Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Annual report and accounts 2014/15

Making a difference together

Tees, Esk and Wear Valleys NHS Foundation Trust

Annual report and accounts 2014/15

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

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(* These items have been subject to audit)

Strategic and Directors' report

Foreword by the Chairman and Chief Executive

Reviewing the past
It has been a challenging year for the NHS and for this Trust. However, despite the pressures on our services, we have achieved a great deal over the last 12 months and our staff have worked hard to give service users and their carers the treatment and support they need. This was born out by the Care Quality Commission's report following the Trust wide inspection of our services in January 2015. The report was published in May 2015 and the inspectors gave us an overall rating of GOOD, which was a tremendous achievement and testament to the caring and positive attitude of our staff.

Over the last year we have continued to develop services that are recovery focussed and we are working with people who have lived experience of mental illness to embed this approach across the organisation. Recovery looks at ways of empowering those with mental health issues to live satisfying and meaningful lives, within the limits of their illness – this could be getting a job, making new friends or finding a place to live. The roll out of model lines (see page 32) is supporting this work and the Recovery College (see page 38) is a great example of organisations and service users working together to promote recovery.

We have received praise and recognition from people at a national level such as Alistair Burns, NHS England's national clinical director for dementia who commended our memory services in Hartlepool for having waiting times significantly below the national average; and Dr Geraldine Strathdee, Mental Health National Clinical Director, who congratulated TEWV on being the top trust in England for standards of physical healthcare in the 2014/15 National Audit of Schizophrenia. More importantly, service users and their carers are giving us good feedback; the national survey of community mental health services placed us among the best performing mental health trusts in the country and our friends and family test results for 2014/15 showed that 88% of over 8500 people surveyed would recommend our services.

Clearly, we don't always get it right and last year we continued to challenge ourselves to learn from our experiences and to use feedback from service users and carers to continually improve our services.

Providing excellent services is only possible because of our staff and we want to be the best employer we can be. Last year's feedback from staff indicates that our efforts are paying off. In 2015 we achieved the gold standard from Investors in People (see page 34) and an independent analysis of our staff survey results (see page 53) named TEWV as the highest rated mental health and learning disability trust in the country. We were also named as one of the top ten NHS employers in the country by the Health Service Journal. We are, however, not complacent and continue to work with staff to improve their working lives.

Many of the new services that we launched last year were developed in partnership with other organisations (see page 37 for examples). These partnerships between TEWV and other public, private and voluntary sector organisations are vital in ensuring that local people get the care and treatment they need, when and where they need it.

As you will read in this report, we are making great progress towards achieving our strategic goals and our success over the last year has only been possible through the commitment of our staff, working with the people who use our services and their carers, and the support of all our stakeholders. Our thanks to them all for helping us make a difference.

Looking to the future

As we look forward to 2015/16 there are half a dozen issues of fundamental importance that will need a lot of attention. The big strategic issue is how the NHS is going to evolve to remain sustainable from an affordability perspective, whilst meeting the growing and changing needs of the population of this country.

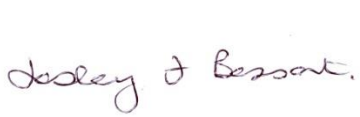
In October 2014 NHS England and other national bodies published the five year forward view which set out some possibilities and a framework for local action. From our perspective it can be summarised as closer integrated working with primary care, acute hospitals and, above all, the individual citizen, especially those citizens with complex needs such as the frail elderly and people who have multiple long term conditions. We seek to play an active and constructive role in each of the localities in which we work to try and ensure the best possible configuration of services and deployment of staff. These discussions started in 2014 and will undoubtedly be a major feature of work in 2015/16.

By the end of May we expect to know whether we have been selected as the preferred provider of mental health and learning disability services in York and Selby. If we are selected as a provider, the contract would be due to start in October 2015. Clearly this will be an important priority to ensure that the transition of staff and services from the present provider to TEWV goes smoothly and that we make an excellent job of supporting those staff and improving service provision.

One of our priorities is to agree a way forward with Harrogate & Rural District Clinical Commissioning Group and Hambleton, Richmondshire & Whitby Clinical Commissioning Group to provide modern, single bedroom inpatient wards to replace the present two wards at the Friarage Hospital in Northallerton and the two wards on the Briary Wing at Harrogate District Hospital. Everywhere else in the Trust we have modern single bedroom, mainly en-suite, inpatient facilities and we need to ensure that people in North Yorkshire who need to spend time in hospital can also benefit from good quality accommodation.

Another key priority of course is our quest to continually improve the quality and value of what we do, including improving productivity. Although the CQC's report was good, it did highlight several areas for improvement and addressing these will be an important priority for us.

We are looking forward to 2015/16 and to working with our staff, service users, carers, partner organisations, commissioners, governors, members and volunteers to meet the challenges that lie ahead and to continue to develop and deliver high quality services.

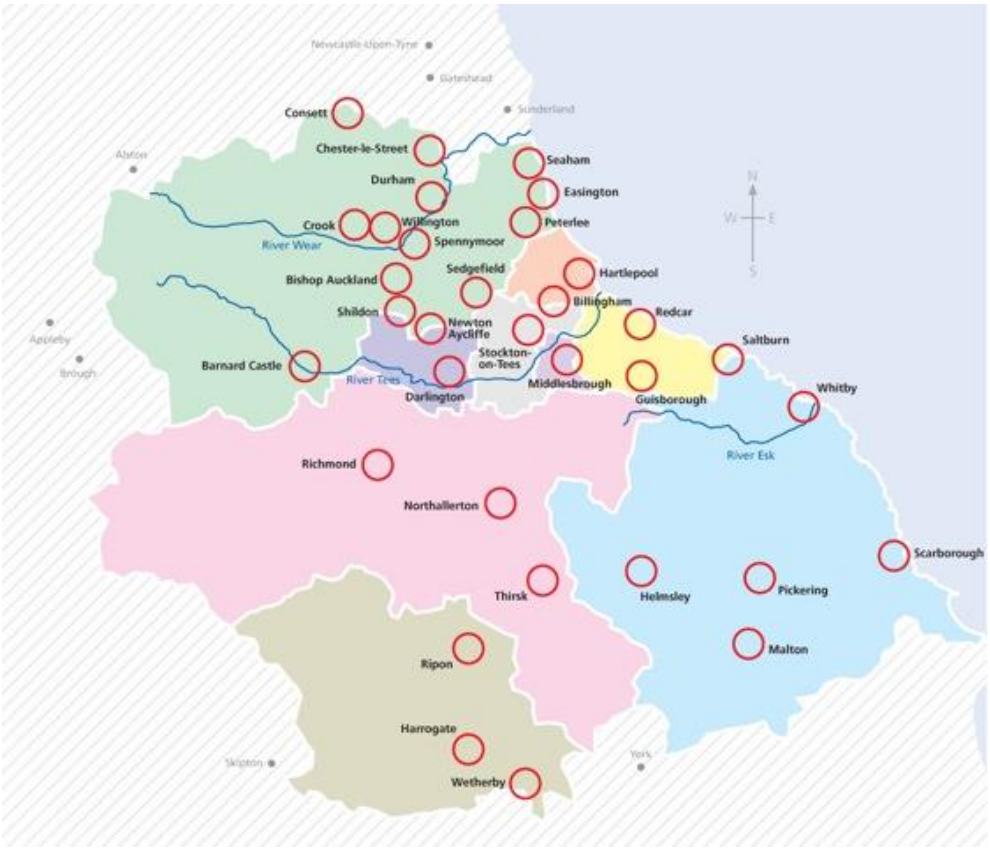


Lesley Bessant
Chairman
26 May 2015

Martin Barkley
Chief Executive
26 May 2015

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

TEWV at a glance



Tees, Esk and Wear Valleys NHS Trust was created in April 2006, following the merger of County Durham and Darlington Priority Services NHS Trust and Tees and North East Yorkshire NHS Trust. In July 2008 we achieved foundation trust status under the NHS Act 2006. In June 2011 we took over the contract to provide mental health, learning disability and substance misuse services to the people of Harrogate, Hambleton and Richmondshire.

As a foundation trust we are accountable to local people through our Council of Governors and are regulated by Monitor, the health sector regulator.

We provide a range of mental health, learning disability and substance misuse services for the 1.6 million people living in County Durham and Darlington, the Tees Valley, most of North Yorkshire (Scarborough, Whitby, Ryedale, Harrogate, Hambleton and Richmondshire) as well as Wetherby in West Yorkshire. With over 6000 staff and an annual operating income of £2.95m million we deliver our services by working in partnership with eight local authorities and clinical commissioning groups, a wide range of other providers from the public, private and voluntary sector, as well as service users, their carers and the public.

Being a foundation trust is helping us:

- build on and improve positive relationships with service users, carers, staff, partners and local people and be more accountable to local people
- strengthen our internal process and systems to meet the challenges of modern health services
- develop locally based specialist services (see pages 28 – 42 for examples)
- respond better to market opportunities (see examples on pages 28 to 42)
- continue to invest in capital developments such as West Lane Hospital in Middlesbrough (see page 28)

The TEWV approach

Our mission

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

Our vision

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

We will achieve our vision and mission through progressing our five strategic goals. These are explained on page 13 along with a number of 'this means that' statements.

Our values

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

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

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

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

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

Our goals

We have five strategic goals

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

This means that…

- We deliver safe and high quality services which improve the health and wellbeing of our users and their carers.
- We safeguard those at risk of harm.
- Users of our services and their carers have positive experiences and outcomes.
- Users of our services are seen when they need to be, at a time convenient to them, with no unnecessary transfers or delays in starting treatment.
- Users of our services are fully involved in the development and delivery of their care plan.
- All of our estate is of high quality.
- We continually seek and act upon feedback, from our service users and carers, on the services we provide.
- We provide high quality accessible information about our services and how people can access them.
- We work with our service users and carers to enable them to achieve their recovery goals.
- We minimise harm occurring to the users of our services

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

- We continually improve patient safety throughout the organisation.
- We are accredited and known locally, nationally and internationally for our high quality services and continuous improvement.
- The quality of our services is demonstrated through real time patient experience and outcome measures

- The TEWV Quality Improvement System is embedded and aligned throughout the Trust to deliver continuous improvement in the quality, and value of our services.

- The Trust and its staff only do things that add value to our customers.

- The Trust promotes a culture that encourages and enables staff to identify and eliminate waste.

- We deliver services that are evidence-based and clinically cost-effective

- We have an active applied programme of funded research and development to improve the services we provide.

- We actively seek out and report good practice and successfully disseminate it throughout the organisation.

- We promote a culture of actively challenging and reporting unsafe practice, quickly learning from our experience and embedding lessons learned.

- We use high quality pathways of care to support standardised work and delivery consistently good outcomes.

- The relevant information to improve services and optimise patient experience and outcomes is readily available to staff

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

- We continuously improve our staff survey results and are in the top 10% performing mental health trusts nationally.

- Our staff feel supported and valued at work.

- Our staff have well defined job roles which add value.

- Our staff work productively, flexibly and with compassion.

- We promote and support the wellbeing of our staff.

- We engage all our staff through effective communication and involvement.

- We proactively support clinical staff to be involved in the leadership and management of the Trust.

- We consistently demonstrate behaviours consistent with the Trust's values.

- The Trust and its staff understand and follow the Trust Compact.

- Our staff access appropriate education, training, development and leadership opportunities.

- We provide high quality placements for students throughout the organisation.

- We have the right staff with the right skills, competencies and attitudes to provide excellent services that deliver our care pathways.

- We have effective workforce and succession planning in place

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

- We support our commissioners to effectively commission mental health, learning disability, substance misuse and other specialist services.

- We engage with NHS England locally, regionally and nationally

- We work closely with all GPs in our area to ensure they can access our services appropriately and provide effective care for patients with mental health or learning disability needs.

- We work in partnership with local authorities to support the delivery of a seamless service for our users and carers.

- We influence and contribute to each Health and Wellbeing Board in the communities we serve.

- We are the mental health and learning disability provider of choice for the training of health and social care professionals.

- We have a growing portfolio of funded research and development which we use to improve the quality of our services.

- We have effective working arrangements with every acute foundation trust in our area.

- We have effective working arrangements with all elements of the criminal justice system.

Strategic Goal 5

To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of the communities we serve

- Our Council of Governors is fit for purpose and actively engaged in our strategic development.

- We maintain our desired rating of regulatory compliance and maintain the level of transparency and candour required.

- We engage the membership of the Trust in the governance arrangements of the organisation.

- We regularly use benchmark and outcomes data to deliver improvements in quality and value.

- The Trust supports staff and services to improve productivity through use of the best available tools and technologies / methodologies.

- We reduce the impact of our business on the environment.

- We actively promote our successes to develop our reputation and brand to all stakeholders and are regarded as the provider of choice.

- We deliver a Trust Business Plan which is dynamic, flexible and responsive to the changing environment.

- The Trust is rated in the top 10% for patient outcomes, experience and cost efficiency.

- The information we produce is accurate, timely and of high quality.

- We invest in the capability we need to be a sustainable and dynamic organisation.

Responding to the external environment

TEWV serves patients across a large geographical area that includes:

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

Challenges for TEWV as a provider include how to:

- balance the different needs and priorities of commissioners while providing a consistent level of quality across the Trust
- manage resources so that we can deliver effectively in urban and rural areas with different financial pressures.
- Manage the changing demand for our services. Using population changes, expected changes in prevalence for different conditions and recent trends we continue to expect
    - demand for adult mental health services to be broadly stable over the medium term, within 3% of current referrals
    - referrals and caseload for children’s and older people’s services to increase by 15% and 21% by 2018 compared to 2013 (unless we and our local health economy partners develop other alternative services that reduce the demand for our inpatient and community services
- respond to new national policy and guidance including the five year forward view, Choice for mental health patients, force reduction, reducing the use of assessment and treatment beds for people with learning disabilities
- make best use of new medical and information technology which opens up additional ways of delivering services.

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

In 2014/15 the Trust received no judgements from a tribunal or court under the Human Rights Act 1998 or the Equality Act 2010. We will continue to work with commissioners to ensure our ongoing compliance the Acts.

Our services

Our services' role is to provide therapeutic and pharmacological treatments and other support to keep patients safe and to help them to achieve the recovery goals that they set for themselves.

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

- Durham and Darlington
- Tees and
- North Yorkshire

There is a fourth directorate covering forensic services.

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

- adult mental health services (including substance misuse services)
- mental health services for older people
- children and young people's services (including child and adolescent mental health services and children's learning disability services)
- adult learning disability services

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

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

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

Services include:

- a wide range of community based assessment and treatment services including primary care, liaison, crisis intervention, assertive outreach, community affective disorders and psychosis teams and eating disorders; we also provide mental health services for people with a sensory impairment (deafness) and Attention Deficit Hyperactivity Disorder (ADHD)
- inpatient assessment and treatment services, including acute, intensive care, challenging behaviour and rehabilitation services
- primary care psychological therapies (also known as IAPT)
- the specialist regional North East and North Cumbria eating disorder inpatient services for adults, with 'step up' and 'step down' day hospital services for Teesside, Durham and Darlington patients
- inpatient services to serving military personnel as part of a national consortium and community based services to military veterans.

Our main hospitals are Lanchester Road Hospital in Durham, West Park Hospital in Darlington, Roseberry Park Hospital in Middlesbrough, Sandwell Park in Hartlepool,

Cross Lane Hospital in Scarborough and wards within The Friarage Hospital in Northallerton and Harrogate District Hospital.

Substance misuse services (SMS)
We provide community substance misuse assessment and treatment services for people aged 18 years and above in County Durham. Our inpatient and community teams assist people with 'dual diagnosis' issues across the whole of our area.

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

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

The services we provide include:

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

Our main inpatient services for MHSOP are provided at the Bowes Lyon Unit on the Lanchester Road Hospital site in Durham, West Park Hospital in Darlington, Roseberry Park Hospital in Middlesbrough, Auckland Park in Bishop Auckland, Cross Lane Hospital in Scarborough and wards within The Friarage Hospital in Northallerton and Harrogate District Hospital.

Children and young people's service (CYP)
This service includes all child and adolescent mental health services across the whole Trust area, and child learning disability services for Durham, Darlington and Teesside.

Most services are provided in the community with inpatient assessment and treatment and low secure services being provided at West Lane Hospital in Middlesbrough. Our hospital at West Lane is also the base for our specialist regional North East and North Cumbria eating disorder inpatient service for children and young people. West Lane Hospital is nearing the end of a major modernisation project to improve the accommodation

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

Our main inpatient sites are at Bankfields Court in Normanby, Teesside and Lanchester Road Hospital in Durham. The Trust also provides community learning disability services across the whole of our area, and additionally for the Craven (Skipton) district.

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

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

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

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

We also provide community forensic services including criminal justice liaison services that work across the whole offending behaviour pathway. This includes street triage services for much of our area.

We provide the mental health service within all prisons within North East England, including 'through the gate' support, working with our partners Northumberland, Tyne and Wear NHS Foundation Trust (NTW), Rethink Mental Illness and Stockton & Middlesbrough MIND.

Our performance 2014/15

Performance against key targets

The Trust met all its national requirements and Monitor targets during 2014/15. In addition to these, each year the Board of Directors set a number of stretching targets (key performance indicators) for the Trust to work towards as part of its commitment to year-on-year improvement.

The scorecard below is the Trust's dashboard of key performance indicators for 2014/15.

The Board received a monthly performance report during 2014/15 which contained performance against a range of indicators linked to the Trust's strategic goals as well as national requirements.

1. Users of Our Services	2014/15 Actual	2014/15 Target	2013/14 Actual	Change on 13/14*	Comment on 2014/15
Percentage of patients who have not waited longer than four weeks for a first appointment	83.74%	98.00%	85.70%	↓	2014/15 full year position
Percentage of patients who have not waited longer than four weeks following an internal referral	85.80%	98.00%	87.54%	↓	2014/15 full year position
Percentage CPA 7 day follow up (AMH only)	97.42%	95.00%	97.86%	↓	2014/15 full year position
Percentage of CPA patients having a formal review documented within 12 months (AMH only)	97.75%	98.00%	97.13%	↑	Snapshot as at 31 March 15
Percentage of admissions to inpatient services that had access to crisis resolution home treatment teams prior to admission (AMH only)	98.42%	95.00%	97.58%	↑	2014/15 full year position
Median number of days from when a patient is discharged as an inpatient to their next admission as an inpatient (AMH and mental health services for older people - MHSOP - only)	136	138	131	↑	2014/15 full year position
Number of Early Intervention Teams (EIP) new cases	659	259	626	↑	Cumulative full year position
Percentage of wards	73.17%	75.00%	70.31%	↑	March 2014 –

who have scored greater than 80% satisfaction in patient survey					February 2015. Data only started to be collected in April 2014.
Percentage of community patients who state they have been involved in the development of their care plan (AMH, MHSOP and LD)	90.58%	80.00%	-	-	March 2014 – February 2015. Data only started to be collected in June 2014.
Number of patients who have 3 or more admissions in a year (AMH & MHSOP)	210	331	358	↑	2014/15 full year position
2. Quality	**2014/15 Actual**	**2014/15 Target**	**2013/14 Actual**	**Change on 13/14**	**Comment on 2014/15**
Number of unexpected deaths classed as a serious incident per 10,000 open cases	12.16	12.00	13.15	↑	2014/15 full year position
Data completeness: outcomes	94.09%	90.00%	92.44%	↑	Snapshot as at 31 March 15
Data completeness: identifiers	99.61%	99.00%	99.25%	↑	Snapshot as at 31 March 15
The number of 'out of locality' admissions**	510	413	459	↓	2014/15 full year position
Percentage of HoNOS ratings that have improved in the non-psychotic and psychosis super classes for patients that are in scope (AMH and MHSOP)	48.05%	43.00%	40.13%	↑	Snapshot as at 31 March 2015
Percentage of HoNOS ratings that have improved in the organic super classes for patients that are in scope (AMH and MHSOP)	31.16%	30.00%	25.78%	↑	Snapshot as at 31 March 2015

Access to psychological therapies adult IAPT – percentage of people that enter treatment against the level of need in the general population (Durham and Darlington locality only)	11.82%	15.00%	8.24%	↑	2014/15 full year position
Recovery rate adult IAPT – percentage of people who complete treatment who are moving to recovery	47.64%	50.00%	48.77%	↓	2014/15 full year position
Mean level of improvement on SWEMWBS (AMH only)	5.66	5.97	5.30	↑	2014/15 full year position
Mean level of improvement on SWEMWBS (MHSOP only)	2.81	3.52	3.09	↓	2014/15 full year position
Number of reds on CQC action plans (including MHA action plans)	0	0	0	↔	2014/15 full year position
3. Workforce	**2014/15 Actual**	**2014/15 Target**	**2013/14 Actual**	**Change on 13/14**	**Comment on 2014/15**
Number of RIDDOR incidents per 100,000 occupied bed days	16.00	12.14	13.78	↓	2014/15 full year position
Percentage of staff in post more than 12 months with a current appraisal ***	89.37%	95.00%	86.93%	↑	Snapshot as at 31 March 15
Percentage compliance with mandatory and statutory training ***	88.11%	95.00%	87.13%	↑	Snapshot as at 31 March 15
Percentage sickness absence rate	5.12%	4.50%	5.09%	↓	March 2014 – February 2015
4. Partnerships	**2014/15 Actual**	**2014/15 Target**	**2013/14 Actual**	**Change on 13/14**	**Comment on 2014/15**
Percentage of non-acute patients whose transfer of care was delayed	2.11%	7.50%	1.89%	↓	2014/15 full year position
Number of reds from each of the four locality dashboards	37	32	38	↔	2014/15 full year position

5. Sustainable organisation	2014/15 Actual	2014/15 Target	2013/14 Actual	Change on 13/14	Comment on 2014/15
Number of GP referrals into the Trust services	40654	37879	37888	↑	2014/15 full year position
Number of other external referrals into Trust services excluding GP referrals	29272	26996	26996	↑	2014/15 full year position
Financial value of ward and teams below the average cost productivity baseline (AMH and MHSOP only in scope of PbR)	9,770,538.08	9,960,000			This Key Performance Indicator is reported quarterly; this figure represents the quarter 3 position.

* Arrows indicate improvement (↑) or deterioration (↓) on previous year
** See notes on comparison between 2014/15 and 2013/14
*** Data reported within the Annual Report 2013/14

Notes

- **Percentage of patients who have not waited longer than four weeks for a first appointment** – The Trust has failed to achieve the 98% target throughout the year, reporting an annual position of 83.74%. However, it should be noted that the number of referrals received by the Trust increased by 7.3% during 2014/15 compared to 2013/14.

- **Percentage of patients who have not waited longer than four weeks following an internal referral** - The Trust has consistently failed to achieve the 98% target throughout the year, reporting an annual position of 85.80%; there has been a 0.5% increase in internal referrals during 2014/15 compared to 2013/14.

- **Percentage of CPA patients having a formal review documented within 12 months (adult mental health (AMH) only)** – The Monitor target of 95% has been achieved, although the Trust has failed to achieve its internal target of 98%, reporting an end of year position of 97.75%. This equates to 98 patients out of 4349 that have not has a formal review documented within 12 month. Performance for 2014/15 is similar to that for 2013/14.

- **Median number of days from when a patient is discharged as an inpatient to their next admission as an inpatient (AMH and mental health services for older people - MHSOP - only)** – The Trust has failed to achieve the target of 138 days throughout the year, reporting a median period of 136 days from discharge to admission for any readmitted adult mental health and older people patient. Performance for 2014/15 is better than for 2013/14.

- **Percentage of wards who have scored greater than 80% satisfaction in patient survey** – The Trust has failed to achieve the 75% target for the percentage of wards scoring greater than 80%. Performance has been variable

throughout the year, with the Trust achieving target for 4 months of the year. Performance for 2014/15 is better than for 2013/14.

- **Number of unexpected deaths classed as a serious incident per 10,000 open cases –** The Trust has failed to achieve the target of 12 unexpected deaths per 10,000 open cases. This equates to 60 unexpected deaths, 1 more than was reported last year. The data was continuously monitored throughout the year and no patterns or trends have been identified. Performance for 2014/15 is better than for 2013/14.

- **The number of "out of locality" admissions** – This indicator measures the number of times a patient is admitted to a hospital within the Trust that is not the one we would expect them to be admitted to.

  It should be noted that whilst it appears that there were considerably more OoL admissions in 2014/15 than in 2013/14 this is due to a change in the ward functions within Auckland Park which results in theses wards being included within this indicator in 2014/15. If these are discounted, to allow a true comparison, the performance for the two years is similar.

  The Trust has on a monthly basis, primarily reported above target for the year, only achieving below target performance for two months (October and January). During 2014/15 we reported 510 'out of locality' patients against a target of 413. This position is significantly above the target that the Board set an 11.1% deterioration on the 2013/14 performance, when we reported 459. The position is closely monitored within the localities. There were no occasions when a patient needed to be admitted outside of the Trust due to the unavailability of beds.

- **Access to psychological therapies adult IAPT** – percentage of people that enter treatment against the level of need in the general population – this indicator only relates to County Durham and Darlington Service. We have consistently under-performed against the Trust target throughout the year, but have achieved a significant improvement on the position reported in 2013/14. An action plan to address this underperformance continues to be implemented; however, delivery has been impacted by a number of vacancies within the teams.

- **Recovery rate adult IAPT** – percentage of people who complete treatment who are moving to recovery – Performance for 2014/15 has not achieved the annual target and is slightly worse than performance in 2013/14 by 1.13%. The services continue to review every patient who has not moved to recovery to ascertain the reasons why and actions are taken to improve this position.

- **Mean level of improvement on SWEMWBS (AMH only)** - The Trust has failed to achieve the mean level of improvement identified as the target for 2014/15. However, it has seen a slight improvement on the 2013/14 position.

- **Mean level of improvement on SWEMWBS (MHSOP only)** – The Trust has failed to achieve the mean level of improvement identified as the target for

2014/15, with performance also lower than in 2013/14.

- **Number of RIDDOR incidents per 100,000 occupied bed days** – the Trust has under-performed against the target of 12.14 RIDDOR incidents per 100,000 occupied bed days and is reporting a worse position than in 2013/14. In 2014/15 there were 45 RIDDOR incidents. All incidents are monitored throughout the year and there were no patterns or trends identified.

- **Percentage of staff in post more than 12 months with a current appraisal** – The Trust has under-performed against the 95% target with an outturn of 89.37% in March 14. However, this is an improvement on the outturn of 86.93% for March 2014. Regular monthly compliance reports are closely monitored at various levels and forums throughout the Trust.

- **Percentage compliance with mandatory and statutory training** – The Trust has under-performed against the 95% target with an outturn of 88.11% in March 15; however this is an improvement on the outturn of 87.93% for March 14. Regular monthly compliance reports are closely monitored at various levels and forums throughout the Trust.

- **Percentage sickness absence rate** – The Trust has under-performed against the 4.50% target with an outturn of 5.12% in February 15 and shows a slightly worse performance than the 2013/14 outturn position of 5.09%. The Operational HR team continue to proactively support line managers to manage staff to facilitate a speedy return to work for staff.

- **Number of reds from each of the four locality dashboards -** The Trust has under-performed against the target of 32 with an outturn of 37 in March 15 remaining consistent with performance in 2013/14.

Working with our commissioners to improve performance

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

There were two operational standards and two national targets included within the 14/15 mental health contract which were:

- Number of episodes of mixed sex accommodation – sleeping
- Percentage CPA 7 day follow up (adult services)
- Data completeness - NHS Number
- Data completeness – Ethnicity Coding

The majority of targets were achieved for the 14/15 financial year for the 9 core CCGs. The only target not achieved was "CPA 7 day follow up" for the Vale of York CCG where they achieved 82.35% against the target of 95%. This was in relation to

3 patients that were not followed up within 7 days of discharge from a total of 17 within the financial year. Two patients were followed up by York Services; however it is the discharging Trust's responsibility to follow patients up. We have reemphasised this to staff in order to prevent it happening again.. The third patient chose to be seen outside the 7 day period.

In relation to "episodes of mixed sex accommodation" during the CQC Inspection it was noted that the boundary of a male zoned corridor had been set so that two female en-suite bedrooms were adjacent to the first male bedroom in the male zoned corridor. CQC considered, on inspection, that this was a breach of the Department of Health guidance. This however had not been reported by the Trust as we did not believe that this was a breach. Whilst the CQC considered this to be a breach of the Department of health guidance it is not a breach of the Mental Health Act Code of Practice on Same Sex Requirements.

All key commissioner targets were also included in the relevant clinical locality performance reports throughout 2014/15 and monitored routinely.

The highlights

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

We are passionate about promoting recovery and wellbeing, supporting our service users to achieve the goals they have set themselves. A number of inter-linked projects are well underway across the Trust and having a positive impact on embedding a recovery-focussed culture. For instance, the recovery programme (see also Recovery College on page 38), the Care Programme Approach (CPA) project and Model Lines (see page 32) are all key to helping the Trust become more recovery focussed.

We continually review and modernise our services with a view to making sure that the people who use them are getting the care they need, when and where they need it and that their experience of our services is positive.

Most people are able (and want) to receive their care and treatment at home. However, those who need to spend time in hospital deserve to be cared for in the best possible environment. Our inpatient facilities are some of the best in the country and over the last year we have continued to invest in our estate.

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

State of the art facilities
The second phase of a multi-million rebuilding project at West Lane Hospital in **Middlesbrough** was completed in early 2015. The newly refurbished **Newberry Centre** offers a safe environment for young people to be assessed and treated for a range of serious mental health problems. The centre offers 24 hour support, seven days a week to young people, their families and carers. The new look unit has 14 en-suite bedrooms, a garden room, games room, American diner, gym and sport facilities as well as family visiting areas. As part of the extensive modernisation work on site the **child and adolescent mental health services (CAMHS) community team** for Middlesbrough has also moved into much improved accommodation.

In 2014 we brought **Harrogate and district's** adult community mental health teams together under one roof at the extensively refurbished **Valley Gardens Resource Centre**. The teams were previously based at four different locations in Harrogate and Ripon and this move enabled us to fully integrate the teams, providing a single point of access for primary care and community mental health teams. As well as a spacious open plan area for hot desking, the new facility has individual offices, meeting rooms and a separate suite of clinic rooms for outpatient appointments.

In January 2015 community mental health services for older people living in Seaham, Easington, Peterlee and the surrounding villages moved into improved accommodation in **Seaham**. **The Old Vicarage** was extensively refurbished to provide much improved accommodation and more space for patients, carers and staff.

Ground breaking initiative
A new allotment garden in the grounds of Lanchester Road Hospital in Durham is helping people with learning disabilities develop new life skills.

Last year service users and staff from the assessment and treatment unit created the 'Together Garden'. The allotment came about as a direct result of inpatients requesting more meaningful activities. Over a period of 14 months of planning and hard work staff and service users turned a bare piece of land into a vegetable allotment, patio and space to keep animals.

The initiative has been a huge success and having far reaching therapeutic benefits. Working on the allotment and planning what needs to be done is boosting the confidence of many service users as they learn new skills and experience new activities.

Help in a crisis

In 2014 the Trust launched its **crisis service for children and young people** in **Durham and Darlington**. This seven-day a week nurse led service, believed to be the first of its kind in the country, is helping young people and their families who find themselves in incredibly difficult situations.

Our aim is make sure that young people get the care and support they need quickly when they are experiencing a mental health crisis. Since the team was established we have already seen a decrease in admissions to acute wards or police detention and a reduction in the time young people are waiting for assessment. Feedback from families has also been extremely positive.

A service for **Teesside** was also agreed in 2014 and this will be launched in 2015/16.

At the end of 2014/15 we were preparing to open a **new crisis assessment suite** in **Middlesbrough,** which will be an integral part of the Teeswide crisis service.

Based at Roseberry Park in Middlesbrough the assessment suite will be open 24 hours a day, seven days a week. Staff will assess adults with urgent mental health needs and the assessment suite will also act as a place of safety for individual's detained under Section 136 of the Mental Health Act and people who attend accident and emergency departments.

This latest development is in response to the Government's mental health crisis care concordat.

Service user awards focus on recovery
Forensic mental health and learning disabilities services at Ridgeway in Middlesbrough, hosted their first recovery awards to celebrate service users' achievements in 2015.

The judges chose five winners from over 180 nominations made by staff, service users and visitors. Winners were presented with trophies and vouchers at the Hollywood themed red carpet ceremony in the transformed sports hall.

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

We are totally committed to continually improving the quality of our services and only doing things that add value to our customers.

Our staff strive to eliminate waste wherever it exists in the organisation so that they can focus on what's important – improving the lives of the people who use our services. Our quality improvement system (TEWV QIS) is fundamental to doing this and to empowering staff to bring about change.

We constantly challenge ourselves to improve and to learn from experience and customer feedback. We also have an active programme of applied research and development (see page 61).

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

Investing in Children
A number of our children's services were awarded Investing in Children (IiC) status over the last year. This membership award recognises and celebrates examples of imaginative practice with children and young people. IiC membership is given to services which show they're engaging with the young people with whom they work, and that this has resulted in change.

Holly Unit, West Park Hospital, Darlington, which provides a short break service for children and young people with learning disabilities, was identified as responsive, caring and inclusive. One parent said "staff are like family".

Harrogate child and adolescent mental health services (CAMHS), were praised by young people for the support they offer, acting as advocates with their families and teachers. One young person said "they listen to your views; if something's happened, you can get it off your shoulders".

Our child and adolescent mental health service (CAMHS) team at Dover House, Hartlepool worked hard to listen to the opinions and concerns of young service users and to involve them in decision making. The young people have designed artwork for patient information leaflets and helped to pick paint colours for rooms.

The Westwood Centre at West Lane Hospital in Middlesbrough involved young people during the recent multi-million pound redevelopment of the centre, giving them the opportunity to have their say about its facilities and furnishings and being involved in decisions about their care.

Quality network
Our forensic services received an excellent report from the Royal College of Psychiatrist's Quality Network for Forensic Mental Health Services. The network's

standards represent best practice and TEWV's low secure services scored 93% and medium secure services scored 95%.

The visiting team noted the excellent facilities in Ridgeway, the secure accommodation at Roseberry Park, including the health centre which was praised for normalising everyday experiences for the patients. Efforts to integrate patients from forensic mental health and forensic learning disability wards were also praised as was the level of information given to patients.

Model Lines
Our model line programme has been set up to help us make sure every step we take adds value to our patients' experiences and outcomes during their care pathways. Model line aims to offer our patients personalised care at a pace and level suitable to each individual throughout their care pathway from onset of symptoms to meaningful recovery.

Last year Hartlepool psychosis team was the first service to roll out the model line programme since it was piloted by teams in Stockton-on-Tees and Durham in 2014.

The service has totally transformed the way it works – moving from having separate psychosis and assertive outreach teams, to a single team with three multidisciplinary 'cells' of between five and seven staff. These cells promote shared ownership and help staff be more responsive to service users' needs. The team adopted the model line (or standardised approach), adapting it to meet local needs.

Feedback from service users and staff has been positive and the team continues to refine their processes.

Reducing restrictive practice
Forensic services have introduced a new minimising restrictive practice framework aimed at reducing practices that limit an individual's movement, liberty and/or freedom to act independently.

Historically many restrictions (such as access to courtyards and kitchens, monitoring visits and telephone calls) were put in place to maintain the safety and security of service users, the site and staff. They were applied universally but the aim of the framework is to apply restrictions on an individual basis to make sure people detained in hospital are subject to the least number of restrictions required to keep them and others safe.

Changes to date include access to certificate 18 films, kitchen access and removing set smoking times on the low secure unit). This work is continuing and priorities for this year include the use of mobile phones.

Recruiting for research
Over the last year, and in line with the national Dementia Challenge, we have been extremely successful in increasing the number of patients with dementia involved in high quality research.

We have established research champions in our older people's services who are actively promoting the importance of involving patients in research with colleagues and, ultimately, the people who use our services. This had led to the Trust being the highest recruiter of people with dementia in the country.

Goal:
To recruit, develop and retain a skilled, compassionate and motivated workforce

We want to be the best employer we can be and this means creating a culture where staff feel valued, where every role counts and where we only ask staff to do things that add value. We are committed to living by the Trust's values and compact and supporting our staff to do the same. We encourage and empower staff to get involved in developing and improving services and aim to make sure they have the skills, tools and support they need to provide excellent services.

Effective leadership is key to achieving our goals and we aim to make sure we have the right people with the right leadership and management skills. This includes proactively supporting clinical staff to be involved in the leadership and management of the Trust.

In September 2014 we were delighted to learn that the Health Service Journal had named TEWV as one of the top ten NHS places to work in the country.

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

National recognition
An initiative that is helping staff manage stress more effectively received national recognition last year.

The mindfulness project won the mental wellbeing for staff category at the Positive Practice in Mental Health Awards. The Trust runs 12 eight week programmes for staff each year to help them develop mindfulness skills. Feedback from staff has been extremely positive.

Gold standard
In 2015 we were awarded the 'Gold Standard' by national business accreditors Investors in People (IIP) putting us in the 7% of Investors in People accredited organisations to have gained this prestigious endorsement.

IIP is a nationally recognised people management standard which assesses how well organisations manage and develop their staff. It considers all aspects of an organisation's employment practice from recruitment through to reward, involvement, development and management.

Three independent reviewers carried out a week-long assessment of the Trust against the IIP framework, meeting with and interviewing around 110 staff. The reviewers were particularly impressed with how staff are encouraged to come forward with ideas to improve their service and how, as a Trust, we welcome feedback from service users and their families to inform service planning. They also highlighted a wide range of initiatives and good practice including our investment in a range of health and wellbeing activities for staff, such as the provision of retreats, access to mindfulness programmes and a comprehensive occupational health service.

Delivering compassionate care
Last year we were amongst the first 100 organisations nationally, and one of the first ten mental health trusts in the country to bring in Schwartz Rounds to help us deliver more compassionate care.

Our forensic services introduced these confidential monthly forums where staff of all disciplines and grades meet to share the emotional and social issues that arise from their work. Schwartz Rounds, which were originally developed in the USA, promote a culture of openness, transparency, team working and a less hierarchical environment.

Staff have said they feel more positive, valued and less stressed; they acknowledged difficult feelings but felt more supported and confident to handle difficult and sensitive issues.

A great place to work or receive treatment
Staff gave TEWV a huge thumbs up in the national survey of NHS staff. The results of the annual survey confirmed the Trust as being one of the best NHS employers in the country.

The Trust was in the top 20% of mental health and learning disability trusts in the country in 22 of the 29 areas covered, scoring the highest rating in two of those areas. We were also in the top 20% of trusts recommended by their staff as a place to work or receive treatment and among the best performing trusts for engaging with staff (see page 53).

Positive behaviour support (PBS)
Over the last twelve months we have been working with staff across our learning disability services to help them support people whose behaviour is challenging.

This work has included training staff in positive behaviour support (PBS) practices. Evidence shows that PBS (adopting a supportive, positive approach) greatly improves the quality of life of service users and reduces behavioural challenges. It also helps reduce restrictive practices including control and restraint.

Inpatient staff have received PBS awareness training and we have rolled out a PBS clinical pathway across the adult learning disability service. We are also rolling out the training to community staff.

Values based recruitment
It's not only what we do that is important, but also the way we do things that makes a huge difference to service users, carers and colleagues. It's important that we recruit staff, who demonstrate our values and behaviours (see page 12) and last year we rolled out values based recruitment across the Trust.

Service users, carers and staff were involved in redesigning the new process which was piloted for health care assistants and band 5 posts initially before being rolled out across the Trust. The new process, which includes specific questions, helps the interview panel get a better sense of how an applicant would work and communicate as part of the team and what someone's values and behaviours would be like at work.

Our goal:

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

It is important that we build strong relationships with the people who use our services and the bodies that represent them, the organisations who commission our services and the organisations we work with to provide those services.

Over the past year we have continued to work closely with our existing partners to develop new initiatives and improve existing services. We have also established links with a range of new organisations and are working with them to implement new services.

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

National pilot
In 2014/15 the Trust piloted a scheme in Teesside to support more people with mental health problems as they go through the criminal justice system.

Early support and treatment helps improve health outcomes and reduce the likelihood of future arrests. The enhanced and extended ‘all age’ custody liaison and diversion service, which was funded by NHS England helped make sure that adults and young people with mental health problems, learning disabilities or other vulnerabilities got the right treatment as quickly as possible.

TEWV already provided separate custody liaison and diversion services for adults and young people. This pilot built on the excellent work we had done in the past to create a seamless service for everyone, regardless of age. With extended hours we were able to provide support in police stations, magistrates and youth courts across Teesside. The service was available from 8am to 8pm in police stations and 9am to 5pm in the courts, enabling us to be on hand to help people when they first come into the justice system.

Following a successful pilot the scheme is now being rolled out across the country and from 1 April, following a successful tender, we extended this sevice to the Durham Police areas.

Place of safety
Last year we opened a new Section 136 place of safety assessment suite at The Friarage Hospital, in Northallerton. The suite provides somewhere for people in mental health crisis to be detained if police believe them to be a danger to themselves or others. The suite means vulnerable people can be assessed in a suitable health environment so that appropriate care and treatment can be arranged. Previously these people would have been detained in a custody suite, even if they had not committed a crime.

We run the suite in partnership with NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group, North Yorkshire Police and North Yorkshire County Council.

Recovery college
Last year we opened a new college for mental health workers and service users in Durham. ARCH recovery college is a learning centre, where service users, carers and staff from the Trust enrol as students to attend courses based on recovery principles.

The college was developed with the support of health, local authority and voluntary sector partner organisations as well as people with experience of mental health issues and services.

Courses aim to equip students with the skills and knowledge they need to manage their recovery, have hope and gain more control over their lives. For staff there is the chance to ensure their practice is more recovery based and to consider their own wellbeing. All courses are developed and delivered by people who have experience of mental health issues as well as professional experts.

The college is part of a two-year pilot project with plans to expand to other parts of the Trust's area. Towards the end of the year we secured funding to develop a virtual recovery college. This online resource will give service users access to a range of self-management resources.

Pilot clinic opens in GP practice
Easington community mental health team is working more closely with Blackhall GP Surgery as part of a pilot project to improve dementia diagnosis, and care for older people in North Durham and Easington. A community psychiatric nurse is now based within the surgery, providing people registered with the practice access to mental health services more quickly and conveniently.

The project also aims to improve communication between GPs and mental health services, making referrals speedier. The pilot has reduced the need for home visits by offering people the chance to be assessed in the familiar surroundings of their own GP surgery. It has also reduced the need for patients to travel to other clinics and helped tackle mental health stigmas by putting mental health care under the same roof as physical health care.

New liaison service launched
A new Scarborough acute liaison psychiatry service was launched in January 2015. Staff from the team are working alongside their colleagues at Scarborough General Hospital, accident and emergency (A&E) department, to improve services for people with mental ill health.

They aim to ensure patients with mental health conditions, who are in the care of the acute hospital, are seen by the relevant professionals as quickly as possible and get the best assessment, care and help they need. The liaison team assess people who come into A&E and where necessary, refer them onto the most appropriate service.

They also visit medical assessment units to assess people who are experiencing both mental ill health and physical problems. The team will help acute staff to develop their understanding of mental health conditions, as well as supporting other wards in the acute hospital.

Our goal:

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

The communities we serve are at the heart of everything we do and we are committed to working with our Governors and members to meet the needs of the people who need our services.

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

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

TEWV welcomes new services
In 2014 we took over three services for the catchment areas we serve in North Yorkshire, which were previously provided by Leeds and York Partnership NHS Foundation Trust.

- The **improving access to psychological therapies (IAPT) service** works with people to overcome stress, anxiety and depression, and to enjoy and participate in life again. It delivers cognitive behavioural therapy through workshops, one-to-one sessions and phone appointments.
- The **vulnerable veterans and adult dependents service** is a bespoke service based at Catterick Garrison. It specialises in working with veterans and dependants of serving personnel, and provides access to treatment for those who are experiencing mental health difficulties.
- The **community eating disorders service** works with our adult community teams across North Yorkshire to provide specialist eating disorders input.

Successful tenders
In January 2015 we were awarded the contract to continue to provide **drug and alcohol services** in County Durham from April 2015, as a sub-contractor for Lineline. Over the coming months we will work with Lifeline to provide a single streamlined service with a clear focus on recovery.

Following a successful tendering process TEWV was awarded the contract to provide **mental health and learning disability services in seven prisons** from April 2015

We will provide services for prisoners at HMP Low Newton, Brasside; HMP Frankland, Brasside; HMP Durham; HMP young offenders institute Deerbolt, Barnard Castle; HMP Holme House, Stockton; HMP Kirklevington Grange, Yarm and HMP Northumberland.

In addition a subcontracting arrangement has been made with Northumberland Tyne and Wear NHS Foundation Trust (NTW) to provide services at the dangerous and

serious personality disorder Westgate unit in Frankland prison.

The services will include a range of treatment and therapies for prisoners with mental health needs including comprehensive assessment; tailored treatment programmes; dedicated primary care services, trauma services, psychiatry clinics and day services, such as art groups, support groups and healthy lifestyle groups.

Spotlight on our services
In January 2015 the Care Quality Commission carried out a Trust wide scheduled inspection of our services. This was part of their national programme of inspections and they visited all our inpatient sites and around 30% of our community teams.

They spoke to clinical and corporate staff as well as service users, carers, partner organisations and commissioners.

Our initial verbal feedback from the inspectors was very positive. Staff were congratulated on their care, compassion and professional behaviour; the inspectors commented that the culture of openness and honesty was observable everywhere they went. Whilst they have identified some areas to improve they quoted a significant number of areas of notable practice.

The full report was published after year end and the Trust received an overall rating of 'good' (there are four possible ratings – outstanding, good, requires improvement and inadequate).

Investing in our facilities
In June 2014 the Board of Directors approved capital expenditure of several millions of pounds to:

- create a new child and adolescent mental health service (CAMHS) team base in Middlesbrough (see page 28
-)
- refurbish some accommodation at the Lanchester Road Hospital site in Durham and demolish some redundant buildings
- find a new team base for both the psychosis team and affective disorders team in Middlesbrough
- upgrade the Rowan building in Darlington to improve the standard of accommodation for the CAMHS team, talking therapies team and mental health liaison
- upgrade Chester-le-Street health centre to improve the environment for both staff and patients
- purchase a fully integrated website, intranet, extranet and document management solution.

Governance assured
Last year Deloitte completed their follow-up review of quality governance arrangements in the Trust. The final report, which as received in July 2014 concluded that the Trust had made good progress resulting in an improved (lower) score of 3.5 compared to 6.0 in August 2013.

We also received Deloitte's Board governance assurance report and feedback from them provided assurance that our Board governance arrangements were robust. It did, however, highlight some areas for improvement and we will continue to work to further improve governance in the Trust.

Principal risks and uncertainties

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

The annual governance statement describes the systems and processes through which risks are identified, managed and mitigated. This can be found on page 237.

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

Potential changes to service models and the provider landscape

In its "Five Year Forward View", published in October 2014, NHS England sets out its vision for the future of the NHS.

The document highlights the importance of breaking down barriers in how care is provided and describes new models for achieving this.

From our perspective the vision creates both significant risks and uncertainties as well as opportunities.

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

The integration of services also creates risks that focus on mental health and learning disability services might suffer due to the focus being prioritised on other health services. However, it may also provide opportunity to ensure that people's mental health is considered alongside their physical health problems, particularly in terms of people with Long Term Conditions which often have a psychological impact.

The timescales for implementing the new models of care are also uncertain. NHS England has established "Vanguards" to take the lead on transforming care; however, no information has yet been published on how learning from these initiatives will be taken forward.

In response to the above risks and uncertainties:

- The Board has considered the implications of the Five Year Forward View for the Trust.
- The Trust is actively seeking to engage with commissioners and emerging GP federations to understand and influence the development of new models of care and to ensure that, if implemented, they have a positive impact on the mental health and well being of the population they serve.

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

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

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

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

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

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

Changes to Mental Health Legislation

The Code of Practice to the Mental Health Act 1983 provides statutory guidance to registered medical practitioners, approved clinicians, managers and staff of providers and approved mental health professionals on how they should carry out their statutory functions.

Following a review a revised Code of Practice came into effect on 1st April 2015. This reflects updates in legislation, policy, case law and professional practice. The main changes include:

- Five new guiding principles
- New chapters on care planning, human rights, equality and health inequalities, consideration of when to use the Mental Health Act and when to use the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- New sections on physical healthcare, blanket restrictions and duty to support people with dementia.
- Updated chapters on the appropriate use of restrictive interventions, particularly seclusion and long-term segregation, police powers and places of safety
- Further guidance on how to support children and young people, and those with a learning disability or autism.

There are risks that that we will not be fully compliant and practice will be inconsistent until staff are familiar with the revised Code and policies are updated and embedded.

To mitigate these risks we have:

- Made the revised Code of Practice and associated revised Reference Guide available electronically to all staff as well as providing hard copies of these documents to all wards and teams
- Undertaken a review to identify all policies which will require updating and new policies which may be required.
- All new requirements have been embedded into the mental health legislation training provided on a rolling programme basis across the Trust and a series of briefing events will be held across the Trust to further raise awareness of the new Code and to highlight the key changes.

Monitor risk ratings

In accordance with the Health and Social Care Act 2012 we must remain licenced with Monitor, the health sector regulator, to provide healthcare services.

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

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

The **continuity of services risk rating** describes the risk of a provider of critical health services failing to carry on as a going concern. It incorporates two common measures of financial robustness: liquidity and capital servicing capacity.

The continuity of services risk ratings are as follows:

- 4 (no evident concerns)
- 3 (emerging or minor concern potentially requiring scrutiny)
- 2* (level of risk material but stable)
- 2 (material risk)
- 1 (significant risk)

The **governance risk rating** sets out Monitor's degree of concern about the governance of the Trust.

The governance risk ratings are as follows:

- green (no evident concerns)
- narrative risk rating (potential material causes for concern) setting out the description of the issue and the steps (formal or informal) being taken to address it
- red (regulatory action being taken).

Risk rating performance 2013/14 and 2014/15

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

2013/14	Annual Plan 2013/14	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Under the Compliance Framework					
Financial risk rating	4	4	4		
Governance risk rating	Green	Red	Red		
Under the Risk Assessment Framework					
Continuity of service rating				4	4
Governance rating				Green	Green

(Notes:

- *The "Compliance Framework" was used by Monitor to assess foundation trusts' compliance with their authorisations prior to the commencement of the licensing regime. Whilst this approach was similar to the Risk Assessment Framework it used different risk ratings.*

  The financial rating (based on achievement of plan, underlying performance, financial efficiency and liquidity) was expressed as 1 (highest risk) to 5 (lowest risk).

  The governance risk rating was expressed as:
  - *green (no material concerns)*
  - *amber-green (limited concerns)*
  - *amber – red (material concerns)*
  - *red (potential or actual significant breach of requirements)*

- *The 'red' governance risk ratings in Quarters 1 and 2, 2013/14, were due to Monitor undertaking an investigation in response to a warning notice issued by the Care Quality Commission that we had failed to address concerns identified during an inspection of Auckland Park Hospital in August 2012. Monitor concluded its investigation in Quarter 3, 2013/14 and returned our governance rating to "green").*

Involving and listening

Service user and carer involvement

It's important that we learn from the experiences of service users and carers and use their expertise to improve our services.

The essential standards patients and carers reference group involves service users and carers. It meets quarterly and supports the Quality and Assurance Committee in ensuring that services within the Trust are safe, providing high quality care and are continuously improving. The group also ensures compliance with the Care Quality Commission's *Essential Standards of Quality and Safety.* Members from the group work with the assurance department to inspect wards and teams in an internal programme of mock inspections to monitor compliance. Part of the inspection includes an inspection of the ward environment and interviewing patients either on wards or attending clinics.

In addition, we have involved service users and carers in many different aspects of our services. Over the last 12 months this has included:

- taking part in the Trust's first recruitment fair where service users and carers led focus groups, sharing their own experiences with potential employees and talking about the values and behaviours needed to work for the Trust
- helping to deliver specific carer awareness training for staff
- working with student nurses, doctors in training and staff undertaking NVQ training (helping with 6Cs training for nurses and providing case studies for doctors in training)
- visiting wards and speaking to staff and patients about their non-clinical environment as part of the Patient Led Assessment of the Care Environment (PLACE)
- participating in quality improvement events such as a rapid process improvement workshop for volunteer services and developing the model lines processes (see page 32)
- helping recruit and train staff (as members of the LD reference group) and helping with the Trust's LD conference
- taking part in the experts by experience programme – developing themselves and helping the Trust to embed the recovery principles within policy and practice
- attending various focus and steering groups including forensic patient experience, adult mental health, falls management, psychosis special interest group, care programme approach, Recovery College, place of safety development, risk assessment processes and force reduction
- helping to develop patient surveys for LD and CAMHS.

