovery College Online now has an Operational Manager and one Peer Trainer working to progress this development. A further Peer Trainer has been recruited and will commence in post early 2017/18.
• Complete implementation of Phase 1 of the Recovery project with a final evaluation report presented to the Executive Management Team by Q1 2017/18.	We completed the implementation of Phase 1 of the Recovery Project in March 2017. A final evaluation report will be presented to EMT and the Recovery Programme Board in June 2017.

• If approved, implement Phase 2 of the Recovery project in line with agreed project plan.	Since approval of Phase 2 we have been developing actions plans and team structures to ensure we are in a position to implement Phase 2 of the recovery project going forward.

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
• Percentage of new Trust staff receiving recovery training as part of their Trust induction.	84%	100%	Q4 2016/17
• To introduce new lived experience/ peer roles into the organisation.	6	25	Q4 2016/17
• Number of self-management pages available on Virtual Recovery College.	30	28	Q4 2016/17
• Number of new opportunities* for individuals with lived experience to take part in service development / improvement initiatives.	30	74	Q4 2016/17

*This relates to the total number of opportunities and includes repeated training slots at different times.

What we plan to do in 2017/18:

This will continue to be an improvement priority for us. Our plans for 2017/18 are set out in **Part 2, 2017/18 Priorities for Improvement section**.

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 patients 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)[1] 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*".

[1] http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_076512.pdf

The Royal College of Psychiatrist's (2013) response to the Francis Report [2]states that, "*we must take complaints more seriously and challenge risk-averse culture*" and acknowledges that assessment "*must at all times involve the patient as fully as possible, weighing risk with input from all those who need to be involved, and putting in place a plan which respects individual autonomy as much as possible, with the understanding that therapeutic risk must be balanced against restrictions putting patients first involves both minimising harm and risk balanced against undue restrictions to individual autonomy*".

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 patients 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 was 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 patients' needs, while recognising everyone's responsibilities – patients, 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 patient rather than risk averse practice which may be detrimental to the patients recovery and rehabilitation.

The benefits / outcomes we aimed to deliver:

- 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 patients, 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 (priority 1).

[2] Royal College of Psychiatrists (2013) *Driving quality implementation in the context of the Francis report.* Occasional Paper OP92. London: Royal College of Psychiatrists.

What we did in 2016/17:

What we said we would do	What we did
• Complete a review of the current Harm Minimisation and Risk Management practice across the Trust by Q1 2016/17	Information was collected directly from services regarding which risk tools they were using, including any that related to engagement and observation. In addition to this we also collected information from other Trusts (e.g. Northumberland Tyne & Wear NHS Foundation Trust). Furthermore, we collected best practice research regarding recovery and harm minimisation principles. An internally completed review identified that there are a number of bespoke 'approved' Risk Assessment tools in use across Trust services. Evidence from audit and post incident investigations suggested that it is often the case that there is minimal inputting into these tools and that a 'ticking the box' culture has evolved. Additionally there was evidence of 'cutting and pasting' from previous assessments when risk assessments are updated, all of which is suggestive of a defensive and risk averse approach.
• Develop and agree Harm Minimisation principles including engagement guidelines by Q1 2016/17	We used the information gleaned from the review to inform the development of a new Recovery Orientated Harm Minimisation Policy and also a new Supportive Engagement and Observation Procedure which are based on 7 agreed principles. Development days were held with representatives from all specialities as well as Experts by Experience to draft the Policy and Procedure. The documents were then finalised by the Harm Minimisation Steering Group and Recovery Project Team, including Experts by Experience, before going out for 6 week Trust wide consultation. The 7 main principles agreed are: 1.Our aim is to promote recovery; 2 Collaborative working and shared decision making; 3 Achieving a shared understanding; 4 Positive care planning; 5 Open and clear communication; 6 Timely reviews; 7 Support and training.
• Develop and complete Harm Minimisation training materials and training plan which will include a Recovery focused approach by Q2 2016/17	We used the information from the review and the Policy & Procedure development to inform the training. A 4 day workshop event was held 31st May to 3rd June 2016 to develop the face to face training programme. Attendees represented all clinical specialities as well as the following projects/teams: Harm Minimisation, Force Reduction, Recovery, PARIS, Management of Violence and Aggression, Workforce Development, Experts by Experience, Shared Decision Making, Medicines Management, and Equality & Diversity. The 4 day workshop produced the outline of the training with workgroups set up to finalise the detail. The Harm Minimisation Steering Group then drafted the training which was approved via the Steering group and the Recovery Programme Board. Regular updates were also given to the QuAC.

• Commence face to face training which includes Expert by Experience input / delivery by Q2 2016/17	Face to face training commenced on Friday 22nd July 2016. The training was available for booking places both via the Education Department and also by managers requesting team training to be delivered within the workplace. We employed three Experts by Experience trainers to co-produce and co-deliver the training. From April 2017 the updated e-learning training will be available which is the mandatory component to be completed by all clinical staff every 2 years.
• Develop an e-learning package which will include a competency framework by Q3 2016/17	In order to ensure expertise at producing a professional and interactive training module, we identified two IT trainers from NHS North of England Commissioning Support Unit to develop the e-learning package. The training will be in 3 parts with parts 1 and 2 forming the mandatory component of the training: • Part 1 – core training for all staff covering the principles of recovery orientated harm minimisation; • Part 2 – briefings (e.g. Trust process to follow when informal patients going on unescorted leave or national NCISH 20 year review); • Part 3 – speciality based training. Parts 1 and 2 of the e-learning packages were co-developed with Experts by Experience. The material for all 3 parts are currently with the developers with the aim of launching the mandatory element of the 1st May 2017.
• Have sufficient staff trained in priority areas by Q4 2016/17.	From the 22nd July 2016 to the end March 2017 we trained 42% of all clinical staff which equates to 2044 members of staff. Of these 713 attended training directly delivered to teams. The teams and members of staff trained via centrally booking with the training department are from a range of teams including inpatient and community as well as a range of disciplines including nursing, medics and allied health professionals. The main delay impacting staff training has been due to the demand on clinical staff stopping them from being able to be released for training. Additional funding has been made available for the training to continue into 2017/18 which aims to ensure the target of 65% of staff trained is achieved.
• Evaluate the project and develop options for future delivery by Q4 2016/17.	A report was completed which included the findings from the training participant's evaluation forms, this informed the Trusts project evaluation form.

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	Timescales
• 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	42%	Q4 2016/17
• Set of outcome measures to be developed in conjunction with Experts by Experience/patients/carers.	We have developed an audit tool which collects quantitative and qualitative data. We have also ensured that the e-learning training enables learners to complete and print off reflective learning points which can be used for supervision/appraisal and re-validation.		Q2 2016/17
• A measured increase in the number of current risk assessments which show evidence of formulation and a narrative from baseline. • 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. • An increase in the number of personal risk and safety plans that demonstrate co-production with patients, their families and/or carers.	Completed a baseline audit in January / February 2017 as the new PARIS documentation did not become 'live' until end October 2016. Therefore any changes in practice will be captured within the January / February 2018 re-audit and reported to the Recovery Programme Board.		Q4 2016/17 Q4 2016/17 Q4 2016/17

What we plan to do in 2017/18:

The project closed at the end of March 2017. From April 2017 harm minimisation has been encompassed within implementation of Phase 2 of our Recovery Strategy and outcomes will be reported via the Recovery Programme Board. The face to face training has been funded for a further year to enable the cultural transition to a recovery orientated approach to harm minimisation. The Recovery Programme Board will develop and monitor a scorecard which identifies outcome measures for the coming year.

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

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 was to embed the work completed to date (within inpatient services and with staff) whilst implementing the smokefree agenda 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 benefit from improved physical health in the long term.

The benefits / outcomes we aimed to deliver:

- 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 did in 2016/17:

What we said we would do	What we did
• Develop a communication plan for the prison services by Q1 2016/17.	A national prisons communications plan was identified to support the prisons when developing voluntary smokefree areas. This was also made available to support those early adopter prisons who have already gone fully smokefree within 2016/17.
• Further embed the Trusts 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.	The Nicotine Management team continued to support the embedding of the smokefree policy within inpatient services/sites. Work took place to support the identification of quantities of nicotine replacement products issued Trustwide. This data was made available each month and a full yearly report will indicate the costings prior to going smokefree and costs one year post smokefree. Recent data shows that by going smokefree, it has increased the amount spent on nicotine replacement products fourfold compared to the amount spent prior to going smokefree.

• Further embed the Trusts 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.	Regular monthly reviews of staff trained within each directorate took place throughout 2016, allowing the Nicotine Management team the opportunity to increase availability of training within areas where staff trained in nicotine management levels have decreased. The development of a training database captured accurate information and bespoke training sessions were made available Trustwide. A new level of training (Brief Intervention) was developed in 2016 and is now regularly available for staff to access.
• 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.	Several sites were identified Trustwide who requested additional support. The Nicotine Management team were able to provide additional training sessions and supported the development of action plans to further embed and implement the Nicotine Management Policy.
• Nicotine management policy and information leaflets developed for prison services by Q3 2016/17.	All North of England Prison services developed or updated smokefree prisons policies which are available for staff and residents to access. Residents supported the development of information leaflets alongside the National Offender Management Services posters and literature which was also available.
• Medication options identified inclusive of the use of disposable e-cigarettes for prison services by Q3 2016/17.	National approval was given for four Nicotine Replacement products to be made available within all prison estates. Alongside these, several models of disposable e-cigarettes were identified and made available to purchase from canteen lists within each prison estate. Current work is ongoing to look at the possibility to access rechargeable e-cigarettes within the prison services to provide greater choice for residents.
• Continue to monitor the implementation plan developed to support staff to stop smoking by Q3 2016/17.	Work continues to regularly monitor the implementation plan which supports staff to stop smoking. Links continue with community stop smoking services to ensure support and free products are available for staff within the North Yorkshire areas. Lloyds Pharmacy continues to support staff in Durham and Teesside who wish to stop smoking. The FFT in 2015 indicated that 10% of staff identified as smokers. The FFT in 2016 identified a reduction of staff smoking and now shows a rate of 8% of staff who smoke.
• Implement nicotine management and smoking cessation training across Trust community teams by Q4 2016/17.	A full training programme was made available for community teams to access and this training will continue in 2017/18. All frontline staff will be encouraged to complete the Level 1 Very Brief Advice training whilst additional staff will complete the Brief Intervention Training and some will progress to Level 2 Assessors. Unfortunately due to increased time spent supporting inpatient services and staff the project team were unable to train as many staff as originally planned, with around 25% of community staff trained to date. An increased number of training sessions are now available between March and May

	2017 to support this training and regular training dates until March 2018 are available for staff to access. We expect that at least 75% of staff will receive the identified training by March 2018 as many community teams have already booked training sessions in-house to address the training needs.
• Support staff to ensure a seamless pathway of support on admission / discharge for patients undertaking smoking cessation by Q4 2016/17.	An electronic referral form is available for staff to access to request additional support for patients on discharge to the community. Staff can also refer via telephone should they wish and have access to all appropriate telephone details. Further work continued in 2016/17 to ensure referrals are made for those patients wishing to remain smokefree on discharge.
• 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.	Work continues to train identified prison staff and allow them the opportunity to deliver training to other staff in the future. Each of the North East prisons have identified the staff requiring training. This now means that training packages will be developed and made available for staff to train residents to support the smokefree prisons agenda.

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 Community staff trained to Level 1 (NCSCT) and Brief Intervention.	75%	25%	Q4 2016/17
• Proportion of relevant Community staff that have been trained to smoking cessation level 2.	75%	25%	Q4 2016/17
• Following a review of adequate numbers of trained staff for inpatient units, the appropriate number of additional staff to be trained to Level 2.	85%	85%	Q4 2016/17
• Proportion of prisons providing smoke free wings for prisoners and staff to access/work within.	75%	100%	Q3 2016/17

What we plan to do in 2017/18:

Project plans have now been drafted to support the three elements of the project; further embedding in inpatient services, roll out to community services and support for the North East Prisons to go smokefree in 2017/18. Key priorities will include training provision; identification of areas requiring additional support to continue to implement the Nicotine Management Policy in full and identification of a “Go Live” date within the North East Prisons whilst ensuring identified staff within prison estates are fully trained and ready to go smokefree prior to the confirmed date.

With regards to the requirement to train an additional 50% of staff within community services, the project team have increased training dates between March and May

2017 and already deliver regular training sessions each week. Numbers trained continues to increase and as dates are already confirmed for training sessions from March 2017 to March 2018 we envisage the 2016/17 planned target of 75% trained will be achieved by March 2018. To date all community crisis and clozapine clinic staff have received training and Early Intervention in Psychosis (EIP) teams have been targeted to be trained by 30th April 2017 to support the new tobacco Commissioning for Quality and Innovation (CQUIN). Additional community teams have also received the identified training and this work continues.

Other Trusts nationally who have also gone smokefree such as South London & Maudsley advise that to fully implement and embed the smokefree agenda can take between 2-3 years and therefore the Trust will continue to work towards a completely smokefree estate whilst supporting the prisons to achieve the same outcome.

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

Why this is important:

Feedback we received from stakeholders both internally and externally identified transitions as an area that should be focused on as a priority. This is due to patients highlighting issues at various points of transitions such as when a patient 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 patients were faced with are a feeling of “emptiness” 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 patients and carers which we would like to minimise as much as possible. By focusing on a specific area of concern we could 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 focused on was Young People transferring from CAMHS to Adult services. This type of transition was highlighted as an issue via audits completed, feedback from stakeholders and through our commissioners providing a CQUIN target on CAMHS transitions.

The benefits / outcomes we aimed to deliver:

- A positive experience at points of transition.
- The young person to be at the centre of their transition plan development and implementation.
- The young person to learn from and be supported by people with lived experience of the transition phase.
- The young person to become an expert in their own plan / developing their own solutions.
- Effective joint working and good information transfer by the services involved with each other and with the patients and their carer(s).
- Continuity of care post transition.

What we did in 2016/17:

What we said we would do	What we did
• Undertake a baseline of the current experiences of patients through a review of transition in CAMHS which includes patient and carer experience feedback by Q1 2016/17.	CAMHS Teams identified young people who were in the process of transition or who had experienced a transition, asking them if they would be interested in participating in a short telephone survey to share their transition experience. The Patient Experience Team then contacted young people and their families/ carers to get details of their experiences. 63% of young people (64% of Carers) who were surveyed felt they were involved within the transition process. 56% of young people (45% for Carers) of those surveyed stated they were satisfied with the current process.
• Review and develop a Safe Transition and Discharge Protocol for CAMHS by Q1 2016/17.	CAMHS reviewed the transition protocol that was in operation making some changes to improve the transition process.
• Implement the Safe Transitions and Discharge Protocol by Q2 2016/17.	An implementation action plan was agreed and used to implement the revised Safe Transition and Discharge Protocol in all CAMHS Teams. To help embed the revised protocol within the CAMHS teams, a flow chart was developed to assist staff with what needs completing during the different stages of transition. Training was provided to staff making them aware of the changes to the protocol. A leaflet has also been developed for patients going through the transitions process to inform them of what to expect.
• Undertake an audit of the protocols to include a further collection of patient and carer experience feedback by Q3 2016/17.	A clinical audit of patient records was undertaken to review young people's transition plans against agreed standards. A further survey of young people and their families and carers was undertaken to collect the experiences of the transition process. 100% of young people surveyed felt they were involved in the transition process (75% of Carers). This shows an increase for both young people and Carers compared to the responses in quarter 1. The results showed a decrease from 56% to 40% of young people satisfied with the transition planning process. Carers showed an increased satisfaction with the process going up from 45% to 75% satisfied. Results were fed back to the service but it was recognised that the protocol was still being implemented and the timescales between the surveys was limited in order to fully demonstrate improvements. In 2017/18 there will be ongoing collection of experiences of young people at transition.

• Review the outcome of the audit with the aim to develop and implement an action plan by Q4 2016/17.	The results of the baseline audit and re-audit were reviewed and compared to measure improvements. The baseline audit undertaken in June 2016 demonstrated that 58% of young people had a transition / discharge plan. The re-audit in December 2016 showed that this had improved to 74% of young people having a transition / discharge plan. The audit findings indicate that further improvements are required to ensure that transition plans are personalised and clearly detail development of the plan with the young person in all cases. The findings were used to develop a detailed clinical audit action plan which will be used by CAMHS to implement further practice improvements during 2017/18.

How will we know we are making a difference?

The following table shows how we have performed against the targets we set ourselves for this priority:

Indicator	Target	Actual	Timescale
• Implement new transitions protocol across CAMHS teams.	100%	100%	Q3 2016/17
• An improvement in the experience of patients going through transitions in CAMHS.	60%	40%	Q3 2017/18

What we plan to do in 2017/18:

This will continue to be an improvement priority for us. Our plans for 2017/18 are set out in **Part 2, 2017/18 Priorities for Improvement section**.

Statement of Assurances from the Board 2016/17

The Department of Health and NHS Improvement 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 2016/17. These statements are contained within the blue boxes. In some cases additional information is supplied and where this is the case this is provided outside of the boxes.

Review of services

During **2016/17** 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 2016/17 represents **100%** per cent of the total income generated from the provision of the relevant health services by TEWV for 2016/17.

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 NICE guidance and the results of clinical audits.
- **Patient experience** – including information on patient satisfaction; carer satisfaction; the FFT; 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 QuAC the sub-committee of the Board which has responsibility for Quality Assurance. The QuAC receives formal reports from each of the LMGBs on a bi-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 a typical inspection team will include members of our Compliance Team, patient 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, Patient Advice and Liaison Service (PALS) / complaints data, CQC compliance reports and Mental Health Act visit reports as well

as any whistleblowing information. At the end of each internal inspection verbal feedback is given to the ward or team manager and any issues are escalated to the Head of Service, Head of Nursing and the Director of Quality Governance. An action plan is produced and implementation is assured via the QuAGs, LMGBs and QuAC, as described above, and in line with the Trusts Clinical Assurance Framework.

In addition each month members of the Executive Management Team and the Non-Executive Directors also undertake visits to our wards and teams across the Trust. They listen to what patients, carers and staff think and feel about the services we provide.

The Trust also continues to develop its Integrated Information Centre (IIC) which is a data warehouse that integrates information from a wide range of source systems e.g. patient information, finance, workforce and incidents. The information within the IIC is updated regularly from the source systems and allows clinical staff and managers to access the information on their service at any time and be able to 'drill' down to the lowest level of the data available. The IIC also sends prompts to staff which ensure that they can be proactive about making sure their work is scheduled in a timely manner thus improving patient experience and 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, 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.

Participation in clinical audits and national confidential inquiries

During 2016/17, **5** national clinical audits and **2** national confidential inquiries covered the relevant health services that TEWV provides.

During that period, TEWV participated in **60%** (3/5) of national clinical audits and **100%** (2/2) 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 2016/17 are as follows:

- POMH Topic 11c: Prescribing antipsychotic medication for people with dementia (ongoing);
- POMH Topic 7e: Monitoring of patients prescribed lithium (ongoing);
- POMH Topic 16a: Rapid tranquillisation;
- POMH Topics 1 & 3: Prescribing high dose and combined antipsychotics;
- EIP National Self-Assessment Audit 2016/17 (ongoing);
- National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH);
- National Confidential Enquiry Into Patient Outcome and death (NCEPOD).

The national clinical audits and national confidential inquiries that TEWV **participated in** during 2016/17 are as follows:

- POMH Topic 11c: Prescribing antipsychotic medication for people with dementia (ongoing);
- POMH Topic 7e: Monitoring of patients prescribed lithium (ongoing);
- EIP National Self-Assessment Audit 2016/17 (ongoing);
- National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH);
- National Confidential Enquiry Into Patient Outcome and death (NCEPOD).

The national clinical audits and national confidential inquiries that TEWV participated in, and for which data collection was completed during 2016/17, are listed below alongside the number of cases submitted to each audit or inquiry as a percentage of the number of registered cases required by the terms of the national audit or inquiry.

Audit Title	Cases Submitted	% of the number of registered cases required
POMH Topic 11c: Prescribing antipsychotic medication for people with dementia (ongoing)	283	Not applicable
POMH Topic 7e: Monitoring of patients prescribed lithium (ongoing)	220	Not applicable
EIP National Self-Assessment Audit 2016/17 (ongoing)	809	Not applicable
National Confidential Inquiry into Suicide & Homicide by People with Mental Illness	n/k*	98%
National Confidential Enquiry into Patient Outcome and Death	n/k*	Unknown

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

The reports of **0** national clinical audits were reviewed by the provider in 2016/17 and TEWV intends to take the following actions to improve the quality of healthcare provided:

- No reports received*.

The reports of **95** local clinical audits were reviewed by the provider in 2016/17 and TEWV intends to take the following actions to improve the quality of healthcare provided:

- **Appendix 4** includes the actions we are planning to take against the **10** key themes from these local clinical audits reviewed in 2016/17.

*Due to the timings of the national audits, the Trust had not reviewed the reports for any of the national audits or confidential inquiries at the time of the publication of this report. Upon receipt of final reports and actions plans the Trust will formally receive these reports and agree actions to improve the quality of healthcare provided.

There were 5 national clinical audits the Trust could have participated in, we did not participate in 2 of these because:

- We have an established in-house audit that goes into more detail than the prescribing high dose and combined antipsychotics POMH (1 & 3) audit, taking part in the POMH audit would duplicate this.
- We withdrew from the POMH (16a) audit on rapid tranquilisation before data collection started due to concerns about the methodology; however we used a robust in-house rapid tranquilisation audit instead.

In addition to the local clinical audits reviewed (i.e. those that were reviewed by our Quality Assurance Committee and Clinical Effectiveness Group), the Trust undertook a further **95** clinical audits in 2016/17. 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 relevant health services provided or subcontracted by TEWV in 2016/17 that were recruited during that period to participate in research approved by a research ethics committee was **945**.

Of the **945, 536** were recruited to **22** National Institute for Health Research (NIHR) portfolio studies. This compares with **331** patients involved as participants in NIHR research studies during 2015/16.

Recruitment into research has increased this year due to a number of higher recruiting studies including the Health and Wellbeing Survey (Mental health) study which has recruited 212 participants and the CYGNUS (Dementia) study which recruited 101 participants. The Trust contributes to the overall Clinical Research Network: North East and North Cumbria targets for recruitment and the Mental Health, Dementia and Neurodegenerative Diseases Research Network (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, forensic mental health, dementia, learning disabilities, personality disorder and CYPS. Our ongoing participation in clinical research through 2016/2017 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 **74** clinical research studies during 2016/17. **48** of these studies were supported by the NIHR through its networks and **16** new portfolio studies approved through the Health Research Authority approval process.

