AGENDA FOR THE MEETING OF THE COUNCIL OF GOVERNORS

25 May 2017, 6.00pm

(Governor registration and hospitality available between 5.00pm and 5.45pm)

Holiday Inn, Scotch Corner, Darlington DL10 6NR

Agenda:

No		What we will talk about	Why are we talking about this	Lead Person	Supporting Paper / Spoken report
6.00pm - 6.20pm Standard Items					
1.	welcome apologies	Welcome and apologies for absence	**For information** To make sure that we have enough Governors present to be quorate and introduce any new attendees. To advise of housekeeping arrangements	Lesley Bessant, Chairman	Spoken
2.	minutes	Minutes of the meeting of the Council of Governors held on 23 February 2017	**To agree** To check and approve the minutes of this meeting	Lesley Bessant, Chairman	Attached
3.	minutes	Public Council of Governors' Action Log	**To discuss** To update on any action items	Lesley Bessant, Chairman	Attached
4.		Declarations of Interest	**To agree** The opportunity for Governors to declare any interests with regard to any matter being discussed today	Lesley Bessant, Chairman	Spoken

<table>
<tr><th>No</th><th></th><th>What we will talk about</th><th>Why are we talking about this</th><th>Lead Person</th><th>Supporting Paper / Spoken report</th></tr>
<tr><td>5.</td><td></td><td>Chairman’s activities</td><td>For information
To hear from the Chairman on what she has been doing since the last meeting.
There will be an opportunity to ask any questions</td><td>Lesley Bessant, Chairman</td><td>Spoken</td></tr>
<tr><td rowspan="2">6.</td><td rowspan="2"></td><td>Questions from Governors</td><td>To discuss
To consider any questions raised by Governors which are not covered elsewhere on the agenda (Governors are asked to provide the Trust Secretary with at least 24 hours written notice if they wish to receive a formal answer to their questions at the meeting.)</td><td>Lesley Bessant, Chairman</td><td>Spoken</td></tr>
<tr><td colspan="4">1. <u>Simon Hughes, Staff Governor Teesside</u>

A number of colleagues are concerned about the current difficulties parking at Roseberry Park. The car park is getting full earlier in the morning (often before 8.30) and fewer spaces appear to become available during the day. Staff based at Roseberry Park with community roles are finding themselves wasting time trying to get parked, staff who have childcare or carer commitments and can’t get in early and work flexibly are feeling stressed with the current parking situation. Is there a long term sustainable solution to this issue that reflects the increased numbers of staff who are based at Roseberry Park?

2. <u>Cliff Allison, Public Governor Durham</u>

Following concerns raised by members, can I ask

1. Why do we have a waiting time of around 2 years from referral to diagnosis for autism?
2. What is being done to address this issue?
3. What support is given to patients and their carers during this period?
4. Following diagnosis, what happens next?</td></tr>
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No		What we will talk about	Why are we talking about this	Lead Person	Supporting Paper / Spoken report
		3. Mary Booth, Public Governor Middlesbrough *How much money does the Trust spend on pharmaceuticals?* 4. Judith Webster, Public Governor Scarborough and Ryedale *An article in the Daily Telegraph on 10th May 2017 reports a rise in mental health patients absconding. It was quoted that the Trust had reported a 64% rise. Can a report be provided on this and updated on a yearly basis broken into locality areas?* 5. Judith Webster, Public Governor Scarborough and Ryedale *As a Governor I would like to know the results of PLACE inspections. As service users and carers put a lot of time and effort into these inspections it is only right that, as Governor, we can feed back to them about the work the Trust has done and intends to do regarding the issues raised?* 6. Sarah Talbot-Landon, Public Governor Durham *For a second year running the CQC has published a 'Safety' rating of 'Requires Improvement', for TEWV. Please could you assure us of how the Trust will ensure a rating of 'Good' for the next CQC inspection?*			
6.20pm – 6.30pm Governance Related Items					
7.	Report	Summary of the discussions held at meetings of the Board of Directors from January 2017 to April 2017	**For information** An opportunity to read through the key areas discussed at recent meetings of the Board of Directors	Lesley Bessant, Chairman	Attached
8.	Report	Constitution	**To agree** To receive a report on proposed changes to the Constitution, Annex 4 in relation to the composition of the Council of Governors	Phil Bellas, Trust Secretary	Attached
9.	Report	Annual Board Certificates	**To review** To review the annual certifications required by NHS Improvement	Phil Bellas, Trust Secretary	Attached

No		What we will talk about	Why are we talking about this	Lead Person	Supporting Paper / Spoken report
6.30pm – 6.40pm Quality Related Items					
10.	Report	i. Compliance activity in relation to the Care Quality Commission ii. An update on any items of relevance following contact with the Care Quality Commission not contained in the report at i.	**For information** To receive a briefing on the latest information from Care Quality Commission Inspections of the Trust	Jennifer Illingworth, Director Quality Governance	Attached
11.	Report	Service Changes	**For information** To receive a briefing on changes and improvements to services in the Trust	Brent Kilmurray, Chief Operating Officer	Attached
12.	Report	Quality Account 2016/17	**For information** To receive the Trust's draft Quality Account for 2016/17	Sharon Pickering, Director of Planning, Performance and Communications	Attached
13.	Report	National Community Mental Health Survey 2016	**For information** To receive a report on the outcome of the National Community Mental Health Survey 2016	Jennifer Illingworth, Director Quality Governance	Attached

No		What we will talk about	Why are we talking about this	Lead Person	Supporting Paper / Spoken report
6.40pm – 6.50pm Performance Related					
14.		The Trust's Performance Dashboard	**For information** To review the performance of the Trust key indicators as at end March 2017	Sharon Pickering, Director of Planning, Performance and Communications	Attached
15.		The Trust's Finance report	**For information** To receive information and review the current financial position of the Trust as at end March 2017	Drew Kendall, Interim Director of Finance	Attached
16.		Development Plan	**To approve** To sign off the 2016/17 Council of Governors' development plan and to approve the development plan for 2017/18	Phil Bellas, Trust Secretary	Attached
6.50pm – 6.55pm Standing Committees					
17.		Involvement and Engagement Committee	**For information** To receive information on the work of this committee and approve any recommendations made	Vanessa Wildon, Chairman of Committee	Spoken
18.		Task and Finish Group: Involvement	**For information** To receive an update on the work undertaken so far	Hugh Griffiths Non Executive Director	Spoken

No		What we will talk about	Why are we talking about this	Lead Person	Supporting Paper / Spoken report
6.55pm Procedural					
19.	communication	Date and Time of next meeting: 13 July 2017, 6.00pm Holiday Inn, Scotch Corner Darlington DL10 6NR 19 July 2017, 6.00pm Annual General and Members meeting Marketplace and guest speaker from 3.30pm			Spoken
20.		<u>Confidential Motion</u> *"That representatives of the press and other members of the public be excluded from the remainder of this meeting on the grounds that the nature of the business to be transacted may involve the likely disclosure of confidential information as defined in Annex 9 to the Constitution as explained below:* *Information relating to a particular employee, former employee or applicant to become an employee of, or a particular office-holder, former office-holder or applicant to become an office-holder under, the Trust.* *Any terms proposed or to be proposed by or to the Trust in the course of negotiations for a contract for the acquisition or disposal of property or the supply of goods or services.*			

Lesley Bessant
Chairman
17 May 2017
Contact: Phil Bellas, Trust Secretary Tel. 01325 55 2001/Email: p.bellas@nhs.net

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

MINUTES OF THE COUNCIL OF GOVERNORS MEETING HELD ON 23 FEBRUARY 2017, 2.00 PM AT HOLIDAY INN, SCOTCH CORNER, DARLINGTON

PRESENT:
Lesley Bessant (Chairman)
Cliff Allison (Durham)
Mary Booth (Middlesbrough)
Peter Burgess (Durham)
Dr Martin Combs (York)
Gary Emerson (Stockton on Tees)
Elizabeth Forbes-Browne (Scarborough and Ryedale)
Chris Gibson (Harrogate and Wetherby)
Glenda Goodwin (Staff, Forensic)
Marion Grieves (Teesside University)
Hazel Griffiths (Harrogate and Wetherby)
Catherine Haigh (Middlesbrough)
Dennis Haithwaite (Darlington)
Dr Peter Harrison (York)
Simon Hughes (Staff, Teesside)
Gary Matfin (Staff, York and Selby)
Cllr Ann McCoy (Stockton Borough Council)
Keith Mollon (Durham)
Jean Rayment (Hartlepool)
Gillian Restall (Stockton on Tees)
Zoe Sherry (Hartlepool)
Dr David Smart (CCG representative for Co Durham and Darlington)
Cllr Helen Swiers (North Yorkshire County Council)
Sarah Talbot-Landon (Durham)
Vanessa Wildon (Redcar and Cleveland)
Colin Wilkie (Hambleton & Richmondshire)

IN ATTENDANCE:
Colin Martin (Chief Executive)
Phil Bellas (Trust Secretary)
Angela Grant (Administrator)
Dr Hugh Griffiths (Non Executive Director)
Marcus Hawthorn (Non Executive Director)
Wendy Johnson (Secretary)
Julie Jones (Head of Communications)
David Levy (Director of Human Resources and Organisational Development)
Elizabeth Moody (Director of Nursing and Governance)
Paul Murphy (Non Executive Director)
Donna Oliver (Deputy Trust Secretary)
Kathryn Ord (Deputy Trust Secretary)
Sharon Pickering (Director of Planning, Performance and Communications)
Shirley Richardson (Non Executive Director)
Richard Simpson (Non Executive Director)

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OBSERVING:
Student Nurses: Rebecca Booth, Maureen Chunye, Emily Dixon, Elizabeth Halliday, Stacey Harland, Clare Hill, Molly Patrick, Jhoie Tablanza, Ashleigh Wrifflesworth, Chris French

17/01 APOLOGIES
Lee Alexander (Durham County Council)
Janice Clark (Durham)
Hilary Dixon (Harrogate and Wetherby)
Dr Nathaniel Drake (York)
Dr John Drury (CCG representative for Hartlepool, Stockton on Tees and South Tees)
Paul Emerson-Wardle (Stockton on Tees)
Claire Farrell (Redcar and Cleveland)
Betty Gibson (Durham)
Andrea Goldie (Darlington)
Anthony Heslop (Durham)
Prof Pali Hungin (Durham University)
Dr Judith Hurst (Staff, Corporate)
David Jennings (Non Executive Director)
Kevin Kelly (Darlington Borough Council)
Drew Kendall (Interim Director of Finance)
Brent Kilmurray (Chief Operating Officer)
Dr Nick Land (Medical Director)
Cllr Ashley Mason (City of York)
Dr Lakkur Murthy (Durham)
Wendy Pedley (Staff, North Yorkshire)
Lisa Pope (representative for North Yorkshire Clinical Commissioning Groups)
Angela Simpson (University of York)
Angela Stirk (Hambleton and Richmondshire)
Richard Thompson (Scarborough and Ryedale)
Jim Tucker (Deputy Chairman)
Judith Webster (Scarborough & Ryedale)

17/02 WELCOME

The Chairman opened the meeting and noted apologies. She advised that Prof Watt and Dr Bobdey had tendered their resignations. Lee Alexander and Angela Simpson had been appointed as the representatives of Durham County Council and York University on the Council.

17/03 MINUTES OF PREVIOUS MEETINGS

The Council of Governors considered the minutes from the public meeting held on 17 November 2016.

Agreed – that the public minutes of the meeting held on 17 November 2016 be approved as a correct record and signed by the Chairman.

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17/04 PUBLIC ACTION LOG

Consideration was given to the public action log.

Arising from the report:

1) Minute 16/54 – Meetings with Appointed Governors
It was noted that Appointed Governors had been contacted and individual meetings with the Chairman had been scheduled to take place where requested.
Action Closed

2) Minute 16/55 – Provision of support for benefit and welfare advice
The Council noted the update report provided on this matter. Mr Burgess added that it was of interest to understand the differences in service provision but he wanted to know what could be done to further assist everyone to be able to access welfare rights officers.

The Chairman agreed to make Mr Kilmurray aware of the comments but advised that it was not within the gift of the Trust to provide equal access due to commissioning and funding differences across the Trust's area.
Action Closed

Cllr McCoy, in response to further comments made by the Council around a coordinated approach to assist people to access advice, agreed to raise this with the Director of the Citizens Advice Bureau in her role as Chair of the District Advice and Information Service for Stockton.
Action Item – Cllr McCoy

3) Minute 16/82 – Governor Development Day discussion on Experts by Experience and Recovery programme
The Council noted the discussion held on 24 January 2017.
Action Closed

4) Minute 16/85 – Community service survey
The Council requested that this was provided for the May 2017 Council meeting and the Action Log updated to reflect this.
Action Item – Mrs Moody

5) Minute 16/87 – Delayed discharges
Mrs Pickering confirmed that a report would be circulated outside of the meeting.
Action Item – Mrs Pickering

17/05 DECLARATIONS OF INTEREST

The Chairman declared an interest in the item in relation to her re-appointment on the private agenda.

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17/06 CHAIRMAN'S REPORT

The Chairman reported on her activities since November 2016. She had:

1) Attended the opening of Parkside Mental Health Resource Centre, which was the new base for four teams providing adult community mental health services in Middlesbrough. The centre had been designed with service users.
2) Presented Living the Values Awards to:
   - Janet Ainsley, support worker at the Richardson Hospital, Barnard Castle who had been nominated by a service user's family for the support she had provided.
   - Alyson Parvin, cognitive behaviour therapist at Bootham Park Hospital in York who had been nominated by a service user.
   - Staff from the children and young people's service at Lake House, Scarborough where a service user had said "Thank you all for being kind people".
   - Matthew Houghton, Ward Manager at Peppermill Court in York who had been nominated by a colleague.
3) Attended a Chairmen's meeting for the northern region where acute trusts reported difficulties with transformation plans and their financial position.
4) Met with Cllr Runciman in York and a number of Appointed Governors.

Cllr McCoy wished to report feedback she had received following attendance at manager hearings where relatives had been present. They had praised the Trust for the services provided to their family members.

17/07 GOVERNOR QUESTIONS

1. Anthony Heslop, Public Governor Durham

   'I note the press reports of the tragic death of a service user within Co Durham and the criticism of his care while an inpatient of the Trust by the coroner. Can the Trust give an account of the issues around the care which contributed to this death, learning points and actions taken to prevent such issues arising again and how these will be propagated across the Trust.'

Mrs Moody advised that:

1) The death had been widely reported in the press and there had been issues regarding care reported by the Coroner. The Trust through its own process investigated every death.
2) Through the investigation undertaken, there had been a strong root cause identified, this finding had been shared with the family and also the Coroner. The Coroner during their investigation had referenced this finding and commented on how open and transparent the Trust had been.
3) The Trust did have in place a full risk assessment process for the management of patient leave for those detained under the Mental Health Act and informal patients.
4) The findings had been that the psychiatrist had been clear within the records that tight arrangements around leave were to be put in place, however on the day the incident occurred, the leave processes were not followed through with no

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evidence of a risk assessment being undertaken. It also found that there had been a lack of involvement with the family around care planning.

5) In terms of learning the Trust had:
- Reviewed its policy for patient leave.
- Put in place mandatory training for the Mental Health Code of Practice.
- Identified a requirement for PIPA boards to be updated.
- Arranged for regular spot checks on compliance.

Mr Allison added that in terms of his view particularly around Forensic services, he previously believed that the psychiatrist responsible for a family member was being over cautious in terms of leave granted. But gaining an understanding as to why detailed plans, and feedback was important he no longer had this opinion.

2. Anthony Heslop, Public Governor Durham

'*In their December 2016 report "Learning, candour and accountability. A review of the way NHS trusts review and investigate the deaths of patients in England", the CQC say:*

"Across our review, we were unable to identify any trust that could demonstrate good practice across all aspects of identifying, reviewing and investigating deaths and ensuring that learning is implemented. However, we have identified trusts that demonstrate elements of promising practice at individual steps in the investigation pathway."

While the recommendations of the report were mainly directed towards initiatives at a national level, Recommendation 7 refers directly to the work of providers.

Would the Trust find value in a proactive review of its own performance against the report's Key Findings in order to become a Trust that does demonstrate good practice across all aspects of identifying, reviewing and investigating deaths and ensuring that learning is implemented?'

Mrs Moody advised that:

1) The CQC did find Trusts that demonstrated good practice but that this was not across the board. The Trust did follow national guidance and had its own central investigation team. Reports were made available to families.

However, no single (NHS Trust) was clear in terms of what the CQC was looking for. The CQC were holding an event in March 17 which the Trust was due to attend. In addition to this Mazars LLP (auditors) was undertaking some work on learning and duties of candour.

3. Mary Booth, Public Governor Middlesbrough

'What data does the Trust collect on seclusion? Was it possible to have this anonymously by unit and locality for the last six months showing the number of days per seclusion.
- *How was the data on seclusion monitored?*
- *How was seclusion reviewed?*

- *Was there an external review particularly of lengthy seclusions?'*

It was noted by the Council that a full written answer had been circulated. Mrs Booth confirmed that this answered her question.

4. Mary Booth, Public Governor Middlesbrough

'At the recent governor development day one of the future changes announced for the Teesside area was to move Fulmar Ward from Forensic services to Teesside Adult Mental Health. Can I please be assured that this transfer would include all relevant staff including nursing, Allied Health Professionals, Psychology and medical staffing resources.'

It was noted by the Council that a full written answer had been circulated.

In response Mr Martin confirmed that all the budgeted establishment would be included within the transfer and not just staff working on Fulmar Ward.

Mrs Booth confirmed that this answered her question.

5. Hazel Griffiths, Public Governor Harrogate and Wetherby

'It seems knowledge of clinical staff for diabetes within mental health services was patchy. Can or does the Trust have a diabetes strategy and would it work towards making diabetes training mandatory. I am concerned that since the disbandment of the physical health focus group that there was still have a long way to go with ensuring physical health was high on the agenda?'

It was noted by the Council that a full written answer had been circulated. Mrs Griffiths confirmed that this answered her question but that she still had concerns regarding the reasonable adjustments made for those patients within Learning Disability services or who had a diagnosis of Autism.

Mrs Moody advised that the physical health and well-being group was being reviewed and it would be beneficial to have a service user/carer representative on the group.

Action Item – Mrs Moody

The Chairman advised that the following questions had been received that were not included within the published agenda.

6. Colin Wilkie – Public Governor Hambleton and Richmondshire

'I understand that Mental Health Trusts must sign off commissioner spending for the sector under radical new plans to make sure cash was reaching the front line. Was this being introduced for the 2017/18 year. If so, how might TEWV manage this process?'

Mr Martin responded that:
1) This statement was correct under the parity of esteem pledge.

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2) There had been concerns raised by NHS England as to whether funding did reach front line services.
3) Contact had been made by Commissioners to confirm:
   - 2 year investment plans for 2017/18 and 2018/19 with evidence of meeting the mental health standard.
   - There had been a number of national 'must do's' contained within the five year forward view. Evidence was required as to whether these were being met.
   - There had been specific allocation for children and young people's services, evidence was required that this was being received and delivered.

7. Sarah Talbot-Landon – Public Governor Durham

'Can a briefing on unexpected deaths be provided?'

The Chairman confirmed that agreement had already been provided for the annual report on patient safety to be presented to the October 17 Governor Development Day.

8. Hazel Griffiths, Public Governor Harrogate and Wetherby

'*Can an update on the position of the new hospital for Harrogate be provided? There were concerns regarding the plans remaining the same and the funding provided from the CCG. What would happen if this cannot be funded?'*

Mr Martin confirmed that the current position was that:
1) Planning permission had been granted and the site had been purchased.
2) There was still a fundamental issue regarding the funding of the build and commitment was required from the CCG.
3) The Trust was moving more to a community service but investment was still required.
4) The Trust was unable to discuss any other options at this stage.

17/08 BOARD OF DIRECTORS FEEDBACK

Mr Bellas presented the report containing the Board roundup summaries from November 2016 to December 2016 for information and to allow questions and clarification of any matters.

Cllr McCoy advised she was pleased to see reference around the Trust values discussed at the Board. It was confirmed that the work to further embed and refresh the values would be discussed with the Council in due course once the action plan had been agreed.

Agreed – The Council of Governors received and noted the content of the Board round up from November 2016 to December 2016 inclusive.

17/09 APPOINTMENTS

Mr Bellas advised that at its meeting on 17 November 2016 (minute 16/85 refers) the Council of Governors reviewed the appointment of Governors to Trust Working Groups and agreed the appointment of Catherine Haigh to the Patient Experience Working Group. Where no nominations had been received agreement had been given to carry this over to the next Council meeting.

Nominations had now been received for:

1. Workforce Development Group - Mary Booth, Martin Combs, Sarah Talbot-Landon
2. Equality and Diversity and Human Rights Working Group – Gary Emerson
3. Environmental Strategy Working Group – Vanessa Wildon

In relation to the appointment of a Governor to observe the work of the Audit Committee on 18 May 2017, Gary Emerson had put himself forward for this role.

Agreed that:

1. ***Mary Booth be appointed to the Workforce and Development Group until November 2018***
2. ***Gary Emerson be appointed to the Equality, Diversity and Human Rights Working Group until November 2018***
3. ***Vanessa Wildon be appointed to the Environmental Working Group until November 2018.***
4. ***Gary Emerson be appointed to observe the work of the Audit Committee for the meeting due to be held on 18 May 2017.***

17/10 ANNUAL REPORT 2016/17

The Council received and noted the proposals for the production of the Trust' annual Report for 2016/17. Examples of options were made available to view.

The Chairman confirmed that the Council was being asked to consider four options presented and the production of an easy read version of the annual report.

The focus of discussion was around what the Trust was required to produce alongside the accessibility and readability of the finalised version.

Governors expressed preferences for Option B and Option D. There was full support for an easy read version to be produced.

The Chairman advised that the feedback would be taken in account in determining the produce arrangements for the annual report.

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17/11 COMPLIANCE ACTIVITY RELATING TO THE CARE QUALITY COMMISSION (CQC)

The Council received and noted the report of the Trust on compliance with the Care Quality Commission including:

1) An update on the CQC's announced inspection of the Well Led Domain and inspections of Learning Disability Services which had not been visited during the inspection held in 2015.
2) Details of the Regulation 17 letter received by the Trust following the unannounced inspection of CQC in November 2016.
3) Confirmation of receipt of the draft reports of the inspection held in November 2016.
4) An update on the visit of NHS England to the Westwood Centre in January 2017.
5) An update on inspections under the Mental Health Act.
6) Information around the following meetings / events:
   - CQC Assurance event
   - Fundamental Standards meeting
   - CQC Engagement Meeting

Agreed – The Council of Governors received and noted the report in relation to compliance with the Care Quality Commission.

17/12 SERVICE CHANGES

The Council received and noted the update report on service changes.

In response to questions it was noted that:

1) The vacancy rate for adult consultant psychiatrists was a national problem within the NHS. The actions put in place by the Trust included:
   - Incentives for junior doctor contracts
   - Enhancement of roles to make them more attractive, eg the inclusion of research roles
   - Incentives to fill short term vacancies
   - Reviewing overseas recruitment activity
   - Reviewing non medical roles eg Psychology

   The Trust had identified this as a high risk area and was looking at new ways of working rather than using agency staff. The current position was that no one was due to retire from these positions in the short term.
2) The current position of availability of care homes was a pressure on services. Conversations had taken place around enhanced input into care homes for Dementia patients.
3) The Trust was working with Public Health departments to raise awareness of self-harm within young people. However, the position for adults was not clear. Mrs Moody agreed to raise this with Mr Kilmurray.

The Chairman confirmed that the Quality Assurance Committee had also requested information on self-harm awareness to be presented in order to understand the challenges.

Cllr McCoy added that Stockton Borough Council had undertaken a significant amount of work and were working with young people on this issue.

Action Item – Mrs Moody/Mr Kilmurray

4) The work to support new models of care within the children and young people's Tier 4 service was with regard to improving the pathway in order to manage the demand for beds and to utilise savings from bed reductions to enhance community services. Referrals on a 'first referral' basis to this service were continuing to rise.
5) The Routine Outcome Measurements (ROMs) were to obtain a better measurement of outcomes and currently there was insufficient data to be representative.

Agreed – The Council of Governors received and noted the service development update report.

17/13 QUALITY ACCOUNT

Mrs Pickering presented the Quarter 3 update on the Quality Account 2016/17.

Arising from questions Mrs Pickering clarified that the percentage of falls were per 1000 patients.

She advised the Council of the requirement to re-convene the Quality Account Task Group to assist the Trust draft its submission. The Chairman asked any interested Governors to put their name forward to Kathryn Ord.

Action item – Kathryn Ord / Governors

Agreed – The Council of Governors received and noted the Quarter 3 Quality Account update for 2016/17.

17/14 PERFORMANCE DASHBOARD

The Council received and noted the Performance Dashboard report as at 31 December 2016 and the availability of the supporting information pack.

Agreed – That the Council of Governors received and noted the Performance Dashboard report as at end of December 2016.

17/15 FINANCE REPORT

Consideration was given to the finance report for the period up to 31 December 2016.

In response to questions, Mr Martin:

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1) Advised that the Trust did offer incentives / bonuses to encourage people to work for the Trust, that this had been undertaken in the York and Selby area with the offer of NMC fees paid and a joining fee paid for newly qualified nurses. In relation to contracts for psychiatrists, this was more difficult and other incentives were being offered such as combined research roles and the entry level of salaries.

Agreed - The Council of Governors received and noted the Finance report as at end December 2016.

17/16 COMMITTEE UPDATE

Ms Wildon updated the Council on the Work of the Involvement and Engagement Committee which last met on 9 February 2017 including:

1) There were no concerns relating to the current public or staff membership of the Trust.
2) The target of recruiting 250 new public members net had been exceeded with 443 new members net being recruited between 01/04/2016 and 01/02/17.
3) 388 people were currently registered as interested in taking part in involvement opportunities within the Trust but a validation exercise was currently underway.
4) Consideration of how social media could be better used by the Trust.
5) An update on the competition for young people for artwork.
6) Plans to survey those members registered for involvement work to establish satisfaction levels.
7) The recommendation that 3 public/member engagement events should be held in Scarborough and Ryedale, Harrogate and Wetherby, County Durham and Darlington which would include workshops alongside information stalls.
8) The recommendation for men and their mental health to be the theme for the Annual General and Members Meeting 2017.
9) A recommendation that the Involvement and Engagement Framework review be postponed until March 2018.

Agreed – That the Council of Governors:

1. ***Received and noted the update on the work of the Involvement and Engagement Committee.***
2. ***Approved the delivery of 3 public engagement events for 2017/18 with the areas identified as Scarborough and Ryedale, Harrogate and Wetherby, County Durham and Darlington and for events to contain workshops as well as information stands.***
3. ***Approved the theme of men and their mental health for the 2017 Annual General and Members meeting.***
4. ***Approved the deferment of the review of the Involvement and Engagement Framework to March 2018.***

17/17 TASK AND FINISH GROUP – Member and Stakeholder Representation and Engagement

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Mr Simpson presented the action plan as a result of the findings and recommendations of the Governor Task and Finish Group which had undertaken a review on how Governors could better represent and engage with their members and stakeholders.

Agreed - That the action plan of the Task and Finish Group - 'Member and Stakeholder Representation and Engagement' be approved.

17/18 DATE AND TIME OF NEXT MEETING

The Chairman confirmed the next meeting would be held on 25 May 2017 at 6pm at Holiday Inn Scotch Corner, Darlington, DL10 6NR.

17/19 CONFIDENTIAL RESOLUTION

Agreed*– that representatives of the press and other members of the public be excluded from the remainder of this meeting on the grounds that the nature of the business to be transacted may involve the likely disclosure of confidential information as defined in Annex 9 to the Constitution as explained below:*

Information relating to the financial or business affairs of any particular person (other than the Trust).

Any advice received or information obtained from legal or financial advisors appointed by the Trust or action to be taken in connection with that advice or information.

The Chairman closed the public session of the meeting at 3.30pm

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ITEM NO 3

FOR GENERAL RELEASE

COUNCIL OF GOVERNORS

DATE:	**25 May 2017**
TITLE:	**Public Action Log**
REPORT OF:	**Phil Bellas, Trust Secretary**
REPORT FOR:	**Information / Assurance**

This report supports the achievement of the following Strategic Goals:	✓
To provide excellent services working with the individual users of our services and their families to promote recovery and wellbeing	✓
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.	✓

Executive Summary:
This report allows the Council of Governors to track progress on agreed actions.

Recommendations:
The Council of Governors is asked to receive and note this report.

Council of Governors Action Log **Item 3**

RAG Ratings:

Colour	Meaning
Green	Action completed/Approval of documentation
Amber	Action due/Matter due for consideration at the meeting.
Pink	Action outstanding but no timescale set by the Council.
Red	Action outstanding and the timescale set by the Council having passed.
Grey	Action superseded
White	Date for completion of action not yet reached

Date	Minute No.	Action	Owner(s)	Timescale	Status
29/09/2016	16/56	To provide an update on the impact of the removal of student nurse bursaries.	Elizabeth Moody	November 17	
17/11/2016	16/82	To provide an update on the use of PARIS and impact on staff time and patient care.	Brent Kilmurray	November 17	
17/11/2016	16/84	Invite the external auditors to a governor development day.	Phil Bellas	April 17	Completed Auditors attended meeting on 5 April 2017
17/11/2016	16/84	To provide an annual report on the work and performance of the external auditors to the Council of Governors.	Marcus Hawthorn	July 17	
17/11/2016	16/85	To present the findings of the community service survey	Elizabeth Moody	May-17	on agenda for 25/5/17
17/11/2016	16/87	To submit a report on delayed discharges identifying the differences within localities.	Sharon Pickering / Brent Kilmurray	March 17	Completed Report circulated on 14 March 2017
23/02/2017	17/04	To discuss whether a collaborative approach could be provided to enable patients to access welfare advice. To raise this with the Director of CAB for Stockton.	Cllr Ann McCoy	May 2017	
23/02/2017	17/07	To consider the appointment of a patient/carer representative on the physical health and well-being group.	Elizabeth Moody		

Date	Minute No.	Action	Owner(s)	Timescale	Status
23/02/2017	17/07	To arrange for the presentation of the annual report on patient safety to a governor development day following consideration by QUAC.	Jennifer illingworth	October 2017	
23/02/2017	17/12	To request an update on the work being done to raise awareness of self harm within the adult services. To circulate the report submitted to the Quality Assurance Committee.	Elizabeth Moody/Brent Kilmurray		

ITEM NO 7

FOR GENERAL RELEASE

COUNCIL OF GOVERNORS

DATE:	**25 May 2017**
TITLE:	**Board round-up**
REPORT OF:	**Phil Bellas**
REPORT FOR:	**Assurance/Information**

This report supports the achievement of the following Strategic Goals:	✓
To provide excellent services working with the individual users of our services and their families to promote recovery and wellbeing	
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.	✓

Executive Summary:

This report allows the Council of Governors to note the summary of discussions that took place at recent meetings of the Board of Directors.