In 2014 a service user's extensive and invaluable involvement in a range of recruitment and training activities was recognised by the Royal College of Psychiatrists. Sarah Holmes was named Service User of the Year at the College's annual awards.

Healthwatch

The Trust liaises with a number of local Healthwatch organisations in County Durham, Darlington, Hartlepool, Tees and North Yorkshire, sharing information and responding to requests. Healthwatch is an independent consumer champion that

gathers and represents the public's views on health and social care services in England.

Patient advice and liaison service (PALS)
People contact PALS using the free phone, send messages to the PALS mobile, send emails and write letters raising concerns or comments about the services.

Between 1 April 2014 and 31 March 2015, 1028 contacts were recorded and responded to by PALS, this was a decrease of 145 contacts from 2013/14 when 1173 contacts were made.

Formal complaints
In 2014/15 we received 199 written complaints, which was an increase of 49 complaints compared to 2013/14.

The Parliamentary and Health Service Ombudsman (PHSO) is responsible for operating the second stage (independent review) of the NHS complaints regulations process. In 2014/15 the PHSO wrote to the Trust with 13 decisions about complaints - three were upheld, four were partially upheld and six were not upheld. We needed to undertake further action relating to seven of these complaints.

Listening and learning
We continue to learn valuable lessons from complaints and concerns from service users and their carers. Improvements identified over the last year in some areas of our services included:

- **Adult inpatient mental health services –** improved contact with and involvement of carers during hospital admission and stay on the ward.
- **Adult community mental health services** – reception area improved following a patient's recommendation to make the area more inviting and welcoming when attending for therapy.
- **Forensic service –** changes to maximise opportunities for patients to take leave from the ward.
- **Mental health service for older people -** improved hospital discharge planning and communication
- **Child and adolescent mental health services (CAMHS)** - greater clarity for inclusion of parents during initial assessment process balancing parental responsibility with wishes of the young person

The Trust also receives hundreds letters of thanks and praise for our services from the people who use them, their carers and families. We have included a selection of their comments in the report.

Supporting our staff

At the end of March 2014 we employed just over 6,000 staff:

250 doctors
1990 qualified nurses
1,500 clinical support staff
650 qualified psychologists, allied health professionals and pharmacists
1,550 administrative and estates staff

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

The number of male and female directors and senior managers (ie members of the Board of Directors and Executive Management Team) is 15 male and seven female.

Health and wellbeing

The Trust has a strong commitment to the positive health and wellbeing of our staff and acknowledges that the workplace offers a major opportunity to drive forward health improvement.

As staff are our most vital resource, it is essential that workplace health is not seen as a separate 'add on' but as integral to enabling our business to meet the challenges we face. The health and wellbeing of our staff therefore remains a high priority and we have continued to work with our occupational health provider to support our staff.

Following a competitive tendering process, North Tees and Hartlepool NHS Foundation Trust commenced the Trust's new occupational health service contract in April 2014. The contract involved a range of improvements such as electronic pre-employment screening to enable faster clearance for recruitment and a new physiotherapy service which provides a fast, responsive and accessible service to our staff.

We hold a case management meeting on a fortnightly basis with the sickness absence team, senior HR representatives and occupational health. The team discuss all staff, who are on long term sickness leave and it is an opportunity to consider if any further support could be offered. The average length of long term absence has significantly decreased from 2012, when the average number of days was 74 days, to 58 days in January 2015. This is due to a combination of support mechanisms including the employee support service, which we expanded in 2014/15, funding an additional post to support staff, and their managers, to return to, or remain at work. Mindfulness training for staff is also provided as part of a three year project. It is showing a significant positive impact on the mental wellbeing of staff and has been recognised nationally as a way to improve staff health and wellbeing (see page 34). An employee psychology service has also recently begun to help staff experiencing work related stress, anxiety or depression.

Despite continued efforts to support staff to remain at work, or return to work sooner than previously, the Trust's sickness absence target of 4.7% was not achieved (at the end of March the rate was 4.99%).

Sickness absence figures for 2014 (calendar year)

Average of 12 months (Jan-Dec 2014)	Average full time equivalent (FTE) staff in post	FTE days available	FTE days lost to sickness absence *	Average sick days per FTE
5.04%	5,417	1,218,486	61,434	11

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

Communicating and engaging with our staff

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

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

- Team briefing system
- Trust magazine (Insight)
- Intranet
- Weekly e-bulletin which includes a round-up of discussions at the Executive Management Team meetings and a weekly message from the Chief Executive. We also include a monthly Board round-up following the public Board of Directors meeting.
- Visits to services and teams by directors
- Quarterly leadership and management groups which give direct access to the Chief Executive
- An anonymous electronic mechanism for raising concerns which are responded to through ebulletin and posted on the intranet.
- The Trust's quality improvement system – staff involvement and engagement in improvement events is fundamental to its success

We also currently developing a knowledge management solution (KMS) which will give us a fully integrated intranet, website, extranet and document management solution. The KMS, which will be implemented in 2015/16, will improve the way staff are able to communicate and engage with each other as well as share information and knowledge.

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

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

Valuing our staff

It is important that we recognise the excellent work and the vital contributions staff make to patient care. This can range from a simple 'thank you' in our weekly e-bulletin to nominating teams and individuals for one of our annual staff awards.

Last year 40 teams or individuals were shortlisted for our eighth **Making a Difference Awards** and invited to a special awards ceremony. The Trust's awards programme is extremely popular and last year received over 220 nominations.

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

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

Human resource policies

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

- An improvement event took place in November 2014 to review the Trust's sickness absence management procedure. Managers, human resources and staff side representatives all contributed to the development of the new procedure based on NHS Employers guidance. The new procedure contains a provision for disability leave so that staff with a disability, who require regular treatment to maintain their health and attendance at work can do so within an agreed number of days leave.
- The recruitment and selection policy is based upon national recruitment standards and as part of the Department of Employment 'Two Ticks' symbol we guarantee to interview all applicants who declare they have a disability and who meet the minimum requirements for the post. The Trust will provide all reasonable adjustments to enable people with a disability to attend for interview. This applies not only to staff applying for their first post with the Trust but also to staff seeking promotion.
- The redeployment process provides the opportunity for staff who are no longer able to carry out their job either on health grounds or because of

organisational change to secure suitable alternative employment with the Trust. This can involve a period of shadowing, training and a trial period to widen the suitable opportunities available.

- The Trust's Human Rights, Equality and Diversity Policy emphasises the Trust's approach to the employment of staff with a protected characteristic. It aims to ensure that we meet the Equality Act 2010 aims of eliminating discrimination, harassment and victimisation along with fostering good relationships between people who share a relevant protected characteristic under the Act and those who do not. Our seven equality objectives include reducing by 50% the number of indicators in the staff survey where staff who have long term health conditions have statistically significantly less favourable responses.
- The Trust's staff development policy recognises that people learn in different ways and that a positive learning environment that endeavours to meet people's needs is likely to impact positively on the level of knowledge retained. Reasonable adjustments work positively in a learning environment as they remove barriers to learning. Staff are far less likely to learn and retain knowledge if they are worried or anxious. Everyone is different, so this could be something that impacts directly on a person within the learning environment or it could be that another factor outside the learning environment is having a detrimental impact on their ability to learn of participate in the training. Managers and staff are encouraged to contact the Education and Training Department to discuss how the Trust can best meet the needs of people from protected groups whilst they are participating in education and training.

The Trust's policy on pay

The Trust is committed to using national terms and conditions of service for staff with the exception of very senior managers, whose terms and conditions are determined by the Nomination and Remuneration Committee of the Board of Directors. The Trust's continuing commitment to national terms and conditions is dependent upon these arrangements aligning with service needs. The pay arrangements that are used must be sustainable, affordable and fair to staff. The Trust will contribute to efforts to ensure that national pay arrangements are responsive to service needs, for example by participation in national and regional consultation exercises and reference groups, as and when opportunities arise.

The use of job evaluation is a key part of ensuring that the Trust can demonstrate its commitment to the principle of equal pay for work of equal value, and to help maintain compliance with the Equal Pay Act. The Trust will continue to use the Agenda for Change job evaluation system for all posts covered by the national agreement and will continue to use independent job evaluation as part of maintaining and developing very senior manager pay arrangements. As part of its commitment to equal pay for work of equal value the Trust completed its first Equal Pay Audit in 2013 and is committed to undertaking equal pay audits every three years.

The Trust's approach to pay and reward will complement its workforce strategy as follows:

- The aim is to develop and use a new local appraisal process, with a streamlined Knowledge and Skills Framework, linking annual pay progression and/or the re-earning of the top two pay increments (Bands 8C and 8D only) to the achievement of objectives. Staff should have a right to earn pay progression not a right to pay progression. This complements the workforce strategy aims of d**elivering great management and leadership** and **ensuring every role counts.** The identification and assessment of employee competencies and performance compared to local standards must be based upon honest conversations between line managers and their staff, whether pay progression is at stake or not.
- **Promoting health and wellbeing amongst our staff** is a key aim of the Workforce Strategy and a Trust priority.
- **Supporting training and development** is a key aim of the Workforce Strategy.

A number of locally determined conditions of employment policy and practice are provided. These locally developed pay and reward initiatives are used to complement national pay and conditions of service and are developed in partnership with local staff representatives.

Staff survey
We were in the top 20% of mental health and learning disability Trusts in 22 of the 29 areas reviewed and received the best score in the country in two of those areas. We were also in the top 20% of trusts for staff engagement, which is based on three indicators:

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

Our top five ranking scores were:

- percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months (14% compared to a national average of 21%). We had the best (lowest) score in the country for mental health and learning disability trusts. (**KF19**)
- percentage of staff believing the trust provides equal opportunities for career progression or promotion (93% compared to a national average of 86%). This was also the best score for mental health and learning disability trusts. (**KF27**)
- percentage of staff agreeing that their role makes a difference to patients (93% compared to a national average of 89%). (**KF2**)
- effective team working (3.99 out of a possible score of 5, compared to a national average of 3.84) (**KF4**)
- fairness and effectiveness of incident reporting procedures (3.70 compared to a national average of 3.52) (**KF14**)

We were in the worst 20% of mental health and learning disability trusts in one area:

- percentage of staff experiencing physical violence from patients, relatives or the public in the last twelve months (22% compared to 18% nationally) (**KF16**)

Our other two lowest ranking scores were

- percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months (28% compared to 29% nationally) (**KF18**)
- Percentage of staff experiencing physical violence from staff in last 12 months (3% which was the same as national average) (**KF17**)

(Full details of our top and bottom ranking scores are included in the table on page 55).

Over the last year we have worked hard to address the issues highlighted in the previous staff survey. Local action plans have been developed and implemented and in addition we have:

- built on the success of our employee support service by funding an additional post to support staff (and their managers) to return to, or remain at, work.
- Provided Mindfulness training for staff. This is already having a significant impact on the mental wellbeing of staff and is being recognised nationally as a way to improve staff health and wellbeing.

There is always room for improvement and your views help us focus on areas where we still need to improve. We will now involve directorates and the staff joint consultative committee in looking at the results of this year's survey in more detail and developing action plans. We intend to use these results with the feedback from the Investors in People assessment and the results of the staff friends and family test to develop a joint action plan based on key themes. This will help to triangulate the results and concentrate on areas where the results overlap.

Summary of Staff Survey Results

	2013/14		2014/15		Trust Improvement/ Deterioration
Response rate	Trust	National Average	Trust	National Average	
	60%	*50%*	*57%*	*44%*	deterioration

	2013/14		2014/15		
Top 5 Ranking Scores	Trust	National Average	Trust	National Average	Trust Improvement/Deterioration
KF 19	*17%*	*20%*	*14%*	*21%*	*improvement*
KF 27	*94%*	*89%*	*93%*	*86%*	*deterioration*
KF 2	*91%*	*90%*	*93%*	*89%*	*improvement*
KF 4	*3.84*	*3.83*	*3.99*	*3.84*	*improvement*
KF14	*3.68*	*3.52*	*3.70*	*3.52*	*improvement*

	2013/14		2014/15		
Bottom 5 Ranking Scores	Trust	National Average	Trust	National Average	Trust Improvement/Deterioration
KF16	*23%*	*19%*	*22%*	*18%*	*improvement*
KF18	*30%*	*30%*	*28%*	*29%*	*improvement*
KF17	*4%*	*4%*	*3%*	*3%*	*improvement*

Partnerships and Alliances

TEWV has a number of partnerships and alliances with other organisations. These are set out below, along with the benefits to service users and funding arrangements.

- **Service improvement partnerships**: TEWV's quality improvement system (QIS) is one of the cornerstones of our ability to improve quality and value by identifying and eliminating waste. Our approach is based on the Virginia Mason Production System, and we maintain a contractual partnership with the Virginia Mason Institute through which we receive advice and guidance to help us further develop our approach to service improvement. We also work closely with the North East Transformation System team, hosted by Gateshead Health NHS Foundation Trust. We have delivered improvement events and training to a number of other healthcare providers including acute, mental health and learning disability organisations, CCGs and local authorities across the UK which benefits patients across the country not just in the North East.

- **Service Delivery Partnerships**:
    - In 2014/15 we secured the contract to provide mental health services within the seven prisons in North East England in partnership with Northumberland, Tyne and Wear Foundation Trust, Rethink Mental Illness and Middlesbrough & Stockton Mind, all of whom are subcontractors to TEWV in this context. This service is commissioned by NHS England and started on 1 April 2015.
    - From 1 April 2015 TEWV will be a subcontractor to Lifeline who secured the contract to deliver substance misuse services in County Durham. This service is commissioned by Durham County Council
    - TEWV has a partnership arrangement with County Durham and Darlington Foundation Trust and Mental Health Matters to deliver IAPT services in Durham and Darlington. The contract is held by the Trust and the other organisations are subcontractors. This service is commissioned by Darlington; Durham Dales, Easington and Sedgefield; and North Durham CCGs
    - TEWV is part of a UK-wide network of NHS providers, subcontracted by South Staffordshire and Shropshire FT to provide mental health services to serving members of HM Forces. This work is funded by the Ministry of Defence.

In addition to this, TEWV has day to day operational relationships with a wide variety of statutory and voluntary organisations for the benefit of our service users and carers.

Essential Contractual and other Relationships

TEWV is reliant on the maintenance of the following relationships and contracts:

- provision of space for inpatient services at The Friarage, Northallerton – South Tees NHS Foundation Trust
- provision of space for inpatient services at Harrogate General Hospital – Harrogate and District NHS Foundation Trust
- Gas Supply – Corona
- Electricity - EDF Energy on large sites & British Gas on smaller sites
- Waste collection – Our main clinical waste contract is with SRCL and domestic waste with O'Briens. However in North Yorkshire we use Yorwaste and various local authorities on smaller sites
- Information technology hardware installations and disposals – Van der Veldt
- Lease car scheme – Knowles
- Construction and design services (various)
- Hospital facilities management
    - West Park Hospital - Integral
    - Lanchester Road Hosital - Grosvenor Facilities Management
    - Roseberry Park - Carillion Integrated Services.
    - Other TEWV facilities have an in-house service.
- Legal advice / representation – Ward Hadaway
- Occupational health service for staff – North Tees and Hartlepool NHS Foundation Trust
- Agency staffing – CorePeople
- Procurement of supplies – County Durham and Darlington NHS Foundation Trust
- Staff survey – Picker Institute

Quality Assurance

Overview of arrangements in place to govern service quality

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

Delivery of the quality strategy is reported through a strategic scorecard with key performance indicators for each framework , reported monthly to the Quality Assurance Committee, a sub-group of the Board of Directors.

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

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

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

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

In addition to the implementation of the quality strategy, the Trust monitors and reports on performance against the national and local quality indicators in the commissioned contracts. Monthly quality reports are produced for all the service

contracts and reviewed by commissioners with the locality operational management teams, corporate performance and quality governance teams. Each locality management team therefore has oversight of their service performance against the internal strategic quality targets and against their contractual quality indicators.

Quality governance

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

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

The Trust uses quality information as a basis for monitoring the performance against the quality strategy targets, external quality and regulatory standards and contractual quality indicators. There has been significant development in improving the systems for collection, analysis and reporting of quality data this year with investment into the expansion of the electronic risk reporting system. This will increase the robustness of the quality information and reports used for the Board assurance framework and evaluation of quality performance.

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

A summary of action plans to improve quality governance

- project plan for the quality assurance and Datix expansion – improving the systems for the reporting, collection and analysis of quality governance information – developing a set of standardised quality reports for the quality assurance groups, locality management and governance boards, Trustwide quality assurance groups, Quality Assurance Committee and commissioners
- learning lessons – enhancing the systems and processes for disseminating lessons derived from the analysis and review of incident, claims, complaints , safeguarding and external inspections – developing the learning culture of the Trust and improving the systems for action plan monitoring and testing of action effectiveness
- implementation of the Duty of Candour – a Trustwide staff development plan to ensure staff are aware of their roles and responsibilities within the new Duty of Candour regulations and are confident in engaging patients, families and carers in this work
- re-design of corporate complaints and PALs management teams and processes in response to the Clywd and Hart national review recommendations

- re-design of corporate patient safety incident management teams and processes in response to the new national serious incident framework recommendations.
- development and implementation of the new role of Director of Quality Governance , an Executive Management Team role, reporting to the Executive Director of Nursing and Governance to give additional expertise and clarity to the leadership of quality governance management.
- development and implementation of the new roles of Locality Professional Nurse Lead to support the locality professional and clinical governance systems.

Arrangements for monitoring improvements to the quality of healthcare

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

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

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

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

Additional quality issues not covered in the quality report

- enhancing the acute care liaison services
- upgrading the inpatient environments at Briary Unit, Harrogate District Hospital and Wards 14 and 15 at the Friarage Hospital, Northallerton
- new facilities: Lake House, Scarborough; Windsor House, Harrogate, new unit at Springwood, Malton
- review and redesign of serious incident management team and processes
- review and redesign of the complaints and PALS processes
- delivery of the first stage of the carer strategy and triangle of care
- introduction of systems to manage Duty of Candour and fit and proper persons regulations.

Research and development

Our ongoing participation in clinical research through 2014/15 reflects our firm commitment to improving the quality of care we provide, as well as contributing to the broader goals of mental health research. We are committed to embedding research participation in all geographies and specialties of the Trust's services and as such we are involved with large scale national research within psychosis, drug safety, forensic mental health, dementia, learning disabilities, personality disorder and children and young people's services.

We are an active and committed partner of the North East and North Cumbria Clinical Research Network (NENC-CRN) which was launched on 1 April 2014. We contributed to the NENC-CRN recruitment targets for the mental health, dementia and neurodegenerative disease specialties. As anticipated, we achieved a lower level of National Institute of Health Research (NIHR) recruitment this year. However, our portfolio consists of a greater number of more complex studies, albeit recruiting lower numbers per trial. We are one of seven NHS trusts across the UK hosting a trial to determine whether giving ketamine during ECT reduces depressive symptoms and whether there is a reduction in cognitive impairment normally associated with ECT. We have successfully completed recruitment to the COBRA study: a randomised controlled trial to determine both the clinical and cost effectiveness of behavioural activation compared to cognitive behavioural therapy (CBT) for depression in adults within primary care. If the findings show that behavioural activation is as effective as CBT in reducing depression severity, then this could mean a significant saving in direct health care costs.

We have continued our collaborative partnership with Durham University across two key areas of shared interest: primary care mental health and evaluation of psychological interventions in young people. Youth Speak, formed as a result of this collaboration, celebrated its first birthday in October. Youth Speak is a group which engages young people in mental health research, and is just one example of our aim to have full service user and carer involvement in all areas of research. Full involvement of people with experience of mental health problems is essential to ensure the quality and relevance of our research in the development of ideas, study design and conduct, and in communicating the results to those who can use them to improve care.

We also continue our collaborations with both York University and Newcastle University as co-applicants on large scale grant applications. York University recently secured a Health Technology Assessment (HTA) grant to fund SCIMITAR PLUS – a trial of smoking cessation intervention for people with severe mental ill health. Newcastle University was awarded a Research for Patient Benefit (RfPB) grant to fund a feasibility study using an immersive virtual reality environment to reduce anxiety in children with autism spectrum disorder. These important studies will begin to recruit participants across the Trust within the next few months.
2014/15 saw a rapid growth in Trust support of large scale dementia research in response to the Prime Minister's Challenge on Dementia. In October 2014, the Executive Management Team considered and approved the business case to embed clinical trials of investigational medicinal products (CTIMPs) into core Trust business. Some of the benefits of this development will be

- an increase in participant numbers in CTIMP studies

- an increase in the number of studies where TEWV is a research site
- better access to research for service users and carers and an increased reputation for TEWV as a research centre in its own right.

The Trust was an early adopter of the 'Join Dementia Research' system and continues to promote the system through research champions based within the memory services. This new national system allows anyone, with or without dementia, to register their interest in becoming involved in dementia research.
The Opting in to Clinical Research (OptiC) System has recently been incorporated within PARIS, our electronic patient records. Systems like this, embedded in NHS records, allow service-users to express an interest (or otherwise) in participating in clinical research and have the potential to enhance and streamline the recruitment of patients to studies. This system has been piloted in two sites and will be rolled out to other sites over the coming months.

Health, safety, security, emergency planning and business continuity

Throughout the year, we have continued to make sure that staff receive advice, support and training on health, safety, security, emergency planning and business continuity issues.

This has included:

- roadshows and support sessions for the health, safety and security workbook champions, as well as the introduction of display screen equipment (DSE) assessor training
- a review of the health, safety and security workbook which will result in the launch of an e-workbook and training sessions for staff
- an audit of the health, safety and security workbook in the following areas:
    - local induction
    - provision of first aid, which identified areas where this is to be increased
    - lone-working
    - re-validation of 25% of workbooks where there had been outstanding actions
- a live exercise – Exercise Two Counties – to test our business continuity plans in conjunction with Cleveland Emergency Planning Unit. The exercise was held to test arrangements around winter planning and fuel shortage situation. Plans worked well and a number of lessons have been learned which, when implemented, will strengthen existing emergency and business continuity planning arrangements.

Reducing our carbon footprint

We are committed to reducing our carbon footprint and our environmental strategy and an implementation plan was approved in April 2010. We are monitoring our performance against the Good Corporate Citizenship assessment model and also propose the launch of the Trust's sustainable development management plan early in 2015/16.

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

In a recent government energy certification exercise which rated our buildings A to G with D being above average, 28 of the 33 properties surveyed were rated D or above.

The Trust is now looking at extending the use of large scale solar photovoltaics and also generating our own power through the use of combined heat and power.

We are also preparing a bid for funding to increase the number of electric vehicle charging points at Trusts sites in an effort to encourage greater take up of electric vehicles.

Quality Report 2014/15

PART 1: STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE OF THE TRUST

I am pleased to be able to present Tees, Esk and Wear Valleys NHS Foundation Trust's (TEWV) quality report / account for 2014/15. This is the seventh quality report / account we have produced and it tells you what we have done to improve the quality of our services in 2014/15 and how we intend to make further improvements in 2015/16.

Note: for the purposes of publication I the Trust's annual report, the quality account is termed the quality report and is therefore referred to as 'quality report / account' throughout this document.

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

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

and our Quality Strategy 2014-2019.

Our Quality Strategy sets a clear direction and outlines what the Trust expects from all staff as we work towards our vision of delivering high quality services that exceed people's expectations.

In delivering quality we believe our services must:

- Provide the perfect experience;
- Be appropriate;
- Be effective;
- Reduce waste;
- Build upon the standards set by the Care Quality Commission (CQC).

Our four Quality Goals are:

- Everyone who uses our services has a positive experience and feeds back that they were listened to, engaged in their care and treated with compassion, respect and dignity.
- We reduce to a minimum the harm that people that use our service suffer.
- We deliver excellent outcomes as reported by patients and clinicians.
- Our staff feel positively engaged with the Trust.

In the 2014 NHS service user survey of community services, the Trust scored **8.7 out of 10** (sample size of 185) for 'did you feel you were treated with respect and dignity by NHS mental health services'. This was a similar score to other mental health Trusts in the survey.

In the Trusts own survey in 2014/15, **74%** of wards scored greater than 80% for patient satisfaction.

In the Trusts own survey 90.6% of our community patients say they have been involved in the development of their own care plan.

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

What we have achieved in 2014/15

In January 2015 over 100 CQC inspectors visited the Trust to carry out a detailed inspection of all of our services. They awarded the Trust an overall rating of 'good'. They rate organisations against a four-point scale: outstanding, good, requires improvement or inadequate. TEWV scored extremely well - 52 of the 60 ratings received were outstanding or good and the inspectors highlighted 16 notable areas of good practice. None of our services were rated as inadequate.

All our services were rated as good or outstanding for being caring and this is reflected in the narrative of the report. Time and again throughout the report the inspectors commented on the positive, caring attitudes of our staff. The inspectors found lots of good evidence of how we keep patients safe. Unfortunately because of four minor breaches we were rated as requiring improvement. The inspectors highlighted six issues that we needed to address. A detailed action plan has been developed and will be monitored regularly. By mid May 2015 we had already completed 50% of the required work. The inspection results are summarised in more detail on pages 95-100 of this document and the full inspection report can be read online.

Part 2 of this quality report / account sets out our progress on our four quality priorities for 2014/15. However, these quality priorities are not the only ways we have improved the quality of our services during 2014/15. The following are other notable examples of quality improvements within our services / localities in 2014/15:

- We have continued to work with our commissioners to deliver new services to meet the needs of those who use our services. For example we have:
  - Started to provide IAPT (often known as "talking therapies") services in North Yorkshire in July 2014. Since then we have seen access rates improve from 195 people entering the service during July 2014 to 516 people during March 2015.
  - Provided a new "place of safety" – also known as a "Section 136 suite" in Northallerton and improved staffing at some of our other Section 136 suites so that police forces do not need to use police station cells for people arrested due to behaviour triggered by a mental health crisis.
  - Extended Acute Hospital Liaison Services across North Yorkshire.
  - Improved Children and Young People Services (CYPS) across Teesside and Durham & Darlington by extending opening hours to weekday evenings and Saturdays and providing additional services to support prevention and early intervention.
  - Participated in the multi-agency, multi-disciplinary team meeting systems being trialled in Darlington to improve the care given to vulnerable elderly patients.

In the 2014 NHS Staff Survey, the Trust scored **3.82 out of 5.00** (sample size of 471) for the question 'would recommend the Trust as a place to work and receive treatment'.

This continued to be within the **top 20%** of all mental health Trusts who participated in the survey.

Overall in 2014 TEWV was in the top 20% of mental health Trusts **in 22 of the 29** areas reviewed.

- Provided mindfulness sessions for service users and staff, which have be very well received.
- Improved our processes for ensuring that service users with a learning disability actively take part in staff selection, interviews and recruitment fairs, to reduce the risk of recruiting staff that do not share the organisation's values.

- We have also continued to invest in ensuring our buildings provide appropriate and therapeutic environments. In 2014/15 we saw the completion of refurbishment of the children's inpatient assessment and treatment unit at West Lane Hospital, Middlesbrough. Patients and staff also benefitted from community team base improvements in Redcar and Cleveland Children and Young Peoples Services (CYPS) (The Ridings, Redcar) and East Durham Older People's Services (Seaham Old Vicarage). Work has commenced at Ripon on a new rehabilitation facility, and community bases in Chester-le-Street and Derwentside are also being improved.

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

- We are using the expertise and resources of the voluntary sector, a local authority and a housing association to deliver courses at our Recovery College in Durham. These courses help service users develop strategies to help them live the life that they want to live.
- We listened to feedback from staff and managers in acute hospitals and care homes to make our liaison teams as effective as they can be in identifying patients with mental health needs and making sure they can access appropriate support or treatment.
- We have piloted locating Mental Health Services for Older People (MHSOP) community staff in GP surgeries in Blackhall, County Durham. The aim of this is to simplify the referral process so that people registered with the GP practice can access mental health services quickly and conveniently. It has reduced the need for patients to travel to other clinics and helped to tackle mental health stigma by putting mental health care under the "same roof" as physical health care.

In the 2014 NHS service user survey of community services, the Trust scored **8.9 out of 10** (sample size of 188) on how well we organise people's care. This was in the best 20% of Trusts.

In addition to the examples above, we have also continued to drive improvements in the quality of our services through using the TEWV Quality Improvement System (QIS). This is the Trust's approach to continuous quality improvement and uses tried and tested techniques to improve the way services are delivered. Some notable examples of what we have achieved in 2014/15 are:

- With the help of carers, who took part in an improvement event, we have redesigned our Serious Untoward Incident (SUI) investigation

In the 2014 NHS service user survey of community services, the Trust scored **6.2 out of 10** (sample size of 190) for 'have you agreed with someone from NHS mental health service what care you will receive'. This was a similar score to other mental health Trusts in the survey, but one that we hope to improve by issuing care plans on yellow paper so that their importance is flagged visually to patients.

process.

- We have developed a new pathway, (including documentation and standard processes) for community psychosis / early intervention teams, piloted this and then commenced a phased Trustwide implementation.
- We used improvement techniques to design a new process and template for discharge letters that are sent to patients' GPs. GPs in the pilot area (South Durham) have reported that the new style letters are easier and quicker to read and help them to understand and digest important information about their patient's ongoing treatment needs.
- We have introduced a new "daily report out" process in our learning d misability wards. As a result we now have quicker decision making regarding patient care and prompter adjustments to care and discharge plans. These changes are reducing length of stay.

In 2014/15 the Trust was also recognised externally in a number of national awards where we were shortlisted and / or won. These are set out in the following table.

Awards Won
Won Royal College of Psychiatrists (RCPsych) Service User/Patient Contributor of the Year.
Won Positive Practice in Mental Health Award (mental wellbeing for staff category) for our Mindfulness project.
Shortlisted
Shortlisted in the **Advancing Healthcare Awards** (for revamping existing intensive interaction training which helps LD staff make a meaningful social connection with patients).
Shortlisted in the innovative technology/device category of the **Bright Ideas in Health Awards** for an invention that helps staff move patients safely whilst displaying serious challenging behaviour.
A member of staff shortlisted in the clinical research nursing category of **the Nursing Times awards** 2014 for her role as principal investigator in a national study on dementia and eye care.
Shortlisted in the 'learning disability nursing' category of **Nursing Times awards** for developing an intervention to address issues of bullying amongst people with learning disabilities.
Shortlisted for carer of the year in the **RCPsych awards**.
Shortlisted for RCPsych Higher Psychiatric Trainee of the Year.
Shortlisted for RCPsych Psychiatrist of the Year.
Shortlisted for the student placement of the year in the **Student Nursing Times awards**.
Shortlisted in the 'Innovations in My Shared Pathway' category of the **National Service User Awards** – this was for a Collaborative Risk Assessment training package used in Forensic services.

What did we learn in 2014/15

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

One area where we identified we needed to do things differently was in our approach to the investigation of Serious Untoward Incidents (SUIs). We recognised that the

quality and timeliness of reviews was often not as good as we would have liked. As a result we have introduced an expert corporate team of dedicated SUI reviewers supported by a network of clinical experts. This new arrangement commenced in December 2014 and was fully in place by 1 April 2015.

We also held an improvement event which used all the feedback from staff and families about how to conduct the review in a more efficient and person centred way. As a result we now include relatives in SUI investigations from the beginning and we always give them copies of the investigation report. We audited this, found it was not working as intended and so conducted further work to develop a standard process. All families and carers have the opportunity to be involved and to have a feedback session when the review is complete. We recognise that some families do not want to engage with this process and respect their wishes, but we now have processes to involve those who do want to be involved. This links to our work on establishing a "culture of candour" – see **section 3**.

We have also developed a learning lessons bulletin to help spread information and embed learning across the Trust. We have set up a new part of the SUI review process so that our staff have the opportunity soon after the incident to quickly highlight issues that could have gone better and those that went well.

In 2014/15 the Trust received **198** complaints. During 2014/15 **74%** of complaints were resolved satisfactorily.

As a result of these complaints **56** action plans to learn the lessons were generated. At the end of March 2015, the Trust had **4** action plans that were outstanding more than one month beyond their originally agreed timescale.

Inspections are a useful source of learning for the Trust. To make the most of this learning, we have improved our post-inspection action planning and ensured that staff are trained in the new approach. We have also set up a performance management system to track progress against the actions. These changes have been audited by our internal audit service (Audit North) who have assessed them as being fit for purpose. We also use clinical audits to check that the actions have been effective in addressing the original problem. The findings of external inspections of the Trust are included in **section 2**. The CQC carried out an inspection of all Trust services and sites during January 2015 and the results from this were published in May 2015 (see **pages 95 - 100**).

Structure of this quality report / account document

The structure of this quality report / account is in accordance with guidance that has been published by both the Department of Health and the Foundation Trust regulator, Monitor, and contains the following information:

- **Section 2** – Information on how we have improved in the areas of quality we identified as important for 2014/15, the required statements of assurance from the Board and our priorities for improvement in 2015/16.
- **Section 3** – Further information on how we have performed in 2014/15 against our key quality metrics and national targets and the national quality agenda.

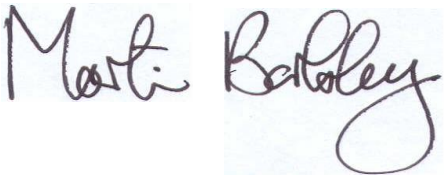
The information contained within this report is accurate, to the best of my knowledge.

A full statement of Directors' responsibilities in respect of the quality report / account is included in **appendix 1**. This is further supported by the signed limited assurance report provided by our external auditors on the content of the 2014/15 quality report / account which is included in **appendix 2**.

The Trust currently has no overdue actions in any of the plans agreed with CQC following its inspections (including Mental Health Act inspections).

I hope you find this report interesting and informative.

If you would like to know more about any of the examples of quality improvement we have highlighted in this report, or have any feedback or suggestions on how we could improve our Quality report / account please do let us know by e-mailing either myself at martinbarkley@nhs.net, Sharon Pickering (Director of Planning, Performance and Communications) at sharon.pickering1@nhs.net or Elizabeth Moody (Director of Nursing and Governance) elizabeth.moody@nhs.net.



Martin Barkley
Chief Executive

PART 2: PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

Update on 2013/14 quality priorities

In last year's Quality report / account we reported on our progress with our quality priorities for 2013/14. Within this we also noted some further actions for 2014/15. In some cases, these actions were to be included within the quality priorities for 2014/15, and therefore, are reported within this quality report / account. In other cases, these quality priorities were discontinued in the quality report / account but remained a priority for the Trust. The following is a brief summary of our progress with the quality priorities that were not continued in the quality report / account priorities for 2014/15.

To improve the delivery of crisis services through implementation of the crisis review's recommendations	A project was established to implement the recommendations following the Durham and Darlington and Teesside review of crisis services. The recommendations included a number of actions for the specific crisis teams to implement as well as service wide proposals in respect of clinical networks, audit etc. The recommendations and actions have all now been implemented and the project has now been closed.
To further improve clinical communication with GPs	During 2014/15 there have been further improvements to ensure the services within the Trust communicate effectively with GPs. One key improvement is that the Trust now has a functioning electronic discharge document that can be sent directly into a GP Practice electronic system. This allows instant transfer of information from the Trust to a GP. This will ensure that information is received in a timely fashion allowing GP Practices to have the most up to date information about a service user when they are discharged from the Trust. A roll out programme is in place to train teams on how to use the electronic discharge document. Upon receipt of the training the document will be made available to the teams that have received training. Further work is also underway to improve other documents that can be sent to a GP from the Trust.

2014/15 Priorities for improvement – how did we do

As part of our 2013/14 quality report / account following consultation with our stakeholders, the Board of Directors agreed four quality priorities to be addressed in the quality report / account in 2014/15.

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

Priority 2: To implement the recommendations of the Care Programme Approach (CPA) review, including,

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

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

Priority 4: To manage the pressure on acute inpatient beds

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

It is important to note that the achievement of these priorities should not be seen as the end point. These priorities are often a key milestone in a journey of quality improvement and further work will continue to embed good practice and deliver further improvements in experience and outcomes for our service users.

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

Why is this important:

Suicide is not just about the death of an individual, it is also a tragic event for family, friends and colleagues. The government has announced that it wants a zero tolerance approach where the target for suicides will be zero.

The table below shows the increases in the number of suicides since 2007 (when the previous decline in suicide rates concluded and rates started to rise again). A particularly high rate in the North East of England, and the high rates for males can be clearly seen:

	2007 – deaths (no)	2007 – deaths per 100,000	2013 – deaths (no)	2013 – deaths per 100,000	% change
England – overall	3993	9.42	4722	10.72	18% increase
England – males	3043	14.77	3684	17.17	21% increase
England – females	950	4.42	1038	4.62	9% increase
North East England - overall	216	10.21	295	13.83	37% increase
North East England – males	169	16.63	229	22.12	36% increase
North East England - females	47	4.29	66	5.87	40% increase
Yorkshire and Humberside - overall	425	9.96	502	11.58	18% increase
Yorkshire and Humberside – males	335	16.14	407	19.11	21% increase
Yorkshire and Humberside – females	90	4.17	95	4.34	6% increase

Local suicide audit figures show that in 2013, in six of the local authority areas the Trust covers (ie not including North Yorkshire) there were 123 deaths by suicide and injury undetermined. 37 (30%) of these 123 people had had some form of recent contact with Mental Health Services (ie within 6 months of death). This shows that if we can improve our own practices then we have the potential to make a significant contribution to reducing suicide. However it also demonstrates that tackling suicide cannot be a role solely for Mental Health Services, and that our work to share our expertise with GPs, Social Services staff and other agencies will continue to be very important.

What benefits / outcomes did we aim to deliver:

- Increased prevention of suicide across services.
- Increased safety for patients.
- Enhanced staff competency and confidence in suicide prevention and clinical risk management.
- An increase in the number of staff trained in specialist suicide prevention and intervention.
- Improved engagement and support for families and carers to promote safety and recovery.
- Care provided in a way that manages risk whilst promoting recovery and keeping our service users safe.
- Service users allocated the appropriate CPA level to support their identified needs.
- Promoting a culture of harm minimisation, working towards zero suicides, actively involving service users to develop resilience, control, choice, in safety planning.
- Carers, family members and workers in other public services will have more knowledge about behaviours that indicate an increased risk of suicide and what do to when they realise that the level of risk is increasing.

What we did in 2014/15:

Once this priority had been identified we agreed that to lead this important work would require dedicated resources in the form of a project manager. Throughout the year there was a significant time that we did not have anyone in this post despite several attempts to recruit. However, we continued to drive this priority forward and whilst there has been some delays we have delivered the majority of the agreed actions as described in the table below:

What we said we would do	What we did
• Approve the project scope by quarter 1 2014/15.	• Project scope was approved in April 2014.
• Recruit the project team and establish the project group to take this forward by quarter 1 2014/15.	• Project Manager was appointed April 2014 but subsequently left. A replacement was appointed in February 2015. Given the delays with recruiting a new Project Manager, the immediate focus had been on developing a framework. • A Project group was established in June 2014. • 3 working groups were identified to take forward developments looking specifically at data / themes / trends and human factors of suicide which will then feed back into the framework and training development. A fourth proposed group will focus on the training aspect and this group will run once the pilot framework is developed.
• Review current practice within the Trust by quarter 1 2014/15.	• The review was completed in July 2014 and discussed at the Patient Safety Group in August 2014.

• Develop a suicide prevention framework and training and implementation plan that describes what training is required, who will provide it and what other support is necessary for staff to provide effective suicide prevention and intervention by quarter 2 2014/15.	• Feedback from clinical services was obtained throughout 2014/15 in relation to the utilisation of the framework. The feedback we received from the clinical services was very positive with minor amendments required. • The framework was approved at the Suicide Mitigation steering group in February 2015. Following minor amendments it will be submitted to the Executive Management Team for approval in July 2015.
• Develop a training needs assessment and training plan which will describe who will receive training and how this will be rolled out across the Trust by quarter 3 2014/15.	• A plan for delivering training was initially agreed and has been rolled out within the MHSOP service. Given that the scope of the project has been extended Trustwide, further training and costing options are being explored by the Project Manager however a plan for training priority staff has been developed.
• Commence training for priority staff (eg crisis teams) by Q4 2014/15 (to be completed for all relevant staff in 2015/16).	• We have not commenced training all priority staff. The resignation of the original project manager and the time for a replacement to arrive in post contributed to the slower than anticipated start to the training. But it also reflects the decision by Trust Board to extend the project to cover other clinical specialities in order to ensure that all relevant Trust staff are given the same skills and information in relation to risk assessment and management. This decision also supports the information coming from the Confidential Enquiry Report relating to increase suicide rates in older people. Durham and Darlington training of priority staff will be completed by Q2 15/16, North Yorkshire and Forensic by Q4 Q15/16 and Teesside by Q2 16/17.

What we plan to do in 2015/16:

We will complete the training as planned for the Adult Mental Health staff that was delayed due to the departure of the previous Project Manager. We will also review the training we have planned to ensure it incorporates the most recent research on those people most at risk from suicide and take into account the work currently being implemented in Detroit on ‘zero tolerance’ to suicide. This will ensure our staff are being trained in the most current models of risk assessment and suicide prevention.

The new Project Manager will also work with the MHSOP staff within their current training programmes to ensure all relevant staff are trained. We will then be extending the training to the other appropriate groups of professionals in other services, then including GPs. We are also exploring training for families and carers.

How we know we will have made a difference:

In order to demonstrate that we are continuing to make progress against this priority we will measure and report on the following metrics:

Indicator	Target	Timescale
• Improve the percentage of users on CPA who have an up to date risk assessment.	To be determined	Q4 2015/16
• Improve the percentage of service users who have a risk assessment completed within 72 hours their face to face contact (baseline 57%).	60%	Q4 2015/16
• Improve the percentage of service users who have their views taken into account in developing their care plan (baseline 36% for community and 60% for inpatients).	40% community 70% inpatients	Q4 2015/16
• Staff have received suicide prevention training.	60%	Q4 2015/16

Priority 2: To implement the recommendations of the Care Programme Approach (CPA) review, including,

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

The Care Programme Approach (CPA) and care planning is critical to the quality of care our service users receive. The full involvement and participation of service users and carers within care planning is associated with improved outcomes and the experience of care. Addressing the issues above for service users, carers, staff and the professionals working in other agencies with whom we work with (e.g. GP Practices, Local Authorities etc.) was a clear priority for improving the quality of the services the Trust delivers.

The Trust included this priority within the 2013/14 quality report / account and our stakeholders felt that it was important to continue to include this as a priority within the 2014/15 quality report / account.

What benefits / outcomes did we aim to deliver:

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

- Improved service user experience, choice and involvement in their personal recovery;
- Services that are personal and meaningful to service users;
- Carers feeling recognised, valued and supported.

What we did in 2014/15:

The following is a summary of the key things we have achieved in 2014/15:

What we said we would do	What we did
• Implement actions relating to CPA from Model Lines pilot team by quarter 2 2014/15.	• Ensured close working with the Model Lines (see **appendix 3** for details) team to ensure the framework of CPA (assessment, risk assessment, care planning, contingency planning and reviews) is person centred and recovery focused. • The CPA project lead and the Recovery project lead participated in events to raise awareness and engage with internal stakeholders on CPA and how this approach supports recovery. • Completed care plan audits for each Psychosis and Early Intervention in Psychosis (EIP) teams within the roll out of Model Lines with specific findings presented to the teams to give an overview of recovery focused care planning and coproduction in the team. • Facilitated recovery focused care planning workshops for the Model Lines teams following on from the care plan audits to engage the staff and increase awareness about person-centred and co-produced care planning. • Developed a model for training Trust staff in care planning along with service users and the ARCH (aspiration, recovery, confidence, hope) Recovery College in Durham for all teams across the Trust. • Developed 'good care planning' guides for staff and services users. • Developed a briefing sheet on the 'principles underpinning recovery focused care planning'. This is used within the care planning and CPA training and has been incorporated into the revised draft CPA policy.

• By quarter 4 2014/15, redesign CPA processes and documentation to ensure they fulfil the following:
  • meeting mandatory requirements whilst reducing unnecessary burden on staff.
  • ensuring the requirements of the Mental Health Act are met whilst reducing unnecessary burden on staff.
  • development of standard work regarding Section 117 of the Mental Health Act – the statutory duty to provide health and social care to some service users following discharge from in-patient care.
	• Standard care (for people not placed on CPA) review documentation on the electronic record system has been redesigned so that both the risk assessment and care plan can be viewed in the form of a letter to make it easier to read. This has been piloted and evaluated in our Mental Health Services for Older People (MHSOP) memory services. The benefits have been a reduction in administration time for clinical staff, which in turn has increased the direct face to face clinical time available with service users and their carers.
	• Identified how we roll out the new process and documentation to all services in order to reduce unnecessary administration and increase direct clinical time. Using our electronic patient record (Paris) the delivery of this is contingent on the Paris Programme business case therefore some of this work will be delivered in 2015/16.
	• Redesigned care documentation for CPA processes such as assessment and review, with an aim to ensure the requirements of the Trusts CPA policy and the Mental Health Act are met in the redesigned Paris in 2015/16.

	• Aligned the new policy on Section 117 after-care legislation with the CPA policy and ensured staff are clear about the requirements of their role and the documentation of after-care needs and services. • Supported all specialities to develop risk assessments that promote safety and link with care planning in a recovery orientated way that is meaningful to the person and their carer and families.
• Implement regular audit and case management / supervision systems to include monitoring of transfer processes within Paris (the electronic patient record) by quarter 4 2014/15.	• Conducted audits of CPA, transfers of care and care plans. The findings of these reports are in the process of being finalised and the results will be used to inform training and development action plans to improve CPA within the Trust in 2015/16. • Developed a CPA audit framework to combine the findings in the reports mentioned above and ensure this is conducted bi-annually to monitor compliance of CPA against the Trust policy. • Developed a standard process for when patients are transferred between teams within the Trust that are aligned to the CPA policy and the protocols that relate to the transition of service users between specialities. • Developed a checklist for use within case management and supervision (with Trust staff) to ensure transitions of service users between teams are as smooth as possible. • Undertaken work to ensure transfers of patient care from one team to another are clearly recorded on our electronic patient record and communicated to GPs effectively.

How we know we have made a difference:

The table below shows improved knowledge and the staff satisfaction levels of those who have received the recovery focused care planning training:

Speciality/Team	Improved Knowledge of recovery focused care planning	Clear intentions of actions to Improve care planning	Satisfied with Training	Would Recommend Training to others
Stockton AMH Psychosis	100%	100%	100%	100%
Hartlepool AMH Psychosis	100%	100%	100%	100%
Chester-le-Street EIP	100%	100%	100%	100%
Whitby Community Mental Health Team	78%	89%	100%	100%
South Tees EIP	82%	82%	91%	100%
Stockton EIP	100%	100%	100%	100%
Northallerton AMH CMHT	100%	100%	100%	100%
North Yorkshire EIP	83%	100%	100%	100%

The recovery focused care planning training will continue during 2015/16 where we aim to achieve the following targets:

Indicator	Target	Timescale
• All Psychosis and EIP teams that have received recovery focused care planning training.	100%	Q4 2015/16
• Percentage of staff attending training who reported an improved information / knowledge of recovery focused care planning.	95%	Q4 2015/16
• Percentage of staff attending training who report they are clear about intended action to take to improve care planning.	95%	Q4 2015/16
• Percentage of staff satisfied with the recovery focused care planning training.	95%	Q4 2015/16
• Percentage of staff who would recommend this training to staff, patients and carers.	95%	Q4 2015/16

What we plan to do in 2015/16:

It is anticipated that further work to fully implement the recommendation of the CPA review will continue into 2015/16 in line with the original 2 year project. In 2015/16 we will:

- Implement core competency frameworks to identify the competencies needed by staff to implement the revised CPA processes and documentation.
- Implement a work based competency tool to assess competency and appraises' / supervisors' performance of assessment and care planning skills.
- Implement systems and standards for training, supervision and case management of care co-ordinators and lead professionals.

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

Why this is important:

Service users want mental health services to focus on their wellbeing and recovery, not merely on reducing their symptoms.

Helping people to recover involves supporting them to;

- **C**onnect with others;
- feel **H**opeful;
- build an **I**dentity beyond their diagnosis;
- find **M**eaning in their lives and
- **E**mpower them to take charge of their lives.

These are known as the CHIME factors.

Many traditional values need to be challenged if we are to become truly recovery orientated. We need to move away from any remaining 'paternalistic' elements in our approach and recognise the importance of expertise by experience that individuals have and coproduction. We need to move away from roles where we 'look after our patients' and instead provide service users with the knowledge and skills to take charge of their own lives.

We need to listen to what service users and carers want and support them to achieve their own personal goals.

What benefits / outcomes did we aim to deliver:

- Recovery focused practice across all Trust services.
- Increased opportunities for people with 'lived experience' of mental illness to co-produce services across the Trust.
- Access to self-management courses via a Recovery College provision (initially Durham).
- The Trust promoting a culture of harm minimisation, actively working to help service users develop resilience, control, choice, hope and empowerment.

What we did in 2014/15:

The following is a summary of the key things we have done in 2014/15:

What we said we would do	What we did
• Develop a programme of work to ensure the principles of recovery are embedded within all key programmes eg CPA, Model Lines, risk assessment & management (ongoing).	• In 2013/14 a recovery strategy and programme of work was developed for implementation throughout 2014/15. This programme recognised that we needed to ensure recovery principles were embedded into a number of different strategic projects / work streams. We have therefore embedded the recovery principles into the following areas of work: ◦ Model Lines Project ◦ CPA Project ◦ Values Based Recruitment Project ◦ Risk Framework These projects are ongoing and recovery principles will continue to be integrated within these projects throughout 2015/16. • Specific Recovery Training has been delivered to over 400 staff including clinical teams, senior medical staff and executive managers. • An evaluation of the recovery training has shown that: ◦ 81% of those who attended the training and responded reported an increased knowledge and understanding of recovery. The remainder reported a high level of knowledge prior to training. ◦ 94% of attendees rated 5-10, (medium – high) when asked if the training would improve their recovery focus within their clinical practice. • We have delivered a number of recovery focused care planning workshops within adult clinical teams across localities. • We have been successful in securing a project to work alongside the Mental Health Foundation (MHF) which will embed shared decision making. The MHF will support us to deliver training to staff in 2015/16 in shared decision making.
• Establish the current position on recovery action planning and devise an implementation plan by quarter 2 2014/15.	• 'Steps to Recovery' is a recovery action planning group intervention designed by a psychologist working within our MHSOP services. A pilot of this intervention has demonstrated a positive impact upon recovery outcomes. In 2014/15 we trained a further 95 Trust staff across MHSOP and Adult Mental Health services to support the delivery of this intervention across the Trust. • Recovery action planning courses are also being delivered within the Durham Recovery College. 'Recovery - the New Me'. This course is delivered to college students and is facilitated by Peer Trainers with lived experience.

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- Recovery action planning has also been embedded as a specific workbook within the Model Lines Project.

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- Increase the opportunities for volunteering by quarter 4 2014/15.

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- A review of our volunteering processes and procedures has taken place and new processes have been developed. A further business case to expand the volunteering opportunities has been approved for 2015/16.
- 7 new volunteering roles have been developed for individuals with lived experience within the Durham Recovery College.
- 23 further volunteers with lived experience have been given roles within a range of the Trust services.

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- Investigate the role of peer support workers (staff with 'lived experience' providing care and support) by quarter 4 2014/15.

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- The scoping of peer support roles has taken place.
- Draft role descriptions have been developed and possible models of delivery have been explored.
- A peer support steering group was set up in Q3 2014/15.
- Funding has been secured from Health Education North East to deliver our first peer support training in 2015/16 at the Durham Recovery College.
- An action plan to offer specific peer volunteer opportunities throughout 2015/16 has been put in place (and commenced development of an action plan to take forward paid peer roles).

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- Establish a cohort of service user / carer trainers to co-design and co-deliver recovery training by quarter 4 2014/15.