- **22** members of our clinical staff participated as researchers in studies approved by a research ethics committee, with **11** of these in the role of principal investigator for NIHR supported studies.
- **492** members of our staff were also recruited as participants to both NIHR portfolio and non-portfolio studies that were undertaken within TEWV.
- **28** researchers from outside the organisation were granted access under the National Research Passport Scheme to perform research with us compared to **76** from 2015/16. This reduced number was due to issuing 37 letters of access for research teams to access research participants in the York and Selby region last year.
- We have developed a new 5 year Research & Development strategy with a strong focus on PPI engagement and academic collaborations which provides us with the aim of becoming a lead research site with further opportunities for research involvement for our patients. 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 (CQUIN) Payment Framework

A proportion of TEWV's income in 2016/17 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 2016/17 and for the following 12 month period are available electronically at http://www.tewv.nhs.uk/site/content/About/How-well-are-we-doing.

As part of the development and agreement of the 2016/17 mental health contract, we were provided with a "pick list" of nationally set CQUINs to choose from and after discussions between the Trust and each of its commissioners we agreed which would be included in the 2016/17 CQUIN scheme. This included indicators around physical healthcare, staff health and wellbeing and CAMHS transitions. These are monitored at meetings every quarter with our commissioners.

An overall total of £6,866,000 was available for CQUIN to TEWV in 2016/17 conditional upon achieving quality improvement and innovation goals across all of its CQUINs, and a total of £6,238,041 is estimated to be received for the associated payment in 2016/17 (90.85%); however this will not be confirmed until May. This compares to £6,452,069 in 2015/16 (99.2% from the TEWV CQUIN prior to the Vale

of York contract and 100% from the Vale of York CQUIN), £5,765,066 (98.02%) in 2014/15 and £5,777,218 (99.28%) in 2013/14 (the estimate for 2016/17 has still to go through all the required governance processes for full approval).

Some examples of CQUIN indicators which the Trust made progress with in 2016/17 were:

- Implementing a system of timely identification and proactive management of frailty. As a Trust we did not routinely screen for frailty and therefore this was implementing a whole new process, which has been achieved. The implementation of this process has had a positive impact on patient care across our MHSOP wards as it has ensured that patients are screened for frailty when they are admitted to the ward. An intervention plan is then put in place to ensure their care is tailored to take into account their frailty. The patient is also given a copy of their care plan so that they are aware of their frailty score and what has been put into place to help manage this.
- Cardio metabolic assessment and treatment for patients with psychoses. This has been a CQUIN for the previous two years, but in 2016/17 community patients were included in the CQUIN for the first time along with the targets for Inpatients and EIP patients being increased. Internal audit results show that we have achieved the target in each of the three areas. Extending this CQUIN to cover patients in the community who have a diagnosis of psychosis ensures that all patients with psychosis across the Trust are now screened for cardio metabolic factors and are provided with interventions where required. This is a positive step in terms of patient care, ensuring that this group of patients are now receiving the screenings and interventions necessary to try to reduce the impact of poor physical health care.
- Recovery Colleges for low and medium Forensic Secure Adult services. The Trust did not have a recovery college for patients in our secure services prior to this CQUIN and there has been some significant work undertaken in developing and implementing the recovery college with patient involvement. The recovery college offers a number of courses that teach patients how to manage and own their recovery for example: meaningful communication, food & mood and positive self-expression. This enables patients with a sense of ownership of their recovery is a positive step forward in terms of patient care. The courses are open to all patients in Forensic services; however over the next two years there will also be courses specifically tailored for patients with Autism and patients who are transferred from prison.
- Reducing Restrictive Practices within low and medium Forensic Secure Adult Services. Although the Trust already had a restrictive practice framework, there have been significant steps forward in reducing restrictive practices such as opening the internal gates, piloting PATTI (patient access to the internet) and mobile phone use on the wards. Opening the internal gates means that patients who have unescorted leave can go to the activity and resource centres without needing a nurse to open the gates for them giving them a greater sense of responsibility and freedom. The mobile phone pilot on the wards has been reported as a success by the patients as it means that instead of having to wait to use a public phone to call their family they can ring them at the time they want to talk. It also means that for those patients who sometimes struggle with talking on the phone, they can text which they feel more comfortable with. This has increased the patient's sense of wellbeing.

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 CQC has not taken enforcement action against TEWV during 2016/17.

TEWV has not participated in any special reviews or investigations by the CQC during the reporting period.

The CQC carried out an unannounced compliance inspection during November 2016 and undertook inspections to all Trust AMH Assessment and Treatment and Psychiatric Intensive Care (PICU) Wards and all Older Persons Mental Health Inpatient Wards. The Trust received the final reports from this visit on 23rd February 2017. The core service ratings for AMH Assessment and Treatment and PICU Wards remained as **Good**; whilst the core service rating for Older Persons Mental Health Inpatient wards has changed from **Good** to **Requires Improvement.**

An announced visit by the CQC to the Trust between 23rd and 27th January 2017 during which they undertook a well led review and compliance inspections to some of the Trusts Learning Disability Community Teams; also during this visit unannounced inspections to Adult Rehabilitation Inpatient services across the Trust were carried out. The Trust received the final reports from this visit on 11th May 2017 and the CQC gave the Community Learning Disability Teams and Rehabilitation Inpatient services both ratings of **Good**. The overall Trust rating has remained **Good**.

CQC's rating for each key domain was:

Are services	
Safe?	Requires improvement
Effective?	Good
Caring?	Good
Responsive?	Good
Well led?	Good

The ratings give for the core services are:

	Safe	Effective	Caring	Responsive	Well led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement	Good	Good	Good	Good	Good
Community mental health services for people with learning disabilities or autism	Good	Good	Outstanding ☆	Good	Good	Good
Long stay/rehabilitation mental health wards for working age adults	Requires improvement	Good	Good	Good	Good	Good
Wards for older people with mental health problems	Requires improvement	Requires improvement	Not rated	Not rated	Requires improvement	Requires improvement

Whilst the inspection highlighted many areas to be proud of there were also areas that both the CQC and the Trust recognised needed to be improved. Following the visits to AMH Acute Inpatient and PICU and MHSOP wards an action plan has been produced and is currently being implemented within the agreed timeframes, the action plan from the reports received on 11th May is currently being developed and is to be submitted to the CQC by 16th June 2017. Below is a summary of some of the quality improvement work that is currently being undertaken as part of this work:

Areas for Improvement	Issues	Actions
Record Keeping	• All risk assessments, care plans and crisis and intervention plans are fully and collaboratively completed, reviewed and updated. • All physical health observations following rapid tranquilisation and all episodes of seclusion to be monitored and recorded. • Ensuring administration of medication is always correctly recorded.	• Regular review of patient records to ensure that all documentation is collaborative, person centred and updated when required. • A retrospective review of patient records to check the completion of physical health observations will be undertaken over a six month period. • A standard process to be put in place for monitoring compliance with seclusion recording process. • Enhanced medicines management assessments will be introduced.
Privacy and Dignity	• All wards to be compliant with Eliminating Mixed Sex Accommodation (EMSA) guidance. • Ensuring that privacy and dignity needs are sensitively met.	• Communal lounges and female only lounges are available on all wards. • All male and female zones will be clearly marked on ward areas. • Doors will be replaced with correct viewing panel glass and privacy film in some units.
Staffing	• Sufficient staffing available on all wards to ensure patient safety. • All staff undertake relevant training to ensure they are fully able to meet the needs of the patients. • Ensure all staff have supervision and appraisals.	• Continue current focus on recruitment and monitoring of planned v actual staffing levels. • Process in place to capture occurrences where planned staffing levels are not met and actions taken to manage this. • Enhanced monitoring of all statutory and mandatory training, appraisal and job relevant clinical training with exception reporting to the Executive Management Team.
Environmental Safety/ Cleanliness (IPC Issues)	• Ensuring specific risks are managed appropriately including ligature risks and blind spots on wards. • Issues of general repair to ward environments are undertaken in a timely manner. • Ensuring all wards are clean and tidy.	• Identified risks from annual environmental surveys to be clearly communicated to all team staff. • A programme is in place to ensure that any outstanding environmental works are completed and weekly environmental checks to be undertaken on wards.

Areas for Improvement	Issues	Actions
		• Infection Prevention and Control audits to be undertaken.
Ensuring Inpatient Rights (Blanket Restrictions)	• Ensuring that restrictive practice does not prevent individual needs from being met.	• Approval and roll out of Trust Policy on Restrictive Practices. • Monitoring the implementation of this policy via regular reports to Quality Assurance Committee.
Patient Safety	• Ensure that all patients are appropriately risk assessed to ensure their safety.	• Reducing harm from falls is a Trust Quality Priority during 2017/18. • Regular audits of risk assessment, admission paperwork and care plans to take place. • On-going monitoring of risk assessments to take place through management supervision.
Monitoring Checks	• Standard daily and weekly checks required to be undertaken on wards are all to be completed as necessary and monitoring to take place.	• Development of a standard template for use by Modern Matrons to monitor the completion of standard checklists on all wards. • Monthly ward based medicines management assessments to be introduced which will be undertaken by Pharmacy staff.

CQC Follow up Visit to Forensic Services February 2016

As reported in the 2015/16 Quality Account TEWV were subject to a CQC Compliance inspection at Ridgeway, Roseberry Park. This was a follow up from a previous inspection visit to the Trust to check on progress with the action plan. The final report from this visit was published in June 2016 and the CQC found that the Trust had successfully implemented the action plan and was no longer in breach of the regulations.

Mental Health Act Inspections

TEWV has participated in **37** Mental Health Act inspections by the Care Quality Commission to the following ward areas during 2016/17:

Ward	Service Type	Locality
Acomb unit (Oak Rise)	Learning Disabilities Assessment and Treatment	York
Bek	Learning Disabilities Assessment & Treatment	Durham
Bilsdale	Adult Mental Health Assessment & Treatment	Middlesbrough
Cedar Ward	Adult Mental Health Assessment & Treatment	Harrogate
Ceddesfeld	Older Peoples Mental Health Assessment & Treatment	Bishop Auckland
Elm	Adult Mental Health Assessment & Treatment	Darlington
Esk	Adult Mental Health Assessment & Treatment	Scarborough
Evergreen Centre	CAMHS Specialist Eating Disorder Service	Middlesbrough
Fulmar	Adult Mental Health Rehabilitation	Middlesbrough
Hamsterley	Older Peoples Mental Health Assessment & Treatment	Bishop Auckland
Kestrel/Kite	Forensic Learning Disability Low Secure	Middlesbrough
Linnet	Forensic Mental Health Medium Secure	Middlesbrough
Lustrum Vale	Adult Mental Health Rehabilitation	Middlesbrough
Mallard	Forensic Mental Health Low Secure	Middlesbrough
Meadowfields	Older Peoples Mental Health Assessment & Treatment	York
Newtondale	Forensic Mental Health	Middlesbrough
Nightingale	Forensic Mental Health	Middlesbrough
Northdale (Hawthorn/Runswick)	Forensic Learning Disability Medium Secure	Middlesbrough
Oak	Older Peoples Mental Health Assessment & Treatment	Darlington
Oakwood	Forensic Learning Disability	Middlesbrough
Overdale	Adult Mental Health Assessment & Treatment	Middlesbrough
Picktree	Older Peoples Mental Health Assessment & Treatment	Durham
Primrose Lodge	Adult Mental Health Rehabilitation	Durham
Ramsey	Learning Disabilities Assessment & Treatment	Durham
Rowan Lea	Older Peoples Mental Health Assessment & Treatment	Scarborough
Rowan Ward	Older Peoples Mental Health Assessment & Treatment	Harrogate
Springwood	Older Peoples Mental Health Assessment & Treatment	Malton
Stockdale	Adult Mental Health Assessment & Treatment	Middlesbrough
Swift	Forensic Mental Health Medium Secure	Middlesbrough

Bankfields Court (The Flats, Units 3 & 4)	Learning Disabilities Assessment & Treatment	Middlesbrough
Bankfields Court (The Lodge)	Learning Disabilities Assessment & Treatment	Middlesbrough
Thistle	Forensic Learning Disability Medium Secure	Middlesbrough
Tunstall	Adult Mental Health Assessment & Treatment	Durham
Ward 14, Friarage	Older Peoples Mental Health Assessment & Treatment	Northallerton
Ward 15, Friarage	Adult Mental Health Assessment & Treatment	Northallerton
Wingfield	Older Peoples Mental Health Assessment & Treatment	Hartlepool
Worsley Court	Older Peoples Mental Health Assessment & Treatment	Selby

Quality of data

TEWV submitted records during 2016/17 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 **99.75%** for admitted patient care.
- Which included the patient's valid General Medical Practice Code was **100.00%** for admitted patient care.

TEWV Information Governance Assessment Report overall score for 2016/17 was **88%** 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 & 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.

88%* (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). Sixteen toolkit requirements scored level 2, 29 toolkit requirements scored level 3.

*The colour green represents the Information Governance Toolkit rating of satisfactory.

TEWV was **not** subject to the Payment by Results clinical coding audit during 2016/17 by the Audit Commission.

NHS England and NHS Improvement issued guidance in March 2016 for the 2016/17 financial year. This continued the need for Mental Health Service providers to report:

- **Clinically Reported Outcome Measure (CROM):** this is the Health of the Nation Outcome Score (HoNOS) and reported via the Mental Health Services Data Set (MHSDS). Further work on this development has resulted in the development of a clinical significance model. This has led to work to revise IIC reporting. In addition discussion with commissioners has taken place on how this will translate into CCG reporting of HoNOS Outcomes.
- **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). Further work has been undertaken in relation to the Clinical Significance model for reporting as per HoNOS. Associated IIC changes are planned. In addition this has also formed part of discussions with commissioners to include CCG PROM reporting from 2017/18.

A training programme for clinical staff to support the introduction of clinical significance was delivered in March 2017. Whilst an intensive training program regarding CROM and PROM has been delivered throughout York and Selby from May 2016.

At the end of March 2017, now including York and Selby:

- **97%** of service users on the Adult Mental Health (AMH) and **98%** 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 2017/18 includes:

- For CYPS a national Pilot for currency and tariff development is due to commence April 2017.
- In relation to Forensic services the cluster currency data is being included in the Mental Health Services Data Set (MHSDS) from April 2017.

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.
- 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.

Mandatory quality indicators

The following are the mandatory quality indicators relevant to mental health Trusts, issued jointly by the Department of Health and NHS Improvement 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 NHS Digital for the most recent and the previous reporting period available.

Care Programme Approach 7 day follow-up

The data made available by NHS Digital with regard to the percentage of patients on Care Programme Approach (CPA) who were followed up within 7 days after discharge from psychiatric inpatient care during the reporting period.

Note the data for Quarters 1, 2 and 3 2016/17 only reports patients discharged on CPA that were followed up within 7 days of discharge. Quarter 4 2016/17 reports all patients discharged that were followed up within 7 days.

TEWV Actual Quarter 4 2016/17	***National Benchmarks in Quarter 3 2016/17***	***TEWV Actual Quarter 3 2016/17***	***TEWV Actual Quarter 2 2016/17***	***TEWV Actual Quarter 1 2016/17***
Trust final reported figure: **98.35%**	NHSIC reported: Highest/best MH Trust = **100%**	Trust final reported figure: **96.67%**	Trust final reported figure: **97.93%**	Trust final reported figure: **96.95%**
Figure reported to NHSI: N/A**	National average MH Trust = **96.2%**	Figure reported to NHSI: N/A**	Figure reported to NHSI: **97.57%**	Figure reported to NHSI: **97.4%**
NHS Digital reported: **Not available**	Lowest/worst MH Trust = **73.3%**	NHS Digital reported: **96.8%**	NHS Digital reported: **97.8%**	NHS Digital reported: **97.5%**

* Latest benchmark data available on NHS Digital at quarters 3 2016/17.
** We are no longer required to report performance to NHSI following the change in the Regulatory Framework in October 2016.

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 NHS Improvement in quarters 1 and 2 2016/17 is due to the fact that the Trust final figure is refreshed throughout the year to reflect a contemporaneous position as data quality issues are resolved. The figure reported to NHSI was the position at quarter end and is not refreshed after submission.
- The discrepancy between the NHS Digital and the Trust / NHSI figure in quarters 2 and 3 is due to the fact the NHS Digital data is submitted at a CCG level, and therefore, excludes data where the CCG is unspecified in the patient record. The Trust figure includes all discharges.
- The key reasons why 54 people in 2016/17 were not followed up within 7 days were:

- Difficulty in engaging with the patient despite efforts of the service to contact the patient (26 patients); and
- Breakdown in processes within the service (28 patients).

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

- Investigating all cases that weren't followed up and identifying lessons to be learned at service level.
- Undertaking an improvement event led by the Chief Operating Officer to improve proactive performance management and eliminate waste in both clinical and corporate services.
- Undertaking a Quality Improvement System session to review and improve the monitoring and validation process.
- Utilising the report out process and Trust performance management system to pro-actively monitor performance and ensure compliance. Supporting the adherence to 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 and why it is important to patient safety, the need to follow the standard procedure and the need to record data accurately considering appropriate exclusions.

Crisis Resolution Home Treatment Team acted as a gatekeeper

The data made available by NHS Digital with regard to the percentage of admissions to acute wards for which the crisis resolution home treatment team acted as a gatekeeper during the reporting period.

TEWV Actual Quarter 4 2016/17	***National Benchmarks in Quarter 3 2016/17***	***TEWV Actual Quarter 3 2016/17***	***TEWV Actual Quarter 2 2016/17***	***TEWV Actual Quarter 1 2016/17***
Trust final reported figure: **96.92%**	NHSIC Reported: National average MH Trust = **98.3%**	Trust final reported figure: **96.27%**	Trust final reported figure: **96.71%**	Trust final reported figure: **96.79%**
Figure reported to NHSI: N/A**	Highest/best MH Trust = **100%**	Figure reported to NHSI: N/A**	Figure reported to NHSI: **97.24%**	Figure reported to NHSI: **96.8%**
NHS Digital Reported: **Not available**	Lowest/worst MH Trust = **88.3%**	NHS Digital Reported: **96.3%**	NHS Digital Reported: **96.7%**	NHS Digital reported: **96.8%**

*Latest benchmark data available on NHS Digital at quarters 3 2016/17

** We are no longer required to report performance to NHSI following the change in the Regulatory Framework in October 2016.

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 NHSI in quarters 1 and 2 2016/17 is due to the fact the Trust final figure is refreshed throughout the year to reflect a contemporaneous position as data quality issues are resolved. The figure reported to NHSI is the position at quarter end and is not refreshed after submission.
- The discrepancy between the NHS Digital and the Trust / NHSI figures is due to the fact the NHS Digital data is submitted at a CCG level, and therefore, excludes data where the CCG is unspecified in the patient record. The Trust figures include these cases.

  The key reasons why **50** people in 2016/17 were not assessed by the Crisis team prior to admission were:
  - Breakdown in process due to failure to follow the standard procedure (38 patients)
  - High levels of demand on the Crisis team (12 patients)

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

- Investigating instances where patients were not seen by a crisis team prior to admission and identifying lessons to be learned at service level.
- Undertaking a Quality Improvement System session to review and improve the monitoring and validation process.
- Undertaking an improvement event led by the Chief Operating Officer to improve proactive performance management and eliminate waste in both clinical and corporate services.
- Utilising the report out process and Trust performance management system to pro-actively monitor performance and ensure compliance. Supporting the adherence to 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 and why it is important, the need to follow the standard procedure and the need to record data accurately considering appropriate exclusions.

Patients' experience of contact with a health or social care worker

The data made available by NHS Digital with regard to the Trust's "patient experience of community mental health services" indicator score regarding 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 from NHS Digital.

An overall Trust score is not provided, due to the nature of the survey, therefore it is not possible to compare Trusts overall. For 2016, we have reported the Health and Social Care Workers section score which compiles the results from the

questions used from the survey detailed below the table.

TEWV Actual 2016	*National Benchmarks in 2016*	*TEWV Actual 2015*	*TEWV Actual 2014*
Overall section score: **7.8** (sample size 234)	Highest/Best MH Trust = **8.1** Lowest/Worst MH Trust = **6.9** Average Score**=7.6**	Overall section score: **8.0** (sample size 239)	NHSIC Reported: **8.1** (sample size of 188)

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:

Based on information derived from the NHS Patient survey report the individual scores for TEWV in relation to the above are described as follows:

- *Did this person listen carefully to you*: TEWV mean score of **8.2**. The lowest national mean was 7.3 and the highest 8.6.
- *Were you given enough time to discuss your needs and treatment*: TEWV mean score of **8.0**. The lowest national mean was 6.8 and the highest 8.2.
- *Did the person or people you saw understand how your mental health needs affect other areas of your life*: TEWV mean score of **7.1**. The lowest national mean was 6.2 and the highest 7.8.

The report identifies if Trusts perform 'better' 'about the same' or 'worse' based on a statistic called the expected range. When comparing TEWV survey results with those of the other organisations the scores were identified as being 'about the same' as other organisation across all 10 sections. There was no overall rating of 'better' or 'worse' than others for any section of the survey (in 2015 TEWV had 4

sections being rated as better than other organisations).

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

TEWV **intends to take** the following actions to improve this indicator, and so the quality of its services, by:

- Continued staff training on positive behavioral support. Full implementation of this approach has improved 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).
- Continuing to carry out our local inpatient and community surveys with established mechanisms in place for action plan development and feedback.
- The Trust has reviewed its Quality Strategy and increased the focus on patient reported experience measures based on what is important to them. Targets will be developed for each measure and these monitored on an ongoing basis.

The Trust continues to carry out regular patient experience surveys across all services which includes the FFT. Between January 2016 and January 2017 the Trust received feedback from 20,050 patients with an average of 86% who would be extremely likely or likely to recommend TEWV services.

Patient safety incidents including incidents resulting in severe harm or death

The data made available by NHS Digital 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 2017.

