SPECIAL MEETING OF THE BOARD OF DIRECTORS
Wednesday 15th June 2022
at 1.00 p.m.

The meeting will be held via MS Teams

Board Members:
Board Members are asked to raise any questions for clarification on matters contained within the reports with the lead Executive Director prior to the meeting.

The 'chat' function on MS Teams should not be used during the meeting.

Governor/Public Observation:
Invitations to observe the meeting have been sent to all Governors and posted on social media and the Trust's website. Those responding will be sent instructions to join the event using MS Teams.

If you are observing the meeting please keep your microphone on mute. No questions or statements are allowed.

The timings provided in the agenda are indicative only.

AGENDA

Standard Items (1.00 pm – 1.05 pm):

1	Apologies.	**Chair**	**-**
2	Chair's welcome and introduction.	**Chair**	**Verbal**
3	To receive any declarations of interest.	**-**	**Verbal**

Strategic Items (1.05 pm – 1.45 pm):

4	Chief Executive's Report.	**CEO**	**Verbal**
5	To consider the report of the Chair of the Audit and Risk Committee.	**Committee Chair (JM)**	**Committee Key Issues Report**

6	**NHS Foundation Trust Annual Report and Accounts 2021/22:** (1) To approve the Annual Report and Annual Accounts 2021/22. (2) To approve the Letter of Representation. (3) To authorise the signing off of: ▪ The Annual Report ▪ The Performance Report ▪ The Accountability Report ▪ The Remuneration Report ▪ The Annual Governance Statement ▪ The Statement on the Accounting Officer's Responsibilities ▪ The Foreword to the Accounts ▪ The Statement of the Financial Position ▪ The Letter of Representation ▪ Any certificates relating to the above as required by NHS England/Improvement. (4) To approve the submission of the Annual Report and Accounts to NHS England/Improvement and Parliament. *(Notes:* *(1) A copy of the External Auditors' Audit Completion report will be circulated to all Board Members.* *(2) Any additional information or updated documents will be circulated prior to the meeting.)*	**CEO/DoFI**	**Draft Annual Report and Accounts 2021/22** **Draft Letter of Representation** **Report of the Director of Finance and Information on the Annual Accounts**
7	To approve the Quality Account 2021/22.	**Asst CEO/ DoN&G**	**Report**

Exclusion of the Public (1.45 pm):

8	**The Chair to move:** *"That representatives of the press and other members of the public be excluded from the remainder of this meeting on the grounds that the nature of the business to be transacted may involve the likely disclosure of confidential information as defined in Annex 9 to the Constitution as explained below:* *Information which, if published would, or be likely to, inhibit -* *(a) the free and frank provision of advice, or* *(b) the free and frank exchange of views for the purposes of deliberation, or* *(c) would otherwise prejudice, or would be likely otherwise to prejudice, the effective conduct of public affairs.*	**Chair**	**Verbal**

Paul Murphy
Chair
9th June 2022

Contact: Phil Bellas, Company Secretary Tel: 01325 552312/Email: p.bellas@nhs.net

Committee Key Issues Report

Report Date: 15 June 2022		**Report of: The Audit and Risk Committee**
Date of last meeting: 10 June 2022		**Membership Numbers: 4** Quoracy met -100% *(Joan Kirkbride, Public Governor for Darlington, observed the meeting on behalf of the Council of Governors)*
1	**Agenda**	The Committee considered the following matters: ▪ The Head of Internal Audit's Annual Report and Opinion 2021/22 ▪ The Internal Audit Plan 2022/23 ▪ The draft Audit Completion Report 2021/22 ▪ The draft Annual Report and Accounts 2021/22 ▪ The Quality Account 2021/22
2a	**Alert**	The Board is alerted to the following matters discussed at the meeting: ▪ In his Annual Report, the Head of Internal Audit (HoIA) identified significant control weaknesses in regard to: ▪ Patient property, monies and valuables ▪ Safety alerts ▪ Training needs analysis The Committee recognised that these are longstanding issues and considered it was imperative for assurance to be provided, either before or at its next meeting, that they are receiving sufficient attention from the Executive and the control weaknesses are being addressed. ▪ The HoIA's Annual Report also highlighted that the review of risk management provided "reasonable" assurance. The significant work undertaken over the last 12 months was recognised; however, the Committee considered that the focus on, and embedding of, risk management should be uppermost on the Executive's agenda as it is fundamental to quality and safety. The new Head of Risk Management is due to come into post shortly. The Committee wishes to receive assurance that this officer will be properly supported. Further improvements are required, at pace, and it is considered that a seminar should be held to provide assurance that systems and processes, capacity and capability are sufficient to deliver robust risk management. ▪ The External Auditors have identified a significant weakness in the Trust's arrangements to secure economy, efficiency and effectiveness in the use of its resources relating to the findings of the CQC inspections during 2021/22. Discussions have been held between the Chief Executive and the Director of Finance and Information and the External Auditors to agree the statement for inclusion in the External Auditors' report.

2b	**Assurance**	The Committee wishes to draw the following positive assurances to the attention of the Board: ▪ Although challenges have been experienced in the delivery of the plan, the HoIA considers that sufficient work has been undertaken to deliver a robust opinion. ▪ Notwithstanding the control weaknesses identified, the HoIA's overall opinion for 2021/22 was that: *"From my review of your systems of internal control, I am providing good assurance that there is a sound system of internal control, governance and risk management designed to meet the organisation's objectives and that controls are generally being applied consistently."* ▪ The External Auditors provided assurance that: ▪ Although some testing needs to be completed, they anticipate they will be issuing an unqualified opinion, without modification, on the financial statements. ▪ Further to the 2020/21 audit, they are satisfied that there is no longer a significant weakness in the Trust's arrangements regarding adult acute wards and PICUs. ▪ Following its review, and subject to any further matters raised by the External Auditors, the Committee was content that the Annual Report and Accounts (as a whole) provide a fair, balanced and understandable appraisal of the position of the Trust as at 31st March 2022. ▪ The Committee is content that the required statements of assurance from the Board included in the draft Quality Account are appropriate. ▪ The Internal Audit Plan 2022/23 is aligned to the Board Assurance Framework, meets the Trust's requirements and that there are sufficient resources provided to deliver it.		
2c	**Advise**	The Committee wishes to advise the Board that the Internal Audit Plan 2022/23 has been approved. The Committee also wishes to express its appreciation to the External and Internal Auditors for their work during the year and the officers in the Company Secretary's Department, the Finance Department, the Planning Department and the Nursing and Governance Directorate for their work on compiling the Annual Report and Accounts and the Quality Report.		
`	**Review of Risks**	Subject to the satisfactory completion of outstanding work, the External Auditors have concluded that there are no material issues to bring to the Trust's attention in regard to the significant risks and key areas of management judgement outlined in the Audit Strategy Memorandum.		
3	**Actions to be considered by the Board**	**Annual Report and Accounts (agenda item 6)** Subject to the completion of work and no material issues being raised by the External Auditors: (1) To approve the Annual Report and Accounts 2021/22. (2) To approve the Letter of Representation. (3) To authorise the Chair, the Chief Executive and the Director of Finance, Information and Estates/Facilities (as appropriate) to sign off the Annual Report, the Accounts and any certificates relating to them required by NHS Improvement. (4) To authorise the submission of the Annual Report and Accounts to NHS Improvement and Parliament. **Quality Account (agenda item 7)** (1) To approve the Quality Account 2021/22 and authorise its submission to the Department of Health and Social Care.		
	Report compiled by	*John Maddison, Chair of Committee* *Phil Bellas, Company Secretary*	**Minutes available from**	*Donna Keeping* *Corporate Governance Manager*

Tees, Esk and Wear Valleys
NHS Foundation Trust

Annual report and accounts

1 April 2021 — 31 March 2022

[Page deliberately left blank]

Tees, Esk and Wear Valleys NHS Foundation Trust
Annual report and accounts 2021/22

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

CONTENTS

Foreword by the chair and chief executive

Last year marked the first step in Our Journey to Change, our five-year plan that sets out where we want to be and how we will get there.

Together we embraced our three values – **respect**, **compassion** and **responsibility** - and continued to work towards our three big goals, to create a great experience for patients and carers, colleagues and partners.

Miriam Harte stood down as Chair in October 2021. We thank her for unwavering dedication and compassion.

We welcomed Paul Murphy as Interim Chair. He has been a non-executive director with the Trust since 2016 and is passionate about the quality of care we provide, and the values we live by as an organisation.

Paul has been ably supported by his Interim Deputy, Shirley Richardson, who has also continued in her position as Senior Independent Director.

There have been more of Our Big Conversations, in particular to support the development of a clinical strategy and to make sure we keep focusing on what matters most to the people who live and work in our communities.

We really value the insights and ideas that people have shared with us. These conversations reinforce our commitment to co-creation, and working together, to achieve what we set out in Our Journey to Change.

To keep up this momentum, and to make sure we involve people in our planning and decision-making in the right way, we have recruited a new Head of Co-creation and bolstered our leadership with more people with lived experience through the appointment of two Lived Experience directors.

The directors will bring a new perspective and understanding to our leadership team, and how we develop our services. No other Trust of our size has created these types of roles and we are very proud to be at the forefront of putting lived experience at the heart of our organisation.

The new roles are an integral part of our new leadership and governance structure that we developed with colleagues this year. The changes, which came into effect on 1 April 2022, mean we're more clinically led and better operationally aligned with the two Integrated Care Systems in our area.

We must also mention COVID-19, our amazing colleagues and partners have worked tirelessly through the ongoing pandemic. It has continued to impact us all, in particular our staffing levels.

A very big thank you to everyone who was involved in our COVID-19 vaccine roll out as well, helping to protect patients, colleagues and our loved ones from the worst of the virus.

Looking to the future, we know there is still more to do. This is clear from the Care Quality Commission (CQC) report published in December 2021 that highlighted areas of good practice, but also areas where we must get better.

Our Trust's overall rating remains at Requires Improvement. Beneath that umbrella rating, it's rated Good for being caring and effective, and Requires Improvement for the well-led, responsive and safe categories.

Our improvement plans are well under way and we're working closely with the CQC to give assurance that patients are safe in our care.

We have seen a great deal of commitment and support from patients, carers and their families, our Council of Governors, colleagues, the Board and our partners for everything we have been doing to take our journey forward.

Thank you for your continued support and commitment to working with us in the future.

[Signature] [Signature]

Brent Kilmurray **Paul Murphy**

Chief Executive **Chairman**

16 June 2022 **16 June 2022**

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

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

Of our 21 key performance measures, there are 10 measures where we have not achieved the standard we set ourselves.

Throughout 2021/22 we met the financial targets defined within the Trust Dashboard. However, it's important to note that this is not at the expense of our other standards.

The key drivers impacting on delivery of the quality, activity and workforce standards are the levels of demand, acuity of patients and availability of colleagues.

We are committed to improving the quality of our services and the health and wellbeing of our patients and colleagues. Considerable work is being done to improve our performance in those areas.

Waiting times standards for our IAPT services are continually met. We consistently meet the standard ensuring all adults discharged from our Clinical Care Group commissioned mental health inpatient services receive a follow-up appointment within 72 hours.

Performance continues to be impacted by national pressures throughout the NHS, and locally within our services in respect of high demand and staffing levels. We remain concerned that at times, we are not assessing or treating our patients in as timely a manner as we would like.

Despite the ongoing pandemic, during 2021/22 we continued our waiting time improvement journey with the development of meaningful waiting time reports for all our clinical services, as well as several reports focused on specialist assessment and treatment for some clinical teams.

Our patient-centred approach to waiting list management, with the focus on safety and risk by the clinical teams, is one of our key areas of achievement this past year. We will be taking forward our lessons learned into 2022/23 and will continue this important journey.

Pressures on our inpatient services are continuing, and our bed occupancy is high, with more patients on our adult and older people wards remaining in beds for over 90 days.

A key challenge continues to be the availability of beds within local funded care homes. We are also reporting an increase in the number of patients that we are placing in beds external to our Trust and are committed to eliminating out of area placements by quarter 3 2022/23.

We do not have as many people accessing our IAPT services as is our ambition across all our CCG areas, and recruitment is ongoing in all areas to facilitate increased access. We are also concerned that we are not treating children and young people with eating disorders in a timely manner.

Whilst this is a pressure in terms of demand that is being experienced nationally, this has been greatly impacted by vacancies within our services. Recruitment continues and work has been undertaken to increase the number of appointments.

Work also continues across all localities to improve our sickness levels, which continue to be higher than we aspire to. Progress is also being made in all areas to ensure that colleagues have up to date appraisals and mandatory and statutory training.

[Signature]

Brent Kilmurray,

Chief Executive,

16 June 2022

TEWV at a glance

Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) provides a range of inpatient and community mental health, learning disability and eating disorders services.

We serve a population of two million people across County Durham, Darlington and North Yorkshire and are geographically one of the largest NHS Foundation Trusts in England.

The main communities we serve include:

- County Durham
- Darlington
- The Teesside boroughs of Hartlepool, Middlesbrough, Redcar and Cleveland and Stockton-on-Tees
- City of York
- North Yorkshire – including Scarborough, Whitby, Ryedale, Hambleton and Richmondshire, Selby, Harrogate and Ripon
- The Pocklington area of East Yorkshire
- The Wetherby area of West Yorkshire
- Prisons located in the North East, Cumbria and parts of Lancashire.

We are also a catchment area for the largest concentration of armed forces personnel in the UK – Catterick Garrison – and our adult inpatient eating disorder services and adult secure (forensic) wards serve the whole of the North East and North Cumbria.

TEWV 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 2008 our Trust became the first mental health Foundation Trust in the North and, since then, it has expanded both geographically and in the number and type of services provided.

Our Trust now has around 7,800 staff, who work out of more than 90 sites, and an annual income of over £420 million.

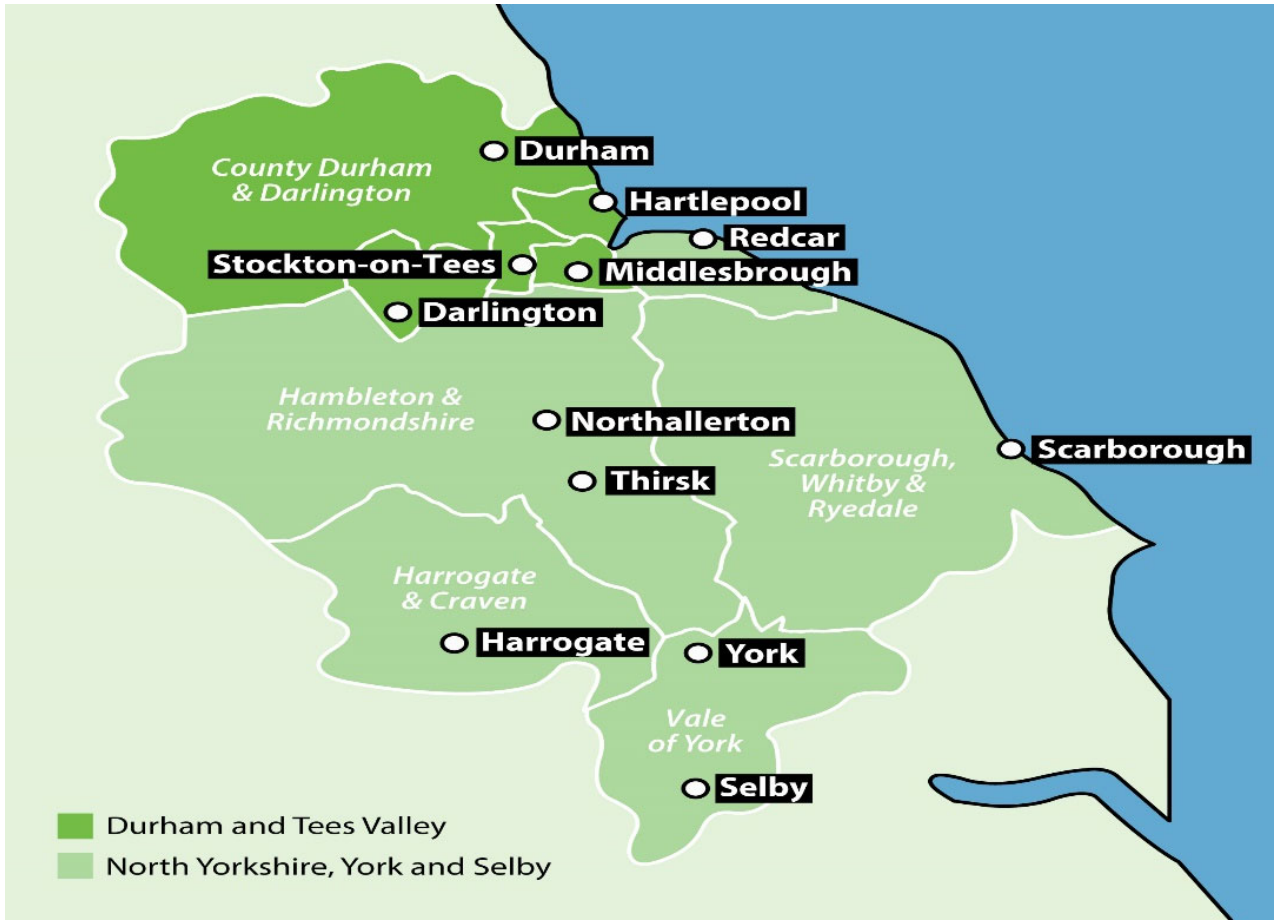
We have five clinical directorates:

- Adult Mental Health Services (AMH)
- Mental Health Services for Older People (MHSOP)
- Children and Young People's services (CYPS)
- Learning Disabilities (LD)
- Forensic (Health and Justice and Secure Inpatients)

Please note our new leadership and governance structure which came into effect on 1 April 2022 has created two separate directorates for health and justice and secure inpatient services.

As a Foundation Trust, we are accountable to local people through our Council of Governors and are regulated by NHS Improvement and the Care Quality Commission.

The principal geographic area we serve:



Purpose, Strategy and Objectives

During 2020 we held an extensive Big Conversation with colleagues, patients, carers and partners. This led to the Our Journey to Change.

It was formally approved by our Board of Directors in January 2021 and was in place for the whole of 2021/22.

Our Journey to Change

Our Journey to Change is about why we do what we do, the kind of organisation we want to be and the three big goals we're committing to over the next five years.

Change won't happen overnight, but Our Journey to Change will be at the centre of everything we do and inspire actions and decision-making at all levels - every time.

Our purpose

We are committed to improving the experience we provide for everyone.

The type of organisation we want to be

We will co-create safe and personalised care that improves the lives of people with mental health needs, a learning disability or autism, involving them and their carers as equal partners. We will listen, learn, improve and innovate together with our communities and will always be respectful, compassionate and responsible.

Our Values

We are respectful:

- We show regard for the feelings, wishes and rights of others.
- We listen actively to people to ensure their voice is heard, to truly understand their needs and perspectives.
- We are fair, inclusive and embrace diversity, in all its forms, while actively tackling inequality.
- We work in partnership with those we serve and those we work with to make the best choices about care, together.

We are compassionate:

- We take the time to develop healing relationships, empathise and support others, this means: We are kind, showing patience and understanding, and treating others as we'd like our loved ones to be treated.
- We are supportive of the wellbeing of everyone, at all times.
- We recognise and celebrate each other's achievements and encourage people to utilise and share their strengths.

We are responsible:

- We are accountable for our actions, learn from our mistakes and always strive to do our best for others, this means:
- We are honest, open and transparent, and help each other to speak up and challenge.
- We acknowledge when things haven't gone well, learn from, and correct our mistakes, and share that learning with others.
- We are ambitious, showing dedication to our roles and the people we serve.

At the heart of Our Journey to Change is our clear and shared ambition to work in partnership with those who use our services. We call this partnership working co-creation.

We want patient and carer voices to be sought out, heard and acted upon at every level of the organisation, from a clinician and patient making decisions together to write a care plan, through to peer workers delivering care as an integral part of our teams.

We are committed to three big goals:

- To co-create a great experience for our patients, carers and families
- To co-create a great experience for our colleagues
- To be a great partner

We believe that through working together, bringing lived experience alongside professional knowledge, we can better understand the needs of the people we support and communities we work in.

The move from traditional engagement and involvement to co-creation reflects our ambition as a Trust to see a shift in power, shared decision making and meaningful change.

Business Plan

The Trust's Business Plan 2021/22-2023/24 sets out the action needed to implement our goals. However, we also recognise that we need some individual strategies to break down our Journey to Change into meaningful action.

Work to develop these journeys will conclude in 2022/23 and includes:

- Clinical Journey
- Quality (including safety, patient experience and clinical outcome) Journey
- Co-creation Journey
- Workforce Journey

- Infrastructure (including digital and estates) Journey

Our Business Plan includes many actions intended to progress us towards our goals. We were not able to successfully implement the whole plan, due to the length of the pandemic and other unanticipated regulatory pressures on the organisation which required capacity to be redirected and some parts of our longer-term plans to be paused.

Achieving our goals

To make sure we achieve our goals we have co-created five key priorities.

1. **Co-creation is at our core**

   We will know we've achieved this when patients, carers and colleagues work confidently together, living our values, sharing a purpose and achieving our goals.

   Patients and carers in particular have a strong and authentic voice, with their views equally considered alongside the views of others.

   Their opinions, feedback, concerns and ideas are always sought out, heard and acted upon at every level and within every location.

   By March 2025 we want to see patients, staff, carers and other groups working together as the "norm" – a way of working we call "co-creation".

To do this we will:

- Expand the way we use peer support.
- Develop an involvement and leadership structure to support services.
- Involve patients and carers as equal partners, in all aspects of service planning, design, implementation, delivery,

evaluation and all aspects of the assurance process.
- Establish a Lived Experience Advisory and Reference Network (LEARN).

2. We have a clear clinical approach

We want to offer compassionate clinical care, to be there when people need us, and provide kindness and care every time someone's in contact with our services. We'll know we've achieved this when we offer care which is:

- Built on and recognises strengths so people stay connected to their community and those who care for them.
- Designed in close collaboration with the individual and their carer – this is what we mean by co-creation.
- Honest and with shared decision-making, with services available where and when people need them to make sure there's continuity of care.
- Safe, effective and inclusive of people's rights.
- Makes the best use of staff expertise.
- Helping people to live well.

To do this we will:

- Make care planning collaborative, co-created and comprehensive.
- Ensure our clinical services comply with the Human Rights Act.
- Provide choice and quality of care which is NICE compliant and safe. We will make sure that the offer is clearly stated, available and accessible to staff, patients and referrers in each area.
- Engage with transformation work in our local communities to provide support and challenge to plans to maximise the benefits of the transformation.

3. Systems Leadership

We'll know we've achieved this when TEWV works effectively with a range of partners in different systems and places, so people's mental health, learning disability and autism needs are better understood and their quality of life is increased and supported.

To do this we will:

- Help communities work in new ways to increase and improve the support available to improve the wellbeing of people with a mental health, learning disability or autism needs.
- Ensure that the views and needs of people with mental health needs, a learning disability or autism, and their carers can positively influence discussions, planning and decisions in all systems and places.
- Work with local partners to promote good mental wellbeing and tackle stigma across all age groups.

4. We're a great place to work

We'll know we've achieved this when we help everyone who works at TEWV to feel proud of their personal contribution to supporting people to live their best possible lives. People feel that working at TEWV positively impacts on their lives and their wellbeing.

To do this we will:

- Engage with staff at all levels to co-create our new ways of working together.
- Support people to be the best they can be through a focus on compassionate and inclusive leadership that supports us all to develop and find our work meaningful.
- Support all colleagues to develop, by making sure there is fair access to training that is relevant and adds value.
- Support career progression by focusing on skills and experiences which people can bring to different roles.
- Ensure organisational systems and processes are supportive of a great place to work.

5. An Empowering Infrastructure

We'll know we've achieved this when we offer excellent, innovative care that's supported by systems that are effective, accessible and empower people who use them. These systems provide wrap around support for our colleagues, patients, carers and partners. People are easily connected to the accurate information they need, our physical spaces support high-quality care and our decision making processes are simple and transparent.

To do this we will:

- Connect the right people with the right expertise to identify problems and create solutions.
- Make sure our governance systems support safe, simple and responsive decision making.
- Ensure our digital systems offer the best possible opportunities for collaboration and communication.
- Always provide the right information, at the right time and in the right format.
- Make sure our physical spaces support the new types of care we want to deliver.

Trust Organisational Structure

On 1 April 2022 we introduced a new governance and organisational structure in a response to environmental changes, and to better pursue Our Journey to Change.

However, during 2021/22, TEWV was still using a four-locality based structure – covering Durham and Darlington, Teesside, North Yorkshire and York and Forensic Services.

Each locality had:

- A Director of Operations and Deputy Medical Director, Head of Nursing and Lead Psychologist in its leadership team.
- A Locality Management and Governance Board and Quality Assurance Groups for the clinical services of CAMHS, Adult Metal Health, Adult Learning Disabilities and Older People.
- The Forensic Locality (which includes secure services and criminal justice services) was organised in a similar way.

Most TEWV services serve either the Humber and North Yorkshire or North East North Cumbria Integrated Care Systems.

We are supporting the integration agenda by working closely with our commissioners and neighbouring trusts. This includes Provider Collaboratives for specialist services and commissioning partnerships in Durham and Tees Valley and

in North Yorkshire.

Key issues, opportunities and risks which could affect the Trust in delivering its objectives and/or its future success and sustainability

TEWV serves around two million people living in a variety of communities across the North East and Yorkshire – some with high levels of deprivation. In such areas, there is clear evidence of health disparities and above-average levels of demand on our services.

However, people living in more affluent communities also have mental health needs and, for a variety of conditions such as eating disorders, the level of demand can be higher.

Many communities served by our Trust in North Yorkshire and County Durham are very rural, with significant areas of low population density. Some of these areas, as well as parts of Tees Valley, also have poor transport links and low/declining levels of social capital.

Although TEWV serves a wide area, it does not include any of the UK's regional capitals – which can make it more difficult to attract medical staff.

There are a number of risks that could impact on the delivery of Our Journey to Change. An analysis of the principal strategic risks, together with the controls and mitigations, is included in our Board Assurance Framework and is described in our Annual Governance Statement.

Some of these risks arise from national conditions such as the availability of staff and high levels of demand which have increased following the pandemic.

In many ways the issues and risks impacting on us also provide opportunities. These include:

- Feedback from Our Big Conversation was challenging but helped us develop Our Journey to Change. This sets out how we will get where we want to be.

- Regulatory action taken by the Care Quality Commission (CQC) and NHS England/Improvement (NHS E/I) has provided greater insight and key learning into the improvements we need to make. With the establishment of the internal Quality Improvement Board and the external regional Quality Board and Improvement Director Team, we have support in moving forward and delivering our strategic goals.
- Our response to weaknesses found in our governance arrangements, by the external and independent well-led review, has provided a platform to strengthen our structures, systems and processes.
- The ongoing defect rectification work at Roseberry Park will allow us to develop a fit for purpose inpatient estate which fully supports the delivery of high quality clinical care.
- The implementation of integrated, system and place based working could impact on our sustainability but also could provide us with greater influence to make changes for the benefit of patients and their carers.

Changes in the policy environment that TEWV has been required to consider during 2021/22 include:

- Working with commissioners and partners to deal with the implications of the pandemic, including developing plans to invest the additional resources identified part-way through the year by the Government. Some of this investment was used for additional clinical posts, but we also worked with commissioners to ensure that funding was also passed to the voluntary and community sector for early intervention and discharge-promoting work.

- Preparations for the introduction of Integrated Care Boards and Partnerships : we have been particularly active in working in partnership with commissioners to decrease unnecessary bureaucracy and maximise value for money achieved from commissioning budgets through clinically informed decision making.

- The NHSE policy of Community Mental Health Transformation: we have worked with the voluntary sector, local authorities and primary care groups to develop multi-agency mental health access and delivery models. These will be rolled out across the area we serve during 2022/23.

- The continuation of the national Transforming Care policy, which sets targets for reduced inpatient bed use for people with learning disabilities. The Trust contributed to the success of the North Yorkshire and York Transforming Care Partnership, but in the North East has found the legal issues around the MM Judgement and lack of suitable community placements to be an issue.

- Autism: We have worked with commissioners to increase training and support available to colleagues and sought to communicate effectively with private sector providers commissioned to offer additional diagnosis capacity after Covid restrictions impeded face-to-face diagnostic services – leading to long waits for patients. We noted, and are also considering, the implications of the new national Autism Strategy.

- The updating of the NHS Patient Safety Strategy.

Performance analysis - how we performed in 2021/22

How we measure our performance

Each year our Board of Directors identifies and agrees a number of stretching, performance and quality standards, that are measured by a number of key performance indicators for the Trust to work towards as part of its commitment to year-on-year improvement. 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 to give assurance that the Trust is continuing to deliver operationally. The report aims to highlight key areas of concern that could impact operationally; areas we feel require additional monitoring as well as providing positive assurance on areas we are performing well on. We also make it available to our patients and carers, commissioners and wider public. A summary is presented and discussed with our Council of Governors as part of the formal Council of Governors meetings.

During 2021/22 we continued with the indicators originally identified for 2020/21. We also continued to use Statistical Process Control charts to support our analysis, and as a way of demonstrating and thinking about whether things were really improving or getting worse – to see if the change being seen in numbers was due to normal variation or real change.

The Board of Directors discusses the Trust Dashboard each month in terms of where we have positive assurance, but also areas of concern where improvement is needed. Where there are areas of concern, detailed analysis is undertaken in the form of a “deep dive” and presented as part of the report. This would include what the key conclusions are from the analysis undertaken, and what actions are being taken to improve performance in this area. If the Board of Directors identifies any trends which could impact on the Trust and operational delivery, then this would be escalated through the Risk Management processes.

It is important to note that we measure performance in several ways and have a range of performance dashboards in use across TEWV – the Trust Dashboard being one example. 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 delivery of high-quality care.

Other examples where we use performance dashboards include the System Oversight Framework, where we measure progress against the national standards set and our Commissioner Reports – which demonstrate progress against the key performance indicators agreed in the contracts we hold with our commissioners. We also have a range of waiting time reports, which provide oversight on the number of patients waiting and the length of time waited. This supports clinical services in monitoring and managing risk from a patient safety and quality perspective.

As part of the continuous improvement of the Trust’s Performance Management Framework, we have been developing a more integrated approach to quality and performance assurance and improvement across the Trust during 2021/22. We will be implementing a new Integrated Performance Dashboard (IPD) in 2022/23 which will enable us to have oversight, monitor and report key measures that demonstrate the delivery of the quality of services we provide and provide assurance to the Board through its sub-committee structure. The measures for the new IPD were identified by the relevant Board Sub Committees and agreed by the Board of Directors.

All the measures have been aligned to one of our three strategic goals and, where appropriate, support the monitoring of the Board Assurance Framework risks.

At Board Level, this new approach will bring together the agreed measures and assurances from the Board Sub Committees into an Integrated Performance Report. The benefits of such an approach include:

- Integrated assurance about the quality of services being delivered to ensure we are meeting our Strategic Goals, the standards within the CQC domains and mitigating the risks within the Board Assurance Framework.
- Triangulation of data and information (both qualitative and quantitative) about the quality of service being provided which should then enable a better and more informed discussion at the Board.
- Ability to identify areas of concern more easily and understand what else is impacting so we can assess whether the actions being taken will have the desired impact.
- One report as opposed to multiple reports where assurance is provided by the Board Sub Committee rather than individual corporate departments.

A more detailed analysis and explanation of the financial and operational performance

The following table is the Trust's dashboard of key performance measures for 2021/22. Please note we have only included commentary on areas requiring improvement.

Quality

Measure Name	Annual Standard 2021/22	Actual Position 2021/22	Commentary
1) Percentage of patients seen within 4 weeks for a 1st appointment following an external referral	90.00%	86.56 %	The Trust standards we agreed for 2021/22 have not been achieved. Performance has been impacted by national pressures throughout the NHS, and locally within Trust services, in respect of high demand and the availability of staff to manage that demand. Throughout 2021/22 we have experienced challenges in recruiting staff. We have undertaken detailed analysis in all 3 geographical localities and a number of key actions are in place to improve performance in this area.
2) Percentage of patients starting treatment within 6 weeks of an external referral	60.00%	57.60%	
3) The total number of inappropriate OAP days over the reporting period (rolling 3 months) *NB This indicator measures the number of days a patient spends in a hospital within the Trust that is not the one to which we would expect them to have been admitted due to no beds being available in the*	1833	701	Performance against this standard has improved in 2021/22 and we have eliminated all internal out of area placements as we have embedded the NHS Continuity of Care Principles across our services. However, we have reported an increase in the number of patients that we have placed in beds external to our Trust, due to current local demand levels, which are being mirrored nationally.

hospital we would have expected them to have been admitted to			During 2021/22 steps were taken to close one of our Adult Mental Health wards due to a number of staff vacancies on the ward; this ensured we were providing clinically safe care for our patients. Five private provider beds were purchased until June 2022, to help mitigate the impact and to manage our capacity. Further actions have been identified to support improved performance in this area, with the plan to eliminate external OAPs by Quarter 3 of 2022/23.
4) Percentage of patients surveyed reporting their overall experience as very good or good	94.00%	89.73%	We have not achieved the standard we set ourselves for 2021/22. Patient Experience Improvement Plans have been established in all of our localities; however, progress has been impacted by operational pressures. We remain dedicated to ensuring our patients experience high quality care in our services.
5) Percentage of Serious Incidents which are found to have a root cause of contributory finding	32.00%	60.40%	This is an area requiring improvement, as the Trust standard we agreed for 2021/22 has not been achieved. All serious incidents are captured on a central database to enable the identification of themes and key learning and there are a range of actions in place to improve performance in this area.
6) Percentage of in scope teams achieving the benchmarks for HoNOS score (AMH and MHSOP) – month behind *This is a clinical outcome measure; an*	60.00%	47.06%	The Trust standards we agreed for 2021/22 have not been achieved, therefore these are areas requiring improvement. We have identified more clinically meaningful measures for our 2022/23 Integrated Performance

improvement in HoNOS is shown by an increase in the patient's actual HoNOS score. The change is identified by comparing the first HoNOS score calculated on admission, and the score on discharge.			Dashboard, which will support the new national Commissioning for Quality and Innovation measures.
7) Percentage of in scope teams achieving the benchmarks for SWEMWBS score (AMH and MHSOP) – month behind	65.00%	64.37%	

Activity

Measure Name	Annual Standard 2021/22	Actual Position 2021/22	Commentary
8) Number of new unique patients referred	N/A	98,147	
9) Percentage of new unique patients referred with an assessment completed (2 months behind)	N/A	77.37%	
10) Percentage of new unique patients referred and taken on for treatment (3 months behind)	N/A	32.92%	Performance has been impacted by high demand and the availability of staff to manage that demand, and throughout 2021/22 we have experienced challenges in recruiting staff. We have undertaken detailed analysis in 3 localities to understand the position better and actions are in place to improve performance in this area.
11) Number of unique patients discharged (treated only)	N/A	34,152	
12) Bed Occupancy (AMH and MHSOP Assessment and Treatment Wards)	90.00%	98.13%	Throughout 2021/22 our inpatient wards have been greatly impacted by high demand and patient acuity. In addition, COVID has continued to impact our services by way of staff absences and restrictive measures that have

			been required to prevent the spread of infection. During 2021/22 steps were taken to close one of our Adult Mental Health wards due to a number of staff vacancies on the ward; this ensured we were providing clinically safe care for our patients. Five private provider beds have been purchased until June 2022 to help manage our capacity, and actions have been identified to support improved performance in this area.
13) Number of patients occupying a bed with a length of stay from admission greater than 90 days (AMH and MHSOP Assessment and Treatment Wards) - Snapshot	61	60	
14) Percentage of patients re-admitted to Assessment and Treatment Wards within 30 days (AMH and MHSOP)	9.90%	8.36%	

Workforce

Measure Name	Annual Standard 2021/22	Actual Position 2021/22	Commentary
15) Finance Vacancy Rate	N/A	-7.83%	
16) Percentage of staff in post with a current appraisal - Snapshot	95.00%	79.95%	Work has been undertaken within all localities and trajectories have been established to ensure we achieve our Trust standard by September 2022.
17) Percentage compliance with all mandatory and statutory training - Snapshot	92.00%	86.67%	Work has been undertaken within all localities to focus on key training, for example Basic Life Support, Safeguarding and Positive Approaches Training, and trajectories have been established to ensure we achieve our Trust standard by September 2022.
18) Percentage Sickness Absence Rate (month behind)	4.30%	6.45%	The Trust standard we agreed for 2021/22 has not been achieved. Whilst our sickness has been impacted by covid throughout the year, in particular the Omicron variant over the winter months, we have undertaken detailed analysis in all localities to understand the position better and actions are in place to improve performance in this area.

Money

Measure Name	Annual Plan 2021/22	Actual Position 2021/22	Commentary
19) Delivery of our financial plan (I and E)	-4,767,000	5,949,000	The Trust targeted a (£4,720k) surplus for the first 6 months of the financial year (H1), and delivered a £5,021k actual surplus. A second half (H2) surplus of (£47k) was planned, providing a full year planned surplus of (£5,068k). Composite financial performance is deficit of £4,032k, adjusted for impairments of (£10,638k) and disposal profits of £509k - both are excluded when measuring performance. The Trust's operational performance is therefore a surplus of (£6,098k) to 31st March, or (£1,030k) ahead of the 2021/22 plan.
20) CRES delivery	2,301,000	2,300,996	As a result of national financial arrangements operating during the pandemic, the focus on CRES was initially suspended. The NHS was asked to recommence CRES delivery in 2021/22 with a view to returning to more normal arrangements from 2022/23; nationally, 0.28% was targeted during H1 (April to September) with a national requirement of 1.1% during H2 (October to March). Guidance included a national tariff efficiency requirement of 1.1% for 22/23. The revenue plan has CRES modelled at 2% in recognition of the non-recurrent requirement scheme delivery during 21/23. In preparation, the Trust is starting to focus on identifying 2022/23 recurrent

			efficiency or waste reduction schemes through annualised Business Planning arrangements and with Financial Sustainability Board oversight.
21) Cash against plan	76,498,000	81,695,554	Cash balances are £5,198k higher than plan. This reflects the £1,030k higher than planned surplus, £701k lower than planned capital expenditure, and other movements in working capital including increased accruals linked to capital, IT equipment, where invoices from suppliers have not yet been received, and Thank you payments that were approved at the March Board of Directors meeting and payable at the end of April.

Financial Performance

In 2021-22 our Trust managed the financial risk presented by the COVID-19 pandemic, working with its Integrated Care System partners to ensure financial plans and capital allocations were delivered.

The 2021-22 Financial Strategy was agreed by the Board of Directors as part of the Trust's Integrated Business Plan and underpinned the achievement of the Trust's strategic objectives.

Our objectives, both planned and achieved, are shown in the following table:

Objectives	Outcomes
Delivering a £4.8m financial surplus.	Financial surplus before impairments and profit on sale of assets of £5.9m realised.
Delivering an EBITDA of £12.9m	EBITDA of £13.3m delivered
Delivery of £2.3m cash releasing efficiency savings	Delivery of £2.3m of non-recurrent cash releasing efficiency savings.
EBITDA margin of 3.0%	EBITDA margin of 3.0% achieved

*EBITDA – earnings before interest taxation depreciation and amortisation

Our Trust planned an operating surplus of £4.8m for the financial year and realised a surplus (excluding impairments and profit on sale) of £5.9m. The surplus was higher than planned mainly due to unplanned income received in year.

The amount Cash Releasing Efficiency Savings (CRES) schemes achieved at 31 March 2022 was £2.3m and was in line with plans, though the total was delivered on a non-recurrent basis. Our Trust is making good progress with future years plans, albeit that the return to more normal national financial arrangements and funding levels will require a return to pre-pandemic ways of working; the basis on which the national funding settlement was agreed.

Capital Investment

Our Trust has worked within its agreed capital allocations to improve the infrastructure and ensure the most modern equipment and technology is available for patient care and to support colleagues.

Over the last 12 months and, working with partners to manage the constraints of a system capital envelope, we have invested cash balances with the aim of providing the best possible environments. During 2021-22, the Trust invested £16.5m in capital assets. Two surplus capital assets were sold for a combined total of £1.9m. Net of those disposals, capital expenditure for the financial year was therefore £14.6m.

Asset Valuation

The Trust's land and buildings were subject to a market price revaluation exercise, which resulted in impairments as follows:

	2021-22 £m	
	Realised in surplus	Realised in reserves
Impairments	16.2	0.1
Reversal of impairments	(5.5)	0
Revaluation gains	0	(1.0)
Total loss (gain) realised	**10.7**	**(0.9)**

When realised in the surplus (or bottom line revenue position), net impairment losses are recognised as expenditure.

Working Capital

The Trust had strong liquidity which decreased from 43.4 to 34.2 days, principally due to expenditure on capital projects.

Equality of service delivery to different groups

Strategic Objectives

A revised Equality, Diversity and Human Rights Strategy for 2020–2023 was
approved by the Board of Directors in January 2020. The revised strategy is more aligned with our vision, mission and strategic goals, as set out in Our Journey to Change.

As part of the development of this strategy a consultation was held with patients, carers, and staff and partner organisations during 2019. There was an encouraging level of engagement in the consultation exercise. A number of very clear themes emerged from this consultation and these themes have helped to shape the objectives in the strategy. Objectives 3, 4 and 5 relate to service delivery.

Objective 3:

To ensure we have a suitably trained and skilled workforce to address the needs of Trans patients and colleagues.

Progress
Good progress has been made with the staff training on working with Trans staff and patients. Feedback from colleagues has been very positive and bespoke sessions have been delivered to some teams who are working with a Trans patient. The review of HR policies to ensure that they meet the needs of Trans staff, particularly in relation to recruitment and staff records will be complete by end of Q2 2021/22. Work is ongoing to ensure all processes relating to Trans staff and patients are in line with legal guidance. A lunch and learn on LGBTQ+, which will be advertised to all staff is to be held in June 2022

Objective 4:

To increase the recording of disability and sexual orientation on Paris and ESR of patients and staff and training is being developed to support staff to ask demographic questions.

Progress
A publicity campaign has been launched to address this issue and training on the importance of asking demographic information and how to ask has been incorporated into the EDHR training and the LGBTQ+ training.

Objective 5:

To increase the number of BAME patients who access services within the Trust and report a positive experience.

Progress
Localities have made good progress in working with their BAME communities. For example, Teesside held a recruitment event for members of the BAME community to encourage them to apply for jobs in the Trust – and to identify barriers to them doing so. Teesside now have a BAME link worker. The voluntary services team's steps towards employment programme have reached out into our diverse communities.

- The full strategy is available at https://www.tewv.nhs.uk/about/equality-and-diversity/strategy/
- Publication of patient information is available on the TEWV website at: https://www.tewv.nhs.uk/about/equality-and-diversity/approach/

Human rights issues

Control measures are in place to ensure that all of our obligations under equality, diversity and human rights legislation are complied with. Human rights issues are reported to the Equality, Diversity and Human Rights steering group. We are also working with the British Institute of Human Rights to provide training to colleagues on human rights issues.

Environmental Matters

Environmental Management: Building a Net Zero NHS

Over the past six months our Trust has developed a Green Plan which seeks to embed sustainability and low carbon practice in the way we offer vital healthcare services and help the NHS to become the first health service in the world with net zero greenhouse gas (GHG) emissions.

This Green Plan serves as the central document for TEWV's sustainability agenda and provides the rationale for sustainability at the Trust. Through this Green Plan, TEWV will work with our staff, patients and partners to take powerful sustainable development and climate action as part of our commitment to offer the highest quality care to our communities.

Our Green Plan Vision

Net Zero: Resource consumption and Greenhouse Gas (GHG) emission reductions that align with NHS net zero targets

Climate Resilience: Reducing the environmental impact of our activities and providing a basis for us to become a climate change-resilient organisation.

Social Value: Actions that leverage our role as a place-based anchor institution to accomplish social value

Our Green Plan has nine Areas of Focus that appraise our status and set actions to be achieved within the next three years: Workforce and Systems Leadership, Sustainable Models of Care, Digital Transformation, Travel and Transport, Estates and Facilities, Medicines, Supply Chain and Procurement, Food and Nutrition and Adaptation.

Single use plastics

Our Trust signed up to the NHS Single-Use Plastics Reduction Campaign Pledge and over the past two years has committed to, and achieved within the deadline, the following: -

- *No longer purchase single-use plastic stirrers and straws, except where a person has a specific need, in line with the government consultation*
- *No longer purchase single-use plastic cutlery, plates or single-use cups made of expanded polystyrene or oxo-degradable plastics*
- *Go beyond these commitments in reducing single-use plastic food containers and other plastic cups for beverages – including covers and lids*

Electric vehicle infrastructure

Using assisted funding provided by The Office of Low Emission Vehicles, our Trust has increased the availability of electric vehicle charging points strategically across our sites.

We have used the maximum permitted available funding and increased the number of plug-in points to 60 over the past five years. Ten of these points are dedicated for electric estates vehicles; 32% of the estates department vehicles are 100% electric powered.

Energy performance operational rating

In the annual Government Display Energy Certification exercise rating of our buildings (A to G with D being typical) of the 36 qualifying properties surveyed, 19 of the buildings were rated C and above with only six properties failing to achieve the typical. Actions to improve performance are being explored, linked to the Trust's Green Plan.

Biodiversity

Greenspace and nature are important for the health and wellbeing of our service users and colleagues alike. At a global scale, greenspace affects the planet's ability to absorb carbon dioxide.

To enhance our greenspace, a project to transform a 3,500m^2 area across four of our sites into wildflower meadows has been implemented. We have also introduced four wellbeing gardens across our Trust, as well as a wooded walkway at Lanchester Road hospital.

Going Concern

For non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern.

After making enquiries, the directors have a reasonable expectation that the services provided by Tees, Esk and Wear Valleys NHS Foundation Trust will continue to be provided by the public sector for the foreseeable future.

For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

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.

[Signature]

Brent Kilmurray
Chief Executive
16 June 2022

The Directors' Report

The Chairman, Deputy Chairman, Chief Executive and other Board Members as at 31 March 2022:

The Chair

Paul Murphy, Chair of the Trust and Chair of the Strategy and Resources Committee and the Nomination and Remuneration Committee.

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 and Related Literature

Principal skills and expertise: Strategic planning, operational management, change management, human resources, communications, education, and articulating the patient voice.

Term of office: 1 September 2019 to 31 August 2022*

Date of Initial appointment: 1 September 2016

Notes:

- *Paul was appointed as the Chair of the Trust in October 2021 on an interim basis pending the appointment of a new substantive Chair.*
- *In addition to being the Chair of the Trust, Paul is also the Chair of Trustees at the York and North Yorkshire Welfare Benefits Unit and Chair of Trustees at the National Centre for Early Music)*

Non-Executive Directors

Shirley Richardson, Deputy Chair, Senior Independent Director and Chair of the People, Culture and Diversity Committee and the West Lane Project Committee.

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. Until October 2021 she was Chair 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 2019 to 31 August 2022*

Date of Initial appointment: 1 September 2016

Note: Shirley was appointed as the Deputy Chair of the Trust in October 2021 on an interim basis pending the appointment of the new substantive Chair.

Dr Charlotte Carpenter

Charlotte is Executive Director of Growth and Business Development at Karbon Homes, a leading social landlord within the North East. She is responsible for Karbon's development programme of 550 new homes a year, the investment plans for Karbon's existing 30,000 properties, and also leads the strategy and insight, and communication and business development teams.

Charlotte began her career in the Civil Service Fast Stream and has a passion for housing's role in the economic and social regeneration of the North East. This was borne from senior roles with One Northeast and The Northern Way – a precursor to the Northern Powerhouse.

Charlotte joined the social housing sector in 2008, working for Home Group as Director of Strategy, Policy and Communications.

Charlotte is an alumnus of Cambridge and York universities and holds a PhD in Medieval History.

She is a member of the CBI North East Council, the CBI's National Infrastructure Board and the Chartered Institute of Housing's Policy Advisory Committee. She also holds a CaCHE Fellowship exploring the role that housing associations can play in the Foundation Economies of 'Left Behind Places'.

Qualifications: PhD, MA (Cantab), MA (York)

Principal Skills and experience: Strategy and strategic planning, communications, marketing and public affairs, organisational transformation, research and insight, programme and project management

Term of office: 1 September 2021 to 31 August 2024

Date of Initial appointment: 1 September 2021

Jill Haley

Jill is an accomplished chief executive and housing professional with extensive and varied leadership skills, knowledge and experience. Having spent the majority of her 40-year housing career in social housing, working with diverse and disadvantaged communities, she has a gained a wide exposure of dealing with people who suffer mental health issues.

Her experience in housing has included a path of continuous learning, growth and personal development which has afforded her a diverse range of skills and knowledge across housing association, local authority and the private sector. Throughout her career, her enthusiasm for excellence in leadership has inspired her to develop further and to develop others.