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- 2 cohorts of experts by experience have received training. 24 service users and carers commenced a five day training programme to support them to develop and deliver recovery stories as a central part of our recovery training. 21 individuals completed the training and we currently have 19 experts by experience actively working alongside the recovery team in the design and delivery of recovery training across the Trust. A breakdown of the locality of the experts is as follows:

<table>
<tr><th>Locality living / or received services</th><th>Number of current experts</th></tr>
<tr><td>Tees - Middlesbrough</td><td>1</td></tr>
<tr><td>Tees Stockton</td><td>2</td></tr>
<tr><td>Tees - Hartlepool</td><td>2</td></tr>
<tr><td>North Yorkshire – Harrogate Hambleton and Richmond</td><td>3</td></tr>
<tr><td>Durham and Darlington - South Durham</td><td>6</td></tr>
<tr><td>Durham and Darlington – North Durham</td><td>4</td></tr>
<tr><td>Out of area</td><td>1</td></tr>
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	• This group of experts have co-facilitated our recovery training, recovery development workshops, CPA care planning workshops.
	• The group of experts have been consulted and provided feedback for a number of Trust developments including the bid for the Virtual Recovery College, the development of CPA documentation and IT projects.
	• Members of the group also sit on a range of steering groups and work streams. Examples include;
	  ◦ Recovery steering group,
	  ◦ Recovery College steering group,
	  ◦ Force reduction steering group,
	  ◦ Peer support work stream group,
	  ◦ Culture work stream group,
	  ◦ Trauma work groups,
	  ◦ Values based recruitment fair planning and delivery group.
	• We are in the process of setting up a new training programme for a 3rd cohort of experts by experience and aim to develop a minimum of 10 further expert roles in 2015/16.

• Establish recovery leads in all localities, specialities and pilot teams by quarter 4 2014/15.	• Medical leads have been identified for North Yorkshire, Durham and Teesside. • A Human Resources (HR) recovery lead has also been identified. • We have service and professional leads that have membership on the Recovery Steering Committee. We have leads from Forensic, MHSOP and Adult services. We also have an Occupational Therapy and Psychology lead.
• Establish a Recovery College and courses by quarter 2 2014/15.	• We have a multi-agency Recovery College Steering Committee in place, which includes 5 positions for individuals with lived experience. • ARCH Recovery College in Durham locality was launched in September 2014 (Durham CCG's have provided specific funding to deliver this). • Two individuals with lived experience have been employed as Peer trainers within the college. • The college currently has 104 students enrolled attending courses / workshops. • The college has offered 19 courses and workshops during 2014/15 and further expansion of courses is planned for Q1 2015/16 (see attached list of courses in **appendix 4**). • Links have been made with a 3rd sector Recovery College in Teesside with a view to joint working and offering TEWV staff input to deliver specific courses / workshops. • Work is currently being conducted to engage commissioners in considering possible options for

	Recovery College provision in North Yorkshire. • We have also been successful in a bid to secure National funding to develop a 'Virtual Recovery College' which will enable services users to access self-help modules online. This will be developed throughout 2015/16.

How we know we have made a difference:

The following shows how we measured against our targets for this priority in 2014/15:

Indicator	Target	Timescale	Achieved
• Number of courses delivered at ARCH Recovery College.	17	Q4 2014/15	19
• Number of students enrolled at College.	100	Q4 2014/15	104
• Number of Experts by Experience.	12	Q2 2014/15	12 by Q2 then 19 by Q4
◦ Number of teams who have been through model line process in order to standardise recovery focused practice.	7	Q4 2014/15	7
• Number of TEWV staff receiving recovery related training.	300	Q4 2014/15	405
◦ % of trust staff receiving training reporting an increase in knowledge following training.	75%	Q4 2014/15	81%
◦ Number of new volunteering opportunities taken up by individuals with lived experience.	5	Q4 2014/16	30

What we plan to do in 2015/16:

The Trust's Recovery Strategy and implementation plan were always intended to be in place for more than one year to enable the complex process and cultural changes required to take place. Our stakeholders were consequently keen to retain Recovery as one of the 15/16 priorities for this quality report / account. Therefore our future actions for this priority can be found on pages 111-112 in the section on our new quality report / account improvement priorities.

Priority 4: To manage the pressure on acute inpatient beds

Why this is important:

Alternatives to hospital admission have shown to increase service users satisfaction with acute mental health care. Evidence and data collected as part of the Crisis Care Concordat, reveals improved patient experience with comparable outcomes to that of inpatient treatment, with a greater potential for sustained recovery.

However, there are times when individuals may require hospital admission. If this is the case then it is important that they are admitted to their local inpatient ward in order to:

- ensure their own sense of connectedness and familiarity is maintained;
- ensure family and carers can remain involved in their care and treatment;
- ensure consistent engagement of their community mental health team which provides continuity of care and supports early discharge;
- ensure we minimise disruption / stress for the service user and their family.

What benefits / outcomes did we aim to deliver:

Through the delivery and continued implementation of this priority, our service users and carers, our partners in care and our staff would see:

- 85% patients receiving inpatient care, do so close to home;
- Greater access to a range of home based treatments / interventions;
- Co-produced crisis management / resilience plans.

The 2014/15 figure for patients receiving inpatient care in the normal hospital for their home area show a slight deterioration compared to the 2013/14 figure. This is mainly due to a change of function in two of our wards which means more wards have been included in the 2014/15 results than in the 2013/14 figures. If these wards were not included, the figures would be similar in 2014/15 compared to 2013/14.

What we did in 2014/15:

The following is a summary of the key things we have done in 2014/15:

What we said we would do	What we did
• Staff are skilled in the delivery of a range of home treatment	• Completed a skills analysis and identified training priorities. From this, e-learning packages for induction training materials have been developed and produced. • Face to face training events have also been designed. • Developed a Crisis Team Toolkit, which has provided staff with “at hand” resources for assessment, psychological formulation and risk assessment / management. It also provides crisis practitioners with the tools to refer to alternative or additional services appropriately and confidently.
• Service users have co-produced high quality care plans that seek to maintain treatment in the community rather than admission to hospital	• This action is linked to the CPA quality priority. • Recovery focused care plan workshop and engagement events have been held, whilst ensuring this linked with the Model Lines Framework. • There has been a redesign of CPA processes and documentation to ensure they fulfil the mandatory requirements whilst reducing an unnecessary burden on Trust staff. • Ensuring the requirements of the Mental Health Act are met whilst reducing unnecessary burden on staff, inclusive of the development of standard work regarding Section 117 of the Mental Health Act – the statutory duty

	to provide health and social care to some service users following discharge from in-patient care. This has been piloted with a plan for phased implementation with briefings and training for Trust staff planned for May 2015.
• Community Mental Health Teams will offer urgent appointment within 72 hours	• All Community Mental Health Teams now offer "urgent appointment" slots. This means that services users can now receive an assessment of their mental health within 72hrs of their referral being received.
• Good quality crisis and contingency plans are available to all service users	• An improvement event has been scheduled in order to create / develop a standard crisis or contingency plan for every service user. The production and documentation of these plans will then become standard across the Trust. • A selection of crisis teams have shared examples of current crisis planning in order to inform the improvement event. • Service User Focus Groups across specialties have been established to provide an expert opinion on the development of crisis plans. The Focus Group will meet again regarding crisis (patient experience) within 3 months; with future meetings scheduled determined by the members of the group.
• Reduce the level of variation across community teams	• Benchmarking data has been collected resulting in the development of action plans for the teams with the highest rates of admission and readmission with timescales for completion of actions by Q2 2015/16. • Share and spread of practice identified in high performing teams will take place through the Quality Assurance Groups.
• Undertake case audit of admissions in Richmondshire to gain an understanding of the reasons behind the high admission rate for that locality	• An initial case audit has been completed and undergone peer review. • Initial findings of the case audit have been reported and a detailed plan has been produced. A managerial and clinician review of the report has been arranged.
• Develop a better understanding within community services of the support/services available for service users from third sector organisations in the locality	• Each locality has developed a directory of services available within their area.

What we plan to do in 2015/16:

The identified pilot sites (in North Durham, Redcar and Cleveland and Northallerton Crisis Teams) will test the training / induction material. Once the testing has been completed we will roll out the approved material across all crisis teams. Qualitative data will be collected and will be taken, discussed and approved at the Acute Care Forum in May 2015 regarding the potential for use of the materials across inpatient areas. Links with the quality report / account priority on Embedding Recovery will continue to ensure this is recovery orientated and includes promoting positive life outcomes.

We will review the use of crisis / contingency plans in informing Purposeful Inpatient Admission and Treatment through audit of existing care and crisis plans and those subsequent interventions planned for inpatient treatment with findings shared and actioned against by Q4 2015/16.

We will also further implement and build upon those recommendations made within the Trustwide Internal Benchmarking report and Out of Locality Action Plan to include a review of the clinical risk assessment and management policy, further improvement in the readmission rates and lengths of stay across the Trust's localities by Q4 2015/16.

Statement of Assurances from the Board 2014/15

The Department of Health and Monitor require us to include our position against a number of mandated statements to provide assurance from the Board of Directors on progress made on key areas of quality in 2014/15. These statements are contained within the blue boxes. In some cases additional information is supplied and where this is the case this is provided outside of the boxes.

Review of services

During **2014/15** TEWV provided and/or sub-contracted **16** relevant health services.

TEWV has reviewed all the data available to them on the quality of care in **16** of these relevant health services.

The income generated by the relevant health services reviewed in 2014/15 represents **100%** per cent of the total income generated from the provision of the relevant health services by TEWV for 2014/15.

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

- **Patient safety** – including information on incidents, serious untoward incidents, levels of violence and aggression, infection prevention and control and health and safety.
- **Clinical effectiveness** – including information on the implementation of National Institute for Clinical Excellence (NICE) guidance and the results of clinical audits.
- **Patient experience** – including information on patient satisfaction; carer satisfaction; the Friends and Family Test; complaints; and contacts with the Trust's patient advice and liaison service.
- **Care Quality Commission (CQC)** – compliance with the essential standards of safety and quality, and the Mental Health Act.

Following discussion at the QuAG any areas of concern are escalated to the relevant Locality Management and Governance Board (LMGB) and from there to the Quality and Assurance Committee the sub-committee of the Board which has responsibility for Quality Assurance.

We also undertake an Internal Inspection Programme, the content of which is based on the Essential Standards of Quality and Safety published by the CQC. These inspections cover all services and the inspection team includes members of our Compliance Team, service user and carer representatives from our Essential Standards Group and peers from other services. In advance of the visit the inspection team review a range of information on the quality of the service being inspected, for example: incident data, PALS / complaints data, CQC compliance reports and Mental Health Act visit reports, and any whistleblowing information. At

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

The Board also undertakes bi-monthly visits, to our wards and teams across the Trust. They listen to what service users, carers and staff think and feel about the services we provide.

In addition to the above the Trust has introduced an Integrated Information Centre (IIC) which is a data warehouse which integrates information from a wide range of source systems eg patient information, finance, workforce and incidents. The information within the IIC is updated regularly from the source systems and allows for the interrogation of the most up to date positions at any time of the day. This allows clinical staff and managers to access the information on their service at any time of day (or night) and to be able to 'drill' down to the lowest level of the data available (according to access rights). The IIC also sends prompts to staff which helps to improve the care and experience of our service users. For example, the IIC sends prompts to Care Coordinators on a weekly basis listing those patients whose care plan reviews are due in the next week, 2 weeks and 1 month. This ensures that staff can be proactive about ensuring these patients have review appointments scheduled in a timely manner thus improving patient safety.

Finally in addition to the internal review of data / information we undertake as outlined above, we also regularly provide our commissioners with information on the quality of our services. We hold regular Clinical Quality Review meetings with commissioners where they review all the information on quality that we provide them, with a particular emphasis on trends and the narrative behind the data. At these meetings we also provide information to our commissioners on any thematic analysis or quality improvement activities we have undertaken and on our responses to national reports that have been published for example the National Confidential Inquiry into Suicide and Homicide and the Francis and Berwick Reports.

Participation in clinical audits and national confidential inquiries

During 2014/15, **4** national clinical audits and **1** national confidential inquiry covered the relevant health services that TEWV provides.

During 2014/15, TEWV participated in **100%** of national clinical audits and **100%** of national confidential inquiries of the national clinical audits and national confidential inquiries which it was eligible to participate in.

The national clinical audits and national confidential inquiries that TEWV was **eligible to participate in** during 2014/15 are as follows:

- National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH).
- POMH UK Topic 14a: Prescribing for substance misuse – alcohol detoxification.
- POMH UK Topic 12b: Prescribing for people with personality disorder.

- POMH UK Topic 9c: Antipsychotic prescribing for people with a learning disability.
- National Audit of Memory Clinics 2014.

The national clinical audits and national confidential inquiries that TEWV **participated in** during 2014/15 are as follows:

- National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH).
- POMH UK Topic 14a: Prescribing for substance misuse – alcohol detoxification.
- POMH UK Topic 12b: Prescribing for people with personality disorder.
- POMH UK Topic 9c: Antipsychotic prescribing for people with a learning disability.
- National Audit of Memory Clinics 2014.

The national clinical audits and national confidential inquiries that TEWV participated in, and for which data collection was completed during 2014/15, are listed below alongside the number of cases submitted to each audit or inquiry as a percentage of the number of registered cases required by the terms of the national audit or inquiry.

Audit Title	Cases Submitted	% of the number of registered cases required
National Audit of Memory Clinics 2014	14	100%
POMH UK Topic 14a: Prescribing for substance misuse – alcohol detoxification	19	100%
POMH UK Topic 12b: Prescribing for people with personality disorder	87	-
POMH UK Topic 9c: Antipsychotic prescribing for people with a learning disability	Data collection in progress	-
National Confidential Inquiry into Suicide & Homicide by People with Mental Illness	n/k*	97%**

* Cases are submitted confidentially and directly by individual consultants, and therefore, the number of cases submitted is not known.

** Extract from National Confidential Inquiry Annual Report July 2014: For the final year of the patient suicide and homicide analysis we therefore estimate the final number of cases based on data completeness in previous years. Projected figures are based on the average annual return of Inquiry questionnaires (provided by the National Confidential team based at Manchester University), ie adjusted to an assumed final figure of 97% for England and 98% for Wales, Northern Ireland and Scotland.

The reports of **2** national clinical audits were reviewed by the provider in 2014/15 and TEWV intends to take the following actions to improve the quality of healthcare provided:

- National Audit of Memory Clinics 2014

  Actions:

  - The Service Development Manager will identify ways to improve service

user involvement in relation to other service users and carers helping support one another at all Quality Assurance Groups.
- The Service Development Manager will discuss improving the appropriate mechanisms for involving service users and carers in the appointment of new staff and delivery of staff training.
- The Service Development Manager will forward the clinical audit report to the Information Department to guide future information requirements/ improvement work.

- POMH UK Topic 14a: Prescribing for substance misuse: alcohol detoxification

Actions:

- A report will be submitted to the Drug and Therapeutics Committee, all clinical audit sub-groups, substance misuse QuAG and forwarded to Adult Mental Health inpatient teams.
- A requirement for relevant blood tests to be carried out on all patients undergoing alcohol detoxification will be added to the Trust Alcohol Detoxification Pathway.
- Issue raised on thiamine supplementation in alcohol detox to be added to the pathway guidance.
- A requirement for assessment of Wernicke's encephalopathy and breath alcohol on admission will be added to the Trust Alcohol Detoxification Pathway.

The reports of **64** local clinical audits (**194** individual audits) were reviewed by the provider in 2014/15 and TEWV intends to take actions to improve the quality of healthcare provided. **Appendix 5** includes the actions we are planning to take against the **10** key themes from these local clinical audits reviewed in 2014/15.

In addition to those local clinical audits reviewed (ie those that were reviewed by our Quality Assurance Committee and Clinical Effectiveness Group), the Trust undertook a further **66** clinical audits in 2014/15. These clinical audits were led by the services and individual members of staff for reasons of service improvement and professional development and were reviewed by the Specialty Clinical Audit Subgroups.

Participation in clinical research

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

Of the **260, 245** were recruited to **28** National Institute for Health Research (NIHR) portfolio studies. This compares with **1256** patients involved as participants in NIHR research studies during 2013/14, **549** in 2012/13 and **433** in 2011/12.
A lower level of NIHR recruitment was anticipated in our planning this year as unlike the previous year when a single study recruited 684 participants, our portfolio this year consists of a greater number of more complex studies recruiting lower numbers per trial. The Trust no longer works to a specific organisational target of recruitment, contributing instead to regional Clinical Research Network targets for the mental health, dementia and neurodegenerative disease specialties.

We continue to be involved with large scale national research across a variety of clinical disciplines such as psychosis, drug safety, forensic mental health, dementia, learning disabilities, personality disorder and children and young people services. Our ongoing participation in clinical research through 2014/15 reflects our firm commitment to improving the quality of care we provide, as well as contributing to the broader goals of mental health research.

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

- We were involved in conducting **94** clinical research studies during 2014/15. This compares with **92** in 2013/14 and **104** in 2012/13. **45** of these studies were supported by the NIHR through its networks and **14** new studies approved through its coordinated research approval process.
- **78** members of our clinical staff participated as researchers in studies approved by a research ethics committee, with **29** of these in the role of principal investigator for NIHR supported studies.
- **417** members of our staff were also recruited as participants to both NIHR portfolio and non-portfolio studies that were undertaken within TEWV.
- **33** researchers from outside the organisation were granted access under the National Research Passport Scheme to perform research with us compared to **19** in 2013/14 and **9** in 2012/13.
- We have continued to develop our collaborative partnership with Durham University across a number of areas of shared interest including primary care mental health, evaluation of psychological interventions in young people and prescribing quality and safety. Our university collaboration is leading the way in engaging young people in mental health research via the YouthSpeak project.
- We also continue our collaborations with both York University and Newcastle University as co-applicants on large scale grant applications. York University recently secured a Health Technology Assessment (HTA) grant to fund SCIMITAR PLUS – a trial of smoking cessation intervention for people with severe mental ill health.

- Newcastle University was awarded a Research for Patient Benefit (RfPB) grant to fund a feasibility study using an immersive virtual reality environment to reduce anxiety in children with autism spectrum disorder. These important studies will begin to recruit participants across the Trust in 2015/16.
- 2014/15 saw a rapid growth in our support of large scale dementia research in response to the Prime Minister's Challenge on Dementia. In October 2014, we approved a business case to embed clinical trials of investigational medicinal products (CTIMPs) into core Trust business. Some of the benefits of this development will be an increase in participant numbers in CTIMP studies; an increase in the number of studies where TEWV is a research site; better access to research for service users and carers and an increased reputation for TEWV as a research centre in its own right. We were an early adopter of the 'Join Dementia Research' system and continue to promote the system through research champions based within the memory services. This new national system allows anyone, with or without dementia, to register their interest in becoming involved in dementia research. We were the first Trust outside of the pilot site to recruit a participant to a study from this system.
- The Opting in to Clinical Research (OptiC) System has recently been incorporated within Paris. Systems like this, embedded in NHS records, allow service-users to express an interest (or otherwise) in participating in clinical research and have the potential to enhance and streamline the recruitment of patients to studies. This system has not yet been fully implemented in practice but has been piloted in two sites and will be rolled out to other sites over 2015/16.
- The Trust is one of seven NHS Trusts across the UK hosting a trial to determine whether ketamine improves cognitive outcomes after Electroconvulsive Therapy (ECT) and also whether ketamine speeds clinical response to ECT.
- Three NHS Trusts in the UK hosted the COBRA (cost and outcome of behavioural activation versus cognitive behaviour therapy for depression) study with us successfully recruiting 157 of the 444 participants. COBRA is a randomised controlled trial to determine the clinical effectiveness of Behavioural Activation (BA) compared to Cognitive Behavioural Therapy (CBT) for depression in adults. The study will also determine the cost-effectiveness of BA compared to CBT at 18 months. If the findings show that BA is non-inferior compared to CBT in reducing depression severity then this could mean a significant saving in direct health care costs; BA will be less costly and thus more cost-effective than CBT.

Goals agreed with commissioners

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

A proportion of TEWV's income in 2014/15 was conditional on achieving quality improvement and innovation goals agreed between TEWV and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2014/15 and for the following 12 month period are available electronically at http://www.tewv.nhs.uk/About-the-Trust/How-well-are-we-doing/CQUIN/.

As part of the development and agreement of the 2014/15 mental health contract, discussions were held between the Trust and each of its commissioners to agree a set of goals and indicators that both parties felt were appropriate and relevant to local and national strategies. Indicators linked to patient experience, patient safety and clinical effectiveness were key to both provider and commissioner. These are monitored at meetings every quarter with our commissioners.

An overall total of **£5,948,750** was available for CQUIN to TEWV in 2014/15 conditional upon achieving quality improvement and innovation goals across all of its CQUINs, and a total of **£5,797,750 (97.46%)** is estimated to be received for the associated payment in 2014/15. This compares to £5,777,218 (99.28%) and £5,938,580 (100%) received in 2013/14 and 2012/13 respectively (the estimate for 2014/15 has been agreed with commissioners however this has still to go through all the required governance processes for full approval).

Some examples of CQUIN indicators which the Trust made progress with in 2014/15 were:

- Increased the number of opportunities for people with lived experience of mental health to be involved in service development and delivery within TEWV. At quarter 1 2014/15 we were unable to report a baseline as we have not traditionally captured the information about people's lived experience, however at quarter 4 2014/15 we now have a robust system in place and reported **48** new roles (voluntary and paid), which was above the target set by commissioners of **25**.
- To improve carer support and engagement within TEWV. In quarter 4 2013/14, **64%** of carers reported a positive experience in AMH. At quarter 4 2014/15 the positive experience of carers had increased to **82%** against a target set by the commissioners of **75%**.
- There has been an improvement in the quality and timeliness of hospital communications across acute and community services with **100%** of all letters to GPs being sent within 5 working days and **100%** of patients being offered a copy of their discharge letter in the community.

However, we did not always make such good progress throughout the whole year and the following CQUIN did not meet the target in 2014/15.

- To demonstrate, through the national audit of schizophrenia, full implementation of appropriate processes for assessing, documenting and acting on cardio metabolic risk factors in patients with schizophrenia. The audit reported only 35% of the sample had documented evidence that patients were screened for all 6 parameters during their inpatient stay. The parameters were:

    1. Smoking status;
    2. Lifestyle (including exercise, diet alcohol and drugs);
    3. Body Mass Index;
    4. Blood pressure;
    5. Glucose regulation (HbA1c or fasting glucose or random glucose as appropriate);
    6. Blood lipids.

Whilst the Trust did not achieve the required level for all 6 parameters, **86%** of patients did have 4 or more of the measures completed.

What others say about the provider

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

TEWV is required to register with the Care Quality Commission (CQC) and its current registration status is **registered to provide services with no conditions attached**. The Care Quality Commission has not taken enforcement action against TEWV during 2014/15.

During 2014/15 TEWV were not subject of any CQC Compliance inspections. The Trust received one report on 17 July 2014 from an inspection in March 2014 which raised **two moderate compliance actions** against TEWV. The Trust have also had four joint CQC and HMPI inspections but are waiting for formal feedback as the reports go directly to Care UK as the main provider.

TEWV has participated in one Trustwide inspection during January 2015 under the Care Quality Commission's new approach to inspections. The overall findings during the inspection were rated as GOOD.

CQC's rating for each key area was:

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

The Trust received a rating of "requires improvement" for the key area "*Are services safe"* which was partially due to an issue CQC raised around privacy and dignity in respect of same sex accommodation in a rehabilitation ward. It is worth noting that the issues raised in respect of this key area relates to a small percentage of TEWVs services with all other areas performing effectively and safely. Further information on the improvement required for this key area can be seen on pages 95-100.

The report highlights several areas of good practice, including:

- The learning disability and autism service have a steering group and champions for positive behaviour support. The role and purpose of the group and champions was to embed teaching and learning across the locations to ensure positive behaviour support was an effective tool to manage complex behaviours which challenged.
- The implementation of a programme, within the substance misuse services, to provide emergency medical treatment for those identified as high risk of opiate overdose. Staff had been told that the programme had prevented a number of

deaths in the community.

- In the wards for the older people service, specifically on Springwood and Rowan Lea wards, staff were using specialist computer programmes to enable them to interact with people with memory problems in a positive way.
- Excellent examples of some crisis teams encouraging patients to develop advance directives to help them determine their future crisis care needs.
- The pharmacy team had worked with some of the wards to develop and implement robust 'step down' procedures to support patients in managing their own medicines in preparation for when they moved on from the ward.

However Inspectors said that the Trust must improve in some areas, including:

- The Trust must take action to review the covert administration of medication without reference to the pharmacist or through a best interest meeting on Ceddesfeld and Hamsterley wards. It must also ensure that on Hamsterley ward staff sign medication administration records for patients as medication is administered.
- The Trust must ensure that in the acute wards, intervention plans are in place which clearly outline measures to manage any risks to patient safety.
- The Trust must ensure that all staff on Ward 15 are given clear guidance on the management of ligature risks and current risks posed by patients and make the appropriate adjustment to observation levels.
- The Trust must ensure that each patient in the learning disability wards has a comprehensive discharge plan which is holistic and person-centred.

An action plan is currently being produced to be sent to the CQC to address the recommendations highlighted during the inspection, the majority of which have been completed.

The CQC also undertook a review of health services for looked after children and safeguarding operating in the areas of the Trust served by Darlington. A specific recommendation for TEWV as a result of this inspection was to ensure that a robust pathway for responding to requests for practitioners to attend child protection meetings is in place to ensure that mental health services are appropriately represented.

Joint recommendations with Darlington CCG, County Durham & Darlington NHS Foundation Trust and Tees, Esk & Wear Valley NHS Foundation Trust were:

- Explore the development and implementation of a consultant led peri-natal mental health pathway that also includes services for those women with mild to moderate mental health needs during pregnancy and postpartum.
- Ensure that there is effective liaison and sharing of expertise between health professionals in early intervention, child in need and child protection cases including the undertaking of joint visits as appropriate.
- Assure themselves that health practitioners are trained in writing referrals to children's social care and that those referrals appropriately assess and articulate risk to enable social workers to make well informed decisions.
- Assure themselves that health practitioners are trained and understand national and local guidance on record keeping and that local health records contain appropriate detail on concerns and action taken by practitioners when working with families.

- Ensure that paperwork relating to safeguarding and child protection is available as part of the electronic patient record to enable practitioners to access the complete record when working with their client.

TEWV has also participated in **44** Mental Health Act inspections by the Care Quality Commission to the following ward areas during 2014/15:

Ward	Service Type	Locality
Abdale	Adult Mental Health Rehab	Harrogate
Bankfields Court	Learning Disabilities Assessment & Treatment	Middlesbrough
Brambling	Forensic Mental Health Low Secure	Middlesbrough
Cedar	Adult Mental Health Assessment & Treatment	Harrogate
Cedar	Adult Mental Health Psychiatric Intensive Care	Darlington
Eagle	Forensic Learning Disability Low Secure	Middlesbrough
Earlston House	Adult Mental Health Rehab	Darlington
Elm	Adult Mental Health Assessment & Treatment	Darlington
Esk	Adult Mental Health Assessment & Treatment	Scarborough
Evergreen	Children's Eating Disorders	Middlesbrough
Hamsterley	Older Peoples Mental Health Assessment & Treatment	Bishop Auckland
Harland	Forensic Mental Health Low Secure (closed 31/07/2014)	Durham
Harrier	Forensic Learning Disability Low Secure	Middlesbrough
Hawthorn	Forensic Learning Disability Medium Secure	Middlesbrough
Ivy	Forensic Learning Disability Low Secure	Middlesbrough
Jay	Forensic Mental Health Low Secure	Middlesbrough
Kestrel	Forensic Learning Disability Low Secure	Middlesbrough
Kingfisher	Forensic Learning Disability Low Secure	Middlesbrough
Linnet	Forensic Mental Health Medium Secure	Middlesbrough
Lustrum Vale	Adult Mental Health Rehab	Tees AMH
Mallard	Forensic Mental Health Medium Secure	Middlesbrough
Merlin	Forensic Mental Health Medium Secure	Middlesbrough
Newtondale	Forensic Mental Health Low Secure Rehabilitation	Middlesbrough
Nightingale	Forensic Mental Health Medium Secure	Middlesbrough
Oak	Older Peoples Mental Health Assessment & Treatment	Darlington
Oakwood	Forensic Learning Disability Rehabilitation	Middlesbrough
Overdale	Adult Mental Health Assessment & Treatment	Middlesbrough
Park House	Adult Mental Health Rehab	Middlesbrough
Picktree	Older Peoples Mental Health Assessment & Treatment	Durham
Primrose Lodge	Adult Mental Health Rehab	Durham
Ramsey	Learning Disabilities Assessment & Treatment	Durham
Rowan	Older Peoples Mental Health Assessment & Treatment	Harrogate
Rowan Lea	Older Peoples Mental Health Assessment & Treatment	Scarborough
Sandpiper	Forensic Mental Health Medium Secure	Middlesbrough
Springwood	Older Peoples Mental Health Assessment & Treatment	Malton
Stockdale	Adult Mental Health Assessment & Treatment	Middlesbrough
Swift	Forensic Mental Health Medium Secure	Middlesbrough
Talbot	Learning Disabilities Assessment & Treatment	Durham
Thistle	Forensic Learning Disability Low Secure	Middlesbrough
Tunstall	Adult Mental Health Assessment & Treatment	Durham
Ward 14	Older Peoples Mental Health Assessment & Treatment	Northallerton
Ward 15	Adult Mental Health Assessment & Treatment	Northallerton
Willow	Adult Mental Health Rehab	Darlington
Wingfield	Older Peoples Mental Health Assessment and Treatment	Hartlepool

The CQC Mental Health Act (MHA) Commissioners undertook a two day inspection in December 2014 in order to monitor under Section 120 of the Mental Health Act 1983 to look at the arrangements for assessment and application for detention that operated in Teesside and North Yorkshire. The primary issues are that within

Teesside there are delays in ambulance transportation for conveying patients to hospital from the community. It was also identified there can be difficulty in securing a second Section 12 approved doctor for formal MHA assessments.

CQC MHA Commissioners undertook a review of seclusion practice on 6 November 2014 on four wards at Ridgeway, Roseberry Park Hospital. No issues were reported.

Actions Taken

Roseberry Park, Learning Disability Forensic Service: Although the inspection was completed in March 2014, the report was received on the 17 July 2014. By March 2015 TEWV had made progress from taking the following actions to address the conclusions or requirements reported by the Care Quality Commission:

Outcome 4 (Regulation 9): Care and Welfare of People who use services. **Compliance Action:** essential standard not met as the provider did not plan and deliver care and treatment in a way that met individual needs of patients and ensured their welfare and safety with moderate impact on people who use services.

Actions and Progress

- My Shared Pathway Intervention Planning training has been rolled out across service to all teams.
- Written copies of care plans are now readily available to all staff.
- Handover discussions and clinical supervision review actions taken by staff are used to implement individual care plans.
- Templates have been developed for daily recording on Paris which links with My Shared Pathway interventions and includes the patient's experience and feedback.
- Regular collaborative activity planning sessions with all patients and their named nurses have been established.
- The options of establishing a Recovery College accessible to forensic patients are progressing.
- A survey of patients and staff to determine whether discrimination is occurring is to be undertaken and a patient and staff reference group regarding equality and diversity meets monthly. Lesbian, Gay, Bisexual and Transgender (LGBT) information leaflets and antidiscrimination posters are available in clinical areas. Equality Champions have been identified for each ward.
- The appropriateness of admissions have been discussed regarding admission criteria with commissioners for Forensic Learning Disability Low Secure services and NHS England Commissioners have agreed appropriate assessment information. An escalation framework for delayed transfers (externally to the Trust) has been developed.
- Awareness has been raised with Staff of the purposes of seclusion and the process of initiating and terminating seclusion and segregation. Guidance for the safe and lawful management of patients who are settled when in seclusion has been agreed and currently a review of current capacity and demand for

seclusion is being undertaken. In addition we are identifying potential non-designated rooms to be used in a crisis situation.
- A programme to implement Positive Behavioural Support has been developed across all ward environments.
- A process for regular reporting on seclusion use has been established.
- A review and development plan on the use of restrictive practices has been implemented and a standard process to ensure risk management intervention plans for individual patients are recorded and regularly reviewed in collaboration with the patients so they are clear why restrictions are required to manage risk and what needs to change to reduce or remove restrictions.

Outcome 7 (Regulation 11): People should be protected from abuse and staff should respect their human rights.

Compliance Action: Essential Standard not met as people who use the service were not protected from the risk of abuse, because the provider had not taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Actions and progress

- Refresher briefings about the principles and processes of safeguarding and patient protection have been undertaken and with a training programme of scenario based level 2 Safeguarding Adults.
- An external peer review of clinical and safeguarding practice has been commissioned.
- A review of seclusion and restrictive practices has been undertaken.
- A Local Safeguarding Review group for Forensic services with the local authority adult team has been established.

Trustwide CQC Inspection 19th January to 30th January 2015:

The Trust have commenced or completed all the improvement actions required to meet the CQC Fundamental Standards where the inspectors found non-compliance with regulations:

- The Trust have provided additional support to our learning disabilities social care unit in Teesside to redesign their management systems to meet the social care standards.
- Programme of challenging and reducing restrictive practice and blanket restrictions to continue.

The Trust is developing an overall improvement plan to address the areas CQC thought we **should** improve.

1. To meet the 2014 Regulation 10 requirements, for Dignity and Respect:

- The en-suite female bedrooms have been relocated, that were **adjacent** to the male corridor in Earlston House, to create a new female zone upstairs.

- A new clinic room has been created just off the main hall in Earlston House, away from both female and male bedroom areas.
- The Trust Privacy and Dignity policy has been reviewed, clarifying the zoning advice and re-issued it, with staff briefings, through the matron group.
- All in-patient areas have been reassessed against the Regulation 10 requirements and given guidance to each ward regarding implementation of the zoning protocol.
- All these actions have been completed.

2. To meet the 2014 Regulation 12 requirements, for Safe Care and Treatment:

- The two cases on Hamsterley and Ceddesfeld wards have been reviewed and where covert medication had been administered and put in place the required safeguarding process.
- The covert medication procedure has been reviewed and improved.
- The nurse who was observed to make an administration error was suspended until competency was achieved further to a retraining programme. A personal statement and learning plan was actioned.
- All the actions were completed and evidence submitted before the end of the inspection period.
- Learning lessons information will be distributed across all MHSOP and monitoring of administration will continue with observation, audit and sampling.

3. To meet the 2014 Regulation 9 requirements, for Person Centred Care:

- The clinical risk management systems have been reviewed and processes on Ward 15, and plans have been put in place for both environmental and process improvements.
- A staff re-training plan for suicide prevention and clinical risk management has commenced as a Board priority for 2014/16.
- The discharge planning processes for those inpatients in learning disability Assessment and Treatment units have been reviewed, through a Kaizen event with partners and we will implement a more commissioning specification approach to the formulation of discharge plans.
- All actions have commenced.

4. To meet the 2014 Regulation 12 requirements, for Safe Care and Treatment:

- A parabolic mirror in the seclusion room at Ward 15 has been installed to ensure there are no blind spots where patients cannot be observed.
- The estates escalation processes for inpatient staff, in hosted environments, has been reviewed to ensure the TEWV Director of Estates and Facilities Management can resolve delays in environmental maintenance and improvement actions. We have briefed the matron and ward managers of those wards about the escalation process.
- The TEWV Director of Estates and Facilities Management has a quality monitoring process in place with partner NHS Trusts where services are provided from.
- All actions have been completed.

Quality of data

TEWV submitted records during 2014/15 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- Which included the patient's valid NHS number was: **99.73**% for admitted patient care.
- Which included the patient's valid General Medical Practice Code was **98.69%** for admitted patient care.

TEWV Information Governance Assessment Report overall score for 2014/15 was **88%** and was granted as **satisfactory***.

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

The Information Governance Toolkit measures performance in the following areas:

- Information Governance Management
- Confidentiality & Data Protection
- Information Security Assurance
- Clinical Information Security Assurance
- Secondary Use Assurance
- Corporate Information Assurance

A satisfactory score in the toolkit is important to patients as it demonstrates that the Trust has safe and secure processes in place to protect the sensitive personal information that we process. It demonstrates that our staff have completed training in areas such as confidentiality and information security. It also shows the Trust carries out its legal duties under the Data Protection Act 1998 and Freedom of Information Act 2000.

88% (satisfactory) means that we have achieved at least level 2 on all of the 45 requirements of the toolkit, however, in a significant number of elements we attained level 3 (the highest score).

TEWV was **not** subject to the Payment by Results clinical coding audit during 2014/15 by the Audit Commission.

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

- **Clinically Reported Outcome Measure (CROM):** this is the Health of the Nation Outcome Score (HoNOS) and reported via the Mental Health Minimum Data Set (MHMDS). The reporting of this is currently being provided monthly to commissioners on a manual basis, however development of clinician level reporting via the Integrated Information Centre (IIC) is underway for implementation in Q1 2015/16.
- **Patient Reported Outcome Measure (PROM):** the Trust is currently implementing further rollout of a patient reported wellbeing measure, the short version of the Warwick-Edinburgh Mental Well-being Scale (SWEMWBS), as recommended in the Monitor 2014/15 Currency and Tariff development guidance. The reporting of this is also being implemented within the IIC for Q1 2015/16.

At the end of March 2015:

- **96%** of service users on the Adult Mental Health (AMH) and **98%** of services users on the Mental Health Services for Older People (MHSOP) caseloads were assessed using the mental health clustering tool.
- **92%** of service users on the Adult Mental Health (AMH) and **92%** of services users Mental Health Services for Older People (MHSOP) caseloads were reviewed within the guideline timeframes.

At the time of publication, there is limited national benchmarking data to compare against the Trust reported figures.

Further work for 2015/16 includes:

- The inclusion of key payment by results development metrics as part of routine performance management.
- Embedding the new outcome metrics into clinical services.
- Further development of the Integrated Information Centre (IIC) within the Trust to assist reporting of payment by results data.

TEWV will be taking the following actions to improve data quality:

- We have a Data Quality Group chaired by the Director of Finance and Information which meets on a monthly basis and addresses data quality issues in terms of patient, staff, financial and risk information.
- We have a data quality strategy and scorecard to monitor improvement. The strategy aims:
    - To maximise the accuracy, timeliness and quality of all our data wherever and however it is recorded.
    - To ensure that every member of our staff understands that data quality is the responsibility of everyone and an integral part of their role.
    - To ensure we achieve compliance with all our statutory and regulatory obligations.
- A data quality working group was formalised in late 2014/15 to identify areas of poor data quality, develop locality specific action plans in relation to data

quality, and provide advice, support and education to teams. This group works to the Trust Data Quality Group.

- We have established regular reports on key elements of data which show how well data is being recorded on the various information systems, particularly the patient information system and the staff information system.
- We report on data quality to the Board as part of our Strategic Direction Scorecard reports.
- In 2015/16, the Trust is continuing to further implement an Integrated Information Centre. Within this there is a data quality function that now enables services and teams to assess and improve the quality of their data in real time, but further refinements and improvements to the system will take place over the year.
- Regular reports are available to all services so that they can target improvement work on areas where problems occur. Data quality is a key item for discussion in the monthly performance meetings that are held between the services and the Chief Operating Officer, the Director of Finance and Information and the Director of Planning, Performance and Communication.
- We have agreed Data Quality Improvement Plans (DQIPs) with our commissioners for key indicators, particularly those that require new data recording or collection systems to be put in place.

Mandatory quality indicators

The following are the mandatory quality indicators relevant to mental health Trusts, issued jointly by the Department of Health and Monitor and effective from February 2013.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127382/130129-QAs-Letter-Gateway-18690.pdf.pdf
For each quality indicator we have presented a mandatory statement and the data on the NHS Information Centre (NHSIC) for the most recent and the previous reporting period available.

Care Programme Approach 7 day follow-up

The data made available by the Health and Social Care Information Centre (NHSIC) with regard to the percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period.

TEWV Actual Quarter 4 2014/15	***National Benchmarks in Quarter 3 2014/15***	***TEWV Actual Quarter 3 2014/15***	***TEWV Actual Quarter 2 2014/15***	***TEWV Actual Quarter 1 2014/15***
Trust final reported and figure reported to Monitor: **97.21%** NHSIC reported: *Not yet available*	NHSIC reported: National average MH Trust = **97.3%** Highest/best MH Trust = **100%** Lowest/worst MH Trust = **90.0%**	Trust final reported figure: **97.6%** Figure reported to Monitor: **97.6%** NHSIC reported: **97.9%**	Trust final reported figure: **98.2%** Figure reported to Monitor: **98.1%** NHSIC reported: **99.1%**	Trust final reported figure: **97.2%** Figure reported to Monitor: **97.0%** NHSIC reported: **97.4%**

* latest benchmark data available on NHSIC at quarters 3 2014/15

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

- The discrepancy between the Trust final reported figure and the figure reported to Monitor in quarters 1 and 2 2014/15 is due to the fact the Trust final figure is refreshed throughout the year to reflect a validated position as data quality issues are resolved. The figure reported to Monitor is the position at quarter end and is not refreshed after submission.
- The discrepancy between the NHSIC and the Trust / Monitor figure is due to the fact the NHSIC data is submitted at a Clinical Commissioning Group (CCG) level, and therefore, excludes data for patients from CCGs outside the Trust area or where the CCG is unspecified in the patient record.
- The few actual breaches, **51** in total in 2014/15, were a result of:
    - Services users not engaging with the service and failing to attend the follow-up appointment despite efforts of the service to contact the patient;
    - Service users changing addresses and not informing the care coordinator;
    - Service being unable to access the service user; and

- Breakdown in processes.

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

- Monitoring this key performance indicator via the Trust's dashboard at team, service and Board level on a monthly basis.
- Investigating all breaches and identifying lessons to be learned at directorate and service level performance meetings.
- Implementing a standard process to ensure patients discharged to other services (eg 24 hour care unit) are not overlooked, including the introduction of visual control boards.
- Reminding staff regarding procedures for follow-up when patients are on leave from the ward or the care coordinator is on annual leave / holiday.
- Reminding staff regarding procedures for follow-up when patients move out of the area subsequent to discharge.
- Continuously raising awareness and reminding staff at ward / team meetings of this national requirement, the need to follow the standard procedure and the need to record data accurately.

Crisis Resolution Home Treatment Team acted as a gatekeeper

The data made available by the Health and Social Care Information Centre (NHSIC) with regard to the percentage of admissions to acute wards for which the crisis resolution home treatment team acted as a gatekeeper during the reporting period.

TEWV Actual Quarter 4 2014/15	***National Benchmarks in Quarter 3 2014/15***	***TEWV Actual Quarter 3 2014/15***	***TEWV Actual Quarter 2 2014/15***	***TEWV Actual Quarter 1 2014/15***
Trust final reported and figure reported to Monitor: **99.69%** NHSIC reported: *Not yet available*	NHSIC Reported: National average MH Trust = **97.8%** Highest/best MH Trust = **100%** Lowest/worst MH Trust = **73.0%**	Trust final reported figure: **96.7%** Figure reported to Monitor: **96.7%** NHSIC Reported: **96.8%**	Trust final reported figure: **97.9%** Figure reported to Monitor: **97.9%** NHSIC Reported: **98.0%**	Trust final reported figure: **99.6%** Figure reported to Monitor: **99.6%** NHSIC reported: **99.6%**

* latest benchmark data available on NHSIC at quarters 3 2014/15

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

- The discrepancy between the NHSIC and the Trust / Monitor figures is due to the fact the NHSIC data is submitted at a Clinical Commissioning Group (CCG) level, and therefore, excludes data for patients from CCGs outside the Trust

area or where the CCG is unspecified in the patient record.
- The few actual breaches, **19** in total in 2014/15, were a result of failure to follow the standard procedure.

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

- Monitoring this key performance indicator via the Trust's dashboard at team, service and Board level on a monthly basis.
- Investigating all breaches and identifying lessons learnt at director and service level performance meetings.
- Continuously raising awareness and reminding staff at ward / team meetings of this national requirement, the need to follow the standard procedure and the need to record data accurately.

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

The data made available by the Health and Social Care Information Centre (NHSIC) with regard to the Trust's "patient experience of community mental health services" indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period.

An overall Trust score is not provided, due to the nature of the survey, therefore it is not possible to compare Trusts overall. For 2014, we have reported the Section score which compiles the results from the questions used from the survey detailed below the table.

TEWV Actual 2014	***National Benchmarks in 2014***	***TEWV Actual 2013***	***TEWV Actual 2012***
Overall section score: 8.1* (sample size 188)	Highest/Best MH Trust = 8.4 Lowest/Worst MH Trust = 7.3	NHSIC Reported: **89.40** (sample size of 217)	NHSIC Reported: **88.42** (sample size of 230)

***not directly comparable with previous years data**

Notes on metric

Prior to 2014, this indicator was a composite measure, calculated by the average weighted (by age and sex) score of four survey questions from the community mental health survey. The four questions were:

Thinking about the last time you saw this NHS health worker or social care worker for your mental health condition…
…Did this person listen carefully to you?
…Did this person take your views into account?
…Did you have trust and confidence in this person?
…Did this person treat you respect and dignity?

However the CQC (who design and collate the results of the survey) now state that:

"We do not provide a single overall rating for each NHS Trust. This would be misleading as the survey assesses a number of different aspects of people's experiences (such as health and social care workers, treatments etc.) and Trust performance varies across these different aspects. The structure of the questionnaire also means that there are a different number of questions in each section. This means that it is not possible to compare Trusts overall."

For 2014, the following questions replace those previously asked around contact with a NHS health worker or social care worker:

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

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

- The figures are derived from the NHS Patient survey report.
- The individual scores that this figure is based on were:
    - Did this person listen carefully to you: **8.5 out of 10**, similar to the national average, with the lowest score being 7.7 and the highest 8.9.
    - Were you given enough time to discuss your needs and treatment: **8.0 out of 10**, similar to the national average, with the lowest score being 7.2 and the highest 8.4.
    - Did the person or people you saw understand how your mental health needs affect other areas of your life: **7.7 out of 10**, similar to the national average, with the lowest score being 6.5 and the highest 8.1.

The survey is carried out by requesting "people to answer questions about different aspects of their care and treatment. Based on their responses, [CQC] gave each NHS Trust a score out of 10 for each question (the higher the score the better). Each Trust also received a rating of 'Above', 'Average' or 'Below'.

- Above (Better): the Trust is better for that particular question compared to most other Trusts that took part in the survey.
- Average (About the same): the Trust is performing about the same for that particular question as most other Trusts that took part in the survey.
- Below (Worse): the Trust did not perform as well for that particular question compared to most other Trusts that took part in the survey."

The CQC has published detailed scores for TEWV which can be found at http://www.cqc.org.uk/provider/RX3/survey/6#undefined. The table below provides the scores by "Question Theme" and shows how we compare to the other mental health Trusts for each of these themes.

Question Theme	TEWV score out of 10	CQC categorisation of TEWV result compared to other mental health Trusts
Health and Social Care Workers	8.1	"About the Same"
Organising Care	8.9	"About the Same"
Planning Care	7.2	"About the Same"
Reviewing Care	8.0	"About the Same"
Changes in who people see	6.6	"About the Same"
Crisis Care	6.3	"About the Same"
Treatments	7.7	"About the Same"
Other Areas of Life	5.4	"About the Same"
Overall Views and Experiences	7.5	"About the Same"

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

- Our Recovery strategy and programme, which will address many of the themes, including addressing the "other areas of life" theme;
- Our ongoing CPA development work to address issues around planning and reviewing care;
- Our Model Lines programme, that will improve patient experience across many of these themes;
- Continuing to carry out our local inpatient and community surveys with established mechanisms in place for action plan development and feedback.

The Trust also carries out regular patient experience surveys across all services. In 2014/15 this included the introduction of the Friends and Family Test Question where the Trust received feedback from 8538 patients of which 88% would be extremely likely or likely to recommend the service and 7% would be unlikely or very unlikely to recommend.

Patient safety incidents including incidents resulting in severe harm or death

The data made available by the Health and Social Care Information Centre (NHSIC) with regard to the number of patient safety incidents, and percentage resulting in severe harm or death, reported within the Trust during the reporting period.

TEWV Actual Quarters 3&4 2014/15	****National Benchmarks in Quarters 1&2 2014/15***	***TEWV Actual Quarters 1&2 2014/15***	***TEWV Actual Quarters 3&4 2013/14***
Trust Reported to NRLS: *as at 31st March 2015 **3,279** incidents reported of which **27** (**0.82%**) resulted in severe harm or death NB: NRLS reporting cut-off date is 29th May 2015.	NRLS Reported: National Average MH Trusts: **2,397** incidents reported of which **25** (**1.04%**) resulted in severe harm or death **Lowest MH Trust: **671** incidents reported of which **2 (0.30%)** resulted in severe harm or death Highest MH Trusts: **5,852** incidents reported of which **87** (**1.49%**) resulted in severe harm or death	Trust Reported to NRLS: **3,617** incidents reported of which **29** (**0.80%**) resulted in severe harm or death NRLS reported: **3,618** incidents reported of which **29 (0.80%)** resulted in severe harm or death	Trust Reported to NRLS: **3,165** incidents reported of which **24** (**0.76%**) resulted in severe harm or death NRLS reported: **3,167** incidents reported of which **24 (0.76%)** resulted in severe harm or death

*latest benchmark data available on NRLS
**One Trust reported 4 incidents but this has been discounted

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

- The Trust reported and National Reporting & Learning System (NRLS) reported data for Quarters 3 & 4 2013/14 shows a variance of 2 and for Quarters 1 & 2 shows a variance of 1. This could relate to incidents that have had grading changed and may now be counted as more than one incident.
- There is a necessity for each Trust to code their incident reporting system to NRLS in order to upload all patient safety incidents. However, different Trusts may choose to apply different approaches. For example, the approach taken to determine a classification such as those 'resulting in severe harm' will often rely on clinical judgement which may, acceptably, differ between professionals. The classification of an incident may also be subject to a potentially lengthy investigation which may result in the classification being changed. The change may not be reported externally and the data held by a Trust may therefore not be the same as that held by the NRLS.
- The number of incidents reported by TEWV to the NRLS for quarters 1 and 2 2014/15 was above the national average; however the percentage resulting in severe harm or death is below the national average. However, it is not possible to use this data to comment of the Trust's culture of incident reporting or the occurrence of incidents. The absolute numbers of incidents reported is a factor of the relative size of Trusts and the complexity of their case-mix. Similarly, the percentage of incidents reported as severe harm or death is a factor of the different methodologies used by Trusts to identify incidents and categorise their severity and therefore comparisons between Trusts are inconclusive. We can say, however:

- The reporting of patient safety incidents in the Trust has shown an increase in Quarters 1 & 2 2014/15 compared to Quarters 3 & 4 2013/14, moving us from the lowest 25% to the middle 50% of reporters.
- Amongst the most common themes are self-harming behaviour, patient accident, disruptive, aggressive behaviour and medication which account for three-quarters of all incidents leading to harm.

Although TEWV has noted an improvement in patient safety incident reporting, we **have taken** the following actions to continue to improve this position, and so the quality of its services, by:

- Analysing all patient safety incidents. These are reported and reviewed by the Patient Safety Group and sub group of the Trust's Quality Assurance Committee. A monthly report is circulated to the QuAC. Safety incidents are reported to commissioners via the Clinical Quality Review Process.
- Investing in the expansion of our web-based reporting system that enables timely and service-specific analysis and a transparent corporate overview.
- Analysing areas of low reporting and trends in high risk incident categories. These are reviewed monthly by the responsible service with action plans developed and monitored as appropriate to address warning signs.
- Subjecting all serious incidents (ie those resulting in severe harm or death) to a serious incident review. This is a robust and rigorous approach to understanding how and why each incident has happened, to identify any causal factors and to implement any lessons for the future. This is now also currently under review following the publication of the NHS England new Serious Incident Framework.
- Raising awareness of staff, through clinical team leads, of the importance and value of reporting and reviewing 'near misses'.
- Reviewing the incident reporting and investigating process to increase the opportunity for learning lessons.

2015/16 Priorities for Improvement

During 2014/15 we held two events inviting our stakeholders to take part in our process of identifying quality priorities for 2015/16 to be included in the quality report / account. These events took place in July 2014 and February 2015: further information can be found in pages 128-130. In addition to the quality priorities identified by our stakeholders, we have a number of additional priorities to improve quality included within the Trusts business plan, details can be found in **appendix 6**.