TEWV Actual Quarters 3&4 2016/17	****National Benchmarks in Quarters 3&4 2016/17***	***TEWV Actual Quarters 1&2 2016/17***	***TEWV Actual Quarters 3&4 2015/16***
Trust Reported to NRLS: as at 31st March 2017 **5359** incidents reported of which **119 (2.2%)** 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: **599** incidents reported of which **5** resulted in severe harm and **31 (5.2%)** in death Highest MH Trusts: **5572** incidents reported of which **49 (0.9%)** resulted in severe harm and **31 (0.6%)** in death. The highest reported rate of deaths as a proportion of overall incidents was **5.2%**	Trust Reported to NRLS: **4,971** incidents reported of which **88 (1.77%)** resulted in severe harm or death* NRLS reported: **4,971** incidents reported of which **88 (1.77%)** resulted in severe harm or death* *21 Severe Harm and 67 Death	Trust Reported to NRLS: **3,789** incidents reported of which **110 (2.9%)** resulted in severe harm or death NRLS reported: **3,789** incidents reported of which **110 (2.9%)** resulted in severe harm or death

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

- The Trust reported and National Reporting & Learning System (NRLS) reported data for Quarters 1 & 2 2016/17 showed no variance in what was reported. This improved position from last year is due to a significant amount of data quality improvement work the Trust has undertaken.
- The number of incidents reported by TEWV to the NRLS for Quarters 1 and 2 2016/17 was improved compared to the previous 2 quarters. 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 in Quarters 1 & 2 2016/17 has considerably increased when compared to with Quarters 3 & 4 2015/16. This is due to the implementation of a new web-based version of our incident reporting process which has had the positive impact of raising staff awareness of reporting.
  - 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 2016/17 TEWV reported 94 incidents as Serious Incidents, of which 59 were deaths due to unexpected causes.

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

- Analysis of all patient safety incidents. These are reported and reviewed by the Patient Safety Group which is a 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.
- Making permanent the central approval team which was put in place to ensure consistent grading of incidents and to improve the overall quality of reporting.
- Ensuring all serious incidents (i.e. 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.
- Introducing mortality reviews on those deaths that are not classed as unexpected. We are following national guidance as it is published in this area – the National Guidance on Learning from Deaths was released in March 2017 and we will be implementing its recommendations throughout 2017/18.

2017/18 Priorities for Improvement

During 2016/17 we held two events inviting our stakeholders to take part in our process of identifying quality priorities for 2017/18 to be included in the Quality Account. These events took place in July 2016 and February 2017: further information can be found in **Part 3, Our Stakeholders' Views section**. The five quality priorities which we identified from this engagement also sit within TEWV's 2017/18-2019/20 Business Plan. The Business Plan includes a further ten priorities all of which will have a positive impact on the quality of Trust services. Details of these priorities can be found in **appendix 5**.

Our five agreed 2017/18 priorities for inclusion in the Quality Account are:

Priority 1: Implement Phase 2 of our Recovery Strategy.
Priority 2: Ensure we have Safe Staffing in all our services.
Priority 3: Improve the clinical effectiveness and patient experience in times of transition from Child to Adult services.
Priority 4: Reduce the number of preventable deaths.
Priority 5: Reduce the occurrences of serious harm resulting from inpatient falls.

Priority 1: Implement Phase 2 of our Recovery Strategy

Why this is important:

Supporting the recovery and wellbeing of individuals is the core aim of the services we provide. Patients 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.

In 2013 the Trust developed a 3 year Recovery and Wellbeing strategy for 2013-2016. Within this strategy it was recognised that cultivating the required change would take an iterative approach over many years.

While significant progress has been made, both internal and external stakeholders have identified that further work is required to further embed a recovery and wellbeing approach within all our services. The Trust recognises that this remains a key priority and is committed to large scale change, ensuring all systems and processes are reviewed from a recovery perspective and we now have a revised Recovery and Wellbeing strategy for 2017-2020.

Our stakeholders and Board therefore agreed it was important that this remained a key Quality Account priority for 2017/18.

The benefits / outcomes our patients and carers should expect:

- The care they receive will be designed to support and achieve their own personal goals.
- To receive assistance that supports them to live a fulfilling and meaningful life.
- To feel listened to, heard and understood.
- To have access to services which involve them in decision making regarding their care and be given meaningful choice wherever possible.
- To receive support that enables them to feel more empowered and take charge of their lives.
- To feel more hopeful about their future or have support to identify more hopeful moments in what can be difficult times.
- To be supported to develop and maintain an identity beyond that of their symptoms or diagnosis, building on their interests and strengths.
- Their views and personal expertise by experience valued and the services they receive are both designed and delivered alongside individuals with lived experience.
- To receive support that identifies and acknowledges the impact of previous adversity and trauma and will be responded to with compassion.
- To be supported to come to an understanding of their difficulties that is meaningful to them.

What we will do in 2017/18:

We will:
• Recovery College Online available online to people living in the TEWV area by Q1 2017/18. • Develop a Recovery Demonstration Site [*a team which is excellent in promoting recovery and which others can learn from*] in community adult services by Q3 2017/18. • Development of a Recovery for Leaders training programme by Q4 2017/18. • Continue to expand Involvement Peer roles by having at least 15 new roles in place by Q4 2017/18. • Develop an infrastructure for embedding a trauma informed approach by Q4 2017/18.

What we will do in 2018/19 and 2019/20:

We will:
• Deliver Recover for Leaders training to at least 60 leaders by Q4 2018/19. • Agree the approach to embedding Experts by Experience in a range of specialities by Q4 2018/19. • Develop proposals for phase 3 of the Recovery Strategy (2020 – 2023) by Q3 2019/20.

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
• To continue to expand the number of paid lived experience / peer roles within the Trust (we currently have 6 of these).	5 new	Q4 2017/18
• Number of newly registered involvement peer roles (we currently have 23 of these).	15 new	Q4 2017/18
• Recovery College Online will expand the number of: 1. self-management pages (from a baseline of 30) and; 2. self-management courses available (2016/17 baseline = 1).	 50 7	 Q4 2017/18 Q4 2017/18
• Increase the number of staff receiving trauma informed care training (from 100 to 300).	300	Q4 2017/18

Priority 2: Ensure we have Safe Staffing in all our services

Why this is important:

Safe Staffing is essential for the delivery of safe, high quality, evidenced-based patient care.

So it's important that we don't just have enough staff on our wards and in our community teams, but also that our staff have the right skills and competencies to deliver excellent care for people with mental health needs or with a learning disability.

This is an issue across the country and so the National Quality Board (NQB) provided updated guidance to all NHS providers in July 2016. Later in 2017 we expect the publication of specific guidance for Learning Disability and mental health services. Our stakeholders and Board agreed that it is important we follow these principles and guidance to help us make local decisions on staffing that will support the delivery of quality within our existing staffing resource and better understand how staffing capacity impacts on the quality of care.

The Carter[3] productivity and efficiency report made it clear that improved workforce efficiency can benefit patient care through better recruitment and retention of permanent staff, better rostering, reduced sickness absence, matching work patterns to patient need and reducing reliance on agency staff.

This agenda is particularly challenging because of the national shortage of qualified nurses – and increasingly other clinical professions such as psychologists, allied health professionals and doctors. It is therefore important that we focus on developing our future workforce so that we can continue to safely deliver new models of care and new ways of working.

[3] https://hee.nhs.uk/hee-your-area/west-midlands/about-us/our-governance/our-letcs/mental-health-institute-letc/safe-staffing-tools-mental-health-learning-disability

The benefits / outcomes our patients and carers should expect:

- Their care is of high quality and timely because it is being delivered by a team with the right staff and right skills, at the right place and time, in line with the 2016 NQB guidance.
- To feel that the Trust is well informed of its 'pressure areas' around safe staffing and has systems in place to act upon these quickly to reduce the risk of harm to patients.
- The Trust robustly thinks through what staff with what skills will be needed when service changes are planned.
- The Trust will do everything it can to ensure continuity for patients – keeping staffing changes (and use of bank and agency staffing) to a minimum.
- Reduced reliance on agency staff, which improves the quality and continuity of care.
- More staff recruited externally to the Trust.
- An increased retention of staff.
- The Trust will develop new roles (such as Nursing Associates) to make sure that all of our clinician's skills are being used to the maximum extent to benefit patients.

What we will do in 2017/18:

We will:
• Establish governance structures by Q1 2017/18. • Agree the Programme Plan which will include benefits and work-streams by Q1 2017/18. • Further actions and metrics will be developed for 2017/18 and 2018/19 upon set-up of programme board by Q2 2017/18. • Implement the agreed actions for 2017/18 by Q4 2017/18. • Introduce a new report for ward managers which brings together data on staffing and other quality and recognised quality safety indicators [*timescale to be confirmed as dependent upon information technology issues*].

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**	**Timescales**
As indicated above, the programme will develop a range of metrics during Q1 and Q2 2017/18 to reflect the emerging guidance on Mental Health and Learning Disability services. This will include:	*[targets and timescales will be set once national guidance has been received and further internal development work has been undertaken]*	

• Outcomes related to the suggested workstreams of:
  • staffing review using the national evidence based Hurst[4] tool;
  • monitoring of escalation processes;
  • review of rostering process to ensure best use of existing resources.	

Priority 3: Improve the clinical effectiveness and patient experience in times of transition from Child to Adult services

Why this is important:

We define transitions for this Quality Account Priority as a purposeful and planned process of supporting young people to move from children's to adults' services. Young people with ongoing or long-term health or social care needs may be required to transition into AMH services, other service provision or back to their GP. The preparation and planning around moving on into new services can be an uncertain time for young people with health or social care needs. There is evidence of service gaps where there is a lack of appropriate services for young people to transition into, and evidence that young people may fail to engage with services without proper support (Watson 2005[5]; Singh 2009[6]).

Transition takes place at a pivotal time in the life of a young person. It is often at a time of cultural and developmental changes that lead them into adulthood. Individuals may be experiencing several transitions simultaneously. There is evidence that transition between services in health and social care can be inconsistent and varied depending on the condition. A loss of continuity in care can be a disruptive experience, particularly during adolescence, when young people are at an enhanced risk of psychosocial problems.

The particular importance of improving the transition from children and young people's services to adult services was recognised by our Quality Account Stakeholders in 2015. We agreed to put a two year quality improvement priority in place, focussing on this specific transition. The actions below are those for the second year of this priority to further embed the improvements commenced in 2016/17.

The benefits / outcomes our patients and carers should expect:

- An improvement in their experience during their transition from Children and Young People's to Adult services.
- Greater involvement in decisions about the care received when they transfer into Adult services.
- To receive care informed by NICE's[7] evidence-based guidelines, which will result in better clinical outcomes.

What we will do in 2017/18:

[4] https://hee.nhs.uk/hee-your-area/west-midlands/about-us/our-governance/our-letcs/mental-health-institute-letc/safe-staffing-tools-mental-health-learning-disability

[5] Watson AR (2005) Problems and pitfalls of transition from paediatric to adult renal care. Paediatric Nephrology 20: 113–7

[6] Singh SP (2009) Transition of care from child to Adult Mental Health services: the great divide. Current Opinion in Psychiatry 22: 386–90

[7] http://www.rcpch.ac.uk/system/files/protected/page/Transition%20from%20children%E2%80%99s%20to%20adults%E2%80%99%20services%20-%20FULL%20published_1.pdf

We will:
• 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 patient and carer experience feedback by Q2 2017/18. • Co-produce surveys and audit tools with young people to ensure that questions asked are meaningful to all involved by Q2 2017/18. • Establish mechanisms to provide stakeholders and staff with regular feedback by Q2 2017/18. • Review the outcome of the audit, updating the current action plan by Q3 2017/18. • Collect patients' stories in writing to gain detailed accounts of young people's experiences 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. • Continue to use patient surveys to gain feedback from young people (ongoing each quarter during 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 CQUIN metrics which Trust have agreed for 2017/18:

Indicator	Target	Timescale
• Percentage of joint agency transition action plans in place for patients approaching transition.	80%	Q4 2017/18
• Percentage of patients who reported feeling prepared for transitions at the point of discharge.	80%	Q4 2017/18
• Percentage of patients who have transitioned to AMH from CYPS who indicate they have met their personal goals as agreed in their transition plan.	70%	Q4 2017/18

Priority 4: Reduce the number of preventable deaths

Why this is important:

Death is a naturally occurring event, and not all deaths of people receiving mental health services from the Trust will represent a failing or problem in the way that person received care before their death. However, sometimes healthcare teams can make mistakes or parts of the system do not work together as well as they could. This means that when things go wrong, a death may have been preventable.

In December the CQC published their report, *Learning, Candour and Accountability* which made recommendations for the improvements that need to be made in the NHS, to be more open about these events.

The Trust already has systems in place to review and investigate deaths in line with national guidance in order to learn from them. Over the next year however, we believe it is important to strengthen the way we identify the need for investigations into the care provided and the way we carry these out. It is recognised that people with a mental health problem or learning disability are likely to experience a much earlier death than the general population; therefore a key focus for the Trust will be to have an increased focus on mortality review processes for this group of people.

It is important that families and carers are fully involved in reviews and investigations following a death as they offer a vital perspective because they will have observed the whole pathway of care that their relative experienced.

In order to reduce preventable deaths, it is also important that learning from deaths is shared and acted on with an emphasis on engaging families and carers in this learning. Last year, through our investigation process, we identified a number of preventable deaths of inpatients which took place while they were on leave. We put actions in place for improvements in this area and it is important that we continue this work to ensure our patients do not suffer preventable harm.

The benefits / outcomes our patients and carers should expect:

- Our processes will reflect national guidance and best practice which will ensure we are delivering the best, evidence based care and treatment to our patients.
- A reduction in the number of preventable harm incidents and deaths of inpatients on leave from hospital.
- To feel listened to during investigations of death and consistently treated with kindness, openness and honesty.
- Increased confidence that investigations are being carried out in accordance with best-practice guidelines and in a way that is likely to identify missed opportunities for preventing death and improving services.
- The Trust learns from deaths, including identifying any themes early so that actions can be taken to prevent future harm.

What we will do in 2017/18:

We will:
• Develop an action plan from recommendations of an external review into Serious Incidents of patients when on a period of leave by Q1 2017/18. • Evaluate the current pilot process of reviewing mortality, revising it accordingly following the review by Q1 2017/18. • Establish quarterly reporting mechanisms for mortality review processes by Q1 2017/18. • Ensure systems are in place to regularly train all new inpatient staff and monitor compliance in relation to leave and time away from the ward Q2 2017/18. • Complete spot compliance audits quarterly to ensure staff are adhering to the leave policy by involving family in leave arrangements and conducting risk assessment and formulation prior to periods of leave by Q4 2017/18. • Complete a review of the root or contributory causes of Serious Incidents each quarter and agree focused areas for targeted implementation by Q4 2017/18. • Undertake a review of the national guidance in relation to mortality each quarter by Q4 2017/18. • Participate quarterly in the regional provider forum focused on learning from preventable deaths by Q4 2017/18. • Report quarterly to the QuAC on progress of the reviewed mortality review processes to enhance learning 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
• To increase the proportion of deaths that are reviewed as part of the mortality review processes (this is in addition to the existing serious incident process).	Baseline in Q1*	Q4 2017/18
• To eliminate preventable deaths of inpatients during periods of leave.	0	Q4 2017/18

*Baseline to be collected in Q1 2017/18 after which a target will be agreed.

Priority 5: Reduce the occurrences of serious harm resulting from inpatient falls

Why this is important:

Falls affect a patient's quality of life including suffering distress, pain, injury, loss of confidence; loss of independence and in some circumstances can lead to death. Falling also affects the family members and carers of people who fall.

Despite work being undertaken in the Trust to implement best practice and NICE guidance, the number of falls has risen. It is important therefore that the Trust is doing everything possible to ensure that falls are being appropriately managed with the aim of reducing the number and severity of harm from falls.

The benefits / outcomes our patients and carers should expect:

- A reduction in moderate and severe harm as a result of falls.
- More falls are prevented during hospital stays.
- To feel more informed about the risks and benefits around falls interventions.
- Their values and preferences informing care.
- That care is managed in line with NICE guideline 161 *'Falls: assessment and prevention of falls in older people*' (2013)[8] and in line with actions from the National Patient Safety Agency '*how to guide for reducing harm from falls in mental health inpatient settings*' (2012)[9].
- Care is delivered by staff with the appropriate skills and competencies to prevent and manage falls.
- Appropriate assessment and treatment is given to people who have fallen.

What we will do in 2017/18:

We will:
• Undertake a baseline assessment of preventable falls by severity, completed by Q1 2017/18.
• Complete a thematic analysis by Specialty completed including direct observations of practice by Q1 2017/18.
• Develop an action plan developed in line with outcome of thematic analysis by Q2 2017/18.
• 'Plan, Do, Study, Act' (PDSA) cycles agreed to address key issues identified via observations by Q2 2017/18.
• Complete a Trustwide implementation of new processes based on PSDA cycles by Q3 2017/18.
• Undertake a baseline assessment of falls by severity and theme reassessed by Q4 2017/18.

[8] https://www.nice.org.uk/guidance/cg161.
[9] https://www.rcplondon.ac.uk/file/927/.

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
• A reduction in the number of people who suffer serious harm as a result of a fall.	TBC	TBC

Monitoring Progress

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

We will also feedback progress made during Quarter 1 at our July Quality Account stakeholder event, send a 6 monthly update to all of our stakeholders, and provide a further update of the position as of 31 December 2017 at our February 2018 Quality Account Stakeholder workshop.

Part 3: Other information on Quality Performance 2016/17

Our performance against our quality metrics

The following table provides details of our performance against our set of agreed quality metrics for 2016/17.

These metrics are the same as those we reported against in our previous Quality Accounts. This allows us to monitor progress over time. However, in some cases we have needed to change our metrics as follows:

- 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 with 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.

During 2016/17 we reviewed and revised our Trust Quality Strategy. In approving the new strategy the Trust Board also agreed a set of metrics which will be routinely monitored each quarter to show the progress that is being made in delivering the objectives within the strategy. It is therefore proposed that we will revisit the quality metrics to be used in the 2017/18 Quality Account in quarter 1 2017/18 to ensure they are aligned to these metrics in the Quality Strategy.

Quality Metrics

	Quality Metrics	2016/17		2015/16	2014/15	2013/14	2012/13
		Target	Actual	Actual	Actual	Actual	Actual
Patient Safety Measures							
1	Number of unexpected deaths classed as a serious incident per 10,000 open cases	<9.00*	**8.59**	14.68	12.16	11.88	15.91
2	Number of outbreaks of Healthcare Associated Infections	0	**0**	0	0	0	0
3	Patient Falls per 1,000 admissions	<28.79	**64.32**	46.69	44.54	35.99	34.09
Clinical Effectiveness Measures							
4	Percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care	> 95.00%	**98.35%**	97.75%	97.42%	97.86%	97.14%
5	Percentage of clinical audits of NICE Guidance completed	100%	**100%**	100%	100%	97%	89.47%
6	Average length of stay for patients in Adult Mental Health and Mental Health Services for Older People Assessment & Treatment Wards	AMH <30.2	**30.08**	26.81	26.67	31.72	35
		MHSOP <52	**78.06**	62.67	62.18	54.08	
Patient Experience Measures							
7	Delayed Transfers of Care	<7.50%	**4.98%**	1.69%	2.11%	1.89%	2.07%
8	Percentage of complaints satisfactorily resolved	> 90.00%	**75.26%**	79.00%	75.38%	65.77%	76.36%
National Patient Survey							
9	Number of questions where our mean score was within 5% of the highest mean scored Mental Health Trusts	Improvement on previous year	4	16**	10**		
	Number of questions where our mean score was within the middle 90% of mean scored Mental Health Trusts		32	17**	23**		
	Number of questions where our mean score was within 5% of the lowest mean scored Mental Health Trusts		0	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

** Not directly comparable with 2016/17 figures

Notes on selected metrics

1. Data for this metric is taken from Incident Reports which are then reported via the national Strategic Executive Information System (STEIS).
2. Outbreaks of healthcare associated infections relates to those of MRSA bacteraemia and C Difficile. The Infection Prevention and Control Team would be notified of any outbreaks direct by the ward and that would then be recorded on an 'outbreak' form before being reported externally.
3. Patient falls excludes the categories 'found on floor' and 'no harm'. Data for this metric is taken from Incident Reports which are then reported via the Trust's Risk Management System, DATIX.
4. Data for CPA 7 day follow up is taken from the Trust's patient systems and is aligned to the national definition.
5. The percentage of clinical audits of NICE Guidance completed is based on the number of audits of NICE guidelines completed against the number of audits of NICE guidelines planned. Data for this metric is taken from audits undertaken by the Clinical Directorates supported by the Clinical Audit Team.
6. Data for average length of stay is taken from the Trust's patient systems.
7. Delayed transfers of care are based on NHS Improvement's definition and therefore exclude CAMHS. 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 Community Mental Health Survey is not directly comparable to previous Community Surveys. In previous years the number of questions reported on related to our position against the top, middle and bottom mean scores of other Trusts. This has now been changed and is reported on as being 'Better', 'About the Same' and 'Worse' than other Trusts. As you can see from the scores provided the Trust is performing the same as or better than all other Trusts. Whilst they are not directly comparable, scores for 2015/16 and 2014/15 have been provided.

Comments on Areas of Under-Performance

Metric 3: Patient falls per 1,000 admissions.

The number of falls reported in 2016/17 is **64.32** per 1,000 admissions as at March 2017, which is significantly above the target of <28.79.

This relates to 399 falls this financial year to date: 84 (21.05%) in Durham and Darlington, 82 (20.55%) in Teesside, 60 (15.04%) Forensics, 103 (25.81%) North Yorkshire, 70 (17.54%) York and Selby.

As shown in the table below the highest number of falls in 2016/17 were recorded within North Yorkshire locality:

Locality	No. of Falls in 2016/17	No. of Falls per 1000 admissions
Durham and Darlington	84	41.2
Forensics	60	1020.4*
North Yorkshire	103	155.8
Teesside	82	25.2
York and Selby	70	346.5
Grand Total	**399**	**64.3**

*note the low throughput of patients within Forensic services skews this figure to an artificially high level.

