# AGENDA FOR THE MEETING OF THE COUNCIL OF GOVERNORS

## 19 May 2015, 6.00pm

(registration and hospitality available between 5pm and 5.45pm)

**Acklam Green Centre, Stainsby Road, Whinney Banks, Acklam, Middlesbrough, TS5 4JS**

NOTE: Cllr Ann McCoy, Lead Governor will be available from 5.30pm to meet with Governors

Apologies for Absence

Standard Items

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| **Item 1** | To approve the minutes of the meeting of the Council of Governors held on 17 February 2015. | **Attached** |
| **Item 2** | Matters arising. | **Verbal** |
| **Item 3** | Declarations of Interest. | **Verbal** |
| **Item 4** | Chairman's Report. | **Verbal** |
| **Item 5** | To consider any questions raised by Governors which are not covered elsewhere on the agenda.<br>(*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.*) | **Verbal** |

1. Janice Clark, Public Governor Durham

'*How are patients made aware that they are able to view their own records when an inpatient. Current leaflets within the Trust around access to medical records do not refer to this right, only stating a Subject Access Request should be made. How are staff made aware of this right and when refusing a patient, how is this undertaken?'*

2. Sandy Taylor, Public Governor Harrogate and Wetherby

'*Has the Trust got any plans to provide mindfulness for Governors?'*

3. Paul Emerson-Wardle – Public Governor Stockton on Tees

'*Can the Trust provide an update on patient leave taken and leave cancelled within the Forensic Learning Disability Services?*

Governance

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| **Item 6** | To receive a summary of the discussions held at meetings of the Board of Directors from February 2015 until end April 2015.<br>(*Phil Bellas, Trust Secretary)* | **Attached** |
| **Item 7** | To receive and note a report on Monitor's Risk Assessment Framework.<br>(*Phil Bellas, Trust Secretary)* | **Attached** |
| **Item 8** | To consider the recommendations of the Governor Task and Finish Group reviewing the conduct of Council of Governors' business.<br>(Mary Booth, Governor Sponsor) | **Attached** |
| **Item 9** | To receive a report from the Lead Governor.<br>*(Cllr Ann McCoy, Lead Governor)* | **Verbal** |
| **Item 10** | To receive a report on the Council of Governors. Development Plan 2014/15<br>(*Phil Bellas, Trust Secretary)* | **Attached** |

Quality

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| **Item 11** | To receive an update on service changes.<br>*(Brent Kilmurray, Chief Operating Officer)* | **Attached** |
| **Item 12** | To receive and note:<br>i. A report on compliance activity in relation to the Care Quality Commission.<br>ii. An update on any items of relevance following contact with the Care Quality Commission not contained in the report at i.<br>*(Chris Stanbury, Director of Nursing and Governan* | **Attached**<br>**Verbal** |
| **Item 13** | To receive a report on the Trust's Quality Account for 2014/15.<br>*(Sharon Pickering, Director of Planning and Performance)* | **Attached** |

Performance

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| **Item 14** | To receive and note the Performance Dashboard as at end March 2015.<br>*(Sharon Pickering, Director of Planning and Performance)* | **Attached** |
| **Item 15** | To receive and note the Finance report as at end March 2015.<br>*(Colin Martin, Director of Finance)* | **Attached** |

Items for Information

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| **Item 16** | To receive and note an update on the work of the Thematic Committees of the Council of Governors:<br>i. Promoting Social Inclusion and Recovery (Cllr Ann McCoy, Chairman)<br>ii. Making the Most of Membership *(Sandy Taylor, Chairman)*<br>iii. Improving the Experience of Service Users *(Catherine Haigh, Chairman)* | **Verbal** |
| **Item 17** | To receive and note feedback reports from:<br>i. Catherine Haigh, Governor Representative on the Patient Experience Working Group<br>ii. Betty Gibson, Governor Representative on the Equality, Diversity and Human Rights Steering Group | **Attached** |

Procedural Items

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| **Item 18** | Date and Time of next meeting<br>7 July 2015, 6pm venue to be confirmed | **Verbal** |

Confidential Motion

**Item 19** *"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.*

*Information which, if published would, or be likely to, inhibit -*
*(a) the free and frank provision of advice, or*
*(b) the free and frank exchange of views for the purposes of deliberation, or*
*(c) would otherwise prejudice, or would be likely otherwise to prejudice, the effective conduct of public affairs."*

