Tees, Esk and Wear Valleys
NHS Foundation Trust

Annual report and accounts 2018/19

Making a difference together

The year the Trust helped celebrate the NHS' 70th birthday

Tees, Esk and Wear Valleys NHS Foundation Trust

Annual report and accounts 2018/19

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

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Foreword by the Chairman and Chief Executive

Reviewing the past

In July last year the National Health Service celebrated its 70th anniversary. This was an important milestone for an incredible institution that continues to support every one of us, each and every day. Much has changed over the last 70 years and mental health services have been totally transformed (although we recognise there is still work to do). Over the last 13 years TEWV has played its part in continuing to improve services and to minimise the impact that mental illness or a learning disability has on people's lives.

Last year was no exception and although there has been continued pressure on our services we achieved a great deal and met all our financial targets.

We have continued to reduce the length of time that people have to wait for an appointment, despite seeing an increase in referrals. People tell us they want to be supported at home whenever possible and our figures show that on the whole service users are spending less time in hospital which is great news. Perhaps more importantly most people who use our services continue to tell us that their experience of TEWV is good or excellent.

Our focus on providing effective community services remains a key priority for us, as does making sure that when people need inpatient care this is provided in a modern, high quality environment.

Placing the emphasis on supporting people at home has had a significant positive impact in Hambleton and Richmondshire. Previously inpatient services were provided in an outdated building and under resourced community services were struggling to support people at home. Following a public consultation we agreed to strengthen community services for adults and older people to reduce the need for hospital admission. Far fewer people now need to spend time in hospital and in February 2019 we successfully transferred inpatient services for adults and older people from the Friarage in Northallerton. Inpatient mental health services are now provided at West Park Hospital in Darlington or Roseberry Park in Middlesbrough. Inpatient services for a small number of people with severe dementia are provided at Auckland Park in Bishop Auckland.

We also worked with the local CCG to review services in the Harrogate area. We are currently not providing the standard of inpatient accommodation we would expect (and local people deserve). This has been highlighted by the Care Quality Commission (CQC) inspections. We needed to make sure we were making best use of our limited resources and plans to build a new hospital in Harrogate were put on hold while we undertook a thorough review of options. We listened to the views of local people and agreed a new model. We will invest in community services which will reduce the number of inpatient admissions as well as the length of time individuals need to spend in hospital (this is what people told us they wanted). We will provide inpatient services in a specialist facility elsewhere within TEWV. This is likely to be in York where we are already building a new mental health hospital. Over the coming months we will work with local people to develop a model for community services.

Work on the new mental health hospital in York got underway last year and we are making good progress on site. We expect the new 72 bed hospital to be completed in Spring 2020.

One of the ways we seek to improve the quality of life of people with mental health problems is to address physical health problems and this includes helping them manage their weight. Last year we developed and piloted a nutrition and body mass index clinical link pathway. This has helped service users achieve a healthy weight and will significantly reduce health risks. This pathway will be rolled out to all inpatient services in 2019.

Developing new and innovative services is vital to achieving our vision of being a recognised centre of excellence with high quality staff providing high quality services that exceed expectations. Last year we were awarded a number of new contracts, some with partner organisations.

In June we were successful in our bid to provide trustwide perinatal services. New services have been launched in County Durham, Darlington and Yorkshire, building on the success of our existing service in Teesside. These important services support women and families who are experiencing significant mental health difficulties and are considering pregnancy as well as those who are currently pregnant or are in the first year after having their baby.

In July we began a two year contract to deliver mental health and substance misuse services within HMP Haverigg in Cumbria. We will be working alongside Rethink and Northumberland Tyne and Wear NHS Foundation Trust.

We have also been awarded the contract to provide liaison and diversion services across the Trust area. TEWV will be the lead provider of the service, which started on 1 April 2019, working in partnership with HumanKind and Spectrum Community Health CIC. The new contract means that, as well as continuing to provide liaison and diversion services in County Durham, Darlington and Teesside, we can now for the first time extend these important services into North Yorkshire. We are looking forward to working with the police in these areas to further improve patient care.

The success of TEWV is wholly depending on its staff and on the Trust making sure it's in a good position to recruit and retain high quality people. We continue to do all we can to support staff to continually improve the way they work. Our quality improvement system (TEWV QIS) and our commitment to coaching are helping us involve staff more effectively in achieving our objectives and overcoming challenges.

Last year's national staff survey showed that we performed well compared to other mental health and learning disability trusts and were better than average in eight of the ten areas surveyed. We also recorded the highest scores of any mental health and learning disability in two areas – equality, diversity & inclusion and safety culture. Of course there were also areas where we can use the feedback to improve and an area of concern was the increase in reports of bullying and harassment. Although this is not reflected in the number of formal cases raised by staff, it's important that we do all we can to encourage and support staff to speak up if they feel they are being bullied. This work has started and will continue next year.

We retained our top ranking from the General Medical Council (GMS) – junior doctors once again rated TEWV as the best NHS Trust in the North East and fifth nationally in the GMS's

national training survey. The Trust equally excelled in the GMC trainer survey which placed us as the fourth best NHS Trust in the UK and the highest ranking organisation for trainer development.

Recruiting nurses continues to be a challenge and last year we worked with the University of Sunderland to develop a new pre-registration mental health and learning disability nursing apprenticeship programme.

The Care Quality Commission once again rated TEWV as 'good' in its annual review of our services. The inspectors commented that staff worked hard to provide quality care, with services meeting the needs of our service users. They thought staff displayed a positive attitude about their role and were motivated and skilled. They said we have effective leadership and support in place and that service users felt listened to and were treated with dignity and respect.

One of our major challenges is addressing the issues at Roseberry Park which were highlighted in last year's report. We took over estates and facilities management services at the hospital in June last year when the previous company went into liquidation and we had to step in. In September the PFI contract was terminated and the Trust is now fully responsible for managing the hospital buildings. Alongside this we have been making plans to fix the extensive range of construction defects at the hospital and we hope that this major piece of work will get underway in the Summer.

The way services are provided and commissioned are changing. Over the last twelve months we have continued to work with partners and commissioners to improve services for local people.

The Durham, Darlington and Teesside NHS mental health and learning disability partnership is already achieving great success in improving the lives of people with a learning disability, particularly those with very complex needs. By working together and developing new ways of working we are enabling families to become more involved in the management of their care packages and making decisions about the best ways to meet individual needs. Work is also underway in North Yorkshire to develop a similar partnership.

We continue to work with partners to progress the New Care Models (NCMs) for tertiary services. We have continued to reduce the reliance on inpatient beds and release funding for reinvestment in the community. Last year we extended our child and adolescent mental health services (CAMHS) crisis service across North Yorkshire and York. The service is now available 24 hours a day, seven days a week across Hambleton and Richmondshire and from 10am to 10pm across the rest of North Yorkshire and York. We plan to move to a 24/7 service in 2019, which will mean we are offering the same service to children and young people wherever they live across Teesside, Durham and Darlington, North Yorkshire and York.

We are also working with partners to develop a business case to take on the management of the commissioning budget for adult eating disorders across the North East, Cumbria, North Yorkshire and York. As with the other NCMs, the aim is to support people in the community wherever possible and reduce the need for hospital admission. This will free up money to be invested in community services.

It has been a busy year and you can read more about our key developments and improvements in the performance report and in the quality report.

Looking to the future

In January the NHS launched its Long Term Plan which was drawn up by staff, patient groups and other experts. This is an important document, which sets out how the NHS wants to improve patient care over the next ten years. Mental health and learning disability services feature strongly in the Plan - there is a recognition that more investment is needed in mental health and we are looking forward to working with partners to use this funding to improve services.

Our business plan fully supports the national priorities and we remain committed to improving the quality of our services and increasing the value that we provide to service users, carers, partner organisations and commissioners. The key themes that underpin our plans for next year are:

- An overarching commitment to promoting recovery, including developing personalised care planning and trauma-informed care, provided by staff with the right skills and values and supported by digital technology
- A continuing focus on improving the quality of our services and ensuring that they 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

We will continue to support our staff to do the best job they can and this includes making sure we do all we can to promote their own good health and wellbeing. The views of staff are important in helping us inform what actions we should take and one of the ways we intend gathering those views is through a series of online conversations. This innovative approach offers a safe space where staff from across all areas of the Trust can share their views and will help us make sure that everyone has a voice.

The quality of our services along with the safety of the people who use them, and our staff, is our main priority. We are fortunate to work with committed staff and supportive partner organisations and commissioners. We also benefit from the expertise and experience of service users, carers and governors. Together we will continue to work towards achieving our goals and continuing to provide the best possible care for the people who use our services.

Miriam Harte	**Colin Martin**
Chairman	**Chief Executive**
21st May 2019	**21st May 2019**

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 goas, 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 our organisation. We met our financial requirements and continued to improve against a number of key performance targets.

Colin Martin
Chief Executive **21st May 2019**

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.

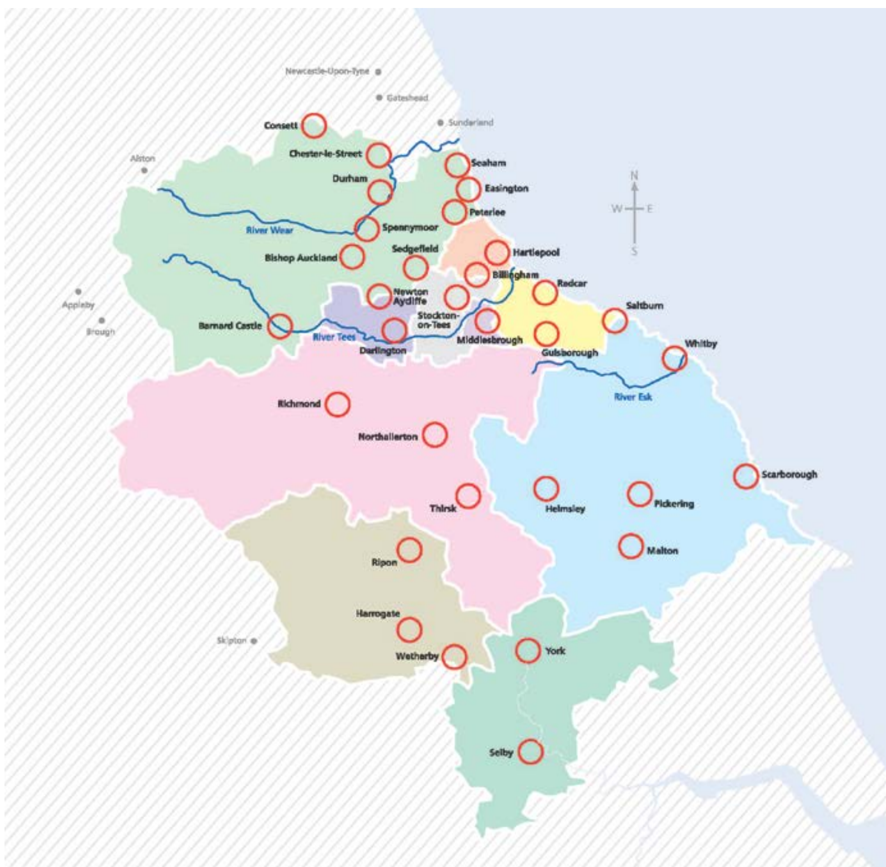
We provide a range of inpatient and community mental health and learning disability services for approximately two million people of all ages living in

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

        - Selby
        - Harrogate and Ripon
    - 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 in North East England, Cumbria and Lancashire.

The area we serve



The TEWV approach

Vision
The Trust's vision is:
To be a recognised centre of excellence with high quality staff providing high quality services that exceed people's expectations.

Mission
The Trust's mission is:
To improve people's lives by minimising the impact of mental ill-health or a learning disability.

Strategic Goals
The mission and vision drives our strategic and operational plans through five strategic goals – these are the things that drive our priorities:

- **To improve the quality of life of service users and their carers by working with them to provide excellent services**
- **To continuously improve the quality and value of our work**
- **To recruit, develop and retain a skilled, compassionate and motivated workforce**
- **To have effective partnerships with local, national and international organisations for the benefit of the communities we serve**
- **To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of the communities we serve.**

The diagram on the next page shows how our mission, which is recovery focussed, is underpinned by our strategic goals, strategic priorities, operational priorities and Quality Account priorities

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.

Diagram 1 – TEWV Strategic Direction

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

Mission: To improve people's lives by minimising the impact of mental ill-health or a learning disability.
Overarching Priority: Implement a recovery-focussed approach across all services

Strategic Goal 1: To improve the quality of life of service users and their carers by working with them to provide excellent services

Strategic Priority 1: Develop and implement a trauma-informed care approach across our services

Operational Priorities:

- Develop and implement a Trust-wide approach to enabling people who have autism to access mental health services
- Complete the transformation of our York and Selby services
- Implement the agreed delivery model for people living in Hambleton and Richmondshire who require our services
- Improve the physical environment at Roseberry Park Hospital
- Implement the NHS Long Term Plan for Mental Health as agreed with each of our Commissioners

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

Strategic Priority 2
Ensure we have the right care provided in the right place

Quality Account Priorities

- Further improve the clinical effectiveness and patient experience at times of transition from CYP to AMH services
- Make Care Plans more Personal
- Develop a Trust-wide approach to dual diagnosis which ensures that people with substance misuse issues can access appropriate and effective mental health services
- Reduce the number of preventable deaths
- Review our Urgent Care services and identify a future model for delivery

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

Strategic Priority 3
Ensure we have the right staffing for our services now and in the future

Strategic Priority 4
Make a Difference Together by embedding TEWV's values and behaviours throughout the organisation

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

Operational Priorities:

- Implement the Transforming Care Agenda
- Implement the agreed future delivery model for people living in Harrogate and Rural District / Wetherby who require our services

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

Strategic Priority 5
Deliver our Digital Transformation Strategy

Strategic Priority 6
Identify and reduce waste

The Trust has a number of strategies that set out our high level approach to achieving our strategic goals. These cover 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. In 2014 we set up Positive Individual Proactive Support Limited (PIPS) as a wholly-owned subsidiary company to address a gap in market provision for social care for individual service users with highly complex health and social care needs.

Our services

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

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

- Durham and Darlington
- Teesside
- North Yorkshire and York

There is a fourth directorate covering forensic and offender health 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
- adult learning disability services

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

Potential changes to service models and the provider landscape
The recently published NHS Long Term Plan published in January 2019 sets out how the NHS will use the additional funding allocated to it to meet the pressures that staff face and accelerate the redesign of patient care to future proof the NHS for the decade ahead. The Long Term Plan builds upon earlier guidance/policy documents , 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 prevention and address inequalities in the wider health and social care economy
- The greater integration of services and how this can be achieved through new models of care, particularly in terms of services being integrated with Primary Care Services
- 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 elements of the Long Term Plan. However there are number of risks associated with this. Firstly, 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 but to meet other demands such as increasing Continuing Health Care expenditure. This could result in key new services not being available at the anticipated levels. Furthermore there is a risk that the workforce required to implement the ambitions within the Long Term Plan 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 continued drive to improve access to services, for community, crisis and inpatient services, is also welcome and indeed the Trust has prioritised access to services for a significant number of years. However there remain 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 3 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 Long Term Plan, 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 3 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 Mental Health and Learning Disability Strategic Partnership 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. This is to ensure that there is increased clinical engagement into commissioning decisions with the aim of ensuring the commissioning budgets are used to best effect.
- 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 North Cumbria 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 Strategic Partnerships, 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.

- The Budget in November 2018 announced that revisions to borrowing and growth created “fiscal windfall” to provide additional NHS revenue funding of £20.5bn.
- Commitment that Mental Health Funding will grow as an overall share of NHS Budget over next five years; a key priority for the10 year Plan. In financial terms this commitment to Mental Health Investment Standard means each CCG must provide the equivalent of their overall CCG Allocation Growth plus (0.7%) into mental health services.
- Whilst funding for NHS services has been ring-fenced, this is not the case for our partners e.g. local authorities. The savings they are required to make will create financial pressures for us going forward.
- In terms of annual efficiency the productivity requirement was 1.1% for 2019/20 compared to 2.2% in recent years. This will help the Trust as it reduce our annual requirement to find new savings but will still be challenging in light of the new services the Trust will be required to deliver as part of the 10 year Plan.
- NHS Improvement quarter 3 report for NHS Providers showed a year to date deficit of £1.3bn that was £0.4bn worse than plan mainly as a result of the financial performance of Acute Trusts. This net forecast position is £931m including the Provider Sustainability Fund.

To seek to mitigate these risks we will:

- Invest in digital transformation as a means of improving efficiency in the future.
- 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.

Our excellent reference costs and strong track record on financial delivery mean that we are in a relatively strong position to respond to the challenges above.

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 and participated in the NHS Improvement led Staff Retention Support Programme
- Has identified and implemented revised and innovative recruitment processes and incentives
- Has implemented 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
- Has introduced a new process to better understand the reasons why staff leave and as part of efforts to improve staff retention
- Is reviewing Trust communications as part of efforts to increase engagement with staff
- Has invested in crowdsourcing to help improve employment policy and practice and to increase the level of staff engagement

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. 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 used the contractual framework available to try to seek resolution to these issues prior to TVH Limited, the Project Company, going into administration on 14 March 2018.

The PFI contract was automatically terminated on 27 September 2018 meaning that the Trust took back full control of the site.

The Trust has utilised experts to help specify the schedule of defects that needs to be rectified and has put in place a process to select a contractor to commence on-site in summer 2019. The final level of defect rectification will only be fully understood as each block is worked on, as the current schedule of work is based upon surveys.

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 and look forward to bring service users back to Roseberry Park from outlying facilities that are being used in the intervening period..

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 2019-20 annual plan provides for a surplus of £5.5m (1.5% 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

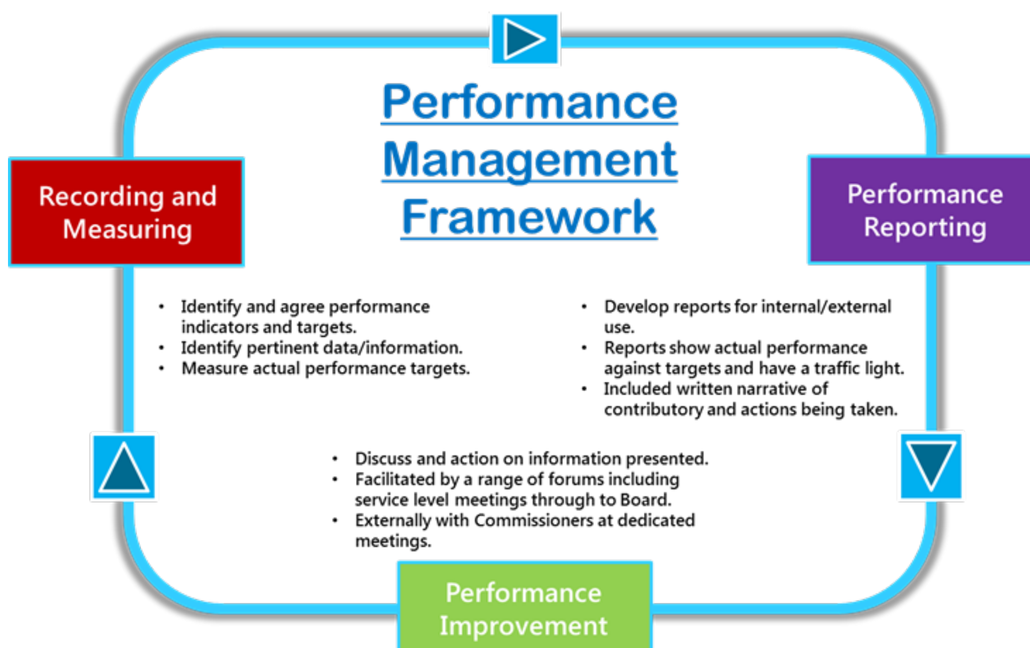
Each year the Board of Directors sets a number of stretching targets (key performance indicators) for the Trust to work towards as part of its commitment to year-on-year improvement. This is undertaken as part of the annual business planning framework where members of the Board, Senior Operational and 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 and carers, the 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 through 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" which demonstrates progress against the key performance indicators agreed in the contract.

In summary we use a range of 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.



The Trust has developed an Integrated Information Centre (IIC) which is a data warehouse which integrates data from a wide range of source systems e.g. patient information, finance, workforce and incidents. This allows a more pro-active response to managing performance through the availability of near real-time information.

The Trust is currently reviewing the Performance Management Framework to ensure it continues to reflect best practice and utilises the most effective tools available. This includes the development of Statistical Process Charts (SPC) to understand performance data and whether improvement has in fact occurred.

How we performed

Performance against key targets

The table below is the Trust's dashboard of key performance indicators for 2018/19. The Board received a monthly performance report during 2018/19 which contained performance against this range of indicators.

1.Quality	2018/19 Actual	2018/19 Target	2017/18 Actual	Change on 17/18*	Improvement / Deterioration on 2018/19
Percentage of patients who were seen within 4 weeks for a first appointment following an external referral	86.82%	90%	90.73%	3.91%	↓
Percentage of patients starting "treatment" within 6 weeks of external referral	54.82%	60%	51.89%	2.93%	↑
The total number of inappropriate Out of Area Placement days over the reporting period (Rolling 3 months)	874	2,264	N/A	N/A	New KPI 18/19
Percentage of patients surveyed	91.41%	92.45%	91.56%	0.15%	↓

reporting their overall experience as excellent or good					
Number of unexpected deaths classed as a serious incident per 10,000 open cases	21.31	12	16.34	4.97	↓
The % teams achieving the agreed improvement benchmarks for HoNOS (clinical outcome measure) total score	59.41%	67.25%	N/A	N/A	New KPI 18/19
The % teams achieving the agreed improvement benchmarks for SWEMWBS (patient reported outcome measure	67.38%	78.25%	N/A	N/A	New KPI 18/19
2.Activity	**2018/19 Actual**	**2018/19 Target**	**2017/18 Actual**	**Change on 17/18***	**Improvement / Deterioration on 2018/19**
Number of new unique patients referred	83,472	N/A	76,871	6,601	↑
The number of new unique patients referred with an assessment completed	51,553	N/A	48,014	3,539	↑
Number of new unique patients referred and taken on for treatment	18,742	N/A	17,048	1,694	↑
Number unique patients referred who received treatment and were discharged	27,682	N/A	24,210	3,472	↑
Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	93.06%	85%	86.63%	6.43%	↓
Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH & MHSOP A&T Wards (Snapshot)	48	68	N/A	N/A	Snapshot
Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)	22.86%	23.93%	N/A	N/A	KPI changed in 18/19 so comparison not possible
3.Workforce	**2018/19 Actual**	**2018/19 Target**	**2017/18 Actual**	**Change on 17/18***	**Improvement / Deterioration on 2018/19**
Actual number of workforce in month (Establishment 95%-100%)	92.38%	95%	93.83%	1.45%	↓
Vacancy fill rate	78.88%	90%	N/A	N/A	New KPI for 18/19
Percentage of staff in post more than 12 months with a current appraisal	92.32%	95.00%	89.24%	3.08%	↑
Percentage compliance with mandatory and statutory training	93.23%	92.00%	90.75%	2.48%	↑
Percentage sickness absence rate (month behind)	5.03%	4.50%	5.18%	0.15%	↑
4. Money	**2018/19 Actual**	**2018/19 Target**	**2017/18 Actual**	**Change on 17/18***	**Improvement / Deterioration on 2018/19**
Delivery of our financial plan (I and E)	58,365	9,864	-24,438	82,803	↑

CRES delivery	8,172	8,241,	6,328	1,844	🡅
Cash against plan	72,728	59,764	58,415	14,313	🡅

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

Notes

- **Percentage of patients who were seen within 4 weeks for a 1st appointment following an external referral** - the Trust position for the financial year is 86.82% which has not met the annual target of 90.00% and a deterioration on the annual outturn for 2017/18 which was 90.73%. Where there are areas of concern, plans are in place to address these. This performance position is also linked to the increase seen in the number of unique referrals received.

- **Percentage of patients starting treatment within 6 weeks of an external referral -** the Trust position for the financial year is 54.82% which has not met the annual target of 60.00% however is an improvement on the 51.89% outturn for 2017/18. Focused work continues in all localities to identify and address issues in this area. This performance position is also linked to the increase seen in the number of unique referrals received.

- **The total number of inappropriate Out of Area Placement (OAP) days over the reporting period (rolling 3 months) -** this indicator measures the number of days a patient spends in a hospital within the Trust that is not the one to which we would expect them to have been admitted. This would be because there were no beds available in the hospital we would have expected them to have been admitted to. The Trust position for the financial year is 874 days, which has met the annual target of 2,264. Action plans are in place to reduce the number of inappropriate out of area admissions and a good reduction has been seen in the latter part of 2017/18. In addition there has been no inappropriate Out of Trust placements within the year.

- **Percentage of patients surveyed reporting their overall experience as excellent or good** - the Trust position for the financial year is 91.41% with has not met the annual target of 92.45%. This is similar to the 91.56% outturn recorded for 2017/18. Work continues within each locality to review performance against this indictor 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 21.31 deaths per 10,000 open cases and an increase on the 16.34 outturn reported for 2017/18.The Patient Safety Team has monitored this information and identified no particular patterns or themes.

- **The percentage % teams achieving the agreed improvement benchmarks for HoNOS total score –** this is a clinical outcome measure; an improvement in HoNOS is shown by an increase in the patient's actual HoNOS score. The change is identified by comparing the first HoNOS score calculated on admission, and the score on discharge. The Trust position for the financial year is 59.41% which has not met the

annual target of 67.25%. Work continues with the services to improve understanding and support increased ownership which this includes the establishment of a Trust-wide all speciality clinical outcomes group.

- **The percentage % teams achieving the agreed improvement benchmarks for SWEMWBS** - this is a patient reported outcome measure; an improvement in SWEMWBS is shown by an increase in the patient's actual SWEMWBS score. The change is identified by comparing the first SWEMWBS score calculated on admission, and the score on discharge. The Trust position for the financial year is 67.38% which has not met the annual target of 78.25%. Work continues with the services to improve understanding and support increased ownership, this includes the establishment of a Trust-wide all speciality clinical outcomes group.

- **Number of new unique patients referred** - the Trust position for the financial year is 83,472 which is an increase on the 76,871 outturn recorded for 2017/18. No target has been set for this KPI. Trust level Statistical Process Control (SPC) charts have been developed and are starting to be used to monitor the position in addition to the data being reviewed by localities.

- **Number of new unique patients referred with an assessment completed** - the Trust position for the financial year is 51,553 which is an increase on the 48,014 outturn recorded for 2017/18. Trust level Statistical Process Control (SPC) charts have been developed and are starting to be used to monitor the position in addition to the data being reviewed by localities.

- **Number of new unique patients referred and taken on for treatment** - the Trust position for the financial year is 18,742 which is an increase on the 17,048 outturn recorded for 2017/18. No target has been set for this KPI. Trust level Statistical Process Control (SPC) charts have been developed and are starting to be used to monitor the position in addition to the data being reviewed by localities.

- **Number of new unique patients referred who received treatment and were discharged** - the Trust position for the financial year is 27,682 which is an increase on the 24,210 outturn recorded for 2017/18. Trust level Statistical Process Control (SPC) charts have been developed and are starting to be used to monitor the position in addition to the data being reviewed by localities.

- **Bed Occupancy –** the Trust has not achieved the target in 2018/19, reporting 93.06% for the financial year against a target of 85.00% with all localities reporting above target. This is a deterioration on the 86.63% outturn reported for 2017/18. All localities are monitoring this on a continual basis and actions are discussed and agreed on a daily basis

- **Number of patients occupying a bed with a length of stay (from admission) greater than 90 days** - the Trust has achieved the target in 2018/19, reporting 48 against the annual target of 68, this is the lowest position recorded since 2016/17. The services continually review patients with a long length of stay to ensure appropriate plans are in place for discharge and appropriate 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 22.86% which has met the annual target of 23.93%.. 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. Analysis of patterns and trends has been completed to improve understanding of issues in this area to inform further work.

- **Actual number of workforce in month (Establishment 95% - 100%)** - the Trust position for the financial year is 92.38% which has not met the annual target of 95.00%, and is a reduction on the 2017/18 outturn of 93.83%. Work is ongoing to maximise all recruitment and workforce planning opportunities within the Trust.

- **Vacancy fill rate** - the Trust position for the financial year is 78.88%, which has not met the annual target of 90.00%.

- **Percentage of staff in post more than 12 months with a current appraisal** – the Trust has under-performed against the 95% target with an outturn of 92.32%. However this is an improvement on the 89.24% outturn reported for 2017/18. 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 met the 92% target with an outturn of 93.23% which is an improvement on the 90.75% outturn reported for 2017/18. The use of operational management huddles is now embedded across the Trust which is having a positive impact on performance.

- **Percentage sickness absence rate** – the Trust has under-performed against the 4.50% target with an outturn of 5.03%. This is an improvement in performance compared to the 2017/18 outturn position of 5.18%. A revised procedure is currently being developed and plans to revise ways of working will be implemented as soon as this process is complete. Work is also underway to review the Occupational Health provision which is due for retendering in 2018/19.

- **Delivery of our financial plan (I and E) -** The comprehensive income outturn for the period ending 31 March 2019 was a surplus of £58,365k, representing 15.0% of the Trust's turnover and was £48,501k ahead of plan.

- **CRES Delivery (snapshot) -** Identified Cash Releasing Efficiency Savings at 31 March 2019 was £6,480k and was £1,761k behind plan for the year. The NHS Improvement reduction in the Trust's annual control total of £1,692k has non-recurrently mitigated the shortfall on CRES delivery. As a result CRES was £69k behind plan at the financial year end. The Trust continues to identify and develop schemes to ensure the full delivery of the next 3 years CRES requirements

- **Cash against plan -** Total cash at 31 March 2019 was £72,728k and was £12,956k higher than planned, largely due to working capital variations and the surplus position being higher than plan

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 in 2019/20 will develop an 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.

The Trust in partnership with a multi-national business solutions provider are in the final stages of completing the installation of three combined heat and power units at Roseberry Park, West Park and Lanchester Road. The units convert gas into electricity and provide subsequent free heating for the hospitals. This in turn will greatly assist the Trust in our attempt to achieve its obligation in meeting the NHS 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 29 qualifying properties surveyed, 12 of the buildings were rated C and above with only 4 properties failing to achieve the typical.

Using assisted funding provided by The Office of Low Emission Vehicles, the Trust has increased the availability of electric vehicle charging points strategically across our sites. We has used the maximum permitted available funding and increased the number of plug in points from sixteen to twenty six in the last 12 months. The Trust is also awaiting delivery for estates purposes of its first 100% electric powered vehicle.

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

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 recently been awarded a grant from the Health Foundation to work with the British Institute of Human Rights to embed a rights based approach to decision making within the trust's Recovery programme. This work builds on work previously carried out with the Early Intervention in Psychosis teams. The trust believes that a Human Rights based approach to decision making within our organisation will support us to:

- Provide a legal framework for services to support our ability to share decisions with service users and carers
- Supports us to consider human rights within the process of decision making, ensuring if we are in a position where we need to restrict an individual's human rights, the action is least restrictive and proportionate to the situation
- Provides the organisation, teams and services with a framework to better support the implementation of a harm minimisation approach to managing risk and supporting safety in the least restrictive way
- Reduce avoidable iatrogenic harm caused by services

- Promote empowerment and reduce disempowerment of individuals accessing our services

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 continues to review 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 **21st May 2019**

The Directors' Report
The Chairman, Deputy Chairman, Chief Executive and other Board Members as at 31st March 2019

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 2019*
Date of Initial appointment: 1 April 2014

(Note: The Chairman had no other material commitments 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. .
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 the Director of The National Registers of Communication Professionals working with Deaf and Deafblind People (NRCPD) and a former Colonel in the British Army. He has extensive command and operations experience in the military and his 30 years' service culminated in a number of senior programme and change management roles in the Ministry of Defence and the Home Office. Prior to his current role at NRCPD he was most recently the Northern Area Manager for the Royal British Legion and Head of Risk and Compliance at AgeUK.
Qualifications: BEng(Hons) Chemical Engineering, MSc Design of Information Systems, Postgraduate Diploma in Law and a 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, 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
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)

Ruth Hill, Chief Operating Officer
Ruth has over 25 years' experience in the NHS and local government, including her role as director of operations in York and Selby at the Trust. Ruth has also worked in commissioning, quality improvement, public health and service development in a number of roles across the North East.
Qualifications: Masters, Nye Bevan Programme
Principal Skills and Expertise: Service improvement, coaching, management and leadership skills, quality improvement, operational delivery.
Appointed: August 2018

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 and a Master Coach. 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

Patrick McGahon, Director of Finance and Information
Patrick started his career in local government before moving to the NHS in the 1994. He has been an NHS Board director for over 20 years mainly in provider organisations and was previously the director of finance for the NHS Business Services Authority.
He is a Chairman of Carlisle College, part of the NCG Group.
Qualifications: Qualified accountant, CPFA, BA(Econ) (Hons) and MBA.
Principal Skills & Expertise: Strategy development including corporate, financial and informatics, financial turnaround, contract management and commercial, systems development, service development, shared services, performance management and PFI finance.
Appointed: April 2018

Elizabeth Moody, Director of Nursing and Governance
Elizabeth was delighted to join the Trust in July 2015 as Director of Nursing and Governance. She has over 25 years' experience in the NHS having registered as an RMN in 1991. Elizabeth has held a variety of clinical, professional and managerial roles across inpatient and community settings and before joining the Trust worked in the region as the Deputy Director of Nursing and then Group Nurse Director for 11 years. She is now the Deputy Chief Executive of the Trust.
Elizabeth is responsible at Board level for the professional leadership of nursing, quality and safety. She is a Certified Leader and Think On coach.
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

- Lesley Bessant retired from the Board of Directors on 31st March 2019 and was replaced as the Chairman of the Trust by Miriam Harte.
  Miriam has a wealth of experience in the NHS having spent the last 12 years as a non-executive director. She was on the Board at City Hospitals Sunderland NHS Foundation Trust for nine years and, most recently, was a non-executive director with Northumberland, Tyne and Wear NHS Foundation Trust. She is also a chartered accountant and has extensive business experience.

- Mr. Brent Kilmurray left the Trust in July 2019 to take up the position of Chief Executive of Bradford District Care NHS Foundation Trust.
  From December 2017, Mr. Kilmurray had stepped back from his substantive role as the Chief Operating Officer but had remained a Board Member as the Deputy Chief Executive.
  Ruth Hill replaced him as the Trust's Chief Operating Officer with Elizabeth Moody being appointed as the Deputy Chief Executive.

Compliance with accounting guidance

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 2018-19.

Accounting policies for pensions and other retirement benefits are set out in page 10 and 11 in the accounts and details of senior managers remuneration can be found on 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 2018-19 was as follows:

	2018-19	
	Number of Invoices	**Value of invoices £000s**
NHS Creditors		
Total bills paid	825	14,285
Total bills paid within target	619	11,534
Percentage of bills paid within target	75.0%	80.7%
Non-NHS Creditors		
Total bills paid	52,768	91,207
Total bills paid within target	49,253	83,049
Percentage of bills paid within target	93.3%	91.1%

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.

The total potential liability to pay interest on invoices paid after their due date during 2018-19 would be £1,251,742, an increase on 2017-18 amounts (£1,005,158). There have been minimal claims under this legislation, therefore the liability is only included within the accounts when a claim is received.

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 skilled 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 each of the Trust's Localities (County Durham and Darlington, Tees, North Yorkshire and York 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

These arrangements are designed to:
- Continually provide assurance on the quality of services to the Board of Directors.
- Deliver 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, are 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, including a shadow board, 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 and quality account priorities (see “The Quality Report”) are identified and agreed.

For 2018/19 our strategic and quality account priorities included:

Strategic Priorities
- Implementation of Phase 2 of the Trust’s Recovery Strategy (years 4-6 of 10) and development of Phase 3

- Development and delivery of the Purposeful and Productive Community Services Programme (PPCS)
- Improvements to the consistency and purposefulness of inpatient care across the Trust
- Ensuring right staffing for our services now and in the future
- Delivery of the Digital Transformation Strategy
- Implementation of procedures and and guidances to support and encourage staff to identify and escalate instances where our values are not being practiced

Quality Account Priorities

- Further improving the clinical effectiveness and patient experience at times of transition from CYP to AMH services
- Making care plans more personal
- Developing a Trust-wide approach to dual diagnosis which ensures that people with substance misuse issues can access appropriate and effective mental health services;
- Reducing the number of preventable deaths

Delivery of the priorities is 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
- Training, development and supervision
- An open learning approach
- The application of the Duty of Candour
- Our focus on coaching which supports staff reflect on their own thoughts; problem solve; and make more effective decisions for themselves and with those they work with.

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 set out the membership, roles and responsibilities of the LMGBS, QuAGs, SDGs and Thematic Quality Groups.
- The Trust's programme and project management arrangements
- The suite of policies and procedures

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.

- **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.

- **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, the transformation of services in North Yorkshire.

- The national patient survey
- Work to embed the triangle of care
- 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 the development of integrated care systems and partnerships and other joint arrangements with commissioners and other providers
- Membership of the northern regional collaborative of nine trusts to support learning from deaths
- Membership and participation in local safeguarding boards
- Regular meetings with representatives of local healthwatch
- Bespoke engagement to support our business plan priorities including new capital developments

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

- The CQC assessment, from its inspection in June/July 2018, 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 2018/19 that there was "… 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 consistently achieved the metrics with the exception of IAPT recovery rate and People with a first episode of psychosis begin treatment with a NICE recommended package of care within 2 weeks of referral, each of which failed to achieve target for one month during the year however all targets were met for each quarter.

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 and progress against the 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 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 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 commenced 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 patient safety team, the compliance team, complaints and PALS teams, clinical audit and effectiveness

team, quality data team and patient and carer experience team. The regulatory compliance team implements a programme of peer and service user inspections across Trust services to monitor the quality of service delivery against the regulatory fundamental standards. All corporate teams then also monitor quality improvement action plans developed from the performance deficits and risks identified and report into the Trustwide assurance groups and the Quality Assurance Committee. Key information on the CQC activity and ratings for the Trust along with data on complaints and incidents can be found within the Quality Report section of this report. The Quality Compliance Group established during 2016/17 further supports quality assurance and improvement in line with CQC requirements. It is chaired by the Director of Quality Governance and attendance includes 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 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.

Progress of 2018/19 Quality Priorities:
Transitions:

- Registered CAMHS and AMH staff have undertaken further specific training on the transitions process
- The Trust intended to undertake a thematic review of patient stories then produce plans to improve the transition experience of young people. The Trust were able to collect very few transitions stories from service users so instead collected their feedback and views using a structured questionnaire
- Transition panels across all localities were reviewed and the additional Service User feedback used to set relevant targets and metrics for 2019/20
- An engagement plan was produced to involve family and carers more in the transition process

Improve the Personalisation of Care Planning:

- An in-depth quality focused audit of the Care Programme Approach was completed and learning from this reported across the trust.