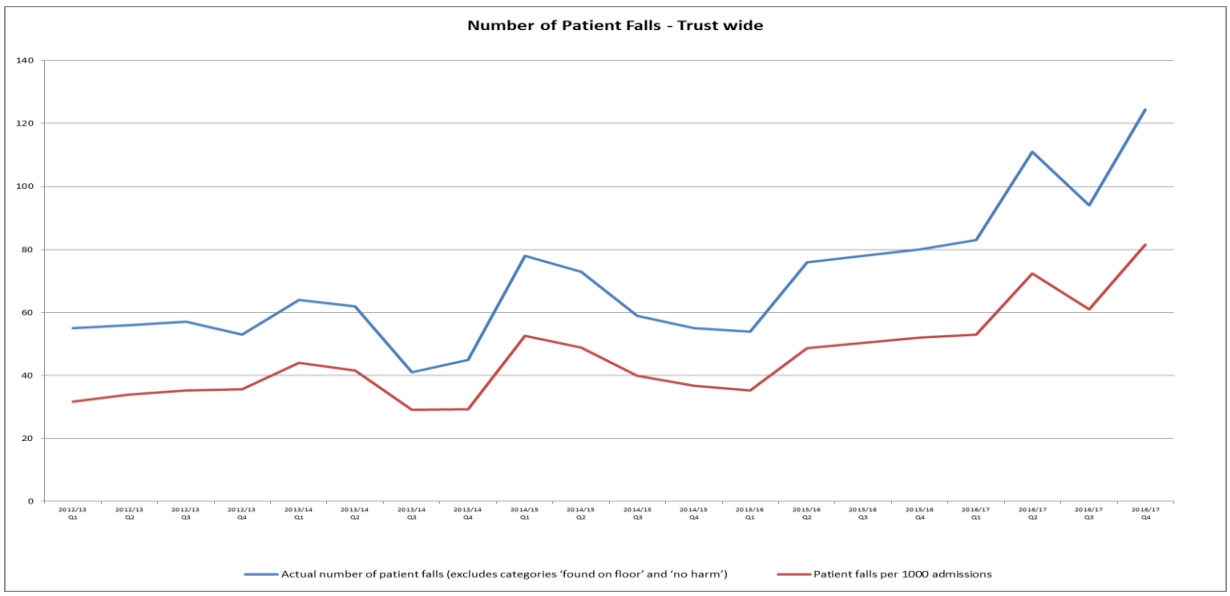
As shown in the table below the majority of falls in 2016/17 were recorded within MHSOP speciality:

Speciality	No. of Falls in 2016/17	No. of Falls per 1000 admissions
MHSOP	251	293.9
Forensics	59	1072.7*
Adults	57	19.3
Learning Disabilities	21	24.05
CYP	11	7.5
Grand Total	**399**	**64.32**

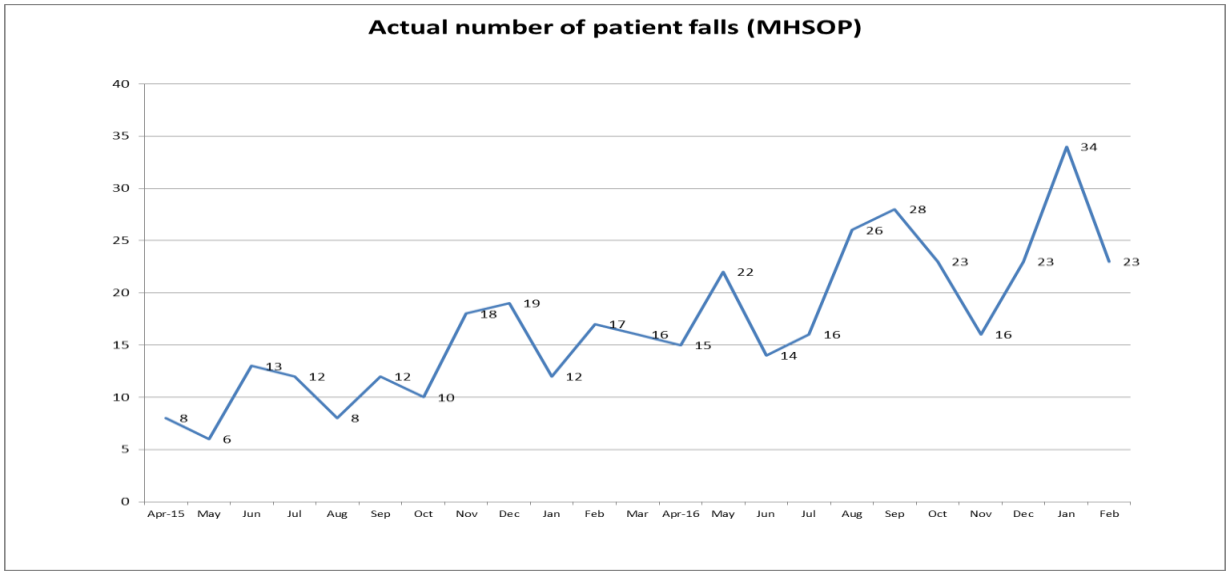
*note the low throughput of patients within forensic services skews this figure to an artificially high level.

Of the falls reported, 321 (80.45%) were classified low with minimal harm, 70 (17.54%) were reported as moderate short term harm and 8 (2.00%) were reported as severe.

The graph below shows that the downwards trend at the end of 2013/14 has been replaced by an upwards trend from 2014/15, 2015/16 and 2016/17. During 2016/17 a significant increase has been seen.



Of the 399 falls, 251 (62.91%) were reported within Mental Health Services for Older People. This is an increase on the 52.43% reported at the same point during 2015/16.



The Trust 'Falls Executive Group' steers and monitors Trust falls management across the Trust and reports into the Patient Safety Group.

A review of the Trust wide falls process has commenced and this is being led by the Associate Director of Nursing. However discussions remain at an early stage and next steps will be consolidated after consultation with the falls leads in each speciality.

Key themes / issues under consideration include:

- Review of the data collection process to adopt a speciality focused data split to improve accountability.
- Consideration of data gaps around patients at risk of multiple falls and identification of preventable incidents.
- Extending the falls CLiP to include frailty.
- A benchmarking exercise to inform understanding of performance compared to a similar Trusts.
- Improved content of reports to include more narrative and provide a greater depth of understanding and context to the statistical data to improve monitoring and inform action.

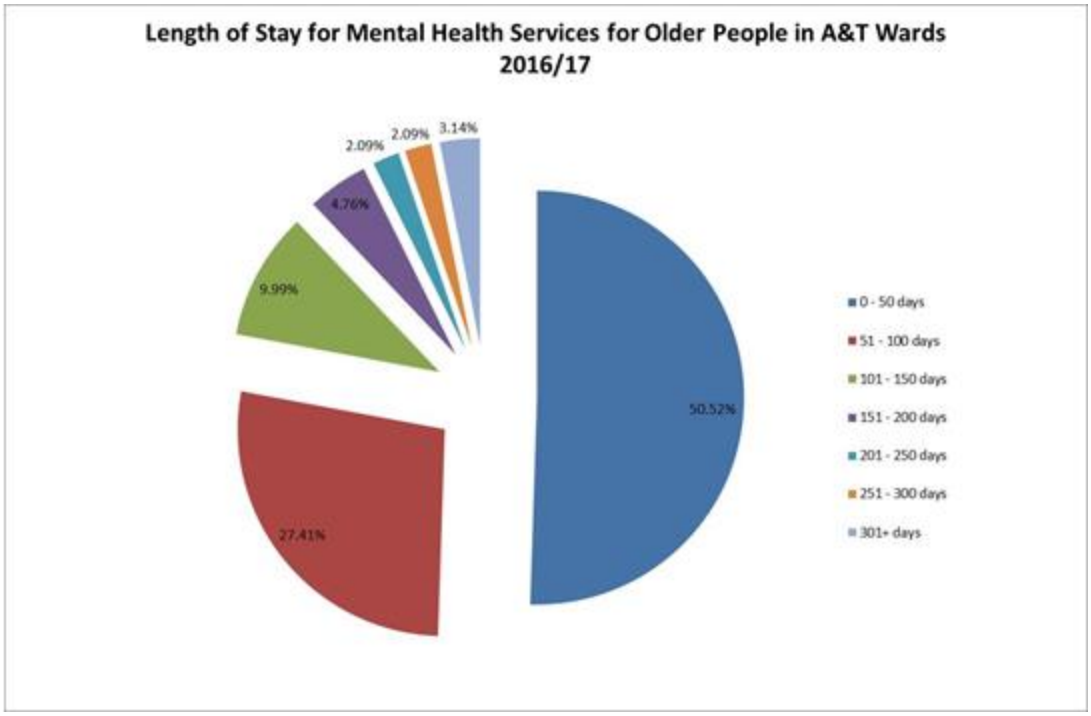
Speciality leads continue to co-ordinate and drive improvements as follows:

- **MHSOP** – The Service Development Manager and the Clinical Lead Physiotherapist have delivered falls summary presentations to the Service Development Group and the Falls Sub Group. The data analysis considered trends at both locality and speciality level and the work will inform the Trust wide review of the Falls Clinical Link Pathway. All current interventions detailed within the Falls CLiP are being adhered to and all wards must complete a weekly falls review to promote effective local management of falls. This is used to identify gaps in response and resolve issues appropriately. This approach promotes local ownership and continuous improvement.
- **ALD** – Falls analysis work is ongoing across the speciality, led by the Falls Analysis Group and an improvement in the recording and reporting of falls has been noted. Local leads provide constructive feedback to staff members regarding each fall analysed. All local incidents are reviewed at Locality Directorate level.
- **Forensics** MH & LD – Physical healthcare rounds on Mallard ward are ongoing (end of April) and this includes actions to support falls reduction. Mallard ward report the highest number of falls within the Forensic service due older patients. The service continues to use the falls focused Multi-Disciplinary Team (MDT) approach, were individual cases are assessed using action plans. Falls training was completed for staff on Mallard ward and these staff are now providing peer support to other staff in the directorate.
- **AMH** – Falls continue to be discussed at the acute care forum. A specific improvement event took place where it was agreed that physical health (including Falls) will have its own visual control board (VCB) linked to the overall VCB and improved standard work. Progress is monitored through the report out process and an annual review is planned for September 2017.

Metric 6: Average length of stay for patients in Adult Mental Health and Mental Health Services for Older People Assessment & Treatment Wards.

The average length of stay for older people has been worse than target since Q3 2013/14 reporting 78.06 days as at March 2016/17, which is 26.06 worse than target and a deterioration compared to the position reported in 2015/16. The pie chart below shows the breakdown for the various lengths of stay during 2016/17.

The median length of stay was **50** days, which is better than the target of 52 days and demonstrates that the small number of patients that had 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 who were discharged after a very long length of stay, which has skewed the overall average. In total 50.52% of lengths of stay were between 0-50 days, with 27.41% between 51 – 100 days. There were 63 patients who 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).

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 as 31 March 2016/17 was 75.26%, which is below the target of 98% and a deterioration on both 2015/16 and 2014/15. This relates to **143** complaints being satisfactorily resolved. Complaints are monitored by the Quality Assurance Committee and each is thoroughly investigated.

There were **47** people who were not satisfied with our response to their complaint since April 2016 to March 2017. 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 2016/17

	FYTD		
	Number of complaints resolution letters sent	**Number of dissatisfied responses received**	**Percentage satisfactorily resolved**
Durham & Darlington	**64**	**17**	**73%**
Adult Mental Health	51	15	70%
Mental Health Services for Older People	3	0	100%
Children & Young People's Services	9	2	78%
Learning Disabilities	1	0	100%
Tees	**45**	**12**	**73%**
Adult Mental Health	33	8	76%
Mental Health Services for Older People	1	1	0%
Children & Young People's Services	10	3	70%
Learning Disabilities	1	0	100%
North Yorkshire	**43**	**8**	**81%**
Adult Mental Health	30	5	83%
Mental Health Services for Older People	7	2	71%
Children & Young People's Services	4	0	100%
Learning Disabilities	2	1	50%
York and Selby	**26**	**7**	**73%**
Adult Mental Health	16	7	56%
Mental Health Services for Older People	8	0	100%
Children & Young People Services	2	0	100%
Learning Disabilities	0	0	N/A
Forensics	**11**	**3**	**73%**
Forensic Learning Disabilities	6	2	67%
Forensic Mental Health	4	1	75%
Forensic Offender Health	1	0	100%
Corporate	**1**	**0**	**100%**
TOTAL	**190**	**47**	**75%**

The Trust has an open culture for people to be able to raise concerns and complaints and the operational services are working hard to continuously improve their services through quality improvement work. Complaints are thoroughly investigated. If the issues are upheld and a service improvement identified, action plans are put in place to ensure changes are made to try and prevent a recurrence of the problem. If the Trust cannot agree with comments we state the findings that result from reviewing clinical records and consulting with staff. We actively encourage people to come back to us for further discussion or investigation.

Our performance against the Risk Assessment Framework and Single Oversight 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, 1st April – 30th September 2016 which also appears in the Single Oversight Framework 1st October 2016 – 31st March 2017.

Risk Assessment Framework and Single Oversight Framework

Indicators		2016/17		2015/16	2014/15	2013/14
		Threshold	Actual	Actual	Actual (exc Y&S)	Actual (exc Y&S)
a	CPA patients having formal review within 12 months	95%	**98.49%**	**98.76%**	97.75%	96.56%
b	Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams	95%	**96.92%**	**96.74%**	98.42%	98.58%
c	Meeting commitment to serve new psychosis cases by early intervention teams	95%	**441.06%***	**265%**	254%	239%
d	Percentage of people experiencing a first episode of psychosis that were treated with a NICE approved care package within two weeks of referral	50%	**70.04%**	**55.91%**		
e	Percentage of people referred to the IAPT programme that were treated within 6 weeks of referral	75%	**95.44%**	**84.01%**		
f	Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral	95%	**99.14%**	**95.93%**		

*The % actual position for 2016/17 is high due to a historic target and recent investments in the service that have enabled improvements in performance.

The figures above include performance for York and Selby from the 1 October 2015.

Notes on Risk Assessment Framework and Single Oversight Framework Targets and Indicators

The indicators reported above are those specified within the Quality Account national guidance.

There is an additional indicator contained within appendix A of the Risk Assessment Framework and the Single Oversight Framework that is relevant however this has been reported in the Quality Metrics table on **page 140**.

- CPA patients receiving follow-up contact within seven days of discharge.

It should be noted that of those indicators listed, CPA patients having formal review within 12 months (a) and Meeting commitment to serve new psychosis cases by early intervention teams (b) do not form part of NHS Improvement's Single Oversight Framework.

The data represents the Trust's position as monitored through internal processes and reports.

Where available the historic information shown for 2013/14 has been taken from the Board of Directors Dashboard report at year end.

External Audit

For 2016/17, our external auditors are required to provide a limited assurance report on whether two of the mandated indicators included in the Quality Account 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 Account 2016/17 are:

- 100% of enhanced CPA patients receiving follow-contact within seven days of discharge from hospital.
- Proportion of admissions to inpatient services which had access to crisis resolution home treatment teams.
- The percentage of clinical audits of NICE Guidance completed (the local indicator chosen by the Council of Governors).

The full definitions for these indicators are contained in **appendix 6.**

Local Improvement Plans

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

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 and policy in line with the recommendations, which are managed and monitored by the Director of Quality Governance.

The policy 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. Work is ongoing within the Quality Governance team to ensure we have systems and processes for capturing Duty of Candour actions (such as family engagement, letters) which are sent directly from clinical services to ensure we have a complete picture of activity in this area.

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 plans she had seen.

Information roadshows have been completed throughout the Trust and presentations made to Directorate QuAGs and LMGBs, Speciality Development Groups (SDGs), Leadership & Network Groups, Modern Matrons, Medics Conference, Health & 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.

Patients and carers have identified what safety means to them and the findings incorporated into the Trustwide Harm Minimisation training and the Trust Suicide/Harm minimisation update training which was initially developed for adult services Darlington and Durham is now available to all services and includes a Sign up to Safety element.

The implementation of the Force Reduction project demonstrates positive assurance with regard to continued reductions in the use of restrictive interventions, notably Prone restraint. The team continue to monitor Safewards through the use of the checklists and ward visits and continue to run alternative injection site workshops for registered nurses.

What we will be doing:
The Sign Up To Safety Campaign is due to end June 2017.

Learning Lessons, Force Reduction and Harm Minimisation projects and metrics have been the focus of the implementation plan. Due to the close alignment between the principles of force reduction and harm minimisation an alliance between the two projects and the Trust wide Recovery Programme has been made to optimise skills/knowledge and resources. Since July 2016 the two teams have been delivering, with Experts by Experience, face to face recovery orientated harm minimisation training and are also supporting the Positive Approaches Training Team to develop their curriculum.

All of the projects supporting Sign Up to Safety ended on the 31st March 2017 and plans are being formulated to ensure that the success of the projects continues. For example the Trust Patient Safety, Legal and Claims Teams will be responsible for ensuring learning lessons becomes business as usual; harm minimisation is embedded with the Trust Recovery Programme and there are proposals for a Force Reduction Lead within the Trust.

NHS Staff Survey Results

The 2016 NHS Staff Survey was distributed to 5952 staff who were eligible to receive the survey (this included only staff who were directly employed by the Trust i.e. excluding external contractors) with a response rate of 49% (2891 staff).

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 Trust results for the two indicators were:

- 18% of staff reported experiencing harassment, bullying or abuse from staff in the last 12 months (indicator KF26). This was one of the better scores of any of the NHS organisations that are solely focused on mental health services. This is a 2% increase on the 2015 score for this indicator.
- 94% of staff stated that they believed that the Trust provides equal opportunities for career progression or promotion (indicator KF21). This is one of the best scores reported by a Mental Health Trust. This is also a 2% increase on the 2015 score for this indicator.

National Quality Improvement Programmes

During 2016/17 TEWV participated in accreditation schemes, quality networks and Quality Improvement (QIP) topics audited by the Prescribing Observatory for Mental Health (POMH-UK) led by the Royal College of Psychiatrists. The table below lists these and provides a list of TEWV services that were involved:

Programmes	Participating services in Trust	Accreditation Status	Number of services participating nationally
MSNAP: Memory Services National Accreditation Project	Hambleton & Richmondshire Memory Service (Northallerton)	Accredited as excellent	107
	Harrogate & District Memory Service	Accredited as excellent	
PLAN: Psychiatric Liaison Accreditation Network	None	N/A	74
QNCC ED: Quality Network for Community CAMHS (Child and Adolescent Community Mental Health Services) Eating Disorders	Durham and Darlington CYPS Eating Disorders Team	Participating but not yet undergoing accreditation	18
	Teesside CYPS Community ED Team	Participating but not yet undergoing accreditation	
QNLD: Quality Network for Learning Disability Wards	None	N/A	40
QNOAMHS: Quality Network Older Adults Mental Health Services	Rowan Lea	Accredited	67
AIMS-WA: Working Age Adult Wards	Farnham Ward, Lanchester Road Hospital	Accredited	136
	Tunstall Ward, Lanchester Road Hospital	Accredited	
	Bilsdale Unit, University Hospital of North Tees	Accredited as excellent	
	Bransdale Unit, University Hospital of North Tees	Accredited as excellent	
	Danby Ward, Cross Lane Hospital	Accredited as excellent	
	Esk Ward, Cross Lane Hospital	Accredited as excellent	
	Lincoln Ward, Sandwell Park	Accredited as excellent	

Programmes	Participating services in Trust	Accreditation Status	Number of services participating nationally
	Maple Ward, West Park Hospital	Accredited as excellent	
	Overdale Unit, Roseberry Park Hospital	Accredited as excellent	
	Stockdale Unit, Roseberry Park Hospital	Accredited as excellent	
ECTAS: Electro Convulsive Therapy Accreditation Service	Needham (York)	Accredited as excellent	101
EIP Self-Assessment (English Teams only): EIP Self-Assessment (English Teams only)	Harrogate, Hambleton & Richmondshire Early Intervention in Psychosis Team	N/A	153
	North Durham & Easington Early Intervention in Psychosis Team	N/A	
	North Tees Early Intervention in Psychosis Team	N/A	
	Scarborough, Whitby & Ryedale Early Intervention in Psychosis Team	N/A	
	South Durham Early Intervention in Psychosis Team	N/A	
	South Tees Early Intervention in Psychosis Team	N/A	
	York & Selby Early Intervention in Psychosis Team	N/A	
Perinatal: Perinatal In-Patient & Community settings	Tees Specialist Perinatal Community Team	Not yet assessed	43
QNCC: Quality Network for Community CAMHS (Child and Adolescent Community Mental Health Services)	None	N/A	32
QNFMHS: Quality Network for Forensic Mental Health Services	Ridgeway (LSU & MSU)	Accreditation not offered by this network	125
QNIC: Quality Network for Inpatient CAMHS (Child and Adolescent Community Mental Health Services)	Evergreen Centre	Accreditation deferred	127
	The Newberry Centre	Accredited	
	Westwood	Accredited	
QNPMHS (Prison): Quality Network for Prison Mental Health Services	HMP Durham	Accreditation not offered by this network	40
	HMP Frankland	Accreditation not offered by this network	
	HMP Holme House (& HMP Kirklevington)	Accreditation not offered by this network	
	HMP Low Newton	Accreditation not offered by this network	
	HMP Northumberland	Accreditation not offered by this network	
	HMYOI Deerbolt	Accreditation not offered by this network	

Programmes	Participating services in Trust	Accreditation Status	Number of services participating nationally
AIMS PICU: Psychiatric Intensive Care Units	Cedar Ward	Accreditation deferred	38
	Bedale Unit	Accredited as excellent	
AIMS Rehab: Rehabilitation Wards	Willow Ward	Accredited as excellent	65
	Lustrum Vale	Participating but not yet undergoing accreditation	
	Primrose Lodge	Participating but not yet undergoing accreditation	
HTAS: Home Treatment Accreditation Service	Hambleton & Richmond CRHTT	Accredited	49
	North Durham Crisis Team	Accredited	
	South Durham & Darlington Crisis Team	Accredited	
	Scarborough, Whitby & Ryedale CRHTT	Accredited as excellent	
QED: Quality Network for Eating Disorder Services	Birch Ward	Accredited	32
APPTS: Accreditation Project for Psychological Therapy Services	None	N/A	22
CofC: Community of Communities	None	N/A	8
AIMS-AT: Assessment Triage	None	N/A	5
EIPN: Early Intervention in Psychosis Network	None	N/A	5
QNLD: Quality Network for Learning Disability Wards	None	N/A	1
ACOMHS: Accreditation for Community Mental Health Services	None	N/A	12
Prescribing Observatory for Mental Health (POMH)	**The Trust is Participating in the following Quality Improvement Programmes (QIP)**		
POMH	QIP 7e: Monitoring of patients prescribed lithium		
POMH	QIP11c: Prescribing antipsychotics in people with dementia		

Participation in these accreditation schemes is recognised by the CQC as it demonstrates that staff members take pride in the delivery of care and are actively engaged in improving quality.

Our stakeholders' views

The Trust recognises the importance of the views of our stakeholders as part of our assessment of the quality of the services we provide and to help us drive change and improvement.