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

# MINUTES OF THE COUNCIL OF GOVERNORS MEETING HELD ON 17 FEBRUARY 2015, 2.00 PM AT MIDDLESBROUGH FOOTBALL CLUB

**PRESENT:**
Lesley Bessant (Chairman)
Cliff Allison (Durham)
Mary Booth (Middlesbrough)
Janice Clark (Durham)
Dr John Drury (CCG representative for Hartlepool, Stockton on Tees and South Tees)
Paul Emerson-Wardle (Stockton on Tees)
Andrew Everett (Durham)
Stuart Fawcett (Durham)
Betty Gibson (Durham)
Chris Gibson (Harrogate and Wetherby)
Andrea Goldie (Darlington)
Catherine Haigh (Middlesbrough)
Cllr Tony Hall (North Yorkshire County Council)
Simon Hughes (Staff, Teesside)
Prof Pali Hungin (Durham University)
Keith Marsden (Scarborough and Ryedale)
Cllr Ann McCoy (Stockton Borough Council)
Jean Rayment (Hartlepool)
Gillian Restall (Stockton on Tees)
Zoe Sherry (Hartlepool)
Dr David Smart (CCG representative for Co Durham and Darlington)
Sarah Talbot-Landon (Durham)
Sandy Taylor (Harrogate and Wetherby)
Richard Thompson (Scarborough and Ryedale)
Judith Webster (Scarborough & Ryedale)
Vanessa Wildon (Redcar and Cleveland)
Colin Wilkie (Hambleton & Richmondshire)

**IN ATTENDANCE:**
Martin Barkley (Chief Executive)
Phil Bellas (Trust Secretary)
Angela Grant (Membership Administrator)
Dr Hugh Griffiths (Non Executive Director)
Marcus Hawthorn (Non Executive Director)
David Jennings (Non Executive Director)
Ulrike Klaerig-Jackson (Team Secretary)
David Levy, (Director of Human Resources and Organisational Development)
Barbara Matthews (Non Executive Director)
Mike Newell (Non Executive Director)
Donna Oliver (Deputy Trust Secretary)
Kathryn Ord (Deputy Trust Secretary)
Sharon Pickering (Director of Planning and Performance)
Richard Simpson (Non Executive Director)
Jim Tucker (Deputy Chairman)

**OBSERVERS:**

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| Staff Members: | Fiona Bainbridge, Ruth Hill |
| Student Nurses: | Sheena Foster, Lawrencia Apimah, Carley Bowen, Kelly Chapman, Sarah Clark, Hannah Clark, Tara Downes, Beth Easton, Angela Goggs, Danielle Graham, Danielle Greenfield, Rachel Harper, Nicole Hallet, Sarah Caney, Tanya Danowski. |

**15/01 APOLOGIES**

Stephen Akers- Belcher (Hartlepool Borough Council)
Richenda Broad (Middlesbrough Council)
Vince Crosby (Durham)
Hilary Dixon (Harrogate and Wetherby)
Jacqui Dyson (Staff, Durham and Darlington)
Gary Emerson (Stockton on Tees)
Claire Farrell (Redcar and Cleveland)
Glenda Goodwin (Staff, Forensic)
Dennis Haithwaite (Darlington)
Dr Judith Hurst (Staff, Corporate)
Lesley Jeavons (Durham County Council)
Prof Paul Keane (University of Teesside)
Brent Kilmurray (Chief Operating Officer)
Dr Nick Land (Medical Director)
Colin Martin (Director of Finance)
Debbie Newton (representative for North Yorkshire Clinical Commissioning Groups)
Wendy Pedley (Staff, North Yorkshire)
John Robinson (Senior Independent Director)
Chris Stanbury (Director of Nursing and Governance)
Angela Stirk (Hambleton and Richmondshire)
Prof Ian Watt (University of York)
Mark Williams (Durham)
Ann Workman (Darlington Borough Council)

**15/02 WELCOME**

The Chairman opened the meeting and welcomed public observers and Governors, Sarah Talbot Landon, Dr David Smart and Dr John Drury to their first meeting.

A special thanks was given to Prof Paul Keane (apologies provided) who would be stepping down from his role as Appointed Governor representing Teesside University at the end of February 2015 and Mike Newell Non Executive Director who was attending his last meeting prior to his retirement from the Board at the end of March.

**15/03 MINUTES OF PREVIOUS MEETING**

The Council of Governors considered the minutes from public meeting held on 27 November 2014.

***Agreed – That the minutes of the meeting held on 27 November 2014 be approved and signed by the Chairman.***

**15/04 MATTERS ARISING**

There were no matters arising.