Jill's work on leading and empowering staff and communities has attracted both regional and national recognition, including various personal and organisational awards. The story surrounding the success of her leadership approach has been included as a chapter in a book titled 'Hope Under Neoliberal Austerity' published in April 2021.

Jill's employment as the chief executive of a housing association for over nine years, has provided her with an in-depth and specialist knowledge of strategic leadership, planning, good governance, assurance, risk management and collaborative working. Her broad skill set includes strategy development, finance, governance, risk management, housing management, housing development, regeneration, business growth, sales and marketing, communications and PR, and customer service excellence. Jill is also a Chartered Management Institute level 5 qualified coach and mentor.

Qualifications: Fellow Chartered Institute of Housing, Bachelor of Arts Degree Housing Studies and Chartered Management Institute - Coaching and Mentoring Level5 Certificate

Principal skills and experience: Excellence in Leadership, Culture and Performance, Business Transformation, Strategic Planning, Finance, Governance, Risk Management, Coaching and Mentoring.

Term of office: 1 September 2021 to 31 August 2024

Date of Initial appointment: 1 September 2021

Professor Pali Hungin, Chair of the Mental Health Legislation Committee

Pali, a GP by background, qualified at Newcastle University and practiced in the Stockton area for 25 years. He was the Founding Dean of Medicine and the Head of the School of Medicine, Pharmacy and Health at Durham University from 2003 to 2014 and the President of the British Medical Association in 2017.

Pali is currently Emeritus Professor at the Institute of Health and Society in the Faculty of Medical Sciences at Newcastle University. Pali served as a Governor of TEWV from its inception as a Foundation Trust, to 2016. He presently leads the Academy of Medical Royal Colleges' commission on impending developments in healthcare and the evolving role of clinicians. He also works with Genome England and is the Trustee Treasurer of the Royal Medical Benevolent Fund.

Qualifications: MBBS MD FRCP FRCGP FRSA

Principal skills and expertise: Academic developments, recruitment and retention of clinical staff, physical health status of patients, organisational culture.

Term of Office: 1 September 2019 to 31 August 2022
Date of initial appointment: 1 September 2019

John Maddison, Chair of the Audit and Risk Committee and the Commissioning Committee

John retired in June 2019 after working in the NHS for 37 years. He studied Economics and Accountancy at Loughborough University and joined the NHS as a graduate trainee accountant in Yorkshire. The majority of John's career was based in the North East working in Finance, primarily in the acute sector and senior positions at the strategic tier including NHS England. He was Director of Finance and Informatics at an acute FT in the North East and a large teaching hospital in the North Midlands prior to joining Gateshead Health FT in 2014 as Group Director of Finance and Informatics and latterly as Deputy Chief Executive and Acting Chief Executive for the final year prior to retirement.

Qualifications: BSc Econ/Acc. Chartered Institute of Public Finance and Accountancy.

Principal Skills and Expertise: Operational and strategic finance and planning, governance and risk management and performance management.

Term of Office 1July 2020 to 30 June 2023

Date of Initial appointment: 1 July 2020 (prior to his appointment John served as an Associate Non-Executive Director of the Trust (non-voting) between 1 January 2020 and 30 June 2020).

Bev Reilly, Chair of the Quality Assurance Committee

Bev has been a Nurse for 35 years. Up until recently, Bev was the Director of Nursing and Quality for NHS England covering Cumbria and the North East. Her long career has spanned a number of organisations across acute, primary and community care settings at a local, regional and national level. She is experienced in quality assurance and regulatory requirements having led on this as part of her role within NHS England and close working with NHS Improvement and the Care Quality Commission.

Qualifications: RGN, BA (Hons)

Principal skills and expertise: Nursing leadership, quality assurance, patient safety, patient and staff experience, risk management, strategic planning, partnership working.

Term of Office: 1 September 2019 to 31 August 2022

Date of initial appointment: 1 September 2019

Jules Preston, Associate Non-Executive Director (non-voting)

Jules has extensive experience in the NHS, having served as the inaugural Chairman of the Northumberland, Tyne and Wear NHS Foundation Trust, one of the largest mental health and learning disability Trusts in the country. During his period of chairmanship, the trust successfully came together having been 3 separate organisations and it achieved Foundation Trust status in 2009/10. In 2012 Jules began a new Chairman's post at Mid Yorkshire Hospitals NHS Trust.

Jules had previously been a Non-Executive Director of other NHS organisations, including the former Sunderland Health Authority (1996-2000) and the then Northumberland, Tyne and Wear Strategic Health Authority (2000-2006).

Jules has also held senior positions with the Manpower Services Commission (Department of Employment) and Chief Executive of Sunderland City Training and Enterprise Council and Business Link. Following that he was, for more than two years, part-time Chief Executive of the National Glass Centre in Sunderland.

He was until 2012 an assessor, both in the UK and internationally, of organisations that were working to achieve 'Investor in People' status and received an MBE in 1999 for services to training, particularly for those with special needs.

Qualifications: Left school at 16 and trained as articled clerk in Chartered Accountancy for 2½ years focussing on audit work before joining the Civil Service as a clerical officer. Principal grade within 20 years, focusing on adult and youth training, small business development and Investors in People. Training and education through personal development, on the job.

Principle Skills and Experience: People skills, leadership, change management, understanding of finance, 25 years involved as a non-executive within the NHS

Term of Office: 1 November 2021 to 30 June 2022

Date of initial appointment: 1 November 2021

Roberta Barker, Associate Non-Executive Director (non-voting)

Roberta is a UK and Ireland HR and OD Director for Teva Pharmaceuticals, a global $17bn business, where she has created a comprehensive people strategy, developed a learning management system and established a technology-led, senior business partner model.

Roberta began her main career in HR with sporting retailing giant Nike where she was Head of Learning and Development EMEA. From there, she moved on to Daichii Sankyo EMEA as Director of People and Performance before taking on responsibility for the Director of People and OD role for the Business Services Authority, covering multiple divisions of services for the NHS.

Roberta has held various permanent and interim leadership positions within the Health Service including Trust Director of Workforce People and OD at Medway NHS Foundation, Director of Workforce and OD at Yorkshire Ambulance Trust, Director of People and OD at NHS Digital and Director of HR and OD at Royal Surrey County Hospital.

Qualifications: Master of Business Administration, Durham University, Common Purpose, Sunderland University

Principal skills and expertise: HR and OD strategy, change management, strategic planning, operational implementation, communications and employee engagement, stakeholder management

Term of Office: 1 November 2021 to 30 June 2022

Date of initial appointment: 1 November 2021

Executive Directors

Brent Kilmurray, Chief Executive

Brent has been a NHS executive director since 2005, working in senior roles across a range of acute, community health and mental health NHS organisations. He joins us after two years as Chief Executive of Bradford District Care NHS Foundation Trust, a combined community and mental health trust providing services in Bradford and the Yorkshire Dales, as well as children's services in Wakefield.

His Board level experience includes Executive and Divisional roles at City Hospitals Sunderland NHS FT, joint Managing Director at NHS South of Tyne and Wear Community Health Services, Executive Director of Business Strategy and Performance for South Tyneside Foundation Trust, and Chief Operating Officer and Deputy Chief Executive for Tees, Esk and Wear Valleys NHS Foundation Trust.

Alongside his Trust role, Brent also sits on the NHS Providers Board of Trustees, which is a national membership body for all NHS organisations where he represents provider views in discussions alongside other Trust Chief Executives and Chairs from across the country.

Qualifications: MA European Studies and BA (Hons) Government and Politics

Principal skills and expertise: Quality improvement and innovation, leadership development, partnership and system working, operational service management, performance management, tendering and business development, contract management, commercial matters.

Appointed: June 2020

Elizabeth Moody, Executive Director of Nursing and Governance and Deputy Chief Executive

Elizabeth was delighted to join the Trust in July 2015 as Director of Nursing and Governance. She has over 25 years' experience in the NHS having registered as an RMN in 1991. Before joining the Trust, Elizabeth held a variety of clinical, professional and managerial roles across inpatient and community mental health and Learning Disability settings. Elizabeth is responsible at Board level for the professional leadership of nursing, quality and safety. She is a Certified Leader for the Trust's Quality Improvement System and Think On coach.

Qualifications: RMN, PGDip Professional practice

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

Appointed: August 2015

Liz Romaniak, Executive Director of Finance, Information and Estates

Liz joined the NHS over 30 years ago and gained extensive associate/deputy director and board-level experience from roles within commissioning and community and mental health provider organisations.

Liz's previous role was as director of finance, contracting and estates at Bradford District Care NHS Foundation Trust, where she led work in 2014 to 2015 to develop the organisation's long term financial plan and successfully navigate all financial aspects of the Trust's Monitor FT application and due diligence processes.

Liz also had responsibility for planning and performance and between 2017-2021, was deputy chief executive, both roles affording opportunities to develop greater operational and clinical perspectives. Liz has lobbied, including via NHS representative bodies, for parity of esteem (and resources) for mental health, including relating to capital developments. Liz is also a board member of the AuditOne NHS Audit consortium and a member of the HFMA's Governance and Audit Committee.

Qualifications: Qualified accountant, ACMA

Principal skills and expertise: NHS finances (strategy, costing, financial accounting and management, commissioner and provider), financial strategy, planning and performance management.

Appointed: October 2020

Dr Stephen Wright, Interim Executive Medical Director

Stephen Wright is an early intervention psychiatrist and Trust medical lead for early intervention services. He was formerly deputy medical director for North Yorkshire and York. He has worked in Community Psychiatry and Early Intervention since EIP services were first developed, supporting the increasing emphasis on prevention.

He is Clinical Lead for Mental Health for Humber Coast & Vale Integrated Care System and also Clinical Lead for Adult Mental Health with Yorkshire & Humber Early Intervention Clinical Networks, through which he provides clinical leadership into the community transformation programmes.

He has a long-standing interest in Youth mental health, and research interests include harnessing the therapeutic wealth of the community (for example in the multicentre SCENE study) and in reducing the physical health inequalities faced by people with mental illness.

He has led study visits to the WHO Collaborating Centre in Trieste, Italy, where they have developed an acclaimed system for mental health care delivery based on human rights and whole system community support, with a view to supporting meaningful development of community mental health care both locally and regionally in the UK.

Qualifications: MBChB MSc DipRCPath MRCPsych

Principal skills and expertise: Adult Mental Health, Early Intervention in Psychosis, Youth Mental Health, Student Mental Health, Research Principle investigator, Quality Improvement System Certified Leader.

Appointed: September 2021

Ann Bridges, Executive Director of Corporate Affairs and Involvement (non-voting)

Ann joined the Trust in September 2021 bringing extensive skills, knowledge and expertise in strategic communications and engagement, having worked in local government and across the public sector at senior level for over 20 years.

Originally from Edinburgh, Ann moved to the North East in 1999 leaving behind a career with Scottish Enterprise in regeneration and economic development marketing roles, having delivered the first and now renowned Edinburgh Christmas Market. Ann cut her teeth in local government having joined Newcastle City Council in 2000, working her way through the organisation as well as with central Government, and was laterally head of communications at Northumberland County Council before joining the Trust.

The new corporate affairs and involvement function will encompass our patient, carer and family involvement and engagement work, feeding into and supporting co-creation, patient experience, feedback, complaints and PALS, plus communications and stakeholder engagement, as well as working with our people and culture team on staff engagement supported by good internal communications.

Ann is also an active member of the CIPR North East, former member of the CIPR Local Public Services Committee, and newly appointed on the CIPR Health Committee.

Qualifications: Professional Diploma from the Chartered Institute of Marketing (CIM), Chartered Institute of Public Relations (CIPR) Accredited Practitioner

Principal skills and expertise: Strategic communications and engagement

Appointed: September 2021

Dr Sarah Dexter-Smith, Director for People and Culture (non-voting)

Sarah is a consultant clinical psychologist who has worked in the NHS for over 25 years alongside roles in social care and education. She was appointed in February 2021 and was previously director of therapies. She brings a broad range of applied psychology experience having worked on regional and national bodies.

Qualifications: Doctorate Clinical Psychology, PhD Psychology, ILM5, PGDips Supervision/ Neuropsychology

Principal skills and expertise: Leadership, coaching and mentoring, applied psychology, research, teaching.

Appointed: February 2021

Sharon Pickering, Assistant Chief Executive (non-voting)

Sharon joined the NHS in 1989 on the then Regional Financial Management Training Scheme. In 1996, moved to the North East and into a planning / commissioning role. Sharon joined one of the predecessor organisations, County Durham and Darlington Priority Services NHS Trust, in 2000 as head of planning and has been with the trust ever since. She became Director of Planning and Performance at the Trust in 2008 (need to check that date) and Assistant Chief Executive in 2021.

Qualifications: Chartered Institute of Public Finance and Accountancy (CIPFA), MBA in Public Services and the Kings Fund Top Management Programme

Principal skills and expertise: Strategic Planning, Business Planning, Business Development Performance Management, Commissioning, Project Management

Appointed: 2000

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

Changes to the Board of Directors

- Miriam Harte stood down from her role as the Chair of the Trust on 1 October 2021

- Dr. Hugh Griffiths retired from his role as a Non-Executive Director on 31 June 2021
- Dr Ahmad Khouja, Medical Director, became the Trust's Chief Clinical Strategy Officer on 30 August 2021
- Ruth Hill was seconded from her role as the Chief Operating Officer to become a Programme Director at Harrogate and District NHS Foundation Trust on 1 August 2021
- Russel Patton was seconded from Cumbria Northumberland Tyne and Wear NHS Foundation Trust to be the Trust's Interim Chief Operating Officer between 30 August 2021 and 28 February 2022
- Patrick Scott and Zoe Campbell are due to join the Board in 2022/23 as the Managing Directors for Durham, Tees Valley and Forensics and North Yorkshire, York and Selby, respectively

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 is available on our website www.tewv.nhs.uk, search register of interests

NHS Improvement's well-led Framework

In this section of the Annual Report, we provide an overview of how we have had regard to NHS Improvement's well-led framework in arriving at our overall conclusions about the position of the organisation.

The well-led framework is based on eight domains covering:

- Clarity of vision and credibility of strategy
- Leadership capacity and capability
- Clarity of roles and systems of accountability
- The appropriateness and accuracy of information
- Engagement with patients and carers, the public, staff and external stakeholders
- Learning, continuous improvement and innovation
- Processes for managing risks, issues and performance
- Culture

In 2020/21 we commissioned the Good Governance Institute (GGI) to carry out an independent developmental review of leadership and governance using the framework:

The Board received GGI's report in April 2021 and accepted all of its recommendations. An implementation plan was approved with progress monitored by the Board.

Developments undertaken during the 2021/22 include:

- An independent and externally led programme of Board development supported by Deloitte LLP
- A skills audit of Board members and the appointment of new Non-Executive Directors
- A refresh of our Board Assurance Framework to align with "Our Journey to Change"
- A review of our risk management arrangements including risk appetite and tolerances
- A review of the Board Committee structure, and associated terms of reference, to focus on assurance, strategic risks and the delivery of Our Journey to Change
- A review and refresh of the delivery of our People Plan
- Improvements to processes to support staff raise concerns and issues
- A review of our management and governance structures focussing on simplification, clarity of accountability and responding to changes to the NHS landscape
- The development of an integrated performance assurance framework which brings together all sources of assurance, both qualitative and quantitative, and provides a clear thread of performance reporting from the new Care Group Boards, through the assurance committees and up to the Board

- Improvements to our arrangements to support the identification and sharing of learning aligned to Our Journey to Safer Care

In recognition of the significant progress made, the Board closed the implementation plan in February 2022. Any ongoing elements are being taken forward through existing programmes and action plans.

The Annual Governance Statement and the performance report reflect the action taken to develop and improve leadership and governance in response to the well-led review.

The NHSI Well-led Framework is available at: www.england.nhs.uk/well-led-framework/

Arrangements for monitoring improvements in the quality of healthcare and progress towards meeting any national and local targets

Between 14 June 2021 and 5 August 2021, our Trust received a series of core service inspections from the CQC. This included inspections of Secure Inpatient Services, Adult Mental Health Crisis Services and Health Based Places of Safety, Adult Mental Health Community Services and Community Child and Adolescent Mental Health Services. Core service inspections were also followed by a well-led inspection of the Trust.

Following the inspection, the CQC raised several areas for improvement with a Section 29A notification received for Secure Inpatient and Community Child and Adolescent Mental Health Services. Immediate action plans were developed in response to these issues, and implementation has been well progressed with robust weekly reporting to the Trust's Quality Improvement Board.

The deadline for implementation was 1 March 2022. It is, however, recognised by the CQC that fully embedding some of these actions, and the impact, will require longer timescales. Section 29a issues were subsequently encompassed by the CQC within the Must Do regulatory actions included within the Trust CQC inspection report issued on 10 December 2021. Our Trust was rated as 'requires improvement' overall.

A copy of the report may be viewed at: https://api.cqc.org.uk/public/v1/reports/39d313da-63b8-4a46-a423-11f1958c89b0?20211223164650

The report identified a number of regulatory breaches from which 'Must Do' and 'Should Do' actions were stipulated. A collective, collaborative approach was taken to the development of a comprehensive Trust action plan and a facilitated event took place on 21 December 2021.

The action plan in response to each of the findings was co-created by patients and carers, staff from across all specialties inspected, senior managers and the senior leadership team. It was approved by the Trust Quality Improvement Board on 19 January 2022 and submitted to the CQC on 21 January 2022. The action plan was formally accepted by the Trust Board on 27 January 2022. A further event was also held in March 2022 to develop the action plan for delivery of the 'should do' actions.

We have robust arrangements for oversight and monitoring of the delivery of all actions arising from inspections undertaken by the CQC. This includes designated Director leads for all actions and review by both strategic and operational governance forums, including the Quality Assurance Committee (a Board sub-committee).

The CQC carried out an inspection of 367 Thornaby Road residential care home between 7 December 2021 and 11 January 2022. The service successfully retained the rating of 'Good' overall and for each domain. A copy of the report can be viewed here: https://www.cqc.org.uk/location/RX3LD

Performance against key health care targets

Our 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 the NHS System Oversight Framework (SOF). This section will focus on the national ones within the SOF, which are formally reported to the Board on a quarterly basis and by exception to the Board on a monthly basis.

There are 10 Long Term Plan priorities for which standards are applied within the System Oversight Framework, underpinned by seven supporting measures. The Trust has consistently achieved the following four measures:

- IAPT/Talking Therapies - waiting time to begin treatment within 6 weeks
- IAPT/Talking Therapies - waiting time to begin treatment within 18 weeks
- Percentage of adults discharged from CCG-commissioned mental health inpatient services receive a follow-up within 72 hours.
- Data Quality Maturity Index

In relation to the remaining 6 measures:

- At Trust level IAPT recovery rate has performed better than standard for 2021/22, although we have not achieved standard within the Vale of York area.
- At Trust level IAPT in-treatment waits are better than standard for 2021/22, although we have not achieved standard within the North Yorkshire and Vale of York areas.
- The proportion of CYP with ED (routine cases) that wait four weeks or less from referral to start of NICE-approved treatment has consistently reported below standard for 2021/22 across all CCG areas. Nationally there has been an increase in demand and this has been reflected in all our teams.
- The proportion of CYP with ED (urgent cases) that wait one week or less from referral to start of NICE-approved treatment has consistently reported below standard for 2021/22 across all CCG areas. Nationally there has been an increase in demand and this has been reflected in all our teams.
- While the number of inappropriate adult acute mental health Out of Area Placement (OAP) bed days (internal or external) have greatly improved, and we have eliminated all internal out of area placements as we have embedded the NHS Continuity of Care Principles across our services, the standard we agreed with NHSE has not been achieved due to an increase in the number of inappropriate external adult acute mental health Out of Areas Placements bed days (*see bullet below*). Nationally demand for inpatient beds has increased and this has been reflected in the occupancy of our beds, thereby increasing the number of patients we have placed in beds external to the Trust.
- The number of Inappropriate adult acute mental health Out of Area Placement (OAP) bed days (external only) have increased. Nationally demand for inpatient beds has increased and this has been reflected in the occupancy of our beds, thereby increasing the number of patients we have placed in beds external to the Trust.

Performance during 2021/22 has been impacted by high demand and staff capacity within many Trust services and actions are in place to support improvement. Significant work has been undertaken to enhance a number of our service models, and to improve recruitment to vacant posts. However, while we work closely with staff to support their health and

wellbeing, staff sickness continues to be higher than we would aspire to.

There are four measures for which national ambitions at Clinical Commissioning Group level have been set:

- Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy.
- Number of CYP aged under 18 supported through NHS funded mental health with at least one contact.
- Number of people accessing IPS services.
- Number of women accessing specialist community PMH services in the reporting period.

While the Trust has not achieved the ambitions set nationally for each individual CCG, work has been undertaken with Clinical Commissioning Group partners to develop a set of local trajectories for these measures as part of the 2022/23 operational planning round for mental health services. These have been submitted to NHS England and Improvement for approval. Our proposals, while achievable, are stretching to support progress towards the national ambitions.

Progress towards targets agreed with local commissioners

We provide regular performance information to commissioners as part of the mental health contract covering activity and key measures of quality.

Our commitment to contract performance management is evidenced through routine contract performance and quality meetings with commissioners, which are regularly attended and have full participation of senior staff.

These meetings/groups focus on areas such as service quality, service development and finance.

There was one operational standard and one national quality requirement included within the 2021/22 mental health contract, which were:

- Number of episodes of mixed sex accommodation – sleeping
- Duty of Candour (failure to notify)

These were consistently achieved for the 2021/22 financial year.

Information on complaints handling

Complaints are managed following national guidance and we endeavour to respond to all formal complaints within 60 days.

We have a complaints manager aligned to each locality area of our Trust, who works with the relevant operational staff member, patient and/or carer to resolve issues raised.

We use the learning from complaints as an opportunity for improvement, in the same ways as feedback from patient surveys. This is built into individual team plans and trust wide work where applicable.

Service improvements following staff or patient surveys/comments and Care Quality Commission reports

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

- AMH community services: Patients thought that if fellow patients could socialise, it would be beneficial for them to see they're not so unusual. The team organised a monthly peer support social group, in collaboration with patients, to support people meeting others who have similar experiences. They have also organised a hearing voices group to support with this experience specifically.

- MHSOP community services: Carers did not feel they had been provided with enough information to help them in their role as a carer. The team identified a nominated nurse, who had the task to contact local carer support services and find out what was available in the local area. We also worked with carers to design a leaflet which can be given at any time in their loved one's journey, which will inform them of what support is available.

- MHSOP inpatient ward: Feedback highlighted that medication side effects were not always explained to them. The ward discussed this with the on-site Pharmacy team and medical team, who are always available should any

questions pertaining to prescribed medications arise. Staff always aim to outline the most likely side effects, however they appreciate that individuals experience medications differently. The most appropriate available staff member was asked to talk with an individual if they felt they haven't remembered what has been said, or if they wanted to revisit the information.

- Forensic Secure Inpatient Ward: Patients reported that they weren't given information regarding external agencies that can aid in recovery. The ward contacted the Independent Mental Health Advocate (IMHA) and Forensic community teams to invite them to attend community meetings for signposting to available agencies. They also created a ward lead for *United Voices* and the *Recovery College,* to maximise recovery and rehabilitation opportunities.

- Eating Disorders Inpatient ward: Patients stated that they didn't feel involved enough in the planning of their care. The ward created a duplication of the current document used in the MDT meeting – a handout for each individual to complete, so that a person can bring their own thoughts on their care to the MDT and discuss the plan moving forward. They also introduced a Clinical lead on any admission date, so they can work through the initial care plan alongside a new individual and highlight personalised needs.

A significant range of improvements have been implemented following the Trust CQC inspections. These include:

- An organisational restructure
- Improved governance arrangements
- Increased leadership capacity
- Board development (with increased oversight through the Board and its sub-groups)
- Revised risk management arrangements
- Improvements in recruitment and Retention
- Quality Assurance Programmes utilising qualitative and quantitative indicators
- Organisational learning infrastructure
- Increase in compliance with statutory and mandatory training

An engagement meeting was held with the CQC on 9 March 2022, where our Trust presented the extensive improvement work undertaken in response to the core service inspections of secure inpatient services and the community child and adolescent mental health services.

We also shared improvements made in relation to key areas of organisational learning.

- Restrictive Practice
- Sexual Safety
- Safeguarding and practice standards
- Observation and Engagement

Feedback was positive and the CQC recognised the significant progress made. However, it was recognised that evidence of impact may be limited until all changes are fully embedded.

New or significantly revised services

During 2021/22 there have been a number of revisions to services. These include:

- The opening of Moor House in Northallerton, which brings our community services for Hambleton together into a modern, fit-for-purpose building. It was officially opened in March 2022 by the Chancellor of the Exchequer, Rishi Sunak, whose constituency includes Northallerton.
- The York-based Children and Young People's Mental Health Service has moved to a new premises, Orca House in Osbaldwick – just outside the city centre. This provides more space, and a better environment, for staff, patients and carers.
- The extension of TEWV's prison mental health services to Hull and Humber prisons.
- Launch of service supporting mental health in schools in Darlington, and extension of the existing Selby, Scarborough and Ryedale *Wellbeing in Mind* service to Harrogate, Hambleton, Richmondshire and the City of York.
- Signing of the Armed Forces Covenant.
- Expansion in peer support roles either directly employed by or commissioned by the Trust

- Creation of two Lived Experience Director roles and a Head of Co-Creation post to ensure the patient voice is front and central in our service design and delivery.
- First Episode Rapid Early Intervention for Eating Disorders pathway introduced for adults and children across County Durham, Darlington and Teesside.

Significant partnerships and alliances entered into by our Trust to facilitate the delivery of improved healthcare

TEWV has prioritised work which supports the move towards NHS system working. We see huge benefits in making commissioning more informed by clinical knowledge.

To help us achieve this, we agreed from 2018/19 to work in new partnership commissioning arrangements with those CCGs to which we provide services. We have:

- Partnership board arrangements covering the Durham and Tees Valley CCG.
- A partnership with North Yorkshire CCG.
- A lead provider contract with Vale of York CCG – which has a similar function.

This work has improved the quality of investment proposals and led to swifter and better-informed decision making. It has also reduced duplication between Trust and CCG planning work.

During 2021/22, our Trust also led a Children and Young People's Whole Pathway Commissioning pilot. This work was able to engage children, young people and their families and has created a common goal among local authorities, CCGs and TEWV to adopt the Thrive Model and to move towards a "one front door" approach into services.

This initiative came to an end, as planned, at the end of the year – but with each local authority and CCG agreeing to progress the agenda in line with their local needs and priorities.

Our Trust is increasingly involved in informal partnership working and subcontracting to the voluntary and community sector. This is where the dynamism, flexibility and local knowledge of the VCS can make a positive difference to patients. TEWV often takes an advisor or supervisory role in these initiatives, for example in the voluntary sector-led Mental Health Support Teams for schools in Teesside.

One of the unfortunate impacts of Covid-19 continues to be the impact on the mental wellbeing of NHS colleagues, who have continued to work through the pandemic – often in circumstances which have caused significant anxiety, stress and trauma.

TEWV has carried on working with partners Navigo and Humber FT in Yorkshire and CNTW FT in the North East to develop and deploy ICS Resilience Hubs, which are supporting health and social care staff. This work is funded by the Humber North Yorkshire and North East North Cumbria ICSs.

Involving local people

Our Journey to Change sets out a clear ambition for TEWV to put patients, families and carers at the heart of all we do through co-creation.

We are committed to seeking out the voices of patients and carers, so that they can be heard and acted upon at every level.

We also recognise the value of lived experience in supporting TEWV become the kind of organisation we want to be – hence this partnership working is called co-creation.

With such a strong mandate for co-creation throughout Our Journey to Change, this past year has seen much-needed developments for patient and carer participation across the trust.

In 2021, the Co-creation working party carried out a review of all participation activities and produced a set of recommendations based on lessons learned and good practice. They were agreed in principle by the Senior Leadership Group and are now beginning to be embedded.

We have appointed two Lived Experience Directors and a Head of Co-creation. These senior posts are pioneering lived experience leadership in the NHS and will advocate for meaningful cocreation across the care groups – centring patient and carer experience in all they do.

We have also started work on a co-creation framework, which will underpin our partnership working by providing clear building blocks of guidance and support and addressing the issues we heard through the review.

In coming months, we will continue to grow the resource by expanding the involvement and engagement team, developing our strategic journey and continuing to embed the recommendations – including setting up a Lived Experience Network and a Lived Experience Advisory Board.

We hope that, with a clear vision based on what our members have told us, plus the growth in resource, co-creation will become the way we do things here.

In the last year we have seen a significant growth in involvement activities. 359 patients and carers registered to take part in a wide range of activities, with recruitment panels being the most frequent. We received 2672 individual claims for involvement in the past year and issued over £63,000 in involvement payments. This is an increase of over £24,000.

Examples of co-creation that the team and members are proud of:

- ***Completion of the Audio Recording Policy***
  It was a challenge for both staff and involvement members to work together on a sensitive subject. This has been a good example of true co-creation and resulted in a new procedure being written by the group. The next phase is for this to be embedded in practice.

- ***Business planning reference group***
  A number of patients and carers have closely supported this year's business planning cycle, meeting regularly and attending the development days for leaders. This has enabled the business plan to be built upon patient and carer experience.

- ***Representation on the new programme boards***
  Each of the five programme boards have a number of involvement members supporting this work and are holding our Trust to account on delivering the strategy.

- ***Community Transformation***
  Involvement members Sandra, Sophie and Michael have recently won South Tees Healthwatch award for Leading Change as part of the Community Mental Health Transformation Programme.
  The co-production group for the Durham transformation programme have recently developed and agreed proposals for a number of lived experience roles.

- ***Governance***
  The MHSOP participation group in Teesside and the Learning disability shadow Quag in North Yorkshire continue to thrive and enhance the governance in these areas.

- ***Carer support groups in Durham***
  Carers have requested speakers to attend to talk about diagnosis, medication and a day in the life of an inpatient.

- ***The Carer working group***
  This group has met regularly to take forward the outcomes of the 2019 and 2020 carer conference. The group are regularly invited to give feedback on ongoing work throughout our Trust, as well as delivering training to staff. They continue to monitor and improve the standards within the Triangle of Care throughout our Trust.

- ***Staff training on formulation***
  Patients have co-developed and co-delivered training on psychological formulation to staff teams in Durham and Darlington, highlighting areas of good practice and concern.

Recent comments from patients and carers about their involvement:

- *"It has been the difference between me seeing my GP for more mental health support. Involvement has kept me focussed and enabled me to maintain my mental wellbeing."*
- *"Through my involvement with the Trust I am really grateful to the team as this has helped me gain confidence and move onto a job I love."*
- *"I want to thank you and all in the Involvement and Engagement team for supporting me and everyone else who gets involved. It's been a tough year and you and the team have made things so easy for us."*
- *"Thanks again for all you do to make I and E work so well for so many".*

Improvement work aligned to national initiatives

The Trust Patient Safety Specialist (PSS) was identified in keeping with requirements of the National Patient Safety Strategy.

Our Trust's PSS provides expert support to the organisation and has direct access to the executive team which facilitates the escalation of patient safety issues or concerns.

The PSS also plays a key role in the development of a patient safety culture, safety systems and improvement activity. This role will be further developed over the coming year.

Our Trust identified via learning feedback that there was a need to develop incident reporting systems that take into account feedback from families, patients and colleagues. This was to improve the governance arrangements and, equally importantly, the emotional and support needs of patient and families.

We have undertaken a significant piece of improvement work to drive this forward, which was initiated with an improvement event held in July 2021.

A project manager was appointed to provide focused leadership on the implementation of changes that are in line with the new national Patient Safety Incident Response Framework (PSIRF) and will assist the Trust in its transition to the Learning from Patient Safety Events (LFPSE) service from the National and Reporting Learning System (NRLS).

The gradual implementation of PSIRF commenced in April 2022 and the transition to the LFPSE service will be completed by June 2023.

Compliance with accounting guidance

The Trust prepared the financial statements in accordance with the NHS Group Accounting Manual (2021-22) as directed by NHS England / Improvement, and fully complies with International Financial Reporting Standards accounting practices (IFRS).

The Trust's accounting policies are set out in the Annual Accounts and have been consistently applied over the comparative period.

Statement as to disclosure to auditors

Each of the directors, holding office on 31 March 2022, 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 to make themselves aware of any such information and to establish that the auditor is aware of that information.

The accounts are independently audited by Mazars LLP as external auditors in accordance with the Health and Social Care Act 2012 and Monitors Code of Audit Practice (as adopted by NHS England / Improvement).

As far as the directors are aware, all relevant audit information has been fully disclosed to the auditor and that no relevant audit information has been withheld or made unavailable. Nor have any undisclosed post balance sheet events occurred.

No political or charitable donations were made by the Trust during 2021-22.

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

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

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. During the Pandemic, the prompt payment of suppliers was even more important. Performance for the financial year 2021-22 was as follows:

	2021-22	
	Number of Invoices	**Value of invoices £000s**
NHS Creditors		
Total bills paid	1,186	15,736
Total bills paid within target	1,136	15,433
Percentage of bills paid within target	95.8%	98.1%

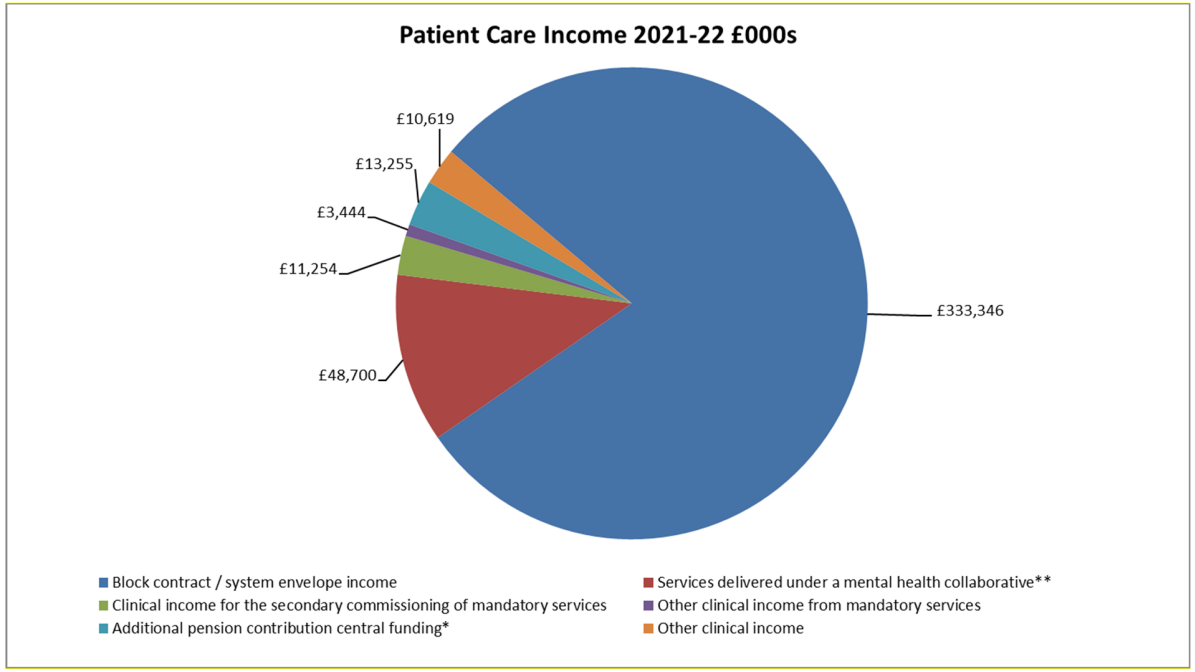
Non-NHS Creditors		
Total bills paid	64,642	108,047
Total bills paid within target	61,789	103,516
Percentage of bills paid within target	95.6%	95.8%

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

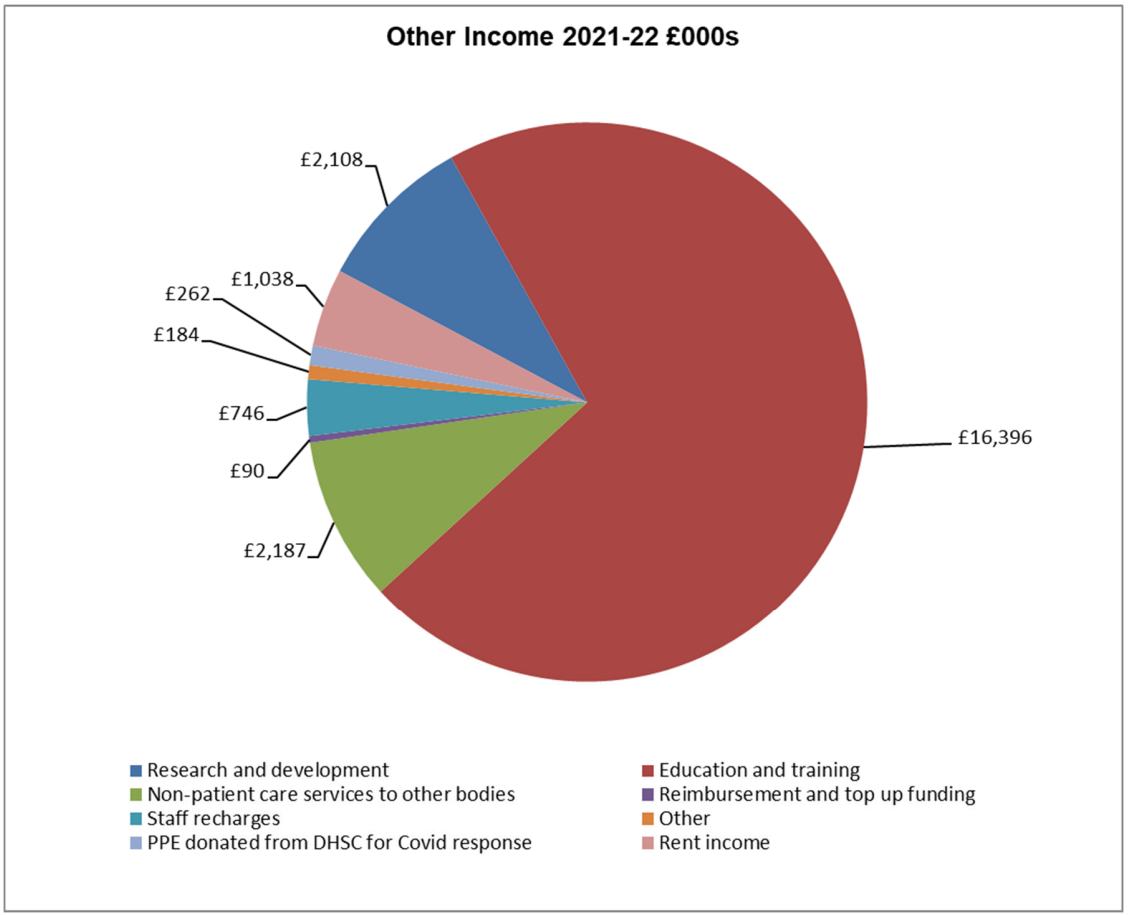
The total potential liability to pay interest on invoices paid after their due date during 2021-22 would be £1,842,761, a small increase on 2020-21 amount of £1,788,261. There have been minimal claims under this legislation, therefore the liability is only included within the accounts when a claim is received.

Income Generation

During 2021-22, income generated was £443.6m from a range of activities; 94.8% from direct patient care. Patient care income totalling £420.6m came from the following areas:



There was a further £23m from education and training, research and development 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. The provision of goods and services for any other purposes had no negative impact on the provision of health services.

The remuneration report

Annual Statement on remuneration

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

The Committee has agreed a Very Senior Manager (VSM) Pay Framework. Details of this policy are set out below.

All VSM achieved their objectives as set out at the start of the year and these were approved by the remuneration committee.

All board members who have remained in the same post have remained on the same salary throughout the year.

When posts have become vacant, we have reviewed the remuneration against the national and regional average pay for comparable roles in comparable organisations in order to set the pay for these newly recruited very senior managers.

Through the restructure the Director of Planning, Performance and Communications took on a new role of Assistant Chief Executive. In line with the national benchmarking this led to an increase in the salary for the postholder.

[Signature]

Paul Murphy
Chair of the Board's Nomination and Remuneration Committee

Senior managers' remuneration policy

The key features of the VSM Pay Framework are set out in the table below. No changes were made to the components of the VSM Pay Framework during 2021/22.

Basic pay	The VSM Pay Framework is based on the national benchmarking for comparable providers and comparable roles. We have reviewed these when new appointments were made in line with the national benchmarks. A paper was presented to the nomination and remuneration committee in September 2021 outlining the current pay rates against these national benchmarks, but no changes were made to current postholders' pay. A national steer had been given that there was the potential for individual VSM postholders to receive non-consolidated pay awards. The committee considered this but felt it was out of step with the concept of a unitary board and therefore no awards were allocated. The same committee reviews the objectives and appraisals of the executive directors to ensure. 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 or lower than those of other similar organisations.

Performance related components	There are no performance related components.
Recruitment and Retention Premia (RRP)	The Nomination and Remuneration Committee has the option of paying Recruitment and Retention Premia (RRP) but these should only be paid where there is clear evidence that the payments can be justified. No VSM staff were paid this during 2020/21.
Allowances	Car and on call allowanced are 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 individual's line manager that their performance over the preceding 12 months period has been rated as being good. The Nomination and Remuneration Committee of the Board of Directors agreed to the incorporation of an 'earn back' clause whereby up to 10% of salary is put at risk pending an annual review of performance against objectives set.
Remuneration above £150,000	A comparison is undertaken with the national benchmarking. All the VSM salaries are reported nationally through the national survey.
Arrangements specific to individual senior managers	Not applicable

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.
- Diversity and inclusion: The Nomination and Remuneration Committee's approach to diversity and inclusion is based on the Trust's Human Rights, Equality and Diversity Policy. This policy, which is available on the Trust's website, lays down expected standards in relation to equality, diversity and human rights in employment and service delivery. These standards say that we:
    - Respect and protect the human rights of all patients, colleagues and anyone else who has a relationship to the Trust.
    - Take breaches of policy very seriously, particularly those that when breached have a harmful effect on other people. Victimisation, harassment, discrimination (or an attempt to do so) and bullying will not be tolerated and will, where substantiated lead to disciplinary action.
    - Colleagues who identify with protected groups have the right to be treated fairly and with dignity and respect and without the fear of unlawful discrimination, harassment, victimisation or bullying.
    - Commit to the ongoing development of staff awareness and knowledge of equality, diversity and human rights. Staff development begins on employment and continues throughout an individual's career until they leave the Trust.
    - Commit to monitoring, evaluating and reporting on issues of equality, diversity and human rights in employment and service provision.
    - Work towards best practice standards of equality, diversity and human rights and not merely comply with legislation.
    - Promote equality, foster good relations and take an anti-discriminatory approach in all areas of employment and service delivery.
    - Ensure barriers to accessing services and employment are identified and removed so that no person is treated less favourably because they identify with a protected group/s.
    - Recognise the importance of this policy in the employment relationship it has with its staff and in provision of services for patients, and will reflect this commitment in all Trust policies, procedures and practices, etc.

The policy extends outside the workplace and Trust staff should be aware that workplace behaviour includes time when they are not physically at work but are participating in activities where work is a factor, for example, team nights out, shopping trips with colleagues etc.

This is because abusive, discriminatory and/or unethical behaviour outside of work could still affect the relationship between the Trust and its employees, particularly if it is deemed to be so serious that it would warrant disciplinary action or allegations of gross misconduct, as would be the case if the individual or group concerned were at work.

The policy supports the delivery of the Trust's Equality Strategy. Progress on the delivery of the equality objectives, included in the strategy, is monitored by the Equality, Diversity and Human Rights Steering Group.

Further information on equality and diversity is provided in the Accountability Report, while demographic information on the Trust's senior managers is provided in the Staff Report.

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 (VSM) remuneration levels in comparable Trusts were used to establish the VSM 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 VSM Pay Framework since 2014. This includes consideration of updated independent remuneration reports.

Non-Executive Director Remuneration

Basic Remuneration	The basic fees payable to the Chair 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. In 2021/22 the Chair shared his fee with the Deputy Chair to reflect their joint working arrangements. Associate Non-Executive Directors receive the same level of remuneration as the Non-Executive Directors. 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 and Risk Committee and the Senior Independent Director.
Allowances	The Chairman and Non-Executive Directors are able to claim reimbursement of expenses (eg travel) in line with Trust policy.

[Signature]

Brent Kilmurray
Chief Executive
16 June 2022

Senior managers' remuneration tables (subject to audit)

Name and Title	2021-22						2020-21					
	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 Colin Martin, Chief Executive (left 29 June 20)	-	-	-	-	-	-	40 - 45	-	2,400	-	45 - 50	0
Mr Brent Kilmurray, Chief Executive (Started 29 June 20)	180 - 185	-	7,300	205.0 - 207.5	395 - 400	600	135 - 140	-	5,600	-	140 - 145	0
Mrs Ruth Hill, Chief Operating Officer (left 31 July 2021)	40 - 45	-	7,000	10.0 - 12.5	60 - 65	100	130 - 135	-	7,700	42.5 - 45.0	180 - 185	200
Mr Russell Patton, Interim Chief Operating Officer (started 30 August 2021, left 31 January 2022)	60 - 65	-	0	-	60 - 65	0	-	-	-	-	-	-
Mr Patrick McGahon, Director of Finance and Information (left 05 August 20)	-	-	-	-	-	-	50 - 55	-5 - 0	0	-	45 - 50	0
Mr Drew Kendall, Acting Director of Finance and Information (Started 18 July 20, left 18 October 20)	-	-	-	-	-	-	20 - 25	-	1,890	-12.5 - -10.0	15 - 20	0
Mrs Liz Romaniak, Director of Finance, Information and Estates (Started 19 October 20) ****	135 - 140	-	0	50.0 - 52.5	185 - 190	9,500	60 - 65	-	0	20.0 - 22.5	80 - 85	0
Mrs Elizabeth Moody, Director of Nursing and Governance and Deputy Chief Executive ***	115 - 120	0 - 5	13,400	32.5 - 35.0	165 - 170	0	115 - 120	0 - 5	14,600	47.5 - 50.0	180 - 185	0
Dr Ahmad Khouja**, Medical Director (ended 31 August 2021), Chief Clinical Strategy Officer (started 01 September 2021)	160 - 165	35 - 40	700	-	200 - 205	200	170 - 175	35 - 40	0	32.5 - 35.0	240 - 245	1,000
Dr Stephen Wright, Medical Director (started 01 September 2021) ******	80 - 85	0 - 5	0	-	85 - 90	0	-	-	-	-	-	-

Mr David Levy, Director of Human Resources and Organisational Development (left 25 February 21)	-	-	-	-	-	-	100 - 105	-	0	-	100 - 105	0
Mrs Sarah Dexter-Smith, Director of Therapies (left 14 February 2021), Director of People and Culture (Started 15 February 2021)	110 - 115	-	0	45.0 - 47.5	155 - 160	0	105 - 110	0 - 5	0	75.0 - 77.5	180 - 185	0
Mrs Sharon Pickering, Director of Planning, Commissioning, Performance and Communications (left 30 September 2021), Assistant Chief Executive (started 01 October 2021)	110 - 115	-	0	67.5 - 70.0	180 - 185	900	110 - 115	-	10,200	25.0 - 27.5	145 - 150	400
Mrs Jennifer Illingworth, Director of Operations - County Durham and Darlington	110 - 115	-	6,700	32.5 - 35.0	150 - 155	500	110 - 115	-	8,400	77.5 - 80.0	195 - 200	200
Mrs Naomi Lonergan, Director of Operations - North Yorkshire and York	110 - 115	-	5,200	27.5 - 30.0	145 - 150	0	110 - 115	-	5,500	40.0 - 42.5	155 - 160	0
Mr Dominic Gardner, Director of Operations – Teesside	105 - 110	-	0	27.5 - 30.0	135 - 140	0	105 - 110	-	0	27.5 - 30.0	135 - 140	600
Mrs. Lisa Taylor, Director of Operations - Forensic Services ***	100 - 105	0 - 5	3,800	30.0 - 32.5	135 - 140	200	100 - 105	-	3,800	40.0 - 42.5	145 - 150	100
Mrs Avril Lowery, Director of Quality Governance ***	100 - 105	0 - 5	0	20.0 - 22.5	125 - 130	0	100 - 105	-	0	107.5 - 110.0	210 - 215	700
Mr Phil Bellas, Company Secretary	85 - 90	-	0	25.0 - 27.5	110 - 115	0	85 - 90	-	0	22.5 - 25.0	110 - 115	0
Mrs Ann Bridges, Director of Corporate Affairs and Involvement (started 13 September 21)	50 - 55	-	1,600	12.5 - 15.0	65 - 70	0	-	-	-	-	-	-
Mrs Miriam Harte, Chairman (left 31 October 2021) *****	55 - 60	-	0	-	55 - 60	2,300	50 - 55	-	0	-	50 - 55	2,600
Mr David Jennings, Non Executive Director (Chairman of the Audit and Risk Committee) (left 31 August 2020)	-	-	-	-	-	-	5 - 10	-	0	-	5 - 10	1,100
Dr Hugh Griffiths, Non-Executive Director (left 30 June 2021)	0 - 5	-	0	-	0 - 5	0	10 - 15	-	0	-	10 - 15	0
Mrs Shirley Richardson, Non-Executive Director, Senior Independent Director (started 23 June 2020), Interim Deputy Chair started 01 November 2021)	20 - 25	-	0	-	20 - 25	500	15 - 20	-	0	-	15 - 20	200
Mr Paul Murphy, Non-Executive Director (Interim Chair started 01 November 2021)	25 - 30	-	0	-	25 - 30	1,300	10 - 15	-	0	-	10 - 15	600
Prof. Pali Hungin, Non-Executive Director	10 - 15	-	0	-	10 - 15	0	10 - 15	-	0	-	10 - 15	0

Mrs Beverley Reilly, Non-Executive Director	10 - 15	-	0	-	10 - 15	0	10 - 15	-	0	-	10 - 15	0
Mr John Maddison, Non-Executive Director (Started as Associate NED 1 January 2020, became full NED 1 July 20) (Chairman of the Audit and Risk Committee - role started 01 September 2020)	15 - 20	-	0	-	15 - 20	0	15 - 20	-	0	-	15 - 20	0
Dr Charlotte Carpenter, Non-Executive Director (started 01 September 2021)	5 - 10	-	0	-	5 - 10	0	-	-	-	-	-	-
Ms Jillian Haley, Non-Executive Director (started 01 September 2021)	5 - 10	-	0	-	5 - 10	0	-	-	-	-	-	-
Mr Jules Preston, Associate Non-Executive Director (started 01 November 2021)	5 - 10	-	0	-	5 - 10	0	-	-	-	-	-	-
Mrs Roberta Barker, Associate Non-Executive Director (started 01 November 2021)	5 - 10	-	0	-	5 - 10	0	-	-	-	-	-	-

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

* Benefits in kind are the provision of lease cars.