How we involve and listen to what our stakeholders say about us is critical to this process. In producing the Quality Account 2016/17, we have tried to improve how we involved our stakeholders in assessing our quality in 2016/17.

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:

- *Well organised useful event with a good structure and feedback.*
- *Meeting other presenters / representatives from TEWV – good to see and hear from them and their expertise and knowledge.*
- *Leeway given i.e. no time restraints.*
- *Precise and compact presentations.*
- *Table discussions worked well.*

Some participants felt that the presentations were not recovery informed, but also requested that the presentations be circulated following the event.

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

In line with national guidance, we have circulated our draft Quality Account for 2016/17 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 7**.

The following are the general themes received from stakeholders in reviewing our Quality Account for 2016/17:

- Stakeholders welcomed the opportunity to receive and comment on the Quality Account;
- The Quality Account accurately represents the Trusts commitment to quality;
- Recognise the progress made on our 2016/17 quality priorities and agree our plans to achieve the 2017/18 quality priorities;
- Note that not all the quality metric targets were met but agree with the mitigations have been put in place;
- The stakeholder events held twice yearly have been helpful and request these continue;
- TEWV has regularly engaged with its service users and carers;
- Concerns that there have been difficulties training staff for harm minimisation and nicotine management, however recognise the reasons for this and are happy with plans to ensure staff receive the training;
- Commended on maintaining the CQC 'Good' standard overall.

The Trust will write to each stakeholder addressing each comment made following publication of the Quality Account 2016/17 and use the feedback as part of an annual lessons learnt exercise in preparation for the Quality Account 2017/18. In our commitment to listen to our stakeholders and learn from their feedback, we are developing an 'easy read' version of the 2016/17 Quality Account 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 2017 on the Trust's progress with delivering its quality priorities and metrics for 2017/18.

APPENDICES

APPENDIX 1: 2016/17 STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE QUALITY ACCOUNT

The Directors are required under the Health Act 2009 and the National Health Service (Quality Account) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS Foundation Trust boards on the form and content of annual Quality Accounts (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 Account.

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

- the content of the Quality Account meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2016/17 and supporting guidance;

- the content of the Quality Account is not inconsistent with internal and external sources of information including:

    - Board minutes and papers for the period April 2016 to May 2017;
    - Papers relating to Quality reported to the Board over the period April 2016 to May 2017;
    - Feedback from the Commissioners dated 12 May and 15 May 2017;
    - Feedback from Governors dated 9 March and 13 April 2017;
    - Feedback from Local Healthwatch organisations one dated May 2017 and one undated but received on 9 May 2017;
    - Feedback from Overview and Scrutiny Committees one dated 11 May 2017 and two undated but received on 12 May 2017;
    - Feedback from Health and Wellbeing Board dated 17 May 2017;
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 17 May 2017;
    - The latest national patient survey published 15 November 2017;
    - The latest national staff survey published 7 March 2017;
    - The Head of Internal Audit's annual opinion over the Trust's control environment dated 18 May 2017;
    - CQC inspection reports dated 23 February 2017.

- the Quality Account presents a balanced picture of the NHS Foundation Trust's performance over the period covered;

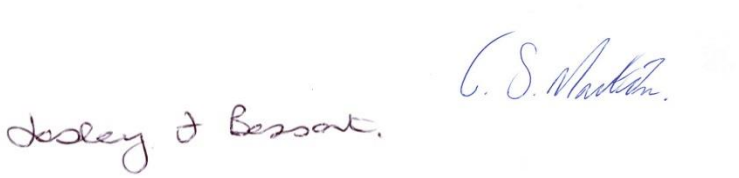
- the performance information reported in the Quality Account is reliable and accurate;

- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account 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 NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts 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 Account.

By order of the Board.



Lesley Bessant
Chairman

Colin Martin
Chief Executive

23 May 2017

APPENDIX 2: 2016/17 LIMITED ASSURANCE REPORT ON THE CONTENT OF THE QUALITY ACCOUNTS 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 2017 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2017 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- 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 NHS Improvement.

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 NHS Improvement's Detailed Requirements for External Assurance on Quality Reports for Foundation Trusts 2016/17; 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 Requirements for External Assurance on Quality Reports for Foundation Trusts 2016/17.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and supporting guidance, and consider 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 2016 to April 2017;
- Papers relating to quality reported to the Board over the period April 2016 to April 2017;
- Feedback from Commissioners; Durham Darlington and Teesside CCGs (dated 12 May 2017), North Yorkshire and York CCGs (dated 15 May 2017);
- Feedback from Governors;
- Feedback from local Healthwatch organisations; Healthwatch Darlington (undated), Healthwatch York (dated May 2017);
- Feedback from Overview and scrutiny committee; Durham County Council (undated), Darlington Borough Council (undated); Tees Valley Joint Scrutiny Committee (dated 11 May 2017);
- 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 2016 to 31 March 2017;
- The 2016 national patient survey;
- The 2016 national NHS staff survey;

- Care Quality Commission inspection reports dated 23 February 2017 and 11 May 2017;
- The Head of Internal Audit's annual opinion over the trust's control environment for the period April 2016 to March 2017; 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 (ICAEW) 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 them 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 2017, to enable the Council of Governors to demonstrate that it has discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Tees, Esk and Wear Valleys NHS Foundation Trust for our work or this report, 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 and supporting guidance.

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 2017:

- 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 NHS Improvement's Detailed Requirements for External Assurance on Quality Reports for Foundation Trusts 2016/17; 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.

Signed: Date: 24 May 2017

Cameron Waddell, Engagement Lead, for and on behalf of Mazars LLP

Chartered Accountants and Statutory Auditor

Salvus House, Aykley Heads, Durham, DH1 5TS

APPENDIX 3: GLOSSARY

Adult Mental Health Service (AMH): Services provided for people aged 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.

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.

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 characterised by social deficits, communication difficulties, stereotyped or repetitive behaviours and interests, and in some cases, cognitive delays.

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 NHS Improvement.

CAMHS: Children and Young People's Mental Health services (together with Child Learning Disability services, this is part of Children and Young People's Services - CYPS).

Care Programme Approach (CPA): describes the approach used in specialist mental health care to assess, plan, review and co-ordinate the range of treatment care and support needs for people in contact with secondary mental health services who have complex characteristics. It is a called "an approach" rather than just a system because the way that these elements are carried out is as important as the actual tasks themselves. The approach is routinely audited.

Care Quality Commission (CQC): the independent regulator of health and social care in England who regulate the quality of care provided in hospitals, care homes and people's own homes by the NHS, local authorities, private companies and voluntary organisations, including protecting the interests of people whose rights are restricted under the Mental Health Act.

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, Teesside and York 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 (NIHR) 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.

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 Inquiry: 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.

Co-production: This is an approach where a policy, and approach or other initiative / action is designed jointly by TEWV and a patient / carer.

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 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.

CTIMP: studies – these are clinical trials of an investigational medicinal product, such as new pharmaceutical (drug) treatments (any other type of research is known as a non-CTIMP).

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.

CYGNUS: Project Cygnus: is a digital brain health platform for improving outcomes of cognitively impaired patients (such as dementia).

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 (DQIPs): 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.

DeNDRoN: is part of the National Institute for Health Research (NIHR) Clinical Research Network (CRN). It supports the development, set-up and delivery of clinical research in the NHS around dementia, Huntington's disease, Motor Neurone disease, Parkinson's disease, and other neurodegenerative diseases.

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.

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.

Expert by Experience Groups and members: None contracted roles, managed under the involvement and engagement structures (offered honorarium) to offer story telling input into training and provide the opportunity to gain a broader range of lived experience views on a range of service developments. 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 patients 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 Adult 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 a 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 (FFT): 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 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 of the Nation Outcome Score (HoNOS): A way of measuring patients' health and wellbeing. It is made up of 12 simple scales on which patients 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 patient'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.

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.

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 (IIC): 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.

Involvement Peer Roles: are none contracted unpaid roles which offer individuals with lived experience an opportunity to share their experiences to support other patients/ carers wellbeing and recovery. They can input into courses or groups but always work alongside paid staff, who led the sessions. Managed under involvement and engagement processes and are offered travel and honorarium.

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 4 Localities and also specific wards for Forensic LD patients. TEWV provides Child LD services in Durham, Darlington, Selby, Teesside and York 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).

Localities: services in TEWV are organised around four Localities (i.e. County Durham & Darlington, Teesside, North Yorkshire and York & Selby). Our Forensic services are not organised as a geographical basis, but are often referred to a fifth "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 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 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.

NHS Improvement: the independent economic regulator for NHS Foundation Trusts – previously known as Monitor.

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).

National Centre for Smoking Cessation and Training (NCSCT): The National Centre for Smoking Cessation and Training (NCSCT) is a social enterprise that delivers evidence-based tobacco control programmes and smoking cessation interventions provided by local stop smoking services.

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 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): 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 Strategic Executive Information System (STEIS): a new Department of Health system for collecting weekly management information from the NHS.

NHS Digital: Previously known as 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.

NHS Patient Survey: the annual survey of patients' experience of care and treatment received by NHS Trusts. In different years has focused both on inpatient and community patients.

NHS Staff Survey: an annual survey of staffs' experience of working within NHS Trusts.

Organic (MHSOP): Older people with a decreased mental function which is due to a medical or physical condition. This includes dementia-related conditions.

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 focused on Health, although Darlington, Middlesbrough, Stockton, Hartlepool and Redcar & Cleveland Councils have a joint Tees Valley Health OSC that performs this function.

Paid Experts by Experience: Paid lived experience roles which offer input into strategic / service developments. These roles are focused on working with staff rather than patients and carers. Examples include Expert co-ordinator, expert trainer posts.

Paid Peer Workers: are paid members of staff who work within clinical / other support services within the Trust to offer peer support to other patients and carers within their process of care.

Paris: the Trust's electronic care record, product name Paris, designed with mental health professionals to ensure that the right information is available to those who need it at all times.

Patient Advice & Liaison Team (PALs): The 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 patients are realised.

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 patients 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 patient or carer) to support other carers and patients. 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 patient or carer) to support other patients, in line with the Recovery Approach.

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.

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 (PIPA) 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 Account: A Quality Account 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 Governance Framework (NHS Improvement): NHS Improvement'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. 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.

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 patients, 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 patients, 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).

Ridgeway: The part of Roseberry Park Hospital that houses our low and medium Forensic Secure Adult wards (also known as Forensic wards).

Risk Assessment Framework: see Single Oversight Framework

Safewards: is a set of interventions proven to reduce conflict within inpatient settings.

Serious Incidents (SIs): 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.

STEIS: National system for reporting serious incidents.

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 Trust: Tees, Esk and Wear Valleys NHS Foundation Trust.

Trustwide: This means across the whole geographical area served by the Trust's 4 Localities.

Unexpected Death: a death that is not expected due to a terminal medical condition or physical illness.

Recovery College Online: 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.*

APPENDIX 4: KEY THEMES FROM 95 LOCAL CLINICAL AUDITS REVIEWED IN 2016/17

Audit Theme	Key quality improvement activities associated with clinical audit outcomes
1. NICE/ Pathway Development	• A briefing sheet on the CYPS Depression Pathway was distributed to teams and plans were developed for roll-out in North Yorkshire, Tees and Durham and Darlington Localities. • To support compliance with NICE CG185 (Bipolar disorder), information resources on the use of valproate in bipolar disorder have been made available to all clinicians and links to information resources have been included in the Trust Bipolar Disorder Pathway. Monitoring requirements for patients prescribed valproate have been added to new Trust guidance. • To support compliance with NICE CG115 (Alcohol-use disorders), the Trust inpatient alcohol detoxification pathway/guidelines will be updated to include blood test that should be performed for patients undergoing detox. • The LD Core Pathway will be updated to include sleep resources and a Sleep CLIP will be developed.
2. Physical Healthcare	• VTE risk assessment guidance and eLearning have been promoted staff by Modern Matrons and via Medical Education. • In Forensic services, the admission checklist has been updated to include completion of the Falls CLIP within 72 hours of admission. • The Care Plan template for pregnant service users has been updated to include provision of health promotion information on blood borne viruses. • Results of the National CQUIN Safety Thermometer are reported to the Clinical Effectiveness Group quarterly.
3. Medicines Management	• Rapid tranquilisation (RT) audit results have been incorporated into a review of Medicines Management training and update of the Trust RT policy/procedure. RT eLearning has been developed. • To support good antimicrobial stewardship, a new Trust Antimicrobial Prescribing Policy has been developed and pharmacy training slides for Junior Doctors and Pharmacists have been updated. • A briefing on Lithium monitoring has been updated and shared with Trust staff and colleagues in Primary Care to emphasise the importance of recording the interval between last lithium dose and serum lithium tests. • The Trust medicines fridge monitoring form has been updated and all old paperwork replaced; a fridge monitoring bulletin was produced and distributed to clinical areas.
4. Risk Assessment/ Violence and Aggression/ Suicide Prevention	• Suicide prevention audit results will be incorporated into the relevant Harm Minimisation Training package and monthly Suicide Prevention update training. • In CYPS, training on collaborative recovery-focused care planning was delivered for relevant teams and the importance of timely risk assessment was promoted. • In CYPS, the Trust self-harm information leaflet for patients and carers was reviewed and made available. • Bespoke MAPPA training has been made available via InTouch; PARIS has been updated to facilitate MAPPA record keeping. • Following a strategic review of the way safeguarding activity and supervision is documented on PARIS, a new Safeguarding Care Document has been made available on PARIS.
5. 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 **87** IPC clinical audits were conducted during 2016/17 in inpatient areas in the Trust. **99% (86/87)** 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.

Audit Theme	Key quality improvement activities associated with clinical audit outcomes
6. Supervision	• Clinical audit findings have informed the development of the training packages to support the implementation of the new Trust Supervision Policy. • There is an ongoing specialist 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 per quarter. • The Trust Preceptorship Policy has been updated, a preceptor preparation session has been designed and delivered and standard scripts introduced to ensure meetings cover required content.
7. 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 the physical examination and harm minimisation documents. • The Trust approved abbreviation list has been reviewed and updated. • The Safeguarding Care Document on PARIS has been reviewed and updated to reduce the administrative burden on staff.
8. Environment and Equipment	• Summary guidance has been issued on the use and maintenance of posture safety belts for MHSOP wards. • Emergency bags have been checked to make sure all relevant equipment is available; work is underway to create an up to date asset register for emergency bags. • MHSOP wards have introduced weekly falls meetings.
9. Serious Incidents and Complaints	• The Clinical Audit and Effectiveness Team continued to validate SI action plans and findings have been fed back to the Patient Safety Group. • The Clinical Audit and Effectiveness Team continued to validate complaint action plans and findings have been fed back to the Patient Experience Group.
10. Transition, Transfer, Discharge and Leave	• In CAMHS a transitions flowchart has been developed and shared with teams along with a template to assist with correct completion of the Transition Care Document on Paris. The Transitions Protocol has been promoted and will be reviewed to include provision for young people who are new to CAMHS after 17.5 years of age. “My Passport” (a template to improve recording of information about patients’ transition/discharge plans) will be added to Paris. • To improve adherence to Trust Protocol for Section 17 leave, a standard flowchart has been developed for display on wards, a Leave Risk Assessment Tool has been developed for completion by the MDT following any changes to leave status. • The Trust Harm Minimisation Policy and supporting Observation and Engagement Procedure have been implemented. Standard work, detailing the process to be followed before facilitating leave, has been developed and implemented; this includes risk assessment and documentation of expectations, documentation on Paris and a Patient Leave Form.

APPENDIX 5: TRUST BUSINESS PLAN ADDITIONAL QUALITY PRIORITIES

The 5 quality priorities within this Quality Account, also sit within TEWV's 2017/18-2019/20 Business Plan. The Business Plan includes a further 10 priorities all of which will have a positive impact on the quality of Trust services. These are shown below.

No	Priority	To conclude by
1	Implement Phase 2 of the Recovery Strategy	2019/20 Q4
2	Develop and deliver the Purposeful and Productive Community Services Programme (PPCS)	2018/19 Q4
3	Improve the consistency and purposefulness of inpatient care across the Trust by implementing and building on the Model Wards work and implementation of the refreshed PIPA process	2019/20 Q4
4	Ensure we have Safe Staffing in all our services (this will address a wide number of factors including recruitment and retention, skill mix and optimisation).	2018/19 Q4
5	Ensure we address the issues with PARIS and clinical recording and maximise the benefits of existing Information Technology	2019/20 Q4
6	Refresh, communicate and implement 'The TEWV Way' across the whole organisation	2019/20 Q4
7	Implement the 5 Year Forward View for Mental Health as agreed with each of our commissioners	2018/19 Q4
8	Evaluate and agree future collaboration with universities on research, education and training	To be confirmed
9	Implement the Transforming Care agenda in Learning Disability Services	2018/19 Q2
10	Improve the clinical effectiveness and patient experience at times of transition	2017/18 Q4
11	Develop a Trustwide approach to delivering services to patients with Autism	2017/18 Q4
12	Deliver improvement to the inpatient estate in Harrogate and York	2019/20 Q2
13	Deliver a new model of care for Adult Mental Health and Mental Health Services for Older People in Hambleton and Richmondshire	2018/19 Q4
14	Reduce the number of preventable deaths	2017/18 Q4
15	Reduce occurrences of serious harm resulting from inpatient falls	2017/18 Q4

In addition to these, many of the operational plans and the enabling priorities set out within our Business Plan underpin our quality improvement agenda.

APPENDIX 6: QUALITY PERFORMANCE INDICATOR DEFINITIONS

100% of enhanced CPA patients receiving follow-contact within seven days of discharge from hospital

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*

Proportion of admissions to inpatient services which had access to crisis resolution home treatment teams

Data definition:

Gate-keeping: in order to prevent hospital admission and give support to informal carers, crisis resolution home treatment teams are required to gate-keep all admission to psychiatric inpatient wards and facilitate early discharge of patients. An admission has been gate-kept by a crisis resolution team if they have assessed** the patient 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 patients 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.*

Percentage of clinical audits of NICE Guidance completed

Data definition:

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.

Numerator:

Number of NICE Guidance audits completed within the month.

Denominator:

Number of NICE Guidance audits scheduled for completion within the month.

APPENDIX 7: FEEDBACK FROM OUR STAKEHOLDERS

County Durham Council Adults Wellbeing and Health Overview and Scrutiny Committee

DURHAM COUNTY COUNCIL ADULTS WELLBEING AND HEALTH OVERVIEW AND SCRUTINY COMMITTEE

COMMENTS ON TEES ESK AND WEAR VALLEYS NHS FOUNDATION TRUST QUALITY ACCOUNT FOR 2016/17

The Committee welcomes Tees Esk and Wear Valleys NHS Foundation Trust's Quality Account and the opportunity to provide comment on it. The Committee are mindful of their statutory health scrutiny role and the need to demonstrate a robust mechanism for providing assurance to the residents of County Durham that health service provision is efficient and effective. The quality account process provides the Committee with one such mechanism.

The Committee has engaged with the Trust on a number of issues during the course of 2016/17 including the review of Inpatient Dementia Wards serving County Durham and Darlington and associated mitigation plans for the reimbursement of additional travelling costs; the work of TEWV in respect of suicide prevention and mental health and wellbeing as part of a detailed scrutiny review and also the implications for TEWV of the NHS Sustainability and Transformation Plans and any potential service developments/variations arising therefrom.

The Committee considers that the Quality Account is clearly set out and that progress made against 2016/17 priorities is clearly identified. The Trust has made significant progress against these priorities and the continuing commitment to the development of phase 2 of the Recovery Strategy; training for staff in respect of Nicotine Management and the continuation of work to support the transition from child to adult services in 2017/18 is to be welcomed.

In considering those quality metrics where the Trust has missed its target, the under-performance in respect of patient falls per 1000 admissions is noted. The identification of this issue within Priority 5 for 2017/18 – Reduce the occurrences of serious harm resulting from inpatient falls is therefore welcome. The Committee is also pleased to see the reduction in the number of unexplained deaths classed as a serious incident per 10,000 open cases.

The Committee acknowledges all of the 2017/18 priorities identified within the draft Quality Account and agrees that from the information received from the Trust, the identified priorities for 2017/18 are a fair reflection of healthcare services provided by the Trust. We note the progress made against the 2016/17 priorities but wish to make a specific comment in relation to the 2017/18 Priority 2 – Ensure that we have safe staffing in all our services. As part of the Committee's Review of Suicide rates and mental health and wellbeing in County Durham, evidence has pointed to concerns amongst service users who have experienced problems when trying to

access Crisis services and accordingly any work undertaken by the Trust as part of Priority 2 in respect of crisis service provision is to be welcomed.

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 2017/18 priorities and performance targets in November 2017.

County Durham Health and Wellbeing Board

Contact: Andrea Petty
Direct Tel: 03000 267312
email: andrea.petty@durham.gov.uk
Your ref:
Our ref:

Sharon Pickering
Director of Planning, Performance and Communications
Tees, Esk and Wear Valleys NHS Foundation Trust
Tarncroft
Lanchester Road Hospital
Durham
DH1 5RD

Wednesday 17th May 2017

Dear Sharon

Re: Tees, Esk & Wear Valleys NHS Foundation Trust Quality Account 2016/17

Thank you for the opportunity to comment on the Tees Esk and Wear Valleys NHS Foundation Trust (TEWV) Quality Account 2016/17. The County Durham Health and Wellbeing Board appreciate this transparency and would like to provide the following comments on the document.

We acknowledge your performance against your four priority areas of improvement over the last year which were:

Priority 1: Continue to develop and implement Recovery focussed 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 the time of transition

These priorities align with the County Durham Joint Health and Wellbeing Strategy.

It was assuring to note that you have maintained your registration status with the Care Quality Commission with no conditions attached and that the Commission took no enforcement action against you during 2016/17.

It is positive to see that the performance figures during 2016/17 for improving access to psychological therapies are above target and it would be helpful to have more of a focus on therapies within the Quality Account.

/Continued…

It is important that the Quality Account aligns, where appropriate, to the County Durham Joint Health and Wellbeing Strategy, Clinical Commissioning Group Commissioning Intentions and the Better Care Fund Plan which have been agreed through the County Durham Health and Wellbeing Board.

A great deal of positive partnership working exists within County Durham between Tees Esk and Wear Valleys NHS Foundation Trust (TEWV) and other partners, including Durham County Council, Clinical Commissioning Groups and Durham Constabulary to ensure a holistic approach is provided for users of services. This can be evidenced in the work of the Mental Health Partnership Board (a sub group of the Health and Wellbeing Board). It is important that the Quality Account continues to evidence this joint work to recognise the contributions partners make to services users with mental health needs and learning disabilities.