- A co-produced action plan was the developed based on the findings
- Simple guidance, along with examples of best practice care plans, were circulated to staff
- New "shared decision making" training is being rolled out across the organisation. This is being collaboratively delivered with Experts by Experience
- TEWV has committed to introducing the "Dialogue+" system which is successfully used in East London

Develop a Trust-wide approach to dual diagnosis which ensures that people with substance misuse issues can access appropriate and effective mental health services

- A Dual Diagnosis Clinical Link Pathway was reviewed by all specialties
- A new policy 'Management of coexisting mental illness and substance misuse (Dual Diagnosis)'was agreed in November 2018
- An Extraordinary Drug Related Incident Directors Panel commenced in November 2018 and will continue to meet bi-annually
- A protocol 'Management of Substance Misuse in Inpatient Settings' was developed and is being implemented across the trust

Reduce the number of Preventable Deaths

- A co-produced family/carer version of the learning from deaths policy was developed
- An engagement plan to involve family, carers and non-Executive Directors was developed
- A family conference was held in conjunction with Leeds and York Partnership FT in March 2019.
- The Patient Safety Team have evaluated the level and effectiveness of engagement with families, carers and Non-Executive Directors

Progress towards targets agreed with local commissioners

The Trust provides regular performance information to its commissioners as part of the mental health contract covering activity, key performance indicators and measures of quality. The Trust's commitment to contract performance management is evidenced through monthly contract meetings, and sub groups with commissioners which are regularly attended and have full participation of senior staff. 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 18/19 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 2018/19 financial year for the 9 core CCGs; however there were some exceptions. 'People with a first episode of

psychosis begin treatment with a NICE recommended package of care within 2 weeks of referral' was not achieved for the three North Yorkshire CCGs:

- Hambleton, Richmondshire & Whitby CCG achieved 33.33% against a target of 50%.
- Harrogate & Rural District CCG achieved 28.57% against a target of 50%.
- Scarborough & Ryedale CCG achieved 15.38% against a target of 50%.

Staff capacity (sickness and vacancies) within those teams was the primary reason for this under-performance. Remedial action was undertaken during the year and action plans were developed. This included reviewing job plans, increasing staff hours and the provision of support from other teams for urgent cases.

'People with a first episode of psychosis begin treatment with a NICE recommended package of care within 2 weeks of referral' was also below target for Vale of York CCG where they achieved 45.65% against a target of 50%. This was also attributable to staff capacity as the teams carried a number or vacancies during the year. A deep dive investigation was undertaken by the service and an action plan put in place.

'Percentage CPA 7 day follow up (adult services)' was below target for Harrogate & Rural District CCG where they achieved 94.86% against a target of 95%. In a number of cases, this was attributable to the team being unable to make contact with the patient within the set timescale; however the majority were attributable to a breakdown in process and actions are being taken within the service to prevent future recurrence.

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 2018/19 we:

- Delivered the actions set out in our Quality Account improvement priorities
- Developed and rolled out the frailty Clinical Link Pathway (CliP) Trust-wide
- Produced example scenarios for staff regarding safeguarding around abuse disclosures. It is hoped that these will be used to support good practice and reduce staff worries around having conversations about trauma
- were awarded a Stage 1 award by The Carer's Trust recognising commitment to becoming an organisation that involves and supports carers through implementation of the Triangle of Care (ToC). The Carer's Trust said the progress made by services over the past year has been impressive and encouraging
- Commenced construction of the new purpose-designed 72-bed hospital located off Haxby Road in York. It will provide two adult single-sex wards and two older people's wards
- Secured funding from NHS England to introduce a new community perinatal mental health services across County Durham and Darlington, North Yorkshire and the Vale of York. We were part of a successful bid with local CCGs and services will support local women who are experiencing mental health difficulties during pregnancy or in the first year after they have had their baby. In addition, the bid includes funding to expand on services that the Trust already provides in Teesside.

- Won the Liaison & Diversion Tenders for the Durham, Cleveland and North Yorkshire Police Force areas. In North Yorkshire and York this will be a new service which commenced on 1st April 2019. TEWV is working in partnership with HumanKind and Spectrum Community Health to deliver this service.
- Launched an area on the Recovery College online for young people providing information and resources, including for parents and carers
- Secured funding for Individual Placement and Support services which will help people with mental health issues stay well by giving them meaningful work opportunities
- Trained several Forensic Services patients in quality improvement techniques so that they can participate in improvement techniques
- Held an Annual Recovery event for Forensic wards in February 2018, enabling service users, friends and family and staff to celebrate service user achievements, recognising individual small steps
- Held a Rapid Process Improvement Workshop (RPIW) which reviewed the current Care Planning Approach, to make the process more patient-focused

New and significantly revised services

We have included information about new and significantly revised services in the Foreword to this report and some are mentioned in the section above including:

- New perinatal mental health services in North Yorkshire, County Durham and Darlington
- A two year contract to deliver mental health and substance misuse services with HMP Haverigg.
- The contract to provide liaison and diversion services across the Trust.
- Development of our CAMHS crisis service across North Yorkshire and York
- Development of adult and older people's community services in Hambleton and Richmondshire and transfer of inpatient beds from Northallerton

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

We gain important feedback from patient and carer surveys, as well as CQC reports, which enable us to focus improvements on specific wards and services for instance:

- Adult mental health services: Patients stated that they need more written information on Services and a better handover to other services. A staff directory booklet and a patient and carer information booklet were implemented to disseminate to service users. In our 2018 inspection the CQC highlighted that there sometimes were not enough activities on the wards for patients to engage in – work has been undertaken to improve this across services who will have a weekly activity schedule in place with a wide range of activities.

- Children and young people's inpatient services: Carers reported that meetings were difficult to attend due to distance. Carers were informed that work was going on in relation to utilising SKYPE for meetings and once the safety issues had been resolved carers would be informed of this option. Following our latest CQC inspection we have fully redecorated the sensory room on the Holly Unit and purchased new equipment.

- Mental health services for older people - inpatients: Patients stated that they would like nicer coffee. The ward had a taste test with different coffees and ordered another brand following the results.

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.

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 provider-led management of NHSE commissioning budgets. We have active projects in adult secure (forensic) and children and young people's specialist inpatient services. We have continued to invest resources into crisis / intensive home treatment teams for under 18s across the area served the Trust and a reduction in admissions, and set up a regional process to manage Forensic admissions.
- Our involvement in the development of strategic commissioning partnerships: - one with the CCGs across Durham, Darlington and Teesside and a second with the North Yorkshire CCGs. This has enabled mental health spending to be ringfenced and improved the quality of case management reviews. It is starting to reduce duplication between commissioning and provider planning work.
- We are formal research partners of 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), and learning disabilities.
- 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 the Cumbria & North East; West Yorkshire & Harrogate; and Humber Coast and Vale Integrated Care Systems as they develop plans for mental health and learning disability services. This has included supporting work on improving the physical health of service users
- We are an active member of the 3 Crisis Care Concordat groups which cover the area we serve which has helped us to build closer relationships with other health provides, ambulance services and police forces.
- 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)

Involving local people
We have continued to deliver an extensive programme of service user and carer involvement, building on our agreed framework and supported by our Involvement and Engagement Team.

This ranges from consultation right through to co-production with a primary focus on delivering high quality person centred services that promote recovery.

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

- Coordination of over 220 requests for involvement
- Over 100 service users or carers, registered for involvement, participating on individual interview panels for staff
- Over 300 service users and carers being formally registered to undertake a wide range of involvement activities. A recent social media comment from a service user following attendance at a national conference quoted *' I listened to amazing stories and innovations, but no Trust is even close to the level of genuine patient involvement that TEWV engage in'.* Further feedback in the annual satisfaction survey said 'The *time the Trust dedicates to involvement is excellent'*
- Service users and carers along with Governors participating in focus groups as part of the selection of the new Chairman – feedback from a facilitator of one of the groups was '*this was not tokenistic, it was real involvement with all comments listened to and taken on board by the appointing panel'*.
- 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
- A pilot development programme comprising over 25 briefings across 4 subjects co-delivered to more than 100 service users and carers. Feedback included '*It is good to know that we are able to undertake appropriate training with staff and other volunteers*'
- A service user undertaking involvement receiving the prestigious highly commended award in the Trust's annual awards in recognition of their remarkable recovery and work at Huntington House.
- City of York Council commending the Trust on the high level of service user and public engagement undertaken prior to the submission of the planning application for the new Foss Park Hospital development.
- Service users and carers promoting and celebrating services through the available NHS 70 celebrations
- The continuing co-delivery of the development programmes; Leadership for Advocates and Service Users, and the Expert by Experience Programme for Adult Mental Health Services
- Co-production with service users and staff in the opening of 'the Haven' in York.
- The participation of 16 service users and carers in 21 inspections of wards and premises under Patient Led Assessment of the Care Environment (PLACE).
- A continuing increase in the membership of steering groups, committees and local governance groups.
- An increase in the number of young people involved through participation groups. The Trust continues to reimburse them for their time and contribution in helping us improve services through the provision of a £5 high street shopping voucher for each hour they work with us.

- Service User and Carer Involvement Groups continuing 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.
- Coproduction of plans by carers to host a Trustwide carer conference and celebration event.
- Participation in service improvement events utilising the Trust Quality Improvement System's methodology.
- 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 including a recent launch of courses for young people.
- The provision of reimbursement to those service users and carers undertaking involvement activities with over £50,000 involvement payments made from processing just under 2000 forms.

A survey of involvement members to identify satisfaction and support mechanisms was undertaken in 2018/19. As a result 96% of those responding reported satisfaction with their involvement. This has highlighted an even stronger desire for those registered for involvement to develop further with a view to increasing their involvement journey aligned with the ladder of participation. However, an area for improvement is to provide engagement prior to activities and feedback on outcomes and decisions.

Consulting with local people
Last year we worked with Harrogate and Rural District CCG to review adult and older people's mental health services. The planned development of the new hospital was put on hold while we carried out this review. We listened to the views of local people who told us that whenever possible they wanted to receive the care and support they need in their home environment. On 6 December 2018 NHS Harrogate and Rural District Clinical Commissioning Group (CCG) approved proposals for the future development services. The agreed model will enable us to reinvest money in community services. It also ensures that when someone needs inpatient care they will receive it in a safe, high quality environment.

By investing in community services we will reduce the number of inpatient admissions as well as the length of time individuals need to spend in hospital. We will provide inpatient services in a specialist facility elsewhere within TEWV and this is likely to be in York where we are already building a new mental health hospital.
We appreciate that a number of people felt it was important to have an inpatient unit in Harrogate and we explored a range of options for doing this. However, we concluded that the approved model was the only option that will allow us to maximise patient safety and patient experience, whilst remaining true to our commitment to providing care as close to home as possible.

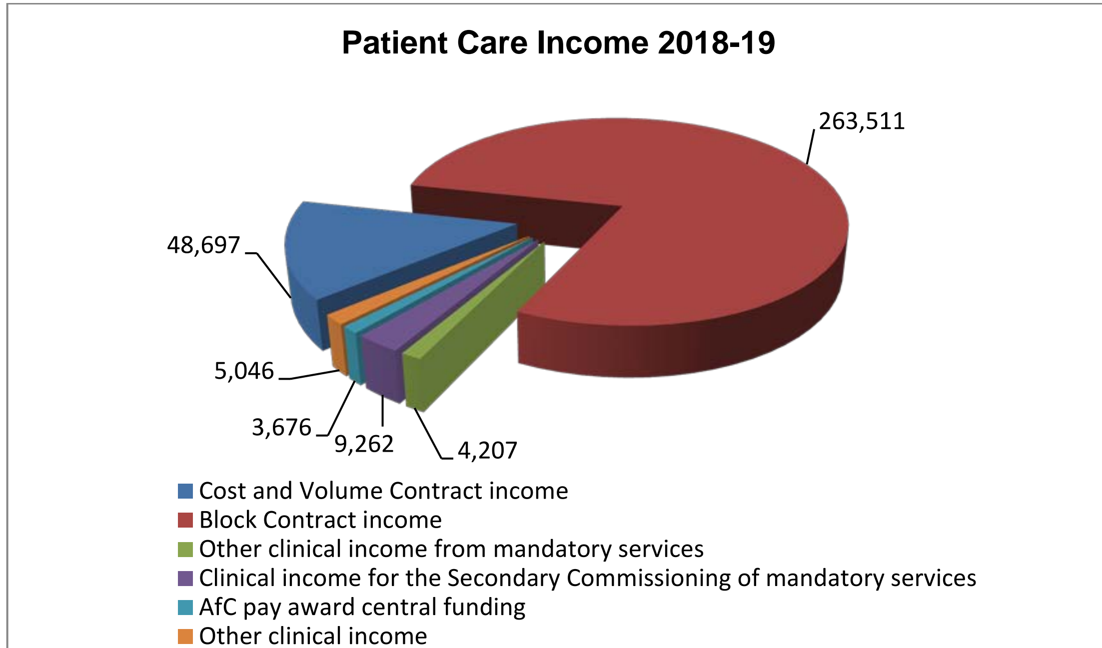
Over the coming months we will work with local people to develop a model for community services.

Fees and charges

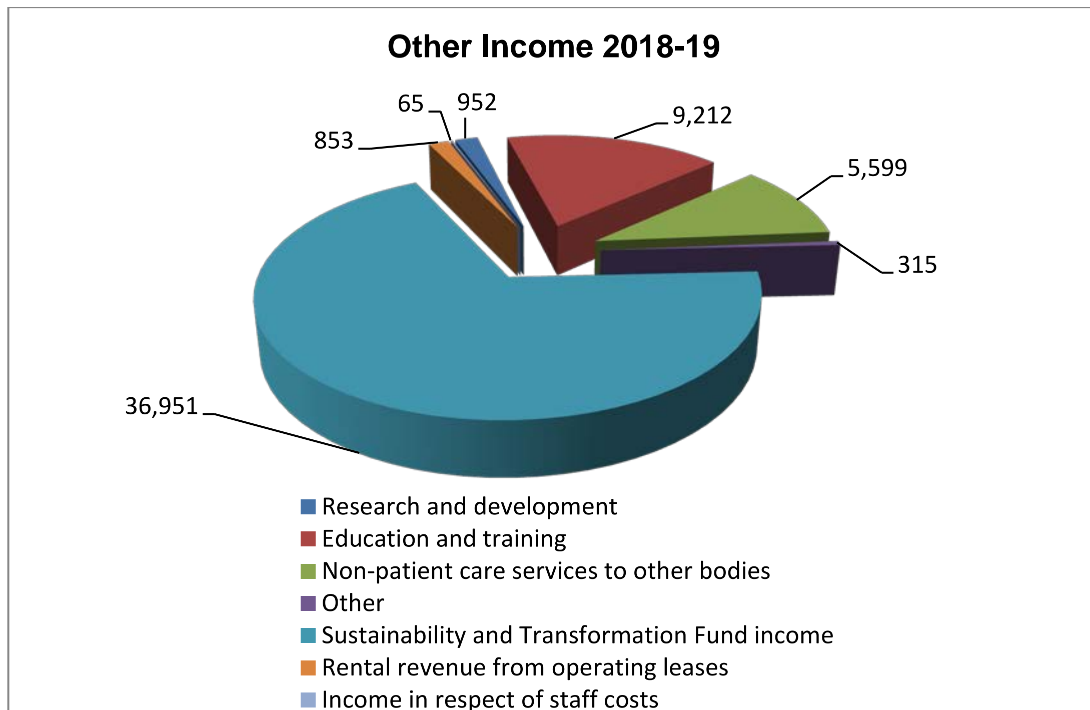
The Trust received no income from fees and charges.

Income Generation

During 2018-19, income generated was £334.4m from a range of activities; 86.1% from direct patient care. Patient care income came from the following areas:



There was a further £53.9m from the provider sustainability fund, education, and other non-patient care services.



As shown above, the Trust's income from the provision of goods and services for the purposes of the health service in the UK was greater than its income from the

provision of goods and services for any other purposes. This income had no negative impact on the provision of health services.

Statement as to disclosure to Auditors

Each of the directors, holding office on 31st March 2019, 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 2018/19 the Committee made a basic pay cost of living increase of £2.075 per annum to those senior managers covered by the EMT Pay Framework. This amount was the same as the cost of living increase awarded to those staff employed on national Agenda for Change Bands pay bands 8C, 8D and 9.

Details of the salaries and allowances and pension benefits of senior managers in 2018/19 and payments made to past senior managers are provided in the tables in this section.

Miriam Harte
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 2018/19.

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 in 2014, updated by any subsequent cost of living increases, and are equivalent to 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 £1,669,775. 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 2018/19.
Allowances	A Directors Travel Allowance of £5,444 is included within basic pay. A temporary (2 years) travel allowance of £6,000 is included for one Director.

Provisions for the recovery of sums paid to Directors or for withholding payments of sums to senior managers	There is contractual provision for making appropriate deductions from notice period payments. Entitlement to pay progression, where applicable, is subject to confirmation from the individual's line manager that their performance over the preceding 12 months period has been rated as being good. The Nomination and Remuneration Committee of the Board of Directors agreed to the incorporation of an earn back clause whereby up to 10% of salary is put at risk pending an annual review of performance against objectives set.
Remuneration above £150,000	A comparison is undertaken with 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 **21st May 2019**

Senior managers' remuneration

Name and Title	2018-19 Salary (bands of £5000) £000	2018-19 Other Remuneration (bands of £5000) £000	2018-19 Benefits in Kind * Rounded to the nearest £100	2018-19 Pension related benefits (bands of £2500) £000	2018-19 Total Remuneration (bands of £5000) £000	2018-19 Expenses Paid Rounded to the nearest £100	2017-18 Salary (bands of £5000) £000	2017-18 Other Remuneration (bands of £5000) £000	2017-18 Benefits in Kind * Rounded to the nearest £100	2017-18 Pension related benefits (bands of £2500) £000	2017-18 Total Remuneration (bands of £5000) £000	2017-18 Expenses Paid Rounded to the nearest £100
Mr Colin Martin, Chief Executive	170-175	0	11,100	17.5-20.0	205-210	900	170-175	0	11,300	92.5-95.0	275-280	800
Mr Brent Kilmurray, Chief Operating Officer (left 1 December 2017) and Deputy Chief Executive (left 19 August 2018)	45-50	0	3,300	77.5-80.0	130-135	700	120-125	0	7,900	30.0-32.5	160-165	1,300
Mrs Ruth Hill, Director of Operations - York and Selby (left 31 July 2018); Chief Operating Officer (starter 1 August 2018)	115-120	0	2,200	102.5-105.0	220-225	900	100-105	0	1,600	25.0-27.5	125-130	600
Mr Patrick McGahon****, Director of Finance and Information (started 1 April 2018)	130-135	5-10	0	120.0-122.5	260-265	1,700	0	0	0	0	0	0
Mr Drew Kendall, Director of Finance and Information (left 31 March 2018)	0	0	0	0	0	0	105-110	0	2,600	0	105-110	1,300
Mrs Elizabeth Moody, Director of Nursing and Governance and Deputy Chief Executive (latter post started 20 August 2018)	110-115	0	11,400	5.0-7.5	130-135	1,800	110-115	0	10,300	27.5-30.0	145-150	1,300
Dr Ahmad Khouja**, Medical Director (started 1 March 2018)	155-160	50-55	0	155.0-157.5	365-370	4,000	5-10	10-15	0	2.5-5.0	20-25	0
Dr Nick Land, Medical Director (left 31 March 2018)	0	0	0	0	0	0	95-100	0	6,300	0	105-110	1,800
Mr David Levy, Director of Human Resources and Organisational Development	105-110	0	0	7.5-10.0	115-120	400	105-110	0	0	7.5-10.0	115-120	0
Mrs Jennifer Illingworth, Director of Quality Governance	95-100	0	6,300	17.5-20.0	125-130	1,500	95-100	0	4,500	30.0-32.5	130-135	1,700
Mrs Sharon Pickering, Director of Planning, Performance and Communications	100-105	0	10,200	17.5-20.0	125-130	1,200	95-100	0	9,100	25.0-27.5	130-135	1,000
Mr Patrick Scott, Director of Operations - County Durham and Darlington (left 31 August 2018); Director of Operations - York and Selby (started 1 September 2018, left 31 January 2019)	90-95	0	4,400	10.0-12.5	105-110	1,100	105-110	0	2,000	100.0-102.5	205-210	700
Mr David Brown, Chief Operating Officer (started 01 December 2017, left 1 August 2018); Director of Operations - York and Selby (started 1 December 2018, left 31 March 2019)	120-125	0	3,600	75.0-77.5	200-205	1,400	105-110	0	4,200	67.5-70.0	180-185	2,000
Mr Levi Buckley, Director of Operations – Forensic Services (left 31 July 2018); Director of Operations - County Durham and Darlington (started 1 August 2018)	100-105	0	0	55.0-57.5	155-160	1,200	95-100	0	0	117.5-120.0	210-215	700
Mrs Adele Coulthard, Director of Operations – North Yorkshire (left 1 September 2017); Director of Transformation - North Yorkshire (started 1 September 2017, left 3 February 2019)	85-90	0	3,400	7.5-10.0	95-100	0	95-100	0	3,300	25.0-27.5	125-130	0
Mr Tim Cate, Director of Operations – North Yorkshire (started 01 September 2017, left 31 March 2019)	70-75	0	1,200	0	70-75	1,700	55-60	0	1,000	0	55-60	1,000
Mr Dominic Gardner, Director of Operations – Teesside - started 01 December 2017	100-105	0	1,300	202.5-205.0	305-310	600	30-35	0	300	5.0-7.5	35-40	100
Mrs. Lisa Taylor, Director of Operations - Forensic Services (started 1 September 2018)	75-80	0	2,700	67.5-70.0	150-155	1,500	0	0	0	0	0	0
Mr Robert Cowell, Director of PFI Projects (left 31 August 2018); Director of Operations - Estates and Facilities Management (started 1 September 2018, left 31 March 2019)	95-100	0	3,900	0	100-105	900	95-100	0	3,100	15.0-17.5	115-120	1,900
Mr Paul Foxton, Director of Operations - Estates and Facilities Management (started 08 January 2018, left 31 August 2018)	75-80	0	1,800	0.0-2.5	75-80	1,600	20-25	0	0	0.0-2.5	20-25	600
Mr Phil Bellas, Trust Secretary	85-90	0	0	20.0-22.5	105-110	0	80-85	0	0	20.0-22.5	105-110	0
Dr Ruth Briel***, Senior Clinical Director, Kaizen Promotion Office	70-75	15-20	0	45.0-47.5	135-140	3,100	65-70	15-20	0	85.0-87.5	165-170	3,500
Mrs Sarah Dexter-Smith, Director of Therapies - started 16 October 2017	90-95	0	0	37.5-40.0	125-130	2,000	40-45	0	0	37.5-40.0	75-80	900
Mrs Lesley Bessant , Chairman - left 31 March 2019	50-55	0	0	0	50-55	4,200	50-55	0	0	0	50-55	3,400
Mr Jim Tucker, Non-Executive Director - left 31 August 2017	0	0	0	0	0	0	5-10	0	0	0	5-10	2,800
Mr Richard Simpson, Non-Executive Director	10-15	0	0	0	10-15	2,700	10-15	0	0	0	10-15	2,900
Mr Marcus Hawthorn, Non-Executive Director (Senior Independent Director)	15-20	0	0	0	15-20	0	15-20	0	0	0	15-20	100
Mr David Jennings, Non Executive Director (Head of Audit Committee from 01 November 2017)	15-20	0	0	0	15-20	1,300	15-20	0	0	0	15-20	1,200
Dr Hugh Griffiths, Non-Executive Director	10-15	0	0	0	10-15	2,800	10-15	0	0	0	10-15	1,800
Mrs Shirley Richardson, Non-Executive Director	10-15	0	0	0	10-15	2,000	10-15	0	0	0	10-15	1,500
Mr Paul Murphy, Non-Executive Director	10-15	0	0	0	10-15	1,300	10-15	0	0	0	10-15	1,900

	2018-19	2017-18
Band of highest paid directors total remuneration (£000) *****	205-210	170-175
Median of total remuneration	29,608	27,635
Ratio (Director to Median)	7.0	6.2

The above table shows the remuneration for time worked as a senior manager only. Where this was for part year (dates shown in table) the table reflects this.
* Benefits in kind are the provision of lease cars
** Other remuneration includes Additional Clinical Programmed Activity worked during the reported period (£17k) & Clinical Excellence award
*** Other remuneration includes Clinical Excellence award
**** Other remuneration includes a recruitment and retention payment
***** Pension related benefits have been excluded from this calculation, as they are not known for *all staff.

Expenses of Governors

At 31 March 2019 the Trust had 42 Governors (2017-18, 45), with 29 receiving reimbursement of expenses (2017-18, 29). The total amount reimbursed as expenses was £6,920, (£6,313 in 2017-18)

Pay Terms and Conditions

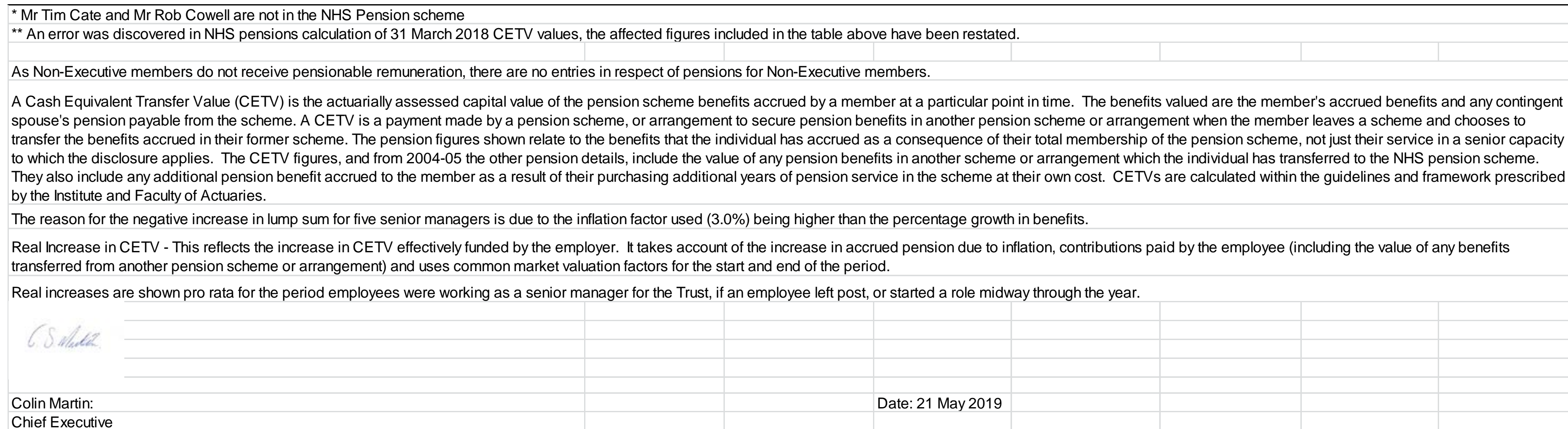
With the exception of directors, non-executives and medical staffing the workforce are covered by Agenda for Change. All inflationary uplifts for staff employed under national terms and conditions have been in accordance with nationally determined pay arrangements. All executive directors are on a permanent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

The Remuneration Committee is responsible for Executive Directors pay.

Colin Martin: Date: 21 May 2019
Chief Executive

Senior managers' pension benefits

Name and title	Real increase in pension at retirement age for time in post	Real increase in pension lump sum at retirement age for time in post	Total accrued pension at retirement age at 31 March 2019	Lump sum at retirement age related to accrued pension at 31 March 2019	Cash Equivalent Transfer Value at 31 March 2019	Cash Equivalent Transfer Value at 31 March 2018**	Real Increase in Cash Equivalent Transfer Value for time in post
	(bands of £2500) £000	(bands of £2500) £000	(bands of £5000) £000	(bands of £5000) £000	£000	£000	£000
Mr Colin Martin, Chief Executive	0.0-2.5	(2.5-5.0)	70-75	195-200	1,510	1,339	171
Mr Brent Kilmurray, Chief Operating Officer (left 1 December 2017) and Deputy Chief Executive (left 19 August 2018)	2.5-5.0	2.5-5.0	40-45	95-100	724	581	143
Mrs Ruth Hill, Director of Operations - York and Selby (left 31 July 2018); Chief Operating Officer (starter 1 August 2018)	5.0-7.5	7.5-10.0	35-40	90-95	667	507	160
Mr Patrick McGahon, Director of Finance and Information (started 1 April 2018)	5.0-7.5	10.0-12.5	50-50	130-135	1,085	866	219
Mrs Elizabeth Moody, Director of Nursing and Governance and Deputy Chief Executive (latter post started 20 August 2018)	0.0-2.5	2.5-5.0	45-50	140-145	957	833	124
Dr Ahmad Khouja, Medical Director (started 1 March 2018)	7.5-10.0	15.0-17.5	50-55	120-125	984	746	238
Mr David Levy, Director of Human Resources and Organisational Development	0.0-2.5	2.5-5.0	30-35	90-95	742	656	86
Mrs Jennifer Illingworth, Director of Quality Governance	0.0-2.5	(0.0-2.5)	30-35	75-80	611	544	67
Mrs Sharon Pickering, Director of Planning, Performance and Communications	0.0-2.5	(0.0-2.5)	40-45	100-105	790	684	106
Mr Patrick Scott, Director of Operations - County Durham and Darlington (left 31 August 2018); Director of Operations - York and Selby (started 1 September 2018, left 31 January 2019)	0.0-2.5	0.0-2.5	50-55	135-140	957	792	27
Mr David Brown, Chief Operating Officer (started 01 December 2017, left 1 August 2018); Director of Operations - York and Selby (started 1 December 2018, left 31 March 2019)	2.5-5.0	10.0-12.5	45-50	145-150	1,200	955	183
Mr Levi Buckley, Director of Operations – Forensic Services (left 31 July 2018); Director of Operations - County Durham and Darlington (started 1 August 2018)	2.5-5.0	0.0-2.5	35-40	50-55	518	410	108
Mrs Adele Coulthard, Director of Operations – North Yorkshire (left 1 September 2017); Director of Transformation - North Yorkshire (started 1 September 2017, left 3 February 2019)	0.0-2.5	(0.0-2.5)	35-40	90-95	752	663	75
Mr Tim Cate, Director of Operations – North Yorkshire (started 01 September 2017, left 31 March 2019)*	0	0	0	0	0	0	0
Mr Dominic Gardner, Director of Operations – Teesside - started 01 December 2017	7.5-10.0	22.5-25.0	20-25	50-55	406	197	209
Mrs. Lisa Taylor, Director of Operations - Forensic Services (started 1 September 2018)	2.5-5.0	7.5-10.0	20-25	55-60	416	279	79
Mr Robert Cowell, Director of PFI Projects (left 31 August 2018); Director of Operations - Estates and Facilities Management (started 1 September 2018, left 31 March 2019)*	0	0	0	0	0	0	0
Mr Paul Foxton, Director of Operations - Estates and Facilities Management (started 08 January 2018, left 31 August 2018)	0.0-2.5	0.0-2.5	20-25	60-65	489	434	23
Mr Phil Bellas, Trust Secretary	0.0-1.5	(0.0-2.5)	15-20	25-30	272	222	50
Dr Ruth Briel, Senior Clinical Director, Kaizen Promotion Office	2.5-5.0	7.5-10.0	45-50	135-140	1,019	871	148
Mrs Sarah Dexter-Smith, Director of Therapies - started 16 October 2017	0.0-2.5	0.0-2.5	20-25	50-55	366	289	77



* Mr Tim Cate and Mr Rob Cowell are not in the NHS Pension scheme

** An error was discovered in NHS pensions calculation of 31 March 2018 CETV values, the affected figures included in the table above have been restated.

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

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004-05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

The reason for the negative increase in lump sum for five senior managers is due to the inflation factor used (3.0%) being higher than the percentage growth in benefits.

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

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

Colin Martin: Date: 21 May 2019

Chief Executive

Staff Report

Analysis of Staff costs and staff numbers

Employee expenses	12 months ended 31 March 2019			12 months ended 31 March 2018		
	Total	Permanently employed	Other	Total	Permanently employed	Other
	£000	£000	£000	£000	£000	£000
Salaries and wages	213,820	200,171	13,649	205,586	197,516	8,070
Social security costs	19,075	17,798	1,277	17,507	16,802	705
Apprenticeship levy	1,018	927	91	981	942	39
Pension cost - employer contributions to NHS pension scheme	24,902	23,065	1,837	24,416	23,375	1,041
Pension cost - other contributions	36	36	0	17	17	0
Temporary staff - agency/contract staff	9,632	0	9,632	6,775	0	6,775
Gross employee expenses	**268,483**	**241,997**	**26,486**	**255,282**	**238,652**	**16,630**
of which:						
Costs capitalised as part of assets	261	261	0	267	267	0
Analysed into operating expenditure (page 14):						
Employee expenses - staff & executive directors	265,815	239,549	26,266	252,881	236,366	16,515
Research & development	907	687	220	631	516	115
Education and training	1,500	1,500	0	1,503	1,503	0
Total employee expenses excluding capitalised costs	**268,222**	**241,736**	**26,486**	**255,015**	**238,385**	**16,630**

The salary costs of the capital development team are capitalised over the full costs of the Trust's capital schemes, of which in 2018-19 the largest scheme was an inpatient unit in York.

Average number of employees (WTE Basis)	12 months ended 31 March 2019			12 months ended 31 March 2018		
	Total Number	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number
Medical and dental	313	216	97	338	296	42
Administration and estates	1,209	1,079	130	1,170	1,108	63
Healthcare assistants and other support staff	320	196	124	319	307	12
Nursing, midwifery and health visiting staff	3,926	3,450	476	3,892	3,484	408
Scientific, therapeutic and technical staff	793	745	48	788	726	63
Healthcare science staff	2	2	0	2	2	0
Social care staff	25	9	16	8	0	8
Total	**6,588**	**5,697**	**891**	**6,517**	**5,922**	**595**
of which						
Number of employees (WTE) engaged on capital projects	6	6	0	5	5	0

Demographic Information

Our workforce is primarily white, broadly in line with our local population and at the end of March 2018 there were 5,378 female members of staff (78%) and 1,561 male members of staff (22%)

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

Sickness absence figures (January to December 2018)

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
6,051	67,069	1,337,864	108,801	11

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

Our average sickness absence rate was 5.01%

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 2018/19 we made efforts to improve the training needs analysis by the greater involvement of services in speciality based training needs identification and planning activities.
- The Trust became a member of the Business Disability Forum, a not for profit registered charity, as part of efforts to improve workplace disability policy and practice.
- Progress made with implementation of the new Trust Workforce Strategy was monitored by the Resources Committee on a quarterly basis. The strategy describes how we intend to improve the quality of our services through workforce supply, development, health and wellbeing and engagement activities.

Occupational health
The 2018/19 staff flu campaign was the most successful to date with 66.60% of frontline healthcare workers receiving a flu vaccination. Demand for physiotherapy and counselling services was significantly greater than expected however, access to these services was maintained during 2018/19. 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:

- Health & Safety Champions day in September which included representation from the Health & Safety Executive who provided a presentation on Work related stress. The day was introduced by Director of HR/OD with delegates from across the Trust. The day included workshops on Risk Assessments, Fire Safety and Safety Culture. As a result of the day the Team have reviewed and updated their training packages, including Managers Training.

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

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

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.

Recording of Trade Union Facility Time - 1/4/18 – 31/3/19

Relevant union officials

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
27	6089.61 (calculated as per Regulations)

Percentage of time spent on facility time

Percentage of time	Number of employees
0%	12
1 – 50%	14
51-99%	0
100%	1

Percentage of pay bill spent on facility time

Total cost of facility time	£63,433.07 (calculated as per Regulations)
Total pay bill	£248,311,201 (calculated as per Regulations)
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.025%

Paid trade union activities

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	18.22% (calculated as per Regulations)

Staff engagement

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 meetings and huddles
- Team briefing system (plans in place to introduce a new system in 2019)
- Intranet (a new system is to be launched in 2019 with added functionality which will support staff communications and engagement)
- Weekly e-bulletin which includes a round-up of discussions at the Executive Management Team meetings
- Video messages from directors and senior managers
- Social media
- 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

We also remain committed to improving the way we use of the staff friends and family test to engage with the workforce. We hope the use of crowdsourcing methodology (to be introduced in 2019) will help improve how staff survey results are communicated to staff and how we engage staff about what our response to the results ought to be

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

NHS staff survey
From 2018 onwards, the results from questions are grouped to give scores in ten indicators. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those.

The response rate to the 2018 survey among trust staff was 30.5% compared to 52.4% in 2017.

Scores for each indicator together with that of the survey benchmarking group (24 mental health and learning disability trusts) are presented below.

	2018/19		2017/18		2016/17	
	Trust	**Benchmarking Group**	**Trust**	**Benchmarking Group**	**Trust**	**Benchmarking Group**
Equality, diversity and inclusion	9.4	8.8	9.3	9.0	9.4	9.0
Health and wellbeing	6.5	6.1	6.4	6.2	6.7	6.2
Immediate managers	7.3	7.2	7.3	7.2	7.2	7.1
Morale	6.5	6.2	N/A	N/A	N/A	N/A
Quality of appraisals	6.1	5.7	5.8	5.5	5.9	5.5
Quality of care	7.3	7.3	7.5	7.3	7.6	7.4
Safe environment – bullying and harassment	8.3	7.9	8.3	8.0	8.4	8.0
Safe environment – violence	9.3	9.3	9.1	9.2	9.1	9.2
Safety culture	7.0	6.7	7.0	6.7	7.0	6.6
Staff engagement	7.2	7.0	7.1	7.0	7.2	6.9

The response rate for the 2018 survey was significantly lower than that in the previous year. Consultations are being undertaken with the aim of understanding the reasons for this reduction to help ensure that the 2019 response rate is higher.

Statistically significant improvements were recorded in four of the ten survey themes in 2018 compared to 2017. These themes were Equality, diversity & Inclusion, Quality of appraisals, Safe environment – violence and staff engagement and Staff engagement. There was as statistically significant deterioration in the Quality of care theme score for 2018 compared to 2017 and this will be a particular focus for improvement in response to the survey results.

The Trust scored above average compared to other mental health and learning disability trusts in eight of the ten themes and had an average score in two themes, Quality of care and Safe environment – violence. The Trust recorded the best scores of any mental health and learning disability trusts for the Equality, diversity & Inclusion and the Safety culture themes.

The intention is to use crowdsourcing methodology to help improve how staff survey results are communicated to staff and how we engage staff about what our response to the results ought to be

Future priorities and targets
Continuing to improve the quality of appraisals, staff health and wellbeing and tackling bullying and harassment of staff are expected to be amongst the priorities for action in response to the 2018 staff survey results, in addition to addressing the Quality of care result.

The Resources Committee, Executive Management Team, Workforce and Development Group, Investors in People Leads Group and the Joint Consultative Committee will receive reports about progress being made. The Trust's Workforce Strategy scorecard will be updated accordingly in line with any changes made in response to the staff survey results.

Exit Packages (subject to audit)

Early retirement due to ill health

During 2018-19 the Trust had 11 employees retire early on the grounds of ill health; the value of these early retirements (from NHS Pensions) is £0.8m.

Exit packages

There were 3 payments for termination benefits valuing £14,000 during the period to March 2019, relating to redundancy (2017-18, 1 payment valued at £23,000).

Cost of exit packages

	12 months ended 31 March 2019			12 months ended 31 March 2018		
Exit package cost	**Total number**	**Compulsory redundancies number**	**Other departures number**	**Total number**	**Compulsory redundancies number**	**Other departures number**
<10,000	3	3	0	0	0	0
£10,001 - £25,000	0	0	0	1	1	0
Total number of exit packages	**3**	**3**	**0**	**1**	**1**	**0**
Total resource cost (£000's)	**14**	14	0	**23**	23	0

Consultancy costs

The Trust paid £726k in consultancy costs during 18/19.

