NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Annual report and accounts 2017/18

Making a difference together

Tees, Esk and Wear Valleys NHS Foundation Trust

Annual report and accounts 2017/18

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

Contents

Foreword by the Chairman and Chief Executive

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Reviewing the past
In 2018 the NHS celebrates its 70th anniversary and it's an opportunity for us to recognise the tremendous work our staff do every day to support the people who use our services.

It's been a busy and, at times, difficult year but time and time again our staff have risen to the challenges and have gone that extra mile. Although we haven't met all our targets we've achieved a great deal (despite significant pressure on our services) and we're very proud of the positive difference our staff have made.

Our staff are our most important asset and it's important that we support them. In December 2017 we achieved gold accreditation from the internationally recognised **Investors in People**. This is a significant achievement as the Gold Standard is only expected to be awarded to the top 2% of organisations that are assessed.

Over the last twelve months we've continued to work with service users, their carers, staff, partner organisations and commissioners to modernise existing services, to develop new and innovative ways of working and to take on responsibility for (and to transform) new services. Our aim is always to make the most of our resources to minimise the impact that mental illness or learning disability has on a person's life.

The way that some mental health and learning disability services are commissioned is changing. An example of this is the introduction of the **new care models for tertiary mental health services**, which are being piloted across the country and which see provider trusts taking over responsibility for the commissioning budget. Last year we started to see a real positive impact from the work we're doing as part of the pilot in **children and young people's services**– fewer young people are being admitted to hospital and, if admission is necessary, we're providing beds nearer to home for more young people. In June our joint application with Northumberland, Tyne and Wear NHS Foundation Trust to be part of wave two, with **adult secure services**, was successful. We hope to build on the work we've done to date in wave 1 to improve adult secure services across our patch.

In February we took over responsibility for **mental health and learning disability services in Pocklington**, which had previously been provided by Humber NHS Foundation Trust on behalf of the Trust and we would like to welcome staff to the Trust.

Work has also started with partners in both Yorkshire and Humber and the North East and North Cumbria region to deliver a new **forensic child and adolescent mental health (FCAMH) service.** This is a new service commissioned by NHS England and is part of the children and young people's mental health transformation programme, aiming to establish FCAMH services across England.

Our staff are passionate about promoting recovery and wellbeing and this means supporting service users to achieve the goals they've set themselves. People tell us that wherever possible they want to receive the care and support they need at home and strengthening our community services is one of our priorities.

Following extensive engagement with local people, including a formal public consultation, NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group (CCG) gave the go ahead for us to transform **mental health services for adults and older people in Hambleton and Richmondshire**. We're now developing plans to strengthen our community mental health services for adults and older people, so that more people can be supported at home, and for moving inpatient care from the Friarage Hospital in Northallerton to more modern inpatient environments. In the future those people who cannot be supported at home will be admitted to their nearest mental health hospital (either Roseberry Park in Middlesbrough or West Park Hospital in Darlington). A small number of people with severe dementia will be admitted to Auckland Park Hospital in Bishop Auckland, the nearest specialist hospital.

In July 2017 the planned development of the new mental health hospital for **Harrogate** was put on hold to undertake a thorough review of options for **developing mental health service for adults and older people** in the area. The decision was made by the Trust and NHS Harrogate and Rural District Clinical Commissioning Group (CCG) as a result of significant financial pressures across the local NHS. We appreciate this was disappointing news for many people. However, it's important that we make best use of our resources and this pause gives us the opportunity to think about how we could do things differently (and hopefully better). We've involved local people in these discussions and this work is continuing into 2018/19.

One of the major setbacks of 2017/18 was finding out that significant work is required to fix a number of construction defects at **Roseberry Park** in Middlesbrough, including problems with the hospital's fire safety system. We took immediate action to mitigate the risks and to address the safety of service users, staff and visitors whilst they're in Roseberry Park. However, these are not long term solutions and since then we've been working with the PFI provider, fire safety and other construction experts to try to establish what is needed to resolve the problems and the most effective way of doing so. This work continues and we remain committed to doing all we can to make sure all works are completed as efficiently as possible with the least disruption to service users, their families and staff.

Our work to improve the environment for services users and staff continues and last year we were granted planning permission for our **new hospital in York**. The 72 bed hospital will be located off Haxby Road in the city. It will provide two adult, single sex wards and two older people's wards.

In October 2017 we also opened our largest **mental health community hub in York.** Huntington House opened following an extensive renovation programme and is the base for around 250 staff from nine clinical teams. It was specifically designed to improve access and to help teams work more closely together.

You can read more about our key developments and improvements in the performance report and in the quality report.

Looking to the future
There is no doubt that next year will be challenging for TEWV although, thanks to the hard work of our staff, we start the year in a good position.

Our key priorities for the coming year are

- A continuing focus on promoting Recovery;
- A continuing focus on improving the quality of our services;
- A continuing focus on ensuring that our services are purposeful and productive;
- A focus on supporting the whole health and social care system to work in a more integrated; effective and efficient way in each local health economy that we contribute to.

We will continue to play our part in the changing landscape of commissioning. We will build on the great work we've done with the new care models in children and young people's services and hope to replicate this in adult secure services by reducing lengths of stay and developing a new step down facility in the community.

We will also work with our clinical commissioning groups to develop accountable care partnerships. The ultimate aim is to improve the quality of care for people with learning disability and mental ill health by improving the way services are commissioned.

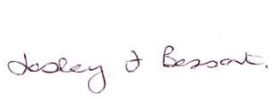
It's important that we make the best of the existing and new technology available to us and over the coming years we'll be working with clinicians to improve our patient record system, PARIS. We want to minimise the time staff spend inputting to patient records and maximise the time they're able to spend with patients. We also want to improve the links between our systems and those in GP surgeries and hospitals and, in the future, want to be able to give patients online access to their own records.

It's important that we listen to people – service users, carers and staff. However, it's more important that we act on what people tell us and we recognise that there is more we can do to use the feedback we receive to improve.

Over the coming year we aim to make better use of the feedback we receive from service users and carers to improve people's outcomes and experience of our services. We will also build on the work we've done to date to involve people with lived experience in developing our services.

Our board of directors has also become increasingly concerned about the feedback we've received from black and minority ethnic staff as well as those with a disability. Statistics shows us that they have a less positive experience of working at TEWV than other staff and this is something we need to address in 2018/19.

These are challenging times for the NHS. However, with the continued support of our service users, carers, staff, governors, partner organisations and commissioners we will continue to do all we can to provide the best possible care for the people who need our services.



Lesley Bessant
Chairman
22 May 2018

Colin Martin
Chief Executive
22 May 2018

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

The performance report

The performance report

Overview of performance

Purpose

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

Statement from the Chief Executive

Overall our performance for the year was good, despite the pressures and challenges facing the organisation. We met our financial requirements and continued to improve against a number of key performance targets. We met our mandatory and statutory training targets and our appraisal levels were the highest they have been for three years. We have seen an increase in our IAPT recovery rates and the number of people admitted out of area has decreased significantly.

Colin Martin
Chief Executive **22 May 2018**

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 gained responsibility for services in Harrogate, Hambleton and Richmondshire and in October 2015 we took over the contract for mental health and learning disability services in the Vale of York.

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

We provide a range of inpatient and community mental health and learning disability services for approximately two million people of all ages living in

- County Durham and Darlington
- The four Teesside boroughs of
    - Hartlepool
    - Stockton-on-Tees
    - Middlesbrough
    - Redcar and Cleveland
- North Yorkshire
    - Scarborough, Whitby, Ryedale

- Hambleton and Richmondshire
- Selby and Harrogate

The city of York

- The Pocklington area of East Yorkshire
- The Wetherby area of West Yorkshire

Our children and young people's wards, our adult inpatient eating disorder services and our adult secure (forensic) wards serve the whole of the North East and North Cumbria. We also provide mental health care within prisons located ni North East England, Cumbria and Lancashire.

The area we serve

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 towards our five strategic goals (see below).

Our values

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

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

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

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

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

Our goals

We have five strategic goals

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

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

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

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

Strategic Goal 5
To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of the communities we serve

The Trust has a number of strategies that set out our high level approach to achieving our strategic goals. There are Trust strategies covering recovery, quality, workforce, leadership development, equalities, finance, digital transformation and data quality. Some of these are being implemented through Trust-wide programmes, linked to our business plan priorities (e.g. recovery and digital Transformation). Others are being driven forward by Trust-wide steering groups who ensure the strategies influence new policies and processes that change the way our core work is delivered.

Our business model focusses on delivering our mission and vision. The Trust assesses opportunities to bid for new business against a range of criteria to ensure that we do not divert resources from our core purpose unnecessarily. The Trust has set up two subsidiary companies where market failure outside our core business was introducing significant clinical or financial risk to our core work. In 2014 we set up Positive Individual Proactive Support Limited (PIPS) in 2014 to address a gap in market provision for social care for individual service users with highly complex health and social care needs. We have also recently created a second subsidiary, TEWV Estates and Facilities Management Ltd to mitigate the risks caused by the winding up of Carillion.

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

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

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

There is a fifth directorate covering forensic services.

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

- adult mental health services
- 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 although we do not provide child learning disability services in Harrogate, Hambleton and Richmondshire)
- adult learning disability services

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

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

The annual governance statement describes the systems and processes through which risks are identified, managed and mitigated. This can be found in the Accountability Report.

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

Potential changes to service models and the provider landscape
In its "Five Year Forward View", published in October 2014, NHS England set out its vision for the future of the NHS. This has been built upon in further guidance/publications including Future in Mind, the Mental Health Five Year Forward View, the Transforming Care for People with a Learning Disability guidance and guidance on the development of Sustainable Transformation Plans (STP)/ Integrated Care Systems

These documents highlight the importance of the following:
- The need to have parity of esteem for mental health and to develop new services which support the wider health and social care economy
- The importance of prompt access to services
- The greater integration of services and how this can be achieved through new models of care
- A reduction in the over reliance on inpatient services with more people being supported in the community

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

The need to ensure parity of esteem nationally is welcome, as is the additional resource that has been identified to support the delivery of the Mental Health 5 Year Forward View and Future in Mind. However there are two risks associated with this. The first being that, whilst CCGs may allocate resources to mental health that meet the national Mental Health Investment Standard, this is not used to deliver the requirements within the guidance. This could result in key new services not being available at the anticipated levels. The second is a risk that the workforce required to implement the ambitions within the various pieces of guidance is not available or that

it leads to a reduction in the workforce in 'core' services as staff are attracted to 'new cutting edge services'.

The drive to improve access to services, both community and inpatient, is also welcome and indeed the Trust has prioritised access to services for a significant number of years. However there are risks that the national targets set do not reflect the starting points of services, that the national construction of the targets is not in line with local service models and the national targets are not achievable due to a shortage in staff with appropriate skills. This could result in the Trust not meeting the governance requirements of NHS Improvement's Single Oversight Framework.

The drive for integration of services and the development of larger planning footprints via the STPs/Integrated Care Systems has gathered pace. Whilst planning on larger footprints is essential for some services, such as inpatient and more specialist services eg perinatal services, for the vast majority of services delivered by mental health providers it is often more appropriate to plan and deliver on much smaller footprints. Furthermore the STP/Integrated Care System boundaries are not aligned to those of the Trust meaning that we are part of 4 different Integrated Care Systems. This complexity creates a number of risks for the organisation including the ability to deliver service models across the Trust geography whilst ensuring these link to the wider STP/ICS's plans and the ability to interface at appropriately senior levels with the STP/ICS's development.

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

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

In response to the above risks and uncertainties:

- The Board continues to keep abreast of changes to the wider environment and the implications of the key external environmental drivers such as the Five Year Forward View, the Mental Health 5 Year Forward View and the Learning Disability Transforming Care agenda and has taken them into consideration in developing its Annual Operational/Business Plan
- The Trust continues to actively engage with the development of the 4 STP/ICS's within which it operates taking a proactive role in the Mental Health and Learning Disability Programmes within these.
- In conjunction with CCGs and Local Authorities the Trust is developing two Accountable Care Partnership (ACP) approaches to the commissioning and delivery of Mental Health and Learning Disability Services in County Durham and Tees Valley and in North Yorkshire. The County Durham and Tees Valley ACP has been operating for over a year and initially focused on Learning Disabilities, however it has been agreed to widen this to include Mental

Health. In North Yorkshire the work is in an early stage of development however it has been agreed it will cover Mental Health and Learning Disability services.

- In partnership with Northumberland Tyne and Wear NHS Foundation Trust and NHS England the Trust has developed a North East and Cumbria Specialised Services Partnership Board which incorporates two New Care Models for the Trust covering Children and Young Peoples Tier 4 services (inpatient beds) and Adult Secure Services. Within these NCMs the Trust has taken on responsibility for the management of the specialised services budget with a view to reducing the need for inpatient beds, providing more support in the community and preventing the need for people to be admitted to beds out of area.
- The Trust continues to engage with commissioners on the development of services outlined in the policy documents
- The Trust has active engagement in the North East and Yorkshire and Humber Transforming Care Boards and continues to work with commissioners on the development of a robust learning disability community model that will allow more individuals to be cared for in the community whilst also ensuring that the required number of inpatients beds can be provided in a financially sustainable way
- The Trust continues to work with commissioners to ensure that they meet the national mental health investment standard and has agreed a ring fence approach, linked to the ACPs, to the total mental health and learning disability commissioning budget with a number of CCGs.

The Financial Challenge

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

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

- Whilst funding for NHS services has been ring-fenced, this is not the case for our partners e.g. local authorities. The savings they are required to make will create financial pressures for us going forward.
- The Government announced that by 2020 additional funding of £10 billion more a year, in real terms, would be provided to the NHS compared to 2014-15.
- More recently in the autumn 2017 budget a further additional £3 bn of revenue funding was allocated to support under pressure NHS finances.
- NHS Improvement quarter3 forecast for NHS Providers is expected to be around £900m deficit mainly as a result of the financial performance of Acute Trusts. This position may deteriorate further in quarter4 and includes the £1.8bn Sustainability and Transformation funding. The planned deficit for 2017/18 was £496m.
- The autumn budget also announced an additional £3.5bn of national capital funding to support longer term system transformation schemes, and which are part of local health sustainability and transformation plans (STPs).

- There continues to be risks that the new funding provided will be focussed on reducing the deficit of the Acute sector at the expense of Mental Health and Learning Disability services.
- Training monies have been excluded from the NHS ring-fence; compounding the impact of recent reductions in training funding.

To seek to mitigate these risks we will:

- Continue to improve the productivity of our services using our well established quality improvement system.
- Continue to work with partners to seek to develop ways of providing services which meet the needs of each organisation whilst maintaining service quality.
- Continue to assess and monitor the impact of proposals for efficiency savings to ensure that they do not impact, adversely, on the quality of our services.

With regard to training:

- Develop a revised approach to how our Training Needs Analysis is compiled and monitor its effectiveness to ensure that we obtain maximum value for money from our investment in training activities.
- Pay constant attention to how we secure vocational training at the lowest cost whilst ensuring that we provide access to good quality training for non-registered staff.
- Develop a Trust approach to making the most of opportunities afforded by the introduction of the apprenticeship levy.

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

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

Recruitment and Retention of Staff

The Trust has found it harder to recruit to a range of healthcare professional posts in recent years albeit with some degree of variation. Our ability to access the right number and quality of clinical staff has been identified as being a key workforce risk for the Trust.

We also believe that the level of risk concerning the maintenance of appropriate future workforce supply could increase given the age profile of clinical staff, which is expected to result in an increase in the number of retirements on age grounds over the next two years. Age retirement is the single biggest reason for staff leaving the Trust, at one in five of all leavers.

Progress has been made during the last year to improve the ability of the Trust to recruit healthcare professional staff and recruitment fill rates are increasing. We recognise however, that there does need to be a greater focus upon improving our ability to retain staff. Though the Trust's staff retention rate compares well to those of its peer organisations it is believed that there is scope for further improvement and

relying upon efforts to increase the number of new recruits only will not be enough given NHS-wide staff shortages.

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

- Has reviewed and updated its recruitment and retention action plan
- Has identified and implemented revised and innovative recruitment processes and incentives
- Has invested in a new recruitment information tracking system to improve understanding of performance and related decision making
- Is embedding efforts to have earlier and more effective engagement with student nurses within the Trust's boundaries and elsewhere
- Has implemented and is evaluating measures to help improve the Trust's supply of temporary staffing
- Is developing new roles and career paths within the Trust and participating in the piloting of nationally developed nursing associate and physician assistant roles
- Is reviewing how staff health and wellbeing activities can assist efforts to improve staff retention
- Is reviewing Trust communications as part of efforts to increase engagement with staff

The impact of Brexit upon the NHS workforce is not yet clear and the Board will be keeping this issue under close scrutiny, particularly in terms of its possible effect on our ability to recruit and retain staff.

Demography and Demand risks

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

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

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

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

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

Roseberry Park Hospital

Roseberry Park Hospital in Middlesbrough is one of the Trust's major inpatient and operational hubs and serves mainly the populations of Teesside and also provides specialist forensic services.

It was purpose built, using the government's Private Finance Initiative, and opened in 2010.

Since the building was handed over to the Trust there have been a number of construction details and problems with the facilities management services on site.

The Trust has used the contractual framework available to try to seek resolution to these issues; however, there are still a large number of defects to be dealt with.

In addition to the wide range of issues identified, the PFI partners informed the Trust in June 2016 that there were a number of defects with the fire safety systems in the hospital. The Trust worked with Cleveland Fire Brigade and immediately implemented a number of measures that mean that services can still be provided from the site. However, these measures are not long term solutions and a range of rectification works will be required to address these critical issues.

The Trust has been working with a range of technical experts to highlight solutions – including the installation of a mist suppression system. A block (5) has been evacuated and patients have been transferred to Hartlepool to allow the team to undertake a range of intrusive surveys. This will inform the scope, cost and timescales associated with fixing the hospital. This information will be subject to a business case in May 2018.

This work continues and we remain committed to doing all we can to make sure all works are completed as efficiently as possible with the least disruption to service users, their families and staff.

Regulatory requirements

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

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

Going Concern

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

The 2018-19 annual plan provides for a surplus of £8.6m (2.5% of turnover) and reflects a significant level of non-recurrent expenditure. The directors view is that the

Trust is a going concern and can make the disclosure as recommended by the accounting standards board that:

“After making enquiries the directors have a reasonable expectation that the Tees, Esk and Wear Valleys NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason they continue to adopt the going concern basis in preparing the accounts”.

Performance analysis

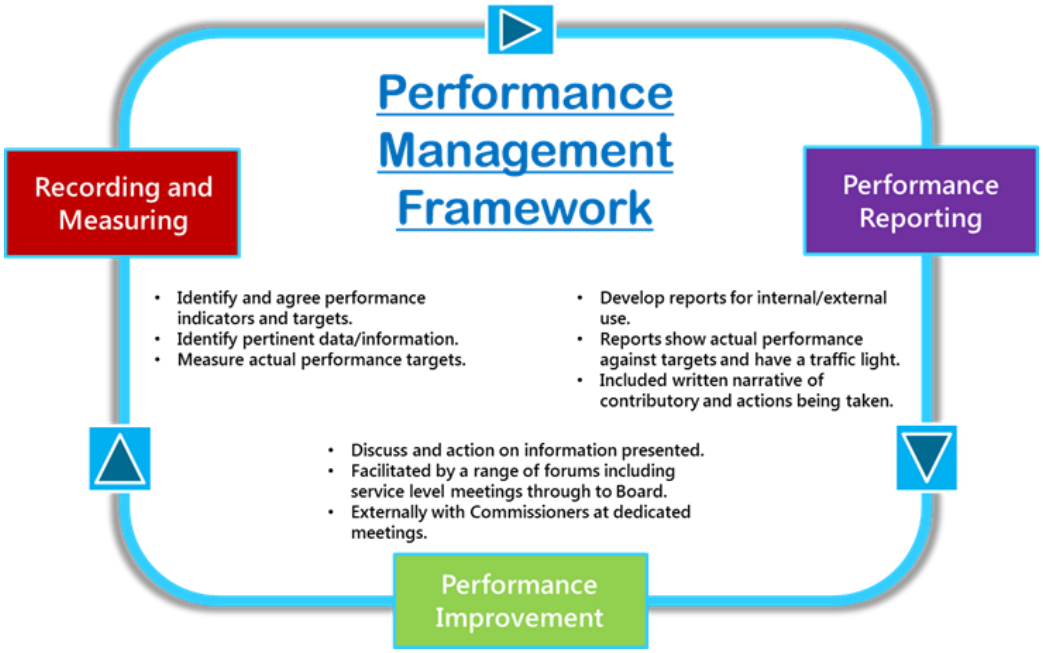
How we measure our performance

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

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

The Board of Directors discusses the "Trust dashboard" each month in terms of areas of good practice but also areas where improvement is needed. If there are any areas where the Trust is significantly underperforming the Board of Directors may request further analysis and/or an action plan if it feels this is necessary. If the Board of Directors' identify any trends which could impact on the Trust and operational delivery then this would be escalated within the risk management processes.

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



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

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

- The availability of 'real time data' for use by the clinical services for clinical and business purposes. Staff are able to access the IIC at any time of day and can interact with the information it contains.
- The availability of information from different source systems in one integrated system.
- The ability to drill down to the lowest level of data available (according to access rights). This means that managers can drill down from service level reports into individual patient or staff information.
- The ability of the IIC to send prompts to staff that an area of performance is about to breach built-in standards.
- It allows our approach on performance management to move from a "reactive" to a more "proactive" one, both in the way we manage performance data in our team and in the way we engage with clinical services.

How we performed

Key developments during 2017/18

During 2017/18 the Trust has implemented its business plan and quality account priorities. These priorities were identified during 16/17 as the initiatives required by

changes in the environment that the Trust operates in, and to ensure that we move towards our strategic goals (which in turn underpin our mission and vision)

Some of these priorities are Trust-wide, long-term initiatives, being delivered through programme management arrangements. These programmes are delivering changes that are vital for long term financial, quality and access expectations to be met.

For example, our recovery programme focused on developing experts by experience to take paid and voluntary roles in staff training and service delivery. It started to train staff in trauma-informed care, and commenced work with a pilot team on designing a recovery-oriented team accreditation system. It also progressed our physical and online recovery colleges. The benefits from this work will accrue in the long term, as cultural change among staff and service users promotes resilience, and as we are able to identify processes that do not add value to patients and eliminate or reduce these.

Our purposeful and productive community services (PPCS) programme is intended to bring about short-medium term gains in quality and efficiency. In 17/18 a number of products were produced which will help teams to improve their efficiency and effectiveness – these included coaching training, electronic diary management, daily huddles (to keep track of team progress and to allocate work), an online caseload management tool and a review of admin roles. This is already starting to feed through into quality improvements and financial savings, but further progress will be made as a result of the work started in winter 2017/18 by 12 pilot teams. These teams are going to try out different ways of working, and in particular test out ways of reducing time spent entering data into computers and using ICT to cut the time spent travelling to meetings.

The Trust's right staffing programme delivered changes that sought to reduce the risk of insufficient clinical staffing being available on inpatient wards. The Trust improved the usage of electronic rostering and its escalation processes. An attempt to improve the way in which the trust rosters agency staff was only partially successful, and lessons are being learned about how to make this process more reliable. The Trust has also identified that improved retention and recruitment are vital to ensure we always have the right staff in the right place, at the right time with the right skills. We supported Sunderland University's successful bid to become a medical school (which will include a specialism in psychiatry) and are working with other providers to increase mental health and learning disability nursing places.

We also continued to improve our inpatient services. This included our model wards programme in forensic services and our ongoing purposeful inpatient admission process in other wards. This process helps us to reduce waits for patients, and hence speeds up discharge. This approach has been successfully implemented in our York wards within the last year, helping to reduce out-of-locality placements for York and Selby patients. We also delivered a number of service changes which are helping to reduce admissions, such as adult learning disability crisis teams in Durham, Darlington and Teesside. However, perhaps the most significant example in the past year has been the work enabled by our participation in a children and young people's new care models pilot. Through this we have moved resources away from expensive out-of-area inpatient beds and into crisis and intensive home treatment

teams. These have helped to reduce admissions and the length of stay for children who have been admitted.

The Trust has also made good progress in addressing substandard inpatient estate within the localities covered by the recent expansion of the Trust. Agreement has been reached with the relevant CCG for adults and older people from Hambleton and Richmondshire to access beds at the modern West Park Hospital in Darlington, Auckland Park Hospital in Bishop Auckland and Roseberry Park Hospital in Middlesbrough. The Trust has also purchased a site at Haxby Road in York which will be the site for a new 72 bed hospital for adults and older people (which will open in 19/20). The Trust's engagement with service users and other stakeholders in York and Selby has been helpful in contributing to the choice of site and the design of the new facility. Progress is already being seen on the ground in York where the Trust's new community team base, Huntingdon House opened in Autumn 2017, and where we have delivered increases in quality and decreases in waiting times in most services. The main challenge for the Trust is now to engage with the Harrogate and Rural District CCG and the stakeholders in that locality to develop options that will allow the Trust to improve quality and ensure system-wide financial sustainability in the long term. Our engagement with stakeholders commenced in 17/18 and this will remain one of our key priorities over the medium term.

As well as the gains made by the CYP New Care Models programme mentioned above, the Trust was also successful in its application (jointly with Northumberland Tyne and Wear NHS Found Trust – NTW FT) to become an Adult Secure New Care Models pilot. This announcement came relatively late in 17/18 but by the end of the year the new systems to work with NTW FT to jointly manage beds and to bring out-of-area patients back into the North East had commenced. The Trust is also progressing Accountable Care Partnership proposals with commissioners in the North East and North Yorkshire. In 17/18 initial work in Durham, Darlington and Teesside led to reviews of over 60 adult learning disability packages / placements, with significant quality and financial gains resulting. This work will continue into 18/19 and beyond.

The Trust also delivered the quality improvement priorities set out in its Quality Account. In particular, the Trust has started to see a reduction in the number of falls causing harm to patients, following 2 years of focus on this in our quality account.

Performance against key targets

The scorecard below is the Trust's dashboard of key performance indicators for 2017/18. The Board received a monthly performance report during 2017/18 which contained performance against this range of indicators.

1.Activity	2017/18 Actual	2017/18 Target	2016/17 Actual	Change on 16/17*	Comment on 2017/18
Total number of external referrals into Trust services test	105,573	91,759	100,109	↓	
Caseload Turnover	3.94%	1.99%	2.39%	↓	
Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	87.82%	85.00%	93.03%	↑	
Number of patients with a length of stay (	57	75		N/A	16/17 KPI was

from admission) of greater than 90 days (A&T wards)					from admission to discharge
Percentage of people re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) Rolling 3 months	8.87%	10.00%	7.61%	🡻	
Number of instances where a patient has had 3 or more admissions in the past year to Assessment & Treatment wards (AMH and MHSOP) Rolling 3 months	309.00	255.00	291.66	🡻	
2.Quality	2017/18 Actual	**2017/18 Target**	**2016/17 Actual**	**Change on 16/17***	**Comment on 2017/18**
Percentage of patients who were seen within 4 weeks for a first appointment following an external referral	90.73%	90.00%	85.65%	🡹	
Percentage of clinic appointments cancelled by the Trust	8.72%	10%		N/A	KPI 16/17 was all appointments
The percentage of Out of Area placements (Post-validated)	14.08%	20.00%	23.07%	🡹	
Percentage of patients surveyed reporting their overall experience as excellent or good (month behind)	91.56%	92.45%	92.45%	🡻	
Number of unexpected deaths classed as a serious incident per 10,000 open cases – post validated	16.34	12.00	8.59	🡻	
3.Workforce	**2017/18 Actual**	**2017/18 Target**	**2016/17 Actual**	**Change on 16/17***	**Comment on 2017/18**
Actual number of workforce in month (Establishment 95%-100%)	93.83%	100%	93.74%	🡹	
Percentage of registered healthcare professional jobs that are advertised two or more times	18.32%	15.00%	17.39%	🡻	
Percentage of staff in post more than 12 months with a current appraisal	94.21%	95.00%	92.88%	🡹	Snapshot as at 31st March 18
Percentage compliance with mandatory and statutory training	90.75%	90.00%	89.18%	🡹	Snapshot as at 31st March 18
Percentage sickness absence rate (month behind)	5.18%	4.50%	5.00%	🡻	
4. Money	**2017/18 Actual**	**2017/18 Target**	**2016/17 Actual**	**Change on 16/17***	**Comment on 2017/18**
Delivery of our financial plan (I and E)	24,438,000	-10,076,000	-19,222,000	🡻	
Delivery of financial plan (I and E) Excluding impairments	-16,800,000	-10,076,000	-22,406,000	🡻	
CRES delivery	6,327,551	6,284,000	6,734,472	🡻	
Cash against plan	58,415,000	52,227,000	57,845,000	🡹	

* Arrows indicate improvement (🡹) or deterioration (🡻) on previous year, when N/A this indicates a KPI has changed and so no comparison can be made.

Notes

- **Total number of external referrals into Trust services** – The Trust has failed to achieve the annual target of 91,759 by 13,814. This is an increase on the outturn of 80,350 recorded in 2016/17.

- **Caseload Turnover** - The Trust has not achieved target in 2017/18, reporting 3.94% for the financial year against a target of 1.99%. Focused work continues in all localities to identify and address issues in this area.

- **Bed Occupancy –** The Trust has achieved the target in 2017/18, reporting 87.82% for the financial year against a target of 85.00% with all localities reporting above target. During the year, the Trust has seen pressures on bed particularly in AMH and particularly in male beds. Each locality continues to proactively monitor and address issues as they arise.

- **Length of stay greater than 90 days** - The Trust has achieved the target in 2017/18, reporting 57 against the annual target of 75. The service continually reviews patients with a long length of stay to ensure appropriate plans are in place and concerns addressed promptly.

- **Percentage of people re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) -** The Trust position for the financial year is 8.87% which has met the annual target of 10%. This is a deterioration on the annual outturn for 2016/17 which was 7.61%. The circumstances of the readmissions have been investigated and all were attributable to the severity of the symptoms and personal circumstances of the patients concerned.

- **Number of patients who have 3 or more admissions in a year (AMH & MHSOP) -** The Trust has failed to achieve the target of 255 with performance of 309. This is a deterioration on the annual outturn for 2016/17. The circumstances of the readmissions have been investigated and all were attributable to the severity of the symptoms and personal circumstances of the patients concerned.

- **Percentage of patients seen within 4 weeks following external referral -** the Trust position for the financial year is 90.73% which has achieved the annual target of 90.00%. This is an improvement on the annual outturn for 2016/17 which was 82.65% and is the best performance in the previous 3 years. Where there are areas of concern, plans are in place to address these.

- **Percentage of clinic appointments cancelled by the Trust –** The Trust has achieved the target of 10% with a performance of 8.72%. Performance in this area continues to see improvements and all localities are achieving target.

- **The percentage of Out of Area placements (Post-validated**) – This indicator measures the number of times a patient is admitted to a hospital within the Trust that is not the one we would expect them to be admitted to.

  The Trust has achieved the 20% target with an outturn of 14.08%, which is also an improvement on the annual outturn for 2016/17 of 23.07%.

- **Percentage of patients surveyed reporting their overall experience as excellent or good** – The Trust has failed to achieve the target of 92.45% with a position of 91.56%. This is also a deterioration compared to the 92.45% achieved in 2016/17. Work

continues within each locality to review performance against this indicator and identify any areas of concern

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

  The Trust has underperformed against this indicator with 16.34 deaths. A meeting took place during March between patient safety, corporate performance team and information team to look at how the data around the coroner's verdicts can be reported in a more meaningful and detailed way. Work is underway to ensure this is in place for 2018/19 reporting.

  In addition to this, during 2017/18 the Trust has developed new mortality processes for reviewing deaths not categorised as serious incidents – 126 of these reviews were undertaken. More detail on this can be found in the 'Learning from Deaths' section of the Quality Account.

  The Trust has robust processes in place for the investigating serious incidents following the guidance set out in the NHS England Serious Incident Framework (2015). We published our 'Learning from Deaths policy in September 2017 which details how we are continuing to improve and increase the numbers of reviews we undertake and also how we are engaging families and carers in a more proactive and inclusive way.

- **Actual number of workforce in month (establishment 95% - 100%)** - The Trust position for the financial year is 93.83% which has not met the annual target, but is a slight improvement on the 2016/17 outturn. It is expected that the establishment rate will continue to improve following the appointment of 30 newly qualified nurses and on-going recruitment.

- **Percentage of registered healthcare professional jobs that are advertised two or more times** - The Trust position for the financial year is 18.32%, which is 3.32% over the annual target and a deterioration of 0.93% compared to the 2016/17 outturn. Across the year there have been a number of posts that have been difficult to recruit to. This area will continue to be monitored closely.

- **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 94.21%. Although this is just below the target of 95% it represents a sustained improvement on the figure reported in February and throughout the year. This is an improvement on the 92.88% achieved in 2016/17. The use of operational management huddles is now embedded across the Trust which includes discussions on appraisal compliance levels; this has had a positive impact on performance levels being achieved.

- **Percentage compliance with mandatory and statutory training** – The Trust has achieved the 90% target with an outturn of 90.75% and is an improvement on the outturn of 89.18% for 16/17. The use of operational management huddles is now embedded across the Trust which includes discussions on appraisal compliance levels.

- **Percentage sickness absence rate** – The Trust has under-performed against the 4.50% target with an outturn of 5.18%. This is a deterioration in performance compared to the 2016/17 outturn position. The operational management huddles continue to drive improvements in performance. The improved frequency of the IIC refresh allows a timelier update of accurate performance information to managers.

- **Delivery of our Financial Plan (I and E) –** The comprehensive income outturn for the financial year ended 31 March 2018 was a deficit of £24,438k, which was £34,514k behind the planned £10,076k surplus.

- **Delivery of financial plan (I and E) excluding impairments -** The deficit position included £41,238k of unplanned asset impairments largely due to a review of Roseberry Park Hospital (RPH) to reflect the cost of rectification works required. Excluding these impairments the Trust's operating surplus was ahead of plan by £6,724k, which represents 1.92% of the Trust's turnover.

- **CRES Delivery (snapshot) -** Identified Cash Releasing Efficiency Savings at 31 March 2018 were £44k ahead of plan for the financial year 2017/18. The Trust has, and continues to, identify and develop schemes to ensure full delivery of recurrent CRES requirements for future years.

- **Cash against plan -** Total cash at 31 March 2018 was £58,415k and was £6,188k ahead of plan largely due to funding from the Sustainability and Transformation Fund in 2016/17 not being confirmed when the plan was submitted together with working capital variations.

Environmental Management : Reducing our carbon footprint

The Trust has a five year 2015-2020 Sustainable Development Management Plan (SDMP) which supports the NHS Sustainable Development Unit's view that a sustainable healthcare system must do more than focus on carbon – it must also consider how to minimise the impact of other negative environmental impacts, such as waste or water, and also to maximise opportunities to support the local economy and community.

The Trust has developed a realistic action plan linked to the new Sustainable Development Unit's national assessment tool. It is an online self-assessment tool to help the Trust understand our sustainable development work, measure progress and help make plans for the future. It uses four cross cutting themes 'Governance & Policy', 'Core responsibilities', 'Procurement and Supply chain' and 'Working with Staff, Patients & Communities' –made up of ten modules, this new approach allows the Trust to demonstrate progress in a way that mirrors our own individual journey.

Looking ahead, the Trust proposes in the near future to be able to enter into partnership with a multi-national business solutions provider to install three combined heat and power units at three specific Trust sites. These in turn could help the Trust achieve its obligation in meeting our carbon reduction target of 34% by 2020.

In the annual Government energy certification exercise rating of our buildings (A to G with D being typical) of the 28 qualifying properties surveyed, 11 of the buildings were rated C and above with only 4 properties failing to achieve the typical.

Using assisted funding provided by The Workplace Charging Scheme, the Trust has increased the availability of electric vehicle charging points strategically across the Trust. Current locations now offering EV charging to staff and visiting members of the public include Lanchester Road Hospital, Parkside MHRC, Cross Lane Hospital, Flatts Lane Centre, West Park Hospital and Huntington House in York.

Whilst the Trust has embarked on many successful recycling initiatives, further improvements can be achieved by segregating and recycling our general waste and following a recent service improvement event at West Lane Hospital on “Waste Recycling”, significant improvements have been made in relation to the onsite recycling of domestic waste and following on from this pilot, we will be rolling this model out across the whole of the Trust during the course of 2018/19.

Emergency Planning and Business Continuity

All Trusts have a duty to prepare for emergencies, maintain plans for preventing emergencies and for reducing or controlling the effects and returning to business as usual as soon as possible.

In order to give assurance that it has addressed this duty, the Trust has developed a comprehensive management framework which addresses NHS England's Core Standards for Emergency Preparedness, Resilience and Response.

An annual report is taken to Audit Committee and the Board of Directors to provide evidence of the annual self-assessment process covering the core standards prior to the submission to Local Health Resilience Partnerships.

In the 2017 submission the Trust achieved full compliance with all the core standard categories.

Responding to the external environment

TEWV serves patients across a large geographical area that includes:

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

Challenges for TEWV as a provider include how to:

- balance the different needs and priorities of commissioners while providing a consistent level of quality across the Trust
- manage resources so that we can deliver effectively in urban and rural areas with different financial pressures
- manage the changing demand for our services
- respond to new national policy and guidance
- make best use of new medical and information technology which opens up additional ways of delivering services.

Human rights

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

rolled out to the positive approaches training team who are to embed this approach in training given to all clinical staff on how to manage behaviour that challenges.

Modern Slavery Act statement

Tees, Esk and Wear Valleys NHS Foundation Trust provides mental health and learning disability services to a population of 2m across Durham, Teesside and North Yorkshire.

All Trust staff, in clinical or non- clinical roles, have a responsibility to consider issues regarding modern slavery, and incorporate their understanding of these issues into their day to day practice. Front line NHS staff are well placed to be able to identify and report any concerns they may have about people who use our services and modern slavery is part of the safeguarding agenda for children and adults.

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

In compliance with the consolidation of offences relating to trafficking and slavery with the Modern Slavery Act 2015, the Trust is currently reviewing its supply chains with a view to confirming that such actions are not taking place.

We will be:

- Reviewing our supply chain and identifying general potential areas of risk including:
  - Provision of food
  - Construction
  - Cleaning
  - Clothing (work wear)
- Contacting the suppliers within these supply chains and asking them to confirm that they are compliant with the Act.
- Contacting our key suppliers and requesting confirmation from them that they too are compliant with the Act.
- Introducing a 'Supplier Code of Conduct' and asking all existing and new suppliers to confirm their compliance

Advice and training about slavery and human trafficking is available to staff through the Safeguarding Team.

Further information on Modern Day Slavery can be found by visiting: https://modernslavery.co.uk/

Anti-bribery policy

The Trust has anti-fraud, bribery and corruption policy and procedure (more detail in the staffing report).

The accountability report

The accountability report

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

Colin Martin
Chief Executive **22nd May 2018**

The Directors' Report

The Chairman, Deputy Chairman, Chief Executive and other Board Members as at 31st March 2018

Lesley Bessant, Chairman of the Trust
Lesley had a long and successful career in local government until her retirement from Gateshead Council in 2005. Since then she has held a number of non-executive roles including pro chancellor on the board of governors for Northumbria University and chair of Northumbria Probation Service Board.
Qualifications: BA Economics
Principal Skills & Expertise: Strategic leadership, strategic planning, performance management, corporate governance and risk management
Term of office: 1 April 2017 to 31 March 2020*
Date of Initial appointment: 1 April 2014
(Note: The Chairman has no other material commitments and this position did not change during the year)

Dr. Hugh Griffiths Non-Executive Director, Deputy Chairman of the Trust and Chairman of the Quality Assurance Committee
Hugh was a consultant psychiatrist from 1988 and for eight years was an NHS trust medical director. In 2000 he also became medical director of the Northern Centre for Mental Health. He was director of policy and knowledge management for the NHS Clinical Governance Support Team in 2003/2004 and from then until 2010 was deputy national clinical director for Mental Health (England) at the Department of Health. Thereafter he was the National Clinical Director for Mental Health (England), leading the development of the Government's mental health strategy 'No Health Without Mental Health'. He retired in March 2013.
Qualifications: MB BS, FRCPsych
Principal Skills & Expertise: Service improvement, policy development, clinical leadership and management
Term of office: 1 April 2018 to 31 March 2021*
Date of Initial appointment: 1st April 2015 (prior to his appointment Hugh served as an Associate Non-Executive Director of the Trust (non-voting) between 1st September 2014 and 31st March 2015).

David Jennings Non-Executive Director and Chairman of the Audit Committee
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 the Programme and Project Assurance Manager of Redcar and Cleveland Borough Council, having been their Financial Services Manager and deputy Section 151 officer until November 2017.
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 2017 to 31 August 2020*
Date of Initial appointment: 1st September 2014

Marcus Hawthorn, Non-Executive Director, Chairman of the Resources Committee and Senior Independent Director
Marcus is a former Colonel in the British Army with extensive command and operations experience. His 30 years' service culminated in a number of senior programme and change management roles in the Ministry of Defence and the Home Office. Since then he was most recently the head of group risk and compliance at Age UK and he is now northern area manager for the Royal British Legion.
Qualifications: BEng(Hons) Chemical Engineering, MSc Design of Information Systems, Postgraduate Diploma in Law. Also, past Fellow of the Chartered Management Institute.
Principal Skills & Expertise: Risk, compliance and audit management, program management, operations, resilience and business continuity, systems development, change management, stakeholder engagement and partnership working, influence and strategic communications, human resource management, public and third sector focus and logistics.
Term of office: 1 September 2016 to 31 August 2019*
Date of Initial appointment: 1 September 2013

Paul Murphy, Non-Executive Director
Paul has had a broad range of experiences at a senior level in public and private (not-for-profit) sectors, as well as central and local government, including spells as a ministerial private secretary and an assistant director at City of York Council. He is now a freelance consultant, with an interest in particular in mental health, wellbeing, and in services for children and young people.
Qualifications: BA (Hons) English & Related Literature
Principal skills and expertise: Strategic planning, operational management, change management, human resources, communications, education, and articulating the service user voice.
Term of office: 1 September 2016 to 31 August 2019
Date of Initial appointment: 1 September 2016

Richard Simpson, Non-Executive Director and Chairman of the Mental Health Legislation Committee
Richard runs his own business delivering coaching, training and public relations consultancy. He has previous experience as a non-executive director in the NHS and is

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

Shirley Richardson, Non-Executive Director
Shirley was the Board Nurse Director at Gateshead Health NHS Foundation Trust for 17 years prior to her retirement in 2010.

She is a registered nurse and has leadership experience in acute, elderly, mental health, learning disability and paediatrics, across both hospital and community.

Since 2011 she has been chairman of Carers Together Foundation, a charity providing information, advice and support to carers in Middlesbrough, Redcar and East Cleveland.
Principal skills and experience: Transformational leadership, strategic planning, coaching and mentoring, service redesign, performance improvement, quality and safety systems, governance and risk management, research and development.
Qualifications: MBA, RN, Diploma of Chartered Institute of Marketing
Term of office: 1 September 2016 to 31 August 2019
Date of Initial appointment: 1 September 2016

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

Colin Martin, Chief Executive
Colin has worked in local government and the NHS for over 30 years and was previously the director of finance for Tees and North East Yorkshire NHS Trust.
He is a Director of North East Transformation System Ltd, a joint venture between the Trust and Gateshead Health NHS Foundation Trust.
Qualifications: Qualified accountant, FCCA.
Principal Skills & Expertise: Programme and project management, systems development, PFI finance, information analysis, performance management and service development
Appointed: 1 May 2016 (prior to his appointment Mr. Martin was the Trust's Director of Finance and Information)

Brent Kilmurray, Deputy Chief Executive and 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.
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
(Note: Brent has stepped back from his role as the Chief Operating Officer to focus on the rectification of defects at Roseberry Park)

Drew Kendall, Interim Director of Finance and Information
Drew has extensive financial experience having worked in NHS Acute and Mental Health services for over 27 years and was previously Associate Director of Finance with the

Trust since 2009. He is a member of the National HFMA (Healthcare Financial Management Faculty) Mental Health Faculty and HFMA Policy group. Drew is also a Board member of the AuditOne NHS Audit consortium.
Qualifications: Qualified accountant, FCCA
Principal Skills & Expertise: Financial management and costing, programme and project management, foundation trust regime and application process, information and systems development.
Appointed: (Interim) June 2016

Dr Ahmad Khouja, Medical Director
Ahmad is a practicing consultant psychiatrist in Forensic Learning Disabilities. He was appointed Medical Director in March 2018; prior to this he was the Deputy Medical Director and Senior Clinical Director for the Forensic Service. He has a research degree in Molecular Medicine from Oxford University. He was a former Training Programme Director for Higher Trainees in the Psychiatry of Learning Disability. He is a Certified Leader for the Trust's Quality Improvement System. He has led on recovery and harm minimisation for the Trust.
Qualifications: MRCPsych, MBChB, BA(Hons) DPhil (Oxon)
Principal Skills & Expertise: Psychiatric practice, clinical leadership, patient safety, clinical effectiveness, programme and project management, service improvement, medical education, research and development
Appointed: March 2018

Elizabeth Moody, Director of Nursing and Governance
Elizabeth took up post as director of nursing and governance in July 2015. Elizabeth has over 25 years' experience in the NHS having registered as an RMN in 1991. Prior to joining the Trust she worked as a deputy director of nursing, group nurse director for inpatient services and community services, leading on the community redesign of pathways of care and service improvement. Elizabeth has also worked nationally on programmes related to patient safety, governance and assurance.
Qualifications: RMN, PGDip Professional practice
Principal Skills and Expertise: Psychiatric nursing skills, project management, service improvement, managerial and leadership skills, patient and carer experience, patient safety, quality and assurance
Appointed: August 2015

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

Changes to the Board of Directors during 2017/18

- Mr. Jim Tucker, Non-Executive Director, Deputy Chairman and Chairman of the Resources Committee, retired from the Board on 31th August 2017.
- Dr. Nick Land retired from his role as the Trust's Medical Director on 28th February 2018.
- Drew Kendall, stepped back from his role as the Trust's Interim Director of Finance and Information on 31st March 2018.
  (Note: Patrick McGahon commenced his role as the Director of Finance and Information on 1st April 2018.)