Our four agreed priorities for inclusion in the quality report / account for 2015/16 are:

Priority 1: Delivery of the recovery project in line with the agreed plan
Priority 2: Nicotine Management and Smoking Cessation
Priority 3: Expand the use of Positive Behavioural Support in our Learning Disabilities Services
Priority 4: Implementation of age appropriate risk assessments and care plans for Children and Young People Services

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

Why this is important:

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

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

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

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

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

- They feel that the care they receive is designed to support and achieve of own personal goals;
- Our practitioners genuinely believe that service users can get their lives back;
- To feel really listened to and heard;
- Their views and personal expertise by experience are valued;

- Staff work in partnership with service users and carers at every level of service delivery;
- They are supported to take charge of their lives, promoting choice and self-management.

What we will do in 2015/16:

We will:
• Expand the number of experts by experience* to 24 within TEWV by quarter 2 2015/16.
• Develop and deliver peer training to 10 potential peers* by quarter 3 2015/16.
• Develop 6 new peer roles within TEWV by quarter 4 2015/16. (See **appendix 3** for details)
• Expand the number of Recovery College courses delivered to 28 and identify options for roll out into other areas by quarter 3 2015/16.
• Roll out recovery training to a further 250 TEWV staff and embed recovery principles into core mandatory training by quarter 4 2015/16.
• Work with the Health Foundation* and using their methodology to embed shared decision making principles within the recovery programme by quarter 4 2015/16.

How will we know we are making a difference:

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

Indicator	Target	Timescale
• Number of courses delivered at ARCH Recovery College (see **appendix 4** for details).	28	Q3 2015/16
• Number of individuals receiving peer support training.	10	Q3 2015/16
• Number of new peer roles established in TEWV.	6	Q4 2015/16
• Number of TEWV staff receiving recovery related training.	250	Q4 2015/16

Priority 2: Nicotine Management and Smoking Cessation

Why this is important:

Recent research[1] suggests that people with severe mental illness die 15-20 years earlier than the general population. A significant contributor to this is that people with mental health problems also have poorer physical health, with many more smoking when compared to the average population.

[1] Graham Thornicroft professor of community psychiatry BMJ 2013;346:f2969 doi: 10.1136/bmj.f2969 (Published 14 May 2013)

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

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

- Encouragement to commit to giving up smoking;
- Effective support to give up smoking including access to Nicotine Replacement Therapy (NRT);
- Access to trained staff able to provide advice around smoking cessation;
- Improved physical health in the longer term.

What we will do in 2015/16:

We will:

- Appoint a Project Manager for the Nicotine Management and Smoking Cessation Project by quarter 1 2015/16.
- Develop a communications plan to inform staff and service users of the Trust's plans to implement its policy on Nicotine Management and Smoking Cessation by quarter 1 2015/16.
- Identify potential/available alternatives to smoking/nicotine and understand mechanisms for prescribing by quarter 1 2015/16.
- Have used the Baseline Assessment Tool (identified within the NICE Public Health guidance 48 (PH48) on smoking cessation) to ensure that the Trust's practice is in line with recommended NICE guidance by quarter 1 2015/16.
- Complete a benchmarking exercise to understand the number of staff smokers in order to set targets for reduction by quarter 2 2015/16 and then monitor performance against those targets in future quarters.
- Work with our Local Authority Smoking Cessation services to host clinics at key Trust localities (such as Roseberry Park or Lanchester Road) by quarter 2 2015/16.
- Advertise, promote and maximise the opportunity provided by Stoptober 2015 by quarter 3 2015/16.
- Review our No Smoking Policy to incorporate Nicotine Management and Smoking Cessation by quarter 3 2015/16.
- Develop an implementation plan to support staff to stop smoking by quarter 3 2015/16.
- Have sufficient staff trained in Nicotine Management and Smoking Cessation pilot sites in each of our localities to sustain the delivery of our smoke free agenda within the pilot sites by quarter 4 2015/16.
- Implement the Trust's standards on Nicotine Management and Smoking Cessation as per the new / revised approved policy by quarter 4 2015/16.

How will we know we are making a difference:

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

Indicator	Target	Timescales
• Proportion of inpatient units that are smoke free.	75%	15/16 Q4
• Proportion of relevant clinical staff that have been trained to smoking cessation level 2.	75%	15/16 Q4
• Delivered reduction in staff smoking in line with target agreed in quarter 2 2015/16.	90%	15/16 Q4

Priority 3: Expand the use of Positive Behavioural Support (PBS) in our Learning Disabilities Services

Why this is important:

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

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

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

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

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

- A values led based, person centred approach;
- Improved quality of life, happiness and well-being;
- To be given the skills and coping capacities to be able to deal with the demands of everyday living;

- A reduction in restrictive practice including control and restraint and use of 'as-required' medication;
- An improved support structure in place for people whose behaviour is described as challenging.

What we will do in 2015/16:

We will:
• Ensure by quarter 4 2015/16 that all people who are referred to the Learning Disabilities Service will receive an initial screening and if behavioural challenges are considered to need a functional assessment, the person will be placed onto Tier 1 of the Positive Behavioural Support pathway. The Brief Behavioural Assessment Tool (BBAT) is a core component of Tier 1 therefore everyone who is placed onto Tier 1 automatically undergoes a Brief Behavioural Assessment.
• Ensure appropriate training is available in order to increase the number of community staff who are trained in Positive Behavioural Support by quarter 4 2015/16.
• Maintain a register of all inpatient staff that have completed the Positive Behavioural Support training (including new employees) and ensure regular Positive Behavioural Support training sessions are provided for inpatient staff to ensure service remains at 95% by quarter 4 2015/16.

How will we know we are making a difference:

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

Indicator	Target	Timescale
• Percentage of people (of those identified as suitable from initial screening) placed onto the Positive Behavioural Support pathway and underwent a Brief Behavioural Assessment Tool (BBAT) assessment.	100%	Q4 2015/16
• Percentage increase in staff training within community teams from 60% to 95%.	95%	Q4 2015/16
• Percentage of staff training maintained in inpatient areas.	95%	Q4 2015/16

In addition to expanding the use of Positive Behavioural Support across our Learning Disabilities service we also intend to implement it across our other specialities.

Priority 4: Implementation of age appropriate risk assessments and care plans for Children and Young People Services

Why this is important:

Children and Young People services (CYPS) assess and treat children at different ages and development stages of their life. There is a vast difference between the verbal, cognitive and social interaction skills of a 4 year old child and a 17 year old adolescent. There are also different risks associated with different age groups or developmental stages.

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

Of course it is not only Children and Young People that can benefit from improvements in risk assessments and care planning, and TEWV's Business Plan includes specific priorities to address this (see Appendix 6). However, our quality report / account contains this specific priority focussed on children and young people as our stakeholder engagement identified that our stakeholders wished to see the development of a specific priority focussed on improving the experience and outcomes for the children and young people treated by our services, and their carers.

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

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

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

What we will do in 2015/16:

We will:
• Draft age appropriate risk assessment and care plans for the revised risk management documentation created by quarter 1 2015/16. • Gather service user feedback on the revised risk management documentation and process by quarter 2 2015/16. • Ensure approval of the revised risk management documentation and process from relevant Trust governance groups including those involving patients and carers by quarter 2 2015/16. • Complete revisions to our risk management documentation and process based on feedback received from Trust governance groups by quarter 3 2015/16. • Upload the approved documents onto to Paris (our electronic patient record system) by quarter 4 2015/16. • Complete staff training on the new documentation and process by quarter 4 2015/16. • Ensure the revised risk management process is implemented across all teams by quarter 4 2015/16.

How will we know we are making a difference:

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

Indicator	Target	Timescale
• Percentage of children offered a paper copy of their completed risk assessment.	100%	Q4 2015/16
• Percentage of all staff trained on new documentation (inpatient and community).	100%	Q4 2015/16
• Reduction in staff time inputting risk management documentation in to Paris.	50%	Q1 2016/17
• Patient and Carer satisfaction (metric and target to be developed).	90%	Q1 2016/17

Monitoring Progress

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

We will also send a 6 monthly update to all of our stakeholders, and provide a further update of the position as of 31 December at our February 2016 quality report / account Stakeholder workshop.

PART 3: OTHER INFORMATION ON QUALITY PERFORMANCE 2013/14

Our performance against our quality metrics

The following table provides details of our performance against our set of agreed quality metrics for 2014/15.

These metrics are the same as those we reported against in our quality report / account, 2013/14 which allows us to monitor progress. However, in some cases, the exact definitions in 2012/13, 2013/14 and 2014/15 have changed from 2009/10 and 2010/11 as we have learned lessons on what is more meaningful to quality. These are:

- The 'number of unexpected deaths' reported in 2009/11 (metric 1) was changed in 2012/13 to the 'number of unexpected deaths classed as a serious incident per 10,000 open cases'. This is because using a rate is a more valid approach for making comparisons across the years as it allows for changes in activity within the Trust.
- The 'number of patient falls per 100,000 occupied bed days' reported in 2009/11 (metric 3) was changed in 2013/14 to the 'number of patient falls per 1,000 admissions' as experience has shown this indicator is more closely linked to new admissions rather than occupied bed days.
- The 'number of complaints per 100,000 patients' reported in 2009/11 (metric 8) was changed in 2013/14 to the 'percentage of complaints satisfactorily resolved' as experience has shown that it is more important to measure the satisfaction of our response to complaints as opposed to the absolute number of complaints. The latter we encourage as important feedback to the Trust on the quality of our services.

Please also note the National Patient Survey for 2014/15 is not directly comparable to previous surveys therefore the historical data has been moved from Table 1 to the "notes on selected metrics".

Table 1: Quality Metrics

Quality Metrics		2014/15		2013/14	2012/13	2011/12	2010/11	2009/10
		Target	Actual	Actual	Actual	Actual	Actual	Actual
Patient Safety Measures								
1	Number of unexpected deaths classed as a serious incident per 10,000 open cases	<12.00*	**12.16**	11.88	15.91	12.00		
2	Number of outbreaks of Healthcare Associated Infections	0	**0**	0	0	0	0	0
3	Patient Falls per 1,000 admissions	<27.79	**44.54**	35.99	34.09	37.44		
Clinical Effectiveness Measures								
4	Percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care	> 95.00%	**97.42%**	97.86%	97.14%	98.08%	98.50%	97.50%
5	Percentage of clinical audits of NICE Guidance completed	100%	**100%**	97%	89.47%	95.20%	66.70%	75.00%
6	Average length of stay for patients in Adult Mental Health and Mental Health Services for Older People Assessment & Treatment Wards	AMH <30.2	**26.67**	AMH: 31.72	35	37	39	47
		MHSOP <52	**62.18**	MHSOP: 54.08				
Patient Experience Measures								
7	Delayed Transfers of Care	<7.50%	**2.11%**	1.89%	2.07%	1.60%	1.60%	2.90%
8	Percentage of complaints satisfactorily resolved	> 90.00%	**75.38%**	65.77%	76.36%			
National Patient Survey								
9	Trust performing > 2 points over 80% percentile	N/A	**4**					
	Trust performing within 2 points of 80% percentile		**9**					
	Trust performing < 2 points of 80% percentile		**2**					

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

Notes on selected metrics

1. Data for this metric is taken from Incident Reports which are then reported via the National Strategic Executive Information System (STEIS).
2. Outbreaks of healthcare associated infections relates to those of MRSA bacteraemia and C Difficile. The Infection Prevention and Control Team would be notified of any outbreaks direct by the ward and that would then be recorded on an 'outbreak' form before being reported externally.
3. Patient falls excludes the categories 'found on floor' and 'no harm'. Data for this metric is taken from Incident Reports which are then reported via the Trust's Risk Management System, DATIX.
4. Data for CPA 7 day follow up is taken from the Trust's patient systems and is aligned to the national definition.
5. The percentage of clinical audits of NICE Guidance completed is based on the number of audits of NICE guidelines completed against the number of audits of NICE guidelines planned. Data for this metric is taken from audits undertaken by the Clinical Directorates supported by the Clinical Audit Team.
6. Data for average length of stay is taken from the Trust's patient systems.
7. Delayed transfers of care are based on Monitor's definition and therefore exclude children and adolescent mental health services. Data for this metric is taken from the Trust's patient systems.
8. The percentage of complaints satisfactorily resolved is based on the number of complaints where the complainant did not report dissatisfaction with the Trust's response expressed as a percentage of the total number of resolution letters sent out. Please note, if the complainant did not respond to the resolution letter it was assumed that the complainant was satisfied with the Trust's response.
9. The National Patient Survey for 2014/15 is not directly comparable to previous Community Surveys. Also the National Patient Survey for 2009/10 is an inpatient survey which is not directly comparable to the community surveys. The metrics previously reported previously were categorised as follows:

    a) Number of questions where our score was within the top 20% of Mental Health Trusts
    b) Number of questions where our score was within the middle 60% of Mental Health Trusts
    c) Number of questions where our score was within the lowest 20% of Mental Health Trusts

Table 2: National Patient Survey historical performance

National Patient Survey	2013/14	2012/13	2011/12	2010/11	2009/10
Number of questions where our score was within 5% of the highest scored Mental Health Trusts	12 (32%)	11 (29%)	12 (32%)	18 (47%)	16 (42%)
Number of questions where our score was within the middle 90% of scored Mental Health Trusts	26 (68%)	27 (71%)	23 (61%)	14 (37%)	22 (58%)
Number of questions where our score was within 5% of the lowest scored Mental Health Trusts	0 (0%)	0 (0%)	3 (8%)	6 (16%)	0 (0%)

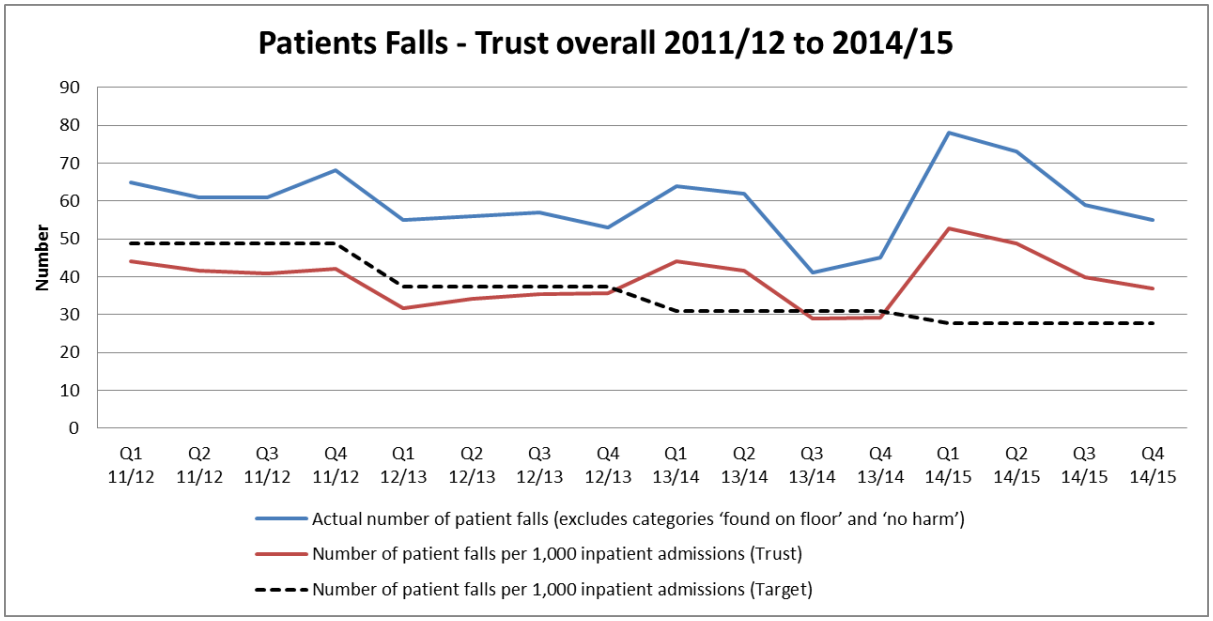
Comments on Areas of Under-Performance

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

The number of unexpected deaths in 2014/15 is **12.16** per 10,000 open cases, which is above the target of 12.00**.** The total number of unexpected deaths was **61** in 2014/15 compared to **60** unexpected deaths in 2013/14. All unexpected deaths classed as a Serious Untoward Incident (SUI) have a detailed coot cause analysis investigation undertaken with a view to identifying any lessons that we should learn. No patterns or trends have been identified from the 2014/15 unexpected deaths.

Metric 3: Patient falls per 1,000 admissions.

The number of falls reported in 2014/15 is **44.54** per 1,000 admissions, which is significantly above the target of **<27.79**. However the number and rate of falls reduced each quarter throughout 2014/15 as can be seen in the graph below.



The overall increase in falls is due in part to better reporting due to increased awareness as well as an increase in the complexity of some patients. This is evidenced by the fact that there are a small number of individual patients responsible for relatively high numbers of falls.

The Trust has taken the following steps to minimise harm from falls:

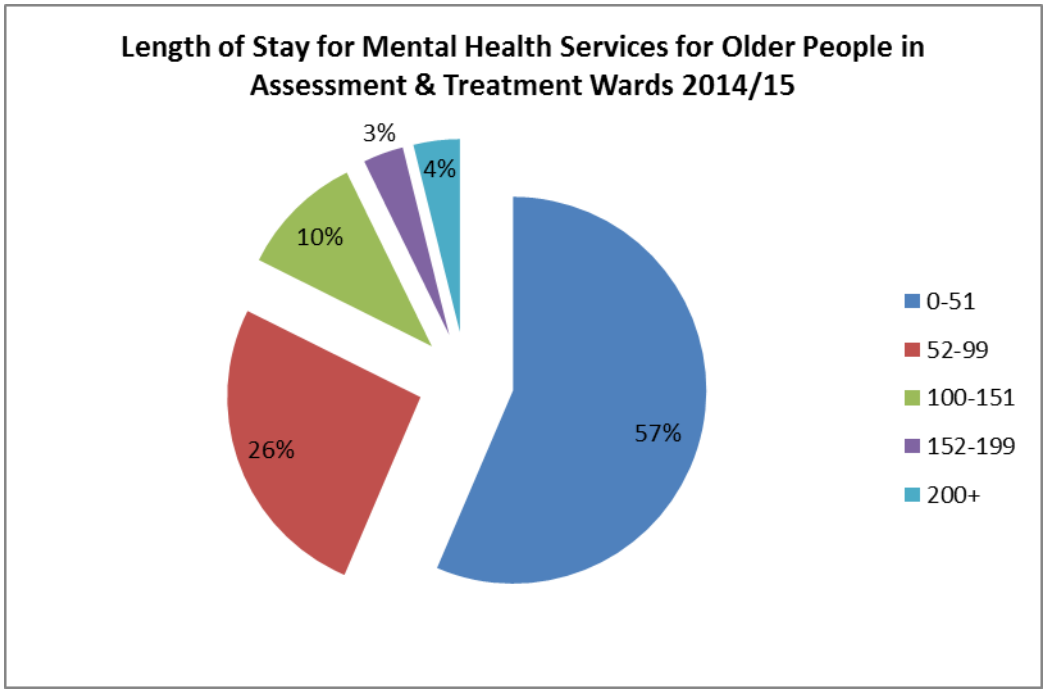
- The Trust 'Falls Executive Group' was reintroduced in January 2015 – this is the body that steers and monitors Trust falls management and will report into the Patient Safety Group (a sub group of the Quality Assurance Committee).
- We are analysing falls across the Trust comparing 2013/14 to 2014/15 and will have a report ready for the end of April 2015 which will go to the Patient Safety Group in May 2015 in order to identify any further action that is required.
- Within the highest risk group, Mental Health Services for Older People, the falls subgroup which report into their Service Development Group complete regular

falls audits and fractured neck of femur audits in order to identify additional action that could be implemented.

- The falls pathway training has been rolled out to Adult Mental Health, Forensic Mental Health and Forensic Learning Disabilities. We have used a 'train the trainer' model with the trainers subsequently becoming falls champions in each service.
- We are developing a falls audit tool to be used in all adult mental health services and falls audits are in all adult services forward audit plans.
- Services will report quarterly to the falls executive about falls management in their service.

Metric 6: Average length of stay for patients in Adult Mental Health and Mental Health Services for Older People assessment & treatment wards.

The average length of stay for adults has remained steady and below the target for 2014/15. The average length of stay for older people during 2014/15 was **62.18** days. This has increased each quarter from **54** days at quarter 1 to **65** days in quarter 4 2014/15, which is above the target of **<52** days. The pie chart below shows the breakdown for the various lengths of stay during 2014/15.



All services closely monitor the length of stay of patients. The reasons for the increase in the length of stay for patients are due to a small number of patients with a very long length of stay which has skewed the overall average. The median length of stay was **44** days which is better than the target of **52** days. There are also more patients with complex needs and sometimes it is difficult to find placements for people to be discharged to.

Metric 8: Percentage of complaints satisfactorily resolved.

The percentage of complaints satisfactorily resolved in 2014/15 was **75.38**% which is below the target of **90.00**% but an improvement on 2013/14. This relates to **198** formal complaints received. Complaints are monitored by the Quality Assurance

Committee and each is thoroughly investigated. Both the Patient Experience Department and Patient Advice and Liaison Services (PALS) strive to resolve as many concerns/complaints as possible informally.

From the 1 April 2015 there will be 3 dedicated locality complaints managers for Tees, Durham and Darlington and North Yorkshire and dedicated support to Forensics from the Head of Complaints. These staff will provide a more dedicated and focussed complaints service, addressing concerns and complaints. Additionally there will also be 3 PALS staff trust-wide who will continue to respond to the helpline, with the aim of providing advice and support for people wishing to raise concerns.

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

Table 3: Complaints Resolution 2014/15

Service	Locality	Total number of complaints resolution letters sent	Percentage (numbers) satisfactorily resolved*
Adult Mental Health	Durham & Darlington	53	75% (40)
	Tees	46	76% (35)
	North Yorkshire	27	59% (16)
Mental Health Services for Older People	Durham & Darlington	5	80% (4)
	Tees	5	60% (3)
	North Yorkshire	4	50% (2)
Children's & Young Peoples Services Mental Health & Learning Disabilities	Durham & Darlington	6	100% (6)
	Tees	7	86% (6)
	North Yorkshire	2	50% (1)
Adult Learning Disabilities	Durham & Darlington	2	100% (2)
	Tees	4	100% (4)
	North Yorkshire	1	100% (1)
Forensic Services	Trustwide	30	80% (24)
Other	Trustwide	3	100% (3)
Total		**195**	**75.38% (147)**

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

Our performance against the Risk Assessment Framework Targets and Indicators

The following table demonstrates how we have performed against the relevant indicators and performance thresholds set out in Appendix A of the Risk Assessment Framework.

Table 4: Risk Assessment Framework

Indicators		2014/15		2013/14	2012/13
		Threshold	**Actual**	**Actual**	**Actual**
a	Care Programme Approach (CPA) patients having formal review within 12 months	95%	**97.75%**	**96.56%**	**96.90%**
b	Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams	95%	**98.42%**	**98.58%**	**97.35%**
c	Meeting commitment to serve new psychosis cases by early intervention teams	95%	**254%**	**239%**	**231%**
e	Mental health data completeness: identifiers	97%	**99.61%**	**98.73%**	**99.18%**
f	Mental health data completeness: outcomes for patients on CPA	50%	**94.09%**	**96.68%**	**96.73%**
g	Certification against compliance with requirements regarding access to health care for people with a learning disability	N/A	**Compliant**	**Compliant**	**Compliant**

Notes on Risk Assessment Framework Targets and Indicators

There are an additional two indicators contained within Appendix A that are relevant however these have been reported in Table 1 Quality Metrics:

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

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

External Audit

For 2014/15, our external auditors have to provide a limited assurance report on whether two mandated indicators included in the quality report / account have been reasonably stated in all material respects. In addition the Council of Governors (CoG) have the option to choose one further local indicator for external assurance. The three indicators which have been included in the external assurance of the quality report / account 2014/15 are:

- the percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care.
- the percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper.
- patient falls per 1000 admissions (the local indicator chosen by the Council of Governors).

The full definitions for these indicators are contained in **appendix 7.**

Progress against National Quality Issues/Reports

The national quality agenda has been driven recently by a number of reports commissioned by the Department of Health such as:

- the Francis Reports into the issues at Mid Staffordshire NHS Foundation Trust and the government's *Hard Truths* response;
- the Clwyd / Hart report *Putting Patients Back in the Picture;*
- the Berwick review into safe staffing, *Improving the Safety of Patients in England;*
- and the Francis' *Freedom to Speak Up* report about the treatment of those who raising concerns / whistleblow in the NHS.

The paragraphs below explain how TEWV is addressing some of the key recommendations of these reports.

Duty of Candour

Before the regulations were enforced we worked with our staff through the professional staff groups (eg Professional Nursing Advisory Groups) and leadership groups to consult on what staff required to ensure this Duty became embedded in Trust Practice. With them we developed a Trustwide briefing and examples to help them make decisions about where Duty of Candour applies. Most importantly we agreed that the development of a **culture of candour** was the most important element of this requirement so that we shared information wherever we could with our services users, families and carers. We then implemented a series of workshops and briefing sessions for all staff across the Trust with a standard presentation and information that could be shared within teams. The workshops were practically based and identified examples where staff would be apologising to patients, families or carers within the definitions of the regulations. In addition we have set up a system for evaluating the serious incidents where patients have suffered significant or severe harm, to test out if Duty of Candour applies and we then have a process

for contacting patients and / or relatives to ensure that they receive the required apology and all the information about the incident. Finally we have identified that staff need to develop their confidence and skills in sharing difficult information so we are organising specific training on working with patients and families in these circumstances.

Review of Trust complaints process

We conducted a review of our existing complaints processes to evaluate how they compared to the recommended process set out in the Clywd and Hart report. We also checked the level of satisfaction of our complainants with the existing process.

We then used our QIS model to identify where the current processes were not customer focused and potentially wasteful and made recommendations for changes to increase efficiency and engage complainants more constructively in the process.

We have already implemented a tracker system to reduce the waiting times in the complaints system so that complainants get a quicker response. Our Action Planning processes have been improved and are now linked into the Learning Lessons systems. We are currently implementing an action plan that includes a redesign of the procedures from point of contact for the complainant to the end resolution. We have also redesigned the corporate team and have now assigned specific complaints managers for each Locality and created a separate PALS team as recommended by Clywd and Hart. Also, in line with Clwyd and Hart, we have separated Patient and Public Involvement team from complaints within our managerial structure so that there are now separate teams. We will be measuring customer satisfaction as well as turnaround time during 2015/16.

Safe Staffing Levels

The Trust has put systems in place to report on the levels of nurse staffing on each of our wards. We collect data on the “fill rate” – ie how many staff were on the shift compared to the number that were planned to be on the shift. We collect this data separately for Health Care Assistants (HCAs) and Registered Nurses, for both day and night-times. The Trust has a daily report board that captures the situation on each ward and makes every effort to cover staff sickness / absence through our roster system and by using our nursing bank.

This data is submitted to the Department of Health, and is reported to the Trust Board. We analyse whether there is a link between incidents, complaints and understaffed wards, but to date no strong correlation has been identified. We have conducted two six monthly reviews as required. We’ve been fully compliant with the Department of Health’s requirements since May 2014. We are in the top 20 (all) Trusts for safe staffing.

In December 2014, our average fill rate for nurses was 90.79% during the day and 98.22% at night. The comparable rate for HCAs was 102.47% by day and 107.13% by night. This reflected the changes in patient need and dependency that were met after the basic roster based on the usual staffing establishment was planned.

Raising Concerns

Sir Robert Francis' inquiries into the events at Mid Staffordshire NHS Foundation Trust showed the importance of staff being able to alert senior managers and Trust Boards to emerging problems within services and the potential consequences where this is not possible. Francis' subsequent *Freedom to Speak Up* report highlights the barriers to this in some parts of the NHS. The Trust has therefore updated its policy around raising concerns (whistleblowing) and provided training for staff on this issue. Staff are also able to raise concerns anonymously and these are discussed at our weekly Executive Management Team with the responses being circulated to all staff in a weekly e-bulletin.

Audit of Quality Governance

During 2014/15 we received the results of an audit of our quality governance arrangements that was carried out by an external independent body. This compared us against the requirements of Monitor's Quality Governance Framework. This confirmed that most aspects of our system were working well and are compliant with Monitor's requirements, but that further improvements could be made. These included changes to the focus of our Quality Assurance Committee which is now focused solely on quality assurance and has a membership that reflects this. A Clinical Leaders Board has also been created to provide a forum for service development to be discussed by our most senior clinicians. Professional Nurse Lead posts are to be established from June 2015 and the new post of Director of Quality Governance has been filled, with the new postholder commencing in post in May 2015.

Our stakeholders' views

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

How we involve and listen to what our stakeholders say about us is critical to this process. In producing the quality report / account 2014/15, we have tried to improve how we involved our stakeholders in assessing our quality in 2014/15.

Our Stakeholder Engagement events were held in a location central to the Trust's area, and included a mixture of presentations on current progress against quality priorities and collective discussion among stakeholders about the focus of future quality improvement priorities. We achieved a balanced participation both geographically and between different types of stakeholders (eg Trust Governors, CCGs, Local Authorities and Healthwatch). Staff engagement is through staff governors involvement in the stakeholder event, and also the engagement the Trust carries out with staff on our business plan, which includes our proposed quality priorities.

The following are some positive comments we received from our stakeholders following the two events we held in July 2014 and February 2015:

- *Informative updates on main issues.*
- *Promoted good discussion.*
- *Thought provoking.*
- *Very good - particular interest in CYP services.*
- *Good to listen to those leading the work.*
- *Positive to see focus on Learning Disabilities and Children's services.*
- *Opportunity to link Children and Young People schemes to self-harm / suicide prevention.*
- *Well managed feedback session.*
- *Good way of sharing ideas.*
- *Look forward to future events.*
- *Good to see / hear updates and to be actively involved in developments of 15/16 plans.*
- *Good to see that 14/15 plans are in the main on track and robust plans in place where not met.*
- *A good interesting and informative discussion.*

The following are the comments from our stakeholders on things we could do better at our stakeholder events:

- *Getting all key stakeholders that are effected by / can contribute to targets to attend the quality report / account improvement priority development events*
- *More direct measurable information ie specific areas what are expected positive outcomes*
- *More CCG involvement would be helpful*
- *Start time too early for people who travel further than others*

- *Disappointed not to see 2 week access for CYPS as a priority – can link access to outcome*
- *Some key factors from July not included*

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

In line with national guidance, we have circulated our draft quality report / account for 2014/15 to the following stakeholders:

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

All the comments we have received from our stakeholders are included verbatim in **appendix 8**.

The following are the general themes received from stakeholders in reviewing our quality report / account for 2014/15:

- *Appreciative of the opportunity to feed back on the content of the quality report / account.*
- *The Trusts engagement of stakeholders through stakeholder events is positive.*
- *Generally stakeholders are pleased with what we have achieved against our 2014/15 quality priorities and support our plans for the 2015/16 quality priorities.*
- *The stakeholders are pleased to see and support the continued focus on the Recovery Approach.*
- *They understand that tackling smoking will result in reducing the mortality gap.*
- *They welcome the commitment to continue to roll-out suicide prevention training across the Trust and to partners in care (although we may call this "harm-reduction" training internally this is the same thing).*
- *There is an understanding that the achievement of targets is positive in a challenging time for healthcare.*
- *They support the work we are doing to create a culture where we learn from mistakes and incidents.*
- *The document is fair / balanced / open / honest.*
- *An summary document, with photos etc should be produced.*

The following are specific comments received from stakeholders in reviewing our quality report / account for 2014/15:

- *County Durham Health and Wellbeing Board:*
  - *Would like explicit reference to Health and Wellbeing Board priorities.*
  - *Does not address how people with complex LD will be supported in the community.*
  - *More focus on carers in the document.*

- *Healthwatch Darlington:*
  - *Would like to involve us in upcoming Healthwatch work on CYP services.*
  - *Would like to understand why we have a high level of incidents compared to other MH Trusts.*
- *Healthwatch Durham:*
  - *There is no reference to the Human Rights Act or Equality Act 2010.*
- *Joint North Yorkshire CCGs:*
  - *NY IAPT services have significantly improved since TEWV took them over.*
  - *NY Liaison and S136 services have made a positive difference to patients.*
  - *New SUI review team and commitment to improve communication with GPs are welcome.*
- *Joint Teesside CCGs:*
  - *Welcome references to the national quality agenda.*
- *Tees Valley Joint Overview and Scrutiny Committee:*
  - *Understand that failures to hit milestones are due to recruitment difficulties, not the impact of health budget cuts.*
  - *Would welcome more information about capacity at Roseberry Park, people being treated out of area and people not being treated in their local hospital.*
  - *Requested a report on the walk-in facility at Roseberry Park after 12 months of operation.*
  - *Concern about Sandwell Park's future was reduced with the assurance given that there are no plans to close it in the next two years.*
  - *Would like to understand if our low number of incidents reflects lack of reporting or few incidents.*
  - *Would have liked a section on Deprivation of Liberty Standards (DoLS) and Safeguarding in the QA document.*

The Trust will write to each stakeholder addressing each comment made following publication of the quality report / account 2014/15 and use the feedback as part of an annual lessons learnt exercise in preparation for the quality report / account 2015/16.

In response to many stakeholders' requests, the Trust has agreed to continue providing all stakeholders with a half-year update in November 2015 on the Trust's progress with delivering its quality priorities and metrics for 2015/16.

APPENDICES

APPENDIX 1: 2014/15 STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE QUALITY REPORT / ACCOUNT

The Directors are required under the Health Act 2009 and the National Health Service (quality report / account) Regulations 2010 to prepare quality report / accounts / Report for each financial year.

Monitor has issued guidance to NHS foundation Trust boards on the form and content of annual quality report / account (which incorporate the above legal requirements) and on the arrangements that NHS foundation Trust boards should put in place to support the data quality for the preparation of the quality report / account.

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

- the content of the quality report / account meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2014/15 and supporting guidance

- the content of the quality report / account is not inconsistent with internal and external sources of information including:

    - Board minutes and papers for the period April 2014 to May 2015;
    - Papers relating to quality reported to the Board over the period April 2014 to May 2015;
    - Feedback from the commissioners dated 14 May and 15 May 2015;
    - Feedback from Governors dated 23 March, 13 April and 19 May 2015;
    - Feedback from Local Healthwatch organisations dated 15 May and 18 May 2015;
    - Feedback from Overview and Scrutiny Committees dated 14 May and 15 May 2015;
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 19 May 2015;
    - The latest national patient survey published 18 September 2014;
    - The latest national staff survey published 24 February 2015;
    - The Head of Internal Audit's annual opinion over the Trust's control environment dated 6 May 2015*;*
    - CQC Intelligent Monitoring Report dated 20 November 2014.

- the quality report / account presents a balanced picture of the NHS Foundation Trust's performance over the period covered;

- the performance information reported in the quality report / account is reliable and accurate;

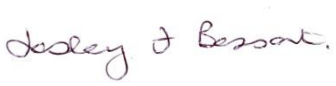
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report / account, and these controls are subject to review to confirm that they are working effectively in practice;

- the data underpinning the measures of performance reported in the quality report / account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review;

- the quality report / account has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the quality report / account regulations) (published at www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the quality report / account (available at: www.monitor.gov.uk/annualreportingmanual).

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report / account.

By order of the Board



Lesley Bessant
Chairman
26 May 2015

Martin Barkley
Chief Executive
26 May 2015

APPENDIX 2: 2014/15 LIMITED ASSURANCE REPORT ON THE CONTENT OF THE QUALITY REPORT / ACCOUNTS AND MANDATED PERFORMANCE INDICATORS

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

We have been engaged by the Council of Governors of Tees, Esk and Wear Valleys NHS Foundation Trust to perform an independent assurance engagement in respect of Tees, Esk and Wear Valleys NHS Foundation Trust's Quality Report for the year ended 31 March 2015 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2015 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

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

We refer to these national priority indicators collectively as the "indicators".

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in section 2.1 of Monitor's Detailed Guidance for External Assurance on Quality Reports 2014/15; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and considered the implications for our report if we became aware of any material omissions.

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

- Board minutes for the period April 2014 to April 2015;
- Papers relating to quality reported to the Board over the period April 2014 to April 2015;
- Feedback from Commissioners, dated 15 May and 20 May 2015 and the feedback on behalf of NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group (CCG), NHS Harrogate and Rural District CCG, and NHS Scarborough and Ryedale CCG (undated);
- Feedback from governors, (undated);

- Feedback from local Healthwatch organisations; Healthwatch Durham dated 15 May 2015, and Healthwatch Darlington (undated);
- Feedback from Overview and scrutiny committee: Darlington Borough Council (undated), Durham County Council (undated) and Tees Valley Joint Health Scrutiny Committee (undated);
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, for the period 1 April 2014 to 31 March 2015;
- The 2014 national patient survey;
- The 2014 national NHS staff survey;
- Care Quality Commission Intelligent Monitoring Report, dated November 2014;
- The Head of Internal Audit's annual opinion over the trust's control environment for the period April 2014 to March 2015;
- Any other information included in our review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the "documents"). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Tees, Esk and Wear Valleys NHS Foundation Trust as a body, to assist the Council of Governors in reporting Tees, Esk and Wear Valleys NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2015, to enable the Council of Governors to demonstrate that it has discharged its governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Tees, Esk and Wear Valleys NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

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

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Tees, Esk and Wear Valleys NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in section 2.1 Monitor's Detailed Guidance for External Assurance on Quality Reports 2014/15; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual.

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

Chartered Accountants and Statutory Auditor

Rivergreen Centre, Aykley Heads, Durham, DH1 5TS

27 May 2015

APPENDIX 3: GLOSSARY

Adult Mental Health Service (AMH): Services provided for people between 18 and 64 – known in some other parts of the country as "working-age services". These services included inpatient and community mental health services. In practice, some patients younger than 64 may be treated in older people's services if they are physically frail or if they have Early Onset Dementia. Early Intervention in Psychosis teams (EIP) may treat patients younger than 18 years old as well as those over that age.

Alcohol Detoxification Pathway: This is the standard set of assessments that we use to identify alcohol dependency and a set of consequent interventions we use to address this.

ARCH (aspiration, recovery, confidence, hope): This is the name of our Durham *Recovery College*, and it reflects the impact that we intend our recovery work to have on our service users' lives.

Audit Commission: This was the national body responsible for appointing external auditors to many public bodies. It also ran counter-fraud work and produced national value for money studies. Government re-assigned its roles to other bodies and the Commission was closed on 31st March 2015.

Audit North: This is an Audit Consortium covering many health, local government and other bodies in the North East, Yorkshire, East Midlands and Cumbria. Audit North provider TEWV's internal audit service (the Trust's external auditors are Mazars).

Autism Services / Autistic Spectrum Disorders: describes a range of conditions including autism, asperger syndrome, pervasive developmental disorder not otherwise specified (PDD-NOS), childhood disintegrative disorder, and Rett syndrome, although usually only the first three conditions are considered part of the autism spectrum. These disorders are typically characterized by social deficits, communication difficulties, stereotyped or repetitive behaviours and interests, and in some cases, cognitive delays.

Behavioural Activation: As a treatment for depression and other mood disorders, behavioural activation is based on the theory that, as individuals become depressed, they tend to engage in increasing avoidance and isolation, which serves to maintain or worsen their symptoms. The goal of treatment, therefore, is to work with depressed individuals to gradually decrease their avoidance and isolation and increase their engagement in activities that have been shown to improve mood. Many times, this includes activities that they enjoyed before becoming depressed, activities related to their values or even everyday items that get pushed aside.

Benchmarking: This is where data on how the same service / team performs clinically, financially or otherwise is compared against other similar services / teams in other places. Often this comparison will be against the average, median, upper or lower quartile position, which is worked out by ranking all of the services / teams. Benchmarking may be "internal" (comparing teams across TEWV) or "external" (comparing across the country).

Board / Board of Directors: The trust is run by the Board of Directors made up of the Chairman, Chief Executive, Executive and Non-Executive Directors. The Board is responsible for ensuring accountability to the public for the services it manages. It also:

- Ensures effective dialogue between the trust and the communities it serves
- Monitors and ensures high quality services
- Is responsible for the trust's financial viability
- Sets general policy direction
- Appoints and appraises the trust's executive management team. It is overseen by a Council of Governors and regulated by Monitor.

C Difficile: a species of bacteria of the genus Clostridium that causes severe diarrhoea and other intestinal disease when competing bacteria in the gut flora have been wiped out by antibiotics.

CAMHS: Children and Young People's Mental Health services (see Children and Young People's Services)

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

Care Programme Approach (CPA) Policy: the Trusts policy on the Care Programme Approach.

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

Care UK: A major provider of NHS and private sector healthcare services, that until March 2015 held the contract for health services in the prisons in North East England, subcontracting the mental health elements of the contract to TEWV.

Children and Young People Service (CYPS): Services for people under 18 years old. These include community mental health services and inpatient services. In Durham, Darlington and Teesside TEWV also provides services to children and young people with learning disability related mental health needs.

Clinical Commissioning Groups (CCGs): NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England. CCGs are clinically led groups that include all of the GP groups in their geographical area. The aim of this is to give GPs and other clinicians the power to influence commissioning decisions for their patients. CCGs are overseen by NHS England.

Clinical Research Network (CRN): This is part of the National Institute for Health Research which provides the infrastructure to allow high quality research to take place within the NHS, so patients can benefit from new and better treatments

Clinical Trials of Investigational Medicinal Products (CTIMPs): These are studies which determine the safety and/or efficacy of medicines in humans.

Clywd / Hart Review: A review of the complaints systems and the use of complaints data carried out by Rt Hon Ann Clwyd (MP for the Cynon Valley) and Professor Tricia Hart, (chief executive, South Tees Hospitals NHS Foundation Trust) who were commissioned by the Secretary of State for Health to lead the review. It came as part of a response to the Francis report, which highlighted that complaints are a warning sign of problems in a hospital.

COBRA (cost and outcome of behavioural activation versus cognitive behaviour therapy for depression): is a research study comparing 2 psychological interventions for the treatment of depression in adults. The study aims to determine both the clinical and cost effectiveness of Behavioural Activation compared to Cognitive Behavioural Therapy for depression in adults within primary care.

Cognitive Behavioural Therapy (CBT): CBT is a “talking therapy.” The therapist will talk with the patient about how they think about themselves, the world and other people and how what they do affects their thoughts and feelings. CBT can help patients change how they think ('Cognitive') and what they do ('Behaviour'). These changes can help the patient to feel better. Unlike some of the other talking treatments, it focuses on the 'here and now' problems and difficulties. Instead of focusing on the causes of your distress or symptoms in the past, it looks for ways to improve the patient’s state of mind now.

Commissioners: The organisations that have responsibility for buying health services on behalf of the population of the area work for.

Commissioning for Quality and Innovation (CQUIN): is a payment framework such that a proportion of NHS providers' income is conditional on quality and innovation. Its aim is to support the vision set out in High Quality Care for All of an NHS where quality is the organising principle**.**

Confidential Enquiry Report: A national scheme that interviews clinicians anonymously to find out ways of improving care by gathering information about which factors contributed to the inability of the NHS to prevent each suicide of a patient within its care. National reports and recommendations are then produced.

Coproduction: This is an approach where a policy, and approach or other initiative / action is designed jointly by TEWV and a service user / service users.

Council of Governors: the Council of Governors is made up of elected public and staff members, and also includes non-elected members, such as the Prison Service, Voluntary Sector, Acute Trusts, Universities, Primary Care Trusts and Local Authorities. The Council has an advisory, guardianship and strategic role including developing the Trust’s membership, appointments and remuneration of the Non-

Executive Directors including Chairman and Deputy Chairman, responding to matters of consultation from the Trust Board, and appointing the Trust's auditors.

Crisis Care Concordat: The Mental Health Crisis Care Concordat is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis.

Culture of Candour: This relates to an open culture where things that go wrong are not kept secret but rather kept in the open so that people can understand and learn from what went on without blame or shame being allocated to individuals.

Dashboard: A report that uses data on a number of measures to help managers build up a picture of operational (day to day) performance or long term strategic outcomes.

Data Protection Act 1998: The law that regulates storage of and access to data about individual people.

Data Quality Improvement Plans: A plan to improve the reliability / accuracy of data collected on a particular subject – often used where data has not been collected in the past and new systems to do this need to be set up.

DATIX: TEWV's electronic system for collecting data about clinical, health and safety and information governance incidents.

Department of Health: The government department responsible for Health Policy.

Directorate(s): TEWV's corporate services are organised into a number of directorates: Human Resources and Organisational Development; Finance and Information; Nursing and Governance; Planning, Performance and Communications; Estates and Facilities Management. In the past our clinical specialities were called clinical directorates. The Specialities are Adult Mental Health services, Mental Health Services for Older People, Children and Young People's Services and Adult Learning Disability Services.

Drug and Therapeutics Committee: This is a subcommittee of the Quality Assurance Committee. It's role is to provide assurance to the Board of Directors, through the monitoring of quality and performance indicator data, planned work streams, guideline development and system implementation that the use of medicines throughout the Trust is safe, evidence-based, clinically and cost effective.

Duty of Candour: From 27 November 2014 all NHS bodies are legally required to meet the Duty of Candour. This requires healthcare providers to be open and transparent with those who use their services in relation to their care and treatment, and specifically when things go wrong

Early Intervention in Psychosis (EIP): Early intervention in psychosis is a clinical approach to those experiencing symptoms of psychosis for the first time. It forms part of a new prevention paradigm for psychiatry and is leading to reform of mental health services especially in the United Kingdom. This approach centres on the

early detection and treatment of early symptoms of psychosis during the formative years of the psychotic condition. The first three to five years are believed by some to be a critical period. The aim is to reduce the usual delays to treatment for those in their first episode of psychosis. The provision of optimal treatments in these early years is thought to prevent relapses and reduce the long-term impact of the condition.

Electroconvulsive Therapy (ECT): ECT is a treatment for a small number of severe mental illnesses. It was developed in the 1930s and was used widely during the 1950s and 1960s for a variety of conditions. It is now only used for fewer, more serious conditions. An electrical current is passed through the brain to produce an epileptic fit – hence the name, electro-convulsive. No-one is certain how ECT works. We do know that it can change patterns of blood flow through the brain and change the metabolism of areas of the brain which may be affected by depression. There is evidence that severe depression is caused by problems with certain brain chemicals. It is thought that ECT causes the release of these chemicals and, probably more importantly, makes the chemicals more likely to work and so help recovery.

Equality Champions: Staff within TEWV who have been appointed to promote good practice in equalities within their service and who attend the Trust-wide Equalities group.

Experts by Experience: experts by experience have been trained to work alongside the recovery team to develop and deliver recovery related training in supporting staff and service development in recovery related practice. Experts by experience work with Trust staff, they do not work with service users and carers (ie they are not acting in a peer role). These roles are managed via our Patient and Public Involvement process.

Forensic Services: forensic mental health and learning disability services work mainly with people who are mentally unwell or who have a learning disability and have been through the criminal justice system. The majority of people are transferred to secure hospital from prison or court, where their needs can be assessed and treated. These services are intended to see that people with severe mental illness or learning disability who enter the criminal justice system get the care they need.

Freedom of Information Act 2000: A law that outlines the rights that the public have to request information from public bodies (other than personal information covered by the Data Protection Act), the timescales they can expect to receive the information, and the exemptions that can be used by public bodies to deny access to the requested information.

Friends and Family Test: A survey question put to patients, carers or staff that asks whether they would recommend a hospital / community service to a friend of family member if they needed that kind of treatment.

General Medical Practice Code: is the organisation code of the GP Practice that the patient is registered with. This is used to make sure that our patients' GP practice is recorded correctly.

Health and Social Care Information Centre (HSCIC): The Health and Social Care Information Centre (HSCIC) was set up as an executive non-departmental public body in April 2013, sponsored by the Department of Health. It is the national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care**.**

Health and Wellbeing Boards: The Health and Social Care Act 2012 established health and wellbeing boards as a forum where key leaders from the health and care system would work together to improve the health and wellbeing of their local population and reduce health inequalities. Health and wellbeing board members collaborate to understand their local community's needs, agree priorities and encourage commissioners to work in a more joined-up way.

Health Education North East: The Health and Social Care Act 2012 established Health Education England which is supported by 13 local education and training boards (LETBs) spread across the country. HENE is the LETB that covers the North East of England, north Cumbria and Richmondshire / Hambleton area of North Yorkshire. It is responsible for the education and training of the whole NHS north east workforce. The professions range from medics, dentists, nurses, dental nurses, allied health professionals and healthcare scientists, to a variety of support staff such as healthcare and nursing assistants, therapists and technical staff.

Health of the Nation Outcome Score (HoNOS): A way of measuring patients health and wellbeing. It is made up of 12 simple scales on which service users with severe mental illness are rated by clinical staff. The idea is that these ratings are stored, and then repeated- say after a course of treatment or some other intervention- and then compared. If the ratings show a difference, then that might mean that the service user's health or social status has changed. They are therefore designed for repeated use, as their name implies, as clinical outcomes measures

Healthwatch: local bodies made up of individuals and community groups, such as faith groups and residents' associations, working together to improve health and social care services. They aim to ensure that each community has services that reflect the needs and wishes of local people.

Health Technology Assessment (HTA): The HTA Programme is the largest of the National Institute for Health Research programmes. We fund independent research about the effectiveness, costs and broader impact of healthcare treatments and tests for those who plan, provide or receive care in the NHS. We fund our studies via a number of routes including commissioned and researcher-led workstreams

Her Majesties Prison Inspectorate (HMPI): The inspectorate reporting on the treatment and conditions for those in prison and other types of custody in England and Wales

Hospital Episode Statistics (HES): is the national statistical data warehouse for England of the care provided by NHS hospitals and for NHS hospital patients treated elsewhere. HES is the data source for a wide range of healthcare analysis for the NHS, Government and many other organisations and individuals.

Human Resources: This phrase is either shorthand for all the staff working for TEWV, or the corporate service within TEWV responsible for ensuring that we have policies, procedures and professional advice that help us to recruit and retain suitably qualified, skilled and motivated workers in our full range of jobs (in other organisations this might be known as the Personnel Department).

IAPT (also known as 'Talking Therapies'): IAPT stands for "Increasing Access to Psychological Therapies" and was introduced in the last.

Infection Prevention and Control Team: The prevention of health care associated infections (HCAI), both in patients and staff, is an integral part of the professional responsibility of all health care workers. TEWV's infection prevention and control team for the trust consists of 2 senior infection prevention and control and physical healthcare nurse (IPCNs), 2infection prevention and control and physical healthcare nurses. The role of Director of Infection Prevention and Control (DIPC) is undertaken by the Director of Nursing and Governance for the trust who is accountable directly to the board and chairs the trust Infection Prevention and Control Committee.

Information Governance Toolkit & Assessment Report: is a national approach that provides a framework and assessment for assuring information quality against national definitions for all information that is entered onto computerised systems whether centrally or locally maintained.

Integrated Information Centre: TEWV's system for taking data from the patient record (Paris) and enabling it to be analysed to aid operational decision making and business planning.

Join Dementia Research (JDR): is a new national system which allows anyone, with or without dementia, to register their interest in becoming involved in dementia research. People can register online, by phone or by post and the system aims to match people to studies they may be able to take part in.

Learning Disabilities Service: Services for people with a learning disability and mental health needs. TEWV has Adult Learning Disability (ALD) service in each of its 3 Localities and also specific wards for Forensic LD patients. TEWV provides Child LD services in Durham, Darlington and Teesside but not in North Yorkshire.

Lived Experience: A member of the public or staff who has been treated for MH issues in the past and so has special insight into the patient perspective of having a mental illness and receiving treatment.

Local Authority Overview and Scrutiny Committee: All "upper-tier" and "unitary" local authorities are responsible for scrutinising health services in their area, and most have a Health Overview and Scrutiny Committee (OSC). Darlington, Hartlepool, Middlesbrough, Stockton and Redcar & Cleveland Councils have formed a joint Tees Valley OSC.

Localities: services in TEWV are organised around three Localities (ie County Durham & Darlington, Tees, North Yorkshire). Our Forensic services are not

organised as a geographical basis, but are often referred to a fourth “Locality” within TEWV.

Locality Management and Governance Board (LMGB): A monthly meeting held in each of our Localities (see above) that involves senior managers and clinical leaders who work in that Locality which takes key decisions that relate to that Locality.