Recommendations:

The Council of Governors is asked to receive and note this report.

MEETING OF:	COUNCIL OF GOVERNORS
DATE:	25 May 2017
TITLE:	Board round-up

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to provide the Council of Governors with an update on the matters considered by the Board of Directors.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The Council of Governors approved the recommendations of its Task and Finish Group on "Holding the Non Executive Directors to Account for the Performance of the Board" at its meeting held on 24th September 2014 (minute 14/70 refers).

2.2 Under recommendation 2 of the review report it was proposed that copies of the Board round-up (a brief summary of key issues which is produced following each Board meeting and published on the intranet) should be presented to the Council of Governors, as an aide memoire, to assist Governors, and others attending the Board meetings, to highlight any business related matters which they consider important to bring to the attention of the Council of Governors.

3. KEY ISSUES:

3.1 Copies of the Board round-ups for the meetings held from January 2017 to April 2017 are attached to this report.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** No risks have been identified.

4.2 **Financial/Value for Money:** No risks have been identified.

4.3 **Legal and Constitutional (including the NHS Constitution):** No risks have been identified

4.4 **Equality and Diversity:** No risks have been identified.

4.4 **Other implications:** No risks have been identified

5. CONCLUSIONS:

5.1 This report is presented to the Council of Governors in accordance with the action plan developed to implement the recommendations of the Task and

Finish group on "Holding the Non Executive Directors to Account for the Performance of the Board".

6. RECOMMENDATIONS:

6.1 The Council of Governors is asked to note the key matters considered by the Board of Directors at its meetings held from January 2017 to April 2017 (as contained in the Board round-ups for those meetings) and raise any issues of concern, clarification or interest.

Phil Bellas,
Trust Secretary

Background Papers:
Report of Task and Finish Group on "Holding the Non Executive Directors to Account for the Performance of the Board

Feedback from Board of Directors meeting held 31 January 2017

Chairman's report
The chairman reported back on discussions at the governor development day held in January.

Locality briefing – County Durham and Darlington
Patrick Scott, director of operations, gave an update on the previous year, which also coincided with his first year in post. In summary, he felt the locality had achieved a great deal although there was still work to do. He said he was very proud of staff and the work they'd done. He said his main challenges were workforce issues – not only having sufficient appropriately trained staff but also making sure they were fully engaged and that there was capacity to deliver improvements. The Board congratulated Patrick on the improvements that had been made since he came into post and asked him to thank staff for all their hard work.

Nurse staffing report
The Board received and noted the six monthly report. There was a lengthy discussion about the report and the Board sought assurances on a number of issues which are detailed in the formal minutes.

Recovery and wellbeing strategy
The Board considered the recovery and wellbeing strategy for 2017-20 which Brent explained was a refresh rather than a re-write that built on the success of the last four years. It was recognised that, whilst we'd made a start on co-production, there was lots more to do and that this was an integral part of the next phase of the strategy. The importance of embedding recovery within the Trust's way of working was emphasised. The Board asked that a statement be included in the strategy that demonstrated the organisation's commitment to recovery and emphasised that it was central to achieving our strategic direction. This was agreed and the Board approved the strategy.

Waiting times in child and adult mental health services
The Board received a progress report on action to minimise waiting times. They noted the significant variation in funding between Teesside and the North Yorkshire and York & Selby localities. The Board were pleased with the improvements made although recognised that there was still pressure on services and that the situation remained fragile. The importance of maintaining focus on this issue was stressed and it was agreed that a further report will be provided to the Board in July 2017.

Finance
The Board received December's finance report.

Performance
The Board received the performance dashboard for December. Of specific note were the waiting time figures, which were extremely positive - the best reported by the Trust since it was first established. There were also promising signs in the figures for out of locality admissions (ie no further increase in the number of admissions).
The Board approved the targets for the key performance indicators in the 2017/18 dashboard.

Workforce report

The Board received the quarterly workforce report. David Levy reported back about attrition rates at recent recruitment fairs. He noted that we'd had more success when running our own fairs (compared to taking part in those run by other organisations). He said a review of recruitment activity was planned. Nick Land noted that consultant posts were becoming increasingly difficult to fill and that we needed to think about what we could do to mitigate.

Feedback from Board of Directors meeting held 23 February 2017

The key items on this month's agenda were

Quality assurance committee (QuAC)
The Board received and discussed the QuAC report. Elizabeth Moody advised the Board that the Trust would be carrying out a gap analysis to identify what actions would be required to meet the recommendations in the CQC's report – 'learning, candour and accountability'. She also assured the Board that although the percentage of complaints that had been satisfactorily resolved was worse than target, there had been no trends identified.

Nurse staffing report
The Board received the monthly nurse staffing reports for December 2016 and January 2017. Much of the discussion focussed on the introduction of severity scores to indicate potential areas of concern and how they would be used alongside other information.

The Board were also advised that they would receive a report on the analysis that was being undertaken on vacancies and staffing pressures in North Yorkshire.

Mental Health Legislation Committee
The Board received the latest report from the committee. They were pleased that recurring themes from CQC Mental Health Act visits were being reviewed and that an action plan was being developed.

Finance
The Board received and noted January's finance report.

Performance
The Board received January's performance dashboard report and Sharon Pickering noted the key points, as highlighted in the report. This included IAPT services (talking therapies), where targets were not being met and the action plans that are in place. The Board also discussed concerns about the increase in external referrals and the potential impact on waiting times.

The Board also received the strategic direction performance report and approved the proposed changes.

Feedback from Board of Directors meeting held 28 March 2017

Action log
Elizabeth Moody gave an update on ongoing work about nurse placements and discussions with Teesside University relating to the quota of learning disability student nurses (there is a risk that the university will not be able to attract sufficient students).

Chairman's report
The chairman reported on the recent meeting for Trust chairmen from the North Yorkshire and Humber region.

Locality briefing – forensic services
Levi Buckley, director of operations for forensic services gave a presentation on key issues facing the service. The Board appreciated the update and the following specific topics were discussed:

- Nurse preceptorships – under the current system the service only receives 2nd year students. It's hoped that discussions with Teesside University will lead to a more flexible approach
- The model wards programme and improvements made to date
- The challenges of the North West prison contract
- The challenges of the Transforming Care agenda

The Board asked Levi to thank staff for their hard work.

Freedom to speak up guardian
Dewi Williams, the Trust's freedom to speak up guardian, presented a report on activities to date. There was a discussion about the importance of maintaining confidentiality so that staff feel able to raise concerns and the challenge, therefore, of making sure that those concerns are fully investigated. The Board also discussed new training that was being introduced for band 7 managers and above on how to handle concerns raised. David Levy explained that the training would focus less on the legal framework for raising concerns and more on creating an environment where people would feel able to raise an issue or concern. The Board welcomed Dewi's report and gave their full support for his role.

Quality Assurance Committee (QuAC)
The Board received and noted the report

Nurse staffing report
The Board received the nurse staffing report and noted that no direct risks or implications to patient safety had been identified.

Recovery and wellbeing strategy
The Board received and approved the recovery and wellbeing strategy and noted specifically the excellent virtual recovery college which had recently been launched by the Trust.

Learning from deaths
Elizabeth Moody talked through the new national reporting requirements as outlined in her report. It was noted that there was limited national guidance for mental health trusts, which gave us the opportunity to work with other trusts to develop a joint and consistent approach. It was noted there were clear expectations of non-executive directors in learning from deaths and that training would be provided.

Finance report
The Board received and noted the finance report.

Performance
The Board received the performance dashboard and were particularly pleased to note that there were only four indicators showing red – an extremely positive position. The Board were extremely encouraged by the positive trends reported, despite pressures on services.

Programme management framework
The Board approved the interim framework and governance arrangements.

Information governance toolkit
The Board approved the submission of the 2016/17.

Feedback from Board of Directors meeting held 25 April 2017

Chairman's report
The Chairman reported back on the governor development day in April and drew attention to the excellent briefing on perinatal services. It was agreed that a briefing on the service should be provided to a future board seminar.

Lesley noted that she'd received very positive feedback from the Darlington affective disorder team (who'd received a living the values award) about the purposeful and productive community services (PPCS) programme.

She also reported back on positive discussions with Teesside University, which had included potential opportunities for further developing partnership working.

Quality assurance committee (QuAC)
The board received and noted the QuAC report.

Nurse staffing report
The Board received the monthly report and noted the new system for tracking hot spots through severity scores. There was a discussion about the programme to review our safe staffing approach which is due to start very soon. The Board also discussed the use of bank/agency, particularly in York and Selby, and the work that's going on to address this.

Finance report
The Board received the finance report as of 31 March 2017 and noted the positive end of year position.

Performance
The Board received the performance dashboard report and commented on the positive year end position. We're making good progress against waiting time targets (this is the best position ever), despite seeing an increase in referrals. We've also seen an increase in the number of appraisals. We've met our financial targets and performance against other targets was better than we've seen for a number of years. The Board recognise the pressures and challenges that staff have faced over the last year and were impressed with what's been achieved over the last twelve months in maintaining and improving performance. They passed on their thanks and appreciation to staff for all the hard work that's going on across the Trust in both clinical and non-clinical services.

Workforce report
The Board received the quarterly workforce report which included the latest staff friends and family test (FFT). There was a discussion about sickness absence rates (which are slowly rising) although the Board also acknowledged the proactive measures in place to support the mental wellbeing of staff.

Composition of Council of Governors
The Board agree the proposal that the University of Newcastle be eligible to appoint a governor.

Single oversight framework
The Board considered the report and agreed a further report to provide assurance on completion of outstanding actions in the York and Selby quality governance action plan be provided to the Board in July.

ITEM NO. 8

FOR GENERAL RELEASE

COUNCIL OF GOVERNORS

DATE:	**25th May 2017**
TITLE:	**Composition of the Council of Governors**
REPORT OF:	**Phil Bellas, Trust Secretary**
REPORT FOR:	**Decision**

This report supports the achievement of the following Strategic Goals:	✓
To provide excellent services working with the individual users of our services and their families to promote recovery and wellbeing	
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.	✓

Executive Summary:

The purpose of this report is to seek the approval of a recommendation from the Board of Directors to amend Annex 4 of the Trust's Constitution to provide a seat on the Council of Governors for the University of Newcastle.

In accordance with the NHS Act 2006, as amended, any changes to the Constitution must be approved by both the Board of Directors and Council of Governors.

Recommendations:

The Council of Governors is asked to approve that:

(a) The University of Newcastle be designated a "partnership organisation" and be eligible to appoint a Governor of the Trust.

(b) Annex 4 to the Constitution be amended as set out in Appendix 1 to this report.

MEETING OF:	Council of Governors
DATE:	25th May 2017
TITLE:	Composition of the Council of Governors

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to seek approval to amend Annex 4 of the Trust's Constitution to provide a seat on the Council of Governors for the University of Newcastle.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 Any changes to the Trust's Constitution must be approved by both the Board of Directors and the Council of Governors.

2.2 The statutory requirements relating to the composition of Councils of Governors of NHS Foundation Trusts are set out in Schedule 7 of the National Health Service Act 2006 (as amended).

3. KEY ISSUES:

3.1 The Constitution provides seats on the Council of Governors for the Universities of Durham, Teesside and York in recognition of their importance to the Trust in relation to medical and clinical education and research.

3.2 It has been decided to transfer Durham University's School of Medicine, Pharmacy and Health to Newcastle University.

3.3 In view of this change, the Board of Directors has approved an amendment to Annex 4 of the Trust's Constitution to provide a seat on the Council of Governors for Newcastle University.

3.4 The proposed revisions to Annex 4 of the Constitution are set out in Appendix 1 to this report.

3.5 The Council of Governors is asked to note that there are no proposals to amend the status of Durham University as a "partnership organisation". The University continues to be of significant importance to the Trust in view of, amongst other matters, its leading psychology department and expertise in medical geography,

3.6 In accordance with Constitutional change processes, the Council of Governors is asked to approve the proposed amendments to Annex 4 of the Constitution. Subject to this, the changes will come into effect on 1st June 2017.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** None identified.

4.2 **Financial/Value for Money:** None identified.

4.3 **Legal and Constitutional (including the NHS Constitution):** The Trust must have a legally compliant Constitution i.e. it must meet the requirements of Schedule 7 of the National Health Service Act 2006 (as amended).

The Act requires any amendments to the Constitution to be approved by both the Board of Directors and Council of Governors.

4.4 **Equality and Diversity:** None identified.

4.5 **Other implications:** None identified.

5. RISKS:

5.1 There are no risks associated with this report.

6. CONCLUSIONS:

6.1 It is considered that the proposed changes to Annex 4 of the Constitution are beneficial for the Trust in view of Newcastle University's key role in medical education and research.

7. RECOMMENDATIONS:

7.1 The Council of Governors is asked to:
(1) Designate the University of Newcastle as a "partnership organisation".
(2) Approve the amendments to Annex 4 (Composition of the Council of Governors) of the Constitution as set out in Appendix 1 to this report.

Phil Bellas, Trust Secretary

Background Papers:
The National Health Service Act 2006 (as amended)
The Trust's Constitution (October 2015)

Appendix 1

ANNEX 4 – COMPOSITION OF COUNCIL OF GOVERNORS

(Paragraphs 11.2 and 11.3)

COMPOSITION OF THE COUNCIL OF GOVERNORS		
Constituency		**Number of Governors from 1/6/17**
Public	Stockton-on-Tees	3
	Hartlepool	2
	Darlington	2
	Durham	8
	Middlesbrough	2
	Redcar & Cleveland	2
	Scarborough and Ryedale	3
	Hambleton and Richmondshire	2
	Harrogate and Wetherby	3
	City of York	3
	Selby	2
	Rest of England	1
Staff	Corporate	1
	Forensic	1
	North Yorkshire	1
	County Durham and Darlington	1
	Teesside	1
	York and Selby	1
Appointed Governors	Durham County Council	1
	Darlington Borough Council	1
	Hartlepool Borough Council	1
	Stockton-on-Tees Borough Council	1
	Middlesbrough Borough Council	1
	Redcar & Cleveland Borough Council	1
	North Yorkshire County Council	1
	City of York Council	1
	University of Teesside	1*
	Durham University	1*
	University of York	1*
	University of Newcastle	1*
	Northern Specialist Commissioning Group	1*
	North Durham Clinical Commissioning Group Durham Dales, Easington and Sedgefield Clinical Commissioning Group Darlington Clinical Commissioning Group	1*
	Hartlepool and Stockton-on-Tees Clinical Commissioning Group South of Tees Clinical Commissioning Group	1*
	Hambleton, Richmondshire and Whitby Clinical Commissioning Group Scarborough and Ryedale Clinical Commissioning Group Harrogate Clinical Commissioning Group Vale of York Clinical Commissioning Group	1*
TOTAL		**55**

(Notes:

1 The terms of Governors holding office on 1st June 2017 are unaffected by any changes to the Constitution which come into force on that day.

2 The appointing organisations marked (*) in the above schedule are specified for the purposes of sub-paragraph 9(7) of Schedule 7 for the 2006 Act (as amended).

3 The arrangements for the appointment of Governors by Clinical Commissioning Groups are set out in Annex 6.)

ITEM NO. 9

FOR GENERAL RELEASE

COUNCIL OF GOVERNORS

DATE:	**25th May 2017**
TITLE:	**Annual Board Certificates**
REPORT OF:	**Phil Bellas, Trust Secretary**
REPORT FOR:	**Consultation**

This report supports the achievement of the following Strategic Goals:	✓
To provide excellent services working with the individual users of our services and their families to promote recovery and wellbeing	
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.	✓

Executive Summary:

NHS Improvement has requested the Boards of Directors of Foundation Trusts to sign off a number of annual certificates relating to the governance of their trusts.

In signing off the certificates the Boards are required to take into account the views of their Councils of Governors.

The Council of Governors is, therefore, asked to raise any matters which it considers would prevent the Board from confirming and signing off the certificates or, if there are none, to endorse the Board's position on them.

Recommendations:

The Council of Governors is asked to raise any matters which it considers would prevent the Board from confirming the certificates or, if there are none, to endorse the Board's position on them.

MEETING OF:	Council of Governors
DATE:	25th May 2017
TITLE:	Annual Board Certificates

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to seek the views of the Council of Governors on the Trust's position in relation to the annual certificates required by NHS Improvement (NHSI).

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 NHS Improvement requires the Boards of Foundation Trusts to sign off a number of annual certificates relating to their governance arrangements.

2.2 In determining their response to the certification, the Boards are required to take into account the views of their Councils of Governors.

2.2 For 2017/18, the signed certificates are not required to be submitted to NHS Improvement; however, the regulator will be undertaking spot audits, from July 2017, to test that Foundation Trusts have carried out the self-certification process.

3. KEY ISSUES:

3.1 The Audit Committee considered the ability of the Board to confirm and sign off the annual certificates, following an assurance review, at its meeting held on 11th May 2017.

3.2 The Audit Committee has recommended to the Board that there is sufficient assurance to enable it to confirm the following certificates:

(a) The certificate of compliance with Licence Condition 6 in the following form:
"Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution."

(b) The Corporate Governance Statement (as required under Licence Condition FT4 (8)) as set out in Annex 1 to this report.

(c) The certificate on the training of Governors (as required by Section 151 of the Health and Social Care Act 2012) in the following form:
"*The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in S.151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role."*

(d) The certificate on compliance with Condition CoS7 of the Licence in the following form:
"After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate."

In making the above declaration of compliance *with Condition CoS7 of the Licence the Board has taken into account:*

- *The Trust's approved NHSI Operational Plan and Business Plan.*
- *The contracts agreed and signed off with all Commissioners as part of the planning round.*
- *The approved budget, signed off by the Board, including the capital programme and CRES programme (based on quality assurance processes).*
- *The control total agreed with NHSI.*
- *Its decision, based on an assurance review, that the Trust remains a "going concern".*
- *The Trust's workforce plans and measures being taken to increase recruitment and retention of clinical staff."*

3.3 The Board will be considering the Audit Committee's recommendations at its meeting held on 23rd May 2017. The Board's decisions, subject to the views of the Council of Governors, will be reported at the meeting.

3.4 To comply with NHS Improvement requirements, the Council of Governors is asked to raise any matters which it considers would prevent the Board from confirming the certificates or, if there are none, to endorse the Board's position on these matters.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** The Trust is required to be registered with the CQC under Licence Condition G7.

4.2 **Financial/Value for Money:** Under the Licence, the Trust has a duty to operate efficiently, economically and effectively.

4.3 **Legal and Constitutional (including the NHS Constitution):** The Trust is required to hold a Licence in order to provide NHS services. Failure to comply with the Licence conditions can result in enforcement action.

4.4 **Equality and Diversity:** None identified.

4.5 **Other implications:** None identified.

5. RISKS:

5.1 There are risks that, if following testing, NHS Improvement does not consider that the Trust's approach to self-certification is sufficiently robust it would consider this to be potential a breach of the Licence and review the Trust's segmentation under the Single Oversight Framework.

6. CONCLUSIONS:

6.1 The annual self-certifications are required by NHS Improvement. The responses agreed by the Board may be used by the Regulator to determine its approach to oversight of the Trust.

7. RECOMMENDATIONS

The Council of Governors is asked to consider whether there are any matters which it considers would prevent the Board from confirming the certificates or, if there are none, endorse the Board's position on these matters.

Phil Bellas, Trust Secretary
Drew Kendall, Interim Director of Finance and Information

Background Papers: The Trust's Provider Licence Email from NHS Improvement to the Chief Executive dated 21/4/17 on the self-certification process for 2017/18

Annex 1

Draft Corporate Governance Statement (May 2017)

	Corporate Governance Statement Component	Risks & Mitigating Actions	Proposed Response (Confirmed/Not Confirmed)
1	The Board is satisfied that Tees, Esk & Wear Valleys NHS Foundation Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	The Trust's corporate governance arrangements have not been subject to an independent review since 2014. *Mitigating Action* *An external governance review, based on NHS Improvement guidance, will be undertaken by the end of Quarter 2, 2017/18*	Confirmed
2	The Board has regard to such guidance on good corporate governance as may be issued by Monitor from time to time	See (1) above	Confirmed
3	The Board is satisfied that Tees, Esk and Wear Valleys NHS Foundation Trust implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	See (1) above	Confirmed
4	The Board is satisfied that Tees, Esk and Wear Valleys NHS Foundation Trust effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny	See (1) above	Confirmed

	and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern; (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements		
5	The Board is satisfied that: (a) There is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) The Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of	See (1) above	Confirmed

	care; (d) It receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) Tees, Esk & Wear Valleys NHS Foundation Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) There is clear accountability for quality of care throughout the Tees, Esk & Wear Valleys NHS Foundation Trust including, but not restricted to, systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.		
6	The Board is satisfied that there are systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	The Trust has recognised that difficulties in recruiting and retaining sufficient staff in all its Localities could impact on its ability to provide high quality care. *Mitigating Actions* *A range of mitigating actions have been developed in response to this risk including:* ▪ *The refresh of the Trust's workforce strategy.* ▪ *The delivery of the Trust's recruitment plan (by March 2018)* ▪ *The establishment of the Safer Staffing Programme* ▪ *The PPCS and model wards programmes* ▪ *Systematic reviews of all consultant vacancies* ▪ *Campaigns and*	Confirmed

		initiatives to attract junior medical staff *Assurance on the delivery of these mitigating actions is being provided regularly to the Board.*	

ITEM NO. 10

FOR GENERAL RELEASE

COUNCIL OF GOVERNORS
PUBLIC AGENDA

DATE:	**Thursday, 25th May 2017**
TITLE:	**To assure the Council of Governors on the position of compliance with Care Quality Commission registration requirements**
REPORT OF:	**Jennifer Illingworth, Director of Quality Governance**
REPORT FOR:	**Information**

This report supports the achievement of the following Strategic Goals:	✓
To provide excellent services working with the individual users of our services and their carers to promote recovery and wellbeing	✓
To continuously improve to quality and value of our work	✓
To recruit, develop and retain a skilled, compassionate and motivated workforce	
To have effective partnerships with local, national and international organisations for the benefit of the communities we serve	✓
To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefits of the communities we serve.	✓

Executive Summary:

This report provides the Trust's current activity in providing assurance on the current position of compliance with the Care Quality Commission.

- **CQC Announced Inspection January 2017 – Well Led Review and Learning Disability Community Services**
- **CQC Unannounced Inspection November 2016 – update**
- **Ofsted Registration – Holly and Baysdale Unit**
- **Mental Health Act Inspections – there have been a total of 9 MHA Reviewer inspections to wards across the Trust since the last report**
- **Quality Compliance Group – 12th April 2017**
- **Feedback from the Fundamental Standards Group held on the 3rd March 2017**

Recommendations:

The Council of Governors are asked to note the CQC registration and information assurance update.

MEETING OF:	COUNCIL OF GOVERNORS
DATE:	Thursday, 25th May 2017
TITLE:	To assure the Council of Governors on the position of compliance with Care Quality Commission registration requirements.

1. INTRODUCTION & PURPOSE

1.1 To provide the Council of Governors with a position statement on the Trust Care Quality Commission (CQC) registration and provide assurance of compliance with the Essential Standards for Quality and Safety required maintaining registration.

2. KEY ISSUES:

2.1 Announced CQC Inspection Visit January 2017 – Well Led Review and LD Community Services Inspection (visit included unannounced inspection of Rehabilitation In-patient Services Trust wide)

The Trust has now received the final reports from the Compliance visit which took place in January 2017. The LD Community Services and Rehabilitation Services both received a rating of 'Good' and the Trust retained a 'Good' rating overall.

2.2 CQC Unannounced Inspection – November 2016

The final reports from the unannounced inspection which took place in November 2016 were published by CQC on 23rd February 2017. The Trust have developed an action plan in response to the issues raised which is currently being progressed and implemented across the Trust and being monitored through relevant Trust Governance Structures.

The following were the key issues raised within the reports:-

- Issues with ward environments
- Training
- Patient Safety
- Record Keeping
- Policy compliance
- Staffing

2.3 Ofsted Registration – Holly and Baysdale

Ofsted Inspectors undertook pre-registration visits to Holly Unit on Tuesday 4th April 2017 and Baysdale on Wednesday 5th April 2017. The Ofsted Inspector was very impressed by the staff and level of training as well as the environment and had no concerns about patient safety. He felt the units were very child centred and stated that care planning documents were very good albeit health focussed. He is going to recommend we are registered from the beginning of May subject to the completion of a Locality Risk Assessment for each unit.

There is no requirement to change our current registration of these units with CQC; following discussion they confirmed that the units would be required to be dual registered to undertake the healthcare requirements of the children.

2.4 Mental Health Act Inspections

There have been nine MHA inspections since the last report to Council of Governors:-

- Lustrum Vale (Tees, AMH) 22nd February 2017
- Bilsdale (Tees, AMH) 1st March 2017
- The Lodge, Bankfields Court (Tees, ALD) 7th March 2017
- Nightingale (Forensic, MH) 15th March 2017
- The Orchards (North Yorkshire, AMH) 21st March 2017
- Ceddesfeld (Durham and Darlington, MHSOP) 22nd March 2017
- Langley (Forensic, LD) 19th April 2017
- Birch Ward (Durham and Darlington, AMH) 28th April 2017
- Roseberry Ward (Durham and Darlington, MHSOP) 3rd May 2017

2.5 Quality Compliance Group

The first two meetings of the Quality Compliance Group took place on 12th April and 12th May 2017. The meetings were well attended by Senior Managers from across the Trust. The main focus of this group is to monitor the actions from CQC Compliance visits and ensure that they are completed on time and shared across the Trust - not just in the areas where the concerns were identified.

The group also discussed key themes that are arising from Mental Health Act visits. The following are the key five themes consistently being raised:-

1. Issues with Care Plans
2. Issues with patient's rights
3. Issues with MHA Section Forms
4. Patients not being referred to IMHA
5. Issues with Section 17 leave forms

2.6 The Fundamental Standards Group

The Fundamental Standards Group met on 3rd March 2017. The group were given a presentation on the Payment by Results and clinical outcome reporting. There was some discussion in relation to the presentation around the following issues:-

- Efficacy of care packages
- Opportunity to involve service users in their care
- Assists review of progress
- Opportunity for care team and service user to work in partnership
- Encourages openness around progress

Group members received copies of the final reports from the unannounced inspection to Adult Mental Health and Older Peoples In-patient services for information and a discussion took place in relation to the informal feedback received following the CQC Compliance visit to the Trust in January 2017. The group were still keen to be

involved in any future mock inspections that are planned in 2017 and also in the PLACE visits to take place in 2017.

3. IMPLICATIONS:

3.1 **Compliance with the CQC Fundamental Standards:** Provision of safe and effective high quality services is a strategic priority for the Trust and the Fundamental Standards of Quality and Safety that underpin CQC registration support and facilitate those quality services. Ongoing full registration reinforces the position of the Trust in maintaining high quality service delivery – any loss of registration has implications for the reputation of the Trust as quality provider.

3.2 **Financial/Value for Money:** Full CQC registration is an essential requirement of the Monitor authorisation the Trust to operate as Foundation Trust –complete loss of registration therefore would have disastrous business impact**.** There are financial implications in maintaining CQC registration – the annual fee structure, the corporate infrastructure required to maintain the evidence base and relationship with CQC and the costs of addressing any challenges to compliance with changing services.

3.3 **Legal and Constitutional (including the NHS Constitution):** Under the 2008 Health and Social Care Act (Regulated Activities) Regulations 2009, CQC registration is a pre-requisite to the status of service provider – the Trust can no longer legally undertake contractual obligations to provide services without registration for those services. In addition all the legal and statutory requirements that underpin the CQC Fundamental Standards forms the operational and professional legislative framework that the Trust has to comply with anyway –compliance with the registration standards enables the Trust to ensure those legal and statutory requirements are being met.

3.4 **Equality and Diversity:** The Equality and Diversity legislation underpins the CQC registration framework and therefore compliance with E&D legislation is monitored to mitigate risk to or compromise of CQC registration status.

4. RISKS: The essential requirement to have services registered before undertaking contractual obligations to provide could compromise the flexibility and nimbleness of the Trust to take on new or reconfigured services as the registration processes are not currently highly responsive. Internally there needs to be proactive and reflexive systems in place to reduce that risk by including registration and compliance advice/action as early as possible in the tender or contracting stage.

5. CONCLUSIONS: The Trust continues to maintain full registration with the CQC with no conditions and continues to strengthen the validated evidence base that demonstrates compliance with the CQC's framework for regulating and monitoring services.

6. RECOMMENDATIONS: The Council of Governors is asked to note the CQC registration and information assurance update.

Jennifer Illingworth
Director of Quality Governance

ITEM NO. 11

FOR GENERAL RELEASE

COUNCIL OF GOVERNORS

DATE:	**25 May 2017**
TITLE:	**Service Changes Report**
REPORT OF:	**Brent Kilmurray, Chief Operating Officer**
REPORT FOR:	**Information**

This report supports the achievement of the following Strategic Goals:	✓
To provide excellent services working with the individual users of our services and their carers to promote recovery and wellbeing	✓
To continuously improve to quality and value of our work	✓
To recruit, develop and retain a skilled, compassionate and motivated workforce	✓
To have effective partnerships with local, national and international organisations for the benefit of the communities we serve	✓
To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefits of the communities we serve.	✓

Executive Summary:

This report sets out high level developments within services across localities and specialties.

Recommendations:

Council of Governors is asked to receive and note this report.