Compliance with accounting guidance

The Trust prepared the financial statements in accordance with the NHS Group Accounting Manual (2017-18) as directed by NHS Improvement, and fully complies with International Financial Reporting Standards accounting practices (IFRS).

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

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

No political or charitable donations were made by the Trust during 2017-18.

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

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

Better Payment Practice Code

The Better Payment Practice code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. Performance for the financial year 2017-18 was as follows:

	2017-18	
	Number of Invoices	**Value of invoices £000s**
NHS Creditors		
Total bills paid	1,271	19,165
Total bills paid within target	608	12,804
Percentage of bills paid within target	47.8%	66.8%
Non-NHS Creditors		
Total bills paid	54,579	84,638
Total bills paid within target	52,897	82,209
Percentage of bills paid within target	96.9%	97.1%

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.

NHS Improvement's well-led framework

In this section of the Annual Report we provide an overview of the arrangements in place to ensure that services are well-led having regard to NHS Improvement's (NHSI) well-led framework.

NHSI's framework is structured around eight characteristics of a well-led organisation.

- **There is Leadership Capacity and Capability to develop high quality sustainable care**

  Our overall leadership is provided by the Board of Directors comprising a Non-Executive Chairman, Executive Directors and Non-Executive Directors.

  As shown in their biographies (provided in the Accountability Report) all Board Members are highly experienced and come from a broad range of professional backgrounds and experience.

  The composition of the Board is regularly reviewed.

  Board Members are subject to an annual performance assessment based on a scheme developed by Deloitte LLP. Details of this scheme are provided as part of the disclosures on the NHS Foundation Trust Code of Governance.

  Arrangements for the regular appraisal of all leaders within the organisation are in place and monitored by the Executive Management Team.

  Leadership of the Trust's Localities (County Durham and Darlington, Tees, North Yorkshire, York and Selby and Forensic Services) is provided by a Director of Operations, Deputy Medical Director and Head of Nursing.

  The Leadership and Management Groups (LMGBs) for each Locality:
  - Provide assurance on the quality and safety of the operational clinical services to the Quality Assurance Committee.
  - Are accountable for the delivery of relevant elements of the Business Plan, contractual requirements, and compliance with CQC and other legislative and regulatory frameworks

  The Clinical Directorate Quality Assurance Groups provide assurance to their respective LMGBs through monitoring inspection reports, user feedback, performance data, audit outcomes, untoward incidents, complaints, CQC reports, etc. and oversight of governance systems, including risk management, and the appropriate delivery of action plans.

  Speciality Development Groups, chaired by the Senior Clinical Directors, are also in place focussing on:
  - The development of quality, including standards of best practice based on lessons learnt from serious incidents, patient outcome and experience data, NICE guidelines, benchmarking, new national policies and strategies etc, and the provision of "thought leadership" to promote

a positive patient focussed culture within their respective specialties (Adult Mental Health, Children and Young People, Forensic, Learning Disability, Mental Health Services for Older People)

- Leadership of the clinical audit programme and implementation of NICE guidelines

Through these arrangements there is:

(a) Continual provision of assurance on the quality of services to the Board of Directors.

(b) Consistency and the implementation of best practice across each Clinical Specialty.

These arrangements enable the Trust to achieve the benefits which come from being large and diverse whilst providing robust building blocks for our clinical governance systems.

Leaders across the organisation place a high importance on being visible and approachable.

"Gemba" walks, the personal observation of work being undertaken, is a key element of our quality improvement system.

Each month, teams of Directors visit services providing staff with opportunities to raise issues. The outcomes of these visits are reported to, and monitored by, the Executive Management Team with an annual report being provided to the Board.

Succession planning and talent management arrangements are in place to identify and develop our next generation of leaders.

- **There is a clear vision and credible strategy to deliver high quality sustainable care to people and robust plans to deliver it.**

Our Strategic Direction, comprising the vision, mission and strategic goals, is focussed on the delivery of high quality, sustainable care (see "The Performance Report").

The business plan, to deliver our Strategic Direction, is refreshed annually taking into account changes to the external and internal environment and the views of stakeholders, Governors, service users and carers, staff and partner organisations.

Through this process, strategic priorities, including the Quality Priorities (see "The Quality Report") are identified and agreed.

For 2017/18 our strategic priorities included:

- Implementing phase 2 of the recovery strategy
- Developing and delivering the Purposeful and Productive Community Services Programme
- Improving the consistency and purposefulness of inpatient care across the Trust
- Ensuring Safe Staffing in all our services

- "Making a Difference Together" focusing on supporting staff live our values
- Implementing the Transforming Care agenda in Learning Disability Services
- Improving the clinical effectiveness and patient experience at times of transition
- Developing a Trust-wide approach to delivering services to service users with Autism
- Improving the inpatient estate in York
- Delivering new models of care for Adult Mental Health and Mental Health Services for Older People in Harrogate and Hambleton and Richmondshire
- Reducing the number of preventable deaths
- Reducing occurrences of serious harm resulting from inpatient falls

Delivery of the priorities in undertaken through a programme approach. The Executive Management Team meets each month as the "Strategic Change Oversight Board" to monitor progress.

A number of strategies also support the delivery of the Strategic Direction. Of these, the Quality Strategy sets our vision and direction for the further development and improvement of the quality of care delivered by the Trust. Each of its goals is supported by high-level measures which seek to enable the Trust, through its Quality Assurance Committee, to monitor that the Quality Vision is being delivered.

- **There is a culture of high quality, sustainable care.**

The Trust promotes an organisational culture which is open, fair and promotes learning. It encourages all staff to adopt a responsive and open approach towards identifying and understanding potential risks and responding to them. This includes requirements to report unsafe acts or conditions and untoward incidents and near misses using the Trust's incident reporting process.

The Trust's Values: commitment to quality, respect, involvement, wellbeing and teamwork, were developed in consultation with service users, carers, Governors and staff.

Expected behaviours to support each of these Values have been identified.

A staff Compact has also been developed which sets out the psychological contract, "gives" and "gets", between the Trust and its staff.

All nursing and healthcare staff are expected to comply with the six enduring values and behaviours of 'compassion in practice' published by NHS England.

Our culture is supported by:

- Our Quality Improvement System which instils a philosophy of continuous improvement
- Our Recovery Programme focussing on the model of co-production with increased opportunities for individuals with lived experience to be involved in the design and delivery of services

During 2017/18 we have introduced a new policy on Conflicts of Interest in response to guidance provided by NHS England.

There are a number of ways in which staff can raise concerns about patient safety:

- Through the "Whistleblowing Policy"
- Through an online system (anonymously if required) with the Executive Management Team
- Through the Freedom to Speak Up Guardian
- Through the Guardian of Safe Working
- Through the quarterly Friends and Family Test surveys
- During Directors' visits to services

- **There are clear responsibilities and roles and systems to support good governance and management**

Clarity of roles and responsibilities within the Trust's governance arrangements is provided in:

- The Constitution including the schedule of matters reserved by the Board and Scheme of Delegation
- The schedule of responsibilities of the Chairman and Chief Executive included in the Integrated Governance Framework
- The Scheme of Delegation of functions included in the Mental Health Act Code of Practice
- The terms of reference of the Board's Committees and the Executive Management Team
- The Trust's Quality Governance arrangements which sets out the membership, roles and responsibilities of the LMGBS, QuAGs, SDGs and Thematic Quality Groups.
- The Trust's programme and project management arrangements

A number of systems are in place to support good governance including:

- The PARIS clinical record system
- The Integrated Information Centre (IIC) which is a data warehouse and supports both corporate decision making and assurance processes and management activity through the provision of "real time" performance information
- The DATIX system enabling us to manage and report on incidents, complaints and risks and which supports our serious incident processes.
- The e-rostering system which supports safe staffing in the Trust's services

- **There are clear processes in place to manage risks, issues and performance**

The key systems and processes in place for managing risks, issues and performance are aligned to our governance structure: the Board, the Board's Committees, the Executive Management Team, the LMGBs, QuAGs and wards and teams.

Daily lean management and escalation procedures, together with the clear roles and responsibilities described above, provide a ward to Board approach.

Further information on our performance management processes are provided in the performance analysis section of the Annual Report.

During 2017/18 we have:

- Strengthened our risk management processes with the development and approval of a revised Operational Risk Management Policy, additional resources being provided to support risk management and training taking into account recommendations made by the Trust's Internal Auditors
- Developed and implemented systems and processes to learn from deaths, working with nine other providers in the North of England, in accordance with the "Learning from deaths framework" published by the National Quality Board (NQB)
- Continued to refine our systems and processes and escalation arrangements in relation to safe staffing

- **Appropriate and accurate information being effectively processed, challenged and acted upon.**

  Our performance metrics, and their targets, are reviewed and refreshed each year as part of our business planning processes.

  Benchmarking and other external sources of information are used as appropriate and available e.g. from the NHS benchmarking team.

  Evidence of information being challenged and acted upon is provided in the minutes of Board and committee meetings which are available on our website.

  Our performance dashboard metrics are subject to data quality checks.

  During 2017/18:

  - We have established an internal group to review and monitor data quality
  - Agreed an annual programme of data quality reviews with our Internal Auditors

- **People who use services, the public, staff and stakeholder partners are engaged and involved to support high quality sustainable services**

  Wide ranging arrangements are in place to enable us to effectively engage with the public, staff and stakeholder partner organisations.

  Principally these include:

  - Our Council of Governors
  - Engagement with our members (see the Membership Report)
  - The work of our involvement and engagement team (details provided later in this section)

- The Recovery Programme including the involvement of experts by experience in cultural change, participation in various project and steering groups, taking part in recruitment and contributing to policy
- Formal consultation on service changes in partnership with our commissioners, for example, in 2017/18 those relating to the development of new models of care in North Yorkshire.
- The national patient survey
- The collection of patient experience data and the involvement of service users in identifying actions for improvement
- The national staff survey and quarterly "friends and family" test surveys
- Our involvement in sustainability and transformation partnerships and other joint arrangements with commissioners and other providers
- Membership and participation in local safeguarding boards
- Regular meetings with representatives of local healthwatch
- Bespoke engagement to support our business plan priorities including, in 2017/18, the TEWV values and staff compact consultation and an event to seek views on tackling the abuse of staff as part of the "Making a Difference Together" priority

The Trust's conclusion that it is well-led is based on:

- The CQC assessment undertaken in January 2017 which rated the Trust as "good" in the well led domain.
- An independent external governance review undertaken by Grant Thornton LLP during 2017. This was based on NHS Improvement's guidance in place at that time and which broadly corresponds to the "Well- led framework".

  The findings of the review were that all areas were rated as either meeting or partly meeting (with confidence in management's capacity to deliver within a reasonable timescale) the regulator's expectations for a well governed foundation trust.
- The achievement of a NHSI Single Oversight Framework rating of 1 (maximum autonomy). Further information on this matter is provided in the "Accountability Report.
- The Head of Internal Audit's Annual Opinion for 2017/18 that "From my review of your systems of internal control, I am providing good assurance that there is a sound system of internal control, designed to meet the Trust's objectives, and that controls are generally being applied consistently."
- There being no material inconsistences identified between the Annual Governance Statement, the quality report, the annual report, the annual corporate governance statement and reports arising from CQC planned and responsive reviews.

Using our Foundation Trust Status to develop services and improve patient care

Being a foundation trust is helping us:

- build on and improve positive relationships with service users, carers, staff, partners and local people and be more accountable to local people
- strengthen our internal process and systems to meet the challenges of modern health services
- develop locally based specialist services
- respond better to market opportunities

- continue to invest in capital developments such as a new hospital for York and Selby
- engage with NHS England and the CCGs to develop new models of care

Performance against key health care targets
The Trust monitors a range of key health care targets which include those set internally by the Board of Directors, those set externally as part of the mental health contracts with Commissioners and the national ones within NHS Improvement's (NHSI) Single Oversight Framework (SOF). This section will focus on the national ones within the NHSI SOF as the former two are covered already within this Annual Report (see Chapter 2 "Overview of Performance" and further below "Progress towards targets as agreed with local commissioners".

There are 9 operational metrics within the Single Oversight Framework (SOF) November 2017, which revises and replaces some of the previously defined SOF metrics. The Trust monitors progress against each of the operational metrics and provides an update to the Board of Directors within its monthly performance report, in addition to a quarterly report that monitors all SOF metrics. The Trust has achieved all targets within 2017/18; however NHSI introduced a metric for Inappropriate out of area placements (OAPs) for adult mental health services in November 2017. The process for agreeing trajectories towards eliminating OAPs was jointly led by NHS England and NHS Improvement regional teams during October to December 2017 and the Trust has agreed a trajectory with the CCGs to improve performance and reduce the 2017/18 figure by 10% each year. Representatives from the Trust have met with CCGs to develop action plans to support this delivery. It should be noted that all Trust out of area admissions reported during 2017/18 are internal, whereby the patient has remained within their home organisation, ie this Trust, but the location of the receiving unit disrupts their continuity of care.

Overview of arrangements in place to govern and improve service quality
The Trust has implemented its quality strategy, launched in 2014 , which describes the arrangements for the governance of quality across the organisation. Those arrangements include the clinical governance systems for the Trust services together with the clinical assurance systems that detail how the corporate governance teams and Trustwide assurance groups manage the relevant assurance processes. The quality strategy is being delivered through frameworks for patient safety, patient experience and clinical effectiveness together with the Trust workforce strategy. The strategy was refreshed in 2016 following consultation with service users, carers and staff and progress against the new metrics is being monitored by relevant Trust groups.

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

Each clinical directorate, in the five operational localities of the Trust, has a quality assurance group (QuAG) that reviews the performance against quality indicators of their clinical teams. Those groups manage their clinical directorate quality improvement plan, monitoring quality data and the local risk register providing assurance and escalating risk where necessary to the five locality management and

governance boards (LMGB). These boards provide exception reports monthly to the Quality Assurance Committee with a regular bi-monthly assurance report on service quality. A set of standardised quality reports for the quality assurance groups, locality management and governance boards, Trustwide quality assurance groups, Quality Assurance Committee and commissioners are in place. Work will continue during 2018/19 to align the agendas with the CQC Fundamental Standards for Quality and Safety.

The corporate quality governance teams manage the operational systems to provide quality performance information for the service and Trustwide quality assurance groups, boards and committee. These include, for example, the complaints and PALS teams, patient safety team, clinical audit team, quality data team and patient and carer experience team. The regulatory compliance team implements a programme of peer and service user inspections across Trust services to monitor the quality of service delivery against the regulatory fundamental standards. All corporate teams then also monitor quality improvement action plans developed from the performance deficits and risks identified and report into the Trustwide assurance groups and the Quality Assurance Committee. Key information on the CQC activity and ratings for the Trust along with data on complaints and incidents can be found within the Quality Report section of this report. During 2016/17 a Quality Compliance Group has been established which is chaired by the Director of Quality Governance and the membership is the Heads of Service and Modern Matrons from across the organisation. The purpose of this group is to provide information and share learning from CQC and other regulatory inspections.

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

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

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

Our most recent comprehensive inspection by the Care Quality Commission was in November 2016. Whilst the inspection highlighted many areas of good practice, there were some areas that both the CQC and the Trust recognised needed to be improved. An action plan was developed following the visit to ensure that all improvements were put in place in a timely manner and this has been implemented

throughout 2017/18. A Trust wide Quality Compliance Assurance Group of senior managers has been established to ensure that the action plan is completed and that all learning from our inspections is shared across all localities and specialities. Senior staff from the Nursing and Governance directorate also have regular engagement meetings throughout the year with staff from the Care Quality Commission to discuss areas of interest and monitor the ongoing completion of Trust actions.

In July 2017, Her Majesty's Inspectorate of Prisons conducted an unannounced inspection of Holme House Prison, a category B local prison near Stockton on Tees. Following the inspection, the Care Quality Commission issued the Trust with a Requirement Notice regarding Regulation 9: Person Centred Care. This states that 'The care and treatment of service users must be appropriate, meet their needs and reflect their preferences'. In response to this the Trust has reviewed its processes (in conjunction with staff from the prison services) and put in place required improvement actions to ensure that appropriate care was consistently provided to meet the needs of these patients. This work was also monitored though the same governance routes mentioned above and discussed during engagement meetings with the Care Quality Commission.

Progress towards targets agreed with local commissioners

The Trust provides regular performance information to its commissioners as part of the contracts we hold 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 four national quality requirements included within the 17/18 mental health contract which were:

- Number of episodes of mixed sex accommodation – sleeping
- Percentage CPA 7 day follow up (adult services)
- Duty of Candour (failure to notify)
- Data completeness - NHS Number
- Data completeness – Ethnicity Coding
- People with a first episode of psychosis begin treatment with a NICE recommended package of care within 2 weeks of referral

The majority of targets were achieved for the 17/18 financial year for the 9 core CCGs. The only target not achieved was 'People with a first episode of psychosis begin treatment with a NICE recommended package of care within 2 weeks of referral' for Darlington CCG where they achieved 40.74% against a target of 50%. Within the Darlington locality the number of referrals received in this area are small and as a result it is easy for an under performance to occur. Within this area patient DNAs are consistently a reason for failure to achieve the target. The service continues to address issues around patient engagement.

We have also continued to drive improvements in the quality of our services. Much of this has been progressed using our Quality Improvement System, and

commissioners / service users and carers have been involved in some of these developments.

During 2017/18 we:

- Delivered the actions set out in our Quality Account improvement priorities (Recovery oriented services, reducing harm from falls, CYP to Adult Transitions, Reducing Preventable Deaths and Safe Staffing
- Redesigned many of our clinical pathways and clinical link pathways (CLiPs).
- Spread the existing Purposeful Inpatient Admissions (PIPA) approach from our Adult wards to our Older People's wards. This reduces delays in assessment, treatment and discharge, encourages multi-disciplinary team working and reduces inconsistencies in approach between different localities within TEWV.
- Improved and standardised practice across our two adult Psychiatric Intensive Care Units (PICUs) leading to a more recovery oriented approach and better arrangements for transfer back to assessment and treatment wards.
- Agreed Crisis Team triage and assessment standards, and criteria for admission and home based treatment interventions by these teams.
- Brought about improvements in the psychological input to the treatment of older people in our services (by improving the processes for referral to psychology). This is reducing waiting times from initial referral to first contact, improving the standard process for formulation, and ensuring more equity in length of time in therapy.
- Observed the daily practice of community mental health teams in all specialities and piloted new ways of entering patient information into our electronic patient record to increase the proportion of time that clinicians can spend with service users.
- Reviewed our Children and Young People's Services (CYPS) care pathways to make them more Learning Disability compatible.

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

- Commenced the delivery of Trauma Informed Care (TiC) training.
- Introduced training for all new inpatient staff in relation to patient leave and time away from the ward.

New and significantly revised services

Information about our key developments during 2017/18 are outlined in the performance report. This includes changes to adult learning disability crisis teams in Durham, Darlington and Teesside and the work we've done in the children's and young people's new care models pilot to reduce admissions and lengths of stay through the use of crisis and intensive home treatment services.

In addition on 1 February 2018 TEWV took over responsibility for delivering mental health and learning disability services in the Pocklington area (these were previously provided on behalf of the Trust by Humber NHS Foundation Trust).

Service improvements following staff or patient surveys/ comments and Care Quality Commission reports
A number of service improvements have been made following inspections by the CQC such as:

- We have appointed a Care Programme Approach Lead Officer to enhance shared decision making and co-production of clinical records and promote person-centred care planning.
- We have enhanced systems in place to ensure physical observations following administration of rapid tranquilisation are monitored and recorded in line with Trust Policy
- We have provided additional Resuscitation Training courses to ensure all relevant staff can access a course when required
- Standard work has been developed to ensure that checks of emergency equipment and other relevant ward checklists are always undertaken
- We have continued to work towards a culture of 'Positive and Safe' that has led to reduction in number of times that staff has needed to use physical restraint. The Care Quality Commission has commended the Trust for demonstrating a positive and therapeutic culture which will continue to reduce the need for restrictive interventions.

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

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

- Forensic Mental Health – Patients stated that they didn't always feel safe on the ward. To try and improve this we have ensured that patients are offered support when incidents are occurring on the ward. We have a 'Safe Wards Reassurance Lead' in place and this is advertised on ward areas so patients know who that is.
- Adult Mental Health - Patients stated they would like more activities on the ward. Following on from an improvement event the ward staff team are working towards increasing activity via a menu of options and more structured approach to the day (and evening).In the interim staff are providing at least one activity every day and a new Occupational Therapist is in post which is increasing the availability of therapeutic activity sessions.
- Mental Health Services for Older People - A carer stated "I found it rather difficult speaking about my father with him present as he doesn't think he is as bad as he is and it is upsetting." We will ensure we give carers the opportunity to speak in private if this is less distressing to their loved one and is beneficial to the assessment.

Working in partnership
TEWV has several significant partnerships and alliances. These include:

- Our work with NHS England (NHSE), Northumberland, Tyne and Wear NHS Foundation Trust (NTW) and other providers to progress new care model

pilots that are testing our provider-led management of NHSE commissioning budgets. We have active projects in adult secure (forensic) and children and young people's specialist inpatient services. The CYPS work is most advance and has led to investment in crisis / intensive home treatment teams across the area served the Trust and a reduction in admissions.

- Our involvement in the development of an Accountable Care Partnership (ACP) with the CCGs across Durham, Darlington and Teesside. In its first phase this has carried out reviews into over 60 adult learning disability NHS funded placements and brought about many improvements in both the quality and value for money of these. All partners have invested existing staff resource into this initiative.
- We have a developing research and development partnership with York University and continue to work with the appropriate research councils, clinical networks and other bodies to increase the number of TEWV service users and services supporting research into mental health (including dementia), learning disabilities and the implications of an ageing workforce.
- We continue to partner with the Virginia Mason Institute and receive continuing advice and guidance on how to further improve our Quality Improvement System.
- We support the work of 4 STPs as they develop plans for mental health and learning disability services – these STPs are Durham,Tees,Hambleton, Richmondshire and Whitby; Humber, Coast and Vale; West Yorkshire; and Northumberland, Tyne & Wear and North Durham.

In addition:

- The Trust works with a number of voluntary and charitable sector organisations. In some services, such as mental health service provision in prisons, or in our Durham and Darlington talking therapies service this is in a contractual form. But we also have more informal day to day links with the third sector, and in the Vale of York we manage a grant-giving scheme for local VCS organisations (York Connects)
- The Trust also supported the Harrogate Vanguard project throughout 2017/18. This promoted new ways of providing joined-up services to older people between different NHS and voluntary sector providers in Harrogate. The project is now closing, but lessons are being learned from this work.
- The trust has worked with GP partners to trial the placement of mental health professionals directly in GP surgeries across the south of County Durham and in Catterick Garrison in Richmondshire.

Involving local people

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

Involvement undertaken by service users and carers ranges from consultation right through to co-production with a primary focus of improving the delivery of high quality person centred services that promote recovery.

Involvement of service users and carers over the last 12 months has included:

- Coordination of over 251 requests for involvement, with an excess of 100 service users or carers registered for involvement participating on individual interview panels for staff.
- The provision of a wide portfolio of training to a range of staff, doctors in training and nurse students through the use of personal experience stories and sharing medical histories, feedback on the carer input into the course was *'Their talk was very moving, emotive and compelling'*.
- 16 service users and carers assisted staff in the inspection of 21 wards and premises under Patient Led Assessment of the Care Environment (PLACE).
- The establishment of a design task group in the Vale of York who are influencing the detail of the interior of new build hospital. Their input is so valuable and really looks at things from a non-staff and architect's perspective.
- Service User and Carer Involvement Groups across North Yorkshire continue to have a significant impact in the business planning priorities and have been heavily involved in the conversations around transformation plans and formal consultation processes in the area in relation to the provision of inpatient and community services.
- Young People are now receiving reimbursement for their time and contribution in helping us improve services. For each hour they work with us they receive a £5 high street shopping voucher.
- We have continued to increase the membership of steering groups, committees and local governance groups. Service users and carers regularly contribute to, and influence, service improvement through the use of the Trust's Quality Improvement System.
- In terms of the support provided to service users and carers. A carer who participated in the recruitment of the Medical Directors commented '*He said everything I wanted to hear as a carer, I almost cried at one point. I really felt the process was a valuable one for the candidates to go through and was grateful for the guidance beforehand. That helped me focus on the presentations and not panic about preparing questions beforehand.'*
- Participation in service improvement events utilising the Trust Quality Improvement System's methodology.
- Co-delivery of the development programmes; Leadership for Advocates and Service Users, Expert by Experience Programme for Adult Mental Health Services has continued.
- Co-delivery of training programmes at ARCH Recovery College and service users has helped to increase the portfolio of training offered on the Trust's Recovery College online.

The Chief Executive received direct feedback from a service user group in York 'H*ow grateful they were for the work the Involvement and Engagement Officer has done with them and the wider service user group in that area'*.

2017 saw two carers shortlisted for the award of Carer of the year by the Royal College of Physiatrists.

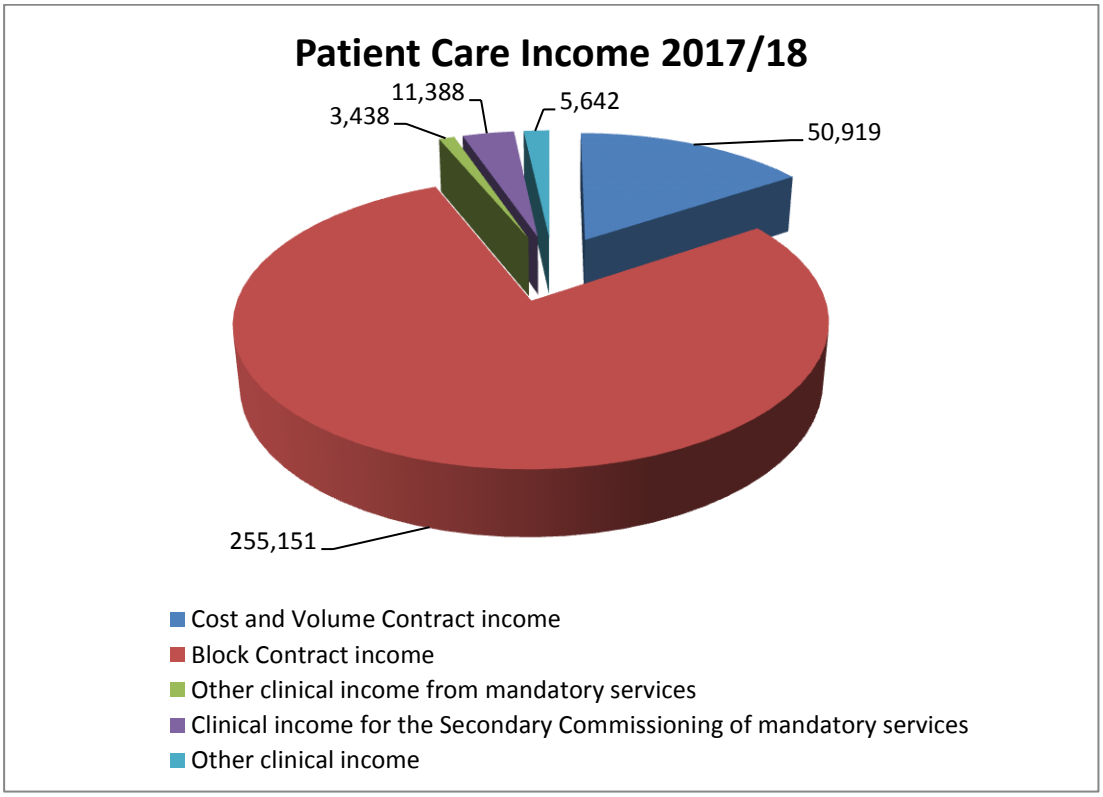
A survey of involvement members to identify satisfaction and support mechanisms was undertaken in 2017. As a result 95% reported satisfaction with their involvement, however it did highlight the need for more support and training to be available. In response the first support and training programme was launched in early 2018.

Consulting with local people
In 2017/18 we worked with NHS Hambleton and Richmondshire Clinical Commissioning Group to engage with local people about options for developing mental health services for adults and older people. This resulted in a formal public consultation on three options, which was overseen by NHS England and North Yorkshire Council's Scrutiny of Health Committee. The approved option will see community services strengthened to support more people at home and inpatient mental health services eventually moving from the Friarage Hospital in Northallerton to either Roseberry Park in Middlesbrough, West Park Hospital in Darlington and, for a small number of people with severe dementia, Auckland Park Hospital in Bishop Auckland. The decision reflects the feedback received from local people, including the consultation survey.

We also started to work with NHS Harrogate and District Clinical Commissioning Group to engage with local people about developing a vision for adult and older people's mental health services in the Harrogate area. The planned development of a new hospital for Harrogate has been put on hold while this review takes place and work will continue into 2018/19.

Fees and charges
The Trust received no income from fees and charges.

Income Generation
During 2017-18, income generated was £350.3m from a range of activities; 93.2% from direct patient care. Patient care income came from the following areas:



Statement as to disclosure to Auditors

Each of the directors, holding office on 31st March 2018, confirms that:

- as far as they are aware, there is no relevant information of which the Trust's Auditor is unaware
- that they have taken all steps they ought to have taken as a Director in order to make themselves aware of any such information and to establish that the Auditor is aware of that information.

Remuneration report

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

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

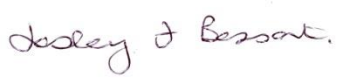
In 2014/15 the Committee agreed an Executive Management Team (EMT) Pay Framework. Details of this policy are set out below.

This Framework does not cover the remuneration of:

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

During 2017/18 the Committee made a 1% cost of living award to those senior managers covered by the EMT Pay Framework. This award was comparable to the cost of living increase covering most NHS staff on Agenda for Change and national medical and dental terms and conditions of service.

Details of the salaries and allowances and pension benefits of senior managers in 2017/18 and payments made to past senior managers are provided in the tables in this section.



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

Senior Managers' Remuneration Policy

The key features of the Executive Management Team (EMT) Pay Framework and pay arrangements for those senior managers not covered by it, except for those

employed under national Agenda for Change and national medical and dental terms and conditions of service are set out in the table below:

No changes were made to the components of the EMT Pay Framework during 2017/18.

Basic Pay	The EMT Pay Framework is based on job evaluation point scores provided by Capita using an independent job evaluation system and agreed job descriptions. The pay levels are equivalent to the mid-point of the pay ranges proposed by Capita and are based upon the upper quartile market pay level for Executive Directors in Mental Health and Learning Disabilities NHS Trusts. The maximum amount which could be paid under the Framework to all members of the EMT, collectively, is £1,361,062. Through these arrangements the Trust has satisfied itself that senior managers' remuneration is reasonable. The basic pay arrangements support the short and long term strategic objectives of the Trust by enabling the Trust to recruit and retain talented individuals who undertake key leadership roles using levels of remuneration that represent value for money and which are comparable to those of other similar organisations.
Performance Related Components	In general, the EMT Pay Framework has no performance related components; however, starting salaries of less than the full amount (typically 7.5%) have been used for new post holders. The full amount becomes payable subject to the post-holder demonstrating good performance in their first year in office taking into account achievement of objectives and the outcome of their appraisals.
Recruitment and Retention Premia (RRP)	The Nomination and Remuneration Committee has the option of paying Recruitment and Retention Premia (RRP) but these should only be paid where there is clear evidence that the payments can be justified. No members of the EMT were paid a RRP during 2017/18.
Allowances	A Directors Travel Allowance of £5,444 is included within basic pay.
Provisions for the recovery of sums paid to Directors or for withholding payments of sums to senior managers	There is contractual provision for making appropriate deductions from notice period payments. Entitlement to pay progression, where applicable, is subject to confirmation from the individual's line manager that their performance over the preceding 12 months period has been rated as being good.

Remuneration above £142,500	A comparison is undertaken with NHS VSM pay-bands and with published salary bands within similar NHS organisations. The scale and complexity of TEWV which services a population of 2m people from over one hundred sites, working with nine Clinical Commissioning Groups, either upper tier local authorities and within three STPs is also a factor.
Arrangements specific to individual Senior Managers	The remuneration of the Senior Clinical Director for the Kaizen Promotion Office is in accordance with national terms and conditions for mental and dental staff

Other Policy Disclosures

- Service Contract Obligations:
  None identified

- Policy on Payment for Loss of Office:
  A contractual entitlement to three months' notice, other than in the case of summary dismissal. Where eligible an entitlement to a redundancy payment in accordance with Section 16 of the National Terms and Conditions of Service.

- Statement of consideration of employment conditions elsewhere in the Foundation Trust:
  A combination of an independent job evaluation scheme, to establish respective job weights, and independently gathered and reported information about Very Senior Manager remuneration levels in comparable trusts were used to establish the Executive Management Team Pay Framework. CAPITA undertook the job evaluation exercise and provided information about remuneration levels of equivalent posts within comparable organisations. This information has been used by the Nomination and Remuneration Committee to establish and operate the Executive Management Team Pay Framework since 2014 including consideration of updated independent remuneration reports. Individual employees directly affected by the Executive Management Team Pay Framework were consulted about the approach being taken and given the opportunity to retain their existing terms and conditions of employment should they wish to do so.

Non-Executive Director Remuneration

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

Colin Martin
Chief Executive **22rd May 2018**

Senior managers' remuneration

Name and Title	2017-18						2016-17					
	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Benefits in Kind * Rounded to the nearest £100	Pension related benefits (bands of £2500) £000	Total Remuneration (bands of £5000) £000	Expenses Paid Rounded to the nearest £100	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Benefits in Kind * Rounded to the nearest £100	Pension related benefits (bands of £2500) £000	Total Remuneration (bands of £5000) £000	Expenses Paid Rounded to the nearest £100
Mr Martin Barkley, Chief Executive - left 28 April 2016	0	0	0	0	0	0	10-15	0	0	0	10-15	300
Mr Colin Martin, Chief Executive	170-175	0	11,300	92.5-95.0	275-280	800	155-160	0	11,800	285.0-287.5	455-460	1,100
Mr Drew Kendall, Director of Finance and Information - started 01 May 2016, left - 31 March 2018	105-110	0	2,600	0	105-110	1,300	95-100	0	2,100	167.5-170.0	265-270	1,100
Mr Brent Kilmurray, Chief Operating Officer - left 01 December 2017 and Deputy Chief Executive	120-125	0	7,900	30.0-32.5	160-165	1,300	120-125	0	0	35.0-37.5	155-160	1,700
Dr Nick Land, Medical Director - left 31 March 2018	95-100	0	6,300	0	105-110	1,800	70-75	55-60	6,200	65.0-67.5	200-205	1,800
Dr Ahmed Khouja**, Medical Director - started 01 March 2018	5-10	10-15	0	2.5-5.0	20-25	0	0	0	0	0	0	0
Mr David Levy, Director of Human Resources and Organisational Development	105-110	0	0	7.5-10.0	115-120	0	105-110	0	0	17.5-20.0	125-130	600
Mrs Elizabeth Moody, Director of Nursing and Governance	110-115	0	10,300	27.5-30.0	145-150	1,300	105-110	0	9,600	110.0-112.5	230-235	1,400
Mrs Jennifer Illingworth, Director of Quality Governance	95-100	0	4,500	30.0-32.5	130-135	1,700	95-100	0	4,000	80.0-82.5	180-185	1,400
Mrs Sharon Pickering, Director of Planning, Performance and Communications	95-100	0	9,100	25.0-27.5	130-135	1,000	95-100	0	7,300	20.0-22.5	125-130	1,600
Dr Ruth Briel***, Senior Clinical Director, Kaizen Promotion Office	65-70	15-20	0	85.0-87.5	165-170	3,500	65-70	15-20	0	25.0-27.5	110-115	3,700
Mr Patrick Scott, Director of Operations - County Durham and Darlington	105-110	0	2,000	100.0-102.5	205-210	700	95-100	0	1,700	395.0-397.5	495-500	2,600
Mr David Brown, Director of Operations – Teesside - left 01 December 2017 and Chief Operating Officer - started 01 December 2017	105-110	0	4,200	67.5-70.0	180-185	2,000	100-105	0	4,900	22.5-25.0	130-135	3,200
Mr Levi Buckley, Director of Operations – Forensic Services	95-100	0	0	117.5-120.0	210-215	700	95-100	0	0	30.0-32.5	125-130	900
Mrs Adele Coulthard, Director of Operations – North Yorkshire - left 01 September 2017 and Director of Transformation - North Yorkshire - started 01 September 2017	95-100	0	3,300	25.0-27.5	125-130	0	95-100	0	2,500	30.0-32.5	130-135	0
Mrs Elizabeth Herring, Director of Operations - North Yorkshire - started 14 November 2016, left 02 January 2017	0	0	0	0	0	0	10-15	0	600	0.0-2.5	10-15	100
Mr Phil Bellas, Trust Secretary	80-85	0	0	20.0-22.5	105-110	0	80-85	0	0	20.0-22.5	105-110	0
Mr Robert Cowell, Director of Operations - Estates and Facilities Management - left 01 March 2018 and Director of PFI Projects - started 01 March 2018	95-100	0	3,100	15.0-17.5	115-120	1,900	95-100	0	2,500	30.0-32.5	130-135	1,100
Mrs Ruth Hill, Director of Operations - York and Selby	100-105	0	1,600	25.0-27.5	125-130	600	95-100	0	1,500	50.0-52.5	145-150	1,500
Mr Paul Foxton, Director of Operations - Estates and Facilities Management - started 08 January 2018	20-25	0	0	0.0-2.5	20-25	600	0	0	0	0	0	0
Mr Tim Cate, Director of Operations – North Yorkshire - started 01 September 2017	55-60	0	1,000	0	55-60	1,000	0	0	0	0	0	0
Mr Dominic Gardner, Director of Operations – Teesside - started 01 December 2017	30-35	0	300	5.0-7.5	35-40	100	0	0	0	0	0	0
Mrs Sarah Dexter-Smith, Director of Therapies - started 16 October 2017	40-45	0	0	37.5-40.0	75-80	900	0	0	0	0	0	0
Mrs Lesley Bessant , Chairman	50-55	0	0	0	50-55	3,400	50-55	0	0	0	50-55	4,000
Mrs Barbara Matthews, Non-Executive Director - left 31 August 2016	0	0	0	0	0	0	5-10	0	0	0	5-10	1,000
Mr Jim Tucker, Non-Executive Director - left 31 August 2017	5-10	0	0	0	5-10	2,800	10-15	0	0	0	10-15	2,600
Mr Richard Simpson, Non-Executive Director	10-15	0	0	0	10-15	2,900	10-15	0	0	0	10-15	2,700
Mr Marcus Hawthorn, Non-Executive Director (Senior Independent Director)	15-20	0	0	0	15-20	100	15-20	0	0	0	15-20	0
Mr David Jennings, Non Executive Director (Head of Audit Committee from 01 November 2017)	15-20	0	0	0	15-20	1,200	10-15	0	0	0	10-15	1,100
Dr Hugh Griffiths, Non-Executive Director	10-15	0	0	0	10-15	1,800	10-15	0	0	0	10-15	2,500
Mrs Shirley Richardson, Non-Executive Director started 01 September 2016	10-15	0	0	0	10-15	1,500	5-10	0	0	0	5-10	900
Mr Paul Murphy, Non-Executive Director started 01 September 2016	10-15	0	0	0	10-15	1,900	5-10	0	0	0	5-10	1,100

Band of highest paid directors total remuneration (£000) ****	170-175	**Band of highest paid directors total remuneration (£000) ********	155-160
Median of total remuneration	27,635	**Median of total remuneration**	27,361
Ratio (Director to Median)	6.2	**Ratio (Director to Median)**	5.8

At 31 March 2018 the Trust had 45 Governors (2016-17, 45), with 29 receiving reimbursement of expenses (2016-17, 35). The total amount reimbursed as expenses was £6,313, (£8,763 in 2016-17).

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 and all Non-Executive Directors of the Trust Board

Colin Martin
Chief Executive

22 May 2018

Staff Report

Analysis of Staff costs and staff numbers

Employee expenses	**12 months ended 31 March 2018**			**12 months ended 31 March 2017**		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
	£000	£000	£000	£000	£000	£000
Salaries and wages	205,586	197,516	8,070	198,641	190,858	7,783
Social security costs	17,507	16,802	705	16,541	15,843	698
Apprenticeship levy	981	942	39	0	0	0
Pension cost – employer contributions to NHS pension scheme	24,416	23,375	1,041	24,170	23,192	978
Pension cost – other contributions	17	17	0	15	15	0
Temporary staff – agency/contract staff	6,775	0	6,775	5,780	0	5,780
Gross employee expenses	**255,282**	**238,652**	**16,630**	**245,147**	**229,908**	**15,239**
Recoveries from other bodies in respect of staff cost netted off expenditure	0	0	0	(11)	(11)	0
Total employee expenses	**255,282**	**238,652**	**16,630**	**245,136**	**229,897**	**15,239**
Of which:						
Cost capitalised as part of assets	267	267	0	228	228	0
Analysed into Operating Expenditure :						
Employee expenses – staff & executive directors	252,881	236,366	16,515	242,923	227,753	15,170
Research & Development	631	516	115	509	440	69
Education & Training	1,503	1,503	0	1,476	1,476	0
Total employee expenses excluding capitalised costs	**255,015**	**238,385**	**16,630**	**244,908**	**229,669**	**15,239**

The salary costs of the capital development team are capitalised over the full costs of the Trust's capital schemes, of which in 2017-18 the largest scheme was an inpatient unit in York.

Average number of employees (WTE Basis)	**12 months ended 31 March 2018**			***Restated 12 months ended 31 March 2017**		
	Total Number	Permanently Employed Number	Other Number	Total Number	Permanently Employed Number	Other Number
Medical and Dental	338	296	42	352	311	41
Administration and estates	1,170	1,108	62	1,204	1,095	109
Healthcare assistants and other support staff	319	307	12	308	295	13
Nursing, midwifery and health visiting staff	3,892	3,484	408	3,776	3,458	318
Scientific, therapeutic and technical staff	788	725	63	729	699	30
Healthcare science staff	2	2	0	10	10	0
Social care staff	8	0	8	24	0	24
Total	**6,517**	**5,922**	**595**	**6,403**	**5,868**	**535**
Of which						
Number of Employees (WTE) engaged on capital projects	5	5	0	6	6	0

*restated following additional guidance.

Demographic Information

Our workforce is primarily white, broadly in line with our local population and at the end of March 2018 there were 5,235 female members of staff (78%) and 1,476 male (22%).

The number of male and female directors and senior managers (i.e. members of the Board of Directors and Executive Management Team) is 16 male and nine female.

Sickness absence figures (January to December 2017)

Average full time equivalent (FTE) staff in post	Adjusted FTE Sick days	FTE days available	FTE days lost to sickness absence *	Average sick days per FTE
5,915	67,990	2,159,106	110,295	11.5

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

Our average sickness absence rate was 5.18%

Staff policies and actions taken

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

- The Trust sickness absence procedure contains a provision for disability leave so that staff with a disability, who require regular treatment to maintain their health and attendance at work, can do so within an agreed number of days leave.
- The recruitment and selection policy is based upon national and Disability Confident recruitment standards and we guarantee to interview all applicants who declare they have a disability and who meet the minimum requirements for the post. The Trust will provide all reasonable adjustments to enable people with a disability to attend for interview. This applies not only to staff applying for their first post with the Trust but also to staff seeking promotion.
- The redeployment process provides the opportunity for staff who are no longer able to carry out their job either on health grounds or because of organisational change to secure suitable alternative employment with the Trust. This can involve a period of shadowing, training and a trial period to widen the suitable opportunities available.
- The Trust's staff development policy recognises that people learn in different ways and that a positive learning environment that endeavours to meet people's needs is likely to impact positively on the level of knowledge retained. Reasonable adjustments work positively in a learning environment as they

remove barriers to learning. Staff are far less likely to learn and retain knowledge if they are worried or anxious. Everyone is different, so this could be something that impacts directly on a person within the learning environment or it could be that another factor outside the learning environment is having a detrimental impact on their ability to learn of participate in the training. Managers and staff are encouraged to contact the education and training department to discuss how the Trust can best meet the needs of people from protected groups whilst they are participating in education and training.

- During 2017/18 we made efforts to improve the training needs analysis by the greater involvement of services in speciality based training needs identification and planning activities.
- A new Trust Workforce Strategy was agreed in 2018 that describes how we intend to improve the quality of our services through workforce supply, development, health and wellbeing and engagement activities.

Occupational health

The 2017/18 staff flu campaign was the most successful to date with 65.62% of frontline healthcare workers receiving a flu vaccination (an increase of 10.19% over the previous year). Demand for physiotherapy and counselling services was significantly greater than expected however, access to these services was maintained during 2017/18. Pre-employment screening activity increased in line with the 5% growth in the number of staff employed by the Trust during the year. The Trust continued to work closely with its occupational health service provider as part of efforts to improve staff health and wellbeing. The occupational health service provider regularly participated in Trust sickness absence team meetings, the infection and prevention control committee, the health safety, security and fire committee, the health and wellbeing group, the mindful employer group, the staff flu vaccination group and health and wellbeing related improvement events.

Health, safety and security

In addition to ensuring that staff receive advice, support and training, incidents are investigated and lessons learnt, our Health, Safety and Security team work to continuously improve the services they provide to the Trust.

Improvements implemented this year include:

- Improving guidance to staff on setting up of their visual display screen equipment by launching a video on the Trust's training site.

- Completing a Kaizen event in relation to RIDDOR investigation process which aimed to speed up the investigation process by minimising re-work for the services and piloting the new system prior to roll out.

- Continued their programme of access audits focussing this year on outpatient locations.

- Completed an audit programme for Health, Safety and Security e-workbooks to give assurance that workbooks were in use throughout the Trust.

Fraud, bribery and corruption policies and procedures
The Trust has an established anti-fraud and corruption policy which aims to minimise the risk of fraud, bribery or corruption by detailing the key roles and responsibilities of employees and related parties; as well as promoting an anti-fraud culture throughout the Trust.