Mental Capacity Act: is a framework to provide protection for people who cannot make decisions for themselves. It contains provision for assessing whether people have the mental capacity to make decisions, procedures for making decisions on behalf of people who lack mental capacity and safeguards. The underlying philosophy of the MCA is that any decision made, or action taken, on behalf of someone who lacks the capacity to make the decision or act for themselves must be made in their best interests**.**

Mental Health Act: The Mental Health Act (1983) is the main piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder. In most cases, when people are treated in hospital or another mental health facility they have agreed or volunteered to be there. However, there are cases when a person can be detained (also known as sectioned) under the Mental Health Act (1983) and treated without their agreement. People detained under the Mental Health Act need urgent treatment for a mental health disorder and are at risk of harm to themselves or others.

Mental Health and Learning Disabilities Data Set (MHLDDS): This contains data about the care of adults and older people using secondary mental health, learning disabilities or autism spectrum disorder services**.** Data is submitted by all providers of NHS funded services (doing so is a contractual requirement). This used to be referred to as the Mental Health Minimum Data Set (MHMDS).

Mental Health Foundation: A UK mental health research, policy and service improvement charity.

Mental Health Minimum Data Set (MHMDS): see *Mental Health and Learning Disabilities Data Set (MHLDDS)* above.

Mental Health Research Network (MHRN): is part of and funded by the National Institute for Health Research and provides the NHS infrastructure to support commercial and non-commercial large scale research in mental health including clinical trials.

Mental Health Services for Older People (MHSOP): Services provided for people over 65 years old. These can be to treat ‘functional’ illness, such as depression, psychosis or anxiety, or to treat ‘organic’ mental illness (conditions usually associated with memory loss and cognitive impairment), such as dementia. The MHSOP service sometimes treats people younger than 65 with organic conditions such as early-onset dementia.

Model Lines: A TEWV programme to support community teams to become recovery focused by using the quality improvement system philosophy and tools to maximise the time staff have available to work with patients, their families and

carers. It also seeks to standardise the approach taken by different staff within a team, and across the Trust as a whole.

Monitor: the independent economic regulator for NHS Foundation Trusts.

MRSA: is a bacterium responsible for several difficult-to-treat infections in humans. MRSA is especially troublesome in hospitals, prisons and nursing homes, where patients with open wounds, invasive devices, and weakened immune systems are at greater risk of infection than the general public.

Multi-agency: this means that more than one provider of services is involved in a decision or a process.

Multi-disciplinary: this means that more than one type of professional is involved – for example: psychiatrists, psychologists, occupational therapists, behavioural therapists, nurses, pharmacist all working together in a Multi-Disciplinary Team (MDT).

My Shared Pathway: My Shared Pathway is used in our Forensic (Adult Secure) wards. It focusses on *recovery*, identifying and achieving outcomes and streamlining the pathway for service users within secure settings. This way of working ensures that service users are treated as individuals by looking at each person's needs. They are encouraged to find new ways of meeting their needs by looking at the whole pathway through secure care, from the very start.

National Audit of Psychological Therapies (NAPT): funded by the Healthcare Quality Improvement Partnership (HQIP) and is an initiative of the College Centre for Quality Improvement (CCQI). Aims to promote access, appropriateness, acceptability and positive outcomes of treatment for those suffering from depression and anxiety.

National Confidential Inquiries (NCI) and National Clinical Audit: research projects funded largely by the National Patient Safety Agency (NPSA) that examine all incidents of, for example suicide and homicide by People with Mental Illness, with the aim is to improve mental health services and to help reduce the risk of these tragedies happening again in the future. Supported by a national programme of audit.

National Reporting and Learning System (NRLS): The National Reporting and Learning System (NRLS) is a central (national) database of patient safety incident reports. All information submitted is analysed to identify hazards, risks and opportunities to continuously improve the safety of patient care.

National Research Passport Scheme: a scheme to streamline procedures associated with issuing honorary research contracts or letters of access to researchers who have no contractual arrangements with NHS organisations who host research, and who carry out research in the NHS that affects patient care, or requires access to NHS facilities.

National Institute for Clinical Excellence (NICE): NHS body that provides guidance, sets quality standards and manages a national database to improve

people's health and prevent and treat ill health. NICE works with experts from the NHS, local authorities and others in the public, private, voluntary and community sectors - as well as patients and carers - to make independent decisions in an open, transparent way, based on the best available evidence and including input from experts and interested parties.

National Institute for Health Research (NIHR): an NHS research body aimed at supporting outstanding individuals working in world class facilities to conduct leading edge research focused on the needs of patients and the public.

National Reporting and Learning System (NRLS): an NHS led central database of information on patient safety incidents used to identify and tackle important patient safety issues at their root cause.

National Research Passport Scheme: a scheme to streamline procedures associated with issuing honorary research contracts or letters of access to researchers who have no contractual arrangements with NHS organisations who host research, and who carry out research in the NHS that affects patient care, or requires access to NHS facilities.

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

NHS England Commissioners: The part of NHS England responsible for commissioning specialist mental health services – e.g. Adult Secure (Forensic), CAMHS Inpatients and Inpatient adult and CYP Eating Disorders.

NHS England – Area Teams: The teams with NHS England responsible for commissioning specialised services and monitoring our performance against our specialist services contracts.

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

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

Opting in to Clinical Research (OptiC): This has recently been incorporated within our local electronic patient records system. Systems like this, which are embedded in NHS records, allow service-users to express an interest (or otherwise) in participating in clinical research and have the potential to enhance and streamline the recruitment of patients to studies.

Out of Locality Action Plan: The Trust wants all inpatients to be admitted to the normal hospital for the place where they live for their condition, unless they express a choice to be treated elsewhere. Sometimes we are unable to do that when there are no beds available in their local hospital in which case the patient would be admitted to another TEWV hospital, further away from where the patient lives. We have an action plan to reduce the number of times this happens.

Overview & Scrutiny Committees (OSCs): These are statutory committees of each Local Authority which scrutinise the development and progress of strategic and operational plans of multiple agencies within the Local Authority area. All local authorities have an OSC that focussed on Health, although Darlington, Middlesbrough, Stockton, Hartlepool and Redcar & Cleveland Councils have a joint Tees Valley Health OSC that performs this function.

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

Paris Programme: Ongoing improvement of the PARIS system to adapt it to TEWV's service delivery models and pathways.

Patient Advice & Liaison Team (PALs): The Patient Advice and Liaison Service (PALS) offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers. TEWV has its own PALS service as do all other NHS providers.

Patient Safety Group: The group monitors on a monthly basis the number of incidents reported, any thematic analysis and seeks assurances from operational services that we are learning from incidents. We monitor within the group any patient safety specific projects that are on-going to ensure milestones are achieved and benefits to service users are realised.

Payment by Results (PBR): a new system being implemented across the NHS, and piloted in mental health Trusts, to provide a transparent, rules-based system for paying NHS Trusts. The system aims to reward efficiency, support patient choice and diversity and encourage activity for sustainable waiting time reductions. Payment will be linked to activity, adjusted for case-mix, and outcomes. Importantly, this system aims to ensure a fair and consistent basis for hospital funding rather than being reliant principally on historic budgets and the negotiating skills of individual managers.

Peer Trainer: someone who is trained and recruited as a paid employee within the Trust in a specifically designed job to actively use their lived experience and to deliver training courses to other service users and carers. They work within the Recovery College.

Peer Volunteer: someone who gives their time freely to the Trust in a specifically defined unpaid role to actively use their lived experience (as a service user or carer) to support other carers and service users. They work alongside and support paid staff as well as providing support to specific groups / tasks.

Peer Worker: someone who is trained and recruited as a paid employee within the Trust in a specifically designed job, to actively use their lived experience (as a service user or carer) to support other service users, in line with the Recovery Approach.

PPI: Patient and Public Involvement.

Prescribing Observatory in Mental Health (POMH): a national agency, led by the Royal College of Psychiatrists, that aims to help specialist mental health services improve prescribing practice via clinical audit and quality improvement interventions.

Prime Minister's Challenge on Dementia: David Cameron's government's five year vision for the future of dementia care, support and research, which was launched in 2012 and updated in 2015. The overall ambition set by the vision is by 2020 for England to be:

- The best country in the world for dementia care and support and for people with dementia, their carers and families to live; and
- The best place in the world to undertake research into dementia and other neurodegenerative diseases.

Project: A one-off, time limited piece of work that will produce a product (such as a new building, a change in a service or a new strategy / policy) that will bring benefits to relevant stakeholders. In TEWV projects will go through a Scoping phase, and then a Business Case phase before they are implemented, evaluated and closed down. All projects will have a project plan, and a project manager.

Purposeful Inpatient Admission and Treatment: This is TEWV's method for ensuring that all patients receive assessments and treatments as quickly as possible so that their length of stay is kept as short as possible.

Quality report / account: A quality report / account is a report about the quality of services by an NHS healthcare provider. The reports are published annually by each provider.

Quality Assurance Committee (QuAC): sub-committee of the Trust Board responsible for quality and assurance.

Quality Assurance Groups (QuAG): Locality / divisional groups within the Trust responsible for quality assurance.

Quality Goals: (see *Quality Strategy*, below).

Quality Governance Framework (Monitor): Monitor's approach to making sure NHS foundation trusts are well run and can continue to provide good quality services for patients.

Quality Strategy: This is a TEWV strategy. The current strategy covers 2014 – 2019. It sets a clear direction and outlines what the Trust expects from its staff to work towards our vision of providing excellent quality care. It helps TEWV continue to improve the quality and value of our work, whilst making sure that it remains clinically and financially sustainable

Quality Strategy Scorecard: A set of numerical indicators related to all aspects of Quality, reported to Trust Board four times per year, that helps the Board ascertain whether the actions being taken to support the Quality Strategy are having the expected positive impact.

Quality Risk Profile Reports: The Care Quality Commission's (CQC) tool for providers, commissioners and CQC staff to monitor provider's compliance with the essential standards of quality and safety.

Recovery Approach: This is a new approach in mental health care that goes beyond the past focus on the medical treatment of symptoms, and getting back to a "normal" state. Personal recovery is much broader and for many people it means finding / achieving a way of living a satisfying and meaningful life within the limits of mental illness. Putting recovery into action means focusing care on what is personally important and meaningful, looking at the person's life goals beyond their symptoms. Helping someone to recover can include assisting them to find a job, getting somewhere safe to live and supporting them to develop relationships.

Recovery College: A recovery college is a learning centre, where service users, carers and staff enrol as students to attend courses based on recovery principles. Our recovery college, called *ARCH,* opened in September 2014 in Durham. This exciting resource is available to TEWV service users, carers and staff in the Durham area. Courses aim to equip students with the skills and knowledge they need to manage their recovery, have hope and gain more control over their lives. All courses are developed and delivered in co-production with people who have lived experience of mental health issues.

Recovery Strategy: TEWV's long term plan for moving services towards the *recovery approach* (see above).

Research for Patient Benefit (RfPB): provides funding for high quality research, inspired by patients and practice, for the benefit of users of the NHS in England. Its main purpose is to realise, through evidence, the huge potential for improving, expanding and strengthening the way that healthcare is delivered for patients, the public and the NHS.

Resilience: Resilience in the context of this quality report / account is the extent to which patients can cope, and maintain their own well-being when they can feel their mental health worsening. We work with patients to build up their resilience as part of the recovery approach, and often develop Resilience Plans with them.

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

Root Cause Analysis (RCA): a technique employed during an investigation that systematically considers the factors that may have contributed to the incident and seeks to understand the underlying causal factors.

Safeguarding Adults / Children: Safeguarding means protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect. It is fundamental to creating high-quality health and social care.

Section 117 of the Mental Health Act: This part of the Act provides for aftercare to be given to some people discharged from mental health inpatient beds to help them avoid readmission to hospital. The duty applies both to the NHS and to Social Services.

Section 136 of the Mental Health Act: The police can use section 136 of the Mental Health Act to take a person to a place of safety when they are in a public place. They can do this if they think the person has a mental illness and are in need of care. A place of safety can be a hospital or a police station. The police can keep the person under this section for up to 72 hours. During this time, mental health professionals can arrange for a Mental Health Act assessment.

Section 136 Suite: A "place of safety" where people displaying behaviours that are a risk to themselves or to the public can be taken by the Police pending a formal mental health assessment. This procedure is contained within Section 136 of the Mental Health Act.

Serious Untoward Incidents (SUIs): defined as an incident that occurred in relation to NHS-funded services and care, to ether patient, staff or member of the public, resulting in one of the following: unexpected / avoidable death, serious / prolonged / permanent harm, abuse, threat to the continuation of the delivery of services, absconding from secure care.

Service User Focus Groups: a discussion group made up of people who either are, or have been users of our services. The outputs from these groups inform management decisions.

Stoptober: This is a Public Health England initiative held in October each year. It is a programme designed to help people quit smoking based on evidence that if you quit for 28 days you are five times more likely to quit for good.

Specialities: The new term that TEWV uses to describe the different types of clinical services that we provide (previously known as "Directorates"). The Specialities are Adult Mental Health services, Mental Health Services for Older People, Children and Young People's Services and Adult Learning Disability Services.

SWEMWBS: The shortened version of *WEMWBS* (see below).

TEWV: see 'The Trust'.

TEWV Quality Improvement System (QIS): the Trust's framework and approach to continuous quality improvement based on Kaizen / Toyota principles.

Trust Board: See 'Board / Board of Directors'.

The Health Foundation: is an independent national charity working to improve the quality of healthcare in the UK. The Health Foundation supports people working in health care practice and policy to make lasting improvements to health services. They carry out research and in-depth policy analysis, run improvement programmes to put ideas into practice in the NHS, support and develop leaders and share evidence to encourage wider change. Each year they give grants in the region of £18m to fund health care research, fellowships and improvement projects across the UK – all with the aim of improving health care quality.

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

Trustwide: This means across the whole geographical area served by the Trust's 3 Localities.

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

Values Based Recruitment Project: This is a recruitment method that does not just focus on the skills and experience but also on the values and likely behaviours of job applicants.

Virtual Recovery College: This is an initiative that would allow people to access recovery college materials and peer-support on-line.

Visual Control Boards: a technique for improving quality within the overall TEWV Quality Improvement System (QIS).

Warwick-Edinburgh Mental Well-Being Scale (WEMWBS): The Warwick-Edinburgh Mental Well-being Scale (WEMWBS) is a scale of 14 positively worded items, with five response categories, for assessing mental wellbeing. There is also a "short" version of this scale – where this is used it is called *SWEMWBS.*

Youth Speak: is a young people's group which aims to give young people a voice and skills in mental health research; reducing mental health stigma for young people through research; and shaping research to influence mental health services for young people.

APPENDIX 4: ARCH DURHAM RECOVERY COLLEGE COURSES

Courses Ran throughout 2014/15

- Recovery – What's it all About? (Taster session plus enrolment)
- Recovery – The New Me (6 week course)
- Sleeping Well (3 week course)
- Lifestyle and Recovery (6 week course)
- Spirituality and Recovery (4 week course)
- Know your Medication:
    - Know Your Medication – Mood Stabilisers,
    - Know Your Medication – Anti-depressants,
    - Know Your Medication – Anti-psychotics.
- 'Diagnosis' workshops:
    - Understanding Bipolar Disorder,
    - Understanding Psychosis,
    - Understanding Personality Disorder,
    - Understanding Depression,
    - Understanding Eating Disorders.
- Getting the Best out of Mental Health Services
- Mindfulness Taster
- CPA Workshops
- Assertiveness
- Resilience
- Volunteering

Most Popular Courses to date (in terms of sign-up and attendance)

- Recovery – What's it all About
- Recovery – The New Me
- Mindfulness Taster
- Sleeping Well
- Understanding Psychosis/
- Understanding Bipolar Disorder

Additional courses for delivery 2015/2016

- Carers and CPA
- Dealing with others
- Finding your way around the benefits system
- Getting the best out of Mental Health Services
- An Introduction to Complementary Therapies
- Making use of community resources
- Managing money

- Managing stress
- Mental Health Act
- Mindfulness 8 weeks course
- Volunteering with TEWV
- Trauma and Mental Health
- Peer Support worker training
- Student residential mindfulness retreat

APPENDIX 5: KEY THEMES FROM 64 LOCAL CLINICAL AUDITS (194 INDIVIDUAL AUDITS) REVIEWED IN 2014/15

Audit Theme	Summary of Actions
Infection prevention and control audits	• All Infection Prevention and Control Audits are continuously monitored by the IPC team and any required actions are rectified collaboratively with the IPC team and ward staff. Assurance of implementation of actions is monitored by the Clinical Audit and Effectiveness team via the clinical audit database.

Physical Health audits	• Modern Matrons to emphasise to teams the process to be followed on admission and issue all ward staff with the Trust's Diabetes Guidelines.
	• Modern Matrons to ensure e-learning is completed by all staff.
	• Review current Psychotropic induced Hyperprolactinaemia Trust guidance to improve clarity and to remove ambiguity and communicate to staff.
	• Incorporate assessment of red flags into annual assessment of practice for nurses.
	• Areas for improvement to be disseminated to teams, including:
	  ◦ Up to date care plans/discharge documents/letters with GPs with evidence this has been shared with GP at point of discharge and following care plan reviews.
	  ◦ Medical Director to remind medical staff to record codes in relevant documents as outlined (via medical directors bulletin and consultant meetings).
	  ◦ Modern Matrons to remind all clinical disciplines to include recovery interventions associated with physical health improvement within relevant documents/plans including:
	  ▪ Lifestyle
	  ▪ Social
	  ▪ Employment
	  ▪ Accommodation
	• Ward managers to add to report out visual display board the status of EWS recording (daily or not daily) to remind the multidisciplinary team to discuss this at report out.
	• Ward clinical leads and champions to be informed again of EWS procedure by email; and that ward staff to attend Trust training on physiological observations and the use of the EWS if they are identified as requiring this in appraisal.

Care Programme Approach audits	• Modern Matrons to:
	  • circulate briefing note to all staff via ward managers highlighting the issue of risk assessments not being reviewed weekly as per policy and emphasise the agreed minimum standards.
	  • audit 5 patients electronic care records across MHSOP inpatient units to assess compliance in relation to standard (risk assessments to be reviewed weekly).
	  • arrange for all staff to be issued with guidelines for correct completion of risk sections on face document by email.
	• Team / Ward Managers to:
	  • arrange FACE risk training sessions for all qualified staff.
	  • review individual practice by measuring completion of FACE documentation against the audit tool.
	  • document discussions about FACE in supervision records.
	  • discuss care plan reviews prior to transfer/transition between services with staff in supervision.
	  • discuss with social care colleagues the FACs criteria to ensure team members are aware of this criterion during supervision and team meetings.

Audits with high risk factors	• Submit a list of areas affected by poor soundproofing to the Trust's CQC team for further assessment (with a view to securing funding for improvement, where needed). • Record the previous family history of mental illness in comprehensive assessment. • Clinical Skills team to increase emergency equipment spot checks across the trust and address areas of non-compliance. Initial spot checks post audit to be completed trust wide. • Ward Managers and Modern Matrons will inform all members of staff of the requirement to comply with this standard and introduce a process for monitoring this clinical practice. • Ensure robust SMART action plans are developed which mitigate all areas of non-compliance identified as part of the audit.
Positive Behavioural Support (PBS) audits	• Undertake staff training as part of PBS rollout. • Design and implement a process to ensure detail of PBS work is captured without being too onerous for staff; process to be linked with record keeping and PBS plan requirements. • Discuss with Consultant Clinical Psychologist the work he is doing on De-briefs and the Trust wide C&R Reduction group Lead as this is a trust wide issue; and develop a workable solution / process that allows teams to use supportive de-briefs or wider MDT input as part of the support process following an incident. • Progress to be reviewed monthly at both the PBS Champions Group and the PBS Steering Group; and at Intervention Planning 60 / 90 day follow up meetings.

Medicines Management audits	• Update the Medicines Code with specific information on storage of controlled stationery. • Briefing sheet on appropriate storage of, and access to, controlled stationery to be provided to teams. • To produce a clinical algorithm to assist staff in understanding NICE guidance in relation to alcohol dementia. • Controlled Drugs data is submitted on a quarterly basis and rolling chart is developed. • Remind prescribers in Pharmacy Bulletin to complete and record in Paris a full cardiovascular assessment, including ECG when appropriate, prior to initiation of treatment with AChE inhibitor.
Record Keeping audits	• Green compliance was assigned as 100% compliance was achieved. • All Mental Health Team Managers to confirm discussion consent documentation with staff during supervision and in staff meetings. • Mental Health Team Managers to discuss clinical record keeping with staff within clinical supervision.
Violence and Aggression audits	• Highlight key messages in august AMH audit bulletin. Key messages to include capacity, trigger factors and preferred strategies. • Coordinate a review of service users PARIS records to provide assurance to Modern Matrons that an advanced directive or case entry has been completed if required. • Management of Violence and Aggression (MOVA) liaison team to request evidence from clinical teams on a monthly basis that post incident reviews have been completed if applicable. Outcome from MOVA liaison monthly ward visits to be fed back to appropriate ward manager and Modern Matron. • Obtain the post incident review checklist and email the checklist to all teams. • Discuss service user involvement when producing advance directives and undertaking post incident reviews with the My Shared Pathway work stream and service user groups to inform development.
Supervision audits	• New supervision matrix template to be drafted. • Team managers to obtain a copy of the supervision matrix to utilise for their team. • Standard email to be sent out to all preceptors and preceptees. • Embed clinical supervision processes for Nurses. • Establish agreed standard for professional portfolio template. • Standard guidance to be issued around portfolio development.

Safeguarding audits	• A variety of communication methods will be developed to raise awareness of link professional contacts.
	  ◦ e-bulletin
	  ◦ InTouch
	  ◦ Email to service managers for dissemination
	• Training packages to be reviewed.
	• Audit tool to be reviewed and revised ahead of re-audit.
	• To review all current referral forms made by TEWV to children's social care to ensure staff have the most up to date version and all others archived.

APPENDIX 6: TRUST BUSINESS PLAN ADDITIONAL QUALITY PRIORITIES

In addition to the 4 quality priorities for 2015/16 set out in this document, the Trust has also included additional quality priorities within out 2015-2017 Business Plan. These are:

- Complete the delivery of our physical health care project
- Undertake a systematic review of current levels of community team productivity across the Trust with aim of increasing the amount of clinical time available for patient contact through the reduction of non-value added activity
- Implement recommendations of the CPA review to deliver effective and efficient care
- Develop the first model line to deliver clinical pathways and underpin service delivery and agree a programme of future model line development
- Review the Trust approach to suicide prevention and complete the implementation of changes required to improve this approach
- Complete the development of effective systems to ensure a learning culture is embedded through change in practice and behaviour
- Implement DH recommendations for the reduction of restrictive practice and improvement of a culture of positive behavioural support
- Introduce a revised risk assessment and management process, that incorporates best practice of co-produced risk information with service users and positive risk management to improve the person's health, wellbeing and quality of life to facilitate their recovery
- Review systems for planning and evaluating safe and clinically cost effective nurse staffing establishment
- Implement the agreed CQC action plan drawn up in response to the January 2015 whole-Trust inspection

In addition to these, many of the operational plans and the enabling priorities set out within our Business Plan underpin our quality improvement agenda. Our Business Plan can found on TEWV's website at http://www.tewv.nhs.uk/About-the-Trust/How-we-do-it/Business-Plans/

APPENDIX 7: QUALITY PERFORMANCE INDICATOR DEFINITIONS

The percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care

Data definition:

All patients discharged to their place of residence, care home, residential accommodation, or to non-psychiatric care must be followed up within 7 days of discharge. All avenues need to be exploited to ensure patients are followed up within 7 days of discharge*. Where a patient has been discharged to prison, contact should be made via the prison in-reach team.

Exemptions:

- Patients who die within 7 days of discharge may be excluded.
- Where legal precedence has forced the removal of the patient from the country.
- Patients transferred to NHS psychiatric inpatient ward.
- CYPS are not included.

The 7 day period should be measured in days not hours and should start on the day after discharge.

Accountability:

Achieving at least 95% rate of patients followed up after discharge each quarter.

* *Follow up may be face-to-face or telephone contact, this excludes text or phone messages*

The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper

Data definition:

Gate-keeping: in order to prevent hospital admission and give support to informal carers, crisis resolution home treatment teams are required to gate-keep all admission to psychiatric inpatient wards and facilitate early discharge of service users. An admission has been gate-kept by a crisis resolution team if they have assessed** the service user before admission and if the crisis resolution team was involved in the decision making-process, which resulted in an admission.

Total exemption from crisis resolution home treatment teams gate-keeping:

- Patients recalled on a Community Treatment Order.
- Patients transferred from another NHS hospital for psychiatric treatment.
- Internal transfers of service users between wards in the Trust for psychiatry treatment.
- Patients on leave under Section 17 of the Mental Health Act.
- Planned admission for psychiatric care from specialist units such as eating disorder unit.

Partial exemption:

Admissions from out of the Trust area where the patient was seen by the local crisis team (out of area) and only admitted to this trust because they had no available beds in the local areas. Crisis resolution home treatment teams should assure themselves that gate-keeping was carried out. This can be recorded as gate-kept by crisis resolution home treatment teams.

** This indicator applies to patients in the age bracket 16-65 years and only applies to CYPS patients where they have been admitted to an adult ward.*
*** An assessment should be recorded if there is direct contact between a member of the team and the referred patient, irrespective of the setting, and an assessment made. The assessment should be face-to-face and only by telephone where face-to-face is not appropriate or possible.*

Patient falls per 1000 admissions

Numerator:

The number of patient falls recorded on Datix across the Trust which are Finally Approved incidents.

Denominator:

The total number of inpatient admissions (all services) / 1000.

Exemptions:

- Found on floor
- No harm / injury

Indicator format:

Actual.

APPENDIX 8: FEEDBACK FROM OUR STAKEHOLDERS

County Durham Health and Wellbeing Board

Contact: Cllr Lucy Hovvels
Direct Tel: 03000 268728
Fax:
email: lucy.hovvels@durham.gov.uk

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

19 May 2015

Dear Sharon

Tees, Esk & Wear Valleys NHS Foundation Trust Quality Account 2014/15

Thank you for the opportunity to comment on the Tees, Esk and Wear Valleys NHS Foundation Trust (TEWVFT) Quality Account 2014/15. The County Durham Health and Wellbeing Board appreciates this transparency and would like to provide the following comments on the document.

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

The Health and Wellbeing Board supports the Trust's 2015/16 priorities for improvement which align to the strategic objectives in the Joint Health and Wellbeing Strategy as follows:

1. Children and young people make healthy choices and have the best start in life
2. Reduce health inequalities and early deaths
3. Improve the quality of life, independence and care and support for people with long term conditions
4. Improve the mental and physical wellbeing of the population
5. Protect vulnerable people from harm
6. Support people to die in the place of their choice with the care and support that they need

Continued.....

Cabinet Office
Durham County Council, County Hall, Durham DH1 5UQ
Main Telephone 03000 260 000 Minicom (0191) 383 3802

Implementation of the recommendations of the review of the Care Programme Approach and work to embed the recovery approach, which has taken place by the Trust in 2014/15 is welcomed by the Health and Wellbeing Board. The continued emphasis on recovery and the specific continued development of the Recovery College for County Durham as a priority for 2015/16 is fully supported by the Board. Recovery is included as part of the Joint Health and Wellbeing Strategy, Better Care Fund Plan and Clinical Commissioning Group Commissioning Intentions.

The Quality Account notes that the recommendations and actions following the Durham, Darlington and Teesside review of crisis services have all now been implemented and the project has now been closed.

Crisis care continues to be a national priority as part of the National Mental Health Crisis Care Concordat which was launched in February 2014, and a local action plan has been developed by the County Durham Mental Health Partnership Board and agreed by the Health and Wellbeing Board to ensure that we improve outcomes for people experiencing mental health crisis.

Discussions with key stakeholders, including TEWV, at the Mental Health Partnership Board has highlighted that the crisis team has a high level of demand and the Health and Wellbeing Board would recommend that this work is continued as a key priority of the Trust going forward, to ensure that we meet our commitments to people experiencing mental health crisis in County Durham.

Evidence in the Joint Strategic Needs Assessment highlights that smoking related death rates are significantly higher in County Durham than in England and that smoking rates are higher within certain vulnerable groups which includes those with mental health needs. Actions to reduce smoking are reflected in the Joint Health and Wellbeing Strategy and the reduction in the number of people with a severe mental illness who are currently smokers has been identified as a CCG Quality Premium indicator for 2015/16. The Health and Wellbeing Board supports the Trust in identifying nicotine management and smoking cessation as a priority for 2015/16.

Expanding the use of Positive Behaviour Support in Learning Disabilities Services is essential for the development of services post Winterbourne, as part of the Transforming Care agenda, and the Health and Wellbeing Board welcomes this as a specific priority for 2015/16.

However, a challenge for all Learning Disabilities Services stakeholders over the next three years will be how providers improve support services to people in the community with complex learning disabilities, and the Health and Wellbeing Board feels this area is not addressed as part of the Trust's Quality Account.

Continued.....

Safeguarding children and adults whose circumstances make them vulnerable is a priority in the Joint Health and Wellbeing Strategy and the implementation of age appropriate risk assessments and care plans for children and young people's services would support this priority in addition to making sure that children and young people have the best start in life. The Health and Wellbeing Board supports this priority for 2015/16.

The Health and Wellbeing Board welcomes the fact that the Quality Account reflects elements of the performance framework for the Health and Wellbeing Board and supports the Trust in continuing to improve indicators linked to its areas of work, for example in reducing suicide rates. To ensure alignment between the Joint Health and Wellbeing Strategy for County Durham and the Quality Account, it would be useful to include reference to adults in contact with secondary mental health services in paid employment.

Census data tells us that our carer population in County Durham is growing and, in addition to this, we also recognise that there is an unaccounted for hidden carer population which also needs support. Supporting Carers is included in the Joint Health and Wellbeing Strategy and the Better Care Fund Plan to recognise the value and contribution that carers make to the health and social care economy.

The Health and Wellbeing Board would suggest that Carers should also be considered as a focus of the work of TEWV in the future to recognise their contribution.

If you require further information on the Joint Health and Wellbeing Strategy, Clinical Commissioning Group Commissioning Intentions and Quality Premium Indicators, please contact Andrea Petty, Strategic Manager – Policy, Planning & Partnerships, on 03000 267312 or by email at andrea.petty@durham.gov.uk.

Yours sincerely

Cllr Lucy Hovvels

Cllr Lucy Hovvels
Chair, County Durham Health and Wellbeing Board

Darlington Health and Partnerships Scrutiny Committee

Tees, Esk and Wear Valleys NHS Foundation Trust – Draft quality report / account 2014/15

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

Members of the Health and Partnerships Scrutiny Committee have considered the draft quality report / account 2014/15 for Tees, Esk and Wear Valleys NHS Foundation Trust and attended both Stakeholder events over the past year. Members would like to acknowledge that the Stakeholder events are always well attended and informally structured to enable meaningful audience participation, with the opportunity for a free exchange of views.

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

In respect of the Quality Improvement Priorities for 2014/15, Members have the following comments to make:

To have more staff trained in specialist suicide prevention and intervention – Members welcome the development of a suicide prevention framework and training implementation plan which described the required training, provider and other necessary support for staff to provide effective prevention and intervention. Members acknowledged the difficulties encountered by the Trust in appointing to the post of Project Manager and in doing so welcomed the establishment of a Project Group which established three working groups to take forward developments looking specifically at data, themes, trends and human factors of suicide to feed into the framework and training development. Members noted that the scope of the project had been extended Trust wide and unfortunately because of that training of all relevant staff had not yet commenced.

Members noted that in 2015/16 the Trust will complete the training for the Adult Mental Health staff that was delayed due to the late appointment of the Project Manager and were pleased to note that the Trust is reviewing its

planned training to ensure it incorporates the most recent research on those people most at risk from suicide.

Members were also pleased to note that The Project Manager will work with the Mental Health Services for Older People (MHSOP) staff within its current training programmes to ensure all relevant staff were trained. Members also noted that The Trust is to extend the training to the other appropriate groups of professionals in other services, including GPs and were also exploring training for families and carers.

To implement recommendations of the Care Programme Approach (CPA) review including improving communication between staff, patients and other professionals and treating people as individuals – Members acknowledged that this priority had arisen following the success of the Care Programme Approach Review and supported its inclusion in the quality report / accounts 2014/15. Members noted that the CPA and care planning was critical to the quality of care that service users received. Members noted that the Trust's outcomes were to deliver improved service user experience, choice and involvement in their personal recovery; services that were personal and meaningful to service users; and carers felt recognised, valued and supported.

Members welcomed the redesign of CPA processes and documentation to ensure they met mandatory requirements, including the requirements of the Mental Health Act, whilst reducing unnecessary burden on staff and the development of standard work regarding Section 117 of the Mental Health Act, the statutory duty to provide health and social care to some service users following discharge from in-patient care.

Scrutiny was pleased to note the implementation of regular audit and case management/supervision systems to include monitoring of transfer processes within Paris (the electronic patient record) as the results of these reports would be used to inform training and development action plans to improve CPA within the Trust in 2015/16.

To Embed the recovery approach in conjunction with CPA – Scrutiny was advised that the aim of this priority was to ensure both the development of an implementation plan, to guarantee the principles of recovery were embedded within all key programmes, and the development of an implementation plan to increase opportunities for co-production.

Scrutiny noted that service users wanted mental health services to focus on their wellbeing and recovery, not merely on reducing their symptoms and this was aided by supporting them to **C**onnect with others, feel **H**opeful, build an **I**dentify beyond diagnosis; find **M**eaning in their lives; and **E**mpowering them to take charge of their lives (CHIME) factors.

Members were pleased to note that the Trust acknowledged that traditional values had to be challenged and it was necessary to move away from any remaining paternalistic approaches if they are to become truly recovery

centred. Scrutiny welcomed the role of the Trust to provide service users with the knowledge and skills to take charge of their own lives and to help both service users and carers achieve their own personal goals.

Scrutiny welcomed that the Trust aimed to deliver recovery focused practice across all Trust services and provide increased opportunities for people with 'lived experience' of mental illness to co-produce services across the Trust. Members were pleased to note that access to self-management courses via a Recovery College, established in Durham, was available with input from service users and the voluntary sectors and provided courses including anger management and how to access benefits.

Scrutiny commended the Trust in promoting a culture of harm minimisation, actively working to help service users develop resilience, control, choice, hope and empowerment.

Members were pleased that the Trust intended to retain the Recovery Strategy in the 2015/16 priorities for quality report / accounts so that the complex process of cultural changes could take place.

To manage pressure on acute inpatient beds – Members embraced this priority as it aimed to treat patients close to home and within the unit that had been identified for their locality thereby reducing 'out of locality' admissions to the Trust target.

Members acknowledged that it was important to admit patients to their local inpatient ward in order that their own sense of connectedness and familiarity was maintained; family and carers could remain involved in their care and treatment; be involved in consistent engagement with their community mental health team which provided continuity of care and supported early discharge; and minimised disruption and stress for the service user and their family.

Members noted that the Trust had developed a Crisis Team Toolkit to assist with patient assessment and provided crisis practitioners with the tools to refer to alternative or additional services appropriate and confidently.

Members welcomed the Community Mental Health Teams now offering 'urgent appointment slots so that service users could have a mental health assessment within 72 hours of a referral being received.

Members acknowledged that good quality crisis and contingency plans were available to all service users and the plans were to become standard across the Trust.

Members have the following comments to make on the Quality Improvement Priorities for 2015/16 –

Delivery of the Recovery Project in line with the Agreed Plan – Members welcomed the continuation of this priority as service users wanted the services to go beyond reducing the symptoms of mental health and required

support to live meaningful and fulfilling lives whether there was an improvement in symptoms or not.

Nicotine Management and Smoking Cessation – Members raised concerns that people with severe mental illness die 15-20 years earlier than the general population with a significant contributor being smoking. Members welcomed this priority to provide behavioural support and alternatives to encourage people with mental health issues to quit smoking ensuring improved physical health in the long term.

Expand the Use of Positive Behavioural Support (PBS) in Learning Disabilities Services – Members look forward to the development of the Positive Behavioural Support strategy which would enhance the quality of life of learning disability service users whilst also reducing behavioural challenges. Members noted the potential benefits and outcomes to service users including a values led based, person centred approach; improved quality of life, happiness and well-being; developing the skills and coping capacities to be able to deal with the demands of everyday living; reduction in restrictive practice including control and restraint and use of 'as-required' medication; and an improved support structure in place for people whose behaviour is described as challenging.

Implementation of Age Appropriate Risk Assessments and Care Plans for Children and Young People Services – Members were pleased at the inclusion of this Priority as they recognised that there was a considerable difference between the verbal, cognitive and social interaction skills of a 4 year old child and a 17 year old adolescent and that the current system for undertaking risk assessments and producing care plans did not reflect the different risks and issues identified at each developmental stage and age group a child presented in. Members also recognised that this could result in an ineffective use of staff time which affects the experience of service users and carers in a negative way.

Overall, Health and Partnerships Scrutiny Committee welcomed the opportunity to comment on the Trust's quality report / accounts and are pleased with the Trusts progress against the chosen priorities, in a challenging year for all NHS organisations. Members would like to receive six monthly reports on the progress being made, to enable them to provide a more detailed and valuable contribution to the quality report / accounts in the future. They would also like to continue to be invited to Stakeholders events.

Councillor Wendy Newall
Chair, Health and Partnerships Scrutiny Committee

Durham County Council Adults Wellbeing and Health Overview and Scrutiny Committee

Contact: Cllr Robin Todd
Direct Tel: 03000 268140
e-mail:
Your ref:
Our ref:

Martin Barkley
Chief Executive
West Park Hospital
Edward Pease Way
Darlington
DL2 2TS

15 May 2015

Dear Mr Barkley,

Tees, Esk and Wear Valleys NHS Foundation Trust – quality report / accounts 2014/15

Following meetings of Durham County Council's Adults Wellbeing and Health Overview and Scrutiny Committee on 11th May, 2015 please find attached the Committee's response to your draft quality report / accounts for 2014/15.

The response provides commentary on the Trust's performance for 2014/15 as well as the identified priorities for 2015/16.

I would like to thank the Trust for providing the opportunity for continued engagement of the Adults Wellbeing and Health Overview and Scrutiny Committee in the aforementioned process.

Yours sincerely,

Cllr Robin Todd
Chair of the Adults, Wellbeing and Health Overview and Scrutiny Committee

DURHAM COUNTY COUNCIL ADULTS WELLBEING AND HEALTH OVERVIEW AND SCRUTINY COMMITTEE

COMMENTS ON TEES ESK AND WEAR VALLEYS NHS FOUNDATION TRUST QUALITY REPORT / ACCOUNT FOR 2014/15

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

The Committee has engaged with the Trust on a number of issues during the course of 2014/15 including service developments that were being implemented across adult mental health and substance misuse; children and young peoples' mental health services; mental health services for older people and learning disabilities.

In August 2014, the Committee received notification regarding changes proposed in respect of improving mental health rehabilitation services for adults in County Durham and Darlington by providing services within the community. This process involved developing a community rehabilitation (intensive support) service to provide an alternative to bed based care or support transition into the community. As part of the move to a more community based service, discussions took place with service users regarding the potential permanent closure of the Mulberry Unit, Horden. Members were consulted on the proposed permanent closure and, in the absence of any formal representations, TEWV were informed that the AWHOSC had no objection to the permanent closure.

The Committee considers that the quality report / account is clearly set out and acknowledges up front that performance during 2014/15 has been challenging, set against a context of a considerable increase in demand particularly in respect of emergency admissions. Progress made against 2014/15 is clearly identified and, where priorities have not been achieved, either wholly or in part, there are explanations given.

In respect of the 2015/16 priorities, the Committee particularly welcomes the continued work being proposed in respect of the delivery of the recovery project in line with the agreed plan. Members are also supportive of the proposed priority in respect of nicotine management and smoking cessation, especially in light of evidence indicating that 77% of premature deaths amongst people with mental health conditions are directly linked to smoking. The continued roll out of the suicide prevention training across the Trust is also welcomed.

In examining performance against quality metrics, the Committee were concerned at the below target performance in respect of the length of stay for

patients in mental health services for older people assessment and treatment wards but accept the trust explanation that these represent some of the most complex service cases and that these small number of complex cases skew the figures somewhat.

In respect of complaints handling, members noted the 75% complaints satisfactorily resolved against a target of 90%, but acknowledge the proposed introduction of dedicated complaints managers across the Trust to ensure an improvement in performance and consistency of approach.

In summary, the Committee agree that from the information received from the Trust, the identified priorities for 2015/16 are a fair reflection of healthcare services provided by the Trust and note the progress made against the 2014/15 priorities. However, the Committee would also seek clarification and assurances from the Trust that the identified priorities are linked to the declared priorities of Clinical Commissioning groups.

Finally, in order to ensure that it continues to provide a robust Health scrutiny function and assurances in this respect to the residents of County Durham, the Committee would reiterate its previous request for more regular access to performance overview information. Members accept that the timelines for the production of the draft quality report / account does not lend itself to the inclusion of year end performance information. However, more timely data up to the end of February would provide members with a fuller picture around performance upon which they could provide a better informed commentary. Nevertheless, the Committee welcomed the Trust's willingness to present an interim progress report upon performance in October 2014 and would request a six monthly progress report on delivery of 2015/16 priorities and performance targets in October 2015.

Healthwatch Darlington

Comments on Tees, Esk and Wear Valley Foundation Trusts quality report / account for 2014-15 from Healthwatch Darlington. These comments are on behalf of the Healthwatch Board and active members of the 'task and finish' groups.

Healthwatch Darlington have welcomed and enjoyed the opportunity to be involved with the quality report / accounts over the last twelve months and benefit from partnership working with Tees, Esk and Wear Valley NHS Foundation Trust. The Trust actively involves and engages with Healthwatch Darlington participants and we believe fully embraces the patient voice. Healthwatch Darlington feel the Trust have meaningfully involved a wide and varied section of stakeholders and members of the public and have been regularly updated on patient engagement activity throughout the year. The organisation is particularly pleased to note the overall ratings from the recent CQC Inspection and encouraged by the Trust's open and honest attitude to facing the challenges highlighted in the report. This honest and open attitude along with the actions already completed, Healthwatch Darlington are confident all improvements will be implemented rapidly. We congratulate the Trust on the 'Outstanding' rating awarded under the inspection area of 'Well-led'.

Priorities 2014/2015

- **Managing Pressures on inpatient beds**

  Healthwatch Darlington are pleased to note that all actions under this priority have been met but recognise the numbers have not changed significantly to date. We hope to see a change in these figures once the changes have been embedded for a greater amount of time. We recognise there have been zero out of area admissions.

- **Suicide Prevention**

We are pleased to note that all but one of the actions have been completed and are rated Green. We understand the reasons for the delay in training of relevant staff and are confident the Trust will complete this outstanding action by the end of Quarter 2 2015/16.

- **Implementing the Care Programme Approach (CPA)**

  Again we are pleased to note most of the actions have been completed. The only action rated Amber/Green we understand to be due to the redesign of documentation and the need to await an electronic record system update. We are confident this will be completed ASAP.

- **Embedding the Recovery Approach**

  Healthwatch Darlington are pleased to note that all actions under this priority have been met and overall rated as Green. We are particularly pleased with the Recovery College in County Durham being set up and education being delivered well from the setting. We are happy that Darlington residents have been able to use the Recovery College and look forward to seeing the cross boundary 'Virtual' Recovery College delivered.

Quality Metrics

We are pleased to see many of the Quality Metrics have been met and were rated green but work still needs to be done on the rate of patient falls, average length of stay for older people, percentage of complaints satisfactorily resolved, under 18's on adult wards, patient safety incidents reported, and percentage of patient safety incidents resulting in severe harm or death. We recognise a Trust wide group has been reinstated to look at patient falls and understand the complex needs many older people have. We welcome the Trust plan to set up a dedicated corporate complaints team and recognise that all of the under 18's were aged between 16-18 and all admissions were clinically appropriate.

Priorities 2015/2016

- **Delivery of the recovery project in line with the agreed plan**
- **Nicotine Management and Smoking Cessation**

- **Expand the use of Positive Behavioural Support in our Learning Disabilities Services**
- **Implementation of age appropriate risk assessments and care plans for Children and Young People Services**

Healthwatch Darlington agree with the priorities set for 2015/2016, especially the work around positive behavioural support and age appropriate risk assessments. We will be completing a lot of work around Children and Young Peoples services in 2015/2016 and would welcome any opportunities to do some collaborative work where appropriate.

Healthwatch Darlington participants have enjoyed attending quality report / account meetings and have actively been involved in round table discussions to discuss objectives and to voice their opinions where appropriate.

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

Kind Regards

15th May 2015

Sharon Pickering
Director of Planning, Performance and Communications
Tees, Esk and Wear Valleys NHS Foundation Trust
Tarncroft
Lanchester Road Hospital Durham
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By e-mail to sharon.pickering1@nhs.net

Dear Sharon,

Healthwatch County Durham response to draft TEWV Foundation Trust Quality Report for 2014/2015

Healthwatch County Durham is the statutory and independent champion for consumers of health and social care services in the county and we appreciate the opportunity to comment on the draft Quality Report for the year ending 31 March 2015.

As the consumer champion, our comments have a particular, but not sole, focus on the patient experience, clinical effectiveness and patient safety aspects of your report. We comment as follows:

We welcome the following in the report:

- Healthwatch County Durham recognises the advances made in the development of the Trust in improving its performance during 2014/2015
- Healthwatch County Durham supports the priorities and recognises the outcomes achieved and level of performance, particularly noting that:
    - The Trust embedded the Recovery approach
    - The Trust managed pressures on inpatient beds
    - The Trust made advances in its Care Programme although it has yet to achieve its target
    - The Trust needs to do more to achieve its targets on suicide prevention
- The Trust recognises that it does not always 'get it right'; this is one of the positive steps in the process of making improvements
- We recognise and appreciate that the Trust has managed two stakeholder events as part of its public engagement activity

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- The Trust has been innovative:
    - In providing an extensive suite of training sessions, including mindfulness sessions for staff as part of the development of the Recovery College and these have had good take-up
    - In enabling those with learning difficulties to take part in staff recruitment
    - In improving the design of discharge letters
    - In tackling suicide and mental health services as a joint activity in partnership with GPs and social services
- Healthwatch notes and would like to better understand why the number of reported incidents, at 3,279, is much higher than the average levels of mental health trusts.
- Nicotine management and smoking cessation for those with mental illness is a key issue that needs to be addressed in 2015/16 as it impacts on the health and life expectancy of patients
- We are pleased to see the implementation of age-appropriate risk assessment and care plans for children and young people as a priority for 2015/16
- There appears to be no reference/results of the Friends and Family Test for the Trust.

Patient Experience

- As children and young people are one of Healthwatch County Durham's priority groups, we are pleased to read that there were significant improvements made by the trust to enhance access to services in County Durham for children and young people by extending opening hours to evenings and Saturdays. We would like to see these arrangements continue.
- Whilst improvements to discharge letters are welcome, we would like to understand what more is being done to improve this further. It would also be interesting to know whether the South Durham pilot is to be extended for 2015/16.
- It might be useful if the report noted the most common complaints against it.

As consumer champions we are pleased that efforts have been made to engage families, carers and staff in improving the trust's approach to serious untoward incidents by making the process more 'person centred'; however we would like to know what has been done with ***service users*** to improve this, as they are key to this process.

General comments on the accessibility of the Quality Report for the public

The document is accessible using screen reader software, however it proved to be very 'heavy reading'. A suggestion is made that maybe it would be possible in future years to create a summary of a report of this size (the word count is 31,392 words).

The summary could consist of updates, new projects etc. Most of the updat
percentages are not easy for someone with sight impairment to read, due t
complexity of the report.

Also:

- There is no wording regarding the Trust's approach to the Equality Act of 2010
- And more words about the Human Rights Act could be added to the report.

We hope that you find our comments constructive and assure you that we want to work with you to improve the performance of TEWV in the forthcoming year, recognising that the management team and staff have worked hard in the past year to deliver an improved quality of service across the North East.

Yours sincerely

Judith Mashiter
Chair

Joint Durham and Darlington CCGs

NHS
North Durham
Clinical Commissioning Group

Our Reference 150520 NO'B – TEWV Quality Account
Your Reference None

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North Durham CCG
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20 May 2015

Martin Barkley
Chief Executive
Tees, Esk and Wear Valleys NHS Foundation Trust
West Park Hospital
Edward Pease Way
Darlington
County Durham DL2 2TS

Dear Martin

Corroborative statement from
NHS North Durham Clinical Commissioning Group (CCG),
NHS Durham Dales, Easington, Sedgefield CCG,
NHS Darlington CCG
for Tees, Esk and Wear Valleys NHS Foundation Trust's Quality Account 2014/15

The clinical commissioning groups (CCG) across County Durham and Darlington welcome the opportunity to review and comment on the Quality Account for 2014/15 and would like to offer the following commentary:

As commissioners NHS North Durham CCG, NHS Durham Dales, Easington and Sedgefield CCG and NHS Darlington CCG are committed to ensuring that our residents receive safe, high quality services from Tees Esk and Wear Valleys NHS Foundation Trust (TEWVFT).

The CCGs would like to commend the trust on their external achievements and are delighted to see the trust are in the top 20% of mental health trusts for the 2014 staff survey and in the 2014 NHS service user survey of community services.

Throughout 2014/15 we have continued to hold monthly bi-monthly clinical quality meetings and monthly contract review meetings with TEWVFT. The organisation has been working with the CCGs to demonstrate transparency in relation to quality concerns and provide assurance that safe and effective care is being delivered and that the views and expectations of patients and the public are listened to and acted upon. To gain further insight and assurance of the quality of care being provided to patients we have continued throughout 2014/15 to conduct frequent commissioner led inspection visits to the trust. The visits have been supported by the trust and provided the CCGs with a valued opportunity to talk with staff and service users.

The Quality Account is presented in the format required by NHS England and reflects a fair and accurate position of the trust's quality profile and we are pleased to see reference to your progress against National Quality reports and issues such as the Francis 'Freedom to Speak up' report, Duty of Candour and safe staffing. We congratulate the trust in being placed in the top 20% of all trusts for safe staffing.

It was also pleasing to see that the trust has achieved a 100% participation rate in national clinical audits and confidential inquiries and the report provides evidence of the actions the organisation has implemented in response.

The CCGs recognise the improvements that the trust has initiated throughout the year to improve the quality and timeliness of serious incident investigations and culture of candour and we look forward to seeing the full benefits of this work in 2015/16. The CCGs expect to see significant improvements in 72 hour and 60 day reports being received against their deadline. Disappointingly the trust has not included any detail on the number of serious incidents, with the exception of unexpected deaths, reported within the year and the organisational learning to prevent similar incidents from occurring. Though it is encouraging to see that a 'learning lessons' bulletin has been introduced to encourage wider learning.

The CCGs acknowledge the work that has been achieved to date in the delivery of the 2014/15 priorities, in particular suicide. It is encouraging to see that training on suicide prevention isn't just being delivered to priority staff groups but will also include other clinical specialities, supporting the findings of the Confidential Enquiry Report into increased suicide rates in older people.

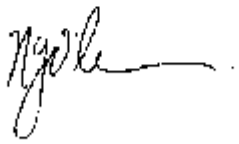
It is encouraging to see that the trust has improved their position in the number of incidents reported to the NRLS from the lowest 25% of reporters in quarter 1 of 2014/15 to the middle 50% of reporters in quarter 2. The CCGs look forward to seeing further improvement when the next organisational patient safety reports are released.

Disappointingly TEWVFT has failed to achieve their target for falls reduction and also failed to achieve the 2014/15 CQUIN associated with this, the CCGs acknowledge the work that is underway to embed audit tools and fall's pathways across forensics and adult mental health.

NHS North Durham CCG, NHS Durham Dales, Easington and Sedgefield CCG and NHS Darlington CCG are supportive of the trust priorities for 2015/16 particularly the focus on implementation of age appropriate risk assessments and care plans for children and young people services and the outcomes that this will bring in improving the experience of your service.

The CCGs look forward to continuing to work in partnership with TEWVFT to assure the quality of services commissioned in 2015/16.