Off payroll arrangements

For all off-payroll engagements as of 31 March 2019, for more than £245 per day and that last for longer than six months:

No. of existing engagements as of 31 March 2019	14
Of which...	
No. that have existed for less than one year at time of reporting.	5
No. that have existed for between one & two years at time of reporting.	7
No. that have existed for between two and three years at time of reporting.	1
No. that have existed for between three and four years at time of reporting.	1
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 2018 and 31 March 2019, 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 2018 and 31 March 2019	5
Of which...	
No. assessed as caught by IR35	5
No. assessed as not caught by IR35	0
No. engaged directly (via PSC contracted to the entity) and are on the departmental payroll	4
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.	21

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.	68
A.1.1	A statement on how disagreements between the Council of Governors and Board of Directors should be resolved.	69
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	28 - 31, 75, 79 & 87
A.1.2	The number of meetings of the Board of Directors and the Audit, Remuneration and Nominations Committees and individual attendance by directors	71-72, 75, 79 & 87
A.5.3	The names of members of the Council of Governors, whether they are elected or appointed, the constituency	84 – 86

	or organisations they represent and the duration of their appointments.	
A.5.3	The name of the Lead Governor.	83
B.1.1	The names of the non-executive directors whom the Board determines to be independent, with reasons where necessary.	28 – 30 & 70
B.1.4	A description of each director's skills, expertise and experience.	28 – 31
B.1.4	A statement about the Board of Directors' balance, completeness and appropriateness to the requirements of the NHS foundation trust.	70
B.2.10	A description of the work of the Nominations Committee(s) including the process used in relation to board appointments.	79 & 87
B.3.1	The other significant commitments of the Chairman and any changes to them during the year.	28
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.	88
B.6.1	A statement on how the performance evaluation of the board, its committees and its directors, including the Chairman, has been conducted.	73 – 74
B.6.2	The identity of any external facilitator who supported the performance evaluation of the board and whether they have any other connection with the trust.	Not applicable
C.1.1	An explanation from the directors of their responsibility for preparing the annual report and accounts. A statement that they consider the annual report and accounts, taken as a whole, are fair, balanced and reasonable and providing the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy.	70 – 71
C.1.1	A statement from the External Auditors about their reporting responsibilities	231
C.1.1	An explanation from the directors of their approach to quality governance in the annual governance statement.	93 – 103

C.2.1	A report that the Board has conducted a review of the effectiveness of the Trust's system of internal controls.	69
C.2.2	Information on how the internal audit function is structured and the role it performs.	78
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.	76 – 77
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.	91
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.	72 – 73
E.1.6	A report on the representativeness of Trust's membership and the level and effectiveness of member engagement.	88

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 Director of Therapies, 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 2019, 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) attend meetings of the Board in a non-voting capacity.

The Board considers that, as at 31st March 2019:

- 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 2019, confirms that the annual report and accounts, taken as a whole, are fair, balanced and reasonable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy.

Attendance at Board meetings

The following table provides details of the attendance at the ten ordinary meetings and two special meetings of the Board of Directors held during 2018/19:

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	12
Colin Martin	▪ Chief Executive ▪ Accounting Officer ▪ Chairman of the Executive Management Team	11
Hugh Griffiths	▪ Non-Executive Director ▪ Deputy Chairman ▪ Chairman of the Quality Assurance Committee	11
Marcus Hawthorn	▪ Non-Executive Director ▪ Senior Independent Director ▪ Chairman of the Resources Committee	10
David Jennings	▪ Non-Executive Director ▪ Chairman of the Audit Committee	12

Paul Murphy	▪ Non-Executive Director	11
Shirley Richardson	▪ Non-Executive Director	12
Richard Simpson	▪ Non-Executive Director ▪ Chairman of the Mental Health Legislation Committee	11
Ruth Hill	▪ Chief Operating Officer (from August 2018)	6 (7)
Ahmad Khouja	▪ Medical Director	9
Brent Kilmurray	▪ Chief Operating Officer and Deputy Chief Executive (to July 2018) *(Brent stepped back from his role as the Chief Operating Officer on 1/12/17)*	5 (5)
Elizabeth Moody	▪ Director of Nursing & Governance ▪ Deputy Chief Executive (from August 2018)?	9
David Levy*	▪ Director of Human Resources and Organisational Development	12
Sharon Pickering*	▪ Director of Planning, Performance and Communications	10
David Brown*	▪ Acting Chief Operating Officer (to July 2018)	3 (5)

(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 2018/19.

In total the Council of Governors held four ordinary meetings and the annual general meeting during 2018/19. Board Member attendance at these meetings was as follows:

Name	Number of Meetings Attended
Lesley Bessant	5
Colin Martin	5
Dr Hugh Griffiths	3
Marcus Hawthorn	5
David Jennings	2
Paul Murphy	5
Shirley Richardson	5
Richard Simpson	5
Brent Kilmurray	2 (2)
Ruth Hill	2 (3)
Dr Ahmad Khouja	2
Patrick McGahon	4
Elizabeth Moody	5
David Levy	5
Sharon Pickering	5
David Brown	0 (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 2018/19 this included assessments of the performance of:
- The Chairman by all other Board Members
- 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.

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 as appropriate

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:

David Jennings (Chairman)	5
Marcus Hawthorn	5
Hugh Griffiths	4
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

The audit committee uses an assurance tracker; a document, updated after each meeting, which enables it review and monitor compliance with its terms of reference.

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

In relation to the annual audit for the year ended 31st March 2019 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.
- reviewed the proposed accounting treatment in regard to the termination of the Roseberry Park PFI scheme
- received the Annual Report of the Head of Internal Audit and considered its findings in relation to the Annual Governance Statement.
- reviewed and commented on the Annual Governance Statement prior to its inclusion in the annual report

A special meeting held on 17th May 2019 provided the Committee with the opportunity to review the Annual Report, including the Quality Report, and Accounts building on conversations, at previous meetings, in relation to progress reports provided by the External Auditors and on the draft Accounts, including the accounting treatment of significant items, and the draft Annual Governance Statement.

In doing so, the Committee took into account the following documents prepared and presented by the External Auditors:

- The draft External Assurance Report on the Trust's Quality Report.
- The Audit Completion Report (supplemented by a letter which provided an update/conclusion on outstanding matters) which set out the significant findings from the audit and their conclusions and observations on the key audit matters and significant risks identified by them during the planning of the audit.

The Committee satisfied itself that, pending completion of outstanding matters, the Annual Report and the Accounts provided a true, balanced and fair view of the position of the Foundation Trust at the end of the financial year.

It was noted that information was still awaited from certain third parties in order to enable the audit to be completed. Discussions were held on the arrangements for the approval and submission of the Annual Report and Accounts should this not be received in time for the scheduled Board meeting.

During the 2018/19 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 sought specific 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; compliance with the healthcare assistance career framework; attendance management; arrangements for staff to raise concerns,; conflicts of interest; the application of the duty of candour; and security management
- sought assurance on the processes in place to ensure the timely delivery of internal audit recommendations
- 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. Two matters arising from the reports have been subject to particular attention: fraud risks and the processes used to assess them; and the adequacy of controls relating to pre-employment checks of agency workers
- 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.
- reviewed the procurement process for the appointment of the external auditors in 2018/19 and identified improvements to the process
- 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 foundation trust accounts; ethical standards for auditors; and the new leasing financial reporting standard

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 2018/19 was £62k 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 2018/19.

The Committee met twice during 2018/19 to:

- consider an issue in relation to the contractual terms of a very senior manager
- review the Trust's process for the Fit and Proper Persons Test
- consider the annual uplift to be applied to the Executive Management Team pay framework taking into account advice received from NHS Improvement

All members of the committee were present at both these meetings.

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) to deliver its Business Plan are appropriate, sufficient and deployed effectively
- To provide assurance to the Board on the robustness, alignment and delivery of key strategies and plans including the financial strategy and capital plan; the workforce strategy and plan, the digital transformation strategy; and the equality strategy and workforce race equality standard plan
- 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 2019 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
- Colin Martin, Chief Executive
- Patrick McGahon, Director of Finance and Information
- Ruth Hill, Chief Operating Officer

(Note: All Board Members are invited to attend and participate (but not to vote) in meetings of the Committee. Executive Directors are expected to attend meetings of the Committee 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 2019 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
- Ruth Hill, Chief Operating Officer

- Elizabeth Moody, Director of Nursing and Governance
- Two public governors or experts by experience (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 2019 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
- Ruth Hill, 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 2018/19.

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 2019 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 four times during 2018/19.

The Council of Governors

Report of the Lead Governor

The responsibilities of a Lead Governor are to notify NHS Improvement and the Care Quality Commission if there are concerns with any aspect of the Appointment Process in the Trust or non-compliance with the Constitution. Once again, I am able to report that there have been none.

There have been a number of issues that the Trust has been dealing with. I can confirm that the Council of Governors has been kept informed and has, and will continue to, monitor, question and where necessary challenge the Trust to ensure these issues are dealt with appropriately.

Governors continue to develop their skills and knowledge by participating in training and seminars.

An important event that some Governors attended was the NHS England Join Our Journey consultation on their 10 Year Plan. It was an opportunity to ensure the voice of Mental Health with regards to funding and legislation was heard.

With Recovery being a positive aspect of the Trust's values, Governors recognise the strong links the Trust has with partners, service users, carers and the public to ensure successful pathways into the community and Governors have a role to play in that by being ambassadors for the Trust.

The Council of Governors is sad to see the departure of the Chair Lesley Bessant. We appreciate the commitment Lesley has given to the Trust during her time as Chair and has been dedicated to improving the lives of the patients, carers and their families. Lesley has also gained the respect of Governors, staff and partners, she will be greatly missed.

Governors, partners, users and carers were involved in the interview process to appoint the new Chair and we look forward to welcoming and working closely with the new Chair Miriam Harte.

Once again on behalf of the Council of Governors, I would like to say that we appreciate the commitment and dedication of the staff and volunteers in their endeavours to provide the best services for patients and carers it what has been a challenging year.

Cllr Ann McCoy
Lead Governor

The Composition of the Council of Governors as at 31st March 2019 (54 seats)

(Note: The Board and the Council of Governors approved a reduction of one seat for staff governors during the year to reflect the proposed merger of the North Yorkshire and York and Selby Localities)

Membership of the Council of Governors during 2018/19

The terms of office of governors and their attendance at the 5 meetings (including the Annual General Meeting) held during 2018/19 was as follows:

Public Governors (Elected)

Name	Constituency	Term of Office		Meetings attended
		From	To	
Lesley Robertson	Darlington	01/07/2017	10/05/2018	0 (0)
Joan Kirkbride	Darlington	01/11/2018	30/06/2020	2 (2)
Audrey Lax	Darlington	01/07/2018	30/06/2020	2(4)
Mary Booth	Middlesbrough	01/07/2017	30/06/2020	5
Keith Marsden	Scarborough & Ryedale	01/11/2018	30/06/2020	2 (2)
Judith Webster	Scarborough & Ryedale	01/07/2017	30/06/2020	2 (4)*
Elizabeth Forbes-Browne	Scarborough & Ryedale	01/07/2016	30/06/2019	0
Alan Williams	Redcar and Cleveland	01/07/2017	30/06/2020	0
Vanessa Wildon	Redcar and Cleveland	01/07/2016	30/06/2019	1 (4)*
Gillian Restall	Stockton-on-Tees	01/07/2017	30/06/2020	1
Mark Eltringham	Stockton-on-Tees	01/07/2017	30/06/2020	3
Gary Emerson	Stockton-on-Tees	01/07/2016	30/06/2019	3
Jacci McNulty	Durham	01/07/2017	30/06/2020	5
Mac Williams JP	Durham	01/07/2017	30/06/2020	3
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	2 (4)*
Keith Mollon	Durham	01/07/2016	30/06/2019	5
Dr Lakkur Murthy	Durham	01/07/2016	19/06/2018	1 (1)
Sandra Grundy	Durham	01/07/2017	30/06/2020	1
Zoe Sherry	Hartlepool	01/07/2017	30/06/2020	4
Jean Rayment	Hartlepool	01/07/2016	30/06/2019	5
Ailsa Todd	Hambleton and Richmondshire	01/07/2017	07/02/2019	1 (4)
Della Cannings QPM	Hambleton and Richmondshire	01/07/2017	06/02/2019	3 (4)
Hilary Dixon	Harrogate & Wetherby	01/07/2016	30/06/2019	4
Chris Gibson	Harrogate & Wetherby	01/07/2016	30/06/2019	4
Hazel Griffiths	Harrogate & Wetherby	01/07/2016	30/06/2019	5
Prof Tom McGuffog MBE	York	01/07/2018	30/06/2021	2 (4)
Christine Hodgson	York	01/07/2018	30/06/2021	2 (4)
Stella Davison	York	01/07/2018	30/06/2021	2 (4)
Dr Martin Combs	York	23/03/2016	30/06/2018	1 (1)
Nathaniel Drake	York	23/03/2016	30/06/2018	0 (1)
Dr Peter Harrison	York	23/03/2016	30/06/2018	0 (1)
Gemma Birchwood (nee Benson)	Selby	01/07/2017	30/06/2020	5
Wendy Fleming-Smith	Selby	01/07/2017	30/06/2020	2

Staff Governors (Elected)

Name	Class	Term of Office		Meetings attended
		From	To	
Rachel Booth	Teesside	01/07/2017	30/06/2020	2
Phil Boyes	County Durham & Darlington	01/07/2017	30/06/2020	3
Dr Judith Hurst	Corporate	01/07/2017	30/06/2020	4
Glenda Goodwin	Forensic	01/07/2017	30/06/2020	5
Gary Matfin	York and Selby	19/02/2016	30/06/2018	1 (1)

Appointed Governors

Name	Appointing Organisation(s)	Term of Office		Meetings attended
		From	To	
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	1 (4)*

Dr John Drury	Hartlepool and Stockton-on-Tees Clinical Commissioning Group / NHS South Tees Clinical Commissioning Group	01/07/2014	30/04/2018	0 (0)
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
Prof Graham Towl	Durham University	23/10/2017	07/02/2019	1 (4)
Cllr Ann McCoy	Stockton Borough Council	08/07/2014	30/06/2019	4
Cllr Kaylee Sirs	Hartlepool Borough Council	05/06/2017	06/06/2018	0 (1)
Cllr Stephen Thomas	Hartlepool Borough Council	07/06/2018	06/06/2019	2 (4)
Kevin Kelly	Darlington Borough Council	13/08/2015	-	0
Lee Alexander	Durham County Council	13/01/2017	-	1
Cllr Helen Swiers	North Yorkshire County Council	24/05/2016	-	3
Ian Hamilton	The University of York	09/03/2018	-	1
Ashley Mason	City of York Council	28/06/2016	11/07/2018	0 (1)
Prof Hamish McAllister-Williams	Newcastle University	06/03/2018	21/11/2018	1 (3)
Dr Andrew Fairbairn	Newcastle University	26/11/2018	-	0 (1)

(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 2018/19

Constituency Name	Date of Election	No of Seats	No. of candidates	No. of Votes cast	No. of eligible voters	Turnout (%)
Staff Governors						
North Yorkshire	21/6/18	1	0	-	-	-
York & Selby	21/6/18	1	0	-	-	-
Public Governors						
York	21/6/18	3	8	65	464	14
Scarborough & Ryedale	21/6/18	1	0	-	-	-
Rest of England	21/6/18	1	0	-	-	-
Middlesbrough	21/6/18	1	0	-	-	-

Darlington	21/6/18	1	1	Uncontested		
Scarborough & Ryedale	1/11/18	1	1	Uncontested		
Darlington	1/11/18	1	1	Uncontested		
Rest of England	1/11/18	1	0	-	-	-

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 Chairman and non-executive directors
- undertook the five yearly review of the remuneration of the Chairman and Non-Executive Directors
- reviewed the process for the Fit and Proper Person Test
- reviewed and agreed a revised process for the appointment of the Chairman and Non-Executive Directors for recommendation to the Council of Governors
- In relation to the appointment of the new Chairman:
    - agreed the search strategy
    - oversaw the recruitment and selection arrangements
    - undertook the shortlisting of candidates to be invited to participate in the selection day
- commenced preparations for the appointment of Non-Executive Directors in 2019/20.

The membership of the committee, and attendance at its four meetings during 2018/19, was as follows:

Lesley Bessant	Chairman of the Trust	3 (3)
Marcus Hawthorn	Senior Independent Director	4
Mary Booth	Public Governor	3
Della Canning QPM	Public Governor	3
Dr. Judy Hurst	Staff Governor	3
Mac Williams JP	Public Governor	4

(Note: Mrs. Bessant was not required to attend one meeting as it was held exclusively to review the applications received and to agree the shortlist of candidates for the appointment of the new Chairman)

Advice and services were provided to the committee by:

- Mike Dixon, Partner, Dixon Walter (in relation to the recruitment and selection of the new Chairman and Non-Executive Directors)
- Phil Bellas, Trust Secretary.
- David Levy, Director of Human Resources and Organisational Development

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.

The training and development programme was reviewed during the year.

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 2018/19 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.

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 2019 the Trust’s membership was as follows:
- Public members – 9,485
- Staff members – 6,747

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	14	382,487
17-21	594	119,838
22+	8,406	1,513,814
Ethnicity:		
White	8,671	1,897,919
Mixed	54	17,513
Asian or Asian British	164	40,256
Black or Black British	70	7,935
Other	15	5,452
Socio-economic groupings*:		
AB	2,077	116,754
C1	2,609	176,896
C2	2,147	136,350
DE	2,585	175,232
Gender analysis		
Male	3,171	989,157
Female	6,260	1,023,257

(Notes: On application:
- *471 public members did not provide a date of birth*
- *511 members did not state their ethnicity*
- *54 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 specific engagement with the membership of the Trust has 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 and formal consultation processes.
- Communications and drop in events to support the awareness of Governor Elections.
- Delivery of the Annual General and Members Meeting with over 220 attendees.
- Website forum and increased use of social media
- A number of social / community events attended such as Durham Pride, Time to Talk Day, NHS 70 celebrations and Darlington's Tea Dance.
- Attendance at College Fresher and wellbeing days.
- Consultation on the business plan priorities including seeking views of the public and formal consultation with the Council of Governors to enable them to engage with their membership.

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

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.

Segmentation

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

This segmentation information is the Trust's position as at 31st March 2019. 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	2018/19 scores				2017/18 scores			
		Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1
Financial sustainability	Capital service capacity	2	3	3	4	2	3	3	3
	Liquidity	1	1	1	1	1	1	1	1
Financial efficiency	I&E margin	1	1	1	1	1	1	1	1
Financial controls	Distance from financial plan	1	1	1	1	1	2	2	2
	Agency spend	4	4	3	3	2	2	2	2
Overall scoring		**3**	**3**	**2**	**3**	**1**	**2**	**2**	**2**

Agency expenditure is in excess of the agency ceiling for 2018/19 reflecting cover for vacancies that have arisen from national shortages of key staff and highly competitive market conditions in some localities. The Trust has developed an action plan for 2019/20 to improve this position.

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 and Social Care Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* (and the *Department of Health and Social Care Group Accounting Manual*) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- *confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy* 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 **21st May 2019**

Annual Governance Statement 2018/19

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 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 NHS Foundation Trust for the year ended 31 March 2019 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 undertakes primary approval of the clinical audit programme and monitors its delivery. The terms of reference of these committees ensures that there is a co-ordinated and complementary approach to risk management.

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

The risk and control framework

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

Key elements of the Risk Management Strategy are:

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

Risk is identified using a number of internal and external mechanisms including; NHS 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.

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

- Foundation Trust membership and Council of Governors
- Patient satisfaction surveys
- Complaints, claims and Patient Advice and Liaison (PALS) concerns
- The Trust involves patients and the public in the development and evaluation of services
- The Trust maintains close links with social services departments to ensure the delivery of integrated care and treatment

In addition an Assurance Framework was in place at 31 March 2019 and remains in place up to the date of approval of the annual report and accounts.

The main risks to the Trust meeting its principal objectives have been identified within the framework together with the key controls in place to manage these risks.

Although the Trust has not identified any significant control issues, it is improving the control and management of some of the risks in the following areas:

The Trust continues to use a process of Quality Impact Assessments (QIA), that are signed-off by the Medical Director and Director of Nursing, 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.. This has included streamlining existing audit activity to allow greater focus on emerging issues such as responding to the Care Quality Commission recommendations for improvement. Action plans are in place and closely monitored to further strengthen and embed clinical audit procedures.

The PFI contract for Roseberry Park has been terminated. TVH Ltd has gone into liquidation and there is an on-going legal process associated with compensation on termination. The outcome of this legal process has not yet concluded; however, it is anticipated that the outcome will not 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 I.T. systems to support the organisation's objectives (including data quality, the implementation of mental health currencies including quality and outcome measures) and the Trust's approach to managing counter fraud.

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 Transformation and Safety Board, to further strengthen and embed Cyber security protocols, to minimise the risk to the Trust.

The Trust has also taken further steps to strengthen its approach to cyber security via external audit of our systems and process to provide independent assurance, introduction of a cyber security group to monitor systems and network security patching, we have reviewed and updated our IT incidents response procedures, we have fully implemented the NHS Digital Advanced Threat Protection (ATP), we are currently upgrading all our computer assets

to windows 10 and updating our mobile devices to the most recent versions of operating systems.

The Trust's financial ledger system (provided by North East Patches) has been subject to a lower level of audit review than in previous years (ISAE Type I Audit was completed, previous years was level II). The plan is to revert to a Type II audit in future years. The ISAE 3402 Type I audit is a point in time audit that provides assurance that

(1) The description fairly presents the NEP controls system as designed and implemented
(2) The controls relating to the control objectives stated in the Description are suitably designed and implemented.

Although this audit review provides a lower level of assurance to the Trust, it is the Trust's view that risk is minimal, as:

- the previous 7 years audits have raised only minor issues
- the majority of security controls for the NEP Cloud system reside with Oracle and they provide independent assurance around these controls through their ISO 27001:2003 certification. and their Service Organization Controls (SOC) are assured by both SOC1 and SOC2 reports
- the Trust has internal controls to ensure the financial position reported is accurate.

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 NHS Digital's Data Security and Protection Programme. The Trust achieved compliance with all mandatory assertions of the Data Security and Protection Toolkit in 2019/20. Importantly, this evidenced that 95% of staff completed mandatory data security and protection training.

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 consulted when there is significant change to information governance process, for example implementing the new requirements under the Data Protection Act 2018 (GDPR).

The Trust has an established anti-fraud and corruption policy which aims to minimise the risk of fraud, bribery or corruption by detailing the key roles and responsibilities of

employees and related parties; as well as promoting an anti-fraud culture throughout the Trust.

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

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

The Trust’s Workforce Strategy is focused upon five key workforce objectives which are:

- Increasing recruitment
- Reducing staff turnover
- Enhancing learning and development
- Reducing sickness absence
- Enhancing staff experience

Progress made with achieving each of these five objectives is captured and associated metrics are reported to the Resources Committee, a sub-committee of the Board of Directors, on a regular basis.

The Medical Director provides regular updates to the Board regarding medical recruitment and retention, which is also monitored through the Board Assurance Framework and Risk Register. A range of initiatives to address the current shortfall in consultants has been enacted. This has included a refreshed recruitment drive, particularly targeting of specialty registrars, and providing existing staff approaching retirement with a more attractive retire and return offer.

Alongside this, there have been developments to support the existing consultant workforce, including introducing new roles such as physician associates, increasing the number of non-medical approved clinicians, as well as expanding the roles consultants can take such as new posts such as academic and research fellows.

Where there are long-term agency doctors in place, they are being offered a bespoke recruitment package to encourage them to join the Trust. Junior doctors are also being encouraged to join the organisation, with the Trust offering a unique career pathway. We have increased the number of Trust grade doctors, and have supported Trust doctors to be accepted on training schemes. There is a specific internal programme to develop staff grade doctors to become consultants, which has also proved positive in attracting new staff grades to the Trust.

To ensure the longer term recruitment of doctors, the Trust has continued to concentrate on providing all students trainees with an excellent educational experience (we are regularly recognised as one of the best mental health trust in

providing medical training). We have also been heavily involved in supporting a local medical school to be established (Sunderland Medical School) and increasing existing student numbers (Hull and York Medical School).

The Board receives quarterly and annual reports from the Guardian of Safe Working providing assurance that Junior Doctors are safely rostered and working hours are compliant with the terms and conditions of service outlined in the 2016 Junior Doctor Contract.

Medical staff recruitment, retention and wellbeing are monitored on a monthly basis within the medical directorate along with the deputy medical directors, to ensure a safe and sustainable workforce. A specific strategy regarding the minimisation of medical agency use is in place, and agency usage is monitored on a monthly basis. Any changes to medical staffing establishment, and or skill mix are subject to a joint Quality Impact Assessment (QIA) by the Medical Director and Director of Nursing and Governance.

The Trust has an established Right Staffing Programme as a business priority, which includes work streams looking at Recruitment and Retention, Staff education and development, staffing establishments and deployment of multi-professional specialist and advanced practice roles.

The programme has been designed in order to comply with earlier NQB staffing guidance, and many of the principles contained with the updated NHS-I Developing Workforce Safeguards recommendations.

Key ways in which the Board ensures that workforce strategies and systems are in place are:

- Systems to undertake an annual establishment and skill mix reviews across all services (based on acuity and dependency data and using an evidence-based toolkit where available) in accordance with NQB guidance and NHS Improvement resources.

- A full Quality Impact Assessment (QIA) is undertaken for the implementation of any new roles such as the Nursing Associate. This process also includes significant skill mix reviews or service changes. The QIA is signed off by the Nursing and Medical Director and approved at the Executive Management Team meeting.

- Processes for escalation of staffing and bed occupancy across in-patient services and community teams aligned to trust business continuity arrangements.

- Board oversight of a suite of workforce strategy metrics, quality and outcome indicators, staffing and productivity measures.

- A diagnostic assessment has been undertaken of agency use across medical, nursing, health care assistants and administration based upon the NHSI model.

The Trust's Executive have endorsed the action plan that includes trajectories to reduce temporary staffing.

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

The foundation trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS guidance.

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

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

The foundation trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

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

- Agreeing a rolling 3 year annual financial strategy and plan
- A rigorous process of setting annual budgets and a detailed cost improvement programme including a Quality Impact Assessment (QIA)
- Annual review of Standing Financial Instructions and Schemes of Delegation
- Robust performance management arrangements
- A programme of supporting directorates to better understand and manage their relative profitability
- Breaking the trust's overall reference cost indicator down to Specialty / directorate
- Levering efficiencies through internal and collaborative procurement initiatives
- Using benchmarking and nationally published performance metrics to inform plans for improved bed and community service efficiency
- Rationalising the estate
- Improving workforce productivity
- Benchmarking management costs
- Utilising an innovative coaching approach to cost reduction idea generation
- Embedding the Quality Improvement Systems (QIS) methodology to review how the Trust operates, maximising efficiency and minimising waste

- Working with partners to improve the overall local health economy in terms of quality and efficiency. The Trust has strategic partnerships with CCGs in both Durham and Tees and North Yorkshire; works collaboratively with NHS England via New Care Models for specialist services and develops new services for people with Learning Disability using PIPS

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 15 incidents reported in the Data Security and Protection Toolkit during the period 1st April 2018 to 31st March 2019. Six incidents were privacy breaches – inappropriate staff access to local or national patient information systems. Six incidents were confidentiality breaches with a variety of causes. Two incidents involved loss of personal information and one incident related to a fake website. All incidents were investigated by the appropriate Trust team.

Annual Quality Report

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

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

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

- Priorities for improvement have been identified from an analysis of serious untoward incidents, complaints, as well as feedback from users and other stakeholders. Theses priorities have been shared with wider stakeholders for comment and were approved by the Quality Assurance Committee before final sign off by the Board of Directors and Council of Governors.

- The Trust has in place an internal group which has the responsibility for ensuring data quality within the Trust. Furthermore data quality is also discussed at monthly performance meetings between the Director of Finance, Director of Planning and Performance and the Chief Operating Officer with each clinical directorate.

- Data quality is included within the corporate risk register which is used by the Board of Directors to monitor the risk of incomplete and inaccurate data. The Trust has 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.

- In the most recent NHS Digital July 2018 – September 2018 published results TEWV gained a score of 95.4% for the Data Quality Maturity Index which is a measurement of data quality in the NHS.

- The Trust has the following policies linked to data quality:
  - Data 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
  - Confidentiality and sharing information 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 and 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 2018/19, 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 **21st May 2019**

Quality Report

(subject to independent review)

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

I am pleased to present the Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) Quality Account for 2018/19. This is the 11th Quality Account that we have produced and it details what the Trust has done to improve the quality of our services in 2018/19 and how we intend to make further improvements during 2019/20.

The Trust provides a range of mental health, learning disability and autism services for around two million people living in County Durham, Darlington, Teesside, North Yorkshire (with the exception of Craven District) and York[1].

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

Our Mission, Vision and Strategy

The Mission of the Trust is:

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

The Trust's 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'

Achieving our vision 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

[1] The Trust's community and inpatient services are also accessed by people living in Wetherby (West Yorkshire / Leeds CCG) and Pocklington (East Yorkshire / Vale of York CCG)

- 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 need to 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

Each goal has high-level measures which the Trust monitors for assurance that the Trust's vision for quality is being delivered. These measures are scrutinised by our Quality Assurance Committee (QuAC) and Board.

A Profile of the Trust

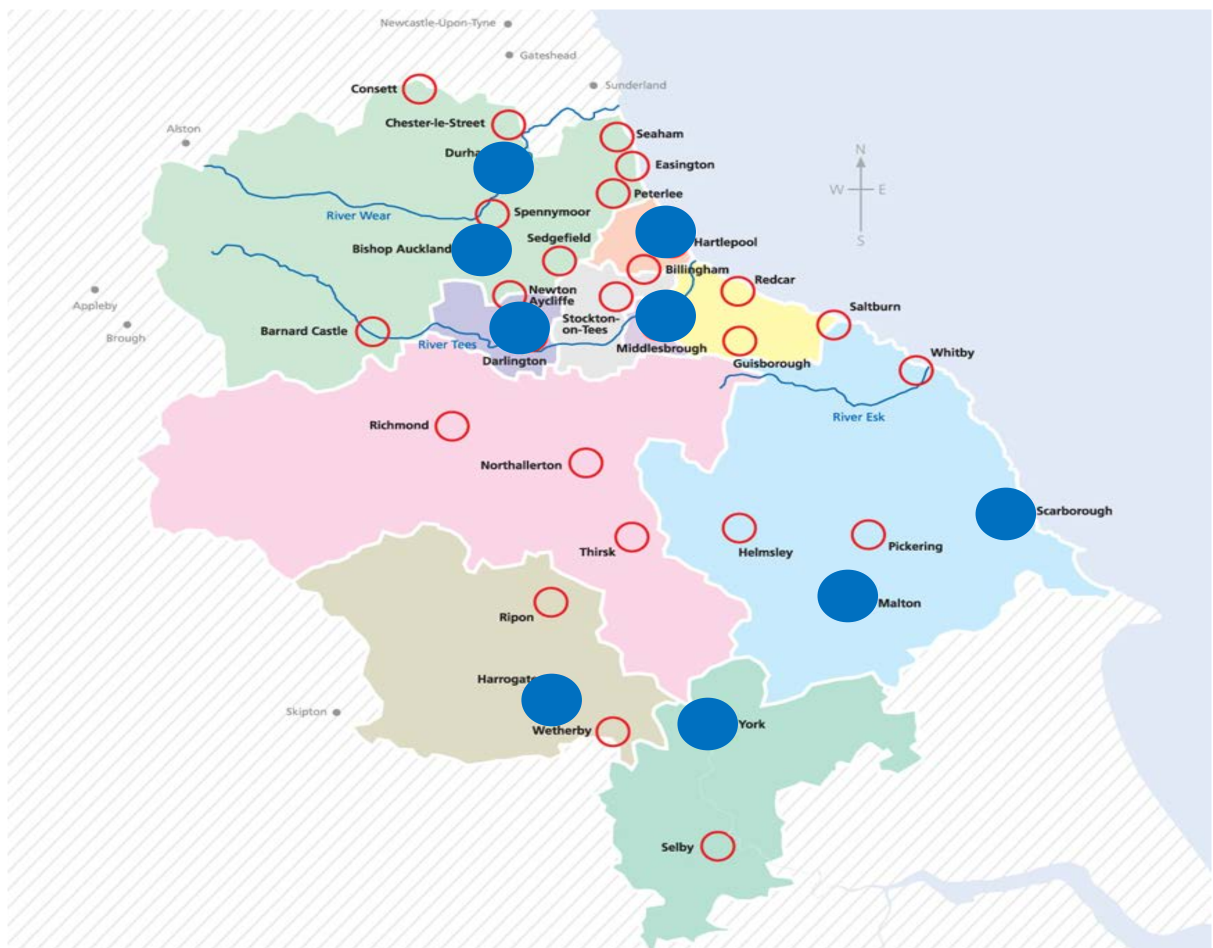
The Trust provides a range of Mental Health, Learning Disability and autism services for around two million people living in County Durham, Darlington, Teesside, North Yorkshire (with the exception of Craven District) and York.

This area covers 4,000 square miles (10,000 square kilometres). A map showing this region is provided on the following page – ***See Figure 1***. The Trust also provides some regional specialist services (e.g. Forensic Services, Children and Young person's inpatient ("tier four") Services and specialist Eating Disorder Services) to the North East and Cumbria region and beyond. The Trust is also commissioned as part of a national initiative to provide inpatient care to Ministry of Defence personnel, and provides mental health treatment to prisoners in North East England and also in parts of the North West.

Services commissioned by Clinical Commissioning Groups (CCGs) are managed within the Trust on a geographical basis. From 1st April 2019 this will be through three Localities, the first covering Durham and Darlington, the second Teesside, and the third North Yorkshire and York. There is also a non-geographic "Locality" which manages Forensic and Offender Health services. Each is led by a Director of Operations, Deputy Medical Director, Head of Nursing and Professional Lead for Psychology, who report to the Chief Operating Officer, Medical Director, Director of Nursing and Governance and Director of Therapies respectively.

- Our income in 2018/19 was **£356.1m**
- On 31st March 2019 **58,426** people had received care from TEWV during 2018/2019
- During 2018/19, on average we had **743** patients occupying an inpatient bed each day - this equates to an average occupancy rate of **86.62%** (This occupancy refers to all TEWV beds, not just to Assessment and Treatment beds where the occupancy rate is higher than this average figure)
- Our Community staff made more than **2.3 million** contacts with patients during 2018/19 (including IAPT Services)
- We have a total of **6,090** whole time equivalent employees, and **6,854** employees in total

Figure 1: Map of TEWV Trust area showing main towns and locations of inpatient beds



Key				
Main Towns	O		Main town and location of TEWV inpatient beds	

What we have achieved in 2018/19:

We have continued to work to improve the quality of our services and to develop new services to meet the needs of those who use our services. For example we have:

- Continued to work with our Experts by Experience ensuring that the work we do across the Trust is co-produced with them as far as possible
- Developed and rolled out the Mental Health Services for Older People (MHSOP) frailty Clinical Link Pathway (CliP) Trust-wide. This means that Baseline Visual Falls Assessment is completed within 12 hours of admission and a full Frailty Assessment within two weeks of admission. All new patients are discussed in Multi-Disciplinary Team (MDT) frailty meetings which take place at least once a week; these meetings are given priority and are attended by the physiotherapist, occupational therapist, pharmacist, physical care practitioner, medic, nurse, psychologist and admin staff
- Produced example scenarios for staff regarding safeguarding around abuse disclosures. These will be used to support good practice and reduce staff worries around having conversations about trauma with service users
- Received a Stage One award from The Carers Trust recognising commitment to becoming an organisation that involves and supports carers through implementation of the Triangle of Care (ToC). The Carers Trust said the progress made by services over the past year has been impressive and encouraging. Work continues to embed ToC across all services, including roll-out to community teams over the next year
- Commenced construction of the new purpose-designed 72-bed hospital, Foss Park, located off Haxby Road in York. It will provide two adult single-sex wards and two older people's wards – one for patients with dementia and one for those with mental health conditions such as psychosis, severe depression or anxiety
- Introduced a new community perinatal mental health service across County Durham and Darlington, North Yorkshire and the Vale of York. Services are supporting local women who are experiencing mental health difficulties during pregnancy or in the first year after they have had their baby. Additionally, we have expanded services that the Trust already provides in Teesside
- Won the Liaison & Diversion Tenders for the Durham, Cleveland and North Yorkshire Police Force areas. In North Yorkshire and York this is a new service; our contract commenced on 1st April 2019. TEWV is working in partnership with HumanKind and Spectrum Community Health to deliver this service
- Launched an area on our Recovery College Online for young people providing information and resources, including for parents and carers
- Trained several Forensic Services patients in quality improvement techniques so that they can participate in improvement events

- Held an Annual Recovery event for Forensic wards in February 2019, enabling service users, friends and family and staff to celebrate service user achievements, recognising individual small steps
- Held a Rapid Process Improvement Workshop (RPIW) which reviewed the current Care Planning Approach, to make the process more patient-focused
- Held a family conference in relation to Preventable Deaths in March 2019, in line with the Trust's commitment to quality and involvement
- Undertaken a Mortality Review Process each month as part of the wider agenda of the Patient Safety Group. The majority of service users reviewed were over the age of 80 and the highest primary diagnosis was that of dementia – many had resided in care homes. The most notable learning point from the reviews so far is that of good practice/care and this has been fed back to the clinical teams involved. Emerging areas for improvement would appear to be similar to those from some of the incidental findings from our serious incident investigations (communication to/from GP, family involvement, early warning score monitoring and multi-agency working). In conjunction with other regional mental health organisations the Trust is trialling a new mortality review tool from the Royal College of Psychiatrists and this will be evaluated throughout 2019/20
- Developed a zero inpatient suicide plan based upon the recommendations from the latest National Confidential Inquiry into Suicide and Homicide in Mental Health report (2018). It covers such areas as undertaking a follow-up to discharged patients within 72 hours rather than seven days, reducing alcohol and drug misuse and guidance on depression. Progress against the plan will be monitored by the Patient Safety Group
- Developed a steering group for the STOMP (Stopping Over-Medication of People with a Learning Disability, Autism or Both Project) and invited representatives to join from across the Trust. STOMP awareness sessions have been held with relevant services and also with student nurses at Teesside University, embedding practice for the future. A Communication Plan to promote good practice has also been developed via TEWV social media. Further work will be ongoing during 2019/20
- Held a Kaizen Quality Improvement Event to develop an autism reasonable adjustment Clinical Link Pathway (CLiP), with the aim of embedding a culture of Reasonable Adjustments across our general mental health services. The CLiP products have been launched at selected pilot sites throughout 2018 and we have received funding (from April 2019 to March 2020) to roll out the CLiP to all adult mental health teams across the Trust. Eventually we plan to seamlessly integrate the CLiP products with the Trust's forthcoming new Electronic Patient Record System, CITO
- Officially launched our Trust Autism Framework in March 2018 and held an event to showcase our work so far and plans for the future
- Delivered the face-to-face *Understanding Autism* training to 1,173 TEWV staff with a further 1,500 TEWV staff viewing our *Autism Awareness* video. We

have received further funding to allow us to continue to deliver the face-to-face training across the Trust

- Reviewed the Learning Disability Specialty Positive Behavioural Support (PBS) CLiP. This has enabled the pathway to be aligned more closely with standards published by the PBS Academy in 2017 and new National Institute for Clinical Excellence (NICE) guidance (NG93) which was published in 2018. The pathway now has an even greater focus on improving quality of life for people with learning disabilities. There is ongoing work to develop a quality of life tool which can be used with service users who have a more significant level of disability to involve them more actively in quality of life assessments. There is also a significant piece of work taking place to develop and deliver an internal programme of competency-based PBS training for staff at the foundation and intermediate levels of the PBS competency framework. It is expected that the first cohort of staff will start this training at the end of May 2019
- Enhanced our Medicines Optimisation and Pharmacy Services by:
    - Developing a new series of lessons learned and safety bulletins designed to encourage reporting, supporting a 'fair blame' culture and enabling learning
    - Significantly improving compliance with our monthly Medicines Management Assessment process which looks at ten key safety standards; over 80% of wards now regularly achieve 100% compliance
    - Building upon the success of our monthly Medicines Management Assessments by launching regular Medicines Optimisation targeting clinical standards

Detailed information on the achievements related to our quality improvement priorities is included in **Part Two** of this document

The Trust is committed to gathering information to find out how we are performing from a wide range of sources and stakeholders. This includes results from the Community Mental Health Survey, the national NHS Staff Survey and the Trust Staff Friends and Family Test. A summary of the results from these surveys can be found in the section over the page.