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

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

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

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

- Team briefing system
- Trust magazine (Insight)
- Intranet
- Weekly e-bulletin which includes a round-up of discussions at the Executive Management Team meetings
- Visits to services and teams by directors
- Quarterly leadership and management groups which give direct access to the Chief Executive
- An anonymous electronic mechanism for raising concerns which are responded to through e-bulletin and posted on the intranet.
- A Trust Freedom to Speak Up Guardian

Staff involvement and engagement is also key to the success of our quality improvement system. TEWV QIS empowers staff to identify and remove waste and streamline processes which enables them to focus on doing things that add value for the people who use our services. We remain committed to improving the way we use of the staff friends and family test to engage with the workforce.

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

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

Staff survey

Our results were compared with 27 other mental health trusts and were positive. We received the best scores in the country in two of the key findings covered by the survey.

Our top five ranking scores were:

- Effective use of patient/service user feedback (3.89 compared to a national average 3.72, out of a possible 5)
- Percentage of staff experiencing discrimination at work in the last 12 months (10% compared to a national average of 14%)
- Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion (90% compared to a national average of 85%)
- Staff confidence and security in reporting unsafe clinical practice (3.84 compared to a national average of 3.71, out of a possible 5)
- Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months (27% compared to a national average of 32%)

Our bottom five ranking scores were:

- Percentage of staff reporting errors, near misses or incidents witnessed in the last month (90% compared to a national average of 93%)
- Percentage of staff experiencing physical violence from staff in the last 12 months (3% compared to a national average of 3%)
- Percentage of staff reporting most recent experience of harassment bullying and abuse (59% compared to a national average of 61%)
- Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months (22% compared to a national average of 22%)
- Percentage of staff satisfied with the opportunities for flexible working patterns (60% compared to a national average of 60%)

	2016		2017		Improvement/deterioration
Response Rate	**Trust**	**National**	**Trust**	**National**	
	49%	49%	52%	52%	**An improvement of 3%**
Top 5 ranking Scores	**Trust**	**National**	**trust**		

KF 32	3.84	3.70	3.89	3.72	**An improvement of 0.05**
KF 20	9%	14%	10%	14%	**A deterioration of 1%**
KF 21	94%	87%	90%	85%	**A deterioration of 4%**
KF 31	3.81	3.67	3.84	3.71	**A deterioration of 0.10**
KF 25*	28%	33%	27%	32%	**An improvement of 1%**
Bottom Ranking Scores	**Trust**		**Trust**		
KF29	92%	92%	90%	93%	**A deterioration of 2%**
KF23	3%	3%	3%	3%	**No change**
KF27	57%	60%	59%	61%	**An improvement of 2%**
KF22*	23%	21%	22%	22%	**An improvement of 1%**
KF15	61**%**	59%	60%	60%	**A deterioration of 1%**

*** The lower the score the better**

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

Suggested areas for action

The feedback from the survey will be used to inform actions. The areas we intend focussing on are:

- Taking action to better support staff to minimise the impact of excessive work related stress by improving supervision, job design, work processes, staff skills and knowledge and communications
- Taking action to increase access for staff to flexible working arrangements by agreeing a new flexible working procedure and providing related awareness sessions for managers and their staff

The Trust Workforce Strategy identifies a number of actions that will complement efforts by the Trust to respond to the staff survey results. Localities and corporate services are considering their own results and forming local action plans where appropriate to support local improvement. Oversight of progress being made is undertaken by the Resources Committee.

Future Priorities and Targets
The 2017 Investors in People assessment report highlighted the importance of improving corporate communications and as part of the Making a Difference Together business plan priority we will:

Use crowdsourcing to improve engagement between the Trust and staff, service users and others.

Put in place a new Bullying and Harassment Resolution Procedure to help reduce conflict between staff by encouraging staff to come forward at an early stage to resolve issues in a non-adversarial way.

Introduce guidance and training for managers and staff about tackling abuse from service users and members of the public.

Use the ladder of participation to help promote and increase the level of co-production between the Trust and service users within training, recruitment and quality improvement activities.

Progress with implementation will be reported to and monitored by the Resources Committee, The Executive Management Team and the Recovery Programme Board on a regular basis throughout 2018/19.

Exit Packages (subject to audit)

Early retirement due to ill health

During 2017-18 the Trust had 11 employees retire early on the grounds of ill health; the value of these early retirements (from NHS Pensions) is £0.7m.

Cost of exit packages

	12 months ended 31 March 2018			12 months ended 31 March 2017		
Exit Package Cost	**Total number**	**Compulsory Redundancies number**	**Other Departures number**	**Total number**	**Compulsory Redundancies number**	**Other Departures number**
<10,000	**0**	**0**	**0**	**1**	**1**	**0**
£10,001 - £25,000	**1**	**1**	**0**	**4**	**4**	**0**
£25,001 - £50,000	**0**	**0**	**0**	**5**	**5**	**0**
£50,001 - £100,000	**0**	**0**	**0**	**0**	**0**	**0**
£100,001 - £150,000	**0**	**0**	**0**	**1**	**1**	**0**
£150,001 - £200,000	**0**	**0**	**0**	**0**	**0**	**0**
>£200,001	**0**	**0**	**0**	**0**	**0**	**0**
Total number of exit packages	**1**	**1**	**0**	**11**	**11**	**0**
Total resource cost (£000's)	**23**	**23**	**0**	**368**	**368**	**0**

There were no other non-compulsory exit packages between 01 April 2017 and 31 March 2018, (2016-17, nil)

Consultancy costs

The Trust paid £496k in consultancy costs during 2017/18.

Off payroll arrangements

Off payroll arrangements longer than 6 months

No. of existing engagements as of 31 March 2018	7
Of which...	
No. that have existed for less than one year at time of reporting.	7
No. that have existed for between one & two years at time of reporting.	0
No. that have existed for between two and three years at time of reporting.	0
No. that have existed for between three and four years at time of reporting.	0
No. that have existed for four or more years at time of reporting.	0

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, for more than £245 per day and that last for longer than six months

No. of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	7
Of which...	
No. assessed as caught by IR35	7
No. assessed as not caught by IR35	0
No. engaged directly (via PSC contracted to the entity) and are on the departmental payroll	7
No. of engagements reassessed for consistency / assurance purposes during the year.	0
No. of engagements that saw a change to IR35 status following the consistency review	0

Off-payroll board member/senior official engagements

No. of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
No. of individuals that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year. This figure should include both off-payroll and on-payroll engagements.	29

Governance including the Foundation Trust Code of Governance Disclosures

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

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

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

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

Under the Code of Governance the Trust is required to disclose the following information on its governance arrangements:

Code ref:	Summary of Disclosure Requirement	Page(s)
A.1.1	A schedule of matters or a summary statement of how the Board of Directors and the Council of Governors operate, including the types of decisions to be taken by each body and which are delegated to the Executive Management Team on behalf of the Board of Directors.	66-67
A.1.1	A statement on how disagreements between the Council of Governors and Board of Directors should be resolved.	67
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	 30 30 32 31 76, 30-32, 84 73 76, 30-32, 84
A.1.2	The number of meetings of the Board of Directors and the Audit, Remuneration and Nominations Committees and individual attendance by directors	69-70, 73, 76 & 84
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.	80-83

A.5.3	The name of the Lead Governor.	79
B.1.1	The names of the non-executive directors whom the Board determines to be independent, with reasons where necessary.	30-32 & 68
B.1.4	A description of each director's skills, expertise and experience.	30-33
B.1.4	A statement about the Board of Directors' balance, completeness and appropriateness to the requirements of the NHS foundation trust.	68
B.2.10	A description of the work of the Nominations Committee(s) including the process used in relation to board appointments.	76 & 84
B.3.1	The other significant commitments of the Chairman and any changes to them during the year.	30
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.	85
B.6.1	A statement on how the performance evaluation of the board, its committees and its directors, including the Chairman, has been conducted.	71-72
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.	72
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.	68-69
C.1.1	A statement from the External Auditors about their reporting responsibilities	214
C.1.1	An explanation from the directors of their approach to quality governance in the annual governance statement.	90-97
C.2.1	A report that the Board has conducted a review of the effectiveness of the Trust's system of internal controls.	67

C.2.2	Information on how the internal audit function is structured and the role it performs.	75
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.	72-76
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.	87
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.	70
E.1.6	A report on the representativeness of Trust's membership and the level and effectiveness of member engagement.	86

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

How the Trust is governed

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

Under this Act the Trust must have:

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

The Chairman of the Trust leads both our Board of Directors and Council of Governors.

The statutory duties of our Council of Governors are:

- to hold the non-executive directors individually and collectively to account for the performance of the Board
- to represent the interests of the members of the Trust as a whole and the interests of the public

It has specific responsibilities:

- to develop our membership and represent their interests
- to assist with the development of the Trust's strategy
- to provide its views on any matter when consulted by the Board of Directors
- to appoint or remove the Chairman and the non-executive directors
- to determine the remuneration and allowances, and the other terms and conditions of office, of the Chairman and non-executive directors
- to approve the appointment of the Chief Executive
- to receive the annual accounts and annual report
- to appoint or remove the Trust's external auditor
- to determine proposals to increase the proportion of the Trust's income earned from non-NHS sources by 5% or more in any financial year
- to inform the Board whether or not it considers that any proposals to provide non-NHS services will interfere, to a significant extent, with the provision of NHS services
- to determine (in conjunction with the Board of Directors) any proposed changes to the Trust's Constitution
- to determine (in conjunction with the Board of Directors) any questions on mergers, acquisitions or separation of the Trust
- to determine (in conjunction with the Board of Directors) whether the Trust should be dissolved
- to determine any significant transactions (as defined in the Constitution) proposed by the Board of Directors
- to consider any matters raised by the Care Quality Commission or NHS Improvement which might affect the Trust's compliance with the terms of its Licence or its registration of services
- to determine whether any matter should be referred to a panel established by NHS Improvement on whether the Trust has failed or is failing to act in accordance with its Constitution, or to act in accordance with Chapter 5 of the NHS Act 2006.

A number of committees and task and finish groups, including the Council of Governors' Nomination and Remuneration Committee, support this work.

Our Board of Directors provides overall leadership and vision to the Trust and is ultimately and collectively responsible for all aspects of performance, including clinical and service quality, financial performance and governance.

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

Our Board of Directors:

- exercises certain functions in conjunction with our Council of Governors.
- has retained certain decisions to itself including the definition of the Trust's strategic goals and objectives, the approval of the annual plan (following consultation with our Council of Governors); the acquisition, disposal or change of use of land or buildings with a value in excess of £500,000; and the introduction or discontinuance of any significant activity or operation.

  Further details are provided in the "scheme of decisions reserved to the Board" which is available on our website as part of our constitution.

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

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

Under the leadership of our Chief Executive, the Executive Management Team (which comprises the executive, corporate and operational directors, the Trust Secretary and the Senior Clinical Director for the Kaizen Promotion Office) is accountable for the ratification of Trust-wide policies for implementation and for ensuring:

- performance against our objectives and key targets is reviewed
- the effective operation of our integrated assurance systems
- the provision of appropriate and accurate information to our Board of Directors.

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

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

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

Nothing within the process restricts the Council of Governors from informing NHS Improvement or the Care Quality Commission of relevant concerns.

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

The Board of Directors

Under our Constitution our Board of Directors comprises:

- a Non-Executive chairman
- five to seven non-executive directors

- five executive directors which must include the Chief Executive (as the accounting officer), the Finance Director, a registered medical practitioner (the Medical Director) and a registered nurse (the Director of Nursing and Governance).

Information on the Board Members as at 31st March 2018, including details of their skills and expertise, is provided in the Accountability Report.

The Trust's corporate directors, Sharon Pickering (Director of Planning, Performance and Communications) and David Levy (Director of Human Resources and Organisational Development) together with David Brown (Acting Chief Operating Officer) attend meetings of the Board in a non-voting capacity.

The Board considers that, as at 31st March 2018:

- Its composition meets the requirements of the National Health Service Act 2006 and the constitution and is appropriate for the organisation
- All its members are "fit and proper" persons to be directors of the Trust in accordance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- There is an appropriate balance and breadth of skills, knowledge and experience amongst the non-executive directors
- All the non-executive directors meet the independence criteria set out in the foundation trust code of governance.

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

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

NHS Improvement, with the approval of HM Treasury, directs that these accounts shall show, and give a true and fair view of the NHS foundation trust's gains and losses, cash flow and financial state at the end of the financial year. NHS Improvement further directs that the accounts shall meet the accounting requirements of the Department of Health Group Accounting Manual that is in force for the relevant financial year, which shall be agreed with HM Treasury.

In preparing these accounts, the directors are required to apply on a consistent basis, for all items considered material in relation to the accounts, accounting policies contained in the Department of Health Group Accounting Manual, make judgements and estimates which are reasonable and prudent; and ensure the application of all relevant accounting standards, and adherence to UK generally accepted accounting practice for companies, to the extent that they are meaningful and appropriate to the NHS, subject to any material departures being disclosed and explained in the accounts.

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

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

Each of the directors, holding office on 31st March 2018, confirms that the annual report and accounts, taken as a whole, are fair, balanced and reasonable and provide the information

necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy.

Attendance at Board meetings

The following table provides details of the attendance at the eleven ordinary meetings and two special meetings of the Board of Directors held during 2017/18:

Board Member	Position	No of Board meetings attended
Lesley Bessant	▪ Chairman of the Trust ▪ Chairman of the Board's Nomination and Remuneration Committee ▪ Chairman of the Council of Governor's Nomination and Remuneration Committee ▪ Chairman of the Commercial Oversight Committee	13
Colin Martin	▪ Chief Executive ▪ Accounting Officer ▪ Chairman of the Executive Management Team	12
Hugh Griffiths	▪ Non-Executive Director ▪ Deputy Chairman (from 25/1/18) ▪ Chairman of the Quality Assurance Committee	13
Marcus Hawthorn	▪ Non-Executive Director ▪ Senior Independent Director ▪ Chairman of the Audit Committee (to 30/9/17) ▪ Chairman of the Resources Committee (from 1/10/17)	11
David Jennings	▪ Non-Executive Director ▪ Chairman of the Audit Committee (from 1/10/17)	10
Paul Murphy	▪ Non-Executive Director	13
Shirley Richardson	▪ Non-Executive Director	12
Richard Simpson	▪ Non-Executive Director ▪ Chairman of the Mental Health Legislation Committee	11
Jim Tucker (to 31/8/17)	▪ Non-Executive Director ▪ Deputy Chairman ▪ Chairman of the Resources Committee	5(5)
Drew Kendall	▪ Interim Director of Finance and Information	12
Ahmad Khouja	▪ Medical Director (from 1/2/18)	1 (1)
Brent Kilmurray	▪ Chief Operating Officer and Deputy Chief Executive *(Brent stepped back from his role as the Chief Operating Officer on 1/12/17)*	13

Nick Land	▪ Medical Director (to 28/2/18)	11 (12)
Elizabeth Moody	▪ Director of Nursing & Governance	9
David Brown*	▪ Acting Chief Operating Officer (from 1/12/17)	3 (4)
David Levy*	▪ Director of Human Resources and Organisational Development	12
Sharon Pickering*	▪ Director of Planning, Performance and Communications	13

(Notes:
*1 * Indicates that the director holds a non-voting position on the Board of Directors*
2 The maximum number of meetings to be attended by those Board Members who held office during part of the year is shown in brackets)

Keeping informed of the views of governors and members
Our Board of Directors ensures it is kept informed of the views of governors and members in a number of ways, including:

- Regular private meetings between the Chairman and governors.
- Attendance at Council of Governors' meetings
- Receiving reports on the outcome of consultations with governors, for example on the business plan
- Updates provided by the Chairman and directors at Board meetings
- Attendance by governors at directors' visits to services (bi-monthly)
- Governors are encouraged to attend public meetings of the Board of Directors
- Attendance at governor development days.

Marcus Hawthorn, as the Senior Independent Director, is also available to governors if they have concerns regarding any issues which have not been addressed by the Chairman, Chief Executive or other usual business arrangements.

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

- The Chairman attends all meetings.
- There is a standing invitation for the non-executive directors to attend meetings.
- Executive and corporate directors attend meetings, if required, for example to deliver reports, or as observers.

The Council of Governors also has powers to require attendance of a director at any of its meetings, under paragraph 26 (2) (aa) of Schedule 7 of the National Health Service Act 2006, for the purpose of obtaining information on the Foundation Trust's performance of its functions or the directors' performance of their duties. The Council of Governors did not exercise these powers during 2017/18.

In total the Council of Governors held four ordinary meetings, one special meeting and the annual general meeting during 2017/18. Board Member attendance at these meetings was as follows:

Name	Number of Meetings Attended
Lesley Bessant	6
Colin Martin	4
Dr Hugh Griffiths	4
Marcus Hawthorn	4
David Jennings	5
Paul Murphy	6
Shirley Richardson	5
Richard Simpson	5
Jim Tucker	3 (3)
Drew Kendall	4
Brent Kilmurray	4
Dr Nick Land	2
Dr Ahmad Khouja	0 (0)
Elizabeth Moody	4
David Levy	3
Sharon Pickering	5
David Brown	1 (2)

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

Evaluating Board performance

Each year the Board's performance is evaluated using a scheme initially developed by Deloitte LLP.

In 2017/18 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 Resources Committee, the Mental Health Legislation Committee and the Quality Assurance Committee by the members of those committees.

The outcomes of the individual performance evaluations are used to inform the appraisals of Board Members. For the Chairman and Non-Executive Directors the outcomes of the evaluations are reported to the Council of Governors' Nomination and Remuneration Committee.

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

During 2017/18 the Board also commissioned an independent external governance review from Grant Thornton LLP based on guidance published by NHS Improvement. This firm has no other connections with the Trust.

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

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

The appointments of the Chairman and the non-executive directors can be terminated for the following reasons:

- by resignation
- by ceasing to be a public member of the Trust
- upon becoming a governor of the Trust
- upon being disqualified by the Independent Regulator
- upon being disqualified from holding the position of a director of a company
- upon being adjudged bankrupt
- upon making a composition or arrangement with, or granting a Trust deed for, his/her creditors
- upon being convicted of any offence and a sentence of imprisonment being imposed (whether suspended or not) for a period of not less than three months (without the option of a fine)
- upon removal by the Council of Governors at a general meeting
- if they cease to be a fit and proper person to be a director of the Trust in accordance with the Licence, the Constitution or the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Reports of the Board's Committees

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

Each committee has terms of reference, including reporting requirements, which have been approved by the Board. Copies of the terms of reference are available in our Integrated Governance Framework which is published on our website.

The membership, roles and activities of these committees are detailed in the following sections.

The Audit Committee

Role and responsibilities

The Audit Committee has overarching responsibility for providing assurance to the Board on the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

The responsibilities of the Audit Committee also include:

- reviewing the adequacy of all risk and control disclosure statements (e.g. the annual governance statement) prior to endorsement by the Board
- ensuring the internal audit function is effective, meets mandatory NHS internal audit standards and provides appropriate independent assurance

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

Membership of the committee
The committee comprises not less than four members all of whom must be independent non-executive directors. There is also a standing invitation for all other non-executive directors to attend meetings of the committee and participate in discussions but not to vote.

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

Marcus Hawthorn (Chairman to 30/9/17)	5
David Jennings (Chairman from 1/10/17)	4
Hugh Griffiths	5
Paul Murphy	5

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

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

The work of the Audit Committee in discharging its responsibilities

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

In relation to the annual audit for the year ended 31st March 2018 the committee has:
- reviewed the terms of engagement with the external auditors and recommended them to the Council of Governors.
- Approved the external auditors' Audit Strategy Memorandum and Strategic Audit Plan and received progress reports on the conduct of the audit.
- Approved the Protocol for Liaison between the internal and external auditors including those areas of internal audit's work of specific interest to the external auditors for reliance.

- Reviewed and assured the Board that the Trust is, and is expected to remain, a "going concern" and that the accounts should be prepared on that basis.
- Approved the schedule of losses and special payments as part of the annual accounts process.
- Received the Annual Report of the Head of Internal Audit and considered its findings in relation to the Annual Governance Statement.
- Reviewed and commented on the Annual Governance Statement

A special meeting held on 18th May 2018 provided the Committee with the opportunity to review the Annual Report and Accounts building on conversations at previous meetings in relation to progress reports provided by the External Auditors and the draft Annual Governance Statement.

At the meeting the Committee received written responses to fifteen questions which they had posed, in advance, on having had sight of the draft accounts. The members of the Committee were content with the responses provided.

In relation to the Annual Report, the Committee raised specific questions about the consistency of disclosures relating to Roseberry Park; cyber security and the national WannaCry Ransomware Cyber-attack in 2017; the disclosures relating to senior manager remuneration; and the role of one of the Non-Executive Directors.

During the 2017/18 financial year the committee has also:

- sought and gained assurance on the development, coverage and resources available to deliver the clinical audit programme and received half yearly progress reports on its implementation
- reviewed and provided assurance to the Board on its ability to sign off certificates and the statements required by NHS Improvement in relation to the annual plan
- reviewed the strategic and operational internal audit plans ensuring that these were aligned to the principal risks facing the Trust and could be adequately resourced
- reviewed progress, at each meeting, against the internal audit plan and considered the outcome of reviews undertaken in the context of the Trust's controls and risk environment. In doing so, the committee has sought assurances from management on the implementation of actions to improve the adequacy and robustness of controls particularly in relation to the handling of patient property; risk management; and record keeping
- paid particular attention to the robustness of controls for tackling fraud, bribery and corruption together with the actions planned to address gaps in the Trust's arrangements against NHS Protect's self-review toolkit
- considered regular reports from the Local Counter Fraud Specialist noting action taken on increasing fraud awareness and in response to alleged cases of fraud in the Trust and elsewhere
- reviewed and provided assurance to the Board on the Trust's submission to NHS England on compliance with the Core Standards for emergency preparedness, resilience and response.
- sought and received assurances on the Trust's cyber security arrangements
- reviewed and commented on the draft organisational risk management policy prior to its presentation to the Board
- sought and received assurance on arrangements to update the Trust's processes and systems to reflect learning from NHS England independent investigations
- reviewed and commented on revisions to the standing financial instructions
- drawn the Board's attention to those matters which it considers have implications for the Trust's assurance framework
- considered corporate governance and accounting developments
- received briefings on cyber security; IT risks, agile working and good governance of IT projects; and NHS Improvement's never events policy and framework.

The external auditors

Mazars LLP are the Trust's external auditors.

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

With the expiry of the contract approaching, the committee, in conjunction with the Council of Governors established a working group to oversee a competitive tendering exercise to appoint the future supplier of external audit services.

The recommendation of the working group, that Mazars LLP should be appointed as the Trust's external auditors for a term of two years with an option to extend, per year, for each of the subsequent three years, was approved by the Council of Governors.

The cost of providing external audit services during 2017/18 was £48k including VAT. This includes the cost of the statutory audit, the review of the quality account, the independent review of the accounts of the charitable funds and the whole Government accounting return.

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

The internal auditors

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

Mr Stuart Fallowfield ACCA, the Director of Internal Audit at Audit One, is the Trust's Head of Internal Audit.

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

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

Safeguarding auditor independence

The Audit Committee has agreed a policy to ensure that auditor objectivity and independence is safeguarded if the firm providing external audit services is commissioned to provide services outside of the external auditor's responsibilities. This policy stipulates that only the Chief Executive, Finance Director and Trust Secretary may commission the external audit firm for non-audit services and the appointment must be approved by the Chairman of the Audit Committee. Safeguards are required that:

- external audit does not audit its own firm's work
- external audit does not make management decisions for the Trust
- no joint interest between the Trust and external audit is created
- the external auditor is not put in the role of advocate for the Trust
- the external audit firm does not undertake certain functions including: preparation of accounting records and financial statements, advising on the selection, implementation or running of IS/IT systems, staff secondments, employee remuneration or selection and recruitment and finance or transaction services work within the Trust

- The external auditor must ensure that the provision of non-audit services meets its own ethical standards and internal operational policies.

The Nomination and Remuneration Committee of the Board

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

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

Advice and/or services were provided to the Committee by Mr David Levy, Director of Human Resources and Organisational Development, and Mr Phil Bellas, Trust Secretary.

No external advice or support was commissioned by the committee during 2017/18.

The Committee met once during 2017/18 to:
- approve the annual uplift to be applied to the remuneration of the executive and other relevant directors
- consider arrangements to fill the substantive position of the Director of Finance and Information and the vacancy arising from the retirement of Dr. Land as the Medical Director
- consider and approve the settlements to be provided in response to successful employment tribunal claims.

All members of the committee were present at this meeting.

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

Resources Committee

The role of the Resources Committee is
- To provide assurance to the Board that the resources available to the Trust (both financial and non-financial) are appropriate and sufficient to deliver its Business Plan
- To provide assurance to the Board on the robustness, alignment and delivery of key strategies and plans
- To review proposals (including evaluating risks) for major business cases and their respective funding sources
- To keep under review potential changes in the external environment in the medium to longer term and to draw any material risks to the sustainability of the Trust to the Board's attention.
- To provide oversight of the management and administration of Charitable Funds held by the Trust.

As at 31st March 2018 the membership of the committee comprised:
- Marcus Hawthorn, Non-Executive Director (Chairman of the Committee)
- Lesley Bessant, Chairman of the Trust
- David Jennings, Non-Executive Director
- Paul Murphy, Non-Executive Director

- Richard Simpson, Non-Executive Director
- Colin Martin, Chief Executive
- David Brown, Acting Chief Operating Officer
- Drew Kendall, Interim Director of Finance and Information*
- Sharon Pickering, Director of Planning, Performance and Communications*
- David Levy, Director of HR and Operational Development*

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

The Committee met 9 times during the year.

Mental Health Legislation Committee (MHLC)

The role of the committee is:

- To provide assurance to the Board on the Trust's compliance with the Mental Health Act 1983 and the Mental Capacity Act 2005, including any statutory Codes of Practice relating them:
- To consider the implications of any changes to statute, including statutory Codes of Practice, or case law relating to the Trust's responsibilities as a provider of mental health services and to make recommendations, as required, for changes to the Trust's policies, procedures and practice
- To ensure appropriate arrangements are in place for the appointment and appraisal of associate managers and oversee managers' hearings

As at 31st March 2018 the membership of the committee comprised:

- Richard Simpson, Non-Executive Director (Chairman of the Committee)
- Lesley Bessant, Chairman of the Trust
- Paul Murphy, Non-Executive Director
- Shirley Richardson, Non-Executive Director
- Dr Ahmad Khouja, Medical Director
- David Brown, Acting Chief Operating Officer
- Elizabeth Moody, Director of Nursing and Governance
- Two public governors (as representatives of service users and carers)

The committee met four times during the year.

Quality Assurance Committee

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

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

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

As at 31st March 2018 the membership of the committee comprised:

- Dr. Hugh Griffiths, Non-Executive Director (Chairman of the Committee)
- Lesley Bessant, Chairman of the Trust
- Richard Simpson, Non-Executive Director
- Shirley Richardson, Non-Executive Director
- Colin Martin, Chief Executive

- David Brown, Acting Chief Operating Officer
- Dr. Ahmad Khouja, Medical Director
- Elizabeth Moody, Director of Nursing and Governance
- Jennifer Illingworth, Director of Quality Governance

The directors of operations and deputy medical directors attend, for the whole meeting, when the reports of their locality management and governance boards are considered by the committee.

The committee met, formally, 9 times during 2017/18.

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

The Commercial Oversight Committee

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

As at 31st March 2018 the membership of the committee comprised:

- Lesley Bessant, Chairman of the Trust (Chairman of the Committee)
- Marcus Hawthorn, Chairman of the Resources Committee
- David Jennings, Chairman of the Audit Committee
- Dr Ahmad Khouja, Medical Director

The committee met five times during 2017/18.

The Council of Governors

Report of the Lead Governor

As Lead Governor I am once again pleased to report that there have been no issues of concern with any aspects of the appointment process in the Trust or non-compliance with the constitution.

Training and development sessions remain a priority for Governors to ensure they have the skills and knowledge to enable both long standing and new Governors to challenge and ask appropriate questions on information presented to the Council of Governors. Governors are always made aware of new rules and regulations that affect the services provided by the Trust. Governors are informed at every Council of Governors meeting of the progress of the Quality Accounts and we review the Quality Accounts at the beginning of each year.

Recovery remains a very positive aspect of the Trust's values and vision and as we see more services users living and working in the community it continues to be an important part of patient's pathways to achieving confidence and independence. Governors have many links with the public and as ambassadors for the Trust have taken the opportunity to speak to community groups and organisations to tell them of the positive things the Trust is doing. Hopefully this can reduce some of the stigma about mental health and depression and encourage people to talk about mental health. We also try to encourage people to become Members of the Trust which can also give them a better understanding of issues to do with mental health.

A Task And Finish Group has been looking at how the Trust and the Council of Governors can improve how we engage with partners, services users, carers and the public. We recognise that engaging with young people is an important issue as we know there has been a rise in children with mental health issues.

The Council of Governors appreciate that this has been another challenging year due to the continued funding pressures of both the Trust and its partners and also the issues at Roseberry Park. It will be important that the Trust continues to work closely with all its partners to ensure the continued provision of high quality services. Finally, on behalf of the Council of Governors I would like to say that we appreciate the commitment and dedication of the staff in their endeavours to provide the best services possible to the patients and cares. We would also like to recognise the contribution of the volunteers which can add that extra help that some patients and carers need.

Cllr Ann McCoy
Lead Governor

The Composition of the Council of Governors as at 31st March 2018

Membership of the Council of Governors during 2017/18

The terms of office of governors and their attendance at the 6 meetings (including the Annual General Meeting) held during 2017/18 was as follows:

Public Governors (Elected)

Name	Constituency	Term of Office	To	Total Attended
Andrea Goldie	Darlington	01/07/2014	30/06/2017	0 (1)
Dennis Parry	Darlington	01/07/2017	10/07/2017	0 (0)
Dennis Haithwaite	Darlington	01/07/2014	30/06/2017	0 (1)
Maureen Powles	Darlington	14/07/2017	17/01/2018	1 (2)
Lesley Robertson	Darlington	01/07/2017	30/06/2020	1 (5)
Catherine Haigh	Middlesbrough	01/07/2016	23/01/2018	1 (4)
Mary Booth	Middlesbrough	01/07/2017	30/06/2020	3
Richard Thompson	Scarborough & Ryedale	01/07/2014	30/06/2017	1 (1)
Judith Webster	Scarborough & Ryedale	01/07/2017	30/06/2020	3 (4) *
Elizabeth Forbes-Browne	Scarborough & Ryedale	01/07/2016	30/06/2019	0
Bernard Cole	Scarborough & Ryedale	01/07/2017	18/03/2018	3 (5)
Claire Farrell	Redcar and Cleveland	01/07/2014	30/06/2017	0 (1)
Alan Williams	Redcar and Cleveland	01/07/2017	30/06/2020	3 (5)
Vanessa Wildon	Redcar and Cleveland	01/07/2016	30/06/2019	5

William Bailey *(previously known as Paul Emerson-Wardle - notified 08/06/2017)*	Stockton-on-Tees	12/11/2014	30/06/2017	0 (1)
Gillian Restall	Stockton-on-Tees	01/07/2017	30/06/2020	6
Mark Eltringham	Stockton-on-Tees	01/07/2017	30/06/2020	5 (5)
Gary Emerson	Stockton-on-Tees	01/07/2016	30/06/2019	4
Betty Gibson	Durham	01/07/2014	30/06/2017	0 (1)
Janice Clark	Durham	01/07/2014	30/06/2017	0 (1)
Anthony Heslop	Durham	01/07/2016	30/06/2017	1 (1)
Jacci McNulty	Durham	01/07/2017	30/06/2020	4 (5)
Mac Williams JP	Durham	01/07/2017	30/06/2020	4 (5)
Sarah Talbot-Landon	Durham	01/07/2016	30/06/2019	4
Cliff Allison	Durham	01/07/2017	30/06/2020	5
Graham Robinson	Durham	01/07/2017	30/06/2019	5 (5)
Keith Mollon	Durham	01/07/2016	30/06/2019	5
Dr Lakkur Murthy	Durham	01/07/2016	30/06/2019	5
Sandra Grundy	Durham	01/07/2017	30/06/2020	3 (4) *
Zoe Sherry	Hartlepool	01/07/2017	30/06/2020	5
Jean Rayment	Hartlepool	01/07/2016	30/06/2019	5
Colin Wilkie	Hambleton and Richmondshire	01/07/2014	30/06/2017	0 (1)
Angela Stirk	Hambleton and Richmondshire	01/07/2014	30/06/2017	1 (1)
Ailsa Todd	Hambleton and Richmondshire	01/07/2017	30/06/2020	4 (5)
Della Cannings QPM	Hambleton and Richmondshire	01/07/2017	30/06/2020	5 (5)
Hilary Dixon	Harrogate & Wetherby	01/07/2016	30/06/2019	5
Chris Gibson	Harrogate & Wetherby	01/07/2016	30/06/2019	5
Hazel Griffiths	Harrogate & Wetherby	01/07/2016	30/06/2019	2 (5) *
Dr Martin Combs	York	23/03/2016	30/06/2018	6
Nathaniel Drake	York	23/03/2016	30/06/2018	0
Dr Peter Harrison	York	23/03/2016	30/06/2018	6
Gemma Benson	Selby	01/07/2017	30/06/2020	4 (5)
Wendy Fleming-Smith	Selby	01/07/2017	30/06/2020	1 (5)

Staff Governors (Elected)

Name	Constituency	Term of Office	To	Total Attended
Simon Hughes	Teesside	01/07/2014	30/06/2017	1 (1)
Rachel Booth	Teesside	01/07/2017	30/06/2020	3 (4) *
Phil Boyes	County Durham & Darlington	01/07/2017	30/06/2020	5 (5)
Dr Judith Hurst	Corporate	01/07/2017	30/06/2020	5
Glenda Goodwin	Forensic	01/07/2017	30/06/2020	6
Wendy Pedley	North Yorkshire	10/10/2014	30/06/2017	0 (1)
Gary Matfin	York and Selby	19/02/2016	30/06/2018	6

Appointed Governors

Name	Appointing Organisation	Term of Office	To	Total Attended
Lisa Pope	Hambleton, Richmondshire and Whitby Clinical Commissioning Group / Scarborough and Ryedale Clinical Commissioning Group / Harrogate Clinical Commissioning Group / Vale of York Commissioning Group	01/11/2016	31/10/2019	0
Dr John Drury	Hartlepool and Stockton-on-Tees Clinical Commissioning Group / NHS South Tees Clinical Commissioning Group	01/07/2014	-	3
Dr David Smart	North Durham Clinical Commissioning Group / Durham Dales, Easington and Sedgefield Clinical Commissioning Group / Darlington Clinical Commissioning Group	25/09/2014	-	3
Marion Grieves	University of Teesside	29/04/2015	-	1
Professor Pali Hungin	Durham University	01/07/2014	30/06/2017	0 (1)
Professor Graham Towl	Durham University	23/10/2017	-	0 (2)
Cllr Ann McCoy	Stockton Borough Council	08/07/2014	30/06/2019	2
Cllr Kaylee Sirs	Hartlepool Borough Council	05/06/2017	-	0 (5)

Kevin Kelly	Darlington Borough Council	13/08/2015	-	0
Lee Alexander	Durham County Council	13/01/2017	-	2
Cllr Helen Swiers	North Yorkshire County Council	24/05/2016	-	4
Professor Angela Simpson	The University of York	27/01/2017	31/01/2018	1 (5)
Professor Steven Ersser	The University of York	01/02/2018	09/03/2018	0 (1)
Ian Hamilton	The University of York	09/03/2018	-	0 (0)
Cllr Ashley Mason	City of York Council	28/06/2016	-	0
Dr Suresh Joseph	Newcastle University	18/07/2017	16/01/2018	0 (4)
Prof Hamish McAllister-Williams	Newcastle University	06/03/2018	-	0 (0)

(Notes: Within the above tables -

- *The maximum number of meetings to be attended for those governors who held office during part of the year is shown in brackets*
- ** indicates that the Governor received a dispensation during the year from the attendance requirements set out in the Constitution for example due to ill-health)*

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

Elections held during 2017/18

Constituency Name	Date of Election	No of Seats	No. of candidates	No. of Votes cast	No. of eligible voters	Turnout (%)
Staff Governors						
Corporate	22/6/17	1	3	155	1066	14
County Durham and Darlington	22/6/17	1	1	-	-	-
Forensic	22/6/17	1	1	-	-	-
North Yorkshire	22/6/17	1	0	-	-	-
Teesside	22/6/17	1	1	-	-	-
Public Governors						
Darlington	22/6/17	2	3	51	755	6
Durham	22/6/17	5	9	174	2041	8
Hambleton and Richmondshire	22/6/17	2	3	78	531	14
Hartlepool	22/6/17	1	1	-	-	-
Middlesbrough	22/6/17	1	2	82	1162	7
Redcar and Cleveland	22/6/17	1	1	-	-	-
Rest of England	22/6/17	1	0	-	-	-
Scarborough and Ryedale	22/6/17	2	3	51	548	9
Selby	22/6/17	2	3	19	233	8
Stockton on Tees	22/6/17	2	2	-	-	-

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

Report of the Council of Governors' Nomination and Remuneration Committee

The Nomination and Remuneration Committee supports the Council of Governors undertake its duties regarding the appointment and setting the remuneration and terms of service of the Chairman and non-executive directors.

Meetings of the committee are chaired by the Chairman of the Trust except that the Senior Independent Director becomes a member of and chairs the committee for the matters relating to the appraisal and appointment of the Chairman.

During the year the committee:

- received assurance on the conduct and outcomes of the appraisals of the non-executive directors
- considered and recommended the re-appointment of Dr. Hugh Griffiths and David Jennings, as Non-Executive Directors, to the Council of Governors
- on the nomination of the Board, considered and recommended the appointment of Dr. Hugh Griffiths as the Deputy Chairman of the Trust
- considered the arrangements for future reviews of non-executive director remuneration
- reviewed the scheme for the payment of special responsibility allowances to the non-executive directors
- received and took assurance from benchmarking information on the remuneration of the non-executive directors

The membership of the committee, and attendance at its two meetings during 2017/18, was as follows:

Lesley Bessant	Chairman of the Trust	2
Betty Gibson	Public Governor	0 (1)
Colin Wilkie	Public Governor	1 (1)
Mary Booth	Public Governor	2
Della Cannings QPM	Public Governor	1 (1)
Mac Williams JP	Public Governor	1 (1)
Dr. Judith Hurst	Staff Governor	2

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

Marcus Hawthorn, the Senior Independent Director was not required to attend the above meetings.

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

Training and Development

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

To meet this requirement the Council of Governors has agreed a training and development programme based on the national "Governwell" programme and local opportunities including inductions for new governors and governor development days.

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

- 92% of governors, elected or appointed in the last 18 months, agreed/slightly agreed that the Trust provided an adequate induction programme
- 96% agreed/slightly agreed that relevant training was provided on an ongoing and timely basis and appropriate briefings were provided in relation to key topics being discussed.
- 96% agreed/slightly agreed that the governor development days and ad hoc briefings had assisted them develop their wider knowledge and understanding of their role and the Trust.

Governor participation in the development of the Operational and Business Plan

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

In 2017/18 the Council of Governors:

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

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

Of those governors responding to the annual performance evaluation, 95% agreed/slightly agreed with the statement that the Council of Governors was successful in influencing the Trust's business plan/strategy.

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

Membership Report

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

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

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

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

As at 31st March 2018 the Trust's membership was as follows:

- Public members – 9,531
- Staff members – 6,555

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

Public constituency	Number of members	Eligible membership
Age (years):		
0-16	30	377,412
17-21	679	121,890
22+	8,321	1,508,697
Ethnicity:		
White	8,706	1,897,919
Mixed	55	17,513
Asian or Asian British	158	40,256
Black or Black British	65	7,935
Other	17	5,452
Socio-economic groupings*:		
AB	2,101	116,754
C1	2,625	176,896
C2	2,159	136,350
DE	2,594	175,232
Gender analysis		
Male	3,249	986,283
Female	6,235	1,021,714

(Notes: On application:
- *501 members did not provide a date of birth*
- *530 members did not state their ethnicity*
- *47 members did not state their gender)*

Member engagement

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

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

A range of activities and actions are in place to support member engagement. Over the last 12 months these have included:

- Welcome packs are issued to every new public member with a unique membership card and number, welcome letters and details of staff governors issued to all new staff members.
- Issue of the insight magazine to all members signed up as an informed member and above which includes articles written by governors and service users and carers within the Members News section.
- Personal invitations issued to public members to attend member engagement events held in five different areas of the Trust.
- Communications and drop in events to support the awareness of Governor Elections.
- Delivery of the Annual General and Members Meeting with over 200 attendees.
- Website forum and increased use of social media

- A number of social / community events attended such as Durham Pride, Time to Talk Day and Darlington's Tea Dance.
- Attendance at College Fresher and wellbeing days.
- Invitations to formal public consultations held within Hambleton and Richmondshire on the provision of inpatient services at The Friarage Hospital and the development of Community Services in the area
- Consultation on the business plan priorities including seeking views of the public and formal consultation with the Council of Governors to enable them to engage with their membership.

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

The Council of Governors has also established a task and finish group to review the involvement of service users and carers across the Trust looking for best practice and identifying where improvements can be made. The group is due to provide a report on its findings, including recommendations, during 2018/19.

Members wishing to contact Governors and/or Directors of the Trust can do so via the Trust Secretary's Department on 01325 552314, email tewv.ftmemberhsip@nhs.et or visit our website www.tewv.nhs.uk

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

NHS Improvement's Single Oversight Framework

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

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

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

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

Segmentation

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

This segmentation information is the Trust's position as at 31st March 2018. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and use of resources

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

Area	Metric	2017/18 scores				2016/17 scores	
		Q4	Q3	Q2	Q1	Q4	Q3
Financial sustainability	Capital service capacity	3	3	3	3	2	2
	Liquidity	1	1	1	1	1	1
Financial efficiency	I&E margin	1	1	1	1	1	1
Financial controls	Distance from financial plan	2	2	2	2	1	1
	Agency spend	2	2	2	2	1	1
Overall scoring		**2**	**2**	**2**	**2**	**1**	**1**

Statement of the chief executive's responsibilities as the accounting officer of Tees, Esk and Wear Valleys NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Tees, Esk and Wear Valleys NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of 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 Department of Health Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance and
- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The accounting officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.
To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

Colin Martin
Chief Executive **22nd May 2018**

Annual Governance Statement 2017/18

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 2018 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Chief Executive is the Trust's Accounting Officer responsible for ensuring that the principles of risk management are embedded throughout the organisation.

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

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

The risk and control framework

The Trust's approach to Risk Management is contained in the Integrated Governance Framework which is subject to regular review. The principal risks to compliance with the NHS foundation trust condition 4 (FT governance) and actions identified to mitigate these risks are detailed below

Key elements of the Risk Management Strategy are:

- To provide clear management structures and responsibilities throughout the organisation leading to the Board of Directors
- To identify a Lead Executive responsibility for each risk
- To outline the Trust's approach to Risk Management and identifying risks
- To outline and implement a system for assessing risk
- To select the approach for dealing with the risk
- Monitoring and reporting of risk
- Use of an integrated risk register for prioritising and reviewing risks
- Decision making on acceptability of risk
- Training and awareness of Risk Management
- Assurance framework mapping objectives to risks, controls and assurances

Risk is identified using a number of internal and external mechanisms including; NHS Resolution (NHSR), Care Quality Commission (CQC), serious incident investigations, complaints management, litigation, staff surveys, task groups, Trust risk register, clinical audit and internal and external audit.

The embedding of risk management can be demonstrated in the Trust by;

- Clear structures and responsibilities with clear reporting arrangements to Trust Board
- A system for risk assessment in place to identify and minimise risk as appropriate
- Consideration of acceptability of risk
- Development of reporting arrangements on serious investigations and complaints
- Framework for assessing and managing clinical risk and harm minimisation
- Development of risk registers at strategic and operational level
- Awareness training for all staff.
- The embedding of an action plan to further strengthen risk management and Board Assurance Framework processes as outlined in the Head of Audit Opinion.
- Assurances provided by reviews undertaken by the Internal Auditors (Audit One)

Public stakeholders are involved in identifying risks and providing assurance that they are mitigated in a variety of ways:

- The 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 local authority social services departments to ensure the delivery of integrated care and treatment

In addition an Assurance Framework was in place at 31 March 2018; remains in place up to the date of approval of the annual report and accounts; and continues to be maintained for the financial year ahead.

The main risks to the Trust meeting its principal objectives have been identified within the framework together with the key controls in place to manage these risks. Although the Trust has not identified any significant control issues, it is improving the control and management of some of the risks in the following areas:

The Trust continues to use a process of Quality Impact Assessments (QIA) which are designed to assess and approve all Cash Releasing Efficiency Savings (CRES) schemes for the impact they have on clinical performance, and ultimately, patient care.

A considerable amount of work has been undertaken to strengthen clinical audit arrangements. Improvements have been made to processes for planning and management of the programme and additional resources have been deployed to increase clinical audit capacity. Action plans are in place to further strengthen and embed clinical audit procedures.

The Trust currently has an ongoing contractual dispute regarding Roseberry Park. The outcome of this legal process has not yet concluded; however, it is not expected that it will have an adverse impact on the Trust. This position will continue to be reviewed as more detail is known, including reporting to Board.

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

Further work has been carried out continuing the improvements put in place in prior years in the development of a robust workforce performance management framework.

Plans are also in place to further develop the Trust's information systems to support the organisation's objectives (including data quality, the implementation of mental health currencies including quality and outcome measures) and the Trust's approach to managing counter fraud.

A key focus has been the issue of Cyber security and ensuring that the Trust has actions in place to meet all of the 10 steps for Data Security and protection and the recommendations from the Lessons Learned Review of the WannaCry Ransomware Cyber-attack. The Trust has established a Digital Safety Board, to further strengthen and embed Cyber security protocols, to minimise the risk to the Trust.