MEETING OF:	Council of Governors
DATE:	25 May 2017
TITLE:	Service Changes Report

1. INTRODUCTION & PURPOSE:

1.1 To provide an update on service changes within Tees, Esk and Wear Valleys NHS Foundation Trust.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 This paper seeks to provide an overview for Governors regarding some of the key current service issues. The update is set out by locality and service.

3. KEY ISSUES:

3.1 Durham and Darlington

Adult Mental Health and Substance Misuse
From the first week of May we will have single sex acute assessment and treatment wards at West Park Hospital, which is a very positive development and we are now seeing the work to deliver cultural change within the site having a noticeable impact. Work is scheduled for completion in July to develop seclusion facilities on our PICU and work is also scheduled to develop a dedicated child visiting area for the site on Maple Ward. Changes to the environment to reflect recovery and make the hospital feel more welcoming are now well advanced, with an artist being commissioned with staff and service users to put in place some inspirational artwork around the site. .

The Directorate continues to work hard to maximise the benefits of Purposeful and Productive Community Services (PPCS) and has held a development session with cell leads to ensure they are supported to deliver the roles now expected of them. A series of events with the leadership teams and cell leads is now planned for the remainder of 2017 to ensure we maintain momentum.

The Directorate have appointed a Consultant Psychologist in Personality Disorders, the successful applicant will begin work over the summer.

Drug and alcohol services continue to be a priority area for us, and we are expecting a re-tender exercise being launched imminently (dependant on Purdah rules with the recently announced general election).

Mental Health Services for Older People
Frailty
The Frailty CQUIN was met with 100% rating across all 4 wards.

Pathways
In January we held a very successful Kaizen event to introduce the functional pathway onto our two functional wards. We believe that we are the first Directorate to have fully implemented a clinical pathway across all teams. Associated to this our Lead Psychologist is preparing staff to work with patients who have experienced trauma.

In May we have a RPIW planned, which will focus on reducing the time between referral and diagnosis for patients on the Dementia Care Pathway.

Location of Organic Beds
A six month evaluation paper was tabled at the two Overview and Scrutiny Committees in March. The evaluation demonstrated that the mitigation plans to assist carers with travelling to Auckland Park Hospital have been operationalised. It also demonstrated that there have been no complaints, no increase in length of stay and continued positive feedback from carers. County Durham Overview and Scrutiny Committee asked us to repeat the evaluation at 12 months. The co-location of our two organic wards at Auckland Park Hospital allowed us to increase the amount of physical health care practitioner time that we have available to our wards (to 16 sessions per week).

Children and Young People's Services
In line with the 5 Year Forward View (5YFV) Durham and Darlington Children & Adolescent Mental Health Services (CAMHS) are striving to support timely access and delivery of evidenced based interventions for young people who require our service. Having introduced the Single Point of Access (SPA) in August 2016 we have seen an improvement in waiting times, however the demand for CAMHS remains high. The service is currently completing a review of the SPA to ensure we continue to use our resources well. Data we have reviewed so far indicates that 49% of referrals into the SPA are now being successfully signposted to other services. We are also reviewing trends around inappropriate referrals to allow us to target referrers, providing support and education on other services available. Early discussions with commissioners have agreed to provide additional funding to support some of this targeted work. This is in line with local transformation plans, where commissioners agreed that the wider children's workforce needed support to reduce inappropriate admissions to CAMHS.

The service used funding from NHS England to reduce the waiting time for Autistic Spectrum Disorder assessments. This had significant impact for those young people and families waiting. Unfortunately this was non recurrent funding which has now ended. We have moved some resource from Tier 3 to support the pathway; however the current demand outweighs the capacity and we anticipate waiting times will increase. Commissioners are well aware of the current provision and demand. The service has worked with the multi-agency autism assessment team and commissioners to develop a business case to secure further funding as ongoing work and is being led by North East Commissioning Support.

Learning Disability Service
Progress continues with the Transforming Care plans for bed reductions in Adult Learning Disability (ALD) services which require a reduction from the current 11 to 6 beds. There is a plan to co-locate ALD/Forensic Learning Disability (FLD) services in a 'hub' model. This is an exciting opportunity for closer working between the two services which will be beneficial to staff and service users in the long term.

Alongside the bed reductions, we need to be able to support people more proactively in the community to try and prevent situations that would result in hospital admissions. The development of the Enhanced Community Service will support this and to ensure the right skill mix we hope that this change will attract staff from inpatient roles willing to take up posts within this new service, working alongside community colleagues.

The eleventh annual Learning Disability Conference will be focussing on advocacy and enabling people with a learning disability to have a voice. The conference entitled 'The Bigger Voice' will be held at the Xcel Centre, Newton Aycliffe on Tuesday 17th October.

3.2 Tees

Adult Mental Health and Substance Misuse
The Specialist Autism Service has developed different working arrangements in Tees, following an RPIW, linking them more directly to access teams and providing training and support. This means some people can be assessed and diagnosed by the CMHT rather than having to wait for the specialist service. This has had a positive impact on waiting times.

The Crisis Assessment Suite (CAS) is continuing to see over 250 referrals a month and is looking forward to moving to a larger facility in the Autumn. The Street Triage service has transferred from the Forensic Directorate and is now being managed with the CAS.

We were delighted with the feedback from NHS England after the 'deep dive' into progress with the EIP access standard.

An RPIW with Lifeline, Addaction and Hartlepool Local Authority took place and has now been tested at 60 days. There are very positive outcomes which will be shared and spread across the rest of Tees after the 90 days of testing.

Mental Health Services for Older People
Nursing home places for older people with challenging behaviour continues to decrease with more nursing homes re registering to residential home status and closing. There are no homes able to take our patients in Hartlepool and patients are having to go to Easington and beyond although there are new providers who may be opening homes later in the year.

The Intensive Community Liaison Service is also involved in supporting homes who are in difficulty and this is taking more time and effort than was envisaged. Their work has been recognised by the Executive Nurse of the CCGs.

Children and Young People's Services
The New Models of Care pilot for inpatient CYP has started and home treatment is now being provided in North Yorkshire and York. Significant savings were demonstrated in the first month.

Referrals continue to rise, although still short of the potential number of children with a diagnosable mental health issue on Tees. Investment in preventative services has been made as part of the Transforming CYP (Children and Young People) agenda.

Learning Disability Service
There has been a slowing pace of transformation as there remains a lack of clarity on dowry funds for patients which is creating difficulties for local authorities and our staff trying to place patients. There are a number of patients at Bankfields Court who are still awaiting a move to community based packages of care (identified as part of the original Winterbourne cohort.)

There are increasing difficulties for providers in the community and our teams are spending more time assisting with CQC identified quality issues with other providers. This has been highlighted to commissioners and the Trust Board. Work has still not started on the Dales although our Trust Board has now agreed funding after NHS England delayed making capital monies avaialable.

3.3 North Yorkshire

Adult Mental Health and Substance Misuse
We are currently expending the daily lean management approach across crisis, Early Intervention Psychosis (EIP), Assertive Outreach Team (AOT) and Primary Care Teams and it is expected that all teams will adopt the six Phase 1 products within PPCS.

Focus remains on delivering the Trust 4 week waiting time standard. Capacity and demand analysis is taking place to help support them. A further kaizen event will take place in late May across primary care looking at access to service, daily triage and DNA rates.

A combined meeting with the locality service user and carer involvement groups took place 9 May, from which we are to develop a service-wide group that keeps the localities linked and brings in our third sector partners so that we shape the direction of the service together.

Mental Health Services for Older People
We are in the final stages of developing options for the remodel of Hambleton and Richmondshire Mental Health Services for Older People, (there is also similar work taking place in Adult Services) focusing on an enhanced community model to reduce length of stay in hospital and in the longer term an ambition to reduce the number of inpatient admissions. This will be open to

public consultation led by the CCG from June to September 2017. Pre engagement events have been taking place with staff and with the local public to continue to inform this development.

We held a recent Pathway Event in North Yorkshire to review our progress to date in implementing clinical pathways for all patients and we have set ourselves targets to complete the roll out of all clinical pathways by September 2017. This is a challenging agenda and will be essential to improve the quality and outcomes for all patients in North Yorkshire. In addition, we have started the planning process for an RPIW in July 2017 to improve the consistency and quality of approach to supporting care homes in meeting patient needs and provide continuity of care. This will be the first improvement event for 2017/2018 in a broader programme to improve memory services, care planning and administrative support in our services.

Children and Young People's Services

The service continues to make improvements around access to service for children and young people. There has been a reduction on the length of time waited for first assessment. These improvements are a result of ongoing implementation of a recovery plan, recruitment to vacancies and the roll out of group interventions across the service.

A key development for the service is the introduction of a Crisis and Home Treatment Service for children and young people. Introduction of the service will be phased in by December 2017 to provide a seven day service. The development results from the Tier 4 Model of Care programme. The service model will eventually link to the North Yorkshire All Age Crisis Service.

Learning Disability Service

A new initiative is being launched looking at increasing cervical smear take up for women with learning disabilities in Scarborough with a view to rolling out wider in NY. A Cancer Screening Task and Finish group has been formed across North Yorkshire with a primary care lead and support from NY Learning Disability's Strategic Health Facilitation team. A bid is being put together to try and secure funding to increase the screening rates of cancer patients with LD. It is hoped this will sit with TEWV as part of the physical health screening programme, linking with the CQUIN target on annual health checks.

The contract transfer for Craven LD community health provision is due to transfer to Bradford District Foundation Trust by July 1st 2017. It has been delayed from the 1st June by Airedale, Wharfedale and Craven CCG and Bradford District Foundation Trust as part of their preparations to take over.

Transforming Care - No change from last month's up-date, but just to add that the Transforming Care Programme (TCP) in NY is considering extending the successful implementation of the Positive Behavioural Support Specialist role, funded by Brain Tumour Research and Support monies for a further year, as we have been unable to recruit into the second post which would have supported the west Learning Disability teams in NY. This was due to the temporary funding in place for the project. This will mean, if agreed at May's TCP meeting, that the current post which covers Scarborough Whitby and

Ryedale and Hambleton & Richmondshire will extend across the NY footprint on a consultancy basis, developing Positive Behavioural Support champions in each team to support the work at a local level.

3.4 York and Selby

Adult Mental Health and Substance Misuse

On a positive note the feedback received from patients and referrers regarding the new Access and Wellbeing Service demonstrates an improved service experience and separating the access work from crisis work has had a positive impact on the work and performance of the Crisis Team. The new service has been challenging from the outset in meeting waiting times standards due to a consistently high volume of referrals. Community services have been deployed to support direct assessments and there is work under way to understand the capacity and demand on this service.

A 'Combined Pathway' for people with affective disorders and psychosis has been developed and implemented from 24 April 2017. This will be monitored via QIS methods.

The Early Intervention Psychosis (EIP) service successfully transferred to TEWV on the 1 April 2017. The York and Selby service was included in a NHS England Deep Dive in March 2017 and development work is progressing in line with feedback, findings and recommendations from the NHS England visit. An action plan is in place working towards meeting NICE concordant care and the access and waiting times standards for EIP.

IAPT – A diagnostic review has been undertaken by NHS England Intensive Support Team (IST) (Feb 2017). Formal feedback was received on 11 April 2017 and we are awaiting the written report. Despite efforts to achieve an improvement in access and recovery for people accessing IAPT services this has not been sustained due to a number of factors such as number of referrals, waiting times, and recruitment and retention difficulties. The IST will continue to work with the service to support the development of a new pathway for IAPT.

Mental Health Services for Older People

Acomb Garth opened on schedule in the week commencing 13 February 2017. The decision was taken to operate the unit on a reduced bed number as the recruitment of qualified nurses had not yielded enough successful candidates to fill the vacancies. The unit is currently operating on 8 beds (total provision is 14) and has full occupancy. There remains pressure to admit to male dementia beds across the locality and also across the Trust. We are reviewing the availability of beds on a weekly basis.

Worsley Court continues to operate as a community base (the beds are all now closed) for the South West MHSOP Community Mental Health Team (CMHT) and work is progressing with the creation of a community hub in that building. Y&S MHSOP Care Homes and Dementia Team now has its new name and continues to operate successfully.

The Purposeful Inpatient Admission (PIPA) process has now been rolled out in all the inpatient wards across MHSOP. Progress is being made on all wards with significant improvements noted. The report out process is capturing these successes and highlighting deficits which then become focus points to further improve and develop systems and processes. Indicators within the monitoring frameworks are all positive with improvements noted across all domains.

The implementation of the Purposeful and Productive Community Services (PPCS) phase one products across all community teams is progressing well and is reflected in the dashboard. External validation is now being planned to support the process. The memory service has made progress in developing the 'One Stop Shop' approach for memory assessments with two trials already completed. The next stages of report out will evaluate these trials. The issue of waiters in the memory service is being addressed via a short term project approach and resources are being allocated to address the backlog. We expect this work will be completed by the end of August 2017.

Children and Young People's Services
The launch event for the Single Point of Access service was well attended, with approximately 50 colleagues from a range of agencies across York and Selby. Feedback on the new model of working was largely positive but it was acknowledged that the four week target from referral to assessment was a challenge. Positive parental feedback was offered during the event on the 30 minute telephone consultation process, whereby the family felt heard and were informed of the next steps following referral.

Unfortunately , pressures on the service for on-going intervention work remain with unacceptably long waiting lists for a number of the pathways. A capacity and demand exercise is under way to help the service produce a gap analysis and then plan how best to address this. Additional capacity is being brought into the service as the CAMHS Crisis and Home Treatment Team becomes established, releasing 2.5 wte (whole time equivalent) back into service from the Hospital Liaison Team as their work will be superseded by the Crisis Team.

Development of the CAMHS Crisis and Home Treatment Team continues to go well, with eight of the nine posts recruited to. Five of the staff will be in post by mid-June. The operational processes of the team will replicate practice in the Teesside service, with the anticipated benefits being realised in York and Selby.

Recruitment into the York and Scarborough hub and spoke of the Enhanced Community Eating Disorders team has been completed, with the final two clinical staff taking up post in April. This will allow the new service to provide additional services to the most seriously ill young people, who may be at risk of admission. It will also provide a variety of group work opportunities to young people and their parents.

Learning Disability Service
Greenlight training is to be rolled out to colleagues in Adult Mental Health Services, with the first tranche to be in Street Triage and Force Control Triage

in June; this will develop proactive joint working between colleagues across all the services, improving the interface between services.

The Core LD pathway is now operational and in use for all new referrals. A repeat questionnaire is being sent to all those on the pathway during May to compare to the baseline position and determine what the benefits of the pathway are.

Building work has commenced at Oak Rise so there are no male beds available on site. A contingency plan has been shared with all relevant parties to manage any potential admissions during the works which are expected to take until early August. Already the team are picking up assertive outreach work to provide community support to individuals that may have otherwise been admitted.

In-patient New Build replacement
In light of the purdah arrangements associated with the general election on June 8th, the Trust Board has chosen to hold an extra Board meeting in mid-June to review the options for the new build hospital, in relation to the number and configuration of beds and the preferred site. The Board's decisions will be communicated after this meeting to all key stakeholders, including the media.

3.5 Forensic Services
Model Ward
The focus of the Model Ward project over the last 8 months has been to develop a solid foundation on which to implement change in the service.

The Model Ward programme board and steering groups have been established within the service to support the governance arrangements for the project and to provide direction for future improvement work and sharing of good practice.

So far there have been two RPIWs and two Kaizen events in 2017. The first RPIW reviewed the Daily Lean Management (DLM) arrangements within inpatient services; this has established a daily management 'huddle' in both Forensic Mental Health and Forensic Learning Disability; this huddle includes daily escalation to Head of Service or Director for issues that require senior support. The daily huddles support the weekly performance and operational report-outs while the weekly huddles use Visual Control Boards to track progress, monitor actions /issues and escalate to the Director for resolution.

The second RPIW focussed on the processes on the wards for the daily allocation of duties for staff including the allocation of staff rest breaks, medication reviews and patient activities such as leave and therapeutic groups. Visual control and standard work has been developed to support the new process. This will be piloted on Clover/Ivy and Mallard wards. The outputs of this event have so far been sustained and plans are being put in place to move the pilot to the Model Wards for initial share and spread.

Two Kaizens were held on each of the model wards. Following the QIS methodology both wards conducted a 5S of the physical ward environment and daily/ weekly and monthly audits and standard ward tasks. The events made a

big impact on the ward environment in terms of decluttering ward offices, MDT rooms and patient stores; the event also identified 20 unnecessary audits and tasks to be removed from the daily work book, saving approximately 620 minutes per week of nursing time across both wards.

Both Model Wards have conducted away days with staff to engage them in the improvement process and generate ideas for future improvement work. Both Forensic Mental Health (FMH) and Forensic Learning Disability (FLD) teams are using the outputs to generate the work plan and priorities for the project.

Forensic Learning Disability

Transforming Care
The implementation of NHS England's Assuring Transformation Programme continues to be the most significant issue facing the service and since the last briefing we have been informed by NHSE that the region needs to reduce more beds than the originally agreed trajectories. The service is currently working with NHSE and Northumberland Tyne and Wear (NTW) on revised proposals but also raising concerns with regard to these additional reductions and potential consequences and reality in delivering such increased closures.

The local community model – Secure Outreach and Transitions Team (SOTT) is being progressed with further recruitment taking place. The extended 8am – 8pm, 7 day per week service is operational from 1st May 2017.

The service continues to face significant pressures on its registered nurse workforce and recruitment challenges none of which will be reduced with the announcement of further bed reductions.

The service is also working closely with local authority colleagues to review discharge plans and timescales with a view to identify timely discharge solutions and identify a wider pool of community providers.

Offender Health
The Street Triage Team for Teesside has successfully moved over to the management of Tees Adult Mental Health Service. This will give a consistent approach to Street Triage across the trust.

The Trust has won the sub contract to provide mental health services into 3 prisons (Preston, Lancaster Farm and Kirkham). The transfer took place on 1st April 2017. The Trust are also tendering for the North East contract.

A restructure of the Service management in Offender Health Community (OHC) has been completed.

Forensic Mental Health
The Forensic Mental Health Service has begun to roll out boundary see-saw training across all inpatient areas.

The boundary see- saw model was produced in 2010 by Rampton; it was designed to enable staff of all grades to manage difficult situations relating to

boundary issues which include crossing, shifting and violations. The majority of violations can be prevented with the appropriate training and knowledge.

The training focusses on working with service users who have a personality disorder diagnosis.

Ridgeway Recovery College
Ridgeway Recovery College has been running courses since September 2015. In April 2016 a CQUIN was introduced for secure services relating to Recovery Colleges.

Fourteen courses have now taken place at Ridgeway Recovery College, with 49 student enrolments.

There are monthly steering group meetings for Ridgeway Recovery College, which are attended by experts by experience and staff members. This group drives forward the development of the college, helping to streamline processes, suggest and create new courses and monitor the success of courses.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** None

4.2 **Financial/Value for Money:** None

4.3 **Legal and Constitutional (including the NHS Constitution):** None

4.4 **Equality and Diversity:** None

4.5 **Other implications:** None

5. RISKS:

None

6. CONCLUSIONS:

6.1 This paper provides a high level summary of some of the key service changes currently being managed.

7. RECOMMENDATION:

7.1 That the Council of Governors note the report and raise any questions they may have.

Brent Kilmurray
Chief Operating Officer & Deputy Chief Executive

ITEM NO. 12

COUNCIL OF GOVERNORS

DATE:	**25th May 2017**
TITLE:	**Quality Account / Report 2016/17**
REPORT OF:	**Sharon Pickering, Director of Planning, Performance and Communications and Elizabeth Moody, Director of Nursing and Governance**
REPORT FOR:	**Assurance**

This report supports the achievement of the following Strategic Goals:	✓
To provide excellent services working with the individual users of our services and their families to promote recovery and wellbeing	✓
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.	✓

Executive Summary:

This report contains the final draft version of the 2016/17 Quality Account / Report including all end of year data and stakeholder feedback. The Auditor's Limited Assurance Report will be included within the document following approval at the Audit Committee on 18th May.

The final Quality Account / Report was considered by the Board on 23rd May. Any changes agreed by the Board at this meeting will be communicated verbally.

The contents of the Quality Account / Report have been influenced by our stakeholders, and the comments of Governors received at the two governor workshops.

Recommendations:

Governors are recommended to receive the final Quality Account / Report 2016/17 document and note the timescales for its publication.

MEETING OF:	Council of Governors
DATE:	25th May 2017
TITLE:	Quality Account / Report

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to present to the Council of Governors the final version of the Quality Account / Report.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The Quality Account has been developed in line with guidance on the production of Quality Accounts published by the Department of Health and the guidance on the production of Quality Reports as published by NHS Improvement.

2.2 The Quality Account / Report has been developed with regard to the views of stakeholders and the Council of Governors Task and Finish Groups (which met on 9th March and 13th April to discuss the draft document).

2.3 The final draft version of the Quality Account is attached at **Appendix 1**. This fulfils the Department of Health and NHS Improvement requirements to produce a Quality Account and a Quality Report.

3. KEY ISSUES:

3.1 The draft Quality Account / Report was subject to external audit and their Limited Assurance Report will been included within the final version as an appendix following review and approval at the Audit Committee on 18th May.

3.2 A statutory requirement of the development of a Quality Account / Report is to obtain feedback from key external stakeholders on their views of the document and their involvement within this process. Their views have been included verbatim as an appendix.

3.3 The final draft version of the Quality Account / Report includes all end of year data.

3.4 Due to the timescale of its meeting, Trust Board received the final Quality Account / Report on 23rd May for consideration and approval. Therefore any changes made to the document by the Board as a condition of approval will be verbally communicated to Governors.

3.5 The Quality Report will be included within the Annual Report which will be published in July 2017 at the Annual Members Meeting. The Quality Account will be published in June on NHS Choices as per the guidance from the Department of Health.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** The information within the Quality Account / Report 2016/17 highlights where we are not achieving our agreed targets and where improvements are needed to ensure our services deliver high quality care and therefore meet the CQC fundamental standards.

4.2 **Financial/Value for Money:** There are no proposals within this document that require funding above that already agreed by the Board in connection with the Trust Business Plan. Should the work on the improvement priorities lead to proposals that require additional funding, these will be considered using the existing mechanisms for agreeing recurring or non-recurring budgets.

4.3 **Legal and Constitutional (including the NHS Constitution):** The Trust has a requirement, via NHS Improvement, to produce an annual Quality Report and to include this in the Annual Report. It is also required to produce a Quality Account by the Department of Health.

4.4 **Equality and Diversity:** Equality and Diversity data and issues will be considered in the work of each improvement priority.

4.4 **Other implications:** The five quality improvement priorities are included within the 2017/18 – 2019/20 Trust Business Plan that was agreed by Board on 28th March 2017. Any amendments to the detail of these 5 priorities will require revisions of the matching priorities in the Business Plan.

5. RISKS:

There are no additional risks associated with this report. Successfully delivering the improvement priorities will address known areas of risk such as transitions.

6. CONCLUSIONS:

6.1 The Quality Account / Report has been produced in line with statutory guidance, and in line with the views of stakeholders, as expressed in their engagement with TEWV.

7. RECOMMENDATIONS:

7.2 Governors are recommended to receive the final Quality Account / Report document and note the timescales for its publication.

Author: Phillip Darvill
Title: Planning and Business Development Manager

Background Papers:
NHS Improvement – NHS Foundation Trust quality reports: 2016/17 requirements.
https://improvement.nhs.uk/resources/nhs-foundation-trust-quality-reports-201617-requirements/

Our Quality Account 2016/17

making a difference together

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

I am pleased to be able to present Tees, Esk and Wear Valleys NHS Foundation Trust's (TEWV) Quality Account for 2016/17. This is the 9th Quality Account we have produced and it tells you what we have done to improve the quality of our services in 2016/17 and how we intend to make further improvements in 2017/18.

TEWV primarily serves the populations of:

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

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

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

Our Mission, Vision & Strategy

The purpose of the Trust is:

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

and our vision is:

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

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

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

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

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

The Quality Strategy contains 3 Goals which are:

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

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

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

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

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

- Providing help with finding support for financial advice or benefits and finding or keeping work;
- Support in taking part in an activity locally;
- Giving information about getting support from people with experience of the same mental health needs.

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

What we have achieved in 2016/17

- We have continued to work with our commissioners to deliver new services to meet the needs of those who use our services. For example we have:
  - Re-established Adult Mental Health (AMH) beds in York following the closure of Bootham Park Hospital (prior to TEWV commencing as the main provider in York in October 2015). A temporary 24 bed facility, Peppermill Court opened

in October 2016. Our plan is to develop a new, fit-for-purpose adult and older people's mental health hospital within York. During 2016/17 we assisted the Vale of York Clinical Commissioning Group (CCG) to carry out a significant engagment programme on the future of mental health inpatient services in York.

- Brought together all of our Middlesbrough adult community mental health teams into one new, purpose built location (Parkside) which offers an improved patient experience.
- Introduced an option for children and their parents to choose a telephone referral rather than face to face referral in our Durham and Darlington CAMHS service. This has proved very popular and has also helped us to reduce waiting times.
- Been chosen by NHS England as one of two national pilots where providers manage how specialist CAMHS budgets are spent. This went live on 1st April 2017 This will mean that more children will be able to receive care close to their home.
- Developed a multidisciplinary physical health team that works within our Forensic Secure Adult wards at Roseberry Park which includes doctors, nurses and physiotherapy. This has enabled delivery of general primary care initiatives including national screening programmes, vaccination programmes and long term condition management.
- Developed and delivered nurse education programmes which focused specifically on improving the skill set in relation to providing physical health care to patients in our Forensic Secure Adult wards (many of whom will be a resident on our secure wards for several years).

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

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

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

and is included within this Quality Account as one of its five priorities for 2017/18.

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

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

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

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

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

In 2016/17 the Trust was also recognised externally in a number of national awards where we were shortlisted and / or won. Awards won by TEWV teams or staff members are shown in the table below:

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

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

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

Structure of this Quality Account document

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

- **Part 2** – Information on how we have improved in the areas of quality we identified as important for 2016/17, the required statements of assurance from the Board and our priorities for improvement in 2017/18.
- **Part 3** – Further information on how we have performed in 2016/17 against our key quality metrics and national targets and the national quality agenda.

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

A full statement of Directors' responsibilities in respect of the Quality Account is included in **appendix 1**. This is further supported by the signed limited assurance report provided by our external auditors on the content of the 2016/17 Quality Account which is included in **appendix 2**.

I hope you find this report interesting and informative.

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

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

A Profile of the Trust

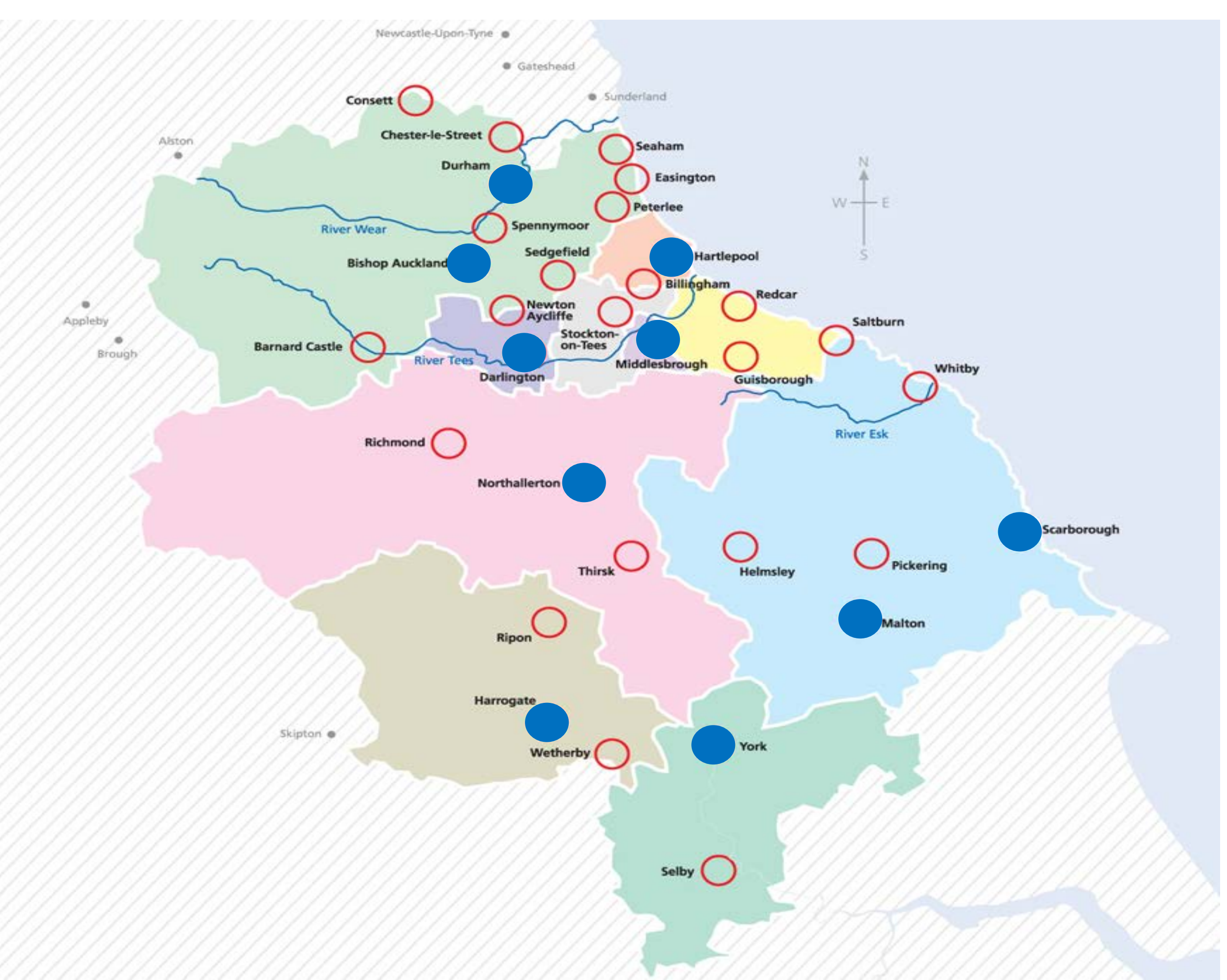
The Trust provides a range of mental health, learning disability and autism services for around two million people across a wide geographical area. Within this area our main towns and cities are: Bishop Auckland, Darlington, Durham, Hartlepool, Harrogate, Malton, Middlesbrough, Northallerton, Redcar, Ripon, Scarborough, Selby, Stockton, Whitby and York and there are numerous smaller seaside and market towns scattered throughout the Trust's geography. A map showing this area is provided on the following page. The Trust also provides learning disability services to the population of Craven and some regional specialist services (e.g. Forensic services, Children and Young People tier 4 Services (CYPS) 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.