Yours sincerely



Dr Neil O'Brien
Clinical Chief Officer
NHS North Durham CCG

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

Cc: Gill Findley, Director of Nursing, DDES and North Durham CCGs
Kirstie Hesketh, Senior Clinical Quality Manager, NECS
Sharon Pickering, Director of Planning, Business Development and Performance, TEWV

Partnership Commissioning Unit
Commissioning services on behalf of:
NHS Hambleton, Richmondshire and Whitby CCG
NHS Harrogate and Rural District CCG
NHS Scarborough and Ryedale CCG
NHS Vale of York CCG

Quality Report Statement 2014/15 for Tees, Esk and Wear Valleys Foundation NHS Trust:

The Partnership Commissioning Unit (PCU) is pleased to be able to review and comment on the 2014/15 quality report, on behalf of NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group (CCG), NHS Harrogate and Rural District CCG, and NHS Scarborough and Ryedale CCG.

Tees Esk and Wear Valleys Foundation NHS Trust (TEWV) and the PCU have worked in close partnership to improve the quality of services for the population of North Yorkshire. Through the contract management process the Trust has provided assurance to the PCU as commissioners, by sharing a range of data and quality metrics which has improved the quality of patient services. We are particularly pleased with the following achievements:

- The transfer of IAPT services (Improving Access to Psychological Therapies) to TEWV - TEWV has worked extremely hard to improve access to IAPT services across North Yorkshire and, although the 15% target was not achieved in Quarter 4, it is acknowledged that TEWV significantly improved the services and we look forward to working closely to further improve access and recovery for the year coming.
- Opening the Place of Safety Suite (S136 suite) in Northallerton has ensured that the Police have a place of safety for people who need mental health assessment and support, rather than transferring them to a police cell. This has provided a significant improvement for individuals and has established closer working relationships between the health and Police teams. The S136 suite in Scarborough opened in January 2014, and the Harrogate suite will open in the near future to offer a place of safety within each CCG locality in North Yorkshire.
- Psychiatric Liaison – TEWV has introduced Liaison Psychiatry teams in Harrogate Hospital (September 2014), Scarborough Hospital (January 2015) and The Friarage Hopsital, Northallerton (September 2014) to provide qualified mental health practitioners to support local acute Trust staff to assess patients effectively and to ensure that they receive treatment in a more timely manner.

Working in partnership has been a key theme throughout the year and a particular example of this is the Transforming Care Agenda. Over the last six months TEWV has worked in partnership with the PCU and key stakeholders to develop an action plan for the Transforming Care Agenda. Alongside this TEWV has undertaken a 3P event for the Learning Disability community services in North Yorkshire to set out their commitment to improving

Partnership Commissioning Unit
Commissioning services on behalf of:
NHS Hambleton, Richmondshire and Whitby CCG
NHS Harrogate and Rural District CCG
NHS Scarborough and Ryedale CCG
NHS Vale of York CCG

services and informing the commissioners of their future intentions, in turn allowing TEWV and the commissioners to plan for the future in order to reduce hospital admissions and enable service users to remain at home with effective and efficient health care supporting their independent living.

The PCU also welcomes the introduction of the expert corporate team dedicated to Serious Incident (SI) reviews supported by a network of clinical experts. In the coming year we would like to use this as an opportunity to focus on improvements and lessons learnt through the SI process.

We acknowledge the improvement of communication with General Practitioners (GPs) by implementing the use of electronic letters across North Yorkshire. In order to monitor the impact of these improvements TEWV undertook and presented the results of the GP questionnaire which identifies improvements within each CCG. Communication was a consistent theme for improvement in the surveys, and we therefore welcome TEWV's commitment to improve communication with primary care.

In addition, TEWV has been successful in achieving the local and national CQUIN targets for the year, and the national and local indicators for 2015/16 CQUIN scheme are currently being agreed with the Trust.

In conclusion the PCU commends this quality report / account for its accuracy and honesty. We recognise that TEWV delivers good quality and effective patient care, which is reflected in the Care Quality Commission (CQC) report published in May and we look forward to continuing our close working partnership with the Trust in 2015/16. .

Joint Teesside CCGs

NHS
Hartlepool and Stockton-on-Tees
Clinical Commissioning Group

NHS
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Date: 15 May 2015

Mrs Chris Stanbury
Director of Nursing and Governance
Tees Esk and Wear Valley NHS Foundation Trust
West Park Hospital
Edward Pease Way
Darlington
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Dear Chris

RE: Tees and Esk Wear Valleys Quality Account

NHS South Tees Clinical Commissioning Group and NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group are pleased to provide a joint response to the Trusts Quality Account 2014/15 and would like to thank the Trust for inviting the commissioners to contribute to its development this year. We look forward to actively engaging with the Trust in future years.

NHS South Tees CCG and NHS Hartlepool and Stockton-On-Tees CCG commission healthcare services for the population of Hartlepool, Stockton and South Tees. The CCGs welcome the opportunity to submit a statement on the annual Quality Account for Tees Esk and Wear Valleys NHS Foundation Trust (TEWVFT).

The CCGs can confirm that to the best of their ability that the information provided within the annual Quality Account is an accurate and fair reflection of the trust's performance for 2014-15.

The Quality Account is clearly presented in the format required by NHS England and the information clearly represents the trust quality profile.

The CCGs would like to provide the following statement:

Firstly, we would like to congratulate the trust on their external achievements and are delighted to see the trust are in the top 20% of mental health trusts for the 2014 staff survey and in the 2014 NHS service user survey of community services.

Stakeholders supported suicide prevention as a priority in 2014/15 and we are aware of the increasing suicide rate nationally and demands associated with this. Therefore it is encouraging to see that training on suicide prevention isn't just being delivered to priority staff groups but will also include other clinical specialities, which is supportive of the findings of the Confidential Enquiry Report relating to increased suicide rates in older people. South Tees and HAST CCGs

would like to see a revised timetable for the delivery of suicide prevention training to ensure there is equity in delivery across Teesside, Durham and North Yorkshire localities.

Throughout 2014/15 the CCGs have continued to hold quality and contract review meetings with TEWVFT and the organisation has been working with the CCGs to demonstrate openness and honesty in relation to quality concerns and provide assurance that safe and effective care is being delivered. The CCGs have also conducted a programme of commissioner led inspection visits to the trust during 2014/15, to gain further insight and assurance of the quality of care provided for patients. This enhanced approach has been welcomed by the trust.

The trust has referenced their progress against National Quality reports and issues such as the Francis *Freedom to Speak up* report, Duty of Candour and safe staffing and the CCGs are pleased to see that the trust are in the top 20% of all trust's for safe staffing.

It was pleasing to see that the trust has achieved a 100% participation rate in national clinical audits and confidential inquiries and the report provides detail of the actions the trust has taken in response.

We recognise the improvements that the trust has initiated to improve the quality and timeliness of serious incident investigations and culture of candour. We look forward to seeing the full benefits of this work in 2015/16, and we will expect to see a significant improvement in reports being received to deadline.

It is encouraging to see that the trust has improved their position in the number of incidents reported to the NRLS from the lowest 25% of reporters in quarter 1 of 2014/15 to the middle 50% in quarter 2. An area the Trust could improve, would be to include the number of other serious incidents in addition to unexpected deaths, reported within the year and the organisational learning to prevent similar scenarios occurring. It is encouraging to see that the trust have introduced a 'learning lessons' bulletin to encourage wider learning.

The CCGs would like to see an improvement in falls reduction where the Trust has not achieved the 2014/15 CQUIN associated with this, the CCGs acknowledge the work that is underway to embed audit tools and fall's pathways across forensics and adult mental health.

The CCGs are supportive of the trust priorities for 2015/16 particularly the focus on implementation of age appropriate risk assessments and care plans for children and young people services and the outcomes that this will bring in improving their experience of your service.

The CCGs look forward to continuing to work in partnership with the trust to assure the quality of services commissioned on behalf of their population in 2015/16.

Yours sincerely,

Mrs Amanda Hume
Chief Officer
NHS South Tees Clinical Commissioning Group

Mrs Ali Wilson
Chief Officer
NHS Hartlepool and Stockton -on-Tees Clinical Commissioning Group

Tees Valley Joint Overview and Scrutiny Committee

Tees Valley Joint Health Scrutiny Committee

Statement for inclusion in Tees, Esk and Wear Valleys NHS Foundation Trust's (TEWV) quality report / account

Members of the Tees Valley Joint Health Scrutiny Committee welcomed the opportunity to comment on the TEWV's quality report / account. The Committee was also represented at the Stakeholder event held on 23 February 2015.

Members considered the progress made against the 2014/15 priorities and it was questioned whether the cuts in funding the Trust had suffered in recent years had had an effect on performance. Members were reassured that this was not considered to be the case. The priorities that had not been met were mainly due to the Trust's inability to appoint to particular posts and this was mainly due to national shortages of appropriately qualified staff.

Members welcomed the update on the priorities for 2013/14 that were not carried over into 2014/15. The Committee noted that suicide prevention was no longer a priority for 2015/16 yet the increasing number of suicides was still a concern in the North East Region. It was outlined to Members that the work on suicide prevention was continuing and was now established as part of normal workloads through its prioritisation over the last year. Members welcomed the continued work on suicide prevention and how it has been embedded into workloads.

It was highlighted that the majority of people who commit suicide are not known to the mental health service.

The number of people detained in police cells due to behaviour triggered by a mental health crisis was questioned. There was a Section 136 Suite available within the force area for any individual that the Police arrest that they may consider needs this facility. The number of people who had died in Police custody or in prison was also questioned.

The Committee considered progress against the priorities for 2014/15 and made the following comments.

Inpatient beds

The quality report / account outlines some of the actions taken with regard to inpatient beds. Members noted the progress made and the reduction of the use of inpatient admissions over the year, although Members were concerned that a number of admissions continue to be 'out of [local] area'. Members were informed that there had been no 'out of (TEWV) area' placements within recent years, but there were still some people 'out of area' that had been placed sometime ago. It was noted that some people may be admitted and placed out of locality but within the TEWV area, at their request, for example,

if they wished to be placed on a single sex ward. Members welcomed assurance that there was sufficient bed capacity to meet demand in the local area; however, Members noted that there was not sufficient capacity to return people who were currently placed out of area.

The Committee would welcome reassurance on the placing of people out of area and out of locality. Further information would be welcomed regarding 'spare' bed capacity for learning disabilities and acute beds at Roseberry Park in Middlesbrough.

Members were informed of the opening of a walk-in facility at Roseberry Park and the Committee indicated that it would be useful for Members to understand the use of this service and asked that a report be brought to the Joint Committee after twelve months operation of the service.

Hartlepool Members questioned what plans there were for mental health services in Hartlepool and what other groups the service used. It was confirmed that TEWV worked with commissioners to improve services wherever possible. The service also worked with MIND and the Alzheimer's Group in Hartlepool. Hartlepool Members welcomed assurance that there were no plans in the immediate future to close Sandwell Park. Services were under constant review as Members would understand but there were no plans to close Sandwell Park in the next two years.

Quality Metrics

There has been an increase in the number of falls recorded, although the level of harm done has decreased. Falls were particularly an issue in learning disability units.

In relation to patient length of stay for older people, Members noted that this had not met targets, however, it was reported that a few long stay individual cases had affected the figures.

The target for the number of bed days occupied by under 18s admitted on adult wards was not achieved, but it had included cases where patients were approaching their 18th birthday and so were judged to be clinically appropriate to be placed on an adult ward. Members were informed that a breach of the regulations in relation to the numbers of days that an under 18 had been catered for on an adult ward would only occur if an under 16 was placed on an adult ward.

Regarding patient safety incidents, although not shown in the quality report / account document, it was shown in the presentation to the Committee that the Trust's electronic reporting system was showing lower than expected levels of reporting, is this decrease due to a lack of reporting or less incidents?

Safeguarding / Deprivation of Liberty (DoLs)

The Committee would welcome reference to the Supreme Court judgement in relation to DoLs and how the Trust has responded to this over the year.

Safeguarding activity is mentioned in response to inspection/audits, however, inclusion of an overall summary of safeguarding activity in the quality report / account would be welcomed.

The amount of detail provided in the quality report / account is good and it is understood that specific elements need to be included; however, it may be worth considering how the design of the quality report / account could be improved to make it more accessible / easier to read by the public, for example, the inclusion of pictures / photographs.

The Committee would like to thank TEWV for their updates and engagement with the Committee throughout the year and would welcome this approach over the coming year.

Cllr Ray Martin-Wells
Chair, Tees Valley Joint Health Scrutiny Committee

Governance review

Overview of governance arrangements

Our governance arrangements are led by the Chairman of the Trust being both the Chairman of our Board of Directors and Council of Governors.

The statutory duties of our Council of Governors are:

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

It has specific responsibilities:

- to develop our membership and represent their interests
- to assist with the development of the Trust's strategy
- to provide its views on any matter when consulted by the Board of Directors
- to appoint or remove the Chairman and the Non-Executive Directors
- to determine the remuneration and allowances, and the other terms and conditions of office, of the Chairman and Non-Executive Directors
- to approve the appointment of the Chief Executive
- to receive the annual accounts and annual report
- to appoint or remove the Trust's external auditor
- to determine proposals to increase the proportion of the Trust's income earned from non-NHS sources by 5% or more in any financial year
- to inform the Board whether or not it considers that any proposals to provide non-NHS services will interfere, to a significant extent, with the provision of NHS services
- to determine (in conjunction with the Board of Directors) any proposed changes to the Trust's Constitution
- to determine (in conjunction with the Board of Directors) any questions on mergers, acquisitions or separation of the Trust
- to determine (in conjunction with the Board of Directors) whether the Trust should be dissolved
- to determine any significant transactions (as defined in the Constitution) proposed by the Board of Directors
- to consider any matters raised by the Care Quality Commission or Monitor which might affect the Trust's compliance with the terms of its Licence or its registration of services
- to determine whether any matter should be referred to Monitor's Panel on whether the Trust has failed or is failing to act in accordance with its Constitution, or to act in accordance with Chapter 5 of the NHS Act 2006.

A number of committees including the Council of Governors' Nomination and Remuneration Committee support this work (see page 217).

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

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

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

Our Board of Directors:

- exercises certain functions in conjunction with our Council of Governors (see above)
- has retained certain decisions to itself including the definition of the Trust's strategic goals and objectives, the approval of the annual plan (following consultation with our Council of Governors); the acquisition, disposal or change of use of land or buildings with a value in excess of £500,000; and the introduction or discontinuance of any significant activity or operation.

  Further details are provided in the "scheme of decisions reserved to the Board" which is available on our website as part of our constitution.

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

The Board, through its Audit Committee, conducts a review on the effectiveness of internal control annually based on the findings of the Head of Internal Audit (see page 200).

Under the leadership of our Chief Executive, the Executive Management Team (which comprises the executive, corporate and operational directors and the Trust Secretary) is accountable for the ratification of Trust-wide policies for implementation and for ensuring:

- performance against our objectives and key targets is reviewed
- the effective operation of our integrated assurance systems
- the provision of appropriate and accurate information to our Board of Directors.

Resolution of disputes between the Board and 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 a number of steps by which the matters in dispute are formally stated, considered and responded to.

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

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

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

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

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

Our Constitution requires our Board of Directors and Council of Governors to seek to comply with the Foundation Trust Code of Governance, including both its main and supporting principles, at all times.

Statement of compliance with the Code of Governance:
In 2014/15 the Trust complied with all relevant requirements of the Code with the following exceptions:

- *Provision A.1.9: The Board of Directors should operate a code of conduct that builds on the values of the NHS foundation trust and reflects high standards of probity and responsibility.*

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

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

- *Provision B.7.1: Non-Executive Directors may, in exceptional circumstances, serve longer than six years (eg, two three-year terms following authorisation of the NHS foundation trust) but this should be subject to annual re-appointment.*

  In 2014/15 Jim Tucker was re-appointed as a Non-Executive Director for a third term of three years. By the end of his present term he will have served for nine years.

  The Council of Governors decided to make the appointment on that basis in view of:
  - His role, as the Deputy Chairman, in supporting the new Chairman during her early months in office.

- Mr. Tucker being the only candidate arising from an open recruitment exercise with both significant commercial skills and experience as a Non-Executive Director.
- Feedback received from Deloitte LLP, from its independent review of governance arrangements, that Mr. Tucker was a high performing Non-Executive Director.
- Mr. Tucker's particular skill set and personal attributes in the context of the national challenges facing the Trust and in supporting the Chairman manage likely changes to the membership of the Board over the next 2/3 years.

- *Provision B.7.2: The names of governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to take an informed decision on their election. This should include prior performance information.*

  Biographical details provided by candidates at elections are provided to Members in accordance with the election rules.

  No other biographical or performance information is provided as the Trust considers that all candidates should be treated equally and fairly.

Governance Disclosures
Under the Code of Governance the Trust is required to disclose the following information on its governance arrangements:

Code ref:	Summary of Disclosure Requirement	Page(s)
A.1.1	A schedule of matters or a summary statement of how the Board of Directors and the Council of Governors operate, including the types of decisions to be taken by each body and which are delegated to the Executive Management Team on behalf of the Board of Directors.	187 – 188
A.1.1	A statement on how disagreements between the Council of Governors and Board of Directors should be resolved.	188
A.1.2	The names of: ▪ The Chairman ▪ The Deputy Chairman ▪ The Chief Executive ▪ The Senior Independent Director ▪ The chairmen and members of the Nominations Committee ▪ The chairmen and members of the Audit Committee ▪ The chairman and members of the Remuneration Committees	 194 194 196 196 207 & 219 202 207 & 219

A.1.2	The number of meetings of the Board of Directors and the Audit, Remuneration and Nominations Committees and individual attendance by directors	198, 202, 207 – 208 & 219
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.	203 – 215
A.5.3	The name of the Lead Governor.	211
B.1.1	The names of the non-executive directors whom the Board determines to be independent, with reasons where necessary.	193 – 196
B.1.4	A description of each director's skills, expertise and experience.	196 – 197
B.1.4	A statement about the Board of Directors' balance, completeness and appropriateness to the requirements of the NHS foundation trust.	193
B.2.10	A description of the work of the Nominations Committee(s) including the process used in relation to board appointments.	207 – 208 & 215 – 219
B.3.1	The other significant commitments of the Chairman and any changes to them during the year.	194
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.	220
B.6.1	A statement on how the performance evaluation of the board, its committees and its directors, including the Chairman, has been conducted.	200 – 201
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.	201
C.1.1	An explanation from the directors of their responsibility for preparing the annual report and accounts. A statement that they consider the annual report and accounts, taken as a whole, are fair, balanced and reasonable and providing the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy.	246

C.1.1	A statement from the External Auditors about their reporting responsibilities	247
C.1.1	An explanation from the directors of their approach to quality governance in the annual governance statement.	237
C.2.1	A report that the Board has conducted a review of the effectiveness of the Trust's system of internal controls.	188
C.2.2	Information on how the internal audit function is structured and the role it performs.	204
C.3.5	A statement from the Audit Committee, if applicable, explaining its recommendation on the appointment/reappointment of the external audit and the reasons why it was not accepted by the Council of Governors.	Not applicable
C.3.9	A description of the work of the Audit Committee in discharging its responsibilities including: ▪ the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; ▪ an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and ▪ if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	202-203
D.1.3	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	Not applicable
E.1.4	Contact procedures for members who wish to communicate with governors and/or directors.	Back page
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.	199 – 200
E.1.6	A report on the representativeness of Trust's membership and the level and effectiveness of member engagement.	222 – 225

The latest version of the code of governance is available on Monitor's website: www.gov.uk

The Board of Directors

Our Board of Directors comprises:

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

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

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

In addition, in 2014/15 the Board appointed Dr. Hugh Griffiths as an associate Non-Executive Director, an advisory non-voting position, to support succession planning prior to his formal appointment as a Non-Executive Director.

All members of the Board:

- Have an explicit duty to avoid conflicts of interest and to declare and take appropriate action should any arise.
- Must be a "fit and proper" person to be a director of the foundation trust in accordance with the constitution, the Licence and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- Are equally responsible for scrutinising the performance of the Trust in meeting agreed goals and objectives and, in doing so, satisfying themselves as to the integrity of financial, clinical and other information and that financial and clinical quality controls and systems of risk management are robust and defensible.

The Board has also agreed a clear division of responsibilities between the Chairman and the Chief Executive which ensures a balance of power and authority such that no one individual has unfettered powers of decision.

The Board considers that, as at 31st March 2015:

- Its composition meets the requirements of the National Health Service Act 2006 and the constitution
- Its size is sufficient and appropriate to meet requirements of the organisation
- All of its members are "fit and proper" persons to be directors of the Trust
- The Chairman and all the Non-Executive Directors are independent in accordance with the criteria set out in the foundation trust code of governance

Mrs. Bessant's last day in office as Chair of Northumbria Probation Trust was 31st July 2014. There were no other changes to her significant commitments during the year.

The membership of the Board as at 31 March 2015 was as follows:

Lesley Bessant, Chairman
Lesley had a long and successful career in local government until her retirement from Gateshead Council in 2005. Since then she has held a number of non-executive roles including chair of the Northumbria Probation Service Board and pro chancellor on the board of governors for Northumbria University.
Qualifications: BA Economics
Principal Skills & Expertise: Strategic leadership, strategic planning, performance management, corporate governance and risk management.
Term of office: 1 April 2014 to 31 March 2017
Date of Initial appointment: 1 April 2014

Jim Tucker, Deputy Chairman and Chairman of the Investment Committee
Jim is a former senior executive with Nike. He spent over 20 years working for Nike in a number of roles in the UK, over 10 of these as General Manager, and before retiring from Nike was General Manager for the developing markets in Eastern Europe, the Middle East and Africa.
Qualifications: BSc Chemical Engineering, Certified Diploma in Finance, Diploma in Management Studies
Principal Skills & Expertise: Strategic leadership, change management, executive selection and team building, mentoring and financial acumen.
Term of Office: 1 September 2014 to 31 August 2017*
Date of Initial appointment: 1st September 2008

David Jennings Non-Executive Director
David is a qualified accountant and worked for the Audit Commission for 26 years, including as acting head of operations. He set up his own business in 2011 and led the creation of a shared service between Redcar and Cleveland and Middlesbrough Councils' internal audit functions. He also acted as a consultant to a consortium of eight national accountancy firms seeking entry to the post-Audit Commission market. He is currently financial services manager at Redcar and Cleveland Borough Council.
Qualifications: Chartered Institute of Public Finance and Accountancy (CIPFA)
Principal Skills & Expertise: expertise primarily in areas associated with finance, performance, and governance and skills in governance, auditing, business planning, the public sector, local government, performance improvement, shared services, business process improvement, performance management, change management, strategy, accounting, management and leadership.
Term of Office: 1 September 2014 to 31 August 2017
Date of Initial appointment: 1st September 2014

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

Barbara Matthews, Non-Executive Director
Barbara is a qualified lawyer and currently works part time for the City of York Council. She has previously worked both in private practice and as a company lawyer in engineering, construction and procurement law concentrating on international process plant development and the petrol-chemical engineering industry.
Qualifications: BA hons, JD (law)
Principal Skills & Expertise: Risk management, public policy development, legal skills/expertise, commercial focus, contract negotiation and tender development skills.
Term of office: 1 September 2013 to 31 August 2016*
Date of Initial appointment: 1 July 2010

Mike Newell, OBE, Non-Executive Director and Chairman of the Quality and Assurance Committee (until 30th November 2014)
Mike is a former Governor of Durham Prison and former President of the Prison Governors Association. He is an executive advisor to the Board of an educational charity and a research consultant with the International Centre for Prison Studies.
Qualifications: BA Engineering, post graduate diploma in management studies
Principal Skills & Expertise: Risk management, commercial mediation (CEDR trained), industrial relations (former National Trade Union leader), performance management, human rights in criminal justice settings, change management and international engagement and partnership working.
Term of office: 1 September 2012 to 31 March 2015*
Date of Initial appointment: 1 July 2008**

John Robinson, Non-Executive Director, Senior Independent Director and Chairman of the Quality Assurance Committee (from 1 December 2014)
John is a former Non-Executive Director for County Durham and Darlington Priority Services NHS Trust. A former head of nursing in Hartlepool, he is now a Councillor for Durham County Council, a Justice of the Peace for County Durham and Darlington and member of Durham and Darlington Fire Authority.
Qualifications: RMN and RGN, CPN Certificate, Further Education Teaching Certificate, Diploma in Management Studies
Principal Skills & Expertise: Clinical skills and expertise, strategic leadership, legal awareness, communication and stakeholder engagement, human resource management, training skills, partnership working, performance management and patient focus.
Term of office: 1 September 2012 to 31 August 2015*
Date of Initial appointment: 1 July 2008**

Richard Simpson Non-Executive Director and Chairman of the Mental Health Legislation Committee
Richard runs his own business delivering coaching, training and public relations consultancy. He has previous experience as a Non-Executive Director in the NHS and is a Trustee of The Millin Centre, an enterprise charity based in the West End of Newcastle and a Trustee of Age UK Newcastle.
Qualifications: BA (Hons) Sociology and Social Anthropology; Advanced Diploma in Leadership and Development Coaching.
Principal Skills & Expertise: Communications, marketing, stakeholder engagement, crisis management, executive coaching, training, organisational development.
Term of office: 1 September 2013 to 31 August 2016
Date of Initial appointment: 1 September 2013

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

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

Brent Kilmurray, Chief Operating Officer
Brent has been an NHS Executive Director since 2005, having previously worked at City Hospitals Sunderland, NHS South of Tyne and Wear and South Tyneside NHS Foundation Trust. Prior to that he worked in Local Government. Brent is also a Parent Governor at his local first school.
Qualifications: BA (Hons), MA
Principal Skills & Expertise: Operational service leadership, performance management, strategy development, service change, risk management, programme and project management.
Appointed: February 2013

Dr Nick Land, Medical Director
Nick has been a consultant psychiatrist for people with learning disabilities for 20 years. Prior to becoming the Medical Director he was Clinical Director for Learning Disability and Forensic Services at the Trust. Interests include service development and medical education. He is on the executive of the NHS Confederation Mental Health Network and a member of The Monitor Mental Health Medical Advisory Group. He chairs the Northern School of Psychiatry's workforce sub-committee and sits on the Northern LETB council.
Qualifications: MA, MBBS, FRCPsych
Principal Skills & Expertise: Strategic leadership, public policy development, clinical skills/expertise, performance management and service change
Appointed: January 2010

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

Chris Stanbury, Director of Nursing and Governance
Chris joined the NHS in 1980 as a psychology graduate and registered as an RMN in 1985. She has held a variety of clinical, managerial and educational roles, gaining further registrations in both psychotherapy and as a nurse tutor, together with a masters degree in education. She was Deputy Director of Nursing in Mental Health and Learning Disabilities at County Durham and Darlington Priority Services NHS Trust and then Associate Director of Nursing at the Trust prior to appointment.
Qualifications: BSc, RMN, RNT, PGDip Psych, M.Ed.
Principal Skills & Expertise: Psychiatric nursing skills, psychodynamic psychotherapy, project management, managerial and leadership, teaching, coaching and mentorship
Appointed: February 2009

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

Changes to Board Membership

- Mike Newell retired from the Board on 31 March 2015.
- Dr. Hugh Griffiths was appointed as a Non-Executive Director from 1st April 2015.

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

  Prior to his appointment Hugh served as an Associate Non-Executive Director of the Trust (non-voting) between 1st September 2014 and 31st March 2015.
  Qualifications: MB BS, FRCPsych.
  Principal Skills & Expertise: Service Improvement, Policy Development, Clinical Leadership and Management.
  Term of office: 1 April 2015 to 31 March 2018
  Date of Initial appointment: 1st April 2015

Board Meetings
The Board formally meets twelve times a year including special meetings in August and December. Further special meetings are held as and when necessary to consider significant or urgent matters.

At each ordinary meeting, the Board receives certain reports, for example on safe staffing, financial and operational performance, risks and assurance reports from its principal committees.

All meetings of the Board are held in public; however, the Board may, by resolution, exclude members of the public from parts of its meetings for special reasons.

Most meetings are held in West Park Hospital, Darlington; however, to support visibility and accountability, one meeting each quarter is usually held elsewhere in the Trust's area.

During 2014/15 meetings were held in Harrogate, Middlesbrough and Scarborough.

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

Attendance at Board meetings
Individual attendance at the 12 Board meetings held during 2014/15 was as follows:

	No. of Board Meetings attended*
Lesley Bessant	12
Martin Barkley	12
Marcus Hawthorn	11
David Jennings	7 (7)
Barbara Matthews	12
Mike Newell	10
John Robinson	9
Richard Simpson	11
Jim Tucker	12
Dr. Hugh Griffiths**	6 (7)
Brent Kilmurray	12
Dr Nick Land	11
Colin Martin	9
Chris Stanbury	12
David Levy**	11
Sharon Pickering **	11

*(*The maximum number of meetings to be attended by those Board members who held office during part of the year is shown in brackets*
***Attendance in a non-voting capacity).*

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

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

- Attendance at Council of Governors' meetings.
- Receiving reports on the outcome of consultations with Governors, for example on the business plan.
- Updates provided by the Chairman and Directors at Board meetings.
- Attendance by Governors at bi-monthly Directors' visits to services.
- Governors are encouraged to attend public meetings of the Board of Directors.
- Attendance at Governor development days.

John Robinson, as the Senior Independent Director, is also available to Governors if they have concerns regarding any issues which have not been

addressed by the Chairman, Chief Executive or other usual business arrangements.

With regard to attendance at meetings of the Council of Governors:

- The Chairman attends all meetings.
- Attendance at meetings by Non-Executive Directors is not compulsory; however, there is a standing invitation for them to attend.
- Executive and Corporate Directors attend meetings if required, for example to deliver reports, or as observers.

Attendance by the members of the Board of Directors at the five ordinary meetings of the Council of Governors during 2014/15, including the Annual General Meeting was as follows:

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

During 2014/15 the Council of Governors did not exercise its powers under paragraph 26 (2) (aa) of Schedule 7 of the National Health Service Act 2006 to require the attendance of a Director at any of its meetings for the purpose of obtaining information on the Foundation Trust's performance of its functions or the directors' performance of their duties.

Evaluating Board performance

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

In 2014/15 this included assessments of the performance of:

- The Chairman by all other Board Members
- The Chairman by a focus group of Governors on those aspects of her role which relate to the Council of Governors.

- Each Board Member by the Chairman and two Non-Executive Directors and two Executive Board Members drawn at random
- The Board of Directors by all Board Members
- The Audit Committee, the Investment Committee, the Mental Health Legislation Committee and the Quality Assurance Committee by the members of those committees prior to 1st December 2014.

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

The outcomes of the collective Board assessment and those of its committees are reviewed by the Board and are used to inform its annual development plan.

The review built upon the independent external Board evaluation conducted by Deloitte LLP in 2013/14.

Committees of the Board

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

Each committee has terms of reference which have been approved by the Board and includes its reporting requirements. Details of the terms of reference are available in our Integrated Governance Framework which is published on our website.

The membership, roles and activities of these committees are detailed in the following sections.

The Audit Committee

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

The responsibilities of the Audit Committee also include:
- reviewing the adequacy of all risk and control disclosure statements (eg the annual governance statement) prior to endorsement by the Board
- ensuring the internal audit function is effective, meets mandatory NHS internal audit standards and provides appropriate independent assurance
- making recommendations to the Council of Governors on the appointment, re-appointment or removal of the external auditor

- making recommendations to the Council of Governors on the terms of engagement of the external auditor and reviewing and monitoring the performance, independence and objectivity of the external auditor
- reviewing the work and findings of the external auditor and considering the implications and management responses to their work
- reviewing the findings of other assurance functions, both internal and external to the organisation (eg the Care Quality Commission, Monitor, etc) and considering the implications for the governance of the Trust
- reviewing and monitoring the integrity of any financial statements including any financial judgements contained in them and ensuring the completeness and accuracy of information provided to the Board
- reviewing arrangements by which staff may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters (the whistleblowing policy).
- overseeing counter fraud activities and monitoring compliance with the Bribery Act 2010
- commissioning value for money studies

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

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

Marcus Hawthorn (Chairman)	5
David Jennings	2 (2)
Barbara Matthews	1 (1)
Mike Newell	3
John Robinson	1 (3)
Richard Simpson	4
Jim Tucker	1 (1)

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

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

At least once a year the committee meets privately with the external and internal auditors.

The work of the Audit Committee in discharging its responsibilities

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

For the year ended 31st March 2015 the Committee has:

- Approved the External Auditors' Audit Strategy Memorandum and Strategic Audit Plan and received progress reports on the conduct of the audit.
- Approved the Protocol of Liaison between the Internal and External Auditors including those areas of Internal Audit's work of specific interest to the External Auditors for reliance.
- Reviewed and assured the Board that the Trust is, and is expected to remain, a "going concern" and that the Accounts should be prepared on that basis.
- Approved the schedule of losses and special payments as part of the Annual Accounts process.
- Received the Annual Report of the Head of Internal Audit and considered its findings in relation to the Annual Governance Statement.
- Reviewed and commented on the Annual Governance Statement (see page 237)

In its review of the Annual Report and Accounts the committee took into account the External Auditors' findings arising from the audit and the limited (scope) review of the Quality Account. In doing to the Committee paid particular attention to the valuation of property, plant and equipment due to its materiality. The External Auditors assured the Committee that the Trust's treatment of this issue was appropriate and in line with guidance.

During the 2014/15 financial year the Committee has also:

- reviewed the development and coverage of the clinical audit programme and received half yearly progress reports on its implementation
- reviewed the strategic and operational internal audit plans ensuring that these were aligned to the principal risks facing the Trust and could be adequately resourced.
- reviewed progress, at each meeting, against the internal audit plan and considered the outcome of reviews undertaken in the context of the Trust's controls and risk environment. The committee has drawn the Board's attention to those matters which it considers have implications for the Trust's assurance framework
- considered quarterly reports from the Local Counter Fraud Specialist noting action taken on increasing fraud awareness and in response to alleged cases of fraud in the Trust
- considered and approved the letters of engagement with the external auditors (including the audit fees) for submission to the Council of Governors.
- received assurance, on behalf of the Board, that all significant actions included in the Bribery Act action plan had been completed by their due dates.
- Reviewed and commented on updates to the Trust's Standing Financial Instructions
- considered corporate governance and accounting developments

The external auditors

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

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

The cost of providing external audit services during 2014/15 was £39,600 exclusive of VAT. This includes the cost of the statutory audit, the review of the quality account required by Monitor, the review of the accounts of the charitable funds and the whole Government accounting return.

The internal auditors

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

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

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

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

Safeguarding auditor independence

The Audit Committee has agreed a policy to ensure that auditor objectivity and independence is safeguarded if the firm providing external audit services is commissioned to provide services outside of the external auditor's responsibilities. This policy stipulates that only the Chief Executive, Finance Director and Trust Secretary may commission the external audit firm for non-audit services and the appointment must be approved by the Chairman of the Audit Committee. Safeguards are required that:

- external audit does not audit its own firm's work
- external audit does not make management decisions for the Trust
- no joint interest between the Trust and external audit is created
- the external auditor is not put in the role of advocate for the Trust
- the external audit firm does not undertake certain functions including: preparation of accounting records and financial statements, advising on the selection, implementation or running of IS/IT systems, staff secondments, employee remuneration or selection and recruitment and finance or transaction services work within the Trust

- The external auditor must ensure that the provision of non-audit services meets its own ethical standards and internal operational policies.

Investment Committee

The principal role of the Investment Committee is to review and provide assurance to the Board on financial and investment policy issues. Its duties include:

- establishing the overall methodology, processes and controls which govern investments
- reviewing the Trust's investment strategy and policy and ensuring their alignment to the business development strategy
- considering and providing assurance to the Board on the appropriateness and robustness of the medium term financial strategy, the estates and facilities management framework and the information strategy
- monitoring the implementation of the business development strategy
- undertaking in-year monitoring of capital expenditure
- reviewing proposals (including evaluating risks) for major business cases and their respective funding sources.
- reviewing the management and administration of Charitable Funds held by the Trust.

- monitoring progress towards the achievement of the "upside" scenarios included in the business plan

During 2014/15 the membership of the committee comprised:

- Jim Tucker, Non-Executive Director (Chairman of the Committee)
- Lesley Bessant, Chairman of the Trust (from 1 December 2014)
- Marcus Hawthorn, Non-Executive Director
- Barbara Matthews, Non-Executive Director
- Richard Simpson, Non-Executive Director (to 31 November 2014)
- Martin Barkley, Chief Executive
- Brent Kilmurray, Chief Operating Officer
- Colin Martin, Director of Finance and Information
- Sharon Pickering, Director of Planning, Performance and Communications

The committee met 8 times during the year.

During 2014/15 the committee reviewed and recommended the following developments to the Board:

- The establishment of a subsidiary, Positive Independent Proactive Support Ltd, to provide high quality social care support to people with learning disabilities who have high support needs, autism and people whose behaviours severely challenge services.
- The introduction of a Knowledge Management Solution (KMS); an IT based system, incorporating a new website, to improve access to information and document management across the Trust.

- The reconfiguration and refurbishment of corporate buildings at Lanchester Road Hospital
- The reprovision of Parkside, an adult mental health community team base in Middlesbrough
- The refurbishment of the Rowan building in the grounds of Darlington Memorial Hospital which accommodates liaison, IAPT and CAMHS community services.
- Improvements to the operating environment of the Chester-le-Street Health Centre.
- The reprovision of accommodation for community teams in Easington
- The future use of Alexander House in Knaresborough

Mental Health Legislation Committee (MHLC)

The duties of the committee are:

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

In the course of fulfilling its functions and duties if the Committee becomes aware of any risk which could impact on the Trust's ability to deliver its strategic goals it shall seek assurances from the appropriate director that the risk is being managed effectively. On considering the director's report it shall:

- when necessary (in conjunction with the Quality Assurance Committee) assure itself that appropriate controls are in place to manage the risk or specify the controls it considers should be established to mitigate the risk
- report to the Audit Committee if the risk raises concerns regarding the effectiveness of the Trust's governance arrangements; risk management and assurance arrangements or system of internal control
- make a recommendation to the Board that the risk be included in the Board's chapter of the integrated assurance framework and risk register if it believes the risk could have a significant impact on the

sustainability/viability of the Trust or on its ability to deliver the strategic direction.

The MHLC meets quarterly and met in April 2014, July 2014, October 2014 and February 2015.

Membership of the committee:

Mr Richard Simpson, Non-Executive Director and Chair
Dr Hugh Griffiths, Non-Executive Director
Mrs Lesley Bessant, Trust Chairman
Mrs Chris Stanbury, Director of Nursing and Governance
Dr Nick Land, Medical Director
Mr Brent Kilmurray, Chief Operating Officer
Two Public Governors (as representatives of service users and carers)

Remuneration Committee/Nomination and Remuneration Committee

Membership of the Nomination and Remuneration Committee of the Board of Directors, previously known as the Remuneration Committee, during 2014/15 comprised the Trust Chairman, who also chaired the committee, all Non-Executive Directors and the Chief Executive. The Director of Human Resources and Organisational Development provided secretarial support to the committee until the meeting on 16th January 2015 from which date the Trust Secretary provided secretarial support to the committee.

Five meetings were held during 2014/15.

Date	Attendance
29/4/14	Mrs Lesley Bessant, Chairman Mr Martin Barkley, Chief Executive Mr Richard Simpson, Non-Executive Director Mrs Barbara Matthews, Non-Executive Director Mr Jim Tucker, Non-Executive Director Mr Mike Newell, Non-Executive Director Mr David Levy, Director of Human Resources and Organisational Development (in attendance)
13/5/14	Mrs Lesley Bessant, Chairman Mr Martin Barkley, Chief Executive Mr Marcus Hawthrorn, Non-Executive Director Mr Mike Newell, Non-Executive Director Mrs Barbara Matthews, Non-Executive Director Mr John Robinson, Non-Executive Director Mr Richard Simpson, Non-Executive Director Mr Jim Tucker, Non-Executive Director Mr David Levy, Director of Human Resources and organisational Development (in attendance)
11/12/14	Mrs. Lesley Bessant, Chairman Mr. Martin Barkley, Chief Executive Mr. Jim Tucker, Non-Executive Director Mr. David Jennings, Non-Executive Director Mr. Richard Simpson, Non-Executive Director

	Mr. Marcus Hawthorn, Non-Executive Director Mr. David Levy, Director of Human Resources and Organisational Development (in attendance)
16/1/15	Mrs Lesley Bessant, Chairman Mr Martin Barkley, Chief Executive Mr Jim Tucker, Non-Executive Director Mr David Jennings, Non-Executive Director Mrs Barbara Matthews, Non-Executive Director Mr Mike Newell, Non-Executive Director Mr Marcus Hawthorn, Non-Executive Director Mr David Levy, Director of Human Resources and Organisational Development (in attendance) Mr Phil Bellas, Trust Secretary (in attendance)
24/2/15	Jim Tucker, Non-Executive Director and Deputy Chairman (in the Chair) David Jennings, Non-Executive Director Barbara Matthews, Non-Executive Director Mike Newell, Non-Executive Director Richard Simpson, Non-Executive Director

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

During 2014/15 the Nomination and Remuneration Committee of the Board of Directors considered information and made decisions about proposals to make three severance payment recommendations to Monitor. The Nomination and Remuneration Committee of the Board of Directors developed and agreed an Executive Management Team pay structure based upon the outcomes of an independent job evaluation exercise and independent information received about NHS director pay rates. The Nomination and Remuneration Committee of the Board of Directors agreed the recruitment process to be followed in respect of appointments to the posts of Director of Quality Governance and Executive Director of Nursing and Governance.

The Quality Assurance Committee

The Quality Assurance Committee (QuAC) meets monthly and provides a report to the Board of Directors on the matters considered at each of its meetings.

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

The Committee receives regular assurance reports from the clinical governance infrastructure – the Locality Management and Governance Boards and the established corporate assurance working groups of the Committee, as well as developmental discussions and progress reports on the Quality Account process.

The clinical governance and assurance infrastructure was redesigned with the new arrangements implemented from 1st October 2013. The corporate

assurance infrastructure was reviewed and new frameworks were implemented from April 2014.

The Committee provides assurance to the Board of Directors with CQC Regulatory requirements, both through updates on the internal validation programme, together with findings from CQC inspections and progress on implementing action plans.

The structure of the Committee was re-designed to provide a more focused assurance function, in line with recommendations from the review of governance processes by Deloitte's LLP earlier in 2014 and the revised Quality Assurance Committee Terms of Reference and membership was established in December 2014.

Membership of the Committee:

1st April 2014 to 30th November 2014 (8 meetings):

Voting Members:

- Mike Newell, Non-Executive Director (Chairman)
- The Chairman of the Trust and all other Non-Executive Directors; however, Barbara Matthews, John Robinson and Jim Tucker were nominated for regular attendance
- Martin Barkley, Chief Executive
- Chris Stanbury, Director of Nursing and Governance
- Dr Nick Land, Medical Director
- Brent Kilmurray, Chief Operating Officer

Non-Voting Members:

- Sharon Pickering, Director of Planning, Performance and Communications
- Directors of Operations: David Brown (Teesside), Levi Buckley (Forensic Services) Adele Coulthard (North Yorkshire) and Paul Newton (County Durham and Darlington)
- Deputy Medical Directors: Dr. Lenny Cornwall (Teesside), Dr. Neil Mayfield (North Yorkshire), Dr. Ahmad Khouja (Forensic Services) and Dr. Ingrid Whitton (County Durham and Darlington)
- Senior Clinical Directors: Dr. Angus Bell (Adult Mental Health), Dr. Tolulope Olusoga (MHSOP), Dr. Lennon Swart (Children and Young Peoples Services)
  (note: Dr. Ahmad Khouja is also the Senior Clinical Director for Forensic Services)
- Stephen Scorer, Deputy Director of Nursing
- Associate Directors of Nursing and Governance: Christine McCann, Lesley Mawson (to November 2014), Craig Hill (from November 2014) and Karen Agar (from November 2014)

1st December 2014 to 31st March 2015 (3 meetings):

- John Robinson, Non-Executive Director (Chairman)
- Lesley Bessant, Chairman of the Trust
- Mike Newell, Non-Executive Director
- Jim Tucker, Non-Executive Director
- Martin Barkley, Chief Executive
- Chris Stanbury, Director of Nursing and Governance
- Dr Nick Land, Medical Director
- Brent Kilmurray, Chief Operating Officer

In addition:

- David Jennings (Non-Executive Director) and Dr Hugh Griffiths (Associate Non-Executive Director) were appointed as observers to the Committee by the Board
- The Directors of Operations and Deputy Medical Directors attend meetings on a bi-monthly basis to coincide with the consideration of their Locality Management and Governance Assurance Board Reports
- The Deputy Director of Nursing and Associate Directors of Nursing attend each meeting.

The Commercial Oversight Committee

In 2014/15 the Board established the Commercial Oversight Committee to oversee and provide assurance to the Board on the operation of the Trust's subsidiaries.

The Committee comprises:

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

The Committee did not meet in 2014/15 as the Trust's subsidiary, Positive Independent Proactive Support Ltd, did not commence trading during that period.

The Council of Governors

Report from Councillor Ann McCoy, Lead Governor on the work of the Council of Governors during 2014/15

I was delighted and honoured to be re-elected as Lead Governor in 2014.

As Lead Governor I have responsibilities to Monitor and CQC.

As I reported last year one of my responsibilities to Monitor is to report any concerns there may be about aspects of the appointment process or non compliance with the constitution and any concerns about the capability of the Chair.

I am again happy to report that this has not happened.

My responsibilities to CQC were of particular importance during the recent CQC Inspection of the Trust. I was interviewed by 2 of the Inspectors. I feel confident that I was able to demonstrate the Trust is delivering quality and progressive care of the highest standard for patients and carers.

Governors now have the opportunity to meet me before the Council Of Governors meetings to raise issues they have on the Trust Board agenda or minutes. This has been introduced to strengthen the governance for Governors.

The Sub-Committees continue to review the policies and procedures of the Trust to monitor and ensure the Governors are fully aware of how the Trust is delivering services to patients and carers.

Projects have included:

- Friends and Family Test
- The Recovery College
- The Advocacy Service
- Associate Hospital Managers and Tribunal Legislation

There have also been a number of Task and Finish Groups which have reviewed how the Council of Governors holds the Non-Executive Directors to account for the performance of the Board (a statutory duty) and how the Council of Governors conducts its business.

The Sub-Committees and Task and Finish Groups submit regular reports to the Council Of Governors to ensure all Governors are aware of all the issues being reviewed and are given the opportunity to question or comment on the reports.

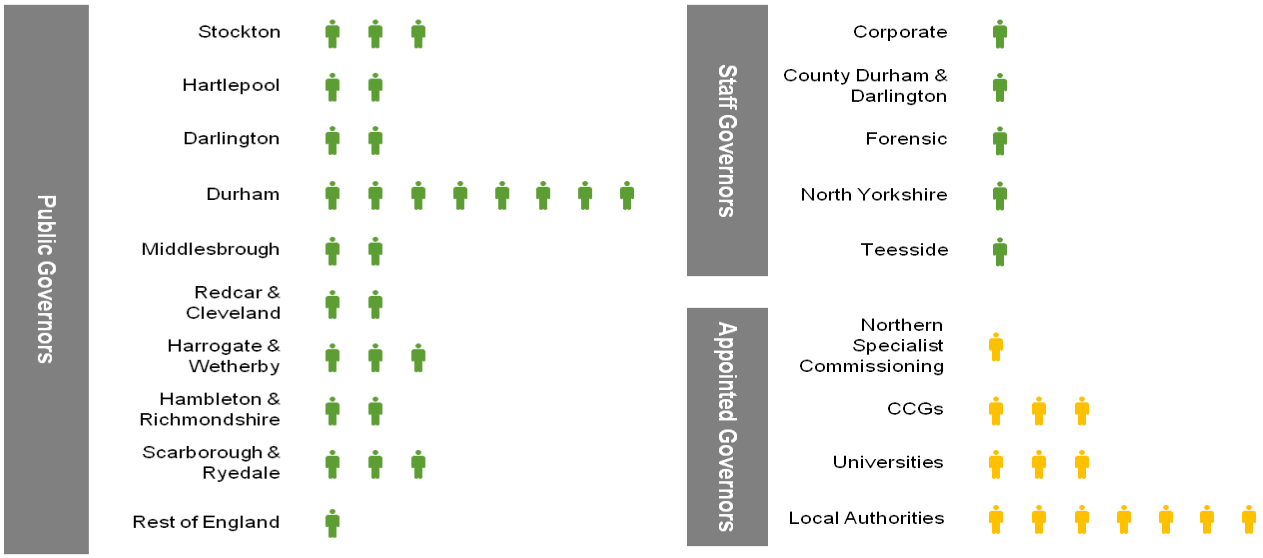
Governors continue to enhance their skills and knowledge through training and development sessions, some of which are mandatory, to enable them to exercise their role effectively and efficiently, training has included.

- Quality Improvement System
- Safeguarding Children
- Safeguarding Adults
- Use of Control and Restraint
- Finance and Business Planning
- Depravation Of Liberty

A suggestion that came from a National Conference I attended recently is that there should be an annual review of Governors to ensure the Council of Governors is strong, committed and has the knowledge to add value to the Trust.
This should be considered by the Council Of Governors as best practice.

The Council Of Governors understands that this year has again been challenging due to reductions in funding and changes to some Legislation and the introduction of new Legislation. This has put enormous pressure on the Trust to maintain quality and we recognise the commitment and dedication of staff and the Board to continue to provide services of the highest standard for the patients and carers.