It is positive to see the performance figures for improving access to psychological therapies are above target and it would be helpful to have more of a focus on therapies within the Quality Account.

The Health and Wellbeing Board supports the Trust's 2017/18 priorities for improvement which align to the strategic objectives in the Joint Health and Wellbeing Strategy, as follows:

	TEWV - Priorities for improvement 2017/18	**Joint Health and Wellbeing Strategy 2016-19 – Strategic Objectives**
1	Implement Phase 2 of our recovery programme	Improve the mental and physical wellbeing of the population
2	Ensure we have safe staffing in all our services	Improve the mental and physical wellbeing of the population Protect vulnerable people from harm
3	Improve the clinical effectiveness and patient experience at times of transition from child to adult services	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
4	Reduce the number of preventable deaths	Reduce health inequalities and early deaths

5	Reduce the occurrences of serious harm resulting from inpatient falls	Improve the quality of life, independence and care and support for people with long term conditions

/Continued…

The positive progress to further develop the recovery approach is welcomed. The new Harm Minimisation Policy introduction into your training programmes to ensure the recovery and wellbeing values are embedded is a positive step forward.

The continuing development of the Recovery College for Durham and Darlington is supported, which will be strengthened by the new Recovery College Online. The progress of this work has been discussed in detail at the Mental Health Partnership Board who look forward to receiving the Phase 1 evaluation of the overall Recovery Project. The Health and Wellbeing Board have also been sighted on the work taking place as part of the County Durham Mental Health Implementation Plan, for example the Children and Young People Mental Health, Emotional Wellbeing and Resilience Plan, suicide and self-harm, dementia, adult mental health and crisis care.

Crisis care continues to be a key priority area for the Health and Wellbeing Board and actions are identified in the Joint Health and Wellbeing Strategy and the local Mental Health Crisis Care Concordat action plan to ensure that we continue to improve outcomes for people experiencing mental health crisis. Conveyancing, the crisis pathway and a single point of access, section 136 responses and 'familiar faces' have been discussed in detail at the Mental Health Partnership Board and reflect positive outcomes in partnership working across agencies within County Durham. Continued partnership working on the Crisis Care Concordat will ensure that people in crisis have the best possible outcomes.

The Health and Wellbeing Board recognise the importance of workforce development to ensure that the workforce has the right skills to enable them to undertake their roles safely and effectively.

Services for people with mental health needs and learning disabilities is an area of focus within the two Sustainability and Transformation Plans which cover County Durham and it is important that there is alignment and recognition of the work taken forward by TEWV and partners within these strategic documents.

Based on feedback consistently presented to the Mental Health Partnership Board, and as evidenced by TEWV's own survey results, significant further work is required to improve the transition experience for young people moving from CAMHS to Adult Mental Health services. Improving the clinical effectiveness and patient experience at times of transition is essential to ensure a seamless service for patients and the developments relating to new telephone referral arrangements in the Durham and Darlington CAMHS service are noted as a positive step to reduce waiting times to improve the patient experience.

The importance of improving the transition process is pleasing to note, however further work is required to embed the Safe Transition and Discharge Protocol in all

CAMHS teams to ensure effective movement to Adult Mental Health services. It is suggested that a broadening of the focus for this work to include other key points of transition from a multi-agency perspective such as the move from children's to adult social care and between agencies would bring greater support to the individual child.

/Continued…

In addition to the areas that have been identified in relation to supporting a reduction in the number of preventable deaths, it is suggested that consideration is given to how people access services, and the responses they are given when in crisis, and how this impacts on preventable deaths.

The Health and Wellbeing Board recognise that the rate of falls, injuries and hip fractures in the over 65's in County Durham are higher than the national average and it is positive to see a priority in the Quality Account in relation to reducing the occurrences of serious harm from inpatient falls.

We welcome the intention to extend/expand the Person-Centred Behavioural Support (PBS) which will be essential if the challenges of post Winterbourne transformation are to be met. To maximise effectiveness it is important that this work is consolidated in the future work of enhanced community services. This would require working with a wide range of contracted care and support providers in the community to prevent future hospital admissions for people with complex learning disabilities. The Health and Wellbeing Board has received regular updates in relation to the Fast Track Plan – Transforming Care for People with a Learning Disability and will continue to do so.

If you require further information, please contact Andrea Petty, Strategic Manager – Policy, Planning & Partnerships, on 03000 267312 or by email at andrea.petty@durham.gov.uk.

Yours sincerely

Dr Stewart Findlay
Vice Chair of the County Durham Health and Wellbeing Board
Chief Clinical Officer, Durham Dales, Easington and Sedgefield
Clinical Commissioning Group

DARLINGTON
BOROUGH COUNCIL

Tees, Esk and Wear Valleys NHS Foundation Trust – Draft Quality Account 2016/17

The Health and Partnerships Scrutiny Committee remit covers the Governance arrangements of the Trust and has the responsibility to comment on the Quality Accounts, in line with its Health Scrutiny Powers. The Adults and Housing Scrutiny Committee remit scrutinises the delivery and provision of mental health and learning disability services.

Members of the Health and Partnerships Scrutiny Committee have considered the draft Quality Account 2016/17 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 2016/17, Members have the following comments to make:

Continue to develop and implement recovery focussed services – 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 which was designed to support service users to achieve their own goals; ensuring patients and their carers genuinely feel listened to and heard; views and personal expertise by experience of service users and carers being valued; service users being supported to take charge of their lives, promoting choice and self-management; and staff working in partnership with service users and carers at every level of service delivery to ensure quality of life reflected in individual care plans.

Scrutiny Members were pleased to see the key actions in relation to staff and training and the expansion of peer roles. Opportunities for individuals with lived

experience taking part in service development resulted in the Trust surpassing its performance targets and Members are delighted that the Trust has once again included this as a Priority Action for 2017/18.

Members were informed that Corporate Staff had undertaken the same training as clinical staff as this gave a better understanding and knowledge of clinical issues.

To implement and embed the revised harm minimisation and risk management approach – Members recognised the importance of this Priority in order to maximise safety for all parties involved in the care and treatment of patients and carers and, in doing so, applauded the new approach which respected patients' needs and recognised everybody's responsibility to maintain personal and public safety.

Members welcomed the benefits and outcomes of this Priority, which also supported delivery of Priority 1. We were pleased to note the recovery approach to harm minimisation which gives patients a greater sense of control, choice, personal growth and opportunities. Members were also pleased to see the involvement of both patients and families and carers in the development of personal safety plans.

Members were encouraged by the work undertaken by The Trust to deliver this Priority and noted its performance against set targets. One area of concern was that the training element target of this priority had not been met but Members were reassured by the Trust that it was taking measures, including the introduction of e-learning, to increase the number of trained staff. Members supported harm minimisation being encompassed within the Recovery Strategy, due to the project closing in March 2017, and the development of a scorecard identifying outcome measures for 2017/18.

Further implementation of the Nicotine Management and Smoking Cessation Policy within the Trust – Members recognised the continuation of this Priority, identified in 2014/15, as it was critical to improving the life expectancy and health of patients and staff.

In particular, Members noted that within the prison population smoking rates were very high at 70 to 80% of prisoners, with a high proportion having an identified mental health condition and that a reduction in smoking rates within the prisons population would improve physical health and benefit prisoners and staff in the long term.

We welcomed the benefits and aims of this Priority which include encouragement and effective support to give up smoking, access to Nicotine Replacement Therapy (NRT), trained staff to provide advice and long term improved health benefits.

Members were pleased to note that key plans for 2017/18 include further training provision for staff, recognition of areas requiring additional support to continue to implement the Nicotine Management Therapy (NRT), ensuring identified staff within North East prison estates are fully trained and ready to go smoke free on a pre-determined 'Go Live' date and rolling out the smoke free agenda to community Teams to support patients in a community setting to stop smoking.

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 were pleased to note the benefits and outcomes of this priority which aims to deliver a more positive experience for young people at points of transition and place that young person at the centre of their transition plan development and implementation to ensure the continuity of care.

A new transitions protocol has been implemented across the CAMHS teams and Members are pleased that this is a continued Priority for 2017/18 and look forward to receiving performance data.

Statement of Assurances from the Board 2016/17

Members noted that the Department of Health and NHS Improvement required the Trust to include its position against a number of mandated statements to provide assurance, from the Board of Directors, on progress made on key areas of quality during 2016/17. This included review of services; participation in clinical audits, national confidential inquiries and clinical research; goals agreed with commissioners; registration with the Care Quality Commission and periodic/special reviews; and quality of data.

We noted that a review of services was undertaken monthly by the relevant Quality Assurance Group relating to Patient Safety, Clinical Effectiveness, Patient Experience and Care Quality Commission to ensure any areas of concern were quickly acted upon.

Members noted the data in relation to the mandatory quality indicators of Care Programme Approach 7 Day follow up; Crisis Resolution Home Treatment Team acted as a gatekeeper; Patients' experience of contact with a health or social care worker; and Patient safety incidents including incidents resulting in severe harm or death and welcomed the actions the Trust had taken to improve the quality of those services.

Quality Metrics – Missed Targets – Members were informed that of 9 Quality Metrics 3 were reported as red at the end of March 2017. Unfortunately the number of in-patient falls has increased.as has the length of stay for patients in Mental Health Services for Older People in Assessment and Treatment Wards. The percentage of complaints not resolved is not on target. Members received a full explanation for these missed targets and the actions being taken by the Trust to address the situations.

Members have the following comments to make on the five Quality Improvement Priorities for 2017/18 –

Implementation of Phase 2 of Recovery Focused Services – Members welcomed the continuation of this priority in order to further embed a recovery and wellbeing approach within all Trust Services.

Ensuring Safe Staffing in all Services – Members recognised this Priority was essential for the delivery of safe, high quality, evidenced-based patient care and the importance of having staff with the right skills and competencies to deliver excellent care for people with mental health needs or with a learning disability.

Improving the Clinical Effectiveness and Patient Experience in Times of Transition from Child to Adult Services – Members supported the continuation of this Priority as a planned process of supporting young people to move from children's to adults' services. Members look forward to receiving six monthly updates at Stakeholder Events and an updated position at a future Quality Account Stakeholder Event.

Reduce the number of preventable deaths – Members recognised the importance of this Priority following the recommendations for improvement within the CQC report, Learning, Candour and Accountability.

Reduce the occurrences of serious harm resulting from inpatient falls - Members support this Priority as falls can affect a patient's quality of life and impact on family members and carers.

Overall, Health and Partnerships Scrutiny Committee welcomed the opportunity to comment on the Trust's Quality Accounts and are pleased with the Trusts progress against the chosen priorities, in a challenging year for all NHS organisations.

Members would like to receive six monthly reports on the progress being made, to enable them to provide a more detailed and valuable contribution to the Quality Accounts in the future. They would also like to continue to be invited to Stakeholders events.

Members noted the Quality Metrics within the Quality Account were to be replaced to align with the Quality Strategy for 2017/18 and this could result in future possible changes.

Councillor Wendy Newall
Chair, Health and Partnerships Scrutiny Committee

NHS
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Clinical Commissioning Group

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12 May 2017

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 2016/17

Corroborative statement from NHS North Durham Clinical Commissioning Group (CCG), NHS South Tees CCG, NHS Hartlepool and Stockton on Tees CCG, NHS Durham Dales, Easington, Sedgefield CCG and NHS Darlington CCG

The Clinical Commissioning Groups (CCGs) welcome the opportunity to review and comment on the Quality Account for Tees Esk and Wear Valleys NHS Foundation Trust for 2016/17 and would like to offer the following commentary:

As commissioners, the CCGs are committed to commissioning high quality services from Tees Esk and Wear Valleys NHS Foundation Trust and take seriously the responsibility to ensure that patients' needs are met by the provision of safe, high quality services and that the views and expectations of patients and the public are listened to and acted upon. We have remained sighted on the Trusts priorities for improving the quality of its services for its patients, and have continued to provide robust challenge and scrutiny through the Clinical Quality Review Group (CQRG) meetings with the monitoring, review and discussion of quality issues.

The CCGs have also continued throughout 2016/17 to conduct regular commissioner led inspection visits to TEWVFT sites to gain assurances and an insight into the quality of care delivered. Therefore the CCGs feel that the quality account is an accurate representation of the services provided during 2016/17 within the Trust.

The report provides a comprehensive description of the quality priorities which the Trust has focused on during 2016/17. The report provides an open account of where improvements have been made and, in particular, the trust is to be commended for their rating of 'Good' from the Care Quality Commission and their excellent work in relation to nicotine replacement which we hope will continue even though it is not highlighted as a priority for 2017/18.

It is pleasing that the Chief Executive's overview to the Quality Account emphasises the achievements made during 2016/17 to meet the needs of the services users. The CCGs would like to commend the trust on all their external achievements won by trust staff for their contributions to service improvements and patient care. The CCGs would like to congratulate TEWVFT on the trust's positive results from both the 2016 NHS staff survey and the NHS community mental health services survey.

The CCGs are pleased to note the increased work on inclusion of physical health needs in assessments of patients and the spread of research work with which the trust has been involved during 2016/17.

We have been encouraged over the last year with the positive behaviour support work, which we have seen in action when we have visited wards within the trust.

Further work undertaken by the Trust to continue development of the Recovery focussed services is acknowledged by the CCGs. This work has had a harm minimisation focus and has resulted in a number of improvements including the expansion of the peer involvement roles and the Recovery College online site. We look forward to these developments being further embedded and enhanced with the implementation of Phase 2 of the project in 2017/18.

The CCGs welcome the specific quality priorities for 2017/18 highlighted in the report and feel that they are appropriate areas to target for continued improvement but would have liked to see more focus on suicide prevention. Recognising that not all people who commit suicide are involved with mental health services the CCGs will continue to develop this work in the wider health economy with TEWVFT as a partner.

The CCGs will be reviewing the serious incident processes for all providers next year in line with the Learning from Deaths national guidance published recently in March 2017 by the National Quality Board.

The CCGs can confirm that to the best of their ability, the information provided within the Annual Quality Account is an accurate and fair reflection of the trust's performance for 2016-17. It is clearly presented in the format required and the information it contains accurately represents the Trust's quality profile and is reflective of quality activity and aspirations across the organisation for the forthcoming year.

The CCGs look forward to continuing to work in partnership with the trust to assure the quality of services commissioned in 2017/18.

Yours sincerely

G Findley

Gillian Findley
Director of Nursing and Quality
NHS North Durham and NHS DDES
Clinical Commissioning Groups

Signed in consultation with:
NHS North Durham CCG,
NHS Durham Dales, Easington

Mrs Amanda Hume
Chief Officer
NHS South Tees
Clinical Commissioning Group

Signed in consultation with:
NHS South Tees CCG and
NHS Hartlepool and Stockton on Tees CCG

Healthwatch Darlington

Comments on Tees, Esk and Wear Valley Foundation Trusts Quality Account for 2016-17 from Healthwatch Darlington.

Healthwatch Darlington have welcomed and enjoyed the opportunity to be involved with the Quality Accounts over the last twelve months and benefit from partnership working with Tees, Esk and Wear Valley NHS Foundation Trust. The Trust actively involves and engages with Healthwatch Darlington 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 2016/2017

- **Delivery of the recovery project in line with the agreed plan.**
- **Nicotine Management and Smoking Cessation.**
- **Expand the use of Positive Behavioural Support in our Learning Disabilities Services**
- **Implementation of age appropriate risk assessments and care plans for Children and Young People Services**

  Healthwatch Darlington have been pleased to see the progress of work carried out and the results that have been achieved over the last year around the above priorities. We also welcome that although some of these will no longer be priorities for TEWV, the work will continue.

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. Healthwatch participants were pleased to see an action plan and timescales in place to help implement the quality improvements. We are especially keen to see the continued progression of patient experience and patient safety and agree with the trust that it is one of the priorities for 2017/2018.

Priorities 2017/2018

Priority 1: Implement Phase 2 of the Recovery Strategy.

Priority 2: Ensure Safe Staffing in all services.

Priority 3: Improve the clinical effectiveness and patient experience in times of transition from Child to Adult service.

Priority 4: Reduce the number of preventable deaths.

Priority 5: Reduce the occurrence of serious harm resulting from inpatient falls.

Healthwatch Darlington agree with the priorities set for 2017/2018 as all 5 are essential to patient experience and care.

Healthwatch Darlington have enjoyed attending Quality Account meetings and hope the two meetings a year continue.

Healthwatch Darlington would like to thank Tees, Esk and Wear Valleys NHS Foundation Trust for their continued engagement and support, we look forward to further partnership working over the next year.

Healthwatch York

May 2017

Response from Healthwatch York to Tees, Esk and Wear Valleys NHS Foundation Trust Quality Account 2016/17

Thank you for giving Healthwatch York the opportunity to comment on your Quality Account 2016/17.

Healthwatch York very much welcomed the opportunities to work in partnership with TEWV at public engagement events during 2016/17, particularly around the consultation on the planned new mental health hospital for York. We are very pleased that TEWV have committed to involving Healthwatch York on an ongoing basis and are grateful for the way the Trust have welcomed our volunteers and enabled their continuing involvement.

In 2016/17 we were pleased to see the extent to which TEWV involved service users and carers in their work to refurbish Peppermill Court and re-establish adult mental health beds in York.

We are pleased to see that the priority to develop and implement recovery based services is being carried forward to 2017/18. Feedback received by Healthwatch York supports the view that patients and carers do want services to go beyond reducing the symptoms of mental health.

It is good to see the focus on young people transferring from CAMHS to adult services. Healthwatch York has received feedback about the lack of appropriate services for young people to transition to, which may result in young people failing to engage with services in the future.

Healthwatch York appreciates the commitment TEWV have shown to working with partners, including ourselves, to improve services.

We have found the Trust to be very responsive to concerns we raised with them following feedback from members of the public during 2016/17.

Healthwatch York shares TEWV's aim to support early intervention and prevention through the provision of good information and advice. We are very grateful to TEWV for providing funding for us to produce the second edition of our Guide to Mental Health and Wellbeing in York.

NHS
Harrogate and Rural District
Clinical Commissioning Group

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Reference: HaRD.052-17

Sent via email to:
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Sharon Pickering
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15 May 2017

Dear Sharon

Quality Account

Thank you for sending us a copy of the latest draft of the Quality Account for 2016-17 and providing me with an opportunity to feedback comments on behalf of the North Yorkshire and York CCGs.

This report has been shared with some key individuals within the CCGs and comments have been collated into my response.

The report is comprehensive and provides a significant amount of assurance that improving quality is indeed at the heart of your organisation.

I would like to focus our response on some key areas of the report but equally recognise the vast amount of work being carried out within the Trust to ensure and improve the quality of services.

The CQC rating for the core services, Adult Mental Health assessment and treatment and PICU wards remain at 'Good' which is pleasing to see and in the areas where improvements have been recommended, we are assured to see additional actions have been taken to make measurable and sustainable progress. We acknowledge and are disappointed that the rating for older peoples' mental health has deteriorated from 'Good' to 'Needs Improvement' and would wish to receive regular updates through our quality surveillance mechanisms including quality board that the progress required is part of a managed process of improvement.

The very positive Staff Survey and Friends and Family test results demonstrate the commitment of the organisation to focus on the development of its staff and was very pleasing to see.

We were invited and attended your Quality Account stakeholder engagement event where we had the opportunity to comment on the proposed priorities for 2017-18. We are pleased to see that Stage 2 of the Recovery Strategy will be a priority for 2016/17 and we agree there is still some significant work that needs to be achieved to improve the outcomes and experience of our patients and carers. We welcome the opportunity to work with you to help achieve these priorities and look forward to receiving your updates of these on a regular basis through our shared quality meetings.

We understand that not all priorities can continue for a further year of the Quality Account. However providing us with an update on the work and progress on the previous year's priorities was well received and we would wish to see momentum on these continue.

We are pleased to see once again that improving the clinical effectiveness and patient experience in times of transition from child to adult services has been chosen as a quality priority for the Trust. We recognise this as being a shared local priority and we remain committed to work with you to understand and address our local system wide issues.

We are also reassured that there will be a renewed focus on the priorities of safe staffing, skill mix and reducing the number of preventable deaths by reviewing and implementing learning from the mortality review process. It would be helpful to see this translating into the process used to embed learning from serious incident investigations or independent enquiries.

The number of local and national audits being carried out in the Trust is commendable and it would be helpful to see more information with a focus on the measurable improvement as a result of the audit recommendations and actions.

Finally, can I express our thanks for the very comprehensive patient and public enagement that took place about the future of the new mental health hospital in York.

The Quality Account provides a very thorough and reassuring account of all the work underway and we have welcomed the opportunity to review the account and note the hard work that goes into continuing to provide high quality services.

Yours sincerely

Joanne Crewe
Director of Quality and Governance / Executive Nurse
NHS Harrogate and Rural District Clinical Commissioning Group

cc: Michelle Carrington, Chief Nurse, Vale of York CCG
Gill Collinson, Executive Nurse, Hambledon, Richmondshire & Whitby CCG
Carrie Wollerton, Chief Nurse, Scarborough & Ryedale CCG

Councillor Eddie Dryden
Chair, Tees Valley Health
Scrutiny Joint Committee
C/o Town Hall
Middlesbrough
TS1 9FX

Sharon Pickering
Director of Planning, Performance and Communications
Tarncroft
Lanchester Road Hospital
Durham
DH1 5RD

11 May 2017

Dear Sharon

The Tees Valley Joint Scrutiny Committee has prepared the following statement for inclusion within the Quality Account 2016/17 for the Tees, Esk and Wear Valley (TEWV) NHS Foundation Trust. The views expressed by Hartlepool Borough Council's Audit and Governance Committee are also incorporated within this submission.

Progress against Quality Priorities 2016/17

Representatives from TEWV attended a meeting of the Tees Valley Health Scrutiny Joint Committee on 26 April 2017. The Committee was advised that TEWV had produced a Quality Account, which covered Mental Health and Learning Disability services for County Durham, York and most of North Yorkshire, as well as the 5 Tees Valley Boroughs. Locally specific data had been drawn from the full report for the benefit of the Joint Committee.

Within the 2015/16 Quality Account the Trust had agreed the following four Quality Priorities for 2016/17:-

1. Continue to develop and implement Recovery focused services;
2. Implement and embed the revised harm minimisation and risk management approach;
3. Further implementation of the nicotine replacement programme and smoking cessation project;
4. Improve the clinical effectiveness and patient experience at times of Transition Monitoring Progress.