In all cases mitigation plans are in place to ensure that these gaps are removed as soon as is practical. This process is managed by the Trust Board's sub committees and reported to the Board.
The Trust recognises the importance of gaining independent assurance that its controls are operating effectively and that its action plans to strengthen controls are successfully implemented. To do this the Trust uses information received from other organisations which is timely, accurate and recorded. This supports robust governance processes that provide assurance that the Trust is compliant with the provisions of the licence

The Trust is committed to meeting the requirements of the Department of Health's Information Governance Assurance Programme. An overall score of 88% was achieved against the Information Governance Toolkit in 2017/18 with all sequences achieving, at least, level 2 compliance. The Director of Finance and Information is the senior information risk owner (SIRO) at Board level. The Trust operates a SIRO network (information asset owners and administrators), which has increased Information

Governance awareness, training and understanding of standards. The network is supported by an Information Governance Campaign to delivery of these activities.

The Trust has an established anti-fraud and corruption policy which aims to minimise the risk of fraud, bribery or corruption by detailing the key roles and responsibilities of employees and related parties; as well as promoting an anti-fraud culture throughout the Trust.

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

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

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

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

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

The foundation trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

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

- Agreeing a rolling 3 year annual financial strategy and plan (including capital)
- 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
- 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, improving and developing the estate
- Improving workforce productivity
- Benchmarking management costs
- Commissioning external consultancy where the Trust believes economy and efficiency can be improved
- Embedding the Quality Improvement Systems (QIS) methodology to review how the Trust operates, maximising efficiency and minimising waste
- Values based recruitment process
- Supporting staff to raise issues through whistleblowing and a “fair blame culture”

The Board plays an active role by:

- Determining the level of financial performance it requires and the consequent implications (including QIA)
- Reviewing in detail each month financial performance, financial risk and delivery against the detailed CRES
- Agreeing the integrated Business Plan, Quality Report and Self Certification submitted to NHS Improvement.
- Considering plans for all major capital investment and disinvestment

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

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

Information Governance

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

The Trust continues to prepare for the implementation of The General Data Protection Regulations (GDPR), through the Digital Safety Board, in May 2018.

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

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

- The Quality Assurance Committee is responsible for producing the Quality Accounts with the Director of Nursing and Governance and the Director of Planning and Performance being lead Directors. The Quality Assurance Committee has received reports throughout the year regarding the development of the Quality Accounts, including an early draft of the accounts.

- Priorities for improvement have been identified from an analysis of serious untoward incidents, complaints, and mortality reviews 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 continues to develop a Data Quality Strategy which provides a framework for improvements in this important area. A Data Quality Strategy Scorecard is also in place to enable the Board of Directors to track progress.

- The Trust has the following policies linked to data quality:

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

    The policies incorporate national standards where available and are regularly reviewed. All the policies are held on the intranet and are available to staff at all times. When policies have been reviewed (or new ones published) there is a mechanism to inform staff through team brief.

- A significant amount of training is provided to support staff using the electronic patient record (PARIS) and to ensure compliance with CPA. Training is provided where issues around data quality have been identified.

- As part of performance reporting to the Board actual data is used to forecast future positions thus improving the decision making process.

- All data returns are submitted in line with agreed timescales.

Review of effectiveness

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

My review is also informed by

- The Care Quality Commission
- NHS Resolution Clinical Negligence Scheme for Trusts (CNST)
- Internal Audit
- External Audit
- Health and Safety Executive
- Internal Clinical Audit Team

The following groups and committees have been involved in maintaining and reviewing the effectiveness of the system of internal control;

- The Board of Directors is responsible for setting the strategic direction of the organisation and monitoring the progress of the organisation against targets. The Board also receives minutes and reports from its sub committees.
- It is the Council of Governors duty to hold the non-executive directors to account for the performance the Board of Directors, and to represent the interests of the public.
- The Audit Committee provides an independent view of internal control by reviewing financial systems, overseeing audit services and providing assurance to the Board on governance issues including reviewing commenting on the clinical audit programme.
- The Quality Assurance Committee oversees on behalf of the Board of Directors all clinical governance activity including a review of the clinical audit processes and programme.
- Internal Audit provides an independent and objective opinion on the degree to which risk management, control and governance support the achievement of the Trust's objectives. The Head of Internal Audit opinion provided good assurance for this area, and all issues raised have been considered appropriately.
- The external auditor provides progress reports to the Audit Committee.
- The annual report and accounts are presented to the Board of Directors for approval.

Conclusion

In summary, the Trust has not identified any significant internal control issues within 2017/18, and has a sound system of Internal Control and Governance in place which is designed to manage the key organisational objectives and minimise the Trust's exposure to risk. The Board of Directors is committed to continuous improvement and enhancement of the systems of internal control.

Colin Martin
Chief Executive

Date: 22nd May 2018

Quality Report
(subject to independent review)

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

I am pleased to be able to present Tees, Esk and Wear Valleys NHS Foundation Trust's (TEWV) Quality Account for 2017/18. This is the 10th Quality Account we have produced and it details what we have done to improve the quality of our services in 2017/18 and how we intend to make further improvements in 2018/19.

TEWV primarily serves the populations of:

- County Durham;
- Darlington;
- North Yorkshire (not including Craven district, but including Wetherby);
- Teesside (the boroughs of Hartlepool, Middlesbrough, Redcar & Cleveland and Stockton);
- The Vale of York (which includes York, Easingwold, Pocklington, Tadcaster and Selby).

Our specialist services such as Child and Adolescent Mental Health Services (CAMHS) inpatient wards, adult eating disorder wards and forensic secure adult wards serve patients from elsewhere in the North East, Cumbria, Yorkshire and the Humber and further afield.

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

Our Mission, Vision & Strategy

The purpose of the Trust is:

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

and our vision is:

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

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

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

It is also supported by our **Quality Strategy** 2017-2020. This outlines our quality vision for the future, which is:

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

The Quality Strategy contains three goals which are:

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

TEWV's 2017 Community Mental Health Survey results show:

- The response rate of 29% was above the national response rate of 26%.
- When comparing TEWV survey results with those of the other organisations the scores were identified as being 'about the same' as other organisations across all 10 sections.
- Whilst there were no questions identified as scoring 'better' than other Trusts, TEWV scored well in three questions.
- TEWV scored 'about the same' as most other Trusts in all but one of the individual questions, which scored 'worse' (question 31: *Were these treatments or therapies explained to you in a way you could understand?)*.
- The overall rating on care experience was 70.9% in 2017 which has declined from the 2016 score of 74.3%. To improve this position, the Trust will examine the data to identify questions which scored low and concentrate improvement activity on these areas.

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

What we have achieved in 2017/18

- We have continued to work to deliver new services to meet the needs of those who use our services. For example we have:
  - Established a 24/7 Adult Learning Disability crisis access service across the Vale of York and North Yorkshire.
  - Set up an Adult Learning Disability Enhanced Crisis Preventative Community Service in Durham, Darlington and Teesside.
  - Improved the number of people with Learning Disabilities seen in collaboration with Adult Mental Health (AMH) services under Greenlight arrangements in

York and Selby, both inpatient and outpatient. We also now have champions for Positive Behavioural Support in our York Adult Learning Disability teams.

- Co-produced a vision for the future of services for people with autism and developed a training programme for staff.
- Introduced a new care planning process and format for Children and Young People's services, which are now written during an appointment with the service user, and written in the first person.
- Been granted planning permission for a new mental health hospital serving adult and older people at Haxby Road in York.
- Received Clinical Commissioning Group (CCG) agreement on a preferred model for the future mental health services for people living in Hambleton and Richmondshire. This will lead to investment into community services that will help to reduce admissions. It also means that there will no longer be mental health beds at The Friarage Hospital. Residents of this area who require inpatient treatment will be admitted to West Park, Roseberry Park or Auckland Park hospitals. These wards provide purpose built modern accommodation that supports the delivery of high quality care.
- Further increased the number of paid and voluntary experts by experience at the Trust. This is having a positive impact on staff culture and practice. Increasingly policies are being co-produced and recovery-friendly language is in use.
- Started work to establish the key features of a recovery oriented community team, enabling a TEWV recovery accreditation scheme to be developed.
- Expanded the range of courses at our Durham Recovery College.
- Launched an online Recovery College, accessible by service users as well as staff across the whole TEWV area.
- Achieved Investors in People (IiP) Gold Accreditation using the revised and more challenging IiP standard, and the Care Quality Commission (CQC) rated the Trust's leadership as "Good" in their most recent Well Led Review.

In the 2017 national NHS Staff Survey, the Trust had a response rate of 52% (3354 of 6402 eligible staff), the average response rate for Mental Health and Learning Disability Trusts.

The Trust scored the same or better than average on 30 of the 32 areas covered by the staff survey, two of which were the best score for Mental Health.

- We have also worked to improve our quality through staff training and, communication. For example we have:
  - Commenced the delivery of Trauma Informed Care (TIC) training.
  - Introduced training for all new inpatient staff in relation to patient leave and time away from the ward.

- As well as the examples above, we have also continued to drive improvements in the quality of our services through using the TEWV Quality Improvement System (QIS). This is the Trust's approach to continuous quality improvement and uses tried and tested techniques to improve the way services are delivered. Some notable examples of what we have achieved in 2017/18 are that we have:
  - Redesiged many of our clinical pathways and clinical link pathways (CLiPs).
  - Spread the existing Purposeful Inpatient Admissions (PIPA) approach from our Adult wards to our Older People's wards. This reduces delays in assessment,

treatment and discharge, encourages multi-disciplinary team working and reduces inconsistenices in approach between different localities within TEWV.

- Improved and standardised practice across our two adult Psyciatric Intensive Care Units (PICUs) leading to a more recovery oriented approach and better arrangments for transfer back to assessment and treatment wards.
- Agreed Crisis Team triage and assessment standards, and criteria for admission and home based treatment interventions by these teams.
- Agreed Visual Control Boards (VCB) for the home-based treatment component of care (including extended assessment where indicated).
- Brought about improvements in the psychological input to the treatment of older people in our services (by improving the processes for referral to psychology). This is reducing waiting times from initial referral to first contact, improving the standard process for formulation, and ensuring more equity in length of time in therapy.
- Observed the daily practice of community mental health teams in all specialities and piloted new ways of entering patient information into our electronic patient record (Paris). This has increased the proportion of time that clinicians can spend with service users.
- Following a patient safety incident, utilising QIS principles, our Durham and Darlington Learning Disabilities service has implemented a new system to make sure that physical health and other checks for people taking lithium is taking place. It also ensures that there are timely reviews of care and intervention.
- Our Children and Young People's Services (CYPS) reviewed their existing care pathways to make them more Learning Disability compatible. This included ensuring any information gathering in the early stages would feed into a decision on whether a Leaning Disability assessment was needed and also contribute to that assessment. These new arrangements were piloted in Durham and Redcar.

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

- 81% are likely or highly likely to recommend treatment at TEWV.
- 70% would recommend TEWV as a place to work.
- 83% agree that they are able to make suggestions for improvement.

- In addition we have worked with our partners to improve services. For example we have:
  - Established a Service Level Agreement (SLA) with a local acute Trust to provide tissue viability advice, support and training for staff (for any pressure ulcer of grade 2 or above).
  - Supported the development of the voluntary and community sector's (VCS) adult learning disability workforce. We have done this by training TEWV staff in an Active Support 'train the trainer' Programme and mentoring other providers' staff through Positive Behavioural Support BTEC (Business and Technology Council) courses.
  - Developed good informal research relationships with the higher education sector in York and with potential new providers of medical and nursing / Allied Health Professional (AHP) training.
  - Continued to organise the TEWV Learning Disability Quality conference. This has now been running for 11 years and each year it has become more successful and popular with over 200 people now attending. It showcases engagement and collaborative working. Service users are at the heart of the

conference and are involved in the development, production and delivery of the conference.

- Worked with NHS England (NHSE), Northumberland, Tyne and Wear NHS Foundation Trust (NTW) and other providers to progress our pilots that are testing our provider-led management of NHSE commissioning budgets. We have active projects in adult secure (forensic) and CYPS specialist inpatient services. The CYPS work is most advanced and has led to investment in Crisis / Intensive Home Treatment teams across the area served by the Trust, and a reduction in admissions. We have also developed an Accountable Care Partnership (ACP) with the CCGs across Durham, Darlington and Teesside. In its first phase this has carried out reviews into over 60 Adult Learning Disability NHS funded placements and brought about many improvements in both the quality and value for money of these.

In 2017/18 the Trust was also recognised externally in a number of national awards where we won or were shortlisted. Awards won / highly commended by TEWV teams or staff members are shown in the table below:

Awarding Body	Award status	Name / Category of Award	Team / individual
British Medical Journal (BMJ) Awards 2017	Highly commended	Education category	Delirium team / Dr Mani Santhanakrishnan
Division of Forensic Psychology	Winner	2017 Senior Award for Distinguished Contributions to Professional Practice in Forensic Psychology	Ruby Bell
Yorkshire Personal Assistant (PA) awards	Runner-up	Best team	Community Learning Disabilities team - secretaries, York
Faculty for the psychology of older people in the British Psychological Society	Awarded	Mid-career - Bill Downes award	Sarah Dexter-Smith
Royal College of Psychiatrists' Centre for Quality Improvement	Awarded	Enabling Environment award	The PIPE (Psychologically Informed Planned Environment) team at HMP/YOI Low Newton
Royal College of Psychiatrists	Awarded	AIMS (Accreditation for Mental Health Inpatient Services)	Esk and Danby wards at Cross Lane Hospital, Scarborough
	Awarded	CCQI (College Centre for Quality Improvement) Quality Network for Inpatient CAMHS Accreditation	Westwood Centre
Royal College of Psychiatrists	Winner	Psychiatric Communicator of the Year	Dr Mani Santhanakrishnan
	Winner	Psychiatric Team of the Year: Non age-specific	Women's Forensic Learning Disabilities Secure Service
	Winner	Foundation Doctor Category	Dr Megan Brown
Positive practice in mental health awards 2017	Highly commended	Specialist Services category	Rollercoaster (parent support group)
	Highly commended	Co-production of care	Rollercoaster (parent support group)
	Highly commended	Innovation in Children and Young People's MH	Rollercoaster (parent support group)

Awarding Body	Award status	Name / Category of Award	Team / individual
	Winner	Psychological Therapies for People with 'Common Mental Health Problems'	Mindfulness team
	Highly commended	Mental wellbeing of staff	The TEWV Employee Support Service
	Highly commended	Integration of physical and mental healthcare	Harrogate Vanguard team
Australian College of Mental Health Nurses	Awarded	Research award 2017	David Ekers
The Investing in Children (IiC) Membership Award Scheme	Awarded	IiC Accreditation - Investing in Children Membership Award	CAMHS Hartlepool
Positive practice in mental health awards 2017	Winner	Carer / Parent / Sibling award	Rollercoaster (parent support group)

Awards where TEWV or one of its teams / staff were shortlisted for an award but did not win that award in 2017/18 were:

Awarding Body	Name / Category of Award	Team / individual
Student nursing times awards 2017	Mentor of the year	Claire Baird
	Student nurse of the year: learning disabilities	Catherine Thompson
BMJ awards 2017	Prevention team	Suicide prevention training
Royal College of Nursing (RCN) Nursing awards 2017	Mental health practice award	Perinatal mental health pathway team at HMP/YOI Low Newton
Health Service Journal (HSJ) Value in Healthcare Awards	Improving the value of NHS support services	Workforce development team
Patient Safety Awards 2017	Mental health	Mental Health Services for Older People, suicide prevention training team
Nursing Times awards	Nursing in Mental Health	Developing a perinatal mental health pathway within a female prison - a collaborative, cross-agency approach
Royal College of Psychiatrists	Specialty Doctor / Associate Specialist of the Year	Dr Ajith Suryadevara
	Psychiatric Team of the Year: Working-age adults	Teesside Crisis Service / Crisis Assessment Suite
		Teesside Rehabilitation Services
	Psychiatric Team of the Year: Older-age adults	Mental Health Services for Older People, Durham and Darlington
	Psychiatric Team of the Year: Quality Improvement	Adult Learning Disability Unit, Durham
		Durham and Darlington Child and Adolescent Mental Health Services Senior Management

Awarding Body	Name / Category of Award	Team / individual
		Team
	Carer Contributor of the Year	Sheena Foster
		Hazel Griffiths (Governor for the Trust)
NHS innovations North Bright ideas in Health	Research Delivery Impact	An innovative method of delivering RESEARCH AWARENESS to TEWV service users, carers and staff
Health Heroes Awards 17	Clinical Support Worker of the Year	Cheryl Young
Dementia Friendly Awards 2017	Dementia Friendly Community of the Year	Dementia Friendly Hartlepool
Health Business Awards	NHS Collaboration Award	Tees, Esk and Wear Valleys NHS Foundation Trust / Durham Constabulary - Street Triage
Patient Experience Network National Awards (PENNA)	Measuring, Reporting and Acting	Tees, Esk and Wear Valley NHS Foundation Trust - Making best use of technology to collect, report and use feedback to improve services

Structure of this Quality Account document

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

- **Part 2** – Information on how we have improved in the areas of quality we identified as important for 2017/18, the required statements of assurance from the Board and our priorities for improvement in 2018/19.
- **Part 3** – Further information on how we have performed in 2017/18 against our key quality metrics and national targets and the national quality agenda.

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

A full statement of Directors' responsibilities in respect of the Quality Account is included in **appendix 1**. This is further supported by the signed limited assurance report provided by our external auditors on the content of the 2017/18 Quality Account which is included in **appendix 2**.

I hope you find this report interesting and informative.

If you would like to know more about any of the examples of quality improvement or have any suggestions on how we could improve our Quality Account please contact:

- Sharon Pickering (Director of Planning, Performance and Communications) at sharon.pickering1@nhs.net; or
- Elizabeth Moody (Director of Nursing and Governance) elizabeth.moody@nhs.net.

Colin Martin **22 May 2018**
Chief Executive
Tees, Esk and Wear Valleys NHS Foundation Trust

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

Update on 2016/17 quality priorities

In last year's Quality Account we reported on our progress with our quality priorities for 2016/17. Within this we also noted some further actions for 2017/18. In some cases, these actions were to be included within the quality priorities for 2017/18, and therefore, are reported within this Quality Account. In other cases, these quality priorities were discontinued in the Quality Account but remained a priority for the Trust. The following is a brief summary of our progress with the quality priorities that were not continued in the Quality Account priorities for 2017/18.

Implement and embed the revised harm minimisation and risk management approach	The Harm Minimisation Project was formally closed down at the end of March 2017. In April 2017 the mandatory Clinical Risk Assessment and Management e-learning was replaced with the new Harm Minimisation e-learning package. The e-learning was co-developed with experts by experience and allows the learner to provide reflective accounts of the harm minimisation and recovery agenda. These reflections are printed off and can be used for supervision / appraisal and as evidence for professional revalidation where appropriate. Given its central importance to good clinical practice, this training will be required every 2 years. Feedback on the e-learning has been mostly positive with staff commenting that doing reflections rather than questions is better and that the service user's narrative within the training is extremely powerful. It was recognised however that to enable the Trust to achieve the cultural change required to move toward recovery orientated harm minimisation which focuses on narrative development and co-production of recovery / safety plans, face to face training would need to continue for at least another year. Therefore during 2017/18 face to face training has continued to be provided by the established project training team consisting of one nurse and two part time experts by experience. The aim for 2017/18 was to deliver training (either face to face or e-learning) to 90% of all clinical staff by the end of quarter four 2017/18. To date 91% of all clinical staff have completed harm minimisation training. Of these, 79% have completed face to face training and the remainder e-learning. Of the 79% who have attended face to face training 67% have attended centrally booked training and the remaining 33% team training. Quarterly progress reports are sent to the recovery programme board and weekly updates to the Chief Operating Officer and Director of Nursing and Governance.

Further implementation of the nicotine replacement programme and smoking cessation project	Work has progressed well for the Nicotine Management Project with 2,971 staff receiving training to date and a full training programme available for staff for 2018/19. The Project Lead has presented at a number of national conferences and is part of the newly formed North East "Smoke free NHS / Treating Tobacco Dependency Taskforce" to further support the smoke free agenda in the region. As part of the work for 2017/18 the team reviewed the Nicotine Management Policy which is planned to be available for internal consultation around May / June 2018. The yearly audit looking at Trustwide smoking rates has been completed and once the final data and draft report are available future actions will be identified. The initial data highlights a reduction in smoking rates in all services Trustwide with Children and Young People Service (CYPS) and adult Learning Disabilities (LD) services having 0% smokers at the time of the audit. With regards to the Project Lead's support for the North East Prisons going smoke free, all eight North East prisons have now safely gone smoke free. Work will continue within 2018/19 to develop new training packages for delivery to prison staff and the development of a "train the trainer" model which will support the sustainability of prison smoke free services for the future.

2017/18 Priorities for improvement – how did we do

As part of our 2016/17 Quality Account following consultation with our stakeholders, the Board of Directors agreed five quality priorities to be addressed via the Quality Account during 2017/18:

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

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

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

Priority 1: Implement phase two of our Recovery Strategy

Why this is important:

Supporting the recovery and wellbeing of individuals is the core aim of the services we provide. Patients and carers continue to make it clear that they want services to go beyond reducing the symptoms of mental health. They want support to live meaningful and fulfilling lives irrespective of whether or not they experience a reduction in symptoms.

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

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

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

The benefits / outcomes we aimed to deliver for our patients and their carers were:

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

What we did in 2017/18:

The following is a summary of the key actions we have completed in 2017/18:

What we said we would do	What we did
• Recovery College Online available online to people living in the TEWV area by Q1 2017/18.	Recovery College Online was launched in March 2017 and made available to staff, service users, carers and the public. It has continued to be developed throughout the year and now has 85 self-management pages available to the public worldwide with six self-management courses and a tutorial course available to: 1. Individuals living in the TEWV catchment areas; 2. Trust staff. We have linked developments with other strategic priorities, for example we have an online introduction to Trauma course. There are a further nine courses in development. We have secured funding from the Academic Health Science Network to support a pilot in which we will offer Cumbria and Northumberland, Tyne and Wear NHS Trusts access to the resource. Additionally TEWV has provided funding for the next financial year to specifically support the development of CYPS resources. This is further being supported by some additional funding from commissioners in CYPS. The online college will continue to be developed and delivered as a 'business as usual' development.
• Develop a Recovery Demonstration Site [*a team which is excellent in promoting recovery and which others can learn from*] in community adult services by Q3 2017/18.	A significant piece of work has been conducted to set up a Recovery Demonstration site in adult services. Work with two teams has identified core areas which will further support the delivery of recovery and wellbeing orientated services. Core areas identified and being developed include: • The need for leaders to create socially safe environments for staff teams including supporting teams to understand team member working style preferences and strengths. • The embedding of shared decision making within practice. • The introduction of peer workers into clinical services. • Expanding levels of participation and aspiring to co-production at individual service level. • The need to enhance relational elements of care and create a framework to support validation and listening. • Embedding of a different language with language guide in development. Additional areas identified as essential is our organisations ability to review and implement a Care Programme Approach (CPA) process that supports recovery and wellbeing. The demonstration site work will be expanded into the next financial year in parallel with progressing the roll out of training of leaders and will inform the design of a recovery accreditation scheme.

• Development of a Recovery for Leaders training programme by Q4 2017/18.	Essential areas of content for the recovery for leaders programme have been identified via the demonstration site work. Some core training materials are in development. The Trust has embedded a programme approach to manage interdependencies across several strategic programmes and priorities over the last year. This has identified the need to co-ordinate all programme requirements relating to leadership teams resulting in the timeline for agreeing and developing the final recovery for leaders programme being extended into the next financial year.
• Continue to expand Involvement Peer roles by having at least 15 new roles in place by Q4 2017/18.	We have continued to set up new Involvement Peer Roles within the Trust but were unable to meet the final quarter four target due to the need for additional resource allocation to sustain this development. The Trust has funded half of a full time staff member to support this expansion in the next financial year and this post is due to go out to be recruited to in April 2018. It is anticipated that this will support future expansion.
• Develop an infrastructure for embedding a trauma informed approach by Q4 2017/18.	A large scale project to embed Trauma Informed Care (TIC) has been set up and the year one project plan is on target to be delivered. The project has delivered a large programme of training across a range of specialities which will continue into next year. One to one and group trauma informed psycho-education materials have been developed with a plan in place to pilot these interventions. A range of resources have been developed including an online course on Recovery College Online. The development of networks and consultations / supervision networks has progressed and remains an ongoing development. A research plan is in place for a number of research projects. Work has commenced and progressed on guidelines for planning in the event of a disaster and work has commenced on identifying needs of staff in relation to working with and experiencing trauma. Funding for the next financial year is in place and year two action plans are in development.

How we know we have made a difference:

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

Indicator	Target	Actual	Timescale
• To continue to expand the number of paid lived experience / peer roles within the Trust (we currently have 6 of these).	5 new	7	Q4 2017/18
• Number of newly registered involvement peer roles (we currently have 23 of these).	15 new	16	Q4 2017/18
• Recovery College Online will expand the number of: 1. Self-management pages (from a baseline of 30) and; 2. Self-management courses available (2016/17 baseline = 1).	50 7	290 6 + 1 tutorial	Q4 2017/18 Q4 2017/18

Indicator	Target	Actual	Timescale
• Increase the number of staff receiving trauma informed care training (from 100 to 300).	300	772	Q4 2017/18

What we plan to do in 2018/19:

We will:
• Peer support - first training course recruited to and delivered by Q1 2018/19. • First Peers recruited by Q1 2018/19. • Commence harm minimisation training to serious incident and safeguarding teams by Q1 2018/19. • Extend recovery to all specialties - identify and employ recovery leads and undertake baseline assessment by Q1 2018/19. • Work with other leadership programmes in TEWV to ensure an integrated approach by Q2 2018/19. • Deliver to a minimum of 60 additional super-cell leads (recovery for leaders training) by Q3 2018/19. • Develop CYP materials for the Recovery College Online by Q4 2018/19. • Develop team / service accreditation pack and gain initial approval by Q4 2018/19. • Develop a draft recovery / TIC team / service accreditation tool by Q4 2018/19. • Develop a research plan to improve the evidence base for TIC to allow TEWV to lead nationally / internationally by Q4 2018/19. • Develop a culture measurement via a 3 year PhD programme of work by Q4 2018/19.

What we plan to do in 2019/20:

• Commence pilot implementation by Q1 2019/20. • Develop and seek approval for Phase 3 of the Recovery strategy (sign off by December 2019) by Q3 2019/20.

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

Why this is important:

Safe Staffing is essential for the delivery of safe, high quality, evidenced-based patient care. So it's important that we don't just have enough staff on our wards and in our community teams, but also that our staff have the right skills and competencies to deliver excellent care for people with mental health needs and / or with a learning disability.

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

The Carter[1] productivity and efficiency report made it clear that improved workforce efficiency can benefit patient care through better recruitment and retention of permanent staff, better rostering, reduced sickness absence, matching work patterns to patient need and reducing reliance on agency staff.

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

The benefits / outcomes we aimed to deliver for our patients and their carers were:

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

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

What we did in 2017/18:

What we said we would do	What we did
• Establish governance structures by Q1 2017/18.	The programme board is now fully functional with regular reports / updates provided to the Trust's Strategic Change Oversight Board (SCOB) and Executive Management Team (EMT) as a result of this.
• Agree the Programme Plan which will include benefits and work-streams by Q1 2017/18.	The initial programme plan, benefits and workstreams were in place by quarter one. These have subsequently been revised due to the restructure and extended scope of the programme. An updated programme plan has been established, workstreams identified and benefits reviewed.
• Further actions and metrics will be developed for 2017/18 and 2018/19 upon set-up of programme board by Q2 2017/18.	After the increase in scope of the programme, actions were reviewed and developed further; these metrics have been identified to measure the benefits of the programme.
• Implement the agreed actions for 2017/18 by Q4 2017/18.	Actions have been agreed and are in place. Revised actions due to restructure and extended scope were developed and agreed, all of which have been achieved.
• Introduce a new report for ward managers which brings together data on staffing and other quality and safety indicators [*timescale to be confirmed as dependent upon information technology issues*].	Monthly and 6-monthly reports are in place (based on safe staffing levels). There remains a technical issue due to the supplier not being able to provide what we require. Mitigations have been put in place locally to support local gathering of information until a solution can be found. Discussions with the IT supplier continue to be explored.

How we know we have made a difference:

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

Indicator	Target	Actual	Timescales
Monitoring of escalation processes.	100%	100%	Q2 2017/18
Staffing review using the national evidence based Hurst[1] tool.	100%	100%	Q3 2017/18
Review of rostering process to ensure best use of existing resources.	100%	100%	Q3 2017/18

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

What we plan to do in 2018/19:

We will:
• Produce improved training packages on effective rostering by Q1 2018/19. • Build Right Staffing* intranet (InTouch) website by Q1 2018/19. • Develop an operational plan and procedure for effective rostering and data quality improvements by Q2 2018/19. • Develop an extended plan to support staff recruitment and retention by Q2 2018/19. • Develop a plan and framework for ongoing and regular establishment reviews annually for all wards by Q2 2018/19. • Evidence-based staffing establishments: Delivery of proposed plan - phase two by Q3 2018/19. • Develop strategy and plan for Training & Development and Workforce Roles by Q3 2018/19. • Enhance and update the plan and framework for establishment reviews based on clinical pathways (linked with work on model wards) by Q4 2018/19. • Begin implementation of Training & Development and Workforce Roles plan by Q4 2018/19.

*This priority has been renamed 'Right Staffing / Workforce'.

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

Why this is important:

We define transitions for this Quality Account Priority as a purposeful and planned process of supporting young people to move from children's to adults' services. Young people with ongoing or long-term health or social care needs may be required to transition into AMH services, other service provision or back to their GP. The preparation and planning around moving on to new services can be an uncertain time for young people with health or social care needs. There is evidence of service gaps where there is a lack of appropriate services for young people to transition into, and evidence that young people may fail to engage with services without proper support (Watson 2005[2]; Singh 2009[3]).

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

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

[2]Watson AR (2005) Problems and pitfalls of transition from paediatric to adult renal care. Paediatric Nephrology 20: 113–7
[3] Singh SP (2009) Transition of care from child to Adult Mental Health services: the great divide. Current Opinion in Psychiatry 22: 386–90

second year of this priority to further embed the improvements commenced in 2016/17.

The benefits / outcomes we aimed to deliver for our patients and their carers were:

- An improvement in the experience of young people during their transition from Children and Young People's to Adult services.
- Greater involvement in decisions about the care received when they transfer into Adult services.
- To receive care informed by NICE's[4] (National Institute for Clinical Excellence) evidence-based guidelines, which will result in better clinical outcomes.

What we did in 2017/18:

What we said we would do	What we did
• Using the audit action plan, further embed the Safe Transitions and Discharge Protocol by monitoring the agreed actions and timescales by Q2 2017/18.	The Commissioning for Quality and Innovation (CQUIN) Steering Group members ensured that the audit action plan was monitored and actioned within the agreed timescales. This included: • Evidence of transitions panel meetings taking place. • Transition plans developed, agreed and shared with the young person. • The GP / referrer being informed of the discharge and provided with a copy of the plan.
• Undertake an additional audit of the protocols to include further collection of patient and carer experience feedback by Q2 2017/18.	The audit undertaken within quarter two showed successful implementation of the protocol. Patient surveys were developed in quarter two and are given to those young people who transitioned out of CAMHS during their last appointment within CAMHS. Young people are encouraged by the clinician to complete the questionnaire and return it to the service.
• Establish mechanisms to provide stakeholders and staff with regular feedback by Q2 2017/18.	The use of inTouch (the Trust's intranet site for staff), e-bulletins and attendance by the CQUIN Team at locality meetings (CAMHS and AMH) has ensured staff members have been given feedback. Other meetings where feedback to staff have been provided are: • CQUIN Steering Group; • Service Development Groups (SDGs); • Quality Assurance Groups (QUAGs). The use of Facebook and attendance at parent support group meetings and young people's meetings has ensured stakeholders have been given feedback.

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

• Review the outcome of the audit, updating the current action plan by Q3 2017/18.	Following the audit an action plan was developed which included the following: • Panel meeting to take place 6 months (or within one month if new to service) prior to transition; • Transition plan to be developed, agreed and shared with the young person in 100% of cases; • The GP/referrer to be informed of the transition/discharge plan and the discharge plan will be shared with the GP. This has been shared with members of the CQUIN Steering Group and at locality meetings.
• Collect patients' stories in writing to gain detailed accounts of young people's experiences by Q3 2017/18.	There have been very few young people and / or parent / carers who are willing to share their experiences. To overcome this, the CQUIN team have a system in place whereby those young people who have transitioned from CAMHS to AMH and are still in service are being given the opportunity to complete a post transitions survey. The case worker is being asked if the young person would be willing to share their experiences by way of phone call with the CQUIN transitions Project Manager. The CQUIN transitions Project Manager will attend the parent / carer and young people's meetings asking for them to share their experience. The feedback we receive is then used to help us learn, adapting our services accordingly.
• Complete an evaluation report on the effectiveness of implementation of the new protocol and feedback to relevant stakeholders by Q4 2017/18.	An evaluation report has been completed. It evaluates the effectiveness of implementation of the new protocol using both quantitative review of the audit data and qualitative feedback from patient stories and staff. Feedback will be provided to stakeholders within quarter one of 2018/19.
• Continue to use patient surveys to gain feedback from young people (ongoing each quarter during 2017/18).	Since July 2017 young people who have transitioned out of CAMHS are given the opportunity to complete a transitions survey. As of 9th March 2018 a total of 35 transitions surveys and 2 post transitions surveys have been returned.

How we know we have made a difference:

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

Indicator	Target	Actual	Timescale
• Percentage of joint agency transition action plans in place for patients approaching transition.	80%	88%	Q4 2017/18
• Percentage of patients who reported feeling prepared for transitions at the point of discharge.	80%	79%	Q4 2017/18
• Percentage of patients who have transitioned to AMH from CYPS who indicate they have met their personal goals as agreed in their transition plan.	70%	100%	Q4 2017/18

What we plan to do in 2018/19:

This will continue to be an improvement priority for us. Our plans for 2018/19 are set out in **Part 2, 2018/19 Priorities for Improvement section**.

Priority 4: Reduce the number of preventable deaths

Why this is important:

Normally death is a naturally occurring event. Therefore not all deaths of people receiving mental health services from the Trust will represent a failing or problem in the way that person received care. However, sometimes healthcare teams can make mistakes or parts of the system do not work together as well as they could. This means that when things go wrong, a death may have been preventable. In December 2016 the CQC published their report, *Learning, Candour and Accountability* which made recommendations for the improvements that need to be made in the NHS, to be more open about these events.

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

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

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

The benefits / outcomes we aimed to deliver for our patients and their carers were:

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

- That the Trust learns from deaths, including identifying any themes early so that actions can be taken to prevent future harm.

What we did in 2017/18:

What we said we would do	What we did
• Develop an action plan from recommendations of an external review into Serious Incidents of patients when on a period of leave by Q1 2017/18.	As a result of several Serious Incidents which were related to people who took their own lives or suffered serious harm while on a period of leave from inpatient care the EMT commissioned an independent thematic review into this matter. The scope of the review was to consider whether there were any specific themes apparent relating to these incidents and to identify any learning opportunities. The North of England Mental Health Development Unit (NEMHDU) was requested to carry out this review which was completed in February 2017 (thematic review of 15 Serious Incidents relating to patients on leave during the period February 2015-October 2016). The completed report from this review was presented at the Patient Safety Group on 19th June 2017 where the action plan was agreed and is being subsequently monitored. In January 2018 the group were provided with the quarter three update regarding the Trustwide action plan for episodes of planned leave. The group noted that one action relating to training for bank / new staff remained outstanding, however further training dates have now been provided. The group will continue to receive quarterly updates regarding progression. It is pleasing to note that within the Patient Safety Report (at quarter one and quarter two 2017/18) leave planning did not appear as a theme in the deaths that had been investigated. This was felt to be very positive.

What we said we would do	What we did
• Evaluate the current pilot process of reviewing mortality, revising it accordingly following the review by Q1 2017/18.	TEWV now has a mortality review policy and process which builds on the pilot of work completed across the region and remains under review as new advice / guidance is published. The Mazars report into the investigation of Serious Incidents by Southern Health NHS Foundation Trust was published in December 2015. The most significant piece of work for Trusts to undertake as a result of this report is to commence a process of mortality review, over and above the usual Serious Incident Review processes that are already in place. Several regional meetings were held throughout 2017/18 in conjunction with Mazars to progress the findings of the report. Key pieces of work from this group are as follows: • Drafting a North of England charter which sets out the common values and identifies the key work streams required to meet them. • Working towards common terms of reference for mortality review processes. • Drafting a 'Responding to Deaths' policy in line with NQB guidance. Whilst the regional work continues, within the Trust the Patient Safety Group monthly reviews all deaths of service users on CPA (other than those that result in a Serious Incident) and decides whether or not the circumstances fit the criteria for a mortality review. Following the draft 'regional' Policy, TEWVs version was ratified on the 27th September 2017, with appendix 1 outlining the mortality review process within TEWV. For those cases which require a mortality review a member of the Patient Safety group currently carries out a structured judgement case review using the methodology guidance developed by the Royal College of Physicians and the findings are taken back to the next Patient Safety Group for discussion. A discussion will then be had regarding availability of death / learning and good practice. Whilst the pilot has proved successful this process is under continual review as new advice/guidance is published.
• Establish quarterly reporting mechanisms for mortality review processes by Q1 2017/18.	NHSE produced a mortality dashboard as a tool to aid the systematic recording of deaths and learning from the care provided by all NHS Trusts and there is a requirement that Trusts publish this data on a quarterly basis. The TEWV dashboard continues to evolve based on learning from other Trusts across the region as well as nationally with the principle aim of enhancing future learning and the continuous improvement of patient care. We have developed this approach and reported formally to the Board of Directors mortality information for quarters one, two, three and four of 2017/18.

What we said we would do	What we did
• Ensure systems are in place to regularly train all new inpatient staff and monitor compliance in relation to leave and time away from the ward Q2 2017/18.	All new inpatient staff have received training in relation to leave and time away from the ward and will continue to do so via the Mental Health Act (MHA) team. As of April 2018 this has become part of the new mandatory MHA e-learning package. Whilst there are systems in place to monitor the training being delivered the information is not as yet available on the Trust IIC (Integrated Information Centre) which would enable us to more easily identify who has accessed the training. There is a work programme to make this happen.
• Complete spot compliance audits quarterly to ensure staff are adhering to the leave policy by involving family in leave arrangements and conducting risk assessment and formulation prior to periods of leave by Q4 2017/18.	Audits have been completed regarding Section 17 (S17) leave by the audit team alongside the MHA team. Audits are currently underway by the audit team regarding those with time away from the ward i.e. patients who are not detained under the MHA and therefore not subject to S17 leave.
• Complete a review of the root or contributory causes of Serious Incidents each quarter and agree focused areas for targeted implementation by Q4 2017/18.	Each quarter the QuAC receives a quarterly assurance report which identifies the key themes from root and contributory causes and identifies the key pieces of work to address them. The report also provides a Trustwide overview of the incidental findings and each locality also receives a locality specific version of this information.
• Undertake a review of the national guidance in relation to mortality each quarter by Q4 2017/18.	As a result of the Learning from Deaths requirements following the Southern Health report there is ongoing review of any national guidance in relation to mortality – any updates are discussed at the Patient Safety Group and incorporated into the TEWV processes as required. This includes for example NHS Improvement provider weekly bulletins which identify any new guidance and learning / case studies from other Trusts.
• Participate quarterly in the regional provider forum focused on learning from preventable deaths by Q4 2017/18.	Several regional meetings have been held throughout the year in conjunction with Mazars to progress the findings of their report (as mentioned above). Key pieces of work from this group are as follows: • Drafting a North of England charter which sets out the common values and identifies the key workstreams required to meet them. • Working towards common terms of reference for mortality review processes. • Drafting a 'Responding to Deaths' policy in line with NQB guidance.
• Report quarterly to the QuAC on progress of the reviewed mortality review processes to enhance learning by Q4 2017/18.	The Trust QuAC now receives a quarterly assurance report from the Trust monthly Patient Safety Group. The report identifies the key areas for learning within the Trust which corresponded with the themes identified from audit.

How will we know we are making a difference?

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

Indicator	Target	Actual	Timescale
• To increase the proportion of deaths that are reviewed as part of the mortality review processes (this is in addition to the existing serious incident process).	90 cases	90*	Q4 2017/18
• To eliminate preventable deaths of inpatients during periods of leave.	0 deaths	1**	Q4 2017/18

*As this is a new process 90 is the baseline figure of case record reviews, deaths reviewed as part of the mortality process by 28/02/2018.
**Whilst there has been one preventable death of inpatients during periods of leave this is in comparison to 12 that occurred in 2015/16.

What we plan to do in 2018/19:

This will continue to be an improvement priority for us. Our plans for 2018/19 are set out in **Part 2, 2018/19 Priorities for Improvement section**.

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

Why this is important:

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

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

The benefits / outcomes we aimed to deliver for our patients and their carers were:

- A reduction in moderate and severe harm as a result of falls.
- More falls are prevented during hospital stays.
- To feel more informed about the risks and benefits around falls interventions.
- Their values and preferences informing care.
- That care is managed in line with NICE guideline 161 *'Falls: assessment and prevention of falls in older people*' (2013)[5] and in line with actions from the National Patient Safety Agency '*how to guide for reducing harm from falls in mental health inpatient settings*' (2012)[6].

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

- Care delivered by staff with the appropriate skills and competencies to prevent and manage falls.
- Appropriate assessment and treatment is given to people who have fallen.

What we did in 2017/18:

What we said we would do	What we did
• Undertake a baseline assessment of preventable falls by severity, completed by Q1 2017/18.	Each locality undertook a review of their own data which determined that the majority of falls occur within MHSOP. This data formed a baseline assessment of the number of preventable falls. The improved revised Trustwide Falls report is produced quarterly, the data and information is shared with each locality who then analyse their own data adding narrative quarterly. The Falls report now identifies: • category of falls; • severity of falls; • time of day of fall; • identifies multiple fallers and across multiple locations.
• Complete a thematic analysis by Specialty completed including direct observations of practice by Q1 2017/18.	Falls data analysis completed, this information was shared and accepted by Durham, Darlington and Tees Clinical Quality Reference Group (CQRG).
• Develop an action plan developed in line with outcome of thematic analysis by Q2 2017/18.	There was a 'Kaizen' event held to review the falls CLiP within quarter two 2017/18. As a result of this there was an action to progress with a frailty CLiP which incorporates falls as a frailty syndrome. This is in line with the outcome of the thematic review.
• 'Plan, Do, Study, Act' (PDSA) cycles agreed to address key issues identified via observations by Q2 2017/18.	There are five wards piloting frailty syndrome CLiP with full roll out planned following the outcome of the pilot. This will determine the next plans. As part of the pilot process, PDSA cycles have been agreed to address any key issues identified.
• Complete a Trustwide implementation of new processes based on PDSA cycles by Q3 2017/18.	A focused implementation will form part of the roll out of the all age frailty CLiP. Other specialities CLiPs are awaiting the outcome of the pilot of the frailty CLiP.
• Undertake a baseline assessment of falls by severity and theme reassessed by Q4 2017/18.	There is ongoing work as part of the Falls Executive Group and ownership and scrutiny of information by service which is included in the Trustwide quarterly falls report and compared to the baseline assessment identified at the beginning of 17/18.

How will we know we are making a difference?

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

Indicator	Target	Actual	Timescale
• A reduction in the number of people who suffer serious harm as a result of a fall.	Less than 9	3	Q4 2017/18

What we plan to do in 2018/19:

We will:
• The Falls Executive Group will continue to meet quarterly, with Trustwide / service user representation. • The work plan for 2018/19 has been developed and is in the process of being finalised. It will include Trust localities analysing their own data and action planning where appropriate. • Development of a root cause analysis report for fractured neck of femur with appropriate oversight within Nursing & Governance.

Statement of Assurances from the Board 2017/18

The Department of Health and NHS Improvement require us to include our position against a number of mandated statements to provide assurance from the Board of Directors on progress made on key areas of quality in 2017/18. 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 **2017/18** TEWV provided and/or sub-contracted **20** relevant health services.

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

The income generated by the relevant health services reviewed in 2017/18 represents **100%** per cent of the total income generated from the provision of the relevant health services by TEWV for 2017/18.

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

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

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

We also undertake an internal peer review inspection programme, the content of which is based on the Fundamental Standards of Quality and Safety published by the CQC. These inspections cover all services and a typical inspection team will include members of our Compliance Team, patient and carer representatives from our Fundamental Standards Group and peers from other services. In advance of the visit the inspection team review a range of information on the quality of the service being inspected, for example: incident data, Patient Advice and Liaison Service (PALS) / complaints data, CQC compliance reports and Mental Health Act visit reports as well

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

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

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

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

Participation in clinical audits and national confidential inquiries

During 2017/18, **5** national clinical audits and **2** national confidential inquiries covered the health services that TEWV provides.

During 2017/18, TEWV participated in **80%** (4/5) of national clinical audits and **100%** (2/2) of national confidential inquiries which it was eligible to participate in.

The national clinical audits and national confidential inquiries that TEWV was **eligible to participate in** during 2017/18 were as follows:

- POMH Topic 17a: Use of depot/long-acting antipsychotic injections for relapse prevention (ongoing);
- POMH Topic 15b: Prescribing Valproate for Bipolar Disorder (ongoing);
- POMH Topic 16b: Rapid Tranquilisation;
- EIP National Self-Assessment Audit 2017/18 (ongoing);
- National Clinical Audit of Psychosis (NCAP) (ongoing);
- National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH);
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD).

The national clinical audits and national confidential inquiries that TEWV **participated in** during 2017/18 are as follows:

- POMH Topic 17a: Use of depot/long-acting antipsychotic injections for relapse prevention (ongoing);
- POMH Topic 15b: Prescribing Valproate for Bipolar Disorder (ongoing);
- EIP National Self-Assessment Audit 2017/18 (ongoing);
- National Clinical Audit of Psychosis (NCAP) (ongoing);
- National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH);
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD).

The national clinical audits and national confidential inquiries that TEWV participated in, and for which data collection was completed during 2017/18, are listed below alongside the number of cases submitted to each audit or inquiry as a percentage of the number of registered cases required by the terms of the national audit or inquiry.