Composition of the Council of Governors during 2014/15



Membership of the Council of Governors during 2014/15

The terms of office of Governors and their attendance at the five ordinary meetings (including the Annual General Meeting) held during 2014/15 was as follows:

Public Governors (Elected)

		Term of Office		
Name	**Constituency**	**From**	**To**	**Total Attended**
Andrea Goldie	Darlington	01/07/2014	30/06/2017	5
Dennis Haithwaite	Darlington	18/12/2011	30/06/2014	0 (1)
Dennis Haithwaite	Darlington	12/11/2014	30/06/2017	0 (2)
Ann Tucker	Middlesbrough	01/07/2011	30/06/2014	1 (1)
Mary Booth	Middlesbrough	01/07/2014	30/06/2017	4 (4)
Catherine Haigh	Middlesbrough	01/07/2013	30/06/2016	4
Andrea Darrington	Scarborough and Ryedale	17/02/2012	30/06/2014	0 (1)
Judith Webster	Scarborough and Ryedale	01/07/2014	30/06/2017	2
Keith Marsden	Scarborough and Ryedale	01/07/2013	30/06/2016	4 (4)
Richard Thompson	Scarborough and Ryedale	01/07/2014	30/06/2017	2 (4)
Jayne Mitchell	Redcar and Cleveland	18/12/2011	30/06/2014	1 (1)
Claire Farrell	Redcar and Cleveland	01/07/2014	30/06/2017	1 (4)
Vanessa Wildon	Redcar and Cleveland	15/07/2013	30/06/2016	4
Cllr Ray McCall	Stockton-on-Tees	18/12/2011	30/06/2014	1 (1)
Gillian Restall	Stockton-on-Tees	01/07/2014	30/06/2017	4 (4)
Paul Emerson-Wardle	Stockton-on-Tees	12/11/2014	30/06/2017	1 (2)
Gary Emerson	Stockton-on-Tees	01/07/2013	30/06/2016	3
Dr Nadja Reissland	Durham	01/07/2013	02/09/2014	0 (2)
David Lawson	Durham	01/07/2013	30/06/2014	0 (1)
Chris Wheeler	Durham	01/07/2011	30/06/2014	0 (1)
Janice Clark	Durham	01/07/2014	30/06/2017	4 (4)
Betty Gibson	Durham	01/07/2014	30/06/2017	5
Stuart Fawcett	Durham	01/07/2014	30/06/2017	4 (4)
Sarah Talbot-Landon	Durham	12/11/2014	30/06/2016	1 (1)

Cliff Allison	Durham	01/07/2014	30/06/2017	4
Andrew Everett	Durham	01/07/2013	30/06/2016	3
Vince Crosby	Durham	01/07/2013	30/06/2016	4
Mark Williams	Durham	01/07/2013	30/06/2016	4
Zoe Sherry	Hartlepool	01/07/2014	30/06/2017	3
Jean Rayment	Hartlepool	01/07/2013	30/06/2016	3
Dr Matthew Kiernan	Hambleton and Richmondshire	01/07/2013	30/06/2014	0 (1)
Angela Stirk	Hambleton and Richmondshire	01/07/2014	30/06/2017	1 (4)
Colin Wilkie	Hambleton and Richmondshire	01/07/2014	30/06/2017	5
Hilary Dixon	Harrogate and Wetherby	01/07/2013	30/06/2016	3
Chris Gibson	Harrogate and Wetherby	01/07/2013	30/06/2016	3
Sandy Taylor	Harrogate and Wetherby	01/07/2013	30/06/2016	3

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

Staff Governors (Elected)

		Term of Office		
Name	**Constituency**	**From**	**To**	**Total Attended**
Dr Judith Hurst	Corporate	01/07/2014	30/06/2017	3 (4)
Simon Hughes	Teesside	01/07/2014	30/06/2017	4
Dr John Kelly	North Yorkshire	31/03/2013	30/06/2014	0 (1)
Wendy Pedley	North Yorkshire	10/10/2014	30/06/2017	0 (2)
Jacqui Dyson	County Durham and Darlington	10/10/2014	30/06/2014	0 (2)
Lisa Taylor	Forensic	17/02/2012	30/06/2014	0 (1)
Glenda Goodwin	Forensic	10/10/2014	30/06/2017	1 (1)

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

Appointed Governors

		Term of Office		
Name	**Constituency**	**From**	**To**	**Total Attended**
Prof Paul Keane OBE	University of Teesside	01/07/2014	28/02/2015	4
Prof Pali Hungin	Durham University	01/07/2014	30/06/2017	4
Gill Alexander	Hartlepool Borough Council	21/10/2013	14/08/2014	0 (2)
Cllr Stephen Akers-Belcher	Hartlepool Borough Council	15/08/2014	30/06/2017	0 (3)
Debbie Newton	Hambleton, Richmondshire and Whitby Clinical Commissioning Group / Scarborough and Ryedale Clinical Commissioning Group / Harrogate Clinical Commissioning Group	11/04/2013	10/04/2016	1
Dr John Drury	Hartlepool and Stockton-on-Tees Clinical Commissioning Group / NHS South Tees Clinical Commissioning Group	01/07/2014	30/06/2017	1 (4)
Richenda Broad	Middlesbrough Council	01/07/2014	30/06/2017	1 (4)
Dr Kate Bidwell	North Durham Clinical Commissioning Group / Durham Dales, Easington and Sedgefield Clinical Commissioning Group / Darlington Clinical Commissioning Group	01/04/2013	23/09/2014	3 (3)
Dr David Smart	North Durham Clinical Commissioning Group / Durham Dales, Easington and Sedgefield Clinical Commissioning Group / Darlington Clinical Commissioning Group	25/09/2014	30/06/2017	1 (2)
Cllr Ann McCoy	Stockton Borough Council	01/07/2014	31/05/2015	3
Ann Workman	Darlington Borough Council	01/07/2014	30/06/2017	1
Lesley Jeavons	Durham County Council	01/07/2014	30/06/2017	2
Cllr Tony Hall	North Yorkshire County Council	01/07/2014	30/06/2017	5
Prof Ian Watt	The University of York	01/07/2014	30/06/2017	0

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

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

Elections held during 2014/15

Constituency Name	Date of Election	No. of Seats	No. of Candidates	No. of Votes Cast	No. of Eligible Voters	Turnout
County Durham	30/6/2014	4	5	172	1722	9.99%
Darlington	30/6/2014	2	1	n/a	n/a	n/a
Hartlepool	30/6/2014	1	1	n/a	n/a	n/a
Hambleton & Richmondshire	30/6/2014	2	2	n/a	n/a	n/a
Middlesbrough	30/6/2014	1	2	85	1137	7.48%
Redcar and Cleveland	30/6/2014		2	72	818	8.80%
Stockton-on-Tees	30/6/2014	2	1	n/a	n/a	n/a
Scarborough & Ryedale	30/6/2014	2	2	n/a	n/a	n/a
Corporate	30/6/2014	1	1	n/a	n/a	n/a
Teesside	30/6/2014	1	1	n/a	n/a	n/a
Darlington	12/11/14	1	3	63	738	8.5%
Durham	12/11/14	1	9	184	1804	10.2%
Stockton	12/11/14	1	2	86	1068	8.1%
County Durham and Darlington	10/10/14	1	1	-	-	-
Forensic	10/10/14	1	1	-	-	-
North Yorkshire	10/10/14	1	1	-	-	-

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

Committees of the Council of Governors

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

The following issues were progressed by the four thematic committees during 2014/15:

Improving the experience of carers
Chairman: Vanessa Wildon

- Assisted in re-drafting the Carer Strategy and monitored its re-implementation. This included receiving assurance that the requirements of the Triangle of Care were embedded in the Strategy.
- Monitored and received updates on the delivery of the Care Programme Approach (CPA) Project.
- Received updates on the work undertaken by the Care Home Liaison Service provided in Teesside, particularly focussing on the experience of Carers in Mental Health Services for Older People (MHSOP).
- Attended Carer Training sessions for Trust staff and received updates on its roll out across the Trust.
- Discussed the use of Carer Link Workers and Carer Champions in the Trust.
- Monitored the achievement of CQUIN targets relating to Carers.
- Received regular updates on Patient and Carer Feedback Survey Results with regular updates from the Patient Experience Group (PEG).
- Briefed on the Trust's 'Model Lines Project'.

Improving the experience of service users
Chairman: Catherine Haigh

- Food Provision in Hospitals. This included committee members taking part in a food tasting session to sample the food served and environment experienced by service users staying on inpatient wards within the Trust.
- Regular updates on results from the Friends and Family Test.
- Regular updates from the Patient Experience Group (PEG) including key themes of patient experience.
- Received a briefing on the Recovery Project, Volunteering Service and Recruitment and Selection processes in terms of how they were linked to involving service users.
- Received a briefing on the implementation of Section 117 and social care budgets.
- Received briefing on the Deprivation of Liberty.
- Briefed on development of access/preferences and choice of service users.

Promoting social inclusion and recovery
Chairman: Cllr Ann McCoy

- Monitored and received regular updates on the 'Connecting Communities Project'. This included attending two events, hearing from the 'Murton Mums' about their experiences and successes.
- Discussed the Recovery Programme, implementation of the Recovery Strategy and how the Trust's Annual General Meeting/Annual Member's Meeting 2014 raised the profile and awareness of Recovery in the Trust.
- World Mental Health Day 2014 and how the Trust supported it.

- Received updates on the TEWV Arts project and the delivery of the art exhibition.
- Reviewed NICE guidance for psychosis and anxiety and considered how the Trust implemented that guidance.
- Agreed the winner and highly commended nominations of the 'Making a Difference Award' for tackling stigma and promoting social inclusion.
- Received a presentation from 'Time to Change' on their campaign.

Making the most of membership
Chairman: Sandy Taylor

- Monitored the implementation of the Membership Strategy and plan 2014/15 and identified key priority areas for 2015/16.
- Reviewed the delivery and evaluation of the Annual General Meeting/Annual Members Meeting 2014 and Information Showcase Events in North Yorkshire.
- Commenced preparations for the 2015 Annual General Meeting/Annual Members Meeting.
- Agreed the member news pages in the 'insight' magazine.
- Contributed to the development of a new Engagement and Involvement Strategy.
- Received a briefing on the Trust's Social Media Framework which aimed to enable Trust staff to utilise social media for Trust business in a safe and responsible way.
- Discussed the importance of Governors encouraging people to become public members of the Trust.
- Discussed how to increase the public membership of the Trust and which areas to target in terms of ensuring a representative membership.

Reports on the work of the thematic committees are provided to each meeting of the Council of Governors.

The nomination and remuneration committee
The nomination and remuneration committee supports the Council of Governors undertake its duties regarding the appointment and setting the remuneration and terms of service of the Chairman and Non-Executive Directors.

During 2014/15 the Committee:
- Provided assurance to the Council of Governors on the performance of the Non-Executive Directors
- Reviewed the Council of Governors' approach to the remuneration of the Chairman and Non-Executive Directors
- Undertook a recruitment exercise for Non-Executive Directors and recommended:
  - The re-appointment of Jim Tucker.
  - The appointment of David Jennings
  - The appointment of Dr. Hugh Griffiths as an Associate Non-Executive Director pending his appointment to a substantive

position when a vacancy arose. Dr. Griffiths was subsequently recommended for appointment as a Non-Executive Director from 1st April 2015

- Reviewed the Trust's approach to the appointment of the Chairman and Non-Executive Directors in the light of new requirements under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the "Fit and Proper Persons" test):

All recommendations made by the Committee were subsequently approved by the Council of Governors.

Meetings of the committee are chaired by the Chairman of the Trust except that the Senior Independent Director becomes a member of and chairs the committee for the matters relating to the appraisal and appointment of the Chairman.

The membership of the committee and attendance at its 5 meetings during 2014/15 was as follows:

Lesley Bessant	Chairman of the Trust	5
John Robinson	Senior Independent Director	1*
Martin Barkley	Chief Executive	0**
Betty Gibson	Public Governor	5
Lesley Jeavons	Appointed Governor	2
Sandy Taylor	Public Governor	4
Colin Wilkie	Public Governor	5

(Notes:
** As the Senior Independent Director, Mr Robinson only attended those meetings at which the appointment, performance and remuneration of the Chairman was considered.*
*** In accordance with the Trust's Procedure for the Appointment of the Chairman and Non-Executive Directors the Chief Executive is ineligible to attend those meetings of the committee at which the shortlisting of candidates is undertaken or when it is acting as an Appointment Panel)*

During 2014/15 the committee received independent advice and support on the recruitment of Non-Executive Directors from the Northern Recruitment Group plc.

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

- by resignation
- by ceasing to be a public member of the Trust
- upon becoming a Governor of the Trust
- upon being disqualified by the Independent Regulator
- upon being disqualified from holding the position of a director of a company
- upon being adjudged bankrupt

- upon making a composition or arrangement with, or granting a Trust deed for, his/her creditors
- upon being convicted of any offence and a sentence of imprisonment being imposed (whether suspended or not) for a period of not less than three months (without the option of a fine)
- upon removal by the Council of Governors at a general meeting
- if they cease to be a fit and proper person to be a Director of the Trust in accordance with the Licence, the Constitution or the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other Governor groups and meetings

In addition to the above committees the following working groups have been established:

Quality account task group
This task group of Governors assists the Trust in the development of the annual quality report (see page 64)

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

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

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

Task and finish groups
Project based task and finish groups are intended to enable Governors to focus on issues which fall between its thematic committees and to make best use of their skills, experience and knowledge.

In 2014/15 the Council of Governors piloted the use of task and finish groups based on the topic of how Governors should hold the Non-Executive Directors to account for the performance of the Board; one of their duties under the Health and Social Care Act 2012. Cllr Ann McCoy, the Lead Governor, was the sponsor of this review.

The findings of this review were accepted by the Council of Governors at its meeting held on 26th November 2014. A copy of the review report is available on the Trust's website.

In view of the success of the approach the Council of Governors considered that use of task and finish groups should be expanded.

In 2014/15 it was agreed to establish a task and finish group to examine the operation of the Council of Governors. The outcome of the review, which was

sponsored by Mary Booth, Public Governor for Middlesbrough, is due to be reported to the Council of Governors in early 2015/16.

Other groups and events

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

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

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

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

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

All Governors must undertake the following mandatory training:

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

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

The Trust also holds development days to enable Governors to receive briefings on and to discuss national and local issues and to provide networking opportunities. The Non-Executive Directors are invited to attend these events.

At the two development days held during 2014/15 the governors received briefings on the following matters:

- The provision of forensic services
- The care programme approach project

- The ripple effect from “Francis”
- The force reduction project

Governors also participated in a workshop to support the review of the operation of the Council of Governors being undertaken by a task and finish group (see above) and considered the findings of the Council’s performance evaluation.

Membership

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

Our membership strategy and plan was developed and monitored by the Making the Most of Membership Committee and was approved by the Council of Governors following consultation with the Board.

In our membership strategy 2014/15 we set ourselves the following objectives:

- to achieve a public membership of 7,737
- to increase public membership in the Harrogate and Wetherby, Hambleton and Richmondshire, Scarborough and Ryedale, and County Durham Constituencies
- to maintain, at least, the number of members in the other Constituencies
- to recruit sufficient members for our Rest of England Constituency to enable an election to be held
- to focus recruitment activities on increasing the number of members from under-represented groups.

As shown below we exceeded our recruitment target.

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

Members wishing to contact Governors and/or Directors of the Trust can do so via the trust secretary’s department on 01325 552314, email tewv.ftmembership@nhs.net or visit our website www.tewv.nhs.uk.

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

Membership recruitment

The key recruitment methods employed by the Trust are:

- Trust website
- attendance at public meetings and events held by the Trust
- attendance at events held by other organisations
- advertising in a range of public venues and in the local press
- promotional stands in organisations, shopping centres, leisure centres, libraries, Trust premises etc

- activities promoting the Time to Change anti-stigma campaign
- involvement of Governors in activities outside of the Trust

- **Public membership**

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

  During 2014/15 the size and movements in public membership were as follows:

Public members as at 1/4/14	7,487
New members during 2014/15	491
Members leaving during 2014/15	206
Public members as at 31/3/15	7,772

  The number of members for each of the public constituencies on 31 March 2015 was as follows:

Public constituencies Total	
▪ Darlington	735
▪ Durham	1,811
▪ Hambleton & Richmondshire	390
▪ Harrogate and Wetherby	373
▪ Hartlepool	723
▪ Middlesbrough	1,154
▪ Redcar & Cleveland	874
▪ Scarborough & Ryedale	512
▪ Stockton	1,074
▪ Rest of England	126

- **Staff membership**

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

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

Our staff membership up to 31 March 2015 was as follows:

Staff constituencies	
▪ County Durham and Darlington	1,563
▪ Corporate	1,022
▪ Forensic	845
▪ North Yorkshire	1,037
▪ Teesside	1,389

Member engagement

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

To support member engagement we have introduced:

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

In 2014/15 engagement with members was undertaken via the following:

- a welcome pack for new members
- Annual General Meeting/Annual Members' Meeting
- inclusion of a members page in our 'Insight' magazine
- personal invitations to attend member engagement events in their localities (see below)
- communication to relevant constituencies to promote awareness of elections
- meeting members at promotional stands at a variety of events.
- website forum for members' information.
- membership cards including unique membership number and contact details
- expanded use of social media.

Member engagement events held during 2014/15 include:

- A "celebrating positive practice" event in Scarborough on 6th June 2014.

  This event focussed on:
  - Access to services
  - Veteran support
  - The provision of IAPT services for children and families
  - Enabling communication with people with learning disabilities
  - Mental health services for older people
  - Work to support carers

  79% of attendees rated this event as excellent.

- The Annual General Meeting/Annual Member's meeting held on 24th July 2014 which focussed on recovery.

- Two information events held on 11th July 2014 in Northallerton and 27th August 2014 in Harrogate.

  These events, which showcased mental health and learning disability services, included both Trust services and voluntary and community sector providers.

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

The Council of Governors plans to establish a task and finish group to review the Trust's approach to member engagement in 2015/16.

Financial Review & Foreword to the Accounts 2014-15

Summary of Financial Performance

In 2014-15 the Trust continued to build on the strong underlying financial position from previous years. This position allowed new investments in services and improvements in quality to take place against a background of low levels of financial risk.

The 2014-15 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 £4.6m financial surplus	Financial surplus of £4.1m achieved
Achieving a Monitor risk rating of 4	Calculated risk rating of 4 achieved
Delivery of £8.5m cash releasing efficiency savings	Delivery of £9.3m cash releasing efficiency savings
EBITDA margin of 7.6%	EBITDA margin of 8.5% achieved

The Trust planned an operating surplus of £4.6m for the financial year and achieved £4.1m. The surplus was marginally lower than planned largely as a result of fixed asset impairments that occurred during the year. This was largely offset by end of year asset revaluations, additional contract income for clinical services and early delivery of CRES.

Total CRES achieved at 31 March 2015 was £9.3m and was ahead of plan. All CRES achieved was recurrent and the Trust is making good progress with future years plans.

Underlying Performance against Monitor's Compliance Regime – Financial Metrics

The Trust's performance against Monitor's compliance regime is shown in the table below:

Financial Metrics

	Performance	Rating
Debt Service Cover	2.11x	3
Liquidity	36.9 days	4
Overall rating		**4**

Improving efficiency and ensuring value for money

The Trust is continuously striving to improve efficiency in its use of resources by reviewing systems and pressures, evaluating skill mix, optimising the use of capacity and ensuring best value through robust procurement practices. In year, £9.3m of our cost base was saved through a variety of ongoing schemes.

Capital Investment

The Trust has utilised its freedoms as a Foundation Trust to improve the infrastructure and ensure the most modern equipment and technology is available for patient care. Over the last twelve months we have reinvested surpluses with the aim of providing the best possible environment. As a Foundation Trust during 2014-15, £8.0m was invested in capital assets.

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

	2014-15 £m
Investment in fixed assets	8.0
Disposal of unprotected assets	0.1

Modern Equivalent Asset (MEA) Valuation

The Trust's land and buildings were subject to revaluations during the financial year ended 31 March 2015, which resulted in impairments as follows:

	2014-15 £m	
	Realised in surplus	Realised in reserves
Impairments	-12.6	-15.6
Reversal of Impairments	5.5	0.0
Revaluation gains	0.0	4.0
Total loss realised	**-7.1**	**-11.6**

When realised in the surplus, impairment losses are recognised as expenditure, and reversals of prior impairments recognised as income.

Working Capital

Throughout the year the Trust had access to a committed working capital facility of £20.5m. This was not required as the Trust had strong liquidity which improved to 36.9 days linked to a £15m loan secured with the Independent Trust Financing Facility (ITFF) and an increase to the operational surplus.

The ITFF loan was used to support the Trust's capital programme. The additional liquidity also enabled the Trust to reduce its PDC dividend payable

by more than the interest charged on the loan which improved the operating surplus.

Accounting Policies

The Trust prepared the financial statements in accordance with the NHS Foundation Trust Annual Reporting Manual (2014-15) as directed by Monitor, and fully complies with International Financial Reporting Standards accounting practices (IFRS).

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

Going Concern

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

The 2015-16 annual plan provides for a surplus of £4.8m (1.7% of turnover) and reflects a significant level of non-recurrent expenditure. The planned financial surplus for 2016-17 improves as non-recurrent expenditure reduces. The directors view is that the Trust is a going concern and can make the disclosure as recommended by the accounting standards board that:

"After making enquiries the directors have a reasonable expectation that the Tees, Esk and Wear Valleys NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason they continue to adopt the going concern basis in preparing the accounts".

Accounting Information

The accounts are independently audited by Mazars LLP as external auditors in accordance with the National Health Service Act 2006 and Monitors Code of Audit Practice. As far as the directors are aware, all relevant audit information has been fully disclosed to the auditor and that no relevant audit information has been withheld or made unavailable. Nor have any undisclosed post balance sheet events occurred.

No political or charitable donations were made by the Trust during 2014-15.

Accounting policies for pensions and other retirement benefits are set out in pages 266 and 268 in the accounts and details of senior managers remuneration can be found on page 229 of the remuneration report.

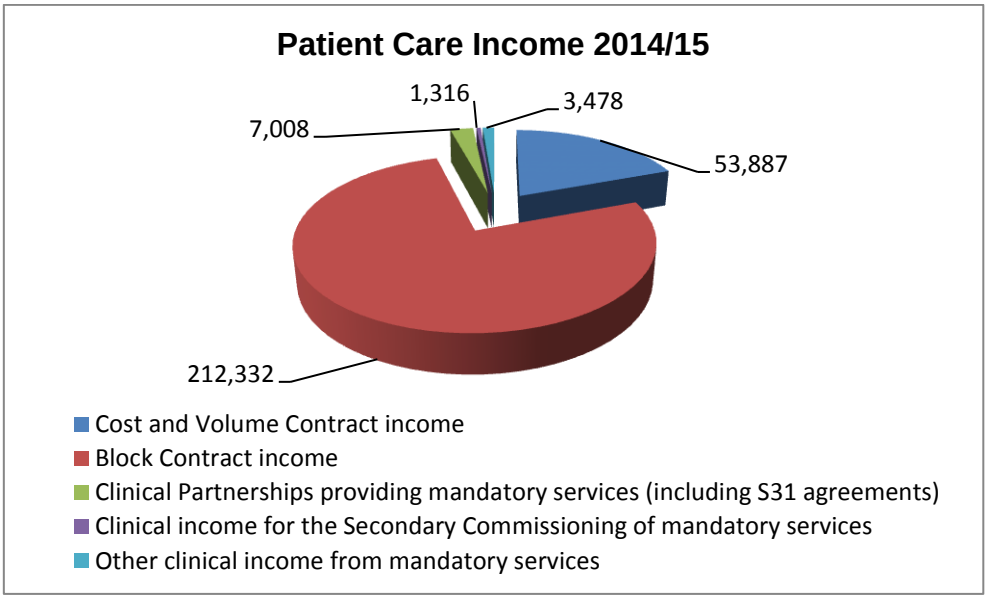
The Trust had complied with the cost allocation and charging requirements as set out in HM Treasury and Office of Public Sector Information guidance.

Ill Health Retirements

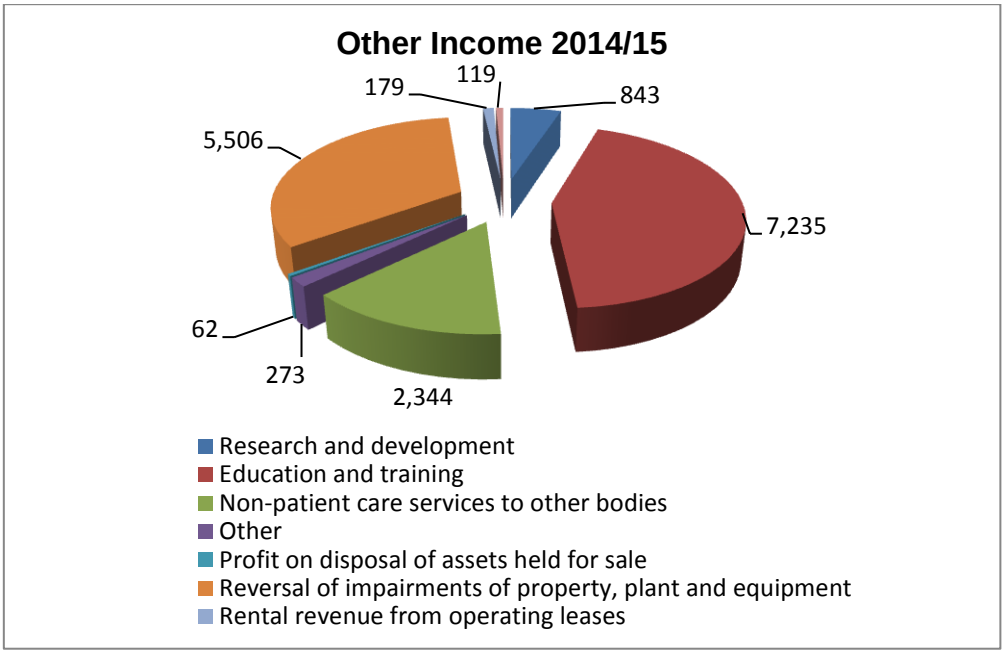
During 2014-15 the Trust had 16 employees retire early on the grounds of ill health; the value of these early retirements (from NHS Pensions) is £0.8m.

Income Generation

During 2014-15, income generated was £294.6m from a range of activities; 94.4% from direct patient care. Patient care income came from the following areas:



There was a further £16.6m from education, reversal of impairments and other non-patient care services.



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

Better Payment Practice Code

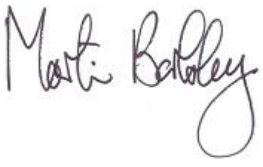
The Better Payment Practice code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. Performance for the financial year 2014-15 was as follows:

	2014-15	
	Number of Invoices	**Value of invoices £000s**
NHS Creditors		
Total bills paid	1,223	12,354
Total bills paid within target	798	9,647
Percentage of bills paid within target	65.25%	78.09%
Non-NHS Creditors		
Total bills paid	52,257	92,939
Total bills paid within target	51,008	91,187
Percentage of bills paid within target	97.63%	98.12%

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

Management Costs

In line with best practice the Trust continues to monitor expenditure on management costs in accordance with Department of Health definitions. In 2014-15, 4.82% of the Trust's total income was incurred on management costs, a marginal increase on 4.78% reported in 2013-14.



Martin Barkley
Chief Executive
26 May 2015

Senior managers' remuneration

Name and Title	2014-15						2013-14					
	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Benefits in Kind * Rounded to the nearest £100	Pension related benefits (bands of £2500) £000	Total Remuneration (bands of £5000) £000	Expenses Paid Rounded to the nearest £100	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Benefits in Kind * Rounded to the nearest £100	Pension related benefits (bands of £2500) £000	Total Remuneration (bands of £5000) £000	Expenses Paid Rounded to the nearest £100
Mr Martin Barkley, Chief Executive	180-185	0	0	0	180-185	2,600	180-185	0	0	2.5-5.0	180-185	3,100
Mr Colin Martin, Director of Finance	120-125	0	8,900	57.5-60.0	190-195	1,300	120-125	0	9,700	20.0-22.5	150-155	300
Dr Nick Land, Medical Director	35-40	170-175	7,800	55.0-57.5	270-275	2,600	35-40	165-170	8,900	72.5-75.0	285-290	300
Mr David Levy, Director of Human Resources and Organisational Development	105-110	0	0	15.0-17.5	120-125	300	105-110	0	0	22.5-25.0	125-130	1,900
Mrs Chris Stanbury, Director of Nursing and Governance	105-110	0	2,900	0	110-115	2,300	105-110	0	3,700	(7.5-10.0)	105-110	200
Mr Chris Parsons, Director of Estates and Facilities***** - left 7 April 2015	0-5	0	0	0	0-5	400	60-65	0	2,600	0	60-65	200
Mrs Sharon Pickering, Director of Planning and Performance	90-95	0	5,600	45.0-47.5	145-150	1,300	90-95	0	5,700	17.5-20.0	115-120	100
Dr Ruth Briel, Senior Clinical Director, Kaizen Promotion Office	65-70	15-20	0	60.0-62.5	140-145	4,400	65-70	10-15	0	7.5-10.0	85-90	3,300
Mr Brent Kilmurray, Chief Operating Officer	120-125	0	0	22.5-25.0	145-150	5,900	120-125	0	0	62.5-65.0	180-185	6,000
Mr Paul Newton, Director of Operations - County Durham and Darlington	100-105	0	600	0	100-105	1,700	100-105	0	2,100	50.0-52.5	150-155	200
Mr David Brown, Director of Operations – Teesside	100-105	0	2,100	12.5-15.0	115-120	200	100-105	0	2,300	60.0-62.5	165-170	100
Mr Levi Buckley, Director of Operations – Forensic Services	90-95	0	0	40.0-42.5	130-135	200	80-85	0	0	42.5-45.0	125-130	1,100
Mrs Adele Coulthard, Director of Operations – North Yorkshire	90-95	0	900	40.0-42.5	130-135	0	80-85	0	0	22.5-25.0	105-110	1,100
Mr Phil Bellas, Trust Secretary****	15-20	0	0	15.0-17.5	35-40	0	0	0	0	0	0	0
Mr Robert Cowell, Director of Estates - started 01 April 2014	85-90	0	2,000	65.0-67.5	150-155	1,400	0	0	0	0	0	0
Mrs Ruth Hill, Project Director - started 01 October 2014	40-45	0	500	37.5-40.0	80-85	400	0	0	0	0	0	0
Mrs Jo Turnbull, Chairman - left 31 March 2014	0	0	0	0	0	800	50-55	0	0	0	50-55	8,900
Mrs Lesley Bessant , Chairman - started 01 April 2014	50-55	0	0	0	50-55	4,200	0	0	0	0	0	0
Mr Andrew Lombard, Non-Executive Director - left 31 August 2013	0	0	0	0	0	0	5-10	0	0	0	5-10	1,600
Mrs Barbara Matthews, Non-Executive Director	10-15	0	0	0	10-15	2,900	10-15	0	0	0	10-15	2,500
Mr Mike Newell, Non-Executive Director - left 31 March 2015	10-15	0	0	0	10-15	1,200	10-15	0	0	0	10-15	1,800
Mr John Robinson, Non-Executive Director	15-20	0	0	0	15-20	1,600	15-20	0	0	0	15-20	2,100
Mr Graham Neave, Non-Executive Director - left 31 August 2013	0	0	0	0	0	0	5-10	0	0	0	5-10	0
Mr Jim Tucker, Non-Executive Director	10-15	0	0	0	10-15	5,100	10-15	0	0	0	10-15	4,200
Mr Richard Simpson, Non-Executive Director - started 1 September 2013	10-15	0	0	0	10-15	3,300	5-10	0	0	0	5-10	1,500
Mr Marcus Hawthorn, Non-Executive Director - started 1 September 2013	15-20	0	0	0	15-20	200	5-10	0	0	0	5-10	600
Mr Douglas Taylor, Non-Executive Director - left 28 February 2014	0	0	0	0	0	0	15-20	0	0	0	15-20	4,000
Mr David Jennings, Non Executive Director - started 1 September 2014	5-10	0	0	0	5-10	400	0	0	0	0	0	0
Mr Hugh Griffiths, Associate Non Executive Director - started 1 September 2014	5-10	0	0	0	5-10	500	0	0	0	0	0	0
	Band of highest paid directors total remuneration (£000) ***				180-185		**Band of highest paid directors total remuneration (£000) *****				180-185	
	Median of total remuneration				26,139		**Median of total remuneration**				25,894	
	Ratio (Director to Median)				6.7		**Ratio (Director to Median)**				6.8	

* Benefits in kind are the provision of lease cars

** Other remuneration includes the full time salary for the role as a consultant psychiatrist (including on-call) plus an additional 2 Additional Clinical Programmed Activities worked during the reported period (For which £29k was paid during 2014-15 (£28k for 2013-14) & Clinical Excellence award

*** Other remuneration includes Additional Clinical Programmed Activity worked during the reported period (For which £6k was paid during 2014-15, £2k for 2013-14) & Clinical Excellence award

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

***** The Chief Executive is shown as the highest paid director, as the Medical Director has a substantive post as a Consultant Psychiatrist as well as Director responsibilities - including this would not show a true and fair ratio. Pension related benefits have also been excluded from this calculation, as they are not known for all staff.

Expenses of Governors

At 31 March 2015 the Trust had 43 Governors (2013-14, 40), with 28 receiving reimbursement of expenses (2013-14, 26). The total amount reimbursed as expenses was £9,548, (£10,445 in 2013-14)

Pay Terms and Conditions

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

The Remuneration Committee is responsible for Executive Directors pay.

Membership:

Mrs Lesley Bessant - Chairman

All Non-Executive Directors of the Trust Board

Martin Barkley

Chief Executive

26 May 2015

Senior managers' pension benefits

Name and title	Real increase in pension at age 60	Real increase in pension lump sum at age 60	Total accrued pension at age 60 at 31 March 2015	Lump sum at age 60 related to accrued pension at 31 March 2015	Cash Equivalent Transfer Value at 31 March 2015	Cash Equivalent Transfer Value at 31 March 2014	Real Increase in Cash Equivalent Transfer Value
	(bands of £2500) £000	(bands of £2500) £000	(bands of £5000) £000	(bands of £5000) £000	£000	£000	£000
Mr Martin Barkley**, Chief Executive	-	-	90-95	270-275	2,170	2,170	0
Mr Colin Martin, Director of Finance	2.5-5.0	7.5-10.0	40-45	130-135	808	741	67
Dr Nick Land, Medical Director	0.0-2.5	5.0-7.5	75-80	225-230	1,501	1,410	91
Mr Brent Kilmurray, Chief Operating Officer	0.0-2.5	2.5-5.0	25-30	85-90	435	407	28
Mrs Chris Stanbury, Director of Nursing and Governance	(0.0-2.5)	(2.5-5.0)	50-55	155-160	1,084	1,078	6
Mrs Sharon Pickering, Director of Planning and Performance	0.0-2.5	5.0-7.5	30-35	90-95	511	465	46
Mr David Levy, Director of Human Resources and Organisational Development	0.0-2.5	0.0-2.5	20-25	70-75	478	452	26
Dr Ruth Briel, Director of Kaizan	2.5-5.0	7.5-10.0	30-35	100-105	623	560	63
Mr Phillip Bellas*, Trust Secretary	0.0-2.5	0.0-2.5	5-10	20-25	131	118	13
Mr Robert Cowell, Director of Estates - started 01 April 2014	2.5-5.0	7.5-10.0	30-35	95-100	636	563	73
Mrs Ruth Hill, Project Director - started 01 October 2014	0.0-2.5	5.0-7.5	20-25	70-75	356	321	35
Mr Paul Newton, Director of Operations - County Durham and Darlington	(0.0-2.5)	(2.5-5.0)	50-55	150-155	1,020	1,011	9
Mr David Brown, Director of Operations – Teesside	0.0-2.5	0.0-2.5	35-40	105-110	735	703	32
Mr Levi Buckley, Director of Operations – Forensic Services	0.0-2.5	5.0-7.5	20-25	65-70	323	289	34
Mrs Adele Coulthard, Director of Operations – North Yorkshire	0.0-2.5	5.0-7.5	25-30	80-85	478	434	44

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

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

*The position of Trust Secretary was made part of the Executive Management Team in 2014/15

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

The reason for the negative increase in pension and lump sum for two senior managers is due to the inflation factor used (2.7%) being higher than the percentage growth in benefits.

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

Martin Barkley
Chief Executive
26 May 2015

For all off-payroll engagements as of 31 Mar 2015, for more than £220 per day and that last for longer than six months	2014/15 Number of engagements Number
No. of existing engagements as of 31 Mar 2015	9
Of which:	
Number that have existed for less than one year at the time of reporting	4
Number that have existed for between one and two years at the time of reporting	4
Number that have existed for between two and three years at the time of reporting	0
Number that have existed for between three and four years at the time of reporting	0
Number that have existed for four or more years at the time of reporting	1
Confirmation:	
Please confirm that all existing off-payroll engagements, outlined above, have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.	Yes

Table 4C: For all new off-payroll engagements, or those that reached six months in duration, between 01 Apr 2014 and 31 Mar 2015, for more than £220 per day and that last for longer than six months	8A2 2014/15 Number of engagements Number
Number of new engagements, or those that reached six months in duration between 01 Apr 2014 and 31 Mar 2015	12
Number of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and national insurance obligations	12
Number for whom assurance has been requested	12
Of which:	
Number for whom assurance has been received	9
Number for whom assurance has not been received *	3
Number that have been terminated as a result of assurance not being received	0

*Where an individual leaves after assurance is requested but before assurance is received and instances where trusts are still waiting for information from the individual at the time of reporting this should be included within “No. for whom assurance has not been received”.

For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 01 Apr 2014 and 31 Mar 2015	2014/15 Number of engagements Number	Subcode
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0	100
Number of individuals that have been deemed "board members and/or senior officials with significant financial responsibility". This figure should include both off-payroll and on-payroll engagements.	16	110

In any cases where individuals are included within the first row of this table, please set out:		Checks
Details of the exceptional circumstances that led to each of these engagements.	0	Pass
Details of the length of time each of these exceptional engagements lasted.	0	Pass

Statements

Annual Governance Statement 2014/15

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 2015 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Chief Executive is the Trust's Accounting Officer responsible for ensuring that the principles of risk management are embedded throughout the organisation.

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

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

The risk and control framework

The Trust's approach to Risk Management is contained in the Integrated Governance Framework which is subject to regular review. The principal risks

to compliance with the NHS foundation trust condition 4 (FT governance) and actions identified to mitigate these risks are detailed below.

Key elements of the Risk Management Strategy are:

- To provide clear management structures and responsibilities throughout the organisation leading to the Board of Directors
- To identify a Lead Executive responsibility for each risk
- To outline the Trust's approach to Risk Management and identifying risks
- To outline and implement a system for assessing risk
- To select the approach for dealing with the risk
- Monitoring and reporting of risk
- Use of an integrated risk register for prioritising and reviewing risks
- Decision making on acceptability of risk
- Training and awareness of Risk Management
- Assurance framework mapping objectives to risks, controls and assurances

Risk is identified using a number of internal and external mechanisms including; NHSLA, Care Quality Commission, complaints management, litigation, staff surveys, task groups, Trust risk register, clinical audit and internal and external audit.

Risk Management can be demonstrated to be embedded in the Trust by;

- Clear structures and responsibilities with clear reporting arrangements to Trust Board
- A system for risk assessment in place to identify and minimise risk as appropriate
- Consideration of acceptability of risk
- Development of risk registers at strategic and operational level
- Awareness training for all staff.

Public stakeholders are also involved in managing risks which impact upon the organisation in a variety of ways:

- Foundation Trust membership and Council of Governors
- Patient satisfaction surveys
- Complaints, claims and Patient Advice and Liaison(PALS) concerns
- The Trust involves patients and the public in the development and evaluation of services
- The Trust maintains close links with social services departments to ensure the delivery of integrated care and treatment

The Trust has been formally assessed against risk standards prescribed by NHSLA and has retained its level 2 status. In addition an Assurance Framework was in place at 31 March 2015 and remains in place up to the date of approval of the annual report and accounts.

The main risks to the Trust meeting its principal objectives have been identified within the framework together with the key controls in place to manage these risks. Although the Trust has not identified any significant control issues, it is improving the control and management of some of the risks in the following areas:

The Trust continues to use a process of Quality Impact Assessments (QIA) which are designed to assess and approve all CRES schemes for the impact they have on clinical performance, and ultimately, patient care.

A considerable amount of work has been undertaken to strengthen clinical audit arrangements. Improvements have been made to processes for planning and management of the programme and additional resources have been deployed to increase clinical audit capacity. Action plans are in place to further strengthen and embed clinical audit procedures.

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

Further work has been carried out continuing the improvements put in place in prior years in the development of a robust workforce performance management framework and the further development of the Trust's I.T. systems to support the organisation's objectives including data quality, the lack of agreed currencies, and quality and outcome measures for the Trust's patient care contracts.

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

The Trust has identified that it needs to improve the level of reliance it can place on assurances it gains that controls are operating and action plans are implemented effectively. This will be achieved by an increasing reliance on validated 3rd party assurances through the development of a system which records and validates the form and frequency of assurances received. This system will allow the Trust to assess the level of assurance that can be taken and what actions are necessary to improve the benefit of all 3rd party assurances. This will ensure that governance processes continue to become more dynamic in the pursuit of effectiveness and efficiency, and enables the Trust to assure itself of the validity of its Corporate Governance Statement, required under NHS foundation trust condition 4(8)(b).

The Trust has confirmed its commitment to ensure on-going compliance with the requirements of the Department of Health Information Governance Assurance Programme. The Trust achieved an overall score of 88% against the Information Governance Toolkit requirement in 2014/15 with all sequences

achieving at least level 2. The Director of Finance and Information is the senior information risk owner (SIRO) at Board level. The Trust operates a SIRO network, which in turn has increased Information Governance awareness, training and understanding through delegation of responsibility to information asset owners and information asset administrators. The network is supported by an Information Governance Campaign to deliver information and training.

The Trust has an established anti-fraud and corruption policy that was reviewed and approved at the Trust's Audit Committee in September 2014. This policy aims to minimise the risk of fraud, bribery or corruption by detailing the key roles and responsibilities of employees and related parties; as well as promoting an anti-fraud culture throughout the Trust.

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

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

The Trust was fully compliant with the registration requirements the Care Quality Commission at the conclusion of 2014/15.

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

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

The foundation trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

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

- Agreeing a rolling 5 year annual financial strategy and plan
- A rigorous process of setting annual budgets and a detailed cost improvement programme including a Quality Impact Assessment (QIA).
- Annual review of Standing Financial Instructions and Schemes of Delegation
- The formalisation of a treasury management policy
- Robust performance management arrangements
- A programme of supporting directorates to better understand and manage their relative profitability
- Breaking the trust's overall reference cost indicator down to Specialty / directorate
- Levering efficiencies through internal and collaborative procurement initiatives
- Using benchmarking and nationally published performance metrics to inform plans for improved bed and community service efficiency
- Rationalising the estate
- Improving workforce productivity
- Benchmarking management costs
- Commissioning external consultancy where the Trust believes economy and efficiency can be improved
- Embedding the Quality Improvement Systems (QIS) methodology to review how the Trust operates, maximising efficiency and minimising waste.

The Board plays an active role by:

- Determining the level of financial performance it requires and the consequent implications (including QIA)
- Reviewing in detail each month financial performance, financial risk and delivery against the detailed CIP
- Agreeing the IBP, Annual Plan, Quality Report and Self Certification submitted to Monitor.
- Considering plans for all major capital investment and disinvestment

The Trust audit committee has a key role on behalf of the Board in reviewing the effectiveness of our use of resources. The Trust has also gained assurance from:

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

Information Governance

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

appropriate sanction for this type of Information Breach.

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

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

- The Quality Assurance Committee is responsible for producing the Quality Accounts with the Director of Nursing and Governance and the Director of Planning and Performance being lead Directors. The Quality Assurance Committee has received reports throughout the year regarding the development of the Quality Accounts, including an early draft of the accounts.

- Priorities for improvement have been identified from an analysis of serious untoward incidents, complaints, as well as feedback from users and other stakeholders. Theses priorities have been shared with wider stakeholders for comment and were approved by the Quality Assurance Committee before final sign off by the Board of Directors and Council of Governors.

- The Director of Finance and Information is the corporate lead for data quality and chairs an internal group which has the responsibility for ensuring data quality within the Trust. Furthermore data quality is also discussed at monthly performance meetings between the Director of Finance, Director of Planning and Performance and the Chief Operating Officer with each clinical directorate.

- Data quality is included within the corporate risk register which is used by the Board of Directors to monitor the risk of incomplete and inaccurate data. The Trust has also developed a Data Quality Strategy which provides a framework for improvements in this important area. A Data Quality Strategy Scorecard is also in place to enable the Board of Directors to track progress.

- The Trust has the following policies linked to data quality:

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

- Information systems business continuity policy
- Data protection policy

The policies incorporate national standards where available and are regularly reviewed. All the policies are held on the intranet and are available to staff at all times. When policies have been reviewed (or new ones published) there is a mechanism to inform staff through team brief.

- A significant amount of training is provided to support staff using the electronic patient record (PARIS) and to ensure compliance with CPA. Training is provided where issues around data quality have been identified.

- As part of performance reporting to the Board actual data is used to forecast future positions thus improving the decision making process.

- All data returns are submitted in line with agreed timescales.

Review of effectiveness

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

My review is also informed by

- The Care Quality Commission
- NHSLA Clinical Negligence Scheme for Trusts (CNST)
- Internal Audit
- External Audit
- Health and Safety Executive
- Internal Clinical Audit Team

The following groups and committees have been involved in maintaining and reviewing the effectiveness of the system of internal control;

- The Board of Directors is responsible for setting the strategic direction of the organisation and monitoring the progress of the organisation

against targets. The Board also receives minutes and reports from its sub committees.

- It is the Council of Governors duty to hold the non-executive directors to account for the performance the Board of Directors, and to represent the interests of the public.
- The Audit Committee provides an independent view of internal control by reviewing financial systems, overseeing audit services and providing assurance to the Board on non-financial governance issues including reviewing and commentating on the clinical governance programme.
- The Quality Assurance Committee oversees on behalf of the Board of Directors all clinical governance activity including a review of the clinical audit processes and programme.
- Internal Audit provides an independent and objective opinion on the degree to which risk management, control and governance support the achievement of the Trust's objectives. The Head of Internal Audit opinion provided significant assurance for this area, and all issues raised have been considered appropriately.
- The external auditor provides progress reports to the Audit Committee.
- The annual report and accounts are presented to the Board of Directors for approval.

Conclusion

In summary, the Trust has not identified any significant internal control issues within 2014-15, and has a sound system of Internal Control and Governance in place which is designed to manage the key organisational objectives and minimise the Trust's exposure to risk. The Board of Directors is committed to continuous improvement and enhancement of the systems of internal control.

Martin Barkley
Chief Executive
26 May 2015

Statement of the Chief Executive's responsibilities as the Accounting Officer of Tees, Esk and Wear Valleys NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by Monitor.

Under the NHS Act 2006, Monitor has directed Tees, Esk and Wear Valleys NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Tees, Esk and Wear Valleys NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

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

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* have been followed, and disclose and explain any material departures in the financial statements;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance; and
- prepare the financial statements on a going concern basis.

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

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

Martin Barkley
Chief Executive
26 May 2015

Statement on the responsibilities of Directors for preparing the accounts

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

Monitor, with the approval of HM Treasury, directs that these accounts shall show, and give a true and fair view of the NHS foundation trust's gains and losses, cash flow and financial state at the end of the financial year. Monitor further directs that the accounts shall meet the accounting requirements of the NHS Foundation Trust Financial Reporting Manual that is in force for the relevant financial year, which shall be agreed with HM Treasury.

In preparing these accounts, the Directors are required to:

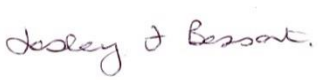
- apply on a consistent basis, for all items considered material in relation to the accounts, accounting policies contained in the NHS Foundation Trust Financial Reporting Manual issued by Monitor
- make judgements and estimates which are reasonable and prudent; and ensure the application of all relevant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

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

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

The Directors confirm that:

- as far as they are aware, there is no relevant information of which the Trust's auditor is unaware
- that they have taken all steps they ought to have taken as a Director in order to make themselves aware of any such information and to establish that the Auditor is aware of that information
- the annual report and accounts, taken as a whole, are fair, balanced and reasonable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy and
- the Trust is a going concern.



Lesley Bessant
Chairman on behalf of the Board of Directors
26 May 2015

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

We have audited the financial statements of Tees, Esk and Wear Valleys NHS Foundation Trust for the year ended 31 March 2015 under the National Health Service Act 2006. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. These financial statements have been prepared under applicable law and the accounting policies set out in the Statement of Accounting Policies.

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

This report is made solely to the Council of Governors of Tees, Esk and Wear Valleys NHS Foundation Trust in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of the accounting officer and the auditor

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

Our assessment of the risks of material misstatement

During the course of the audit we identified the following risks that had the greatest effect on our overall audit strategy:

- the risk of management override of controls as International Standards on Auditing (UK and Ireland) state that this risk must always be treated as significant;
- property valuation; and
- revenue and expenditure recognition.

Our assessment and application of materiality

We apply the concept of materiality both in planning and performing our audit, and in evaluating the effect of misstatements on the financial statements and our audit. Materiality is used so we can plan and perform our audit to obtain reasonable, rather than absolute, assurance about whether the financial statements are free from material misstatement. The level of materiality we set is based on our assessment of the magnitude of misstatements that individually or in aggregate, could reasonably be expected to have influence on the economic decisions the users of the financial statements may take based on the information included in the financial statements.

When establishing our overall audit strategy, we determined a magnitude of uncorrected misstatements that we judged would be material for the financial statements as a whole. The overall materiality level we set for Tees, Esk and Wear

Valleys NHS Foundation Trust's financial statements was £2.81 million, which is approximately 1% of Operating expenses. We used Operating expenses to calculate our materiality as, in our view, this is the most relevant measure of the underlying financial performance of Tees, Esk and Wear Valleys NHS Foundation Trust.

We agreed with the Audit Committee that we would report to the Committee all audit differences in excess of £84,000, as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of whether the accounting policies are appropriate to Tees, Esk and Wear Valleys NHS Foundation Trust's circumstances and have been consistently applied and adequately disclosed, the reasonableness of significant accounting estimates made by the accounting officer and the overall presentation of the financial statements. In addition we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

We scoped our audit approach in response to the risks outlined on the previous page as follows

Risk	Audit approach
Management override of controls In all entities, management at various levels within an organisation are in a unique position to perpetrate fraud because of their ability to manipulate accounting records and prepare fraudulent financial statements by overriding controls that otherwise appear to be operating effectively. Due to the unpredictable way in which such override could occur, we consider there to be a risk of material misstatement due to fraud and thus a significant risk on all audits.	Our approach involved: • testing the appropriateness of journal entries and other adjustments made in preparing the financial statements; • reviewing the key areas within the financial statements where management has used judgement and applied estimation techniques; and • reviewing significant transactions outside the normal course of business or that otherwise appear to be highly unusual.
Property valuation Land and buildings are the Trust's highest value assets. Management engage an expert, to assist in determining the fair value of property to be included in the financial statements. Changes in the value of property may impact on the Statement of Comprehensive Income depending on	Our approach involved: • updating our understanding on the approach taken by the Trust in its valuation of land and buildings; • reviewing the scope and terms of the engagement with the valuer and how management used the valuation report to value land and buildings in the financial

Risk	Audit approach
the circumstances and the specific accounting requirements of the Annual Reporting Manual.	statements; • obtaining information on the methodology and the valuer's procedures to ensure objectivity and quality; and • considering evidence of regional valuation trends.
Revenue and Expenditure recognition There is a risk of fraud in the financial reporting relating to revenue and expenditure recognition due to the potential to inappropriately record revenue and expenditure in the wrong period. Due to there being a risk of fraud in revenue and expenditure recognition we consider it to be a significant risk on all audits.	Our approach involved evaluating the design and implementation of any controls to mitigate these risks and undertaking a range of substantive procedures including: • testing of material income and expenditure including tests to ensure transactions are recognised in the correct year; • testing material year end receivables, payables, accruals and provisions; • reviewing intra-NHS reconciliations and data matches; • reviewing management oversight of material accounting estimates and any changes to accounting policies; • reviewing judgements about whether the criteria for recognising provisions were satisfied; and • testing of material adjustment journals.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the state of Tees, Esk and Wear Valleys NHS Foundation Trust's affairs as at 31 March 2015 and of its income and expenditure for the year then ended;
- have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2014/15; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts

In our opinion the part of the Remuneration Report to be audited has been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts.

Matters on which we are required to report by exception

We have nothing to report in respect of the following:

Under the ISAs (UK and Ireland), we are required to report to you if, in our opinion, information in the annual report is:

- materially inconsistent with the information in the audited financial statements; or
- apparently materially incorrect based on, or materially inconsistent with, our knowledge of Tees, Esk and Wear Valleys NHS Foundation Trust acquired in the course of performing our audit; or
- is otherwise misleading.

In particular we are required to consider whether we have identified any inconsistencies between our knowledge acquired during the audit and the directors' statement that they consider the annual report is fair, balanced and understandable and whether the annual report appropriately discloses those matters that we communicated to the audit committee which we consider should have been disclosed.

We also have nothing to report where under the Audit Code for NHS Foundation Trusts we are required to report to you if, in our opinion, the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading or is not consistent with our knowledge of Tees, Esk and Wear Valleys NHS Foundation Trust and other information of which we are aware from our audit of the financial statements. We are not required to assess, nor have we assessed, whether all risks and controls have been addressed by the Annual Governance Statement or that risks are satisfactorily addressed by internal controls.