** Other remuneration includes clinical excellence award and additional clinical programmed activity worked during the reported period.

*** Other remuneration is the sale of unused annual leave.

**** Expenses are linked to relocation support.

***** Salary includes a severance payment.

****** Other remuneration is a clinical excellence award.

Pension related benefits, other remuneration and benefit in kind have been excluded from this calculation, as they are not known for all staff.

The salary of the highest paid director was for the Medical Director in 2020-21, as the Chief Executive was in post for part of the year.

In 2020-21 investment in community services was the main factor impacting on the increase to median salary

Pension related benefits

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.

This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide.

The pension benefit table provides further information on the pension benefits accruing to the individual.

Expenses of Governors

At 31 March 2022 the Trust had 41 Governors (2020-21, 47), with 14 receiving reimbursement of expenses (2020-21, 16). The total amount reimbursed as expenses was £449, (£348 in 2020-21).

Fair Pay

NHS foundation trusts are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the lowest quartile, median and upper quartile remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in the organisation in the financial year 2021-22 was £ 180k – 185k. This is a change between years of 5.8%. Total remuneration includes salary, non-consolidated performance-related pay, benefits in kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

For employees of the Trust as a whole, the range of remuneration in 2021-22 was from £0 – 5k to £180k – 185k (2020-21 £5k – 10k to £170k – 175). The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by full time equivalent number of employees) between years is 3.0%. No employees received remuneration in excess of the highest-paid director in 2021-22.

2021-22	25th Percentile	Median	75th percentile
Salary component of pay	21,777	31,534	39,027
Total pay and benefits excluding pension benefits			
Pay and benefits excluding pension: pay ratio for highest paid director	#DIV/0!	#DIV/0!	#DIV/0!

2020-21	25th Percentile	Median	75th percentile
Salary component of pay	21,142	30,615	37,890
Total pay and benefits excluding pension benefits			
Pay and benefits excluding pension: pay ratio for highest paid director	#DIV/0!	#DIV/0!	#DIV/0!

Pay Terms and Conditions

With the exception of directors, non-executives and medical staffing, the workforce is 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 3 months.

The Nomination and Remuneration Committee of the Board is responsible for executive directors pay.

[Signature]

Brent Kilmurray
Chief Executive
16 June 2022

Senior managers' pension benefits table

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 2021	Lump sum at retirement age related to accrued pension at 31 March 2021	Cash Equivalent Transfer Value at 31 March 2021	Cash Equivalent Transfer Value at 31 March 2020	Real Increase in Cash Equivalent Transfer Value for time in post less employee pension contributions
	(bands of £2500) £000	(bands of £2500) £000	(bands of £5000) £000	(bands of £5000) £000	£000	£000	£000
Mr Brent Kilmurray, Chief Executive	10.0 - 12.5	17.5 - 20.0	55 - 60	120 - 125	1,042	848	180
Mrs Ruth Hill, Director of Operations - Chief Operating Officer	0.0 - 2.5	0.0 - 2.5	45 - 50	100 - 105	885	830	0
Mrs Liz Romaniak, Director of Finance, Information and Estates	2.5 - 5.0	0.0 - 2.5	55 - 60	115 - 120	1,014	947	50
Mr Russell Patton, Interim Chief Operating Officer (started 30 August 2021, left 31 January 2022)	0	0	55 - 60	165 - 170	1,385	1,361	10
Mrs Elizabeth Moody, Director of Nursing and Governance and Deputy Chief Executive	2.5 - 5.0	0.0 - 2.5	60 - 65	170 - 175	1,322	1,258	48
Dr Ahmad Khouja**, Medical Director (ended 31 August 2021), Chief Clinical Strategy Officer (started 01 September 2021)	0	0	60 - 65	115 - 120	1,173	1,177	0
Mrs Sarah Dexter-Smith, Director of People and Culture	2.5 - 5.0	0.0 - 2.5	30 - 35	60 - 65	539	488	36
Mrs Sharon Pickering, Director of Planning, Performance and Communications	2.5 - 5.0	5.0 - 7.5	50 - 55	105 - 110	989	902	73
Mrs Jennifer Illingworth, Director of Operations - County Durham and Darlington	0.0 - 2.5	0.0 - 2.5	40 - 45	85 - 90	805	755	35
Mrs Naomi Lonergan, Director of Operations - North Yorkshire and York	0.0 - 2.5	0	15 - 20	15 - 20	255	225	16
Mr Dominic Gardner, Director of Operations – Teesside	0.0 - 2.5	0.0 - 2.5	30 - 35	55 - 60	542	502	25
Mrs. Lisa Taylor, Director of Operations - Forensic Services	0.0 - 2.5	0.0 - 2.5	35 - 40	70 - 75	629	588	27
Mrs Avril Lowery, Director of Quality Governance	0.0 - 2.5	2.5 - 5.0	50 - 55	150 - 155	1,236	1,170	52
Mr Phil Bellas, Trust Secretary	0.0 - 2.5	0.0 - 2.5	20 - 25	25 - 30	373	339	22
Mrs Ann Bridges, Director of Corporate Affairs and Involvement (started 13 September 21)	0.0 - 2.5	0	0 - 5	0	13	0	6

Dr Stephen Wright has claimed his NHS Pension.

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

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme.

A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme.

The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies.

The CETV figures, and from 2004-05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost.

CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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

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.

[Signature]

Brent Kilmurray
Chief Executive
16 June 2022

Analysis of staff costs

Staff costs

	Permanent	Other	2021/22 Total	2020/21 Total
	£000	£000	£000	£000
Salaries and wages	250,614	18,048	**268,662**	251,346
Social security costs	22,574	1,677	**24,251**	22,374
Apprenticeship levy	1,184	102	**1,286**	1,181
Employer's contributions to NHS pension scheme	40,224	3,463	**43,687**	41,024
Pension cost - other	101	9	**110**	87
Termination benefits	203	-	**203**	-
Temporary staff	-	13,813	**13,813**	8,421
Total gross staff costs	**314,900**	**37,112**	**352,012**	**324,433**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**314,900**	**37,112**	**352,012**	**324,433**
Of which				
Costs capitalised as part of assets	460	-	**460**	302

Average number of employees (WTE basis)

	Permanent	Other	2021/22 Total	2020/21 Total
	Number	Number	Number	Number
Medical and dental	280	111	**391**	312
Administration and estates	1,228	142	**1,369**	1,285
Healthcare assistants and other support staff	354	16	**370**	351
Nursing, midwifery and health visiting staff	3,687	690	**4,377**	4,183
Scientific, therapeutic and technical staff	996	216	**1,212**	1,037

Healthcare science staff	4	-	**4**	6
Social care staff	-	34	**34**	22
Total average numbers	**6,549**	**1,209**	**7,758**	**7,196**
Of which:				
Number of employees (WTE) engaged on capital projects	6	-	**6**	5

Demographic information

Our workforce is primarily white, which is broadly in line with our local population. As of the end of March 2022 there were 6076 female members of staff (79%) and 1593 male members of staff (21%).

The number of male and female directors and senior managers (members of the Board of Directors and Senior Leadership Group) is five male and eight female.

Sickness Absence Figures (January to December 2021)

Sickness Absence figures for the Trust can be accessed via NHS Digital using the following link:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

Staff policies and actions applied/taken

We have a range of policies and procedures which support our commitment to being a good employer and providing equal opportunities to present and potential employees:

- Policies for giving full and fair consideration to applications for employment made by disabled persons having regard to their particular aptitudes and abilities.
- Policies for the continuing employment of, and for arranging appropriate training for, employees who have become disabled persons during the period.
- Policies for the training, career development and promotion of disabled employees.

Our recruitment and selection procedure is followed for each recruitment episode. The procedure has been equality impact assessed, ensuring application of the procedure does not impact negatively on people with disabilities.

We are signed up to the disability confident scheme and guarantee an interview to all applicants with a disability who meet the minimum essential criteria for a job vacancy. We will make reasonable adjustments to the recruitment process if this is required.

- We provide a number of health and wellbeing support mechanisms to help staff throughout their employment. Specific advice can be gained from Occupational Health as to recommendations to support a staff member whilst at work. Reasonable adjustments will be made for staff with disabilities, and we have implemented a reasonable adjustment pack to support this process. If a staff member can no longer work in the role they are employed, we will explore redeployment into another suitable alternative role.

- We are fully committed to ensuring all colleagues with disabilities and long-term health conditions have a positive experience and equitable access to training, career development and promotion. To facilitate this, our workplace adjustments procedure provides for individual workplace adjustment plans detailing the adjustments that staff would need to undertake their job role, access training and career development and achieve promotion.

- We know that non-disabled staff are 1.29 times more likely to be appointed from shortlisting and that 84% of disabled staff believe our Trust provides equal opportunities for career progression or promotion. Work is ongoing as part of the Trust's Workforce Disability Equality Scheme (WDES) to address these issues.

- We regularly share information with colleagues on matters of concern to them as employees through our weekly staff briefing and on our staff intranet.

- We hold monthly coffee breaks for staff to talk with the director for people and culture and other leads about anything relating to employment in the Trust.

- Local consultative committees (LCC) take place on a monthly basis within each locality and a joint consultative committee (JCC) takes place bi-monthly. Items affecting the workforce are discussed at both LCC and JCC at which staff side representation are in attendance.

For any formal changes affecting the workforce we follow the organisational change procedure and consultation consisting of group meetings and one to one meetings with staff (along with staff side representation). Staff have an opportunity to provide comments in relation to proposals prior to implementation.

Occupational Health

During the 2021/22 staff flu campaign around 61.5% of frontline healthcare workers across the Trust received a flu vaccination, this means that 4,840 staff were vaccinated.

Uptake rates were around 10% lower than the previous year. This may have been due to several factors, such as:

- More Trust staff receiving an external flu vaccination and the data not being retrieved
- Overall national data recording and reporting issues
- A change in staff classed as ‘frontline healthcare workers’
- A continued NHS focus on meeting the ongoing Covid-19 vaccination rollout
- Vaccination fatigue in the workforce

Our Trust was not unique in its final flu vaccination uptake rates, as national and regional uptake was generally lower for 2021-22 than previous years.

At beginning of March 2022, TEW recorded 97% of staff had received a first Covid-19 vaccination, with 94% having had a second dose and 78% having a Booster dose.

As the Covid-19 pandemic develops, our Trust may need to mobilise a further vaccination programme in the future, both internally and through continued joint-working with local Acute Trust partner organisations, which have been successful delivery models to date.

People Asset Management (PAM) provides a comprehensive occupational health service to our Trust.

Provision includes a range of services including pre-employment screening, vaccination and immunisation, specialist occupational health employment advice, employee assistance and MSK specialist services. We continue to work collaboratively to maintain and improve staff health and wellbeing.

In addition to occupational health services our Trust provides a wide range of health and wellbeing support services for colleagues, such as an employee support service, employee psychology service and a staff mindfulness service – as well as health improvement information through our staff intranet and weekly e-bulletins.

Countering fraud and corruption

Our 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.

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 our premises.

Our Trust's Local Counter Fraud Specialist (LCFS) reports to the Audit and Risk Committee quarterly, and through an annual report, and performs a programme of work designed to provide assurance to the Board about fraud and corruption.

The LCFS provides regular fraud awareness sessions to staff, investigates concerns reported by staff and liaises with the police. If any issues are substantiated, we take appropriate criminal, civil or disciplinary measures.

Equality Strategy and Objectives 2020-2023

Further information about the Equality, Diversity and Human Rights (EDHR) strategy can be found in the Performance Report. Information from the strategy relating to staff is below:

Objective 1:

Ensure that where it is agreed, staff that require a workplace adjustment have these in place.

Progress
Good progress is being made on the actions in the EDHR strategy and the WDES relating to workplace adjustments and the revised workplace adjustments procedure has been completed and awareness raising of the procedure is ongoing. Some limited central resource to support workplace adjustments is now available from the EDHR team and consideration is being given to piloting a centralised team to support staff who need reasonable adjustments. Work is also taking place into how to better support staff who have neurodivergent needs.

Objective 2:

To ensure we support and respond to colleagues who experience verbal aggression and that we take actions that reduce the number of incidents of verbal aggression towards staff.

Progress
A publicity campaign to reduce verbal aggression against staff has been launched trust wide and posters are displayed in all inpatient and reception areas. Processes are in place to support staff who experience verbal aggression and training is available to support staff to address this issue. Lunch and learn sessions are being run around hate crime and internal procedures

Key Equality Data

The Trust publishes the following equality data annually. These reports were all published in 2021 with the exception of the EDS2 relating to staff.

- Publication of information on staff
- Workforce Race Equality Standard and Action Plan
- Workforce Disability Equality Standard and Action Plan
- Equality Delivery System 2
- Sexual Orientation Equality Standard and Action Plan

https://www.tewv.nhs.uk/about/equality-and-diversity/approach/

Actions taken by the Trust

We have taken a number of actions to address issues of differences in outcomes and experiences for both staff and patients from protected groups. Details of these are contained in:

- The equality objective section above.
- The Equality Strategy 2020–2023.
- The Workforce Race Equality Standard document.
- The Workforce Disability Equality Standard document.
- The Sexual Orientation Workforce Equality Standard document

www.tewv.nhs.uk/about/equality-and-diversity/strategy/

Staff turnover

Staff turnover figures can be accessed via NHS Digital using the following link:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

Staff engagement

We believe that good staff engagement is essential to delivering better quality care to patients and carers. Through Our Big Conversation, colleagues actively helped us shape our purpose, vision, values, goals and priorities.

To co-create a great experience for our colleagues is one of our three Big Goals included in Our Journey to Change. This means by 2025 we are committed to colleagues feeling:

- Proud, because their work is meaningful.
- Involved in decisions that affect them.
- Well-led and managed.
- That their workplace is fit for purpose.

It will be the norm that opinions, feedback, concerns and ideas are always sought out, heard and acted upon at every level and within every location.

Staff Survey

The Indicators for the NHS Staff Survey have changed from 2021 to align to the NHS People's Promise.

Therefore, no previous Trust benchmarking scores are available, only that from other Mental Health and Learning Disabilities Trusts across the country.

The indicator scores are based on a score out of 10 for certain questions, with the indicator being the average of those questions. The 2021 response rate was 50% compared to only 38% in 2020.

	Trust score 2021	Benchmarking group
We are compassionate and inclusive	7.4	7.9
We are recognised and rewarded	6.2	6.8
We each have a voice that counts	6.9	7.4
We are safe and healthy	6.2	6.6
We are always learning	5.4	6.1
We work flexibly	6.3	7.1

We are a team	6.9	7.4
Staff engagement	6.8	7.4
Morale	5.9	6.5

While there was an increase in responses to the staff survey, when colleagues were asked if they would “recommend the organisation as a place to work”, TEWV was named as one of the bottom five Trusts in England.

It was also reported as one of the most deteriorated Trusts in the North East and Yorkshire region, as only 52% of people recorded a positive response in 2021 compared to 66% in 2020.

The trend in staff engagement scores is shown below

Year	2016	2017	2018	2019	2020	2021
Staff engagement	7.2	7.1	7.2	7.0	7.1	6.8

The areas that were most improved for our Trust were in relation to not experiencing physical violence or bullying and harassment, and not feeling pressurised to come to work.

The top five scores for TEWV above the survey average were related to not working additional unpaid hours, acting fairly for career progression, not having MSK problems due to work, not experiencing discrimination from patients or relatives and staff having the right equipment to do their work.

Recording of trade union facility time (1 April 2021 – 31 March 2022)

Relevant union officials

What was the total number of your employees who were relevant union officials during the relevant period?

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
40	6900.66 FTE (calculated as per Regulations)

Percentage of time spent on facility time

How many of your employees who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time?

Percentage of time	Number of employees
0%	28
1 – 50%	11
51-99%	0
100%	1

Percentage of pay bill spent on facility time

Provide the figures requested in the first column of the table below to determine the percentage of your total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period.

First Column	Figures
Provide the total cost of facility time	£74,823.13 (calculated as per Regulations)
Provide the total pay bill	£351,552,000 (calculated as per Regulations)
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.021%

Paid trade union activities

As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid trade union activities?

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	9.73% (calculated as per Regulations)

Consultancy Costs

Expenditure on consultancy costs was £885k during 2021/22.

Off-payroll arrangements

For all off-payroll engagements as of 31 March 2022, for more than £245 per day:

	Number
Number of existing engagements as of 31 March 2021	58
Of which:	
The number that have existed for less than 1 year at the time of reporting	41
The number that have existed for between 1 and 2 years at the time of reporting	4
The number that have existed for between 2 and 3 years at the time of reporting	2
The number that have existed for between 3 and 4 years at the time of reporting	3
The number that have existed for 4 or more years at the time of reporting	8

For all off-payroll engagements between 1 April 2021 and 31 March 2022, for more than £245 per day

	Number
Number of temporary off-payroll workers engaged between 1 April 2020 and 31 March 2021	188
Of which:	
Number not subject to off-payroll legislation	0
Number subject to off-payroll legislation and determined as in-scope of IR35	188
Number subject to off-payroll legislation and determined as out of scope of IR35	0
Number of engagements reassessed for compliance or assurance purposes during the year	0

Of which, number of engagements that saw a change to IR35 status following review	0

	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0
Total number of individuals on payroll and off-payroll that have been deemed 'board members, and/or, senior officials with significant financial responsibility', during the financial year. This figure must include both on payroll and off-payroll engagements	16

All managers that received pay on remuneration report (excluding NEDs)

Exit packages (subject to audit)

During 2021-22 the Trust had 4 employees retire early on the grounds of ill health; the value of these early retirements (from NHS Pensions) is £0.2m.

Reporting of compensation schemes - exit packages 2021/22

Exit package cost band (including any special payment element)	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages Number
£10,000 - £25,000	-	1	**1**
£50,001 - £100,000	1	-	**1**
£100,001 - £150,000	1	-	**1**

Total number of exit packages by type	**2**	**1**	**3**
Total cost (£)	£203,000	£21,000	**£224,000**

Exit packages: other (non-compulsory) departure payments

	2021/22		2020/21	
	Payments agreed	**Total value of agreements**	**Payments agreed**	**Total value of agreements**
	Number	**£000**	**Number**	**£000**
Contractual payments in lieu of notice	1	21	-	-
Total	**1**	**21**	**-**	**-**

Gender pay gap

The latest gender pay gap report can be accessed via the Cabinet Office using the following link: https://gender-pay-gap.service.gov.uk/.

A copy of the report and previous reports are available on the Trust website which can be accessed via the following link: www.tewv.nhs.uk/content/uploads/2021/02/gender-pay-report-as-at-March-2020.pdf

Code of governance disclosures

Purpose

In this section we provide information on our corporate governance arrangements. We explain who sits on the Board of Directors, its committees, and Council of Governors and how they operate.

How the Trust is governed

As a public benefit corporation, our Trust is required to have the following governance arrangements:

- A legally binding constitution
- A non-executive Chair
- 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

Our Trust's Constitution requires both the Board and the Council of Governors to:

- Observe the Nolan principles of Public Life of selflessness, integrity, objectivity, accountability, openness, honesty and leadership
- Seek to comply, at all times, with the NHS Foundation Trust Code of Governance

Statement on the Application of the Code of Governance

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:

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	96,102 &128
A.1.1	A statement on how disagreements between the Council of Governors and Board of Directors should be resolved	109
A.1.2	The names of: • The Chairman • The Deputy Chairman • The Chief Executive • The Senior Independent Director	34 - 42

	• The Chairmen and members of the Audit and Risk Committee • The Chairman and members of the Remuneration Committees	
A.1.2	The number of meetings of the Board of Directors and the Audit, Remuneration and Nominations Committees and individual attendance by Directors	104 – 106, 113 – 114, 120 – 121 & 132
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.	131 – 135
A.5.3	The name of the Lead Governor.	129
B.1.1	The names of the Non-Executive Directors whom the Board determines to be independent, with reasons where necessary	35 – 41 & 102
B.1.4	A description of each director's skills, expertise and experience	34 – 46
B.1.4	A statement about the Board of Directors' balance, completeness and appropriateness to the requirements of the NHS Foundation Trust	102
B.2.10	A description of the work of the Nominations Committee(s) including the process used in relation to board appointments	119 – 121

B.3.1	The other significant commitments of the Chairman and any changes to them during the year.	35
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	138
B.6.1	A statement on how the performance evaluation of the Board, its committees and its Directors, including the Chairman, has been conducted	109
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	109
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	103

	stakeholders to assess the NHS Foundation Trust's performance, business model and strategy	
C.1.1	A statement from the External Auditors about their reporting responsibilities	164
C.1.1	An explanation from the Directors of their approach to quality governance in the annual governance statement	147 – 163
C.2.1	A report that the Board has conducted a review of the effectiveness of the Trust's system of internal controls	113
C.2.2	Information on how the internal audit function is structured and the role it performs	117
C.3.5	A statement from the Audit Committee, if applicable, explaining its recommendation on the appointment/reappointment of the external audit and the reasons why it was not accepted by the Council of Governors	N/A
C.3.9	A description of the work of the Audit and Risk 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	114 - 116

	• 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 • 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	
D.1.3	Where an NHS Foundation Trust releases an Executive Director, for example to serve as a Non-Executive Director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings	N/A
E.1.4	Contact procedures for members who wish to communicate with Governors and/or Directors	142
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	106 – 108
E.1.6	A report on the representativeness of Trust's membership and the level and effectiveness of member engagement	139 - 141

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

Board of Directors

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:

- Has retained certain decisions to itself as set out in the scheme of delegation included in the Constitution (available on our website).
- Exercises certain functions in conjunction with our Council of Governors.

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

Information on the Board Members as at 31 March 2022, including details of their qualifications, skills and expertise, is provided in the Accountability Report.

The Board considers that, as at 31 March 2022:

- Its composition meets the requirements of the National Health Service Act 2006 and the Constitution
- 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 31 March 2022, 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 nine meetings of the Board of Directors held during 2021/22:

Board Member	Position	No. of Board meetings attended
Miriam Harte	• Chair of the Trust (to October 2021)	4 (4)
Paul Murphy	• Chair of the Trust (from October 2021) • Deputy Chair (to October 2021) • Chair of the Strategy and Resources Committee	9
Brent Kilmurray	• Chief Executive and Accounting Officer	9
Shirley Richardson	• Non-Executive Director • Senior Independent Director • Deputy Chair (from October 2021) • Chair of the People Culture and Diversity Committee • Chair of the West Lane Project Committee	9
Roberta Barker	• Associate Non-Executive Director (from November 2021)	3 (4)

Dr Charlotte Carpenter	• Non-Executive Director (from September 2021)	4 (5)
Dr Hugh Griffiths	• Non-Executive Director (to June 2021)	3 (3)
Jill Haley	• Non-Executive Director (from September 2021)	4 (5)
Prof Pali Hungin	• Non-Executive Director • Chair of the Mental Health Legislation Committee	7
John Maddison	• Non-Executive Director • Chair of the Audit and Risk Committee • Chair of the Commissioning Committee	9
Jules Preston	• Associate Non-Executive Director (from November 2021) •	4 (4)
Bev Reilly	• Non-Executive Director • Chair of the Quality Assurance Committee	9
Ann Bridges	• Director of Corporate Affairs and Involvement (from September 2021) •	5 (5)
Dr Sarah Dexter-Smith	• Director of People and Culture	6
Ruth Hill	• Chief Operating Officer (to July 2021)	4 (4)

Dr Ahmad Khouja	• Medical Director (to August 2021)	3 (4)
Elizabeth Moody	• Director of Nursing and Governance • Deputy Chief Executive	9
Russell Patton	• Interim Chief Operation Officer (August 2021 to February 2022)	3 (3)
Sharon Pickering*	Assistant Chief Executive	9
Liz Romaniak	• Director of Finance Information and Estates	9
Dr Steve Wright	• Interim Medical Director (from September 2021)	5 (5)

***(Note:** 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

The following arrangements were maintained during the year to ensure the Board was kept informed of the views of Governors and members:

- Regular meetings between the Chair and Governors in their localities
- Attendance by Board Members at meetings of the Council of Governors
- The provision of reports on the outcome of consultations with Governors, for example on the business plan

- Pre-Board question and answer sessions with Governors with matters raised at Board meetings
- Governors encouraged to observe public Board meetings
- Regular liaison between the Chair and the Lead Governor
- Feedback from Governors on briefings circulated to them

Shirley Richardson, as the Senior Independent Director, was also available to Governors if they had concerns regarding any issues which had not been addressed by the Chair, Chief Executive or other usual business arrangements.

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

- The Chair attends all meetings
- There is a standing invitation for the Non-Executive Directors to attend meetings
- Executive Directors attend meetings, if required, for example to deliver reports, or as observers

The Council of Governors 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 2021/22.

In total the Council of Governors held six formal meetings, including the Annual General Meeting (AGM), during 2020/21. Board Member attendance at these meetings was as follows:

Board Member	No. of Council meetings attended (inc the AGM)
Miriam Harte	3 (3)
Paul Murphy	5
Brent Kilmurray	6
Shirley Richardson	6
Roberta Barker	0 (2)
Dr Charlotte Carpenter	2 (4)
Dr Hugh Griffiths	0 (1)
Jill Haley	3 (4)
Prof Pali Hungin	5
John Maddison	6
Jules Preston	2 (2)
Bev Reilly	5
Ann Bridges	4 (4)
Dr Sarah Dexter-Smith	2
Ruth Hill	1 (2)
Dr Ahmad Khouja	0 (2)
Elizabeth Moody	6
Russell Patton	1 (3)
Sharon Pickering*	5
Liz Romaniak	3
Dr Steve Wright	2 (4)

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

Resolution of disputes with the Council of Governors

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 discrete 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.

The dispute resolution procedure was not invoked during the year.

Further details on the dispute resolution procedure are Provided in Annex 9 of our Constitution.

Evaluating Board Performance

A survey to evaluate the Board's performance was undertaken in April 2022, as part of the Board Development Programme, and was facilitated by Deloitte LLP.

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

The terms of office of the Chair 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 Chair 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

During 2021/22 the Board reviewed the structure and terms of reference of its Committees, taking into account the recommendations made by the Good Governance Institute (see the Accountability Report).

The key changes arising from the review were as follows:

- The alignment of each committee's strategic purpose to the Trust's Strategic Goals
- The strengthening the assurance role of the Committees to ensure focus on risks included in Board Assurance Framework as relevant to their responsibilities and as part of the integrated performance assurance framework
- The division of the responsibilities of the predecessor Resources Committee by establishing two new Committees, the People Culture and Diversity Committee and the Strategy and Resources Committee, to provide greater capacity and focus
- The establishment of the Commissioning Committee in response to the Trust assuming new responsibilities

As of 31 March 2022, there were eight standing Committees of the Board: the Audit and Risk Committee; the Commissioning Committee; the Mental Health Legislation Committee; the People, Culture and Diversity Committee; the Quality Assurance Committee; the Strategy and Resources Committee; the Nomination and Remuneration Committee; and the West Lane Project Committee.

The roles, functions and membership of the Committee are set out in their reports, together with relevant disclosures required by the Code of Governance.

The Audit and Risk Committee

Role and responsibilities

The Audit and Risk 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 and Risk 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
    - Systems and processes for risk management within the Trust
    - The Board Assurance Framework (BAF) and the underlying processes that indicate the degree of achievement of the corporate objectives and the effectiveness of the management of principal organisational risks
- 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
- 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 (for example 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 colleagues 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 as appropriate

The Board, through the Audit and Risk Committee, conducts a review on the effectiveness of internal control annually based on the findings of the Head of Internal Audit.

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 held six formal meetings during the year. Attendance at which was as follows:

	No. of meetings attended
John Maddison (Chair)	6
Paul Murphy	4 (4)
Hugh Griffiths	3 (3)
Charlotte Carpenter	2 (3)
Bev Reilly	2 (2)

Jules Preston	2 (2)
Pali Hungin (as a substitute for Charlotte Carpenter)	1 (1)

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

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 Company 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 and Risk Committee in discharging its responsibilities

The Audit and Risk Committee uses an assurance tracker, which is updated after each meeting, to document and monitor compliance with its terms of reference.

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 31 March 2022 the Committee has:

- Reviewed the terms of engagement with the external auditors and approved the fees for conducting the audit

- Reviewed 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
- Reviewed the draft annual accounts paying particular attention to the accounting treatment of significant items; material movements from prior years; and any key matters of note
- 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 prior to its inclusion in the annual report

A special meeting of the Committee was held on June 2022 to enable the Committee to review the Annual Report and Accounts and the External Auditors draft reports on them.

During the 2021/22 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 a 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
- Reviewed the strategic and operational internal audit plans ensuring that these were aligned to key strategies and reflected the principal risks facing the Trust
- 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. In doing so, the committee sought specific assurances from management on the implementation of actions to improve the adequacy and robustness of controls for those assignments where limited or reasonable assurance had been reported
- Considered regular reports from the local counter fraud specialist (LCFS) noting action taken on increasing fraud awareness and in response to alleged cases of fraud in the Trust and elsewhere. The committee paid particular

attention, as potential areas of risk, to the recommendations arising from the proactive reviews and the timely delivery of recommendations arising from them
- Reviewed progress on the delivery of recommendations arising from assignments undertaken by the internal auditors.
- Reviewed the performance of the external auditors and, taking this into account, considered whether there were any matters which needed to be raised with the Council of Governors in regard to the extension of their contract
- Reviewed progress on the development of the Board Assurance Framework and risk management processes
- Paid particular attention to tender waivers and the controls relating to them
- Reviewed the Quality Account prior to its approval by the Board
- Reviewed assurances on the effectiveness of the Trust's emergency planning and business continuity arrangements
- Drew the Board's attention to those matters which it considers have implications for the Trust's assurance framework
- Considered corporate governance and accounting developments including the implications of IFRS 16

The External Auditors

Mazars LLP have been the Trust's external auditors since 2013.

Following a competitive tendering process exercise in 2017/18, overseen by members of the Committee and Governors, the Council of Governors as recommended re-appointed the firm for an initial period of two years (from 1 April 2018) with the option to extend for a further three years (in one year increments).

The cost of providing external audit services during 2021/22 was £49k excluding VAT. This includes the cost of the statutory audit, 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 4.2 and 6.2 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.

Carl Best, the Director of Internal Audit at Audit One, is the Trust's Head of Internal Audit.

Each year the Audit and Risk Committee agrees an internal audit plan which sets out the reviews to be undertaken during the year which is aligned to the principal strategic 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 and Risk 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 Chair of the Audit and Risk 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 Commissioning Committee

The Commissioning Committee contributes to the delivery of our Strategic Goals "To co-create a great experience for our patients, carers and families" and "To be a great partner" by providing oversight and assurance, on behalf of the Board of Directors, on the development and effectiveness of the Trust's commissioning functions and arrangements.

Its functions include:

- Providing assurance that arrangements are in place for the effective delivery of the Trust's responsibilities through the specialised services provider collaboratives and partnership commissioning arrangements with the Clinical Commissioning Groups
- Maintaining oversight of, and gaining assurance on, the management of clinical service sub-contracts
- Providing assurance that the Trust's commissioning arrangements comply with statutory and regulatory requirements and best practice
- Maintaining oversight of, and providing assurance on, the effective management of commissioning budgets devolved to the Trust
- Maintaining oversight of, and gaining assurance on, the regulatory and contractual compliance and the quality of services commissioned by the Trust
- Maintaining oversight of the Trust's relationships with external partners, involved in the specialised services provider collaboratives and partnership commissioning arrangements
- Gaining assurance that the Trust's commissioning arrangements support and contribute to the seamless delivery of pathways between providers
- Consideration of changes at national and system levels that might impact on the Trust's commissioning functions and arrangements

As at 31 March 2022 the membership of the committee comprised:

- John Maddison, Non-Executive Director (Chair of the Committee)
- Jill Haley, Non-Executive Director
- Sharon Pickering, Assistant Chief Executive
- Elizabeth Moody, Director of Nursing and Governance

The Committee was established in September 2021 and three meetings were held during the year.

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 they 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 agreement of locally determined terms and conditions of service for all TEWV staff employed on national medical terms and conditions and all staff paid at, or above, Agenda for Change Band 8

The membership of the Committee comprises the Chairman of the Trust and all the Non-Executive Directors.

The Committee held three meetings during 2021/22. The matters considered were as follows:

- The revised organisational and leadership structures and progress on their implementation

- The outcome of the appraisals of the Executive Directors for 2021/22, progress on the delivery of their objectives and the establishment of their new objectives for 2022/23
- The pay arrangements of very senior managers
- The statutory and regulatory responsibilities of the Executive Directors

Attendance at these teleconferences/meetings was as follows:

	No. of meetings attended
Miriam Harte (Chair of the Committee to October 2021)	2 (2)
Paul Murphy (Chair of the Committee from October 2021)	3
Charlotte Carpenter	2 (2)
Hugh Griffiths	1 (1)
Jill Haley	2 (2)
Pali Hungin	3
John Maddison	2

Bev Reilly	3
Shirley Richardson	3

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

The Chief Executive is an ex-officio member of the Committee in relation to all matters pertaining to the appointment to those director positions (excluding the role of the Chief Executive) which fall within its remit.

Advice and/or services were provided to the Committee by:

- Brent Kilmurray, Chief Executive
- Sarah Dexter-Smith, Director of People and Culture
- Phil Bellas, Company Secretary

The Mental Health Legislation Committee (MHLC)

The Mental Health Legislation Committee contributes to the delivery of our Strategic Goal Strategic Goal “To co-create a great experience for our patients, carers and families” by providing oversight and assurance to the Board on the Trust’s compliance with the Mental Health Act 1983 (as amended); the Mental Capacity Act 2005, the Deprivation of Liberty Standards/Liberty Protection Standards and any statutory Codes of Practice.

Its functions include:

- Gaining assurance that mental health legislation is applied to each individual patient and that practice is compliant with statutory and regulatory requirements.
- Identifying themes arising from the findings of the Care Quality Commission following visits to Trust services and gaining assurance that appropriate learning and action is being undertaken in response to them
- Gaining assurance that the Trust actively listens to, and learns from, the experiences of patients, families and carers in the application of mental health legislation.
- Gaining assurance that the Trust meets its reporting obligations to the Care Quality Commission in relation to deaths of detained patients and instances of absence without leave.
- Gaining assurance that the Trust is acting in accordance with the Mental Health Act Scheme of Delegation
- Reviewing the Scheme of Delegation, prepared in accordance with the Mental Health Act Code of Practice, and making recommendations relating to its confirmation to the Board of Directors
- Considering 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 advising the Board accordingly
- Reviewing national reports on mental health legislation
- Commenting on relevant policies and procedures.
- Ensuring appropriate arrangements are in place for the appointment and appraisal of associate managers and to oversee managers' hearings.

As at 31 March 2022 the membership of the committee comprised:

- Pali Hungin, Non-Executive Director (Chair of the Committee)
- Bev Reilly, Non-Executive Director
- Dr Steve Wright, Medical Director
- Elizabeth Moody, Director of Nursing and Governance

The Committee held four meetings during 2021/22.

The People Culture and Diversity Committee

The People Culture and Diversity Committee principal provider of oversight and assurance to the Board on the delivery of the Trust's Strategic Goal "To co-create a great experience for our colleagues".

Its functions include:

- Gaining assurance that the Trust understands its strategic workforce needs including wellbeing, culture, recruitment, retention, development of people, and organisational capacity) and overseeing the development and monitoring of plans to progress their delivery
- Reviewing and gaining assurance that:
    - The Trust's values and standards of behaviour are being practiced within all services and at all levels of the organisation.
    - The Trust is compliant with its statutory, regulatory and contractual obligations as an employer.
    - The Trust is compliant with the Equality Act 2010 including the Public Sector Equality Duty.
    - The health and wellbeing of colleagues is being effectively promoted and supported.
    - Arrangements for raising concerns, including the functions of the Freedom to Speak Up Guardian, meet national expectations and have the confidence of staff.
    - Appropriate action is taken to support the transformation of services and teams where issues are identified.
    - Effective and inclusive arrangements, which reflect best practice, are in place to communicate with and involve staff.
    - Appropriate arrangements are in place to support and maintain good relations with employees including through their recognised trade unions and professional bodies.
    - Keeping abreast of changes in employment law and regulation
    - Reviewing and making recommendations to the Board on:
    - Changes to the staffing establishment, including financial implications, arising from strategic staffing reviews, major service changes or where quality or workforce concerns are identified which could impact on the delivery of Our Journey to Change or the Trust's statutory and regulatory obligations
    - The appropriateness of the findings of external staffing reviews, including culture reviews, and management's response to them

- The efficacy of actions proposed by management to tackle NHS workforce equality and diversity issues including, but not limited to, the delivery of improvements on pay gaps and national equality and diversity standards
- The implementation of the Equality Delivery System of the NHS.

As at 31 March 2022 the membership of the committee comprised:

- Shirley Richardson, Non-Executive Director (Chair of the Committee)
- Jill Haley, Non-Executive Director
- Sarah Dexter-Smith, Director for People and Culture
- Ann Bridges, Director of Corporate Affairs and Involvement

The Managing Directors will become members of the Committee on commencing their roles with the Trust.

The Committee was established in September 2021 and three meetings were held during the year.

The Quality Assurance Committee

The Quality and Assurance Committee is the principal provider of oversight and assurance on the delivery of the Trust's Strategic Goal "To co-create a great experience for our patients, carers and families" including the quality, safety and effectiveness of clinical and operational services.

Its functions include:

- Providing assurance that the Trust is discharging its duty of quality and safety in compliance with the Health and Social Care Act 2008.
- Gaining and providing assurance on compliance with:
    - Regulatory requirements enabling the Trust to maintain registration with the Care Quality Commission to undertake regulated activities at each location

    - Standards of quality and safety as set out in the Fundamental Standards prescribed in the Health and Social Care Act (Regulated Activities) Regulations 2014
    - Other statutory and regulatory requirements and national guidance relating to quality and safety including safe staffing; infection prevention and control; safeguarding, medical devices; medicines management, mortality reviews; health and safety; the Duty of Candour; and security management
- Overseeing and gaining assurance that effective structures, systems and processes are put in place, maintained and continually improved to co-create and deliver a high quality experience and outcomes for all patients and their carers and families; to identify and manage risks to quality and safety; to investigate, review, and report on complaints, adverse events and serious incidents; to learn from and ensure that best practice is shared, implemented and embedded across the Trust; to deliver clinical care with other providers including transfers of care.
- Promoting a compassionate and open culture in which incident and risk reporting is encouraged and supported as part of the delivery of safe and effective care.
- Considering findings of reviews and investigations into the delivery of healthcare services by the Trust (including those undertaken or commissioned by the Care Quality Commission or NHS England) and management's responses to them, and monitoring progress on the implementation of agreed actions
- Gaining assurance on compliance with national clinical standards including NICE guidelines/guidance
- Overseeing the development and monitoring the delivery of the priorities included in the Trust's annual Quality Account.
- Overseeing the governance of research and development
- Agreeing an annual Clinical Audit programme

As at 31 March 2022 the membership of the committee comprised:

- Bev Reilly, Non-Executive Director (Chair of the Committee)
- Pali Hungin, Non-Executive Director
- Shirley Richardson, Deputy Chair and Senior Independent Director
- Elizabeth Moody, Director of Nursing and Governance
- Dr Steve Wright, Interim Medical Director

The Managing Directors will become members of the Committee on commencing their roles within the Trust

The Committee held nine meetings during 2021/22.

The Strategy and Resources Committee

The Strategy and Resources Committee provides assurance on the delivery of the Trust's Vision and Strategy articulated in "Our Journey to Change" and is the principal provider of oversight and assurance on the delivery of the Trust's Strategic Goal "To be a great partner".

On behalf of the Board of Directors it oversees the stewardship of the Trust's finances, investments, sustainability, reputation and physical and digital infrastructure.

Its functions include:

- Leading the development and updating of the Trust Strategy and Business Plan
- Providing assurance that the priorities identified in the Business Plan are aligned to, and will effectively deliver, Our Journey to Change
- Gaining assurance that the priorities identified in the Business Plan are aligned to those of strategic partners
- Gaining assurance that the non-staffing resources available to the Trust (both financial and non-financial for example estates, digital, etc) are appropriate and sufficient to deliver its Business Plan and are deployed effectively
- Monitoring the delivery of the Business Plan and to assuring itself and the Board that any changes proposed by management will not impact materially on the delivery of Our Journey to Change
- Receiving updates on system-wide programmes and developments, considering their alignment to the Trust Strategy and drawing any opportunities, implications or risks to the attention of the Board
- Overseeing the development and monitoring of strategic plans and gaining assurance that they are aligned to and support the delivery of Our Journey to Change.
- Overseeing investments and business cases for strategic projects
- Overseeing statutory consultations on major service changes
- Overseeing and providing assurance on the performance of the Trust's subsidiaries and other trading vehicles.
- Providing oversight of the management and administration of Charitable Funds held by the Trust.

As at 31 March 2022 the membership of the committee comprised:

- Paul Murphy, Chair of the Trust (Chair of the Committee)
- Charlotte Carpenter, Non-Executive Director
- John Maddison, Non-Executive Director
- Liz Romaniak, Director of Finance and Information
- Sharon Pickering, Assistant Chief Executive
- Ann Bridges, Director of Corporate Affairs and Involvement

The Committee was established in September 2021 and three meetings were held during the year.

The West Lane Project Committee

The West Lane Project Committee's principal objectives relate to the provision of vision, oversight and assurance on the investigation and learning from the events at the Hospital in 2019 and on the future service model of child and adolescent mental health inpatient services

As at 31 March 2022 the membership of the committee comprised:

- Shirley Richardson, Deputy Chair and Senior Independent Director (Chair of the Committee)
- John Maddison, Non-Executive Director
- Elizabeth Moody, Director of Nursing and Governance
- Dr Steve Wright, Interim Medical Director

The Managing Directors will become members of the Committee on commencing their roles within the Trust

The Committee held five meetings during 2021/22.

The 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 which it exercises by itself or in conjunction with the Board of Directors. These include:

- To develop our membership and represent their interests
- To assist with the development of the Trust's strategy
- To appoint or remove the Chairman and the Non-Executive Directors and to determine their remuneration and other terms and conditions of service
- 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 or whether it 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

Report of the Lead Governor

With the lifting of the Covid restrictions, Governors understand that the pressure and stresses remain on all clinical and non-clinical staff working in many various areas of our Trust.

Governors appreciate the dedication and commitment of staff to maintain Mental Health Services for services users and carers for both inpatients and those in the community.

Governors have once again been able to hold face to face meetings. These meetings have given us the opportunity to catch up with colleagues from across the Trust and meet new Governors who we have only been able to see on our computer screens.

As Lead Governor I have regular meetings with the Trust Chair and Chief Executive. The meetings enable me to communicate any concerns or questions that Governors have asked me to discuss with them. I am then able to feed back to Governors on the outcome of those discussions.

Our Trust has continued to provide training and development sessions, including external training, to ensure Governors are kept up to date and enhance their knowledge on new or changes to National Legislation and Guidance and many other relevant topics.

The sessions have been both virtual and more recently face to face.

How the Trusts is dealing with the recent Care Quality Commission (CQC) report is important to the Council of Governors.

The Council of Governors receive regular reports on the progress of the strategy to address the issues of concern raised by the CQC.

Governors will continue to monitor and scrutinise the improvements, the morale of staff, the Trust's Journey To Change and support the Trust's determination to provide the best mental health services for services users and carers.

Governors are pleased to work and support the Interim Chair Paul Murphy until a new Chair is appointed.

Cllr Ann McCoy
Lead governor

The Composition of the Council of Governors as at 31 March 2022

(54 seats)

Membership of the Council of Governors during 2021/22

Information on the Governors who held office during 2020/21, including their attendance at the six meetings of the Council, is presented below.

Public Governors

Constituency	Name	Term of Office (From – To)	CoG meeting attendance incl. AGM
Darlington	Joan Kirkbride	01/09/2020 - 30/06/2023	4
	Audrey Lax	01/09/2020 - 30/06/2023	5**
Durham	Jacci McNulty	01/09/2020 - 30/06/2023	3
Durham	Jill Wardle	01/09/2020 - 30/06/2023	5
Durham	Pamela Coombs	01/07/2021 - 30/06/2022	2 (4)*
Durham	Dominic Haney	01/07/2021 - 30/06/2022	3 (4)*
Durham	Graham Robinson	01/07/2019 - 30/06/2022	4
Durham	Jaclyn Stoker	01/07/2021 - 30/06/2022	2 (5)
Durham	James Creer	01/07/2019 - 30/06/2021	1 (1)
Durham	Anthony Heslop	01/07/2019 - 28/02/2022	4 (5)

Durham	Anne Carr	01/09/2020 - 28/02/2022	2 (5)
Hambleton and Richmondshire	Stanley Stevenson	01/09/2020 - 30/06/2023	1 (4)*
Harrogate and Wetherby	Jules Preston	04/12/2019 - 31/10/2021	3 (4)
Harrogate and Wetherby	Christine Gibson	01/07/2019 - 30/06/2022	5
Harrogate and Wetherby	Hazel Griffiths	01/07/2019 - 30/06/2022	5
Hartlepool	Zoe Sherry	01/09/2020 - 30/06/2023	3
Hartlepool	Jean Rayment	04/12/2019 - 30/06/2022	4
Middlesbrough	Mary Booth	01/09/2020 - 30/06/2023	5**
	Marie Cunningham	01/07/2019 - 06/07/2021	0 (1)
Redcar and Cleveland	Dr Sara Baxter	01/09/2020 - 30/06/2023	4
Redcar and Cleveland	Mark Carter	01/07/2019 - 30/06/2022	5
Rest of England	Carol Jones	01/07/2019 - 30/06/2022	0 (5)*
Scarborough and Ryedale	Keith Marsden	01/09/2020 - 30/06/2023	5 **
	Judith Webster	01/09/2020 - 30/06/2023	3 (4)*
	Janet Goddard	01/09/2020 - 30/06/2022	0
Selby	Gemma Birchwood	01/09/2020 - 30/06/2023	3

Selby	John Venable	01/09/2020 - 30/06/2023	3
Stockton on Tees	Gillian Restall	01/09/2020 - 30/06/2023	1
Stockton on Tees	Dr Mojgan Sani	01/09/2020 - 14/01/2022	1 (5)
Stockton on Tees	Gary Emerson	01/07/2019 - 30/06/2022	5
York	Christine Hodgson	01/07/2021 - 30/06/2024	4
York	Dr Martin Combs	01/07/2021 - 30/06/2024	3 (5)** Had technical issues and could not join 2 meetings virtually
York	John Manson	01/07/2021 - 22/03/2022	4 (5)
York	Prof. Tom McGuffog MBE	01/07/2018 - 30/06/2021	0 (1)

Staff Governors

Class within the Staff Constituency	**Name**	**Term of Office (From – To)**	**CoG meeting attendance incl. AGM**
County Durham and Darlington	Jane King	01/07/2021 - 30/06/2024	2 (5)
Corporate	Louis Bell	01/09/2020 - 31/12/2021	2 (5)
Forensic	Ray Godwin	01/09/2020 - 30/06/2023	0 (1)

North Yorkshire and York	Sarah Blackamore	01/07/2021 - 30/06/2022	3 (5)
Teesside	Emmanuel Chan	01/09/2020 - 30/06/2023	3 (6)

Appointed Governors

Class within the Staff Constituency	**Name**	**Term of Office (From – To)**	**CoG meeting attendance incl. AGM**
NHS Tees Valley CCG	Dr Boleslaw Posmyk	Appointed 24/06/2020	3
NHS County Durham CCG	Mike Brierley	Appointed 01/05/20	0
University of Teesside	Rachel Morris	Appointed 20/10/20	0
NHS Vale of York CCG	Dr Ruth Walker	05/08/2020 - 14/10/2021	0 (3)
University of York	Ian Hamilton	09/03/2018 - 31/03/2022	1
Newcastle University	Dr Andrew Fairbairn	Appointed 26/11/18	4** Couldn't join virtual AGM and another meeting due to technical issues.
Sunderland University	Sue Brent	Appointed 03/07/20	3

Middlesbrough Council	Erik Scollay	Appointed 29/04/20	0
Stockton Borough Council	Cllr Ann McCoy	Appointed 12/07/2019	6
Hartlepool Borough Council	Cllr Stephen Thomas	18/06/2020 - 10/05/2021	0 (0)
Darlington Borough Council	Kevin Kelly	Appointed 13/08/2015	0
Durham County Council	Lee Alexander	Appointed 03/01/2017	0
North Yorkshire County Council	Cllr Helen Swiers	Appointed 24/05/2016	3
City of York Council	Cllr Derek Wann	Appointed 26/06/2019	0

Notes: Within the above tables -

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

**** indicates that the Governor received a dispensation during the year from the attendance requirements set out in the Constitution (for example due to ill-health)***

***** indicates that the Governor reported being unable to attend a meeting virtually, including the AGM, due to technical issues***

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 possibly 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 2021/22

Constituency/ Class	Date of Election	No of Seats	No. of candidates	No. of Votes cast	No. of eligible voters	Turnout (%)
Public Governors						
Durham	24.6.21	2	4	140	2,139	6.6%
York	24.6.21	3	3	-	-	-
Staff Governors						
Durham and Darlington	24.6.21	1	3	225	1,943	11.6%
North Yorkshire and York	24.6.21	1	1	-	-	-

No valid nominations were received to enable an election to the vacant seat on the Council of Governors for the Hambleton and Richmondshire Public Constituency.