TEWV's 2018 Community Mental Health Survey Results

- The response rate of **25%** was lower than the national response rate of **28%** (This is a decrease of **4%** from the response rate of **29%** in 2017/18, which was higher than the national response rate)
- TEWV scored *'better'* than the other Trusts in the question - *'Were you given information about your medicines in a way that you were able to understand?'* – the score in all other questions was *'about the same'* as the majority of other Trusts
- The highest scoring section for the Trust was *Planning Care* which scored **7.3** against the highest national score of **7.5**. Each of the three individual questions in this section scored relatively highly against the national results and also showed good improvement on 2017 Trust scores
- The overall rating on care experience has declined to **66.4%** compared to **70.9%** in 2017 and **74.3%** in 2016
- There was one question which was marked as a statistically significant improvement on that achieved in 2017 – *'Do you know who to contact out of office hours if you have a crisis?'* – 2017 score **6.4**, increased to **7.4** in 2018
- The section with the lowest overall scores for TEWV was once again *'Support and Wellbeing'* – scoring **4.5** against the highest national score of **5.2**. When comparing the 2018 scores for the six individual questions in this section, all had deteriorated from those achieved in 2017
- The overall results for the Trust for 2018 present a mixed picture, with scores across the top, intermediate and lower ranges of the data. Unfortunately scores have decreased over the last two years, although the Trust's performance is still in line with national norms across all sections

TEWV's National NHS Staff Survey Results 2018*

*This data covers the calendar year 2018

Previously, the Trust only invited a sample of staff to complete the National NHS Staff Survey. In 2018 the invitation was extended to include all TEWV staff via an electronic survey only.

In the 2018 national NHS Staff Survey, the Trust had a response rate of **30.5%** (**1,988** of **6,518** eligible staff). The average response rate for Mental Health and Learning Disability Trusts was **54%**

The Trust scored better than average on nine of the 10 themes covered by the Staff Survey, two of which were the best score for Mental Health providers (Equality, diversity and inclusion; and Safety Culture). Our score on the Quality of Care theme was equal to the national average.

TEWV's Staff Friends and Family Test Results

Our *Staff Friends and Family Test (FFT)* results include (from **2,172** responses)*:*

- **81%** are likely or highly likely to recommend treatment at TEWV
- **69%** would recommend TEWV as a place to work
- **83%** agree that they are able to make suggestions for improvement

National Awards – Won or Shortlisted

In 2018/19 the Trust was recognised externally in a number of national awards where we won or were shortlisted. Awards won or highly commended by TEWV teams or staff members are shown in the table below:

Awarding Body	Award Status	Name/Category of Award	Team/Individual
The Carers Trust	Awarded	Stage 1 Award (Triangle of Care)	TEWV
Royal College of Psychiatrists	Awarded	Memory Services National Accreditation Programme	Harrogate Memory Service
Love York Awards (University of York)	Winner	Honorary Contribution to Student Life Award	IAPT Team (York, Selby, Tadcaster & Easingwold)

Student Nursing Times	Winner	Student Nurse of the Year: Mental Health	Joe Atkinson
CYPS Celebrating Good Practice Awards	Winner	Team Achievement of the Year	Rachel Orr Katy Philips
Durham & Tees Valley GP Training Programme	Awarded	Clinical Supervisor of the Year	Mani Krishnan
HSJ Patient Safety Awards	Winner	Maternity & Midwifery Services	Perinatal MDT, HMP YOI Low Newton
Healthwatch York Making a Difference	Winner	Excellence in Health and Social Care Services	MHSOP Team, Acomb Garth, York
NEPACS	Awarded	New approach to management and therapeutic support of prisoner with mental health issues	Integrated Support Unit, I Wing, HMP Durham
Positive Practice in Mental Health Awards	Winner	Mental Health & Emergency Services/Criminal Justice	All-age Liaison & Diversion Service, Middlehaven Police Station
Positive Practice in Mental Health Awards	Awarded	Outstanding initiatives to improve patient care	Older Person's Functional Community Mental Health Team, Lustrum Vale
Royal College of Psychiatrists Awards	Winner	Team of the Year – Quality Improvement Category	MHSOP, Teesside
Cavell Star Award	Winner	For nurses, midwifes and health care assistants who shine bright and show exceptional care	Jenny Trowsdale Stacey Daniels Kali Penfold Sarah Waite Linda Schumacher Deborah Jeffery
Royal College of Psychiatrists Awards	Winner	Specialty Doctor of the Year	Thandar Win
Teesside University	Awarded	Certificate of Excellence	North Tees Liaison Psychiatry Team, Farnedale
Durham Constabulary	Awarded	Wow! Award	Rebecca Stainsby
HSJ Partnership Awards	Winner	Legal Services Provider of the Year	TEWV & Ward Hadaway

Autism Professionals Awards	Winner	Outstanding Health Services	Trust-wide Autism Project Team
Autism Professionals Awards	Winner	Outstanding Health Services	The Northdale Centre, Roseberry Park

Awards where TEWV as an organisation, or one of our teams/a member of staff were shortlisted for an award but did not win that award in 2018/19 were:

Awarding Body	Award Status	Name/Category of Award	Team/Individual
BBC One Show NHS 70 Awards	Shortlisted	Lifetime Achievement Awards	Dr Muthukrishnan
Nursing Times	Shortlisted	Learning Disabilities Nursing Category	Learning Disabilities Service, North Yorkshire
		Team of the Year	MHSOP Community Team, Harrogate
Positive Practice in Mental Health Awards	Highly Commended	Older Adult Functional Mental Health Service	Stockton Community Mental Health Team
Royal College of Psychiatrists	Finalists	Older Adults Team of the Year	Stockton Community Mental Health Team
Great British Care Awards	Shortlisted	N/A	Deborah Jeffery
			Lynne Taylor
NHS70 Parliamentary Awards	Nominated	Excellence in Mental Health Care	Sarah McGeorge
HSJ Awards	Shortlisted	Improved Partnerships between Health & Local Government	Durham Liaison & Diversion Team

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 2018/19, the required statements of assurance from the Board and our priorities for improvement in 2019/20
- **Part 3:** Further information on how we have performed in 2018/19 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 Director's 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 2018/19 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
- Elizabeth Moody (Director of Nursing and Governance) at elizabeth.moody@nhs.net

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

Part 2: Priorities for Improvement and Statements of Assurance from the Board

2018/19 and 2019/20 Priorities for Improvement – How did we do and our future plans

During 2018/19 we held two events inviting our stakeholders to take part in our process of identifying quality priorities for 2019/20 to be included in the Quality Account. These events took place in July 2018 and February 2019; further information can be found in **Part 3, Our Stakeholders' Views** section. The five quality priorities which we identified from this engagement also sit within TEWV's 2019/20-2021/22 Business Plan. The Business Plan includes a further 13 priorities all of which have a positive impact on the quality of Trust services. Details of these priorities can be found in **Appendix 5.**

Our five agreed 2019/20 priorities for inclusion in the Quality Account are:

Priority 1: Improve the clinical effectiveness and patient experience in times of transition from Child to Adult Services
Priority 2: Reduce the number of Preventable Deaths
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 5: Review our Urgent Care Services and identify a future model for delivery

Priorities 1 - 4 were priorities in 2018/19 and the section below includes information on what we have done during 2018/19 and what we will do in 2019/20. Priority 5 is a new priority which we have developed for 2019/20.

Priority 1: 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 Adult Services. Young people with ongoing or long-term health or social care needs may be required to transition into Adult 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.

Transition takes place at a pivotal time in the life of a young person. It is often at a time of cultural and developmental changes that lead them into adulthood. Individuals may experience several transitions simultaneously. A loss of continuity in care can be a disruptive experience, particularly during adolescence, when young people are at 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 in 2015. We initially agreed to put a two-year quality improvement priority in place, focusing on this specific transition. The paragraphs below show what we achieved in 2018/19.

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 evidence-based guidelines, which will result in better clinical outcomes

What we did in 2018/19:

What we said we would do:	What we did:
• Implement actions from the thematic review (conducted at the end of 2017/18) of patient stories by Q1 2018/19.	• Only three stories were received in the first nine months of the year which was not enough to complete a thematic review. This action was therefore changed to 'Share and embed best practice from the stories received so far'. We have now collated feedback/views from 11 young people who have moved from CAMHS to AMH services. It provides a varied picture of their experiences ranging from excellent to poor. This information has been shared with CAMHS and AMH Heads of Service and relevant Service Development Managers to use as learning with their teams
• Registered CAMHS and Adult Services staff to undertake further specific training on the Transitions process by Q1 2018/19	• Registered CAMHS and Adult Services staff have undertaken further specific training on the Transitions process. There are plans to roll out a training presentation until the end of May 2019

• Review Transitions panels already in place (set up during 2017/18), gain additional service user perspective and set relevant targets and metrics by Q3 2018/19	• Transitions panels have been observed and reviewed and service user perspective was gained from 11 young people. These panels are in place in all localities; however the format and attendees remain slightly different in each. We will use the data to inform improvement metrics in 2019/20
• Produce an engagement plan to involve family and carers in the process by Q4 2018/19	• An engagement plan has been produced by the CAMHS Head of Service for Durham & Darlington and the Trust CAMHS Service Development Manager

How do we know we have made a difference?

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

Indicator	Target	Actual	Timescale
• Percentage of joint agency transition action plans in place for patients approaching transition	**80%**	**94.2%**	Q4 2018/19
• Percentage of patients who reported feeling prepared for transitions at the point of discharge	**80%**	**76%**	Q4 2018/19
• Percentage of patients who have transitioned to AMH from CYPS who indicate that they have met their personal goals as agreed in their transition plan	**70%**	**69%**	Q4 2018/19

At the Quality Account event held in July 2018 to discuss priorities for 2019/20 it was agreed that transitions remain an area of concern and that this should be carried forward for at least another year. The actions below are those for the third year of this priority to further embed the improvements already undertaken.

What we will do in 2019/20:

We will:

• Use available data from Q4 2018/19 to undertake a gap analysis of numbers of transitions occurring and numbers of transitions panels occurring per locality (including attendance by Adult Services and CAMHS staff) by Q1 2019/20
 	
• Set improvement trajectories for the remainder of 2019/20 based on outcomes of the analysis above during Q1 2019/20 and report on these trajectories during Q2, Q3 and Q4 2019/20
 	
• Review the Healthcare Safety Investigation Branch report 'Transition from child and adolescent mental health services to adult mental health services' and identify any action or learning for the Trust during Q1 2019/20 and report on progress during Q3 and Q4 2019/20
 	
• Hold a joint CYPS & Adult Services Engagement Event during Q2 2019/20 and report on the actions from this event during Q3 and Q4 2019/20
 	
• Establish any potential barriers to successful transitions and consider how these could be overcome
  ◦ Establish agreed models for transition panels
  ◦ Include Experts by Experience sharing their experiences of transitions
  ◦ Include presenting case studies of difficult to manage transitions and the learning regarding how to overcome difficult to manage transitions
  ◦ Include partners from other organisations
 	
• Evaluate the effectiveness of transition panels across the Trust during Q4 2019/20

How will we know we are making a difference?

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

Indicator:	Target:	Timescale:
• Percentage of young people (who are moving to adult services) who have a transition plan in place	**100%**	Q4 2019/20
• Percentage of joint agency transition action plans in place for patients approaching transition	**80%**	Q4 2019/20
• Percentage of patients who reported feeling prepared for transitions at the point of discharge	**80%**	Q4 2019/20

Priority 2: Reduce the number of Preventable Deaths

Why this is important:

It is recognised that people with a mental health problem, autism and/or a learning disability are likely to experience a much earlier death than the general population; therefore a key focus for the Trust will be an increased focus on mortality review processes for this group of people. Not all deaths of people receiving mental health services from the Trust will represent a failing or a 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 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 2017/18, 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.

In addition to the work done under our Quality Account priority, TEWV has also been supporting the work of the Cumbria and North East Integrated Care System to tackle issues related to the physical health of people with a mental health condition. This has been focussing on collecting service user stories, promoting physical activity and weight loss and improving the knowledge of non-mental health NHS workers about the needs of their services users who also have mental health needs.

The benefits/outcomes we aimed to deliver for our patients and their carers in 2018/19 were:

- That our processes 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 are 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 2018/19:

What we said we would do:	What we did:
• Develop a co-produced family and carer version of the Learning from Deaths policy by Q1 2018/19	• A co-produced family and carer version of the Learning from Deaths policy has now been produced
• Produce an engagement plan to involve family, carers and non-Executive Directors within the review process by Q2 2018/19	• An engagement plan to involve family, carers and non-Executive Directors within the review process has now been developed
• Implement the engagement plan by Q3 2018/19	• The engagement plan is now being implemented
• Hold a family conference in conjunction with Leeds & York Partnership NHS 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	• A family conference was held on 8th March 2019 which included gathering feedback from families/carers and staff about how they can be better engaged in the process moving forward. The conference was organised by TEWV and attended by representatives from TEWV, Northumberland, Tyne & Wear (NTW), Leeds & York Partnership, and Sheffield Health & Social Care NHS Trust
• Evaluate the level and effectiveness of engagement with families, carers and Non-Executive Directors (NEDs) by Q4 2018/19	• Using findings from the above we have completed an evaluation of progress and created an action plan to move forward which will be monitored throughout 2019/20. The NEDs have provided their support for this approach with an agreement that they may become more involved with the mortality review process in future

How do we know we have made a difference?

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

Indicator	Target	Actual	Timescale
• Increase the number of deaths that are reviewed as part of the mortality review processes (this is in addition to the existing Serious Incident process)	**120**	**204**	Q4 2018/19
• Eliminate preventable deaths of inpatients during periods of leave	**0**	**1**	Q4 2018/19
• Reduce the number of Serious Incidents where it was identified that the Trust contributed to the incident	**37**	**39**	Q4 2018/19

What we will do in 2019/20:

At the Quality Account event held in July 2018 to discuss priorities for 2019/20 it was agreed that reducing preventable deaths remains a priority and that this should be carried forward for at least another year. The actions below are those for the next year of this priority to further embed the improvements already undertaken.

We will:
• Produce an action plan from the March 2019 Family Conference by Q1 2019/20, and implement this plan by Q4 2019/20
• Commence circulation of a new guidance booklet to families who have lost a loved one during Q1 2019/20, and review and evaluate the impact of this booklet by Q4 2019/20
• Review the Trust-wide policy in relation to Preventable Deaths and make necessary amendments during Q1 2019/20
• Participate in all of the regional Mental Health Learning from Deaths Forum meetings during 2019/20
• Implement any new national guidance once released – by Q4 2019/20

How will we know we are making a difference?

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

Indicator:	Target:	Timescale:
• Increase the number of deaths that are reviewed as part of the mortality review processes (this is in addition to the existing Serious Incident process)	**300**	Q4 2019/20
• Eliminate preventable deaths of inpatients during periods of leave	**0**	Q4 2019/20
• Reduce the number of Serious Incidents where it was identified that the Trust contributed to the incident	**30**	Q4 2019/20

Priority 3: Making Care Plans more personal

Why this is important:

Personalisation is defined in the skills and education document by NHS England 'Person Centred Approaches' (2016) as '*Recognising people as individuals who have strengths and preferences and putting them at the centre of their own care and support. Personalised approaches involve enabling people to identify their own needs and make choices about how and when they are supported to live their lives'*

Feedback from services users shows that our current approach to care planning does not always promote a personalised approach, hence this being identified as a priority in 2018/19.

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

- To have their personal circumstances viewed as a priority when planning care and treatment
- To have an accessible, understandable and personalised 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 them

What we did in 2018/19:

What we said we would do:	What we did:
• Co-produce an action plan with service users, carers and staff teams based on the findings and recommendations of the 2017/18 audit by Q1 2018/19	• An action plan has now been co-produced
• Co-produce guidance about what Personalised Care Planning means and how to demonstrate this through clinical records by Q1 2018/19	• Guidance has now been co-produced
• Co-develop training and development packages, aligning these to, and incorporating where possible, the training and development work of other programmes, projects and business as usual – these must include evaluation measures by Q2 2018/19	• Training packages have been co-developed and in conjunction with the Recovery Programme which links with audit findings and focus group themes; it will now be rolled out for delivery
• Co-deliver training and development packages – Trustwide by Q3 2018/19	• Training is now being delivered across the Trust which enabled approximately 200-300 people to be trained by the end of Q4 2018/19
• Re-audit and report as per Q4 2017/18 by Q4 2018/19	• The original audit and subsequent report did not take place until Q3 2018/19 and so the re-audit and report has been pushed back to Q3 2019/20

How do we know we have made a difference?

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

Indicator	Target	Actual	Timescale
The following indicators are for TEWV from the National Mental Health Community Survey 2018 (% for 2017)			
• Do you know who to contact out of office hours if you have a crisis? (64%)	**74%**	**74%**	

• 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%) • Do the people you see through NHS mental health services help you with what is important to you? (66%) • Were you involved as much as you wanted to be in agreeing what care you will receive? (71%) • Were you involved as much as you wanted to be in discussing how your care is working? (75%) • Does the agreement on what care you will receive take your personal circumstances into account? (75%)	**78%** **42%** **76%** **81%** **85%** **85%**	**76%** **31%** **69%** **76%** **71%** **79%**	All Q4 2018/19

What we will do in 2019/20:

At the Quality Account Stakeholder event held in July 2018 to discuss priorities for 2019/20 it was agreed that Care Planning remains an area where further improvement is needed and that this should be carried forward for at least another year. The actions below are those for the next year of this priority to further embed the improvements already undertaken.

We will:
• Complete appropriate impact assessments in relation to DIALOG and seek approval via the relevant channels (DIALOG is a clinical tool that allows for assessment, planning, intervention and evaluation in one procedure) by Q1 2019/20 • Involve experts by experience in care planning training workshops to provide feedback on the training and the process in general by Q4 2019/20 • Review the training package and produce an options appraisal regarding how to proceed (including non-face-to-face resources) by Q1 2019/20

- Continue with training package roll-out as per the agreement following options during Q2 and Q3 2019/20
- Test DIALOG within existing IT systems during Q2 2019/20
- Re-audit and report as per Q4 2017/18 during Q3 2019/20 (booked with Clinical Audit for October 2019)
- Compare and contrast review of Patient Experience during Q4 2019/20

How will we know we are making a difference?

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

Indicator:	Target:	Timescale:
• Do you know who to contact out of office hours if you have a crisis?	**84%**	All Q4 2019/20
• Were you involved as much as you wanted to be in deciding what treatments or therapies to use?	**86%**	
• 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?	**41%**	
• Do the people you see through NHS mental health services help you with what is important to you?	**79%**	
• Were you involved as much as you wanted to be in agreeing what care you will receive?	**86%**	
• Were you involved as much as you wanted to be in discussing how your care is working?	**81%**	
• Does the agreement on what care you will receive take your personal circumstances into account?	**89%**	

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

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 service gaps for patients with dual diagnosis. The Trust has recognised the importance of adapting to these changes and becoming more proactive in developing services that address the specific needs of this group of service users. In addition, the feedback we received from stakeholders identified that this should be a priority for 2018/19.

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

- Service users with mental health and co-existing substance misuse get the same level of care as people without substance misuse problems
- Staff treat every service user with the same level of respect, without judgement
- Support for family and carers of service users with dual diagnosis improves
- Staff work collaboratively across organisations, with a creative, flexible and proactive approach
- Staff 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 did in 2018/19:

What we said we would do:	What we did:
• Circulate Dual Diagnosis CliP to all localities, specialities and specialty sub-groups for them to agree the most appropriate place to integrate within their pathways by Q1 2018/19	• The CLiP has been circulated to relevant directorates, specialties and sub-groups
• Establish a process with the Patient Safety Team that incorporates Dual Diagnosis in investigations/reviews by Q1 2018/19	• A process has been established so that Dual Diagnosis is now formally considered within investigation/ review processes
• Directorate specialties to confirm their use of the Dual Diagnosis CliP (proportionate to their need) within relevant pathways by Q2 2018/19	• The Dual Diagnosis CLiP has now been fully rolled out and is confirmed to be in use by directorates and localities where this is appropriate

• Introduce a Training Needs Analysis (TNA) which includes Dual Diagnosis and identify those staff with dual diagnosis capabilities by Q2 2018/19	• The TNA has been undertaken and has identified a list of leads who have Dual Diagnosis capabilities
• Establish a training structure linked to Locality and Specialty requirements by Q3 2018/19	• This Training Structure has now been agreed
• Ensure all services have at least one person trained in Dual Diagnosis issues or have access to a trained clinician (proportionate to each directorate's needs) as a contact regarding Dual Diagnosis issues by Q4 2018/19	• There is at least one Dual Diagnosis champion in each locality but not within each service in all localities; however these champions provide cross-cover and allow services to access their expertise wherever it is needed
• Complete an annual thematic review of risks and Serious Incidents involving service users with Dual Diagnosis by Q4 2018/19	• A thematic review was completed in November 2018 and has been presented to the appropriate forums; all Serious Incidents involving service users with dual diagnosis are reviewed at the Extraordinary Drug Related Incidents Directors panel
• 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	• All drug-related deaths are reviewed at the Extraordinary Drug Related Incidents Directors panels to identify whether there have been any missed MH factors and where lessons can be learnt - links are now established with the confidential enquiry process but these need to be made more robust and reliable
• Engage partners and stakeholders to agree a future approach and produce the framework/document which outlines the forward view for Dual Diagnosis by Q4 2018/19	• Due to the Trust-wide Dual Diagnosis lead acting into another role and no permanent replacement being appointed as yet this has not been completed. Therefore this will now be completed during Q1 2019/20

How do we know we have made a difference?

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

Indicator	Target	Actual	Timescale
• Percentage of services* that have at least one person trained or have access to a trained clinician	**100%**	**100%**	Q4 2018/19
• Percentage of services* which have access to an identified staff member who has enhanced dual diagnosis capabilities	**100%**	**100%**	Q4 2018/19

*AMH, CYPS, MHSOP, Learning Disabilities and Forensics

What we will do in 2019/20:

At the Quality Account Stakeholder event held in July 2018 to discuss priorities for 2019/20 it was agreed that Dual Diagnosis remains an area of concern and that this should be carried forward for at least another year. The actions below are those for the next year of this priority to further embed the improvements already undertaken.

We will:
• Review how current Dual Diagnosis networks across the Trust work to ensure they are effective, sustainable and fit for purpose during Q2 2019/20
• Review attendance at these Dual Diagnosis networks across the Trust and identify additional attendees to target to ensure these networks are truly multi-agency during Q3 2019/20
• Implement new reporting procedures via Datix (the Trust's internal incident logging system) so incidents that are drug/alcohol related are flagged by Q1 2019/20
• Undertake a qualitative evaluation into how the new Datix reporting procedure is working and whether these incidents are being picked up and recorded correctly by Q4 2019/20
• Explore how peer workers can be better involved with Dual Diagnosis work across the Trust area; including consideration of how a Peer Leadership Network could be established by Q4 2019/20
• Complete a further survey of staff Dual Diagnosis capabilities and skills and produce strategy paper by Q1 2019/20
• Complete further follow up work that is identified via the above survey and related strategy paper by Q4 2019/20

How will we know we are making a difference?

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

Indicator:	Target:	Timescale:
• Maintain Dual Diagnosis networks with at least quarterly meetings in every locality	**100%**	Q4 2019/20
◦ AMH Community Teams in attendance at one or more Dual Diagnosis network meetings	**80%**	Q4 2019/20
◦ Inpatient representatives to attend Dual Diagnosis meetings	**50%**	Q4 2019/20
• Each of the four localities to have at least one peer worker in place with a dedicated role in Dual Diagnosis	**100%**	Q4 2019/20

Priority 5: Review our Urgent Care services and identify a future model for delivery

Feedback from our stakeholders during 2018/19 has indicated that they see urgent care as very important and so we have agreed to include this as our fifth quality priority for 2019/20. This is also identified as a priority for Trusts in the NHS Long-Term Plan (2019). In this case, Urgent Care refers to crisis, acute liaison and street triage services across the Trust. In the short-term our focus is on crisis services, with longer-term focus on urgent care more widely.

Why this is important:

- Feedback from our service users, carers and families and our stakeholders has suggested that crisis/urgent care services across the Trust are not fully meeting patient needs
- Staff are often perceived to operate under high pressure and are unable to meet service user expectations
- Service users are sometimes unable to access crisis/urgent care services in a timely way; there are also differences across the Trust in the provision of 'pre-crisis' brief interventions, which would help individuals before they enter a 'crisis' state and would reduce demands on the crisis teams

Along with our Stakeholders we therefore identified this as a 'new' priority for 2019/20. Although this was not a Quality Account priority during 2018/19, the Trust has been taking action to review and improve urgent care services over the past year. For example, we have:

- Produced a new Crisis Operational Policy in March 2018
- Produced guidance and standards in relation to alcohol and substance misuse
- Held the first Trust-wide Urgent Care Conference in May 2018
- Reviewed patient and carer information – ‘Your stay in hospital’, ‘Crisis Teams’ and ‘What to do in a Crisis’
- Conducted an RPIW post-implementation audit of triage, assessment and intensive home treatment quality standards between May and October 2018
- Held an RPIW refresh event in October 2018 (which built on a previous event held in 2017)
- Held a CITO (electronic patient record) launch event in December 2018
- Introduced a Regional Suicide Prevention Strategy and local groups
- Completed Phase 1 of national benchmarking in conjunction with NHS England
- Established a Trust-wide Crisis Network and Acute Care Group
- Supported commissioner-led reviews in Durham & Darlington and Teesside

The benefits/outcomes our patients and carers should expect:

- To receive the right care at the right time by the right person
- Fewer service users reach a ‘crisis’ state because of improved access to ‘pre-crisis’ services
- To always be able to contact mental health urgent care services
- To have their complex needs and experience of trauma taken into account when they come into contact with crisis services
- Staff will always be caring and compassionate
- The role of Trust urgent care teams to be clear and understood by service users and their families

What we will do in 2019/20:

We will:
• Review the current Crisis Operational Policy by Q2 2019/20 • Host a Trust-wide Urgent Care Conference by Q3 2019/20 • Undertake internal Trust-wide peer review visits in line with Home Treatment Accreditation Scheme (HTAS) / TEWV standards by Q4 2019/20 • Ensure ambulance services can check whether any person they are called to see has a Mental Health crisis plan in place by Q1 2019/20 • Agree CITO (electronic patient record) pathway/journey for crisis services by Q4 2019/20 • Implement a new Crisis Operational Model for Durham and Darlington Crisis

Teams by Q1 2019/20 • Implement the agreed actions arising from the Teesside urgent care review by Q4 2019/20 • Develop key principles and future vision for future urgent care model by Q3 2019/20

How will we know we are making a difference?

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

Indicator:	Target:	Timescale:
• Percentage of patients triaged via the Crisis Team assessed within four hours of referral	**100%**	Q4 2019/20
• Percentage of patients with a crisis and recovery plan devised and shared with the patient/carer following an episode of Intensive Home Treatment (IHT)	**100%**	Q4 2019/20

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 our stakeholders, and provide a further update on the position as of 31st December 2019 at our February 2020 Quality Account stakeholder workshop.

Statement of Assurances from the Board 2018/19

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 2018/19. 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 **2018/19** TEWV provided and/or sub-contracted **20** relevant health services, including Adult Mental Health Services, Mental Health Services for Older People, Children and Young People's Services and Adult Learning Disability Services in four localities, Forensic Learning Disability Services, Forensic Mental Health Services, Offender Health Services and Children's Tier 4 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 2018/19 represents **100%** of the total income generated from the provision of the relevant health services bv TEWV for 2018/19

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 incidents, levels of violence and aggression, infection prevention and control and health and safety
- **Clinical Effectiveness:** including information on the implementation of NICE guidance and the results of clinical audits
- **Patient Experience:** Including information on patient satisfaction, carer satisfaction, the Friends and Family Test (FFT); complaints; and contact with the Trust's patient advice and liaison service
- **Care Quality Commission:** 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 Trust Board's Quality Assurance Committee (QuAC). 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 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 Trust's Clinical Assurance Framework.

In addition, each month members of the Executive Management Team (EMT) 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 Integrated Information Centre (IIC), which is a data warehouse that integrates information from a wide range of source systems e.g. patient information, finance, workforce and incidents. The information within the IIC is updated regularly from the source systems and allows clinical staff and managers to access the information on their service at any time and '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 analyses 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 2018/19, **seven** national clinical audits and **two** confidential inquiries covered the health services that TEWV provides

During 2018/19, TEWV participated in **86% (6/7)** 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 2018/19 were as follows:

- POMH (Prescribing Observatory for Mental Health) Topic 7f: Monitoring of patients prescribed Lithium (ongoing)
- POMH Topic 6d: Assessment of the side effects of depot antipsychotics (ongoing)
- POMH Topic 18a: prescribing Clozapine (ongoing)
- National Clinical Audit of Anxiety and Depression (NCAAD) (ongoing)
- National Clinical Audit of Anxiety and Depression (NCAAD): Spotlight Audit in Psychological Therapies
- National Audit of Care at End of Life (NACEL) (ongoing)
- National Clinical Audit of Psychosis (NCAP): Spotlight Audit in Early Intervention in Psychosis (EIP) Services (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 2018/19 are as follows:

- POMH Topic 17f: Monitoring of Patients Prescribed Lithium (ongoing)
- POMH Topic 6d: Assessment of side effects of depot antipsychotics (ongoing)
- POMH Topic 18a: prescribing Clozapine (ongoing)
- National Clinical Audit of Anxiety and Depression (NCAAD) (ongoing)
- National Audit of Care at End of Life (NACEL) (ongoing)
- National Clinical Audit of Psychosis (NCAP): Spotlight Audit in Early Intervention in Psychosis (EIP) Services (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 2018/19, 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 7f: Monitoring of Patients Prescribed Lithium (ongoing)	234	Not Applicable
POMH Topic 6d: Assessments of side effects of depot antipsychotics (ongoing)	270	Not Applicable
POMH Topic 18a: Prescribing Clozapine (ongoing)	133	Not Applicable
National Clinical Audit of Anxiety and Depression (NCAAD) (ongoing)	100	100%
National Audit of Care at End of Life (NACEL) (ongoing)	1*	100%
National Clinical Audit of Psychosis (NCAP): Spotlight Audit in Early Intervention in Psychosis (EIP) Services (ongoing)	370	100%
National Confidential Inquiry into Suicide & Homicide by People with Mental Illness	42**	82%
National Confidential Enquiry into Patient Outcome and Death	n/k***	Unknown

*Organisation Level data was required for Mental Health Services
** The NCISH no longer send out homicide questionnaires from April 2018 and figures represent response rate for suicide questionnaires returned from the provider
*** 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 **174** local clinical audits were reviewed by the provider in 2018/19 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 **seven** key themes from these local clinical audits reviewed in 2018/19.

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 **25** clinical audits in 2018/19 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 and were reviewed by the Specialty Clinical Audit Subgroups.

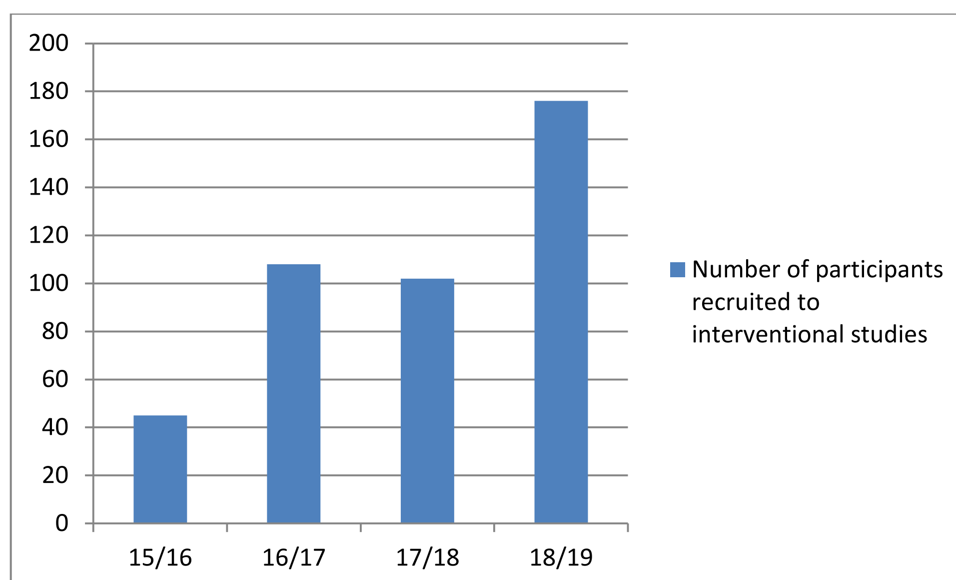
Participation in Clinical Research

The number of patients receiving relevant health services provided or subcontracted by TEWV in 2018/19 that were recruited during that period to participate in research approved by a Research Ethics Committee was **800**.

Of the **800** participants, **664** were recruited to **43** National Institute for Health Research (NIHR) portfolio studies. This compares with **1,299** patients involved as participants in NIHR research studies during 2017/18.

During 2018/19, we have successfully increased opportunities for participation in more complex interventional research studies which have lower recruitment targets than the large-scale observational studies recruited to in 2017/18. Although the overall number of participants in research has decreased, the chart below demonstrates the increase in recruitment to interventional studies which has grown from **45** participants in 2015/16 to **174** in 2018/19

Figure 2: Number of participants in interventional studies between 2015/16 and 2018/19



In 2018/19, we had feedback from **75** research participants in TEWV about their experience of taking part in research. **94%** of participants strongly agreed or agreed that taking part in research should be a normal part of NHS Healthcare. **91%** strongly agreed or agreed that they would be happy to take part in another research study

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

- We were involved in conducting **111** clinical research studies during 2018/19. **48** of these studies were supported by the NIHR through its networks
- **42** members of our clinical staff participated as researchers in studies approved by a Research Ethics Committee, with **21** of these in the role of Principal Investigator for NIHR supported studies, which is almost double the number in 2017/18
- **170** members of our staff were also recruited as participants to NIHR portfolio studies
- Following the success of identifying members of staff in the Clinical Teams in Mental Health Services for Older People to become Research Champions to promote opportunities for service users to participate in research, we have begun to roll out this model to other specialties to have Research Champions in place by the end of 2019/20
- We continue to collaborate with a wide range of universities and other NHS providers to deliver large multi-site research studies for the benefit of our service users, carers and staff

In December 2017, the Trust and the University of York (UoY) signed a long-term Memorandum of Understanding to collaborate on research, aiming for both local and global impact, with benefits for the people we serve

Key achievements from the TEWV/UoY partnership during 2018/19 are:

- Christina Van der Feltz-Cornelis has been appointed to the Department of Health Sciences at Hull York Medical School as Professor of Psychiatry and Epidemiology from July 2018, with an honorary clinical consultant appointment at the Trust as Liaison Psychiatrist. Her work focuses on common mental disorders such as somatic symptom disorders, depression and anxiety, and the promotion of mental and physical health amongst those with combined chronic medical conditions and mental disorders
- David Ekers was awarded an Honorary Visiting Professorship with the University in May 2018. He is the Trust's first Nurse Professor, having studied at York to gain his PhD and established a successful programme of research in Primary Care Mental Health in his Trust role as a Nurse Consultant
- Lina Gega from Health Sciences UoY has been appointed as an Honorary Nurse Consultant in Mental Health in TEWV
- Consultant Forensic Psychiatrist Anne Aboaja has been appointed as Honorary Visiting Fellow to the University and also an NIHR North East and

North Cumbria Clinical Research Network Lead for research career development in mental health

- The University has been successful in securing a Mental Health Network Plus programme grant from the UK's Research Councils to investigate new approaches to physical health in severe mental illness, entitled "Closing the Gap"
- The mental health charity MQ, identified the University as one of the top ten UK institutions receiving the highest levels of funding for mental health research
- The Trust has been successful in winning £2.4 million in its first hosted NIHR Programme Grant for Applied Research, developing and trialling psychological approaches to depression in older people with multi-morbidity
- A number of smaller grant successes including the development of a Patient and Public Involvement Network at York and an amalgam to share research findings on the completed workforce project have also been achieved and others are in development
- An Economic and Social Research Council-supported Knowledge Mobilisation Project led by Professor Rachel Churchill is working closely with library services across both TEWV and Northumberland, Tyne and Wear (NTW) Mental Health NHS Foundation Trusts to better implement research findings into practice. The project has developed seven new online critical appraisal skills resources which will develop the research skills of staff across the Trusts
- The Partnership identified a number of research priorities for the future including workforce mental health, common mental disorders, and improving physical health in severe mental illness

Goals agreed with Commissioners

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

A proportion of TEWV's income in 2018/19 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 (CQUIN) payment framework.

Further details on the agreed goals for 2018/19 and for the following 12-month is available electronically at:

https://www.tewv.nhs.uk/about-us/how-are-we-doing/

As part of the development and agreement of the 2017/19 (which ran from 1st April 2017 to 31st March 2019) 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 **£4,992,919** was available for CQUIN to TEWV in 2018/19, conditional upon achieving quality improvement and innovation goals across all of its CQUINs. A total of **£4,634,789 (93%)** is estimated to be received for the associated payment in 2018/19; however this will not be confirmed until May 2019. This represents **1.5%** of the Trust income rather than 2.5% as in previous years; as 0.5% was allocated for engagement in STPs (Sustainability and Transformation Partnerships, now replaced by Integrated Care Partnerships) and a further 0.5% towards achieving our control total. Including the further 1% available, a total of **£7,458,346** was available and **£7,100,216 (95%)** is estimated to be achieved.

This compares to **£7,240,867** in 2017/18 **(98.1%)**, **£6,418,793** in 2016/17 **(92.19%)**, **£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). (The estimate for 2018/19 has still to go through all the required governance processes for full approval).