Services commissioned by CCGs are managed within the Trust on a geographical basis in four Localities covering, Durham and Darlington; Teesside; North Yorkshire and York & Selby. There is also a Locality covering Forensic Services. Each is led by a Director of Operations and a Deputy Medical Director who report to the Chief Operating Officer and Medical Director.

- Our income in 2016/17 was **£345.9m***.
- On 31 March 2017 there were **55,919** people receiving care from TEWV.
- During 2016/17 on average we had **809** patients occupying an inpatient bed each day (this equates an average occupancy rate of **89%**[1]).
- Our community staff made more than **2.16 million** contacts with patients during 2016/17.
- We have **6,586** employees. Some of these employees work part-time hours, therefore the whole time equivalent workforce of the Trust is **5,842.01**.

*Unaudited figure for 2016/17 financial year as a whole, will be updated in final version.

[1]This occupancy rate refers to all TEWV beds, not just to Assessment and Treatment beds (where the occupancy rate is higher than this average figure)



Key				
Main Towns	O		Main town and location of TEWV inpatient beds	●
Durham and Darlington			**Teesside**	
County Durham			Stockton	
Darlington			Hartlepool	
North Yorkshire			Middlesbrough	
Scarborough and Ryedale			Redcar & Cleveland	
Hambleton and Richmondshire			**York and Selby**	
Harrogate			York and Selby	

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

Update on 2015/16 quality priorities

In last year's Quality Account we reported on our progress with our quality priorities for 2015/16. Within this we also noted some further actions for 2016/17. In some cases, these actions were to be included within the quality priorities for 2016/17, and therefore, are reported within this Quality Account. In other cases, these quality priorities were discontinued in the Quality Account but remained a priority for the Trust. The following is a brief summary of our progress with the quality priorities that were not continued in the Quality Account priorities for 2016/17.

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

2016/17 Priorities for improvement – how did we do

As part of our 2015/16 Quality Account following consultation with our stakeholders, the Board of Directors agreed four quality priorities to be addressed via the Quality Account during 2016/17:

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

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

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

Priority 1: Continue to develop and implement Recovery focused services

Why this is important:

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

This has been a continuation of the priority originally identified in 2014/15 and it recognises that while cultural change is occurring, it will require ongoing work for a number of years to embed the recovery approach meaningfully. An extension of work in this area is essential for ensuring recovery orientated care is available across all Trust areas including the York and Selby locality and corporate services. In addition we need to ensure that recovery principles are embedded within other key strategic projects

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

The benefits / outcomes we aimed to deliver were:

- The care patients receive would be designed to support and achieve their own personal goals.
- Patients and their carers would feel really listened to and heard.
- Patients and their carer's views and personal expertise by experience would be valued.

- Patients would feel supported to take charge of their lives, promoting choice and self-management.
- Our staff would work in partnership with patients and their carers at every level of service delivery; genuinely believing that patients will benefit from an improved quality of life and this would be reflected in care plans.

What we did in 2016/17:

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

What we said we would do	What we did
• Ensure Recovery Principles are embedded within the Trust's Harm Minimisation project by including them within the training being implemented by the project by Q2 2016/17.	The central Recovery Programme team and the Harm Minimisation project team have worked in close partnership throughout the year to both review and set up a new Harm Minimisation Policy and to ensure that recovery and wellbeing values and principles have been embedded within both the face to face and e-learning training packages. The process has followed a co-production approach with individuals with lived experience co-designing the training packages throughout.
• Expand Peer involvement within the Trust, having 6 new peer roles by Q3 2016/17.	We have worked to expand both paid and unpaid lived experience roles during this financial year. This has included employing 3 paid Expert Trainers as part of the Harm Minimisation project, 1 Peer within the Outcomes teams and a further Peer Trainer to work within the development of the Recovery College Online. We have also registered 24 Involvement Peers with 20 new Involvement Peer roles being commenced. Throughout expanding developments we have identified that our Involvement Peer handbook can be enhanced. We are currently in the process of reviewing this. We have also identified, that not all Involvement Peers that initially register go on to actively engage in a role. This is for a variety of reasons such as moving into paid work, deciding this is not the right time for them to engage in this role and/or service changes. Evaluations of Peer roles both paid and unpaid indicate that they are highly valued by both staff and patients.
• Continue to implement Phase 1 of the Recovery Project with an interim evaluation report presented to the Executive Management team (EMT) providing an update on progress to date by Q3 2016/17.	In August 2016 we implemented a process to review both the Phase 1 Recovery and Wellbeing Strategy and the Recovery Programme business case. As part of the development of a new 2017- 2020 Recovery and Wellbeing strategy we completed an interim evaluation of Phase 1 achievements and this was submitted to the Board of Directors in January 2017. We have achieved the majority of our targets and actions that were set out in the initial strategy. The interim summary evaluation is available within the appendix of our new Recovery and Wellbeing strategy.

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

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

How we know we have made a difference:

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

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

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

What we plan to do in 2017/18:

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

Priority 2: Implement and embed the revised harm minimisation and risk management approach

Why this is important:

Harm minimisation is an approach to proactively identifying, assessing, evaluating, reducing and communicating risk in order to maximise safety for all parties involved in the care and treatment of our patients and carers. Clinical risk assessment and management in practice provides a protective process within which to promote the principles of recovery. Best Practice in Managing Risk (Department of Health June 2007)[2] states that: "*Safety is at the centre of all good health care, this is particularly important in mental health, but it is also more sensitive and challenging*'. Furthermore, "*Patient autonomy has to be considered alongside public safety. A good therapeutic relationship must include both sympathetic support and objective assessment of risk and an understanding of the benefits of positive risk taking*".

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

The Royal College of Psychiatrist's (2013) response to the Francis Report [3]states that, "*we must take complaints more seriously and challenge risk-averse culture*" and acknowledges that assessment "*must at all times involve the patient as fully as possible, weighing risk with input from all those who need to be involved, and putting in place a plan which respects individual autonomy as much as possible, with the understanding that therapeutic risk must be balanced against restrictions putting patients first involves both minimising harm and risk balanced against undue restrictions to individual autonomy*".

Traditionally, approaches to risk management for people within mental health and learning disability services have been concerned with protecting individuals and those around them from danger and reducing harm. A recent review of our risk management practices identified that within TEWV there was evidence that risk identification had become a 'tick box' exercise leading to poor risk identification and management. Little analysis of risks, lack of bringing together supporting information from different sources and minimal engagement of patients in their own assessment were regular findings of incident reviews. There was also an emerging picture of disconnection with identification of risk and subsequent development of a plan to mitigate and manage the risk.

A cultural shift was therefore required towards recovery focused harm minimisation and safety planning based on shared decision making and the joint development of personal safety plans. This presents an approach which respects patients' needs, while recognising everyone's responsibilities – patients, professionals, family, and friends – to behave in ways which will maintain personal and public safety. This recovery-orientated approach to harm minimisation is concerned with the development of hope, facilitation of a sense of control, choice, autonomy and personal growth, and the provision of opportunities for the patient rather than risk averse practice which may be detrimental to the patients recovery and rehabilitation.

The benefits / outcomes we aimed to deliver:

- An increase in personal risk and safety plans that demonstrate clear formulation of risk and show direct correlation to the care and intervention plan.
- An increase in the number of current risk assessments which show evidence of formulation.
- An increase in the number of personal risk and safety plans that demonstrate co-production with patients, their families and/or carers.
- A reduction in the occurrence of inadequate risk management practice as a root or contributory finding in the review of serious incidents from the baseline.
- An agreed set of practice standards for the initiation, maintenance and termination of engagement and observation procedures based on the principles of harm minimisation intervention.

This project also supports delivery of the Recovery Project (priority 1).

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

What we did in 2016/17:

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

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

How we know we have made a difference:

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

Indicator	Target	Actual	Timescales
• Face to face training to be developed and delivered alongside Experts by Experience. This will support recovery orientated harm minimisation practice which focuses on narrative formulation and co-production of recovery / safety plans.	65% of all clinical staff received face to face training	42%	Q4 2016/17
• Set of outcome measures to be developed in conjunction with Experts by Experience/patients/carers.	We have developed an audit tool which collects quantitative and qualitative data. We have also ensured that the e-learning training enables learners to complete and print off reflective learning points which can be used for supervision/appraisal and re-validation.		Q2 2016/17
• A measured increase in the number of current risk assessments which show evidence of formulation and a narrative from baseline.	Completed a baseline audit in January / February 2017 as the new PARIS documentation did not become 'live' until end October 2016. Therefore any changes in practice will be captured within the January / February 2018 re-audit and reported to the Recovery Programme Board.		Q4 2016/17
• An increase in personal risk and safety plans that demonstrate clear formulation of risk and show direct correlation to the care and/or intervention plan.			Q4 2016/17
• An increase in the number of personal risk and safety plans that demonstrate co-production with patients, their families and/or carers.			Q4 2016/17

What we plan to do in 2017/18:

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

Priority 3: Further implementation of the nicotine replacement programme and smoking cessation project

Why this is important:

This is a continuation of the priority identified in 2014/15 and recognises that delivery of the smokefree agenda is critical to improving the life expectancy and health of our patients and staff. Our stakeholders and Board therefore agreed it was important that this remained a key priority in 2016/17.

The work undertaken in 2015/16 enabled the Trust's inpatient areas to go smokefree on 9 March 2016. The aim of the extension of the priority was to embed the work completed to date (within inpatient services and with staff) whilst implementing the smokefree agenda further within the Trust's community teams – to support patients in a community setting to stop smoking.

In addition within the prison population, smoking rates are very high, at around 70-80% of prisoners, and a high proportion of these smokers have an identified mental health condition. By reducing smoking rates within the prisons population both prisoners and staff benefit from improved physical health in the long term.

The benefits / outcomes we aimed to deliver:

- Encouragement to commit to giving up smoking.
- Effective support to give up smoking including access to Nicotine Replacement Therapy (NRT).
- Access to trained staff able to provide advice around smoking cessation.
- Improved physical health in the longer term.
- The provision of voluntary smoke free wings in prisons in the North East for prisoners and staff eventually leading to a completely smoke free estate.

What we did in 2016/17:

What we said we would do	What we did
• Develop a communication plan for the prison services by Q1 2016/17.	A national prisons communications plan was identified to support the prisons when developing voluntary smokefree areas. This was also made available to support those early adopter prisons who have already gone fully smokefree within 2016/17.
• Further embed the Trusts policy on being smoke free within inpatient sites by conducting an audit to show if levels of nicotine replacement / management products have increasingly been prescribed across inpatient sites by Q2 2016/17.	The Nicotine Management team continued to support the embedding of the smokefree policy within inpatient services/sites. Work took place to support the identification of quantities of nicotine replacement products issued Trustwide. This data was made available each month and a full yearly report will indicate the costings prior to going smokefree and costs one year post smokefree. Recent data shows that by going smokefree, it has increased the amount spent on nicotine replacement products fourfold compared to the amount spent prior to going smokefree.

• Further embed the Trusts policy on being smoke free within inpatient sites by reviewing levels (and maintenance) of staff trained in nicotine management and smoking cessation by Q2 2016/17.	Regular monthly reviews of staff trained within each directorate took place throughout 2016, allowing the Nicotine Management team the opportunity to increase availability of training within areas where staff trained in nicotine management levels have decreased. The development of a training database captured accurate information and bespoke training sessions were made available Trustwide. A new level of training (Brief Intervention) was developed in 2016 and is now regularly available for staff to access.
• Following the above audit and review of training, if necessary, identify inpatient sites that require additional support and provide training / one to one visits by Q2 2016/17.	Several sites were identified Trustwide who requested additional support. The Nicotine Management team were able to provide additional training sessions and supported the development of action plans to further embed and implement the Nicotine Management Policy.
• Nicotine management policy and information leaflets developed for prison services by Q3 2016/17.	All North of England Prison services developed or updated smokefree prisons policies which are available for staff and residents to access. Residents supported the development of information leaflets alongside the National Offender Management Services posters and literature which was also available.
• Medication options identified inclusive of the use of disposable e-cigarettes for prison services by Q3 2016/17.	National approval was given for four Nicotine Replacement products to be made available within all prison estates. Alongside these, several models of disposable e-cigarettes were identified and made available to purchase from canteen lists within each prison estate. Current work is ongoing to look at the possibility to access rechargeable e-cigarettes within the prison services to provide greater choice for residents.
• Continue to monitor the implementation plan developed to support staff to stop smoking by Q3 2016/17.	Work continues to regularly monitor the implementation plan which supports staff to stop smoking. Links continue with community stop smoking services to ensure support and free products are available for staff within the North Yorkshire areas. Lloyds Pharmacy continues to support staff in Durham and Teesside who wish to stop smoking. The FFT in 2015 indicated that 10% of staff identified as smokers. The FFT in 2016 identified a reduction of staff smoking and now shows a rate of 8% of staff who smoke.
• Implement nicotine management and smoking cessation training across Trust community teams by Q4 2016/17.	A full training programme was made available for community teams to access and this training will continue in 2017/18. All frontline staff will be encouraged to complete the Level 1 Very Brief Advice training whilst additional staff will complete the Brief Intervention Training and some will progress to Level 2 Assessors. Unfortunately due to increased time spent supporting inpatient services and staff the project team were unable to train as many staff as originally planned, with around 25% of community staff trained to date. An increased number of training sessions are now available between March and May

	2017 to support this training and regular training dates until March 2018 are available for staff to access. We expect that at least 75% of staff will receive the identified training by March 2018 as many community teams have already booked training sessions in-house to address the training needs.
• Support staff to ensure a seamless pathway of support on admission / discharge for patients undertaking smoking cessation by Q4 2016/17.	An electronic referral form is available for staff to access to request additional support for patients on discharge to the community. Staff can also refer via telephone should they wish and have access to all appropriate telephone details. Further work continued in 2016/17 to ensure referrals are made for those patients wishing to remain smokefree on discharge.
• Support prison services with their plans to go smoke free by identifying prison trainers to deliver level 1 and level 2 smoking cessation and nicotine management training by Q4 2016/17.	Work continues to train identified prison staff and allow them the opportunity to deliver training to other staff in the future. Each of the North East prisons have identified the staff requiring training. This now means that training packages will be developed and made available for staff to train residents to support the smokefree prisons agenda.

How we know we have made a difference:

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

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

What we plan to do in 2017/18:

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

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

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

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

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

Why this is important:

Feedback we received from stakeholders both internally and externally identified transitions as an area that should be focused on as a priority. This is due to patients highlighting issues at various points of transitions such as when a patient is moving from an inpatient unit where care is provided 24/7 to a community setting where care is provided less intensively or from CAMHS to Adult services. Examples of issues patients were faced with are a feeling of “emptiness” and finding it difficult to access clinical staff for advice in “sub-crisis” situations.

The various points of transition can be distressing with increased risk of harm for our patients and carers which we would like to minimise as much as possible. By focusing on a specific area of concern we could influence quality, improve patient safety risks and experience for the area of concern in order to sustain high levels of support for patients during times of transition. The area of concern we focused on was Young People transferring from CAMHS to Adult services. This type of transition was highlighted as an issue via audits completed, feedback from stakeholders and through our commissioners providing a CQUIN target on CAMHS transitions.

The benefits / outcomes we aimed to deliver:

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

What we did in 2016/17:

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

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

How will we know we are making a difference?

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

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

What we plan to do in 2017/18:

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

Statement of Assurances from the Board 2016/17

The Department of Health and NHS Improvement require us to include our position against a number of mandated statements to provide assurance from the Board of Directors on progress made on key areas of quality in 2016/17. These statements are contained within the blue boxes. In some cases additional information is supplied and where this is the case this is provided outside of the boxes.

Review of services

During **2016/17** TEWV provided and/or sub-contracted **20** relevant health services.

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

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

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

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

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

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

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

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

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

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

Participation in clinical audits and national confidential inquiries

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

During that period, TEWV participated in **60%** (3/5) of national clinical audits and **100%** (2/2) of national confidential inquiries of the national clinical audits and national confidential inquiries which it was eligible to participate in.

The national clinical audits and national confidential inquiries that TEWV was **eligible to participate in** during 2016/17 are as follows:

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

- National Confidential Enquiry Into Patient Outcome and death (NCEPOD).

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

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

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

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

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

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

- No reports received*.

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

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

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

In addition to the local clinical audits reviewed (i.e. those that were reviewed by our Quality Assurance Committee and Clinical Effectiveness Group), the Trust undertook a further **95** clinical audits in 2016/17. These clinical audits were led by the services and individual members of staff for reasons of service improvement and professional development and were reviewed by the Specialty Clinical Audit Subgroups.

Participation in clinical research

The number of patients receiving relevant health services provided or subcontracted by TEWV in 2016/17 that were recruited during that period to participate in research approved by a research ethics committee was **945**.

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

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

We continue to be involved with large scale national research across a variety of clinical disciplines such as psychosis, forensic mental health, dementia, learning disabilities, personality disorder and CYPS. Our ongoing participation in clinical research through 2016/2017 reflects our firm commitment to improving the quality of care we provide, as well as contributing to the broader goals of mental health, learning disability and dementia research. The Trust has also supported national research into the implications of later retirement ages in the NHS.

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

- We were involved in conducting **74** clinical research studies during 2016/17. **48** of these studies were supported by the NIHR through its networks and **16** new portfolio studies approved through the Health Research Authority approval process.
- **22** members of our clinical staff participated as researchers in studies approved by a research ethics committee, with **11** of these in the role of principal investigator for NIHR supported studies.
- **492** members of our staff were also recruited as participants to both NIHR portfolio and non-portfolio studies that were undertaken within TEWV.
- **28** researchers from outside the organisation were granted access under the National Research Passport Scheme to perform research with us compared to **76** from 2015/16. This reduced number was due to issuing 37 letters of access for

research teams to access research participants in the York and Selby region last year.

- We have developed a new 5 year Research & Development strategy with a strong focus on PPI engagement and academic collaborations which provides us with the aim of becoming a lead research site with further opportunities for research involvement for our patients. We continue to be co-applicants on large scale grant applications in collaboration with our university partners.
- We have setup a clinical trials pharmacy department which will provide the infrastructure to enable us to participate in future CTIMP studies.
- We have research champions embedded across all of our memory services which provides a link to ensure equality of access to research opportunities across the Trust. Our research champions promote the national Join Dementia Research system and we have been a pilot site for a 'JDR' on prescription scheme in collaboration with the Alzheimer's Society.

Goals agreed with commissioners

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

A proportion of TEWV's income in 2016/17 was conditional on achieving quality improvement and innovation goals agreed between TEWV and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2016/17 and for the following 12 month period are available electronically at http://www.tewv.nhs.uk/site/content/About/How-well-are-we-doing.

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

An overall total of £6,866,000 was available for CQUIN to TEWV in 2016/17 conditional upon achieving quality improvement and innovation goals across all of its CQUINs, and a total of £6,238,041 is estimated to be received for the associated payment in 2016/17 (90.85%); however this will not be confirmed until May. This compares to £6,452,069 in 2015/16 (99.2% from the TEWV CQUIN prior to the Vale of York contract and 100% from the Vale of York CQUIN), £5,765,066 (98.02%) in 2014/15 and £5,777,218 (99.28%) in 2013/14 (the estimate for 2016/17 has still to go through all the required governance processes for full approval).

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

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

What others say about the provider

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

TEWV is required to register with the Care Quality Commission (CQC) and its current registration status is **registered to provide services with no conditions attached**. The CQC has not taken enforcement action against TEWV during 2016/17.

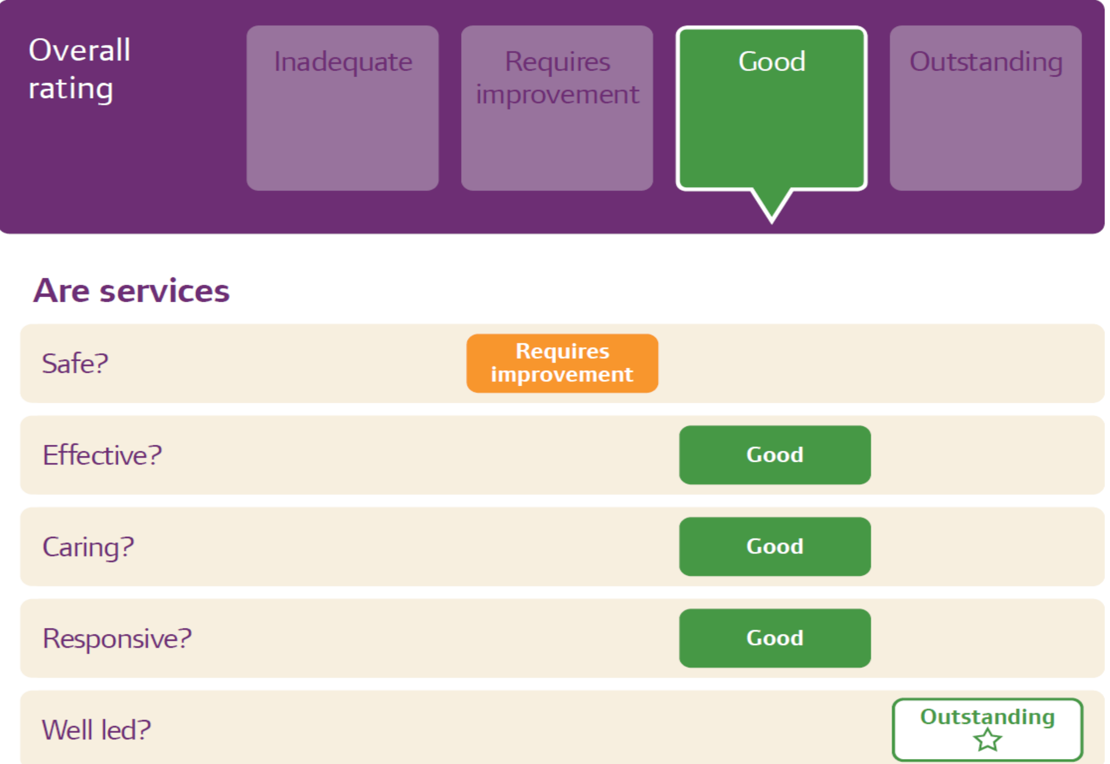
TEWV has not participated in any special reviews or investigations by the CQC during the reporting period.

The CQC carried out an unannounced compliance inspection during November 2016 and undertook inspections to all Trust AMH Assessment and Treatment and Psychiatric Intensive Care (PICU) Wards and all Older Persons Mental Health Inpatient Wards. The Trust received the final reports from this visit on 23rd February 2017. The outcome of this visit has not altered the overall ratings given to the Trust following the inspection in January 2015. The core service ratings for AMH Assessment and Treatment and PICU Wards remained as **Good**; whilst the core service rating for Older Persons Mental Health Inpatient wards has changed from **Good** to **Requires Improvement.**

At the time of writing this report the Trust is awaiting formal feedback from an announced visit by the CQC to the Trust between 23rd and 27th January 2017 during which they undertook a well led review and compliance inspections to some of the Trusts Learning Disability Community Teams; also during this visit unannounced inspections to Adult Rehabilitation Inpatient services across the Trust were carried out.

It is expected that the overall rating and core service ratings will be updated following the publication of these reports.

CQC's rating for each key domain was:



Whilst the inspection highlighted many areas to be proud of there were also areas that both CQC and the Trust recognised needed to be improved. Following the visit an action plan has been produced and is currently being implemented within the agreed timeframes. Below is a summary of some of the quality improvement work that is currently being undertaken as part of this work:

Areas for Improvement	Issues	Actions
Record Keeping	• All risk assessments, care plans and crisis and intervention plans are fully and collaboratively completed, reviewed and updated. • All physical health observations following rapid tranquilisation and all episodes of seclusion to be monitored and recorded. • Ensuring administration of medication is always correctly recorded.	• Regular review of patient records to ensure that all documentation is collaborative, person centred and updated when required. • A retrospective review of patient records to check the completion of physical health observations will be undertaken over a six month period. • A standard process to be put in place for monitoring compliance with seclusion recording process. • Enhanced medicines management assessments will be introduced.
Privacy and Dignity	• All wards to be compliant with Eliminating Mixed Sex Accommodation (EMSA) guidance. • Ensuring that privacy and dignity needs are sensitively	• Communal lounges and female only lounges are available on all wards. • All male and female zones will be clearly marked on ward areas.

Areas for Improvement	**Issues**	**Actions**
	met.	• Doors will be replaced with correct viewing panel glass and privacy film in some units.
Staffing	• Sufficient staffing available on all wards to ensure patient safety. • All staff undertake relevant training to ensure they are fully able to meet the needs of the patients. • Ensure all staff have supervision and appraisals.	• Continue current focus on recruitment and monitoring of planned v actual staffing levels. • Process in place to capture occurrences where planned staffing levels are not met and actions taken to manage this. • Enhanced monitoring of all statutory and mandatory training, appraisal and job relevant clinical training with exception reporting to the Executive Management Team.
Environmental Safety/ Cleanliness (IPC Issues)	• Ensuring specific risks are managed appropriately including ligature risks and blind spots on wards. • Issues of general repair to ward environments are undertaken in a timely manner. • Ensuring all wards are clean and tidy.	• Identified risks from annual environmental surveys to be clearly communicated to all team staff. • A programme is in place to ensure that any outstanding environmental works are completed and weekly environmental checks to be undertaken on wards. • Infection Prevention and Control audits to be undertaken.
Ensuring Inpatient Rights (Blanket Restrictions)	• Ensuring that restrictive practice does not prevent individual needs from being met.	• Approval and roll out of Trust Policy on Restrictive Practices. • Monitoring the implementation of this policy via regular reports to Quality Assurance Committee.
Patient Safety	• Ensure that all patients are appropriately risk assessed to ensure their safety.	• Reducing harm from falls is a Trust Quality Priority during 2017/18. • Regular audits of risk assessment, admission paperwork and care plans to take place. • On-going monitoring of risk assessments to take place through management supervision.
Monitoring Checks	• Standard daily and weekly checks required to be undertaken on wards are all to be completed as necessary and monitoring to take place.	• Development of a standard template for use by Modern Matrons to monitor the completion of standard checklists on all wards. • Monthly ward based medicines management assessments to be introduced which will be undertaken by Pharmacy staff.

CQC Follow up Visit to Forensic Services February 2016

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

Mental Health Act Inspections

TEWV has participated in **36** Mental Health Act inspections by the Care Quality Commission to the following ward areas during 2016/17:

Ward	Service Type	Locality
Acomb unit (Oak Rise)	Learning Disabilities Assessment and Treatment	York
Bek	Learning Disabilities Assessment & Treatment	Durham
Bilsdale	Adult Mental Health Assessment & Treatment	Middlesbrough
Cedar Ward	Adult Mental Health Assessment & Treatment	Harrogate
Elm	Adult Mental Health Assessment & Treatment	Darlington
Esk	Adult Mental Health Assessment & Treatment	Scarborough
Evergreen Centre	CAMHS Specialist Eating Disorder Service	Middlesbrough
Fulmar	Adult Mental Health Rehabilitation	Middlesbrough
Hamsterley	Older Peoples Mental Health Assessment & Treatment	Bishop Auckland
Kestrel/Kite	Forensic Learning Disability Low Secure	Middlesbrough
Linnet	Forensic Mental Health Medium Secure	Middlesbrough
Lustrum Vale	Adult Mental Health Rehabilitation	Middlesbrough
Mallard	Forensic Mental Health Low Secure	Middlesbrough
Meadowfields	Older Peoples Mental Health Assessment & Treatment	York
Newtondale	Forensic Mental Health	Middlesbrough
Nightingale	Forensic Mental Health	Middlesbrough
Northdale (Hawthorn/Runswick)	Forensic Learning Disability Medium Secure	Middlesbrough
Oak	Older Peoples Mental Health Assessment & Treatment	Darlington
Oakwood	Forensic Learning Disability	Middlesbrough
Overdale	Adult Mental Health Assessment & Treatment	Middlesbrough
Picktree	Older Peoples Mental Health Assessment & Treatment	Durham
Primrose Lodge	Adult Mental Health Rehabilitation	Durham
Ramsey	Learning Disabilities Assessment & Treatment	Durham
Rowan Lea	Older Peoples Mental Health Assessment & Treatment	Scarborough
Rowan Ward	Older Peoples Mental Health Assessment & Treatment	Harrogate
Springwood	Older Peoples Mental Health Assessment & Treatment	Malton
Stockdale	Adult Mental Health Assessment & Treatment	Middlesbrough
Swift	Forensic Mental Health Medium Secure	Middlesbrough
Bankfields Court (The Flats, Units 3 & 4)	Learning Disabilities Assessment & Treatment	Middlesbrough

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

Quality of data

TEWV submitted records during 2016/17 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- Which included the patient's valid NHS number was **99.75%** for admitted patient care.
- Which included the patient's valid General Medical Practice Code was **100.00%** for admitted patient care.

TEWV Information Governance Assessment Report overall score for 2016/17 was **88%** and was granted as **satisfactory***.

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

The Information Governance Toolkit measures performance in the following areas:

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

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

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

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

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

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

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

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

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

- **97%** of service users on the Adult Mental Health (AMH) and **98%** of services users on the Mental Health Services for Older People (MHSOP) caseloads were assessed using the mental health clustering tool.
- **91%** of service users on the Adult Mental Health (AMH) and **91%** of services users Mental Health Services for Older People (MHSOP) caseloads were reviewed within the guideline timeframes.

Further work for 2017/18 includes:

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

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

- We have a Data Quality Group chaired by the Director of Finance and Information which meets on a monthly basis and addresses data quality issues in terms of patient, staff, financial and risk information.
- We have a data Quality Strategy and scorecard to monitor improvement. The strategy aims:

    - To maximise the accuracy, timeliness and quality of all our data wherever and however it is recorded.
    - To ensure that every member of our staff understands that data quality is the responsibility of everyone and an integral part of their role.
    - To ensure we achieve compliance with all our statutory and regulatory obligations.