The Committee was advised that 33 of the 35 actions within these 4 priorities were Green and 2 actions were Red - priority 3 and 4 (Transitions and Nicotine). The first Red action related to the training element of implement and embed the revised harm minimisation and risk management approach. The target had been to train 3137 TEWV clinicians by the end of March 2017 (65 per cent of the total clinical workforce of 4827). It was advised that 2044 (42 per cent) of staff had been trained. The period during which training would be provided had been extended and e-learning would be introduced from May 2017 to increase the proportion of staff trained.

The second Red action related to the training element of further implementation of the nicotine replacement programme and smoking cessation project. The target had been to train 75 per cent of community clinicians by the end the end of March 2017. During 2016/17 10 per cent of community staff had received the relevant training. The training period had now been extended to May 2017 in an effort to increase the proportion of staff trained.

Members of Hartlepool Borough Council's Audit and Governance Committee expressed concern in relation to the numbers of staff trained i.e. less than half the overall clinical workforce. Representatives indicated that the Trust was looking at a variety of ways to train staff. In addition to this, work was being undertaken in relation to recruitment through local Universities, which included ensuring that any placements offered were good quality, as many qualified nurses tended to return to work where they experienced a good placement. A representative from TEWV also indicated that recruitment of nurses was a national problem and work was ongoing across the region to explore the potential of utilising associate nurses with a foundation degree through a condensed form of nursing training.

In terms of the Quality Metrics 6 of the 9 were reported as Green and 3 Red at the end of March 2017 (full year). The 3 Red Quality Metrics were as follows:-

- Patient falls per 1000 admissions

It was advised that TEWV's position for the period April 2016 to the end of March 2017 was 64.32 i.e. 35.53 above the target of 28.79. This equated to 399 falls during this period; 120 related to people from the Tees Valley; 90 (23%) were classified low with minimal harm (patient required extra observation or minor treatment) and 27 (7%) were reported as moderate short term harm (patient required further treatment). It was explained that many of the older people in receipt of MH services were frail, displayed challenging behaviour and had complex health issues. Reporting of this issue had also improved in recent years. It was emphasised that sustained efforts including additional training and the use of hip protectors were in place in an effort to prevent patient falls.

- Average length of stay for patients

TEWV's position for the period April 2016 to the end of March 2017 in MHSOP was 78.06 i.e. 26.06 above (worse than) target of <52 days. The median length of stay was 50 days. A number of factors impacted on achieving this target including Social Care provision, Care Home capacity, lack of Nursing Home placements and the physical health difficulties experienced by older patients.

- Percentage of complaints satisfactorily resolved

The end of year data indicated that 74.87 per cent (143/191) of complaint letters did not have requests from the complainant for further review/action by the Trust. A follow up request was received in the remaining 25.13 per cent (48/191) of cases against a 10 per cent target. It was emphasised that the complaints received can be complex. These ranged from complaints regarding clinical treatment to those concerned with waiting times.

Reference was made to the high percentage of prisoners with mental health conditions and the services in place to support them. It was confirmed that TEWV does provide mental health input in prisons and a joint presentation with the prison service could be arranged for the Committee in 2017/18.

The Quality Priorities for 2017/18 were as follows:-

- Ensure Safe Staffing in all services.
- Implement phase 2 of the Recovery Strategy (a 3 year priority).
- Reduce the number of preventable deaths.
- Reduce the occurrences of serious harm resulting from inpatient falls.
- Improve the clinical effectiveness and patient experience in times of transition from Child to Adult services (second year).

In relation to staffing, Members of Hartlepool Borough Council's Audit and Governance Committee questioned how safe staffing was achieved. In response to this, representatives confirmed that it was about having the right number of staff operating at the required skill set. Representatives referred to a tool kit published by K Hurst which was being used to assess staffing levels across the region. This tool would be utilised alongside the judgement of senior nursing staff based on the wards. In relation to the staffing establishment and the ongoing work with the Hurst tool, Hartlepool Borough Council's Audit and Governance Committee requested an update on the outcome of this work when TEWV were in a position to do so regarding recommended safe staffing levels.

Reference was made to reducing the number of preventable deaths and the panel requested the figures for 2016/17. It was advised that there 107 deaths recorded and following careful consideration 2 of those cases had been viewed as preventable by the Trust.

Reference was made to concerns raised locally and nationally in respect of Children and Young People's Mental Health Services. Yet none of the Quality Priorities, other

than with reference to transitions, related specifically to Children and Young People. The Committee was advised that very few children were in receipt of inpatient MH services and South Tees CCG had commissioned a Children's Crisis Team for all 4 Boroughs, with the exception of Darlington. The Crisis Team ensured that children were kept out of hospital 24 hours a day, 7 days a week and waiting times in the Tees Valley were much lower than in other parts of the country.

TEWV have continued to engage with the Committee throughout the 2016/17 Municipal Year and Members of the Committee have welcomed the information that is shared with them.

Yours sincerely

Cllr Eddie Dryden
Chair, Tees Valley Joint Scrutiny Committee

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 2017 under the Local Audit and Accountability Act 2014. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows, and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards as adopted by the European Union, and as interpreted and adapted by the Government Financial Reporting Manual 2016-17 as contained in the Department of Health Group Accounting Manual 2016-17, and the Accounts Direction issued under section 25(2) of Schedule 7 of the National Health Service Act 2006.

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 Council of Governors of Tees, Esk and Wear Valleys NHS Foundation Trust, as a body, in accordance with section 24(5) of Schedule 7 of the National Health Service Act 2006 and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of the accounting officer and the auditor

As described more fully in the Statement of Accounting Officer's Responsibilities, the accounting officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practice's Board's Ethical Standards for Auditors.

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 1 of Schedule 10 of the National Health Service Act 2006, to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. 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:

- income and expenditure recognition;
- property valuation; and
- the risk of management override of controls. The ISAs mandate that this risk is deemed to be significant on all audits.

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's financial statements was £3.181 million, which is approximately 1% of operating expenses of continuing operations. Operating expenses of continuing operations was chosen as the appropriate benchmark for overall materiality as this is a key measure of financial performance for users of the financial statements.

We agreed with the Audit Committee that we would report to the Committee all audit differences in excess of £0.095 million, 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 as follows:

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.	Our approach involved a range of substantive procedures including: • testing of income and expenditure including tests to ensure transactions are recognised in the correct year; • testing 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 adjustment journals.

Risk	Audit approach
Property valuation Land and buildings are the Trust's highest value assets. Management engage an expert, to assist in determining the 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 Group Accounting 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; • testing the valuation of assets and valuation movements in the year; and • considering evidence of regional valuation trends.

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 2016, 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 2017.

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.

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 2017 and of its income and expenditure for the year then ended;
- have been prepared properly in accordance with the Department of Health Group Accounting Manual 2016-17; 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 of the NHS Foundation Trust Annual Reporting Manual 2016-17; 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 Annual Governance Statement does not comply with the NHS Foundation Trust Annual Reporting Manual 2016-17;
- we refer a 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 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 Annual 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 financial statements of Tees, Esk and Wear Valleys NHS Foundation Trust in accordance with the requirements of chapter 5 of part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Cameron Waddell CPFA
For and on behalf of Mazars LLP

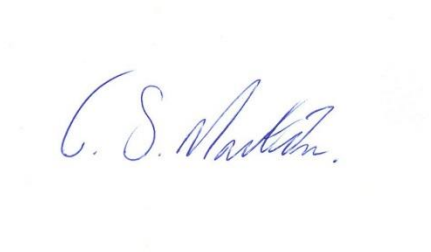
Salvus House
Aykley Heads
Durham
DH1 5TS

24 May 2017

The accounts 2016/17

(subject to audit)

The 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



Colin Martin
Chief Executive

23rd March 2017

Statement of Comprehensive Income for 12 months ended 31 March 2017

	Note	12 months ended 31 March 2017 £000	* Restated 12 months ended 31 March 2016 £000
Revenue			
Operating income from patient care activities	2	318,450	297,713
Other operating income	2	27,438	11,910
Total operating income from continuing operations		**345,888**	**309,623**
Operating expenses of continuing operations	3	(318,092)	(301,057)
Operating surplus		**27,796**	**8,566**
Finance costs			
Finance income	8	163	202
Finance expense - financial liabilities	9	(5,349)	(5,422)
Finance expense - unwinding of discount on provisions		(5)	(17)
PDC dividends payable		(3,368)	(3,494)
Net Finance Costs		**(8,559)**	**(8,731)**
Gains/(losses) of disposal of assets		(15)	434
Surplus from continuing operations		**19,222**	**269**
Other comprehensive income			
Will not be reclassified to income and expenditure			
Impairments		(983)	(4,379)
Revaluations		1,500	3,541
Other recognised gains and losses		(27)	0
Total comprehensive income / (expense) for the year		**19,712**	**(569)**

* restated following additional guidance

Statement of Financial Position as at 31 March 2017

	Note	31 March 2017 £000	31 March 2016 £000
Non-current assets			
Property, plant and equipment	12	212,320	210,388
Investments in associates (and joint arrangements)	16	125	80
Trade and other receivables	22	45	47
Other financial assets	20	420	0
Total non-current assets		**212,910**	**210,515**
Current assets			
Inventories	21	205	181
Trade and other receivables	22	16,726	6,873
Other financial assets	20	80	0
Cash and cash equivalents	25	57,845	54,148
Total current assets		**74,856**	**61,202**
Current liabilities			
Trade and other payables	26	(24,612)	(24,360)
Borrowings	27	(5,469)	(5,429)
Provisions	30	(591)	(650)
Other liabilities	28	(225)	(299)
Total current liabilities		**(30,897)**	**(30,738)**
Total assets less current liabilities		**256,869**	**240,979**
Non-current liabilities			
Borrowings	27	(80,712)	(86,181)
Provisions	30	(2,753)	(1,106)
Total non-current liabilities		**(83,465)**	**(87,287)**
Total assets employed		**173,404**	**153,692**
Financed by taxpayers' equity			
Public dividend capital		145,053	145,053
Revaluation reserve	32	19,158	18,641
Income and expenditure reserve		9,193	(10,002)
Total taxpayers' equity		**173,404**	**153,692**

The notes 1-43 form part of these financial statements.

The financial statements on pages 204-242 were approved by the Board and signed on its behalf by

Colin Martin
Chief Executive 23 May 2017

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 2016	**153,692**	**145,053**	**18,641**	**(10,002)**
Surplus for the year	**19,222**	0	0	19,222
Impairments	**(983)**	0	(983)	0
Revaluations - property, plant and equipment	**1,500**	0	1,500	0
Other recognised gains and losses*	**(27)**	0	0	(27)
Taxpayers' Equity at 31 March 2017	**173,404**	**145,053**	**19,158**	**9,193**
Taxpayers' Equity as 1 April 2015 - as previously stated	**153,891**	144,683	19,606	(10,398)
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)**

Statement of Cash Flows for 12 months ended 31 March 2017

	Note	12 months ended 31 March 2017 £000	* Restated 12 months ended 31 March 2016 £000
Cash flows from operating activities			
Operating surplus from continuing operations		27,796	8,566
Operating surplus		**27,796**	**8,566**
Non-cash income and expense:			
Depreciation and amortisation	3	3,873	4,150
Net Impairments	3	3,184	13,118
Increase in trade and other receivables		(9,733)	(304)
Increase in Other Assets		(500)	0
Increase in inventories		(24)	(10)
Increase in trade and other payables		1,331	3,403
Decrease in other liabilities		(74)	(86)
Increase in provisions		1,583	328
Net cash generated from operations		**27,436**	**29,165**
Cash flows from investing activities			
Interest received		163	202
Purchase of property, plant and equipment		(9,592)	(9,299)
Sales of property, plant and equipment		85	875
Cash from acquisitions / sales of business units and subsidiaries		(45)	(80)
Net cash used in investing activities		**(9,389)**	**(8,302)**
Cash flows from financing activities			
Public dividend capital received		0	370
Loans repaid to the Department of Health		(3,000)	(3,000)
Capital element of PFI, LIFT and other service concession payments		(2,429)	(2,319)
Interest paid		(152)	(196)
Financing element of PFI, LIFT and other service concession obligations		(5,222)	(5,258)
PDC dividend paid		(3,547)	(3,459)
Net cash used in financing activities		**(14,350)**	**(13,862)**
Increase in cash and cash equivalents	25	**3,697**	**7,001**
Cash and cash equivalents at 1 April	25	**54,148**	**47,147**
Cash and cash equivalents at 31 March	25	**57,845**	**54,148**

* restated following additional guidance

Notes to the Accounts

Note 1. Accounting Policies

NHS Improvement has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the DH Group Accounting Manual, which has been agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2016-17 DH Group Accounting Manual issued by NHS Improvement. 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 14	Regulatory deferral accounts
IFRS 15	Revenue from contracts with customers
IFRS 16	Leases

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 Inc. 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 group accounting 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 group accounting manual. The Trust has not consolidated its joint venture for the provision of North East Transformation System services (NETS) within the main accounts on the grounds of materiality as per guidance within the group accounting 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;
- the Trust does not capitalise grouped assets.

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 Group Accounting Manual. 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 are 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:

	2016/17	2015/16
Short term (<5 years)	-2.70%	-1.55%
Medium term (5-10 years)	-1.95%	-1.00%
Long term	-0.80%	-0.80%
Pensions rate	0.24%	1.37%

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.

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 2017.

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 2017. 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 has a wholly owned subsidiary company "Positive Individualised Proactive Support Limited", however the Trust has not consolidated within the Trust's Accounts on the grounds of materiality.

The Trust is a shareholder in the newly established company "North East Transformational Support Ltd", however this has not traded in 2016/17, so has no entries consolidated into the 2016/17 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 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 2017 is based on valuation data as 31 March 2016, updated to 31 March 2017 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.

The next actuarial valuation is to be carried out as at 31 March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

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 2017. 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.

Operating segments

The Trust has no elements that require segmental analysis for the period ended 31 March 2017. The chief operating decision maker has been identified as the Executive Director Chief Operating Officer post within the Trust; and on this basis the Trust has identified healthcare as the single operating segment.

The Trust does not undertake any material income generation activities with an aim of achieving profit.

Note 2.1 Operating income (by classification)	12 months ended 31 March 2017	*Restated 12 months ended 31 March 2016
Income from activities	**£000**	**£000**
Cost and Volume Contract income	53,053	52,849
Block Contract income	250,904	235,853
Clinical income for the Secondary Commissioning of mandatory services	6,971	1,752
Other clinical income from mandatory services	3,143	3,312
Other clinical income	4,379	3,947
Total income from activities	**318,450**	**297,713**
Other operating income		
Research and development	558	759
Education and training	8,077	7,482
Non patient care services to other bodies	3,519	2,550
Sustainability and Transformation Fund income	9,231	0
Other revenue	5,271	300
Rental revenue from operating leases - minimum lease receipts	568	535
Income in respect of staff costs where accounted on gross basis	214	284
Total other operating income	**27,438**	**11,910**
Total operating income	**345,888**	**309,623**

*restated following additional guidance

Note 2.2 Operating lease income	£000	£000
Rental revenue from operating leases	568	535
Future minimum lease receipts		
not later than one year;	564	507
later than one year and not later than five years;	1,279	12
later than five years.	290	24
Total future minimum lease receipts	**2,133**	**543**

Note 2.3 Non NHS income

The Trust had Non NHS income totalling £11,997k (2015-16, £8,810k)

Note 2.4 Operating income (by type)	12 months ended 31 March 2017 £000	* Restated 12 months ended 31 March 2016 £000
Income from activities		
NHS Foundation Trusts	971	880
NHS Trusts	1	0
CCGs and NHS England	312,454	292,346
Local Authorities	2,331	2,003
NHS Other	549	430
Non NHS Other	2,144	2,054
Total income from activities	**318,450**	**297,713**
* restated following additional guidance		
Other operating income		
Research & Development	558	759
Education and training	8,077	7,482
Non-patient care services to other bodies	3,519	2,550
Sustainability and Transformation Fund income	9,231	0
Other	5,271	300
Rental revenue from operating leases - minimum lease receipts	568	535
Income in respect of staff costs where accounted on gross basis	214	284
Total other operating income	**27,438**	**11,910**
Total operating income	**345,888**	**309,623**
Analysis of income from activities - non NHS other		
Other government departments and agencies	771	595
Other*	1,373	1,459
	2,144	**2,054**

*Other income is mainly from the Trusts Lifeline Project contract (£1,304k), (2015-16, £1,321k).

Analysis of other operating income - other		
Catering	141	115
Other*	5,130	185
	5,271	**300**

*Other income of £4,711k was received from commercial settlement agreements, (2015-16, nil)

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 services	322,581	292,799
Income from activities from non-commissioner requested services	23,307	16,824
	345,888	**309,623**

Note 3 Operating expenses (by type)	12 months ended 31 March 2017	*Restated 12 months ended 31 March 2016
	£000	£000
Services from NHS Foundation Trusts	5,955	4,795
Services from NHS Trusts	0	3
Services from CCGs and NHS England	9	0
Purchase of healthcare from non NHS bodies	6,723	4,073
Employee expenses - executive directors	1,081	1,194
Remuneration of non-executive directors	157	157
Employee expenses - staff	243,318	227,258
Supplies and services - clinical (excluding drug costs)	3,025	2,359
Supplies and services - general	3,570	3,198
Establishment	4,109	3,911
Research and development - (not included in employee expenses)	149	34
Research and development - (included in employee expenses)	509	744
Transport (business travel only)	3,192	2,712
Transport (other)	1,330	1,095
Premises - business rates payable to local authorities	1,480	1,277
Premises - other	15,583	14,864
Increase in provision for impairment of receivables	388	66
Change in provisions discount rate(s)	674	(57)
Drug costs (non inventory drugs only)	3,635	3,562
Rentals under operating leases - minimum lease payments	8,187	6,727
Depreciation on property, plant and equipment	3,873	4,150
Net impairments of property, plant and equipment	3,184	13,118
Audit fees payable to the external auditor		
audit services- statutory audit	40	39
other auditor remuneration (external auditor only) - analysis in note 5.5	16	8
Clinical negligence - amounts payable to the NHSLA (premiums)	1,162	902
Legal fees**	1,265	917
Consultancy costs**	684	472
Internal audit costs - (not included in employee expenses)	220	222
Training, courses and conferences	1,549	1,448
Patient travel	64	45
Car parking & security	300	155
Redundancy - (not included in employee expenses)	368	231
Hospitality	111	131
Insurance	173	104
Losses, ex gratia & special payments- (not included in employee expenses)	1,252	591
Other	757	552
Total operating expenses	**318,092**	**301,057**

*restated following additional guidance

**increased consultancy and legal expenditure was related to the commercial settlement detailed in note 2.4

Analysis of operating expenses - other

Services from local authorities	23	38
Other patients' expenses	213	185
CQC and accreditation fees	166	94
Miscellaneous	355	235
	757	**552**

Note 4.1 Employee expenses

	12 months ended 31 March 2017			* Restated 12 months ended 31 March 2016		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
	£000	£000	£000	£000	£000	£000
Salaries and wages	198,641	190,858	7,783	189,093	180,866	8,227
Social security costs	16,541	15,843	698	12,994	12,317	677
Pension costs - defined contribution plans (Employers contributions to NHS Pensions)	24,170	23,192	978	22,635	21,687	948
Pension Cost - other contributions	15	15	0	11	11	0
Agency/contract staff	5,780	0	5,780	4,971	0	4,971
Gross employee expenses	**245,147**	**229,908**	**15,239**	**229,704**	**214,881**	**14,823**
less income in respect of salaries and wages where netted off expenditure	(11)	(11)	0	(170)	(170)	0
Total employee expenses	**245,136**	**229,897**	**15,239**	**229,534**	**214,711**	**14,823**
of which:						
Costs capitalised as part of assets	228	228		338	338	0
Analysed into Operating Expenditure (page 14):						
Employee Expenses - Staff	243,318	228,148	15,170	227,258	212,552	14,706
Employee Expenses - Executive directors	1,081	1,081	0	1,194	1,194	0
Research & development	509	440	69	744	627	117
Total employee expenses excluding capitalised costs	**244,908**	**229,669**	**15,239**	**229,196**	**214,373**	**14,823**

* restated following additional guidance

The salary costs of the capital development team are capitalised over the full costs of the Trust's capital schemes, of which in 2016-17 the largest completed scheme was Parkside.

Note 4.2 Average number of employees (WTE Basis)

	12 months ended 31 March 2017			* Restated 12 months ended 31 March 2016		
	Total Number	Permanently Employed Number	Other Number	Total Number	Permanently Employed Number	Other Number
Medical and dental	324	311	13	312	302	10
Administration and estates	1,129	1,095	34	1,097	1,060	37
Healthcare assistants and other support staff	305	295	10	283	272	11
Nursing, midwifery and health visiting staff	3,466	3,458	8	3,288	3,267	21
Scientific, therapeutic and technical staff	719	699	20	687	675	12
Healthcare science staff	10	10	0	0	0	0
Social care staff	24	0	24	25	0	25
Agency and contract staff	158	0	158	120	0	120
Bank staff	268	0	268	257	0	257
Total	**6,403**	**5,868**	**535**	**6,069**	**5,576**	**493**
of which						
Number of Employees (WTE) engaged on capital projects	6	6	0	7	7	0

* restated following additional guidance

Note 4.3 Early retirements due to ill health

During the period to 31 March 2017 there were 11 (2015-16, 5) early retirements from the Trust on the grounds of ill-health. The estimated additional pension liabilities of the ill-health retirement will be £927,379 (2015-16, £384,305). 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 11 payments for termination benefits valuing £368,000 during the period to March 2017, relating to redundancy (2015-16, 4 payments valuing £231,000).

Note 4.5 Cost of exit packages

	12 months ended 31 March 2017			12 months ended 31 March 2016		
Exit Package Cost	Total number	Compulsory Redundancies number	Other Departures number	Total number	Compulsory Redundancies number	Other Departures number
<10,000	1	1	0	1	1	0
£10,001 - £25,000	4	4	0	0	0	0
£25,001 - £50,000	5	5	0	0	0	0
£50,001 - £100,000	0	0	0	2	2	0
£100,001 - £150,000	1	1	0	1	1	0
Total number of exit packages	**11**	**11**	**0**	**4**	**4**	**0**
Total resource cost (£000's)	**368**	368	0	**231**	231	0

Note 4.6 Exit packages: other non compulsory

There were no other non compulsory exit packages between 01 April 2016 and 31 March 2017, (2015-16, nil)

Note 5.1 Operating leases	12 months ended 31 March 2017 £000	12 months ended 31 March 2016 £000
Minimum lease payments	8,187	6,727
Total	**8,187**	**6,727**

Note 5.2 Arrangements containing an operating lease	12 months ended 31 March 2017 £000	12 months ended 31 March 2016 £000
Future minimum lease payments due:		
not later than one year	7,169	4,971
later than one year and not later than five years	5,982	5,894
later than five years	5,333	2,404
Total	**18,484**	**13,269**

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 2015-16).