Some examples of CQUIN indicators which the Trust made progress with in 2018/19 were:

- Healthy food for NHS staff, visitors and patients – This CQUIN will help to reduce the consequence of excessive sugar consumption including obesity, dental decay and other health issues for our staff visitors and patients. Building on some of the achievements in 2016/17 and 2017/18, we have continued to be part of the national SSB (Sugar-Sweetened Beverages) reduction scheme; ensured that SSB are 10% or less of all litre drinks sold, that all confectionary and sweets do not exceed 250kcal; and we have achieved the standards in relation to reducing the calories for sandwiches and other savoury pre-packed meals

- Preventing ill health by risky behaviours – this CQUIN aims to incentivise and support healthier behaviour by encouraging smoking cessation and reduced alcohol consumption in patients, where appropriate. For both alcohol and smoking, this involves undertaking screening, providing brief advice, referral to specialist services (where appropriate) and the offer of stop smoking medication. We have achieved all targets across all localities during the year, supporting our patients to quit smoking and/or reduce their alcohol consumption to enable them to lead healthier lives

- Virtual Recovery College - This was our local scheme agreed with the commissioners and one that we felt was very important. The Trust launched the Virtual Recovery College two years ago and the site now hosts over 100 pages, an increase of 25% from last year. The site is accessible to all internet users and was visited 20,639 times during the two-year CQUIN period, between April 2017

and March 2019 by 15,666 users. Of these users 87.5% have been first-time users whilst 12.5% were returning visitors. The site contains 19 e-learning courses which have recently been made available to those in the geographical area of Northumberland, Tyne and Wear NHS Foundation Trust and Cumbria Partnership NHS Foundation Trust, as well as those within our Trust localities. The number of students, who have signed up for an account on the e-learning platform, has more than doubled over the past year, with a current total of over 1000 students

- Reducing Restrictive Practices within Adult Specialist Services – The overall aim of this CQUIN is to develop an ethos in which patients are able to fully participate in formulating plans for their wellbeing, risk management and care in a collaborative manner, reducing the need for restrictive interventions. Over the past three years, a framework has been put in place to review and reduce restrictive practices, where appropriate, to ensure more patient involvement and to provide staff training. Over the last year, work has been undertaken to further improve our practices and outcomes for patients, including an audit of our blanket restrictions (those routinely applied to all patients) and a system to identify and monitor patients who are involved in their treatment and discussions around individualised restrictive practices

- Patient Experience with Street Triage - This is the second year of this CQUIN which has again shown positive results throughout the year and continues to be a success. Results for Patient Experience Surveys during Quarter 4 (January-March 2019) show that 95% of patients were satisfied. Last year, the team also developed a measure regarding an experience survey for the police who are involved in the cases they worked with. Questionnaires are now available to be completed on electronic devices and to send via text messages

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 and its current registration status is **registered to provide services with no conditions attached.** The CQC **has not** taken enforcement action against TEWV during 2018/19

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

The CQC undertook an unannounced inspection during 2018 and inspected six core services, concluding with a ‘Well-Led’ review in July 2018. The core services inspected included Adult Mental Health wards, Mental Health Services for Older

People wards, Children and Young People's Services Tier 4 wards, Forensic, Adult Mental Health Community Teams and Adult Autism and Learning Disability Community Teams.

The CQC's rating for each key domain overall was:

Ratings

Overall rating for this trust	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

The Trust retained a 'Good' rating overall with no elements being rated as inadequate. The CQC found that without exception, all staff were enthusiastic, caring and compassionate. They particularly highlighted good medical engagement, professional nursing leadership and were impressed with the quality improvement activities including the daily lean management process which the Trust has implemented. On visiting the wards, the CQC noted that there were always good interactions between staff and patients and across many areas care plans were felt to be more person-centred which is a significant improvement from findings of the previous inspection.

Key areas highlighted for improvement were as follows (there were no 'must dos' relating to CAMHS)

'Must Do' issue highlighted by CQC	AMH	MHSOP	ALD	Forensic
Ligature risk assessments	x			
Privacy & Dignity	x			
Risk Assessments	x			
Physical Health recording after rapid tranquilisation	x	x		
Seclusion recording	x			
Staffing Levels	x			
Personalised Care Planning	x			
Blanket Restrictions/Restrictive Practices	x			x
Nurse call alarms		x		
Recording of covert medication		x		
Capacity to consent being considered and recorded			x	
Activities at weekends				x
Fridge and clinic room temperature recording				x

The Trust has looked carefully at the issues raised by the CQC as 'must dos' and 'should dos'. The Director of Quality Governance has then worked closely with Directors of Operations and Directors of Corporate Services to develop an action plan based on the CQC's findings. This action plan is reviewed and monitored by EMT on a monthly basis and is reported quarterly to the Board. There is engagement on a monthly basis between the CQC and the Trust. The Director of Quality Governance also holds an annual session with Governors to review the CQC findings. The deadline for completion of this action plan is the end of June 2019.

Mental Health Act Inspections

32 Mental Health Act inspections were undertaken by the Care Quality Commission during 2018/19, across a wide range of services in all localities.

There were several key themes identified from these inspections, including:

- Issues with Capacity assessments/consent
- Issues with Care Plans
- Issues with Section 17 leave forms
- Issues with MHA section forms
- Issues with Patients' Rights

Where issues are identified there are action plans put in place to address them, with a monthly report to QUAGs and quarterly report to LMGBs.

Quality of Data

TEWV submitted records during 2018/19 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 **100%** for admitted patient care
- Which included the patient's valid General Medical Practice code was **99.68%** for admitted patient care

TEWV has provided **100** out of 100 mandatory evidence items and **40** out of 40 assertions have been confirmed for the Data Protection and Security Toolkit

The 2018/19 version of the toolkit is significantly different to the 2017/18 toolkit.

The new toolkit is called the Data Protection and Security Toolkit. There is no overall score for the new toolkit.

The toolkit assertions are based on the ten National Data Guardian Standards:

- Standard One: Personal Confidential Data (eight out of eight assertions met)
- Standard Two: Staff Responsibilities (two out of two assertions met)
- Standard Three: Training (four out of four assertions met)
- Standard Four: Managing Data Access (three out of three assertions met)
- Standard Five: Process Reviews (one out of one assertion met)
- Standard Six: Responding to Incidents (four out of four assertions met)
- Standard Seven: Continuity Planning (two out of two assertions met)
- Standard Eight: Unsupported Systems (three out of three assertions met)
- Standard Nine: IT Protection (three out of three assertions met)
- Standard Ten: Accountable Suppliers (two out of two assertions met)

The Trust has no unmet assertions.

The Data Security and Protection (DSP) Toolkit is an online tool that enables organisations to measure their performance against data security and information governance requirements which reflect legal rules and Department of Health policy. The Toolkit has been developed in response to The NDG Review (Review of Data Security, Consent and Opt-Outs) published in July 2016 and the government response published in July 2017. The Data Security and Protection Toolkit is the successor framework to the Information Governance Toolkit.

Progress to evidence compliance is monitored weekly by our Information Governance Manager and reported monthly to the Trust's Digital Safety and Information Governance Board where progress is reviewed and action to mitigate slippage against targets is agreed.

TEWV was **not** subject to any external clinical coding audits during 2018/19 by Public Sector Audit Appointments Ltd, the National Audit Office, Financial Reporting Council or Cabinet Office (replacements of the Audit Commission)

There is growing emphasis within healthcare on the importance and relevance of clinical outcome collection and reporting (NHS England, 2014; 2019). Within TEWV we are working to embed meaningful, timely and accurate clinical outcome reporting for all clinical services in line with guidance within the Five Year Forward View vision (NHS England, 2014) and Currency Tariff Development Guidance (NHS England and NHS Improvement 2016; 2019).

<table>
<tr><th>Service</th><th>Update</th></tr>
<tr><td>AMH & MHSOP (in-scope services)</td><td>
Within AMH & MHSOP services we are mandated to report the following:

Clinically Reported Outcome Measure (CROM): Within in-scope AMH & MHSOP services we use the Health of the Nation Outcome Score (HoNOS). Completion of this is reported via the Mental Health Services Data Set (MHSDS)
Patient Reported Outcome Measure (PROM): Within in-scope MHSOP services we use the short version of the Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS)

Of the patients discharged from services between November 2018 – January 2019, we were able to report outcome for the following:
Within AMH Services – HoNOS (80%) and SWEMWBS (72%)
Within MHSOP Services – HoNOS (82%) and SWEMWBS (45%)
These figures do not include those patients we were unable to report outcome for due to them being in service prior to CROM/PROM collection, those whose care spell is less than 2 weeks, those discharged from a cluster zero or those patients that died or disengaged prior to the second outcome measure being collected
Within EIP Services all new patients from 1st March 2018 will have been offered the Process of Recovery Questionnaire (QPR) as a PROM rather than SWEMWBS. This change is in line with NHS England guidance for implementing the Early Intervention in Psychosis: Access and Waiting Time Standards (NHS England, 2016)
Commissioners receive quarterly reports describing complexity of current caseload and clinical outcomes for discharged patients using an established model of clinical significance for both HoNOS and SWEMWBS. Discussions with commissioners will agree how QPR reporting will be integrated in to existing commissioner reports
Internally outcome data is reported within the clinical outcomes dashboard. There are regular discussions within both OMT & EMT meetings exploring outcome performance
Eating Disorder Examination Questionnaire (EDE-Q) may be collected and reported as a PROM across specialist in-patient eating disorder services
An ongoing training programme is available to all clinical staff
</td></tr>
<tr><td>CAMHS</td><td>

CROM: CAMHS clinicians currently complete HoNOSCA (Health of the Nation Outcome Scale for Children and Adults) which is a broad-focused CROM and rates the general functioning of young people accessing services. Clinicians are currently required to complete HoNOSCA at the time of assessment, at review and at the end of a care episode

</td></tr>
</table>

	• **PROM:** Child Outcome Rating Scale (CORS)/Outcome Rating Scale (ORS) were introduced into the CAMHS services from February 2018. Clinicians are expected to complete CORS/ORS with service users and carers at every session in a clinically meaningful way, in the context of collaborative working and shared-decision making • **Current view** is a data collection tool used to rate a number of presenting problems, complexity and contextual problems, school work or training difficulties according to a shared understanding of their presence/impact upon the child or young person at that time. The final step in following completion of the current view tool is assigning a needs-based grouping in collaboration with the service user and their parent/carer. Needs based groupings were developed as part of the national currency and tariff project in an attempt to define and categorise the work CAMHS does. The data contained in current view and the choice of needs based grouping not only informs the currency and tariff project at a national and trust level, but also guides service managers in structuring CAMHS teams and performance managing individual clinicians Performance reports are being managed via a CAMHS currency development steering group. Ongoing discussions with commissioners will agree the integration into existing reports An ongoing training programme is available to all clinical staff
Learning Disability	• **CROM:** Learning disability services across Teesside, York and North Yorkshire have begun recording HoNOS -LD at initial assessment, review and discharge for new patients. Within Durham & Darlington services, roll out has been delayed due to identified data extraction problems as a result of care records being recorded within the social services IT system rather than TEWV's. Clinical groupings have been identified, and these were due to be added onto Paris (TEWV's electronic patient record system) at the beginning of March. This will help to work towards a model of clinical significance to report outcomes. In the short term compliance reports will be published identifying timely completion at initial assessment and discharge • **PROM:** No PROM has yet initiated with learning disability services, and discussion is required to find or develop a suitable PROM and begin rollout An ongoing training programme is available to all clinical staff
Perinatal	• **CROM:** Since 1st April 2019, Perinatal Services complete HoNOS and indicate which perinatal pathway is appropriate. TEWV will report outcomes against the five perinatal pathways for Psychotic and Non Psychotic patients using a Reliable Change Index (RCI) developed for adult patients as a result of clustering and HoNOS model development

	• **PROM:** Since 1st April 2019, Perinatal Services complete CORE-10. Outcome for CORE-10 will be reported using a model of clinical significance An ongoing training programme is available to all clinical staff Outcome data will be reported within the clinical outcomes dashboard. Initially this will focus on timely completion of the CROM & PROM until outcome data starts to flow as patients are discharged from service
Forensic Inpatient	• **CROM:** Since April 2018, forensic in-patient services have been using HoNOS secure or HoNOS LD as relevant

Further work for 2019/20 includes:

- Consideration of clinical outcome metrics for prison in-reach services
- Development of outcome data reporting within IIC

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

- A Data Quality Strategy and Scorecard was signed off by the Trust EMT in May 2018. The strategy has a broader remit than previous documents that have been developed by the Trust. We will continue to implement this strategy during 2019/29; it has five key objectives. These are:
  - We will improve the understanding and need for high quality data throughout the Trust
  - We will ensure that the clinical effort required for inputting accurate, complete data into systems will be minimal
  - We will reduce the volume of reports currently produced, improve consistency and standardisation
  - We will have systems in place that enable Trust staff to 'self-serve' their own information requirements
  - We will improve the satisfaction of partner organisations in regards to the information provided by the Trust

- A review of the governance arrangements to support the data quality agenda has been undertaken and this identified a need to revise the terms of reference for the Managing the Business Group and Data Quality Sub-Group. Both meetings now have a wider representation and are pro-actively working through a work plan aligned to the strategy
- Data Quality Improvement Plans (DQIPs) have been agreed with Commissioners during 2018/19. Over 18 DQIPs have either been delivered or are on track to be delivered this financial year. Additional DQIPs are in the final process of being agreed for 2019/20
- 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. The IIC development plan for 2019/20 is currently in the process of being prioritised and approved

Learning from Deaths

Following the publication of the Southern Health report in 2015 there has been enhanced national scrutiny on how all NHS organisations respond to deaths of service users in their care. This culminated in the release of a 'Learning from Deaths Framework' which was published by the National Quality Board in 2017. In Mental Health and Learning Disability Services the vast majority of our service users are cared for in the community and often we have very minimal contact with them. This means that most of our service users who die do so through natural causes as happens in the wider population. This explains the difference between the total number of deaths (from all causes including natural causes) and the numbers we go on to investigate further which are generally deaths that are unexpected.

All deaths which are reported through our incident management system (1,414 in 2018/19) are subject to an initial review by a senior clinician in the Patient Safety Team. We have also undertaken some analysis of the average age of service users who died during 2018/19, which was found to be 81 years of age.

There is no agreed or validated tool to determine whether problems in the care of the patient contributed to their death within Mental Health or Learning Disability Service. We 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 different Mental Health and Learning Disability organisations are using differing ways currently of assessing this.

During 2018/19 **2,308** TEWV patients died; this comprised the following number of deaths which occurred in each quarter of that reporting period:

- **652** in the first quarter
- **578** in the second quarter
- **593** in the third quarter
- **485** in the fourth quarter

By 31st March 2019, **204** case reviews and **126** investigations have been carried out in relation to **330** of the deaths included in the figures above

In **zero** cases a death was subject 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:

- **89** in the first quarter
- **97** in the second quarter
- **75** in the third quarter
- **69** in the fourth quarter

10, representing **0.43%** 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. The incident review has then been used as a way to determine if the patient death may have been attributable to problems with care provided.

In relation to each quarter, this consisted of:

- **1** representing **0.15%** in the first quarter
- **4** representing **0.69%** in the second quarter
- **3** representing **0.51%** in the third quarter
- **2** representing **0.41%** in the fourth quarter

These numbers have 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 to determine if the patient death may have been attributable to problems with care provided

Root or contributory findings from serious incident reviews undertaken in 2018/19 have highlighted the following areas for learning and improvement:

- Risk Assessment
- Adherence to procedure/policy/pathway
- Family Involvement
- Access to services/referral processes
- Communication and information sharing
- Record keeping

The bullets below show the actions we have already taken, or will take during 2019/20 in response to what we have learned from reviews of deaths:

- 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 in place
- A new safety summary is being designed as part of the roll-out of CITO – an enhanced electronic care record
- Work is underway to improve personalised care planning by the Trust Care Programme Approach (CPA) Project Lead. 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
- TEWV held a Family Conference in March 2019 which included gathering feedback from families/carers and staff about how they can be better engaged in the Learning from Deaths process moving forward

These key pieces of work will continue through 2019/20 in addition to ongoing 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.

49 case record reviews and **37** investigations completed after 31st March 2018 which related to deaths which took place before the start of the reporting period.

Two, representing **2.3%** 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 findings from Serious Incident investigations. Where there has been a root cause found from 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.

The impact of these case record reviews and investigations on the data submitted in our 17/18 Quality Account is as follows (the figures reported in our 17/18 Quality Account are stated in the brackets):

155 (106) case record reviews and 163 (126) investigations were carried out in relation to the 2,322 deaths of TEWV patients which TEWV was notified about in 17/18. 13 (11) representing 0.56% (0.47%) of the patient deaths during the 171/18 reporting period are therefore now judged to be more likely than not to have been due to problems in the care provided to the patient.

Freedom to Speak Up

The Trust has a policy which details how staff can speak up about risk, malpractice, or wrongdoing. Most of the time staff will choose to raise their concerns with their line manager. However sometimes they may feel this is inappropriate. They then have the option to 'Speak Up' anonymously using our Raising Concerns telephone number (which can be found on the Trust InTouch) or by contacting the Trust's Freedom to Speak Up Guardian via mobile telephone or dedicated email address.

Part of the role of the Freedom to Speak Up Guardian is to ensure that staff receive feedback on how their concerns are being addressed e.g. who is conducting the service review or investigation, what they found and what, if any, subsequent actions are being taken. Depending on the case, this feedback can be verbal or via email. It often forms part of regular feedback aimed at developing a trusting relationship.

Ensuring that people who speak up do not experience detriment is a central commitment of the Guardian's role. It is also clearly stated within the Trust policy. Staff are also regularly reminded that they should not tolerate any negative consequences of their speaking up. At the end of their involvement, staff are asked to answer two questions – "Would you feel confident to speak up in the future?" and "Did you feel you experienced any detriment?"

The Trust has little evidence of overt actions leading to detriment. However, some staff have felt a loss of trust in the organisation to keep them safe. This loss of trust has on some occasions resulted in staff feeling unable to remain in their current post. Many have moved to another post within the organisation and have reported their satisfaction with this outcome.

The Freedom to Speak Up guardian provides a report to the Trust Board on a twice-yearly basis. This report contains numbers of new cases taken on, the number closed, the broad category of the concern, and any feedback. It also contains anonymised case studies/examples and any lessons learnt.

During 2018/19, there were 40 cases referred to the Freedom to Speak Up Guardian. Of these, seven were submitted anonymously. 11 of the concerns related to patient safety/patient care and 27 to a culture of bullying.

Reducing Gaps in Rotas

The Guardian of Safe Working for Junior Doctors within the Trust produces quarterly reports to the Trust Board that focus on gaps in medical rotas and safety issues.

The Trust's Board received the Guardian's annual report at its meeting of 30th April 2019. The role sits independently from the management structure, with a primary aim to represent and resolve issues related to working hours. The Guardian is required to levy a fine against a department(s) if a doctor works on average over 48 hours/week, works over 72 hours in 7 days or misses more than 25% of required rest breaks. The work of the Guardian is subject to external scrutiny of doctors' working hours by the Care Quality Commission and by the continued scrutiny of the quality of training by Health Education England.

The Guardian's Annual Report notes that: "The 2016 Junior Doctor Contract was implemented for psychiatry trainees starting new contracts in February 2017. Mandated monitoring processes for the year have not identified any breaches to terms and conditions of service requiring the levy of a fine. Exception Reports mainly reflect variation in work on non-resident rotas and a new process for this has been implemented and is under review. Processes are in place for ongoing scrutiny and review of work schedules to provide assurance of safe working environments and consideration of training and service needs. There has been extensive Junior Doctor engagement in planning & implementation of rota changes and recording activity. Junior Doctor Locality Forums are running in each area, including operational and educational leaders as well as the guardian, in order to find systemic solutions.

The Guardian's main concern is filling of vacant resident night-shifts in York with non-resident locum doctors. The complexity of the service makes it difficult for key members of staff to understand the implications of calling the doctor, and this needs to be considered during the planned transformation of services in Harrogate. Attention is drawn to the need to address the Fatigue & Facilities charter during 19/20, considering the appropriateness of different grades of doctor in different posts and the impact of further planned service change.

The Guardian attends the Medical Directorate Management meeting and the Trust Strategic Medical Education meeting. Actions captured in relation to reducing gaps in rotas of medical staffing are RAG rated and managed through these meeting cycles as part of the Medical Education Operating Framework. More substantial plans and strategic pieces of work are part of an ongoing Quality Improvement plan, which is overseen by Health Education England.

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 Seven-Day follow-up

The data made available by NHS with regard to the percentage of patients on Care Programme Approach (CPA) who were followed up within seven days after discharge from psychiatric inpatient care during the reporting period. As per the Single Oversight Framework guidance, this reports all patients discharged that were followed up within seven days.

TEWV Actual Q4 18/19	****National benchmarks in Q3 18/19***	***TEWV Actual Q3 18/19***	***TEWV Actual Q2 18/19***	***TEWV Actual Q1 18/19***
Trust final reported figure: **98.09%**	NHSIC reported - Highest/Best MH Trust: **100.00%**	Trust final reported figure: **96.49%**	Trust final reported figure: **96.67%**	Trust final reported figure: **98.07%**
NHS Digital reported: **Not available**	National average MH Trust: **95.52%**			
	Lowest/Worst NHS Trust: **81.60%**	NHS Digital reported figure: **96.69%**	NHS Digital reported figure: **97.43%**	NHS Digital reported figure: **98.16%**

*Latest benchmark data available on NHS Digital at Quarter 3 2018/19

- 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

- **81** people were not followed up within seven days during 2018/19; the main reasons for this were as follows:
  - Difficulty engaging with the patient despite efforts of the service to contact the patient (**34** patients); and
  - Breakdown in processes within the service (**32** patients)

- TEWV has taken the following actions to improve the 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
  - Continuing to utilise the report out process and Trust performance management system to proactively 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 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 gatekeeper during the reporting period.

TEWV Actual Q4 18/19	****National benchmarks in Q3 18/19***	***TEWV Actual Q3 18/19***	***TEWV Actual Q2 18/19***	***TEWV Actual Q1 18/19***
Trust final reported figure: **98.80%**	NHSIC reported - National Average MH Trust: **97.81%**	Trust final reported figure: **98.49%**	Trust final reported figure: **98.01%**	Trust final reported figure: **97.81%**
NHS Digital reported: **Not available**	Highest/Best MH Trust: **100.00%**			
	Lowest/Worst NHS Trust: **78.79%**	NHS Digital reported figure: **98.64%**	NHS Digital reported figure: **98.13%**	NHS Digital reported figure: **97.75%**

*Latest benchmark data available on NHS Digital at Quarter 3 2018/19

TEWV considers that this data is 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 figures include these cases
- **36** people during 2018/19 were not assessed by the Crisis Team prior to admission; the main reasons for this were as follows:
    - Breakdown in process due to failure to follow the standard procedure (**22** patients)
    - High levels of demand on the Crisis Team (**seven** patients)

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

- Investigating instances where patients were not seen by a crisis team prior to admission and identifying lessons to be learned at a service level
- Continuing to utilise the report out process and Trust performance management system to proactively monitor performance and ensure compliance. Supporting the adherence to standard process to ensure patients discharged to other services (i.e. 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 regards 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 working 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 2018, we have reported the Health and Social Care Workers section score which compiles the results from the questions used from the survey detailed below in the table.

TEWV Actual 2018	***National benchmarks in 2018***	***TEWV Actual 2017***	***TEWV Actual 2016***	***TEWV Actual 2015***
Overall section score: 7.3 (sample size 209)	Highest/Best MH Trust: **7.7** Lowest/Worst MH Trust: **5.9** Average Score: **7.2**	Overall section score: **7.7** (sample size 232)	Overall section score: **7.8** (sample size 234)	Overall section score: **8.0** (sample size 239)

Notes on Metric

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

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

From 2014, the CQC (who design and collate the results of the survey) ceased the provision of a single overall rating for each NHS Trust and the following questions replaced those previously asked around contact with an 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?

However, during the development of the 2018 survey, stakeholders felt the question "Did the person or people listen carefully to you?" to be unnecessary and possibly misleading and therefore it was removed from the survey with no replacement introduced

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

- *Were you given enough time to discuss your needs and treatment:* TEWV mean (average) score was **7.6** The lowest national mean (average) was **6.2** and the highest **8.0**
- *Did the person or people you saw understand how your mental needs affect other areas of your life:* TEWV mean (average) score of **6.9**. The lowest national mean (average) was **5.7** and the highest **7.5**

The report identified 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 organisations across all 11 sections. As with the 2017 survey, there was no overall rating of 'better' or 'worse' than others for any section of the survey (in 2015 TEWV had four sections that were rated 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

Issues raised at the Patient Experience Group (PEG) are also often acted on immediately by the Group's members, often by taking an agreed course of action to each of the Trust's Locality Management and Governance Boards (LMGBs). An example is given in relation to inpatients reporting not feeling safe due to incidents where some patients have become aggressive due to their illness. The PEG discussed a number of suggestions on how patients who witness such incidents should be supported. It was agreed that the best ideas would be taken back to LMGBs, such as a 1:1 compassionate approach and offering debriefings

The Trust continues to carry out regular patient experience surveys across all services which includes the FFT. Between January 2018 and January 2019 the Trust received feedback from 18,536 patients with an average of 91% 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 2019

TEWV Actual Q3 & Q4 18/19	***National Benchmark in Q1 & Q2 18/19***	***TEWV Actual Q1 & Q2 18/19***	***TEWV Actual Q3 & Q4 17/18***
Trust reported to NRLS: **7,288** incidents reported of which **73 (1.00%)** resulted in severe harm or death	NRLS Reported: National Average MH Trusts: **3,494** incidents reported of which **83 (2.38%)** resulted in severe harm or death Lowest MH Trust: **16** incidents reported of which **0** resulted in severe harm and **1 (6.25%)** in death Highest MH Trust: **9,204** incidents reported of which **12 (0.13%)** resulted in severe harm and **65 (0.71%)** death The highest reported rate of death as a proportion of all incidents was **2.3%**	Trust reported to NRLS: **9,204** incidents reported of which **77 (0.84%)** resulted in severe harm or death* NRLS reported: **9,204** incidents reported of which **77 (0.84%)** resulted in severe harm or death* ***12** Severe Harm and **65** Death	Trust reported to NRLS: **7,244** incidents reported of which **85 (1.17%)** resulted in severe harm or death NRLS Reported: **8,134** incidents reported of which **63 (0.77%)** resulted in severe harm or death* ***9** Severe Harm and **54** 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 2018/19 and TEWV were identified as the highest (worst) MH Trust. 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 2018/19 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 2018/19 has considerably increased when compared with quarters three and four 2017/18. 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 2018/19 TEWV reported 142 incidents as Serious Incidents, of which 126 were deaths due to unexpected causes
- TEWV is one of the largest Mental Health Trusts in England in terms of population served and caseload

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 2018/19

Part 3: Other Information on Quality Performance 2018/19

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 2018/19 Quality Account to ensure that 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 2018/19.

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. We expect a year-on-year improvement in these figures as we get nearer to achieving these three-year targets.

Quality Metrics

The following table demonstrates how we have performed against the relevant quality metrics

Quality Metrics		**2018/19**		**2017/18**	**2016/17**	**2015/16**	**2014/15**
		Target	**Actual**	**Actual**	**Actual**	**Actual**	**Actual**
Patient Safety Metrics							
1	Percentage of patients reported 'yes always' to the question 'do you feel safe on the ward'?	**88%**	**61.50%**	**62.30%**	**N/A**	**N/A**	**N/A**
2	Number of incidents of falls (level 3 and above) per 1000 occupied bed days (for inpatients)	**0.35**	**0.18**	**0.12**	**0.37**	**N/A**	**N/A**
3	Number of incidents of physical intervention/restraint per 1,000 occupied bed days	**19.25**	**33.81**	**30.65**	**20.26**	**N/A**	**N/A**

Clinical Effectiveness Measures							
4	Existing Percentage of patients on Care Program Approach who were followed up within seven days after discharge from psychiatric inpatient care	**>95.00 %**	**96.49%**	**94.78%**	**98.35%**	**97.75%**	**97.42%**
5	Percentage of clinical audits of NICE guidance completed	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
6a	Average length of stay for patients in Adult Mental Health (days)	**<30.2**	**24.70**	**27.64**	**30.08**	**26.81**	**26.67**
6b	Average length of stay for patients in Mental Health Services for Older People (days)	**<52**	**66.53**	**67.42**	**78.06**	**62.67**	**62.18**
Patient Experience Measures							
7	Percentage of patients who reported their overall experience as excellent or good	**94%**	**91.41%**	**90.50%**	**90.53%**	**N/A**	**N/A**
8	Percentage of patients that report that staff treated them with dignity and respect	**94%**	**85.70%**	**85.90%**	**N/A**	**N/A**	**N/A**
9	Percentage of patients that would recommend our service to friends and family if they needed similar care or treatment	**94%**	**86.9%**	**87.20%**	**86.58%**	**85.51%**	**N/A**

Notes on selected Metrics

4. Data for CPA seven day follow-up is taken from the Trust's patient systems and is aligned to the national definition
5. The percentage of clinical audits of NICE Guidance completed is based on the number of audits of NICE guidelines completed against the number of audits of NICE guidelines planned. Data for this metric is taken from audits undertaken by the Clinical Directorates supported by the Clinical Audit Team
6. Data for average length of stay is taken from the Trust's patient systems

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 **61.5%** which relates to **1,980** out of **3,218** surveyed. This is **26.5%** below the Trust target of **88.00%.**

All localities underperformed this year. **North Yorkshire** was closest to the target with **68.6%** and **Forensic Services** was furthest away with **57.3%**

When brief analysis has been undertaken of why patients do not feel safe in a ward environment, the most often cited cause has been due to the behaviour of other patients. It has also been noted that due to the acuity level of patients who are admitted, they are likely to feel unsafe due to the fact that they are acutely unwell. 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 1,000 occupied bed days

The end of year position was **33.81;** this is **14.56** above the Trust target of 19.25.

Durham and Darlington, North Yorkshire and Forensic Services achieved the target this year. Of the underperforming localities, York & Selby was closest to the target with **30.34** and Teesside was furthest away with **76.57**.

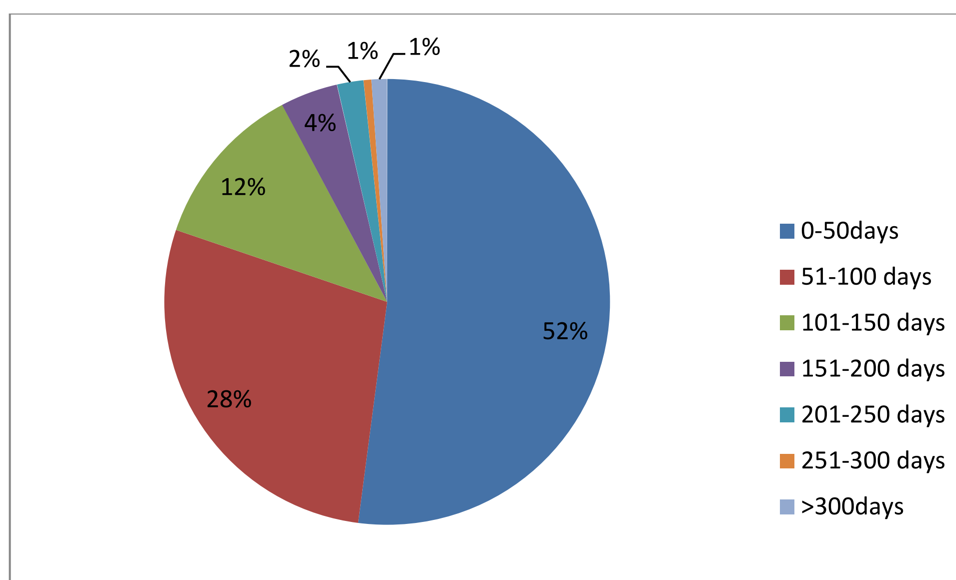
The high amount of physical restraints on Teesside reflects the high use of restraint within West Lane Hospital (CAMHS inpatient services) which is managed by the Trust’s Teesside Locality, which however serves the whole Cumbria and North East England region and beyond due to the specialist services available. This high amount is largely due to restraint to enable nasogastric feeding. The rate of restraint in the Teesside Locality excluding this site is largely in line with the rest of the localities across the Trust.

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 66.53 days as at end March 2019, which is 14.53 worse than target but an improvement compared to the position reported in 2017/18. Figure 3 over the page shows the breakdown for the various lengths of stay during 2018/19.

The median length of stay was 49 days, which is three days below the target of 52 days and demonstrates the small number of patients that had very long lengths of stay have a significant impact on the mean figures reported.

Figure 3: Length of Stay for Mental Health Services for Older people in Assessment & Treatment Wards during 2018/19



The length of stay of patients (for both adults and older people) is closely monitored by all services within the Trust. The reasons for the increase in the average length of stay for patients is due to the small number of patients who were discharged after a very long length of stay, which has distorted the overall average. In total (across AMH and MHSOP) 79.79% of lengths of stay were between 0-50 days, with 13.21% between 51-100 days. There were 52 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/or 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 **91.41%**, which relates to **18,412** out of **20,142** surveyed. This is **2.59%** below the Trust target of 94.00%.

All localities underperformed against this target in 2018/19. **Durham and Darlington** was closest to the target with **92.68%** and **Forensic Services** was performing furthest away from the target at **82.95%.**

Metric 8: Percentage of patients that report that staff treated them with dignity and respect

The end of year position was **85.7%** which relates to **16,151** out of **18,848** surveyed. This is **8.3%** below the Trust target of 94.00%.

All localities underperformed in 2018/19. **North Yorkshire** was closest to the target with **88.9%** and **Forensic Services** was performing furthest away from the target with **72.4%.**

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 **86.9%** which relates to **17,722** out of **20,401** surveyed. This is **7.1%** below the Trust target of 94.00%.

None of our localities achieved this target in 2018/19. **Durham & Darlington** was closest to the target with **88.6%** and **Forensic Services** was performing furthest away from the target with **77.9%.**

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.

Single Oversight Framework

Indicators		2018/19		2017/18	2016/17	2015/16	2014/15	2013/14
		Threshold	Actual	Actual	Actual	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%	**64.89%**	**73.32%**	**70.04%**	**55.91%**	**N/A**	**N/A**
B	Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in inpatient wards*	90%	**92.00%**	**92.50%**	**N/A**	**N/A**	**N/A**	**N/A**
C	Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in early intervention in psychosis services**	90%	**91.55%**	**91.00%**	**N/A**	**N/A**	**N/A**	**N/A**
D	Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in community mental health services (people on CPA)*	65%	**78.00%**	**74.39%**	**N/A**	**N/A**	**N/A**	**N/A**
E	IAPT/Talking Therapies – proportion of people completing treatment who move to recovery (from IAPT minimum dataset)	50%	**51.29%**	**50.44%**	**48.32%**	**N/A**	**N/A**	**N/A**
F	Percentage of people referred to the IAPT programme that were treated within six weeks of referral	75%	**97.91%**	**95.49%**	**95.44%**	**84.01%**	**N/A**	**N/A**

G	Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral	95%	**99.73%**	**99.89%**	**99.14%**	**95.93%**	**N/A**	**N/A**
H	Percentage of patients on Care Programme Approach who were followed up within seven days after discharge from psychiatric inpatient care	>95.0 0%	**97.31%**	**96.52%**	**98.35%**	**97.75%**	**97.42%**	**97.86%**
I	Admissions to adult facilities of patients who are under 16 years old		**0**	**1**	**N/A**	**N/A**	**N/A**	**N/A**
J	Inappropriate out of area placements (OAPs) for adult mental health services		**874**	**1913**	**N/A**	**N/A**	**N/A**	**N/A**

*This figure is different to that published elsewhere for 2018/19 due to the timing of the 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 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 C: Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in early intervention in psychosis services

Data collection using the College of Psychiatrists' Centre for Quality Improvement (CCQI) self-assessment tool was submitted to NHS England/Royal College of Psychiatrists during quarters three and four; this was based on a sample of data.

External Audit

For 2018/19, 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 aspects. In addition the Council of Governors (CoG) have chosen one further local indicator for external assurance. Therefore the three indicators which have been included in the external assurance of the Quality Account 2018/19 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
- Percentage of patients who report 'yes, always' to the question 'Do you feel safe on the ward?'

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 2018/19, we have tried to improve how we involved our stakeholders in assessing our quality in 2018/19.

Our stakeholder engagement events were held in a location central to the area served by the Trust, 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 in our business planning process.

The positive feedback we have received was mostly within the following themes:

- *Good mix of stakeholders on Group – OSC, Healthwatch, TEWV Governors, NECS*
- *Opportunity to network – share learning and information*
- *Informative*
- *A good range of speakers*

However, stakeholders also suggested that we allow more time for questions about our quality priorities and give attendees more time to feed back their thoughts, which we will take on board for our Stakeholder Events to be held during 2019/20.

In line with national guidance, we have circulated our draft Quality Account for 2018/19 to the following stakeholders:

- NHS England
- North East Commissioning Support
- Clinical Commissioning Groups (x9)
- Local Authority Overview & Scrutiny Committees (x8)

- Local Authority Health & Wellbeing Boards (x7)
- Local Healthwatch Organisations (x7)

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 2018/19:

- Welcomed the opportunity to receive and comment on the Quality Account
- Recognised the progress made against our 2018/19 quality priorities and agree with our plans to achieve the 2018/19 quality priorities, and were particularly supportive of the new Urgent Care priority
- Noted that not all the quality metric targets were met but agreed with the mitigations that had been put in place
- Acknowledged the progress on leaning from incidents but feel that further work is needed
- Commended the Trust on their improved links with service providers and positive partnership working, to ensure a holistic approach is provided for service users
- Commended the Trust on their specific focus on perinatal mental health
- Noted the Trust had maintained their CQC rating of 'good,' although some areas were highlighted for improvement
- Would like to receive six-monthly updates

The Trust will write to each stakeholder addressing each comment made following publication of the Quality Account 2018/19 and use the feedback as part of the annual lessons learnt exercise in preparation for the Quality Account 2019/20.

In response to many stakeholders' requests, the Trust has agreed to continue providing all stakeholders with a half-year update in November 2019 on the Trust's progress with delivering its quality priorities and metrics for 2019/20.

APPENDICES

Appendix 1: 2018/19 Statement of Director's Responsibilities in respect of the Quality Account

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

NHS Improvement has issued guidance to NHS Foundation Trust boards on the form and content of annual Quality Accounts/Reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust boards should put in place to support the data quality for the preparation of the Quality Account/Report.

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

- The content of the Quality Account/Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2018/19 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 2018 to May 2019
    - Papers relating to quality reported to the Board over the period April 2018 to May 2019
    - Feedback from the Commissioners dated 13th May 2019 and 15th May 2019
    - Feedback from Governors dated 4th March 2019 and 11th April 2019
    - Feedback from local Healthwatch organisations dated 9th May 2019, 13th May 2019, 13th May 2019 and 16th May 2019
    - Feedback from Overview and Scrutiny Committees dated 1st May 2019, 3rd May 2019, 8th May 2019 and 9th May 2019
    - Feedback from Health and Wellbeing Board dated 10th May 2019
    - The Trust's complaints information reported to its Quality Assurance Committee of the Board of Directors, which will be published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
    - The latest national patient survey published 22nd November 2018
    - The latest national staff survey published 26th February 2019
    - The Head of Internal Audit's annual opinion over the Trust's control environment dated 8th May 2019
    - CQC inspection report dated 23rd October 2018

- The Quality Account/Report presents a balanced picture of the NHS Foundation Trust’s performance over the period covered

- The performance information reported in the Quality Account/Report is reliable and accurate

- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account/Report, and these controls are subject to review to confirm that they are working effectively in practice

- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review

- The Quality Report has been prepared in accordance with NHS Improvement’s annual reporting manual and supporting guidance (which incorporates the Quality Account regulations) as well as the standards to support data quality for the preparation of the Quality Report

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account/Report

By order of the Board:

-- May 2019…………………………………………………………………Chairman

-- May 2019…………………………………………………………………Chief Executive

Appendix 2: 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 2019 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2019 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 2018/19; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance and the six dimensions of data quality set out in the Detailed Requirements for External Assurance on Quality Reports.