- A data quality working group (formed in late 2014/15) continues to identify areas of poor data quality, develop locality specific action plans in relation to data quality, and provide advice, support and education to teams. This group reports into the Trust Data Quality Group.
- We have established regular reports on key elements of data which show how well data is being recorded on the various information systems, particularly the patient information system and the staff information system.
- We report on data quality to the Board as part of our Strategic Direction Scorecard reports.
- Regular reports are available to all services so that they can target improvement work on areas where problems occur.
- We have agreed Data Quality Improvement Plans (DQIPs) with our commissioners for key indicators, particularly those that require new data recording or collection systems to be put in place.

Mandatory quality indicators

The following are the mandatory quality indicators relevant to mental health Trusts, issued jointly by the Department of Health and NHS Improvement and effective from February 2013.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127382/130129-QAs-Letter-Gateway-18690.pdf.pdf

For each quality indicator we have presented a mandatory statement and the data on NHS Digital for the most recent and the previous reporting period available.

Care Programme Approach 7 day follow-up

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

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

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

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

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

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

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

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

- Investigating all cases that weren't followed up and identifying lessons to be learned at service level.
- Undertaking an improvement event led by the Chief Operating Officer to improve proactive performance management and eliminate waste in both clinical and corporate services.
- Undertaking a Quality Improvement System session to review and improve the monitoring and validation process.
- Utilising the report out process and Trust performance management system to pro-actively monitor performance and ensure compliance. Supporting the adherence to standard process to ensure patients discharged to other services (e.g. 24 hour care unit) are not overlooked, including the introduction of visual control boards.
- Continuously raising awareness and reminding staff at ward / team meetings of this national requirement and why it is important to patient safety, the need to follow the standard procedure and the need to record data accurately considering appropriate exclusions.

Crisis Resolution Home Treatment Team acted as a gatekeeper

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

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

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

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

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

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

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

- Investigating instances where patients were not seen by a crisis team prior to admission and identifying lessons to be learned at service level.
- Undertaking a Quality Improvement System session to review and improve the monitoring and validation process.
- Undertaking an improvement event led by the Chief Operating Officer to improve proactive performance management and eliminate waste in both clinical and corporate services.
- Utilising the report out process and Trust performance management system to pro-actively monitor performance and ensure compliance. Supporting the adherence to standard process to ensure patients discharged to other services (e.g. 24 hour care unit) are not overlooked, including the introduction of visual control boards.
- Continuously raising awareness and reminding staff at ward / team meetings of this national requirement and why it is important, the need to follow the standard procedure and the need to record data accurately considering appropriate exclusions.

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

The data made available by NHS Digital with regard to the Trust's "patient experience of community mental health services" indicator score regarding a patient's experience of contact with a health or social care worker during the reporting period. The figures we have included are from the CQC website but at the time of writing comparative figures were not available from NHS Digital.

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

questions used from the survey detailed below the table.

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

Notes on metric

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

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

However the CQC (who design and collate the results of the survey) no longer provide a single overall rating for each NHS Trust. Therefore, for 2014 onwards, the following questions replaced those previously asked around contact with a NHS health worker or social care worker:

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

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

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

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

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

sections being rated as better than other organisations).

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

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

- Continued staff training on positive behavioral support. Full implementation of this approach has improved the experience for inpatients due to reduced use of restraint.
- Increasing the amount of time available for clinical staff to spend in direct contact with patients through improvements to other processes that they are involved with (including reducing the time taken to input essential information into our electronic care record).
- Continuing to carry out our local inpatient and community surveys with established mechanisms in place for action plan development and feedback.
- The Trust has reviewed its Quality Strategy and increased the focus on patient reported experience measures based on what is important to them. Targets will be developed for each measure and these monitored on an ongoing basis.

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

Patient safety incidents including incidents resulting in severe harm or death

The data made available by NHS Digital with regard to the number of patient safety incidents, and percentage resulting in severe harm or death, reported within the Trust during the reporting period. The next reporting period is March 2017.

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

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

- The Trust reported and National Reporting & Learning System (NRLS) reported data for Quarters 1 & 2 2016/17 showed no variance in what was reported. This improved position from last year is due to a significant amount of data quality improvement work the Trust has undertaken.
- The number of incidents reported by TEWV to the NRLS for Quarters 1 and 2 2016/17 was improved compared to the previous 2 quarters. However, it is not possible to use the NRLS data to comment on a Trust's culture of incident reporting or the occurrence of incidents. The absolute numbers of incidents reported is a factor of the relative size of a Trust and the complexity of their case-mix. We have noted that:
  - The reporting of patient safety incidents in the Trust in Quarters 1 & 2 2016/17 has considerably increased when compared to with Quarters 3 & 4 2015/16. This is due to the implementation of a new web-based version of our incident reporting process which has had the positive impact of raising staff awareness of reporting.
  - Amongst the most common themes reported are self-harming behaviour, patient accident, disruptive, aggressive behaviour and medication which account for three-quarters of all incidents leading to harm.
  - During 2016/17 TEWV reported 94 incidents as Serious Incidents, of which 59 were deaths due to unexpected causes.

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

- Analysis of all patient safety incidents. These are reported and reviewed by the Patient Safety Group which is a sub group of the Trust's Quality Assurance Committee. A monthly report is circulated to the QuAC. Safety incidents are reported to commissioners via the Clinical Quality Review Process.
- Making permanent the central approval team which was put in place to ensure consistent grading of incidents and to improve the overall quality of reporting.
- Ensuring all serious incidents (i.e. those resulting in severe harm or death) are subject to a serious incident review. This is a robust and rigorous approach to understand how and why each incident has happened, to identify any causal factors and to identify and share any lessons for the future.
- Introducing mortality reviews on those deaths that are not classed as unexpected. We are following national guidance as it is published in this area – the National Guidance on Learning from Deaths was released in March 2017 and we will be implementing its recommendations throughout 2017/18.

2017/18 Priorities for Improvement

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

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

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

Priority 1: Implement Phase 2 of our Recovery Strategy

Why this is important:

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

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

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

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

The benefits / outcomes our patients and carers should expect:

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

What we will do in 2017/18:

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

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

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

How will we know we are making a difference?

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

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

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

Why this is important:

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

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

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

The Carter[4] productivity and efficiency report made it clear that improved workforce efficiency can benefit patient care through better recruitment and retention of permanent staff, better rostering, reduced sickness absence, matching work patterns to patient need and reducing reliance on agency staff.

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

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

The benefits / outcomes our patients and carers should expect:

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

What we will do in 2017/18:

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

How will we know we are making a difference?

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

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

• Outcomes related to the suggested workstreams of: • staffing review using the national evidence based Hurst[5] tool; • monitoring of escalation processes; • review of rostering process to ensure best use of existing resources.	

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

Why this is important:

We define transitions for this Quality Account Priority as a purposeful and planned process of supporting young people to move from children's to adults' services. Young people with ongoing or long-term health or social care needs may be required to transition into AMH services, other service provision or back to their GP. The preparation and planning around moving on into new services can be an uncertain time for young people with health or social care needs. There is evidence of service gaps where there is a lack of appropriate services for young people to transition into, and evidence that young people may fail to engage with services without proper support (Watson 2005[6]; Singh 2009[7]).

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

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

The benefits / outcomes our patients and carers should expect:

- An improvement in their experience during their transition from Children and Young People's to Adult services.
- Greater involvement in decisions about the care received when they transfer into Adult services.
- To receive care informed by NICE's[8] evidence-based guidelines, which will result in better clinical outcomes.

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

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

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

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

What we will do in 2017/18:

We will:
• Using the audit action plan, further embed the Safe Transitions and Discharge Protocol by monitoring the agreed actions and timescales by Q2 2017/18. • Undertake an additional audit of the protocols to include further collection of patient and carer experience feedback by Q2 2017/18. • Co-produce surveys and audit tools with young people to ensure that questions asked are meaningful to all involved by Q2 2017/18. • Establish mechanisms to provide stakeholders and staff with regular feedback by Q2 2017/18. • Review the outcome of the audit, updating the current action plan by Q3 2017/18. • Collect patients' stories in writing to gain detailed accounts of young people's experiences by Q3 2017/18. • Complete an evaluation report on the effectiveness of implementation of the new protocol and feedback to relevant stakeholders by Q4 2017/18. • Continue to use patient surveys to gain feedback from young people (ongoing each quarter during 2017/18).

How will we know we are making a difference?

In order to demonstrate that we are making progress against this priority we will measure and report on the CQUIN metrics which Trust have agreed for 2017/18:

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

Priority 4: Reduce the number of preventable deaths

Why this is important:

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

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

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

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

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

The benefits / outcomes our patients and carers should expect:

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

What we will do in 2017/18:

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

How will we know we are making a difference?

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

Indicator	Target	Timescale
• To increase the proportion of deaths that are reviewed as part of the mortality review processes (this is in addition to the existing serious incident process).	Baseline in Q1*	Q4 2017/18
• To eliminate preventable deaths of inpatients during periods of leave.	0	Q4 2017/18

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

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

Why this is important:

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

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

The benefits / outcomes our patients and carers should expect:

- A reduction in moderate and severe harm as a result of falls.
- More falls are prevented during hospital stays.
- To feel more informed about the risks and benefits around falls interventions.
- Their values and preferences informing care.
- That care is managed in line with NICE guideline 161 *'Falls: assessment and prevention of falls in older people*' (2013)[9] and in line with actions from the National Patient Safety Agency '*how to guide for reducing harm from falls in mental health inpatient settings*' (2012)[10].
- Care is delivered by staff with the appropriate skills and competencies to prevent and manage falls.
- Appropriate assessment and treatment is given to people who have fallen.

What we will do in 2017/18:

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

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

How will we know we are making a difference?

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

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

Monitoring Progress

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

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

Part 3: Other information on Quality Performance 2016/17

Our performance against our quality metrics

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

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

- The 'number of unexpected deaths' reported in 2011/12 (metric 1) was changed in 2012/13 to the 'number of unexpected deaths classed as a serious incident per 10,000 open cases'. This is because using a rate is a more valid approach for making comparisons across the years as it allows for changes in activity within the Trust.
- The 'number of patient falls per 100,000 occupied bed days' reported in 2011/12 and 2012/13 (metric 3) was changed in 2013/14 to the 'number of patient falls per 1,000 admissions' as experience has shown this indicator is more closely linked to new admissions rather than occupied bed days.
- The 'number of complaints per 100,000 patients' reported in 2011/12 and 2012/13 (metric 8) was changed in 2013/14 to the 'percentage of complaints satisfactorily resolved' as experience has shown that it is more important to measure the satisfaction with our response to complaints as opposed to the absolute number of complaints. The latter we encourage as important feedback to the Trust on the quality of our services.

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

Quality Metrics

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

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

** Not directly comparable with 2016/17 figures

Notes on selected metrics

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

Comments on Areas of Under-Performance

Metric 3: Patient falls per 1,000 admissions.

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

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

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

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

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

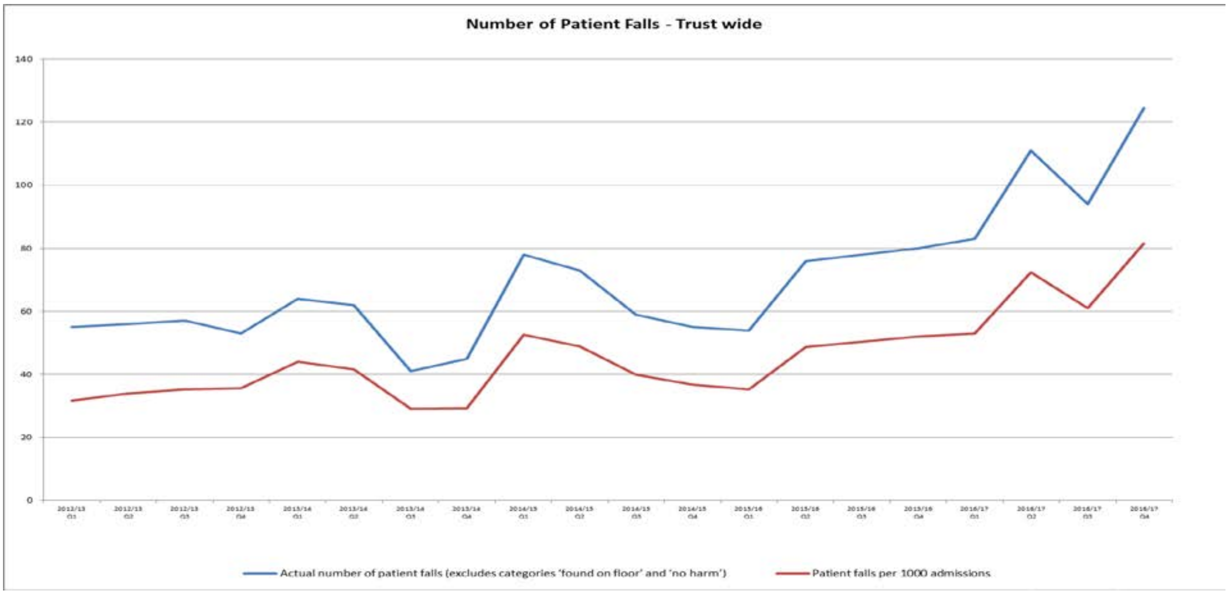
As shown in the table below the majority of falls in 2016/17 were recorded within MHSOP speciality:

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

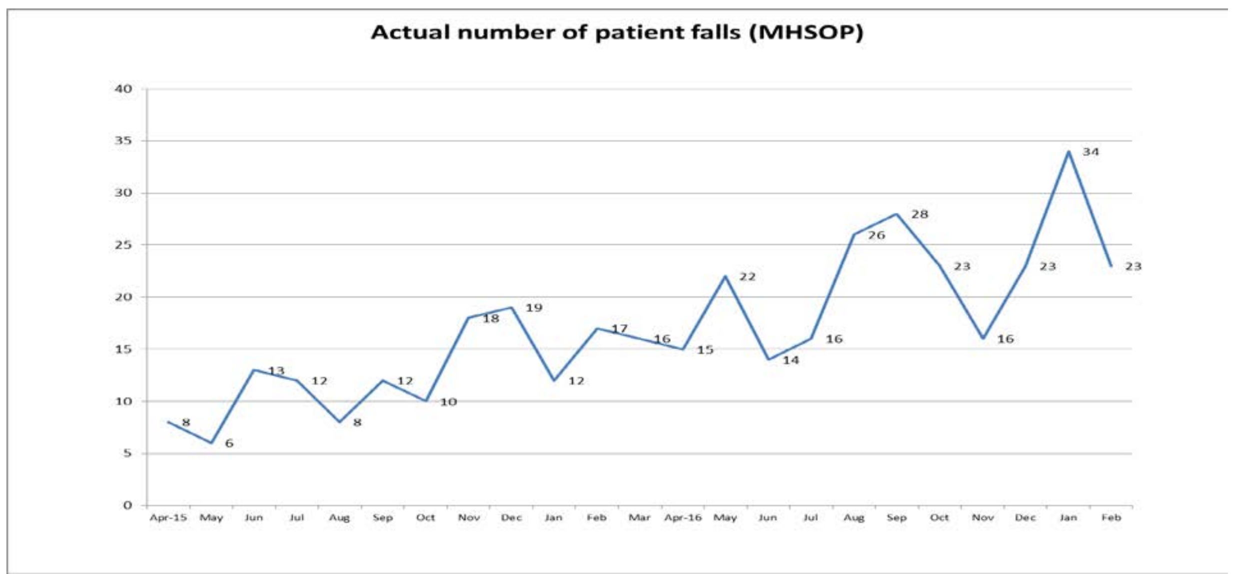
*note the low throughput of patients within forensic services skews this figure to an artificially high level.

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

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



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



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

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

Key themes / issues under consideration include:

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

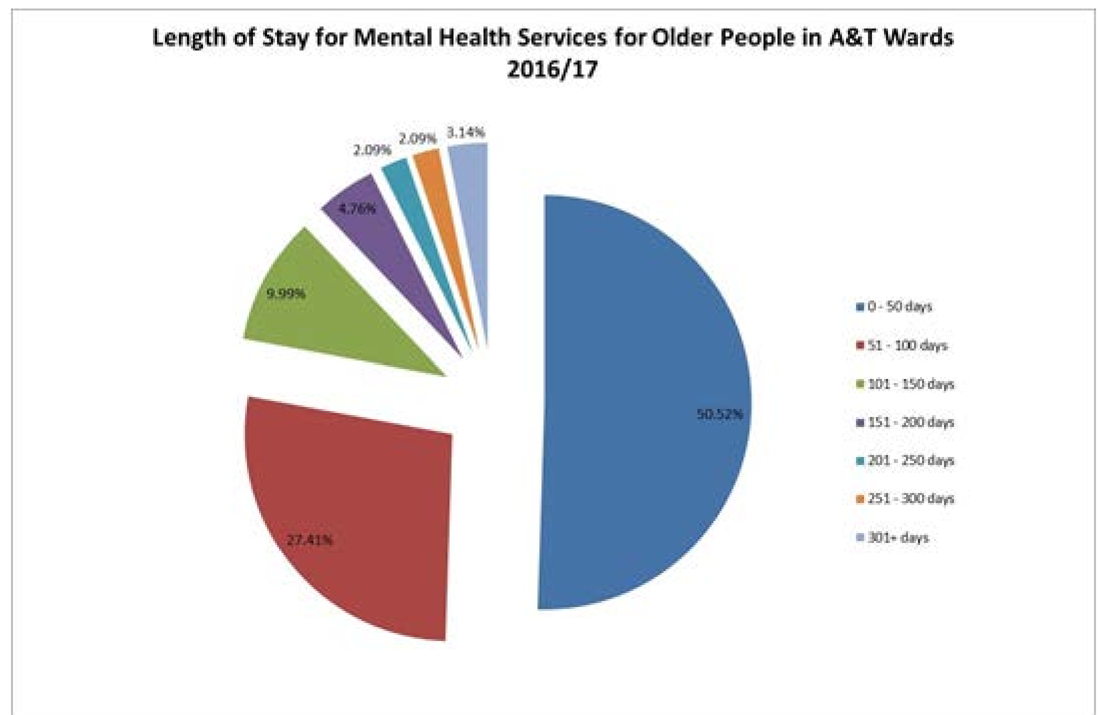
Speciality leads continue to co-ordinate and drive improvements as follows:

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

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

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

The median length of stay was **50** days, which is better than the target of 52 days and demonstrates that the small number of patients that had very long lengths of stay have a significant impact on the mean figures reported.



The length of stay of patients is closely monitored by all services within the Trust. The reasons for the increase in the average length of stay for patients are due to a small number of patients who were discharged after a very long length of stay, which has skewed the overall average. In total 50.52% of lengths of stay were between 0-50 days, with 27.41% between 51 – 100 days. There were 63 patients who had a length of stay greater than 200 days; the majority were attributable to the complex needs of the patients (such as co-morbidity with physical health problems).

Metric 8: Percentage of complaints satisfactorily resolved.

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

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

There were **47** people who were not satisfied with our response to their complaint since April 2016 to March 2017. The subject of complaints or those that expressed dissatisfaction are varied but predominately are about clinical care, which covers a number of different subjects including ineffective treatment and care, medication and

discharge/Transfer/continuity of care. Trust wide there were no specific trends or patterns identified in the reasons given for dissatisfaction.

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

Complaints Resolution 2016/17

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

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

Our performance against the Risk Assessment Framework and Single Oversight Framework Targets and Indicators

The following table demonstrates how we have performed against the relevant indicators and performance thresholds set out in appendix A of the Risk Assessment Framework, 1st April – 30th September 2016 which also appears in the Single Oversight Framework 1st October 2016 – 31st March 2017.

Risk Assessment Framework and Single Oversight Framework

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

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

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

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

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

There is an additional indicator contained within appendix A of the Risk Assessment Framework and the Single Oversight Framework that is relevant however this has been reported in the Quality Metrics table on **page 59**.

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

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

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

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

External Audit

For 2016/17, our external auditors are required to provide a limited assurance report on whether two of the mandated indicators included in the Quality Account have been reasonably stated in all material respects. In addition the Council of Governors (CoG) have the option to choose one further local indicator for external assurance. The three indicators which have been included in the external assurance of the Quality Account 2016/17 are:

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

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

Local Improvement Plans

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

Duty of Candour

Since Regulation 20: Duty of Candour of the Health and Social Care Act 2008 (amended 2015) has been enforced, TEWV has developed a Duty of Candour register and policy in line with the recommendations, which are managed and monitored by the Director of Quality Governance.

The policy outlines the legal responsibility to inform a patient and carer should anything go wrong that causes or has potential to cause harm and distress. This underpins the culture of candour. Work is ongoing within the Quality Governance team to ensure we have systems and processes for capturing Duty of Candour actions (such as family engagement, letters) which are sent directly from clinical services to ensure we have a complete picture of activity in this area.

Sign Up To Safety

Sign up to Safety is a three year national patient safety programme launched on 24 June 2014 with the mission being to strengthen patient safety in the NHS and make it the safest healthcare system in the world.

What we have done:
A Trust Safety Improvement Plan was submitted based on the guidance provided by the Sign up to Safety campaign office. The Plan comprises the Trust Quality Strategy with Driver Diagrams identifying the three areas of patient safety (Harm Minimisation, Force Reduction and Learning Lessons) which the Trust will focus on as part of the campaign. The National Sign Up To Safety Lead Suzette Woodward stated that it was one of the best plans she had seen.

Information roadshows have been completed throughout the Trust and presentations made to Directorate QuAGs and LMGBs, Speciality Development Groups (SDGs), Leadership & Network Groups, Modern Matrons, Medics Conference, Health & Safety Team, North of England Mental Health Development Unit Suicide Prevention Conference.

A communication strategy has also been developed and information is regularly provided via the Trust internal e-communications, linking to a Sign Up To Safety intranet page which includes links to the national campaign webinars and information. Posters have been circulated to all wards and teams and two main reception areas of the Trust.

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

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

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

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

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

NHS Staff Survey Results

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

The NHS recognises that the percentage of staff reporting that they have been harassed, bullied or abused by managers / colleagues and the percentage reporting

that they believe the organisation provides equal opportunities for career progression and promotion are important indicators that correlate with high quality patient care. The Trust results for the two indicators were:

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

National Quality Improvement Programmes

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

<table>
<tr><th>Programmes</th><th>Participating services in Trust</th><th>Accreditation Status</th><th>Number of services participating nationally</th></tr>
<tr><td rowspan="2">MSNAP: Memory Services National Accreditation Project</td><td>Hambleton & Richmondshire Memory Service (Northallerton)</td><td>Accredited as excellent</td><td rowspan="2">107</td></tr>
<tr><td>Harrogate & District Memory Service</td><td>Accredited as excellent</td></tr>
<tr><td>PLAN: Psychiatric Liaison Accreditation Network</td><td>None</td><td>N/A</td><td>74</td></tr>
<tr><td rowspan="2">QNCC ED: Quality Network for Community CAMHS (Child and Adolescent Community Mental Health Services) Eating Disorders</td><td>Durham and Darlington CYPS Eating Disorders Team</td><td>Participating but not yet undergoing accreditation</td><td rowspan="2">18</td></tr>
<tr><td>Teesside CYPS Community ED Team</td><td>Participating but not yet undergoing accreditation</td></tr>
<tr><td>QNLD: Quality Network for Learning Disability Wards</td><td>None</td><td>N/A</td><td>40</td></tr>
<tr><td>QNOAMHS: Quality Network Older Adults Mental Health Services</td><td>Rowan Lea</td><td>Accredited</td><td>67</td></tr>
<tr><td rowspan="7">AIMS-WA: Working Age Adult Wards</td><td>Farnham Ward, Lanchester Road Hospital</td><td>Accredited</td><td rowspan="7">136</td></tr>
<tr><td>Tunstall Ward, Lanchester Road Hospital</td><td>Accredited</td></tr>
<tr><td>Bilsdale Unit, University Hospital of North Tees</td><td>Accredited as excellent</td></tr>
<tr><td>Bransdale Unit, University Hospital of North Tees</td><td>Accredited as excellent</td></tr>
<tr><td>Danby Ward, Cross Lane Hospital</td><td>Accredited as excellent</td></tr>
<tr><td>Esk Ward, Cross Lane Hospital</td><td>Accredited as excellent</td></tr>
<tr><td>Lincoln Ward, Sandwell Park</td><td>Accredited as excellent</td></tr>
</table>

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

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

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

Our stakeholders' views

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

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

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

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

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

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

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

In line with national guidance, we have circulated our draft Quality Account for 2016/17 to the following stakeholders:

- NHS England;
- North East Commissioning Support;
- Clinical Commissioning Groups (x9);
- Health & Wellbeing Boards (x8);
- Local Authority Overview & Scrutiny Committees (x8);
- Local HealthWatch (x8).

All the comments we have received from our stakeholders are included verbatim in **appendix 7**.

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

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

The Trust will write to each stakeholder addressing each comment made following publication of the Quality Account 2016/17 and use the feedback as part of an annual lessons learnt exercise in preparation for the Quality Account 2017/18. In our commitment to listen to our stakeholders and learn from their feedback, we are developing an ‘easy read’ version of the 2016/17 Quality Account which will be published on Trust’s website.

In response to many stakeholders’ requests, the Trust has agreed to continue providing all stakeholders with a half-year update in November 2017 on the Trust’s progress with delivering its quality priorities and metrics for 2017/18.

APPENDICES

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

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

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

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

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

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

  - Board minutes and papers for the period April 2016 to May 2017;
  - Papers relating to Quality reported to the Board over the period April 2016 to May 2017;
  - Feedback from the Commissioners dated 15 May and 16 May 2017;
  - Feedback from Governors dated 9 March, 13 April and 25 May 2017;
  - Feedback from Local Healthwatch organisations dated 9 May and 16 May 2017;
  - Feedback from Overview and Scrutiny Committees dated 12 May and 15 May 2017;
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 17 May 2017;
  - The latest national patient survey published 15 November 2017;
  - The latest national staff survey published 7 March 2017;
  - The Head of Internal Audit's annual opinion over the Trust's control environment dated xx May 2017;
  - CQC inspection reports dated 23 February 2017.

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

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

- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review;

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

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

By order of the Board.

............Date...Chairman

............Date...Chief Executive

APPENDIX 2: 2016/17 LIMITED ASSURANCE REPORT ON THE CONTENT OF THE QUALITY ACCOUNTS AND MANDATED PERFORMANCE INDICATORS

APPENDIX 3: GLOSSARY

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

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

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

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

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

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

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

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

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

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

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

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

CLiP (Clinical Link Pathway): Completed on the Trust's electronic patient record (Paris) for Falls allowing them to be monitored effectively.

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

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

Commissioning for Quality and Innovation (CQUIN): is a payment framework such that a proportion of NHS providers' income is conditional on quality and innovation. Its aim is to support the vision set out in High Quality Care for All of an NHS where quality is the organising principle.

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

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

Council of Governors: the Council of Governors is made up of elected public and staff members, and also includes non-elected members, such as the Prison Service, Voluntary Sector, Acute Trusts, Universities and Local Authorities. The Council has an advisory, guardianship and strategic role including developing the Trust's membership, appointments and remuneration of the Non-Executive Directors including Chairman and Deputy Chairman, responding to matters of consultation from the Trust Board, and appointing the Trust's auditors.

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

Culture of Candour: This relates to an open culture where things that go wrong are not kept secret but rather kept in the open so that people can understand and learn from what went on without blame or shame being allocated to individuals.

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

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

Data Protection Act 1998: The law that regulates storage of and access to data about individual people.

Data Quality Improvement Plans (DQIPs): A plan to improve the reliability / accuracy of data collected on a particular subject – often used where data has not been collected in the past and new systems to do this need to be set up.

DATIX: TEWV's electronic system for collecting data about clinical, health and safety and information governance incidents.

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

Department of Health: The government department responsible for Health Policy.

Directorate(s): TEWV's corporate services are organised into a number of directorates: Human Resources and Organisational Development; Finance and Information; Nursing and Governance; Planning, Performance and Communications; Estates and Facilities Management. In the past our clinical specialities were called clinical directorates. The Specialities are Adult Mental Health services, Mental Health Services for Older People, Children and Young People's Services and Adult Learning Disability Services.

Duty of Candour: From 27 November 2014 all NHS bodies are legally required to meet the Duty of Candour. This requires healthcare providers to be open and transparent with those who use their services in relation to their care and treatment, and specifically when things go wrong.

Early Intervention in Psychosis (EIP): Early intervention in psychosis is a clinical approach to those experiencing symptoms of psychosis for the first time. It forms part of a new prevention paradigm for psychiatry and is leading to reform of mental health services especially in the United Kingdom. This approach centres on the early detection and treatment of early symptoms of psychosis during the formative years of

the psychotic condition. The first three to five years are believed by some to be a critical period. The aim is to reduce the usual delays to treatment for those in their first episode of psychosis. The provision of optimal treatments in these early years is thought to prevent relapses and reduce the long-term impact of the condition.

Expert by Experience Groups and members: None contracted roles, managed under the involvement and engagement structures (offered honorarium) to offer story telling input into training and provide the opportunity to gain a broader range of lived experience views on a range of service developments. Experts by Experience have been trained to work alongside the recovery team to develop and deliver recovery related training in supporting staff and service development in recovery related practice. Experts by Experience work with Trust staff, they do not work with patients and carers (ie they are not acting in a peer role). These roles are managed via our Patient and Public Involvement process.

Forensic Services: Forensic Adult Mental Health and Learning Disability services work mainly with people who are mentally unwell or who have a learning disability and have been through the criminal justice system. The majority of people are transferred to a secure hospital from prison or court, where their needs can be assessed and treated. These services are intended to see that people with severe mental illness or learning disability who enter the criminal justice system get the care they need.

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

Freedom of Information Act 2000: A law that outlines the rights that the public have to request information from public bodies (other than personal information covered by the Data Protection Act), the timescales they can expect to receive the information, and the exemptions that can be used by public bodies to deny access to the requested information.

Friends and Family Test (FFT): A survey question put to patients, carers or staff that asks whether they would recommend a hospital / community service to a friend of family member if they needed that kind of treatment.