Audit Title	Cases Submitted	% of the number of registered cases required
POMH Topic 17a: Use of depot/long-acting antipsychotic injections for relapse prevention	241	Not applicable
POMH Topic 15b: Prescribing Valproate for Bipolar Disorder	191	Not applicable
EIP National Self-Assessment Audit 2017/18	889	Not applicable
National Clinical Audit of Psychosis (NCAP)	272	91%
National Confidential Inquiry into Suicide & Homicide by People with Mental Illness.	57	81%
National Confidential Enquiry into Patient Outcome and Death	n/k*	Unknown

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

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

The reports of **163** local clinical audits were reviewed by the provider in 2017/18 and TEWV intends to take actions to improve the quality of healthcare provided.

Appendix 4 includes the actions we are planning to take against the **8** key themes from these local clinical audits reviewed in 2017/18.

*To be confirmed within final version.

In addition to those local clinical audits reviewed (i.e. those that were reviewed by our Quality Assurance Committee and Clinical Effectiveness Group), the Trust undertook a further **12** clinical audits in 2017/18 which include clinical effectiveness projects undertaken by Junior Doctors, Consultants or other Directorate / Specialty Groups. These clinical audits were led by the services and individual members of staff for reasons of service improvement and professional development.

Participation in clinical research

The number of patients receiving relevant health services provided or subcontracted by TEWV in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was **1341**.

Of the **1341, 1299** were recruited to **32** National Institute for Health Research (NIHR) portfolio studies. This compares with **952** patients involved as participants in NIHR research studies during 2016/17.

Recruitment into research has increased this year due to a number of higher recruiting studies including the Health and Wellbeing Survey (Mental health) study which has recruited 212 participants and the CYGNUS (Dementia) study which recruited 101 participants. The Trust contributes to the overall Clinical Research Network: North East and North Cumbria targets for recruitment and the Mental Health, Dementia and Neurodegenerative Diseases Research Network (DeNDRoN) and Health Service Delivery specialties that we contribute to have all exceeded recruitment targets for this year.

We continue to be involved with large scale national research across a variety of clinical disciplines such as psychosis, forensic mental health, dementia, learning disabilities, personality disorder and CYPS. Our ongoing participation in clinical research through 2017/18 reflects our firm commitment to improving the quality of care we provide, as well as contributing to the broader goals of mental health, learning disability and dementia research. The Trust has also supported national research into the implications of later retirement ages in the NHS.

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

- We were involved in conducting **96** clinical research studies during 2017/18. **53** of these studies were supported by the NIHR through its networks and **16** new portfolio studies approved through the Health Research Authority approval process.
- **29** members of our clinical staff participated as researchers in studies approved by a research ethics committee, with **11** of these in the role of principal investigator for NIHR supported studies.
- **50** members of our staff were also recruited as participants to NIHR portfolio studies.
- **40** researchers from outside the organisation were granted access under the National Research Passport Scheme to perform research with us compared to **28** from 2016/17. This reduced number was due to issuing 37 letters of access for research teams to access research participants in the York and Selby region last year.
- We have developed a new 5 year Research & Development Strategy with a strong focus on Patient and Public Involvement (PPI) engagement and academic collaborations which provides us with the aim of becoming a lead research site with further opportunities for research involvement for our patients. We continue

to be co-applicants on large scale grant applications in collaboration with our university partners.

- We have setup a clinical trials pharmacy department which will provide the infrastructure to enable us to participate in future CTIMP studies.
- We have research champions embedded across all of our memory services which provides a link to ensure equality of access to research opportunities across the Trust. Our research champions promote the national Join Dementia Research (JDR) system and we have been a pilot site for a 'JDR' on prescription scheme in collaboration with the Alzheimer's Society.

Goals agreed with commissioners

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

A proportion of TEWV's income in 2017/18 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 2017/18 and for the following 12 month period are available electronically at http://www.tewv.nhs.uk/site/content/About/How-well-are-we-doing.

As part of the development and agreement of the 2017/19 mental health contract, we were provided with a list of nationally mandated CQUINs and then were given an option to add one further local CQUIN which the Trust opted to do in agreement with the commissioners. This included indicators around physical healthcare, staff health and wellbeing and discharge and resettlement within specialist services. These are monitored at meetings every quarter with our commissioners.

An overall total of £4,896,823 was available for CQUIN to TEWV in 2017/18 conditional upon achieving quality improvement and innovation goals across all of its CQUINs. A total of £4,532,823 (92.56%) is estimated to be received for the associated payment in 2017/18; however this will not be confirmed until May (the estimate for 2017/18 has still to go through all the required governance processes for full approval). This represents 1.5% of the Trust income rather than 2.5% as in previous years. For the first year 0.5% was allocated for engagement in STPs and a further 0.5% towards achieving our control total. Including this 1% a total of £7,328,422 was available and £6,963,647 (95.02%) is estimated to be achieved. This compares to:

- £6,418,793 in 2016/17 (92.2%);
- £6,452,069 in 2015/16 (99.2% from the TEWV CQUIN prior to the Vale of York contract and 100% from the Vale of York CQUIN);
- £5,765,066 (98.0%) in 2014/15;
- £5,777,218 (99.3%) in 2013/14.

Some examples of CQUIN indicators which the Trust made progress with in 2017/18 were:

- Improving the uptake of flu vaccinations for frontline clinical staff. This was a CQUIN in 2016/17 as well as going forward into the 2017/19 scheme. Before this became a CQUIN, the 2015/16 Trust uptake of the flu jab was 39%. Over the last two years the Trust has committed to a flu vaccination scheme, introducing staff incentives. In 2016/17 we achieved a 16% increase of staff taking up the offer of a flu jab in 2017/18 achieved a further 11% increase. This gives us an overall increase of 27% over the two years which is a real achievement and helps to keeping our staff and patients safe from flu. We aim to further increase this uptake in 2018/19.
- Virtual Recovery College. This was our local scheme agreed with the commissioners and one that we felt very important. The Trust has a physical recovery college based in Durham; however acknowledged that due to the geography of the Trust this was not accessible to a lot of our patients and therefore the decision was made to set up a virtual recovery college (known as recovery college online). Since its launch at the start of the year the site now hosts over 80 pages, which are accessible to all internet users and 7 courses, which are accessible to people within the Trust's geographical area and there are over 1000 people viewing the site every month.
- Discharge and Resettlement within specialist services. This CQUIN spans all specialist services and looks to reduce delayed discharges by ensuring that discharge planning is started right from the point of the patients admission by setting an expected discharge date. This CQUIN involved setting up a whole new system within each service and devising a two year strategy on how the services were going to look to reduce delayed discharges. During its first year services have successfully embedded all of the processes required to ensure the success of the CQUIN. All patients have had an expected discharge date set within the required 12 weeks of admission and there have been some cases of patients being discharged before their expected discharge date which is fantastic progress for the first year of the CQUIN.
- Patient Experience within Street Triage. This is the first year that we have had a CQUIN from the Health and Justice contract and it has definitely been a success. The Street Triage team already had a patient experience measure in place as part of the Trust monitoring; however work has been undertaken to assess how best to offer the patient experience surveys, as it is acknowledged that due to the nature of the work it is not the best time when the patient is being seen. The team has seen satisfaction scores increase from 82% at the start of the year to 100% by the end of the year. The team have also, as an additional measure, developed an experience survey for the police who are involved in the cases they worked with and have received very positive feedback via this.

What others say about the provider

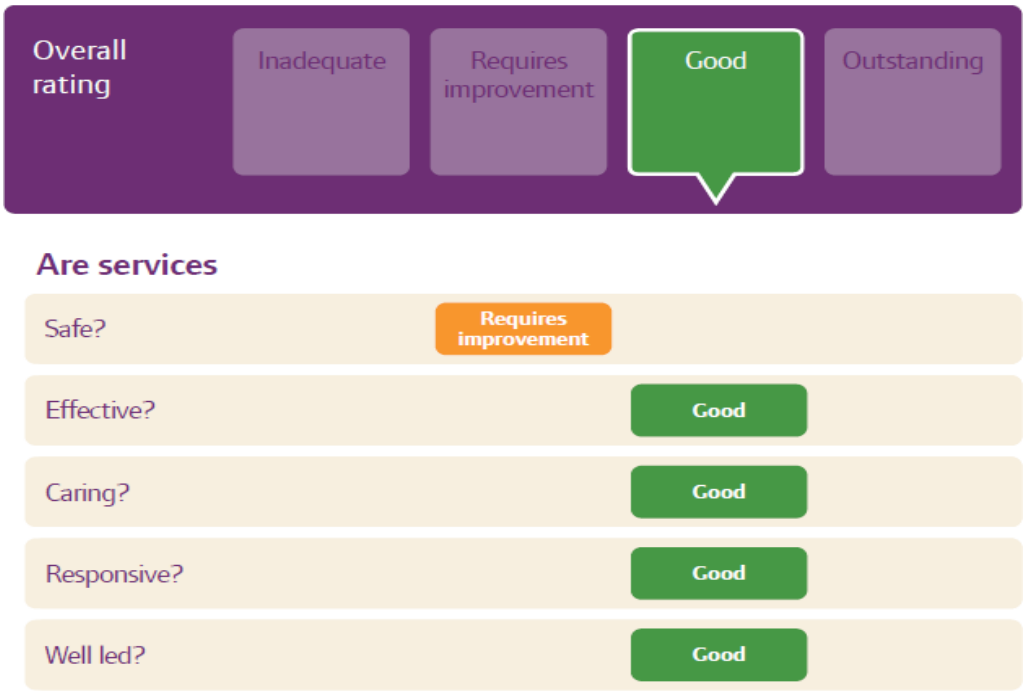
Registration with the Care Quality Commission (CQC) and periodic / special reviews

TEWV is required to register with the Care Quality Commission (CQC) and its current registration status is **registered to provide services with no conditions attached**. The CQC **has not** taken enforcement action against TEWV during 2017/18.

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

The Trust has not received any CQC compliance inspections during 2017/18 and the overall Trust rating remains **Good**.

The Trust CQC ratings for each domain are currently as follows:



In July 2017, Her Majesty's Inspectorate of Prisons conducted an unannounced inspection of Holme House Prison, a category B local prison near Stockton-On-Tees. Following inspection the CQC issued the Trust with a Requirement Notice regarding Regulation 9: Person Centred Care. This states that 'The care and treatment of service users must be appropriate, meet their needs and reflect their preferences'. In response, the Trust reviewed processes and put in place required improvement actions to ensure that appropriate care was consistently provided to meet the needs of patients and reflect their preferences.

The Trust also has two premises that are registered with Ofsted. The two Units are classified by Ofsted as children's home premises. The Units provide care and

accommodation for children and young people who have a learning and/or physical disability for short breaks. Following registration with Ofsted in August 2017, both units received their first inspections with one unit being rated as 'Good' and the other as 'Requires Improvement'. All improvement requirements have been met and formal responses submitted to Ofsted to ensure compliance with statutory guidance and the requirements of the Care Standards Act 2000.

Mental Health Act Inspections

34 Mental Health Act inspections were undertaken by the Care Quality Commission during 2017/18:

Ward	Service Type	Location
Acomb Garth	Wards for older people with mental health problems	York
Bankfields Court	Wards for people with learning disabilities or autism	Middlesbrough
Bedale Ward	Acute wards for adults of working age and psychiatric intensive care units	Teesside
Birch Ward	Acute wards for adults of working age and psychiatric intensive care units	Darlington
Brambling Ward	Forensic inpatient (low/medium)	Middlesbrough
Bransdale Unit	Acute wards for adults of working age and psychiatric intensive care units	Middlesbrough
Cedar (PICU)	Acute wards for adults of working age and psychiatric intensive care units	Darlington
Cherry Trees	Wards for older people with mental health problems	York
Danby Ward	Acute wards for adults of working age and psychiatric intensive care units	Scarborough
Ebor Ward	Acute wards for adults of working age and psychiatric intensive care units	York
Eagle/Osprey	Forensic inpatient (low/medium)	Middlesbrough
Elm Ward	Acute wards for adults of working age and psychiatric intensive care units	Darlington
Farnham Ward	Acute wards for adults of working age and psychiatric intensive care units	Durham
Hamsterley Ward	Wards for older people with mental health problems	Bishop Auckland
Harland Ward	Ward for people with learning disability or autism	Durham
Ivy/Clover Ward	Forensic inpatient (low/medium)	Middlesbrough
Jay Ward	Forensic inpatient (low/medium)	Middlesbrough
Kirkdale Ward	Long stay/rehabilitation mental health wards for working age adults	Middlesbrough
Langley Ward	Forensic Learning Disability Low Secure	Durham
Lark Ward	Forensic inpatient (low/medium)	Middlesbrough
Lincoln Ward	Acute wards for adults of working age and psychiatric intensive care units	Hartlepool
Mandarin Ward	Forensic inpatient (low/medium)	Middlesbrough
Maple ward	Acute wards for adults of working age and psychiatric intensive care units	Darlington
Merlin Ward	Forensic inpatient (low/medium)	Middlesbrough
Newtondale	Forensic inpatient (low/medium)	Middlesbrough
Northdale Centre	Forensic inpatient (low/medium)	Middlesbrough
Oak Ward	Wards for older people with mental health problems	Darlington
Ramsey Ward	Wards for people with learning disabilities or autism	Durham
Rowan Lea Ward	Wards for older people with mental health problems	Scarborough
Sandpiper Ward	Forensic inpatient (low/medium)	Middlesbrough
Westerdale North	Wards for older people with mental health problems	Middlesbrough
Westerdale South	Wards for older people with mental health problems	Middlesbrough

Ward	Service Type	Location
Westwood Centre	Child and adolescent mental health wards	Middlesbrough
Willow Ward	Long stay/rehabilitation mental health wards for working age adults	Darlington

Quality of data

TEWV submitted records during 2017/18 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 **99.79%** for admitted patient care.
- Which included the patient's valid General Medical Practice Code was **98.40%** for admitted patient care.

TEWV Information Governance Assessment Report overall score for 2017/18 was **88%** and was granted as **satisfactory***.

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

The Information Governance (IG) Toolkit measures performance in the following areas:

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

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

88% (satisfactory*) means that we have achieved at least level 2 on all of the 45 requirements of the toolkit, however, in a significant number of elements we attained level 3 (the highest score). Sixteen toolkit requirements scored level 2, 29 toolkit requirements scored level 3.

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

The IG toolkit changed in April 2018 and is now known as the Data Security and Protection Toolkit. The 45 requirements of the former IG toolkit have been replaced by 'assertions' that relate to the 10 National Data Guardian standards.

TEWV was **not** subject to the Payment by Results clinical coding audit during 2017/18 by the Audit Commission.

NHS England and NHS Improvement issued guidance in December 2016 for the contracting period 2017-2019. This continued the need for Mental Health Service providers to report:

- **Clinically Reported Outcome Measure (CROM):** this is the Health of the Nation Outcome Score (HoNOS) and reported via the Mental Health Services Data Set (MHSDS). Commissioners receive quarterly reports describing complexity of current caseload and clinical outcomes for discharged patients using an established model of clinical significance. The IIC will routinely report this information during 2018/19.
- **Patient Reported Outcome Measure (PROM):** the Trust has implemented the use of the patient reported wellbeing measure, the short version of the Warwick-Edinburgh Mental Well-being Scale (SWEMWBS). Commissioners receive quarterly reports describing complexity of current caseload and clinical outcomes for discharged patients using an established model of clinical significance. The IIC will routinely report this information during 2018/19. EIP services have replaced SWEMWBS with The Process of Recovery Questionnaire (QPR) for all new patients from 1st March 2018. Discussions with commissioners will agree how QPR reporting will be integrated in existing commissioner reports.
  A training program is ongoing with regards to cluster accuracy and factors affecting the ability to report outcomes effectively and accurately. Performance relating to clinical outcomes is monitored and managed throughout TEWV.
- **CAMHS services:** Child Outcome Rating Scale (CORS)/Outcome Rating Scale (ORS) were introduced into the CAMHS services from February 2018 and will be used to report clinical outcomes. Ongoing discussions with commissioners will agree the integration into existing reports.
  Performance reports are being managed via a CAMHS currency development steering group and training and support to staff is ongoing.

At the end of March 2018:

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.
90% of service users on the Adult Mental Health (AMH) and **91%** of services users Mental Health Services for Older People (MHSOP) caseloads were reviewed within the guideline timeframes.

Further work for 2018/19 includes:

- Consideration of clinical outcome metrics for Learning Disability services.

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

- We are currently in the process of producing a revised Data Quality (DQ) Strategy and scorecard, with a plan for this to have a much broader focus than the previous version and be inclusive of all Trust data, rather than just patient focused data. The draft strategy has been written and engagement / consultation was conducted with a variety of groups within the Trust, including LMGB's, Operational Management Team (OMT) and service users. The draft strategy was submitted and approved at the Managing the Business April 2018 meeting - this group is chaired by the Director of Finance and Information and meets monthly. Other Directors also attend the meetings from Planning, Performance and Communication, Nursing and Governance and Human Resources. It is expected that the Data Quality Strategy will be approved by EMT in quarter one 2018/19.
- The Trust has a new DQ working group which is a sub group of the Managing the Business Group. It is chaired by the Head of Supporting Users and has representation from Planning, Performance and Communications, Quality Data, Human Resources and Information attend. The DQ working group will focus on issues with data quality identified either by corporate or clinical services and attempt to provide resolutions. For example, this may be to help with training on how to enter information correctly in Paris or it may be working with services to provide clarity on recording of activity.
- Data Quality Improvement Plans (DQIPs) have been agreed with commissioners for 2017/18. Over 40 DQIPs have either been delivered or are on track for being delivered this financial year. Additional DQIPs are in the final process of being agreed for 2018/19.
- New reports continue to be developed within the IIC to allow services to easily identify data quality concerns and target improvement work. A data quality IIC dashboard has been developed and evidences data quality completeness of key data items within the clinical record. A development plan for the IIC for 2018/19 was finalised in April 2018.

Learning from deaths

During 2017/18 2,322 of TEWV patients died[1]. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 541 in the first quarter;
- 524 in the second quarter;
- 574 in the third quarter;
- 683 in the fourth quarter.

By 31st March 2018, 106 case record reviews and 126 investigations have been

carried out in relation to 2,322 of the deaths included in the figures above.

In 2 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 65 in the first quarter;
- 47 in the second quarter;
- 67 in the third quarter;
- 53 in the fourth quarter.

11 representing 0.47% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:

- 1 representing 0.18% for the first quarter;
- 3 representing 0.57% for the second quarter;
- 4 representing 0.69% for the third quarter;
- 3 representing 0.43% for the fourth quarter.

These numbers have been estimated using the findings from Serious Incident investigations[2]. Where there has been a root cause found from the incident review then this has been used as a way to determine if the patient death may have been attributable to problems with care provided[3].

A summary of what TEWV has learnt from case record reviews and investigations conducted in relation to the deaths identified above:

Root or contributory findings from serious incident reviews undertaken in 2017/18 have highlighted the following areas for learning and improvement:

- Risk assessment;
- Physical health deterioration/recognition of symptoms;
- Adherence to procedure/policy/pathway;
- Family Involvement;
- Access to services/referral processes;
- Communication and information sharing;
- Medicines Management;
- Record keeping.

A description of the actions which TEWV has taken in 2017/18, and proposes to take following 2017/18, in consequence of what TEWV has learnt during 2017/18:

Our Harm Minimisation policy and training for staff is a recovery-orientated approach to clinical risk assessment and management. Experts by experience were employed as part of the Harm Minimisation Project team to co-produce and co-deliver face to face harm Minimisation training and a mandatory e-learning harm minimisation training package is also available.

The Trust Care Programme Approach (CPA) project lead is currently undertaking work in relation to care/intervention planning. Both the CPA and Harm Minimisation Projects support the principles of family involvement and shared decision making which are also core principles of the Trust Recovery Strategy.

The Trust has a Physical Health project team in place to assist with the education and training of staff in physical health related matters. The team developed a set of Physical Health Standards and then visited all inpatient services to offer support to clinical staff to implement the standards and improve the physical health of their patients.

These key pieces of work will continue through 2018/19 in addition to on-going service improvements across the organisation. Improved family involvement will be a particular focus and we intend to launch family friendly versions of some of our patient safety policies.

An assessment of the impact of the actions described above which were taken by the TEWV during 2017/18:

A widespread audit has been undertaken in relation to the quality of our risk assessment and care plan documents. The purpose of the audit is to provide a baseline assessment for future work which will also support improvements to our community and in-patient services and help with the delivery of the Recovery Strategy. One of the themes identified by the Trust in 2016/17 was inadequate leave planning. A key piece of work was undertaken across the Trust to remind clinical staff of their responsibilities in relation to this which included training for all registered nurses and a policy refresh. This does not appear as a theme in the Serious Incidents from 2017/18 which would suggest a positive impact from the remedial actions taken.

16 case record reviews and 25 investigations completed after 31st March 2017 which related to deaths which took place before the start of the reporting period.

1 representing 0.04% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the findings from Serious Incident investigations. Where there has been a root cause found from the incident review then this has been used as a way to determine if the patient death may have been attributable to problems with care provided[3]..

10 representing 0.43% of the patient deaths during 2017/18 are judged to be more likely than not to have been due to problems in the care provided to the patient.

Notes to accompany above table

1. In mental health and learning disability services the majority of our patients live in the community and many have infrequent contact with our teams. This can lead to a delay in us being notified of a death occurring in some cases. All deaths which are reported through our incident management system (1,622 in 2017/18) are

subject to an initial review by a senior clinician in the patient safety team. We also have undertaken some analysis of the average age of the service users who have died and it was found to be 85 years.

2. The Serious Incident Framework (2015) forms the basis of the Trust policy which guides our staff about the reporting, investigating and learning from incidents, including deaths. The Learning from Deaths policy, which was approved by our Board of Directors in September 2017, further enhances the processes of investigation and learning.

3. There is no agreed or validated tool to determine whether problems in the care of the patient contributed to a death within mental health or learning disability services. We have decided to use the approach of considering a root cause being found in an incident review until a nationally agreed tool becomes available. This means that currently mental health and learning disability organisations are using differing ways of assessing this.

Mandatory quality indicators

The following are the mandatory quality indicators relevant to mental health Trusts, issued jointly by the Department of Health and NHS Improvement and effective from February 2013.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127382/130129-QAs-Letter-Gateway-18690.pdf.pdf

For each quality indicator we have presented a mandatory statement and the data on NHS Digital for the most recent and the previous reporting period available.

Care Programme Approach 7 day follow-up

The data made available by NHS Digital with regard to the percentage of patients on Care Programme Approach (CPA) who were followed up within 7 days after discharge from psychiatric inpatient care during the reporting period. As per Single Oversight Framework guidance, this reports all patients discharged that were followed up within 7 days.

TEWV actual quarter four 2017/18	****National benchmarks in quarter three 2017/18***	***TEWV actual quarter three 2017/18***	***TEWV actual quarter two 2017/18***	***TEWV actual quarter one 2017/18***
Trust final reported figure: **96.52%**	NHSIC reported: Highest/best MH Trust = **100%**	Trust final reported figure: **97.13%**	Trust final reported figure: **95.80%**	Trust final reported figure: **96.46%**
Figure reported to NHSI: N/A**	National average MH Trust = **95.9%**			
NHS Digital reported: **Not available**	Lowest/worst MH Trust = **69.2%**	NHS Digital reported figure: **97.2%**	NHS Digital reported figure: **95.2%**	NHS Digital reported figure: **96.4%**

*Latest benchmark data available on NHS Digital at quarter three 2017/18.
**We are no longer required to report performance to NHSI following the change in the Regulatory Framework in October 2016.

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

- The discrepancy between the NHS Digital and the Trust is due to the fact the NHS Digital data is submitted at a CCG level, and therefore, excludes data where the CCG is unspecified in the patient record. The Trust figure includes all discharges.
- The **key reasons** why **95** people during 2017/18 to date were not followed up within 7 days were:
  - difficulties in engaging with the patient despite efforts of the service to contact the patient (58 patients); and
  - breakdown in processes within the service (30 patients).

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

- Investigating all cases that were not followed up and identifying lessons to be

learned at service level.

- Undertaking an improvement programme led by the Chief Operating Officer to improve proactive performance management and eliminate waste in both clinical and corporate services.
- Continuing to utilise the report out process and Trust performance management system to pro-actively monitor performance and ensure compliance. Supporting the adherence to standard process to ensure patients discharged to other services (e.g. 24 hour care unit) are not overlooked, including the introduction of visual control boards.
- Continuously raising awareness and reminding staff at ward / team meetings of this national requirement and why it is important to patient safety, the need to follow the standard procedure and the need to record data accurately considering appropriate exclusions.

Crisis Resolution Home Treatment Team acted as a gatekeeper

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

TEWV actual quarter four 2017/18	****National benchmarks in quarter three 2017/18***	***TEWV actual quarter three 2017/18***	***TEWV actual quarter two 2017/18***	***TEWV actual quarter one 2017/18***
Trust final reported figure: **97.53%**	NHSIC Reported: National average MH Trust = **98.3%**	Trust final reported figure: **96.57%**	Trust final reported figure: **97.55%**	Trust final reported figure: **97.58%**
Figure reported to NHSI: N/A**	Highest/best MH Trust = **100%**			
NHS Digital Reported: **Not available**	Lowest/worst MH Trust = **84.3%**	NHS Digital Reported: **96.3%**	NHS Digital Reported: **97.3%**	NHS Digital reported: **97.6%**

*Latest benchmark data available on NHS Digital at quarters 3 2017/18.
**We are no longer required to report performance to NHSI following the change in the Regulatory Framework in October 2016.

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

- The discrepancy between the NHS Digital and the Trust / NHSI figures is due to the fact the NHS Digital data is submitted at a CCG level, and therefore, excludes data where the CCG is unspecified in the patient record. The Trust figures include these cases.

  The **key reasons** why **46** people in 2017/18 were not assessed by the Crisis team prior to admission were:
  - breakdown in process due to failure to follow the standard procedure (29 patients); and
  - high levels of demand on the Crisis team (7 patients).

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

- Investigating instances where patients were not seen by a crisis team prior to admission and identifying lessons to be learned at service level.
- Undertaking an improvement programme led by the Chief Operating Officer to improve proactive performance management and eliminate waste in both clinical and corporate services.
- Continuing to utilise the report out process and Trust performance management system to pro-actively monitor performance and ensure compliance. Supporting the adherence to standard process to ensure patients discharged to other services (e.g. 24 hour care unit) are not overlooked, including the introduction of visual control boards.
- Continuously raising awareness and reminding staff at ward / team meetings of this national requirement and why it is important, the need to follow the standard procedure and the need to record data accurately considering appropriate exclusions.

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

The data made available by NHS Digital with regard to the Trust's "patient experience of community mental health services" indicator score regarding a patient's experience of contact with a health or social care worker during the reporting period. The figures we have included are from the CQC website but at the time of writing comparative figures were not available from NHS Digital.

An overall Trust score is not provided, due to the nature of the survey, therefore it is not possible to compare Trusts overall. For 2017, we have reported the Health and Social Care Workers section score which compiles the results from the questions used from the survey detailed below the table.

TEWV actual 2017	***National benchmarks in 2017***	***TEWV actual 2016***	***TEWV actual 2015***	***TEWV actual 2014***
Overall section score: **7.7** (sample size 232)	Highest/Best MH Trust = **8.1** Lowest/Worst MH Trust = **6.4** Average Score**=7.6**	Overall section score: **7.8** (sample size 234)	Overall section score: **8.0** (sample size 239)	NHSIC Reported: **8.1** (sample size 188)

CQC design and collate the results of the community mental health patient experience survey. Since 2014 the survey has asked community service users the following questions about their contacts with a NHS health worker or social care worker:

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

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

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

- *Did this person listen carefully to you*: TEWV mean score of **8.1**. The lowest national mean was 7.2 and the highest 8.7.
- *Were you given enough time to discuss your needs and treatment*: TEWV mean score of **8.0**. The lowest national mean was 6.2 and the highest 8.1.
- *Did the person or people you saw understand how your mental health needs affect other areas of your life*: TEWV mean score of **7.0**. The lowest national mean was 5.8 and the highest 7.8.

The report identifies if Trusts perform 'better' 'about the same' or 'worse' based on a statistic called the expected range. When comparing TEWV survey results with those of the other organisations the scores were identified as being 'about the same' as other organisation across all 10 sections. As with the 2016 survey, there was no overall rating of 'better' or 'worse' than others for any section of the survey (in 2015 TEWV had 4 sections being rated as better than other organisations).

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

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

- Reviewing the way we do care planning in the Trust to make them more personal (a Quality Account priority for 2018/19).
- Recruiting experts by experience (including peer workers) to help make services think more about the patient experience.
- Taking action to re-provide care from outdated wards in York, Northallerton and Harrogate so that all inpatient wards will have single en-suite bedrooms by 2019/20.
- Continuing to carry out our local inpatient and community surveys with established mechanisms in place for action plan development and feedback.
- Transferring to the new external provider Optimum Health, which is a live system that enables managers to monitor level of feedback received and act upon any issues in a timely manner.
- A pilot of SMS/Web based surveying using staff smartphones is coming to an end and will be rolled out Trustwide in April.

In addition, patient experience kiosks are now installed in 31 sites where there is a high footfall of patients and carers, which enables them to complete the survey anytime, and a quarterly narrative audit is undertaken to ensure areas address issues from narrative feedback.

The Trust continues to carry out regular patient experience surveys across all services which includes the FFT. Between April 2017 and March 2018 the Trust received feedback from 20,568 patients with an average of 87% who would be extremely likely or likely to recommend TEWV services.

Patient safety incidents including incidents resulting in severe harm or death

The data made available by NHS Digital with regard to the number of patient safety incidents, and percentage resulting in severe harm or death, reported within the Trust during the reporting period. The next reporting period is March 2018.

TEWV actual quarters three & four 2017/18	***National benchmarks in quarters three & four 2017/18***	***TEWV actual quarters one & two 2017/18***	***TEWV actual quarters three & four 2016/17***
Trust Reported to NRLS: **7,244** incidents reported of which 85 **(1.17%)** resulted in severe harm or death	NRLS Reported: National average MH Trusts: incidents reported of which resulted in severe harm or death. Lowest MH Trust: **603** incidents reported of which **5** resulted in severe harm and **13 (2.2%)** in death. Highest MH Trusts: **6,447** incidents reported of which **2 (0%)** resulted in severe harm and **14 (0.2%)** in death. The highest reported rate of deaths as a proportion of overall incidents was **3.8%.**	Trust Reported to NRLS: **7,372** incidents reported of which **47 (0.64%)** resulted in severe harm or death* NRLS reported: **7,372** incidents reported of which **47 (0.64%)** resulted in severe harm or death* *15 Severe Harm and 32 Death.	Trust Reported to NRLS: **6,244** incidents reported of which **54 (0.86%)** resulted in severe harm or death. NRLS reported: **6,244** incidents reported of which **54 (0.86%)** resulted in severe harm or death.

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

- The Trust reported and National Reporting & Learning System (NRLS) reported data for quarters one and two 2017/18 showed no variance in what was reported. This improved position from last year is due to a significant amount of data quality improvement work the Trust has undertaken.
- The number of incidents reported by TEWV to the NRLS for quarters one and two 2017/18 was improved compared to the previous two quarters. However, it is not possible to use the NRLS data to comment on a Trust's culture of incident reporting or the occurrence of incidents. The absolute numbers of incidents reported is a factor of the relative size of a Trust and the complexity of their case-mix. We have noted that:
  - The reporting of patient safety incidents in the Trust in quarters one and two 2017/18 has considerably increased when compared to with quarters three and four 2016/17. This is due to the implementation of a new web-based version of our incident reporting process which has had the positive impact of raising staff awareness of reporting.
  - Amongst the most common themes reported are self-harming behaviour, patient accident, disruptive, aggressive behaviour and medication which account for three-quarters of all incidents leading to harm.

- During 2017/18 TEWV reported 178 incidents as Serious Incidents, of which 156 were deaths due to unexpected causes (as at end of February 2018).

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

- Analysis of all patient safety incidents. These are reported and reviewed by the Patient Safety Group which is a sub group of the Trust's Quality Assurance Committee. A monthly report is circulated to the QuAC. Safety incidents are reported to commissioners via the Clinical Quality Review Process.
- Making permanent the central approval team which was put in place to ensure consistent grading of incidents and to improve the overall quality of reporting.
- Ensuring all serious incidents (i.e. those resulting in severe harm or death) are subject to a serious incident review. This is a robust and rigorous approach to understand how and why each incident has happened, to identify any causal factors and to identify and share any lessons for the future.
- Introducing mortality reviews on those deaths that are not classed as unexpected. We are following national guidance as it is published in this area – the National Guidance on Learning from Deaths was released in March 2017 and have implemented its recommendations throughout 2017/18.

2018/19 Priorities for Improvement

During 2017/18 we held two events inviting our stakeholders to take part in our process of identifying quality priorities for 2018/19 to be included in the Quality Account. These events took place in July 2017 and February 2018: further information can be found in **Part 3, Our Stakeholders' Views section**. The four quality priorities which we identified from this engagement also sit within TEWV's 2018/19-2020/21 Business Plan. The Business Plan includes a further 10 priorities all of which will have a positive impact on the quality of Trust services. Details of these priorities can be found in **appendix 5**.

Our four agreed 2018/19 priorities for inclusion in the Quality Account are:

Priority 1: Reduce the number of preventable deaths;
Priority 2: Improve the clinical effectiveness and patient experience in times of transition from Child to Adult services;
Priority 3: Making Care Plans more personal;
Priority 4: Develop a Trust-wide approach to dual diagnosis which ensures that people with substance misuse issues can access appropriate and effective mental health services.

Priority 1: Reduce the number of preventable deaths

Why this is important:

As mentioned in **Part 2** (above) where we provided an update on our Quality Priorities for 2017/18, the Trust identified that this was an important priority for our Quality Account because:

- Sometimes healthcare teams can make mistakes or different teams / organisations do not work together as well as they could. This means that when things go wrong, a death may have been preventable.
- The CQC made recommendations for the improvements that need to be made in the NHS regarding deaths.
- We believe it is important to strengthen the way we identify the need for investigations into the care provided and the way we carry these out.
- It is important that families and carers are fully involved in reviews and investigations following a death.
- To reduce preventable deaths, it is important that learning from deaths and near misses are shared and acted on with an emphasis on engaging families and carers in this learning.

The benefits / outcomes we aimed to deliver:

- Our processes will reflect national guidance and best practice which will ensure we are delivering the best, evidence based care and treatment to our patients.
- A reduction in the number of preventable harm incidents and deaths of inpatients on leave from hospital.
- That patients and carers feel listened to during investigations of death and consistently treated with kindness, openness and honesty.

- Increased confidence that investigations are being carried out in accordance with best-practice guidelines and in a way that is likely to identify missed opportunities for preventing death and improving services.
- The Trust learns from deaths, including identifying any themes early so that actions can be taken to prevent future harm.

What we will do in 2018/19:

We will:
• Develop a co-produced family and carer version of the learning from deaths policy by Q1 2018/19.
• Produce an engagement plan to involve family, carers and non-Executive Directors within the review process by Q2 2018/19.
• Implement the engagement plan by Q3 2018/19.
• Hold a family conference in conjunction with Leeds and York Partnership Foundation Trust. This will allow us to share good practice and continue to develop the further involvement of families and carers in the preventable deaths process by Q3 2018/19.
• Evaluate the level and effectiveness of engagement with families, carers and Non-Executive Directors by Q4 2018/19.

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
• Increase the proportion of deaths that are reviewed as part of the mortality review processes (this is in addition to the existing serious incident process).	120	Q4 2018/19
• Eliminate preventable deaths of inpatients during periods of leave.	0	Q4 2018/19
• Reduce the number of Serious Incidents where it was identified that the Trust contributed to the incident.	37	Q4 2018/19

Priority 2: Improve the clinical effectiveness and patient experience in times of transition from Child to Adult services

Why this is important:

As mentioned in **Part 2** (above) where we provided an update on our Quality Priorities for 2017/18, the Trust identified that this was an important priority for our Quality Account because:

- Young people with ongoing or long-term health or social care needs may be required to transition into AMH services, other service provision or back to their GP.

- The preparation and planning around moving into new services can be an uncertain time for young people with health and / or social care needs.
- There is evidence of service gaps where there is a lack of appropriate services for young people to transition into. There is also evidence that without proper support young people may fail to engage with services (Watson 2005[7]; Singh 2009[8]).
- Transition takes place at a pivotal time in the life of a young person.
- A loss of continuity in care can be a disruptive experience, particularly during adolescence, when young people are at an enhanced risk of psychosocial problems.
- The particular importance of improving the transition from children and young people's services to adult services was recognised by our Quality Account Stakeholders in 2015.

The benefits / outcomes we aimed to deliver:

- An improvement in the experience of young people during their transition from Children and Young People's to Adult services.
- Greater involvement in decisions about the care received when they transfer into Adult services.
- To receive care informed by NICE's[9] evidence-based guidelines, which will result in better clinical outcomes.

What we will do in 2018/19:

We will:
• Implement actions from the thematic review (conducted at the end of 2017/18) of patient stories by Q1 2018/19. • Registered CAMHS and AMH staff to undertake further specific training on the transitions process by Q1 2018/19. • Review transition panels already in place (set up during 2017/18), gain additional service user perspective and set relevant targets and metrics by Q3 2018/19. • Produce an engagement plan to involve family and carers in the process by Q4 2018/19.

[7]Watson AR (2005) Problems and pitfalls of transition from paediatric to adult renal care. Paediatric Nephrology 20: 113–7
[8] Singh SP (2009) Transition of care from child to Adult Mental Health services: the great divide. Current Opinion in Psychiatry 22: 386–90
[9]http://www.rcpch.ac.uk/system/files/protected/page/Transition%20from%20children%E2%80%99s%20to%20adults%E2%80%99%20services%20-%20FULL%20published_1.pdf

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
• Percentage of joint agency transition action plans in place for patients approaching transition.	80%	Q4 2018/19
• Percentage of patients who reported feeling prepared for transitions at the point of discharge.	80%	Q4 2018/19
• Percentage of patients who have transitioned to AMH from CYPS who indicate they have met their personal goals as agreed in their transition plan.	70%	Q4 2018/19

Priority 3: Making our Care Plans more personal

Why this is important:

Personalisation is defined in the skills and education document by NHS England 'Person Centred Approaches' (2016) as *'Recognising people as individuals who have strengths and preferences and putting them at the centre of their own care and support. Personalised approaches involve enabling people to identify their own needs and make choices about how and when they are supported to live their lives'*.

Feedback from service users shows that our current approach to care planning does not always promote a personalised approach. By undertaking the actions agreed for 2018/19 we aim to improve the experience of service users and carers. For this to be sustainable a change in culture will be required.

The benefits / outcomes our patients and carers should expect:

- To have their personal circumstances viewed as a priority when planning care and treatment.
- To have an accessible, understandable and personalised crisis plan containing contact details of those people and services that are best placed to help when the need arises.
- To have discussions that lead to shared decision making and co-production of meaningful care plans.
- To have agreed plans recorded in a way that can be understood by the service user and everybody else that needs to have this information.
- To receive information about getting support from people who have experience of the same mental health needs.
- To have help with what is important to the service user and carers.

What we did in 2017/18:

We will:
• Completed and reported on an in-depth quality focused audit of the Care Programme Approach, including the care plan.

What we will do in 2018/19:

We will:
• Co-produce an action plan with service users, carers and staff teams based on the findings and recommendations of the audit by Q1 2018/19. • Co-produce guidance about what Personalised Care Planning means and how to demonstrate this through clinical records by Q1 2018/19. • Co-develop training and development packages aligning these to, and incorporate where possible, the training and development work of other programmes, projects and business as usual – these must include evaluation measures by Q2 2018/19. • Co-deliver training and development packages – Trustwide by Q3 2018/19. • Re-audit and report as per Q4 2017/18 by Q4 2018/19.

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
The following indicators are for TEWV from the National Mental Health Community service user Survey 2017 (% for 2017) • Do you know who to contact out of office hours if you have a crisis? (64.8%) • Were you involved as much as you wanted to be in deciding what treatments or therapies to use? (68%) • Have you been given information by NHS mental health services about getting support from people who have experience of the same mental health needs as you? (32.8%) • Do the people you see through NHS mental health services help you with what is important to you? (66.9%) • Were you involved as much as you wanted to be in agreeing what care you will receive? (70.8%) • Were you involved as much as you wanted to be in discussing how your care is working? (75.5%) • Does the agreement on what care you will receive take your personal circumstances into account? (74.9%)	All 2017 indicators to increase by 10% points minimum	Q4 2018/19

Priority 4: Develop a Trustwide approach to dual diagnosis which ensures that people with substance misuse issues can access appropriate and effective mental health services.

Why this is important:

Service users with severe mental health problems who are also misusing substances (known as **dual diagnosis**) have high risks of harm to themselves or others, poor outcomes and high treatment costs. Changes in commissioning arrangements of substance misuse services could lead to increased risk of have service gaps for patients with a dual diagnosis. The Trust has recognised the importance of adapting to these changes and become more proactive in developing services that address the specific needs of this group of service users.

The benefits / outcomes our patients and carers should expect:

- That service users with mental health and co-existing substance misuse get the same level of care than people without substance misuse.
- Staff treat every service user with the same level of respect, without judging someone because they abuse drugs or alcohol.
- Support for family and carers of service users with dual diagnosis.
- Staff will work collaboratively across organisations, with a creative, flexible and proactive approach.
- The Trust will consider the whole picture when considering the discharge of service users who have started / increased their misuse of substances.
- The organisation will learn from incidents if things go wrong.

What we will do in 2018/19:

We will:
• Circulate Dual Diagnosis CLiP to all Localities, specialties and specialty sub-groups for them to agree the most appropriate place to integrate within their pathways by Q1 2018/19. • Establish a process with the patient safety team that incorporates dual diagnosis in investigations / reviews by Q1 2018/19. • Directorate specialties to confirm their use of Dual Diagnosis CLiP (proportionate to their need) within relevant pathways by Q2 2018/19. • Introduce a Training Needs Analysis (TNA) which includes dual diagnosis and identify those staff with dual diagnosis capabilities by Q2 2018/19. • Establish a training structure linked to Locality and speciality requirements by Q3 2018/19. • Ensure all services have at least 1 person trained or have access to a trained clinician (proportionate to each directorate's needs) as a contact regarding dual diagnosis issues by Q4 2018/19. • Complete an annual thematic review of risks and Serious Incidents involving service users with Dual Diagnosis by Q4 2018/19. • Establish links with the confidential enquiry process and identify whether there are any potential missed mental health factors in recorded drug-related deaths by Q4 2018/19.

- Engage partner and stakeholders to agree a future approach and produce the framework/document which outlines the forward view for dual diagnosis by Q4 2018/19.

What we will do in 2019/20:

We will:
• Complete an audit of staff dual diagnosis capabilities and skills by Q4 2019/20, and then repeat this every two years.

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 services* that have at least one person trained or have access to a trained clinician.	100%	Q4 2018/19
• Percentage of services* which have access to an identified staff member who has enhanced dual diagnosis capabilities.	100%	Q4 2018/19

*AMH, CYPS, MHSOP, Learning Disabilities and Forensics.

Monitoring Progress

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

We will also feedback progress made during quarter one at our July Quality Account stakeholder event, send a six monthly update to all of our stakeholders, and provide a further update of the position as of 31 December 2018 at our February 2019 Quality Account Stakeholder workshop.

Part 3: Other information on Quality Performance 2017/18

Our performance against our quality metrics

During 2016/17 we reviewed and revised our Trust's Quality Strategy. In approving the new strategy the Trust Board agreed a set of metrics to be routinely monitored each quarter to show the progress that is being made in delivering the objectives within the strategy. As a consequence we revisited the quality metrics to be used in the 2017/18 Quality Account to ensure they are aligned to the metrics in the Quality Strategy.

The following table provides details of our performance against our set of agreed quality metrics for 2017/18. As the majority of these metrics now align to the Trust Quality Strategy, they do vary from those we have reported in previous years.

The targets in the table below are taken from TEWV's Quality Strategy 2017/18 to 2020/21. We intend to achieve these targets by March 2021. In the first year we have started progress towards these, and we expect a year-on-year improvement in these figures as we get nearer to achieving these 3 year targets.

Quality Metrics

Quality Metrics		2017/18		2016/17	2015/16	2014/15	2013/14
		Target	Actual	Actual	Actual	Actual	Actual
Patient Safety Measures							
1	Percentage of patients reported 'yes always' to the question, 'do you feel safe on the ward'?	88%	**62.30%**	NA	NA	NA	NA
2	Number of incidents of falls (level 3 and above) per 1000 occupied bed days (for in patients)	0.35	**0.12**	0.37	NA	NA	NA
3	Number of incidents of physical intervention / restraint per 1000 occupied bed days	19.25	**30.65**	20.26	NA	NA	NA
Clinical Effectiveness Measures							
4	Existing Percentage of patients on Care Program Approach who were followed up within 7 days after discharge from psychiatric in-patient care	> 95.00%	**94.78%**	98.35%	97.75%	97.42%	97.86%
5	Percentage of clinical audits of NICE Guidance completed	100%	**100%**	100%	100%	100%	97%
6a	Average length of stay for patients in Adult Mental Health and	AMH <30.2	**27.64**	30.08	26.81	26.67	31.72

Quality Metrics		2017/18		2016/17	2015/16	2014/15	2013/14
		Target	Actual	Actual	Actual	Actual	Actual
6b	Mental Health Services for Older People Assessment & Treatment Wards	MHSOP <52	**67.42**	78.06	62.67	62.18	54.08
Patient Experience Measures							
7	Percentage of patients who reported their overall experience as excellent or good	94%	**90.50%**	90.53%	NA	NA	NA
8	Percentage of patients that report that staff treated them with dignity and respect	94%	**85.90%**	NA	NA	NA	NA
9	Percentage of patients that would recommend our service to friends and family if they needed similar care or treatment	94%	**87.20%**	86.58%	85.51%	NA	NA

Notes on selected metrics

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.
   As at the 28th February, there were no NICE audits due for completion. There are three to be completed by the end of March 2018.
6. Data for average length of stay is taken from the Trust's patient systems.