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 (2015-16, £nil).

Note 5.5 Other audit remuneration

The Trust paid it's external auditors additional remuneration totalling £16k for the period to 31 March 2017 £8k in respect of the delivery of workshops on developing approaches to learning from deaths, providing project support and benchmarked information and £8k for work on the Quality Report (31 March 2016, £8k). Auditors remuneration for statutory audit is shown in note 3.

Note 6 Discontinued operations

The Trust has no discontinued operations at 31 March 2017 (31 March 2016, £nil).

Note 7 Corporation tax

The Trust has no Corporation Tax liability or asset at 31 March 2017 (31 March 2016, £nil).

Note 8 Finance income	12 months ended 31 March 2017 £000	12 months ended 31 March 2016 £000
Interest on bank accounts	163	202
Total	**163**	**202**

Note 9 Finance costs	12 months ended 31 March 2017 £000	12 months ended 31 March 2016 £000
Interest expense:		
Capital loans from the Department of Health	127	164
Finance costs in PFI obligations:		
Main finance cost	3,884	3,999
Contingent finance cost	1,338	1,259
Total	**5,349**	**5,422**

Note 10.1 Gains / (losses) on disposal / derecognition of assets	12 months ended 31 March 2017 £000	12 months ended 31 March 2016 £000
Gains on disposal/derecognition of other property, plant and equipment	2	0
Gains on disposal/derecognition of assets held for sale	0	439
Losses on disposal/derecognition of land and buildings	0	(5)
Losses on disposal/derecognition of assets held for sale	(17)	0
Total gains/(losses) on disposal of assets	**(15)**	**434**

Note 10.2 Impairment of assets	12 months ended 31 March 2017 £000	12 months ended 31 March 2016 £000
Over specification of assets	1,930	0
Changes in market price	3,185	15,368
Reversal of impairments	(1,931)	(2,250)
Total Impairments charged to operating surplus	**3,184**	**13,118**
Impairments charged to the revaluation reserve	983	4,379
Total Impairments	**4,167**	**17,497**

Note 11 Intangible assets

The Trust has no intangible assets as at 31 March 2017 (31 March 2016, £nil).

Note 12.1 Property, plant and equipment 2016-17

	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 2016	**213,315**	**12,771**	**195,758**	**1,305**	**662**	**84**	**1,388**	**1,347**
Valuation/ gross cost at start of period for new FTs	0	0	0	0	0	0	0	0
Additions - purchased	8,572	0	4,758	3,345	156	0	313	0
Impairments charged to operating expenses	(5,115)	(113)	(5,002)	0	0	0	0	0
Impairments charged to the revaluation reserve	(983)	0	(983)	0	0	0	0	0
Reversal of impairments credited to operating expenses	1,931	0	1,931	0	0	0	0	0
Reclassifications	0	0	918	(918)	0	0	0	0
Revaluations	1,500	0	1,500	0	0	0	0	0
Transfers to assets held for sale and assets in disposal groups	(100)	0	(100)	0	0	0	0	0
Derecognition*	(2,449)	0	(2,449)	0	0	0	0	0
Cost or valuation at 31 March 2017	**216,671**	**12,658**	**196,331**	**3,732**	**818**	**84**	**1,701**	**1,347**
Accumulated depreciation at 1 April 2016	**2,927**	**0**	**0**	**0**	**421**	**62**	**1,097**	**1,347**
Depreciation at start of period for new FTs	0	0	0	0	0	0	0	0
Provided during the year	3,873	0	3,720	0	44	12	97	0
Derecognition*	(2,449)	0	(2,449)	0	0	0	0	0
Accumulated depreciation at 31 March 2017	**4,351**	**0**	**1,271**	**0**	**465**	**74**	**1,194**	**1,347**

* Derecognition of valuation and accumulated depreciation is due to a modern equivalent asset valuation.

Note 12.2 Property, plant and equipment 2015-16

	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 2015	**223,494**	**11,916**	**205,064**	**3,620**	**610**	**84**	**853**	**1,347**
Prior period adjustments*	0	0	0	0	0	0	0	0
Restated cost or valuation at 1 April 2013	**223,494**	**11,916**	**205,064**	**3,620**	**610**	**84**	**853**	**1,347**
Valuation/ gross cost at start of period for new FTs	0	**0**	**0**	**0**	**0**	**0**	**0**	**0**
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 revaluation reserve	(4,379)	(1)	(4,378)	0	0	0	0	0
Reversal of impairments credited to operating expenses	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**
prior period adjustments	0	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Restated accumulated depreciation at 1 April 2013	**4,570**	**0**	**2,360**	**0**	**379**	**50**	**438**	**1,343**
Depreciation at start of period for new FTs	0	**0**	**0**	**0**	**0**	**0**	**0**	**0**
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 12.3 Property, plant and equipment financing

Net book value - 31 March 2017	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	125,029	12,658	107,769	3,732	353	10	507	0
PFI	87,291	0	87,291	0	0	0	0	0
Net book value total at 31 March 2017	**212,320**	**12,658**	**195,060**	**3,732**	**353**	**10**	**507**	**0**
Net book value - 31 March 2016								
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**

Note 13 Non current assets acquired by government grant

The Trust has no assets acquired by government grant (2015-16, 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
	£000	£000	£000
Net book value of assets disposed	**(100)**	0	(100)
Sale proceeds*	**90**	0	90
Expenditure associated with sale	**(5)**	0	(5)
Loss on sale	**(15)**	**0**	**(15)**

* 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 2017

	Total	Land	Buildings exc. Dwellings
	£000	£000	£000
as at 1 April 2016	**18,639**	1,864	16,775
movement in year	**519**	(25)	544
as at 31 March 2017	**19,158**	**1,839**	**17,319**

Note 15.3 NBV of property, plant and equipment in the Revaluation Reserve as at 31 March 2016

	Total	Land	Buildings exc. Dwellings
	£000	£000	£000
as at 1 April 2015	**19,606**	964	18,642
movement in year	**(967)**	900	(1,867)
as at 31 March 2016	**18,639**	**1,864**	**16,775**

Note 16 Investments	12 months ended 31 March 2017 Total £000	12 months ended 31 March 2016 Total £000
as at 1 April	80	0
additions	125	80
disposals	(80)	0
as at 31 March	**125**	**80**

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 2017 (31 March 2016, £nil) on the basis of materiality (as disclosed in note 1).

Note 18.1 Non current assets for sale and assets in disposal groups 2016-17	Total £000	PPE: Land £000	Property, Plant & Equipment £000
NBV of non-current assets for sale and assets in disposal groups at 31 March 2016	**0**	0	0
At start of period for new FTs	**0**	0	0
Plus assets classified as available for sale in the year	**100**	0	100
Less assets sold in year	**(100)**	0	(100)
NBV of non-current assets for sale and assets in disposal groups at 31 March 2017	**0**	**0**	**0**

Note 18.2 Non current assets for sale and assets in disposal groups 2015-16	Total £000	PPE: Land £000	Property, Plant & Equipment £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	306
Less assets sold in year	**(436)**	(130)	(306)
NBV of non-current assets for sale and assets in disposal groups at 31 March 2016	**0**	**0**	**0**

Note 18.3 Liabilities disposal groups
The Trust has no liabilities in disposal groups as at 31 March 2017 (31 March 2016, £nil).

Note 19 Other assets
The Trust has no other assets as at 31 March 2017 (31 March 2016, £nil).

Note 20 Other financial assets

Other financial assets at 31 March 2017 relate to a loan provided to Positive Individual Proactive Support (PIPS) services (31 March 2016, £nil).

Note 21.1 Inventories	12 months ended 31 March 2017 £000	12 months ended 31 March 2016 £000
Carrying Value at 1 April	181	171
Additions	205	181
Inventories recognised in expenses	(181)	(171)
Carrying Value at 31 March	**205**	**181**

Note 22 Trade receivables and other receivables

	31 March 2017 £000	*Restated 12 months ended 31 March 2016 £000
Current		
NHS receivables - revenue	2,715	2,371
Other receivables with related parties - revenue	709	553
Provision for impaired receivables	(443)	(86)
Prepayments (non-PFI) - revenue	3,043	2,522
PFI Prepayments - lifecycle (capital)	624	571
Accrued income	8,356	47
PDC dividend receivable	65	0
VAT receivable	698	564
Other receivables - revenue	959	331
Total current trade and other receivables	**16,726**	**6,873**
*restated following additional guidance		
Non Current		
Other receivables - revenue	45	47
Total non current trade and other receivables	**45**	**47**

Note 23.1 Provision for impairment of receivables	31 March 2017 £000	31 March 2016 £000
At 1 April	86	542
Increase in provision	436	86
Amounts utilised	(31)	(522)
Unused amounts reversed	(48)	(20)
At 31 March	**443**	**86**

Note 23.2 Analysis of impaired receivables	31 March 2017 £000	31 March 2017 £000	31 March 2016 £000	31 March 2016 £000
Ageing of impaired receivables	**Trade and other receivables**	**Investments & Other financial assets**	**Trade and other receivables**	**Investments & Other financial assets**
0 - 30 days	49	0	1	0
30-60 Days	0	0	1	0
60-90 days	158	0	38	0
90- 180 days	192	0	3	0
over 180 days	44	0	43	0
Total	**443**	**0**	**86**	**0**
Ageing of non-impaired receivables past their due date				
0 - 30 days	1,223	0	1,839	0
30-60 Days	228	0	190	0
60-90 days	440	0	130	0
90- 180 days	535	0	143	0
over 180 days	266	0	77	0
Total	**2,692**	**0**	**2,379**	**0**

Note 24 Finance leases

The Trust does not have any finance lease obligations other than PFI commitments (2015-16, nil).

Note 25.1 Cash and cash equivalents

	12 months ended 31 March 2017 £000	12 months ended 31 March 2016 £000
At 1 April	54,148	47,147
Net change in year	3,697	7,001
At 31 March	**57,845**	**54,148**
Broken down into:		
Commercial banks and cash in hand	60	133
Cash with Government Banking Service	57,785	54,015
Cash and cash equivalents as in SoFP	**57,845**	**54,148**
Cash and cash equivalents as in SoCF	**57,845**	**54,148**

Note 25.2 Third party assets held

	12 months ended 31 March 2017 £000	12 months ended 31 March 2016 £000
At 1 April	1,416	1,180
Gross inflows	3,159	3,297
Gross Outflows	(3,138)	(3,061)
At 31 March	**1,437**	**1,416**

Note 26.1 Trade and other payables

Current	31 March 2017 £000	31 March 2016 £000
NHS payables - capital (including capital accruals)	0	376
NHS payables - revenue	1,599	1,807
Amounts due to other related parties - revenue	3,683	3,766
Other trade payables - capital	606	1,197
Other trade payables - revenue	2,872	2,300
Social security costs	2,833	2,291
VAT payable	57	73
Other taxes payable	2,694	2,159
Other payables	8	2
Accruals	10,260	10,302
PDC dividend payable	0	87
Total current trade and other payables	**24,612**	**24,360**

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 were no early retirement costs in the NHS payables balance at 31 March 2017 (2015-16, £nil).

Note 27 Borrowings Current	31 March 2017 £000	31 March 2016 £000
Capital loans from Department of Health	3,000	3,000
Obligations under Private Finance Initiative contracts	2,469	2,429
Total current borrowings	**5,469**	**5,429**
Non current		
Capital loans from Department of Health	6,000	9,000
Obligations under Private Finance Initiative contracts	74,712	77,181
Total other non-current liabilities	**80,712**	**86,181**

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 2017 £000	31 March 2016 £000
Current		
Deferred income - goods and services	225	299
Total other current liabilities	**225**	**299**

Note 29 Other financial liabilities

The Trust has no other financial liabilities at 31 March 2017 (31 March 2016, £nil).

Note 30.1 Provisions for liabilities and charges 2016-17	Total	Pensions- Early departure costs	Other legal claims **	Redundancy	Other
	£000	£000	£000	£000	£000
At 1 April 2016	**1,756**	**1,157**	**431**	**168**	**0**
Change in the discount rate	674	674	0	0	0
Arising during the year	1,646	1,239	222	185	0
Utilised during the year	(520)	(171)	(181)	(168)	0
Reversed unused	(217)	0	(217)	0	0
Unwinding of discount	5	5	0	0	0
At 31 March 2017	**3,344**	**2,904**	**255**	**185**	**0**
Expected timing of cash flows:					
not later than one year	591	151	255	185	0
Current	**591**	**151**	**255**	**185**	**0**
later than one year and not later than five years	602	602	0	0	0
later than five years	2,151	2,151	0	0	0
Non Current	**2,753**	**2,753**	**0**	**0**	**0**
TOTAL	**3,344**	**2,904**	**255**	**185**	**0**

Pensions - early departure costs relating to other staff is a provision for injury benefit pensions.

Other legal claims relate to the following; employer / public liability claims notified by the NHS Litigation Authority £209,989 (2015-16, £125,651), and the provision for employment law £45,000 (2015-16, £305,000).

Note 30.2 Provisions for liabilities and charges 2015-16	Total	Pensions- Early departure costs	Other legal claims **	Redundancy	Other
	£000	£000	£000	£000	£000
At 1 April 2015	**1,411**	**1,129**	**274**	**8**	**0**
At 1 April 2015	**1,411**	**1,129**	**274**	**8**	**0**
Change in the discount rate	(57)	(57)	0	0	0
Arising during the year	734	225	341	168	0
Utilised during the year - accruals	(290)	(157)	(133)	0	0
Reversed unused	(59)	0	(51)	(8)	0
Unwinding of discount	17	17	0	0	0
At 31 March 2016	**1,756**	**1,157**	**431**	**168**	**0**
Expected timing of cash flows:					
not later than one year	650	51	431	168	0
Current	**650**	**51**	**431**	**168**	**0**
later than one year and not later than five years	206	206	0	0	0
later than five years	900	900	0	0	0
Non Current	**1,106**	**1,106**	**0**	**0**	**0**
TOTAL	**1,756**	**1,157**	**431**	**168**	**0**

Note 30.3 Clinical negligence liabilities

£1,308,490 (2015-16, £525,202) is included in the provisions of the NHS Litigation Authority at 31 March 2017 in respect of clinical negligence liabilities of the NHS Foundation Trust.

Note 31.1 Contingent liabilities	31 March 2017	31 March 2016
	£000	£000
Gross value of contingent liabilities	(99)	(182)
Net value of contingent liabilities	**(99)**	**(182)**

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 an ongoing contractual legal dispute which may result in future economic benefits relating to past events. Income has been recognised in the financial statements when it meets the criteria detailed in the Group Accounting Manual. The ongoing dispute may result in additional future economic benefits, however these have not 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.

Note 32 Revaluation reserve	31 March 2017 £000	31 March 2016 £000
Revaluation reserve at 1 April	**18,641**	**19,606**
Impairments	(983)	(4,379)
Revaluations	1,500	3,541
Asset disposals	0	(127)
Revaluation reserve at 31 March	**19,158**	**18,641**

Note 33.1 Related Party Transactions	Income	Expenditure
2016-2017	**£000**	**£000**
Value of transactions with other related parties in 2016-2017		
Department of Health	285	2
Other NHS Bodies	333,606	12,451
Subsidiaries / Associates / Joint Ventures	1,304	0
Other	2,546	42,460
Total	**337,741**	**54,913**
2015-2016		
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**

Note 33.2 Related Party Balances	Receivables	Payables
2016-2017	**£000**	**£000**
Value of balances (other than salary) with related parties in relation to doubtful debts at 31 March 2017	(150)	0
Value of balances with other related parties at 31 March 2017		
Department of Health	65	47
Other NHS Bodies	9,941	2,132
Subsidiaries / Associates / Joint Ventures	110	0
Other	1,218	9,600
Total	**11,184**	**11,779**
2015-2016		
Value of balances (other than salary) with related parties in relation to doubtful debts at 31 March 2016	(86)	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**

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 Organisations

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 2017):

Entity	Income £000	Expenditure £000	Receivables £000	Payables £000
NHS England - North East Specialised Commissioning Hub	50,087	1	327	0
NHS Durham Dales, Easington and Sedgefield CCG	47,425	0	3	0
NHS South Tees CCG	41,180	8	138	0
NHS Vale of York CCG	38,586	1	22	0
NHS North Durham CCG	36,488	12	37	0
NHS Hartlepool and Stockton-on-Tees CCG	33,646	0	0	66
NHS Hambleton, Richmondshire and Whitby CCG	15,343	0	0	60
NHS Harrogate and Rural District CCG	14,718	0	0	59
NHS Scarborough and Ryedale CCG	14,125	1	285	0
NHS Darlington CCG	13,550	0	2	0
NHS England - Core (including sustainability & transformation fund)	9,381	9	7,684	7
Health Education England	8,025	28	452	0
NHS England - Cumbria and North East Local Office	5,286	0	106	0
NHS Leeds North CCG	1,080	0	2	0
NHS Property Services	248	2,472	51	114
South Tees Hospitals NHS Foundation Trust	250	1,453	137	379
Humber NHS Foundation Trust	44	1,283	14	267
NHS Litigation Authority	27	1,162	0	0
Other DH Group	4,402	6,023	746	1,227

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	24,274	0	3,263
HM Revenue & Customs	0	16,820	0	5,527
Other Government Bodies	3,850	1,366	1,328	810

Note 34 Contractual capital commitments	31 March 2017 £000	31 March 2016 £000
Property, plant and equipment	2,644	2,397
Total as at 31 March	**2,644**	**2,397**

Note 34.2 Other Financial Commitments
The Trust has no other financial commitments as at 31 March 2017 (31 March 2016, £nil).

Note 35 Finance lease obligations
The Trust has no finance lease obligations as at 31 March 2017 (31 March 2016, £nil).

Note 36.1 On SoFP PFI obligations (finance lease element)	31 March 2017 Total £000	31 March 2017 Lanchester Rd PFI £000	31 March 2017 Roseberry Park PFI £000	31 March 2016 Total £000
Gross PFI liabilities	**187,896**	**37,618**	**150,278**	**194,043**
of which liabilities are due				
not later than one year	7,777	1,439	6,338	7,651
later than one year and not later than five years	32,223	6,298	25,925	31,350
later than five years	147,896	29,881	118,015	155,042
Finance charges allocated to future periods	(110,715)	(22,975)	(87,740)	(114,433)
Net PFI liabilities	**77,181**	**14,643**	**62,538**	**79,610**
not later than one year	2,469	448	2,021	2,429
later than one year and not later than five years	10,672	2,130	8,542	10,204
later than five years	64,040	12,065	51,975	66,977
	77,181	**14,643**	**62,538**	**79,610**

Note 36.2 On SoFP PFI service concession commitments	31 March 2017 Total £000	31 March 2017 Lanchester Rd PFI £000	31 March 2017 Roseberry Park PFI £000	31 March 2016 Total £000
Commitments				
not later than one year	10,934	2,032	8,902	10,584
later than one year and not later than five years	46,552	8,649	37,903	45,056
later than five years	270,894	45,372	225,522	280,714
Total	**328,380**	**56,053**	**272,327**	**336,354**

Note 36.3 On SoFP PFI unitary payments	31 March 2017 Total £000	31 March 2017 Lanchester Rd PFI £000	31 March 2017 Roseberry Park PFI £000	*Restated 12 months ended 31 March 2016 Total £000
Unitary payment	**10,393**	**1,939**	**8,454**	**10,604**
Consisting of:				
Interest charge	3,884	708	3,176	3,999
Repayment of finance lease liability	2,429	481	1,948	2,319
Service element	2,427	389	2,038	2,723
Capital lifecycle maintenance	307	35	272	289
Contingent rent	1,338	273	1,065	1,259
Addition to lifecycle prepayment	8	53	(45)	15
Total	**10,393**	**1,939**	**8,454**	**10,604**

*restated following additional guidance

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 2017 (31 March 2016, £nil).

Note 38 Events after the reporting period
The Trust has no events after the reporting period.

Note 39.1 Financial assets by category Assets as per SoFP	Total £000	Loans and receivables £000
Trade and other receivables excluding non financial assets (at 31 March 2017)	12,341	12,341
Other Financial Assets (at 31 March 2017)	500	500
Cash and cash equivalents at bank and in hand (at 31 March 2017)	57,845	57,845
Total at 31 March 2017	**70,686**	**70,686**

	Total £000	Loans and receivables £000
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**

Note 39.2 Financial liabilities by category	Total £000	Other financial liabilities £000
Borrowings excluding finance lease and PFI liabilities (at 31 March 2017)	9,000	9,000
Obligations under PFI, LIFT and other service concession contracts (at 31 March 2017)	77,181	77,181
Trade and other payables excluding non financial liabilities (at 31 March 2017)	19,028	19,028
Provisions under contract (at 31 March 2017)	210	210
Total at 31 March 2017	**105,419**	**105,419**

	Total £000	Other financial liabilities £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 (31 March 2016)	79,610	79,610
Trade and other payables excluding non financial liabilities (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**

Note 39.3 Fair values of financial assets at 31 March 2017	Book Value £000	Fair Value £000
Non current trade and other receivables	45	45
Other investments	125	125
Total	**170**	**170**

Note 39.4 Fair values of financial liabilities at 31 March 2017	Book Value £000	Fair Value £000
Loans	6,000	6,000
Total	**6,000**	**6,000**

Note 39.5 Maturity of Financial liabilities	31 March 2017 £000	31 March 2016 £000
In one year or less	24,707	25,305
In more than one year but not more than two years	5,343	5,469
In more than two years but not more than five years	11,329	13,735
In more than five years	64,040	66,977
Total	**105,419**	**111,486**

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 2017	Number of cases	Value £000
Losses		
Cash losses	4	0
Special payments		
Ex gratia payments	44	8
Total at 31 March 2017	**48**	**8**

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**

Note 42 Third party assets and liabilities

The Trust held £909k cash at bank and in hand at 31 March 2017 (31 March 2016, £906k) 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 £528k cash at bank and in hand at 31 March 2017 (31 March 2016, £510k) 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.

If you would like additional copies of this report please contact:

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For more information about the Trust and how you can get involved visit our website

www.tewv.nhs.uk