Certificate

We certify that we have completed the audit of the accounts of Tees, Esk and Wear Valleys NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

Cameron Waddell (CPFA) for and on behalf of Mazars LLP

Chartered Accountants and Statutory Auditor

Rivergreen Centre, Aykley Heads, Durham, DH1 5TS

27 May 2015

Annual Accounts 2014/15

Financial Statements 2014/15

Statement of Comprehensive Income for 12 months ended 31 March 2015

	Note	12 months ended 31 March 2015 £000	12 months ended 31 March 2014 £000
Revenue			
Income from activities	2	278,021	274,946
Other operating income	2	16,561	16,028
Total operating income		**294,582**	**290,974**
Operating expenses	3	(281,129)	(269,538)
Operating surplus		**13,453**	**21,436**
Finance costs			
Finance income	8	151	84
Finance expense - financial liabilities	9	(5,396)	(5,232)
Finance expense - unwinding of discount on provisions		(12)	(22)
PDC dividends payable		(4,076)	(4,054)
Net Finance Costs		**(9,333)**	**(9,224)**
Surplus for the year		**4,120**	**12,212**
Other comprehensive income			
Will not be reclassified to income and expenditure			
Gain/(loss) from transfer by absorption from demising bodies		0	7,042
Impairments - property, plant and equipment		(15,596)	(1,523)
Revaluations		3,960	9,090
Total comprehensive income for the year		**(7,516)**	**26,821**

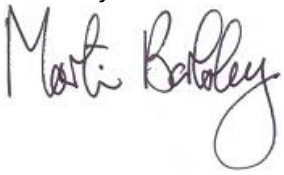
Statement of Financial Position as at 31 March 2015

	Note	31 March 2015 £000	31 March 2014 £000
Non-current assets			
Property, plant and equipment	12	218,924	233,912
Trade and other receivables	22	50	53
Total non-current assets		**218,974**	**233,965**
Current assets			
Inventories	21	171	182
Trade and other receivables	22	6,566	5,449
Non-current assets for sale and assets in disposal groups	18	0	135
Cash and cash equivalents	25	47,147	24,342
Total current assets		**53,884**	**30,108**
Current liabilities			
Trade and other payables	26	(20,242)	(17,072)
Borrowings	27	(5,319)	(2,138)
Provisions	30	(337)	(313)
Other liabilities	28	(385)	(199)
Total current liabilities		**(26,283)**	**(19,722)**
Total assets less current liabilities		**246,575**	**244,351**
Non-current liabilities			
Borrowings	27	(91,610)	(81,929)
Provisions	30	(1,074)	(1,045)
Total non-current liabilities		**(92,684)**	**(82,974)**
Total assets employed		**153,891**	**161,377**
Financed by taxpayers' equity			
Public dividend capital		144,683	144,653
Revaluation reserve	32	19,606	31,242
Income and expenditure reserve		(10,398)	(14,518)
Total taxpayers' equity		**153,891**	**161,377**

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

:

The financial statements on pages 252-286 were approved by the Board and signed on its behalf by:



Martin Barkley
Chief Executive
26 May 2015

Statement of Changes in Taxpayers' Equity

	Total	Public Dividend Capital (PDC)	Revaluation Reserve	Statement of Comprehensive Income Reserve
	£000	£000	£000	£000
Taxpayers' Equity at 1 April 2014	**161,377**	**144,653**	**31,242**	**(14,518)**
Surplus for the year	**4,120**	0	0	4,120
Impairments	**(15,596)**	0	(15,596)	0
Revaluations - property, plant and equipment	**3,960**	0	3,960	0
Public dividend capital received	**30**	30	0	0
Taxpayers' Equity at 31 March 2015	**153,891**	**144,683**	**19,606**	**(10,398)**
Taxpayers' Equity at 1 April 2013	**133,743**	**143,840**	**21,387**	**(31,484)**
Surplus for the year	**12,212**	0	0	12,212
Transfers by MODIFIED absorption: Gains/(losses) on 1 April transfers from demising bodies.	**7,042**	0	0	7,042
Transfers by MODIFIED absorption: transfers between reserves	**0**	0	2,439	(2,439)
Transfers between reserves	**0**	0	(151)	151
Impairments	**(1,523)**	0	(1,523)	0
Revaluations	**9,090**	0	9,090	0
Public Dividend Capital received	**889**	889	0	0
PDC adjustment for cash impact of receivables transferred from legacy teams	**(76)**	(76)	0	0
Taxpayers' Equity at 31 March 2014	**161,377**	**144,653**	**31,242**	**(14,518)**

Statement of Cash Flows for 12 months ended 31 March 2015

	Note	12 months ended 31 March 2015 £000	12 months ended 31 March 2014 £000
Cash flows from operating activities			
Operating surplus		**13,453**	**21,436**
Non-cash income and expense:			
Depreciation and amortisation	3	4,247	4,254
Impairments	3	12,560	4,888
Reversals of impairments	2	(5,506)	(5,388)
Gain on disposal of PPE	2	(62)	(106)
Increase in trade and other receivables		(1,114)	(1,261)
Decrease in inventories		11	26
Increase/(Decrease) in trade and other payables		3,139	(1,623)
Increase / (Decrease) in other liabilities		186	(361)
Increase / (Decrease) in provisions		41	(183)
Other movements in operating cash flows		0	(128)
Net cash generated from operations		**26,955**	**21,554**
Cash flows from investing activities			
Interest received		151	84
Purchase of property, plant and equipment		(7,957)	(13,536)
Sales of property, plant and equipment		199	3,306
Net cash generated used in investing activities		**(7,607)**	**(10,146)**
Cash flows from financing activities			
Public dividend capital received		30	889
Public dividend capital repaid		0	(76)
Loans received from the Independent Trust Financing Facility		15,000	0
Capital element of Private Finance Initiative obligations		(2,138)	(2,110)
Interest element of Private Finance Initiative obligations		(5,286)	(5,225)
PDC dividend paid		(4,149)	(4,004)
Net cash generated / (used) in financing activities		**3,457**	**(10,526)**
Increase in cash and cash equivalents	25	**22,805**	**882**
Cash and cash equivalents at 1 April	25	**24,342**	**23,460**
Cash and cash equivalents at 31 March	25	**47,147**	**24,342**

Notes to the Accounts

Note 1. Accounting Policies

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual, which has been agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2014-15 NHS Foundation Trust Annual Reporting Manual issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

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

Accounting standards issued that have been adopted early

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

IFRS 9	Financial instruments
IFRS 13	Fair value measurement
IAS 36	Recoverable amount disclosures
IAS 19 (amendment)	Employer contributions to defined benefit schemes
IFRIC 21	Levies
Annual improvements 2012	n/a
Annual improvements 2013	n/a

Critical accounting judgements and key sources of estimation uncertainty

These are methods adopted by the Trust to arrive at monetary amounts, corresponding to the measurement basis selected for assets, liabilities, gains, losses and charges to the Reserves. Where the basis of measurement for the amount to be recognised under Accounting Policies is uncertain, an estimation technique is applied.

The Trust has identified the valuation of the Trust estate and the valuation of Provisions as critical accounting judgements and key sources of uncertainty. DTZ Ltd provide third party assurance of the value of the estate completing a full modern equivalent valuation exercise every 3 years. Provisions are, in the main, injury benefits provisions which are valued using actuarial tables.

The Trust has not consolidated its charitable fund within the main accounts on the grounds of materiality as per guidance within the annual reporting manual. The Trust has not consolidated its Joint Associate for the provision of improving access to psychological therapies (IAPT) services within the main accounts on the grounds of materiality as per guidance within the annual reporting manual.

Income recognition

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. Main source of income for the Trust is contracts with commissioners in respect of healthcare services.

Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Retirement benefit costs
Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.
For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

Other expenses
Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

Property, plant and equipment

Recognition
Property, plant and equipment is capitalised if:

- an item has a cost of at least £5,000; or
- it forms part of the initial equipping and setting-up cost of a new building, ward or unit irrespective of their individual or collective cost;
- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably.
- Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Valuation
All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

Depreciated replacement cost has been applied for assets with a short life and/or low values.

Each piece of new equipment has its useful economic life assessed prior to capitalisation; however, the range of useful lives is shown below:

- IT Equipment is depreciated over 5 years
- Furniture and Equipment and other Equipment are depreciated between 5 and 10 years
- Plant aligned to buildings is depreciated between 15 and 30 years

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being fair value at the date of revaluation less subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use

In line with HM Treasury guidance with effect from 31 March 2010, Trust owned assets have been valued on modern equivalent asset (MEA) valuations, based on an alternative site valuation where the location meets the requirements of service provision. Owned assets lives were assessed as part of the MEA valuation exercise at 31 March 2010. The MEA value and assessed asset life are the basis for the depreciation charge. The depreciation charge for non-owned assets is based on the capital expenditure being depreciated over the remaining lease license life of the asset.

A full MEA valuation was carried out on the Trusts land and buildings 31 March 2013, and the assets have been treated as prescribed in the FT Annual Reporting Manual (ARM). Accumulated depreciation on these assets has been written to zero, and the cost or valuation at 31 March 2013 amended to the MEA values to reflect this. Due to material movements in indexation rates during 2014/15 the Trust had an MEA valuation of all fixed assets (apart from those valued at open market value) completed at 31 March 2015. All of the Trusts MEA valuations have been completed by DTZ (independent qualified valuer).

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Until 31 March 2008, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost. From 1 April 2008 indexation ceased. At that date it was decided that the carrying value of existing assets at that date would be written off over their remaining useful lives. New fixtures

and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure
Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

Intangible assets
Intangible assets are capitalised when they are capable of being used in a Trust's activities for more than one year; they can be valued; and they have a cost of at least £5,000.

Intangible fixed assets held for operational use are valued at historical cost and are depreciated over the estimated life of the asset on a straight line basis, except capitalised research and development which is revalued using an appropriate index figure. The carrying value of the intangible assets is reviewed for impairment at the end of the first full year following acquisition and in other periods if events or changes in circumstances indicate the carrying value may not be recoverable.

The Trust does not recognise any intangible assets.

Depreciation, amortisation and impairments
Freehold land and properties under construction are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

At each reporting period end, the Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount.

If there has been an impairment loss, the asset is written down to its recoverable amount, with the loss charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that

would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

Donated assets
Donated property, plant and equipment assets are capitalised at their fair value on receipt. The donation is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met. The donated assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Legacy Transfers
For property plant and equipment assets that have been transferred to the Trust from another NHS body, the assets transferred are recognised in the accounts as at the date of transfer. The cost and accumulated depreciation balances from the transferring entity's accounts are preserved on recognition in the Trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the Trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

Government grants
"Government grants are grants from government bodies other than revenue from NHS bodies for the provision of services. Where a grant has been used to fund revenue expenditure it is taken to the Statement of Comprehensive income to match that expenditure.

Grant income relating to assets is recognised within income when the foundation trust becomes entitled to it, unless the grantor imposes a condition that the future economic benefits embodied in the grant are to be consumed as specified by the grantor and if it is not, the grant must be returned to the grantor, e.g. a grant that is conditional on the construction of an asset."

Non-current assets held for sale
Non-current assets are classified as held for sale when the following conditions are met:

1. The asset is available for immediate sale in its present condition

2. The sale must be highly probable i.e.:

    - management are committed to a plan to sell the asset
    - an active programme has begun to find a buyer and to complete the sale
    - the asset is being actively marketed at a reasonable price
    - the sale is expected to be completed within 12 months of the date of classification as "Held for Sale"
    - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to the statement of comprehensive income reserve. For donated and government-granted assets, a transfer is made to or from the relevant reserve to the profit/loss on disposal account so that no profit or loss is recognised in income or expenses. The remaining surplus or deficit in the donated asset or government grant reserve is then transferred to the statement of comprehensive income reserve.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

Private finance initiative (PFI)
HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The Trust therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a. Payment for the fair value of services received;
b. Payment for the PFI asset, including finance costs; and
c. Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Services received
The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

PFI asset
The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

PFI liability
A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.
An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

Lifecycle replacement
Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised.
The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the Trust to the operator for use in the scheme
Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the Trust's Statement of Financial Position.

Inventories
Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

Cash and cash equivalents
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management.

Provisions
Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate. The discount rate has changed as follows, resulting in changes to the amount of provision made:

	2014/15	2013/14
Short term (<5 years)	-1.50%	-1.90%
Medium term (5-10 years)	-1.05%	-0.65%
Long term	2.20%	2.20%
Pensions rate	1.30%	1.80%

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

Clinical negligence costs
The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 30.3.

Non-clinical risk pooling
The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

Contingencies
A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

The Trust has no contingent assets

Where the time value of money is material, contingencies are disclosed at their present value.

Financial assets
Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories: financial assets at fair value through income and expenditure; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced directly/through a provision for impairment of receivables.

Financial liabilities
Financial liabilities are recognised on the statement of financial position when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Leases
Operating leases are lease agreements where the Trust is not exposed to the risks and rewards of ownership of a leased asset. Rentals are charged to operating expenses on a straight-line basis over the term of the lease.

Corporation tax
Foundation Trusts are exempt from corporation tax on their principle health care income under section 519A Income and Corporation Taxes Act 1988. In determining whether other income may be taxable, a full review of the Trust's activities has been carried out in accordance with guidance published by HM Revenue and Customs to establish any activities that are subject to Corporation Tax. Based on this review there is no corporation tax liability in the period ended 31st March 2015.

Other financial liabilities
After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

Value Added Tax
Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the

capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Foreign currencies
The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March 2015. Resulting exchange gains and losses for either of these are recognised in the Trust's surplus/deficit in the period in which they arise.

Third party assets
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in Note 42 to the accounts.

Public Dividend Capital (PDC) and PDC dividend
Public Dividend Capital represents taxpayers' equity in the NHS Foundation Trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as PDC dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities, except for donated assets and daily average cash balances with the Office of the Paymaster General. The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets. The dividend payable is based on the average relevant net assets for the year.

Losses and Special Payments
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS foundation trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses and compensations register which reports amounts on an accruals basis with the exception of provisions for future losses.

Joint operations
Joint operations are activities undertaken by the Trust in conjunction with one or more other parties but which are not performed through a separate entity.

"The Trust has entered into a joint operation with Mental Health Matters and County Durham & Darlington NHS Foundation Trust to provide services to improve access to psychological therapies (IAPT services). The Trust is the host organisation and only the Trusts share of the income and expenditure; gains and losses; assets and

liabilities; and cash flows are recognised in the accounts. The Trust has not consolidated the joint operation on the grounds of materiality.

The Trust is also Trustee for the “Tees Esk and Wear Valleys NHS Trust General Charitable Fund”, the balances of which are not consolidated with the Trusts accounts on the grounds of materiality."

The Trust is a shareholder in the newly established company "Positive Individualised Proactive Support Limited", however this has not traded in 2014/15, so has no entries consolidated into the 2014/15 Financial Statements.

Pension costs
Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

(a) Accounting valuation

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

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

The valuation of the scheme liability as at 31 March 2015, is based on the valuation data as 31 March 2014, updated to 31 March 2015 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

(b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

NHS pension scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

Annual Pensions

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Pensions Indexation

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) replaced the Retail Prices Index (RPI).

Ill-Health Retirement

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Death Benefits

A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

Additional Voluntary Contributions (AVCs)

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

Transfer between Funds

Scheme members have the option to transfer their pension between the NHS Pension Scheme and another scheme when they move into or out of NHS employment.

Preserved Benefits

Where a scheme member ceases NHS employment with more than two years' service they can preserve their accrued NHS pension for payment when they reach retirement age.

Auto-Enrolment

To comply with auto-enrolment the Trust has opened a second pension scheme, for employees not eligible to be enrolled in the NHS Pension Scheme. The NHS Scheme will always be the default selection, however employees not eligible for membership are entered into the National Employment Savings Trust (NEST) scheme. This is a defined contribution scheme, and as such the cost to the NHS Body of participating in the scheme is equal to the contributions payable to the scheme for the accounting period.

Operating Segments

The Trust has no elements that require segmental analysis for the period ended 31 March 2015. The chief operating decision maker has been identified as the Executive Director Chief Operating Officer post within the Trust; and on this basis the Trust has identified healthcare as the single operating segment.

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

Note 2.1 Operating income (by classification)	**12 months ended 31 March 2015**	**12 months ended 31 March 2014**
Income from activities	**£000**	**£000**
Cost and Volume Contract income	53,887	53,574
Block Contract income	212,332	208,194
Clinical Partnerships providing mandatory services (including S75 agreements)	7,008	8,076
Clinical income for the Secondary Commissioning of mandatory services	1,316	1,809
Other clinical income from mandatory services	3,478	3,293
Total income from activities	**278,021**	**274,946**
Other operating income		
Research and development	843	1,006
Education and training	7,235	6,593
Non patient care services to other bodies	2,344	2,368
Other revenue	273	282
Profit on disposal of assets held for sale	62	111
Reversal of impairments of property, plant and equipment	5,506	5,388
Rental revenue from operating leases - minimum lease receipts	179	100
Income in respect of staff costs where accounted on gross basis	119	180
Total other operating income	**16,561**	**16,028**
Total operating income	**294,582**	**290,974**

Note 2.2 Operating lease income		
	£000	**£000**
Rental revenue from operating leases	179	100
Future minimum lease receipts		
not later than one year;	96	100
later than one year and not later than five years;	68	100
later than five years.	0	0
Total future minimum lease receipts	**164**	**200**

Note 2.3 Non NHS income

The Trust had Non NHS income totalling £15,140k (2013-14, £16,187k)

Note 2.4 Operating income (by type)	12 months ended 31 March 2015 £000	12 months ended 31 March 2014 £000
Income from activities		
NHS Foundation Trusts	872	745
NHS Trusts	12	0
CCGs and NHS England	268,478	264,954
Local Authorities	4,444	5,599
Department of Health - other	0	14
NHS Other	1,193	778
Non NHS Other	3,022	2,856
Total income from activities	**278,021**	**274,946**
Other operating income		
Research & Development	843	1,006
Education and training	7,235	6,593
Non-patient care services to other bodies	2,344	2,368
Other	273	282
Profit on disposal of assets held for sale	62	111
Reversal of impairments of property, plant and equipment	5,506	5,388
Rental revenue from operating leases - minimum lease receipts	179	100
Income in respect of staff costs where accounted on gross basis	119	180
Total other operating income	**16,561**	**16,028**
Total operating income	**294,582**	**290,974**
Analysis of income from activities - non NHS other		
Other government departments and agencies	525	514
Other*	2,347	2,342
	2,872	**2,856**

*Other income is mainly from the Trusts Care UK contract (£1,879k), (2013-14, £1,900k)

Analysis of other operating income - other		
Catering	134	159
Other	139	123
	273	**282**

Revenue is mainly from the supply of services. Revenue from the sale of goods is not material.

Commissioner requested services		
Income from activities from commissioner requested services	268,555	265,243
Income from activities from non-commissioner requested services	26,027	25,731
	294,582	**290,974**

Note 3 Operating expenses (by type)	12 months ended 31 March 2015	Restated* 12 months ended 31 March 2014
	£000	£000
Services from NHS Foundation Trusts	3,787	3,945
Purchase of healthcare from non NHS bodies	1,512	1,603
Purchase of social care (under s.75 or other integrated care arrangements)	639	853
Executive directors costs	1,144	1,198
Non-executive directors costs	168	168
Staff costs	212,892	212,927
Supplies and services - clinical (excluding drug costs)	1,665	1,553
Supplies and services - general	2,854	2,956
Establishment	4,117	4,303
Research and development - (Not included in employee expenses)	220	321
Research and development - (Included in employee expenses)	765	684
Transport (Business travel only)	2,716	2,698
Transport (other)	988	1,097
Premises - business rates payable to local authorities	1,155	1,258
Premises - other	14,190	10,720
Increase in bad debt provision	423	102
Change in provisions discount rate(s)	229	12
Drug costs	3,290	3,456
Inventories consumed (excluding drugs)	182	208
Rentals under operating leases - minimum lease receipts	5,710	5,579
Depreciation on property, plant and equipment	4,247	4,254
Impairments of property, plant and equipment	12,560	4,888
Audit fees		
audit services - statutory audit	47	45
Clinical negligence - amounts payable to the NHSLA (premiums)	665	577
Loss on disposal of assets held for sale	0	5
Legal fees	635	582
Consultancy costs	1,538	896
Training courses and conferences	1,370	1,375
Patient travel	62	57
Redundancy - (Not included in employee expenses)	71	95
Early retirements - (Not included in employee expenses)	82	0
Hospitality	145	156
Insurance	90	76
Other services, eg external payroll	231	230
Losses, ex gratia & special payments- (Not included in employee expenses)	156	105
Other	584	556
Total operating expenses	**281,129**	**269,538**

*Additional classifications for purchase of social care and business rates have resulted in restatements of prior year comparatives.

Analysis of operating expenses - other

Services from local authorities	67	159
Other patients' expenses	239	236
CQC and accreditation fees	87	85
Miscellaneous	191	76
	584	**556**

Note 4.1 Employee expenses

	12 months ended 31 March 2015			12 months ended 31 March 2014		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
	£000	£000	£000	£000	£000	£000
Salaries and wages	176,668	168,819	7,849	177,809	170,661	7,148
Social security costs	12,707	11,969	738	12,652	12,073	579
Pension costs - defined contribution plans (Employers contributions to NHS Pensions)	21,240	20,206	1,034	21,928	21,118	810
Pension Cost - other contributions	9	9	0	7	7	0
Agency/contract staff	4,375	0	4,375	3,346	0	3,346
Gross employee expenses	**214,999**	**201,003**	**13,996**	**215,742**	**203,859**	**11,883**
less income in respect of salaries and wages where netted off expenditure	127	127	0	255	255	0
Total employee expenses	**215,126**	**201,130**	**13,996**	**215,997**	**204,114**	**11,883**
of which:						
Costs capitalised as part of assets	325	325	0	335	335	0
Analysed into Operating Expenditure (page 14):						
Employee Expenses - Staff	212,892	199,066	13,826	213,780	201,978	11,802
Employee Expenses - Executive directors	1,144	1,144	0	1,198	1,198	0
Research & development	765	595	170	684	603	81
Total employee expenses excluding capitalised costs	**214,801**	**200,805**	**13,996**	**215,662**	**203,779**	**11,883**

The salary costs of the capital development team are capitalised over the full costs of the Trust's capital schemes, of which in 2014-15 the largest were The Orchards and West Lane hospital.

Note 4.2 Average number of employees (WTE Basis)

	12 months ended 31 March 2015			12 months ended 31 March 2014		
	Total Number	Permanently Employed Number	Other Number	Total Number	Permanently Employed Number	Other Number
Medical and dental	285	274	11	290	274	16
Administration and estates	1,039	995	44	1,020	1,010	10
Healthcare assistants and other support staff	310	289	21	288	285	3
Nursing, midwifery and health visiting staff	3,167	3,143	24	3,271	3,255	16
Scientific, therapeutic and technical staff	643	637	6	638	608	30
Social care staff	27	0	27	34	0	34
Agency and contract staff	115	0	115	102	0	102
Bank staff	273	0	273	261	0	261
Total	**5,859**	**5,338**	**521**	**5,904**	**5,432**	**472**
of which						
Number of Employees (WTE) engaged on capital projects	7	7	0	7	7	0

Note 4.3 Early retirements due to ill health

During the period to 31 March 2015 there were 16 (2013-14, 12) early retirements from the Trust on the grounds of ill-health. The estimated additional pension liabilities of the ill-health retirement will be £827,272 (2013-14, £1,047,972). The cost of this ill-health retirement will be borne by the NHS Business Services Authority - Pension Division.

Note 4.4 Analysis of termination benefits

There were 7 payments for termination benefits valuing £188,000 during the period to March 2015, 6 relating to redundancy and 1 early retirement in the efficiency of the service (2013-14, 4 payments valuing £95,000).

Note 4.5 Cost of exit packages

	12 months ended 31 March 2015			12 months ended 31 March 2014		
Exit Package Cost	Total number	Compulsory Redundancies number	Other Departures number	Total number	Compulsory Redundancies number	Other Departures number
<10,000	3	3	0	0	0	0
£10,001 - £25,000	2	2	0	3	3	0
£25,001 - 50,000	0	0	0	0	0	0
£50,001 - £100,000	2	1	1	1	1	0
Total number of exit packages	**7**	**6**	**1**	**4**	**4**	**0**
Total resource cost (£000's)	**188**	106	82	**95**	95	0

Note 4.6 Exit packages: other non compulsory

There were no other non compulsory exit packages between 01 April 2014 and 31 March 2015, (2013-14, nil)

Note 4.7 Analysis of off-payroll engagements

Off payroll arrangements are now part of the annual report.

Note 5.1 Operating leases	12 months ended 31 March 2015 £000	12 months ended 31 March 2014 £000
Minimum lease payments	5,710	5,579
Total	**5,710**	**5,579**

Note 5.2 Arrangements containing an operating lease	12 months ended 31 March 2015 £000	12 months ended 31 March 2014 £000
Future minimum lease payments due:		
not later than one year	4,703	4,096
later than one year and not later than five years	6,166	4,842
later than five years	3,365	1,973
Total	**14,234**	**10,911**

The Trust operating leases includes leased vehicles for staff, property rental and telephony rental.

Note 5.3 Limitation on auditor's liability

There is no specified limitation stated in the engagement letter of the Trust's auditors.

Note 5.4 The late payment of commercial debts (interest) Act 1998

The Trust did not pay any interest payable arising from claims or pay compensation to cover debt recovery costs under this legislation (2013-14, £nil).

Note 5.5 Other audit remuneration

The Trust did not pay external auditors any additional remuneration during 31 March 2015 (31 March 2014, £nil). Auditors remuneration for statutory audit is shown in note 3.

Note 6 Discontinued operations

The Trust has no discontinued operations at 31 March 2015 (31 March 2014, £nil).

Note 7 Corporation tax

The Trust has no Corporation Tax liability or asset at 31 March 2015 (31 March 2014, £nil).

Note 8 Finance income	12 months ended 31 March 2015 £000	12 months ended 31 March 2014 £000
Interest on bank accounts	151	84
Total	**151**	**84**

Note 9 Finance costs - interest expense	12 months ended 31 March 2015 £000	12 months ended 31 March 2014 £000
Loans from the Independent Trust Financing Facility	105	0
Finance costs in PFI obligations		
Main finance cost	4,108	4,209
Contingent finance cost	1,183	1,023
Total	**5,396**	**5,232**

Note 10 Impairment of assets	12 months ended 31 March 2015 £000	12 months ended 31 March 2014 £000
Abandonment of assets in course of construction	0	12
Changes in market price	12,560	4,876
Reversal of impairments	(5,506)	(5,388)
Total Impairments charged to operating surplus	**7,054**	**(500)**
Impairments charged to the revaluation reserve	15,596	1,523
Total Impairments	**22,650**	**1,023**

Note 11 Intangible assets

The Trust has no intangible assets as at 31 March 2015 (31 March 2014, £nil).

Note 12.1 Property, plant and equipment 2014-15

	Total	Land	Buildings exc. Dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2014	**237,120**	**11,916**	**221,983**	**0**	**735**	**523**	**84**	**532**	**1,347**
Additions purchased	7,951	0	4,250	0	3,293	87	0	321	0
Impairments charged to operating expenses	(12,560)	0	(12,560)	0	0	0	0	0	0
Impairments charged to the revaluation reserve	(15,596)	0	(15,596)	0	0	0	0	0	0
Reversal of impairments credited to operating income	5,506	0	5,506	0	0	0	0	0	0
Reclassifications	0	0	408	0	(408)	0	0	0	0
Revaluations	3,960	0	3,960	0	0	0	0	0	0
Derecognition *	(2,887)	0	(2,887)	0	0	0	0	0	0
Cost or valuation at 31 March 2015	**223,494**	**11,916**	**205,064**	**0**	**3,620**	**610**	**84**	**853**	**1,347**
Accumulated depreciation at 1 April 2014	**3,208**	**0**	**1,231**	**0**	**0**	**318**	**38**	**355**	**1,266**
Provided during the year	4,247	0	4,014	0	0	61	12	83	77
Derecognition *	(2,885)	0	(2,885)	0	0	0	0	0	0
Accumulated depreciation at 31 March 2015	**4,570**	**0**	**2,360**	**0**	**0**	**379**	**50**	**438**	**1,343**

* Derecognition of valuation and accumulated depreciation is due to a modern equivalent asset valuation.

Note 12.2 Property, plant and equipment 2013-14

	Total	Land	Buildings exc. Dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2013	**211,956**	**11,435**	**193,313**	**0**	**4,739**	**536**	**84**	**456**	**1,393**
Transfers by absorption - MODIFIED	6,886	2,100	4,373	0	0	91	0	322	0
Additions purchased	13,205	0	12,361	0	735	33	0	76	0
Additions - Leased	121	0	121	0	0	0	0	0	0
Impairments charged to operating expenses	(4,888)	(854)	(3,597)	0	(12)	(97)	0	(322)	(6)
Impairments charged to the revaluation reserve	(1,523)	(550)	(973)	0	0	0	0	0	0
Reversal of impairments credited to operating income	5,388	0	5,388	0	0	0	0	0	0
Reclassifications	0	(215)	4,942	0	(4,727)	0	0	0	0
Revaluations	6,390	0	6,390	0	0	0	0	0	0
Transfers to/from assets held for sale and assets in disposal groups	(335)	0	(335)	0	0	0	0	0	0
Disposals	(80)	0	0	0	0	(40)	0	0	(40)
Cost or valuation at 31 March 2014	**237,120**	**11,916**	**221,983**	**0**	**735**	**523**	**84**	**532**	**1,347**
Accumulated depreciation at 1 April 2013	**1,734**	**0**	**0**	**0**	**0**	**281**	**26**	**256**	**1,171**
Provided during the year	4,254	0	3,931	0	0	77	12	99	135
Revaluations	(2,700)	0	(2,700)	0	0	0	0	0	0
Disposals	(80)	0	0	0	0	(40)	0	0	(40)
Accumulated depreciation at 31 March 2014	**3,208**	**0**	**1,231**	**0**	**0**	**318**	**38**	**355**	**1,266**

Note 12.3 Property, plant and equipment financing

Net book value - 31 March 2015	Total	Land	Buildings exc. Dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned	126,327	11,916	110,107	0	3,620	231	34	415	4
PFI	92,597	0	92,597	0	0	0	0	0	0
Net book value total at 31 March 2015	**218,924**	**11,916**	**202,704**	**0**	**3,620**	**231**	**34**	**415**	**4**
Net book value - 31 March 2014									
Owned	128,614	11,916	115,454	0	735	205	46	177	81
PFI	105,298	0	105,298	0	0	0	0	0	0
Net book value total at 31 March 2014	**233,912**	**11,916**	**220,752**	**0**	**735**	**205**	**46**	**177**	**81**

Note 13 Non current assets acquired by government grant

The Trust has no assets acquired by government grant (2013-14, nil).

Note 14 Economic life of property, plant and equipment	Min Life Years	Max Life Years
Buildings excluding dwellings	1	90
Assets under Construction & POA	10	90
Plant & Machinery	1	10
Transport Equipment	1	7
Information Technology	1	5
Furniture & Fittings	1	10

Note 15.1 Land and buildings disposed previously used to provide commissioner requested services

	Total	Land	Buildings exc. Dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value of assets disposed	**135**	0	135	0	0	0	0	0	0
Sale proceeds*	**200**	0	200	0	0	0	0	0	0
Expenditure associated with sale	**(3)**	0	(3)	0	0	0	0	0	0
Profit on sale	**62**	**0**	**62**	**0**	**0**	**0**	**0**	**0**	**0**

* The sale of these assets does not impact on the Trusts ability to meet its obligation to provide commissioner requested services as no sales are authorised without full consideration of the impact on service provision. Services previously provided in these buildings are now delivered within existing Trust estate, or the service has transferred to another provider.

Note 15.2 NBV of property, plant and equipment in the Revaluation Reserve as at 31 March 2015

	Total	Land	Buildings exc. Dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
as at 1 April 2014	**31,242**	964	30,278	0	0	0	0	0	0
movement in year	**(11,636)**	0	(11,636)	0	0	0	0	0	0
as at 31 March 2015	**19,606**	**964**	**18,642**	**0**	**0**	**0**	**0**	**0**	**0**

Note 15.3 NBV of property, plant and equipment in the Revaluation Reserve as at 31 March 2014

	Total	Land	Buildings exc. Dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
as at 1 April 2013	**21,387**	933	20,454	0	0	0	0	0	0
movement in year	**9,855**	31	9,824	0	0	0	0	0	0
as at 31 March 2014	**31,278**	**964**	**30,278**	**0**	**0**	**0**	**0**	**0**	**0**

Note 16 Investments

The Trust holds no investments as at 31 March 2015 (31 March 2014, £nil).

Note 17 Associate and jointly controlled operations

The Trust has no investments in associates or joined controlled operations consolidated in these accounts as at 31 March 2015 (31 March 2014, £nil) on the basis of materiality (as disclosed in note 1).

Note 18.1 Non current assets for sale and assets in disposal groups 2014-15	Total £000	Property, Plant & Equipment £000
NBV of non-current assets for sale and assets in disposal groups at 31 March 2014	**135**	135
Less assets sold in year	**(135)**	(135)
NBV of non-current assets for sale and assets in disposal groups at 31 March 2015	**0**	**0**

Note 18.2 Non current assets for sale and assets in disposal groups 2013-14	Total £000	Property, Plant & Equipment £000
NBV of non-current assets for sale and assets in disposal groups at 31 March 2013	**3,000**	3,000
Plus assets classified as available for sale in the year	**335**	335
Less assets sold in year	**(3,200)**	(3,200)
NBV of non-current assets for sale and assets in disposal groups at 31 March 2014	**135**	**135**

Note 18.3 Liabilities disposal groups

The Trust has no liabilities in disposal groups as at 31 March 2015 (31 March 2014, £nil).

Note 19 Other assets

The Trust has no other assets as at 31 March 2015 (31 March 2014, £nil).

Note 20 Other financial assets

The Trust has no other financial assets as at 31 March 2015 (31 March 2014, £nil).

Note 21.1 Inventories	12 months ended 31 March 2015 £000	12 months ended 31 March 2014 £000
Carrying Value at 1 April	182	208
Additions	171	182
Inventories recognised in expenses	(182)	(208)
Carrying Value at 31 March	**171**	**182**

Note 22 Trade receivables and other receivables

	31 March 2015 £000	31 March 2014 £000
Current		
NHS receivables	2,394	1,870
Other receivables with related parties	497	618
Provision for impaired receivables	(542)	(230)
Prepayments	2,784	2,191
PFI Prepayments		
Prepayments - lifecycle replacements	555	176
Accrued income	60	125
VAT receivable	577	503
Other trade receivables	241	196
Total current trade and other receivables	**6,566**	**5,449**
Non Current		
Other trade receivables	50	53
Total non current trade and other receivables	**50**	**53**

Note 23.1 Provision for impairment of receivables	31 March 2015 £000	31 March 2014 £000
At 1 April	230	197
Increase in provision	542	229
Amounts utilised	(111)	(69)
Unused amounts reversed	(119)	(127)
At 31 March	**542**	**230**

Note 23.2 Analysis of impaired receivables	31 March 2015 £000	31 March 2015 £000	31 March 2014 £000	31 March 2014 £000
Ageing of impaired receivables	**Trade receivables**	**Other receivables**	**Trade receivables**	**Other receivables**
0 - 30 days	457	0	89	0
30-60 Days	85	0	0	0
60-90 days	0	0	0	0
90- 180 days	0	0	141	0
over 180 days	0	0	0	0
Total	**542**	**0**	**230**	**0**
Ageing of non-impaired receivables past their due date				
0 - 30 days	1,187	35	430	56
30-60 Days	101	22	107	17
60-90 days	1	8	45	0
90- 180 days	68	53	85	26
over 180 days	11	9	202	62
Total	**1,368**	**127**	**869**	**161**

Note 24 Finance leases

The Trust does not have any finance lease obligations other than PFI commitments (2013-14, nil).

Note 25.1 Cash and cash equivalents

	12 months ended 31 March 2015 £000	12 months ended 31 March 2014 £000
At 1 April	24,342	23,460
Net change in year	22,805	882
At 31 March	**47,147**	**24,342**
Broken down into:		
Commercial banks and cash in hand	278	100
Cash with Government Banking Service	46,869	24,242
Other current investments	0	0
Cash and cash equivalents as in SoFP	**47,147**	**24,342**
Bank overdraft	0	0
Cash and cash equivalents as in SoCF	**47,147**	**24,342**

Note 25.2 Third party assets held

	12 months ended 31 March 2015 £000	12 months ended 31 March 2014 £000
At 1 April	1,400	1,669
Gross inflows	3,069	3,721
Gross Outflows	(3,289)	(3,990)
At 31 March	**1,180**	**1,400**

Note 26.1 Trade and other payables

Current	31 March 2015 £000	31 March 2014 £000
NHS payables	459	192
Amounts due to other related parties - capital	0	1
Amounts due to other related parties - revenue	2,950	2,974
Other trade payables - capital	861	866
Other trade payables - revenue	3,181	1,349
Social Security costs	2,096	2,111
VAT payable	39	44
Other taxes payable	2,020	2,001
Other payables	34	0
Accruals	8,550	7,409
PDC dividend payable	52	125
Total current trade and other payables	**20,242**	**17,072**

Non current

The Trust has no non current trade and other payables

The Directors consider that the carrying amount of trade payables approximates to their fair value.

Note 26.2 Early retirements detail included in NHS payables above

There were no early retirement costs in the NHS payables balance at 31 March 2015 (2013-14, £nil).

Note 27 Borrowings Current	31 March 2015 £000	31 March 2014 £000
Loans from Independent Trust Financing Facility	3,000	0
Obligations under Private Finance Initiative contracts	2,319	2,138
Total current borrowings	**5,319**	**2,138**
Non current		
Loans from Independant Trust Financing Facility	12,000	0
Obligations under Private Finance Initiative contracts	79,610	81,929
Total other non-current liabilities	**91,610**	**81,929**

PFI borrowings are in relation to Lanchester Road Hospital and Roseberry Park Hospital which all operate under a standard form PFI contract i.e. unitary payments are payable from the date construction completion and are not subject to re-pricing. Inflation linked to RPI is applied annually. Final settlements are expected in May 2038 and March 2040 respectively.

During 2014-15 the Trust receiving a £15,000k loan repayable over 5 years from the Independent Trust Finance Facility (ITFF), which was used to support the Trust's capital programme

Note 28 Other liabilities

	31 March 2015 £000	31 March 2014 £000
Current		
Deferred income - goods and services	385	199
Total other current liabilities	**385**	**199**

Note 29 Other financial liabilities

The Trust has no other financial liabilities at 31 March 2015 (31 March 2014, £nil).

Note 30.1 Provisions for liabilities and charges 2014-15	Total	Pensions other staff	Legal claims	Restructuring	Other
	£000	£000	£000	£000	£000
At 1 April 2014	**1,358**	**1,099**	**259**	**0**	**0**
Change in the discount rate	229	229	0	0	0
Arising during the year	213	0	205	0	8
Utilised during the year - accruals	(284)	(158)	(126)	0	0
Reversed unused	(117)	(53)	(64)	0	0
Unwinding of discount	12	12	0	0	0
At 31 March 2015	**1,411**	**1,129**	**274**	**0**	**8**
Expected timing of cash flows:					
not later than one year	337	55	274	0	8
Current	**337**	**55**	**274**	**0**	**8**
later than one year and not later than five years	222	222	0	0	0
later than five years	852	852	0	0	0
Non Current	**1,074**	**1,074**	**0**	**0**	**0**
TOTAL	**1,411**	**1,129**	**274**	**0**	**8**

Pensions relating to other staff is a provision for injury benefit pensions.

Legal claims relate to the following; employer / public liability claims notified by the NHS Litigation Authority £114,550 (2013-14, £140,185), and the provision for employment law £159,145 (2013-14, £118,450).

Note 30.2 Provisions for liabilities and charges 2013-14	Total	Pensions other staff	Legal claims	Restructuring	Other
	£000	£000	£000	£000	£000
At 1 April 2013	**1,519**	**1,122**	**252**	**145**	**0**
Change in the discount rate	12	12	0	0	0
Arising during the year	311	83	228	0	0
Utilised during the year	(447)	(140)	(168)	(139)	0
Reversed unused	(59)	0	(53)	(6)	0
Unwinding of discount	22	22	0	0	0
At 31 March 2014	**1,358**	**1,099**	**259**	**0**	**0**
Expected timing of cash flows:					
not later than one year	313	54	259	0	0
Current	**313**	**54**	**259**	**0**	**0**
later than one year and not later than five years	217	217	0	0	0
later than five years	828	828	0	0	0
Non Current	**1,045**	**1,045**	**0**	**0**	**0**
TOTAL	**1,358**	**1,099**	**259**	**0**	**0**

Note 30.3 NHSLA provisions for liabilities and charges

£589,225 (2013-14, £266,380) is included in the provisions of the NHS Litigation Authority at 31 March 2015 in respect of clinical negligence liabilities of the NHS Foundation Trust.

Note 31.1 Contingent liabilities	31 March 2015	*Restated 31 March 2014
	£000	£000
Gross value of contingent liabilities	(118)	(172)
Net value of contingent liabilities	**(118)**	**(172)**

*restated following updated guidance

The contingencies relate to employer liability legal cases, all cases relate to the NHSLA and are due within 1 year.

Note 31.2 Contingent assets

The Trust has no contingent assets at 31 March 2015 (31 March 2014, £nil)

Note 32 Revaluation reserve	31 March 2015 £000	31 March 2014 £000
Revaluation reserve at 1 April	**31,242**	**21,387**
Transfers by absorption - MODIFIED	0	2,439
Impairments	(15,596)	(1,523)
Revaluations	3,960	9,090
Transfers to other reserves	0	(151)
Revaluation reserve at 31 March	**19,606**	**31,242**

Note 33.1 Related Party Transactions	Income	Expenditure
2014-2015	**£000**	**£000**
Value of transactions with board members in 2014-2015	0	0
Value of transactions with key staff members in 2014-2015	0	0
Value of transactions with other related parties in 2014-2015		
Department of Health	260	4
Other NHS Bodies	279,182	6,824
Subsidiaries / Associates / Joint Ventures	1,879	350
Other	5,946	36,910
Total	**287,267**	**44,088**
2013-2014		
Value of transactions with board members in 2013-2014	0	0
Value of transactions with key staff members in 2013-2014	0	0
Value of transactions with other related parties in 2013-2014		
Department of Health	349	0
Other NHS Bodies	274,438	6,521
Subsidiaries / Associates / Joint Ventures *	2,058	107
Other	6,797	37,915
Total	**283,642**	**44,543**

*restated to include transactions with joint associates (Care UK)

Note 33.2 Related Party Balances	Receivables	Payables
2014-2015	**£000**	**£000**
Value of balances (other than salary) with board members in 2014-2015	0	0
Value of balances (other than salary) with key staff members in 2014-2015	0	0
Value of balances (other than salary) with related parties in relation to doubtful debts at 31 March 2015	(522)	0
Value of balances (other than salary) with related parties in respect of doubtful debts written off in year at 31 March 2015	0	0
Value of balances with other related parties at 31 March 2015		
Department of Health	1	52
Other NHS Bodies	1,854	911
Subsidiaries / Associates / Joint Ventures	157	0
Other	972	7,570
Total	**2,462**	**8,533**
2013-2014		
Value of balances (other than salary) with board members at 31 March 2014	0	0
Value of balances (other than salary) with key staff members at 31 March 2014	0	0
Value of balances (other than salary) with related parties in relation to doubtful debts at 31 March 2014	(230)	0
Value of balances (other than salary) with related parties in respect of doubtful debts written off in year at 31 March 2014	0	0
Value of balances with other related parties at 31 March 2014		
Department of Health	48	125
Other NHS Bodies	1,733	453
Subsidiaries / Associates / Joint Ventures *	165	0
Other	1,125	8,275
Total	**2,841**	**8,853**

*restated to include transactions with joint associates (Care UK)

During the period none of the Board members or members of the key management staff or parties related to them has undertaken any material transactions with Tees, Esk and Wear Valleys NHS Foundation Trust.

Note 33.3 - Related Party Organisations

Tees, Esk and Wear Valleys NHS Foundation Trust is a corporate body established by order of the Secretary of State for Health.

The Department of Health is regarded as a related party. During the period Tees, Esk and Wear Valleys NHS Foundation Trust has had a significant number of material transactions (total transactions greater than £1,000k) with the Department, and with other entities for which the Department is regarded as the parent department, or a related party. These entities are detailed in the table below (income and expenditure totals are for the accounting period, receivables and payables balances are at 31 March 2015):

Entity	Income £000	Expenditure £000	Receivables £000	Payables £000
Cumbria, Northumb, Tyne & Wear Area Team	48,432	0	281	0
NHS Durham Dales, Easington And Sedgefield CCG	46,790	0	0	0
NHS South Tees CCG	42,480	0	109	50
NHS North Durham CCG	36,257	0	82	0
NHS Hartlepool And Stockton-On-Tees CCG	33,982	0	94	0
NHS Hambleton, Richmondshire And Whitby CCG	15,142	65	303	0
NHS Darlington CCG	13,691	0	0	0
NHS Harrogate And Rural District CCG	13,452	62	0	0
NHS Scarborough And Ryedale CCG	12,592	57	51	0
Health Education England	7,170	14	328	28
NHS Leeds North CCG	1,153	0	6	0
NHS Vale Of York CCG	1,138	0	0	166
Durham, Darlington & Tees Area Team	1,098	0	0	0
NHS England - Core	1,004	0	123	43
South Tees Hospitals NHS Foundation Trust	231	1,396	20	99
Harrogate and District NHS Foundation Trust	49	1,008	17	3
Other DH Group	4,781	4,226	441	574

In addition, the Trust has had a number of material transactions (total transactions greater than £1,000k) with other Government Departments and other central and local Government bodies. These are detailed in the table below:

Entity	Income £000	Expenditure £000	Receivables £000	Payables £000
Durham County Council	2,240	777	181	63
NHS Pension Scheme	0	21,240	0	2,851
HM Revenue & Customs	0	12,707	0	4,116
Other Government Bodies	3,706	2,220	791	540

Note 34 Contractual capital commitments	31 March 2015 £000	31 March 2014 £000
Property, plant and equipment	6,913	2,156
Total as at 31 March	**6,913**	**2,156**

Note 34.2 Other Financial Commitments
The Trust has no other financial commitments as at 31 March 2015 (31 March 2014, £nil).

Note 35 Finance lease obligations
The Trust has no finance lease obligations as at 31 March 2015 (31 March 2014, £nil).

Note 36.1 PFI obligations (on Statement of Financial Position)	31 March 2015 Total £000	31 March 2015 Lanchester Rd PFI £000	31 March 2015 Roseberry Park PFI £000	31 March 2014 Total £000
Gross PFI liabilities	**204,237**	**40,756**	**163,481**	**215,120**
of which liabilities are due				
not later than one year	7,577	1,477	6,100	7,428
later than one year and not later than five years	31,265	5,854	25,411	31,263
later than five years	165,395	33,425	131,970	176,429
Finance charges allocated to future periods	(122,308)	(25,144)	(97,164)	(131,053)
Net PFI liabilities	**81,929**	**15,612**	**66,317**	**84,067**
not later than one year	2,319	486	1,833	2,138
later than one year and not later than five years	9,874	1,828	8,046	9,560
later than five years	69,736	13,298	56,438	72,369
	81,929	**15,612**	**66,317**	**84,067**

Note 36.2 On SoFP PFI commitments	31 March 2015 Total £000	31 March 2015 Lanchester Rd PFI £000	31 March 2015 Roseberry Park PFI £000	31 March 2014 Total £000
Commitments				
not later than one year	2,563	408	2,155	2,507
later than one year and not later than five years	11,071	1,738	9,333	10,824
later than five years	79,992	11,130	68,862	82,500
Total	**93,626**	**13,276**	**80,350**	**95,831**

The Trust have full control of clinical services provided from PFI funded hospitals, and full access and use of the buildings, which are maintained by the PFI project companies as part of the PFI procurement contract.

PFI project companies provide services for “hard” facilities management including building maintenance and life cycle replacement programmes. A contractual commitment exists for the PFI project companies to maintain the building at “category b” status for the contract life (30 years from commencement for Lanchester Road and 30 years from financial close for Roseberry Park).

The contract can be terminated within the 30 year contract period if contractual obligations for service delivery (maintenance) and building availability are not met. This is controlled by a points based payment deduction methodology within the standard PFI contract. The Trust have the right to cease the contract early, subject to payment of a financial penalty.

Note 37 Off-SoFP PFIs commitments
The Trust has no off-SoFP PFIs as at 31 March 2015 (31 March 2014, £nil).

Note 38 Events after the reporting period
The Trust has no events after the reporting period.

Note 39.1 Financial assets by category	Total	Loans and receivables
Assets as per SoFP	**£000**	**£000**
NHS Trade and other receivables excluding non financial assets (at 31 March 2015)	2,700	2,700
Cash and cash equivalents at bank and in hand (at 31 March 2015)	47,147	47,147
Total at 31 March 2015	**49,847**	**49,847**

	Total	*Restated loans and receivables
	£000	**£000**
NHS Trade and other receivables excluding non financial assets (at 31 March 2014)	2,632	2,632
Cash and cash equivalents at bank and in hand (at 31 March 2014)	24,342	24,342
Total at 31 March 2014	**26,974**	**26,974**

*restated following additional guidance

Note 39.2 Financial liabilities by category	Total	Other financial liabilities
	£000	**£000**
Borrowings excluding Finance lease and PFI liabilities (at 31 March 2015)	15,000	15,000
Obligations under PFI, LIFT and other service concession contracts (at 31 March 2015)	81,929	81,929
NHS Trade and other payables excluding non financial assets (at 31 March 2015)	16,035	16,035
Provisions under contract (at 31 March 2015)	115	115
Total at 31 March 2015	**113,079**	**113,079**

	Total	*Restated other financial liabilities
	£000	**£000**
Obligations under PFI, LIFT and other service concession contracts (at 31 March 2014)	84,067	84,067
NHS Trade and other payables excluding non financial assets (at 31 March 2014)	12,791	12,791
Provisions under contract (at 31 March 2014)	140	140
Total at 31 March 2014	**96,998**	**96,998**

*restated following additional guidance

Note 39.3 Fair values of financial assets at 31 March 2015	Book Value	Fair Value
	£000	**£000**
Non current trade and other receivables	50	50
Total	**50**	**50**

Note 39.4 Fair values of financial liabilities at 31 March 2015	Book Value	Fair Value
	£000	**£000**
Loans	12,000	12,000
Total	**12,000**	**12,000**

Note 39.5 Maturity of Financial liabilities	31 March 2015	*Restated 31 March 2014
	£000	**£000**
In one year or less	21,469	15,068
In more than one year but not more than two years	5,429	2,319
In more than two years but not more than five years	16,445	7,242
In more than five years	69,736	72,369
Total	**113,079**	**96,998**

*restated following additional guidance

Note 40 On SoFP pension schemes

The Trust does not operate an on-statement of financial position pension scheme. Refer to note 1 for details.

Note 41 Losses and special payments

NHS Foundation Trusts are required to report to the Department of Health any losses or special payments, as the Department still retains responsibility for reporting these to Parliament.

By their very nature such payments should not arise, and they are therefore subject to special control procedures compared to payments made in the normal course of business.

These amounts are reported on an accruals basis, but exclude provisions for future losses.

A breakdown of losses and special payments recognised by the trust is below:

At 31 March 2015	Number of cases	Value £000
Losses		
Cash losses	0	0
Special payments		
Ex gratia payments	58	15
Total at 31 March 2015	**58**	**15**

At 31 March 2014	Number of cases	Value £000
Losses		
Cash losses	5	0
Special Payments		
Ex gratia payments	55	8
Total at 31 March 2014	**60**	**8**

Note 42 Third party assets and liabilities

The Trust held £715k cash at bank and in hand at 31 March 2015 (31 March 2014, £973k) which related to monies held by the NHS Trust on behalf of patients. This has been excluded from cash at bank and in hand figure reported in the accounts.

The Trust held £465k cash at bank and in hand at 31 March 2015 (31 March 2014, £426k) which related to monies held by the Trust for a staff savings scheme. This has been excluded from the cash at bank and in hand figure reported in the accounts.

Note 43 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Due to the continuing service provider relationship that the NHS Foundation Trust has with Clinical Commissioning Groups and the way those Clinical Commissioning Groups are financed, the NHS Foundation Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Foundation Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Foundation Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Market risk

The main potential market risk to the Trust is interest rate risk. 100% of the Trust's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest. Tees, Esk and Wear Valleys NHS Foundation Trust is not, therefore, exposed to significant interest-rate risk.

Credit risk

Credit risk exists where the Trust can suffer financial loss through default of contractual obligations by a customer or counterparty.

Trade debtors consist of high value transactions with Clinical Commissioning Groups under contractual terms that require settlement of obligation within a time frame established generally by the Department of Health. Due to this the credit risk exposure is not significant.

Credit risk exposures of monetary financial assets are managed through the Trust's treasury policy which limits the value that can be placed with each approved counterparty to minimise the risk of loss. The counterparties are limited to the approved financial institutions with high credit ratings. Limits are reviewed regularly by senior management.

Liquidity risk

The Trust's net operating costs are mainly incurred under legally binding contracts with Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. This provides a reliable source of funding stream which significantly reduces the Trust's exposure to liquidity risk.

The Trust also manages liquidity risk by maintaining banking facilities and loan facilities to meet its short and long term capital requirements through continuous monitoring of forecast and actual cash flows.

In addition to internally generated resources the Trust has a working capital facility of £20,500,000, unused at 31 March 2015.

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

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