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 become 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 2018 to April 2019;
- Papers relating to quality reported to the Board over the period April 2018 to April 2019;
- Feedback from Commissioners, NHS Vale of York Clinical Commissioning Group (dated 13 May 2019), NHS Harrogate and Rural District Clinical Commissioning Group (dated 15 May 2019) and NHS Darlington Clinical Commissioning Group (dated 20 May 2019);
- Feedback from governors;
- Feedback from local Healthwatch organisations, Healthwatch Hartlepool (undated), Healthwatch Darlington (undated), Healthwatch South Tees (undated), and Healthwatch County Durham (undated);
- Feedback from Overview and Scrutiny Committee, Darlington Borough Council (undated), Durham County Council (dated 10 May 2019), Hartlepool Borough Council (dated 1 May 2019), North Yorkshire County Council (dated 1 May 2019), and Tees Valley Joint Health Scrutiny Committee (dated 9 May 2019);
- The Trust's complaints information that will inform its complaints report to be published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- The latest national patient survey dated 2018;
- The latest national NHS staff survey dated 2018;
- Care Quality Commission inspection (dated 23 October 2018);
- The Head of Internal Audit's annual opinion over the trust's control environment for the year ending 31 March 2019; and
- Any other information included in our review.

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

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales

(ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Tees, Esk and Wear Valleys NHS Foundation Trust as a body, 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 2019, to enable the Council of Governors to demonstrate that it has discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Tees, Esk and Wear Valleys NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

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

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

Limitations

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

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

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

Conclusion

Based on the results of our procedures nothing has come to our attention that causes us to believe that for the year ended 31 March 2019:

- 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 2018/19; 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: 24 May 2019

Chartered Accountants and Statutory Auditor
Salvus House
Aykley Heads
Durham
DH1 5TS

Appendix 3: Glossary

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

Audit: An official inspection of records; this can be conducted either by an independent body or an internal audit department

Autism Services/Autistic Spectrum: This describes a range of conditions including autism, Asperger’s 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

Benefits: This term is often used when describing and measuring the positive and negative (disbenefits) elements of a project or programme of work

Board/Board of Directors: The Trust is run by a Board of Directors made up of the Chairman, Chief Executive, Executive and Non-Executive Directors. The Board is responsible for ensuring accountability to the public for the services in manages. It is overseen by a Council of Governors and monitored by NHS Improvement. It also:

- Ensure effective dialogue between the Trust and the communities it serves
- Monitors and ensures high quality services
- Is responsible for the Trust’s financial viability
- Appoints and appraises the Trust’s executive management team

Business Plan: A document produced once a year by the Trust to outline what we intend to do over the next three years in relation to the services that we provide

Child and Adolescent Mental Health Services (CAMHS): See Children and Young People’s Services (CYPS)

Care Planning: See Care Programme Approach (CPA)

Care Programme Approach: describes the approach used in specialist mental health care to assess, plan, review and coordinate the range of treatment options and support needs for people in contact with secondary mental health services who have complex characteristics. It is called ‘an approach’ rather than a system because of the way these elements are carried out, which is as important as the tasks themselves. The approach is routinely audited

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

Children and Young People's Services (CYPS): Mental Health Services for children and young people under the age of 18 years old. This includes community mental health services, inpatient services and learning disability services

CITO: An information technology system which overlays the Trust's patient record system (PARIS) which makes it easier to record and view the patient's records

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

Clinical Link Pathway (CLiP): 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's care are defined, optimised and sequenced using the Trust's electronic patient record system (PARIS)

Commissioners: The organisations that have responsibility for purchasing health services on behalf of the population in the area they work for

Commissioning for Quality and Innovation (CQUIN): A payment framework where a proportion of NHS providers' income is conditional on quality and innovation

Community Mental Health Survey: a survey conducted every year by the CQC. It represents the experiences of people who have received specialist care or treatment for a mental health condition in 55 NHS trusts in England over a specific period during the year

Confidential Inquiry: A national scheme that interviews clinicians anonymously to find out ways of improving care by gathering information about factors which contributed to the inability of the NHS to prevent each suicide of a patient within its care. National reports and recommendations are then produced

Co-production/Co-produced: This is an approach where a policy or other initiative/action is designed jointly between TEWV staff and service users, carers and families

Council of Governors: Made up of elected public and staff members, and includes non-elected members such as the Prison Service, Voluntary Sector, Acute Trusts, Universities and Local Authorities. The Council has an advisory, guardianship and strategic role including developing the Trust's membership, appointments and

remuneration of the Non-Executive Directors including Chairman and Deputy Chairman, responding to matters of consultation from the Trust Board, and appointing the Trust's auditors

Crisis Resolution & Home Treatment (CRHT) Team: Provide intensive support at home for individuals experiencing an acute mental health crisis. They aim to reduce both the number and length of hospital admissions and to ease the pressure on inpatient units

Dashboard: A report that uses data on a number of measures to help managers build up a picture of operational (day-to-day) performance or long-term strategic outcomes

Data Protection and Security Toolkit: A national approach that provides a framework and assessment for assuring information quality against national definitions for all information that is entered onto computerised systems whether centrally or locally maintained

Data Quality Improvement Plan (DQIP): 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 established

Data Quality Strategy: A TEWV strategy which sets out clear direction and outlines what the Trust expects from its staff to work towards our vision of providing excellent quality data. It helps TEWV continue to improve the quality and value of our work, whilst making sure that it remains clinically and financially sustainable

Department of Health: The government department responsible for Health Policy

DIALOG: A clinical tool that allows for assessment, planning, intervention and evaluation in one procedure and allows more personalised Care Planning

Directorate: 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

Early Intervention in Psychosis (EIP): A clinical approach to those experiencing symptoms of psychosis for the first time. The approach centres on the early detection and treatment of 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 treatment in these early years is thought to prevent relapses and reduce the long-term impact of the condition

Executive Management Team (EMT): Individuals at the senior level of management within the organisation (e.g. Directors) who meet on a regular basis. They are responsible for the overall management of TEWV and the high-level decisions within the organisation

Experts by Experience: Non-contracted roles, to offer story-telling input into trainer and provide the opportunity to gain a broader perspective of lived experience views on a range of services developments. Experts by Experience have been trained to work alongside the Recovery Team to develop and delivery Recovery-related training and supporting staff and service developments in Recovery-related practice. Experts by Experience work with Trust staff, they do not work with patients and carers (i.e. they are not acting in a peer role)

Forensic Adult and Mental Health and Learning Disability Services: Work mainly with people who are mentally unwell or who have a learning disability and have been through the criminal justice system. The majority of people are transferred to a secure hospital from a prison or court, where their needs can be assessed and treated

Formulation: When clinicians use information obtained from their assessment of a patient to provide an explanation or hypothesis about the cause and nature of the presenting problems. This helps in developing the most suitable treatment approach

Freedom 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 information

Freedom to Speak Up Guardian: Provides guidance and support to staff to enable them to speak up safely within their own workplace

Friends and Family Test (FFT): A survey put to service users, carers and staff that asks whether or not they would recommend a hospital/community service to a friend or family member if they need treatment

Gatekeeper/Gatekeeping: Assessing the service user before admission to hospital to consider whether there are alternatives to admission and the involvement in the decision-making processes that result in admission

General Medical Practice Code: The organisation code of the GP Practice that the patient is registered with. This is used to make sure a patient's GP code is recorded correctly

Guardian of Safe Working: Provides assurance that rotas and working conditions are safe for doctors and patients

Harm Minimisation: Aims to prevent and reduce the myriad of 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 (i.e. Local Authorities and the NHS) would work together to improve the

health and wellbeing of their local population and to reduce health inequalities. Health and wellbeing board members collaborate to understand their local community's needs, agree priorities and encourage commissioners to work in a more joined-up way

Healthcare Safety Investigation Branch: Undertakes investigations of accidents which have happened within the NHS

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 – for example, after a course of treatment or other intervention – and then compared. If the ratings show a difference, this might mean that the patient's health or social status has changed

Health Services Journal (HSJ): A peer-reviewed journal that contains articles on health care

HealthWatch: Local bodies made up of individuals and community groups, such as faith groups and resident's organisations associations, working together to improve health and social care services. They aim to ensure that each community has services that reflect the needs and wishes of local people

Home Treatment Accreditation Scheme (HTAS): Works with teams to assure and improve the quality of crisis resolution and home treatment services for people with acute mental illness and their carers

Hospital Episode Statistics (HES): The national statistical data warehouse for England of the care provided by NHS hospitals and for NHS hospital patients treated elsewhere. HES is the data source for a wide range of healthcare analysis for the NHS, Government and many other organisations and individuals

Improving Access to Psychological Therapies (IAPT): An NHS initiative to increase the provision of evidence-based treatments for common mental health conditions such as depression and anxiety by primary care organisations

Integrated Care Partnerships: An emerging NHS initiative to encourage integration and place-based planning

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

Intensive Home Treatment: See Crisis Resolution and Home Treatment Team above

InTouch: This is the Trust's internal website used for staff to access relevant information about the organisation, such as Trustwide policies and procedures

Involvement Peer Roles: Non-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 lead the sessions. They are managed under the involvement and engagement process and are paid travel expenses and an honorarium

Kaizen: A word used as part of the Quality Improvement System (QIS) process; it is a Japanese word that means 'change for the better' and is also known as 'continuous improvement'

Learning Disability Services: Services for people with a learning disability and mental health needs. TEWV has an Adult Learning Disability (ALD) service in each of its three localities and also has specific wards for Forensic LD patients. TEWV provides Child LD services in Durham, Darlington, Teesside and York but not in North Yorkshire

Liaison & Diversion: A process whereby people of all ages with mental health problems, a learning disability, substance misuse problems and other vulnerabilities are identified and assessed as early as possible as they pass through the youth and criminal justice systems

Local Authority Overview and Scrutiny Committee: Statutory committees of each Local Authority which scrutinise the development and progress of strategic and operational plans of multiple agencies within the Local Authority area. All Local Authorities have an OSC that focusses on Health, although Darlington, Middlesbrough, Stockton, Hartlepool and Redcar and Cleveland councils have a joint Tees Valley Health OSC that performs this function

Locality: Services in TEWV are organised around three localities (Durham and Darlington, Teesside and North Yorkshire & York). Forensic Services are not organised on a geographical basis, but are often referred to as a fourth 'Locality' within TEWV

Locality Management and Governance Board (LMGB): A monthly meeting held in each locality (see above) that involves senior managers and clinical leaders who work in that Locality and take key decisions

Mazars: An international, integrated and independent organisation specialising in audit, accountancy, tax, legal and advisory services. They are TEWV's current external auditors

Memorandum of Understanding: An agreement between two or more parties that expresses a convergence of will between them, indicating a common line of action

Managing the Business Group: A director-level group which means monthly and manages the operational corporate business of the Trust; similar to the Operational Management Team (OMT) however its focuses are on corporate services rather than clinical services. The Group holds overall responsibility for the Data Quality Strategy

Memory Services: Services for people who are experiencing memory difficulties, including the early onset of dementia

Mental Health Act (1983): The main piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder. In most cases when people are treated in hospital or in another mental health facility they have agreed or volunteered to be there. However, there are cases when a person can be detained (also known as sectioned) under the Mental Health Act and treated without their agreement. People detained under the Mental Health Act need urgent treatment for a mental health disorder and are at risk of harm to themselves or others

Mental Health Services for Older People (MHSOP): Services provided for people over 65 years old with a mental health problem. They can be treated for 'functional' illness, such as depression, psychosis or anxiety, or for 'organic' mental illness (conditions usually associated with memory loss and cognitive impairment) such as dementia. The MHSOP Service sometimes treats people less than 65 years of age with organic conditions such as early-onset dementia

Ministry of Defence: The British government department responsible for implementing the defence policy set by Her Majesty's Government and is the headquarters of the British Armed Forces

Mortality Review Process: A Trust process to review deaths, ensuring a consistent and coordinated approach, and promoting the identification of improvements and the sharing of learning

Multi-Agency Public Protection Arrangements (MAPPA): The process through which various agencies such as the police, the Prison Service and Probation work together to protect the public by managing the risks posed by violent and sexual offenders living in the community

Multi-Disciplinary: This means that more than one type of professional is involved, for example, psychiatrists, psychologists, occupational therapists, behavioural therapists, nurses, pharmacists all working together in a Multi-Disciplinary Team (MDT)

Multi-morbidity: Where an individual has two or more long-term health conditions

National Institute for Clinical Excellence (NICE): NHS body that provides guidance, sets quality standards and manages a national database to improve people's health and to prevent and treat ill health. NICE works with experts from the NHS, local authorities and others in the public, private, voluntary and community sectors – as well as patients and carers – to make independent decisions in an open, transparent way, based on the best available evidence and including input from experts and interested parties

National Institute for Health Research (NIHR): An NHS research body aimed at supporting outstanding individuals working in world class facilities to conduct leading edge research focused on the needs of the patients and the public

National Reporting and Learning System (NRLS): A central (national) database of patient safety incident reports. All information submitted is analysed to identify hazards, risks and opportunities to continuously improve the safety of patient care

NHS Digital: Previously known as the Health and Social Care Information Centre (HSCIC) and 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 (NHSI): The independent economic regulator for NHS Foundation Trusts – previously known as Monitor

NHS Long-Term Plan (2019): A new plan for the NHS to improve the quality of patient care and health outcomes. It sets out how the £20.5 billion budget settlement for the NHS, announced by the Prime Minister in summer 2018, will be spent over the next five years

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

NHS Staff Survey: Annual survey of staff experience of working within NHS Trusts

Non-Executive Directors (NEDs): Members of the Trust Board who act as a 'critical friend' to hold the Board to account by challenging its decisions and outcomes to ensure they act in the best interests of patients and the public

North Cumbria and North East Integrated Care System: Consists of four Integrated Care Partnerships – North, South, East and West (see Integrated Care Partnerships)

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, designed with mental health professionals to ensure that the right information is available to those who need it at all times

Patient Advice and Liaison Service (PALS): A service within the Trust that offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers

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 ongoing 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

Perinatal Mental Health Service: A service for any woman with mental health problems who is planning a pregnancy, is pregnant, or has a baby up to one year old

Positive Behavioural Support (PBS): is a person-centred approach to people who display or are at risk of displaying behaviours that 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 that 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

Programme: A coordinated group of projects and/or 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 Programme, setting actions, tasks and deadlines

Project: A one-off, time limited piece of work that produces a product (such as a new building, a change in service or a new strategy/policy) that will bring benefits to relevant stakeholders. Within TEWV, projects will go through a scoping phase, and then a Business Case phase before they are implemented, evaluated and closed down. All projects will have a project plan and a project manager

Psychiatric Intensive Care Unit (PICU): A unit (or ward) that is designed to look after people who cannot be managed on an open (unlocked) psychiatric ward due to the level of risk they pose to themselves or others

Quality Account: A report about the quality of services provided by an NHS Healthcare Provider, The report is published annually by each provider

Quality Assurance Committee (QuAC): Sub-Committee of the Trust Board responsible for Quality and Assurance

Quality Assurance Groups (QuAG): Locality/divisional groups within the Trust responsible for Quality and Assurance

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 it remains clinically and financially sustainable

Quality Strategy Scorecard: A set of numerical indicators related to all aspects of Quality, reported to the Trust Board four times a year that helps the Board ascertain whether the actions being taken to support the Quality Strategy are having the expected positive impact

Quarter One/Quarter Two/Quarter Three/Quarter Four: Specific time points within the financial year (1st April to 31st March). Quarter One is from April to June, Quarter Two is from July to September, Quarter Three is October to December and Quarter Four is January to March

RAG rated: A measuring tool used to measure progress against a specific action; e.g. green if it has been achieved and red if it has not. Some scales also use amber ratings to indicate where an action has been delayed but will still be completed

Rapid Process Improvement Workshop (RPIW): A workshop held over a number of days focusing on a particular process in which the people who do the work are empowered to eliminate waste and reduce the burden of work. It is designed around the plan-do-study-act (PDSA) method

Reasonable Adjustments: A change or adjustment unique to a person's needs that will support them in their daily lives, e.g. at work, attending medical appointments, etc.

Recovery Approach: 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 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 learning centre where patients, carers and staff can enrol as students to attend courses based on recovery principles. Our recovery college, *ARCH*, opened in September 2014 in Durham. This resource is available to TEWV patients, carers and staff in the Durham area, and 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: An initiative that allows people to access Recovery College materials and peer support online (see above). This is available to service users and staff in all areas served by TEWV

Recovery Strategy: TEWV's long-term plan for moving services towards the Recovery Approach *(see above)*

Research Ethics Committee: An independent committee of the Health Research Authority, whose task it is to consider the ethics of proposed research projects which will involve human participants and which will take place, generally, within the NHS

Royal College of Psychiatrists: The professional body responsible for education and training, and setting and raising standards in psychiatry

Safeguarding: Protecting vulnerable adults or children from abuse or neglect, including ensuring such people are supported to get good access to healthcare and stay well

Section 17 (S17): 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 where they are detained under the Mental Health Act

Secondary Uses Service: The single, comprehensive repository for healthcare data in England which enables a range of reporting and analysis to support the NHS in the delivery of healthcare services

Serious Incident (SI): An incident that occurred in relation to NHS-funded services and care, to either patient, staff or member of the public, resulting in one of the following – unexpected/avoidable death, serious/prolonged/permanent harm, abuse, threat to the continuation of delivery of services, absconding from secure care

Single Oversight Framework: sets out how NHS Trusts and NHS Foundation Trusts are overseen

Specialties: The term that TEWV uses to describe the different types of clinical services that we provide (previously known as Directorates). The Specialties are Adult Mental Health Services, Mental Health Services for Older People, Children and Young People's Services and Adult Learning Disabilities

Staff Friends and Family Test: A feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. It helps the Trust to identify what is working well, what can be improved and how

Steering Group: Made up of experts who oversee key pieces of work to ensure that protocol is followed and provide advice/troubleshoot where necessary

STOMP (Stopping Over-Medication of People with a Learning Disability, Autism or Both Project): A national project involving many different organisations which are helping to stop the over use of psychotropic medications with people who have a Learning Disability, Autism or both. STOMP is about helping people to stay well and have a good quality of life

Substance Misuse: A pattern of psychoactive substance use (including illegal drugs, alcohol 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: Shortened version of WEMWBS *(see below)*

TEWV: Tees, Esk and Wear Valleys NHS Foundation Trust

TEWV Quality Improvement System (QIS): The Trust's framework and approach to continuous quality improvement based on Kaizen/Virginia Mason principles

Tier 4 Children's Services: Deliver specialist inpatient and day patient care to children who are suffering from severe and/or complex mental health conditions that cannot be adequately treated by community CAMHS services

Thematic Review: A piece of work to identify and evaluate Trustwide practice in relation to a particular theme. This may be to identify where there are problems/concerns or to identify areas of best practice that could be shared Trust-wide

The Trust: see TEWV above

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 Adult Services

Trauma-Informed Care: Involves understanding, recognising and responding to the effects of all types of trauma

Triangle of Care (ToC): A working collaboration, or 'therapeutic alliance' between the service user, professional and carer that promotes safety, supports recovery and sustains wellbeing

Trust Autism Framework: A document which sets out how the Trust aims to become more autism aware, informed and responsive to needs of people with autism through better access and clearer pathways to services

Trust Board: See Board/Board of Directors above

Trustwide: The whole geographical area served by the Trust's localities

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

Urgent Care Services: Crisis, Acute Liaison and Street Triage services across the Trust

Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS): A scale of 14 positively-worded items which is used to measure changes over time in service user wellbeing

Workstreams: The progressive completion of tasks completed by different groups which are required to complete a single project or programme

Year (e.g. 2018/19): These are financial years, which start on the 1st April in the first year and end on the 31st March in the second year

Appendix 4: Key themes from 174 Local Clinical Audits reviewed in 2018/19

Audit Theme	Key quality improvement activities associated with clinical audit outcomes
1. Infection Prevention and Control (IPC)	• All Infection Prevention and Control Audits are continually 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 action monitoring database • A total of **101** IPC clinical audits were conducted during 2018/19 in inpatient areas in the Trust.**79% (80/101)** 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. Medicines Management	• Audit results have been used to help refine the wording regarding key labelling requirements in the Trust's medicines storage policy • Standards for prescription writing on Trust prescription and administration charts have been updated to include an instruction to state the indication for antimicrobials in the comments box and the Trust pharmacy junior doctor induction presentation regarding the need to record indication, dose, frequency, start date and review/stop dates for oral antimicrobials on PARIS as well as the prescription and administration chart • There has been a roll-out of a new formal prescription chart and compliance with key standards for prescription writing is monitored via the monthly Medicines Optimisation Assessments (MOA) • Further clinical audit results have influenced changes to be included within these monthly Medicines Optimisation Assessments including monitoring appropriateness of antimicrobial course length • National Prescribing Observatory for Mental Health (POMH) clinical audit results have been shared with prescribers highlighting the need for all patients on depot antipsychotics to have side effects and therapeutic response reviewed annually • A medication lessons learned bulletin has been produced following National audit results including aspects relating to provision of information, service user involvement, and the discussions regarding

	pros and cons of medication • A Medication Safety Series on the Valproate PPP (pregnancy prevention programme) was published • Changes have been made to Trust psychotropic monitoring guidance to add the broader physical health monitoring parameters (BP, glucose/HbA1c, lipids) from CG185 on valproate and other drugs used in bipolar disorder • Following the Trust's High Dose Antipsychotic Treatment (HDAT) audit, the Trust will be assessing the impact of electronic HDAT registers which have been implemented within specific teams with a view to share and spread this good practice • A regular Controlled Drugs newsletter was launched highlighting key lessons learned
3. Physical Healthcare	• Trust Nasogastric Tube Insertion Training has been delivered for relevant teams following clinical audit results • Results of the National CQUIN Safety Thermometer are reported to the Clinical Effectiveness Group quarterly • A VTE workstream has been established following clinical audit activities. Developments are ongoing around exploring changes in the admission pathway for medical staff and progress with the addition of new physical health admission documentation on PARIS. The workstream will be reviewing the current Trust VTE policy as well as the checklist document, in particular in relation to ensuring that history of VTE is considered • A briefing has been circulated to medical and nursing staff providing information about VTE assessment including bleeding risk factors and prescribing VTE prophylaxis wand why this is crucial in practice to ensure care is safe and effective • The Positive Approaches Training (PAT) programme curriculum has been amended to include training on reporting the use of physical intervention • A Soft-Restraint Device (SRD) physical health check form has been devised which will be completed by a medic prior to the implementation of SRDs
4. Records Management	• Work is ongoing around changing elements of the electronic patient record system including merging the care plan and intervention plan into one single plan and redesigning these documents in

	collaboration with the recovery programme and digital transformation team to promote the principles of CPA • A standard report has been made available within the Trust's Integrated Information Centre (IIC) to allow staff to review young people at the age of 17.25 to allow better planning for Transition meetings. In addition to this, a prompt sheet has been rolled out in CYPS and AMH services for discharge/transition planning • A policy review has been undertaken to standardise the way in which time taken away from the ward is documented by clinical staff/teams. In addition to this, changes have been made to the Trust approved Record Keeping/Abbreviation Document • Operational policies have been updated in MHSOP Services following clinical audit activities investigating compliance with age discrimination requirements of the Equality Act 2010 and the Trust Human Rights, Equality and Diversity Policy • Standard work is ongoing for reviewing the format for how evidence will be documented in the clinical record in AMH services in terms of managing risks posed by people with borderline personality disorder in the community mental health service as it is recommended that these should be managed by the whole multi-disciplinary team • The Safeguarding Team's MAPPA Standard Process Description will include a safety precaution and quality check to ensure actions from MAPPA meetings are completed
5. Risk Assessment/Patient Safety	• The admissions checklist has been updated and considers the assessment of pain in MHSOP inpatient services • DNA (Did Not Attend) risk assessment requirements have been clarified following clinical audit results in relation to what is meant by carrying out an assessment of risk in relation to DNA • Measures have been put in place to improve compliance in risk areas relating to Duty of Candour policy adherence including amending the 72 hour report form. Serious Incident Investigators now review the details provided on the 72 hour report form in relation to Duty of Candour and offer telephone support to ensure all fields are competed and the information is transferred to PARIS • Harm Minimisation Training resources programme content has been informed by 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 where consent is documented within the electronic patient record system • The Positive and Safe Team have developed Behaviour Support Planning Masterclasses for all Registered Nursing Staff as well as drop in clinical support sessions for staff following Positive and Safe Practice clinical audit. As well as this, an incident reporting template has been developed and will be rolled out within the updated Rapid Tranquilisation Policy • The Trust's policy on the use of Global Restrictive Practices in inpatient units has been updated following clinical audit results to include the requirement to document plans to lift temporary blanket restrictions and a flow chart summarising the process staff should following when implementing a blanket restriction. Further developments are ongoing to ensure there is a process in place for Directorates to set a minimum frequency for review of blanket restrictions, to minute the reviews at ward-level meetings, and to review these in the Quality Assurance Groups • There is ongoing work for implementing a process with Modern Matrons to review Section 17 Leave forms each month and report this to Locality Quality Assurance Groups
6. Supervision	• 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 received, with a target of a minimum of 2 hours per quarter • Trust policy has been updated for CPD/supervision requirements so that it is clear what supervision is needed in the first 6 months as Level 1 Non-Medical Prescriber • Clinical Audit has facilitated documentation of supervision requirements within Offender Health, Prison and Liaison & Diversion Teams
7. NICE/Pathway Development	• Tier 4 CAMHS wards have included a section on the Visual Display Boards to identify which service users are on the Positive Behaviour Support (PBS) pathway for quick reference • MHSOP community teams have shared audit results to inform local improvements required as part of the Purposeful and Productive Community Services (PPCS) initiative • The dietetic leaflet within the Trust ADHD Pathway was updated • A review of the Falls CLiP was undertaken to determine whether the existing CLiP is suitable for use in LD services and to adapt this to make the CLiP more relevant to LD services • Guidance has been developed for staff in LD services to support "the who, when & how of 'routine

	inquiry'" in conjunction with the Trauma Informed Care Project • Autism Post-diagnostic interventions have been reviewed following clinical audit results and patients are now offered occupational therapy and social care assessment once an autism diagnosis is made. In addition to this, quality improvement work has been undertaken to reduce waiting times for autism assessments following referral and there is ongoing work with regards to improving care plan documentation through CPA work streams, and crisis plan development will be considered as part of this work

Appendix 5: Trust Business Plan additional Priorities

The Quality Improvement priorities set out in Part 2 of this Quality Account document are also included in the Trust's Business Plan (in which they are priorities 14-18). The other priorities in the Business Plan will all have a positive impact on the quality of Trust services, and are listed in the table below.

No	Title	Lead	To conclude by
Overarching Priorities			
0	Implement a recovery-focused approach across all services	Medical Director	Q4 21/22
Strategic Priorities			
1	Develop and implement a trauma-informed care approach across our services	Medical Director	Q4 21/22
2	Improve the purposefulness and productivity of our services	Chief Operating Officer	Q4 21/22
3	Ensure we have the right staffing for our services now and in the future	Director of Nursing & Governance	Q4 21/22
4	Make a Difference Together by embedding TEWV's values and behaviours throughout the organisation	Chief Executive	Q4 21/22
5	Deliver our Digital Transformation Strategy	Director of Finance & Information	Q4 21/22
6	Identify and reduce waste	Chief Executive	Q4 21/22
Operational Priorities			
7	Implement the Transforming Care agenda	Chief Operating Officer	Q4 19/20
8	Develop and implement a Trust-wide approach to enabling people who have autism to access mental health services	Chief Operating Officer	Q4 19/20
9	Complete the transformation of our York & Selby services	Chief Operating Officer	Q2 21/22
10	Implement the agreed future delivery model for people living in Harrogate and Rural District and Wetherby who require our services	Chief Operating Officer	Q2 20/21
11	Implement the agreed delivery model for people living in Hambleton and Richmondshire who require our services	Chief Operating Officer	Q4 20/21
12	Improve the physical environment at Roseberry Park Hospital	Chief Operating Officer	Q1 24/25
13	Implement the NHS Long Term Plan for Mental Health as agreed with each of our commissioners	Chief Operating Officer	Q4 21/11

In addition to these, many of the operational plans 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 two 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) 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 have not 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 three-month period

Exemptions:

All beds except for acute mental health care – Assessment and Treatment, Acute Older Adult Mental Health Care (Organic and Functional) Assessment and Treatment and PICU. The age range excludes anyone who is under 18 years

Percentage of patients who reported 'yes, always' to the question 'Do you feel safe on the ward?'

Data definition:

Percentage of patients who answer 'yes, always' to the question on the FFT 'Do you feel safe on the ward?'

Exemptions:

There are no exemptions for this indicator

Accountability:

QuAC and Patient Safety Group

Numerator:

The actual percentage of patients who answer 'yes, always' to this question

Denominator:

The total number of responses to this question

Appendix 7: Feedback from our Stakeholders

Darlington Borough Council Health and Partnership Scrutiny Committee

Tees, Esk and Wear Valleys NHS Foundation Trust – Draft Quality Account 2018/19

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 2018/19 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.

Members have the following comments to make:

Reduce the number of preventable deaths – Members welcomed the work that had been achieved the reduce the number of preventable deaths and the implementation of the Engagement Plan produced to involve families, carers and non-Executive Director within the review process.

Improve the Clinical Effectiveness and Patient Experience in times of transition from Child to Adult Services – Members were pleased to note that Transition Panels were now in place and have been reviewed to gain additional service user perspective and to set relevant targets and metrics and an engagement plan had been produced to further involve families and carers in this process.

Improve the personalisation of Care Planning – Members noted that an in-depth quality focused audit had been completed and an action plan had been developed via a series of focus groups and that the delivery of training was on going.

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 Dual Diagnosis Clinical Link Pathway (CLiP) and the new policy and protocols in place to deal with the management of Substance Misuse and the improved links with service providers. Members also support the continued priority for the prevention of harm to people with mental health needs and learning disabilities.

Statement of Assurances from the Board 2018/19
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 assurances from the Board of Directors, on progress made on key areas of quality during 2018/19. This included review of services, participation in clinical audits and national confidential inquiries; 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 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 nine Quality Metrics, five were reported as red at the end of March 2019. Unfortunately the number of patients who felt safe on the ward was 26.5 per cent below the Trust target of 88 per cent although Members noted that this was mainly due to the behaviour of 'other patients' and due to the acuity level of patients who are admitted they were likely to feel unsafe due to the fact that they are acutely unwell. Physical interventions/restraints was 31.75, this was above the Trust target of 19.25 and Members noted that the high amount of physical restraints on Teesside reflected the high use of restrain within West Lane Hospital (CAMHS inpatient services) and the rate of restraint in the Teesside Locality excluding this site was largely in line with the rest of the localities across the Trust; and also noted that the there was a low threshold for reporting these incidents. The length of stay for patients in Mental Health Services for Older People in Assessment and Treatment Wards was 66.53 days, which is 14.53 worse than the target of 52 days and demonstrated the small number of patients that had very long lengths of stay having a significant impact on the mean figures reported, however, Members noted that this was an improvement compared to the position in 2017/18. The percentage of patients who reported their overall experience as excellent or good for April 2018 to the end of March 2019 was 91.41 percent, 8.3 per cent 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 2018 to the end of March 2019 was 85.7 per cent, 8.3 per cent below the Trust's target of 94 per cent. The Percentage of patients that would recommend the service to friends and family if they needed a similar care or treatment for the period April 2018 to end of March 2019 was 86.9 per cent which was 7.1 per cent below the Trust target of 94 per cent.

Members received a full explanation for those missed targets and the actions being taken by the Trust to address the situations.

Members have the following comments to make on the five Quality Improvement Priorities for 2019/20 –

Review our Urgent Care Services and identify a future model of delivery – Members welcomed this new priority resulting from feedback at stakeholder events during 2018/19 and the focus on crisis services and look forward to receiving six monthly updates at Stakeholder Events and an updated position at a future Quality Account Stakeholder Event.

Improve 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.

Improve the personalisation of Care Planning - 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 noted the continuation of this priority and welcomed the benefits of this priority which included services users with mental health and co-existing substance misuse receiving the same level of care as people without substance misuse ensuring that staff work collaboratively across organisations.

Reduce the Number of Preventable Deaths – Members welcomed the continuation of this priority.

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.

Councillor Wendy Newall
Chair, Health and Partnerships Scrutiny Committee

Durham County Council Health and Wellbeing Board

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10th May 2019

Dear Sharon

Re: Tees, Esk & Wear Valleys NHS Foundation Trust Quality Account 2018/19

Thank you for the opportunity to comment on the Tees, Esk and Wear Valleys NHS Foundation Trust Quality Account 2018/19. The County Durham Health and Wellbeing Board appreciate this transparency and would like to provide the following comments on the document.

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

Priority 1: Improve the clinical effectiveness and patient experience in times of transition from child to adult services
Priority 2: Reduce the number of preventable deaths
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

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

It was assuring to note that again, 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 2018/19.

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

Positive partnership working in County Durham is evidenced through the Mental Health Partnership Board, which has partners from TEWV, Durham County Council, Clinical Commissioning Groups, and Durham Constabulary to ensure a holistic approach is provided for service users.

The Mental Health Partnership Board's strategic plan has a specific focus on perinatal mental health, and the Board is pleased to note the range of services supporting local women who are experiencing mental health difficulties during pregnancy of in the first year after having their baby on the back of the new community perinatal mental health service.

The Health and Wellbeing Board supports the Trust's 2019/20 priorities for improvement which align to the following draft strategic objectives in the Joint Health and Wellbeing Strategy which is being developed for 2019-23 and were agreed by the Health and Wellbeing Board at its meeting in November 2018.

It is to be noted that further work is taking place with partners to ensure the strategic objectives reflect the range of work taking place across the county, so these may be amended slightly moving forward, to ensure they remain fit for purpose:

	TEWV - Priorities for improvement 2019/20	**Joint Health and Wellbeing Strategy 2019/23 – Strategic Objectives**
1	Improve the clinical effectiveness and patient experience in times of transition from child to adult services (continuation priority)	Every child has the best start in life Good mental health for everyone
2	Reduce the number of preventable Deaths (continuation priority)	Good mental health for everyone Improving health outcomes by addressing the social determinants of health
3	Making care plans more personal (continuation priority)	Better quality of life for all
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 (continuation priority)	Support positive behaviour change Good mental health for everyone Improving health outcomes by addressing the social determinants of health
5	Review our urgent care services and identify a future model for delivery (new priority)	Better quality of life for all

The importance of improving the transition process is pleasing to note and it is acknowledged that a great deal of positive work is taking place to improve transitions, including training and the review of transitions panels.

Greater involvement in decisions young people make about the care received when they transfer to adult services will help towards making them feel empowered. It is pleasing that review

panels are already in place, and that these have been established with staff who have appropriate and adequate training and experience around managing risk and empowering young people, however the Health and Wellbeing Board would like further assurance that the voice of children and young people really is present at panels, to ensure the services meet their needs.

Analysis will be beneficial to assess how many people have the opportunity to attend a transition panel and receive a transition plan.

It would be useful to receive additional information on the learning from young people's feedback on their move from CAMHS to Adult Health Services, and from the joint Children and Young People's Services and Adult Services engagement event to see if young people feel that outcomes are improving.
In addition, the Health and Wellbeing Board would be interested to know if the engagement plan improves outcomes around involvement of family and carers in the transitions process.

Although a great deal of positive partnership working exists within County Durham to ensure a smooth transition from children's to adult services, this remains an area of focus, therefore I am pleased to see it has been identified as a priority area for another year, as the progress of this work is integral to the overall integration work for County Durham.

The positive progress to further reduce preventable deaths is welcomed, and the work to review and investigate deaths, and involve families and carers in the process offers perspective on the whole pathway of care received which will inform learning and shape practice improvements. The Board believe the guidance booklet for families will be appreciated and anticipate that evaluations on the impact of the booklet will be positive.

The Health and Wellbeing Board support the development of a zero inpatient suicide plan, which will monitor discharged patients within 72 hours, reduce alcohol and drug misuse and provide guidance on depression.

In addition, the Health and Wellbeing Board commends the Trust in relation to tobacco control across the Trust's settings which is an area in which the Health and Wellbeing Board are keen to see positive improvements. The board recently received a presentation from TEWV colleagues to outline the measures in place across the Trust and were impressed by the range of work being undertaken.

The Health and Wellbeing Board has a clear ambition to achieve 5% smoking prevalence level by 2025 and supports the vision that 'A child born now in any part of County Durham will reach adulthood breathing smoke free air, being free from tobacco addiction and living in a community where to smoke is unusual'.

The Board acknowledge the range of work that has taken place to throughout 2018/19, to personalise care planning including the rapid response process improvement workshops, to make the care planning process more patient focused.

Following feedback from services users that care planning does not always promote a personal approach, the Health and Wellbeing Board are keen to ensure that moving forward care planning is based on shared decision making, and co-production which focuses on meeting the needs of the individual patients rather than the needs of the service.

The Board recognises the continued importance of workforce development to ensure the workforce has the right skills to enable them to undertake their roles safely and effectively.

Continued training and development provides assurance that care planning will be meaningful and undertaken in a timely way by experienced professionals to minimise the need to do this when an individual is in distress. Furthermore, the work being undertaken across the Board organisation on mental health at scale will further develop partners' workforce in relation to mental health needs and awareness.

It is assuring to know that there are a range of interventions to address dual diagnosis, and that drug related deaths are now being reviewed to identify any missed mental health factors and establish where there are lessons to be learned.

The Board acknowledges that Dual Diagnosis patients can pose serious risks on wards to themselves and others and welcomes the establishment of Dual Diagnosis champions in each locality, allowing services to access expertise where needed.

The Board supports the new priority for 2019/20 to review urgent care services and identify a future model for delivery, and acknowledges the work already undertaken around this priority in 2018/19. The Board recognises that this work is identified as a priority for NHS Trusts in the NHS 10-year plan and will await further information on this review as part of the health and social care system plan for County Durham, in order to have an understanding of how this review fits across health and social care organisations and how outcomes for local people will be improved as part of the review.

The Board are pleased to see that a focus of this work will be around ensuring that ambulance services are able to check if patients they are called to see have a mental health crisis plan in place, as this will enable the care and support to be tailored to meet their needs.

It is noted that the Trust reported 142 serious incidents during 2018/19, of which 126 were deaths due to unexpected causes. The Board acknowledges that TEWV is one of the largest mental health Trusts in England in terms of caseload and population served, and is assured that that these incidents have been subject to analysis, and serious incident reviews where necessary to understand why the incident happened, and identify and share lessons learned, however we will be looking to see a reduction of serious incidents in the trust's next Quality Account.

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

Durham County Council Health and Wellbeing Overview and Scrutiny Committee

Contact: Councillor John Robinson
Direct Tel: 03000 268140
email: John.robinson@durham.gov.uk
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

10 May 2019

Dear Mr Martin,

Tees Esk and Wear Valleys Foundation Trust – Quality Accounts 2018/19

Please find attached Durham County Council's Adults Wellbeing and Health Overview and Scrutiny Committee's response to your draft Quality Accounts for 2018/19.

The response provides commentary on the Trust's performance for 2018/19 as well as the identified priorities for 2019/20.

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,

Councillor John Robinson,
Chair of Durham County Council's 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 2018/19

The Committee welcomes Tees, Esk and Wear Valleys NHS Foundation Trust's Quality Account 2018/19 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 primarily in respect of the Committee's Review of Suicide Rates and Mental Health and Wellbeing in County Durham as well as undertaking in-year monitoring of the Trust's progress against Tees, Esk and Wear Valleys NHS Foundation Trust 2018/19 priorities during the course of the past year.