Functional (MHSOP): Older people with a decreased mental function which is not due to a medical or physical condition.

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

Health and Wellbeing Boards: The Health and Social Care Act 2012 established health and wellbeing boards as a forum where key leaders from the health and care system would work together to improve the health and wellbeing of their local population and reduce health inequalities. Health and wellbeing board members collaborate to understand their local community's needs, agree priorities and encourage commissioners to work in a more joined-up way.

Health of the Nation Outcome Score (HoNOS): A way of measuring patients' health and wellbeing. It is made up of 12 simple scales on which patients with severe mental illness are rated by clinical staff. The idea is that these ratings are stored, and then repeated- say after a course of treatment or some other intervention- and then compared. If the ratings show a difference, then that might mean that the patient's health or social status has changed. They are therefore designed for repeated use, as their name implies, as clinical outcomes measures.

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

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

IAPT (also known as 'Talking Therapies'): IAPT stands for "Increasing Access to Psychological Therapies" and was introduced in the last.

Infection Prevention and Control Team: The prevention of health care associated infections (HCAI), both in patients and staff, is an integral part of the professional responsibility of all health care workers. TEWV's infection prevention and control team for the Trust consists of 2 senior infection prevention and control and physical healthcare nurse (IPCNs), 2infection prevention and control and physical healthcare nurses. The role of Director of Infection Prevention and Control (DIPC) is undertaken by the Director of Nursing and Governance for the Trust who is accountable directly to the board and chairs the Trust Infection Prevention and Control Committee.

Information Governance Toolkit & Assessment Report: is a national approach that provides a framework and assessment for assuring information quality against national definitions for all information that is entered onto computerised systems whether centrally or locally maintained.

Integrated Information Centre (IIC): TEWV's system for taking data from the patient record (Paris) and enabling it to be analysed to aid operational decision making and business planning.

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

Learning Disabilities Service: Services for people with a learning disability and mental health needs. TEWV has Adult Learning Disability (ALD) service in each of its 4 Localities and also specific wards for Forensic LD patients. TEWV provides Child LD services in Durham, Darlington, Selby, Teesside and York but not in North Yorkshire.

Lived Experience: A member of the public or staff who has been treated for MH issues in the past and so has special insight into the patient perspective of having a mental illness and receiving treatment.

Local Authority Overview and Scrutiny Committee: All “upper-tier” and “unitary” local authorities are responsible for scrutinising health services in their area, and most have a Health Overview and Scrutiny Committee (OSC).

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

Locality Management and Governance Board (LMGB): A monthly meeting held in each of our Localities (see above) that involves senior managers and clinical leaders who work in that Locality which takes key decisions that relate to that Locality.

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

Mental Health Services for Older People (MHSOP): Services provided for people over 65 years old. These can be to treat ‘functional’ illness, such as depression, psychosis or anxiety, or to treat ‘organic’ mental illness (conditions usually associated with memory loss and cognitive impairment), such as dementia. The MHSOP service sometimes treats people younger than 65 with organic conditions such as early-onset dementia.

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

MRSA: is a bacterium responsible for several difficult-to-treat infections in humans. MRSA is especially troublesome in hospitals, prisons and nursing homes, where patients with open wounds, invasive devices, and weakened immune systems are at greater risk of infection than the general public.

Multi-agency: this means that more than one provider of services is involved in a decision or a process.

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

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

National Confidential Inquiries (NCI) and National Clinical Audit: research projects funded largely by the National Patient Safety Agency (NPSA) that examine all incidents of, for example suicide and homicide by People with Mental Illness, with the aim is to improve mental health services and to help reduce the risk of these tragedies happening again in the future. This is supported by a national programme of audit.

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

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

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

National Research Passport Scheme: a scheme to streamline procedures associated with issuing honorary research contracts or letters of access to researchers who have no contractual arrangements with NHS organisations who host research, and who carry out research in the NHS that affects patient care, or requires access to NHS facilities.

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

NHS Digital: Previously known as the Health and Social Care Information Centre (HSCIC), was set up as an executive non-departmental public body in April 2013, sponsored by the Department of Health. It is the national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care.

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

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

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

Overview & Scrutiny Committees (OSCs): These are statutory committees of each Local Authority which scrutinise the development and progress of strategic and operational plans of multiple agencies within the Local Authority area. All local authorities have an OSC that focused on Health, although Darlington, Middlesbrough, Stockton, Hartlepool and Redcar & Cleveland Councils have a joint Tees Valley Health OSC that performs this function.

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

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

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

Patient Advice & Liaison Team (PALs): The Patient Advice and Liaison Service (PALS) offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers. TEWV has its own PALS service as do all other NHS providers.

Patient Safety Group: The group monitors on a monthly basis the number of incidents reported, any thematic analysis and seeks assurances from operational services that we are learning from incidents. We monitor within the group any patient safety specific projects that are on-going to ensure milestones are achieved and benefits to patients are realised.

Peer Trainer: someone who is trained and recruited as a paid employee within the Trust in a specifically designed job to actively use their lived experience and to deliver training courses to other patients and carers. They work within the Recovery College.

Peer Volunteer: someone who gives their time freely to the Trust in a specifically defined unpaid role to actively use their lived experience (as a patient or carer) to support other carers and patients. They work alongside and support paid staff as well as providing support to specific groups / tasks.

Peer Worker: someone who is trained and recruited as a paid employee within the Trust in a specifically designed job, to actively use their lived experience (as a patient or carer) to support other patients, in line with the Recovery Approach.

PPI: Patient and Public Involvement.

Prescribing Observatory in Mental Health (POMH): a national agency, led by the Royal College of Psychiatrists, which aims to help specialist mental health services improve prescribing practice via clinical audit and quality improvement interventions.

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

Purposeful Inpatient Admission (PIPA) and Treatment: This is TEWV's method for ensuring that all patients receive assessments and treatments as quickly as possible so that their length of stay is kept as short as possible.

Quality Account: A Quality Account is a report about the quality of services by an NHS healthcare provider. The reports are published annually by each provider.

Quality Assurance Committee (QuAC): sub-committee of the Trust Board responsible for quality and assurance.

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

Quality Governance Framework (NHS Improvement): NHS Improvement's approach to making sure NHS foundation Trusts are well run and can continue to provide good quality services for patients.

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

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

Recovery Approach: This is a new approach in mental health care that goes beyond the past focus on the medical treatment of symptoms, and getting back to a "normal" state. Personal recovery is much broader and for many people it means finding / achieving a way of living a satisfying and meaningful life within the limits of mental illness. Putting recovery into action means focusing care on what is personally important and meaningful, looking at the person's life goals beyond their symptoms. Helping someone to recover can include assisting them to find a job, getting somewhere safe to live and supporting them to develop relationships.

Recovery College: A recovery college is a learning centre, where patients, carers and staff enrol as students to attend courses based on recovery principles. Our recovery college, called *ARCH,* opened in September 2014 in Durham. This exciting resource is available to TEWV patients, carers and staff in the Durham area. Courses aim to equip students with the skills and knowledge they need to manage

their recovery, have hope and gain more control over their lives. All courses are developed and delivered in co-production with people who have lived experience of mental health issues.

Recovery Strategy: TEWV's long term plan for moving services towards the *recovery approach* (see above).

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

Risk Assessment Framework: see Single Oversight Framework

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

Serious Incidents (SIs): defined as an incident that occurred in relation
to NHS-funded services and care, to ether patient, staff or member of the public, resulting in one of the following: unexpected / avoidable death, serious / prolonged / permanent harm, abuse, threat to the continuation of the delivery of services, absconding from secure care.

STEIS: National system for reporting serious incidents.

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

SWEMWBS: The shortened version of *WEMWBS* (see below).

TEWV: see 'The Trust'.

TEWV Quality Improvement System (QIS): the Trust's framework and approach to continuous quality improvement based on Kaizen / Toyota principles.

Trust Board: See 'Board / Board of Directors'.

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

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

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

Recovery College Online: This is an initiative that would allow people to access recovery college materials and peer-support on-line.

Visual Control Boards: a technique for improving quality within the overall TEWV Quality Improvement System (QIS).

Warwick-Edinburgh Mental Well-Being Scale (WEMWBS): The Warwick-Edinburgh Mental Well-being Scale (WEMWBS) is a scale of 14 positively worded items, with five response categories, for assessing mental wellbeing. There is also a "short" version of this scale – where this is used it is called *SWEMWBS.*

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

Audit Theme	Key quality improvement activities associated with clinical audit outcomes
1. NICE/ Pathway Development	• A briefing sheet on the CYPS Depression Pathway was distributed to teams and plans were developed for roll-out in North Yorkshire, Tees and Durham and Darlington Localities. • To support compliance with NICE CG185 (Bipolar disorder), information resources on the use of valproate in bipolar disorder have been made available to all clinicians and links to information resources have been included in the Trust Bipolar Disorder Pathway. Monitoring requirements for patients prescribed valproate have been added to new Trust guidance. • To support compliance with NICE CG115 (Alcohol-use disorders), the Trust inpatient alcohol detoxification pathway/guidelines will be updated to include blood test that should be performed for patients undergoing detox. • The LD Core Pathway will be updated to include sleep resources and a Sleep CLIP will be developed.
2. Physical Healthcare	• VTE risk assessment guidance and eLearning have been promoted staff by Modern Matrons and via Medical Education. • In Forensic services, the admission checklist has been updated to include completion of the Falls CLIP within 72 hours of admission. • The Care Plan template for pregnant service users has been updated to include provision of health promotion information on blood borne viruses. • Results of the National CQUIN Safety Thermometer are reported to the Clinical Effectiveness Group quarterly.
3. Medicines Management	• Rapid tranquilisation (RT) audit results have been incorporated into a review of Medicines Management training and update of the Trust RT policy/procedure. RT eLearning has been developed. • To support good antimicrobial stewardship, a new Trust Antimicrobial Prescribing Policy has been developed and pharmacy training slides for Junior Doctors and Pharmacists have been updated. • A briefing on Lithium monitoring has been updated and shared with Trust staff and colleagues in Primary Care to emphasise the importance of recording the interval between last lithium dose and serum lithium tests. • The Trust medicines fridge monitoring form has been updated and all old paperwork replaced; a fridge monitoring bulletin was produced and distributed to clinical areas.
4. Risk Assessment/ Violence and Aggression/ Suicide Prevention	• Suicide prevention audit results will be incorporated into the relevant Harm Minimisation Training package and monthly Suicide Prevention update training. • In CYPS, training on collaborative recovery-focused care planning was delivered for relevant teams and the importance of timely risk assessment was promoted. • In CYPS, the Trust self-harm information leaflet for patients and carers was reviewed and made available. • Bespoke MAPPA training has been made available via InTouch; PARIS has been updated to facilitate MAPPA record keeping. • Following a strategic review of the way safeguarding activity and supervision is documented on PARIS, a new Safeguarding Care Document has been made available on PARIS.
5. Infection Prevention and Control (IPC)	• All Infection Prevention and Control Audits are continuously monitored by the IPC team and any required actions are rectified collaboratively with the IPC team and ward staff. Assurance of implementation of actions is monitored by the Clinical Audit and Effectiveness team via the clinical audit database. • A total of **87** IPC clinical audits were conducted during 2016/17 in inpatient areas in the Trust. **99% (86/87)** of clinical areas achieved standards between 80-100% compliance. • Clinical audits have been undertaken to assess compliance with Hand Hygiene standards and a monthly Essential Steps audit is completed in inpatient areas.

Audit Theme	Key quality improvement activities associated with clinical audit outcomes
6. Supervision	• Clinical audit findings have informed the development of the training packages to support the implementation of the new Trust Supervision Policy. • There is an ongoing specialist contract requirement which involves undertaking an audit for specialist services to establish the duration of clinical supervision which staff have achieved, with a target of a minimum of 2 hours per quarter. • The Trust Preceptorship Policy has been updated, a preceptor preparation session has been designed and delivered and standard scripts introduced to ensure meetings cover required content.
7. Records management	• Clinical audit activities have assessed clinical record keeping and informed changes within the electronic patient record (Paris) for the Trust. Examples of aspects which have been assessed against record keeping standards include the physical examination and harm minimisation documents. • The Trust approved abbreviation list has been reviewed and updated. • The Safeguarding Care Document on PARIS has been reviewed and updated to reduce the administrative burden on staff.
8. Environment and Equipment	• Summary guidance has been issued on the use and maintenance of posture safety belts for MHSOP wards. • Emergency bags have been checked to make sure all relevant equipment is available; work is underway to create an up to date asset register for emergency bags. • MHSOP wards have introduced weekly falls meetings.
9. Serious Incidents and Complaints	• The Clinical Audit and Effectiveness Team continued to validate SI action plans and findings have been fed back to the Patient Safety Group. • The Clinical Audit and Effectiveness Team continued to validate complaint action plans and findings have been fed back to the Patient Experience Group.
10. Transition, Transfer, Discharge and Leave	• In CAMHS a transitions flowchart has been developed and shared with teams along with a template to assist with correct completion of the Transition Care Document on Paris. The Transitions Protocol has been promoted and will be reviewed to include provision for young people who are new to CAMHS after 17.5 years of age. “My Passport” (a template to improve recording of information about patients’ transition/discharge plans) will be added to Paris. • To improve adherence to Trust Protocol for Section 17 leave, a standard flowchart has been developed for display on wards, a Leave Risk Assessment Tool has been developed for completion by the MDT following any changes to leave status. • The Trust Harm Minimisation Policy and supporting Observation and Engagement Procedure have been implemented. Standard work, detailing the process to be followed before facilitating leave, has been developed and implemented; this includes risk assessment and documentation of expectations, documentation on Paris and a Patient Leave Form.

APPENDIX 5: TRUST BUSINESS PLAN ADDITIONAL QUALITY PRIORITIES

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

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

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

APPENDIX 6: QUALITY PERFORMANCE INDICATOR DEFINITIONS

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

Data definition:

All patients discharged to their place of residence, care home, residential accommodation, or to non-psychiatric care must be followed up within 7 days of discharge. All avenues need to be exploited to ensure patients are followed up within 7 days of discharge*. Where a patient has been discharged to prison, contact should be made via the prison in-reach team.

Exemptions:

- Patients who die within 7 days of discharge may be excluded.
- Where legal precedence has forced the removal of the patient from the country.
- Patients transferred to NHS psychiatric inpatient ward.
- CYPS are not included.

The 7 day period should be measured in days not hours and should start on the day after discharge.

Accountability:

Achieving at least 95% rate of patients followed up after discharge each quarter.

* *Follow up may be face-to-face or telephone contact, this excludes text or phone messages*

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

Data definition:

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

Total exemption from crisis resolution home treatment teams gate-keeping:

- Patients recalled on a Community Treatment Order.
- Patients transferred from another NHS hospital for psychiatric treatment.
- Internal transfers of patients between wards in the Trust for psychiatry treatment.
- Patients on leave under Section 17 of the Mental Health Act.
- Planned admission for psychiatric care from specialist units such as eating disorder unit.

Partial exemption:

Admissions from out of the Trust area where the patient was seen by the local crisis team (out of area) and only admitted to this Trust because they had no available beds in the local areas. Crisis resolution home treatment teams should assure themselves that gate-keeping was carried out. This can be recorded as gate-kept by crisis resolution home treatment teams.

** This indicator applies to patients in the age bracket 16-65 years and only applies to CYPS patients where they have been admitted to an adult ward.*
*** An assessment should be recorded if there is direct contact between a member of the team and the referred patient, irrespective of the setting, and an assessment made. The assessment should be face-to-face and only by telephone where face-to-face is not appropriate or possible.*

Percentage of clinical audits of NICE Guidance completed

Data definition:

The percentage of clinical audits of NICE Guidance completed is based on the number of audits of NICE guidelines completed against the number of audits of NICE guidelines planned. Data for this metric is taken from audits undertaken by the Clinical Directorates supported by the Clinical Audit Team.

Numerator:

Number of NICE Guidance audits completed within the month.

Denominator:

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

APPENDIX 7: FEEDBACK FROM OUR STAKEHOLDERS

County Durham Council Adults Wellbeing and Health Overview and Scrutiny Committee

DURHAM COUNTY COUNCIL ADULTS WELLBEING AND HEALTH OVERVIEW AND SCRUTINY COMMITTEE

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

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

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

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

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

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

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

Finally, in order to ensure that it continues to provide a robust Health scrutiny function and assurances in this respect to the residents of County Durham, the Committee would request a six monthly progress report on delivery of 2017/18 priorities and performance targets in November 2017.

Darlington Borough Council Health and Partnerships Scrutiny Committee

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

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

Members of the Health and Partnerships Scrutiny Committee have considered the draft Quality Account 2016/17 for Tees, Esk and Wear Valleys NHS Foundation Trust and attended Stakeholder events over the past year. Members would like to acknowledge that the Stakeholder events are always well attended and informally structured to enable meaningful audience participation, with the opportunity for a free exchange of views.

Members agreed that the presentation of the document was user friendly and readable.

In respect of the Quality Improvement Priorities for 2016/17, Members have the following comments to make:

Continue to develop and implement recovery focussed services – Members recognised the continuation of this Priority, identified in 2014/15, as service users wanted the service to go beyond reducing symptoms of mental health and required support to live meaningful and fulfilling lives whether or not there was improvement in symptoms.

Members welcomed the benefits and aims of this Priority which included care which was designed to support service users to achieve their own goals; ensuring patients and their carers genuinely feel listened to and heard; views and personal expertise by experience of service users and carers being valued; service users being supported to take charge of their lives, promoting choice and self-management; and staff working in partnership with service users and carers at every level of service delivery to ensure quality of life reflected in individual care plans.

Scrutiny Members were pleased to see the key actions in relation to staff and training and the expansion of peer roles. Opportunities for individuals with lived experience taking part in service development resulted in the Trust surpassing its performance

targets and Members are delighted that the Trust has once again included this as a Priority Action for 2017/18.

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

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

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

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

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

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

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

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

Improve the Clinical Effectiveness and Patient Experience at Times of Transition – Members noted that the Trust had highlighted this priority as a result of

feedback from stakeholder events due to service users raising issues when moving from an inpatient unit to a community setting. Transition is particularly important when a child moves to adult services as care is provided in a different way.

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

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

Statement of Assurances from the Board 2016/17

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

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

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

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

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

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

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

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

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

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

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

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

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

Councillor Wendy Newall
Chair, Health and Partnerships Scrutiny Committee

Durham, Darlington and Teesside Joint CCGs

NHS
South Tees
Clinical Commissioning Group

NHS
North Durham
Clinical Commissioning Group

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12 May 2017

Elizabeth Moody
Director of Nursing and Governance
Tees Esk and Wear Valleys NHS Foundation Trust
Trust Headquarters
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Edward Pease Way
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Dear Elizabeth

RE: Tees, Esk and Wear Valleys NHS Foundation Trust (TEWVFT) Quality Account 2016/17

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

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

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

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

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

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

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

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

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

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

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

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

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

Yours sincerely

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

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

Mrs Amanda Hume
Chief Officer
NHS South Tees
Clinical Commissioning Group

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

Healthwatch Darlington

Healthwatch Darlington

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

Healthwatch Darlington have welcomed and enjoyed the opportunity to be involved with the Quality Accounts over the last twelve months and benefit from partnership working with Tees, Esk and Wear Valley NHS Foundation Trust. The Trust actively involves and engages with Healthwatch Darlington and we believe fully embraces the patient voice. Healthwatch Darlington feel the Trust have meaningfully involved a wide and varied section of stakeholders and members of the public and have been regularly updated on patient engagement activity throughout the year.

Priorities 2016/2017

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

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

Quality Indicators

We are pleased to see many of the Quality Indicators have been met, but acknowledge along with the Trust that areas are still to be improved. Healthwatch participants were pleased to see an action plan and timescales in place to help implement the quality improvements. We are especially keen to see the continued progression of patient experience and patient safety and agree with the trust that it is one of the priorities for 2017/2018.

Priorities 2017/2018

Priority 1: Implement Phase 2 of the Recovery Strategy.

Priority 2: Ensure Safe Staffing in all services.

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

Priority 4: Reduce the number of preventable deaths.

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

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

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

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

Healthwatch York

May 2017

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

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

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

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

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

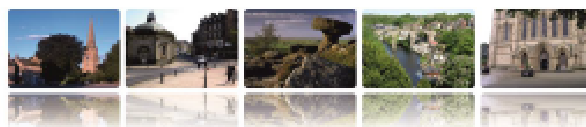
It is good to see the focus on young people transferring from CAMHS to adult services. Healthwatch York has received feedback about the lack of appropriate services for young people to transition to, which may result in young people failing to engage with services in the future.

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

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

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

North Yorkshire and York CCGs



Email: j.crewe@nhs.net
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Reference: HaRD.052-17

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Sharon.pickering1@nhs.net
Sharon Pickering
Director of Planning, Performance and Communications
Tees, Esk and Wear and Wear Valleys NHS Foundation Trust
Tarncroft
Lanchester Road Hospital
Lanchester Road
Durham DH1 5RD

15 May 2017

Dear Sharon

Quality Account

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

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

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

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

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

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

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

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

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

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

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

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

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

Yours sincerely

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

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

Tees Valley Joint Scrutiny Committee

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

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

11 May 2017

Dear Sharon

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

Progress against Quality Priorities 2016/17

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

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

1. Continue to develop and implement Recovery focused services;

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

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

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

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

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

- Patient falls per 1000 admissions

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

- Average length of stay for patients

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

- Percentage of complaints satisfactorily resolved

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

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

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

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

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

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

Reference was made to concerns raised locally and nationally in respect of Children and Young People's Mental Health Services. Yet none of the Quality Priorities, other than with reference to transitions, related specifically to Children and Young People. The Committee was advised that very few children were in receipt of inpatient MH services and South Tees CCG had commissioned a Children's Crisis Team for all 4

Boroughs, with the exception of Darlington. The Crisis Team ensured that children were kept out of hospital 24 hours a day, 7 days a week and waiting times in the Tees Valley were much lower than in other parts of the country.

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

Yours sincerely

Eddie Dryden

Cllr Eddie Dryden
Chair, Tees Valley Joint Scrutiny Committee

ITEM NO. 13

FOR GENERAL RELEASE

COUNCIL OF GOVERNORS

DATE:	**Thursday, 25th May 2017**
TITLE:	**National Community Mental Health Survey 2016 Results**
REPORT OF:	**Jennifer Illingworth, Director of Quality Governance**
REPORT FOR:	**Information**

This report supports the achievement of the following Strategic Goals:	✓
To provide excellent services working with the individual users of our services and their carers to promote recovery and wellbeing	✓
To continuously improve to quality and value of our work	✓
To recruit, develop and retain a skilled, compassionate and motivated workforce	✓
To have effective partnerships with local, national and international organisations for the benefit of the communities we serve	
To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefits of the communities we serve.	

Executive Summary:

The report provides information relating to the National Community Mental Health Survey 2016. The report highlights key issues in relation to areas of good practice and where improvements can be made.

When comparing TEWV survey results with those of the other organisations the scores were identified as being ‘about the same’ as other organisations across all 10 sections.

Recommendations:

(i) To note the results of the survey.

MEETING OF:	COUNCIL OF GOVERNORS
DATE:	Thursday, 25th May 2017
TITLE:	National Community Mental Health Survey 2016 Results

1. INTRODUCTION & PURPOSE:

1.1 The report provides information relating to the National Community Mental health Survey 2016. The report highlights key issues in relation to areas of good practice and where improvements can be made.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The 2016 survey of people who use community mental health services involved 58 providers of NHS mental health services in England.

13,000 people responded to the survey, giving an overall response rate of 28%.

The CQC use the results from the survey in the regulation, monitoring and inspection of NHS Trusts in England and forms a key source of evidence to support the judgements and inspection ratings published for Trusts.

3. KEY ISSUES:

3.1 A total of 234 people completed the TEWV survey giving a response rate of 28% which mirrors the National response rate. There were a similar number of men and women completing the survey – males 47% and females 53%. The age range of respondents was lowest in the 18 to 35 age range (10%) with the largest group being over 66 years of age (57%). In relation to ethnicity 96% of respondents identified themselves as 'White' with 1% 'multiple ethnic groups' and 2% 'not known'.

3.2 The survey covers 10 sections covering health and social care workers, organising care, planning care, reviewing care, changes in who people see, crisis care, treatments, support and wellbeing, overall views of care and services and overall experience.

3.3 The report identifies if Trusts perform 'better' 'about the same' or 'worse' based on a statistic called the expected range. When comparing TEWV survey results with those of the other organisations the scores were identified as being 'about the same' as other organisation across all 10 sections. For a comparison of TEWV with other organisations see appendix 1.

3.4 In relation to individual questions (rather than whole sections) TEWV scored 'better' than the majority of other Trusts in the following questions:

- Were you given enough time to discuss your needs and treatments? (Mean score 8.04 out of 10)

- Were you involved as much as you wanted to be in agreeing what care you will receive? (Mean score 8.03 out of 10)
- Were you involved as much as you wanted to be in decisions about which medicines you receive? (Mean score 7.6 out of 10)
- Were you given information about new medicines(s) in a way that you were able to understand? (Mean score 7.75 out of 10)

3.5 Whilst there were no individual questions that scored worse than other Trusts, the section with the lowest overall scores for TEWV were in relation to the support and wellbeing section, particularly in relation to the following questions:

- In the last 12 months, did NHS mental health services give you any help or advice with finding support for finding or keeping work? (Mean score 4.06 out of 10)
- 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? (Mean score 3.85 out of 10)

3.6 In relation to being treated with dignity and respect under overall views of care and services the Trust scored well with a mean score of 8.62.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** The CQC use the results from the survey in the regulation, monitoring and inspection of NHS trusts in England and forms a key source of evidence to support the judgements and inspection ratings published for Trusts.

4.2 **Financial/Value for Money:** None identified.

4.3 **Legal and Constitutional (including the NHS Constitution):** None identified.

4.4 **Equality and Diversity:** The survey results can be further analysed in relation to the demographic information captured but both locally and nationally BAME responses are low.

4.5 **Other implications:** None identified.

5. RISKS: None identified.

6. CONCLUSIONS:

6.1 In the 2016 Community Mental Health Survey results demonstrate that the Trust is performing ‘about the same’ as other Trusts in relation to expected results.

7. RECOMMENDATIONS:

7.1 To note the contents of this report.

Jennifer Illingworth
Director of Quality Governance

Background Papers:

https://www.cqc.org.uk/content/community-mental-health-survey-2016

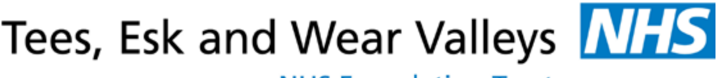
Appendix 1

Comparison of Scores

Key

Green = better than other organisation, White = about the same as other originations, Red = worse than other organisations

	H&SC Workers	Organising Care	Planning care	Reviewing care	Changes in who people see	Crisis care	Treatments	Support and wellbeing	Overall views of care and services	Overall experience
Avon and Wiltshire Mental health Partnership Trust							Green			
Barnet, Enfield and Haringey Mental Health NHS Trust										
Berkshire Healthcare NHS Foundation Trust										
Birmingham and Solihull Mental Health NHS Foundation Trust										
Black Country Partnership NHS Foundation Trust										
Bradford District Care NHS Foundation Trust										
Cambridgeshire and Peterborough NHS Foundation Trust										
Camden and Islington NHS Foundation Trust										
Central and North West London NHS Foundation Trust										
Cheshire and Wirral Partnership NHS Foundation Trust							Green			
Cornwall Partnership NHS Foundation Trust										
Coventry and Warwickshire Partnership NHS Trust										
Cumbria Partnership NHS Foundation Trust										
Derbyshire Healthcare NHS Foundation Trust							Green			
Devon Partnership NHS Trust										
Dorset Healthcare University NHS Foundation Trust										
Dudley and Walsall Mental Health Partnership NHS Trust								Green		
East London NHS Foundation Trust					Green					
Greater Manchester West Mental Health NHS Foundation Trust	Green	Green								Green
Hertfordshire Partnership University NHS Foundation Trust							Green			
Humber NHS Foundation Trust										
Kent and Medway NHS and Social Care Partnership Trust	Red								Red	
Lancashire Care NHS Foundation Trust										
Leeds and York Partnership NHS Foundation Trust										
Leicestershire Partnership NHS Trust										
Lincolnshire Partnership NHS Foundation Trust					Red					



Plymouth Community Healthcare CIC (AKA LIVEWELL SOUTHWEST)										
Manchester Mental Health and Social Care Trust										
Mersey Care NHS Foundation Trust										
Navigo Health and Social Care CIC										
Norfolk and Suffolk NHS Foundation Trust										
North East London NHS Foundation Trust										
North Essex Partnership University NHS Foundation Trust										
North Staffordshire Combined Healthcare NHS Trust										
Northamptonshire Healthcare NHS Foundation Trust										
Northumberland, Tyne and Wear NHS Foundation Trust										
Nottinghamshire Healthcare NHS Foundation Trust										
Oxford Health NHS Foundation Trust										
Oxleas NHS Foundation Trust										
Pennine Care NHS Foundation Trust										
Rotherham Doncaster and South Humber NHS Foundation Trust										
Sheffield Health and Social Care NHS Foundation Trust										
Solent NHS Trust										
Somerset Partnership NHS Foundation Trust										
South Essex Partnership University NHS Foundation Trust										
South London and Maudsley NHS Foundation Trust										
South Staffordshire and Shropshire Healthcare NHS Foundation Trust										
South West London and St George's Mental Health NHS Trust										
South West Yorkshire Partnership NHS Foundation Trust										
Southern Health NHS Foundation Trust										
Surrey and Borders Partnership NHS Foundation Trust										
Sussex Partnership NHS Foundation Trust										
Tees, Esk and Wear Valleys NHS Foundation Trust										
Isle of Wight NHS Trust										
West London Mental Health NHS Trust										
Worcestershire Health and Care NHS Trust										
2gether NHS Foundation Trust										
5 Boroughs Partnership NHS Foundation Trust										

Item 14

FOR GENERAL RELEASE

COUNCIL OF GOVERNORS

DATE:	**25th May 2017**
TITLE:	**Board Dashboard as at 31st March 2017**
REPORT OF:	**Sharon Pickering, Director of Planning, Performance & Communication**
REPORT FOR:	**Assurance**

This report supports the achievement of the following Strategic Goals:	✓
To provide excellent services working with the individual users of our services and their carers to promote recovery and wellbeing	✓
To continuously improve to quality and value of our work	✓
To recruit, develop and retain a skilled, compassionate and motivated workforce	✓
To have effective partnerships with local, national and international organisations for the benefit of the communities we serve	✓
To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefits of the communities we serve.	✓

Executive Summary:

The purpose of this report is to provide the Council of Governors with the Board Dashboard as at 31st March 2017 (Appendix A) in order to identify any significant risks to the organisation in terms of operational delivery. The dashboard is now inclusive of performance relating to York and Selby.