All elections to the Council of Governors have been administered and overseen by Civica Election Services (formerly 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

Chaired by the Chairman of the Trust, 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.

Three meetings of the Committee were held during 2021/22 to consider the arrangements for the appointment of two new Non-Executive Directors and the new Chair of the Trust; the outcome of the appraisals of the Chair and Non-Executive Directors; and revisions to the Trust's procedure on the Fit and Proper Persons Test.

		No. of meetings attended
Miriam Harte	Chair of the Trust and Chair of the Committee to October 2021	2 (2)
Paul Murphy	Chair of the Trust and Chair of the Committee from October 2021	1 (1)
Mary Booth	Public Governor	3
Gary Emerson	Public Governor	3
Jules Preston	Public Governor	2 (2)
Graham Robinson	Public Governor	3
Jill Wardle	Public Governor	1
Shirley Richardson	Senior Independent Director	1 (1)

Notes:

- *The maximum number of meetings to be attended by Members of the Committee is shown in brackets*
- *The Senior Independent Director is an ex officio member of the Committee when matters relating to the appointment and appraisal of the Chair of the Trust are being considered)*

Training and Development

A training and development programme is in place to support the Trust meet its duty under the National Health Service Act 2006, to equip Governors with the skills and knowledge they require to undertake their role.

The provision of training and development was significantly curtailed due to the Covid-19 pandemic; however, induction courses were offered to all new Governors and the Trust participated in the national ‘GovernWell’ programme.

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 business plan.

Some Governors participated in the annual stakeholder event, as part of the business planning process, as patients and carers and representatives of stakeholder organisations.

Sessions were also held for Governors before and after the event on the business planning process, including initial thoughts on priorities and to provide feedback on the discussions.

A formal report on the outputs of the stakeholder event, through which comments were sought on current and new potential projects, was considered by the Council of Governors in November 2021.

These arrangements enabled Governors to be assured that feedback received from their members was being reflected in the development of the draft Business Plan.

Membership Report

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

Public membership

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

Staff membership

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

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

As at 31 March 2022 the Trust’s membership was as follows:

- Public members – 9,206
- Staff members – 7,719

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	2	382,681
17-21	200	116,215
22+	8,516	1,544,224
Ethnicity:		
White	8,404	1,897,919
Mixed	55	17,513
Asian or Asian British	155	40,256
Black or Black British	79	7,935
Other	22	5,452
Socio-economic groupings*:		
AB	2,002	166,657
C1	2,526	258,886
C2	2,088	203,414
DE	2,519	261,462
Gender analysis		
Male	3,070	1,005,516
Female	6,073	1,037,601
Other	4	-

Notes:

On application:

443 public members did not provide a date of birth

491 members did not state their ethnicity

59 members did not specify their gender

Member Engagement

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

The Trust has levels of membership (support, informed, active and involved member) from which members can choose so that their engagement with the Trust is aligned to their aspirations.

Member engagement activities were significantly affected by the Covid-19 pandemic; however, during the period:

- Emails were sent to new members to welcome them to the Trust
- Governor Elections were held
- Personal invitations were sent for the Annual General and Members' Meeting
- The Trust continued its use of social media to encourage attendance at meetings of the Board and Council of Governors
- Members, who were also registered as involvement members, participated in a wide range of involvement and engagement activities.

Members wishing to contact Governors and/or Directors of the Trust can do so by emailing tewv.governors@nhs.net or via our website at www.tewv.nhs.uk

Applications for membership should be sent to the Company Secretary's Department at West Park Hospital or submitted using the online form on the Trust's website.

NHS system oversight framework

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

- Quality of care, access and outcomes
- Preventing ill health and reducing inequalities
- Finance and use of resources
- People
- Leadership and capability

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.

Segmentation

Our Trust has been placed in segment 3.

This segmentation information is the Trust's position as at 31 March 2022. Current segmentation information for NHS trusts and foundation trusts is published on the NHS England and NHS Improvement website**:**

https://www.england.nhs.uk/publication/nhs-system-oversight-framework-segmentation/.

Modern Slavery Act statement

All staff in clinical or non-clinical roles have a responsibility to consider modern slavery and incorporate their understanding of this into their day to day practice.

Front-line NHS staff are well placed to be able to identify and report any concerns they may have about people who use our services, and modern slavery is part of the safeguarding agenda for children and adults.

The Trust is fully aware of its responsibilities towards patients, employees and the local community and, as such, we have a strict set of ethical values that we use as guidance with regard to our commercial activities. We therefore expect that all our suppliers adhere to the same ethical principles.

In compliance with the consolidation of offences relating to trafficking and slavery with the Modern Slavery Act 2015 we continue to review our supply chains with a view to confirming that such actions are not taking place.

Advice and training about slavery and human trafficking is available to staff through the safeguarding team.

Further information on modern day slavery can be found by visiting: **https://modernslavery.co.uk/**

Accounting Officer statement

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 Tees, Esk and Wear Valleys NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care 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 and Social Care 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.
- Confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust’s performance, business model and strategy.

- Prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

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 them 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.

As far as I am aware, there is no relevant audit information of which the Foundation Trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

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

[Signature]

Brent Kilmurray

Chief Executive

16 June 2022

Annual governance statement 2021/22

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 2022 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Oversight of the Trust's risk and control framework is provided by the Board of Directors which has also retained responsibility for the approval of risk management policies; setting the organisation's risk appetite and risk tolerances; and establishing the tone and culture for risk management in the Trust.

The Audit and Risk Committee provides independent assurance to the Board on risk management and internal control. As set out in the Annual Report, membership of this Committee is limited to independent Non-Executive Directors.

Other Board Committees have responsibility for scrutinising and monitoring relevant risks, both strategic and operational, as included in the Board Assurance Framework and Corporate Risk Register respectively and providing assurance to the Board that they are being managed effectively.

As the Chief Executive I have responsibility and accountability for maintaining a sound system of internal control, assurance and risk management that supports the achievement of the organisation's objectives.

I discharge these duties through the executive team, with clear designation of accountability to individuals to support me in this role. Responsibility for specific areas of risk is delegated to individual Executive Directors in line with their portfolios.

The Executive Team maintains a dynamic Board Assurance Framework and operational risk management arrangements through which the Board, and its Committees can monitor and gain assurance that a satisfactory level of internal control, safety and quality is being achieved.

Within the clinical, operational and corporate services, senior managers are responsible for ensuring they, and their staff, fulfil their responsibility for risk management by operating in accordance with the Trust's systems, policies and procedures and ensuring that risks are escalated appropriately within the Trust's governance structures.

All staff are expected to have an awareness of risk in the performance of their day-to-day duties and to escalate situations which present risk to their line manager.

Guidance and training in the risk assessment process is aimed at all levels of staff.

We have recently worked with the Good Governance Institute and Deloitte LLP to identify best practice and areas for development in terms of risk management.

The risk and control framework

In response to the identification of some significant weaknesses in our governance arrangements, as described in the Annual Governance Statement for the year ended 31st March 2021, the Trust has undertaken significant work to strengthen its risk and internal control framework.

Early in 2021/22 the Board received the final report of the Good Governance Institute, following its independent leadership and developmental review of the Trust under NHS Improvement's well-led framework.

All the recommendations of the report were accepted and have been developed and implemented; however, some elements did not come into effect until 1st April 2022. Certain residual elements are also being taken forward through established programme boards and groups. This position has been taken into account by the Board in its appraisal of the Trust's Corporate Governance Statement and the risks and mitigations identified within it.

The following section provides details of the risk and control framework in place during 2021/22; the developments planned, and progress made on their implementation; and the interim arrangements to maintain internal controls during the transitionary period and in response to the Covid-19 pandemic.

A risk management policy was in place during the year which was aligned to our (then) governance structure and set out the processes to systematically identify, assess, manage, monitor, mitigate and review risk.

Risks facing the organisation will be identified from a number of sources, both internal and external to the organisation, for example:

Internal - though risk assessments; the development of the business plan; consultations with staff and patients; internal inspections and audits; and complaints, incidents and claims.

External – through assessments by regulators; environmental appraisals; intelligence from regional partnerships/developing system arrangements and information disseminated by national bodies; consultation with external stakeholders; and benchmarking.

The Board has identified the principal risks to the delivery of its Strategic Direction, "Our Journey to Change", and these are monitored and managed through the Board Assurance Framework (BAF).

The BAF and the Corporate (operational) Risk Register are designed to identify the controls in place to manage risk and related sources of assurance, positive assurance, gaps in control and assurance and mitigation plans.

All risks are scored against set criteria for consequence and likelihood. Each risk also has a target (residual) risk score; the level of risk once all reasonable mitigating actions have been implemented.

A new risk management policy is awaiting approval. This codifies and collates many improvements to our governance, assurance and risk management arrangements described below.

As at 31 March 2022 the following strategic risks were included in the Board Assurance Framework:

Ref	Strategic Goals			Risk Name & Description	Oversight Committee
	To co-create a great experience for our patients, carers and families	To co-create a great experience for our Colleagues	To be a great partner		
1	✓	✓		**Recruitment and Retention** Inability to recruit and retain sufficient qualified and skilled staff might jeopardise our ability to provide high quality/safe services	**People Culture & Diversity Committee**
2	✓			**Demand** Demand for our services, particularly as a result of the post-Covid surge, might result in us not being able to meet patient/carer expectations or commissioner requirements	**Quality Assurance Committee**
3	✓			**Involvement and Engagement** A fragmented approach to service user and carer engagement and involvement might prevent us from co-creating a great experience	**Quality Assurance Committee**
4	✓			**Experience** We might not always provide a good enough experience for those who use our services, their	**Quality Assurance Committee**

				carers and their families, in all places and all of the time (see also BAF refs 1 (recruitment and retention) and 6 (Learning))	
5	✓	✓		**Culture & Wellbeing** Pockets of poor culture or low staff wellbeing could undermine our ability to provide a safe and sustainable service as well as putting individual staff and patients at risk of harm	**People Culture & Diversity Committee**
6	✓			**Safety** Failure to effectively undertake and embed learning could result in repeated serious incidents	**Quality Assurance Committee**
7	✓	✓	✓	**Infrastructure** Poor quality physical or digital infrastructure could impede our ability to co-create a great experience both for staff and for patients [excludes CITO (see risk 12), Cyber security (see risk 8) and RPH (see risk 14)].	**Strategy & Resources Committee**
8	✓	✓	✓	**Cyber Security** A successful cyber-attack could compromise patient safety, business continuity, systems and information integrity and cause reputational damage	**Strategy & Resources Committee**
9	✓	✓	✓	**Regulatory Action** Further regulatory action could result in loss of confidence and affect our reputation among service users, staff, and other key stakeholders (see also BAF ref. 11 – Governance and Assurance)	**Quality Assurance Committee**
10			✓	**Influence** Changes in the external environment, and insufficient capacity to respond or to align our objectives with those of partners, might lead to loss of strategic influence and reputation	**Strategy & Resources Committee**

11	✓			**Governance & Assurance** The absence of a clear line of sight from ward to Board, due to ineffective governance and assurance processes, could result in the inconsistent quality of services and increased risks to patients	**Quality Assurance Committee**
12	✓	✓	✓	**Roseberry Park** The necessary Programme of rectification works at Roseberry Park and associated legal case could adversely affect our service quality/safety and financial, reputational and regulatory standing	**Board**
13	✓	✓	✓	**West Lane** The outcome of the independent enquiry, coroners' investigations, and civil legal actions could affect our reputational and regulatory standing if the Trust is not able to demonstrate the necessary improvements and approach	**West Lane Project Committee**
14	✓	✓	✓	**CITO** Failure to deliver the CITO project to its revised timescale will delay its benefits for patients and staff	**Strategy & Resources Committee**
15	✓	✓	✓	**Financial Sustainability** Failure to gain a fair share of resources for the Trust and mental health could impact on the delivery of Our Journey to Change and the sustainability of services	**Strategy & Resources Committee**

It is not envisaged these risks will change significantly over the coming year.

During 2021/22, the Trust's governance structure was based on:

- The Board of Directors
- Its committees, each chaired by a Non-Executive Director

- A Senior Leadership Group comprising the Executive Directors, Corporate Directors and senior operational managers and clinical staff representing the Localities
- Locality Management and Governance Boards and Quality Assurance Groups
- Speciality Development Groups
- Thematic quality assurance groups

The terms of reference of the Board's Committees have been aligned to the provision of oversight and assurance on the delivery of our Strategic Goals.

All of them have responsibility for providing assurance to the Board on the effectiveness of controls to manage risks and identifying and escalating new risks that could impact significantly on the Trust's ability to deliver Our Journey to Change to the Board.

The Audit and Risk Committee had specific responsibilities for:

- Providing assurance to the Board (through its oversight of governance, risk management and internal control) on the effectiveness and robustness of the Trust's risk management arrangements and controls environment.
- Reviewing the adequacy of all risk and control related statements (e.g. the Annual Governance Statement) prior to endorsement by the Board.
- Reviewing the Assurance Framework, prior to its presentation to the Board, to provide assurance on its coverage and comprehensiveness and the appropriateness and effectiveness of the mitigations for each principal risk.

The Committee utilises reports of management and internal audit to provide assurance to the Board as to the effectiveness of the BAF and risk management as components of the internal control framework.

The Internal Audit and Counter Fraud Plans are aligned with the Trust's principal risks.

The Trust's quality governance arrangements are focussed on the Quality Assurance Committee of the Board. It has responsibility for overseeing the Trust's compliance against the fundamental standards for quality and safety. It also considers statutory and regulatory compliance, in regard to relevant matters (including health and safety; safeguarding; and medicines management); clinical audit; and research and development.

During the year the Committee received assurance from:

- Locality based governance arrangements.

- The Quality Assurance and Improvement Group through the Quality and Learning Report (which includes patient safety, clinical effectiveness, patient experience and well led).

Organisational risk management is aligned to the Trust's governance arrangements based on the significance of risk.

Very high-level risks were monitored directly by the Senior Leadership Group supported by sub-groups covering clinical leadership, quality assurance and improvement, operational delivery and development, people and culture and portfolio management.

The Corporate Risk Register was supported by risk registers which were managed through the Locality Management and Governance Boards and the Quality Assurance Groups.

Speciality Development Groups, chaired by Senior Clinical Directors, with responsibilities for ensuring consistent clinical approaches across the geographical areas of the Trust continued to meet.

Mindful that 2021/22 was a period of transition, the following additional groups were maintained:

- The Quality Improvement Board which provided oversight of organisational management of responses to defined circumstances, for example regulatory inspections or where urgent escalation was required.
- Gold Command which provided oversight and direction of the Trust's response to the Covid-19 pandemic.

Risk is embedded in the activities of the organisation in the following ways:

- Equality impact assessments which are undertaken for all new initiatives and policies.

- Quality Impact Assessments (QIA), requiring sign-off by the Medical Director and Director of Nursing and Governance, for all Cash Releasing Efficiency Savings (CRES) schemes to assess the impact they will have on clinical performance, and ultimately, patient care.

- An open reporting culture which encourages staff to report all incidents through its internal reporting system.

- The arrangements, as set out in the Trust's Incident Policy CORP 0043, by which all incidents are openly reported within the Trust and where appropriate externally and are systematically reviewed and analysed to

prevent/minimise their repetition. These include the involvement of patients and families from the beginning of the incident where appropriate.

- Business case approvals processes through which investment requirements are articulated, risk assessed, costed and refined to ensure value for money.

The Trust involves public stakeholders in identifying and managing risks to its strategic objectives in a number of ways. These include:

- Feedback from Governors on concerns raised by their Members.
- Patient satisfaction surveys including the "Friends and Family Test".
- Complaints, claims and Patient Advice and Liaison (PALS) concerns.
- The involvement of patients and the public in the development and evaluation of services.
- Feedback received from patients, staff and the public through CQC enquiries and Mental Health Act complaints.
- Close links with Local Authorities, Clinical Commissioning Groups and Integrated Care Systems/partners to ensure the delivery of integrated care and treatment.

In line with the NHS Long Term Plan and associated People Plan, the Trust continued to develop and embed its approach to workforce planning with oversight provided by the Workforce Sub-Group of Senior Leadership Group (now executive leaders) throughout the year.

The Trust was one of fewer than a handful of trusts to develop workforce plans as the focus shifted to better understanding impacts from the Covid-19 pandemic. These have been recognised nationally and implemented targeted recruitment based on a clear model of the impact on people needing the services of each specialty as a result of Covid-19.

The Trust has also restructured through the last year in order to ensure better clinical leadership.

Workforce data is reported to the new People Culture and Diversity Committee and the BAF contains risks on recruitment, retention, wellbeing and culture which are actively monitored.

Staffing establishment reviews are carried out, underpinned by the National Quality Board's 2016 guidance, and reported to the Board. These consider and triangulate professional judgement with workforce data and outcomes alongside the assessment of acuity and dependency via the mental health optimal staffing tool (MHOST). Risks to safety and quality,

financial areas, performance and staff and patient experience are described in the reviews. Benchmarking data for Care Hours Per patient Day and skill mix is used to support decision making including peer review and the Model System. Six monthly safe staffing reports are provided to the Trust Board highlighting any areas of concern together with mitigating actions with monthly assurances also provided by the Quality Assurance Committee

Quality impact assessments are undertaken for any required changes to the roster demand templates and the budgeted establishments, taking into consideration staffing numbers and skill mix.

Acuity-dependency based rostering is completed daily for inpatient wards to support daily staffing discussions and is underpinned by the staffing escalation process for any red flags as part of a dynamic staffing risk assessment.

The Trust is currently working to consider community acuity and dependency daily assessments to support caseload management discussions and decisions.
Services are expected to carry out business-as-usual dynamic staffing risk assessments including formal escalation processes.

Concerns about staffing are escalated to Executive Directors and either: short term actions improve the situation are implemented; or a longer-term plan is required and the service is formally registered as in Business Continuity. Those teams are discussed on a weekly or fortnightly basis at either Gold Command, Oversight and Assurance, or the Quality Improvement Board depending on the Opel level of the Trust as a whole. Analysis at these meetings is focused on whether the service is safe today and over the next week and then how to build the service back to a sustainable level of workforce provision that can be maintained.

A working group has been established which aims to achieve the Trust's goal to ensure that its highly skilled workforce and staffing resource are made available at the right place and time to deliver the best possible experience for patients that is safe and of high quality. It will support the delivery of the agenda of the People, Culture and Diversity Group and its objectives towards the Trust's workforce strategy. The strategy is focussed on significantly increasing the capability of our existing workforce by ensuring that we have the right number of staff with the right skills to deliver high quality care to our patients/service users and carers.

The Trust has actioned specific processes to address areas where staffing risks remain despite mitigations and has established and implemented responsive business continuity plans to maintain safety and care quality. These actions

have included full and partial closure of wards, reduced bed provision, commissioning of independent sector bed capacity and realignment of teams to support quality and safety requirements.

The principal risks to compliance with licence condition 4 of the (foundation trust governance) are included in the BAF.

The assessment of these risks has taken into account:

- The report on the independent leadership and development review undertaken by the Good Governance Institute (May 2021); the recommendations of which were reflected in the Care Quality Commission's report of December 2021.
- The mitigations delivered during the year which have included:
  - A Board Development Programme and Board Performance Evaluation facilitated by Deloitte LLP.
  - The appointment of new Non-Executive Directors to increase the skills, experience and diversity on the Board.
  - Increased capacity in the Executive Director team and changes to portfolios to support the delivery of Our Journey to Change and alignment with the new architecture of the NHS with its focus on integration and place.
  - A refresh of the Board Assurance Framework to ensure its alignment with the strategic goals of Our Journey to Change approved in January 2021.
  - The review and agreement of risk appetite statements and tolerances by the Board taking into account the strategic goals of Our Journey to Change and guidance from the Good Governance Institute and the Institute of Risk Management.
  - The alignment of the Board's agendas and business cycle to the strategic goals and the BAF.
  - Changes to the terms of reference of the Board's Committees to align their strategic purpose to the strategic goals and to provide clarity on their responsibilities for the oversight of risk.
  - The development, consultation on, and work to implement a new organisational structure effective from April 2022, with the establishment of Care Groups, which is designed to increase capacity, accountability, and enable to Trust to be more responsive to local need.
  - The development of a revised governance structure to improve line of sight from ward to Board; improve the flow of assurances; and enable greater oversight of risk.
  - Improvements to risk management with work to design and prepare to establish risk groups at both executive and care group levels of the new structure from 2022/23 and improved reporting to the Board and its Committees through a new risk escalation framework.

    - The introduction of a new integrated performance assurance framework to support oversight, monitoring and reporting of key measures to demonstrate the delivery of the quality of services and provide assurance to the Board through its sub-committee structure.
- An annual review of precautions taken by the Trust to maintain compliance with its provider licence conditions.
- The findings of inspections by the Care Quality Commission; the regulatory action taken; and the progress made by the Trust in response.
- The ongoing independent investigation commissioned by NHS E/I.

The Board has also considered the above matters in assessing the validity of its Corporate Governance Statement. Four of its six components have been confirmed and two, not confirmed. Risks, and mitigations relate to the embeddedness of the Trust's operational and governance arrangements; present uncertainty about the outcome of the NHS E/I investigation; continuing regulatory oversight by the CQC; and the availability of staffing. All these risks are covered in the BAF.

The Trust continues to be registered with the Care Quality Commission; however, this remains conditional on it not providing CAMHS inpatient services at West Lane Hospital (now Acklam Road Hospital).

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past twelve months as required by the *Managing Conflicts of Interest in the NHS* guidance.

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 Trust has undertaken risk assessments and ***has plans in place which take account of the 'Delivering a Net Zero Health Service' report under the Greener NHS programme.*** The Trust ensures that its 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 processes to ensure that resources are used economically, efficiently and effectively that (outside of 2021/22 Covid financial arrangements) would involve:

- Agreeing an annual financial plan and longer-term strategy
- A rigorous process of setting annual budgets and a detailed cash releasing efficiency savings (CRES) programme including a Quality Impact Assessment (QIA)
- Annual review of Standing Financial Instructions and Schemes of Delegation
- Robust performance management arrangements
- A programme of supporting localities to better understand and manage their respective income and expenditure, including using service line reporting and benchmarking
- Breaking down the trust's overall reference cost indicator to support benchmarking of costs
- Leveraging efficiencies through internal and collaborative procurement initiatives
- Using benchmarking and nationally published performance metrics to inform plans for improved inpatient and community service efficiency
- Rationalising the estate
- Improving workforce productivity, including through innovation and technology
- Benchmarking costs of corporate functions, including reference to national tools including Model Hospital
- Utilising annualised Business Planning and innovative coaching approaches to generate ideas for cost reductions
- Embedding the Quality Improvement Systems (QIS) methodology to review how the Trust operates, maximising efficiency and minimising waste
- Working with partners to improve the overall local health economy in terms of quality and efficiency, including developing non-Trust pathways and assuming commissioning functions to improve cost effectiveness and outcomes. The Trust has strategic partnerships with CCGs in both Durham and Tees and North Yorkshire; works collaboratively with NHS England and CNTW via New Care Models for specialist services and develops new services for people with Learning Disability using PIPS
- Robust capital planning function locally adopting the NHS England business case approvals process guidance, coordination of prioritisation processes to ensure transparent agreement of relative priorities and impact assessments where resource constraints limit Trust ambitions.

The Board plays an active role by:

- Determining the level of financial performance it requires and the consequent implications (including ensuring QIA)

- Reviewing in detail at each meeting financial performance, financial risk and delivery against the detailed CRES, supplemented by more detailed discussion at Strategy and Resources Committee
- 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 and Risk 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 and Local Counter Fraud Specialist findings in relation to fraud
- External audit reports on specific areas of interest
- The Care Quality Commission reports.

Information governance

There were 17 incidents reported in the Data Security and Protection Toolkit during the period 1st April 2021 to 31st March 2022.
- 9 incidents were privacy breaches affecting 10 persons – inappropriate staff access to local or national patient information systems.
- 8 incidents were confidentiality breaches with a variety of causes.
- All incidents were investigated by the appropriate Trust team.
- No cases resulted in regulatory action by the Information Commissioners Office.

Due to the ongoing Covid-19 pandemic, NHS Digital has delayed submission of the Data Security and Protection Toolkit 2021-22 until 30th June 2022. Of the 110 mandatory evidence items and 38 assertions, we anticipate publishing the Toolkit with all except 1 evidence item provided and a status of 'Approaching Standards'. We are currently experiencing a higher than usual sickness absence rate, making the mandatory requirement to ensure at least 95% of all staff have completed their annual Data Security Awareness Training difficult. The Trust is implementing an action plan that identifies the actions and timescales to achieve compliance. To mitigate the risk to data security, the Trust issues monthly cyber security eLearning to all staff; all new staff complete mandatory Data Security and Protection Training for New Starters; and we regularly perform phishing simulations with the findings and learning shared Trust-wide.

In November 2021 the Information Commissioner's Office (ICO) conducted a consensual audit to determine the extent to which the Trust is complying with data protection legislation. The audit focused on 2 areas:

- Governance and accountability: The extent to which information governance accountability, policies and procedures, performance measurement controls, and reporting mechanisms to monitor data protection compliance to both the UK GDPR and national data protection legislation are in place and in operation throughout the organisation.
- Data Sharing: The design and operation of controls to ensure the sharing of personal data complies with the principles of all data protection legislation

The Trust achieved reasonable assurance in both areas and has agreed an action plan with the ICO. Progress against this action plan is reported through the Strategy and Resources Committee (and will additionally be reported to the Audit and Risk Committee for assurance on controls).

Data quality and governance

The following steps have been put in place to ensure that appropriate controls are in place to ensure the accuracy of data:

- The Trust has in place an internal group which has the responsibility for monitoring Trust-wide data quality issues and developing action plans. The group was put on-hold during the COVID-19 response and reinstated in February 2022 as part of the Trust's revised governance structure.
- 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.
- A Data Quality Strategy Scorecard is in place to enable the Board of Directors to track progress.
- Our Digital and Data Journey To Change sets out the Trust's strategy for how we will use data to help us deliver a great experience for patients, carers and families.

In the most recent NHS Digital published results (January 2022) TEWV gained a score of 98.0% for the Data Quality Maturity Index which is a measurement of data quality in the NHS.

The Trust has the following policies linked to data quality:

- Data management policy
- Minimum standards for record keeping
- Policy and procedure for PARIS (Electronic patient record / information system)
- Information governance policy

- Information systems business continuity policy
- Confidentiality and sharing information policy.

The policies incorporate national standards where available and are regularly reviewed. All the policies are held on the intranet. When policies have been reviewed (or new ones published) staff are informed through team brief and other cascade mechanisms.

- Training is provided to support staff using the electronic patient record (PARIS). Training is provided where issues around data quality have been identified.
- As part of performance reporting to the Board, real-time data is used to forecast future positions thus improving the decision-making process. Trust dashboards are available via the Integrated Information Centre (IIC) to support and enhance decision making.

All data returns are submitted in line with agreed timescales.
An independent audit of data quality in relation to performance data reported against Health of the Nation Outcome Scales (HoNOS) saw the Trust achieve a rating of 'Substantial'. The report identified that governance, risk management and control arrangements provide substantial assurance that the risks identified are managed effectively.

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 Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on 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 and Risk Committee and the Quality Assurance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

My review has specifically taken into account:

- The conclusions of the Board on signing off the leadership and development (well-led) implementation plan developed in response to the recommendations of the Good Governance Institute.

- The section 29A notices received from the CQC and the compliance issues identified and downgrading of the rating for well-led in its inspection report of December 2021.

  In this regard I have also considered the rapid improvements made to secure the positive re-rating of adult acute and PICU inpatient wards (to requires improvement) and in response to more recent CQC inspection findings and the feedback provided by the regional Quality Board.
- The conclusions of the Head of Internal Audit in his annual opinion which provides good assurance on the Trust's systems of internal control notwithstanding weaknesses being identified with processes for the management of patient property, money and valuables and property lease management (the latter subsequently re-audited with a 'good' assurance conclusion).
- The assurances provided to the External Auditors by the Audit and Risk Committee on the controls in place to manage fraud and the application of laws and regulations.
- The assurances provided through the Board effectiveness review undertaken by Deloitte LLP.

Conclusion

In 2020/21 the Trust recognised that there were some significant weaknesses in internal control processes. These were reflected in the report of the Good Governance Institute and echoed by the Care Quality Commission.

Whilst work has been undertaken during the year and significant improvements have been made I must conclude that, with regulatory action being taken by the CQC, significant weaknesses in internal control will remain until I have received positive assurance from the Trust's regulators.

Plans are in place to implement the changes required which are being actively monitored.

Brent Kilmurray

Accounting Officer

16 June 2022

The auditors' report and opinion

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

The accounts 2021/22

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

Brent Kilmurray
Chief Executive
16th June 2022

** If you would like additional copies of this report please contact:

The communications team
Email: tewv.enquiries@nhs.net

Our chairman, directors and governors can be contacted through the Trust secretary's office by emailing: tewv.ftmembership@nhs.net

For more information about the Trust and how you can get involved please visit our website www.tewv.nhs.uk

Statement of Comprehensive Income

	Note	2021/22 £000	2020/21 £000
Operating income from patient care activities	3	420,618	391,456
Other operating income	4	23,011	31,809
Operating expenses	6, 8	(444,567)	(436,814)
Operating deficit from continuing operations		**(938)**	**(13,549)**
Finance income	11	44	17
Finance expenses	12	(1,054)	(1,053)
PDC dividends payable		(2,801)	(2,156)
Net finance costs		**(3,811)**	**(3,192)**
Other gains	13	509	-
Deficit for the year		**(4,240)**	**(16,741)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	907	(32)
Revaluations	16	-	381
Total comprehensive expense for the period		**(3,333)**	**(16,392)**

The Trust's performance against financial plans agreed with NHS England is included in note 2.2

Statement of Financial Position

	Note	31 March 2022 £000	31 March 2021 £000
Non-current assets			
Intangible assets	15	1,554	1,554
Property, plant and equipment	16	141,727	138,833
Receivables	21	573	524
Total non-current assets		**143,854**	**140,911**
Current assets			
Inventories	20	829	1,007
Receivables	21	15,900	17,922
Non-current assets for sale and assets in disposal groups	23.1	-	1,080
Cash and cash equivalents	24	81,736	80,936
Total current assets		**98,465**	**100,945**
Current liabilities			
Trade and other payables	25	(49,631)	(47,011)
Borrowings	27	(895)	(890)
Provisions	30	(3,696)	(7,553)
Other liabilities	26	(1,061)	(1,595)
Total current liabilities		**(55,283)**	**(57,049)**
Total assets less current liabilities		**187,036**	**184,807**
Non-current liabilities			
Borrowings	27	(11,409)	(12,304)
Provisions	30	(8,213)	(4,006)
Total non-current liabilities		**(19,622)**	**(16,310)**
Total assets employed		**167,414**	**168,497**
Financed by			
Public dividend capital		155,468	153,218
Revaluation reserve		5,942	5,035
Income and expenditure reserve		6,004	10,244
Total taxpayers' equity		**167,414**	**168,497**

The notes form part of these accounts.

Name

Position

Date 16 June 2022

Statement of Changes in Equity for the year ended 31 March 2022

	Public dividend capital	Revaluation reserve*	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2021 - brought forward	**153,218**	**5,035**	**10,244**	**168,497**
(deficit) for the year	-	-	(4,240)	**(4,240)**
Impairments	-	907	-	**907**
Public dividend capital received	2,250	-	-	**2,250**
Taxpayers' and others' equity at 31 March 2022	**155,468**	**5,942**	**6,004**	**167,414**

*The revaluation reserve is used to record revaluation gains and losses on property, plant and equipment. This reserve is currently used solely for tangible assets only.

Statement of Changes in Equity for the year ended 31 March 2021

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2020 - brought forward	**147,126**	**4,686**	**26,985**	**178,797**
(deficit) for the year	-	-	(16,741)	**(16,741)**
Impairments	-	(32)	-	**(32)**
Revaluations	-	381	-	**381**
Public dividend capital received	6,092	-	-	**6,092**
Taxpayers' and others' equity at 31 March 2021	**153,218**	**5,035**	**10,244**	**168,497**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the trust.

Statement of Cash Flows

	Note	2021/22 £000	2020/21 £000
Cash flows from operating activities			
Operating (deficit)		(938)	(13,549)
Non-cash income and expense:			
Depreciation and amortisation	6.1	3,523	3,799
Net impairments	7	10,698	25,841
Decrease in receivables and other assets		746	1,881
(Increase) / decrease in inventories		178	(261)
Increase in payables and other liabilities		4,017	8,974
Increase in provisions		386	3,590
Net cash flows from operating activities		**18,610**	**30,275**
Cash flows from investing activities			
Interest received		44	17
Purchase of PPE and investment property		(18,419)	(27,365)
Sales of PPE and investment property		1,869	-
Net cash flows (used in) investing activities		**(16,506)**	**(27,348)**
Cash flows from financing activities			
Public dividend capital received		2,250	6,092
Movement on other loans		(238)	(238)
Capital element of PFI, LIFT and other service concession payments		(652)	(580)
Interest paid on PFI, LIFT and other service concession obligations		(1,090)	(1,077)
PDC dividend (paid)		(1,574)	(3,102)
Net cash flows from / (used in) financing activities		**(1,304)**	**1,095**
Increase in cash and cash equivalents		**800**	**4,022**
Cash and cash equivalents at 1 April - brought forward		**80,936**	**76,914**
Cash and cash equivalents at 31 March	24.1	**81,736**	**80,936**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2021/22 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These accounts 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.

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity’s services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

Note 1.3 Interests in other entities

Joint operations
Joint operations are arrangements in which the trust has joint control with one or more other parties and has the rights to the assets, and obligations for the liabilities, relating to the arrangement. The trust includes within its financial statements its share of the assets, liabilities, income and expenses.
The trust is trustee for the “Tees Esk and Wear Valleys NHS Trust General Charitable Fund”, the balances of which are not consolidated with the trust's accounts on the grounds of materiality.

The trust has two wholly owned subsidiary companies "Positive Individualised Proactive Support Limited", and "TEWV Estates and Facilities Management Limited", however the trust has not consolidated within the trust's accounts on the grounds of materiality. "TEWV Estates and Facilities Management Limited" was made dormant during 2019/20.

Note 1.4 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the trust accrues income relating to performance obligations satisfied in that year. Where the trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

The majority of the trust's revenue from contracts with customers is received from annual contracts with NHS commissioners. Cash is received monthly in 1/12ths, and performance criteria are met as the contracted services are provided.

Revenue from NHS contracts

The main source of income for the trust is contracts with commissioners for health care services. In 2021/22 and 2020/21, the majority of the trust's income from NHS commissioners was in the form of block contract arrangements. The trust receives block funding from its commissioners, where funding envelopes are set at an Integrated Care System level. For the first half of the 2020/21 comparative year these blocks were set for individual NHS providers directly, but the revenue recognition principles are the same. The related performance obligation is the delivery of healthcare and related services during the period, with the trust's entitlement to consideration not varying based on the levels of activity performed.

The trust also receives additional income outside of the block payments to reimburse specific costs incurred and, in 2020/21, other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the trust's interim performance does not create an asset with alternative use for the trust, and the trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

Note 1.5 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the consolidated Statement of Comprehensive Income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.6 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy 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.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Note 1.7 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that, they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.8 Discontinued operations

Discontinued operations occur where activities either cease without transfer to another entity, or transfer to an entity outside of the boundary of Whole of Government Accounts, such as private or voluntary sectors. Such activities are accounted for in accordance with IFRS 5. Activities that are transferred to other bodies within the boundary of Whole of Government Accounts are ‘machinery of government changes’ and treated as continuing operations.

Note 1.9 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

• 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 item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

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 lives.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs 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.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the trust’s Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the trust.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

A desktop MEA valuation was carried out on the trust's land and buildings at 31 March 2022, and the assets have been treated as prescribed in the Group Accounting Manual. All of the trust's MEA valuations have been completed by Cushman and Wakefield Inc. (independent qualified valuer).

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as ‘held for sale’ cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of ‘other impairments’ are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as ‘held for sale’ once the criteria in IFRS 5 are met, i.e. the sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their ‘fair value less costs to sell’. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as ‘held for sale’ and instead is retained as an operational asset and the asset’s useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant 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/grant 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 and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's Financial Reporting Manual (*FReM)* , are accounted for as 'on-Statement of Financial Position' by the trust. In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost, the charges for services and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

PFI 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.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	1	90
Plant & machinery	1	15
Transport equipment	1	7
Information technology	1	7
Furniture & fittings	1	10

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.10 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Software

Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently, intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits. The trust's intangible assets are licenses that are to be held in perpetuity, as such they do not have a maximum life.

Note 1.11 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

In 2020/21 and 2021/22, the trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

Note 1.12 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. Cash, bank and overdraft balances are recorded at current values.

Note 1.13 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive, or a legal obligation to pay, cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets and liabilities are classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income as a financing income or expense.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the trust recognises an allowance for expected credit losses.

The trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

Expected credit losses are calculated for non government funded organisations only, based on the level of risk attached to individual transactions.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

De-recognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.14 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The trust as a lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the commencement of the lease. Thereafter, the asset is accounted for as an item of property plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the Statement of Financial Position and subsequently as a reduction of rentals on a straight-line basis over the lease term. Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

The trust as a lessor

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the leases.

Operating leases

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.15 Provisions

The trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2022:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	0.47%	Minus 0.02%
Medium-term	After 5 years up to 10 years	0.70%	0.18%
Long-term	After 10 years up to 40 years	0.95%	1.99%
Very long-term	Exceeding 40 years	0.66%	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2022:

	Inflation rate	Prior year rate
Year 1	4.00%	1.20%
Year 2	2.60%	1.60%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 1.30% in real terms (prior year: minus 0.95%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 30.2 but is not recognised in the trust’s accounts.

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 NHS Resolution 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 when the liability arises.

Note 1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity’s control) are not recognised as assets, but are disclosed in note 31 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 31, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity’s control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.17 Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the “pre-audit” version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.18 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.

Note 1.19 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 2021.

Note 1.20 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.21 Foreign exchange
The functional and presentational currency of the trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Note 1.22 Third party assets

Assets belonging to third parties in which the trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury’s *FReM*.

Note 1.23 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.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.24 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.25 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2021/22.

Note 1.26 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases

IFRS 16 Leases will replace *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the Statement of Financial Position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the Statement of Financial Position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the trust will apply the standard retrospectively without restatement and with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be defined by HM Treasury. For 2022, this rate is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The trust has estimated the impact of applying IFRS 16 in 2022/23 on the opening Statement of Financial Position and the in-year impact on the Statement of Comprehensive Income and capital additions as follows:

	£000
Estimated impact on 1 April 2022 Statement of Financial Position	
Additional right of use assets recognised for existing operating leases	24,768
Additional lease obligations recognised for existing operating leases	(24,768)
Net impact on net assets on 1 April 2022	**-**
Estimated in-year impact in 2022/23	
Additional depreciation on right of use assets	(2,773)
Additional finance costs on lease liabilities	(235)
Lease rentals no longer charged to operating expenditure	2,478
Other impact on income	428
Estimated impact on surplus / deficit in 2022/23	**(102)**

The trust does not estimated any increase in capital additions for new leases commencing in 2022/23.

From 1 April 2022, the principles of IFRS 16 will also be applied to the trust's PFI liabilities where future payments are linked to a price index representing the rate of inflation. The PFI liability will be remeasured when a change in the index causes a change in future repayments and that change has taken effect in the cash flow. Under existing accounting practices, amounts relating to changes in the price index are expensed as incurred. This is expected to increase the PFI liability on the Statement of Financial Position upon transition to IFRS 16. The effect of this has not yet been quantified.

Other standards, amendments and interpretations

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 14 Regulatory Deferral Accounts has not been endorsed by the European Financial Reporting Advisory Group and is not applicable to DHSC bodies.
IFRS 16 Leases as interpreted and adapted by the FReM, is to be effective from 1 April 2022.
IFRS 17 Insurance Contracts is planned to be adopted from the 2023/24 financial year.

The trust does not anticipate these changes in accounting standards to have a material impact on the 2022/23 accounts.

Note 1.27 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below), that management has made in the process of applying the trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

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 to 5 years.

Provisions are, in the main, injury benefits provisions (which are valued using actuarial tables), operating penalties (informed by legal advice) and annual leave pay following the Flowers legal case (informed by national negotiations).

On the grounds of materiality, as per guidance within the group accounting manual, the trust has not consolidated its Charitable Fund, its subsidiaries for the provision of Positive Individual Proactive Support (PIPS) services, or TEWV Estates and Facilities Management (TEWV EFM, now dormant) service within the main accounts.

Note 1.28 Sources of estimation uncertainty

The trust has made no assumptions about the future and has no other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Note 2.1 Operating Segments

The trust has no elements that require segmental analysis for the period ended 31 March 2022. The chief operating decision maker has been identified as the Chief Executive, an Executive Director post within the trust; and on this basis the trust has identified healthcare as the single operating segment.

Note 2.2 Performance against planned financial position

For the year ending 31st March 2022 the performance of NHS organisations is measured against delivery of their agreed planned financial position. Certain exceptional and technical revenue streams are excluded from the calculation of 'performance' to ensure true operational performance is measured.

The trust's planned operational performance, as confirmed formally through national plan submissions for 2021/22, and excluding technical adjustments, was a surplus of £4,767k. The trust reported an adjusted financial surplus position (excluding AME impairments and profit on sale of assets) of £5,949k, which was £1,182k ahead of plan i.e. target achieved. Inclusive of technical adjustments, the accounts show a composite deficit of £4,240k.
A reconciliation of the trust's performance against agreed financial plans is shown below:

	2021/22	2020/21
	£000	£000
Deficit for the year from SoCI	(4,240)	(16,741)
Add back net impairments	10,698	25,841
Remove profit on sale of assets	(509)	-
Actual surplus for performance assessment	**5,949**	**9,100**
Required / planned surplus / (deficit)	4,767	(1,998)
Performance ahead of required level	**1,182**	**11,098**

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

Note 3.1 Income from patient care activities (by nature)	2021/22 £000	2020/21 £000
Mental health services		
Block contract / system envelope income	333,346	361,125
Services delivered under a mental health collaborative**	48,700	-
Clinical income for the secondary commissioning of mandatory services	11,254	5,580
Other clinical income from mandatory services	3,444	4,156
All services		
Additional pension contribution central funding*	13,255	12,445
Other clinical income	10,619	8,150
Total income from activities	**420,618**	**391,456**

*The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

**Mental health collaborative arrangements commenced 1 April 2021, the income recognised here previously flowed through as Block Contract / system envelope funding.

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2021/22 £000	2020/21 £000
NHS England	25,069	78,490
Clinical commissioning groups	338,671	302,745
Other NHS providers	45,955	1,417
NHS other	288	368
Local authorities	2,103	1,010
Non NHS: other	8,532	7,426
Total income from activities	**420,618**	**391,456**
Of which:		
Related to continuing operations	420,618	391,456

Analysis of income from patient care activities (by source) - non NHS other	2021/22 £000	2020/21 £000
Other government departments and agencies	355	390
Other*	8,177	7,036
	8,532	**7,426**

*Other income is mainly from Spectrum Community Health Contract £7,142k (2020/21 £6,677k).

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

The trust had no income relating to overseas visitors (non-reciprocal, chargeable to the patient) (2020/21 £nil).

Note 4 Other operating income	2021/22			2020/21		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	2,108	-	**2,108**	1,327	-	**1,327**
Education and training	15,116	1,280	**16,396**	12,925	825	**13,750**
Non-patient care services to other bodies	2,187		**2,187**	3,094		**3,094**
Reimbursement and top up funding*	90		**90**	7,967		**7,967**
Income in respect of employee benefits accounted on a gross basis	746		**746**	600		**600**
Consumables (inventory) donated from DHSC group bodies for Covid response		262	**262**		3,901	**3,901**
Rental revenue from operating leases		1,038	**1,038**		692	**692**
Other income	184	-	**184**	478	-	**478**
Total other operating income	**20,431**	**2,580**	**23,011**	**26,391**	**5,418**	**31,809**
Of which:						
Related to continuing operations			23,011			31,809

*Other income is mainly from catering £164k, 2020/21 was mainly from contract penalties received £350k.

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2021/22	2020/21
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	1,595	245

Note 5.2 Transaction price allocated to remaining performance obligations

	31 March 2022	31 March 2021
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	£000	£000
within one year	1,061	1,595
Total revenue allocated to remaining performance obligations	**1,061**	**1,595**

Note 5.3 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2021/22	2020/21
	£000	£000
Income from services designated as commissioner requested services	420,618	377,704
Income from services not designated as commissioner requested services	23,011	45,561
Total	**443,629**	**423,265**

Note 5.4 Profits and losses on disposal of property, plant and equipment

The trust sold 2 buildings during 2021/22. These buildings had a net book value of £1,360k, and were sold for £1,869k, generating a £509k profit on disposal. Both buildings were unused, and had no future potential use for the trust.

Note 5.5 Fees and charges

The trust received no income from fees and charges - aggregate of all schemes that, individually, have a cost exceeding £1m (2020/21 £nil).

Note 6.1 Operating expenses

	2021/22 £000	2020/21 restated** £000
Purchase of healthcare from NHS and DHSC bodies	1,351	3,713
Purchase of healthcare from non-NHS and non-DHSC bodies	13,107	8,145
Staff and executive directors costs	346,747	320,928
Remuneration of non-executive directors	203	157
Supplies and services - clinical (excluding drugs costs)*	3,278	7,122
Supplies and services - general	6,314	6,991
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	4,668	4,761
Consultancy costs	885	781
Establishment**	4,425	5,018
Premises	23,855	23,938
Transport (including patient travel)**	6,153	5,563
Depreciation on property, plant and equipment	3,523	3,799
Net impairments	10,698	25,841
Movement in credit loss allowance: contract receivables / contract assets	(3)	(69)
Increase/(decrease) in other provisions	-	4,535
Change in provisions discount rate(s)	106	139
Fees payable to the external auditor for audit services- statutory audit	60	66
Internal audit costs	232	234
Clinical negligence	1,354	1,113
Legal fees	2,333	1,938
Insurance	266	297
Research and development	2,288	1,739
Education and training	7,735	5,048
Rentals under operating leases**	2,894	2,901
Redundancy	203	-
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	575	529
Hospitality	56	68
Losses, ex gratia & special payments	613	18
Other	648	1,501
Total	**444,567**	**436,814**
Of which:		
Related to continuing operations	444,567	436,814

*includes £262k of DHSC procured consumables linked to Coronavirus pandemic, the majority being PPE or domestic items (2020/21 £3,901k)

** prior year restated to recategorise operating leases following new guidance.

Note 6.2 Other auditor remuneration

The trust has not paid its auditors any additional remuneration for the period to 31 March 2022 (31 March 2021, £nil).