The Committee considers that the Quality Account is clearly set out and that progress made against 2018/19 priorities is clearly identified. Members have considered the Trust's 2018 Community Mental Health Survey results and are disappointed to see that the overall rating on care experience has declined to 66.4% compared to 70.9% in 2017 and 74.3% in 2016.

With reference to Priority 1 - Improve the Clinical Effectiveness and Patient Experience in times of transition from Child to Adult Services, the Committee welcomes the positive performance in terms of the percentage of joint agency transition plans in place for patients approaching transition from children's to adults services. In view of the below target performance for the percentage of patients who feel prepared for transitions at the point of discharge the Committee supports the retention of this priority for 2019/20.

Regarding Priority 2 – Reduce the number of preventable deaths, the Committee recommended as part of its review of suicide rates and mental health and wellbeing in County Durham that a multi-agency approach to develop learning from suicides was needed with case conferences introduced for each incident. Clearly TEWV will be involved in this process and the Committee welcome the Trust's work in this respect, particularly the commitment to participating in all regional Mental Health learning from deaths forum meetings.

In welcoming Priority 3 – Making care plans more personal, the Committee would particularly support the focus on patients' experience of care and the Trust's commitment to ensuring patients know who to contact out of office hours in a crisis episode, that they are involved in the care that they receive and that they are engaged in discussing the effectiveness of their care.

In respect of 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. The Committee's Review into Suicide Rates and Mental Health and Wellbeing identified the importance of having a co-ordinated approach to supporting those patients with mental health problems who are also misusing substances particularly between the health service and the criminal justice system. Members therefore support the continuation of this priority and the associated initiatives proposed for 2019/20 which aim to review the effectiveness and sustainability of dual diagnosis networks across the Trust.

The new priority identified for 2019/20 – Review our Urgent Care services and identify a future model for delivery is also welcomed. The services being examined as part of this priority, namely crisis, acute liaison and street triage are all areas which were identified in the Committee's Review into Suicide Rates and Mental Health and Wellbeing as potentially having the greatest impact upon an individual's mental health and wellbeing but which were experiencing service demand pressures. Any improvements which the Trust can deliver as part of this priority are supported.

Finally, in order to ensure that it continues to provide a robust Health scrutiny function and to provide assurances in this respect to the residents of County Durham, the Committee would request a six monthly progress report on delivery of 2019/20 priorities and performance targets in November 2019.

Healthwatch Hartlepool

Response to
DRAFT TEWV QUALITY ACCOUNT

Hartlepool Healthwatch was pleased to receive this report and in general was happy with the contents and proposed changes.

We were pleased to note the priorities for 2019/20.
The changes to the age range for transition from child to adult services can only improve the service to young people and give more individual support to them through this process.
It was noted that our local CAMHS services have a better response and waiting time than other areas of the country. The repeated lack of response to crises in children has been published as a national crisis. Our local CAMHS service is running a trial with immediate response to allay crises and support children and their families through the initial referral. This is very successful

The 'Reduction in preventable deaths.' This is a major priority.
As a coastal town we have a high number of unexplained deaths. Our local R.N.L.I. coxswain tells us that many of their rescue call outs are suicide / attempted suicide related. The lifeboat volunteers have had to be trained to be able to respond appropriately to these incidents, it is important that the issue of preventable deaths be urgently addressed.

In regard to priority 4. It is good to see services develop around dual diagnosis. This is a concern, not only to TEWV Mental Health Trust, but also to the Local Authorities.
There is an urgent need to ensure diagnosis and access to appropriate services and making use of partnership working.
It was noted on the indicator that not all targets were 100%. In this format the targets were unclear. Why are not all 100%?

Hartlepool Healthwatch would like to have consideration for an additional priority. 6
To work together to promote and strengthen the use of partnership working, both within the Trust, and with service providers, Agencies, and the wider community.

It was good to see that the Street Triage has ongoing success.

It was pleasing to note that there are no conditions attached to the TEWV registration and the C.Q.C. rating of good, although some areas were highlighted for improvement. There was a clear differentiation between the in-house and the community-based services that contributed to the overall rating.

Hartlepool Healthwatch were pleased to note the increased response rate for IAPT referrals within the 6week target

There is concern about the high numbers of out of area placements for OAP's and it is hoped that this can be resolved as the Roseberry Park remedial work is completed and patients are returned to their local area.

Hartlepool Healthwatch is pleased to acknowledge the esteem in which the TEWV mental health Trust is held amongst peers.

We feel that future Quality Accounts could have a section dealing with interagency working. i.e. Local Authorities, community, voluntary sector, private providers and other organisations such as Healthwatch to confirm partnership working.

Hartlepool Borough Council Audit & Governance Committee

Councillor Brenda Loynes
Chair, Audit and Governance Committee
C/o Civic Centre
Hartlepool
TS24 8AY

Laura Kirkbride
Planning and Business Development Manager
Tees, Esk and Wear Valley NHS Foundation Trust

1 May 2019

Dear Laura,

Audit and Governance Committee – Third Party Declaration

Following consideration of the Tees, Esk and Wear Valley NHS Foundation Trust Quality Accounts in March 2019, Hartlepool Borough Council's Audit and Governance Committee would like the following comments to be included in this year's Quality Account:-

The Committee commended the Trust on progress against the quality improvement priorities identified for 2018-19 and supported the Trusts carryover of these priorities into 2019/20. The Committee also welcomed the addition of a fifth priority in terms of a review of Urgent Care Services and identification of a future model for delivery.

Yours faithfully

COUNCILLOR BRENDA LOYNES

North Yorkshire County Council Scrutiny of Health Committee

Over the past 12 months, the North Yorkshire Scrutiny of Health Committee has continued to work with the Tees, Esk and Wear Valleys NHS Foundation Trust to better understand the financial, workforce and clinical pressures within the local health system and the measures that have been put in place to respond to them.

The Scrutiny of Health Committee has scrutinised changes, both planned and delivered, to mental health in-patient provision in Northallerton, Harrogate and Middlesbrough. The committee has also reviewed the development of models for enhanced community services and how developments in community-based working will impact upon the future use of in-patient services. The scrutiny process has been actively supported by the Trust, which has enabled the committee to gain a fuller understanding of what the level of need is in the county and how best it can be responded to.

There is a legacy of underinvestment in mental health services in the county and services that are commonly available in other local authority areas are not currently available in North Yorkshire. The committee recognises, however, that the Trust has worked hard to correct this in-balance over the past year.

The NHS nationally, regionally and locally is undergoing a sustained period of change both planned and reactive. The Scrutiny of Health Committee is committed to maintaining a system-wide view of services that helps to ensure people are not disadvantaged in accessing services by virtue of where they live in the county.

Over the next year, the Scrutiny of Health Committee looks forward to working with mental health commissioners and providers on the development of integrated and sustainable systems of care in rural areas.

County Councillor Jim Clark
Chairman, North Yorkshire Scrutiny of Health Committee
1 May 2019

Tees Valley Joint Health Scrutiny Committee

Big plans, bright future

Municipal Buildings
Church Road Stockton-on-Tees
TS18 1LD SAT NAV code: TS19 1UE

9 May 2019

Dear Sharon,

Please accept the following as the statement of assurance from Tees Valley Joint Health Scrutiny Committee for inclusion in the 2018-19 Quality Account for Tees Esk and Wear Valleys NHS Foundation Trust:

‘The Joint Committee welcomes the opportunity to again consider and comment on the quality of services at the Trust. The Trust has engaged with partners in a positive manner during 2018-19. The Committee has met once with Trust representatives to consider the quality priorities and overall performance. Members and officers were also invited to the Trust’s Stakeholder Events.

It is really positive to see the range and number of awards won by staff working in the Trust during 2018-19.

The Committee reviewed progress against the Quality Priorities. Support for young people in transition to adult services remains a key areas of interest for Members, and it is welcomed that Transitions Panels are already in place across Tees. It is however noted that one in four young people did not feel prepared for their transition at the point of discharge by the end of 2018-19 and so Members support the continued inclusion of this topic as a Priority, and the commitment to undertaking further co- production.

A high priority for the Joint Committee is the prevention of harm to people with mental health needs and learning disabilities, and Members support the continued priority given to this work. Members also supported the continued focus on ensuring care planning is more meaningful to the patient and that plans are written in the voice of the patient.

Although the Trust was no longer the provider of substance misuse services, the increase in patients with a dual diagnosis of substance misuse affecting their mental health has led the Trust to improve links with the service providers, and rebuild its expertise on these issues. The Committee recognises that this is a particular issue in the Tees area, especially in relation to drug use, and supports the Trust's improvement work on Dual Diagnosis.

The Trust was continuing to review its Urgent Care services; this priority was originally suggested by Local Authority stakeholders and is proposed to be formally included as a Priority for 2019-20. The NHS Long Term Plan also committed to looking further at this issue, and localities have been tasked with taking forward more joint working.

The Committee was pleased to note that the Crisis Suite at Roseberry Park was seen as innovative practice, and that both ambulance services covered by the Trust were due to have the facility to see whether patients they care for have mental health crisis plans in place. The Committee was pleased to note mental health nurses were located in the police control room and there was positive Acute Liaison links in place. Feedback from patients indicates that services are not always provided in a timely manner and further work on prevention would be welcome.

During 2018-19, CQC inspected six core services and the 'well-led' element. Although the Trust retained its overall 'Good' rating and inspectors found staff to be caring and compassionate, a number of issues in relation to patient safety were identified. An Action Plan is due for completion in June 2019 and the Committee would welcome sight of the details during consideration of next year's Quality Account.

In relation to the core Quality Metrics, Members requested and received further details regarding comparative information where appropriate.

The Committee noted the relatively low percentage of patients stating they 'always' feel safe on the ward. It was accepted that negative responses were most often due to the behaviour of other patients, and another key factor was the acuity level of the patients themselves. However Members would support more follow up with patients to better understand the reasons behind these responses.

Although the Trust had not achieved its targets in relation to patient experience measures, Members did recognise that the Trust had set itself challenging targets; these were to be achieved over three years and were aspirational.

The Committee is aware of the overall incidence regarding the use of restraint. The Trust noted this varied between localities, but was significantly higher within Teesside which included the CAMHS Eating Disorder service at West Lane. This specialised service is hosted by the Trust for the region and uses restraint within its care to enable feeding. Although Members would wish to see the need for restraint reduced wherever possible, including at West Lane, Members received assurance that use of restraint in Teesside aside from the Eating Disorders service was in line with the rest of the Trust.

The Trust was not meeting its targets in relation to average length of stay in Mental Health Services for Older People. In discussion with Committee it was noted the data varies across the Trust, with some care home capacity issues in the Tees area having an impact. However the year end data also suggests that a small number of patients with very long lengths of stay are

impacting on the overall figures. Should there be continuing care home capacity issues, the Committee would welcome whole system approaches to resolve these where necessary. During 2018-19 the Committee undertook a review examining the impact of the remedial works at Roseberry Park on service delivery and patients. Members were very concerned to hear of the extent of the identified issues and required remedial works at the hospital. A Task and Finish Group was established by the Joint Committee in order to understand the impact on patients and service delivery.

In relation to service delivery, Members found that through the efforts of the Trust and its staff, the situation has been well managed, with the impact on service users and families minimised as far as possible.

Members have been particularly impressed by the approach of staff associated with the affected ward moves, with all feedback indicating that the teams have gone above and beyond in their continued delivery of care. The Group agree that the commitment of staff represents the best of public service. The Committee has requested further updates on the remedial works as they continue.

Yours Sincerely

Peter Mennear Scrutiny Officer

To:

Sharon Pickering
Director of Planning, Performance and Communications Tees, Esk and Wear Valley NHS Foundation Trust

Cc:

Cllr Lisa Grainge Chair
Tees Valley Joint Health Scrutiny Committee

Healthwatch Darlington

healthwatch Darlington

Tees, Esk and Wear Valley NHS Foundation Trust (TEWV) Quality Accounts for 2018-19.

These comments are on behalf of Healthwatch Darlington Limited.

Healthwatch Darlington (HWD) have welcomed the opportunity to be involved with Tees Esk & Wear Valley NHS Foundation Trust (TEWV) Quality Accounts over the last twelve months.

HWD have been pleased to see the progress on areas of their Quality Accounts where targets have been achieved. We recognise that there is still work to be done on those not achieved and appreciate the Trust's open and honest report.

Patient safety metrics: - It is encouraging to see that there has been a reduction in patient falls, although other areas on patient safety remain below target. These areas continue to be of concern to HWD but we understand the complex needs of some of the patients, and appreciate the commentary within the report explaining these complexities and the reflection they have on targets. HWD are pleased to note the encouragement the Trust give to staff to report all incidents.

Clinical effectiveness: - it is pleasing to see that the Trust have achieved 3 out of the 4 areas and it is encouraging that there is a decrease year on year for the average stay for older people.

Patient Experience: - unfortunately the Trust has not reached it targets on patient experience, although the report has indicated that Darlington and Durham were closest to 2 out of the 3 areas monitored which is encouraging to see.

<u>Priorities 2018/2019</u>

Priority 1: Improve the clinical effectiveness and patient experience in times of transition from Child to Adult service.

It is good to see that some progress has been made to improve the transition between services and the Trusts commitment to continue with this priority. HWD feel there is still work to be done and this compares with feedback and the report we produced around Children and Young People's Mental Health where feedback was obtained from young people and their families.

Priority 2: Reduce the number of preventable deaths

We are encouraged to see the work the Trust is doing around the engagement with families, learning and implementation of lessons learnt along with the increase in reviews that are carried out. We are pleased and encouraged that the Trust will continue with this priority next year.

Priority 3: Improving the personalisation of care planning

HWD are pleased and happy to see some progress made on care planning and understand there is still progress to be made. This reflects service user feedback received via HWD Substance Misuse Report where patients reported they didn't have a care plan or understand what one was.

Priority 4: Dual Diagnosis.

We welcome this priority and appreciate the work carried out by the Trust over the year. HWD are pleased and encouraged that the priority will remain, as our own findings from our Substance Misuse report published and shared with the Trust, highlights a lot of the problems faced by people having a dual diagnosis.

Priorities 2019/2020

Pleasing to see that the priorities from 2018/2019 will continue this year with the added priority of **'Reviewing Urgent Care Services and identify a future model'**

Healthwatch Darlington agree with the priorities set out by the Trust for 2019-20 and thank you for involving Healthwatch Darlington in the stakeholder events and the feedback sessions. Healthwatch Darlington have enjoyed the opportunity to work with Tees Esk and Wear Valley NHS Foundation Trust. We look forward to working with the Trust in 2019-2020.

Healthwatch South Tees

Tel: 01642 955605 or 0800 989 0080
Email: general@healthwatchsouthtees.org.uk
www.healthwatchmiddlesbrough.co.uk
www.healthwatchredcarandcleveland.co.uk

Dear Laura,

Here is the Healthwatch South Tees response to the 'Draft Quality Account'

Tees, Esk and Wear Valley Trust Quality Account 2018-2019

Healthwatch South Tees comments:

Pg 7.
We are pleased to see the use of Kaizen Quality Improvement to develop reasonable adjustment Clinical Link Pathways (CLiP) across the Trust's general adult mental health services.

Pg 9.
The response rate of 25% to TEWV's 2018 Community Mental Health Survey was lower than the national response rate of 28% and a decrease of 4% from the response rate of the previous year. This might suggest a bias in the results obtained and may not reflect a true picture of how service users view service provision.

Pg 9.
The report states that the overall rating on care experience has declined to 66.4% compared to 70.9% in 2017 and 74.3% in 2016 and the section with the lowest overall scores for TEWV was once again *'Support and Wellbeing'* - scoring 4.5 against the highest national score of 5.2. Despite this later in the report it is stated that the CQC rating to the question "are services caring" as being "good", but evidently not good enough not to require improvement which we hope to see evidence of in next year's quality account.

Pg 10.
The TEWV's National NHS Staff Survey Results for 2018 also show a low response rate (30.5%) compared to the average response rate for Mental Health and Learning Disability Trusts of 54%. Healthwatch South Tees has concerns that this could be taken as a reflection of staff morale. However, we are pleased to note later in the report (Pg. 49) that "the Trust has a policy which details how staff can speak up about risk, malpractice, or wrongdoing" and that there is a "Trust Freedom to Speak Up Guardian" ensuring that people who speak up do not experience detriment".

Pg 14.
Because of previous concerns raised regarding provision of mental health care to young people, Healthwatch South Tees is pleased to see in priority 1 of the Trust's 2019/20 priorities that there are plans to improve the clinical effectiveness and patient experience during the times of transition from Child to Adult Services. The indicators to date do show promise of improvement and we look forward to the production of future indicators of clinical effectiveness and positive patient experience.

Pg 14.
Because of previous concerns raised regarding provision of mental health care to young people, Healthwatch South Tees is pleased to see in priority 1 of the Trust's 2019/20 priorities that there are plans to improve the clinical effectiveness and patient experience during the times of transition from Child to Adult Services. The indicators to date do show promise of improvement and we look forward to the production of future indicators of clinical effectiveness and positive patient experience.

Pg 25.
In the development of a zero inpatient suicide plan based upon the recommendations from the National Confidential Inquiry into Suicide and Homicide in Mental Health report (2018), mention is made of reducing alcohol and drug misuse and guidance on depression This might be linked to previous problems regarding perceived lack of support for patients with dual diagnosis. We are therefore pleased to see that in priority 4 of the Trust's 2019/20 priorities for inclusion in the Quality Account that a Trust wide approach is to be developed to Dual Diagnosis to ensure that people with substance misuse issues can access appropriate and effective mental health services. We would agree that there is a need to circulate a Dual Diagnosis CliP to all localities, specialities and specialty sub-groups so that they can agree the most appropriate place to integrate within their pathways. The appointment of at least one Dual Diagnosis champion in each locality should help in this respect and we look forward to hearing of the appointment of a Trust-wide Dual Diagnosis lead during 2019/20.

Pg 59.
With regard to performance against quality metrics, particularly Metric 1: Percentage of patients reporting 'yes always' to the question 'do you feel safe on the ward'?
The end of year position was 61.5% which is 26.5% below the Trust target of 88.00%. Again, we hope to see evidence of improvement reported in next year's quality account.

Pg 61.
In view of recent adverse media coverage we note the comments on restraint as applied to West Lane hospital; "The high amount of physical restraints on Teesside reflects the high use of restraint within West Lane Hospital (CAMHS inpatient services) which is managed by the Trust's Teesside Locality.......This high amount is largely due to restraint to enable nasogastric feeding".

Pg 64.
Also, because of previous concerns raised regarding IAPT/Talking Therapies, we are pleased to see from the Trust's performance indicators that there is some improvement in the proportion of people completing treatment who move to recovery.

Pg 79.
Also, pleased to see the expansion of community perinatal mental health services that the Trust provides in Teesside to include the full period of pregnancy and the first year following childbirth.

Healthwatch Middlesbrough and Healthwatch Redcar and Cleveland are delivered by MVDA in partnership with RCVDA. Middlesbrough Voluntary Development Agency registered charity no: 1094112. Company limited by guarantee. Registered in England no: 4509224. Registered office: St Mary's Centre, 82-90 Corporation Road, Middlesbrough TS1 2RW

Healthwatch South Tees is pleased to see the extent of the Trust's involvement in clinical audit and participation in clinical research, both of which can be used, as stated in the report, to improve the quality of healthcare provided. We also note examples of Commissioning for Quality and Innovation (CQUIN) indicators which aim to improve the often poor physical health of people with mental illness through the provision of healthy food and supporting patients to quit smoking and reduce alcohol consumption. Perhaps additional action could be taken to improve uptake of physical exercise?

Kind regards

Lisa Bosomworth

Healthwatch South Tees Development & Delivery Manager

Healthwatch Middlesbrough and Healthwatch Redcar and Cleveland are delivered by MVDA in partnership with RCVDA. Middlesbrough Voluntary Development Agency registered charity no: 1094112. Company limited by guarantee. Registered in England no: 4509224. Registered office: St Mary's Centre, 82-90 Corporation Road, Middlesbrough TS1 2RW

NHS Vale of York Clinical Commissioning Group

NHS Vale of York CCG
West Offices
Station Rise
York
YO1 6GA
Telephone: (01904) 555870

13th May 2019
Website: www.valeofyorkccg.nhs.uk

Dear Mr Martin,

Many thanks for the submission of the TEWV Quality Accounts. NHS Vale of York CCG is pleased to provide comments on the TEWV Quality Accounts for 2018/19.

There are very many positive and encouraging examples of excellent quality patient care and improvements as well as the candid recognition of areas requiring an aim to perform better over the coming year.

On behalf of the Vale of York CCG and the population of York and Selby I would like to welcome the stated aim to improve partner organisations satisfaction with information from the Trust. We are currently working with local Service Leads and additional TEWV colleagues to improve communication mechanisms and processes with primary care colleagues in the Vale of York locality including discharge letters so GPs can see immediately what is expected from them to support their patients in conjunction with mental health services. To develop this further we would like to strongly encourage collaborative work with the emerging Primary Care Networks recognising that GPs need clear access to support as well as clarity and robust processes to share changes to mental health service provision in order to jointly provide efficient care for service users. We also recognise the need for TEWV services to work alongside GPs and the voluntary sector in localities to promote opportunities for signposting effectively, the positive value of which was identified at a recent Primary Care Protected Learning Time event.

The CCG would like to note that although the overall organisational benchmarks well against national scores it is disappointing to note so many indicators for community mental health indicators reducing and hope to see an improving status.

It is extremely impressive to see the high number of awards obtained by the Trust and individual practitioners included within the Quality Accounts and the CCG would like to note our ambition to see more of these within the VOY services. The CCG would like to acknowledge the high number of committed and compassionate staff the CCG have encountered in all of the clinically led quality visits we have undertaken to a variety of services.

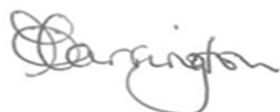
We would like to urge the Trust to recognise the need in our locality to improve the Care Coordinator input and leadership around specifying after care needs following discharges from Sections, in order to robustly design S117

aftercare plans and maintain patient safety. We are pleased to read of the improvements to the CPA approach as this had been raised as a recurrent theme identified through the Serious Incident process.

As the CCG had been informed by a carer who attended the CCG Quality and Patient Experience Committee we welcome the commitment the Trust identifies to improve working with families. We would appreciate receiving information to support the progress against this including updates against any actions which emerged from the recently held family conference at the CCG Quality forum. The CCG will also look forward to receiving a summary against progress against all identified indicators in the Quality accounts.

NHS Vale of York CCG is pleased to provide comments on TEWV NHS Foundation Trust's Quality Report for 2018/19.

Yours sincerely,



Michelle Carrington

Executive Director Quality and Nursing

NHS Vale of York Clinical Commissioning Group

NHS Harrogate and Rural District Clinical Commissioning Group

Email: Paula.Middlebrook@nhs.net
Direct Tel: 01423 799328
Reference: HaRD.047-19

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LETTER SENT VIA EMAIL

15 May 2019

Dear Sharon

Re: Quality Report for Tees Esk and Wear Valleys NHS Foundation Trust 2018-19.

On behalf of the 3 North Yorkshire CCG's, NHS Hambleton, Richmondshire and Whitby CCG, (HRWCCG), NHS Scarborough and Ryedale CCG (SRCCG) and Harrogate and Rural District Clinical Commissioning Group, (HaRD CCG) I am writing to share with you feedback following receipt of your quality account. We welcome the opportunity to review and provide a statement for the Trust's Quality Report for 2018/19. 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 the 3 North Yorkshire CCG's and their views have been collated into my response.

HaRD CCG as the lead Commissioner for Mental Health services remains 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.

The Quality Report clearly identified the priorities for 2018/19 and the work undertaken to achieve these.

We wish to highlight some of the positive work which is evident throughout the report:

- The level of service user engagement throughout a range of service developments is evident. This includes the involvement of Experts by Experience, training of Forensic Service patients in quality improvement techniques so they can be active participants in improvement events, family conference regarding preventable deaths. This demonstrates a clear commitment to develop and improve services in a patient centred way which is meaningful to both patients and carers.

- Work undertaken to improve care for older people, in particular those patients with frailty and ensuring their wider physical health needs and overall safety.

- Work undertaken to improve transitions from children's to adult services. We also welcome the decision to continue this as a quality priority for 2019/20.

- Introduction of a new perinatal mental health service.

- Recognising the challenges within Clinical Research, the Trust has continued to recognise the importance of participation where possible and significantly increased the number of participants within interventional studies.

- The work to improve staff skills and therefore care for people with Learning Disabilities and Autism who experience mental health problems is recognised. We would welcome this to be continued to ensure patients receive equitable care regardless of any other conditions they may have.

- We commend the Trust in its commitment to hearing the views of its staff through expansion of the patient survey from being a sample to including all staff. This recognises the pivotal importance that staff wellbeing can have upon direct patient care.

- Learning from deaths remains a clear priority with examples provided of how learning from reviews has been taken forward across the Trust. It would be helpful to know how many cases have been referred for an LeDeR review.

- We recognise the work commenced to reduce preventable deaths. We would welcome more information in the coming year regarding work to reduce preventable deaths for inpatients who are home on leave and work to improve discharge follow up for inpatients.

Whilst we recognise it is not possible for the Quality Account to exhaustively cover all developments we would have welcomed more information on:

The overall rating of 'Good' from the CQC is testament to the overall work undertaken by the Trust to deliver high quality services. We would however welcome more detail regarding the specific areas which contributed to the 'Requires Improvement' for Safety. The identified 'must dos' are listed, however we would welcome an update regarding actions which have been taken as a result.

The Trust has seen a significant reduction in the number of out of area placements for adult mental health services. This is clearly positive progress and it would be helpful to understand what actions have contributed to this.

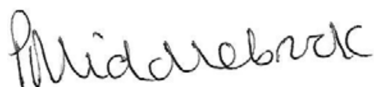
We would welcome more information regarding equity of services across the Trust in particular quality of CAMHs Services (other than the information provided regarding transition) and assurance regarding safeguarding.

We note the number of incidents of physical intervention and restraint and the variation between services, which we understand is likely to be proportional to the type of service delivery. However we request that further information is shared regarding appropriateness of restraint and work which is being undertaken to reduce the need.

In summary the key successes of the 2018/19 quality priorities are clearly reflected and subsequent identification of areas which will continue to be a priority in 2019/20.

We welcome the opportunity to review the report and hope that our feedback is accepted as a fair reflection of the report. We look forward to seeing the progress made over the coming year and working alongside the Trust to see and achieve progress on the 2019/20 priorities.

Yours sincerely



Paula Middlebrook
Head of Nursing and Quality

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

Healthwatch County Durham

Dear Mr. Martin

Healthwatch County Durham (HWCD) is pleased to receive the quality accounts and be invited to comment.

We commend TEWV on their award from the Carer's Trust and their commitment to supporting carers. The new community perinatal service is also a positive development. This has been identified as a need by many local Healthwatch and reported by Healthwatch England, so it good to see the need being addressed in County Durham.

We are pleased to see the commitment to improving support and quality of life for people with learning disabilities and the launch of the Trust's Autism Framework. Dementia services were a priority for people in the HWCD public votes so we have been pleased to see the learning being taken from the mortality review and improvements in GP communication, family involvement and multi-agency working identified.

It is a positive move to give all staff the opportunity to complete the staff survey and we hope that action plans are developed as a result of feedback. TEWV were supportive of staff being given the opportunity to share their views with HWCD in our 2018 survey and have been receptive to the findings.

Healthwatch County Durham
Whitfield House, St Johns Road
Meadowfield Industrial Estate
Durham, DH7 8XL
Tel: 0191 378 1037
Email: healthwatchcountydurham@pcp.uk.net
Web: healthwatchcountydurham.co.uk

healthwatch
County Durham

It is disappointing that transitions from children's to adult services remains a concern. We acknowledge this is a challenging area, it was also deemed a priority by people in Co Durham, and are pleased to see it being carried forward as an ongoing priority for next year. We also welcome access to urgent care being identified as a priority in 2019-20 as we have received a lot of feedback that this is important to people.

We look forward to working with TEWV next year.

Yours sincerely

B. Jackson

Brian Jackson
Chair
Healthwatch County Durham

Healthwatch County Durham
Whitfield House, St Johns Road
Meadowfield Industrial Estate
Durham, DH7 8XL
Tel: 0191 378 1037
Email: healthwatchcountydurham@pcp.uk.net
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County Durham
Volunteering

NHS
Darlington
Clinical Commissioning Group

Darlington CCG
Billingham Health Centre
Queensway
Billingham
TS23 2LA

20 May 2019

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 2018/19

Response statement from NHS Darlington Clinical Commissioning Group and on behalf of (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 2018/19 and would like to offer the following commentary:

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 opening statement from the Chief Executive clearly sets out the vision and quality strategy for 2017-20. Some notable achievements the Trust made in 2018/19 are:

- The development and roll out of the Mental Health Services for Older People (MHSOP) service
- Introduction of the new perinatal mental health service across the region
- Development of the zero inpatient suicide plan
- Launch of Trust Autism Framework

The CCGs endorse the five agreed priorities which will be continued to be worked towards in 2019/2020. The CCGs were represented at both stakeholders events the Trust held regarding the Quality Account for 2019/20, these events were found to be engaging and informative in shaping the quality priorities for the year ahead.

The priority for 'Improvement of clinical effectiveness and patient experience in terms of transition from Child to Adult Services' has made great progress in 2018/19. TEWVFT have demonstrated that both training of staff and engagement of family and carers has been carried out. The further improvements identified for 2019/20 around this priority are encouraging and the targets the Trust have set for themselves show the determination to improve.

'Reducing the number of Preventable Deaths' was another priority area in 2018/19. The Trust undertook a number of engagement events and are working with other Mental Health Trusts to ensure better engagement with family and carers. The evidence gathered from the last year will help embed the priority in 2019/20 and the CCGs look forward to seeing the progress made in this key area of Mental Health.

'Making Care Plans more personal' is a vital in ensuring patients are put at the centre of their own care. In 2018/19, TEWVFT have clearly made good progress on this priority, focusing on training and guidance in particular. There is still a lot of work TEWVFT have identified for this priority in 2019/20 and the CCGs are keen to see the outcomes.

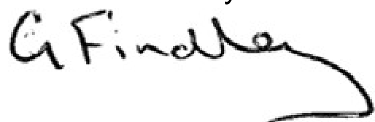
'Develop a Trust-wide approach to Dual Diagnosis which ensures that people with substance misuse issues can access appropriate and effective mental health services'. TEWVFT have carried out a great deal of work on this priority and the 100% target being achieved for 2018/19 is commendable.

'Review our Urgent Care services and identify a future model for delivery'. This is a new priority for 2019/20 and the CCGs see this as being a very important area for service users. It is noted that the Trust have already carried out some work toward this priority. The targets and achievements set by TEWVFT around this priority in 2019/20 will ensure urgent health care and service users experience is vastly improved.

Congratulations to all TEWV staff and teams who were winners and nominees of national awards over 2018/19.

The CCGs look forward to continuing to work in partnership with the trust to assure the quality of services commissioned in 2019/20.

Yours sincerely



Gillian Findley
Director of Nursing/Nurse Advisor

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 on the financial statements

We have audited the financial statements of Tees, Esk and Wear Valleys NHS Foundation Trust (‘the Trust’) for the year ended 31 March 2019 which 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 interpreted and adapted by the Government Financial Reporting Manual 2018/19 as contained in the Department of Health and Social Care Group Accounting Manual 2018/19, and the Accounts Direction issued under section 25(2) of Schedule 7 of the National Health Service Act 2006 (“the Accounts Direction”).
In our opinion, the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2019 and of its 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 2018/19; and
- have been properly prepared in accordance with the requirements of the National Health Service Act 2006 and the Accounts Direction issued thereunder.

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.

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 and challenging intra-NHS reconciliations and data matches provided by the Department of Health and Social Care; • review of management oversight of material accounting estimates, review of changes to accounting policies and challenge/testing of material accounting estimates including income accruals; and • testing of adjustment journals, including material journals posted to revenue accounts. 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 current value of property to be included in the financial	We liaised with management to update our understanding on the approach taken by the Trust in its valuation of land and buildings, which included review and challenge of the methodology that the Trust has adopted in 2018/19 of valuing an alternative site as part of its modern equivalent asset valuation. Our work also included review of the underlying data, and sample testing to gain assurance of its accuracy. We reviewed and considered:

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.	• 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, including compliance with professional standards. We tested a sample of valuation movements to gain assurance that the accounting treatment is appropriate, and also considered evidence of regional valuation trends. Our work identified a number of matters in respect of valuations. Management agreed to adjust the financial statements for all matters raised, with the exception of two findings which were not material. There is no impact upon our opinion on the financial statements in relation to the matters identified and our work provided the assurance we sought in respect of this key audit matter.

Emphasis of Matter

In forming our opinion on the financial statements, which is not modified, we have considered the adequacy of the disclosures made in note 31.1 (Contingent Liabilities) to the Annual Accounts concerning the termination of the Trust's PFI contract for the Roseberry Park site. At this stage the liquidators of Three Valleys Healthcare Limited (the project company for the Roseberry Park Hospital PFI scheme) have not come forward with their position on the Trust's Proof of Debt nor their view on compensation on termination. At this point it is not possible to estimate the time it will take to conclude all legal processes associated with the termination of the PFI contract. The ultimate outcome of the matter cannot presently be determined, and no provision for any liability that may result has been made in the financial statements.

Our application of materiality

The scope of our audit was influenced by our application of materiality. We set certain quantitative thresholds for materiality. These, together with qualitative considerations, helped us to determine the scope of our audit and the nature, timing and extent of our audit procedures on the individual financial statement line items and disclosures, and in evaluating the effect of misstatements, both individually and on the financial statements as a whole. Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

Overall materiality	£5.192m
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.
Performance materiality	£4.154m
Reporting threshold	£0.156m

An overview of the scope of our audit

As part of designing our audit, we determined materiality and assessed the risk of material misstatement in the financial statements. In particular, we looked at where the Accounting Officer made subjective judgements such as making assumptions on significant accounting estimates.

We gained an understanding of the legal and regulatory framework applicable to the Trust and the sector in which it operates. We considered the risk of acts by the Trust which were contrary to the applicable laws and regulations including fraud. We designed our audit procedures to respond to those identified risks, including non-compliance with laws and regulations (irregularities) that are material to the financial statements.

We focused on laws and regulations that could give rise to a material misstatement in the financial statements, including, but not limited to, the National Health Service Act 2006.

We tailored the scope of our audit to ensure that we performed sufficient work to be able to give an opinion on the financial statements as a whole. We used the outputs of our risk assessment, our understanding of the Trust's accounting processes and controls and its environment and considered qualitative factors in order to ensure that we obtained sufficient coverage across all financial statement line items.

Our tests included, but were not limited to:

- 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 irregularities including fraud or error;

- review of minutes of board meetings in the year; and
- enquiries of management.

As a result of our procedures, we did not identify any Key Audit Matters relating to irregularities, including fraud.

The risks of material misstatement that had the greatest effect on our audit, including the allocation of our resources and effort, are discussed under ‘Key audit matters’ within this 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 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 nothing to report in these regards.

Responsibilities of the Accounting Officer for the financial statements

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.

Auditor's responsibilities for the audit of the financial statements

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.

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 2018/19; 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 2018/19; 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.

The Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Matter on which we are required to report by exception

We are required to report to you if, in our opinion, we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.
We have nothing to report in this respect.

Responsibilities of the Accounting Officer

The Chief Executive as Accounting Officer is 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 for the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required by Schedule 10(1)(d) 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, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General 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

Comptroller and Auditor General 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 2019.
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.

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.

Certificate

We certify that we have completed the audit 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

24 May 2019

The accounts 2018/19

The accounts are prepared in accordance with paragraphs 24 and 25 of Schedule 7 to the NHS Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006

Colin Martin
Chief Executive **21st May 2019**

Tees Esk & Wear Valleys NHS Foundation Trust - Annual Accounts 12 months ended 31 March 2019

Statement of Comprehensive Income for 12 months ended 31 March 2019

	Note	12 months ended 31 March 2019 £000	12 months ended 31 March 2018 £000
Revenue			
Operating income from patient care activities	2	334,399	326,538
Other operating income	2	53,947	23,811
Total operating income from continuing operations		**388,346**	**350,349**
Operating expenses of continuing operations	3	(384,205)	(366,629)
Operating surplus / (deficit)		**4,141**	**(16,280)**
Finance costs			
Finance income	8	539	165
Finance expense - financial liabilities	9	(3,195)	(5,411)
PDC dividends payable		(2,549)	(2,916)
Net finance costs		**(5,205)**	**(8,162)**
Other gains*	10	59,554	4
Share of loss of joint ventures	16	(125)	0
Surplus / (Deficit) from continuing operations		**58,365**	**(24,438)**
Other comprehensive income			
Will not be reclassified to income and expenditure			
Impairments		(7,593)	(9,905)
Revaluations		325	655
Total comprehensive income / (expense) for the year		**51,097**	**(33,688)**

* In September 2018 the Trust terminated the PFI contract agreement at Roseberry Park Hospital.

Tees Esk & Wear Valleys NHS Foundation Trust - Annual Accounts 12 months ended 31 March 2019

Statement of Financial Position as at 31 March 2019

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	11	1,554	700
Property, plant and equipment	12	134,035	170,694
Investments in joint ventures and associates	16	0	125
Other investments / financial assets	20	50	50
Trade and other receivables	22	39	42
Total non-current assets		**135,678**	**171,611**
Current assets			
Inventories	21	520	221
Trade and other receivables	22	48,498	19,275
Other investments / financial assets	20	0	420
Non-current assets for sale and assets in disposal groups	18	0	350
Cash and cash equivalents	25	72,728	58,415
Total current assets		**121,746**	**78,681**
Current liabilities			
Trade and other payables	26	(41,111)	(25,978)
Borrowings	27	(3,789)	(5,343)
Provisions	30	(450)	(580)
Other liabilities	28	(342)	(660)
Total current liabilities		**(45,692)**	**(32,561)**
Total assets less current liabilities		**211,732**	**217,731**
Non-current liabilities			
Borrowings	27	(14,010)	(75,369)
Provisions	30	(5,448)	(2,646)
Total non-current liabilities		**(19,458)**	**(78,015)**
Total assets employed		**192,274**	**139,716**
Financed by taxpayers' equity			
Public dividend capital		146,530	145,053
Revaluation reserve	32	2,640	9,908
Income and expenditure reserve		43,104	(15,245)
Total taxpayers' equity		**192,274**	**139,716**

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

The financial statements were approved by the Board and signed on its behalf by Colin Martin, Chief Executive on 21 May 2019

Tees Esk & Wear Valleys NHS Foundation Trust - Annual Accounts 12 months ended 31 March 2019

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 as 1 April 2018 - brought forward	**139,716**	**145,053**	**9,908**	**(15,245)**
Impact of implementing IFRS 9 on opening reserves	**(16)**	0	0	(16)
Surplus for the year	**58,365**	0	0	58,365
Net impairments	**(7,593)**	0	(7,593)	0
Revaluations - property, plant and equipment	**325**	0	325	0
Public dividend capital received	**1,477**	1,477	0	0
Taxpayers' equity at 31 March 2019	**192,274**	**146,530**	**2,640**	**43,104**

	Total	Public Dividend Capital (PDC)	Revaluation Reserve	Statement of Comprehensive Income Reserve
Taxpayers' and others' equity as 1 April 2017 - as previously stated	**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)**

Tees Esk & Wear Valleys NHS Foundation Trust - Annual Accounts 12 months ended 31 March 2019

Statement of Cash Flows for 12 months ended 31 March 2019

	Note	12 months ended 31 March 2019 £000	12 months ended 31 March 2018 £000
Cash flows from operating activities			
Operating surplus/(deficit) from continuing operations		**4,141**	**(16,280)**
Non-cash income and expense:			
Depreciation	3	4,346	3,489
Impairments and reversals	3	43,680	41,238
Increase in receivables		(29,962)	(1,563)
Increase in inventories		(299)	(16)
Increase/(decrease) in trade and other payables		16,130	(342)
Increase/(decrease) in other liabilities		(318)	435
Increase/(decrease) in provisions		2,664	(121)
Net cash generated from operations		**40,382**	**26,840**
Cash flows from investing activities			
Interest received		539	165
Purchase of financial assets / investments		0	(50)
Proceeds from settlements of financial assets		420	80
Purchase of intangible assets		(1,539)	0
Purchase of property, plant and equipment and investment property		(19,138)	(11,795)
Proceeds from sales of property, plant and equipment and investment property		360	6
Net cash used in investing activities		**(19,358)**	**(11,594)**
Cash flows from financing activities			
Public dividend capital received		1,477	0
Movement in loans from the Department of Health and Social Care		(3,000)	(3,000)
Movement in other loans		952	0
Capital element of PFI, LIFT and other service concession payments		(1,340)	(2,469)
Interest on loans		(71)	(111)
Interest element of PFI, LIFT and other service concession obligations		(3,133)	(5,308)
PDC dividend paid		(1,596)	(3,788)
Net cash used in financing activities		**(6,711)**	**(14,676)**
Increase in cash and cash equivalents	25	**14,313**	**570**
Cash and cash equivalents at 1 April - Brought Forward	25	**58,415**	**57,845**
Cash and cash equivalents at 31 March	25	**72,728**	**58,415**

Notes to the Accounts

Note 1. Accounting policies

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention
These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Going concern
These accounts have been prepared on a going concern basis.