Comments on Areas of Under-Performance

Metric 1: Percentage of patients reported 'yes always' to the question, 'do you feel safe on the ward'?

The end of year position was 62.33%, which relates to 2,290 out of 3,674 surveyed. This is 25.67% below the Trust target of 88.00%.

All localities underperformed this year. Durham and Darlington is closest to the target with 69.58% and Forensic Services are furthest away with 48.78%.

The Trust's Patient Safety Group is conducting a "deep dive" to better understand the data for this action and are developing an action plan to monitor and resolve any issues highlighted.

Metric 3: Number of incidents of physical intervention / restraint per 1000 occupied bed days.

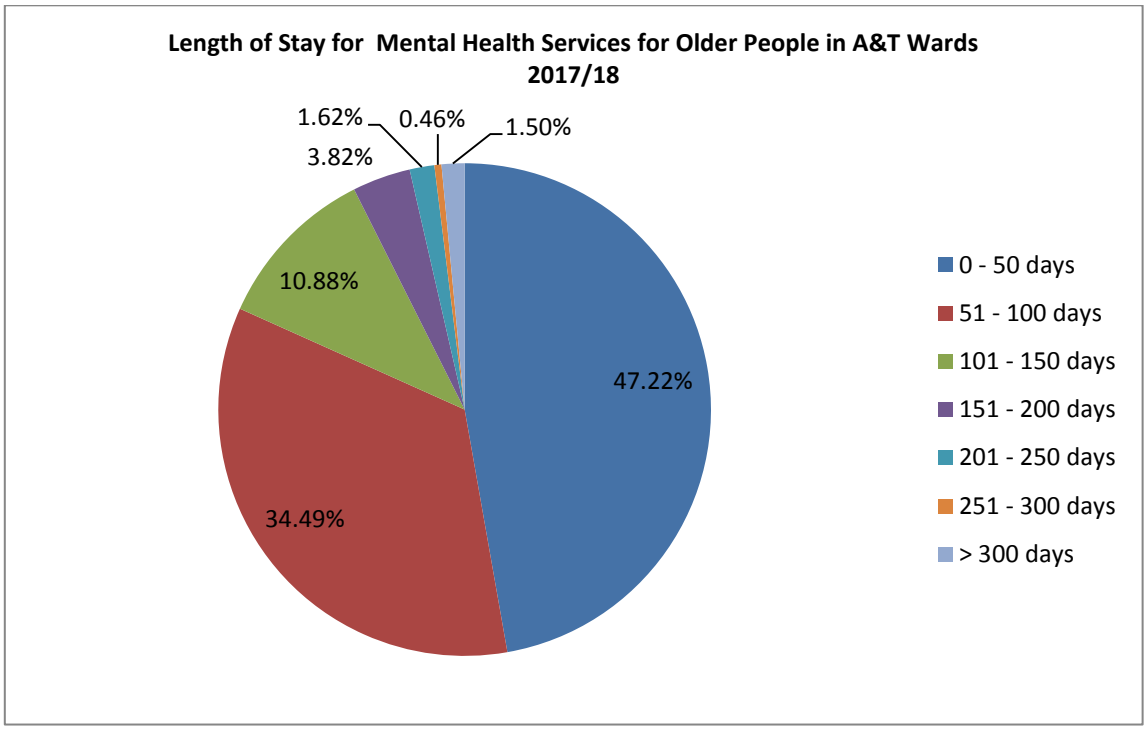
The end of year position was 30.65, which relates to 8,492 incidents out of 277,030 occupied bed days. This is 11.40 above the Trust target of 19.25.

Durham & Darlington and North Yorkshire achieved the target during year. Of the underperforming localities Forensic Services is closest to the target with 24.28 and Teesside are furthest away with 55.91.

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

The average length of stay for older people has been worse than target since quarter three 2013/14 reporting 67.42 days as at March 2018, which is 12.42 worse than target but an significant improvement compared to the position reported in 2016/17. The pie chart below shows the breakdown for the various lengths of stay during 2017/18.

The median length of stay was **53** days, which is only one day above the target of 52 days and demonstrates that the small number of patients that had very long lengths of stay have a significant impact on the mean figures reported.



The length of stay of patients (for both adults and older adults) is closely monitored by all services within the Trust. The reasons for the increase in the average length of stay for patients are due to a small number of patients who were discharged after a very long length of stay, which has distorted the overall average. In total 77.88% of lengths of stay were between 0-50 days, with 14.54% between 51 – 100 days. There were 63 patients who had a length of stay greater than 200 days; the majority were attributable to the complex needs of the patients (including physical health problems) and delays in accessing suitable placements for patients subsequent to discharge.

Metric 7: Percentage of patients who reported their overall experience as excellent or good.

The end of year position was 90.50%, which relates to 13,772 out of 15,218 surveyed. This is 3.50% below the Trust target of 94.00%.

All localities underperformed this year. Teesside is closest to the target with 91.98% and Forensic Services performing furthest away with 79.90%.

Metric 8: Percentage of patients that report that staff treated them with dignity and respect.

The end of year position was 85.94%, this relates to 14,567 out of 16,950 surveyed and is 8.06% below the Trust target of 94.00%.

All localities underperformed this year. North Yorkshire is closest to the target with 90.08% and Forensic Services performing furthest away with 64.45%.

Metric 9: Percentage of patients that would recommend our service to friends and family if they needed similar care or treatment.

The end of year position was 87.22%, which relates to 12,424 out of 14,244 surveyed. This is 6.78% below the Trust target of 94.00%.

All localities underperformed this year. Teesside is closest to the target with 89.08% and Forensic Services performing furthest away with 72.63%.

Our performance against the Single Oversight Framework Targets and Indicators

The following table demonstrates how we have performed against the relevant indicators and performance thresholds set out in appendix three of the Single Oversight Framework November 2017, representing the position as at February 2018**.

Single Oversight Framework

Indicators		2017/18		2016/17	2015/16	2014/15	2013/14
		Threshold	Actual	Actual	Actual		
A	Percentage of people experiencing a first episode of psychosis that were treated with a NICE approved care package within two weeks of referral*	50%	**74.11%**	70.04%	55.91%		
B	Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in inpatient wards*	90%	**92.50%**				

Indicators		2017/18		2016/17	2015/16	2014/15	2013/14
		Threshold	Actual	Actual	Actual		
C	Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in early intervention in psychosis services**	90%	**91.00%**				
D	Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in community mental health services (people on CPA)*	65%	**74.39%**				
E	IAPT/Talking Therapies - proportion of people completing treatment who move to recovery (from IAPT minimum dataset)	50%	**50.44%**	48.32%			
F	Percentage of people referred to the IAPT programme that were treated within 6 weeks of referral	75%	**95.49%**	95.44%	84.01%		
G	Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral	95%	**99.89%**	99.14%	95.93%		
H	Percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care	> 95.00%	**96.52%**	98.35%	97.75%	97.42%	97.86%
I	Admissions to adult facilities of patients who are under 16 years old		**1**				
J	Inappropriate out of area placements (OAPs) for adult mental health services		**1913**				

*This figure is different to that published elsewhere for 2017/18 due to the timing of data extracted.
**The figures provided are based on a Trust assessment of the sample audit data.

Notes on the Single Oversight Framework Targets and Indicators

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

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

Metric I: Admissions to adult facilities of patients who are under 16 years old

In July one patient aged 14 years old was admitted to an adult ward. The admission was the most appropriate option to keep the patient safe until a CAMHS learning disability bed became available; however this was not clinically appropriate and therefore a serious incident report was raised.

Metric J: Inappropriate out of area placements for adult mental health services

The Trust is currently seeking clarity from NHS Improvement on the calculation of this metric as it appears that the guidance issued for the Quality Account conflicts with that for the Single Oversight Framework (SOF) and we believe the two should align. In the interim the figure shown in the table is based on the calculation within the SOF. This allows providers a certain amount of interpretation in its application for internal OAPs and we have been commended by NHS Improvement and NHS England on our interpretation and transparent application of the metric. However, this means that direct comparison between providers may not be possible.

Using the SOF definition for this indicator the rolling three month position for the period ending 31st March 2018 was 1,913 inappropriate out of area placement bed days. This equates to a monthly average of 638 for each of the months in question. This may appear quite high, however all of these were internal OAPs within the Trust as opposed to an external OAP.

An internal OAP is where the patient remains within their home organisation, but the location of the receiving unit disrupts their continuity of care. An external OAP is where the sending organisation is paying another provider to care for their patient, usually because they do not have an available bed. We have now agreed a trajectory with the CCGs to improve performance and we plan to reduce this figure by 10% each year which has been discussed with NHS England who are supportive of our approach. Representatives from the Trust have met with CCGs to develop action plans to support this delivery.

External Audit

For 2017/18, our external auditors are required to provide a limited assurance report on whether two of the mandated indicators included in the Quality Account have been reasonably stated in all material respects. In addition the Council of Governors (CoG) have the option to choose one further local indicator for external assurance. The three indicators which have been included in the external assurance of the Quality Account 2017/18 are:

- Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE)-approved care package within two weeks of referral.
- Inappropriate out-of-area placements for adult mental health services.
- Number of incidents of physical intervention / restraint per 1000 occupied bed days (Governor selected indicator).

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

Our stakeholders' views

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

How we involve and listen to what our stakeholders say about us is critical to this process. In producing the Quality Account 2017/18, we have tried to improve how we involved our stakeholders in assessing our quality in 2017/18.

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

The positive feedback we have received was mostly within the following themes:

- *Well organised useful event with a good structure and feedback.*
- *Table discussions work well.*
- *Good mix of knowledge on tables.*
- *Really positive information sharing exercise.*
- *Good range of topics covered.*
- *Interesting agenda and good speakers.*
- *Everything was excellent and very informative.*
- *Clear ideas and aims / decisions.*

In line with national guidance, we have circulated our draft Quality Account for 2017/18 to the following stakeholders:

- NHS England;
- North East Commissioning Support;
- Clinical Commissioning Groups (x9);
- Health & Wellbeing Boards (x8);
- Local Authority Overview & Scrutiny Committees (x8);
- Local HealthWatch organisations (x8).

All the comments we have received from our stakeholders are included verbatim in **appendix 7**.

The following are the general themes received from stakeholders in reviewing our Quality Account for 2017/18:

- Stakeholders welcomed the opportunity to receive and comment on the Quality Account;
- Recognise the progress made on our 2017/18 quality priorities and agree our plans to achieve the 2018/19 quality priorities;
- Understand that there are issues affecting the Trust in terms of staffing levels and recruitment;
- Note the difficult financial position affecting health and mental health but are pleased to see the Trust financial position;
- Note that not all the quality metric targets were met but agree with the mitigations have been put in place;
- Acknowledge the progress on learning from incidents but feel that further work is needed to avoid incidents;
- Would like to receive six monthly update reports;
- The Trust actively engages its partners.

The Trust will write to each stakeholder addressing each comment made following publication of the Quality Account 2017/18 and use the feedback as part of an annual lessons learnt exercise in preparation for the Quality Account 2018/19.

In response to many stakeholders' requests, the Trust has agreed to continue providing all stakeholders with a half-year update in November 2018 on the Trust's progress with delivering its quality priorities and metrics for 2018/19.

APPENDICES

APPENDIX 1: 2017/18 STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE QUALITY ACCOUNT

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

NHS Improvement has issued guidance to NHS Foundation Trust boards on the form and content of annual Quality Accounts/Reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust boards should put in place to support the data quality for the preparation of the Quality Account/Report.

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

- the content of the Quality Account/Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18 and supporting guidance;

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

    - Board minutes and papers for the period April 2017 to May 2018;
    - Papers relating to quality reported to the Board over the period April 2017 to May 2018;
    - Feedback from the Commissioners dated 23 April, 13 May and 17 May 2018;
    - Feedback from Governors dated 8 March and 13 April 2018;
    - Feedback from Local Healthwatch organisations two undated with one received on 3 May 2018 and one received on 9 May 2018;
    - Feedback from Overview and Scrutiny Committees two dated 11 May 2018, one undated but received on 11 May 2018 and one dated 17 May 2018;
    - Feedback from Health and Wellbeing Board dated 10 May 2018;
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, received 9th May 2018;
    - The latest national patient survey published 1 August 2017 and 15 November 2017;
    - The latest national staff survey published March 2018;
    - The Head of Internal Audit's annual opinion over the Trust's control environment dated May 2018;
    - CQC inspection reports dated 11 May 2017 and September 2017.

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

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

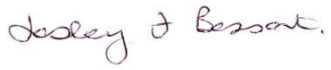
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account/Report, and these controls are subject to review to confirm that they are working effectively in practice;

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

- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account/Report.

By order of the Board.



Lesley Bessant
Chairman

Colin Martin
Chief Executive

22 May 2018

APPENDIX 2: 2017/18 LIMITED ASSURANCE REPORT ON THE CONTENT OF THE QUALITY ACCOUNTS AND MANDATED PERFORMANCE INDICATORS

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

We have been engaged by the Council of Governors of Tees, Esk and Wear Valleys NHS Foundation Trust to perform an independent assurance engagement in respect of Tees, Esk and Wear Valleys NHS Foundation Trust's Quality Report for the year ended 31 March 2018 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE)-approved care package within two weeks of referral; and
- Inappropriate out-of-area placements for adult mental health services.

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

Respective responsibilities of the Directors and auditors

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

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

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's Detailed Requirements for External Assurance for Quality Reports 2017/18; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance and the six dimensions of data quality set out in the Detailed Requirements for External Assurance for Quality Reports.

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

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

- Board minutes for the period April 2017 to April 2018;

- Papers relating to quality reported to the Board over the period April 2017 to April 2018;
- Feedback from Commissioners: Joint Durham, Darlington and Teesside CCGs (dated 23 April 2018), Joint North Yorkshire CCGs (dated 17 May 2018), Vale of York CCG (dated 13 May 2018);
- Feedback from Governors;
- Feedback from local Healthwatch organisations: Healthwatch Darlington (undated), Healthwatch South Tees (undated);
- Feedback from the Overview and Scrutiny Committee: Darlington Borough Council (undated), Durham County Council (dated 11 May 2018), North Yorkshire County Council (dated 17 May 2018), Tees Valley Joint Health Scrutiny Committee (dated 11 May 2018);
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- The national patient survey (dated 2017);
- The national NHS staff survey (dated 2017);
- Care Quality Commission inspection reports (dated 11 May 2017 and 13 July 2017);
- The Head of Internal Audit's annual opinion over the trust's control environment for the period April 2017 to March 2018 (dated May 2018); and
- Any other information included in our review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the "documents"). Our responsibilities do not extend to any other information.
We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts. We apply International Standard on Quality Control (UK & Ireland) 1 and accordingly maintain a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

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, 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 2018, to enable the Council of Governors to demonstrate that it has discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Tees, Esk and Wear

Valleys NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

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

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

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

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

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

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

Conclusion
Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;

- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvements' Detailed Requirements for External Assurance on Quality Reports 2017/18; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance.

Signed:

Cameron Waddell
Partner, for and on behalf of Mazars LLP
Date: 22 May 2018
Chartered Accountants and Statutory Auditor
Salvus House
Aykley Heads
Durham
DH1 5TS

APPENDIX 3: GLOSSARY

Academic Health Science Network (AHSN): There are 15 AHSNs across England; they focus on two main areas: improving population health and generating economic growth. AHSNs have also been established to deliver a 'step-change' in the way healthcare providers identify, develop, adopt and spread new technologies.

Accountable Care Partnership (ACP): are alliances of NHS providers that work together to deliver care by agreeing to collaborate rather than compete. These providers include hospitals, community services, mental health services and GPs. Social care and independent and third sector providers may also be involved.

Acute Trust: provide physical healthcare services within hospitals, with some providing services within the community.

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

Allied Health Professional (AHP): is the term used for a range of professional roles such as Dietitians, Occupational Therapists, Physiotherapists and Speech and Language Therapists.

Audit: is an official inspection of records. This can be conducted either by an independent body or an internal audit department.

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

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

Bank Staff: This is a pool of staff that can be called upon to cover vacant shifts on inpatient wards. These staff are employed by the Trust.

Benefits: This term is often used when describing and measuring the positive and negative (dis-benefits) elements of a project or programme.

Board / Board of Directors: The Trust is run by the Board of Directors made up of the Chairman, Chief Executive, Executive and Non-Executive Directors. The Board is

responsible for ensuring accountability to the public for the services it manages. It also:

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

Business as usual: This is a way of describing day to day business.

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

Care Planning: see Care Programme Approach (CPA).

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

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

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

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

College Centre for Quality Improvement (CCQI): works with the majority of mental health Trusts in the UK focusing on quality networks, accreditation, national clinical audits and research.

Clinical pathway: is a multidisciplinary management tool based on evidence-based practice for a specific group of patients with a predictable clinical course, in which the different tasks (interventions) by the professionals involved in the patient care are defined, optimised and sequenced.

CLiP (Clinical Link Pathway): Completed on the Trust's electronic patient record (Paris) for Falls allowing them to be monitored effectively.

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.

Community Mental Health Survey: is conducted every year by the CQC. It represents the experiences of over 13,000 people who received specialist care or treatment for a mental health condition in 55 NHS Trusts in England during a specified time each year.

Confidential Inquiry: A national scheme that interviews clinicians anonymously to find out ways of improving care by gathering information about which factors contributed to the inability of the NHS to prevent each suicide of a patient within its care. National reports and recommendations are then produced.

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

Council of Governors: the Council of Governors is made up of elected public and staff members, and also includes non-elected members, such as the Prison Service, Voluntary Sector, Acute Trusts, Universities and Local Authorities. The Council has an advisory, guardianship and strategic role including developing the Trust's membership, appointments and remuneration of the Non-Executive Directors including Chairman and Deputy Chairman, responding to matters of consultation from the Trust Board, and appointing the Trust's auditors.

Dashboard: A report that uses data on a number of measures to help managers build up a picture of operational (day to day) performance or long term strategic outcomes.

Data Protection Act 1998: The law that regulates storage of and access to data about individual people.

Data Quality Improvement Plans (DQIPs): A plan to improve the reliability / accuracy of data collected on a particular subject – often used where data has not been collected in the past and new systems to do this need to be set up.

Data Quality (DQ) Strategy: This is a TEWV strategy. It sets a clear direction and outlines what the Trust expects from its staff to work towards our vision of providing excellent quality data. It helps TEWV continue to improve the quality and value of our work, whilst making sure that it remains clinically and financially sustainable.

DeNDRoN: is part of the National Institute for Health Research (NIHR) Clinical Research Network (CRN). It supports the development, set-up and delivery of

clinical research in the NHS around dementia, Huntington's disease, Motor Neurone disease, Parkinson's disease, and other neurodegenerative diseases.

Department of Health: The government department responsible for Health Policy.

Directorate(s): TEWV's corporate services are organised into a number of directorates: Human Resources and Organisational Development; Finance and Information; Nursing and Governance; Planning, Performance and Communications; Estates and Facilities Management. In the past our clinical specialities were called clinical directorates. The Specialities are Adult Mental Health services, Mental Health Services for Older People, Children and Young People's Services and Adult Learning Disability Services.

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.

Executive Management Team: A regular meeting of individuals at the senior level of management within the organisation (e.g. Directors) who are responsible for the overall management of TEWV; they are responsible for the high-level decisions within the organisation.

Expert by Experience Groups and members: Non contracted roles, managed under the involvement and engagement structures (offered honorarium) to offer story telling input into training and provide the opportunity to gain a broader range of lived experience views on a range of service developments. Experts by Experience have been trained to work alongside the recovery team to develop and deliver recovery related training in supporting staff and service development in recovery related practice. Experts by Experience work with Trust staff, they do not work with patients and carers (ie they are not acting in a peer role). These roles are managed via our Patient and Public Involvement process.

Forensic Services: Forensic Adult Mental Health and Learning Disability services work mainly with people who are mentally unwell or who have a learning disability and have been through the criminal justice system. The majority of people are transferred to a secure hospital from prison or court, where their needs can be assessed and treated. These services are intended to see that people with severe mental illness or learning disability who enter the criminal justice system get the care they need.

Formulation: This is where clinicians use information obtained from their assessment of a patient to provide an explanation or hypothesis about the cause and nature of the presenting problems. This helps in developing the most suitable treatment approach.

Freedom of Information Act 2000: A law that outlines the rights that the public have to request information from public bodies (other than personal information covered by the Data Protection Act), the timescales they can expect to receive the information, and the exemptions that can be used by public bodies to deny access to the requested information.

Friends and Family Test (FFT): A survey question put to patients, carers or staff that asks whether they would recommend a hospital / community service to a friend of family member if they needed that kind of treatment.

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.

Greenlight: is a framework and self-audit toolkit for improving mental health support for people with learning disabilities.

Harm Minimisation: aims to prevent and reduce the myriad harms associated with the use of psychoactive drugs in the community.

Health and Wellbeing Boards: The Health and Social Care Act 2012 established health and wellbeing boards as a forum where key leaders from the health and care system would work together to improve the health and wellbeing of their local population and reduce health inequalities. Health and wellbeing board members collaborate to understand their local community's needs, agree priorities and encourage commissioners to work in a more joined-up way.

Health of the Nation Outcome Score (HoNOS): A way of measuring patients' health and wellbeing. It is made up of 12 simple scales on which patients with severe mental illness are rated by clinical staff. The idea is that these ratings are stored, and then repeated- say after a course of treatment or some other intervention- and then compared. If the ratings show a difference, then that might mean that the patient's health or social status has changed. They are therefore designed for repeated use, as their name implies, as clinical outcomes measures.

Health Research Authority (HRA): In accordance with the provision of the Care Act 2014, the HRA was established as an executive non-departmental public body sponsored by the Department of Health. Its purpose is to regulate different aspects of health and social care research.

Healthwatch: local bodies made up of individuals and community groups, such as faith groups and residents' associations, working together to improve health and social care services. They aim to ensure that each community has services that reflect the needs and wishes of local people.

Hospital Episode Statistics (HES): is the national statistical data warehouse for England of the care provided by NHS hospitals and for NHS hospital patients treated elsewhere. HES is the data source for a wide range of healthcare analysis for the NHS, Government and many other organisations and individuals.

IAPT (also known as 'Talking Therapies'): IAPT stands for "Increasing Access to Psychological Therapies" and was introduced in the last.

Information Governance Toolkit & Assessment Report: is a national approach that provides a framework and assessment for assuring information quality against national definitions for all information that is entered onto computerised systems whether centrally or locally maintained.

Integrated Information Centre (IIC): TEWV's system for taking data from the patient record (Paris) and enabling it to be analysed to aid operational decision making and business planning.

inTouch: This is the Trusts internal website used for staff to access relevant information about the organisation, such as Trustwide policies and procedures.

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

Join Dementia Research: is a national service that enables individuals to register their interest and be matched to take part in suitable research studies.

Kaizen: is a word used as part of the QIS process, it is a Japanese word that means 'change for the better' and is known as 'continuous improvement'.

Learning Disabilities Service: Services for people with a learning disability and mental health needs. TEWV has Adult Learning Disability (ALD) service in each of its 4 Localities and also specific wards for Forensic LD patients. TEWV provides Child LD services in Durham, Darlington, Selby, Teesside and York but not in North Yorkshire.

Lived Experience: A member of the public or staff who has been treated for MH issues in the past and so has special insight into the patient perspective of having a mental illness and receiving treatment.

Local Authority Overview and Scrutiny Committee (OSC): These are statutory committees of each Local Authority which scrutinise the development and progress of strategic and operational plans of multiple agencies within the Local Authority area. All local authorities have an OSC that focused on Health, although Darlington, Middlesbrough, Stockton, Hartlepool and Redcar & Cleveland Councils have a joint Tees Valley Health OSC that performs this function.

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

Locality Management and Governance Board (LMGB): A monthly meeting held in each of our Localities (see above) that involves senior managers and clinical leaders who work in that Locality which takes key decisions that relate to that Locality.

Mazars: is an international, integrated and independent organisation specialising in audit, accountancy, tax, legal and advisory services.

Memorandum of understanding: is an agreement between two or more parties. It expresses a convergence of will between the parties, indicating an intended common line of action.

Managing the Business Group: is a director level group which meets monthly and manages the operational corporate business of the Trust. Similar to the Operational Management Group (OMT), however its focus is corporate services rather than clinical services. The group holds overall responsibility for the Data Quality Strategy.

Memory Services: are for people who may be experiencing memory difficulties, which includes the early onset of dementia.

Mental Health Act: The Mental Health Act (1983) is the main piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder. In most cases, when people are treated in hospital or another mental health facility they have agreed or volunteered to be there. However, there are cases when a person can be detained (also known as sectioned) under the Mental Health Act (1983) and treated without their agreement. People detained under the Mental Health Act need urgent treatment for a mental health disorder and are at risk of harm to themselves or others.

Mental Health Services for Older People (MHSOP): Services provided for people over 65 years old. These can be to treat 'functional' illness, such as depression, psychosis or anxiety, or to treat 'organic' mental illness (conditions usually associated with memory loss and cognitive impairment), such as dementia. The MHSOP service sometimes treats people younger than 65 with organic conditions such as early-onset dementia.

Multi-disciplinary: this means that more than one type of professional is involved – for example: psychiatrists, psychologists, occupational therapists, behavioural therapists, nurses, pharmacist all working together in a Multi-Disciplinary Team (MDT).

National Confidential Inquiries (NCI) and National Clinical Audit: research projects funded largely by the National Patient Safety Agency (NPSA) that examine all incidents of, for example suicide and homicide by People with Mental Illness, with the aim is to improve mental health services and to help reduce the risk of these tragedies happening again in the future. This is supported by a national programme of audit.

National Institute for Clinical Excellence (NICE): NHS body that provides guidance, sets quality standards and manages a national database to improve people's health and prevent and treat ill health. NICE works with experts from the NHS, local authorities and others in the public, private, voluntary and community

sectors - as well as patients and carers - to make independent decisions in an open, transparent way, based on the best available evidence and including input from experts and interested parties.

National Institute for Health Research (NIHR): an NHS research body aimed at supporting outstanding individuals working in world class facilities to conduct leading edge research focused on the needs of patients and the public.

National Quality Board (NQB): The purpose of the NQB is to provide coordinated leadership for quality on behalf of the Department of Health, Public Health England, NHS England, the Care Quality Commission, NHS Improvement and the National Institute for Care Excellence.

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.

NHS Digital: Previously known as the Health and Social Care Information Centre (HSCIC), was set up as an executive non-departmental public body in April 2013, sponsored by the Department of Health. It is the national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care.

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

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

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

North of England Mental Health Development Unit (NEMHDU): offers health and social care consultancy.

Operational Management Team (OMT): work on a localised level and are responsible for the day-to-day management of TEWV; they report to the Executive Management Team.

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

Patient Safety Group: The group monitors on a monthly basis the number of incidents reported, any thematic analysis and seeks assurances from operational services that we are learning from incidents. We monitor within the group any patient safety specific projects that are on-going to ensure milestones are achieved and benefits to patients are realised.

Peer Worker: someone who is trained and recruited as a paid employee within the Trust in a specifically designed job, to actively use their lived experience (as a patient or carer) to support other patients, in line with the Recovery Approach.

Positive Behavioural Support: is a person-centred approach to people who display or are at risk of displaying behaviours with challenge. It involves understanding the reasons for behaviour and considering the person as a whole including their life history, physical health and emotional needs, to implement ways of supporting the person. It focuses on creating physical and social environments that are supportive and capable of meeting people's needs and teaching people new skills to replace the behaviours which challenge.

Prescribing Observatory in Mental Health (POMH): a national agency, led by the Royal College of Psychiatrists, which aims to help specialist mental health services improve prescribing practice via clinical audit and quality improvement interventions.

Pressure Ulcer: also known as pressure sores are localised damage to the skin and / or underlying tissue that usually occur over a bony prominence as a result of pressure or pressure in combination with shear and / or friction.

Professional Revalidation: is the process that all Nurses and Midwives need to go through in order to renew their registration with the Nursing and Midwifery Council (NMC).

Programme: A set of coordinated group of projects and change management activities designed to achieve outputs and / or changes that will benefit the organisation.

Programme Board: A group of individuals established to meet and discuss a particular programme, providing input, discussions and / or approval on issues affecting the progress of the programme, setting tasks, actions and deadlines.

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.

Psychiatric Intensive Care Unit (PICU): are units (or wards) that are designed to look after patients who cannot be managed on open (unlocked) psychiatric wards due to the level of risk they pose to themselves or others.

Purposeful Inpatient Admission (PIPA) and Treatment: This is TEWV's method for ensuring that all patients receive assessments and treatments as quickly as possible so that their length of stay is kept as short as possible.

Quality Account: A Quality Account is a report about the quality of services by an NHS healthcare provider. The reports are published annually by each provider.

Quality Assurance Committee (QuAC): sub-committee of the Trust Board responsible for quality and assurance.

Quality Assurance Groups (QuAG): Locality / divisional groups within the Trust responsible for quality assurance.

Quality Strategy: This is a TEWV strategy. It sets a clear direction and outlines what the Trust expects from its staff to work towards our vision of providing excellent quality care. It helps TEWV continue to improve the quality and value of our work, whilst making sure that it remains clinically and financially sustainable.

Quality Strategy Scorecard: A set of numerical indicators related to all aspects of Quality, reported to Trust Board four times per year, that helps the Board ascertain whether the actions being taken to support the Quality Strategy are having the expected positive impact.

Quarter one (Q1) / quarter two (Q2) / quarter three (Q3) / quarter four (Q4): These refer to specific points within the financial year (1st April to 31st March). Quarter one is the period of time from April until June. Quarter two is the period of time from July to September. Quarter three is the period of time from October to December. Quarter four is the period of time from January to March.

Recovery Approach: This is a new approach in mental health care that goes beyond the past focus on the medical treatment of symptoms, and getting back to a "normal" state. Personal recovery is much broader and for many people it means finding / achieving a way of living a satisfying and meaningful life within the limits of mental illness. Putting recovery into action means focusing care on what is personally important and meaningful, looking at the person's life goals beyond their symptoms. Helping someone to recover can include assisting them to find a job, getting somewhere safe to live and supporting them to develop relationships.

Recovery College: A recovery college is a learning centre, where patients, carers and staff enrol as students to attend courses based on recovery principles. Our recovery college, called *ARCH,* opened in September 2014 in Durham. This exciting resource is available to TEWV patients, carers and staff in the Durham area. Courses aim to equip students with the skills and knowledge they need to manage their recovery, have hope and gain more control over their lives. All courses are developed and delivered in co-production with people who have lived experience of mental health issues.

Recovery College Online: This is an initiative that would allow people to access recovery college materials and peer-support on-line.

Recovery focused: see Recovery Approach.

Recovery Strategy: TEWV's long term plan for moving services towards the *recovery approach* (see above).

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

Royal College of Psychiatrists: is the professional body responsible for education and training, and setting and raising standards in psychiatry.

Section 17 (S17): This is a Section within the Mental Health Act (1983) which allows the Responsible Clinician (RC) to grant a detained patient leave of absence from hospital. It is the only legal means by which a detained patient may leave a secure hospital site when they are detained under the Mental Health Act.

Serious Incidents (SIs): defined as an incident that occurred in relation to NHS-funded services and care, to ether patient, staff or member of the public, resulting in one of the following: unexpected / avoidable death, serious / prolonged / permanent harm, abuse, threat to the continuation of the delivery of services, absconding from secure care.

Service Development Group (SDG): A group of individuals established to review how changes can be made to improve patient care.

Single Oversight Framework: sets out how NHS Trusts and NHS Foundation Trusts are over overseen.

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.

Steering Group: These are made up of experts who oversee key pieces of work to ensure that protocol is followed and provide advice / troubleshoot where necessary.

Strategic Change Oversight Board (SCOB): A meeting of members of EMT to oversee and discuss and / or approve development and improvement of the Trust's services.

Strategic Programme: A programme that considers the 'big picture', overseeing how they can benefit the Trust as a whole in order to help improve services and patient experience.

Substance Misuse: A pattern of psychoactive substance use (including illegal drugs, alcohol, smoking and misuse of prescription drugs) that is causing damage to health or has adverse social consequences. Substances can be misused on a regular or intermittent basis (e.g. binge drinking).

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.

Thematic Review: A piece of work to identify and evaluate Trustwide practice in relation to a particular theme. This may be to identify where there are problems / concerns or to identify areas of best practice that could be shared Trustwide.

The Process of Recovery Questionnaire (QPR): is a 15 item measurement tool developed from service users' accounts of recovery from psychosis in collaboration with local service users.

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

Tissue Viability Advice: is advice provided to healthcare professionals who are involved in the management of complex wounds such as pressure ulcers.

Transitions: For the transitions Quality Account Priority we define a transition as a purposeful and planned process of supporting young people to move from children's to adults' services.

Trauma informed care (TiC): involves understanding, recognising and responding to the effects of all types of trauma.

Trust Board: See 'Board / Board of Directors'.

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

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

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.*

Workstreams: is the progressive completion of tasks completed by different groups which are required to complete a single project or programme.

Years 2015/16 / 2016/17 / 2017/18 / 2018/19 / 2019/20 / 2020/21: These are financial years, which start on the 1st April of the first part of the year and end on the 31st March on the second part of the year on each of the years shown.

APPENDIX 4: KEY THEMES FROM 163 LOCAL CLINICAL AUDITS REVIEWED IN 2017/18

Audit Theme	Key quality improvement activities associated with clinical audit outcomes
1. Infection Prevention and Control (IPC)	• All Infection Prevention and Control Audits are continuously monitored by the IPC team and any required actions are rectified collaboratively with the IPC team and ward staff. Assurance of implementation of actions is monitored by the Clinical Audit and Effectiveness team via the clinical audit database. • A total of **99** IPC clinical audits were conducted during 2017/18 in inpatient areas and a sample of community areas in the Trust. **96% (95/99)** of clinical areas achieved standards between 80-100% compliance. • Clinical audits have been undertaken to assess compliance with Hand Hygiene standards and a monthly Essential Steps audit is completed in inpatient areas.
2. Supervision	• Supervisory staff and Durham County Council (DCC) employees have been provided with details of DCC training requirements and provision. Local Authority staff have been given access to and registered on ESR and IIC so all can access training information for supervision. • A Task and Finish Group is scheduled to be developed which includes Team Managers from both DCC and TEWV to work locally to develop common documentation for recording staff supervision. The goals for the team that reflect DCC and TEWV required outcomes are to be identified by a leadership team and will be incorporated into individual appraisals. • There is an ongoing specialist contract requirement which involves undertaking an audit for specialist services to establish the duration of clinical supervision which staff have achieved, with a target of a minimum of 2 hours per quarter.
3. Records management	• There have been newly established work streams to rectify documentation recording within Prison patient systems and subsequent clinical audit re-audits have identified high compliance within Offender Health services documentation showing significant improvements made. • In CYPS Tier 4 Services, there have been developments following clinical audit activities which have influenced the recording of incidents of restraint within the TEWV Datix system. The developments related to including prompts for staff to document the appropriate information as required. Additional information posters were also displayed in clinical areas. • In MHSOP Services, clinical audits have identified outdated guidance and reference to age of 65 within operational policies for Age and Discrimination. These have been updated to specify 'older people' and referenced by the RCP guidance. • Following a clinical audit investigating the Claims Management Policy, the Claims and Legal Services Manager have reviewed the process of sharing lessons learnt from the claim to relevant Heads of Services. • In CYPS new guidelines and a flowchart have been developed around the requirements for documentation in a transition plan and panel meetings.
4. NICE/ Pathway Development	• Adult Mental Health services have reviewed and updated the Positive Behaviour Support (PBS) Pathway, linking to the Force Reduction Team, and awareness sessions have taken place for staff around PBS. • The Forensic Service has developed PBS awareness sessions for carers to support their involvement when service users express a wish for their involvement during behaviour support or intervention plan development. • In CYPS services, a checklist was rolled out for assessment of low mood to support compliance with NICE Guidance for Depression and this was incorporated into the CYPS Pathway shared area to be accessible. • A Memory Clinic Initial Assessment crib sheet was included within the Dementia Care Pathway document.
5. Physical Healthcare	• A new frailty CLiP has been introduced following clinical audit activities considering Falls assessment and management in MHSOP services. • AMH Teams have been provided with additional support from the Nicotine Management Team to continue to further reduce smoking rates. A Toolkit has been developed to support implementation of the Nicotine Management policy and this has been cascaded by the Smoking Cession Project Lead during ward visits to support smokers on admission. • The Trust Rapid Tranquilisation (RT) and Early Warning Score (EWS) policies have been updated to clarify the need for EWS total scores to be

Audit Theme	Key quality improvement activities associated with clinical audit outcomes
	transferred from the paper EWS chart to the post Rapid Tranquilisation physical health case note. The RT policy has also been updated to include instructions to complete the post-Rapid Tranquilisation paper form which has been developed to provide a single place to record incident details and debrief and to provide a prompt to record EWS as per policy. • RT clinical audit findings have influenced updates to the Health Care Assistant physiological observation training detailing more information on RT and EWS, and also influenced updates to the Trust Incident reporting system to allow reporting of RT without physical intervention and to prompt recording of EWS post RT. • Trust Nasogastric Tube Insertion training materials were updated following clinical audit findings to emphasise the correct tests to check NG tube positioning and the intended use for the Cortrak system. • Results of the National CQuIN Safety Thermometer are reported to the Clinical Effectiveness Group quarterly.
6. Medicines Management	• Covert medicine checklist was updated to include space in which to indicate who is responsible for reviewing covert administration. Covert medicines Standard Process Description was amended to include the option to make reference to covert administration instructions set out in the covert medicines plan, rather than recording instructions in the comments section in the prescription and administration chart. • The Trust's High Dose Antipsychotic Treatment (HDAT) monitoring sheet was updated to include reminders for documenting the reason for HDAT, consent/T3, and Paris medication alert. • There have been updates made to the lithium initiation proforma and lithium register recording patient weight/BMI and the requirement to inform women of childbearing age of lithium's teratogenic potential. • A monitoring information sheet has been produced for GP practices as part of the new lithium shared care guidelines.
7. Risk Assessment/ Patient Safety	• Harm Minimisation Training resources programme content have been influenced from findings from clinical audit activities. • The Clinical Audit and Effectiveness Team provided immediate feedback to clinical teams as appropriate to mitigate risks identified from clinical audit activities assessing Safety Summary documentation within patient electronic records. • Guidance notes have been developed detailing requirements for Safety Summary documentation following clinical audit findings. • Safeguarding clinical audits have resulted in points of contact for the Team published on the Trust Intranet and electronic posters shared in clinical teams. A Rapid Process Improvement Workshop (RPIW) has also been arranged with a focus on addressing improvements to the process following findings from the clinical audits. • MCA/DoLS training has been made mandatory within the Trust and bespoke briefing sessions and ward visits have been facilitated to support practice delivery following a MCA assessment audit.
8. Environment and Equipment	• The Trust Resuscitation policy has been updated following clinical audit findings to comply with new training requirements. • As part of ongoing improvement work regarding improving the state and readiness of Emergency Equipment in the Trust, a process has been developed by Nursing and Governance to implement a new monitoring process for this equipment. Modern Matrons and Service Managers will receive completed daily checklists on a 4 week basis and validation checks undertaken by these will provide assurance to the Quality Assurance Groups.

APPENDIX 5: TRUST BUSINESS PLAN ADDITIONAL QUALITY PRIORITIES

The 4 quality priorities within this Quality Account also sit within TEWV's 2018/19-2020/21 Business Plan. The Business Plan includes a further 15 priorities all of which will have a positive impact on the quality of Trust services. These are shown below.

No	Priority	To conclude by
1	Implement Phase 2 of the Trust's Recovery Strategy (years 4-6 of 10) and develop Phase 3	Q4 2020/21
2	Develop and deliver the Purposeful and Productive Community Services Programme (PPCS)	Q4 2020/21
3	Improve the consistency and purposefulness of inpatient care across the Trust	Q4 2020/21
4	Ensure we have the right staffing for our services now and in the future	Q4 2018/19
5	Deliver our Digital Transformation Strategy	Q4 2020/21
6	Refresh, communicate and implement Making a Difference Together across the whole organisation	Q4 2018/19
7	Develop and implement New Care Models	Q4 2020/21
8	Evaluate and agree future collaboration with universities on research, education and training	Q4 2018/19
9	Implement the Transforming Care agenda in Learning Disability Services	Q4 2018/19
10	Develop a Trust-wide approach to enabling service users with autism to access Trust mental health services	Q4 2018/19
11	Complete the transformation of our York and Selby services	Q3 2019/20
12	Agree and implement future service delivery model for service users from Harrogate and Rural District CCG and Wetherby area	Q3 2019/20
13	Deliver the agreed new model of care for Adult Mental Health and Mental Health Services for Older People in Hambleton and Richmondshire	Q4 2018/19
14	Improve the physical environment at Roseberry Park	Q4 2020/21
15	Implement the 5 Year Forward View for Mental Health as agreed with each of our commissioners	Q4 2020/21

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

APPENDIX 6: QUALITY PERFORMANCE INDICATOR DEFINITIONS

Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE)-approved care package within two weeks of referral

Data definition:
Percentage of people with a first episode of psychosis beginning treatment with a NICE-recommended care package within two weeks of referral. The clock stops at the start of the first definitive treatment for 2 different patient cohorts:

a) those experiencing first episode psychosis - when a person has been accepted onto caseload, an EIP care coordinator allocated and a NICE concordant package* of care commenced - this will need to be incorporated into the KPI when details are published. ALL THESE CONDITIONS MUST HAVE BEEN MET;

UNTIL THE NICE CARE PACKAGE DETAILS ARE KNOWN, THE CLOCK WILL STOP WHEN PATIENT HAS HAD A FIRST SUCCESSFUL FACE TO FACE CONTACT AFTER NEW REFERRAL RECEIVED DATE

b) for those possibly at risk mental state (ARMS) - when the person has been accepted onto caseload, an EIP care coordinator allocated and a specialist ARMS assessment commenced by an appropriately qualified EIP clinician - ALL THESE CONDITIONS MUST HAVE BEEN MET.

Exemptions:
The only suspected cases of first episode psychosis exempt from this KPI will be referrals of individuals who are experiencing psychotic symptoms in the context of organic illness e.g. dementia.

Accountability:
This standard applies to anyone with a suspected first episode of psychosis who is aged 14 to 65. People aged over 35 who may historically not have had access to specialist early intervention in psychosis services should not be excluded. Technical guidance is available at: www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/02/tech-cyped-eip.pdf.

Provider boards must be fully assured that RTT data submitted is complete, accurate and in line with published guidance. Both 'strands' of the standard must be delivered:

- performance against the RTT waiting-time element of the standard is being measured via MHSDS and UNIFY2 data submissions.
- performance against The National Institute for Health and Care Excellence concordance element of the standard is to be measured via:

    - a quality assessment and improvement network being hosted by the College Centre for Quality Improvement at the Royal College of Psychiatrists; all providers will be expected to take part in this network and submit self-assessment data, which will be validated and performance-scored on a four-point scale at the end of the year. This assessment will be used to track progress against the trajectory set out in Implementing the Five Year

Forward View for Mental Health: www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf.

- submission of intervention and outcomes data using SNOMED-CT codes in line with published guidance. Provider boards must be fully assured that intervention and outcomes data submitted is complete and accurate.

Inappropriate out-of-area placements for adult mental health services

Data definition:
An out of area placement that is solely or primarily necessitated because of the unavailability of a local acute bed will not meet the criteria for being appropriate. The total number of OAP days is the number of bed days associated with open OAPs in the rolling 3 month period.

Exemptions:
All beds except for acute adult mental health care - Assessment & Treatment, Acute older adult mental health care (Organic and Functional) Assessment & Treatment and PICU. The age range excludes anyone who is under 18 years.

Number of incidents of physical intervention / restraint per 1000 occupied bed days

Data definition:
Number of incidents of physical intervention / restraint per 1000 occupied bed days

Exemptions:
There are not any exemptions for this indicator.

Accountability:
QuAC and Patient Safety Group

Numerator:
The actual number of incidents of physical intervention / restraint .

Denominator:
The total number of responsible ward / team occupied bed days divided by 1000.

APPENDIX 7: FEEDBACK FROM OUR STAKEHOLDERS

County Durham Health and Wellbeing Board

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

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

10th May 2018

Dear Sharon

Re: Tees, Esk & Wear Valleys NHS Foundation Trust Quality Account 2017/18

Thank you for the opportunity to comment on the Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) Quality Account 2017/18. The County Durham Health and Wellbeing Board appreciate this transparency and would like to provide the following comments on the document.

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

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

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

It was assuring to note that you have maintained your registration status with the Care Quality Commission with no conditions attached and that the Commission took no enforcement action against you during 2017/18.

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…

It is positive to see that the overall performance figures during 2017/18 are improving. We further note that only 2 actions have not been delivered within the timeframe and support your determination to drive continued better performance to get nearer to achieving your established three year targets.

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

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

The Health and Wellbeing Board supports the Trust's 2018/19 priorities for improvement which align to the strategic objectives in the Joint Health and Wellbeing Strategy, as follows:

	TEWV - Priorities for improvement 2018/19	**Joint Health and Wellbeing Strategy 2016-19 – Strategic Objectives**
1	Reduce the number of preventable deaths (continued from 2017/18)	Improve the mental and physical wellbeing of the population
2	Improve the clinical effectiveness and patient experience in times of transition from Child to Adult services (continued from 2017/18)	Improve the mental and physical wellbeing of the population Protect vulnerable people from harm
3	Making Care Plans more personal (New)	Improve the quality of life, independence and care and support for people with long term conditions Improve the mental and physical wellbeing of the population Protect vulnerable people from harm
4	Develop a Trust-wide approach to dual diagnosis which ensures that people with substance misuse issues can access appropriate and effective mental health services (New)	Reduce health inequalities and early deaths Improve the quality of life, independence and care and support for people with long term conditions

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…

The positive progress to further reduce the number of preventable deaths is welcomed. The new intervention to strengthen your learning process is further welcomed and it is important you have recognised the role that families and carers have in this assessment.