Note 6.3 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2021/22 or 2020/21.

Note 7 Impairment of assets

	2021/22	2020/21
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	10,698	25,841
Total net impairments charged to operating surplus / deficit	**10,698**	**25,841**
Impairments charged to the revaluation reserve	(907)	32
Total net impairments	**9,791**	**25,873**

The trust realised impairments totalling £9,791k during 2021/22 following a modern equivalent asset valuation of its sites.

Note 8 Employee benefits

	2021/22 Total £000	2020/21 Total £000
Salaries and wages	268,662	251,346
Social security costs	24,251	22,374
Apprenticeship levy	1,286	1,181
Employer's contributions to NHS pensions	43,687	41,024
Pension cost - other	110	87
Termination benefits	203	-
Temporary staff (including agency)	13,813	8,421
Total staff costs	**352,012**	**324,433**
Of which		
Costs capitalised as part of assets	460	302

Note 8.1 Retirements due to ill-health

During 2021/22 there were 4 early retirements from the trust agreed on the grounds of ill-health (4 in the year ended 31 March 2021). The estimated additional pension liabilities of these ill-health retirements is £234k (£218k in 2020/21).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 9 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 for Health and Social Care 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 is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 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 report of the scheme actuary, which forms part of the annual NHS Pension Scheme 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 recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

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.

Note 10 Operating leases

Note 10.1 Tees, Esk and Wear Valleys NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where Tees, Esk and Wear Valleys NHS Foundation Trust is the lessor.

Operating lease income is from property rental.

	2021/22 £000	2020/21 £000
Operating lease revenue		
Minimum lease receipts	1,038	692
Total	**1,038**	**692**

	31 March 2022 £000	31 March 2021 £000
Future minimum lease receipts due:		
- not later than one year;	1,086	692
- later than one year and not later than five years;	938	949
- later than five years.	1,654	2,100
Total	**3,678**	**3,741**

Note 10.2 Tees, Esk and Wear Valleys NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Tees, Esk and Wear Valleys NHS Foundation Trust is the lessee.

The trust's operating leases are all for proprty rental.

	2021/22 £000	2020/21 restated* £000
Operating lease expense		
Minimum lease payments	2,894	2,901
Total	**2,894**	**2,901**

	31 March 2022 £000	31 March 2021 £000
Future minimum lease payments due:		
- not later than one year;	2,895	2,699
- later than one year and not later than five years;	11,576	10,269
- later than five years.	12,136	4,881
Total	**26,607**	**17,849**
Future minimum sublease payments to be received	-	-

* restated as lease cars and equipment no longer operating leases

Note 11 Finance income

Finance income represents interest received on assets and investments in the period.

	2021/22	2020/21
	£000	£000
Interest on bank accounts	44	17
Total finance income	**44**	**17**

Note 12.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2021/22	2020/21
	£000	£000
Interest expense:		
Main finance costs on PFI and LIFT schemes obligations	592	620
Contingent finance costs on PFI and LIFT scheme obligations	498	458
Total interest expense	**1,090**	**1,078**
Unwinding of discount on provisions	(36)	(25)
Total finance costs	**1,054**	**1,053**

Note 12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

The trust did not pay any interest payable arising from claims or pay compensation to cover debt recovery costs under this legislation (2020/21, £nil).

Note 13 Other gains / (losses)

	2021/22	2020/21
	£000	£000
Gains on disposal of assets	509	-
Total other gains / (losses)	**509**	**-**

Note 14 Discontinued operations

The trust has no discontinued operations at 31 March 2022 (31 March 2021, £nil).

Note 15 Intangible assets

The trust's intangible assets are licenses for a software system that are to be held in perpetuity. Asset balances as at 31 March 2022 were £1,554k (31 March 2021, £1,554k).

Note 16.1 Property, plant and equipment - 2021/22

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2021 - brought forward	**10,888**	**100,789**	**26,699**	**2,269**	**84**	**2,283**	**1,347**	**144,359**
Additions	-	13,399	778	119	-	2,192	-	**16,488**
Impairments	(27)	(16,216)	-	-	-	-	-	**(16,243)**
Reversals of impairments	862	5,590	-	-	-	-	-	**6,452**
Revaluations*	-	(2,245)	-	-	-	-	-	**(2,245)**
Reclassifications	503	22,688	(25,642)	-	-	2,451	-	**-**
Transfers to / from assets held for sale	(90)	(190)	-	-	-	-	-	**(280)**
Valuation/gross cost at 31 March 2022	**12,136**	**123,815**	**1,835**	**2,388**	**84**	**6,926**	**1,347**	**148,531**
Accumulated depreciation at 1 April 2021 - brought forward	**-**	**1,303**	**-**	**950**	**84**	**1,842**	**1,347**	**5,526**
Provided during the year	-	3,212	-	180	-	131	-	**3,523**
Revaluations*	-	(2,245)	-	-	-	-	-	**(2,245)**
Accumulated depreciation at 31 March 2022	**-**	**2,270**	**-**	**1,130**	**84**	**1,973**	**1,347**	**6,804**
Net book value at 31 March 2022	**12,136**	**121,545**	**1,835**	**1,258**	**-**	**4,953**	**-**	**141,727**
Net book value at 1 April 2021	**10,888**	**99,486**	**26,699**	**1,319**	**-**	**441**	**-**	**138,833**

* Revaluations within both valuation and accumulated depreciation of buildings includes the write out of depreciation amounts following a revaluation exercise.

Note 16.2 Property, plant and equipment - 2020/21

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2020 - as previously stated	**10,486**	**111,937**	**15,431**	**2,146**	**84**	**2,283**	**1,347**	**143,714**
Additions	-	6,807	21,380	123	-	-	-	**28,310**
Impairments	(26)	(27,637)	-	-	-	-	-	**(27,663)**
Reversals of impairments	63	1,727	-	-	-	-	-	**1,790**
Revaluations*	365	(2,157)	-	-	-	-	-	**(1,792)**
Reclassifications	-	10,112	(10,112)	-	-	-	-	**-**
Valuation/gross cost at 31 March 2021	**10,888**	**100,789**	**26,699**	**2,269**	**84**	**2,283**	**1,347**	**144,359**
Accumulated depreciation at 1 April 2020 - as previously stated	**-**	**-**	**-**	**774**	**84**	**1,695**	**1,347**	**3,900**
Provided during the year	-	3,476	-	176	-	147	-	**3,799**
Revaluations*	-	(2,173)	-	-	-	-	-	**(2,173)**
Accumulated depreciation at 31 March 2021	**-**	**1,303**	**-**	**950**	**84**	**1,842**	**1,347**	**5,526**
Net book value at 31 March 2021	**10,888**	**99,486**	**26,699**	**1,319**	**-**	**441**	**-**	**138,833**
Net book value at 1 April 2020	**10,486**	**111,937**	**15,431**	**1,372**	**-**	**588**	**-**	**139,814**

* Revaluations within both valuation and accumulated depreciation of buildings includes the write out of depreciation amounts following a revaluation exercise.

Note 16.3 Property, plant and equipment financing - 2021/22

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Total
	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2022						
Owned - purchased	12,136	115,090	1,835	1,258	4,953	**135,272**
On-SoFP PFI contracts and other service concession arrangements	-	6,455	-	-	-	**6,455**
NBV total at 31 March 2022	**12,136**	**121,545**	**1,835**	**1,258**	**4,953**	**141,727**

Note 16.4 Property, plant and equipment financing - 2020/21

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Total
	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021						
Owned - purchased	10,888	94,131	26,699	1,319	441	**133,478**
On-SoFP PFI contracts and other service concession arrangements	-	5,355	-	-	-	**5,355**
NBV total at 31 March 2021	**10,888**	**99,486**	**26,699**	**1,319**	**441**	**138,833**

Note 17 Investment Property

The trust has no investment property (2020/21, £nil).

Note 18 Investments in associates and joint ventures

The trust has no investments in associates or jointly controlled operations consolidated in these accounts as at 31 March 2022 (31 March 2021, £nil) on the basis of materiality (as disclosed in note 1).

Note 19 Other investments / financial assets (non-current)

The trust has no other investments / financial assets (non-current) at 31 March 2022, (2020/21, £nil).

Note 19.1 Other investments / financial assets (current)

The trust has no other investments / financial assets (current) at 31 March 2022, (2020/21, £nil).

Note 20 Inventories

	31 March 2022 £000	31 March 2021 £000
Drugs	204	208
Consumables	625	799
Total inventories	**829**	**1,007**

Inventories recognised in expenses for the year were £1,269k (2020/21: £4,647k). Write-down of inventories recognised as expenses for the year were £0k (2020/21: £0k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2021/22 the trust received £262k of items purchased by DHSC (2020/21: £3,901k).

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

The deemed cost of these inventories was charged directly to expenditure on receipt with the corresponding benefit recognised in income.

Note 21.1 Receivables

	31 March 2022 £000	31 March 2021 £000
Current		
Contract receivables	14,502	15,691
Allowance for impaired contract receivables / assets	(6,161)	(6,262)
Prepayments (non-PFI)	6,023	5,529
PFI lifecycle prepayments	465	465
PDC dividend receivable	132	1,359
VAT receivable	935	1,010
Other receivables	4	130
Total current receivables	**15,900**	**17,922**
Non-current		
Other receivables	573	524
Total non-current receivables	**573**	**524**
Of which receivable from NHS and DHSC group bodies:		
Current	2,857	6,569
Non-current	542	491

Note 21.2 Allowances for credit losses

	2021/22	2020/21
	Contract receivables and contract assets	Contract receivables and contract assets
	£000	£000
Allowances as at 1 April - brought forward	**6,262**	**6,331**
New allowances arising	-	50
Changes in existing allowances	(3)	-
Reversals of allowances	-	(119)
Utilisation of allowances (write offs)	(98)	-
Allowances as at 31 Mar 2022	**6,161**	**6,262**

Note 21.3 Exposure to credit risk

	2021/22 receivables and	2020/21 receivables and
	£000	£000
Non-impaired receivables past their due date by:		
0 - 30 days	2,324	870
30-60 Days	115	159
60-90 days	238	34
90- 180 days	246	46
over 180 days	742	1,442
Total	**3,665**	**2,551**

Note 22 Other assets

The trust has no other assets as at 31 March 2022 (31 March 2021, £nil).

Note 23.1 Non-current assets held for sale and assets in disposal groups

	2021/22	2020/21
	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**1,080**	**1,080**
Assets classified as available for sale in the year	280	-
Assets sold in year	(1,360)	-
NBV of non-current assets for sale and assets in disposal groups at 31 March	**-**	**1,080**

The trust sold 2 buildings during 2021/22. Cardale Park was valued at £1,080k and Brompton House was valued at £280k. Sale proceeds were £1,869k and the total profit on sales was £509k.

The sale of these assets does not impact on the trust's ability to meet its obligation to provide commissioner requested services as no sales are authorised without full consideration of the impact on service provision.

Note 23.2 Liabilities in disposal groups

The trust has no liabilities in disposal groups as at 31 March 2022 (31 March 2021, £nil).

Note 24.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2021/22	2020/21
	£000	£000
At 1 April	**80,936**	**76,914**
Net change in year	800	4,022
At 31 March	**81,736**	**80,936**
Broken down into:		
Cash at commercial banks and in hand	1,504	179
Cash with the Government Banking Service	80,232	80,757
Total cash and cash equivalents as in SoCF	**81,736**	**80,936**

Note 24.2 Third party assets held by the trust

Tees, Esk and Wear Valleys NHS Foundation Trust held cash and cash equivalents which relate to monies held by the trust on behalf of patients or other parties and in which the trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2022	31 March 2021
	£000	£000
Bank balances	853	850
Total third party assets	**853**	**850**

Note 25.1 Trade and other payables

	31 March 2022 £000	31 March 2021 £000
Current		
Trade payables	8,641	8,778
Capital payables	2,282	4,213
Accruals	30,304	26,362
Social security costs	3,949	3,604
VAT payables	1,271	1,283
Other taxes payable	3,184	2,771
Total current trade and other payables	**49,631**	**47,011**
Of which payables from NHS and DHSC group bodies:		
Current	3,390	3,951

The trust has no non current trade and other payables (2020/21 £nil).

The Directors consider that the carrying amount of trade payables approximates to their fair value.

Note 25.2 Early retirements in NHS payables above

There were no early retirement costs in the NHS payables balance at 31 March 2021 (2019/20, £nil).

Note 26 Other liabilities

	31 March 2022 £000	31 March 2021 £000
Current		
Deferred income: contract liabilities	1,061	1,595
Total other current liabilities	**1,061**	**1,595**

Non-current

The trust has no other non current liabilities (2020/21, £nil)

Note 27.1 Borrowings

	31 March 2022 £000	31 March 2021 £000
Current		
Other loans	238	238
Obligations under PFI, LIFT or other service concession contracts	657	652
Total current borrowings	**895**	**890**
Non-current		
Other loans	-	238
Obligations under PFI, LIFT or other service concession contracts	11,409	12,066
Total non-current borrowings	**11,409**	**12,304**

PFI borrowings are in relation to Lanchester Road Hospital which operates under a standard form PFI contract i.e. unitary payments are payable from the date of construction completion and are not subject to re-pricing. Inflation linked to RPI is applied annually. Final settlement is expected in May 2038.

Note 27.2 Reconciliation of liabilities arising from financing activities - 2021/22

	Other loans	PFI and LIFT schemes	Total
	£000	£000	£000
Carrying value at 1 April 2021	**476**	**12,718**	**13,194**
Cash movements:			
Financing cash flows - payments and receipts of principal	(238)	(652)	**(890)**
Financing cash flows - payments of interest	-	(592)	**(592)**
Non-cash movements:			
Application of effective interest rate	-	592	**592**
Carrying value at 31 March 2022	**238**	**12,066**	**12,304**

Note 27.3 Reconciliation of liabilities arising from financing activities - 2020/21

	Other loans	PFI and LIFT schemes	Total
	£000	£000	£000
Carrying value at 1 April 2020	**714**	**13,297**	**14,011**
Prior period adjustment	-	-	**-**
Carrying value at 1 April 2020 - restated	**714**	**13,297**	**14,011**
Cash movements:			
Financing cash flows - payments and receipts of principal	(238)	(580)	**(818)**
Financing cash flows - payments of interest	-	(619)	**(619)**
Non-cash movements:			
Application of effective interest rate	-	620	**620**
Carrying value at 31 March 2021	**476**	**12,718**	**13,194**

Note 28 Other financial liabilities

The trust has no other financial liabilities at 31 March 2022 (31 March 2021, £nil).

Note 29 Finance leases

The trust does not have any finance lease obligations other than PFI commitments (2020/21, £nil).

Note 30.1 Provisions for liabilities and charges analysis

	Pensions: injury benefits	Legal claims*	Other**	Total
	£000	£000	£000	£000
At 1 April 2021	**2,879**	**182**	**8,498**	**11,559**
Change in the discount rate	106	-	-	**106**
Arising during the year	47	116	2,397	**2,560**
Utilised during the year	(152)	(99)	(75)	**(326)**
Reversed unused	-	-	(1,954)	**(1,954)**
Unwinding of discount	(36)	-	-	**(36)**
At 31 March 2022	**2,844**	**199**	**8,866**	**11,909**
Expected timing of cash flows:				
- not later than one year;	154	199	3,343	**3,696**
- later than one year and not later than five years;	638	-	3,767	**4,405**
- later than five years.	2,052	-	1,756	**3,808**
Total	**2,844**	**199**	**8,866**	**11,909**

*Legal claims relate to employer / public liability claims notified by the NHS Litigation Authority.

**Other provisions relate to potential clinical penalties, an employment tribunal linked to holiday pay, potential contract refunds and a provision for clinical pensions tax reimbursement. No provision has been made relating to the 2018 PFI Termination; this is disclosed under Note 30 - Contingent Liabilities.

Note 30.2 Clinical negligence liabilities

At 31 March 2022, £2,922k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Tees, Esk and Wear Valleys NHS Foundation Trust (31 March 2021: £1,854k).

Note 31 Contingent assets and liabilities

	31 March 2022 £000	31 March 2021 £000
Value of contingent liabilities		
NHS Resolution legal claims	(225)	(116)
Net value of contingent liabilities	**(225)**	**(116)**

The contingent liabilities relate to employer liability legal cases, all cases relate to NHS Resolution and are due within 1 year.

The trust has a potential liability linked to a prior year PFI Contract termination. The trust is currently engaged in a court process in order to rebut any related liability. This is with Three Valleys Healthcare Limited (in liquidation – the former PFI provider) and the liquidators of that company. The court process will take some time to complete.

It is the trust's opinion that disclosure of any potential (or range of) liability may prejudice this process, and it is applying the disclosure exemption available under IAS 37.

Note 32 Contractual capital commitments

	31 March 2022 £000	31 March 2021 £000
Property, plant and equipment	612	2,981
Total	**612**	**2,981**

Note 33 Other financial commitments

The trust has no other financial commitments as at 31 March 2022 (31 March 2021, £nil).

Note 34 Defined benefit pension schemes

The trust does not operate an on-Statement of Financial Position pension scheme.

Note 35 On-SoFP PFI, LIFT or other service concession arrangements

The trust has full control of clinical services provided from its PFI funded hospital (Lanchester Road), and full access and use of the buildings, which are maintained by the PFI project company as part of the PFI procurement contract.

The PFI project company provides services for “hard” facilities management including building maintenance and life cycle replacement programmes. A contractual commitment exists for the PFI project company to maintain the building at “category b” status for the contract life (30 years from commencement for Lanchester Road).

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 has the right to cease the contract early, subject to payment of a financial penalty.

Note 35.1 On-SoFP PFI, LIFT or other service concession arrangement obligations

The following obligations in respect of the PFI, LIFT or other service concession arrangements are recognised in the Statement of Financial Position:

	31 March 2022 £000	31 March 2021 £000
Gross PFI, LIFT or other service concession liabilities	**31,497**	**31,597**
Of which liabilities are due		
- not later than one year;	1,845	1,742
- later than one year and not later than five years;	6,526	6,229
- later than five years.	23,126	23,626
Finance charges allocated to future periods	(19,431)	(18,879)
Net PFI, LIFT or other service concession arrangement obligation	**12,066**	**12,718**
- not later than one year;	657	652
- later than one year and not later than five years;	2,046	2,091
- later than five years.	9,363	9,975

Note 35.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future commitments under these on-SoFP schemes are as follows:

	31 March 2022 £000	31 March 2021 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**50,437**	**49,768**
Of which payments are due:		
- not later than one year;	2,541	2,333
- later than one year and not later than five years;	10,815	9,929
- later than five years.	37,081	37,506

Note 35.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2021/22	2020/21
	£000	£000
Unitary payment payable to service concession operator	**2,340**	**2,270**
Consisting of:		
- Interest charge	592	620
- Repayment of balance sheet obligation	652	580
- Service element and other charges to operating expenditure	575	529
- Capital lifecycle maintenance	23	83
- Contingent rent	498	458
Total amount paid to service concession operator	**2,340**	**2,270**

Note 36 Off-SoFP PFI, LIFT and other service concession arrangements

The trust has no off-SoFP PFIs as at 31 March 2022 (31 March 2021, £nil).

Note 37 Financial instruments

Note 37.1 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. Whilst CCGs will be dis-established from 1 July 2022, their functions will be assumed by new Integrated Care Boards, with no change to financial exposure as a consequence.

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 and 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 and Foundation Trusts under contractual terms that require settlement of obligation within a time frame established generally by the Department of Health. Due to this the credit risk exposure is not significant.

Credit risk exposures of monetary financial assets are managed through the trust's treasury policy which limits the value that can be placed with each approved counterparty to minimise the risk of loss. The counterparties are limited to the approved financial institutions with high credit ratings. Limits are reviewed regularly by senior management.

Liquidity risk
The trust's net operating costs are mainly incurred under legally binding contracts with Clinical Commissioning Groups, NHS England Commissioners and Foundation Trusts, all of 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.

Note 37.2 Carrying values of financial assets

All of the trust's financial assets are carried at amortised cost. Fair value is not considered to be significantly different from book value.

Carrying values of financial assets as at 31 March 2022	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	8,372	**8,372**
Cash and cash equivalents	81,736	**81,736**
Total at 31 March 2022	**90,108**	**90,108**

Carrying values of financial assets as at 31 March 2021	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	9,462	**9,462**
Cash and cash equivalents	80,936	**80,936**
Total at 31 March 2021	**90,398**	**90,398**

Note 37.3 Carrying values of financial liabilities

All of the trust's other financial liabilities are carried at amortised cost. Fair value is not considered significantly different from book value

Carrying values of financial liabilities as at 31 March 2022	Held at amortised cost	Total book value
	£000	£000
Obligations under PFI, LIFT and other service concession contracts	12,066	**12,066**
Other borrowings	238	**238**
Trade and other payables excluding non financial liabilities	41,227	**41,227**
Provisions under contract	199	**199**
Total at 31 March 2022	**53,730**	**53,730**

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost	Total book value
	£000	£000
Obligations under PFI, LIFT and other service concession contracts	12,718	**12,718**
Other borrowings	476	**476**
Trade and other payables excluding non financial liabilities	39,353	**39,353**
Provisions under contract	182	**182**
Total at 31 March 2021	**52,729**	**52,729**

Note 37.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the Statement of Financial Position which are discounted to present value.

	31 March 2022 £000	31 March 2021 £000
In one year or less	43,509	41,515
In more than one year but not more than five years	6,526	6,467
In more than five years	23,126	23,626
Total	**73,161**	**71,608**

Note 37.5 Fair values of financial assets and liabilities

It is the trust's opinion that book value is a reasonable approximation of the fair value of financial assets and liabilities.

Note 38 Losses and special payments

	2021/22		2020/21 restated*	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	1	-	1	-
Stores losses and damage to property	1	-	-	-
Total losses	**2**	**-**	**1**	**-**
Special payments				
Ex-gratia payments	30	11	1,650	1,105
Total special payments	**30**	**11**	**1,650**	**1,105**
Total losses and special payments	**32**	**11**	**1,651**	**1,105**

* prior year restated following updated guidance

The entries for 2020/21 have been restated to reflect that there were 1,637 ex gratia payments linked to annual leave payments following the outcome of the Flowers legal case (£1,105k). For 2021/22 these are no longer classified as special payments.

The trust received no compensation payments (2020/21 £nil).

Note 39 Related parties

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 and Social Care is regarded as the parent department, and a related party. During the period Tees, Esk and Wear Valleys NHS Foundation trust has had a significant number of material transactions with entities for which the Department is regarded as the parent department, or a related party.

The main entities that the trust has dealings with are its commissioners, namely;

NHS Tees Valley CCG
NHS County Durham CCG
NHS North Yorkshire CCG
NHS Vale of York CCG
Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
Health Education England
NHS England

The trust also has material expenditure with the following:

NHS Pension Scheme
HM Revenue & Customs

The related parties disclosure below includes organisations the trust has a joint venture, subsidiary or other partnership arrangement with. The trust is not required to report other public bodies as related parties.

The trust has two subsidiary companies, Positive Individualised Proactive Support Ltd, and TEWV Estates and Facilities Management Ltd (made dormant in 2019/20 financial year). The trust is also sole corporate trustee for the Tees Esk and Wear Valleys NHS General Charitable Fund.

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, or any of the subsidiary companies or charities.

2021/22	**Income**	**Expenditure**	**Receivables**	**Payables**
Entity	**£000**	**£000**	**£000**	**£000**
Non-consolidated subsidiaries and associates / joint ventures	7	-	530	-
Other bodies or persons outside of the whole of government accounting boundary	83	76	-	-
Total balances with related parties	**90**	**76**	**530**	**-**

2020/21	**Income**	**Expenditure**	**Receivables**	**Payables**
Entity	**£000**	**£000**	**£000**	**£000**
Non-consolidated subsidiaries and associates / joint ventures	74	-	765	2
Other bodies or persons outside of the whole of government accounting boundary	100	74	98	-
Value of provisions for doubtful debts held against related parties (excludes salaries)	-	-	(98)	-
Total balances with related parties	**174**	**74**	**765**	**2**

Note 40 Events after the reporting date

The trust has no events after the reporting period to disclose.

** If you would like additional copies of this report please contact:

The communications team
Email: tewv.enquiries@nhs.net

Our chairman, directors and governors can be contacted through the Trust secretary's office by emailing: tewv.ftmembership@nhs.net

For more information about the Trust and how you can get involved please visit our website www.tewv.nhs.uk

Tees, Esk and Wear Valleys
NHS Foundation Trust

16 June 2022

Ref:

Office of the Chief Executive
West Park Hospital
Edward Pease Way
Darlington
Co Durham
DL2 2TS

T: 01325 552 077

Cameron Waddell
The Corner
Bank Chambers
26 Mosley Street
Newcastle upon Tyne
NE1 1DF
June 2022

Dear Cameron,

Tees, Esk and Wear Valleys NHS Foundation Trust, including group -audit for year ended 31 March 2022

This representation letter is provided in connection with your audit of the financial statements of Tees, Esk and Wear Valleys NHS Foundation Trust for the year ended 31 March 2022 for the purpose of expressing an opinion as to whether the financial statements give a true and fair view in accordance with the DHSC Group Accounting Manual.

I confirm that the following representations are made on the basis of enquiries of management and staff with relevant knowledge and experience (and, where appropriate, inspection of supporting documentation) sufficient to satisfy ourselves that I can properly make each of the following representations to you.

My responsibility for the financial statements and accounting information

I believe that I have fulfilled my responsibilities for the true and fair presentation and preparation of the financial statements in accordance with the Group Accounting Manual and relevant legislation and International Financial Reporting Standards (IFRS) as adapted and adopted by HM Treasury.

My responsibility to provide and disclose relevant information.

I have provided you with:

- Access to all information of which we are aware that is relevant to the preparation of the financial statements such as records, documentation and other material;

- Additional information that you have requested from us for the purpose of the audit; and

- Unrestricted access to individuals within the Trust you determined it was necessary to contact in order to obtain audit evidence.

I confirm as Accountable Officer that I have taken all the necessary steps to make me aware of any relevant audit information and to establish that you, as auditors, are aware of this information.

As far as I am aware there is no relevant audit information of which you, as auditors, are unaware.

Accounting records

I confirm that all transactions that have a material effect on the financial statements have been recorded in the accounting records and are reflected in the financial statements. All other records and related information, including minutes of all Board and relevant committee meetings, have been made available to you.

Accounting policies

I confirm that I have reviewed the accounting policies applied during the year in accordance with Group Accounting Manual and International Accounting Standard 8 and consider these policies to faithfully represent the effects of transactions, other events or conditions on the Trust's financial position, financial performance and cash flows.

Accounting estimates, including those measured at fair value

I confirm that any significant assumptions used by the Trust in making accounting estimates, including those measured at fair value, are reasonable.

Contingencies

There are no material contingent losses including pending or potential litigation that should be accrued where:

- Information presently available indicates that it is probable that an asset has been impaired or a liability had been incurred at the balance sheet date; and

- The amount of the loss can be reasonably estimated.

There are no material contingent losses that should be disclosed where, although either or both the conditions specified above are not met, there is a reasonable possibility that a loss, or a loss greater than that accrued, may have been incurred at the balance sheet date.

There are no contingent gains which should be disclosed. All material matters, including unasserted claims, that may result in litigation against the Trust or Group have been brought to your attention.

All known actual or possible litigation and claims whose effects should be considered when preparing the financial statements have been disclosed to you and accounted for and disclosed in accordance with the Group Accounting Manual and relevant legislation and IFRSs as adapted and adopted by HM Treasury.

Laws and regulations

I confirm that I have disclosed to you all those events of which I am aware which involve known or suspected non-compliance with laws and regulations, together with the actual or contingent consequences which may arise therefrom.

We have complied with all aspects of contractual agreements that would have a material effect on the accounts in the event of non-compliance.

Fraud and error

I acknowledge my responsibility as Accountable Officer for the design, implementation and maintenance of internal control to prevent and detect fraud and error. I have disclosed to you:

- All the results of my assessment of the risk that the financial statements may be materially misstated as a result of fraud;

- All knowledge of fraud or suspected fraud affecting the Trust involving:
  - management and those charged with governance;
  - employees who have significant roles in internal control; and
  - others where fraud could have a material effect on the financial statements.

I have disclosed to you all information in relation to any allegations of fraud, or suspected fraud, affecting the Trust or Group financial statements communicated by employees, former employees, analysts, regulators or others.

Related party transactions

I confirm that all related party relationships, transactions and balances, have been appropriately accounted for and disclosed in accordance with the requirements of the Group Accounting Manual and relevant legislation and IFRSs.

I have disclosed to you the identity of the Trust's related parties and all related party relationships and transactions of which I am aware.

Impairment review

To the best of my knowledge, there is nothing to indicate that there is a permanent reduction in the recoverable amount of the property, plant and equipment and intangible assets below their carrying value at the statement of financial position date. An impairment review is therefore not considered necessary.

Charges on assets

All the Trust's assets are free from any charges exercisable by third parties except as disclosed within the financial statements.

Future commitments

I am not aware of any plans, intentions or commitments that may materially affect the carrying value or classification of assets and liabilities or give rise to additional liabilities.

Service Concession Arrangements

I am not aware of any material contract variations, payment deductions or additional service charges in 2021/22 in relation to the Trust PFI schemes that you have not been made aware of.

Subsequent events

I confirm all events subsequent to the date of the financial statements and for which the Group Accounting Manual, relevant legislation and IFRSs require adjustment or disclosure have been adjusted or disclosed.

Should further material events occur after the date of this letter which may necessitate revision of the figures included in the financial statements or inclusion of a note thereto, I will advise you accordingly.

Other matters

I can confirm in relation to the following matters that:

- Brexit - we have assessed the potential impact of the United Kingdom leaving the European Union and that any disclosure in the Annual Report fairly reflects that assessment.

- COVID-19 - we have assessed the impact of the COVID-19 Virus pandemic on the Trust and the financial statements, including the impact of mitigation measures and uncertainties, and are satisfied that the financial statements and supporting notes fairly reflect that assessment.

- Ukraine - we confirm that we have carried out an assessment of the potential impact of Russian Forces entering Ukraine on the Trust and there is no significant impact on the Trust’s operations from restrictions or sanctions in place .

Going concern

I confirm that I have carried out an assessment of the potential impact of the COVID-19 Virus pandemic on the Trust, including the impact of mitigation measures and uncertainties and am satisfied the going concern assumption remains appropriate and that no material uncertainty has been identified.

To the best of my knowledge there is nothing to indicate that the Trust will not continue as a going concern in the foreseeable future. The period to which I have paid particular attention in assessing the appropriateness of the going concern basis is not less than twelve months from the date of approval of the accounts.

Annual Governance Statement

I am satisfied that the Annual Governance Statement (AGS) fairly reflects the Trust's risk assurance and governance framework and I confirm that I am not aware of any significant risks that are not disclosed within the AGS.

Annual Report

The disclosures within the Annual Report and Remuneration Report fairly reflect my understanding of the Trust's financial and operating performance over the period covered by the financial statements

Other representations

I confirm that all provisions required under IAS37 have been included in the financial statements. I confirm that I do not consider that group accounts should be prepared incorporating our Subsidiaries or Charitable Funds on the grounds of materiality

Unadjusted misstatements

I confirm that the effects of any uncorrected misstatements are immaterial, both individually and in aggregate, to the financial statements as a whole. A list of the uncorrected misstatements is attached to this letter as an Appendix.

Yours faithfully

Brent Kilmurray
Accounting Officer

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO. 6

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**15 June 2022**
TITLE:	**Approval of accounts for the financial year ended 31 March 2022**
REPORT OF:	**Liz Romaniak, Director of Finance, Information and Estates**
REPORT FOR:	**Approval**

This report supports the achievement of the following Strategic Goals:	✓
To provide excellent services working with the individual users of our services and their carers to promote recovery and wellbeing	
To continuously improve to quality and value of our work	
To recruit, develop and retain a skilled, compassionate and motivated workforce	
To have effective partnerships with local, national and international organisations for the benefit of the communities we serve	
To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefits of the communities we serve.	✓

Executive Summary:

The Board is required to approve and formally adopt the accounts for the period ended 31st March 2022 for submission to NHS England / Improvement (NHSE/I).

The Trust reported a **deficit** for the financial year of £4.2m. After removing impairments and profit on the sale of land (as these are not included in NHSE/I assessment of financial performance), the Trust had a reported **surplus** of £5.9m.

This was higher than planned mainly due to unplanned income streams, offset by increased inpatient staffing costs, and higher than planned purchase of healthcare (see section 3.1 for more detail).

Recommendations:

The Board of Directors:

- is requested to adopt the accounts and authorise the auditors to submit them as the audited accounts of the Trust for the period ended 31st March 2022 to NHS E/I.
- has previously supported a recommendation from the Audit & Risk Committee that the Trust should be considered as a going concern and that the year-end accounts should be prepared on that basis and is asked to reaffirm this.
- is asked to confirm that by approving the Annual Report they are confirming as far as they are aware, there is no relevant information of which the Trust's auditors are unaware.
- is asked to confirm that in approving the Annual Report they agree to the Modern Slavery Act 2015 statements included in the Annual Report.

1. PURPOSE OF REPORT

1.1 The purpose of this report is to ask the Board of Directors to approve the accounts for the period ended 31st March 2022.

2. BACKGROUND

2.1 In line with statutory requirements the Board is required to approve and formally adopt the accounts for the period ended 31st March 2022 for submission to NHS England / Improvement (NHSE/I), with NHSI performing the function of Independent Regulator for NHS Foundation Trusts.

2.2 Mazars LLP has carried out an audit of the accounts and they presented the outcome of the audit to the Audit & Risk Committee on the 10th June 2022.

3. KEY ISSUES

3.1 Key areas of Performance

The Audit & Risk Committee (ARC) received a copy of the unaudited accounts on 20th May 2022. A copy of the latest unaudited accounts for 2021-22 is enclosed within Appendix 1 (please note at time of delivery these have not received final External Audit sign off, however the planned audit has completed, with an unqualified opinion provided by Mazars – any updates will be tabled); these were shared with the ARC on 10th June 2022. The highlights are summarised below;

Income

Total operating income for the financial year ended 31 March 2022 was £443.6m which was higher than the previous year.

Block contract / system envelope income reduced due to the introduction of provider collaboratives, income for which is now reported on a separate row. This was partially offset by Mental Health Investment Standard (MHIS) / System Development Funding (SDF) investments, and Covid funding being brought into block contracts (was included as “other operating income” last financial year).

Other clinical income is predominantly contracts for prison services.

Other operating income decreased due to Covid funding being added to block contracts and reduced receipt of clinical equipment (face masks, wipes etc.) and associated funding from the Department for Health and Social Care (DHSC). This was partly offset by increased training income received from Health Education England (HEE) for IAPT trainees.

Operating Expenses

Pay expenditure increased mainly due to the nationally agreed pay award, full year effects of costs (and continued recruitment) relating to the Trust Board’s decision to permanently bolster acute and forensic inpatient safer staffing,

increased bank and agency costs to cover patient packages and cohorting, sickness and other Covid-related absences, and MHIS / SDF related staffing.

Non pay expenditure decreased mainly due to impairments being £15.1m lower than the previous year, and reduced expenditure on clinical equipment (face masks, wipes etc.).

Training expenditure increased in line with the additional funding received from HEE, and purchase of healthcare increased to support demand, with the block purchase of beds at the Priory part way through the year and additional spot purchase independent sector bed utilisation to mitigate bed pressures.

Surplus / Deficit for the year

The Trust reported a **deficit** for the year of £4.2m. When adjusted to exclude impairments and profit on sale of land and buildings (the basis on which financial performance is assessed); the Trust achieved an adjusted **surplus** of £5.9m; which was higher than planned and reflects higher than planned income, offset in part by increased inpatient staffing costs and higher than planned purchased healthcare due to the need to provide additional bed capacity.

This adjusted surplus was in excess of the Trust's agreed financial plan as detailed below, but consistent with forecast financial performance agreed with partners in the North East and North Cumbria Integrated Care System (ICS);

2021-22 Financial Performance	£m
(Deficit) for the year	(4.2)
Remove impact of impairments	10.7
Remove profit on sale of land and buildings	(0.5)
Surplus for financial plan performance	**5.9**
Surplus plan requirement	4.7
Ahead of financial plan by	**1.2**

Statement of Financial Position

Property, Plant and Equipment carrying totals increased over the year by £2.9m, as follows:

	£m
Property, Plant and Equipment NBV 31 March 2021	**138.8**
Additions	16.5
Depreciation	(3.5)
Impairments - Operating expenses	(10.7)
Revaluation gains - Revaluation reserve	0.9
Transfer to asset held for sale	(0.3)
Property, Plant and Equipment NBV 31 March 2022	**141.7**

Cash at bank and in hand has increased by £0.8m to £81.7m. The increase reflects the operating surplus offset by in-year capital investment (the costs of which were offset due to successful bids to secure national capital funding, and from VAT recovery and asset sales) as well as working capital variations.

3.2 Items of note in the accounts

There are items of special note in the accounts for 2021-22 which have been discussed with the Trust's auditors.

- The property valuation movements of £25.5m.
- A contingent liability linked to the termination of the Roseberry Park Hospital Private Finance Initiative (PFI).
- All provisions held, including:
    - Flowers legal case linked to holiday pay on overtime and additional hours worked.
    - Potential fines.
- Technical entries to account for DHSC procured supplies to support the pandemic response.
- Capital funding support by PDC dividend (additional cash and capital 'budget' / ICS allocation) was received totalling £2.3m.

3.3 Explanations to some notes in the accounts

Some of the notes contained in the accounts require some guidance and the following explanations may be of assistance;

- After the main financial statements in the accounts there are notes on accounting policy (commencing page 166) which describe the basis on which the accounts have been completed. These summarise the methodology used and highlight any change in policy from last year.
- The 'financed by' section of the statement of financial position is predominantly supported by the Statement of Changes in Taxpayers' Equity (page 168) and details the changes in the year.
- The supporting note to property, plant and equipment (note 16.1) shows a column headed 'assets under construction'. This relates to schemes in the capital programme that were not completed as at 31 March 2022 and in line with capital accounting policy these cannot be capitalised. The £1.8m at the end of 2021-22 related largely to ongoing rectification works at Roseberry Park.
- Details of the Trust's PFI schemes in operation are shown under note 35, page 209.
- Note 2.2 demonstrates how the Trust's performance is measured against the agreed financial plan. A reference to this note is included on the SoCI.
- Note 1.26 includes an estimate of the impact of IFRS16 leases, which will be adopted by all NHS organisations from 1st April 2022.

3.4 Annual Governance Statement

The Annual Governance Statement included in the Annual Report has been reviewed by Mazars LLP and the Audit & Risk Committee.

3.5 Annual Report

The disclosure to auditors' statement is also included within the Annual Report. This disclosure states that the Board of Directors confirms, as far as members are aware, there is no relevant information of which the Trust's auditors are unaware.

3.6 Going Concern

NHS Foundation Trusts are required to prepare their accounts in accordance with relevant accounting rules. One of the requirements is to prepare the accounts on a going concern basis unless an organisation is to cease trading or there are significant doubts on the organisation's ability to continue as a going concern.

Those charged with governance (i.e. the Board) need to consider whether this Trust is clearly a going concern. A Trust is considered a Going Concern provided it meets the following criteria:

"For non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern.

DHSC group bodies must therefore prepare their accounts on a going concern basis unless informed by the relevant national body or DHSC sponsor of the intention for dissolution without transfer of services or function to another entity."

The Audit & Risk Committee previously recommended to Board, who agreed that the Trust should be considered as a going concern and that the year end accounts should be prepared on that basis.

3.7 Audit

The audit of the Trust's Annual Accounts has largely completed and was reported to ARC 10th June 2022 with an unqualified opinion, and there were no unadjusted misstatements.

3.8 Submission

The accounts and Annual Report will both be submitted to NHSE/I on 22nd June 2022.

4. IMPLICATIONS

4.1 There are no direct financial implications associated with this paper.

4.2 The Trust is required within the terms of its authorisation as a Foundation Trust to submit accounts to Parliament.

5. RISKS

5.1 There are no risks associated with this paper.

6. CONCLUSION

6.1 The Trust has prepared accounts in line with the requirements of NHSE/I and the Group Accounting Manual, with the audit process only making minor changes from the accounts submitted on the 26th April 2022.

7. RECOMMENDATIONS

The Board of Directors:

- is requested to adopt the accounts and authorise the auditors to submit them as the audited accounts of the Trust for the period ended 31 March 2022 to NHS England / Improvement.

- has previously supported the recommendation of the Audit & Risk Committee that the Trust should be considered as a going concern and that the year-end accounts should be prepared on that basis and is asked to re-affirm this.

- is asked to confirm that by approving the Annual Report they are confirming as far as they are aware, there is no relevant information of which the Trust's auditors are unaware.

- is asked to confirm that in approving the Annual Report they agree to the Modern Slavery Act 2015 statements included in the Annual Report.

Liz Romaniak
Director of Finance, Information and Estates

Associated Papers:
Audit & Risk Committee item 21 (Going Concern) (17th March 2022)
Audit & Risk Committee item 18 (Draft Annual Governance Statement) (20th May 2022)
Audit and Risk Committee item 6 (Audit Completion Report) (10th June 2022)
Audit & Risk Committee item 7 (Draft Annual Report and Accounts) (10th June 2022)

ITEM NO. 7

General Release

Meeting of:	**Board of Directors**
Date:	**16th June 2022**
Title:	**Quality Account 2021/22**
Executive Sponsor(s):	**Elizabeth Moody, Director of Nursing & Governance** **Sharon Pickering, Assistant Chief Executive**
Author(s):	**Chris Lanigan, Assoc Director of Strategic Planning** **Avril Lowery, Director of Quality Governance**

Report for:				
	Assurance		***Decision***	√
	Consultation		***Information***	

Strategic Goal(s) in Our Journey to Change relating to this report:

1: To co-create a great experience for our patients, carers and families	√
2: To co-create a great experience for our colleagues	√
3: To be a great partner	√

Contribution to the delivery of the Strategic Goal(s):

The Quality Account is a statutory document which allows us to set out in detail the quality context (strengths and issues) facing the Trust. By setting out the progress and impact of 2021/22's quality improvement priorities and our plans for 2022/23 it allows our partners to understand and comment on what we intend to do. The actions set out for next year are designed to improve the quality and safety of our services.

Strategic Risks relating to this report:

BAF ref no.	*Risk Title*	*Context*
NA	**NA**	***This is a statutory report and so its purpose is not to provide assurance on the BAF. However, the improvement actions set out in the document mitigate BAF risks 4, 6 and 9 (experience, safety and regulatory action)***

Executive Summary:

Purpose:

This report gives the Board of Directors the opportunity to consider the proposed Quality Account document **(Appendix 1)** prior to its publication.

The Board should take note that this has been previously discussed at the Quality Assurance Committee (9th June) and Audit & Risk Committee (10th June) and amended in light of comments received. It should also consider the feedback from stakeholders which is contained in page 73 onwards in the Quality Account document (and summarised in the feedback section below).

Proposal:

The Quality Account document will be published on the Trust's website and sent to NHSE/I once the Board of Directors have given their approval to its contents as per the guidance.

Overview:

Every NHS provider must complete and publish a Quality Account by 30th June. This must include statutory reports on the previous year's quality data and the updates in terms of the completion of quality improvement priorities for the previous year. It must also include between 3 and 5 quality priorities for the year ahead.

Prior Consideration and Feedback

The draft Quality Account has been discussed at QuAC, and at Audit and Risk Committee on 9 and 10 June respectively. Feedback from both meetings was positive.

The draft document was also sent to a range of stakeholders as required by national Regulations and Guidance. The responses received by 13th June are included within the document from page 73. Any further letters received prior to the Board's meeting will be circulated by email and included in the published version of the document. This is likely to include responses by the Directors of Nursing for Tees Valley and Durham CCGs.

Analysis of the letters received shows widespread support and no opposition to the 3 proposed improvement priorities. There are also some positive comments about the clarity / transparency of the Quality Account, O*ur Journey to Change,* our commitment to working in partnership, progress made in addressing CQC recommendations, and local service developments such as the mental health support teams that work with schools.

However, some of our stakeholders were concerned about the continued worse than target rate of restraints per occupied bed day. There were also concerns about waiting times for CYP services, and the lack of progress in implementing improved care planning arrangements. Some stakeholders considered that the document is too focussed on inpatients and has insufficient data and commentary on community services. Both of our Durham local authority stakeholder letters expressed concerns about CYP to adult transitions.

None of this feedback would suggest that the Board should not approve the Quality Account. We are already aware of the issues raised. Care Planning is an ongoing quality improvement priority within the document, and the other issues raised are the subject of ongoing work by the relevant Trust services). Further improvements to the content and format of the document will be considered once the ongoing national review into Quality Accounts has reported.

A reply will be drafted for each stakeholder letter by the AD Strategic Planning and Director of Quality Governance. As part of this any actions requiring work from a Trust Care Group or corporate service will be discussed and agreed with them prior to the reply letter being sent.

Implications:

The Trust has a legal / regulatory duty to approve and publish its Quality Account 2021/22 by 30th June 2022. If the Board of Directors felt unable to approve the document at this meeting, it would be possible to bring it back for further consideration on 30th June, although this increases the risk of not being able to load the document onto our website in time.

The document contains *required statements of assurance from the Board*. These can be found in the blue boxes that occur between pages 33-53 in the Quality Account document (appendix 1). There is also a statutory declaration by the Chair and Chief Executive on pages 61-62.

Recommendations:

The Board of Directors are recommended to approve the Quality Account document, including the statutory declarations within it and to require its publication on TEWV's website by 30th June 2022.

Tees, Esk and Wear Valleys
NHS Foundation Trust

Quality Account 2021/22

Table of Contents

Part One: Introduction & Context

What is a Quality Account?

A Quality Account is an annual report describing the quality of services provided by an NHS healthcare organisation. Quality Accounts aim to increase public accountability and drive quality improvements in the NHS. Our Quality Account looks back on how well we have done in the past year at achieving our quality goals. It also looks forward to the year ahead and defines what our priorities for quality improvement will be and how we expect to achieve and monitor them.

What are the aims of the Quality Account?

1. To help patients and their carers make informed choices about their healthcare providers
2. To empower the public to hold providers to account for the quality of their services
3. To engage the leaders of the organisation in their quality improvement agenda

Who reads the Quality Account?

Lots of different people read the Quality Account. Some are people who use our services, their carers, staff, commissioners, partners and regulating bodies. We produce our report for anyone who wants to know more about the quality of our services, and how we plan to maintain and improve them.

What information can be found in the Quality Account?

In this document, you will find information about how we measure and review the quality of services that we provide. You will also find our priorities for improvement for the year ahead. Like all NHS healthcare providers, we focus on three different aspects or "domains" of quality:

- Patient **safety**
- Clinical **effectiveness**
- Patient **experience**

Structure of this Quality Account document

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

- **Part 1** Introduction and Context
- **Part 2:** Information on how we have improved in the areas of quality we identified as important for 2021/22, our priorities for improvement in 2022/23 and the required statements of assurance from the Board and
- **Part 3:** Further information on how we have performed in 2021/22 against our key quality metrics and national targets and the national quality agenda

A Profile of the Trust

Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) is a large and complex organisation with around 7,800 employees who provide a range of inpatient and community mental health, learning disability and autism services for approximately 2 million people of all ages living in

- County Durham
- The five Tees Valley boroughs of Darlington; Hartlepool, Stockton, Middlesbrough and Redcar and Cleveland

- The Scarborough, Whitby, Ryedale, Hambleton, Richmondshire, Selby and Harrogate areas of North Yorkshire
- The City of York
- The Pocklington area of East Yorkshire; and
- The Wetherby area of West Yorkshire

In addition, our adult inpatient eating disorder services, and our Secure Inpatient (Forensic) wards serve the whole of the North East and North Cumbria. TEWV also provides mental health care within prisons located in North East England, Yorkshire and the Humber, and North West England.

Our Quality Account. Quality Governance and Quality Issues

TEWV has changed its governance arrangements from 1st April 2022.

This is because it has become clear that the way we were structured, and the way our governance operated, needed to change so we provide well-governed clinical care alongside partners across our systems.

Our new governance structure will help us achieve 'Our Journey to Change' (see figure 1, page 6) by making sure the Trust is:

- Clinically led and operationally enabled
- Better able to align around the regional changes in the form of the two Integrated Care Systems in which we provide services
- Able to deliver on individual and collective system wide accountability effectively and consistently, by making all roles clearer and manageable for post holders
- Organised in a more simple, less complex way formally incorporating patient leadership into our structures.

The changes will help TEWV to provide safe, high quality, effective clinical services, and the best possible experience for people in our care, families and carers, our colleagues, and our partners.