As at the end of March 2017, 4 (21%) of the indicators reported are not achieving the expected levels and are red, which is the same position as at the end of February. Of those red indicators, 1 is showing an improving trend over the previous 3 month period. There are a further 7 indicators which whilst not completely achieving the target levels are within the amber tolerance levels(compared to 6 in February) and 5 of those show an improving trend over the previous 3 months. In terms of the full year position 6 indicators are red, and 7 are amber.

There has been some slight change in the key issues/risks. The key issues risk are:

- Referrals (KPI1)
- Bed Occupancy (KPI 3)
- Access – Waiting Times (KPI 7)
- Out of Locality Admissions (KPI 9)
- Actual Number of Workforce in the month (KPI14)

In respect of performance against the key NHSI operational indicators as at the end of March (and for Quarter 4) all operational indicators were met. However work is

continuing on the various IAPT action plans as the target is not being achieved in every CCG area. The first meeting of the Trust wide IAPT Steering Group is to be held in early May.

Recommendations:

It is recommended that the Board Council of Governors receive this report for information.

MEETING OF:	Council of Governors
DATE:	25th May 2017
TITLE:	Board Dashboard as at 31st March 2017

1. INTRODUCTION & PURPOSE:

1.1 To present to the Council of Governors the Trust Dashboard as at 31st March 2017 (Appendix A). Further detail for each indicator, including trends over the previous 3 years, will be available within the information pack available at the Council of Governors meeting or can be provided electronically on request from the Trust Secretary's department tewv.ftmembership@nhs.net .

2. KEY ISSUES:

2.1 The key issues are as follows:

- As at the end of March 2017, 4 (21%) of the indicators reported are not achieving the expected levels and are red, which is the same position as at the end of February. Of those red indicators, 1 is showing an improving trend over the previous 3 month period. There are a further 7 indicators which whilst not completely achieving the target levels are within the amber tolerance levels (compared to 6 in February) and 5 of those show an improving trend over the previous 3 months. In terms of the full year position 6 indicators are red, and 7 are amber.

- In respect of performance against the key NHSI operational indicators as at the end of March (and for Quarter 4) all operational indicators were met. Work is continuing on the various locality IAPT action plans to ensure the targets are met in each CCG area. The first meeting of the Trust wide IAPT Steering Group is to be held in early May.

2.2 The key risks are as follows:

- Referrals (KPI1) – the number of referrals increased considerably in March to the highest level in the year. This continued increase in demand will impact on our ability to respond in a timely manner and work is ongoing in a number of localities on a demand and capacity analysis. In addition work has commenced on developing a better forecasting model for demand.
- Bed Occupancy (KPI 3) – The Dashboard shows that there has been a slight deterioration in the Trust wide position with only North Yorkshire now showing a bed occupancy level above 90%. York and Selby have the lowest Bed Occupancy figure which is mainly driven by low numbers of admissions in MHSOP services.
- External Waiting Times (KPI 7) – The Trust remains worse than the target of 90% at the end of March with a deterioration compared to the positon reported in February. A key driver of this is the increased referrals that were received in January and then again during March (indeed the increase in referrals in March may impact on the performance against this

indicator in future months). It should however be noted that the position in 2016/17 has been consistently higher than that in the previous two years which is positive given that the number of referrals has increased year on year. The main areas of concern continue to be Children and Young Peoples Services in North Yorkshire and York and Selby and the agreed action plans are continuing to be implemented. The North Yorkshire service has identified a trajectory for recovery of June 2017.

- Out of Locality Admissions (OoL) (KPI 9). The performance for March continues to be worse that the target but there has been a further improvement in the position in March. Only Teesside are within target with North Yorkshire and York and Selby continuing to be outliers although both continue to show an improving position.
- Actual Number of Workforce in the Month (KPI14) – This indicator is continuing to report as amber and there has been a slight deterioration in March. York and Selby continue to be the areas of greatest concern and work is continuing to improve the recruitment of staff within all localities with a number of recruitment fayres planned over the next quarter. In addition there are 100 students who have been recruited to commence work with the Trust when they qualify in September 2017.

2.3 Appendix C provides further details of unexpected deaths including a breakdown by locality.

2.4 Appendix D provides a glossary of indicators.

3. RECOMMENDATIONS:

3.1 It is recommended that the Council of Governors receive this paper for information.

Sharon Pickering
Director of Planning, Performance and Communications

Background Papers:

Appendix A

Trust Dashboard Summary for TRUST

Activity

	March 2017				April 2016 To March 2017			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
1) Total number of External Referrals into Trust Services	7,793.00	9,321.00	Red	Down	91,759.00	100,109.00	Amber	91,759.00
2) Caseload Turnover	1.99%	2.39%	Amber	Down	1.99%	2.39%	Amber	1.99%
3) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	85.00%	88.01%	Amber	Up	85.00%	93.03%	Red	85.00%
4) Number of patients with a length of stay (admission to discharge) of greater than 90 days (A&T wards)	24.00	20.00	Green	Up	277.00	355.00	Red	277.00
5) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) Rolling 3 months	15.00%	8.74%	Green	Down	15.00%	7.61%	Green	15.00%
6) Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP) Rolling 3 months	20.00	24.67	Red	Down	237.00	291.66	Red	237.00

Quality

	March 2017				April 2016 To March 2017			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
7) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral.	90.00%	86.65%	Amber	Up	90.00%	85.65%	Amber	90.00%
8) Percentage of appointments cancelled by the Trust	0.67%	0.54%	Green	Up	0.67%	0.71%	Red	0.67%
9) The percentage of Out of Locality Admissions to assessment and treatment wards (AMH and MHSOP) - post-validated	15.00%	24.66%	Red	Up	15.00%	23.07%	Red	15.00%
10) Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind)	91.44%	90.86%	Amber	Down	91.44%	92.45%	Green	91.44%
11) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	0.86	Green	Down	12.00	8.59	Green	12.00

Trust Dashboard Summary for TRUST

Workforce

	March 2017				April 2016 To March 2017			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
14) Actual number of workforce in month (Establishment 95%-100%)	100.00%	93.74%			100.00%	93.74%		100.00%
15) Percentage of registered healthcare professional jobs that are advertised two or more times	15.00%	20.99%			15.00%	17.39%		15.00%
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	95.00%	92.88%			95.00%	92.88%		95.00%
17) Percentage compliance with mandatory and statutory training (snapshot)	95.00%	89.18%			95.00%	89.18%		95.00%
18) Percentage Sickness Absence Rate (month behind)	4.50%	4.98%			4.50%	5.00%		4.50%

Money

	March 2017				April 2016 To March 2017			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
19) Delivery of our financial plan (I and E)	225,441.00	-607,000.00			-8,057,087.00	-12,120,000.00		-8,057,087.00
20) CRES delivery	550,854.00	590,459.00			6,610,251.00	6,734,472.00		6,610,251.00
21) Cash against plan	49,036,000.00	57,824,000.00			49,036,000.00	57,824,000.00		49,036,000.00

		Data Source					Data Reliability					KPI Construct/Definition									
		A (5)	B (4)	C (3)	D (2)	E (1)	5	4	3	2	1	5	4	3	2	1					
		Direct Electronic transfer from System	Data extracted from Electronic System but data is then processed manually	Other Provider System	Access database or Excel Spreadsheet	Paper or telephone collection	Always reliable	Mostly reliable	Sometimes reliable	Unreliable	Untested Source	KPI is clearly defined	KPI is defined but could be open to interpretation	KPI is defined but is clearly open to interpretation	KPI construction is not clearly defined	KPI is not defined	Total Score	**Percentage as at April 2016**	**Percentage**	Notes	**Notes**
1	Total number of external referrals into trust services	5					5					5					15	**100%**	**100%**		
2	Caseload Turnover	5					5					5					15		**100%**		
3	Number of patients with a length of stay over 90 days (AMH & MHSOP A&T wards)	5					5					5					15		**100%**		
4	Bed occupancy (AMH & MHSOP A&T wards)	5					5					5					15		**100%**		
5	Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)	5						4				5					14	**93%**	**93%**		York and Selby historic data is not in the system so any admissions prior to 1st April may not be on the system. As a result it may appear that Y&S locality position deteriorates as the year progresses.
6	Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP)	5						4				5					14	**100%**	**93%**		York and Selby historic data is not in the system so any admissions prior to 1st April may not be on the system.
7	Number of unexpected deaths classed as a serious incident per 10,000 open cases		4				5					5					14	**67%**	**93%**		Data will be directly extracted from Datix into the IIC; however, this process is not fully embedded. IAPT caseload is currently a manual upload. Data reliability has improved following the introduction of the central approval team
8	Percentage of patients who have not waited longer than 4 weeks following an external referral	5						4				5					14	**93%**	**93%**		Data reliability is 4 due to issues over recording of Did not attends which would stop the clock. Although this is improving, York and Selby locality still have data quality issues to amend following transfer onto PARIS.
9	Percentage of out of locality admissions to assessment and treatment wards (AMH and MHSOP) - post validated		4					4				5					13	**87%**	**87%**		Data is now imported back into IIC following manual validation. This increases reliability; however, there will be some discharges discounted because complete validation has not been possible within the time. These could subsequently be determined to be breaches. In addition there is an issue with staff updating a patient's GP but overwriting historical data - work is underway with Civica in order to amend PARIS to prevent this.
10	Percentage of patients surveyed reporting their overall experience as excellent or good.				2		5					5					12		**80%**		All questionnaires are paper-based, except for some CAMHS units, where patients use a touch screen facility to record their comments. The manual questionnaires from Trust are sent to CRT and scanned into their system. Raw data files are received from CRT, which are accessed by IPT and uploaded into the IIC. TEWV are changing provider during the year. Procurement is currently underway. Transition from CRT to new system will be planned and closely monitored.
11	Percentage of appointments cancelled by the Trust	5									1				2		8	**87%**	**53%**		Codes have been changes and KPIs updated however this is only for outpatient appointments. Community contacts have not been updated and there is an issue because you cannot future date appointments. The release of staff diary on PARIS should resolve this however this will not be until next financial year.

		Data Source					Data Reliability					KPI Construct/Definition									
		A (5)	B (4)	C (3)	D (2)	E (1)	5	4	3	2	1	5	4	3	2	1					
		Direct Electronic transfer from System	Data extracted from Electronic System but data is then processed manually	Other Provider System	Access database or Excel Spreadsheet	Paper or telephone collection	Always reliable	Mostly reliable	Sometimes reliable	Unreliable	Untested Source	KPI is clearly defined	KPI is defined but could be open to interpretation	KPI is defined but is clearly open to interpretation	KPI construction is not clearly defined	KPI is not defined	Total Score	**Percentage as at April 2016**	**Percentage**	Notes	**Notes**
14	Percentage of staff in post more than 12 months with a current appraisal – snapshot	5						4				5					14	**93%**	**93%**		Issues with appraisal dates being entered to ESR have lessened - there appears to be greater confidence in the data being reported. York and Selby staff were transferred on 1st October and will begin to be reported in November through the IIC. Robust process recently implemented within York and Selby to regularly review appraisal compliance information as part of regular management meeting. Fortnightly reports being produced by Workforce Information team to support monitoring.
15	Percentage compliance with mandatory and statutory training – snapshot	5						4				5					14	**93%**	**93%**		Issues with training dates being entered to ESR have lessened - there appears to be greater confidence in the data being reported. York and Selby staff were transferred on 1st October, training information input ESR. There is an ongoing issue associated with idenitification of training requirements linked to training matrix. There is a piece of work being undertaken associated with this which may provide a resolution.
16	Percentage Sickness Absence Rate (month behind)	5						4				5					14	**87%**	**93%**		Whilst the sickness absence data for inpatient services is now being taken directly from the rostering system which should help to eliminate inaccuracies the remainder of the Trust continue to input directly into ESR and there are examples whereby managers are failing to end sickness in a timely manner or inaccurately recording information onto the system – this is picked up and monitored through sickness absence audits that the Operational HR team undertake. York and Selby services are now in line with the remainder of the Trust using MSS or the rostering system - so actions highlighted above will be replicated.
17	Actual number of workforce in month		4				5					5					14		**93%**		Data extracted elecronically but processed manually
18	Percentage of registered health care professional jobs that are advertised two or more times				2			4				5					11		**73%**		Mostly reliable - the form to capture this information has been amended but is still reliant on recruiting managers completing the section of the form. The recruitment team are more proactive in recording on the tracking spreadsheet where they are aware it is a readvertisement because they know this is being reported through a KPI. The recording of the information is a manual input into a spreadsheet which has the potential for human error.

		Data Source					Data Reliability					KPI Construct/Definition					Total Score	Percentage as at April 2016	Percentage	Notes	Notes
		A (5)	B (4)	C (3)	D (2)	E (1)	5	4	3	2	1	5	4	3	2	1					
		Direct Electronic transfer from System	Data extracted from Electronic System but data is then processed manually	Other Provider System	Access database or Excel Spreadsheet	Paper or telephone collection	Always reliable	Mostly reliable	Sometimes reliable	Unreliable	Untested Source	KPI is clearly defined	KPI is defined but could be open to interpretation	KPI is defined but is clearly open to interpretation	KPI construction is not clearly defined	KPI is not defined					
19	Are we delivering our financial plan (I and E)		4				5					5					14	93%	93%		Mostly reliable - the form to capture this information has been amended but is still reliant on recruiting managers completing the section of the form. The recruitment team are more proactive in recording on the tracking spreadsheet where they are aware it is a readvertisement because they know this is being reported through a KPI. The recording of the information is a manual input into a spreadsheet which has the potential for human error.
20	Delivery of CRES against plan				2		5					5					12		80%		Data is collected on Excel with input co-ordinated and controlled by the Financial Controller and version control in operation.
21	Cash against plan		4				5					5					14		93%		An extract is taken from the system then processed manually to obtain actual performance.

Number of unexpected deaths and verdicts from the coroner April 2016 - March 2017

	Number of unexpected deaths in the community					Number of unexpected deaths of patients who are an inpatient and took place in the hospital					Number of unexpected deaths where the patient is an inpatient but the death took place away from the hospital					Number of unexpected deaths where the patient was no longer in service					Total
	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	
Accidental death																					**0**
Natural causes	1	1															1				**3**
Hanging					1												1				**2**
Suicides	4	1	2		2							1	2					1			**13**
Open			1																		**1**
Drug related death																					**0**
Drowning													1								**1**
Misadventure																					**0**
Awaiting verdict	6	3	8	2	6	1					1						1	1	2	1	**32**
Total	**11**	**5**	**11**	**2**	**9**	**1**	**0**	**0**	**0**	**0**	**1**	**1**	**3**	**0**	**0**	**0**	**3**	**2**	**2**	**1**	**52**

Number of unexpected deaths classed as a serious untoward incident											
April	May	June	July	August	September	October	November	December	January	February	March
5	4	3	7	4	3	1	6	7	5	2	5

Number of unexpected deaths total by locality				
Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby
13	9	16	4	10

Number of unexpected deaths and verdicts from the coroner 2015 / 2016

This table has been included into this appendix for comparitive purposes only

	Number of unexpected deaths in the community					Number of unexpected deaths of patients who are an inpatient					Number of unexpected deaths where the patient is an inpatient but the					Number of unexpected deaths where the patient was no longer					Total
	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	
Accidental death	1																				**1**
Natural causes	1					1															**2**
Hanging	3	1	2								1						1		1		**9**
Suicides	7	3	6										1				1				**18**
Open	1		1																		**2**
Drug related death	1	2																			**3**
Drowning																					**0**
Misadventure	1		1																		**2**
Awaiting verdict	13	9	7	2		2		1			2	2	2			1	6	1	1		**49**
Total	**28**	**15**	**17**	**2**	**0**	**3**	**0**	**1**	**0**	**0**	**3**	**2**	**3**	**0**	**0**	**1**	**8**	**1**	**2**	**0**	**86**

Number of unexpected deaths classed as a serious untoward incident											
April	May	June	July	August	September	October	November	December	January	February	March
7	10	9	10*	5	4	9	9	7	6	8	2

Number of unexpected deaths total by locality				
Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby
35	25	22	4	0

Y&S recorded in old Datix not included

Appendix D

Glossary of Indicators

Table no.	Description	Comment
1	Total number of External Referrals into the Trust Services	This indicator counts the number of external referrals received into Trust services (GP and other); all external referrals to all services are included.
3	Bed Occupancy (AMH and MHSOP Assessment & Treatment Wards)	This indicator reports the number of occupied bed days in AMH and MHSOP Assessment and treatment wards in the month against the number of available occupied bed days
4	Number of patients admitted with a length of stay (admission to discharge) greater than 90 days (A&T wards)	This indiccator reports the number of patients admitted to Assessment & Treatment Wards with a length of stay greater than 90 days that have been discharged in the month
5	Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - Rolling 3 months	This indicator reports the total number of admissions to AMH and MHSOP Assessment and Treatment wards in the rolling 3 months period and, of those, the percentage that were readmissions within 30 days of a discharge from any Trust ward.
6	Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP) - Rolling 3 months	This indicator counts the number of patients who were admitted in the month that had previously been admitted on 2 or more occasions during the previous 12 months
7	Percentage of patients who were seen within 4 weeks for a first appointment following an external referral	These waiting times are in relation to patients being referred from external sources (for example GPs). They relate to patients seen in the month, and of those, the percentage who were seen within four weeks.
8	Percentage of appointments cancelled by the Trust	This indicator counts the number of direct (face to face or telephone) appointments regardless of the outcome of the appointment and, of those, measures the percentage that were cancelled by the Trust.
9	Percentage of out of locality admissions to assessment and treatment wards (AMH and MHSOP) - post- validated	Out of locality admissions relates to people who need to be admitted into a ward which is not in the same locality as their GP. Localities have reviewed all wards and a template has been developed to show where patients from each commissioning area would be expected to be admitted to. This indicator measures the percentage of patients that were not admitted to the assigned wards. E.g. an Adult Mental Health patient within Durham City should be admitted to Lanchester Road Hospital, and if the patient has then been admitted to West Park, this will be recorded as 'out of locality admission.'
10	Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind)	This indicator reports the number of patients who have scored "excellent" or "good" in the patient survey to the Question: "Overall how would you rate the care you have received?" of those total patients who responded to this question.
11	Number of unexpected deaths classed as a serious incident per 10000 open cases - post validated	This KPI measures the number of unexpected deaths classed as a serious incident per 10,000 open cases. The total number of open cases on the Paris system is divided by 10,000 to obtain the correct ratio for this calculation.
14	Actual number of workforce in month (Establishment 90-95%)	This KPI reports the actual number of contracted whole time equivalent staff in the month
15	Percentage of registered healthcare professional jobs that are adversided two or more times	This KPI Reports the number of registered healthcare professional jobs advertised for the second (or more) time in the reporting month
16	Percentage of staff in post more than 12 months with a current appraisal (snapshot)	Staff employed by the trust must have completed an appraisal with their supervisor, and informed the workforce information department Information is entered onto ESR at least once a year.
17	Percentage compliance with mandatory and statutory training (snapshot)	This indicator reports the number of courses completed for compliance with the 7 core mandatory and statutory training as a percentage of the number of courses to be completed for compliance. Bank staff and non-Trust staff are excluded
18	Percentage Sickness Absence Rate (month behind)	This indicator measures the number of days lost within the month due to sickness absence, as a percentage of the number of days available.
19	Delivery of financial plan (I and E)	This indicator measures the Income and Expenditure plan at TRUST LEVEL, reporting the actual "surplus or deficit" compared to the "planned surplus" (target). If the figure is plus (positive) this denotes a deficit; if the figure is minus (negative) this denotes a surplus.
20	CRES Delivery	This indicator reports the value of CRES delivered.
21	Cash against plan	This indicator reports actual cash balance

Tees, Esk and Wear Valleys **NHS**
NHS Foundation Trust

Item 15

FOR GENERAL RELEASE

COUNCIL OF GOVERNORS

DATE:	**25 May 2017**
TITLE:	**Finance Report for Period 1 April 2016 to 31 March 2017**
REPORT OF:	**Drew Kendall, Interim Director of Finance and Information**
REPORT FOR:	**Assurance and Information**

This report supports the achievement of the following Strategic Goals:	✓
To provide excellent services working with the individual users of our services and their carers to promote recovery and wellbeing	
To continuously improve to quality and value of our work	
To recruit, develop and retain a skilled, compassionate and motivated workforce	
To have effective partnerships with local, national and international organisations for the benefit of the communities we serve	
To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefits of the communities we serve.	✓

Executive Summary:

The comprehensive income outturn for the period ending 31 March 2017 was a surplus of £12,121k, representing 3.6% of the Trust's turnover. The Trust was ahead of plan by £4,064k largely due to contract variations with commissioners, a refund of historic National Insurance payments, and vacancies.

The Trust has received confirmation it will be awarded income from the incentivised sustainability and transformation fund, however the amount is unconfirmed at the time of writing. The figures reported do not include any amounts related to this.

Identified Cash Releasing Efficiency Savings at 31 March 2017 were marginally ahead of plan. The Trust continues to progress schemes to deliver CRES for future years.

The Use of Resources Rating for the Trust was assessed as 1 for the period ending 31 March 2017 and was in line with plan.

The Trust's annual accounts are subject to external audit and any findings may alter the financial outturn position and associated financial risk rating indicators.

Recommendations:

The Council of Governors are requested to receive the report, to note the conclusions in section 6 and to raise any issues of concern, clarification or interest.

MEETING OF:	Council of Governors
DATE:	25 May 2017
TITLE:	Finance Report for Period 1 April 2016 to 31 March 2017

1. INTRODUCTION & PURPOSE

1.1 This report summarises the Trust's financial performance from 1 April 2016 to 31 March 2017.

2. BACKGROUND INFORMATION

2.1 The financial reporting framework of a Foundation Trust places an increased emphasis on cash and the statement of financial position as well as the management of identified key financial drivers. The Board receives a monthly summary report on the Trust's finances as well as a more detailed analysis on a quarterly basis.

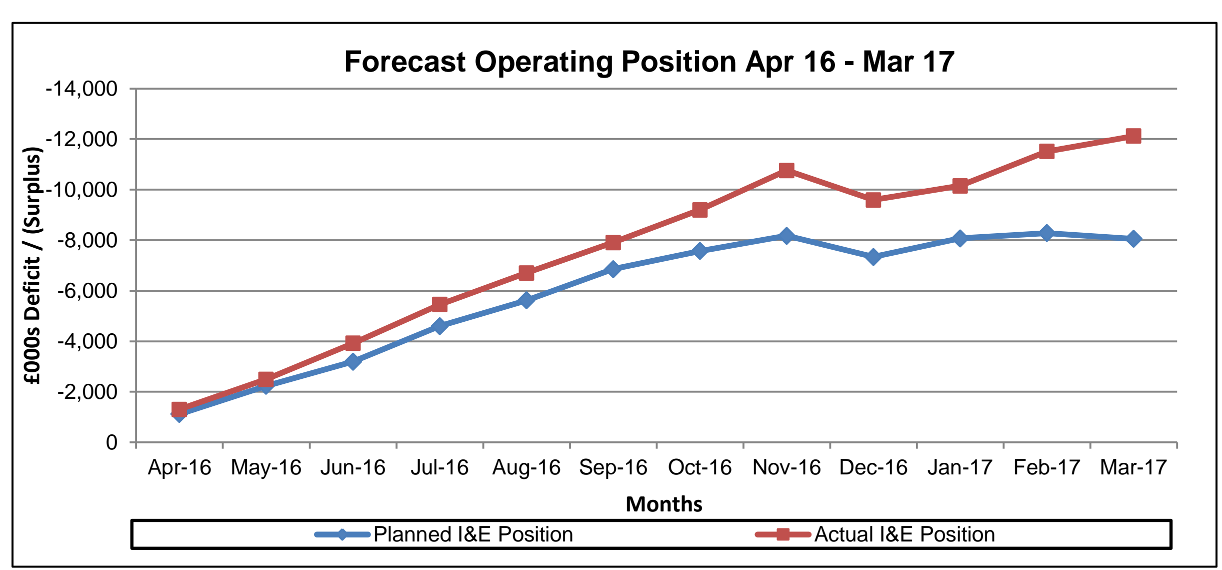
3. KEY ISSUES:

3.1 Statement of Comprehensive Income

The comprehensive income outturn for the period ending 31 March 2017 was a surplus of £12,121k, representing 3.6% of the Trust's turnover. The Trust was ahead of plan by £4,064k largely due to contract variations with commissioners, a refund of historic National Insurance payments linked to widening access trainees, and vacancies. Recruitment to posts is ongoing.

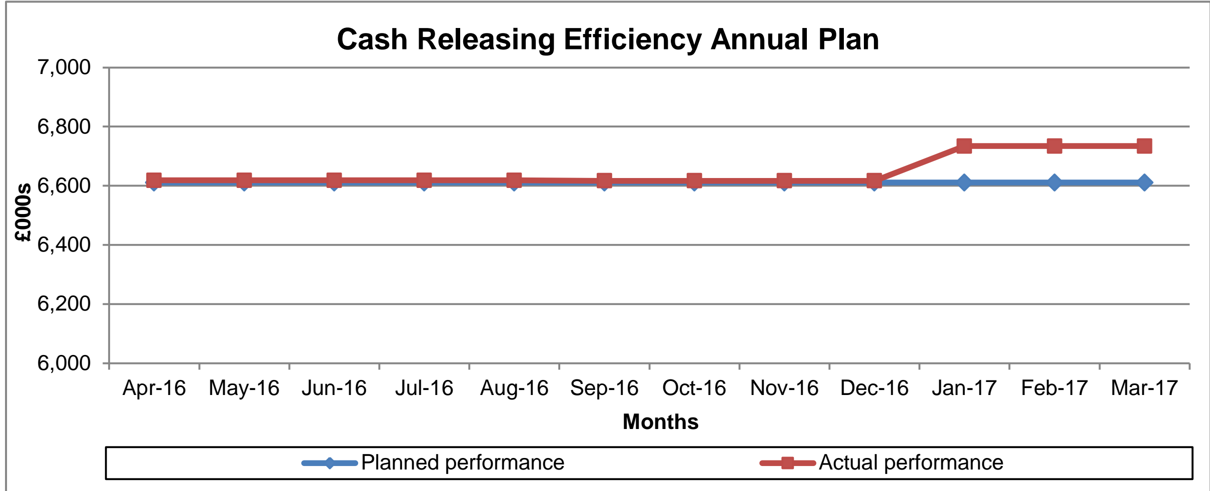
The Trust has received confirmation it will be awarded income from the incentivised sustainability and transformation fund, however the amount is unconfirmed at the time of writing. The figures reported do not include any amounts related to this.

The graph below shows the Trust's planned operating surplus against actual performance.

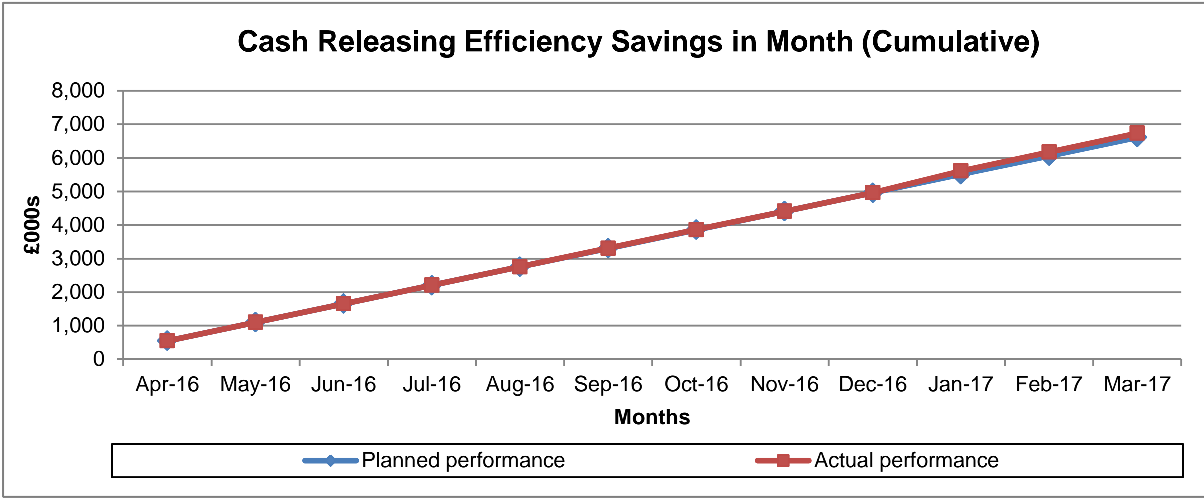


3.2 Cash Releasing Efficiency Savings

Total CRES identified at 31 March 2017 was £6,734k and was ahead of plan. The Trust continues to progress schemes to deliver CRES for future years.