In addition to the areas that have been identified in relation to supporting a reduction in the number of preventable deaths, it is suggested that consideration is given to how people access services, and the responses they are given when in crisis, and how this impacts on preventable deaths. The evaluation planned for Q4 will be important to share with stakeholders as it will allow better understanding for improvement opportunities.

The continuing development of the clinical effectiveness and patient experience in times of transition from Child to Adult services is supported. The progress of this work is integral to our overall integration strategy for County Durham and we who look forward to receiving and understanding the actions highlighted in the thematic review evaluation. The Health and Wellbeing Board have also been sighted on the work taking place as part of the County Durham Mental Health Implementation Plan, for example the Children and Young People Mental Health, Emotional Wellbeing and Resilience Plan, suicide and self-harm, adult mental health and crisis care.

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

The importance of improving the transition process is pleasing to note, however further work is still required to continue to embed the Safe Transition and Discharge Protocol in all CAMHS teams to ensure effective movement to Adult Mental Health services.

The Health and Wellbeing Board welcomes a new priority that looks to focus Care Plans to individuals and co-production will be a key area within this work.

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

The Health and Wellbeing Board welcome the new intention to focus on a Trust-wide approach to dual diagnosis which ensures that people with substance misuse issues can access appropriate and effective mental health services. Joint work with new Drug and Alcohol Treatment Service provider will be important in this respect.

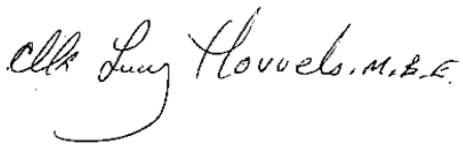
/Continued
…

A key focus of this service will be to tackle the intergenerational cycle of substance misuse by utilising a holistic approach to family support, regardless of the entry point into health and social care services. Key priorities for the new contract include; Integration, Family Focus, Outreach support and reinvigoration of the prevention agenda to include wider health and well-being interventions. A key area of development is understanding the hospital and primary care referrals and involvement and we therefore welcome your action on engagement to agree a future approach and produce a delivery framework.

In addition, the Health and Wellbeing Board commends the Trust in relation to tobacco control within a mental health setting, the increase in front line clinical flu vaccinations and the work on falls prevention which are all areas the Board are keen to see positive improvements.

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

Yours sincerely



Cllr Lucy Hovvels M.B.E
Chair of the County Durham Health and Wellbeing Board
Cabinet Portfolio Holder for Adult and Health Services

Darlington Borough Council Health and Partnerships Scrutiny Committee

DARLINGTON
BOROUGH COUNCIL

Tees, Esk and Wear Valleys NHS Foundation Trust – Draft Quality Account 2017/18

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

Members of the Health and Partnerships Scrutiny Committee have considered the draft Quality Account 2017/18 for Tees, Esk and Wear Valleys NHS Foundation Trust and attended Stakeholder events over the past year. Members would like to acknowledge that the Stakeholder events are always well attended and informally structured to enable meaningful audience participation, with the opportunity for a free exchange of views.

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

In respect of the five Quality Improvement Priorities for 2017/18, Members noted that two out of the 37 actions within those five priorities had not been completed by 31 March. The first red action related to the training element of Preventable Deaths. It was reported that although the training had been completed data system issues had prevented real time compliance figures being made available.

The second red action related to completion of an evaluation report within the Transitions Monitoring. It was reported that the Trust's target of 31 March had not been met because the other actions needed to be completed before the evaluation took place.

Members have the following comments to make:

Implementation of Phase 2 of the Recovery Strategy – Members recognised the continuation of this Priority, identified in 2014/15, as service users wanted the service to go beyond reducing symptoms of mental health and required support to live meaningful and fulfilling lives whether or not there was improvement in symptoms.

Members welcomed the substantial progress made whilst noting that both internal and external stakeholders had identified further work was required to embed a recovery and wellbeing approach within all its services.

Scrutiny Members were pleased to see the key actions in relation to continued expansion of the number of paid lived experience/peer roles and newly registered involvement peer roles within the Trust; expansion of Recovery College Online; and the increased number of staff receiving trauma informed care training.

Members are delighted that the Trust has once again included this as a Priority Action for 2018/19 and in doing so committed to large scale change, ensuring all systems and processes are reviewed from a recovery perspective and as described within its Recovery and Wellbeing Strategy for 2017-2020.

Ensure Safe Staffing in All Service Areas – Members recognised essential safe staffing for the delivery of safe, high quality, evidence-based patient care ensuring not just sufficient staff for all services but that all staff have the right skills and competencies to deliver excellent care for people with mental health needs and/or a learning disability.

Members accepted the difficulties and challenges faced by The Trust due to the national shortage of qualified nurses and other clinical professions such as psychologists, allied health professionals and doctors making it more important that the Trust focus on developing its future workforce so that new models of care and new ways of working can continue to be safely delivered.

Members noted the key actions of established governance structures; an agreed Programme Plan including benefits and work streams; and introduction of a new report for Ward Managers which brings together data on staffing and other quality and safety indicators.

Improve the Clinical Effectiveness and Patient Experience at Times of Transition from Child to Adult Services – Members welcomed continuation of this Priority, identified in 2015, providing support for young people with ongoing or long-term health or social care needs to transition into Adult Mental Health Services, other service provision or back to their GP. A loss of continuity in care can be a disruptive experience, particularly during adolescence, when young people are at an enhanced risk of psychosocial problems.

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

Members welcomed the success of the new transitions protocol implemented across the CAMHS Teams.

Members are pleased that this is a continued Priority for 2018/19.

Reduce the Number of Preventable Deaths - Members recognised the importance of this Priority following the recommendations for improvement within the 2016 CQC report, Learning, Candour and Accountability.

It was noted that the Trust had systems in place to review and investigate deaths, in line with national guidance, and believed it important to continue to reinforce how to identify the need for investigations into the care provided and the way those investigations were undertaken.

Whilst recognising that people with a mental health problem or learning disability were likely to experience an earlier death than the general population, the Trust had an increased focus on the mortality review processes for this group of people.

Members welcomed the actions put in place to address the number of preventable deaths undertaken whilst inpatients were on leave and also accepted the importance of involving family and carers in reviews and investigations.

Scrutiny Committee welcomed the actions the Trust had undertaken during 2017/18 to reduce the number of preventable deaths and are pleased that this is a continued Priority for 2018/19.

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

It was noted that regardless of the work of the Trust to implement best practice and NICE guidance, the number of falls had risen although the severity had reduced. Members welcomed the further work undertaken by the Trust and the continued work of the Trust during 2018/19 to address inpatient falls.

Statement of Assurances from the Board 2016/17

Members noted that the Department of Health and NHS Improvement required the Trust to include its position against a number of mandated statements to provide assurance, from the Board of Directors, on progress made on key areas of quality during 2017/18. This included review of services; participation in clinical audits; participation in clinical research; goals agreed with commissioners; registration with the Care Quality Commission and periodic/special reviews; quality of data; and learning from deaths.

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

Quality Metrics – Missed Targets – Members were informed that of ten Quality Metrics, six were reported as red at the end of March 2018. Unfortunately the number of patients who felt safe on the ward was 25.67 percentage points below the

Trusts target of 88 per cent although Members noted that this was mainly due to 'other patients'. Physical interventions/restraints was 8.492 out of 277,030 bed days although it was recognised that some restraints were relatively minor such as a guiding hand to a particular place. The length of stay for patients in Mental Health Services for Older People in Assessment and Treatment Wards was 69.47 days which is 17.47 worse than the target of <52 but an improvement compared to the position reported in 2016/17. The percentage of patients who reported their overall experience as excellent or good for the period April 2017 to the end of March 2018 was 90.50 per cent, 3.95 percentage points below the Trust's target of 94 per cent. Patients that reported that staff had treated them with dignity and respect for the period April 2017 to the end of March 2018 was 85.94 per cent, 8.06 per cent below the Trust target of 94 per cent. Percentage of patients that would recommend the service to friends and family if they needed similar care or treatment for the period April 2017 to the end of March 2018 was 87.22 per cent, 6.78 per cent below the Trust's target of 94.00 per cent.

Members received a full explanation for these missed targets and the actions being taken by the Trust to address the situations.

Members have the following comments to make on the four Quality Improvement Priorities for 2018/19 –

Reduce the number of preventable deaths – Members welcomed the continuation of this priority following the recommendations for improvement within the CQC report, Learning, Candour and Accountability.

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

Making Care Plans More Personal – Members recognised the importance of this priority to ensure patients were recognised as individuals with their own strengths and preferences. This personalised approach will involve enabling people to identify their own needs and make choices about how and when they are supported to live their lives.

Develop a Trust-wide approach to dual diagnosis which ensures that people with substance misuse issues can access appropriate and effective mental health services – Members welcomed the benefits of this priority which included service users with mental health and co-existing substance misuse receiving the same level of care as people without substance mis-use ensuring that staff worked collaboratively across organisations with a creative, flexible and assertive approach.

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

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

Members acknowledged that the Trust was only in the first year of a three year Quality Strategy and that some red metrics were to be expected.

Councillor Wendy Newall
Chair, Health and Partnerships Scrutiny Committee

Durham County Council Adults Wellbeing and Health Overview and Scrutiny Committee

Contact: Cllr John Robinson
Direct Tel: 03000 268140
e-mail:
Your ref:
Our ref:

Colin Martin
Chief Executive
Tees, Esk and Wear Valleys NHS Foundation Trust,
West Park Hospital
Edward Pease Way
Darlington
DL2 2TS

11 May 2018

Dear Mr Martin,

County Durham and Darlington Foundation Trust – Quality Accounts 2017/18

Following a special meeting of Durham County Council's Adults Wellbeing and Health Overview and Scrutiny Committee on 9 May 2018 please find attached the Committee's response to your draft Quality Accounts for 2017/18.

The response provides commentary on the Trust's performance for 2017/18 as well as the identified priorities for 2018/19.

I would like to thank the Trust for providing the opportunity for continued engagement of the Adults Wellbeing and Health Overview and Scrutiny Committee in the aforementioned process.

Yours sincerely,

Cllr John Robinson
Chair of the Adults, Wellbeing and Health Overview and Scrutiny Committee

DURHAM COUNTY COUNCIL ADULTS WELLBEING AND HEALTH OVERVIEW AND SCRUTINY COMMITTEE

COMMENTS ON TEES ESK AND WEAR VALLEYS NHS FOUNDATION TRUST QUALITY ACCOUNT FOR 2017/18

The Committee welcomes Tees, Esk and Wear Valleys NHS Foundation Trust's Quality Account 2017/18 and the opportunity to provide comment on it. The Committee are mindful of their statutory health scrutiny role and the need to demonstrate a robust mechanism for providing assurance to the residents of County Durham that health service provision is efficient and effective. The quality account process provides the Committee with one such mechanism.

The Committee has engaged with the Trust on a number of issues during the course of 2017/18 including undertaking a post implementation review of changes to inpatient dementia wards serving County Durham and Darlington and associated mitigation plans for the reimbursement of additional travelling costs; the service reconfigurations arising from structural issues at Roseberry Park, Middlesbrough; the development of an Accountable Care Partnership and the merger of mental health rehabilitation services for adults into Willow Ward, West Park, Darlington.

The Committee considers that the Quality Account is clearly set out and that progress made against 2017/18 priorities is clearly identified. The Trust has made significant progress against these priorities and the Committee welcome the completion of 35 of the 37 actions identified by the Trust under the 5 priorities. Of the 2 actions that are reported as having been missed, the Committee acknowledge that:-

(i) In respect of the preventable deaths priority and training carried out in relation to patients taking leave and time away from the ward, the action has not been achieved because real time data for compliance is not yet available from the Trust's IT systems. However, the Committee are assured that this will be addressed during 2018/19;
(ii) In respect of the transitions priority, the production of an evaluation report of the implementation of the new transitions protocol has been delayed and will not now be completed until the end of June 2018.

In considering those quality metrics where the Trust has missed its target, the Committee note that the percentage of patients who reported "yes-always" to the question "do you feel safe on the ward" for the Durham and Darlington locality whilst below the Trust-wide target is the closest to target at 69.5%. The Committee is however concerned that there appears to be a contradiction between this safety metric and the percentage of patients who reported their overall experience as excellent or good (90.38%).

The Committee is satisfied that whilst Trust-wide there are delayed transfers of care which mean patients have lengthy stays in older peoples' assessment and treatment wards this is not the case across County Durham.

The Committee acknowledges all of the 2018/19 priorities identified within the draft Quality Account and agrees that from the information received from the Trust, they are a fair reflection of healthcare services provided by the Trust. The Committee are particularly pleased to see that the Trust is to develop a Trust-wide approach to dual diagnosis which ensures that people with substance misuse issues can access appropriate and effective mental health services. The move to more personalised care plans is also supported by the Committee.

During consideration of the progress made against the Trust's 2017/18 Quality Account priorities and performance metrics, the Committee have sought assurances that robust improvement action plans are in place to improve those below target metrics and would welcome sight of these plans in due course.

Finally, in order to ensure that it continues to provide a robust Health scrutiny function and assurances in this respect to the residents of County Durham, the Committee would request a six monthly progress report on delivery of 2018/19 priorities and performance targets in November 2018.

Healthwatch Darlington

Comments on Tees, Esk and Wear Valley Foundation Trusts Quality Account for 2017-18 from Healthwatch Darlington.

Healthwatch Darlington have welcomed and enjoyed the opportunity to be involved with the Quality Accounts over the last twelve months and benefit from partnership working with Tees, Esk and Wear Valley NHS Foundation Trust. The Trust actively involves and engages with Healthwatch Darlington and we believe fully embraces the patient voice. Healthwatch Darlington feel the Trust have meaningfully involved a wide and varied section of stakeholders and members of the public and have been regularly updated on patient engagement activity throughout the year. Healthwatch Darlington are satisfied with the progress that Tees, Esk and Wear Valley Foundation Trust are making to achieve their set priorities.

Priorities 2017/2018

- **Implement Phase 2 of the Recovery Strategy.**
- **Ensure Safe Staffing in all services.**
- **Improve the clinical effectiveness and patient experience in times of transition from Child to Adult service.**
- **Reduce the number of preventable deaths.**
- **Reduce the occurrence of serious harm resulting from inpatient falls.**

Healthwatch Darlington have been pleased to see the progress of work carried out and the results that have been achieved over the last year around the above priorities.

Quality Indicators

We are pleased to see that many of the Quality Indicators have been met, but acknowledge along with the Trust that there are areas still to be improved. Healthwatch participants are pleased to see that the trust continues to push for quality improvements especially around patient experience and patient safety.

Future Priorities 2018/2019

Priority 1: Care Planning

Priority 2: Dual Diagnosis.

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

Priority 4: Reduce the number of preventable deaths

Healthwatch Darlington agree with the priorities set for 2018/2019 as all 4 are essential to patient experience and care.

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

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

Healthwatch South Tees

Healthwatch South Tees
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Email:general@healthwatchsouthtess.org.uk

Dear Phillip,

Here is the Healthwatch South Tees response to the:

Tees Esk and Wear Valleys NHS Foundation Trust draft quality account 2017/18

The TEWV's 2017 community mental health survey results response rate (page 4) may have been above the national rate but at 29% is still low enough to be likely to introduce a fair degree of bias in the results.

The decline in overall rating on care experience is a cause for concern and is something that needs to be monitored.

Why did only 52% of staff take the trouble to respond in the 2017 NHS national staff survey (page 5)? To what extent Is this a reflection of staff interest in their work?

From the information given in this draft report, the occupancy rates of assessment and treatment beds must be in excess of 86%. Is this therefore impacting on the quality of care?

South Tees Healthwatch looks forward to receiving data on the percentage of patients who have transitioned from CYPS to AMH who indicate that they have met their personal goals as agreed in the TEWV transition plan (page 23).

Does the TEWV have or are there plans to introduce Kaizen systems into Trust areas as a way of minimising falls due to environmental factors (page 29)?

In view of the report in the BMJ (21st April 2018) on the teratogenic effects of Valproate in pregnancy, does the Trust intend to review the prescription of this drug in cases of bipolar disorder (page 33)?

South Tees Healthwatch is pleased to note the level of the Trusts active involvement in clinical research, not least because this is likely to have a positive impact on quality of care.

Despite improvements in staff uptake of influenza vaccine (page36) there is still a need to further increase staff uptake both to minimise risk of infection to patients and maintain staffing levels in all Trust areas.

Priority 2 for improvement (page 50): There is a need for sufficient support to be provided to young people to ensure that they do engage with the transition process from CYPS to AMH services and do not subsequently lose out on service provision.

Priority 4 for improvement (page 54): There is a need to provide further training and identify staff with dual diagnosis skills to ensure this particularly vulnerable group of patients get the support they need and so avoid poor outcomes. The stigma sometimes attached to substance abuse patients should not be an issue in a mental health Trust.

The Trust's performance against quality metrics needs to improve in several areas, particularly metric 8 (page 59) which covers the percentage of patients reporting that staff treat them with dignity and respect.

There is no mention in this report of provision of respite care to enable carers of patients with long term conditions obtain short term relief. What involvement, if any, does the Trust have in provision of such care?

Yours sincerely

Natasha Judge

Healthwatch South Tees Development & Delivery Manager

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NHS
Darlington
Clinical Commissioning Group

Darlington CCG
Billingham Health Centre
Queensway
Billingham
TS23 2LA

23 April 2018

Elizabeth Moody
Director of Nursing and Governance
Tees Esk and Wear Valleys NHS Foundation Trust
Trust Headquarters
West Park Hospital
Edward Pease Way
Darlington
DL2 2TS

Dear Elizabeth

RE: Tees, Esk and Wear Valleys NHS Foundation Trust (TEWVFT) Quality Account 2017/18

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

The Clinical Commissioning Groups (CCGs) welcome the opportunity to review and comment on the Quality Account for Tees Esk and Wear Valleys NHS Foundation Trust for 2017/18 and would like to offer the following commentary:

As commissioners, the CCGs are committed to commissioning high quality services from Tees Esk and Wear Valleys NHS Foundation Trust and take seriously the responsibility to ensure that patients' needs are met by the provision of safe, high quality services and that the views and expectations of patients and the public are listened to and acted upon. We have remained sighted on the Trust's priorities for improving the quality of its services for its patients, and have continued to provide robust challenge and scrutiny through the Clinical Quality Review Group (CQRG) meetings with the monitoring, review and discussion of quality issues. The amalgamation of the two CQRGs across the Trust's Teesside and County Durham and Darlington localities during 2017/18 has strengthened this assurance process.

The CCGs have also continued throughout 2017/18 to conduct regular commissioner led inspection visits to TEWVFT sites to gain assurances and an insight into the quality of care delivered. Therefore the CCGs feel that the quality account is an accurate representation of the services provided during 2017/18 within the Trust.

The report provides a comprehensive description of the quality priorities which the Trust has focused on during 2017/18. The report provides an open account of where improvements have been made.

It is pleasing that the Chief Executive's overview to the Quality Account emphasises the achievements made during 2017/18 and the intentions of their Quality Strategy to further meet the

needs of the services users and their families over the next two years. The CCGs would like to commend the trust on all their external achievements won by trust staff for their contributions to service improvements and patient care and congratulate TEWVFT on the positive results from both the 2017 NHS staff survey and the NHS community mental health services survey.

The CCGs would like to commend the Trust for the improvements that are demonstrated in the report, particularly the achievement of its goals relating to reducing the number of preventable deaths. It is hoped that the ongoing work to address the quality priorities not achieved in year will yield the desired results in 2018/19.

It is pleasing to note the work being undertaken by the Trust to promote a safety culture in the organisation where the reporting of incidents, errors and near misses is encouraged. However it has been disappointing to note during 2017/18 that many of the Trust's Serious Incident reports do not identify root causes or contributory factors and it is hoped that the work underway by TEWVFT in reviewing the learning from incidents and the Serious Incident review processes will support this further during 2018/19.

We are encouraged by the Trust's approach and commitment to implementing continued development of the Recovery focussed services. This work has had a harm minimisation focus and the CCGs look forward to these developments being further embedded and enhanced with additional recovery leads and peer support recruitments during the next phase of the project in 2018/19.

The CCGs welcome the specific quality priorities for 2018/19 highlighted in the report and feel that they are appropriate areas to target for continued improvement.

The CCGs can confirm that to the best of their ability, the information provided within the Annual Quality Account is an accurate and fair reflection of the trust's performance for 2017/18. It is clearly presented in the format required and the information it contains accurately represents the Trust's quality profile and is reflective of quality activity and aspirations across the organisation for the forthcoming year.

The CCGs look forward to continuing to work in partnership with the trust to assure the quality of services commissioned in 2018/19.

Yours sincerely

Diane Murphy

Diane Murphy
Director of Nursing and Quality
NHS Darlington Clinical Commissioning Group
(Signed on behalf of NHS North Durham Clinical Commissioning Group)

Mrs Amanda Hume
Chief Officer
NHS South Tees Clinical Commissioning Group

Signed in consultation with:
NHS North Durham CCG
NHS South Tees CCG
NHS Durham Dales, Easington and Sedgefield CCG
NHS Hartlepool and Stockton on Tees CCG
NHS Darlington CCG

Joint North Yorkshire CCGs

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Harrogate and Rural District
Clinical Commissioning Group

Email: j.crewe@nhs.net
Direct Tel: 01423 799334
Reference: HaRD.047-18

Harrogate and Rural District
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LETTER SENT VIA EMAIL

Sharon Pickering
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17 May 2018

Dear Sharon

Quality Account for Tees, Esk and Wear Valley Trust for 2017-18.

Harrogate and Rural District Clinical Commissioning Group (HaRDCCG) welcomes the opportunity to review and provide a statement for the Trust's Quality Account for 2017/18. This Quality Account has been reviewed in accordance with the Department of Health and Social Care (Quality Accounts) Amendment Regulations 2017.

This report has been shared with key individuals across HaRDCCG and other CCGs in North Yorkshire and their views have been collated into my response.

The CCGs in North Yorkshire remain committed to ensuring, with its partner organisations, that the services it commissions provide the highest of standards in respect to clinical quality, safety and patient experience.

It is recognised by Commissioners that the Trust and its staff, demonstrate resilience and dedication to ensure they deliver safe and effective services, as referenced throughout the Quality Account and we congratulate the Trust in consistently maintaining improvements in:

- Its priority to reduce the number of preventable deaths, and continuing to build on the lessons learnt from the reviews of deaths. It would be helpful, to describe how learning from all deaths and those falling into the LeDeR

process is captured.

- Participation in research with an increase in the total number recruited to clinical trials, along with the commitment to establish a strong patient perspective to research. It would be helpful to see some examples of how the research project findings link to quality improvements, and what benefit is anticipated from the 15 new Involvement Peer roles.

- The review of existing Children and Young People's Services (CYPS) as a pilot in Durham and Redcar, to make them more Learning Disability compatible. It would be helpful, to see learning and interventions from the pilot being introduced into the services provided in North Yorkshire.

- The Trusts strategic approach to recovery and wellbeing which will ensure all systems and processes remain recovery focused.

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

We recognise the work undertaken by the Trust, to improve the quality of patient care and patient experience through the 2017/18 CQUIN schemes, and it is helpful to see the results and the expected impact of these schemes in the quality account.

The Trust reported the progress on improving learning from incidents, and we were pleased to read about the number of measures which have been put in place to improve reporting of incidents. We would have expected more emphasis and progress on learning the lessons from incidents or complaints, and how these have informed changes in practice and how actions will be monitored across the Trust.

The Trust reported a similar number of serious incidents causing severe harm or death as reported in 2016/17. We would have liked to see more reference to timeliness of completed incident investigation, and the learning from these included in the narrative of the Quality Account.

The Trust has experienced some challenges as referenced in their Quality Account, due to specialist inpatient care demand and therefore performance against the 'Inappropriate out of area placements for adult mental health services' indicator. The CCG has agreed a trajectory to improve performance, and we will, work with the Trust to support achievement of its actions and improve performance.

Alongside improving performance, on out of area placements, the CCGs would also like to see the Trusts continued commitment and involvement in the system wide workstreams to support reducing delayed transfers of care. Whilst we recognise the complexity of needs of many patients, and potential delays in accessing suitable placements as a contributing factor, we would wish to see significant progress in

reducing inpatient length of stay for those patients who are medically fit for discharge.

Partnership working is evident throughout the report, and some good examples of where improvements have been made to support patients, and their carers. Of particular note, should be the work in improving the clinical effectiveness and patient experience in times of transition from Child to Adult services. This work demonstrates the improvement in information sharing, with family and carers. It will have a further positive impact on the patient and relatives' experience, and we recognise this remains a quality priority for 2018/19.

The Trust appears to have a real commitment through this report to patient/service user involvement. This is really evident in how the Trust are implementing their overarching strategy, around hearing the voice of service users, this will be further strengthened by the 2018/19 priority of Making our Care Plans more personal - where there will be a refreshed approach to 'Personalisation' and therefore a positive and sustainable impact on improving the experience of service users and carers.

On another positive note, the Trust should be congratulated on their results from the National Community Services Survey 2017. We look forward to the Trust's continued progress during 2018/19 particularly in the areas set by the Trust as priority areas for improvement.

We acknowledge the work undertaken by the Trust to improve safe staffing as a priority for 2017/18. We also note reference to the expected outcomes for improvement; however we would have expected to see evidence of the impact, and more detail about the differences made by the interventions, described or reference to the plan, developed by the Trust to support this ongoing work as this remains a key national area of concern.

The North Yorkshire CCGs were pleased to read about the Trusts refreshed quality strategy, and quality performance metrics, and would like to see these and the regular reporting of progress against the Trusts 2018/19 quality priorities, as a clear focus within the CCG/TEWV monthly Quality and Safety meetings.

The key successes of the 2017/18 quality priorities are clearly reflected in the Quality Account. We welcome the opportunity to review progress on the Trust's quality improvements, and hope that our feedback is accepted as a fair reflection of the report, and look forward to working alongside the Trust to achieve the objectives of the 2018/19 priorities.

Yours sincerely

Joanne Crewe

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

Cc: Colin Martin, Chief Executive, TEWV
Elizabeth Moody, Director of Nursing & Governance, TEWV
Phillip Darvill, Planning and Business Development Manager, TEWV

North Yorkshire Scrutiny of Health Committee

County Councillor Jim Clark (Chairman)
North Yorkshire Scrutiny of Health Committee
c/o Overview and Scrutiny
North Yorkshire County Council
Room 39, Brierley Block
County Hall, Northallerton
North Yorkshire, DL7 8AD
17 May 2018

Dear Sir/Madam

Re: Quality Account 2017/18

Over the past 12 months, the North Yorkshire Scrutiny of Health Committee has continued to liaise with the Tees, Esk and Wear Valleys NHS Foundation Trust to better understand some of the pressures that they face.

Throughout 2017/18 the Scrutiny of Health Committee has been heavily involved in the formal scrutiny of proposed changes to mental health commissioning and provision in the county, particularly in-patient treatment and the development of community services in rural areas of the county. The committee has also looked into what breadth and depth of services it is reasonable to expect to have in place in the county, when compared to similar areas. The trust has been highly supportive of this scrutiny work. The information, data and analysis provided has helped the committee to appreciate the issues across the whole system and the support of the trust has been much appreciated.

It is recognised that the rural nature of the county and the length of time that it can take to travel to and from appointments can have an impact upon how services are planned and delivered. The committee, however, remains committed to ensuring that people are not excluded from services based upon where they live. The presumption is that you should be able to access the same type and quality of care no matter where you live in North Yorkshire.

The current financial pressures within the health system in North Yorkshire are of great concern. Whilst there are doubts as to whether the funding formula for health and mental health is fair and concerns that it disadvantages rural areas, we need to work together to find a way to make the money that we have work the hardest and result in good outcomes across the health and social care system.

The Scrutiny of Health Committee remains committed to a system-wide view of services that helps to ensure that decisions on the commissioning, planning and delivery of mental health care are not made in isolation and that the key role that a broad base of community services have to play is not overlooked. This will not be easy going forward as the health commissioners and providers in the county are pulled in three different directions as the new NHS integrated systems for planning and delivery in the West, South and North of the county are put in place.

Yours faithfully

County Councillor Jim Clark
Chairman of the North Yorkshire Scrutiny of Health Committee

Tees Valley Joint Health Scrutiny Committee

Sharon Pickering
Director of Planning, Performance and Communications
Tees Esk and Wear Valleys NHS Foundation Trust
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Lanchester Road Hospital
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sharon.pickering1@nhs.net

11 May 2018

Dear Sharon

The Tees Valley Joint Health Scrutiny has prepared the following statement for inclusion within the Quality Account 2017/18 for the Tees, Esk and Wear Valley (TEWV) NHS Foundation Trust

Progress Against Quality Priorities 2017/18

Representatives from TEWV attended a meeting of the Tees Valley Health Joint Scrutiny Committee on 18 April 2018. The Committee was advised that TEWV had produced a Quality Account which covered Mental Health and Learning Disability Services for County Durham, York and most of North Yorkshire, as well as the five Tees Valley Boroughs. Locally specific data had been drawn from the full report for the benefit of the Joint Committee.

Within the 2016/17 Quality Account the Trust had agreed the following five Quality Priorities for 2017/18:-

(a) Implementation of Phase Two of the Recovery Strategy;

(b) Ensure safe staffing in all services;

(c) Improve clinical effectiveness and patient experience in times of transition from Child to Adult Services;

(d) Reduce the number of preventable deaths; and

(e) Reduce the occurrences of serious harm resulting from inpatient falls

The Committee was advised two out of the 37 actions within those five priorities had not been completed by 31 March. The first red action related to the training element of Preventable Deaths. It was reported that although the training had been completed data system issues had prevented real time compliance figures being made available.

The second red action related to completion of an evaluation report within the Transitions Monitoring. It was reported that the Trust's target of 31 March had not been met because the other actions needed to be completed before the evaluation took place.

Hartlepool Borough Council's Audit and Governance Committee were of the view that learning from deaths was a significant issue particularly around men's mental health and Hartlepool's suicides statistics were poor, both of which were areas that required continued improvement.

In terms of the Quality Metrics six of the ten were reported as red and three green at the end of March 2018 (full year). The six red Quality Metrics were as follows:-

1. Percentage of Patients reported 'yes always' to the question, 'do you feel safe on the ward'

It was advised that TEWV's position for the period April 2017 to the end of March 2018 was 62.13 per cent, which related to 2290 out of 3,7674 surveyed. This was 25.67 percentage points below the Trust target of 88 per cent. All localities underperformed this year with Durham and Darlington being closest to the target. It was emphasised that one of the most frequently cited reasons for not feeling safe was 'other patients' and that the Trust's Patient Safety Group was undertaking a 'deep dive' to better understand the data and develop an Action Plan to resolve the issues highlighted.

2. Number of Incidents of Physical Intervention/restraint per 1000 occupied bed days

TEWV's end of year position was 30.65 which related to 8,492 incidents out of 277,030 occupied bed days resulting in 11.40 above the target of 19.25. Scrutiny was advised that a small number of patients account for a high proportion of the restraints recorded and that some of the recorded instances of restraint were relatively minor – for example a hand on a shoulder or a guiding hand towards a dining area is classed as a restraint.

3. Average length of stay for patients in both Adult Mental Health and Mental Health Services for Older People Assessment and Treatment Wards

TEWV's position for the period April 2017 to the end of March 2018 in Mental Health Services for Older People was 69.47 days which is 17.47 worse than the target of <52 but an improvement compared to the position reported in 2016/17. The median length of stay was 54 days. Scrutiny was informed that a number of factors impacted on achieving this target including complexity of patient's needs and delays in accessing suitable placement for patients subsequent to discharge. Members acknowledged that MHSOP were reliant on Social Care provision and Care Home Capacity, both Residential and Nursing Home, which could slow the process down and that there were some difficulties around several providers.

4. Percentage of patients who reported their overall experience as excellent or good

The end of year position for the period April 2017 to the end of March 2018 was 90.50 per cent which related to 13,772 out of 15,218 surveyed. Although it was reported that nine out of ten patients had a good experience this was 3.95 percentage points below the Trust's target of 94.00 per cent.

5. Percentage of patients that report that staff had treated them with dignity and respect

The end of year position for the period April 2017 to the end of March 2018 was 85.94 per cent which related to 14,567 out of 16,950 surveyed. It was reported that this figure equated to 17 out of 20 people which was 8.06 per cent below the Trust target of 94 per cent. Members noted that the Trust were striving to improve on this target.

6. Percentage of patients that would recommend the service to friends and family if they needed similar care or treatment

The end of year position for the period April 2017 to the end of March 2018 was 87.22 per cent which related to 12,424 out of 14,244 surveyed. It was reported that this was 6.78 per cent below the Trust's target of 94.00 per cent and that all localities had underperformed.

Scrutiny Committee established that the current CQC rating of The Trust was good and that an inspection was due in the near future. The Trust is committed to working alongside Inspectors to demonstrate its competencies and, in doing so, hoped that it had made enough progress to ensure the CQC were now satisfied with the services of York which had received a poor rating prior to becoming under the responsibility of TEWV Foundation Trust. Members were keen to know the result of the Inspection which was expected in Autumn.

Whilst Scrutiny Committee did have concerns over staffing levels within The Trust and the impact on service provision, reassurances were provided by the TEWV representative that staff planning addressed this issue. The recruitment and retention pathways were being explored and staffing levels reported on a weekly basis to determine where the need was. Scrutiny welcomed the new medical school due to open in Sunderland and hoped it would encourage students from the north

east to remain in the area post-graduation. Due to more people seeking help there was increased demand on mental health services in some areas. Scrutiny Committee welcomed the increased staff training whilst recognising that some staff were near retirement age and the increased demand on mental health services.

Scrutiny Committee recommended a metric for staff and staff surveys be included within the Trust's future Quality Accounts.

Whilst noting there was no financial information within the Quality Accounts, Scrutiny Committee was pleased to learn that TEWV was performing well and no deficit had been reported although each year became more challenging due to increased demand on services.

TEWV have continued to engage with the Tees Valley Joint Health Scrutiny Committee throughout the 2017/18 Municipal Year and Members have welcomed the information that is shared with them.

Yours sincerely

Councillor Wendy Newall
Chair, Tees Valley Joint Health Scrutiny Committee

Vale of York CCG

NHS
Vale of York
Clinical Commissioning Group

West Offices

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Website: www.valeofyorkccg.nhs.uk

13 May 2018

Dear Colin

On behalf of NHS Vale of York Clinical Commissioning Group (the CCG) I am pleased to provide a response to TEWV Quality Account 2017/18.

In line with your quality priorities it is particularly important to recognise the achievement in:

- The 24/7 learning disability access centre
- Increased resources for positive behavioural support and
- Good progress towards the building of the new mental health hospital in York.

Over the past year the CCG have been welcomed to undertake a variety of clinical quality visits to meet staff and patients and observe service delivery in action and continue to work with you going forward to ensure safe effective services.

NHS
Vale of York
Clinical Commissioning Group

We want to recognise key achievements in:

1. The positive improvement in preventable deaths during periods of leave
2. The significant increase in staff uptake of flu vaccination
3. The support of Consultant Psychiatrist Perinatal Mental Health (PNMH) bid and specialist placement with contribution resulting in successful bid submission to develop PNMH services
4. The reduction in inpatient falls identified as a priority and
5. Increased commissioner reengagement with Serious Incident process

It is good to see that reducing preventable deaths and improving clinical effectiveness and patient experience in times of transition from child to adult remain a priority for this coming year.

We appreciate the increased focus on improving access to services especially in Children's Mental Health (CAMHs) that you have engaged with us on and although not featured as a key priority in this Quality Account, we are working together to ensure improvements are made.

Although TEWV did not achieve all of the CQUIN for 2017/18 we have agreed to reinvest the money in key services of CAMHs and IAPT to support improvement in this area.

Performance against some other quality indicators we recognise are not yet reaching the high standard you aspire to e.g. patients treated with dignity and respect on Mental Health Older People's wards – current figure of 85.9% against a trajectory of 95% by 2021, patients who would recommend your service to family and friends – current figure 87.2% against 95% by 2021, and it is good to see a detailed plan for achievement and a governance process which supports this.

We would want to recognise the progress made and the relationships which focus around identifying with commissioners the areas of greatest risk and a focus on the action planning around these. We would wish to reiterate and support the work needed to be undertaken on the data flows around these services.

As the CCG develops its placed based plans for out of hospital provision working with all key partners, we would wish to encourage active participation and engagement with our locality developments and for TEWV to harness their relationships and clinical expertise around these for the benefit of our population.

NHS
Vale of York
Clinical Commissioning Group

NHS Vale of York CCG commend the work of the trust in 2017/18, are satisfied with the accuracy of the Quality Account and look forward to working collaboratively with you in 2018/19.

Yours sincerely

Michelle Carrington

Executive Director of Quality and Nursing

The External Auditor's Report and Opinion

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

Opinion

We have audited the financial statements of Tees, Esk and Wear Valleys NHS Foundation Trust ('the Trust') for the year ended 31 March 2018. 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 notes to the financial statements, including the summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Government Financial Reporting Manual 2017/18 as contained in the Department of Health and Social Care Group Accounting Manual 2017/18, and the Accounts Direction issued under section 25(2) of Schedule 7 of the National Health Service Act 2006.

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2018 and of the Trust's income and expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2017/18; and
- have been properly prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Use of the audit report

This report is made solely to the Council of Governors of Tees, Esk and Wear Valleys NHS Foundation Trust as a body in accordance with Schedule 10(4) 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 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.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Accounting Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the Trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Key audit matters

Key audit matters are those matters that, in our professional judgement, were of most significance in our audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) we identified, including those which had the greatest effect on: the overall audit strategy, the allocation of resources in the audit; and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

Key audit matter	Our response and key observations
Revenue recognition There is a risk of fraud in the financial reporting relating to revenue recognition due to the potential to inappropriately record revenue in the wrong period.	We undertook a range of substantive procedures including: • testing of income around the year-end to ensure transactions are recognised in the correct financial year; • testing year-end receivables to ensure transactions are recognised in the correct financial year; • reviewing intra-NHS reconciliations and data matches provided by the Department of Health and Social Care/NHSI; • review of management oversight of material accounting estimates, review of changes to accounting policies and challenge/testing of material accounting estimates; and • testing of adjustment journals, selected using specific risk characteristics. Our work provided the assurance we sought in respect of this key audit matter.

Property valuations

Land and buildings are the Trust's highest value assets. Management engage Cushman & Wakefield, as an expert, to assist in determining the fair value of property to be included in the financial statements. There is a high degree of estimation uncertainty and changes in the value of property may impact on the Statement of Comprehensive Income depending on the circumstances and the specific accounting requirements of the Department and Health and Social Care Group Accounting Manual.

We liaised with management to update our understanding on the approach taken by the Trust in its valuation of land and buildings.

We reviewed and considered:

- the scope and terms of the engagement with Cushman & Wakefield; and
- how management use the Cushman & Wakefield's report to value land and buildings in the financial statements.

We wrote to Cushman & Wakefield to obtain information on the methodology and their procedures to ensure objectivity and quality.

We tested a sample of valuation movements to gain assurance that the accounting treatment is appropriate, and also considered evidence of regional valuation trends. We also reviewed and challenged the impairment at Roseberry Park.

Our work provided the assurance we sought in respect of this key audit matter.

Our 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.

Based on our professional judgement, we determined materiality for Tees, Esk and Wear Valleys NHS Foundation Trust for the financial statements as a whole as follows:

Overall materiality	£4.877m.
Basis for determining materiality	Approximately 1.5% of operating expenses of continuing operations, adjusted for impairments.
Rationale for benchmark applied	Operating expenses of continuing operations, adjusted for impairments, was chosen as the appropriate benchmark for overall materiality as this is a key measure of financial performance for users of the financial statements.

We agreed with the Audit Committee that we would report to the Committee all audit differences in excess of £146,000, as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds.

An overview of the scope of our audit

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed, the reasonableness of significant accounting estimates made by the Accounting Officer and the overall presentation of the financial statements. The risks of material misstatement that had the greatest effect on our audit, including the allocation of our resources and effort, are discussed in the “Key audit matters” section of this report. 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.

Other information

The directors are responsible for the other information. The other information comprises the information included in the Annual Report, other than the financial statements and our auditor’s report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2017/18; and
- the other information published together with the audited financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Annual Governance Statement	
We are required to report to you if, in our opinion: • the Annual Governance Statement does not comply with the NHS Foundation Trust Annual Reporting Manual 2017/18 ; or • the Annual Governance Statement is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.	We have nothing to report in respect of these matters.

Reports to the regulator and in the public interest	
We are required to report to you if: • we refer a matter to the regulator under Schedule 10(6) of the National Health Service Act 2006 because we have a reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency; or • we issue a report in the public interest under Schedule 10(3) of the National Health Service Act 2006.	We have nothing to report in respect of these matters.

Use of resources	
We are required to report to you if the Trust has not put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.	We have nothing to report in respect of this matter.

Other information	
We are required to read the other information and report to you if the other information is: • materially inconsistent with the audited financial statements or our knowledge obtained in the course of performing our audit; or • otherwise appears to be materially misstated. We are also 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 have not identified any such material inconsistencies or misstatements.

Responsibilities of the Accounting Officer

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for the preparation of the financial statements and for being

satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

The Accounting Officer is required to comply with the Department of Health and Social Care Group Accounting Manual and prepare the financial statements on a going concern basis, unless the Trust is informed of the intention for dissolution without transfer of services or function to another entity. The Accounting Officer is responsible for assessing each year whether or not it is appropriate for the Trust to prepare its accounts on the going concern basis and disclosing, as applicable, matters related to going concern.

The Chief Executive as Accounting Officer is also responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the Trust's use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are also required under Schedule 10(1) of the National Health Service Act 2006 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice prepared by the Comptroller and Auditor General (C&AG), having regard to the guidance on the specified criterion issued by the C&AG in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The C&AG determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary.

Certificate
We certify that we have completed the audit of the financial statements of Tees, Esk and Wear Valleys NHS Foundation Trust in accordance with the requirements of chapter 5 of part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Cameron Waddell
For and on behalf of Mazars LLP

Salvus House
Aykley Heads
Durham
DH1 5TS

22 May 2018

The Accounts 2017/18
(subject to audit)

The accounts are prepared in accordance with paragraphs 24 and 25 of Schedule 7 to the NHS Act 2006 and are presented to parliament pursuant to Schedule 7, paragraph 25 (4) of the National Health Service Act 2006

Colin Martin
Chief Executive **22 May 2018**

Statement of Comprehensive Income for 12 months ended 31 March 2018

	Note	12 months ended 31 March 2018 £000	12 months ended 31 March 2017 £000
Revenue			
Operating income from patient care activities	2	326,538	318,450
Other operating income	2	23,811	27,438
Total operating income from continuing operations		**350,349**	**345,888**
Operating expenses of continuing operations	3	(366,629)	(318,092)
Operating Surplus / (deficit)		**(16,280)**	**27,796**
Finance costs			
Finance income	8	165	163
Finance expense - financial liabilities	9	(5,411)	(5,354)
PDC dividends payable		(2,916)	(3,368)
Net Finance Costs		**(8,162)**	**(8,559)**
Other gains/(losses)	10	4	(15)
Surplus / (Deficit) from continuing operations		**(24,438)**	**19,222**
Other comprehensive income			
Will not be reclassified to income and expenditure			
Impairments		(9,905)	(983)
Revaluations		655	1,500
Other recognised gains and losses		0	(27)
Total comprehensive income / (expense) for the year		**(33,688)**	**19,712**

Statement of Financial Position as at 31 March 2018

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	11	700	0
Property, plant and equipment	12	170,694	212,320
Investments in joint ventures and associates	16	125	125
Other investments / financial assets	20	50	420
Trade and other receivables	22	42	45
Total non-current assets		**171,611**	**212,910**
Current assets			
Inventories	21	221	205
Trade and other receivables	22	19,275	16,726
Other investments / financial assets	20	420	80
Non-current assets for sale and assets in disposal groups	18	350	0
Cash and cash equivalents	25	58,415	57,845
Total current assets		**78,681**	**74,856**
Current liabilities			
Trade and other payables	26	(25,978)	(24,612)
Borrowings	27	(5,343)	(5,469)
Provisions	30	(580)	(591)
Other liabilities	28	(660)	(225)
Total current liabilities		**(32,561)**	**(30,897)**
Total assets less current liabilities		**217,731**	**256,869**
Non-current liabilities			
Borrowings	27	(75,369)	(80,712)
Provisions	30	(2,646)	(2,753)
Total non-current liabilities		**(78,015)**	**(83,465)**
Total assets employed		**139,716**	**173,404**
Financed by taxpayers' equity			
Public dividend capital		145,053	145,053
Revaluation reserve	32	9,908	19,158
Income and expenditure reserve		(15,245)	9,193
Total taxpayers' equity		**139,716**	**173,404**

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

The financial statements on 223-261 were approved by the Board and signed on its behalf by:

Colin Martin, Chief Executive **22 May 2018**

Tees Esk & Wear Valleys NHS Foundation Trust - Annual Accounts 12 months ended 31 March 2018

Statement of Changes in Taxpayers' Equity

	Total	Public Dividend Capital (PDC)	Revaluation Reserve	Statement of Comprehensive Income Reserve
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2017 - brought forward	**173,404**	**145,053**	**19,158**	**9,193**
Deficit for the year	**(24,438)**	0	0	(24,438)
Net impairments	**(9,905)**	0	(9,905)	0
Revaluations - property, plant and equipment	**655**	0	655	0
Taxpayers' Equity at 31 March 2018	**139,716**	**145,053**	**9,908**	**(15,245)**
Taxpayers' and other' equity at 1 April 2016	**153,692**	**145,053**	**18,641**	**(10,002)**
Surplus for the year	**19,222**	0	0	19,222
Net impairments	**(983)**	0	(983)	0
Revaluations - property, plant and equipment	**1,500**	0	1,500	0
Other recognised gains and losses	**(27)**	0	0	(27)
Taxpayers' Equity at 31 March 2017	**173,404**	**145,053**	**19,158**	**9,193**

Statement of Cash Flows for 12 months ended 31 March 2018

	Note	12 months ended 31 March 2018 £000	12 months ended 31 March 2017 £000
Cash flows from operating activities			
Operating surplus/(deficit) from continuing operations		(16,280)	27,796
Operating surplus/(deficit)		**(16,280)**	**27,796**
Non-cash income and expense:			
Depreciation and amortisation	3	3,489	3,873
Impairments and reversals	3	41,238	3,184
Increase in trade and other receivables		(1,563)	(9,733)
Increase in other assets		0	(500)
Increase in inventories		(16)	(24)
Increase/(decrease) in trade and other payables		(342)	1,331
Increase/(decrease) in other liabilities		435	(74)
Increase/(decrease) in provisions		(121)	1,583
Net cash generated from operations		**26,840**	**27,436**
Cash flows from investing activities			
Interest received		165	163
Purchase of financial assets		(50)	0
Proceeds from settlements of financial assets		80	0
Purchase of property, plant and equipment and investment property		(11,795)	(9,592)
Proceeds from sales of property, plant and equipment and investment property		6	85
Cash movement from acquisitions of business units and subsidiaries		0	(45)
Net cash used in investing activities		**(11,594)**	**(9,389)**
Cash flows from financing activities			
Movement in loans from the Department of Health and Social Care		(3,000)	(3,000)
Capital element of PFI, LIFT and other service concession payments		(2,469)	(2,429)
Interest paid		(111)	(152)
Interest element of PFI, LIFT and other service concession obligations		(5,308)	(5,222)
PDC dividend (paid)		(3,788)	(3,547)
Net cash used in financing activities		**(14,676)**	**(14,350)**
Increase in cash and cash equivalents	25	**570**	**3,697**
Cash and cash equivalents at 1 April - Brought Forward	25	**57,845**	**54,148**
Cash and cash equivalents at 31 March	25	**58,415**	**57,845**

Notes to the Accounts

Note 1. Accounting Policies

NHS Improvement has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the DH Group Accounting Manual, which has been agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2017-18 DH Group Accounting Manual issued by NHS Improvement. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

The financial statements have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Accounting standards issued that have been adopted early

The following standards and updates have been published by the International Accounting Standards Board as adopted but are not required to be followed until after the current reporting period.