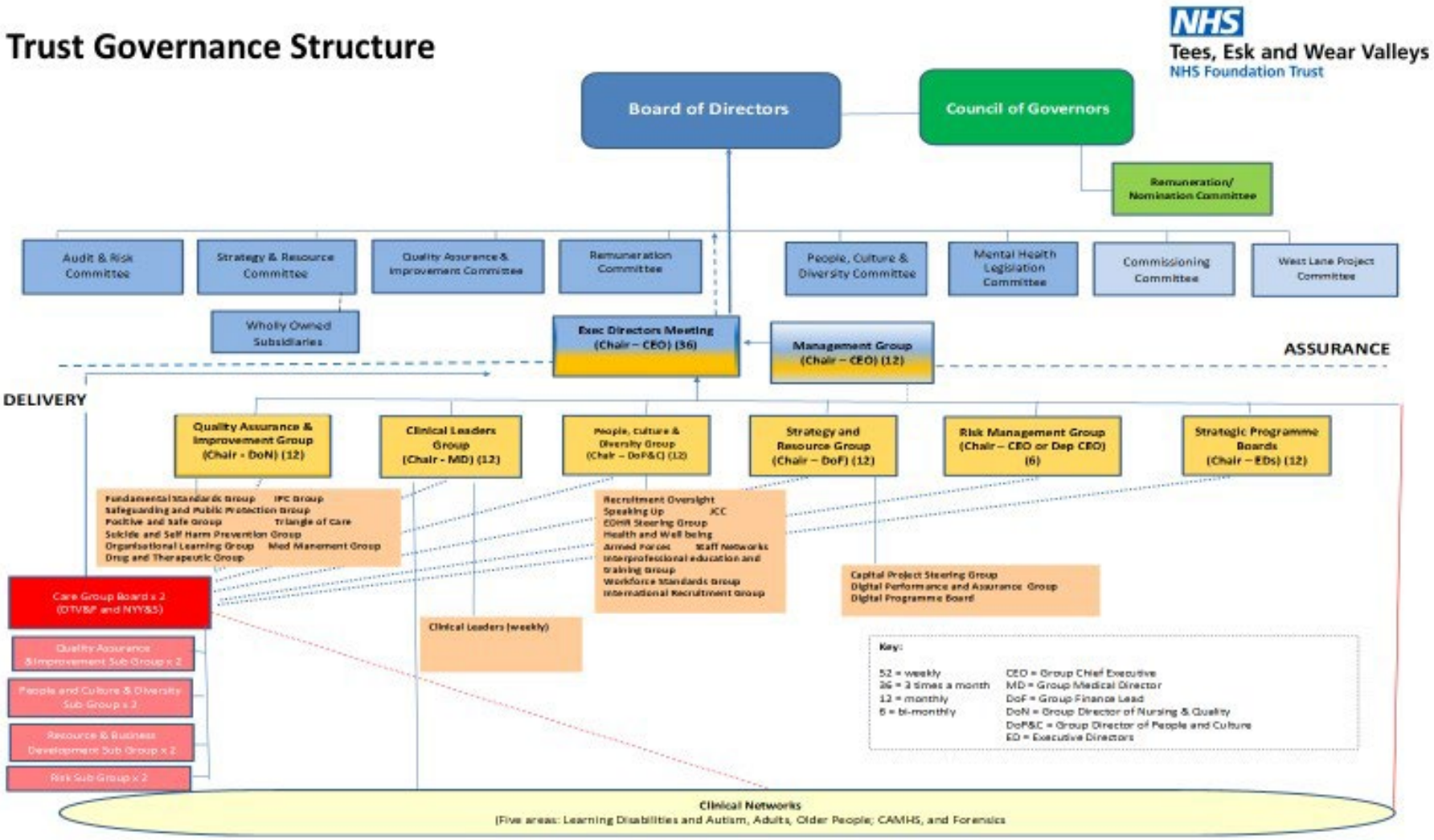
The new structure is shown in ***Figure 2, page 7.*** However, the data and commentary contained in this document were produced using the governance structures and processes in place prior to April 2022. The key features of this were that In line with our previous Clinical Assurance Framework the review of data and information relating to our services was undertaken monthly by the relevant Quality Assurance Group (QuAG) for each service. A monthly report was produced for each QuAG which includes information on:

- **Patient Safety:** Including information on incidents, serious 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 Friends and Family Test (FFT); complaints; and contact with the Trust's patient advice and liaison service (PALS)
- **Care Quality Commission:** Compliance with the essential standards of safety and quality, and the Mental Health Act

Figure 1: Summary of the Trust Journey to Change

Figure 2: Trust Governance from 1st April 2022

This diagram shows the new structures and governance within TEWV. An important feature is the creation of two Care Groups – one serving the population of the North East North Cumbria ICS and the other serving Humber and North Yorkshire ICS.



(Continued from page 5). Following discussion at the QuAG any areas of concern were escalated to the relevant Locality Management and Governance Board (LMGB) and from there to the Trust Board's Quality Assurance Committee (QuAC). The QuAC received formal Quality and Learning reports from each of the LMGBs on a monthly basis, as well as a Trust level report.

We also implemented a Quality Assurance programme that focused on the quality of patient risk assessments, safety summary and safety plans as well as broader care standards. A range of methods were used to gather this information and involved Trust staff as well as some of our CCG colleagues. This was supported by other activities such as clinical audits and leadership walkabouts.

Some normal aspects of governance were disrupted by the restrictions related to the Covid-19 pandemic. Peer review and Board visits to wards and teams, for example, were affected with some only taking place virtually via Microsoft Teams.

However, as staff updated the electronic patient record, online incident log, complaints database and other systems we were increasingly able to triangulate different sources of data and intelligence and to report/act on a holistic (whole) picture. Our Integrated Information Centre is a key tool in enabling this.

We also regularly provide our commissioners with information on the quality of our services. This includes holding regular Clinical Quality Review meetings with commissioners where we review key information on quality that we provide, with a particular emphasis on providing assurance on the quality of our services. At these meetings, we also provide information on any thematic analyses or quality improvement activities we have undertaken and on our responses to national reports that have been published.

In last year's Quality Account, we noted that, following an unannounced inspection from the Care Quality Commission (CQC), our acute wards for Adults and Psychiatric Intensive Care Units were rated as 'inadequate' for both 'safe' and 'well-led'. During 2021/22 we made significant achievements in implementing the resulting CQC Action Plan.

Following further CQC inspections, our CQC core service and well-led inspection report was issued on 10th December 2021. The Trust's overall rating remained at 'requires Improvement'. CQC rated the 'safe', 'responsive' and 'well-led' domains as "requires improvement", and the effective and caring domains as 'good'.

In the inspection report the CQC acknowledged that TEWV had embarked on a significant change programme to change our governance and organisational arrangements. They also acknowledged that Our Journey to Change showed we had a clear strategy, co-created with service users, staff and stakeholders which would help the organisation to address the changes which needed to be made.

The CQC also highlighted positive practice in the report including:

- Further workforce investment and recruitment into inpatient services
- A strategic approach to people and culture within the trust, including a

good record of developing staff and engagement with staff side
- Robust systems in place in relation to the effective management of medicines and controlled drugs.
- More effective systems in place to comprehensively assess and manage patient risks

Issues that the CQC found in their inspection included:

- A variable culture across some services within the Trust
- Systems to identify, understand, monitor, and reduce or eliminate risks were not always effective and required further development
- Improvements were needed to safeguarding policies and processes, particularly in Adult Mental Health Services
- Insufficient staffing levels for the Trust's Community CAMHS caseload
- Some areas of poor compliance with mandatory training
- TEWV's approach to equality and diversity could be improved
- Investigations into complaints and serious incidents were not always carried out in line with Trust policies.

A further action plan has been developed. Some of the actions have already been delivered but others will be delivered during 2022/23. There is more detail about the CQC's findings, inspection rating and our action plan on page **37**

During 2020/21 we have reported to and been supported by an external Quality Board chaired by the North East North Cumbria ICS Lead Officer.

Unfortunately, the Trust is not always successful in preventing patients from ending their lives. We are very grateful to those relatives who have worked with us to help us better understand the root cause of these serious incidents and what we could do to reduce risk in the future. In addition to our own serious incident investigations, inquests are also a chance to reflect on what has gone wrong and what could be done better in the future.

Our newly developed Clinical Journey to Change (Clinical Strategy) describes our ambition to be an outward looking, modern Mental Health, Learning Disability and Autism service by providing a roadmap through co-created transformation. The purpose is to improve the overall health and wellbeing of people with mental health issues, a learning disability or autism in our region. Our approach is to consider the whole person, whole life, whole system to deliver personalised care sooner, safer, and more holistically.

We have also developed Our Journey to Safer Care that sets out our key safety priorities and enablers. This forms part of the new Quality and Safety Journey (our Quality Strategy) that is in development and will also include our ambitions for improving the experience of our patients.

The Trust fully acknowledges that our services are not always of the quality our public and patients require and deserve. But we are absolutely committed to improving and Our Journey to Change which we developed in 2020/21 is starting to move us in the right direction.

In addition to the quality improvement priorities included within this Quality Account, the Trust also has a Business Plan which summarises all of our

change plans. You can find this on the internet at www.tewv.nhs.uk

We think it is essential to highlight the good work that Trust staff have achieved in 2021/22 as well as highlighting the issues that we still need to tackle. Therefore, we have included a short section on the following pages which highlights the positive progress made by the Trust and the individuals who work for us.

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

A full statement of Director's responsibilities in respect of the Quality Account is included in **Appendix 1.** I hope you find this report interesting and informative.

If you would like to know more about any of the examples of Quality Improvement or have any suggestions on how we could improve our Quality Account, please contact:

- Elizabeth Moody (Director of Nursing & Governance) at: elizabeth.moody1@nhs.net
- Avril Lowery (Director of Quality Governance) at a.lowery1@nhs.net

In line with the Guidance this document has been shared for comment with Trust Governors, local Clinical Commissioning Groups (CCGs), Healthwatch Organisations and Local Authority Health Overview and Scrutiny Committees (including the Tees Valley Joint Health Scrutiny Committee). Their full responses to this consultation are included in ***Appendix 4.***

Brent Kilmurray
Chief Executive
Tees, Esk and Wear Valleys NHS Foundation Trust

What we have achieved in 2021/22

In his introduction on the previous pages, the Chief Executive notes the importance of highlighting the positive progress made by the Trust as a whole and by individuals who work for it. Some of these positives are presented below. By doing this we hope to give our staff and stakeholders confidence that we will overcome the ongoing quality issues that still face the Trust in the months and years ahead.

Trust achievements in 2021/22 include:

- TEWV lived experience members were successful in receiving an award for 'Leading Change' from South Tees Healthwatch as part of their role within the programme to create a new vision for how services will work in the future
- We reviewed our process for Freedom to Speak Up and Whistle Blowing and produced standard work to ensure consistency across the trust, and continued to encourage staff to speak out when they see unacceptable quality
- We implemented an improved children and young people's pathway including an initial risk assessment for every child and a robust Keeping in Touch process.
- Over 4,000 Trust staff have been trained in how to use our new electronic patient record system (cito), which will go live in autumn 2022
- In September 2021, Children and Young People's Mental Health Services in York moved to new premises at Orca House, on the Link Business Park is Osbaldwick, just outside York City Centre. Young people and their parents and carers were involved at every stage and level, from the naming of the premises to the look and feel of the main reception area and the clinical/therapy rooms
- The Trust has supported the creation and operations of the North East North Cumbria Resilience Hub and manages the and Humber, Coast and Vale Resilience Hub. These were launched in early 2021 in response to the Covid-19 pandemic. These offer a wide range of emotional and wellbeing support to the health, care, and emergency services workforce across the area we serve. They provide outreach support and training, therapeutic interventions, assessments, and support groups. The Humber Coast and Vale Hub's Long Covid Support Programme has been recognised as a national exemplar
- The new Care Home Liaison service in Durham recruited a variety of multi-disciplinary professionals to work closely with care home staff to prevent placement breakdown and which in turn improved outcomes for patients in these settings (e.g., removal from 'behaviours that challenge' Clinical Link Pathway (CLiP)
- In August 2021, the Trust opened a new community mental health hub at North Moor House in Northallerton. This hub houses mental health and learning disability services under one roof and provides modern outpatient facilities for local people of all ages who need to access these services. It also contains community team offices and increased consulting room space, supporting improved access to services and allowing more people to be seen as quickly as possible
- The 'Wellbeing in Mind' service, which supports young people and helps education establishments to develop a 'whole school approach' to wellbeing has received additional funding and now covers Harrogate, York and Hambleton and Richmondshire, supporting a further 27 schools and colleges to evaluate and develop their current wellbeing provision, to deliver staff training, co-facilitate student/pupil workshop and assemble and support student forums, campaigns and events to help raise awareness about the common problems young people experience and how to deal with them
- A successful partnership between Scarborough Survivors and TEWV helped Accident & Emergency workers during peak times in the winter period by providing support to people attending Scarborough General Hospital A&E department who presented with a suspected

mental health condition; helping improve communication between A&E and mental health services and strengthening the multi-agency approach to mental health care in the area

- The Trust have taken a proactive approach to national nurse recruitment by launching an international nurse recruitment programme overseen by a dedicated programme co-ordinator, and provides dedicated pastoral care and support with accommodation and education for those joining the Trust
- The Memory Service in Hambleton and Richmondshire has maintained its Memory Service National Accreditation Programme status for the 9th year. The team were commended for maintaining the same level of service throughout the pandemic by adapting and using virtual appointments and post-diagnostic sessions for individuals and groups, including virtual clinical environments to include families who live away from their loved ones and improving access for those who find it hard to travel
- The Care Home Wellbeing service in Durham and Darlington was set up to improve the wellbeing of care home residents and staff and to support recovery from the impacts of the Covid-19 pandemic
- We have co-created workshops to discuss our new values and how they can support new works of working together. A number of workshops have been delivered and will now be running on an ongoing basis. Evaluation data is demonstrating significant improvement in understanding of values and confidence in having conversations about them
- We have also co-created the first module of the collective leadership programme with service users and staff, which has now been piloted and rolled out
- The Trust signed the Armed Forces Covenant in March 2022; the Covenant is a pledge that together we understand that serving personnel, veterans, their families, and service leaders should be treated with fairness in respect in the communities, economy, and society they serve with their lives
- The Trust has developed two lived experience director roles for people with lived experience of mental illness, to ensure that services continue to be developed and improved by working closely with our network of patients and carers, local communities, and colleagues in other lived experience roles. We are one of the first Trusts nationally to create this role, and the postholders will commence their work in 2022/23.
- The Trust has established an Enhanced Physical Health Facilitation Team – a proactive and preventative approach to supporting physical health needs in our learning-disabled population in the Tees Valley, alongside further developments to the Specialist Health Teams enhanced capabilities in Durham
- A new role has been introduced – a STOMP (Stopping Over Medication of People with learning disabilities) lead nurse in Tees, who will work with the PCN pharmacists and GP Practices to raise knowledge and understanding and support structured medication reviews
- We introduced a new listening service in Teesside to provide a 24/7 telephone call line to support service users prior to the need to access crisis services

National Awards – Won or Shortlisted

In addition to the Trust achievements listed above, external bodies have recognised the work of individuals or teams through the award shortlisting, or award wins listed in the two tables below.

Awarding Body	Award Status	Name/Category of Award	Team/Individual
Positive Practice Mental Health Collaborative	Highly Commended	All Age Crisis and Acute Mental Health Care	Crisis & Assessment Suite: Roseberry Park
Positive Practice Mental Health Collaborative	Highly Commended	Addressing Inequalities in Mental Health	Westerdale North Inpatient Team: Sandwell Park
Patient Experience Network	Won	Transformer of Tomorrow Award	Dementia-friendly Village Project: Easington
NEPACS	Awarded	Ruth Cranfield Awards 2021	Speech & Language Therapy Team: HMP Holme House
Building Better Healthcare	Won	Best Interior Design (2020)	Foss Park Hospital
Building Better Healthcare	Highly Commended	Best Healthcare Development £10m+ (2020)	Foss Park Hospital
Healthcare Financial Management Association – Northern Branch	Won	Apprenticeship of the Year	Alex Pederson
Healthcare Financial Management Association – Northern Branch	Won	Chair's Unsung Hero Award	Andrea Reid
Bright Ideas in Mental Health	Won	Innovation Champion Award	Dr Mani Santhanakrishnan
The Dizzy's Life on the Level	Won	Best Balance Friend	Tracey Marston
Royal College of Psychiatrists (RCP)	Awarded	Enabling Environment Award	Primrose Service, HMP Low Newton

Awards where TEWV as an organisation, or one of our teams/staff members were nominated or shortlisted for an award but did not win that award during 2021/22 were:

Awarding Body	Award Status	Name/Category of Award	Team/Individual
Royal College of Psychiatrists (RCP)	Shortlisted	Care Contributor of the Year	Patient & Carer Participation Group: Tees-wide MHSOP Community Services
Royal College of Psychiatrists (RCP)	Shortlisted	Psychiatric Team of the Year: Quality Improvement	Research & Development: ECG Project
Royal College of Psychiatrists (RCP)	Shortlisted	Psychiatric Team of the Year: Older-age adults	MHSOP Inpatient Services: Lustrum Vale
Royal College of Psychiatrists (RCP)	Shortlisted	Psychiatrist of the Year	Dr Mani Santhanakrishnan
Royal College of Psychiatrists (RCP)	Shortlisted	Higher Psychiatric Trainee of the Year	Dr Sundar Gnanavel
Dynamo North East	Shortlisted	Tech for Good & People's Choice	TEWV & NENC AHSN
Health Service Journal	Shortlisted	NHS Communications Initiative of the Year	Preventing Suicide (Tees)

Awarding Body	Award Status	Name/Category of Award	Team/Individual
Bright Ideas in Mental Health	Shortlisted	Development of an Innovative Device or Technology	Anti-Psychotic Medication Monitoring
Bright Ideas in Mental Health	Shortlisted	Demonstrating an Impact upon Patient Safety and/or Quality Improvement	Remote Autism Assessments
Bright Ideas in Mental Health	Shortlisted	Helping our Workforce to recover from the Pandemic	Humber, Coast & Vale Resilience Hub
Health Technology Newspaper	Shortlisted	Health Tech Leader of the Year	Kam Sidhu

Part 2: Quality Priorities for 2021/22 and 2021/22 and required statements of assurance from the Board

2021/2022 and 2022/2023 Priorities for Improvement – How did we do and our future plans

In this first section of part 2, we look backwards at the progress we made in implementing our quality priorities during 2021/22 and the impact this had. Following this, we set out our quality improvement priorities for 2022/23.

Where we look back at 21/22, we use colours to show how much progress we made. The key for this is:

	Action completed by time of publication of this Quality Account
	Action not completed.

Our Progress on implementing our 2021/2022 Quality Improvement Priorities

Priority One: Making Care Plans more personal

Why this is important:

Personalisation is defined in the skills and education document by NHS England Person Centred Approaches (2016) as *'Recognising people as individuals who have strengths and preferences and putting them at the centre of their own care and support. Personalised approaches involve enabling people to identify their own needs and make choices about how and when they are supported to live their lives'.*

Feedback from service users shows that our current approach to Care Planning does not always promote a personalised approach, hence this being identified as a priority in 2021/22.

The benefits/outcomes we aimed to deliver for our patients and their carers were:

- To have their personal circumstances viewed as a priority when planning care and treatment
- To have an accessible, understandable, and personalised care plan (including a crisis plan) containing contact details of those people and services that are best placed to help when the need arises
- To have discussions that lead to shared decision-making and co-production of meaningful care plans
- To have agreed plans recorded in a way that can be understood by the service user and everybody else that needs to have this information
- To receive information about getting support from people who have experience of the same mental health needs
- To have personal circumstances, and what is most important to the person and those closest, viewed as a priority when planning care and treatment

What we did in 2021/22:

What we said we would do	Did we achieve this?	Comment
Develop and implement a communications plan to ensure all relevant stakeholders are aware of changes to CPA processes, primarily via the introduction of DIALOG and other Cito developments		
Work with IT and other key stakeholders to ensure finalised, working version of DIALOG is embedded within CITO		Cito, the Trust's new electronic patient record interface, is planned to go live in Autumn 2022
Develop multi-media guidance and training to support the implementation of DIALOG in a variety of clinical settings and scenarios		
Undertake a current state assessment to identify how many patients and agreed others receive a care plan, and to understand key elements of safety, quality, timeliness, and accessibility to inform a plan to address the issues identified		This wasn't needed because an existing baseline assessment gave enough information to allow the Cito plan to be developed
Produce a plan to address the issues identified in the above current state assessment		This was addressed in the design of the care planning elements into Cito
Review and revise local CPA policy in line with system changes and national guidance – especially in relation to guidance around the implementation of the Community Services Framework for Adults and Older Adults		We are still waiting for updated, clearer national guidance before reviewing and revising our CPA policy
Review and update care planning training to include a co-created and co-delivered explanation of the legal requirements set out by the Human Rights Act		This has not been progressed as we want to wait for national clarity on care planning requirements. We also need to consider the implications of the commitment given by government in December 2021 to abolish the Human Rights Act
Assess additional actions and priorities to remove barriers to care planning, including skills, clinical capacity, right staffing and mandatory training		
Work with teams and commissioners to ensure sufficient capacity is built into clinic scheduling to properly co-create and develop care plans, and that is reflected in efficiency requirements within our CCG contracts		This was completed, later than planned in May 2022. A one-day event was held to set the principles and interim position and two workshops took place in June 2022 shortly before publication of this Quality Account, to look forward and work out how to build in sufficient capacity, and in particular look at what Cito can do to help with this

How do 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 2021/22	Actual 2021/22	Timescale
Patients know who to contact outside of office hours in times of crisis	84%	80%	Q4 21/22
Patients were involved as much as they wanted to be in what treatments or therapies, they received	85%	85%	Q4 21/22
Patients were involved as much as they wanted to be in terms of what care they received	85%	73%	Q4 21/22
Percentage of patients who were involved as much as they wanted to be in the planning of their care	70%	75.53%	Q4 2021/22

The measures for the above come from the NHS Community Mental Health Survey which is administered by the CQC. It is pleasing to see that we have achieved good standards of service, however involving patients as much as they want to be in the care that they received is an area that we need to further improve upon, which is why this will continue to be a quality improvement priority for us in 22/23.

Priority Two: Safer Care

Why this is important:

Patient Safety continues to be the key priority for the Trust, and we have already identified four Patient Safety priority areas that we will focus upon going forward:

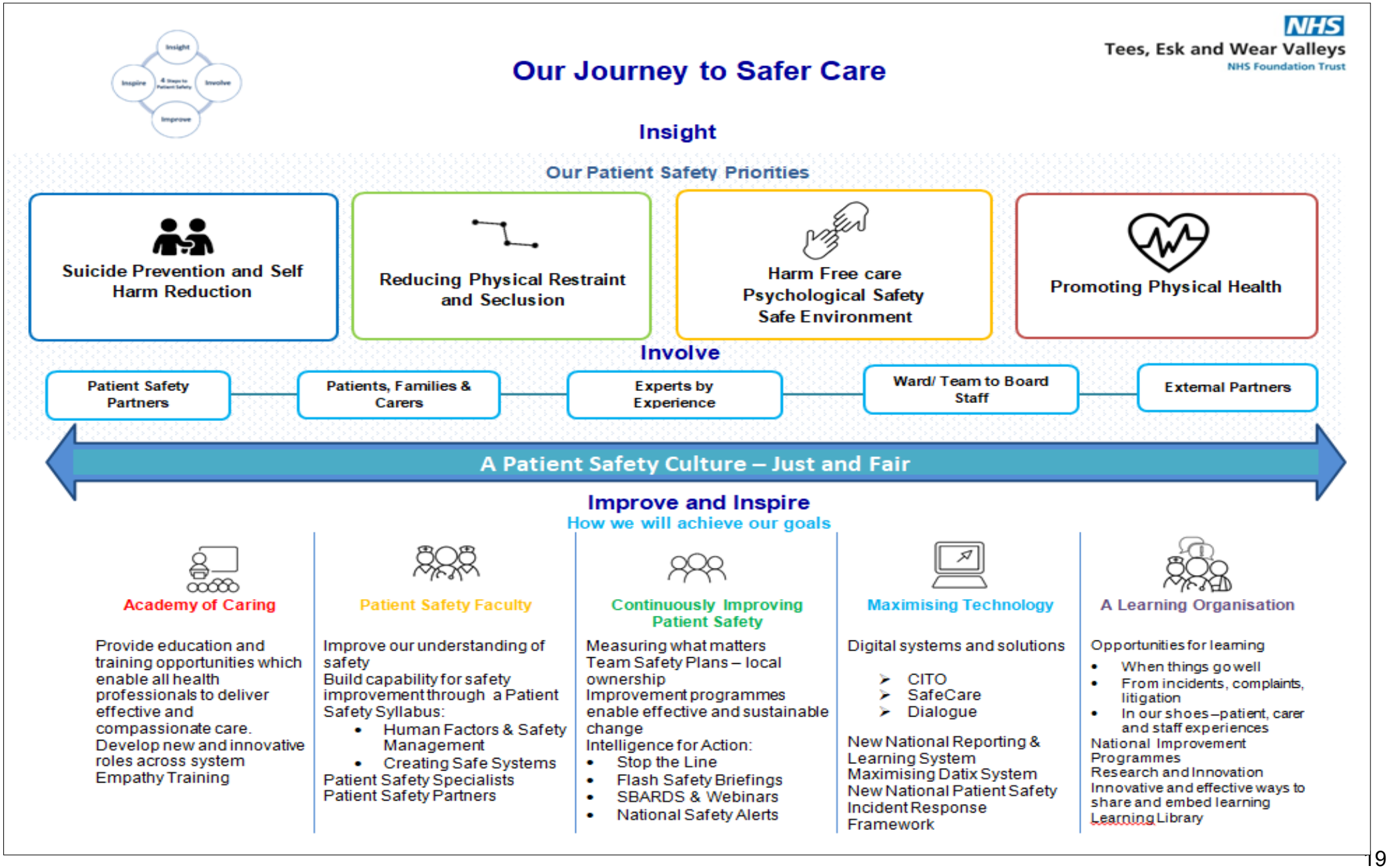
- Suicide prevention and self-harm reduction
- Reducing physical restraint and seclusion
- Promoting harm-free care, improving psychological and sexual safety (allowing staff and patients to speak out safely by fostering an open and transparent culture), providing a safe environment
- Promoting physical health

These are illustrated in ***Figure 3 - 'Our Journey to Safer Care'.*** This provides an overview of our approaches and key enablers.

The benefits/outcomes we aimed to deliver for our patients and their carers were:

- Improved patient safety and reduction of patient harm
- Increased capability for patient safety improvement
- Increased confidence that investigations are being carried out in accordance with best-practice guidelines and in a way that is likely to optimise learning opportunities
- An increase in the percentage of our service users feeling safe when they are in a Trust inpatient setting
- Increased collaboration between service users, staff, and peers
- A reduction in incidents e.g. violence and aggression, absence without leave, drug misuse
- Improved understanding of ward environments and why service users feel unsafe
- Increased opportunity to use digital technology to support the delivery of care

Figure 3: Our Journey to Safer Care



What we did in 2021/2022:

What we said we would do	Did we achieve this?	Comment
Implement 'Our Journey to Safer Care'		
Determine the programmes of work for each of the four patient safety priorities		
Identify process and outcome KPIs for each of the four patient safety priorities		This will now be completed during 22/23 as it is linked to the revision of Our Journey to Safer Care.
Assess current baseline for each performance indicator identified and set incremental targets for improvement throughout 2022/23		This will also be completed during 22/23
Promote the role of the Trust's Patient Safety Specialist		
Work in collaboration with the ISC 'Better Tomorrow programme: learning from deaths, learning from lives' to improve our processes for identifying lessons learned using information to improve future care and to develop support networks in undertaking mortality reviews within a wider community of practice		
Review and update Learning from Deaths Policy		
Increase the percentage of our inpatients who feel safe on our wards:		
Work proactively within the newly formed Regional Patient Experience Network; maximise opportunities for benchmarking patient experience data		
Use existing data to identify priority wards/teams and actions: collating existing Friends and Family Test (FFT) and other data		Robust exploration of the data and intelligence influencing the FFT scoring completed. Patient Experience Team have worked with services to implement more robust governance and setting up of Patient Experience Groups.
Develop a plan for each ward/team identified as a priority, with involvement from clinical staff, management and service users and deliver actions throughout the year		This has been rescheduled for 22/23
People with lived experience to talk to people currently on wards with highest and lowest current FFT scores		This was not possible due to Covid restrictions. We will reconsider this in the future depending on the covid situation.
Further review information from patient experience surveys and concerns raised from patients and carers through PALS contact and complaints and use this to feed into report and action plan, and deliver actions throughout the year		

Seek ideas as part of the 'mutual help' meetings that take place on the wards on what we can do to make patients feel safe - roll out across the Trust		
Review current 'ward orientation' process for patients being admitted onto our wards and incorporate into personal safety plans - roll out across the Trust (currently in Tees only)		
Continue existing pilot of body cameras to a further six wards and an additional 60 cameras		It was initially agreed to commence the body camera project in April 2020; however, delays occurred due to the pandemic. The project commenced in November 2020 with four wards. Following an initial review in April 2021, Senior Leadership Group agreed to a six-month extension of the pilot and an increase in participation to ten services across the Trust Since implementation in November 2020 staff have reported the use of cameras as a positive addition to the ward environment that improves staff safety. There has been some concerns raised from some patients and it is acknowledged that further co-creation and lived experience is needed to gain a greater appreciation within this sensitive area. The data currently available shows no significant impact on the use of restrictive interventions, however delays in implementation due to safety concerns or technical issues may have limited effectiveness. Further embedding and review of footage needs to be undertaken to fully evaluate the impact of the body worn cameras. Learning from other Trusts that have successfully embedded the approach has identified that it can take several years to fully embed systems and skills required to fully access the ability of this technology and achieve the benefits for patient care
Develop a business case for further roll-out of body cameras (if supported by monitoring of benefit Key Performance Indicators		See above with reference to extension of pilot project

Strengthen organisational learning, including learning from deaths:		
Implement an Organisational Learning Group (OLG)		Relatives/carers were invited to join this group to talk about their experiences and discuss how we could embed learning Trust-wide
Deliver the four organisational learning work programmes that aim to strengthen and embed robust systems for the identification and sharing of learning (infrastructure and governance, systems for communication of immediate patient safety concerns, development and launch of a Learning Library and share learning from West Lane Hospital*	*	These workstreams were implemented and have made good progress: Infrastructure & Governance: developed the terms of reference for the OLG and developed the strategic infrastructure for 1) the identification and capture of learning from patient safety events, 2) communication of learning and actions to be taken, 3) assessing the impact of actions taken as a consequence of learning Systems for communication of immediate patient safety concerns: the work has focused on the development of Safety Briefings, and these are now well-embedded in the organisation The creation of a learning library: a learning library has been developed and is hosted on the Trust Intranet site. It contains a wide range of information for staff to access from across the organisation. This includes safety briefings, learning bulletins, medication safety information, safeguarding information, and information related to the Trust's improvement work relating to patient safety and quality *This action was placed in our Quality Account in the expectation that the independent review into West Lane would report during 2021/22 but this is now anticipated to be late summer or early autumn of 2022. The Trust will of course closely study the findings and learn from them

Have in place an Integrated Organisational Learning Report with an initial focus on learning from patient safety issues		
Have in place a mechanism assessing the impact of organisational learning		
Increase the percentage of our inpatients who feel safe on our wards:		
Work proactively within the newly formed Regional Patient Experience Network; maximise opportunities for benchmarking patient experience data		The Trust are members of the newly formed Regional Patient Experience Network, sharing ideas and best practice. Work is underway to benchmark our feeling safe data with the network. This has been slightly delayed due to capacity in services
Further review information from patient experience surveys and concerns raised from patients and carers through PALS contact and complaints and use this to feed into report and action plan, and deliver actions throughout the year		All patient experience surveys have a developed action plan and is displayed on trust notice boards in the form of 'you said, we did'. Learning from Patient Experience, PALS and Complaints is captured within a learning database. Further work is needed to ensure that these are shared more robustly across the Trust

How do 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 2021/22	Actual 2021/22
Expand the pilot use of staff body cameras to include a further five wards	Body cameras in place in a further five wards	Roll-out extended to ten sites across the Trust
Percentage of inpatients who report feeling safe on our wards	88%	64.37%
Percentage of inpatients who report that they were supported by staff to feel safe	65%	68.04%

As the table above shows, we continue to see a gap between our target for the percentage of people who report feeling safe on our wards, and our survey results. Therefore, we are continuing to make this an improvement priority for 22/23.

Priority Three: Compassionate Care

Why this is important:

'Our Journey to Change' (see page **6**) describes the kind of organisation we want to be and says, *We will co-create safe and personalised care that improves the lives of people with mental health needs, a learning disability or autism, involving them and their carers as equal partners. We will listen, learn, improve, and innovate together with our communities and will always be respectful, compassionate, and responsible*.

Fundamental to achieving this is by living these three values, one of which is Compassion, and through ensuring our systems and processes support these.

The benefits/outcomes we aimed to deliver for our patients and their carers were:

- Personalised, compassionate care
- Co creation of care that optimises and improves life experiences
- Feeling involved and listened to when there is a serious incident investigation
- Responses to complaints and concerns that are underpinned by an empathetic and compassionate approach

What we did in 2021/22:

What we said we would do	Did we achieve this?	Comment
Serious Incident reviews		
Develop the Serious Incident review process to take account of feedback from patients and families regarding a more collaborative and informed approach		This will be further developed and embedded during 2022/23
Undertake an evaluation of the new process		As above
Refresh current improvement plan related to responses to complaints		
Embed the new Trust Values and Behaviours within the Trust:		
Hold engagement events with staff at all levels to develop our new ways of working together, with involvement of service users and carers		Engagement sessions with staff began in May 2022; there is consideration of making these sessions mandatory for new staff
Share outputs of initial engagement events so all staff, service users and carers can access tools and resources which help to describe our new ways of working		We are developing a section on the Trust intranet to share tools and resources; however, this is still work in progress. It is anticipated that this will be completed during Q1 2022/23
Further roll-out of engagement events, to be attended by all staff		These are ongoing and are being led by the Trust Organisational Development Team
Work with staff, service users and carers to identify work which has already been developed which supports the new values.		The Trust Organisational Development Team run a service user leadership course annually; 'Our Journey to Change' will play a prominent role in the content. Specific training has also been undertaken with service users who attend our Programme Boards – these were very well received
Agree how we will learn from and build on this work		As above
All teams to co-create their ways of working and development plans		This now sits under People and Culture – there is an ongoing project to roll out a new digital solution called 'Workpal' which will help align personal objectives, team, service, and organisational level goals – this will be implemented by Q2 2022/23

Roll out empathy and compassion training across locality and corporate services		
Establish a baseline of those requiring training		A programme of training has been delivered throughout 2021/22 to staff within the localities and corporate services
Undertake a formal evaluation of training		

How do we know we have made a difference?

Indicator:	Target 2021/22:	Actual 2021/22	Timescale:
Percentage of patients reporting that they felt treated with dignity and respect	94%	87.98%	Q4 2021/22
Percentage of patients who report being listened to and heard by staff	76%	79.64%	Q4 2021/22
Reduction in the number of complaints that request a further local resolution	18%	9% (27 out of 293 complaints)	Q4 2021/22

We achieved 2 of these 3 standards but will develop further actions linked to the new Quality and Safety journey we are currently developing.

Quality Improvement Priorities for 22/23

Developing the Priorities

Following initial discussion and a review of quality data, risks, and future innovation, we have developed our priorities in collaboration with our staff, service users, families and carers. Our priorities will support the Trust as we continue with our mission to make sure that safe, quality care is at the heart of all we do.

TEWV did not hold our traditional quality account stakeholder workshops in 2021/22. This was partly due to the risks associated with Covid infection which meant that large public face-to-face events could not take place. However, it also reflected our belief that:

- We have improved day to day, continuous engagement with service users, carers and stakeholders and should use what we learn from this to inform our Quality Account, rather than hold special one-off events
- The extensive engagement undertaken (mostly online) during the creation of Our Journey to Change has given a strong sense of where TEWV needs to improve, and the large number of participants (e.g., over 300 service users and carers) gives this feedback and data particular weight in considering priorities

Priority One: Care Planning

Information on why this is important and the benefits/outcomes that we aim to deliver for our patients and their carers can be found earlier in this document on page 16

Priority 1 – Improving Care Planning

By 2022/23 Q4 we will:

a) Ensure all clinical staff are trained in our new DIALOG care planning system
b) Record all care plans on our new cito patient record system
c) Publish new policies and procedures in relation to care planning and new ways of working (linked to Community Mental Health Framework)
d) Introduce improvements to care planning in Secure Inpatient Services
e) Update all service user and carer information resources about care planning
f) Have data collection and monitoring systems in place to assess the impact of our clinical interventions on the goals set out in service users' care plans

How will we know we are making things better?

To demonstrate that we are making progress against this priority we will measure and report on the following metrics

Indicator	Actual 2021/22	Target for end 22/23
Patients know who to contact outside of office hours in times of crisis	80%	90%
Patients were involved as much as they wanted to be in what treatments or therapies they received	85%	95%
Patients were involved as much as they wanted to be in terms of what care they received	73%	83%
Percentage of patients who were involved as much as they wanted to be in the planning of their care	75.5%	#

target to be agreed as part of development of Trust Integrated Performance Dashboard following publication of the Quality Account

Priority Two: Feeling Safe

Information on why this is important and the benefits/outcomes that we aim to deliver for our patients and their carers can be found earlier in this document on page 18

By 2022/23 Q4 we will:

a) Review the information we have available from patient surveys, incidents and complaints from adult inpatient services to identify any new emerging themes that may help inform our programme of improvement work in this area
b) Increase the visibility of staff within adult inpatient areas
c) Focus on reducing patient-on-patient violence through exploring further use of Information Technology solutions

d) Continue to implement the Safe Wards initiative (an evidence-based tool to reduce violence and support a safe ward environment)

How will we know we are making things better?

To demonstrate that we are making progress against this priority we will measure and report on the following metrics

Indicator	Actual 2021/22	Target for end 22/23
Percentage of inpatients who report feeling safe on our wards	64.37%	#
Percentage of inpatients who report that they were supported by staff to feel safe	68.04%	75%

target to be agreed as part of development of Trust Integrated Performance Dashboard following publication of the Quality Account

Priority Three: Implementation of the new Patient Safety Incident Reporting Framework

We have made excellent progress on this work over the past few months; following the event that was held in July 2021, in relation to reviewing the current reporting and learning processes from the perspective of patients, carers and families, our staff and our external colleagues. We have used this information to design the way that we work, and this has been in collaboration with service colleagues and families. Our new processes set out how we will respond to patient safety incidents reported by staff and patients, their families, and carers as part of the work to continually improve the quality and safety of the care provided. The plan sets out the ways the Trust intends to respond to patient safety incidents to learn and improve through Patient Safety Incident Investigations and Patient Safety Reviews. The new processes are in line with the requirements of the new National Patient Safety Incident Reporting Framework that will go live in 2022.

By 2022/23 Q4 we will:

a) Roll out the two-part incident approval process across all areas of the Trust. (This involves operational staff taking responsibility for reviewing and approving incidents that have occurred within their service before submitting centrally)
b) Introduce a triage process for incidents that have been categorised as moderate and serious harm to determine quickly the appropriate route for review
c) Develop the daily patient safety huddle to include service staff and subject matter experts (to ensure we can effectively review reported incidents in a timely way and where rapid reviews can be undertaken where appropriate that lead to immediate actions and improve safety)
d) Improve our Serious Incident Review process so that it is robust and utilises evidence-based tools and involves families to the level of their satisfaction
e) Provide updates for staff on the duty of candour to ensure all have a full understanding
f) Improve the quality and oversight of action plans
g) Refresh the Terms of Reference for the Director Assurance Panels

How will we know we are making things better?

These actions relate to process improvements, and we will consider which numerical measures will show whether those changes are having a positive impact. That impact may lag behind the achievement of these actions.

Monitoring Progress

The Trust will monitor its progress in implementing these priorities at the end of each quarter and will report to our Quality Assurance Committee, our Council of Governors and, on request to Overview and Scrutiny Committees.

Conclusion and links to the next section of this document

Pages 16 to 27 have explained:

- The progress made in implementing our 2021/22 Quality Improvement priorities and the impact this has had
- Our quality improvement plans for 2022/23

The rest of Part 2 of this Quality Account document summarises a number of data sources which together paint a picture of the quality of services in our Trust. We have followed the national Quality Account guidance in the selection of this material and have included the mandatory text where required. This is contained in blue boxes.

TEWV's 2021 Community Mental Health Survey Results

- There were 311 completed surveys returned within the Trust, a response rate of 26%. This is the same as the national response rate and compares with a rate of 28% in 2020.

The following table shows how the Trust performed for each section of the Survey in comparison to the national average (all scores are out of 10)

Section	Trust Score	Comparison
Section 1: Health and Social Care Workers	7.3	About the same
Section 2: Organising Care	8.6	
Section 3: Planning Care	6.7	
Section 4: Reviewing Care	7.6	
Section 5: Crisis Care	7.1	
Section 6: Medicines	7.4	
Section 7: NHS Talking Therapies	7.6	
Section 8: Support and Wellbeing	4.8	
Section 9: Feedback	2.3	
Section 10: Overall views of care and services	7.1	
Section 11: Overall experience	7.1	
Section 12: Care during the Covid-19 pandemic	6.6	

The Trust did not score significantly better or worse than comparable Trusts for any of the individual questions or sections as a whole; however, the Trust did score somewhat better than expected on *Q12: Do you know how to contact this person [person in charge of their care] if you have a concern about your care?*

The Trust's top five scores against the national average were for the following questions:

- Q19: Would you know who to contact out of office hours within the NHS if you had a crisis? This should be a person or team within NHS mental health services
- Q17: In the last 12 months, have you had a specific meeting with someone from NHS mental health services to discuss how your care is working?
- Q23: Have the possible side effects of your medicines ever been discussed with you?
- Q32: In the last 12 months, did NHS mental health services support you with your physical health needs (this might be an injury, a disability, or a condition such as diabetes, epilepsy, etc?
- Q10: Have you been told who is in charge of organising your care and services? (This person can be anyone providing your care, and may be called a 'care coordinator' or 'lead professional')

The Trust's bottom five scores against the national average were for the following questions:

- Q34: In the last 12 months, did NHS mental health services give you any help or advice with finding support for finding or keeping work (paid or voluntary)?
- Q20: Thinking about the last time you tried to contact this person or team, did you get the help you needed?
- Q35: Have NHS mental health services involved a member of your family or someone else close to you as much as you would like?
- Q3: In the last 12 months, do you feel you have seen NHS mental health services often enough for your needs? (This includes contact in person, via video call and telephone)
- Q33: In the last 12 months, did NHS mental health services give you any help or advice with finding support for financial advice or benefits?

The following questions demonstrate where there was a statistically significant change in the Trust's results between 2020 and 2021:

- Q33: In the last 12 months, did NHS mental health services give you any help or advice with finding support for financial advice or benefits? ↓
- Q3: In the last 12 months, do you feel you have seen NHS mental health services often enough for your needs? ↓

The areas where service user experience is best are:

✓ Crisis care contact: service users knowing who to contact out of hours in the NHS if they have a crisis

- ✓ Review of care: service users meeting with NHS mental health services to discuss how their care is working
- ✓ Side effects: possible side effects of medicines being discussed with service users
- ✓ Support with physical health needs: service users being given support with their physical health needs
- ✓ Who organises care: service users being told who is in charge of organising their care and services

The areas where service user experience could improve are:

- × Support with work: service users being given help or advice with finding support for finding support for finding or keeping work
- × Crisis care help: service users getting the help needed when they last contacted the crisis team
- × Friends/Family involvement: service user's family/someone close to them is involved in their care as much as they like
- × Seen often enough: service users being seen by NHS mental health services often enough for their needs
- × Support with financial advice: service users being given help or advice with finding support for financial advice

Full results of the Survey for the Trust can be found at:

https://nhssurveys.org/all-files/05-community-mental-health/05-benchmarks-reports/2021/

In order to take forward these results in relation to improving our patient experience, we will:

- Circulate the National Community Mental Health Survey report and findings across the Trust for discussion at local governance groups and add this report to the agendas for discussion at patient and service user involvement groups
- Develop a further action plan with particular emphasis on the availability of services, people being involved as much as they wanted to be, the help provided by crisis teams and help finding support for finding or keeping work

TEWV's 2021 National NHS Staff Survey Results

The National NHS Staff Survey is commissioned by the Picker Institute on behalf of TEWV and 24 other Mental Health and Learning Disabilities Trusts. All Trust staff were invited to participate, and returned 3,747 completed questionnaires, which is a response rate of 50%, compared to a median response rate of 52%. This is a significant increase on the response rate in 2020 (38%). TEWV were ranked 20 out of 24 compared to 11 out of 27 back in 2020

The 2021 annual NHS staff survey results for TEWV show that the Trust's overall results are around average to a little below average for mental health providers.

The questions for the 2021 survey onwards are aligned to the NHS People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements.

The following table shows how the Trust performed on each of the seven aspects of the People Promise, compared to the highest, lowest, and mean scores from similar Trusts. The domains of staff engagement and morale were also measured and have also been included here

Section	TEWV	Mean	Highest	Lowest
We are compassionate and inclusive	7.4	7.5	7.9	7.1
We are recognised and rewarded	6.2	6.3	6.8	5.9
We each have a voice that counts	6.9	7.0	7.4	6.4
We are safe and healthy	6.2	6.2	6.6	5.8
We are always learning	5.4	5.6	6.1	4.8
We work flexibly	6.3	6.7	7.1	6.1
We are a team	6.9	7.1	7.4	6.6
Staff engagement	6.8	7.0	7.4	6.5
Morale	5.9	6.0	6.5	5.5

The most improved results compared to 2020 are shown in the following table. They mostly relate to values and behaviours and suggest that work over the last couple of years to encourage positive leadership and management behaviours, and to put effective processes in place to encourage and investigate concerns raised by staff who 'speak up' is starting to have a positive impact

Question	2021	2020
Q13d: Last experience of physical violence reported	92%	87%
Q11e: Not felt pressure from manager to come to work when not feeling well enough	82%	78%
Q14c: Not experienced harassment, bullying or abuse from other colleagues	86%	84%
Q14b: Not experienced harassment, bullying or abuse from managers	92%	90%
Q14d: Last experience of harassment/bullying/abuse reported	59%	57%

The scores that declined the most between 2020 and 2021 are shown below. The impact of increased demand for mental health services and workforce availability linked to Covid can clearly be seen.

Question	2021	2020
Q3i: Enough staff at organisation to do my job properly	28%	42%
Q21c: Would recommend organisation as place to work	52%	66%
Q21d: If friend/relative needed treatment would be happy with standard of care provided by organisation	54%	65%
Q4b: Satisfied with extent organisation values my work	43%	53%
Q11d: In last three months, have not come to work when not feeling well enough to perform duties	45%	55%

Areas where the Trust scored low compared to national average:

- Support from immediate manager
- Would recommend Trust as a place to work or receive care
- Making adequate adjustments
- There is a significant piece of work to do looking at improving appraisals and linking them to feeling valued and improve how we undertake our roles

Areas where the Trust scored better than the national average:

- Career development
- Not working additional hours
- Experiencing musculoskeletal problems as a result of work

Review of Services

During 2021/22 the Trust provided and/or subcontracted **20** relevant health services. The Trust 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 2021/22 represents **100%** of the total income generated from the provision of relevant health services by the Trust for 2021/22.

Participation in clinical audits and national confidential inquiries

A clinical audit is the process by which the quality of care and services provided are measured against agreed standards. Where services do not meet the agreed standard, the audit provides a framework where suggestions for improvements can be made. A third party conducts national audits. Participating in these audits gives organisations the opportunity to compare their results with other organisations. Local audits are conducted by the organisation itself. Here they evaluate aspects of care that the healthcare professionals themselves have selected as being important to their team. The statements on a clinical audit demonstrate the healthcare provider is concerned with monitoring the quality of their services and improving the healthcare provided.

During 2021/22, **seven** national clinical audits and **three** national confidential inquiries covered the health services that TEWV provides.