Accounting standards issued that have not yet been adopted for public sector
The following standards and updates have been published by the International Accounting Standards Board as adopted but are not required to be followed until after the current reporting period.

IFRS 14	Regulatory deferral accounts
IFRS 16	Leases
IFRS 17	Insurance Contracts
IFRIC 23	Uncertainty over Income Tax Treatments

The Trust does not anticipate these changes in accounting standards to have a material impact on the 2019/20 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 to 5 years. Provisions are, in the main, injury benefits provisions which are valued using actuarial tables.

The Trust amended its approach regarding valuation of buildings in 2018/19. In previous years, the Trust has applied the MEA approach to existing buildings based on their actual locations and current dimensions. For the 2018/19 annual accounts the Trust has applied the MEA approach to an optimally sized and configured estate, based on occupied / contracted bed numbers at 31st March 2019.

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.

Revenue from contracts with customers
Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

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

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

Revenue from NHS contracts
The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

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 such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Retirement benefit costs
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they are defined contribution schemes.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

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

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

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

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, 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.

An MEA valuation was carried out on the Trusts land and buildings on 31 March 2019, 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 2019 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.

All fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

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

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

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.

During 2018/19 The Royal Institution of Chartered Surveyors (RICS) provided additional guidance on how to measure useful asset lives. As this was new guidance received during the 2018/19 financial year, the Trust has applied the changes from 01 April 2018. This resulted in a decrease to asset lives for Trust properties, which has increased the amount of depreciation recognised in the year by £909k.

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.

Revaluation gains and losses

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

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

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

Donated assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

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

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

1. The asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
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.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been me.

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

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.

Private finance initiative (PFI)

PFI and LIFT transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate. The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

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'.

PFI lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure.

They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

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

Provisions
The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury. The discount rates have changed as follows, resulting in changes to the amount of provision made:

	2018/19	2017/18
Short term (<5 years)	0.76% (nominal)	-2.42% (real)
Medium term (5-10 years)	1.14% (nominal)	-1.85% (real)
Long term	1.99% (nominal)	-1.56% (real)
Pensions rate	0.29% (real)	0.10% (real)

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
NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 30.3 but is not recognised in the Trust's accounts.

Non-clinical risk pooling
The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any “excesses” payable in respect of particular claims are charged to operating expenses when the liability arises.

Contingencies
Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity’s control) are not recognised as assets, but are disclosed in note 31.2 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 31.1, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity’s control; or

- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

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

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust’s normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques. Financial assets and liabilities are classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition of financial assets

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Leases
Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

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 2019.

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 (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

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.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for:

(i) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

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 the trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

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's is a shareholder in "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 for Health in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

(a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period.

This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes.

The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

(b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

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 2019. The chief operating decision maker has been identified as the Executive Director Chief Operating Officer post within the Trust; and on this basis the Trust has identified healthcare as the single operating segment.

Operating segments

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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 2019	12 months ended 31 March 2018
Income from activities	**£000**	**£000**
Cost and volume contract income	48,697	50,919
Block contract income	263,511	255,151
Clinical income for the secondary commissioning of mandatory services	9,262	11,388
Other clinical income from mandatory services	4,207	3,438
AfC pay award central funding	3,676	0
Other clinical income	5,046	5,642
Total income from activities	**334,399**	**326,538**
Other operating income		
Other operating income recognised in accordance with IFRS 15:		
Research and development	952	671
Education and training (excluding notional apprenticeship levy income)	8,985	8,483
Non-patient care services to other bodies	5,599	4,879
Provider sustainability fund	36,951	6,599
Income in respect of employee benefits accounted on a gross basis	65	153
Other	315	2,489
Other operating income recognised in accordance with other standards:		
Education and training - notional income from apprenticeship fund	227	49
Rental revenue from operating leases	853	488
Total other operating income	**53,947**	**23,811**
Total operating income	**388,346**	**350,349**

Note 2.2 Operating lease income

	£000	£000
Rental revenue from operating leases*	853	488
Future minimum lease receipts		
not later than one year;	853	488
later than one year and not later than five years;	1,971	1,164
later than five years.	2,300	9
Total future minimum lease receipts	**5,124**	**1,661**

*operating lease income is from property rental

Note 2.3 Non NHS income

The Trust had Non NHS income totalling £10,196k (2017-18, £10,990k).

Note 2.4 Income from overseas visitors

The Trust had no income relating to overseas visitors (non-reciprocal, chargeable to the patient) (2017-18 £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 (2017-18 £nil).

Note 2.6 Contract revenue recognised in the period

The Trust recognised £525k in the reporting period that was previously included in the contract liability balance (i.e. release of deferred IFRS 15 income). There was no income recognised in the period relating to performance obligations satisfied (or partially satisfied) in previous periods.

Note 2.7 Operating income (by type)	12 months ended 31 March 2019 £000	12 months ended 31 March 2018 £000
Income from activities		
NHS England	57,453	59,438
Clinical Commissioning Groups	265,879	260,265
NHS Foundation Trusts	1,864	1,027
NHS Trusts	11	0
Local Authorities	3,522	2,936
Department of Health and Social Care	3,784	0
NHS other (including Public Health England)	379	576
Non NHS: other	1,507	2,296
Total income from activities	**334,399**	**326,538**
Other operating income		
Other operating income recognised in accordance with IFRS 15:		
Research and development	952	671
Education and training (excluding notional apprenticeship levy income)	8,985	8,483
Non-patient care services to other bodies	5,599	4,879
Provider sustainability fund	36,951	6,599
Income in respect of employee benefits accounted on a gross basis	65	153
Other	315	2,489
Other operating income recognised in accordance with other standards:		
Education and training - notional income from apprenticeship fund	227	49
Rental revenue from operating leases	853	488
Total other operating income	**53,947**	**23,811**
Total operating income	**388,346**	**350,349**

Analysis of income from activities - non NHS other

Other government departments and agencies	644	742
Other*	863	1,554
	1,507	**2,296**

*Other income is mainly from Spectrum Community Health Contract £800k (2017-18 £800k).

Analysis of 'other (recognised in accordance with IFRS 15)' in 'Other operating income' above

Catering	211	185
Other income not already covered	104	2,304
	315	**2,489**

*Other income is mainly from catering sales £211k. 2017-18 included one off income from commercial settlement agreements £2,116k.

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	361,607	327,260
Income from activities from non-commissioner requested services	26,739	23,089
	388,346	**350,349**

Note 3 Operating expenses (by type)	**12 months ended 31 March 2019**	**12 months ended 31 March 2018**
	£000	**£000**
Purchase of healthcare from NHS and DHSC bodies	1,923	2,711
Purchase of healthcare from non-NHS and non-DHSC bodies	6,505	7,090
Staff and executive directors costs	265,815	252,881
Non-executive directors	154	158
Supplies and services – clinical (excluding drugs costs)	2,219	2,074
Supplies and services - general	6,391	6,432
Drugs costs (drugs inventory consumed and purchase of non-inventory drugs)	4,356	4,013
Consultancy	726	496
Establishment	4,152	3,620
Premises - business rates collected by local authorities	1,904	1,491
Premises - other	15,698	12,626
Transport (business travel only)	2,899	3,320
Transport - other (including patient travel)	1,768	1,423
Depreciation	4,346	3,489
Impairments net of (reversals)	43,680	41,238
Movement in credit loss allowance: contract receivables/assets	1,720	0
Movement in credit loss allowance: all other receivables & investments	0	4,393
Provisions arising / released in year	41	213
Change in provisions discount rate	(102)	91
Audit services - statutory audit	44	40
Other auditor remuneration (payable to external auditor only)	8	12
Internal audit - non-staff	221	223
Clinical negligence - amounts payable to NHS Resolution (premium)	1,066	1,178
Legal fees	1,285	1,458
Insurance	92	36
Research and development - staff costs	907	631
Research and development - non-staff	636	74
Education and training - staff costs	1,500	1,503
Education and training - non-staff	2,274	1,412
Education and training - notional expenditure funded from apprenticeship fund	227	49
Operating lease expenditure (net)	8,767	8,481
Redundancy costs - non-staff	14	23
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT) on IFRS basis	1,545	2,582
Hospitality	106	121
Other losses and special payments - non-staff	93	198
Other	1,225	849
Total operating expenses	**384,205**	**366,629**

*consultancy and legal expenditure includes expenditure related to the commercial settlement detailed in note 2.7

Analysis of operating expenses - other

Services from local authorities	375	23
Other patients' expenses	131	155
National offender health services	125	198
CQC and accreditation fees	185	246
Miscellaneous	409	227
	1,225	**849**

Note 4.1 Employee expenses

	12 months ended 31 March 2019			12 months ended 31 March 2018		
	Total	**Permanently employed**	**Other**	**Total**	**Permanently employed**	**Other**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
Salaries and wages	213,820	200,171	13,649	205,586	197,516	8,070
Social security costs	19,075	17,798	1,277	17,507	16,802	705
Apprenticeship levy	1,018	927	91	981	942	39
Pension cost - employer contributions to NHS pension scheme	24,902	23,065	1,837	24,416	23,375	1,041
Pension cost - other contributions	36	36	0	17	17	0
Temporary staff - agency/contract staff	9,632	0	9,632	6,775	0	6,775
Gross employee expenses	**268,483**	**241,997**	**26,486**	**255,282**	**238,652**	**16,630**
of which:						
Costs capitalised as part of assets	261	261	0	267	267	0
Analysed into operating expenditure (page 14):						
Employee expenses - staff & executive directors	265,815	239,549	26,266	252,881	236,366	16,515
Research & development	907	687	220	631	516	115
Education and training	1,500	1,500	0	1,503	1,503	0
Total employee expenses excluding capitalised costs	**268,222**	**241,736**	**26,486**	**255,015**	**238,385**	**16,630**

The salary costs of the capital development team are capitalised over the full costs of the Trust's capital schemes, of which in 2018-19 the largest scheme was an inpatient unit in York.

Note 4.2 Average number of employees (WTE Basis)

	12 months ended 31 March 2019			12 months ended 31 March 2018		
	Total Number	**Permanently employed Number**	**Other Number**	**Total Number**	**Permanently employed Number**	**Other Number**
Medical and dental	313	216	97	338	296	42
Administration and estates	1,209	1,079	130	1,170	1,108	63
Healthcare assistants and other support staff	320	196	124	319	307	12
Nursing, midwifery and health visiting staff	3,926	3,450	476	3,892	3,484	408
Scientific, therapeutic and technical staff	793	745	48	788	726	63
Healthcare science staff	2	2	0	2	2	0
Social care staff	25	9	16	8	0	8
Total	**6,588**	**5,697**	**891**	**6,517**	**5,922**	**595**
of which						
Number of employees (WTE) engaged on capital projects	6	6	0	5	5	0

Note 4.3 Early retirements due to ill health

During the period to 31 March 2019 there were 11 (2017-18, 11) early retirements from the Trust on the grounds of ill-health. The estimated additional pension liabilities of the ill-health retirement will be £757,078 (2017-18, £678,470). The cost of this ill-health retirement will be borne by the NHS Business Services Authority - Pension Division.

Note 4.4 Analysis of termination benefits

There were 3 payments for termination benefits valuing £14,000 during the period to March 2019, relating to redundancy (2017-18, 1 payment valued at £23,000).

Note 4.5 Cost of exit packages

	12 months ended 31 March 2019			12 months ended 31 March 2018		
Exit package cost	**Total number**	**Compulsory redundancies number**	**Other departures number**	**Total number**	**Compulsory redundancies number**	**Other departures number**
<10,000	3	3	0	0	0	0
£10,001 - £25,000	0	0	0	1	1	0
Total number of exit packages	**3**	**3**	**0**	**1**	**1**	**0**
Total resource cost (£000's)	**14**	14	0	**23**	23	0

Note 4.6 Exit packages: other non compulsory

There were no other non compulsory exit packages between 01 April 2018 and 31 March 2019, (2017-18, nil)

Note 5.1 Operating leases

	12 months ended 31 March 2019 £000	12 months ended 31 March 2018 £000
Minimum lease payments	8,767	8,481
Total	**8,767**	**8,481**

The Trust operating leases includes leased vehicles for staff, property rental and telephony rental.

Note 5.2 Arrangements containing an operating lease at 31 March 2019

	Total £000	Buildings £000	Other £000
Future minimum lease payments due:			
not later than one year	7,980	4,385	3,595
later than one year and not later than five years	7,232	4,823	2,409
later than five years	3,416	3,416	0
Total	**18,628**	**12,624**	**6,004**

Note 5.3 Arrangements containing an operating lease at 31 March 2018

	Total £000	Buildings £000	Other £000
Future minimum lease payments due:			
not later than one year	7,441	3,796	3,645
later than one year and not later than five years	7,840	5,094	2,746
later than five years	8,920	8,920	0
Total	**24,201**	**17,810**	**6,391**

Note 5.4 Limitation on auditor's liability

There is no specified limitation stated in the engagement letter of the Trust's auditors (no specified limitation 2017-18).

Note 5.5 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 (2017-18, £nil).

Note 5.6 Other audit remuneration

The Trust paid it's external auditors additional remuneration totalling £8k for the period to 31 March 2019, for work on the Quality Report (31 March 2018, £12k). Auditors remuneration for statutory audit is shown in note 3.

Note 6 Discontinued operations

The Trust has no discontinued operations at 31 March 2019 (31 March 2018, £nil).

Note 7 Corporation tax

The Trust has no Corporation Tax liability or asset at 31 March 2019 (31 March 2018, £nil).

Note 8 Finance income	**12 months ended 31 March 2019**	**12 months ended 31 March 2018**
	£000	**£000**
Interest on bank accounts	539	165
Total	**539**	**165**

Note 9 Finance costs	**12 months ended 31 March 2019**	**12 months ended 31 March 2018**
	£000	**£000**
Interest expense:		
Interest on loans from the Department of Health and Social Care:		
- Capital loans	53	100
Finance costs in PFI obligations:		
- Main finance costs	2,133	3,763
- Contingent finance costs	1,001	1,545
Total interest expense	**3,187**	**5,408**
Unwinding of discount on provisions	8	3
Total	**3,195**	**5,411**

Note 10.1 Other gains	**12 months ended 31 March 2019**	**12 months ended 31 March 2018**
	£000	**£000**
Gains on disposal of property, plant and equipment	10	4
Fair value gains on financial liabilities*	59,544	0
Total other gains	**59,554**	**4**

* In September 2018 the Trust terminated the PFI contract agreement at Roseberry Park Hospital.

Note 10.2 Impairment of assets	**12 months ended 31 March 2019**	**12 months ended 31 March 2018**
	£000	**£000**
Abandonment of assets in the course of construction	82	0
Changes in market price	43,598	41,238
Total impairments and (reversals) charged to operating surplus	**43,680**	**41,238**
Impairments charged to the revaluation reserve	7,593	9,905
Total impairments and (reversals)	**51,273**	**51,143**

The Trust realised impairments totalling £51.2m following a modern equivalent asset valuation of its sites, mainly linked to a move to an optimal estate model.

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 2019 was £1,554k (31 March 2018, £700k).

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Note 12.1 Property, plant and equipment 2018-19

	Total	Land	Buildings exc. dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2018	**176,216**	**12,210**	**150,664**	**0**	**8,977**	**925**	**84**	**2,009**	**1,347**
Additions - purchased (including capital lifecycle additions)	18,650	0	1,182	0	16,361	1,107	0	0	0
Impairments charged to operating expenses	(48,050)	(2,545)	(45,423)	0	(82)	0	0	0	0
Impairments charged to the revaluation reserve	(7,593)	(489)	(7,104)	0	0	0	0	0	0
Reversal of impairments credited to operating expenses	4,370	150	4,220	0	0	0	0	0	0
Revaluations	325	325	0	0	0	0	0	0	0
Reclassifications	(15)	2,181	0	0	(2,181)	0	0	(15)	0
Derecognition	(6,292)	0	(6,292)	0	0	0	0	0	0
Cost or valuation at 31 March 2019	**137,611**	**11,832**	**97,247**	**0**	**23,075**	**2,032**	**84**	**1,994**	**1,347**
Accumulated depreciation at 1 April 2018	**5,522**	**0**	**2,193**	**0**	**0**	**530**	**79**	**1,373**	**1,347**
Provided during the year	4,346	0	4,099	0	0	88	5	154	0
Derecognition	(6,292)	0	(6,292)	0	0	0	0	0	0
Accumulated depreciation at 31 March 2019	**3,576**	**0**	**0**	**0**	**0**	**618**	**84**	**1,527**	**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 2017-18

	Total	Land	Buildings exc. dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2017	**216,671**	**12,658**	**196,331**	**0**	**3,732**	**818**	**84**	**1,701**	**1,347**
Additions - purchased	12,710	0	6,026	0	6,252	124	0	308	0
Impairments charged to operating expenses	(43,195)	(335)	(42,860)	0	0	0	0	0	0
Impairments charged to the revaluation reserve	(9,905)	0	(9,905)	0	0	0	0	0	0
Reversal of impairments credited to operating expenses	1,973	0	1,973	0	0	0	0	0	0
Revaluations	655	0	655	0	0	0	0	0	0
Reclassifications	0	0	1,007	0	(1,007)	0	0	0	0
Transfers to/from assets held for sale and assets in disposal groups	(375)	(113)	(262)	0	0	0	0	0	0
Disposals/derecognition	(2,318)	0	(2,301)	0	0	(17)	0	0	0
Cost or valuation at 31 March 2018	**176,216**	**12,210**	**150,664**	**0**	**8,977**	**925**	**84**	**2,009**	**1,347**
Accumulated depreciation at 1 April 2017	**4,351**	**0**	**1,271**	**0**	**0**	**465**	**74**	**1,194**	**1,347**
Provided during the year	3,489	0	3,232	0	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	0
Disposals / derecognition*	(2,309)	0	(2,301)	0	0	(8)	0	0	0
Accumulated depreciation at 31 March 2018	**5,522**	**0**	**2,193**	**0**	**0**	**530**	**79**	**1,373**	**1,347**

Note 12.3 Property, plant and equipment financing

Net book value - 31 March 2019	Total	Land	Buildings exc. dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	126,376	11,832	89,588	0	23,075	1,414	0	467	0
On-SoFP PFI contracts and other service concession arrangements	7,659	0	7,659	0	0	0	0	0	0
Net book value total at 31 March 2019	**134,035**	**11,832**	**97,247**	**0**	**23,075**	**1,414**	**0**	**467**	**0**
Net book value - 31 March 2018									
Owned - purchased	129,559	12,210	107,336	0	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	0
Net book value total at 31 March 2018	**170,694**	**12,210**	**148,471**	**0**	**8,977**	**395**	**5**	**636**	**0**

Note 13 Non current assets acquired by government grant

The Trust has no assets acquired by government grant (2017-18, 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	15
Transport Equipment	1	7
Information Technology	1	7
Furniture & Fittings	1	10

*Plant and machinary maximum life years increased due to assets purchased with an economic life of 15 years

Note 14.1 Economic life of intangible assets

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

	Total £000	**Land £000**	**Buildings exc. dwellings £000**
Net book value of assets disposed	**350**	0	350
Sale proceeds*	**(360)**	0	(360)
Profit on sale	**(10)**	**0**	**(10)**

* The sale of these assets does not impact on the Trusts ability to meet its obligation to provide commissioner requested services as no sales are authorised without full consideration of the impact on service provision. Services previously provided in these buildings are now delivered within existing Trust estate, or the service has transferred to another provider.

Note 15.2 NBV of property, plant and equipment in the Revaluation Reserve as at 31 March 2019

	Total £000	**Land £000**	**Buildings exc. dwellings £000**
as at 1 April 2018	**9,909**	1,839	8,070
movement in year	**(7,269)**	(165)	(7,104)
as at 31 March 2019	**2,640**	**1,674**	**966**

Note 15.3 NBV of property, plant and equipment in the Revaluation Reserve as at 31 March 2018

	Total £000	**Land £000**	**Buildings exc. dwellings £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 16 Investments	**12 months ended 31 March 2019 Total £000**	**12 months ended 31 March 2018 Total £000**
as at 1 April	125	125
Share of profit/(loss)	(125)	0
as at 31 March	**0**	**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 2019 (31 March 2018, £nil) on the basis of materiality (as disclosed in note 1).

Note 18.1 Non current assets for sale and assets in disposal groups 2018-19	**Total £000**	PPE: Land £000	Property, plant & equipment £000
NBV of non-current assets for sale and assets in disposal groups at 31 March 2018	**350**	113	237
Less assets sold in year	**(350)**	(113)	(237)
NBV of non-current assets for sale and assets in disposal groups at 31 March 2019	**0**	**0**	**0**

Note 18.2 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 18.3 Liabilities disposal groups

The Trust has no liabilities in disposal groups as at 31 March 2019 (31 March 2018, £nil).

Note 19 Other assets

The Trust has no other assets as at 31 March 2019 (31 March 2018, £nil).

Note 20 Other financial assets

Other financial assets at 31 March 2019 (£50k) relate to a loan provided to Positive Individual Proactive Support (PIPS) services (31 March 2018, £470k).

Note 21.1 Inventories	**12 months ended 31 March 2019 £000**	**12 months ended 31 March 2018 £000**
Carrying value at 1 April	221	205
Additions	520	221
Inventories consumed (recognised in expenses)	(221)	(205)
Carrying value at 31 March	**520**	**221**

Note 22 Trade receivables and other receivables

	31 March 2019 Total £000	31 March 2019 NHS Receivables £000	31 March 2019 Non NHS Receivables £000	31 March 2018 Total £000
Current				
Contract receivables (IFRS 15): invoiced*	14,140	4,796	9,344	0
Contract receivables (IFRS 15): not yet invoiced / non-invoiced*	34,078	35,721	(1,643)	0
Trade receivables (comparative only)*	0	0	0	6,515
Accrued income (comparative only)*	0	0	0	5,014
Allowance for impaired contract receivables*	(6,284)	0	(6,284)	0
Allowance for impaired other receivables	0	0	0	(4,836)
Prepayments (revenue) [non-PFI]	4,692	1	4,691	3,822
PFI lifecycle prepayments (capital)	946	0	946	735
PDC dividend receivable	0	0	0	937
VAT receivable	830	0	830	833
Other receivables	96	0	96	6,255
Total current trade and other receivables	**48,498**	**40,518**	**7,980**	**19,275**
Non Current				
Other receivables	39	0	39	42
Total non current trade and other receivables	**39**	**0**	**39**	**0**

*Following the application of IFRS 15 from 1 April 2018, the trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Note 23.1 Allowance for credit losses

	31 March 2019 £000	31 March 2018 £000
At 1 April - brought forward	4,836	443
Impact of IFRS 9 (and IFRS 15) implementation on 1 April 2018 balance	16	0
New allowances arising	1,770	4,824
Reversals of allowances (where receivable is collected in-year)	(50)	(431)
Utilisation of allowances (where receivable is written off)	(288)	0
At 31 March	**6,284**	**4,836**

Note 23.2 Analysis of allowance for credit losses & non impaired receivables

	31 March 2019 £000 Trade and other receivables	31 March 2019 £000 Investments & other financial assets	31 March 2018 £000 Trade and other receivables	31 March 2018 £000 Investments & other financial assets
Ageing of allowance for credit losses				
0 - 30 days	4	0	1,086	0
30-60 Days	3	0	0	0
60-90 days	0	0	3,116	0
90- 180 days	377	0	25	0
over 180 days	5,900	0	609	0
Total	**6,284**	**0**	**4,836**	**0**
Ageing of non-impaired receivables past their due date				
0 - 30 days	442	0	1,995	0
30-60 Days	351	0	183	0
60-90 days	353	0	1,002	0
90- 180 days	714	0	69	0
over 180 days	1,747	0	122	0
Total	**3,607**	**0**	**3,371**	**0**

Note 24 Finance leases

The Trust does not have any finance lease obligations other than PFI commitments (2017-18, nil).

Note 25.1 Cash and cash equivalents

	12 months ended 31 March 2019 £000	12 months ended 31 March 2018 £000
At 1 April	58,415	57,845
Net change in year	14,313	570
At 31 March	**72,728**	**58,415**
Broken down into:		
Commercial banks and cash in hand	104	196
Cash with Government Banking Service	72,624	58,219
Cash and cash equivalents as in SoFP	**72,728**	**58,415**
Cash and cash equivalents as in SoCF	**72,728**	**58,415**

Note 25.2 Third party assets held

	12 months ended 31 March 2019 £000	12 months ended 31 March 2018 £000
At 1 April	1,499	1,437
Gross inflows	2,944	3,092
Gross outflows	(3,582)	(3,030)
At 31 March	**861**	**1,499**

Note 26.1 Trade and other payables

Current	31 March 2019 Total £000	31 March 2019 NHS Payables £000	31 March 2019 Non NHS Payables £000	31 March 2018 Total £000
Trade payables	17,425	7,335	10,090	5,299
Capital payables (including capital accruals)	1,355	0	1,355	2,332
Accruals (revenue costs only)	15,667	818	14,849	12,262
Social security costs	3,031	0	3,031	2,921
VAT payables	1,262	0	1,262	908
Other taxes payable	2,355	0	2,355	2,215
PDC dividend payable	16	0	16	0
Accrued interest on DHSC loans*	0	0	0	36
Other payables	0	0	0	5
Total current trade and other payables	**41,111**	**8,153**	**32,958**	**25,978**

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note 27. IFRS 9 is applied without restatement therefore comparatives have not been restated.

The Trust has no non current trade and other payables (2017-18 £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 2019 (2017-18, £nil).

Note 27.1 Borrowings

Current	31 March 2019 £000	31 March 2018 £000
Loans from the Department of Health and Social Care		
Capital loans	3,018	3,000
Other loans (non-DHSC)	238	0
Obligations under PFI, LIFT or other service concession contracts (excl lifecycle)	533	2,343
Total current borrowings	**3,789**	**5,343**
Non current		
Loans from the Department of Health and Social Care		
Capital loans	0	3,000
Other loans (non-DHSC)	714	0
Obligations under PFI, LIFT or other service concession contracts (excl lifecycle)	13,296	72,369
Total other non-current liabilities	**14,010**	**75,369**

PFI borrowings are in relation to Lanchester Road Hospital which operates under a standard form PFI contract i.e. unitary payments are payable from the date construction completion and are not subject to re-pricing. Inflation linked to RPI is applied annually. Final settlement is expected in May 2038.

The Trust terminated its PFI contract for the Roseberry Park site on 27 September 2018.

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 27.2 Reconciliation of liabilities arising from financing activities

	Loans from DHSC £000	Other loans £000	Finance leases £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2018	6,000	0	0	74,712	**80,712**
Cash movements:					
Financing cash flows - payments and receipts of principal	(3,000)	952	0	(1,340)	**(3,388)**
Financing cash flows - payments of interest	(71)	0	0	(3,133)	**(3,204)**
Non-cash movements:					
Impact of implementing IFRS 9 on 1 April 2018	36	0	0	0	**36**
Application of effective interest rate	53	0	0	2,133	**2,186**
Other changes	0	0	0	(58,543)	**(58,543)**
Carrying value at 31 March 2019	**3,018**	**952**	**0**	**13,829**	**17,799**

Note 28 Other liabilities

	31 March 2019 £000	31 March 2018 £000
Current		
Deferred income: contract liability (IFRS 15)	342	660
Total other current liabilities	**342**	**660**

Note 29 Other financial liabilities

The Trust has no other financial liabilities at 31 March 2019 (31 March 2018, £nil).

Note 30.1 Provisions for liabilities and charges 2018-19

	Total £000	Pensions - Injury benefits* £000	Legal claims ** £000	Redundancy £000	Other*** £000
At 1 April 2018	**3,226**	**2,798**	**384**	**44**	**0**
Change in discount rate	(102)	(102)	0	0	0
Arising during the year	3,210	99	92	0	3,019
Utilised during the year - accruals	(5)	0	(5)	0	0
Utilised during the year - cash	(289)	(158)	(131)	0	0
Reversed unused	(150)	0	(106)	(44)	0
Unwinding of discount rate	8	8	0	0	0
At 31 March 2019	**5,898**	**2,645**	**234**	**0**	**3,019**
Expected timing of cash flows:					
not later than one year	450	143	234	0	73
Current	**450**	**143**	**234**	**0**	**73**
later than one year and not later than five years	3,518	572	0	0	2,946
later than five years	1,930	1,930	0	0	0
Non current	**5,448**	**2,502**	**0**	**0**	**2,946**
TOTAL	**5,898**	**2,645**	**234**	**0**	**3,019**

*Pensions - injury benefits costs relating to other staff is a provision for injury benefit pensions.

**Legal claims relate to the following; employer / public liability claims notified by the NHS Litigation Authority £232,398 (2017-18, £303,597), and the provision for employment law £1,500 (2017-18, £80,200).

***Other provisions relate to an employment tribunal linked to annual leave pay

Note 30.2 Provisions for liabilities and charges 2017-18

	Total £000	Pensions - Injury benefits* £000	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**

Note 30.3 Clinical negligence liabilities

£1,896,117 (2017-18, £1,351,227) is included in the provisions of the NHS Litigation Authority at 31 March 2019 in respect of clinical negligence liabilities of the NHS Foundation Trust.

Note 31.1 Contingent liabilities

	31 March 2019 £000	31 March 2018 £000
Gross value of contingent liabilities	(154)	(89)
Net value of contingent liabilities	**(154)**	**(89)**

The contingencies relate to employer liability legal cases, all cases relate to the NHSLA and are due within 1 year.

The Trust has a potential liability linked to the PFI Termination mentioned in note 27.1. The Trust is currently assessing whether there is any liability owed to the liquidators of Three Valleys Healthcare Limited (TVH) (the project company for the Roseberry Park Hospital PFI scheme). There are various calculations which need to be undertaken in order to assess whether there is a negative or positive amount of compensation payable. The Trust is undertaking several exercises to assist with these calculations. At this stage liquidators have not come forward with their proposals on compensation on termination and there is no confirmed timeline.

It is the Trust's opinion that disclosure of any potential (or range of) liability may prejudice these discussions, and is applying the disclosure exemption available under IAS 37.

Note 31.2 Contingent assets

The Trust has contingent assets linked to the PFI termination detailed in note 31.1.

Note 32 Revaluation reserve

	31 March 2019 £000	31 March 2018 £000
Revaluation reserve at 1 April	**9,908**	**19,158**
Net impairments	(7,593)	(9,905)
Revaluations	325	655
Revaluation reserve at 31 March	**2,640**	**9,908**

Note 33 - 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 and Social Care is regarded as the parent department, and a related party. During the period Tees, Esk and Wear Valleys NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent department, or a related party. The Trust also has a non consolidated charity, foir which it acts as the sole corporate trustee.

The main entities that the Trust has dealing with are its commissioners, namely;

NHS England
NHS Durham Dales, Easington and Sedgefield CCG
NHS South Tees CCG
NHS Vale of York CCG
NHS North Durham CCG
NHS Hartlepool and Stockton-on-Tees CCG
NHS Harrogate and Rural District CCG
NHS Hambleton, Richmondshire and Whitby CCG
NHS Darlington CCG
NHS Scarborough and Ryedale CCG
Health Education England
NHS Pension Scheme
HM Revenue & Customs

The related parties disclosure below includes organisations the Trust has a joint venture, subsidiary or other partnership arrangement with. The Trust is not required to report other public bodies as related parties.

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.

2018-2019 **Entity**	**Income £000**	**Expenditure £000**	**Receivables £000**	**Payables £000**
Non-consolidated subsidiaries and associates / joint ventures	155	1,404	738	0
Other bodies or persons outside of the whole of government accounting boundary	436	236	217	8
Value of provisions for doubtful debts held against related parties (excludes salaries)	0	0	217	0
Total balances with related parties	**591**	**1,640**	**1,172**	**8**

2017-2018 **Entity**	**Income £000**	**Expenditure £000**	**Receivables £000**	**Payables £000**
Non-consolidated subsidiaries and associates / joint ventures	113	73	244	0
Other bodies or persons outside of the whole of government accounting boundary	1,019	0	1,154	36
Value of provisions for doubtful debts held against related parties (excludes salaries)	0	0	255	0
Total balances with related parties	**1,132**	**73**	**1,653**	**36**

Note 34.1 Contractual capital commitments

	31 March 2019	31 March 2018
	£000	£000
Property, plant and equipment	23,203	1,031
Total as at 31 March	**23,203**	**1,031**

Note 34.2 Other financial commitments
The Trust has no other financial commitments as at 31 March 2019 (31 March 2018, £nil).

Note 35 Finance lease obligations
The Trust has no finance lease obligations as at 31 March 2019 (31 March 2018, £nil).

Note 36.1 On SoFP PFI obligations (finance lease element)

	31 March 2019	31 March 2018
	Total	Total
	£000	£000
Gross PFI liabilities	**35,205**	**182,342**
of which liabilities are due		
not later than one year	1,589	7,697
later than one year and not later than five years	6,545	33,778
later than five years	27,071	140,867
Finance charges allocated to future periods	(21,376)	(107,630)
Net PFI liabilities	**13,829**	**74,712**
not later than one year	533	2,343
later than one year and not later than five years	2,267	11,521
later than five years	11,029	60,848
	13,829	**74,712**

Note 36.2 On SoFP PFI service concession commitments

	31 March 2019	31 March 2018
	Total	Total
Commitments	£000	£000
not later than one year	2,161	11,335
later than one year and not later than five years	9,197	48,252
later than five years	41,209	261,394
Total	**52,567**	**320,981**

Note 36.3 On SoFP PFI unitary payments

	31 March 2019	31 March 2019	31 March 2019	31 March 2018
	Total	Lanchester Rd PFI	Roseberry Park PFI	Total
	£000	£000	£000	£000
Unitary payment	**6,565**	**2,108**	**4,457**	**10,792**
Consisting of:				
- Interest charge	2,133	665	1,468	3,763
- Repayment of finance lease liability	1,340	365	975	2,469
- Service element (and other charges to operating expenditure excluding revenue lifecycle)	1,545	451	1,094	2,582
- Capital lifecycle maintenance	333	89	244	323
- Contingent rent	1,001	325	676	1,545
- Addition to lifecycle prepayment	213	213	0	110
Total	**6,565**	**2,108**	**4,457**	**10,792**

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).

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.

On 27th September 2018 the Trust terminated the PFI contract for Roseberry Park, liabilities relating to that PFI contract are therefore not shown in the balances as at 31 March 2019 above.

Note 37 Off-SoFP PFIs commitments
The Trust has no off-SoFP PFIs as at 31 March 2019 (31 March 2018, £nil).

Note 38 Events after the reporting period
The Trust has no events after the reporting period.

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

Note 39.1 Financial assets by category*	**Total**	**Loans and receivables**
Assets as per SoFP	**£000**	**£000**
2018-19		
Receivables (excluding non financial assets) - with DHSC group bodies	40,517	40,517
Receivables (excluding non financial assets) - with other bodies	1,552	1,552
Other investments / financial assets	50	50
Cash and cash equivalents	72,728	72,728
Total at 31 March 2019	**114,847**	**114,847**

*All of the Trust's financial assets are carried at amortised cost. Fair value is not considered to be significantly different from book value.

	Total	**Loans and receivables**
2017-18	**£000**	**£000**
Receivables (excluding non financial assets) - with DHSC group bodies	10,856	10,856
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**

Note 39.2 Financial liabilities by category*	**Total**	**Other financial liabilities**
	£000	**£000**
2018-19		
DHSC loans	3,018	3,018
Other borrowings excluding finance lease and PFI liabilities	952	952
Obligations under PFI, LIFT and other service concession contracts	13,829	13,829
Trade and other payables (excluding non financial liabilities) - with DHSC group bodies	8,153	8,153
Trade and other payables (excluding non financial liabilities) - with other bodies	26,187	26,187
IAS 37 provisions which are financial liabilities	234	234
Total at 31 March 2019	**52,373**	**52,373**

*All of the Trust's other financial liabilities are carried at amortised cost. Fair value is not considered significantly different from book value

	Total	**Other financial liabilities**
	£000	**£000**
2017-18		
DHSC loans	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 DHSC group bodies	1,593	1,593
Trade and other payables (excluding non financial liabilities) - with other bodies	18,305	18,305
IAS 37 provisions which are financial liabilities	384	384
Total at 31 March 2018	**100,994**	**100,994**

Note 39.3 Fair values of financial assets at 31 March 2019	**Book Value**	**Fair Value**
	£000	**£000**
Non current trade and other receivables	39	39
Total	**39**	**39**

Note 39.4 Fair values of financial liabilities at 31 March 2019

The Trust has no non current financial liabilities at 31 March 2019 (31 March 2018, £3,000k)

Note 39.5 Maturity of financial liabilities	**31 March 2019**	**31 March 2018**
	£000	**£000**
In one year or less	38,363	25,625
In more than one year but not more than two years	818	5,633
In more than two years but not more than five years	2,163	8,888
In more than five years	11,029	60,848
Total	**52,373**	**100,994**

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 41.1 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 2019	Number of cases	Value £000
Special payments		
Ex gratia payments	45	8
Total at 31 March 2019	**45**	**8**

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**

Note 41.2 Recovered losses

The Trust recovered £216k as at 31 March 2019 in relation to a mandate fraud committed in 2011 (total value of fraud was £261k); (31 March 2018 £nil).

Note 42 Third party assets and liabilities

The Trust held £862k cash at bank and in hand at 31 March 2019 (31 March 2018, £901k) 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.

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.

Note 44.1 Initial application of IFRS 9
IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £36k, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in a £16k decrease in the carrying value of receivables.

Note 44.2 Initial application of IFRS 15
IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

The application of IFRS 15 had no material impact on the Trust's financial statements.

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