IFRS 9	Financial instruments
IFRS 14	Regulatory deferral accounts
IFRS 15	Revenue from contracts with customers
IFRS 16	Leases
IFRS 17	Insurance Contracts
IFRIC 22	Foreign Currency Transactions and Advance Consideration
IFRIC 23	Uncertainty over Income Tax Treatments

The Trust does not anticipate these changes in accounting standards to have a material impact on the 2018/19 accounts.

Critical accounting judgements and key sources of estimation uncertainty

These are methods adopted by the Trust to arrive at monetary amounts, corresponding to the measurement basis selected for assets, liabilities, gains, losses and charges to the Reserves. Where the basis of measurement for the amount to be recognised under Accounting Policies is uncertain, an estimation technique is applied.

The Trust has identified the valuation of the Trust estate and the valuation of Provisions as critical accounting judgements and key sources of uncertainty. Cushman and Wakefield Inc. provide third party assurance of the value of the estate completing a full modern equivalent valuation exercise every 3 years. Provisions are, in the main, injury benefits provisions which are valued using actuarial tables.
The Trust has not consolidated its charitable fund within the main accounts on the grounds of materiality as per guidance within the group accounting manual. The Trust has not consolidated its subsidiaries for the provision of Positive Individual Proactive Support (PIPS) services, and TEWV Estates and Facilities Management (TEWV EFM) services within the main accounts on the grounds of materiality as per guidance within the group accounting manual. The Trust has not consolidated its joint venture for the provision of North East Transformation System services (NETS) within the main accounts on the grounds of materiality as per guidance within the group accounting manual.

Income recognition
Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. Main source of income for the Trust is contracts with commissioners in respect of healthcare services.

Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.
Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Retirement benefit costs
Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.
For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

Other expenses
Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

Property, plant and equipment

Recognition
Property, plant and equipment is capitalised if:

- an item has a cost of at least £5,000; or
- it forms part of the initial equipping and setting-up cost of a new building, ward or unit irrespective of their individual or collective cost;
- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably.
- the Trust does not capitalise grouped assets.

Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Valuation
All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.
Depreciated replacement cost has been applied for assets with a short life and/or low values.
Each piece of new equipment has its useful economic life assessed prior to capitalisation; however, the range of useful lives is shown below:

- IT Equipment is depreciated over 5 years
- Furniture and Equipment and other Equipment are depreciated between 5 and 10 years
- Plant aligned to buildings is depreciated between 15 and 30 years

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being fair value at the date of revaluation less subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised Buildings – Depreciated Replacement Cost

In line with HM Treasury guidance with effect from 31 March 2010, Trust owned assets have been valued on modern equivalent asset (MEA) valuations, based on an alternative site valuation where the location meets the requirements of service provision. Owned assets lives were assessed as part of the MEA valuation exercise at 31 March 2010. The MEA value and assessed asset life are the basis for the depreciation charge. The depreciation charge for non-owned assets is based on the capital expenditure being depreciated over the remaining lease license life of the asset.

A full MEA valuation was carried out on the Trusts land and buildings on 31 March 2016, and the assets have been treated as prescribed in the Group Accounting Manual. Accumulated depreciation on these assets has been written to zero, and the cost or valuation at 31 March 2016 amended to the MEA values to reflect this. All of the Trusts MEA valuations have been completed by Cushman and Wakefield Inc. (independent qualified valuer).

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

A non current asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IFRS 5.

All fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

Intangible assets

Intangible assets are capitalised when they are capable of being used in a Trust's activities for more than one year; they can be valued; and they have a cost of at least £5,000.

Intangible fixed assets held for operational use are valued at historical cost and are depreciated over the estimated life of the asset on a straight line basis, except capitalised research and development which is revalued using an appropriate index figure. The carrying value of the intangible assets is reviewed for impairment at the end of the first full year following acquisition and in other periods if events or changes in circumstances indicate the carrying value may not be recoverable.

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:

	2017/18	**2016/17**
Short term (<5 years)	-2.42%	-2.70%
Medium term (5-10 years)	-1.85%	-1.95%
Long term	-1.56%	-0.80%
Pensions rate	0.10%	0.24%

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.
Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.
A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

Clinical negligence costs
The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 30.3.

Non-clinical risk pooling
The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

Contingencies
A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.
A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed where an inflow of economic benefits is probable.
Where the time value of money is material, contingencies are disclosed at their present value.

Financial assets

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.
Financial assets are classified into the following categories: financial assets at fair value through income and expenditure; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.
For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced directly/through a provision for impairment of receivables.
A provision for impairment of receivables is recognised upon notification that a debt is unlikely to be settled. The provision reflects amounts that are unlikely to be settled, where this is part of a larger debt only that which is uncertain is provided for.

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 2018.

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 2018. Resulting exchange gains and losses for either of these are recognised in the Trust's surplus/deficit in the period in which they arise.

Third party assets
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in Note 42 to the accounts.

Public Dividend Capital (PDC) and PDC dividend
Public Dividend Capital represents taxpayers' equity in the NHS Foundation Trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.
An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as PDC dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities, except for donated assets and daily average cash balances with the Office of the Paymaster General. The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets. The dividend payable is based on the average relevant net assets for the year.

Losses and Special Payments
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS foundation trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses and compensations register

which reports amounts on an accruals basis with the exception of provisions for future losses.

Joint operations

Joint operations are activities undertaken by the Trust in conjunction with one or more other parties but which are not performed through a separate entity.
The Trust has entered into a joint operation with Mental Health Matters and County Durham & Darlington NHS Foundation Trust to provide services to improve access to psychological therapies (IAPT services). The Trust is the host organisation and only the Trusts share of the income and expenditure; gains and losses; assets and liabilities; and cash flows are recognised in the accounts. The Trust has not consolidated the joint operation on the grounds of materiality.

The Trust is also Trustee for the “Tees Esk and Wear Valleys NHS Trust General Charitable Fund”, the balances of which are not consolidated with the Trusts accounts on the grounds of materiality.
The Trust has two wholly owned subsidiary companies "Positive Individualised Proactive Support Limited", and "TEWV Estates and Facilities Management Limited", however the Trust has not consolidated within the Trust's Accounts on the grounds of materiality.
The Trust is a shareholder in the newly established company "North East Transformational Support Ltd", however the Trust has not consolidated within the Trust's Accounts on the grounds of materiality.

Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.
Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.
In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

(a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period.

This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes.
The valuation of scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 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 Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

(b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.
The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.
The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.
The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

NHS pension scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

Annual Pensions

From 01 April 2015 the 1995 and 2008 final salary based schemes were replaced with a career average scheme. Annual pensions are accrued at a rate of 1/54th of pensionable pay each year of membership. All employees without pension scheme protection ended their 1995 / 2008 scheme and started in the 2015 scheme. Upon retirement employees may get 2 pensions, their 2015 scheme pension and any 1995/2008 scheme pension held.
The 1995 and 2008 schemes are “final salary” schemes. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service. From 01 April 2015 only members with pension scheme protection can continue to accrue additional years in these schemes.
With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as “pension commutation”.

Pensions Indexation

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) replaced the Retail Prices Index (RPI).

Ill-Health Retirement

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity.
For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Death Benefits

A death gratuity of twice final year’s pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

Additional Voluntary Contributions (AVCs)

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC’s run by the Scheme’s approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

Transfer between Funds

Scheme members have the option to transfer their pension between the NHS Pension Scheme and another scheme when they move into or out of NHS employment.

Preserved Benefits

Where a scheme member ceases NHS employment with more than two years service they can preserve their accrued NHS pension for payment when they reach retirement age.

Auto-Enrolment

To comply with auto-enrolment the Trust has opened a second pension scheme, for employees not eligible to be enrolled in the NHS Pension Scheme. The NHS Scheme will always be the default selection, however employees not eligible for membership are entered into the National Employment Savings Trust (NEST) scheme. This is a defined contribution scheme, and as such the cost to the NHS Body of participating in the scheme is equal to the contributions payable to the scheme for the accounting period.

Operating segments

The Trust has no elements that require segmental analysis for the period ended 31 March 2018. 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.

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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 2018 £000	12 months ended 31 March 2017 £000
Income from activities		
Cost and volume contract income	50,919	53,053
Block contract income	255,151	250,904
Clinical income for the secondary commissioning of mandatory services	11,388	6,971
Other clinical income from mandatory services	3,438	3,143
Other clinical income	5,642	4,379
Total income from activities	**326,538**	**318,450**
Other operating income		
Research and development	671	558
Education and training	8,483	8,077
Education and training - notional income from apprenticeship fund	49	0
Non patient care services to other bodies	4,879	3,519
Sustainability and transformation fund (STF)	6,599	9,231
Income in respect of employee benefits accounted on a gross basis	153	214
Rental revenue from operating leases	488	568
Other revenue	2,489	5,271
Total other operating income	**23,811**	**27,438**
Total operating income	**350,349**	**345,888**

Note 2.2 Operating lease income

	£000	£000
Rental revenue from operating leases	488	568
Future minimum lease receipts		
not later than one year;	488	564
later than one year and not later than five years;	1,164	1,279
later than five years.	9	290
Total future minimum lease receipts	**1,661**	**2,133**

Note 2.3 Non NHS income

The Trust had Non NHS income totalling £10,990k (2016-17, £11,997k).

Note 2.4 Income from Overseas Visitors

The Trust had no income relating to overseas visitors (non-reciprocal, chargeable to the patient) (2016-17 £nil).

Note 2.5 Fees and Charges

The Trust received no income from fees and charges - aggregate of all schemes that, individually, have a cost exceeding £1m (2016-17 £nil).

Note 2.6 Operating income (by type)	12 months ended 31 March 2018 £000	*Restated 12 months ended 31 March 2017 £000
Income from activities		
NHS England	59,438	55,718
Clinical Commissioning Groups	260,265	256,736
NHS Foundation Trusts	1,027	971
NHS Trusts	0	1
Local Authorities	2,936	2,331
NHS other (including Public Health England)	576	549
Non NHS: other	2,296	2,144
Total income from activities	**326,538**	**318,450**
Other operating income		
Research & Development	671	558
Education and training	8,483	8,077
Education and training - notional income from apprenticeship fund	49	0
Non-patient care services to other bodies	4,879	3,519
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Income in respect of employee benefits accounted on a gross basis	153	214
Rental revenue from operating leases	488	568
Other	2,489	5,271
Total other operating income	**23,811**	**27,438**
Total operating income	**350,349**	**345,888**

* restated following additional guidance.

Analysis of income from activities - non NHS other		
Other government departments and agencies	742	771
Other*	1,554	1,373
	2,296	**2,144**

*Other income is mainly from the Trusts Lifeline Project/Grow, Change, Live contract (£1,019k), (2016-17, £1,304k) and Spectrum Community Health Contract £800k (2016-17 £nil)

Analysis of other operating income - other		
Catering	185	141
Other income not already covered*	2,304	5,130
	2,489	**5,271**

*Other income of £2,116k was received from commercial settlement agreements, (2016-17, £4,711k)

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	327,260	322,581
Income from activities from non-commissioner requested services	23,089	23,307
	350,349	**345,888**

Note 3 Operating expenses (by type)	12 months ended 31 March 2018	*Restated 12 months ended 31 March 2017
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	2,711	2,040
Purchase of healthcare from non-NHS and non-DHSC bodies	7,090	6,723
Staff and executive directors costs	252,881	242,923
Non-executive directors	158	157
Supplies and services – clinical (excluding drugs costs)	2,074	3,025
Supplies and services - general	6,432	7,494
Drugs costs (drugs inventory consumed and purchase of non-inventory drugs)	4,013	3,635
Consultancy**	496	684
Establishment	3,620	4,109
Premises - business rates collected by local authorities	1,491	1,480
Premises - other	12,626	13,389
Transport (business travel only)	3,320	3,192
Transport - other (including patient travel)	1,423	1,394
Depreciation	3,489	3,873
Impairments net of (reversals)	41,238	3,184
Increase in impairment of receivables	4,393	388
Provisions arising in year	213	190
Change in provisions discount rate	91	674
Audit services - statutory audit	40	40
Other auditor remuneration (payable to external auditor only)	12	16
Internal audit - non-staff	223	220
Clinical negligence - amounts payable to NHS Resolution (premium)	1,178	1,162
Legal fees**	1,458	1,075
Insurance	36	97
Research and development - staff costs	631	509
Research and development - non-staff	74	149
Education and training - staff costs	1,503	1,476
Education and training - non-staff	1,412	1,549
Education and training - notional expenditure funded from apprenticeship fund	49	0
Operating lease expenditure (net)	8,481	8,187
Redundancy costs - non-staff	23	368
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT) on IFRS basis	2,582	2,427
Car parking and security	0	143
Hospitality	121	111
Other losses and special payments - non-staff	198	1,252
Other	849	757
Total operating expenses	**366,629**	**318,092**

* restated following additional guidance.

**consultancy and legal expenditure includes expenditure related to the commercial settlement detailed in note 2.6

Analysis of operating expenses - other

Services from local authorities	23	23
Other patients' expenses	155	213
National offender health services	198	146
CQC and accreditation fees	246	166
Miscellaneous	227	209
	849	**757**

Note 4.1 Employee expenses

	12 months ended 31 March 2018			* Restated 12 months ended 31 March 2017		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
	£000	£000	£000	£000	£000	£000
Salaries and wages	205,586	197,516	8,070	198,641	190,858	7,783
Social security costs	17,507	16,802	705	16,541	15,843	698
Apprenticeship levy	981	942	39	0	0	0
Pension cost - employer contributions to NHS pension scheme	24,416	23,375	1,041	24,170	23,192	978
Pension Cost - other contributions	17	17	0	15	15	0
Temporary staff - agency/contract staff	6,775	0	6,775	5,780	0	5,780
Gross employee expenses	**255,282**	**238,652**	**16,630**	**245,147**	**229,908**	**15,239**
Recoveries from other bodies in respect of staff cost netted off expenditure	0	0	0	(11)	(11)	0
Total employee expenses	**255,282**	**238,652**	**16,630**	**245,136**	**229,897**	**15,239**
of which:						
Costs capitalised as part of assets	267	267	0	228	228	0
Analysed into Operating Expenditure (page 14):						
Employee expenses - staff & executive directors	252,881	236,366	16,515	242,923	227,753	15,170
Research & development	631	516	115	509	440	69
Education and training	1,503	1,503	0	1,476	1,476	0
Total employee expenses excluding capitalised costs	**255,015**	**238,385**	**16,630**	**244,908**	**229,669**	**15,239**

The salary costs of the capital development team are capitalised over the full costs of the Trust's capital schemes, of which in 2017-18 the largest scheme was an inpatient unit in York.

Note 4.2 Average number of employees (WTE Basis)

	12 months ended 31 March 2018			* Restated 12 months ended 31 March 2017		
	Total Number	Permanently Employed Number	Other Number	Total Number	Permanently Employed Number	Other Number
Medical and dental	338	296	42	352	311	41
Administration and estates	1,170	1,108	62	1,204	1,095	109
Healthcare assistants and other support staff	319	307	12	308	295	13
Nursing, midwifery and health visiting staff	3,892	3,484	408	3,776	3,458	318
Scientific, therapeutic and technical staff	788	725	63	729	699	30
Healthcare science staff	2	2	0	10	10	0
Social care staff	8	0	8	24	0	24
Total	**6,517**	**5,922**	**595**	**6,403**	**5,868**	**535**
of which						
Number of Employees (WTE) engaged on capital projects	5	5	0	6	6	0

* restated following additional guidance.

Note 4.3 Early retirements due to ill health

During the period to 31 March 2018 there were 11 (2016-17, 11) early retirements from the Trust on the grounds of ill-health. The estimated additional pension liabilities of the ill-health retirement will be £678,470 (2016-17, £927,379). 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 was 1 payment for termination benefits valuing £23,000 during the period to March 2018, relating to redundancy (2016-17, 11 payments valuing £368,000).

Note 4.5 Cost of exit packages

	12 months ended 31 March 2018			12 months ended 31 March 2017		
Exit Package Cost	Total number	Compulsory Redundancies number	Other Departures number	Total number	Compulsory Redundancies number	Other Departures number
<10,000	0	0	0	1	1	0
£10,001 - £25,000	1	1	0	4	4	0
£25,001 - £50,000	0	0	0	5	5	0
£50,001 - £100,000	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	1	1	0
£150,001 - £200,000	0	0	0	0	0	0
>£200,001	0	0	0	0	0	0
Total number of exit packages	**1**	**1**	**0**	**11**	**11**	**0**
Total resource cost (£000's)	**23**	23	0	**368**	368	0

Note 4.6 Exit packages: other non compulsory

There were no other non compulsory exit packages between 01 April 2017 and 31 March 2018, (2016-17, nil)

Note 5.1 Operating leases	12 months ended 31 March 2018 £000	12 months ended 31 March 2017 £000
Minimum lease payments	8,481	8,187
Total	**8,481**	**8,187**

Note 5.2 Arrangements containing an operating lease	12 months ended 31 March 2018 £000	12 months ended 31 March 2017 £000
Future minimum lease payments due:		
not later than one year	7,441	7,169
later than one year and not later than five years	7,840	5,982
later than five years	8,920	5,333
Total	**24,201**	**18,484**

The Trust operating leases includes leased vehicles for staff, property rental and telephony rental.

Note 5.3 Limitation on auditor's liability

There is no specified limitation stated in the engagement letter of the Trust's auditors (no specified limitation 2016-17).

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 (2016-17, £nil).

Note 5.5 Other audit remuneration

The Trust paid it's external auditors additional remuneration totalling £12k for the period to 31 March 2018, £4k in respect of the delivery of workshops on developing approaches to learning from deaths and £8k for work on the Quality Report (31 March 2017, £16k). Auditors remuneration for statutory audit is shown in note 3.

Note 6 Discontinued operations

The Trust has no discontinued operations at 31 March 2018 (31 March 2017, £nil).

Note 7 Corporation tax

The Trust has no Corporation Tax liability or asset at 31 March 2018 (31 March 2017, £nil).

Note 8 Finance income	12 months ended 31 March 2018 £000	12 months ended 31 March 2017 £000
Interest on bank accounts	165	163
Total	**165**	**163**

Note 9 Finance costs	12 months ended 31 March 2018 £000	12 months ended 31 March 2017 £000
Interest expense:		
Interest on loans from the Department of Health and Social Care:		
- Capital loans	100	127
Finance costs in PFI obligations:		
- Main finance costs	3,763	3,884
- Contingent finance costs	1,545	1,338
Total interest expense	**5,408**	**5,349**
Unwinding of discount on provisions	3	5
Total	**5,411**	**5,354**

Note 10.1 Gains / (losses) on disposal of assets	12 months ended 31 March 2018 £000	12 months ended 31 March 2017 £000
Gains on disposal of property, plant and equipment	4	2
Losses on disposal of assets held for sale	0	(17)
Total other gains/(losses)	**4**	**(15)**

Note 10.2 Impairment of assets	12 months ended 31 March 2018 £000	12 months ended 31 March 2017 £000
Over specification of assets	0	1,930
Changes in market price	43,211	3,185
Reversal of impairments	(1,973)	(1,931)
Total impairments and (reversals) charged to operating surplus	**41,238**	**3,184**
Impairments charged to the revaluation reserve	9,905	983
Total impairments and (reversals)	**51,143**	**4,167**

The Trust realised an impairment totalling £50.8m following confirmation of rectification works required on one of its PFI sites.

Note 11 Intangible assets

The Trust's intangible assets are licenses for a software system that are to be held in perpetuity. Balance as at 31 March 2018 was £700k (31 March 2017, £nil).

Note 12.1 Property, plant and equipment 2017-18

	Total	Land	Buildings exc. Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2017	**216,671**	**12,658**	**196,331**	**3,732**	**818**	**84**	**1,701**	**1,347**
Additions - purchased	12,710	0	6,026	6,252	124	0	308	0
Impairments charged to operating expenses	(43,195)	(335)	(42,860)	0	0	0	0	0
Impairments charged to the revaluation reserve	(9,905)	0	(9,905)	0	0	0	0	0
Reversal of impairments credited to operating expenses	1,973	0	1,973	0	0	0	0	0
Revaluations	655	0	655	0	0	0	0	0
Reclassifications	0	0	1,007	(1,007)	0	0	0	0
Transfers to assets held for sale and assets in disposal groups	(375)	(113)	(262)	0	0	0	0	0
Disposals/derecognition	(2,318)	0	(2,301)	0	(17)	0	0	0
Cost or valuation at 31 March 2018	**176,216**	**12,210**	**150,664**	**8,977**	**925**	**84**	**2,009**	**1,347**
Accumulated depreciation at 1 April 2017	**4,351**	**0**	**1,271**	**0**	**465**	**74**	**1,194**	**1,347**
Provided during the year	3,489	0	3,232	0	73	5	179	0
Transfers to/from assets held for sale and assets in disposal groups	(9)	0	(9)	0	0	0	0	0
Disposals/derecognition	(2,309)	0	(2,301)	0	(8)	0	0	0
Accumulated depreciation at 31 March 2018	**5,522**	**0**	**2,193**	**0**	**530**	**79**	**1,373**	**1,347**

* Derecognition of valuation and accumulated depreciation of buildings is due to a modern equivalent asset valuation.

Note 12.2 Property, plant and equipment 2016-17

	Total	Land	Buildings exc. Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2016	**213,315**	**12,771**	**195,758**	**1,305**	**662**	**84**	**1,388**	**1,347**
Additions - purchased	8,572	0	4,758	3,345	156	0	313	0
Impairments charged to operating expenses	(5,115)	(113)	(5,002)	0	0	0	0	0
Impairments charged to the revaluation reserve	(983)	0	(983)	0	0	0	0	0
Reversal of impairments credited to operating expenses	1,931	0	1,931	0	0	0	0	0
Revaluations	1,500	0	1,500	0	0	0	0	0
Reclassifications	0	0	918	(918)	0	0	0	0
Transfers to/from assets held for sale and assets in disposal groups	(100)	0	(100)	0	0	0	0	0
Disposals/derecognition	(2,449)	0	(2,449)	0	0	0	0	0
Valuation/gross cost at 31 March 2017	**216,671**	**12,658**	**196,331**	**3,732**	**818**	**84**	**1,701**	**1,347**
Accumulated depreciation at 1 April 2016	**2,927**	**0**	**0**	**0**	**421**	**62**	**1,097**	**1,347**
Provided during the year	3,873	0	3,720	0	44	12	97	0
Disposals / derecognition*	(2,449)	0	(2,449)	0	0	0	0	0
Accumulated depreciation at 31 March 2017	**4,351**	**0**	**1,271**	**0**	**465**	**74**	**1,194**	**1,347**

* Derecognition of valuation and accumulated depreciation is due to a modern equivalent asset valuation.

Note 12.3 Property, plant and equipment financing

Net book value - 31 March 2018	Total	Land	Buildings exc. Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	129,559	12,210	107,336	8,977	395	5	636	0
On-SoFP PFI contracts and other service concession arrangements	41,135	0	41,135	0	0	0	0	0
Net book value total at 31 March 2018	**170,694**	**12,210**	**148,471**	**8,977**	**395**	**5**	**636**	**0**
Net book value - 31 March 2017								
Owned - purchased	125,029	12,658	107,769	3,732	353	10	507	0
On-SoFP PFI contracts and other service concession arrangements	87,291	0	87,291	0	0	0	0	0
Net book value total at 31 March 2017	**212,320**	**12,658**	**195,060**	**3,732**	**353**	**10**	**507**	**0**

Note 13 Non current assets acquired by government grant

The Trust has no assets acquired by government grant (2016-17, 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 14.1 Economic life of property, plant and equipment

The Trust's intangible assets are licenses for a software system that are to be held in perpetuity, as such they do not have a maximum life.

Note 15.1 Land and buildings disposed previously used to provide commissioner requested services

The Trust has not disposed of any land or buildings in year.

Note 15.2 NBV of property, plant and equipment in the Revaluation Reserve as at 31 March 2018

	Total	Land	Buildings exc. Dwellings
	£000	£000	£000
as at 1 April 2017	**19,158**	1,839	17,319
movement in year	**(9,249)**	0	(9,249)
as at 31 March 2018	**9,909**	**1,839**	**8,070**

Note 15.3 NBV of property, plant and equipment in the Revaluation Reserve as at 31 March 2017

	Total	Land	Buildings exc. Dwellings
	£000	£000	£000
as at 1 April 2016	**18,639**	1,864	16,775
movement in year	**519**	(25)	544
as at 31 March 2017	**19,158**	**1,839**	**17,319**

Note 16 Investments	12 months ended 31 March 2018 Total £000	12 months ended 31 March 2017 Total £000
as at 1 April	125	80
additions	0	125
disposals	0	(80)
as at 31 March	**125**	**125**

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 2018 (31 March 2017, £nil) on the basis of materiality (as disclosed in note 1).

Note 18.1 Non current assets for sale and assets in disposal groups 2017-18	Total £000	PPE: Land £000	Property, Plant & Equipment £000
NBV of non-current assets for sale and assets in disposal groups at 31 March 2017	**0**	0	0
Plus assets classified as available for sale in the year	**366**	113	253
Less impairment of assets held for sale	**(16)**	0	(16)
NBV of non-current assets for sale and assets in disposal groups at 31 March 2018	**350**	**113**	**237**

Note 18.2 Non current assets for sale and assets in disposal groups 2016-17	Total £000	PPE: Land £000	Property, Plant & Equipment £000
NBV of non-current assets for sale and assets in disposal groups at 31 March 2016	**0**	0	0
Plus assets classified as available for sale in the year	**100**	0	100
Less assets sold in year	**(100)**	0	(100)
NBV of non-current assets for sale and assets in disposal groups at 31 March 2017	**0**	**0**	**0**

Note 18.3 Liabilities disposal groups
The Trust has no liabilities in disposal groups as at 31 March 2018 (31 March 2017, £nil).

Note 19 Other assets
The Trust has no other assets as at 31 March 2018 (31 March 2017, £nil).

Note 20 Other financial assets

Other financial assets at 31 March 2018 (£470k) relate to a loan provided to Positive Individual Proactive Support (PIPS) services (31 March 2017, £500k).

Note 21.1 Inventories	12 months ended 31 March 2018 £000	12 months ended 31 March 2017 £000
Carrying Value at 1 April	205	181
Additions	221	205
Inventories consumed (recognised in expenses)	(205)	(181)
Carrying Value at 31 March	**221**	**205**

Note 22 Trade receivables and other receivables

	31 March 2018 £000	*Restated 12 months ended 31 March 2017 £000
Current		
Trade receivables	6,515	3,424
Accrued income	5,014	8,356
Provision for impaired receivables	(4,836)	(443)
Prepayments (revenue) [non-PFI]	3,822	3,043
PFI lifecycle prepayments (capital)	735	624
PDC dividend receivable	937	65
VAT receivable	833	698
Other receivables	6,255	959
Total current trade and other receivables	**19,275**	**16,726**
*restated following additional guidance		
Non Current		
Other receivables	42	45
Total non current trade and other receivables	**42**	**45**

Note 23.1 Provision for impairment of receivables	31 March 2018 £000	31 March 2017 £000
At 1 April - brought forward	443	86
Increase in provision	4,824	436
Amounts utilised	0	(31)
Unused amounts reversed	(431)	(48)
At 31 March	**4,836**	**443**

Note 23.2 Analysis of impaired receivables	31 March 2018 £000	31 March 2018 £000	31 March 2017 £000	31 March 2017 £000
Ageing of impaired receivables	Trade and other receivables	Investments & Other financial assets	Trade and other receivables	Investments & Other financial assets
0 - 30 days	1,086	0	49	0
30-60 Days	0	0	0	0
60-90 days	3,116	0	158	0
90- 180 days	25	0	192	0
over 180 days	609	0	44	0
Total	**4,836**	**0**	**443**	**0**
Ageing of non-impaired receivables past their due date				
0 - 30 days	1,995	0	1,223	0
30-60 Days	183	0	228	0
60-90 days	1,002	0	440	0
90- 180 days	69	0	535	0
over 180 days	122	0	266	0
Total	**3,371**	**0**	**2,692**	**0**

Note 24 Finance leases

The Trust does not have any finance lease obligations other than PFI commitments (2016-17, nil).

Note 25.1 Cash and cash equivalents

	12 months ended 31 March 2018 £000	12 months ended 31 March 2017 £000
At 1 April	57,845	54,148
Net change in year	570	3,697
At 31 March	**58,415**	**57,845**
Broken down into:		
Commercial banks and cash in hand	196	60
Cash with Government Banking Service	58,219	57,785
Cash and cash equivalents as in SoFP	**58,415**	**57,845**
Cash and cash equivalents as in SoCF	**58,415**	**57,845**

Note 25.2 Third party assets held

	12 months ended 31 March 2018 £000	12 months ended 31 March 2017 £000
At 1 April	1,437	1,416
Gross inflows	3,092	3,159
Gross Outflows	(3,030)	(3,138)
At 31 March	**1,499**	**1,437**

Note 26.1 Trade and other payables

Current	31 March 2018 £000	* Restated 12 months ended 31 March 2017 £000
Trade Payables	5,299	8,154
Capital payables (including capital accruals)	2,332	606
Accruals	12,262	10,205
Social security costs	2,921	2,833
VAT payable	908	57
Other taxes payable	2,215	2,694
Accrued interest on DHSC loans	36	55
Other Payables	5	8
Total current trade and other payables	**25,978**	**24,612**

*restated following additional guidance

Non current

The Trust has no non current trade and other payables (2016-17 £nil).
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 2018 (2016-17, £nil).

Note 27 Borrowings Current	31 March 2018 £000	31 March 2017 £000
Loans from the Department of Health and Social Care Capital loans	3,000	3,000
Obligations under PFI, LIFT or other service concession contracts (excl lifecycle)	2,343	2,469
Total current borrowings	**5,343**	**5,469**
Non current		
Loans from the Department of Health and Social Care Capital loans	3,000	6,000
Obligations under PFI, LIFT or other service concession contracts (excl lifecycle)	72,369	74,712
Total other non-current liabilities	**75,369**	**80,712**

PFI borrowings are in relation to Lanchester Road Hospital and Roseberry Park Hospital which all operate under a standard form PFI contract i.e. unitary payments are payable from the date construction completion and are not subject to re-pricing. Inflation linked to RPI is applied annually. Final settlements are expected in May 2038 and March 2040 respectively.

During 2014-15 the Trust received a £15,000k loan repayable over 5 years from the Department of Health, which was used to support the Trust's capital programme.

Note 28 Other liabilities

	31 March 2018 £000	31 March 2017 £000
Current		
Deferred income	660	225
Total other current liabilities	**660**	**225**

Note 29 Other financial liabilities

The Trust has no other financial liabilities at 31 March 2018 (31 March 2017, £nil).

Note 30.1 Provisions for liabilities and charges 2017-18	Total £000	Pensions- Early departure costs * £000	Other legal claims ** £000	Redundancy £000	Other £000
At 1 April 2017	**3,344**	**2,904**	**255**	**185**	**0**
Change in discount rate	91	91	0	0	0
Arising during the year	363	65	275	23	0
Utilised during the year - accruals	(9)	0	(9)	0	0
Utilised during the year - cash	(416)	(153)	(99)	(164)	0
Reversed unused	(150)	(112)	(38)	0	0
Unwinding of discount rate	3	3	0	0	0
At 31 March 2018	**3,226**	**2,798**	**384**	**44**	**0**
Expected timing of cash flows:					
not later than one year	580	152	384	44	0
Current	**580**	**152**	**384**	**44**	**0**
later than one year and not later than five years	605	605	0	0	0
later than five years	2,041	2,041	0	0	0
Non Current	**2,646**	**2,646**	**0**	**0**	**0**
TOTAL	**3,226**	**2,798**	**384**	**44**	**0**

*Pensions - early departure costs relating to other staff is a provision for injury benefit pensions.

**Other legal claims relate to the following; employer / public liability claims notified by the NHS Litigation Authority £303,597 (2016-17, £209,989), and the provision for employment law £80,200 (2016-17, £45,000).

Note 30.2 Provisions for liabilities and charges 2016-17	Total £000	Pensions- Early departure costs £000	Other legal claims ** £000	Redundancy £000	Other £000
At 1 April 2016	**1,756**	**1,157**	**431**	**168**	**0**
Change in discount rate	674	674	0	0	0
Arising during the year	1,646	1,239	222	185	0
Utilised during the year - cash	(520)	(171)	(181)	(168)	0
Reversed unused	(217)	0	(217)	0	0
Unwinding of discount rate	5	5	0	0	0
At 31 March 2017	**3,344**	**2,904**	**255**	**185**	**0**
Expected timing of cash flows:					
not later than one year	591	151	255	185	0
Current	**591**	**151**	**255**	**185**	**0**
later than one year and not later than five years	602	602	0	0	0
later than five years	2,151	2,151	0	0	0
Non Current	**2,753**	**2,753**	**0**	**0**	**0**
TOTAL	**3,344**	**2,904**	**255**	**185**	**0**

Note 30.3 Clinical negligence liabilities

£1,351,227 (2016-17, £1,308,490) is included in the provisions of the NHS Litigation Authority at 31 March 2018 in respect of clinical negligence liabilities of the NHS Foundation Trust.

Note 31.1 Contingent liabilities	31 March 2018 £000	31 March 2017 £000
Gross value of contingent liabilities	(89)	(99)
Net value of contingent liabilities	**(89)**	**(99)**

The contingencies relate to employer liability legal cases, all cases relate to the NHSLA and are due within 1 year.

The Trust has contingent liabilities linked to the legal dispute detailed in note 31.2.

Note 31.2 Contingent assets

The Trust is currently involved in an ongoing contractual legal dispute which may result in future economic benefits relating to past events. Income has been recognised in the financial statements when it meets the criteria detailed in the Group Accounting Manual. The ongoing dispute may result in additional future economic benefits, however these have not been recognised in the financial statements due to uncertainty around the amount of these economic benefits, and because an appeals process is available following the outcome.

Note 32 Revaluation reserve	31 March 2018 £000	31 March 2017 £000
Revaluation reserve at 1 April	**19,158**	**18,641**
Net impairments	(9,905)	(983)
Revaluations	655	1,500
Revaluation reserve at 31 March	**9,908**	**19,158**

Note 33.1 Related Party Transactions	Income	Expenditure
2017-2018	**£000**	**£000**
Value of transactions with other related parties in 2017-2018		
Non-consolidated subsidiaries and associates / joint ventures	113	73
Other bodies or persons outside of the whole of government accounting boundary	1,019	0
Total	**1,132**	**73**
2016-2017 Restated *		
Value of transactions with other related parties in 2016-2017 Restated *		
Non-consolidated subsidiaries and associates / joint ventures	26	0
Other bodies or persons outside of the whole of government accounting boundary	1,303	0
Total	**1,329**	**0**

Note 33.2 Related Party Balances	Receivables	Payables
2017-2018	**£000**	**£000**
Value of balances with other related parties at 31 March 2018		
Non-consolidated subsidiaries and associates / joint ventures	244	0
Other bodies or persons outside of the whole of government accounting boundary	1,154	36
Value of provisions for doubtful debts held against related parties (excludes salaries)	(255)	0
Total	**1,143**	**36**
2016-2017 Restated *		
Value of balances with other related parties at 31 March 2017		
Non-consolidated subsidiaries and associates / joint ventures	29	0
Other bodies or persons outside of the whole of government accounting boundary	65	55
Total	**94**	**55**

* restated following additional guidance.

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 2018):

Entity	Income £000	Expenditure £000	Receivables £000	Payables £000
NHS England - North East Specialised Commissioning Hub	50,523	0	1,982	0
NHS Durham Dales, Easington and Sedgefield CCG	46,951	0	419	0
NHS South Tees CCG	42,485	0	180	0
NHS Vale of York CCG	40,156	0	156	0
NHS North Durham CCG	38,545	0	494	0
NHS Hartlepool and Stockton-on-Tees CCG	33,943	0	5	0
NHS Hambleton, Richmondshire and Whitby CCG	15,478	0	9	0
NHS Harrogate and Rural District CCG	15,103	3	18	0
NHS Scarborough and Ryedale CCG	14,606	0	171	0
NHS Darlington CCG	13,753	0	35	15
Health Education England	8,629	25	444	187
NHS England - Core (including 1718 sustainability & transformation fund)	6,297	6	4,990	19
NHS England - Cumbria and North East Local Office	6,013	0	852	0
NHS Leeds North CCG	1,085	0	1	0
NHS Property Services	248	2,543	93	281
South Tees Hospitals NHS Foundation Trust	92	1,485	38	126
NHS Resolution (formerly NHS Litigation Authority)	0	1,178	0	9
Humber NHS Foundation Trust	0	1,175	0	441
York Teaching Hospital NHS Foundation Trust	159	1,032	34	278
Other DH Group	5,293	4,874	938	506

In addition, the Trust has had a number of material transactions (total transactions greater than £1,000k) with other Government Departments and other central and local Government bodies. These are detailed in the table below:

Entity	Income £000	Expenditure £000	Receivables £000	Payables £000
NHS Pension Scheme	0	24,416	0	3,322
HM Revenue & Customs	0	18,488	0	5,136
Other Government Bodies	4,491	1,240	1,488	1,934

Note 34 Contractual capital commitments	31 March 2018 £000	31 March 2017 £000
Property, plant and equipment	1,031	2,644
Total as at 31 March	**1,031**	**2,644**

Note 34.2 Other Financial Commitments
The Trust has no other financial commitments as at 31 March 2018 (31 March 2017, £nil).

Note 35 Finance lease obligations
The Trust has no finance lease obligations as at 31 March 2018 (31 March 2017, £nil).

Note 36.1 On SoFP PFI obligations (finance lease element)	31 March 2018 Total £000	31 March 2018 Lanchester Rd PFI £000	31 March 2018 Roseberry Park PFI £000	31 March 2017 Total £000
Gross PFI liabilities	**182,342**	**36,570**	**145,772**	**187,896**
of which liabilities are due				
not later than one year	7,697	1,356	6,341	7,777
later than one year and not later than five years	33,778	6,780	26,998	32,223
later than five years	140,867	28,434	112,433	147,896
Finance charges allocated to future periods	(107,630)	(22,375)	(85,255)	(110,715)
Net PFI liabilities	**74,712**	**14,195**	**60,517**	**77,181**
not later than one year	2,343	365	1,978	2,469
later than one year and not later than five years	11,521	2,422	9,099	10,672
later than five years	60,848	11,408	49,440	64,040
	74,712	**14,195**	**60,517**	**77,181**

Note 36.2 On SoFP PFI service concession commitments	31 March 2018 Total	31 March 2018 Lanchester Rd PFI	31 March 2018 Roseberry Park PFI	31 March 2017 Total
Commitments	**£000**	**£000**	**£000**	**£000**
not later than one year	11,335	2,108	9,227	10,934
later than one year and not later than five years	48,252	8,973	39,279	46,552
later than five years	261,394	43,592	217,802	270,894
Total	**320,981**	**54,673**	**266,308**	**328,380**

Note 36.3 On SoFP PFI unitary payments	31 March 2018 Total £000	31 March 2018 Lanchester Rd PFI £000	31 March 2018 Roseberry Park PFI £000	31 March 2017 Total £000
Unitary payment	**10,792**	**1,898**	**8,894**	**10,393**
Consisting of:				
- Interest charge	3,763	685	3,078	3,884
- Repayment of finance lease liability	2,469	448	2,021	2,429
- Service element (and other charges to operating expenditure excluding revei	2,582	298	2,284	2,427
- Capital lifecycle maintenance	323	51	272	307
- Contingent rent	1,545	306	1,239	1,338
- Addition to lifecycle prepayment	110	110	0	8
Total	**10,792**	**1,898**	**8,894**	**10,393**

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 2018 (31 March 2017, £nil).

Note 38 Events after the reporting period
The Trust has no events after the reporting period.

Note 39.1 Financial assets by category Assets as per SoFP 2017-18	Total £000	Loans and receivables £000
Trade and other receivables (excluding non financial assets) - with NHS and DH bodies	10,856	10,856
Trade and other receivables (excluding non financial assets) - with other bodies	2,134	2,134
Other investments / financial assets	470	470
Cash and cash equivalents	58,415	58,415
Total at 31 March 2018	**71,875**	**71,875**

2016-17	Total £000	Loans and receivables £000
Trade and other receivables excluding non financial assets	9,941	9,941
Other Investments	2,400	2,400
Other Financial Assets	500	500
Cash and cash equivalents at bank and in hand	57,845	57,845
Total at 31 March 2017	**70,686**	**70,686**

Note 39.2 Financial liabilities by category 2017-18	Total £000	Other financial liabilities £000
Borrowings excluding finance lease and PFI liabilities	6,000	6,000
Obligations under PFI, LIFT and other service concession contracts	74,712	74,712
Trade and other payables (excluding non financial liabilities) - with NHS and DH bodies	1,593	1,593
Trade and other payables (excluding non financial liabilities) - with other bodies	18,305	18,305
Provisions under contract	384	384
Total at 31 March 2018	**100,994**	**100,994**

2016-17	Total £000	Other financial liabilities £000
Borrowings excluding finance lease and PFI liabilities	9,000	9,000
Obligations under PFI, LIFT and other service concession contracts	77,181	77,181
Trade and other payables (excluding non financial liabilities) - with NHS and DH bodies	2,179	2,179
Trade and other payables (excluding non financial liabilities) - with other bodies	16,849	16,849
Provisions under contract	210	210
Total at 31 March 2017	**105,419**	**105,419**

Note 39.3 Fair values of financial assets at 31 March 2018	Book Value £000	Fair Value £000
Non current trade and other receivables	42	42
Other investments	125	125
Total	**167**	**167**

Note 39.4 Fair values of financial liabilities at 31 March 2018	Book Value £000	Fair Value £000
Loans	3,000	3,000
Total	**3,000**	**3,000**

Note 39.5 Maturity of Financial liabilities	31 March 2018 £000	31 March 2017 £000
In one year or less	25,625	24,707
In more than one year but not more than two years	5,633	5,343
In more than two years but not more than five years	8,888	11,329
In more than five years	60,848	64,040
Total	**100,994**	**105,419**

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 2018	Number of cases	Value £000
Losses		
Cash losses	1	0
Special payments		
Ex gratia payments	32	7
Total at 31 March 2018	**33**	**7**

At 31 March 2017	Number of cases	Value £000
Losses		
Cash losses	4	0
Special Payments		
Ex gratia payments	44	8
Total at 31 March 2017	**48**	**8**

Note 42 Third party assets and liabilities

The Trust held £901k cash at bank and in hand at 31 March 2018 (31 March 2017, £909k) 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 £598k cash at bank and in hand at 31 March 2018 (31 March 2017, £528k) which related to monies held by the Trust for a staff savings scheme. This has been excluded from the cash at bank and in hand figure reported in the accounts.

Note 43 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Due to the continuing service provider relationship that the NHS Foundation Trust has with Clinical Commissioning Groups and the way those Clinical Commissioning Groups are financed, the NHS Foundation Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Foundation Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Foundation Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Market risk

The main potential market risk to the Trust is interest rate risk. 100% of the Trust's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest. Tees, Esk and Wear Valleys NHS Foundation Trust is not, therefore, exposed to significant interest-rate risk.

Credit risk

Credit risk exists where the Trust can suffer financial loss through default of contractual obligations by a customer or counterparty.

Trade debtors consist of high value transactions with Clinical Commissioning Groups under contractual terms that require settlement of obligation within a time frame established generally by the Department of Health. Due to this the credit risk exposure is not significant.

Credit risk exposures of monetary financial assets are managed through the Trust's treasury policy which limits the value that can be placed with each approved counterparty to minimise the risk of loss. The counterparties are limited to the approved financial institutions with high credit ratings. Limits are reviewed regularly by senior management.

Liquidity risk

The Trust's net operating costs are mainly incurred under legally binding contracts with Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. This provides a reliable source of funding stream which significantly reduces the Trust's exposure to liquidity risk.

The Trust also manages liquidity risk by maintaining banking facilities and loan facilities to meet its short and long term capital requirements through continuous monitoring of forecast and actual cash flows.

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

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For more information about the Trust and how you can get involved visit our website

www.tewv.nhs.uk