During 2021/22, TEWV participated in **100% (seven out of seven)** of the national clinical audits and **100% (three out of three)** of 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 2021/22 were as follows:

- Prescribing Observatory for Mental Health (POMH):
  - POMH Topic 10b: Prescribing for depression in adult mental health services
  - POMH Topic 14c: Prescribing for substance misuse: alcohol detoxification
- National Clinical Audit of Psychosis (NCAP)
  - Spotlight re-audit in EIP Services
  - AMH Community Services
- National Audit of Inpatient Falls (NAIF)
- Facilities Audit
- National Audit of Care at the End of Life (NACEL)
- National Audit of Dementia (NAD)
- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD):
- Physical Healthcare in Mental Health Hospitals
- Transition from Child to Adult Services Study

The national clinical audits and national confidential inquiries that TEWV was **participated in** during 2021/22 were as follows:

- Prescribing Observatory for Mental Health (POMH):
  - POMH Topic 10b: Prescribing for depression in adult mental health services
  - POMH Topic 14c: Prescribing for substance misuse: alcohol detoxification
- National Clinical Audit of Psychosis (NCAP)
  - Spotlight re-audit in EIP Services
  - AMH Community Services
- National Audit of Inpatient Falls (NAIF)
- Facilities Audit
- National Audit of Care at the End of Life (NACEL)
- National Audit of Dementia (NAD)
- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD):
- Physical Healthcare in Mental Health Hospitals
- Transition from Child to Adult Services Study

The national clinical audits and national confidential inquiries that TEWV participated in, **and for which data collection was completed during 2021/22** 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 number of registered cases required
POMH Topic 19b: Prescribing for depression in adult mental health services	Sample provided: 89	100%
POMH Topic 14c: Prescribing for substance misuse: alcohol detoxification	Sample provided: 11	100%
National Clinical Audit of Psychosis (NCAP): Spotlight re-audit in EIP	Sample provided: 510	100%
National Clinical Audit of Psychosis (NCAP): AMH Community	Sample provided: 100	100%
National Audit of Inpatient Falls (NAIF): Facilities Audit*	Not applicable – organisational questionnaire only	Not applicable
National Audit of Care at the End of Life (NACEL)*	Sample provided: 9	100%
National Audit of Dementia (NAD): Spotlight audit of Community-Based Memory Services*	Sample provided: 512	100%
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)	27 questionnaires sent to the Trust; 22 returned	81%
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) – Physical Healthcare in Mental Health Hospitals*	27 clinician questionnaires sent; 10 submitted questionnaires	37%
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) – Transition from Child to Adult Services Study	Not applicable – organisational questionnaire only	Not applicable

** The Trust was eligible to also participate in organisational/hospital level questionnaires for these national clinical audits/confidential inquiries. These were completed in all cases*

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

The reports of **106** local clinical audits were reviewed by the Trust in 2021/22 and TEWV intends to take actions to improve the quality of healthcare provided. **Appendix 3** includes the actions the Trust is planning to take against the **five** key themes from these local clinical audits reviewed in 2021/22

In addition to those local clinical audits reviewed (i.e., those that were reviewed by our Quality Assurance Committee and Clinical Effectiveness Group), the Trust undertook a further **72** clinical audits in 2021/22 which include clinical effectiveness projects undertaken by Trainee Doctors, Consultants, or other Directorate/Specialty Groups. 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 specialities. Over the next year the Trust intends to use clinical audit applications to make clinical audits more efficient and to make it easier for teams to review their clinical quality information in a live format and to make any changes needed to improve practice and ultimately the quality of care and experience of our patients and their families.

The Trust implemented an extensive Quality Assurance Programme during 2021/22. This programme has delivered ongoing assurance for key quality and risk issues identified within the Trust. Significant improvements in practice and patient safety have been facilitated through this programme.

Participation in Clinical Research

The Trust participates in research activity to help provide new knowledge that has the potential to be valuable in improving care for patients. It is important that such research is open to critical examination and open to all that would benefit from it.

The number of patients receiving relevant health service provided or sub-contracted by TEWV in 2021/2022 that were recruited during that period to participate in research approved by a Research Ethics Committee was **806**. Of the 806 participants, 768 were recruited to 27 National Institute for Health Research (NIHR) portfolio studies. This compares with 826 patients involved as participants in NIHR research studies during 2020/21.

During 2021/2022, the Trust has continued to focus on successful continuation and delivery of the BASIL+ study. The Basil C19 study examines the use of behavioural activation in older adults with low mood or loneliness and long-term health conditions during Covid-19. Sponsored by TEWV, 435 participants were recruited across 12 sites in the UK, with TEWV recruiting 60 participants to the trial.

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

- We continue to work closely with the NIHR Clinical Research Network North Est and North Cumbria to support large scale national portfolio research studies, and to measure patient research experience when taking part in studies with feedback and any actions reported to our Research Governance Group.
- We were involved in conducting **66** clinical research studies in mental health, dementias and neurodegeneration, health services research and infection, during 2021/22; 49 of these studies were supported by the NIHR through its networks

- **45** members of our clinical staff participated as researchers in studies approved by a Research Ethics Committee, with **31** of these in the role of Principal Investigator for NIHR supported studies
- **371** members of our staff were also recruited as participants to NIHR portfolio studies
- We continue to collaborate with a wide range of universities and other NHS providers to deliver large multi-site research studies for the benefit of our service users, carers, and staff, through these collaborations, we have been awarded a further two NIHR Research for Patient Benefit grants during this year.

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

Due to the ongoing Covid-19 pandemic NHS England and NHS Improvement stood down all CQUIN requirements

What the Care Quality Commission (CQC) says about us

The Care Quality Commission (CQC) is the independent regulator for health and social care in England. It ensures that services such as hospitals, care homes, dentists and GP surgeries provide people with safe, effective, compassionate, and high-quality care, and encourages these services to improve. The CQC monitors and inspects these services, and then publishes its findings and ratings to help people make choices about their care.

Tees, Esk and Wear Valley NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is **registered without conditions for services being delivered by the Trust**. The Trust is therefore licensed to provide services.

The CQC **has** taken enforcement action against TEWV during 2020/21. TEWV **has** participated in a special review/investigation by the CQC during the reporting period.

Between 14th June 2021 and 5th August 2021, the Trust received a series of unannounced core service inspections from the CQC. This included inspection of Secure Inpatient Services, Adult Mental Health Crisis Services and Health-Based Places of Safety, Adult Mental Health Community Services and Community Child and Adolescent Mental Health Services. Core service inspections were also followed by a well-led inspection of the Trust.

Following the inspection, the CQC raised several areas for improvement with a Section 29A notification received for Secure Inpatient and Community Child and Adolescent Mental Health Services.

Inspections of the Secure Inpatient Services observed some issues with staffing levels, safeguarding processes and governance arrangements. Inspections of the Community Child and Adolescent Mental Health Services observed some issues with staffing, the size of caseloads and systems and processes for monitoring patients.

Immediate action was taken in response to these concerns and a comprehensive action plan was developed to ensure these areas of risk were being adequately addressed. Implementation has been well progressed with robust weekly reporting and oversight through the Trust's Quality Improvement Board. The deadline for implementation was 1st March 2022. It is however recognised by the CQC that fully embedding some of these actions and the impact will require longer timescales. Further plans are in place to ensure that improvements are sustained, and that service delivery continues to be safe and effective.

Section 29A issues were subsequently encompassed by the CQC with the 'Must Do' regulatory actions included within the Trust CQC inspection report issued on 10th December 2021. The Trust was rated as 'Requires Improvement'

The follow-up CQC inspection of the Adult Mental Health Inpatient Services in June 2021 noted significant improvements in risk assessment and management processes and subsequently re-rated the service as 'Requires Improvement'.

In addition to clearly evidencing delivery of the required actions, the Trust continues to implement a wider programme of change and improvement. During 2021, this has included restructuring how services are delivered, strengthening governance arrangements, increasing leadership capacity and oversight, improving staffing establishments and improving mandatory training, expertise, clinical supervision, and sustainable support to our clinical teams. Work has also been achieved to enhance and embed organisational learning from a range of internal and external sources. This has included reviewing, strengthening, and developing mechanisms for capturing and communicating learning and importantly gaining assurance of the impact of our actions to improve care for service users and their families. This work continues to support the Trust in nurturing a culture of patient safety and continuous quality improvement.

Since the inspections, we have sustained a quality assurance schedule that includes a review of the quality of care documentation. This has provided ongoing assurance that patient's risks are assessed and that they have care, safety and observation plans in line with their needs.

A 'Quality Improvement Board' chaired by the Chief Executive with executive team attendance with responsibility for ward/team to board reporting on implementation has been sustained to oversee quality assurance standards including regular audit and direct observation on wards and to provide assurance to the Trust Board that appropriate actions are being taken to address improvements in patient safety.

Improvement Plan

A Regional Quality Board was established where TEWV reports on progress to other partners such as NHS England and the Integrated Care Systems as well as the CQC. The Trust is also accessing expert external support for rapid improvement and embedding actions.

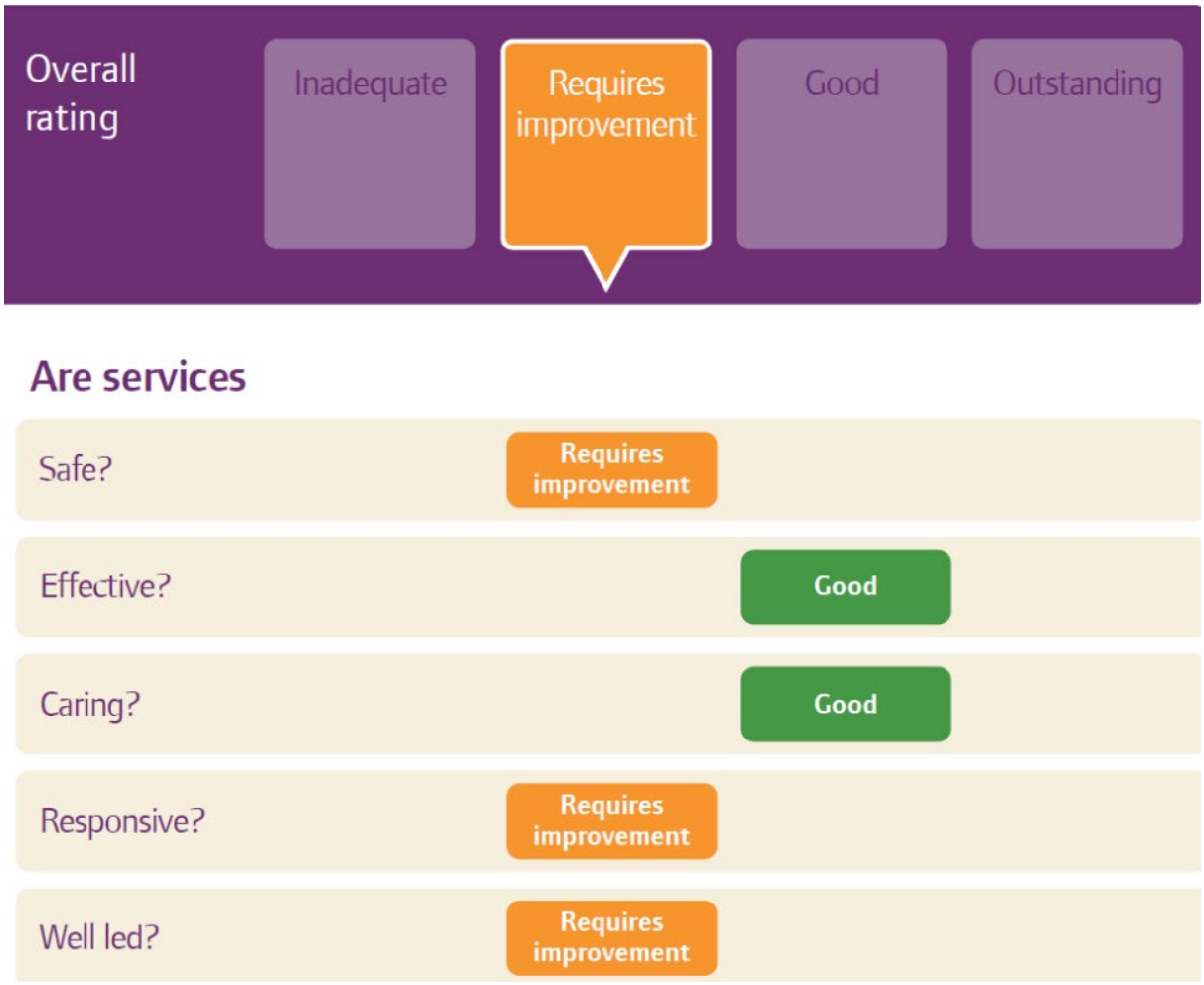
In addition to the attainment of all recommendations and conditions related to the Section 29A warning notice issued by the CQC in March 2021, an umbrella improvement plan is being implemented with overarching workstreams including:

- Implementation of the Trust's new strategy – 'Our Journey to Change'
- Board development
- Strengthening 'Ward/Team to Board governance flow' and focus on the Board Assurance Framework/Risk Registers
- Embedding organisational learning including reviewing the involvement of families and carers in Serious Incident reviews
- Simplification of management and governance structures to support the line of sight, communication, and flow of information
- Development of new Board integrated assurance performance report and strengthening capacity and capability in corporate and locality/specialist governance roles
- Training and professional development for clinical staff
- Sustainability of improvements including leadership and development and strengthening lines of accountability
- Technological improvements including the development of a new electronic patient record system

We are confident that we will continue to improve services and will work with staff, service users, carers, volunteers, governors, commissioners, and partners to address the areas where standards were not as expected.

CQC Rating

The Trust has retained an overall rating of 'Requires Improvement' with a number of actions being taken to improve the quality and safety of our services.



Further information can be found at: https://www.cqc.org.uk/provider/RX3

Information Governance

Information Governance requires the Trust to set a high standard for the handling of information. The aim is to demonstrate that it can be trusted to maintain the confidentiality and security of personal information, by helping individuals to practice good information governance.

Due to the ongoing Covid-19 pandemic, NHS Digital has delayed submission of the Data Security and Protection Toolkit 2021-22 until 30th June 2022. Of the **110** mandatory evidence items and **38** assertions, we anticipate publishing the Toolkit with all except one evidence item provided and assertions met.

Similar to many other Trusts, the Trust is currently experiencing a higher than usual sickness absence rate making the mandatory requirement to ensure at least 95% of all staff have completed their annual Data Security Awareness Training problematic.

Not achieving an evidence item would require an action plan to be submitted that identifies the actions and timescales to achieve compliance.

Due to cyber security risk, NHSE/I have advised there is no appetite to reduce the mandatory 95%

In mitigation, the Trust issues monthly cyber security eLearning to all staff; all new staff complete mandatory Data Security and Protection Training for New Starters, and we have undertaken a number of phishing simulations with the findings and learning shared Trust-wide.

The following steps have been put in place to ensure that appropriate controls are in place to ensure the accuracy of data:

- The Trust has in place an internal group which has the responsibility for ensuring data quality within the Trust; this was put on-hold during the COVID-19 response but is set to be reinstated as part of the Trust's revised governance structure
- 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 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)
- Data Management Policy
- Information Governance Policy
- Information Systems Business Continuity Policy
- Confidentiality and Sharing Information Policy

These policies incorporate national standards where available and are regularly reviewed. All the policies are held on the staff 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 monthly policy bulletins and other cascade mechanisms.

- As part of performance reporting to the Board, real-time data is used to forecast future positions, thus improving the decision-making process. Trust dashboards are available via the Integrated Information Centre (IIC) to support and enhance decision-making
- All data returns are submitted in line with agreed timescales

Freedom to Speak Up

Following a review by Sir Robert Francis in 2015, a national standard 'Freedom to Speak Up' policy was published by NHS Improvement and NHS England. This policy has the aim of developing a more open and supportive culture for staff to raise any issues of patient care, quality, or safety. The Trust has subsequently adopted this standard policy in its own policy.

The Trust has a policy which details how staff can speak up about risk, malpractice, or wrongdoing. Most of the time staff will choose to raise their concerns with their line manager. However sometimes they may feel this is inappropriate. They then have the option to 'Speak Up' anonymously using our Raising Concerns email address (which can be found on the Trust Intranet) or by contacting the Trust's Freedom to Speak Up Guardian via mobile telephone or dedicated email address.

Part of the role of the Freedom to Speak Up Guardian is to ensure that staff receive feedback on how their concerns are being addressed e.g., who is conducting the service review or investigation, what they found and what, if any, subsequent actions are being taken. Depending on the case, this feedback can be verbal or written. It often forms part of regular feedback aimed at developing a trusting relationship.

Ensuring that people who speak up do not experience detriment is a central commitment of the Guardian's role. It is also clearly stated within the Trust policy. Staff are also regularly reminded that they should not tolerate any negative consequences of their speaking up. At the end of their involvement, staff are asked to answer two questions – "Would you feel confident to speak up in the future?" and "Did you feel you experienced any detriment?"

The Trust has little evidence of overt actions leading to detriment. However, some staff have felt a loss of trust in the organisation to keep them safe. This loss of trust has on some occasions resulted in staff feeling unable to remain in their current post. Many have moved to another post within the organisation and have reported their satisfaction with this outcome.

The Freedom to Speak Up guardian attends the Trust Board on a twice-yearly basis to deliver their report. This report contains numbers of new cases taken on, the number closed, the broad category of the concern, and any feedback. It also contains anonymised case studies/examples and any lessons learnt.

During 2021/22, there were **78** cases referred to the Freedom to Speak Up Guardian. Of these, **25** were submitted anonymously. **34** of the concerns related to culture of bullying, and **38** related to patient safety and **15** to staff safety. The remainder related to other issues such as culture or systems/processes. We are committed to creating an open and transparent culture where every member of staff can speak out safely. Over the next year we will continue to raise the profile of the Freedom to Speak Up Guardian and triangulate the information we have with other sources to ensure the best and safest care for our service users.

Reducing Gaps in Rotas

The Guardian of Safe Working for Junior Doctors within the Trust produces quarterly reports to the Trust Board that focus on gaps in medical rotas and safety issues. The role sits independently from the management structure, with a primary aim to represent and resolve issues related to working hours. The work of the Guardian is subject to external scrutiny of doctors' working hours by the Care Quality Commission and by the continued scrutiny of the quality of training by Health Education England.

The Guardian is required to levy a fine against a department(s) if a Junior Doctor:

- Works on average over 48 hours/week
- Works over 72 hours in seven days
- Misses more than 25% of required rest breaks
- On non-residential on call (NROC) does not have a minimum of continuous rest for five hours between 22:00 and 07:00
- Does not have the minimum eight hours total rest per 24-hour NROC shift
- Has more than the maximum 13-hour residential shift length
- Does not have the minimum 11 hours rest between resident shifts

The Guardian of Safe Working for Junior Doctors within the Trust produces quarterly and annual reports to the Trust Board that focus on gaps in medical rotas and safety issues.

The Trust's Board received the Guardian's annual report for 2021/22 at its meeting of 26th May 2022. During the year, the most common reasons for needing short-term/locum cover was due to vacancies on the rotas, staff sickness (short/long term) and COVID-19 related absences (sickness or self-isolation).

Exception reports received related mostly to claiming additional hours whilst on Non-Residential On-Call, having to stay later than normal working hours or shift end time or missing teaching/training due to staff shortages. Discussions on these issues have taken place where appropriate and additional staffing put in place where possible.

Bolstering staffing in adult and older adult community mental health services

One of the consequences of the additional investment into mental health services in recent years (and the Trust's decision to invest in clinical posts to address the Covid surge in demand) has been an increase in our workforce. During 2021/22 this trend has continued and our workforce in January 2022 was 206 whole time equivalent posts higher than at the start of the financial year (although workforce size peaked in November 2021). Through Commissioners, national transformation investment and Covid surge monies, the Trust has increased staffing across all clinical services, including adult and older adult community mental health services.

Examples of service improvements enabled by additional staffing include:

- Additional Healthcare Assistants appointed to combat increased demand for physical health monitoring
- Additional staff recruited into Mental Health Support Teams to allow the full target population to be able to access support, particularly in relation to issues surround Covid/Covid lockdowns
- Allied Health Professionals (Speech and Language Therapy, Physiotherapy, Occupational Therapy) plus Pharmacist recruited into the Care Home Liaison Team in Durham
- Increased staffing across Perinatal teams in Durham, Darlington, and Tees to support further delivery of the NHS Long-Term Plan
- Increased staffing within Tees AMH Community Teams to provide additional support for service users with Autism/ADHD and also into Early Intervention in Psychosis

The Trust is currently agreeing with Commissioners their investment plans for 2021/22, which it is anticipated will be mobilised to implement a range of roles in both Inpatient and Community-based -Services.

Learning from Deaths

Following publication of the Southern Health report in 2015 there has been enhanced national scrutiny on how all NHS organisations respond to deaths of service users in their care. This culminated in the release of a 'Learning from Deaths Framework' which was published by the National Quality Board in 2017. The Trust collects data on all known deaths and has processes in place to determine the scope of deaths which require further review or investigation. The Board of Directors (meeting in public) receive a quarterly Learning from Deaths dashboard and report summarising learning. As well as being included in this Quality Account, information is also included in the annual Patient Safety report.

In Mental Health and Learning Disability Services we have a significant number of older people who are cared for in the community and their needs are such they only require minimal contact with us. Many of these people who die do so through natural

causes as happens in the wider population. This explains the difference between the total number of deaths (from all causes including natural causes) and the numbers we go on to investigate further. To support staff in their decision making regarding the investigation of deaths, staff have clear policy guidance, setting out criteria for categories and types of review. This is currently being reviewed as part of development work in preparation for the new Patient Safety Incident Response Framework which will be implemented gradually during 2022/23 in line with national guidance.

Despite the pressures of COVID-19, good progress has been made to improve both the quality and the number of Serious Incident and Mortality reviews completed over the year, notably the number of Learning Disability Deaths that have been reviewed internally and reported to LeDeR (Learning Disabilities Mortality Review).

It is recognised that team development and skilled staff are key to the delivery of high quality, safe care, and high functioning teams to minimise the risk of incidents occurring. Community Matrons, Practice Development Practitioners and Peer Workers appointed to support co-creation, recovery and involvement are embedding their roles which has enhanced senior clinical leadership during 2021/22.

In 2019, a family conference was held with bereaved families who had experienced the serious incident process. One of the aims of the conference was to identify how we could improve the way we engage with families. May 2021, an improvement event was held to consider how we could further improve involvement with families to facilitate a more equal partnership in the Serious Incident Investigation process. (Further information can be found in relation to our new priority for 2022/23 on pages 27 to 28). The Trust was due to hold its second annual family conference in March 2020; this was put on hold due to the COVID-19 pandemic and is regularly under review.

Any death of a person open to Trust services, which is reported through our Incident Management System, is subject to an initial review by the Central Approvals Team. During 2021/22 **2,163** TEWV patients died; this comprised the following number of deaths which occurred in each quarter of that reporting period:

- **486** in the first quarter
- **556** in the second quarter
- **638** in the third quarter
- **483** in the fourth quarter

The following were Learning Disability Deaths (reported to LeDer)

- **18** in the first quarter
- **26** in the second quarter
- **23** in the third quarter
- **19** in the fourth quarter

There were 26 inpatient deaths; 22 of these deaths related to physical health, 3 deaths were potential patient safety incidents; 1 cause of death remains unknown.

In Q1, 31 serious incidents resulting in death were reported. 23 serious incidents were reviewed. Of those 23 cases, 14 had lapses in care/service delivery

In Q2, 15 deaths were reported. 18 serious incidents were reviewed. Of those 18 cases, 11 had lapses in care/service delivery

In Q3, 23 deaths were reported. 15 serious incidents were reviewed. Of those 15 cases, 12 had lapses in care/service delivery

In Q4, 31 deaths were reported. 21 serious incidents were reviewed. Of those 21 cases, 8 had lapses in care/service delivery

By 31st March 2022, in relation to unexpected and expected physical health deaths, 430 mortality reviews, including 71 structured judgement reviews had either been carried out or requested

Recurring themes relate to:

- Risk assessment/safety summaries/safety plans
- Care Programme Approach (CPA), care plans/interventions plans/formulations
- Relative/carer involvement
- Record keeping

Detailed below are some of the structures to support and embed learning in response to what we have learned from reviews of deaths during 2021/22:

Practice Development Group (PDG)

The Practice Development Teams (PDT) overseen by the PDG are addressing the areas of learning as identified by lapses of care during 2021/22, namely safety summaries/safety plans, care planning and relative/carer involvement as detailed above. Practice Development Practitioners (PDP) have been appointed and continue to develop in their posts across inpatient wards. They are also offering training in relation to risk assessment and safety summaries Trust-wide, including to community staff.

Organisational Learning Group (OLG)

The Trust continues to strengthen its arrangements for organisational learning via the Organisational Learning Group. As part of the work undertaken by this group, urgent patient safety briefings are now circulated Trust-wide. Examples of these urgent safety messages relate to new anchor points/ligature risks identified within the Trust and how these risks are to be addressed. The briefings are specific about any assurance required from services; on receipt of completed actions these are stored

in the learning database. 'Learning from Serious Incidents Bulletins' are also regularly distributed across the Trust. The bulletins have shared key learning and good practice highlighted in serious incident reports presented at the Director's assurance panel. All briefings and bulletins are stored in the learning library on the Trust's intranet for easy access. A quality improvement event is planned for August 2022 to focus on how we can further improve the communication and impact of learning in front line services.

Patient Safety Priorities

The Journey to Safer Care as part of the Trust's 'Journey to Change' highlights four key patient safety priorities:

- Suicide Prevention and Self-Harm Reduction
- Reducing Physical Restraint and Seclusion
- Harm Free Care, Psychological Safety including sexual safety and a Safe Environment
- Promoting Physical Health

The Service Development Managers (SDMs) who are members of the Patient Safety Campaign steering group have been tasked to map out work that is taking place across services in relation to these priorities. This will be used to inform the work plan for the Quality and Safety Programme Board.

Suicide Prevention and Harm Minimisation

A period of engagement has been carried out with staff, service users, carers/relatives, and partners to help shape the Trust's draft Preventing Suicide Strategy, Leadership for suicide prevention is through the Clinical Strategy Lead supported by a multi-disciplinary Preventing Suicide and Self-Harm Reduction Group which will monitor progress against the strategy's action plan. All actions will be aligned to our 'Our Journey to Change'

In support of the above strategy, the preventing suicide project leads continue to work closely with the Patient Safety Team and our partners by:

- Sharing information from the early alerts system in areas where this is available. This applies to suspected suicides (not just people open to the Trust) to facilitate shared learning with partners
- Attending and working with partners in all localities where there have been multiple suicides in a particular area or site (not just people open to the Trust)
- Targeted work with rail network, to work closer together with shared protocols for preventing suicides
- Providing direct support and guidance to teams on completing Rapid Reviews, reflecting on lessons learnt and how the project workers can support clinical services
- Identifying emerging themes within their locality then engaging with those services directly to share the learning and provide guidance and support on best practice

The Trust is participating in the National Collaborative Work on reducing restrictive practices

Harm-Free Care – Safe Environment

The Environmental Risk Group receives monthly incident reports involving ligatures and other risks where environmental factors may have contributed to harm as well as progression of initiatives to reduce harm. Any urgent learning from this group is disseminated Trust-wide via Patient Safety Briefings or SBARDS. As part of the ligature reduction programme, in inpatient areas, ensuite doors and main bedroom doors are currently being replaced. Main bedroom doors are being replaced with sensor doors in designated wards. The roll-out of Oxehealth continues to support patient safety through enhanced observation. An early learning report has been undertaken and will go through various governance routes over the next month to highlight progress and areas for further development. Environmental surveys with input from estates, health and safety and clinical services have been recommenced. Completion of these has been impacted by Covid.

Promoting Physical Health

Work continues in relation to improving the physical health of people with mental health problems, in keeping with ICS priorities when learning from deaths. This includes weight management, care of the deteriorating patient, reducing alcohol and drug use, reducing falls.

Safeguarding

Despite improvement work already undertaken to embed the principles of 'think family' and the use of the PAMIC tool, it continued to be a finding in serious incident investigations. It was agreed that the issue is above the qualitative aspect of how parental mental health impacts on children and that this should be considered as part of a comprehensive risk assessment under the category of risk to others. Having this as a narrative in the risk assessment has enabled fuller information to be shared/documented about what has been considered from a 'think family' perspective. Outcomes of this improvement work will be triangulated with evidence from the Central Approvals Team, Patient Safety Team, and the Safeguarding Team to determine the impact of changes made on patient safety. Links between the Patient Safety Team and the Safeguarding Team continue to be strengthened with joint working on serious incident cases and in the Patient Safety Team huddle.

Serious Incident Investigation Process

A quality improvement event 'Improving the Experience of Patients, Families and Staff during Serious Untoward Incident Reviews (SIRs)' commissioned by the Director of Quality Governance, built on existing work already being carried out to improve the SI investigation process. A further event was held in February 2022 where four additional workstreams relating to the SI process and incident reporting were identified. A Project Manager is in place to drive delivery of this improvement work as well as the wider standards in keeping with 'Our Journey to Change', and event has been planned for the 20th of May 2022 to facilitate full engagement with all

relevant stakeholders. Improvement work has continued to identify early learning/themes from rapid reviews ensuring that clinical services embed early actions into practice. This work has been supported by Serious Incident Reviewers and the Preventing Suicide project leads. A more proactive approach to learning from deaths has been taken by facilitating closer working relationships between clinical services and the Patient Safety Team. In some cases, clinicians, and where required subject matter advisors, are invited into the Patient Safety Team huddle to discuss early learning and immediate actions required. Reviewers are now working with clinicians in areas such as perinatal services, suicide prevention, physical health and health and safety to share Trust-wide learning at these groups. This is promoting a more 'wrap-around' approach to learning between corporate and organisational services. All newly appointed Serious Incident Reviewers are attending serious incident investigation training which is being provided by the Healthcare Safety Investigation Branch (HSIB)

Better Tomorrow Programme

The Trust is working with the Better Tomorrow Programme to review current Mortality Review Systems and processes to help identify and support with potential areas of development. This work was put on hold due to the pandemic but has recently recommenced.

Training

'Connecting for people' suicide awareness training continues with plans for further Trust staff to be trained as trainers during 2022. The Trust's mandatory harm minimisation training continues to include updated headlines from serious incidents in relation to learning from deaths. As part of the improvement work around the serious incident process and learning from deaths, several training needs for staff Trust-wide have been identified. These include incident reporting, holding difficult conversations with bereaved relatives, duty of candour/culture of candour, report writing and writing smart action plans. These have been fed into the Trust-wide training needs analysis event. The Trust will be participating in patient safety training released as part of the National Patient Safety Strategy

Clinical Strategy

Learning from deaths during 2021/22 highlighted that patients with dual diagnoses were often not followed-up proactively by mental health services. This workstream will be picked up in the clinical strategy.

Patient Safety Specialist

The Trust's Patient Safety Specialist continues to attend the Patient Safety Specialist Improvement Programme Webinars, arranged by the National Patient Safety Team. These interactive forums connect over 700 Specialists from around the country. There is also the opportunity to discuss any issues relating to patient safety including learning from deaths on the Patient Safety Specialist's workspace both from a national and regional perspective.

The definitions used by the Trust are as follows:

- **Root Cause** - The prime reason(s) why an incident occurred: A root cause is a fundamental factor, an act or omission that had a direct effect on the incident occurring. Removal of these will either prevent or reduce the chances of a similar type of incident from happening in similar circumstances in the future**.**
- **Contributory Factor/Influencing Factor -** An act or omission that influences the likelihood of the incident occurring and hence contributed to the incident

PALS and Complaints

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.

The Trust's Policy and Procedure for the Management of Compliments, Comments, Concerns and Complaints outlines the Trust's approach to receiving valuable feedback and information from patients and their carers about the services provided by the Trust. When people raise concerns, they are given options by the Patient Advice and Liaison Service (PALS)/Complaints Team for taking their concerns forward. They may opt to have their concerns addressed by PALS staff liaising on their behalf with clinical staff or through meetings with the Clinicians.

People may also choose at any point to have their concerns registered under the NHS Complaints Regulations (2009) with a more formal investigation and a written response letter from the Chief Executive.

During 2021/22 PALS dealt with **2,279** concerns or issues from patients and carers, an increase of **152** when compared to 2020/21. **1,123 (49%)** of the concerns raised were around AMH services across the Trust.

1,800 of the PALS concerns (**79%**) were closed within 15 working days (although no formal target is set for this). Non-compliance was largely as a result of the Covid-19 pandemic where it has not always been possible to obtain timely feedback from operational services.

301 formal complaints were received and registered during 2021/22 compared to 265 for the same period last year.

Complaints across services: **196** in AMH services, **58** in CYPS, **17** in MHSOP, **22** in Secure Inpatient Services, **0** in Health and Justice, **2** in ALD services and **6** in Corporate Services.

The most common cause for complaints across the Trust related to aspects of clinical care (216 or 71.76%) followed by communication (36) and attitude (26). Complaints have also been received relating to discharge arrangements (8), environment (6), waiting times (4), medical records (2), Hotel Service (1) and Bereavement (1).

249 responses were sent out during 2021/22, **49** (**20%**) were within timescales (60 working days). Non-compliance was in respect of the complexity of the complaints being received and the Covid-19 pandemic. The number of complaints received and closed are published on the Trust's website.

The Trust continues to deliver specific training to support and empower a wide range of our staff to develop reasoned empathy emotional awareness and intelligence, compassion, and resilience to promote wellbeing and a just, caring culture. Learning is applied within the context of duty of candour, ensuring a person-centred approach to complaints, resilience, and leadership culture. The training is supporting our staff to understand vulnerability in themselves and others and prevent psychological harm. It does this in a thought-provoking, honest, and supportive learning environment. Learning the science and reality behind meaningful, empathic communication, as well as self-care and to build confidence in why empathy and emotional awareness is a key and important focus.

An example is the session of experimental learning; it not only identifies what empathy is, but enables those attending to 'feel' empathy, analyse, and understand it on a deeper level, and why it is so important within complaints. The session takes empathy out of the textbook and into real life as delegates go on a journey of empathy and emotional awareness and the importance of both these things when an incident occurs to support patients, loved ones and themselves.

Part 3: Further information on how we have performed in 2021/22

Introduction to Part 3

Part 3 of this document contains further information which the legal guidance requires us to include. This includes statutory statements. As with Part 2, this helps to develop an overall picture of quality at the Trust.

Mandatory Quality Indicators

Since 2012/13, all NHS Foundation Trusts have been required to report performance against a core set of indicators. Normally the Trust is required to present a mandatory statement and the data on NHS Digital for the most recent and the previous reporting period available. However, due to the ongoing Covid-19 pandemic, this mandatory collection was stood down by NHS Digital

Care Programme Approach 72-hour follow-up

327 people were not followed up within 72 hours during 2021/22. Given the unprecedented times, it has not been possible to gather the level of intelligence in terms of this area of underperformance that would normally be included within the report, as all efforts have been diverted to manage the Covid-19 situation and the need to ensure that the Trust's focus remains on this clinical priority.

Crisis Resolution Home Treatment team acted as gatekeeper

In March 2020, the national collection of this measure by NHS Digital was suspended due to the Covid-19 pandemic and the need to release capacity across the NHS to support the response. Subsequently, a consultation on the Quarterly Mental Health Community Teams Activity return opened and the outcome was published on 15th April 2021 announcing the decision to retire this collection. A replacement for this measure will not be introduced immediately; time will be taken to explore developing an alternative indicator(s) to help measure meaningful contact with Crisis Resolution & Home Treatment Teams before admission.

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

The figures we have included are from the CQC website

An overall Trust score is not provided, due to the nature of the survey, therefore it is not possible to compare trusts overall. For 2021, we have reported the Health and Social Care Workers section score which compiles the results from the questions used from the survey detailed below in the table.

TEWV Actual 2021	*National benchmarks in 2021*	*TEWV Actual 2020*	*TEWV Actual 2019*	*TEWV Actual 2018*
Overall section score: 7.3 (Sample size 282)	*Highest/Best MH Trust: 7.7* *Lowest/Worst MH Trust: 6.0*	Overall section score: 7.34 (Sample size 340)	Overall section score: 7.3 (Sample size 209)	Overall section score:7.3 (Sample size 209)

For more information, please see the section on results of the NHS Community Mental Health Survey on pages 29 to 31

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.

TEWV Actual Q3 21/22	*National Benchmark in Q1 & Q2 21/22*	*TEWV Actual Q1 & Q2 21/22*	*TEWV Actual Q3 20/21*
Trust reported to NRLS: 4,297 incidents reported of which 29 (0.7%) resulted in severe harm or death* *7 Severe Harm and 22 Death	*Not available*	Trust reported to NRLS: 6,215 incidents reported of which 84 (1.35%) resulted in severe harm or death* *25 Severe Harm and 59 Death	Trust reported to NRLS: 3,105 incidents reported of which 27 (0.9%) resulted in severe harm or death

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

- Although this may seem like a large number of total incidents, this is in line with expected numbers for a Trust with a caseload the size of TEWV; the absolute numbers of incidents reported is a factor of the relative size of the Trust and the complexity of their case-mix

- The Trust is reporting 56.2 as the rate of incidents (calculated by dividing the number of incidents reported by the number of occupied bed days); the national average is 75.4 (the highest reported rate was 235.8 and the lowest 21.4)
- Amongst the most common themes reported are self-harming behaviour, patient accident, disruptive/aggressive behaviour, and medication errors which account for three-quarters of all incidents leading to harm

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

- The Trust introduced incident reporting in September 2021 as a mandatory training requirement with all staff across the Trust. This has led to an increased focus on incident reporting with an increase of incidents being reported
- To support the training, additional tools have been developed to support those reporters of incidents ensuring data quality of the incidents being reported

Our performance against our quality metrics

The Quality Account 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 Report

Quality Metrics 21/22

Quality Metrics		2021/22		2020/21	2019/20	2018/19	2017/18
		Target	Actual	Actual	Actual	Actual	Actual
Patient Safety Metrics							
1	Percentage of patients reported 'yes always' to the question 'do you feel safe on the ward'?	88%	65.30%	67.54%	62.39%	61.50%	62.30%
2	Number of incidents of falls (level 3 and above) per 1000 occupied bed days (for inpatients)	0.35	0.07	0.18	0.15	0.18	0.12
3	Number of incidents of physical intervention/restraint per 1,000 occupied bed days	19.25	28.62	26.27	30.45	33.81	30.65
Clinical Effectiveness Measures							
4	Existing Percentage of patients on Care Program Approach who were followed up within 72 hours after discharge from psychiatric inpatient care	>80%	88.51%	N/A*	N/A*	N/A*	N/A*
5	Percentage of Quality Account audits of NICE guidance completed	100%	N/A**	100%	100%	100%	100%
6	Patients occupying a bed over 90 days	<61	60	N/A*	N/A*	N/A*	N/A*
Patient Experience Measures							
7	Percentage of patients who reported their overall experience as excellent or good	94%	94.34%	90.32%	91.65%	91.41%	90.50%
8	Percentage of patients that report that staff treated them with dignity and respect	94%	86.04%	84.59%	85.80%	85.70%	85.90%
9	Percentage of patients that would recommend our service to friends and family if they needed similar care or treatment	94%	87.76%	89.94%	86.70%	86.90%	87.20%

Notes on selected Metrics

1. Data for CPA 72-hour follow-up is taken from the Trust's patient systems and is aligned to the national definition
2. The percentage of Quality Account 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
3. Data for average length of stay is taken from the Trust's patient systems

Comments on areas of under-performance

Metric 1: Percentage of patients reported 'yes always' to the question 'do you feel safe on the ward'?

The end of **2021/22** position was **64.37%** which relates to **402** out of **625** surveyed. This is **23.63%** below the Trust target of **88.00%.** All localities underperformed this year. Durham & Darlington was closest to the target with 67.66% and Forensic Services was furthest away with 59.31%

When brief analysis has been undertaken of why patients do not feel safe in a ward environment, the most often cited cause has been due to the behaviour of other patients. It has also been noted that due to the acuity levels of patients who are admitted, they are likely to feel unsafe due to the fact that they are acutely unwell. As there is a persistent significant gap between our target and performance on this metric, improving safer care has been identified as a Quality Improvement priority for 2022/23 (see page **27**).

Metric 3: Number of incidents of physical intervention/restraint per 1,000 occupied bed days (OBDs)

The end of **2021/22** position was **28.62;** which relates to **234,555** interventions and **61156** OBDs; this is **9.37** worse than the Trust target of **19.25**

Durham & Darlington were the only locality achieving the target with a rate of 17.7. Of the underperforming localities, Teesside had the highest number of incidents per 1000 OBD with 34.39

A large proportion of restrictive intervention usage across the Trust occurs in a small number of wards and is more likely to occur with a small group of patients with complex needs. Severe forms of physical restraint i.e., prone (face-down) have significantly reduced in recent years.

The Trust continues to work towards the long-term reduction of all forms of restrictive intervention. A range of actions are in progress across the Trust via our Restrictive Intervention Reduction Plan.

Metric 8: Percentage of patients that report that staff treated them with dignity and respect

The end of **2021/22** position was **86.04%** which relates to **2997** out of **3484** surveyed. This is **7.96%** below the Trust target of **94.00%.**

All localities underperformed in 2021/22. Teesside were closest to the target with 87.98% and Forensic Services were furthest away from the target with 75.99%.

We continue to focus on this important area of patient experience; our patients tell us that treating people with dignity and respect includes staff treating people in a caring and compassionate way which will be strengthened by the work we are doing on our Trust values and empathy training for staff. It is also about involving people in

decisions around their care which will be supported by the ongoing quality priority around personalised care planning and our goal of co-creation. Having an environment that respects privacy and dignity is important and we are proud that we have eliminated all dormitory accommodation and all patient bedrooms are now single, many with ensuite facilities.

Metric 9: Percentage of patients that would recommend our service to friends and family if they needed similar care or treatment

The end of **2021/22** position was **87.76%** which relates to **3238** out of **3690** surveyed. This is **6.24%** below the Trust target of **94.00%.**

Whilst the Trust has not met its own target, we are pleased that the majority of our patients would recommend our services and we continue to focus on a range of improvement work focused on providing high quality and responsive services that provide a good patient experience. Examples are given throughout this report.

All localities underperformed in 2021/22. **Teesside** were closest to the target with **89.59%** and **Forensic Services** were furthest away from the target with **79.86%.**

Quality Metrics for 2022-23

The current set of quality metrics have been in place for several years, but changes in the national and local quality agendas now require a revised set of metrics to be monitored.

Work is underway to review the suite of metrics to align them more closely with our new quality journey and our improvement priorities.

Some of the current metrics will remain the same; however, we will analyse our data in a more sophisticated way, so that it can be identified where things are really improving or getting worse

Our Performance against the System Oversight Framework Targets and Indicators

A new System Oversight Framework (SOF) was released in June 2021, setting out NHS England and NHS Improvement's approach to the oversight of Integrated Care Systems, CCGs, and Trusts, with a focus on system-led delivery of care.

Indicators	2021/22	
	Threshold	Actual
Total access to IAPT Services: Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy	N/A	28295
IAPT: The proportion of people who are moving to recovery	50%	52.22%
3.A1: The proportion of people who wait 6 weeks or less from referral to accessing IAPT against the number of people who finish a course of treatment in the reporting period	75%	99.04%
3.A2: The proportion of people who wait 18 weeks or less from referral to accessing IAPT against the number of people who finish a course of treatment in the reporting period	95%	99.92%
3.B1: The proportion of people who wait six weeks or less from referral to their first IAPT treatment appointment against the number of people who enter treatment in the reporting period	N/A (supporting measure)	99.01%
3.B2: The proportion of people who wait 18 weeks or less from referral to their first IAPT treatment appointment against the number of people who enter treatment in the reporting period	N/A (supporting measure)	99.90%
3.C1: Number of ended referrals in the reporting period who received a course of treatment against the number of ended referrals in the reporting period who received a single treatment appointment	N/A (supporting measure)	1.80
3.C2: IAPT: Average number of treatment sessions	N/A (supporting measure)	7.94
3.C3: IAPT: The proportion of people who waited less than 28 days from their first treatment appointment to their second treatment appointment	N/A (supporting measure)	50.49%
3.C4: IAPT: The proportion of people who waited less than 90 days from their first treatment appointment to their second treatment appointment	N/A (supporting measure)	91.52%
Percentage of people who have waited more than 90 days between first and second appointments	<10%	8.48%
Implementation of IAPT – Long-Term Condition pathways	N/A (CCG ambition)	No
Number of CYP aged under 18 supported through NHS funded mental health with at least one contact	N/A (CCG ambition)	31,796
The proportion of CYP with ED (routine cases) that wait four weeks or less from referral to start of NICE-approved treatment (rolling 12 months)	95%	53.82%
The proportion of CYP with ED (urgent cases) that wait one week or less from referral to start of NICE-approved treatment (rolling 12 months)	95%	50.91%
Number of people accessing Individual Placement Support (IPS) services as a rolling total each quarter	N/A (CCG ambition)	674
Number of people who receive two or more contacts from NHS or NHS-commissioned community mental health services for adults and older adults with severe mental illnesses	N/A (CCG ambition)	269,446
13a: Number of inappropriate OAP bed days for adults by quarter that are either 'internal' or 'external' to the sending provider	0 by Q4	701
13b: Number of inappropriate OAP bed days for adults by quarter that are 'external' to the sending provider	0 by Q4	701
Percentage of people who are admitted to hospital without having had any prior contact with community mental health services	N/A (CCG ambition)	14.79%

Indicators	2021/22	
	Threshold	Actual
Percentage of adults discharged from CCG-commissioned mental health inpatient services receive a follow-up within 72 hours	80%	90.21%
Number of women accessing specialist community Perinatal Mental Health services in the reporting period (12-month rolling)	N/A (CCG ambition)	1126
Percentage of women accessing specialist community Perinatal Mental Health services in the reporting period (12-month rolling)	N/A (CCG ambition)	5.41%
Data Quality Maturity Index	90%	98.10%

Notes on the System Oversight Framework Targets and Indicators

IAPT: The Trust does not have as many people accessing IAPT Services as is our ambition. This continues to be impacted by staff sickness and vacancies within our services, and recruitment is ongoing in all areas. The Trust level IAPT recovery is a positive position with the standard being achieved consistently.

OAP: The Trust continuing to see an increase in the number of patients that are being placed in external beds. Whilst this is a national issue due to current demand levels, the Trust remains concerned and are committed to eliminating out of area placements by Quarter 3 2022/23.

Eating Disorders: The Trust is concerned that Children and Young People with an eating disorder are not being treated in a timely manner. Whilst this is a pressure in terms of demand that is being experienced nationally, this has been greatly impacted by vacancies within our services. Recruitment continues and work has been undertaken to increase the number of appointments.

IPS: Whilst the Trust has not achieved the ambitions set nationally for each individual CCG, work has been undertaken with partners to develop a set of local trajectories for these measures as part of the 2022/23 operational planning round for mental health services. These have been submitted to NHS England and NHS Improvement for approval.

Perinatal Mental Health Services: Whilst the Trust has not achieved the ambitions set nationally for each individual CCG, work has been undertaken with partners to develop a set of local trajectories for these measures as part of the 2022/23 operational planning round for mental health services. These have been submitted to NHS England and NHS Improvement for approval.

General: Our sickness levels continue to be higher than we aspire to in all localities and whilst all sickness is managed in line with Trust policy and is closely monitored within operational services, this is impacting on the delivery of some of our services.

External Audit

Due to the COVID-19 pandemic, the external audit of the 2021/22 Quality Account was stood down.

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. Due to the Covid-19 pandemic we have been unable to hold our usual Stakeholder engagement events; however, we have sought views from our Stakeholders, service users, carers, and staff through a variety of other means throughout the year, including Our Big Conversation. We have used this feedback when formulating our priorities and actions for 2022/23.

In line with national guidance, we have circulated our draft Quality Account for 2021/22 to the following stakeholders:

- NHS England
- North East Commissioning Support
- Clinical Commissioning Groups (County Durham, Tees Valley, North Yorkshire, Vale of York)
- Local Authority Overview & Scrutiny Committees (x9 inc. Tees Valley Joint Committee)
- Local Authority Health & Wellbeing Boards (x7)
- Local Healthwatch Organisations (x8)

All the comments we have received from our stakeholders are included verbatim in **Appendix 4.**

Analysis of the letters received shows widespread support and no opposition to the 3 proposed improvement priorities. There are also some positive comments about the clarity / transparency of the Quality Account, O*ur Journey to Change,* our commitment to working in partnership, progress made in addressing CQC recommendations, and local service developments such as the mental health support teams that work with schools.

However, some of our stakeholders were concerned about the continued worse than target rate of restraints per occupied bed day. There were also concerns about waiting times for CYP services, and the lack of progress in implementing improved care planning arrangements. Some stakeholders considered that the document is too focussed on inpatients and has insufficient data and commentary on community services. Both of our Durham local authority stakeholder letters expressed concerns about CYP to adult transitions.

The Trust will write to each stakeholder addressing each comment made following publication of the Quality Account 2021/22 and use the feedback as part of the annual lessons learnt exercise in preparation for the Quality Account 2022/23.

APPENDICES

Appendix 1: 2021/22 Statement of Director's Responsibilities in respect of the Quality Account

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) 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/Reports (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/Report.