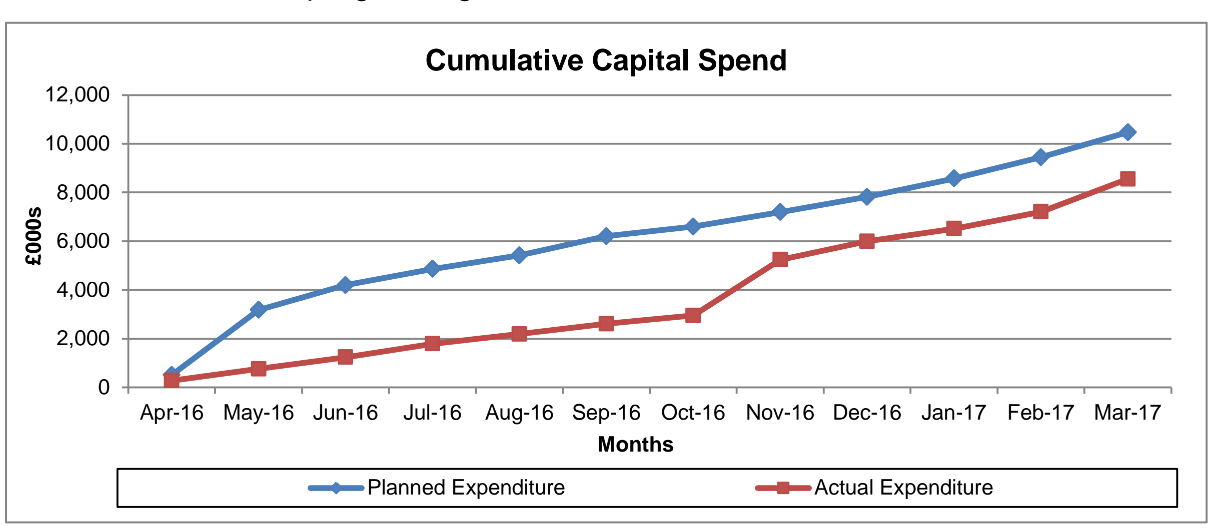


The monthly profile for CRES identified by Localities is shown below.



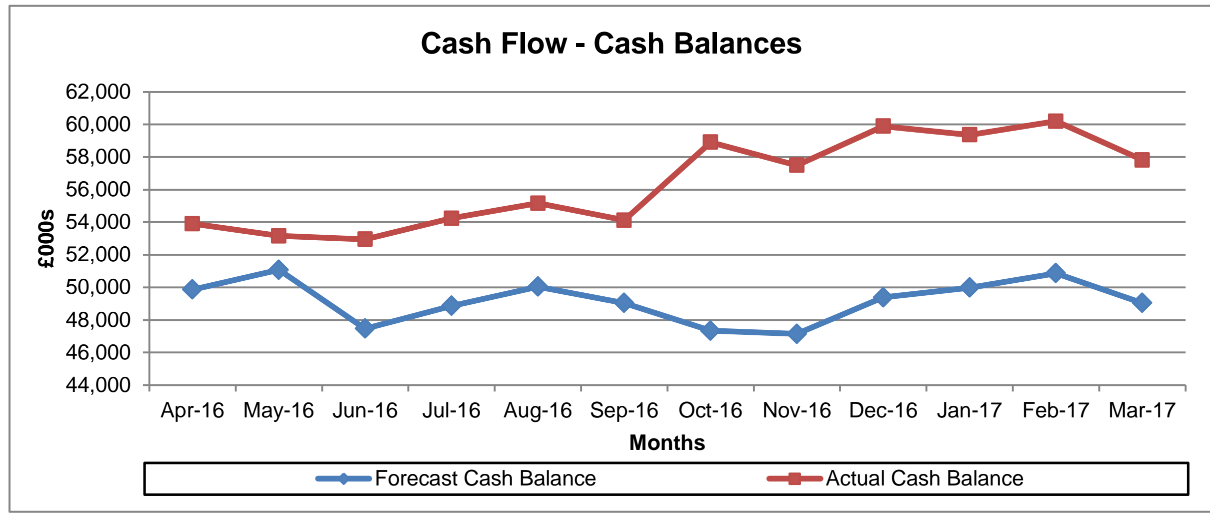
3.3 Capital Programme

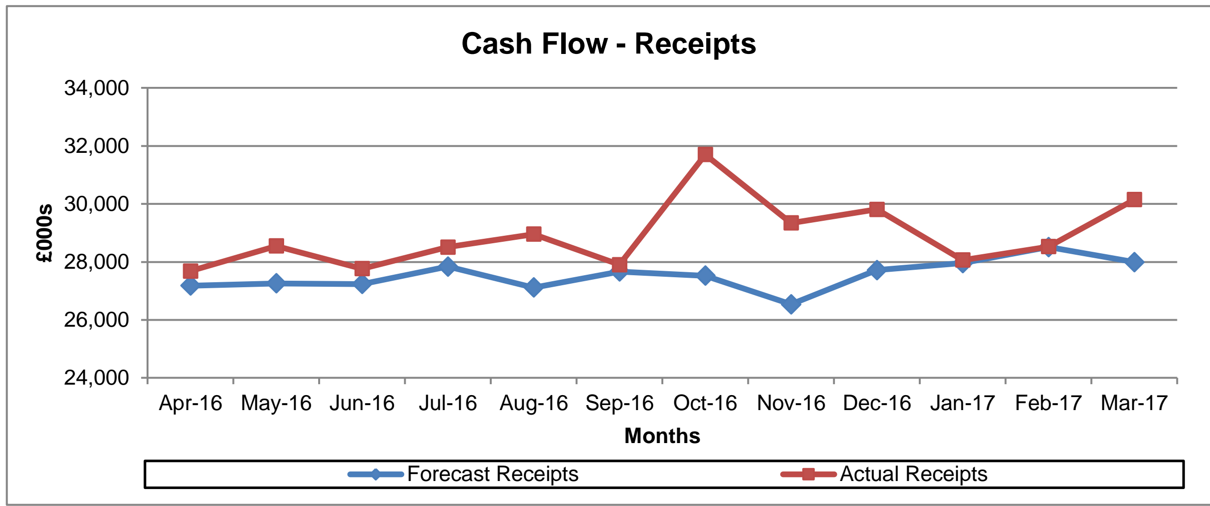
Capital expenditure to 31 March 2017 was £8,555k and was behind plan with schemes now progressing.

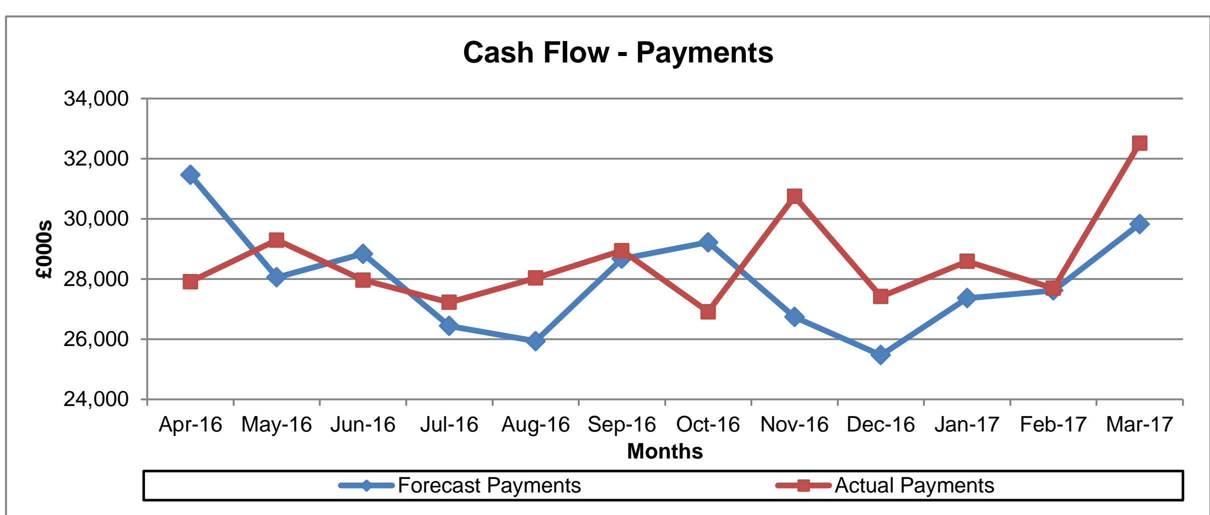


3.4 Cash Flow

Total cash at 31 March 2017 was £57,824k and was ahead of plan largely due to the Trusts surplus position, unanticipated cash receipts related to projects and some delay in the capital programme.



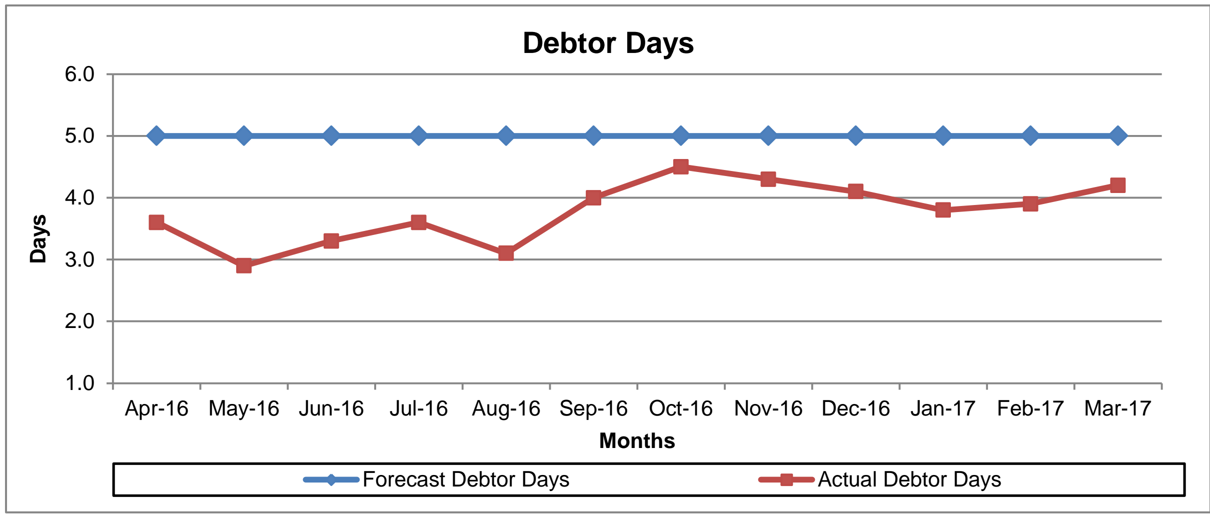




The payments profile fluctuated over the year for PDC dividend payments, financing repayments and capital expenditure.

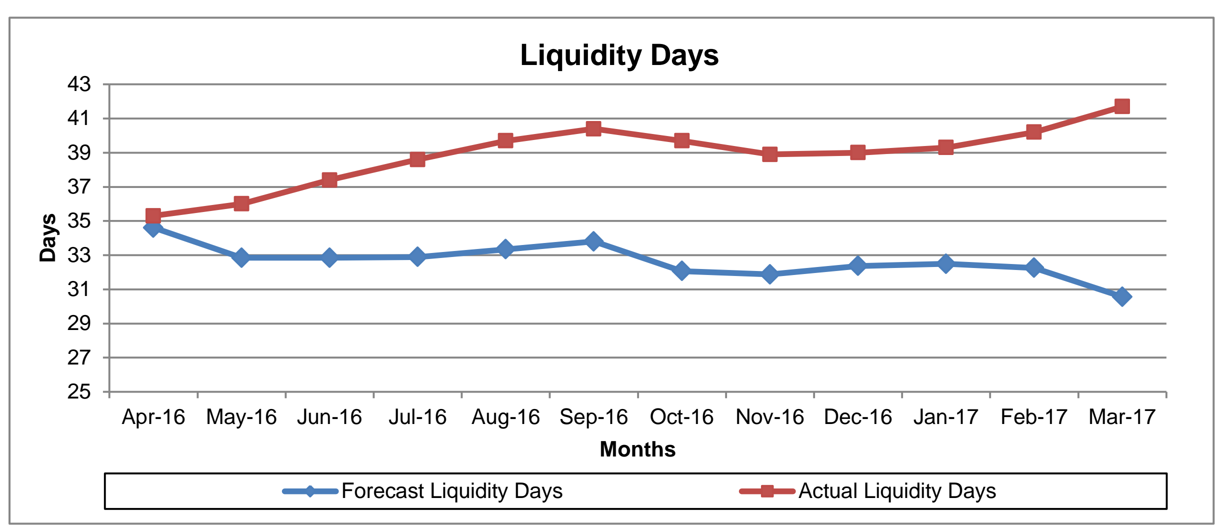
Working Capital ratios for period to 31 March 2017 were:

- Debtor Days of 4.2 days
- Liquidity of 41.9 days
- Better Payment Practice Code (% of invoices paid within terms)
  NHS – 56.64%
  Non NHS 30 Days – 97.14%



The Trust has a debtors' target of 5.0 days, and actual performance of 4.2 days at 31 March 2017, which was ahead of plan.

The liquidity days graph below reflects the metric within NHS Improvement's risk assessment framework. The Trust's liquidity day's ratio was ahead of plan.



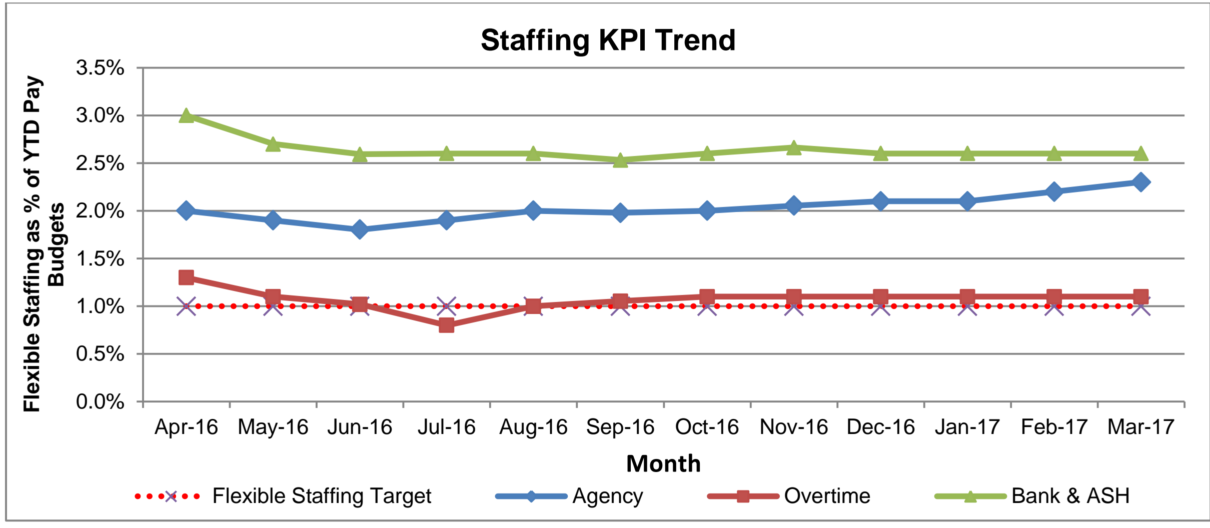
3.5 Financial Drivers

The following table and chart show the Trust's performance on some of the key financial drivers identified by the Board.

Tolerance	Oct	Nov	Dec	Jan	Feb	Mar
Agency (1%)	2.0%	2.1%	2.1%	2.1%	2.2%	2.3%
Overtime (1%)	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%
Bank & ASH (flexed against establishment)	2.6%	2.7%	2.6%	2.6%	2.6%	2.6%
Establishment (90%-95%)	94.6%	93.7%	93.7%	93.5%	93.9%	93.7%
Total	**100.3%**	**99.6%**	**99.5%**	**99.3%**	**99.8%**	**99.7%**

The tolerances for flexible staffing expenditure are set at 1% of pay budgets for agency and overtime, and flexed in correlation to staff in post for bank and additional standard hours (ASH). For March 2017 the tolerance for Bank and ASH was 4.3% of pay budgets.

The following chart shows performance for each type of flexible staffing.



Additional staffing expenditure was 6.0% of pay budgets. The requirement for bank, agency and overtime was due to a number of factors including cover for vacancies (54%), enhanced observations (18%) and sickness (13%).

3.6 Use of Resources Rating and Indicators

3.6.1 The Use of Resources Rating was assessed as 1 at 31 March 2017, and was in line with plan.

3.6.2 The capital service capacity rating assesses the level of operating surplus generated, to ensure Trusts are able to cover all debt repayments due in the reporting period. The Trust had a capital service capacity of 1.92x (can cover debt payments due 1.92 times), which was ahead of plan and rated as a 2.

3.6.3 The liquidity metric assesses the number of days operating expenditure held in working capital (current assets less current liabilities). The Trust liquidity metric was 41.9 days, this was ahead of plan and rated as a 1.

3.6.4 The income and expenditure (I&E) margin assesses the level of surplus or deficit against turnover, excluding exceptional items e.g. impairments. The Trust had an I&E margin of 4.5% and rated as a 1.

3.6.5 The variance from plan assesses the level of surplus or deficit against plan, excluding exceptional items e.g. impairments. The Trust surplus was 1.5% ahead of plan and rated as a 1.

3.6.6 The agency rating assesses agency expenditure against a capped target for the Trust. Agency expenditure was less than the cap and rated as a 1.

The margins on Use of Resource Rating are as follows:

- Capital service cover - to reduce to a 3 a surplus decrease of £2,557k was required.
- Liquidity - to reduce to a 2 a working capital reduction of £36,091k was required.
- I&E Margin – to reduce to a 2 an operating surplus decrease of £11,918k was required.
- I&E Margin variance from plan – to reduce to a 2 an operating surplus decrease of £2,427k was required.
- Agency Cap rating – to reduce to a 2 an increase in agency expenditure of £393k was required.

Use of Resource Rating at 31 March 2017

NHS Improvement's Rating Guide	**Weighting %**	**Rating Categories**			
		1	**2**	**3**	**4**
Capital service Cover	20	>2.50	1.75	1.25	<1.25
Liquidity	20	>0	-7.0	-14.0	<-14.0
I&E margin	20	>1%	0%	-1%	<=-1%
I&E variance from plan	20	>=0%	-1%	-2%	<=-2%
Agency	20	<=0%	-25%	-50%	>50%

TEWV Performance	**Actual**		**YTD Plan**		**RAG Rating**
	Achieved	Rating	Planned	Rating	
Capital service cover	1.92x	2	1.57x	2	
Liquidity	41.9 days	1	32.9 days	1	
I&E margin	4.5%	1	3.1%	1	
I&E variance from plan	1.5%	1	0.0%	1	
Agency	£5,778k	1	£6,170k	1	
Overall Use of Resource Rating		**1**		**1**	

3.6.7 11.8% of total receivables (£538k) are over 90 days past their due date. This was above the 5% finance risk tolerance, but was not a cause for concern as £384k of debts are supported by a SLA and recent discussions to resolve debts have been positive.

Excluding debts supported by an SLA the ratio reduces to 3.4%.

3.6.8 1.3% of total payables invoices (£168k) held for payment are over 90 days past their due date. This was below the 5% finance risk tolerance.

3.6.9 The cash balance at 31 March 2017 was £57,824k and represents 67.9 days of annualised operating expenses.

3.6.10 The Trust does not anticipate the Use of Resources Rating will deteriorate below a 2 in the next 12 months.

4. IMPLICATIONS:

4.1 There are no direct CQC, quality, legal or equality and diversity implications associated with this paper.

4.2 The Trust's annual accounts are subject to external audit.

5. RISKS:

5.1 Any findings from the external audit may alter the financial outturn position and associated financial risk rating indicators.

6. CONCLUSIONS:

6.1 The comprehensive income outturn for the period ending 31 March 2017 was a surplus of £12,121k, representing 3.6% of the Trust's turnover. The Trust was ahead of plan by £4,064k largely due to contract variations with commissioners, a refund of historic National Insurance payments linked to widening access trainees, and vacancies. Recruitment to posts is ongoing.

6.2 Total CRES identified at 31 March 2017 was £6,734k and was ahead of plan. The Trust continues to progress schemes to deliver CRES for future years.

6.3 The Use of Resources Rating for the Trust was a 1 for the period ending 31 March 2017 which was in line with plan.

7. RECOMMENDATIONS:

7.1 The Council of Governors are requested to receive the report, to note the conclusions in section 6 and to raise any issues of concern, clarification or interest.

Drew Kendall
Interim Director of Finance and Information

ITEM NO 16

FOR GENERAL RELEASE

COUNCIL OF GOVERNORS

DATE:	**25 May 2017**
TITLE:	**Council of Governors' Development Plan**
REPORT OF:	**Phil Bellas**
REPORT FOR:	**Assurance/Information**

This report supports the achievement of the following Strategic Goals:	✓
To provide excellent services working with the individual users of our services and their families to promote recovery and wellbeing	
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.	✓

Executive Summary:

For the Council of Governors to receive an update on its Development Plan for 2016/17 and approve its achievement.

For the Council of Governors to review the findings of the 2016 self-assessment and the workshop held on 5 April 2017 and approve its Development Plan for 2017/18.

Recommendations:

The Council of Governors is asked to receive and approve the sign off of the 2016/17 Development Plan and approve its 2017/18 Development Plan.

MEETING OF:	COUNCIL OF GOVERNORS
DATE:	25 May 2017
TITLE:	Council of Governors' Development Plan

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to enable the Council of Governors to:

a) Sign off the end year position on its Development Plan for 2016/17.

b) Approve its Development Plan for 2017/18.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 In accordance with the Foundation Trust Code of Governance the Council of Governors should periodically review its collective performance and should regularly communicate to members and the public details on how it has discharged its responsibilities including its impact and effectiveness on:

- Holding the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors.
- Communicating with their member constituencies and transmitting their views to the Board of Directors.
- Contributing to the development of forward plans of NHS Foundation Trusts.

2.2 In June 2009 the Council of Governors decided to undertake a review by self-assessment using a similar approach to that adopted for the performance evaluation of the Board of Directors. This process has been repeated in subsequent years.

3. KEY ISSUES:

3.1 A development plan was approved by the Council of Governors at its meeting held on 19 May 2016 (minute 16/35 refers) in response to issues identified from the self-assessment undertaken during 2015.

3.2 The end of year position against the 2016/17 Development Plan is provided at Annex 1 to this report.

3.3 The Council of Governors is asked to note that all actions have been fully achieved within the 2016/17 Development Plan.

3.4 A self-assessment questionnaire was issued to all Governors in post on 15/2/17. 26 Governors (57%) responded including responses from all types of Governors. The full summary of the responses received is available within the Information Pack for the meeting.

3.5 A workshop to discuss the findings of the self-assessment was held at the Governor Development Day on 5/4/17.

3.6 The overall analysis of the findings of the self-assessment for 2017/18 was very positive and reflects the training and experience gained by members of the Council of Governors. In summary:

- 50% (16 out of 32) scored higher than in 2015
- 37% (12 out of 32) scored lower than in 2015
- 4 remained static (12%)

The lowest scores relate to questions around reliance on Governors and those linked to membership and engagement.

The highest scores relate to questions around conduct, communication and roles and responsibilities.

3.7 The Governor Task and Finish Group: Representing and Engaging with Members and Stakeholders identified a number of actions which should address the perception and actions of Governors in relation to membership and engagement. These actions have not yet been fully implemented.

3.8 The findings from the self-assessment and workshop have informed the development of the Council of Governors' draft Development Plan for 2017/18 which can be found at Annex 2 to this report.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** Not applicable.

4.2 **Financial/Value for Money:** No risks have been identified.

4.3 **Legal and Constitutional (including the NHS Constitution):** The annual review supports compliance with the Foundation Trust Code of Governance.

4.4 **Equality and Diversity:** No risks have been identified.

4.5 **Other implications:** None.

5. CONCLUSIONS:

5.1 There are no issues of significant concern arising from the self-assessment. The workshop held with Governors identified that where scores were marginally lower than in previous years, this was not significant enough to cause concern and in most cases it was a result of responses stating don't know / not applicable to questions.

6. RECOMMENDATIONS:

6.1 The Council of Governors is asked to:

a) Sign-off the end of year position on its Development Plan for 2016/17 (as set out in Annex 1 to this report).

b) Approve its Development Plan for 2017/18 (as set out in Annex 2 to this report).

Phil Bellas,
Trust Secretary

Background Papers:
Council of Governors workshop findings 5/4/17
Council of Governors Development Plan 2016/17
Summary of the self-assessment completed by Governors during February 2017
Foundation Trust Code of Governance

Annex 1

ACTION PLAN

PLAN LOCATION/TEAM: COUNCIL OF GOVERNORS DEVELOPMENT PLAN 2016/17 — **DATE PLAN AGREED: 19/5/16**
PLAN DEVELOPED BY: KATHRYN ORD — **POSITION AT: 31/3/17**

NO	RECOMMENDATION/ FINDING	INTENDED OUTCOME/RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
1	To refresh the Governor Training programme.	Tailored training internal and external available to Governors.	To issue a schedule of internal training events. To issue a schedule of Governwell (external) training events.	Kathryn Ord	July 2016	• Training Programme and schedule. • Record of training undertaken by Governors.	**Completed** **Training programme launched in September 2016.**
2	To have greater contact with Non Executive Directors.	To facilitate greater understanding of the role of a Non Executive Director. To provide more opportunities for Governors and Non Executive Directors to enter into dialogue.	Non Executive Directors invited to: • Governor Development Days. (4 per year) • Council of Governor Meetings (5 per year) • Meetings with Directors of Operations (2 per year) Governors invited to attend Board and EMT visits to services (approx. 7 visits on a bi monthly basis)	Kathryn Ord / Governors	June 2016	• Schedule of meetings. • Diary records of Governors attending visits.	**Completed** • **Schedule of meetings issued for 2016 and 2017.** • **Governor Development Days – 4 per year held.** • **Meetings held with Directors of Operations – 2 per year.** • **Governors informed of Board schedule visits through Governor Briefing.**

NO	RECOMMENDATION/ FINDING	INTENDED OUTCOME/RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
3	To hold Chairman/Non Executive / Public Governor meetings twice per year.	To allow an open discussion of key issues with the Chairman. Non Executive Directors invited to attend. To provide a greater opportunity to discuss issues on an informal basis.	Dates to be set within meeting schedule. Non Executive Directors to be informed of meeting dates.	Kathryn Ord	September 2016	• Actions from meetings.	**Completed** • **Two full Public Governor / Chairman meetings held (23/2/17 & 13/7/16).** • **Three locality Public Governor/ Chairman meetings held. (19/9/16 Teesside, 8/9/16 Durham and Darlington 25/8/16 North Yorkshire and York).** • **Staff Governor meeting held 23/2/17.** • **All Appointed Governors were offered the opportunity to meet with the Chairman during 2016/17.**
4	Governors to influence the agenda setting for Governor Development Days.	Greater ownership of items being discussed that are relevant and timely for Governors. Raising awareness and providing briefings on key initiatives within the Trust.	Governors to suggest items for future agendas of Governor Development Days.	Kathryn Ord	June 2016	• Governor Development Day agenda's	**Completed** • **A schedule of topics suggested by Governors is held.** • **The priority of topics is discussed at each Governor Development Day.**

NO	RECOMMENDATION/ FINDING	INTENDED OUTCOME/RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
5	Raising awareness of the work of the Council of Governors.	Clarity on what being a Governor on the Council of Governors means. Showcasing what work Governors undertake and how this influences the work of the Trust which in turn benefits service users and carers.	For the Task and Finish Group looking at Member and Stakeholder representation and engagement to consider and recommend to the Council of Governors a proposed booklet.	Task and Finish group members.	November 2016	• Recommendations from Task and Finish Group	**Completed** **Recommendation made and approved in November 2016 and included within action plan.**
6	To ensure that the Council of Governors is fully representation in terms of its membership.	To ensure that that the positions of Appointed Governors on the Council are filled and encourage Appointed Governors to attend Council meetings and events.	To contact appointing organisations to seek representation. To include within induction events the importance of involvement of those Governors appointed by stakeholders.	Phil Bellas / Kathryn Ord	August 2016	• Membership of the Council of Governors	**Completed** **Work has been undertaken but it is the responsibility of the appointing organisation**

Annex 2

DRAFT COUNCIL OF GOVERNORS DEVELOPMENT PLAN

PLAN LOCATION: Council of Governors **PLAN DEVELOPED BY: Phil Bellas, Trust Secretary** **DATE PLAN AGREED: xxxxx**

NO.	RECOMMENDATION/ FINDING	INTENDED OUTCOME/ RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)
1	To refresh the training and development programme available for Governors	• Governors have opportunity to attend national training related to their role. • Training delivered at times suitable to enable governors to attend.	• To issue a full schedule of training and development available with dates • To ensure that all new Governors have the opportunity to attend the Core Skills national training programme • To identify, depending on roles undertaken, further national training for Governors and arrange attendance • To look to deliver training alongside other council / Governor events to reduce the time commitment required	Deputy Trust Secretary	September 2017	Training Programme Schedule Register of Governor training compliance

NO.	RECOMMENDATION/ FINDING	INTENDED OUTCOME/ RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)
2	To consider what training and / or support Governors may need to assist them to engage with the public, members and stakeholders.	• Better informed Council of Governors in terms of their statutory duty. • Governors more confident at talking and engaging with the view of seeking feedback. • Governors more confident at recruiting new members.	• To link this requirement with the recommendations and actions reported as a result of the Task and Finish Group on Member and Stakeholder Engagement and Representation. (This will include the consideration of the development of training on this topic by the Involvement and Engagement Committee)	Involvement and Engagement Committee	September 2017	Training Programme Schedule Register of Governor training compliance
3	To better inform Governors of their rights to request information or ask questions.	• For Governors to be more aware of the opportunity to request agenda items or questions for Council of Governors' meetings.	• To provide notice on when deadlines are approaching to enable questions to be included on agendas.	Trust Secretary/ Deputy Trust Secretary	September 2017	Induction programme briefing

NO.	RECOMMENDATION/ FINDING	INTENDED OUTCOME/ RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)
4	To consider the use of social media and technology to enable communication and engagement with the membership and stakeholders.	• Better mechanisms for holding conversations and obtaining feedback. • Governors able to engage better with the public, members and stakeholders. • Raise awareness of membership to a wider audience.	• To link this requirement with the recommendations and actions reported as a result of the Task and Finish Group on Member and Stakeholder Engagement and Representation. (This will include the consideration of the social media as an engagement tool by the Involvement and Engagement Committee)	Involvement and Engagement Committee	September 2017	Social media posts and summary each week on 'reaches' and 'interaction'.
5	To align issue of documentation to Governors more to their needs and requirements.	• To allow more timely sharing of information • To take into account what personal preferences Governors have to receive documents. • To reduce requirements to print on personal hardware.	• To hold a workshop with Governors to identify what is issued to them and seek recommendations on how best to match this to requirements.	Deputy Trust Secretary	October 2017	Workshop outcome Standard Process on how documents are issued to Governors.