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

- The content of the Quality Account/Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2021/22 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 2021 to May 2022
    - Papers relating to quality reported to the Board over the period April 2021 to May 2022
    - Feedback from the Commissioners dated 14 and 15/6/22
    - Feedback from local Healthwatch organisations dated 6/6/22
    - Feedback from Overview and Scrutiny Committees dated 8/6/22, 9/6/22 and 13/6/22
    - Feedback from Health and Wellbeing Boards dated 9/6/22
    - The Trust's complaints information reported to its Quality Assurance Committee of the Board of Directors, which will be published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
    - The latest national patient survey published 3rd December 2021
    - The latest national staff survey published 11th March 2022
    - CQC inspection report dated 27th August 2021 and 10th December 2021

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

- The performance information reported in the Quality Account/Report is reliable and accurate

- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account/Report, and these controls are subject to review to confirm that they are working effectively in practice

- The data underpinning the measures of performance reported in the Quality Account 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 Account 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/Report

By order of the Board:

16th June 2021……. Paul Murphy (Interim Chairman)

16th June 2021 ……Brent Kilmurray (Chief Executive)

Appendix 2: Glossary

Adult Mental Health (AMH) Services: Services provided for people aged between 18 and 64 – known in some other parts of the country as 'working-age services. These services include 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 have Early Onset Dementia. Early Intervention in Psychosis (EIP) teams may treat patients less than 18 years of age as well as patients aged 18-64

Audit: An official inspection of records; this can be conducted either by an independent body or an internal audit department

Autism: This describes a range of conditions typically characterised by social deficits, communication difficulties, stereotyped or repetitive behaviours and interests, and in some cases cognitive delays. People with autism are sometimes known as "neuro-diverse". Autism cannot be "cured", but the mental illnesses which are more common for people with autism can be treated.

Board/Board of Directors: The Trust is run by a 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 in manages. It is overseen by a Council of Governors and monitored by NHS Improvement. It also:

- Ensure effective dialogue between the Trust and the communities it serves
- Monitors and ensures high quality services
- Is responsible for the Trust's financial viability
- Appoints and appraises the Trust's executive management team

Business Plan: A document produced once a year by the Trust to outline what we intend to do over the next three years in relation to the services that we provide

Child and Adolescent Mental Health Services (CAMHS): See Children and Young People's Services (CYPS)

Care Planning: See Care Programme Approach (CPA)

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

Care Quality Commission (CQC): The independent regulator of health and social care in England. They 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's Services (CYPS): Mental Health Services for children and young people under the age of 18 years old. This includes community mental health services, inpatient services and learning disability services

Cito: An information technology system which overlays the Trust's patient record system (PARIS) which makes it easier to record and view the patient's records

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 GP practices 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 Supervision: a supportive mechanism which involves clinicians meeting regularly to reflect on practice, with the intention of learning, developing practice and providing high quality, safe care to patients

Commissioners: The organisations that have responsibility for purchasing health services on behalf of the population in the area they work for

Commissioning for Quality and Innovation (CQUIN): A payment framework where a proportion of NHS providers' income is conditional on quality and innovation

Community Mental Health Survey: a survey conducted every year by the CQC. It represents the experiences of people who have received specialist care or treatment for a mental health condition in 55 NHS Trusts in England over a specific period during the year

Confidential Inquiry: A national scheme that interviews clinicians anonymously to find out ways of improving care by gathering information about factors which 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/Co-creation: This is an approach where a policy or other initiative/action is designed jointly between TEWV staff and service users, carers, and families

Council of Governors: Made up of elected public and staff members and 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

Crisis Resolution & Home Treatment (CRHT) Team: Provide intensive support at home for individuals experiencing an acute mental health crisis. They aim to reduce both the number and length of hospital admissions and to ease the pressure on inpatient units

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 and Security Toolkit: 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

Data Quality Strategy: A TEWV strategy which sets out clear direction and outlines what the Trust expects from its staff to work towards our vision of providing excellent quality data. It helps TEWV continue to improve the quality and value of our work, whilst making sure that it remains clinically and financially sustainable

Department of Health: The government department responsible for Health Policy

DIALOG: A clinical tool that allows for assessment, planning, intervention, and evaluation in one procedure and allows more personalised Care Planning

Forensic Adult and 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 a prison or court, where their needs can be assessed and treated

Formulation: When 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 to Speak Up Guardian: Provides guidance and support to staff to enable them to speak up safely within their own workplace

Friends and Family Test (FFT): A survey put to service users, carers and staff that asks whether or not they would recommend a hospital/community service to a friend or family member if they need treatment

Gatekeeper/Gatekeeping: Assessing the service user before admission to hospital to consider whether there are alternatives to admission and the involvement in the decision-making processes that result in admission

General Medical Practice Code: The organisation code of the GP Practice that the patient is registered with. This is used to make sure a patient's GP code is recorded correctly

Guardian of Safe Working: Provides assurance that rotas and working conditions are safe for doctors and patients

Harm Minimisation: Our way of working to minimise the risks of sometimes multiple and conflicting harm to both service users and other people

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 (i.e., Local Authorities and the NHS) would work together to improve the health and wellbeing of their local population and to 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

HealthWatch: Local bodies made up of individuals and community groups, such as faith groups and resident's organisations 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

Home Treatment Accreditation Scheme (HTAS): Works with teams to assure and improve the quality of crisis resolution and home treatment services for people with acute mental illness and their carers

Hospital Episode Statistics (HES): 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

Improving Access to Psychological Therapies (IAPT): An NHS initiative to increase the provision of evidence-based treatments for common mental health conditions such as depression and anxiety by primary care organisations

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

Intranet: This is the Trust's internal website used for staff to access relevant information about the organisation, such as Trustwide policies and procedures

Learning Disability Services: Services for people with a learning disability and/or mental health needs. TEWV has an Adult Learning Disability (ALD) service in each of its three localities and also has specific wards for Forensic LD patients. TEWV provides Child LD services in Durham, Darlington, Teesside, and York but not in North Yorkshire

LeDeR: The learning from deaths of people with a Learning Disability (LeDeR) programme was set up as a service improvement programme to look at why people are dying and what we can do to change services locally and nationally to improve the health of people with a Learning Disability and reduce health inequalities

Local Authority Overview and Scrutiny Committee: 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 focusses on Health, although Darlington, Middlesbrough, Stockton, Hartlepool and Redcar and Cleveland councils have a joint Tees Valley Health OSC that performs this function

Mental Health Act (1983): 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 in 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 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 with a mental health problem. They can be treated for 'functional' illness, such as depression, psychosis, or anxiety, or for 'organic' mental illness (conditions usually associated with memory loss and cognitive impairment) such as dementia. The MHSOP Service sometimes treats people less than 65 years of age with organic conditions such as early-onset dementia

Mortality Review Process: A Trust process to review deaths, ensuring a consistent and coordinated approach, and promoting the identification of improvements and the sharing of learning

Multi-Disciplinary: This means that more than one type of professional is involved, for example, psychiatrists, psychologists, occupational therapists, behavioural therapists, nurses, pharmacists all working together in a Multi-Disciplinary Team (MDT)

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 to 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 the patients and the public

National Reporting and Learning System (NRLS): 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

NHS England (NHSE): leads the National Health Service in England

NHS Improvement (NHSI): The independent economic regulator for NHS Foundation Trusts – previously known as Monitor. This will be abolished if the current Health and Care Bill is passed by parliament, and its functions have already been subsumed into NHS England.

NHS Long-Term Plan (2019): A new plan for the NHS to improve the quality of patient care and health outcomes. It sets out how the £20.5 billion budget settlement

for the NHS, announced by the Prime Minister in summer 2018, will be spent over the next five years

NHS Staff Survey: Annual survey of staff experience of working within NHS Trusts

Non-Executive Directors (NEDs): Members of the Trust Board who act as a 'critical friend' to hold the Board to account by challenging its decisions and outcomes to ensure they act in the best interests of patients and the public

North Cumbria and North East Integrated Care System: Consists of four Integrated Care Partnerships – North, South, East, and West (see Integrated Care Partnerships)

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

Patient Advice and Liaison Service (PALS): A service within the Trust that offers confidential advice, support, and information on health-related matters. They provide a point of contact for patients, their families, and their carers

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

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

Programme: A coordinated group of projects and/or change management activities designed to achieve outputs and/or changes that will benefit the organisation

Project: A one-off, time limited piece of work that produces a product (such as a new building, a change in service or a new strategy/policy) that will bring benefits to relevant stakeholders. Within 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

Psychiatric Intensive Care Unit (PICU): A unit (or ward) that is designed to look after people who cannot be managed on an open (unlocked) psychiatric ward due to the level of risk they pose to themselves or others

Quality Account: A report about the quality of services provided by an NHS Healthcare Provider, the report is 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 and Assurance

Quarter One/Quarter Two/Quarter Three/Quarter Four: Specific time points within the financial year (1st April to 31st March). Quarter One is from April to June, Quarter Two is from July to September, Quarter Three is October to December and Quarter Four is January to March

Reasonable Adjustments: A change or adjustment unique to a person's needs that will support them in their daily lives, e.g., at work, attending medical appointments, etc.

Research Ethics Committee: An independent committee of the Health Research Authority, whose task it is to consider the ethics of proposed research projects which will involve human participants, and which will take place, generally, within the NHS

Royal College of Psychiatrists: The professional body responsible for education and training, and setting and raising standards in psychiatry

Safeguarding: Protecting vulnerable adults or children from abuse or neglect, including ensuring such people are supported to get good access to healthcare and stay well

Secondary Uses Service: The single, comprehensive repository for healthcare data in England which enables a range of reporting and analysis to support the NHS in the delivery of healthcare services

Section 29a Notice: This is a warning notice served by the CQC where concerns are identified across either the whole or part of an NHS Trust and where it is decided that there is a need for significant improvements in the quality of healthcare

Senior Leadership Group (SLG): Individuals at the senior level of management within the organisation (e.g., Directors) who meet on a regular basis. They are responsible for the overall management of TEWV and the high-level decisions within the organisation

Serious Incident (SI): An incident that occurred in relation to NHS-funded services and care, to either 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 delivery of services, absconding from secure care

Single Oversight Framework: sets out how NHS Trusts and NHS Foundation Trusts are overseen

Staff Friends and Family Test: A feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. It helps the Trust to identify what is working well, what can be improved and how

Statistical Process Control (SPC) charts: a graph used to show how a process changes over time and to see whether a situation is improving or deteriorating,

whether the system is likely to be capable to meet the standard and whether the process is reliable or variable

Steering Group: Made up of experts who oversee key pieces of work to ensure that protocol is followed and provide advice/troubleshoot where necessary

Strategic Framework: primarily intended as a framework for thinking about the future and a guide to inform the investment and disinvestment decisions by those tasked with future planning

Substance Misuse Services: Clinical services who work with people who abuse alcohol, illegal drugs or over the counter or prescription medications in a way that they are not meant to be used

TEWV: Tees, Esk and Wear Valleys NHS Foundation Trust

Thematic Review: A piece of work to identify and evaluate Trustwide practice in relation to a particular theme. This may be to identify where there are problems/concerns or to identify areas of best practice that could be shared Trust-wide

The Trust: see TEWV above

Trust Board: See Board/Board of Directors above

Trustwide: The whole geographical area served by the Trust's localities

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

Urgent Care Services: Crisis, Acute Liaison and Street Triage services across the Trust

Whistleblowing: this is a term used when a worker highlights a concern about their organisation and/or services to the Freedom to Speak Up Guardian or NHS Regulators. This will normally be regarding something they have witnessed at work

Year (e.g., 2022/23): These are financial years, which start on the 1st of April in the first year and end on the 31st of March in the second year

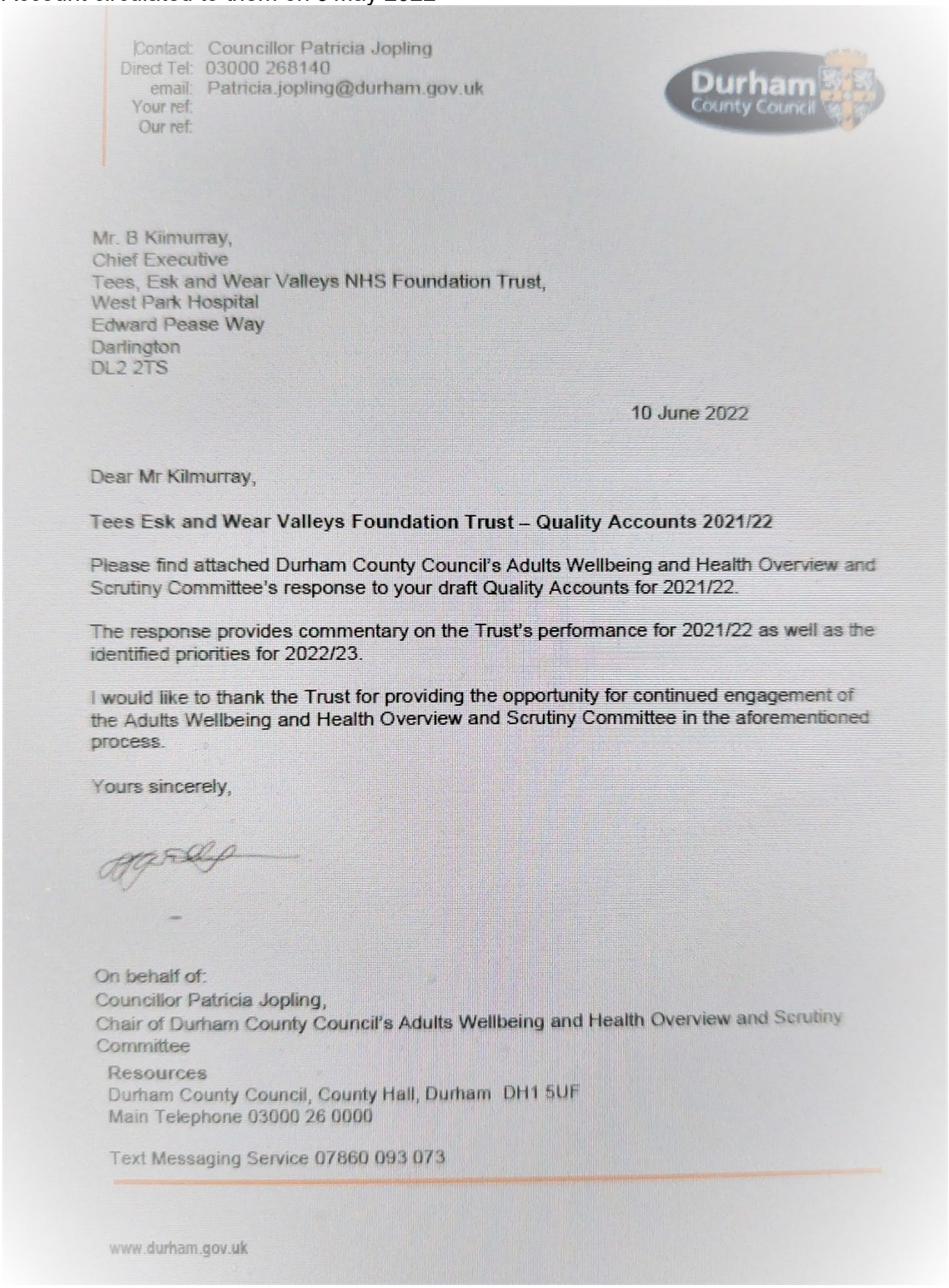
Appendix 3: Key themes from action plans produced in response to 130 Local Clinical Audits in 2021/22

Audit Theme	Key quality improvement activities associated with clinical audit outcomes
1. Infection prevention and control	• All infection prevention and control (IPC) audits are continuously monitored by the IPC Team and any required actions are rectified collaboratively by the IPC team and ward staff. Assurance of implementation of actions is monitored using the Clinical Audit and Effectiveness Team via the clinical audit action monitoring database • A total of 76 IPC clinical audits were conducted during 2021/22 in inpatient areas, prison teams, and community teams where there is a clinic. 74% (56/76) of clinical areas achieved standards between 90-100% compliance. Local clinical audit plans were implemented in collaboration with the IPC Team and the clinical team members to mitigate any areas of non-compliance
2. Medicines Management	• The Pharmacy Team has a central mechanism to scrutinise quarterly controlled drugs (CD) audit data as it comes in. Where audits show any areas for improvement, the CD accountable officer will contact the ward manager • The Pharmacy Team will explore the feasibility of introducing electronic controlled drugs registers • A valproate initiation and monitoring chart will be developed to prompt staff to record indication/target symptoms for valproate treatment, discussions around off-label prescribing, baseline and ongoing physical health monitoring for people prescribed valproate for bipolar disorder • The Pharmacy Team will develop a valproate Pregnancy Prevention Programme (PPP) register to help teams give relevant guidance and track timely Annual Risk Acknowledgement Form (ARAF) completion • The Pharmacy Team will review all identified instances of women under 55 years of age being prescribed valproate without an ARAF in their clinical record • Following the National Clinical Audit of Psychosis (NCAP) audit, cases where patients with first episode psychosis had not been offered clozapine (after failed trials of two antipsychotics) were reviewed. This included exploration of barriers for patients commencing clozapine medication • A request will be submitted for a change to the new electronic record system to support prescribers in offering clozapine and documenting the offer to patients • A flowchart will be developed to enhance staff knowledge around offering clozapine to patients • Wards with a medicines omission rate >0.5% have implemented a ‘second checker’ process to ensure that no doses of medication are omitted unintentionally • Amendments and additions will be made to the Clozapine Initiation Checklist and Annual Review Checklist • The Pharmacy Team will develop and implement a sub-process for adding clozapine to the GP record if this is not present at the clinical check of 6-month prescriptions

Audit Theme	Key quality improvement activities associated with clinical audit outcomes
3. Safeguarding	• Safeguarding Adults Procedure audit findings were fed into the Datix task and finish group to improve reporting • Updated guidance on how to raise and complete a safeguarding concern on PARIS was shared via a Staff Briefing and also shared with staff when disseminating the audit findings • Safeguarding duty workers were reminded to follow standard processes to support safeguarding adult referrals • Safeguarding supervision details were updated within the Trust's Clinical Supervision Policy • An action briefing has been developed to be shared with staff. This reminds practitioners of their responsibility to ensure that service users' wishes, and feelings are part of the safeguarding process and are recorded • Regular reminders of the Safeguarding process will be incorporated within the Safeguarding Team's briefing • The Safeguarding Team will review a sample of records every three months to monitor compliance with the Safeguarding processes • The Safeguarding Adults Flow Chart, PARIS briefing, and eLearning package has been promoted via a Staff Briefing and the Safeguarding Link Professionals • The Safeguarding Adults intranet page will be updated to include links to PARIS briefings and eLearning packages to increase ease of access for practitioners • A briefing will be produced specifying the requirements of the Safeguarding Children Policy and this will be shared with Community Modern Matrons. A review will be undertaken with the Community Modern Matrons and learning from this will be shared focusing on the positive practice observed as well as implementing improvements to sustain high quality practice standards
4. Risk assessment and CPA	• Assessment packs will be developed for the Health and Justice service to include useful guidance in relation to the Care Programme Approach (CPA), neurodevelopmental assessments prompts, a trauma leaflet, and a leaflet about the team • Outcomes measures training will be provided to all Health and Justice Teams and a recording system will be developed for all screening tools • All Age Liaison and Diversion Teams will be developing aide memoire cards for staff and updating the visual control boards in order to improve recording of assessment and consent documentation
5. Physical Health	• The Trust-wide Physical Health Group will be reviewed and recommenced in order to provide further support to improve assessment and recording of relevant physical health activities. This will be chaired by a Clinical Director • Staff will be reminded to ensure that when physical health measures are unable to be obtained due to patients declining these, this must be recorded within the electronic patient record • The Tissue Viability and Physical Health Specialist Nurse in collaboration with Ward Managers will produce a flowchart which shows the agreed process for ensuring that all patients have a Waterlow Pressure Ulcer Risk Assessment completed and updated, along with documented evidence of interventions for those identified with a pressure ulcer (in line with the Assessment, Prevention and Management of Pressure Ulcers Procedure)

Appendix 4: Feedback from our Stakeholders

This Appendix contains letters received from our Stakeholders in response to the draft Quality Account circulated to them on 9 May 2022



Contact: Councillor Patricia Jopling
Direct Tel: 03000 268140
email: Patricia.jopling@durham.gov.uk
Your ref:
Our ref:

Durham County Council

Mr. B Kilmurray,
Chief Executive
Tees, Esk and Wear Valleys NHS Foundation Trust,
West Park Hospital
Edward Pease Way
Darlington
DL2 2TS

10 June 2022

Dear Mr Kilmurray,

Tees Esk and Wear Valleys Foundation Trust – Quality Accounts 2021/22

Please find attached Durham County Council's Adults Wellbeing and Health Overview and Scrutiny Committee's response to your draft Quality Accounts for 2021/22.

The response provides commentary on the Trust's performance for 2021/22 as well as the identified priorities for 2022/23.

I would like to thank the Trust for providing the opportunity for continued engagement of the Adults Wellbeing and Health Overview and Scrutiny Committee in the aforementioned process.

Yours sincerely,

On behalf of:
Councillor Patricia Jopling,
Chair of Durham County Council's Adults Wellbeing and Health Overview and Scrutiny Committee

Resources
Durham County Council, County Hall, Durham DH1 5UF
Main Telephone 03000 26 0000

Text Messaging Service 07860 093 073

www.durham.gov.uk

DURHAM COUNTY COUNCIL ADULTS WELLBEING AND HEALTH OVERVIEW AND SCRUTINY COMMITTEE

COMMENTS ON TEES ESK AND WEAR VALLEYS NHS FOUNDATION TRUST QUALITY ACCOUNT FOR 2021/22

The Adults Wellbeing and Health Overview and Scrutiny Committee welcomes Tees, Esk and Wear Valleys (TEWV) NHS Foundation Trust's draft Quality Account 2021/22 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.

Members have continued to engage with the Trust in respect of the specific impact of the COVID-19 pandemic on the services provided by TEWV particularly regarding the time for referral into services as well as accessing initial and follow up treatments. Additional engagement with the Trust has taken place in respect of the Trust's 2021/22 business plan; Care Quality Commission inspection results and associated improvement action plans; adult mental health rehabilitation and recovery services for County Durham and Darlington provided at Primrose Lodge, Chester-le-Street together with stakeholder engagement feedback.

The Committee considers that the Quality Account is clearly set out and that progress made against 2021/22 priorities is clearly identified. Whilst the Committee expressed concerns at the number of quality metrics that are below target, they noted that the identified targets were stretch targets within the Quality Account. In examining the Trust performance across these metrics the Committee were also concerned at the incidents of physical restraint within County Durham. Whilst it is acknowledged that these related to a small number of acutely unwell patients at Lanchester Road hospital who have extremely complex needs, the Committee would welcome information on how the trust will improve performance in this area.

It is noted that the Trust has identified below target performance in a number of areas due to the ongoing impact of the COVID 19 pandemic specifically in respect of the Trust's ability to reinstate face to face patient consultations and engagement together with the redeployment of frontline staff to deal with infection prevention and support the COVID-19 vaccination programme. During consideration of the Quality Account members raised a number of issues for which they would like a response from the Trust. These include:-

- Measures to improve the performance of the Trust in ensuring that patients are treat with dignity and respect;
- Members were informed that whilst resources within the Trust are split 50/50 between inpatient and community services, patient numbers receiving services from the Trust are split 10/90 between inpatient and community services respectively. In order for members to have more clarity in respect of this data, the Committee have requested that the Trust provides data for those patients receiving inpatient/community based services across key service areas including CAMHS, Adult Mental Health Services, Older Peoples Mental Health Services and Learning Disabilities/Autism;
- The Trust's plans to address previously reported concerns in respect of transitioning arrangements for service users from CAMHS to Adult Mental Health Services;
- Confirmation of how the Trust will improve performance in terms of the time taken from initial referral into services to subsequent treatment particularly in respect of CAMHS;
- Whilst members noted the value of services being accessible remotely such as the talking changes service, they feel that these are not appropriate for everyone and that face to face appointments should be offered to patients where necessary. The Committee would welcome information on how the availability of face to face appointments is to be increased.

Members remain concerned about the impact of the current COVID-19 pandemic on mental health within the community, which is likely to result in a further increase in demand upon mental health services and therefore are keen to learn from TEWV as to how they are working with partners across the health and social care system to ensure that service users continue to be supported. In respect of the proposed Quality Account priorities for 2022/23, the Committee supports them and the associated actions.

Members agree with the importance of continued investment in mental health services and welcome the work being undertaken by TEWV in association with local authorities and NHS County Durham CCG and the continued investment in mental health services, particularly in terms of counselling services. The Committee also support the engagement of the community and voluntary sector organisations to deliver mental health support and advice services, whilst acknowledging that this will require resource investment.

Finally, in order to ensure that it continues to provide a robust health scrutiny function and to provide assurances in this respect to the residents of County Durham, the Committee would request a progress report on delivery of 2022/23 priorities and performance targets.

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

Chris Lanigan
Tees, Esk and Wear Valleys NHS Foundation Trust
Tarncroft
Lanchester Road
Durham
DH1 5RD

BY EMAIL chris.lanigan@nhs.net

9 June 2022

Dear Chris

Re: Tees, Esk & Wear Valleys NHS Foundation Trust Quality Account 2021-22

Thank you for the opportunity to comment on the Tees, Esk and Wear Valleys NHS Foundation Trust Quality Account 2021-22. The County Durham Health and Wellbeing Board appreciate this transparency and have taken account of the impact of Covid-19 on the Quality Accounts, as well as the delays and changes brought about by this and as such would like to provide the following comments on the document.

The Health and Wellbeing Board note the changes to TEWVs governance arrangements from 1 April 2022, to enable well governed clinical care to be provided across the system and acknowledge that this will support the 'journey to change' as outlined in the quality account. We look forward to seeing how these changes impact on service delivery.

It is noted in the 2020-21 Quality Account, that the Care Quality Commission (CQC) inspection rated acute wards for Adults and Psychiatric Intensive Care Units as 'inadequate' for both 'safe' and 'well-led'. The HWB are pleased to read that significant achievements have taken place in implementing CQC Action Plan, and that improvements have been demonstrated in the subsequent inspections.

It is also noted that, following further CQC inspections, the Trusts overall rating remained at 'requires improvement', but the CQC acknowledge that the Trust have embarked on a significant governance and organisational change programme which should enable the required service improvements to be achieved.

We acknowledge performance against the following priority areas of improvement for 2021-22 and wish to provide feedback against these:

Priority 1: Making care planning more personal
Priority 2: Safer care
Priority 3: Compassionate care

We also note the areas of focus for 2022-23 as follows, noting that these are based on continuous engagement with service users, carers and stakeholders, rather than one-off engagement events:

Priority 1: Care Planning
Priority 2: Feeling Safe
Priority 3: Implementation of the new Patient Safety Incident Reporting Framework

It is important that the Quality Account aligns, where appropriate to the County Durham Joint Health and Wellbeing Strategy 2021-25 and the County Durham Place Based Commissioning Plan which have been agreed through the County Durham Health and Wellbeing Board.

The Health and Wellbeing Board adopts a life course approach to its priorities, recognising the importance of mental health, wellbeing and the social determinants of health cutting across our priorities. The three TEWV priorities for improvement align with our three strategic priorities of Starting Well, Living Well and Ageing Well.

As outlined in last year's Quality Account response, as part the development of the Joint Health and Wellbeing Strategy 2021-25 we worked with young people through Investing in Children and Durham Youth Council to gather their views. Young People agreed that mental health should be a priority, especially given the impact of the pandemic as it has been difficult throughout the pandemic for young people to maintain routines and enjoy aspects of normal life. Young people will be consulted during 2022/23 as part of the JHWS refresh.

Positive partnership working in County Durham is evidenced through a number of different partnership boards including the Mental Health Strategic Partnership Board, Children, Young People and Families Partnership Board and the Resilient Communities Group and is a key priority across the integrated health and care system, now and in future arrangements. The Board would have liked to see greater reference to partnership working and integration in delivering responsive care and support.

Whilst it is acknowledged that this is not included as a specific priority for TEWV, the Board would welcome updates on transitions from child to adult services as these developments are integral to the overall integration work for County Durham.

Making care plans more personal
The Board acknowledge that Covid has had a significant impact on this area during the last year and that, of the nine actions, only four have been completed, although it is noted that some of this work has been picked up in 'Cito', the new electronic patient record system which will go live in autumn, and some actions are awaiting further national guidance.

We acknowledge that service users are more likely to provide feedback should they have a negative experience, and it is noted that you have acknowledged this as an area to work on, but we would encourage you to gather feedback from service users across the whole service, ensuring a wider range of feedback and views are reflected.

We note the targets for 2021-22 were not met, and although some of the factors behind this are provided, the Board feels that it is important to continue to have aspirational targets for service users and their families. However, the importance of workforce development cannot be underestimated as it provides assurance that care planning will be meaningful and timely, undertaken by experienced staff to mitigate having to do this when an individual is in crisis or distress.

It is positive that the communications plan has been developed and that work has taken place to reduce/remove barriers to care planning.

Safer care
It is noted that this is a key priority for the Trust, and it's pleasing to see that of the 21 actions, only 4 are outstanding, one of which has been encompassed in the body cam pilot, and two rescheduled to 2022-23, and one not possible due to Covid-19 restrictions.

It is noted that the development of a plan for each ward/team has been rescheduled to 2022-23, and that due to Covid restrictions it was not possible to bring those with lived experience into wards to talk to patients – however the Board would like to know if the latter is still a consideration, as the benefits of hearing from those with lived experience is really valuable.

The Board are pleased with the 'mutual help' approach, as patients are more likely to be reciprocal to receiving help if they feel safe.

It is promising that technology is being used in care settings, and although Covid delayed implementation, that the body cameras are being rolled out and that feedback indicated these are a positive addition to ward environments.

The Board promotes the appropriate, and personalised use of modern technology to support patients, but caution must be taken not to exclude those who are not able or willing to access this.

We are pleased to see that two of the performance targets have been achieved and have noted the work taking place with the Patient Experience Teams and the feedback that will be gathered through patient reference groups.

Compassionate Care
The Board recognise your 'journey to change' ambition, which is supported by the delivery of compassionate care.

It is noted that the changes to governance only came into effect from 1 April 2022, and that some of these priority areas will be further developed and embedded during 2022-23.

We are pleased to see that there is commitment to compassionate care and that a service user leadership course, as well as a range of engagement events will be hosted annually to support this.

We are also pleased to see that you have adopted a 'co-create' approach to safe and personalised care, involving people with care needs and their carers' as equal partners. An approach that aligns well to the County Durham Approach to Wellbeing which the Health and Wellbeing Board has championed.

In relation to the performance indicators, 87.98 % of patents reported that they felt they were treated with dignity and respect. This falls short of the 94% target, but it is hoped that the new governance and ambition will see an increase in 2022-23.

It is noted that the TEWV's 2021 National NHS Staff Survey Results had an increased response on the previous year, a 50% response rate compared to a 38% in 2020, with improved results in:

- experience of physical violence reported
- not feeling pressure from manager to come to work when not feeling well enough
- not experiencing harassment, bullying or abuse from other colleagues or from managers
- experience of harassment/bullying/abuse reported

There were however, decreased results in the following, which is a concern:

- enough staff at organisation to do my job properly

- recommending the organisation as place to work
- being happy with standard of care provided by organisation if friend/relative needed treatment
- satisfied with extent organisation values my work
- coming to work when not feeling well enough to perform duties

Serious Incidents
In relation to serious incidents, 77 were reviewed and of these 45 were found to have lapses in care/service delivery, and the learning highlighted that patients with dual diagnoses were often not followed-up proactively by mental health services. The Board notes the structures which are/have been implemented in response to learning from these reviews and hope to see a reduction in serious incidents in 2022-23.

We are pleased to see that the quality accounts recognise areas of improvement as well as areas which have been improved, and the Board note the trust's achievements in 2021-22 and note that a range of external bodies have also recognised this work, resulting in a range or award entries, shortlists and wins.

We are particularly pleased to hear that the 'Wellbeing in Mind' service, which supports a 'whole school approach' now covers more areas in North Yorkshire and would welcome this in Durham to help raise awareness about the common problems young people experience and how to deal with them, help building resilience.

The Board welcome the Care Home Wellbeing service that was set up in Durham and Darlington to improve the wellbeing of care home residents and staff, and to support recovery from the impacts of the Covid-19 pandemic and look forward to hearing how this had developed.

The Board also support the STOPM campaign and receive regular updates on our approach to 'Transforming Care' across County Durham.

The County Durham Health and Wellbeing Board look forward to continuing to work with TEWV as an important partner to achieve our vision of being "a healthy place, where people live well for longer", and to support the place-based system.

We understand that TEWV have developed two lived experience director roles and would welcome conversations as to how their experience can be shared with and considered by the Board.

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

Yours sincerely

Councillor Paul Sexton
Chair of the County Durham Health and Wellbeing Board
Cabinet Portfolio Holder for Adult and Health Services

Tees, Esk and Wear Valleys NHS Foundation Trust – Quality Account 2021/2022

Members of the Health and Housing Scrutiny Committee welcomed the opportunity to consider the draft Quality Account 2021/2022 for Tees, Esk and Wear Valleys NHS Foundation Trust and had the following comments to make:

The Committee considers that the Quality Account is clearly set out and notes the progress made against the three priorities, 'Improve the personalisation of Care Planning', 'Safer Care' and 'Compassionate Care', acknowledging the reasons, both Covid and non-Covid, for delays in implementation for those actions that have not been achieved.

In relation to the Quality Metrics – Missed Targets, Members note that of nine Quality Metrics, five are reported as red at the end of Quarter 4 2022 for Durham and Darlington. Members received an explanation for those missed targets and the actions being taken by the Trust to address these.

Members remain concerned regarding the number of incidents of physical intervention/restraint per 1000 occupied bed days. Members also questioned the number of patients occupying a bed over 90 days and look forward to receiving details of how this metric is measured.

Members are also concerned regarding the metric 'Existing percentage of patients on Care Programme approach who were followed up within 72 hours after discharge from psychiatric inpatient care' and would like to receive further detailed information regarding the reasons for the underperformance for this metric in future.

The committee queried the impact of increased admissions during Covid-19 on demand on mental health services, noting the importance of building community resilience. Members welcomed details of work being undertaken by the Trust to improve community resilience and the prevention agenda.

Members welcome a review of the suite of metrics which is underway to align them more closely with the Trusts new quality journey and the improvement priorities.

In respect of the proposed quality account priorities for 2022/23, the committee supports the priorities 'Care Planning', 'Implementation of the new Patient Safety Incident Reporting Framework' and 'Feeling Safe' and the actions in place to deliver these priorities.

Overall, the Health and Housing Scrutiny Committee welcomes the opportunity to comment on the Trust's Quality Accounts and are pleased with the Trusts progress against the chosen priorities, in a particularly 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.

Tees Valley Joint Health Scrutiny Committee

The Joint Committee welcomed the opportunity to consider and comment on the Tees, Esk and Wear Valley NHS Foundation Trust Quality Account 2021/2022 and the Quality Improvement priorities for 2022/2023 at its meeting held on 8 June 2022.

The Committee met previously with Trust representatives to consider the Trust's quality improvement priorities and overall performance, and is grateful to representatives of the Trust for attending and discussing the key features of the 2021-22 Quality Account.

In relation to the Quality Metrics – Missed Targets, Members noted that of nine Quality Metrics, four were reported as red by the Trust at the end of Quarter 4 2021/2022. Members received an explanation for those missed targets and the actions being taken by the Trust to address these. Members also noted that the Trust deliberately set stretching targets and that whilst four metrics were reported as red, two were close to meeting their target.

The committee was particularly concerned at the high number of incidents of physical intervention/restraints per 1000 occupied bed days with 37.66 against the Trust target of 19.25, a decrease in performance when compared to the previous year. The committee was advised that the incidents relate to a small number of patients and were provided with details of the work programme that was in place to address this issue and were informed that this was a key workstream for the Trust.

Members also highlighted concern in relation to the long wait times for CAMHS. The Trust assured Members that a range of processes and systems were in place to monitor and address the waiting lists. We also noted the i-THRIVE framework, a whole system approach to meet the needs of the population and welcomed the 12 month training programme for Mental Health Support Teams in schools across Teesside. Members would appreciate regular updates on the waiting lists for CAMHS.

Members would like to see the inclusion of comparative data in future Quality Account update reports to this Joint Committee in order to provide context for Members.

Members would also like to receive regular briefings on various aspects reported on in the Quality Accounts at future meetings of the Joint Committee. Members felt that it would be helpful if 'spotlight sessions' could be prepared ahead of the meetings and these would focus on topic which could be identified at any given time based on the priorities/concerns at that given time.

Members welcomed a review of the suite of metrics which was underway to align them more closely with the Trusts new quality journey and the improvement priorities. Furthermore when preparing the presentation of the metrics, it would be useful to consider any 'information gaps' which would support the straightforward understanding of the metrics by Members.

The Committee noted the progress made against the three priorities, ‘Improve the personalisation of Care Planning’, ‘Safer Care’ and ‘Compassionate Care’, noting that 30 of the 46 actions for these priorities were achieved or on track at the end of 2021/22. We acknowledged the reasons, both Covid and non-Covid, for delays in implementation for those actions that have not been achieved.

In respect of the proposed quality account priorities for 2022/23, the committee supports the priorities ‘Care Planning’, ‘Implementation of the new Patient Safety Incident Reporting Framework’ and ‘Feeling Safe’ and the actions in place to deliver these priorities.
The Committee thanked the Trust for its continued engagement with the Committee and looks forward to continuing to receive updates on progress against the priorities during the year ahead.

County Councillor Andrew Lee (Chairman)
North Yorkshire Scrutiny of Health Committee
North Yorkshire County Council
County Hall, Northallerton

North Yorkshire, DL7 8AD
13 June 2022

Dr Chris Lanigan
Associate Director of Strategic Planning and Programmes
Planning, Commissioning, and Performance Directorate
Tees, Esk and Wear Valleys NHS FT
Tarncroft
Lanchester Road Hospital
Durham DH1 5RD

Dear Chris

Re: Quality Account for 2021/22

Thank you for your sending me a copy of the Trust's final draft Quality Account for 2021/22. In my capacity as Chairman of the North Yorkshire County Council Scrutiny of Health Committee, I have noted the Quality Account and the work being done by the Trust to achieve the highest standards of services across the large geography within which it operates and wish to make the following statement for inclusion in the Stakeholder response.

"The North Yorkshire County Council Scrutiny of Health Committee has been in regular contact with the Tees Esk and Wear Valleys NHS Foundation Trust for a number of years and has appreciated the open and constructive dialogue that has been maintained as mental health services in the county have gone through a significant number of changes. We continue to see a reduced emphasis upon in-patient treatment generally and subsequent investment in community services; the relocation of Children and Young People's Mental Health Services to new premises in Osbaldwick, the creation of resilience hubs in response to the Covid-19 pandemic providing support to the workforce across the area, a new community mental health hub in Northallerton and additional funding being received for the 'wellbeing in mind' service allowing support to young people in a further 27 educational establishments. The committee were particularly pleased with the efforts made by the Trust to enable the re-opening of the Esk ward at Cross Lane Hospital, Scarborough following a temporary closure due to staffing shortages. Additionally it's pleasing to see continued success with the Memory Service in Hambleton and Richmondshire maintaining its Memory Service National Accreditation Programme status for the 9th year.

The Foundation Trust has kept the committee fully informed of how it continues to adapt to new ways of working following the pandemic and the future plans and support in place in relation to the recovery from the impacts of the Covid-19 pandemic. It is recognised that it is still very early days in the recovery journey and this will be a long term objective.

Whilst recognising the huge amount of work that the Foundation Trust has done over the past year to support service users and staff and implement new ways of working, there have been some concerns raised by the Care Quality Commission following inspections in June 2021 and August 2021 namely around staffing, governance arrangements and systems for the monitoring of patients. It is recognised that these and other issues, around safeguarding for example, raise our concerns for the public and the services they access and that there is work still to be done in order to rectify this.

The committee has been kept informed of the reasons for the issues identified in the inspections and the plans that have been developed and implemented to respond to and rectify them both immediately, and more longer term, which has been appreciated. The committee will continue to monitor progress with the Trust's action plan for dealing with the CQC's concerns".

Councillor Andrew Lee
Chairman
North Yorkshire County Council Scrutiny of Health Committee

Contact:
Christine Phillipson
Principal Democratic Services and Scrutiny Officer
North Yorkshire County Council
County Hall, Northallerton, North Yorkshire, DL7 8AD
T: 01609 533887, E: christine.phillipson@northyorks.gov.uk

NHS
Vale of York
Clinical Commissioning Group

NHS Vale of York CCG
West Offices
Station Rise
York
YO1 6GA
Telephone: (01904) 555870

13th June 2022

Website: www.valeofyorkccg.nhs.uk

Dear Mr Kilmurray,
Re: Tees Esk and Wear Valleys NHS FT Quality Account 2021/22

Many thanks for the submission of the TEWV Quality Accounts. This details what the Trust has done to improve the quality of your services in 2021/22 and how you intend to make further improvements during 2022/23. NHS Vale of York CCG welcomes the opportunity to provide comments on this report.

Firstly, we would like to take this opportunity to thank all staff at Tees Esk and Wear Valleys NHS FT for their hard work and dedication during the ongoing pandemic and subsequent response to recovery.

We recognise the amount of progress that has been made following the CQC inspections in 2021 including the governance and organisation arrangements to provide a renewed focus upon ensuring safe high quality care for our patients and their families.

We welcome the engagement that TEWV has taken with families of patients who have ended their own lives, in order to learn from what has happened and how improvements can be made moving forward. We also wish to extend our condolences to these families and our gratitude for their feedback and involvement to help us make things better for other people.

We acknowledge the range of improvements the Trust has made during 2021. For the Vale of York population, we can clearly see the benefit in the following achievements shared in your report:

- Strengthened Freedom to Speak Up arrangements
- Risk assessments for children waiting to be seen and initiatives to 'keep in touch'
- Inclusion of young people and their families in the development of new facilities at Orca House, York
- Support to the Humber Coast and Vale Resilience hub to offer a wide range of emotional and wellbeing support to the health, care, and emergency services workforce and the Long Covid Support Program
- The support to young people in schools through the ‘Wellbeing in Mind’ initiative
- The focus upon ensuring services are developed in collaboration with and informed by people with lived experience

We would also like to pass on our congratulations to the individuals and teams who have both won or been shortlisted for national awards as this demonstrates their commitment to initiatives for improving patient care.

The Trust set out to focus upon three overarching priorities in 2021/22. We appreciate that due to the ongoing impact of the pandemic varying levels of progress have been made against these priorities. Our comments are focussed mainly upon these key priorities

- **Making Care Plans more personal** – This is a priority that has continued since 2020. We can see the progress being made and positive to see the patient feedback and agree there needs to be continued focus upon ensuring patients are involved as much as they want to be in their care.
- **Safer Care** – We recognise the progress which has been made through the overarching strategy of 'Our Journey to Safer care' and the continued workstreams to take forward into 2022/23.
- **Compassionate Care** – We welcome the work to ensure compassion underpins all interactions with patients. We particular welcome the activities of engagement with both staff and service users to co create improvement opportunities.

Quality Priorities for 2022/23
It is evident that aspects of the above priorities need to be continued. We welcome and support the Trust's identified Quality Improvement Priorities for 2022/23 of:-

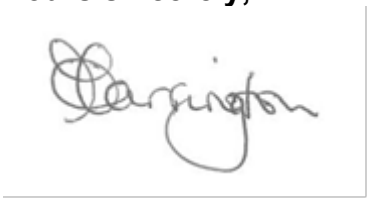
- Care Planning
- Feeling safe
- Implementation of the new Patient Safety Incident Reporting Framework

We recognise the sustained impact that the pandemic has continued to place upon all healthcare services and are pleased that the Trust has continued to work towards its improvement journey despite this. We understand that you are committed to your priorities for 2022/23 and commend your continued focus on patient quality and safety.

Never before has it been more important to work collaboratively with system partners to achieve improvements in patient pathways and outcomes as we address the consequences of the pandemic and continued recovery. As we transition into the Integrated Care System, we as commissioners remain committed to working collaboratively with the Trust and its regulators to improve the quality and safety of services available for our population.

I can confirm that NHS Vale of York CCG are satisfied with the accuracy of this Quality Account and consider it to be a fair reflection of the Trust's performance and acknowledges the progress made to improve patient safety and experience despite the challenges brought about by the ongoing pandemic. The key successes and challenges are reflected in the Quality Account.

Yours sincerely,



Michelle Carrington
Executive Director Quality and Nursing
NHS Vale of York Clinical Commissioning Group

Healthwatch Middlesbrough and RedcarHealthwatch Redcar and Cleveland
The Live Well Centre
Dundas Shopping Centre
Dundas Street
Middlesbrough
TS1 1HR
Tel: 0800 118 1691
Text only: 07451 288789
Email: healthwatchsouthtees@pcp.uk.net
www.healthwatchmiddlesbrough.co.uk
www.healthwatchredcarandcleveland.co.uk

Dear Laura,

Healthwatch South Tees response to TEWV Quality Account 2021-2022

Healthwatch South Tees (HWST) comments:

Healthwatch South Tees is pleased to have the opportunity to again comment on the TEWV quality account which, for the most part, reflects the high standards of care the area has grown to expect from this particular healthcare institution. None-the-less, we would make the following comments, given below:

Priority One: Making Care Plans more personal

Review and update care planning training to include a co-created and co-delivered explanation of the legal requirements set out by the Human Rights Act. In a document concerned with quality of service

- Why should the government's proposal to abolish the human rights act make a difference? Surely this remains an important aspect of quality of care and, the government has stated its intention to replace the act with similar legislation.

Work with teams and commissioners to ensure sufficient capacity is built into clinic scheduling to properly co-create and develop care plans.

- If TEWV planned to do this during 2021/22, what are the reasons for not doing so?

Patients were involved as much as they wanted to be in terms of what care they received.

- HWST looks forward to seeing improvements in the proportions of patients involved as much as they want to be in the care that they received, in line with the TEWV target.

Priority Two: Safer Care

Develop a plan for each ward/team identified as a priority, with involvement from clinical staff, management and service users and deliver actions throughout the year.

- TEWV should be explicit as to why this had to be re-scheduled to 2022-23.

Percentage of inpatients who report feeling safe on our wards.

- It is not clear whether this proportion applies to South Tees or elsewhere in TEWV Trust, nor the reasons for the shortfall in patients feeling safe on wards compared to the planned target. This was also an area of concern mentioned in the previous TEWV Quality Account.

TEWV's 2021 Community Mental Health Survey Results

The section on service user experience, indicates a deficiency of input into the support of patients living in the community, which may exacerbate any symptoms of anxiety and depression that they may suffer from. The TEWV report goes on to state how the Trust intends to improve patient experience in this area.

- This is an area that HWST will be taking a close interest in.

HWST is pleased to see a significant increase in the response rate in staff survey results compared to the previous year. Those areas in which the score has declined we would agree may be a reflection of the ongoing impact of the COVID-19 pandemic on staff morale. However, this is also an area worth reviewing in the future.

TEWV is to be commended on the degree to which it has participated in national clinical audits and confidential enquiries for the reasons stated on page 33 in the report.

It is also pleasing to again see the amount of participation in local clinical audit and clinical research as this indicates the degree of interest that those staff involved take in their work.

HWST has followed reports of the enforcement action taken by CQC against TEWV and we note the subsequent actions taken by the Trust (page 38), which are what would be expected to take place. However, given the media interest in these proceedings it would be of benefit if this section could be written with greater clarity to enable a better understanding by interested lay members of the public.

- We will continue to take appropriate interest in aspects of those services considered by CQC to require improvement.

Information Governance

HWST notes the problems faced by TEWV in achieving compliance with Data Security and Protection and the actions taken in mitigation.

We also note the ability of staff to speak up on issues that concerns them but there is no clear indication of the extent to which the various issues have been resolved.

Similarly, there is no clear indication of the extent to which junior doctors were employed in excess of their expected working hours (page 43). However, the increase in staff numbers employed by the Trust is noted but this does not indicate any increase in medical staff employed.

Learning from Deaths

In the TEWV quality account HWST takes a particular interest in those inpatient deaths where there have been known lapses in care/service delivery. We note the four key patient safety priorities (page 47) and other initiatives undertaken by the Trust and look forward to them resulting in a reduction in the occurrence of such deaths in future reports. The inclusion of the promotion of physical health as a patient safety priority is to be commended given the known impact of poor physical health on mental well-being.

Complaints

We note that there was an almost 14% increase in the number of formal complaints against the Trust in 21/22 compared to the previous year (page 50) and wondered if this increase was generally reflected across all services or if the greater part arose from perceived difficulties in one particular aspect of service provision?

Quality metrics 21/22

HWST notes the Trusts underperformance against metrics 1, 3, 8 and 9 (page 57) and the actions undertaken to try and ensure improved future performance in these areas. We note the introduction of a revised set of metrics but hope to see evidence of improved performance in future reports through appropriate changes in data analysis.

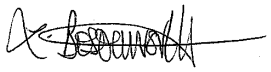
Performance against the System Oversight Framework Targets and Indicators

HWST notes the inappropriate length of time being waited before CYP cases are able to begin treatment and the recruitment drive by TEWV to try and remedy this situation (page 60).

We also note the increase in OAP patients being placed in external beds due to current demand, both locally and nationally, and wish you luck in solving this one without an appropriate increase in funding.

We hope you find our findings and comments helpful to inform your next steps and priorities for the next 12 months.

Kind Regards



Lisa Bosomworth
HWST Project Lead