**15/05 DECLARATIONS OF INTEREST**

There were no declarations of interest.

**15/06 CHAIRMAN'S REPORT**

The Chairman reported on her activities since November 2014. She had:

(1) Met with Dr David Smart to discuss relationships between the Trust and Clinical Commissioning Groups (CCGs).
(2) Accompanied Dr Ingrid Whitton on ward rounds at West Park Hospital in Darlington.
(3) Presented Living the Values awards to staff and teams at the:
- Briary Wing at Harrogate District Hospital.
- Holly Unit at West Park Hospital.
- Stockton Children and Adolescent Mental Health Services (CAMHS) where a receptionist had received a citation from a member of the pubic on the difference they had made to visits to the service.

(4) Visited Westerdale Ward at Roseberry Park.
(5) Attended a meeting of the NHS Providers Network in London.
(6) Been involved in the recent inspection of the Trust by the Care Quality Commission (CQC).

**15/07 GOVERNOR QUESTIONS**

1. Cllr Ann McCoy, Appointed Governor Stockton Borough Council

'*With regards to the recent case of a nurse who was struck off by the Nursing and Midwifery Council following a charge of harassment and criminal damage. The report stated that the Panel Chairman commented that their behaviour had put staff and patients at risk. The report also states that they had not informed the Trust of the charges faced. Considering Adult Safeguarding, is there anything in the Terms and Conditions of employment that require an employee to inform the Trust of any charges they face that could impact on the safety of staff and patients?'*

A written answer had been provided to Cllr McCoy which had been circulated with the agenda outlining:

(1) The requirement was for staff to inform the Trust, as their employer, of any charges or convictions of criminal offences.
(2) That an overarching information sharing agreement between the Trust and partner agencies was in place for when matters may have an impact on the safety or treatment of patients.
(3) When charges or allegations were managed by the police, the Trust would be informed if offences against children or vulnerable adult were of an abusive nature. Any offences that were criminal in nature but did

not fall within this category, the reliance was on the staff member to report this to the Trust.

(4) If a registered professional was convicted, the police were obliged to inform the relevant regulatory body, however if no disclosure had been made about the employer, the Trust may not be notified.

Cllr McCoy requested that the Tees-wide Adult Safeguarding Board be advised of this instance.

**Action Item: Mrs Stanbury**

2. Cllr Ann McCoy, Appointed Governor Stockton Borough Council

*'Is it mandatory for Trust staff to attend Mental Health Act and/or Mental Capacity Act training, and how does this compare against other Mental Health Trusts?'*

A written answer had been provided to Cllr McCoy which had been circulated with the agenda outlining:

(1) That Mental Health and Capacity Act training had not been mandated for staff. However, this was integral to the professional requirements of Trust staff.

(2) The recent Care Quality Commission (CQC) inspection had recognised the significant evidence of staff being trained and understanding the implementation of the relevant Acts.

(3) The Trust would re-consider if there was a requirement to mandate this training.

3. Janice Clark, Public Governor, Durham

*a. How does the Trust record the number of data breaches that occur?*
*b. How does the Trust record the outcome of investigations into these data breaches?*
*c. Can the Trust explain why it did not respond to a Freedom of Information request sent to all NHS trusts in April 2014 by Big Brother Watch?*
*d. Can the Governors be provided with the information that was requested by Big Brother Watch in April 2014?'*

A written answer had been provided to Ms Clark which had been circulated with the agenda outlining:

(1) A computerised system (DATIX) was the mechanism used by the Trust to record and report on all incidents including those of an Information Governance nature.

(2) Assessment of all incidents was undertaken using guidance issued by the Health and Social Information Centre (HSCIC). Any incident classed as a level 2 or above was visible to the Information Commissioners Office (ICO). Incidents below level 2 in nature were investigated by the Trust's Information Governance Department.

(3) Outcomes of investigations result in a report issued to the relevant line manager with recommendations for any disciplinary action.

(4) The Trust did receive a request under the Freedom of Information Act 2000 in April 2014; it was acknowledged that this was not responded to.
(5) The information requested at (4) above was provided to Ms Clark, with the omission of the reasons for breaches of data protection. This would be followed up and circulated.

**Action Item – Mrs Ord**

**15/08 BOARD OF DIRECTORS FEEDBACK**

Mr Bellas presented the report containing the Board roundup summaries from November 2014 to January 2015 for information and to allow questions and clarification of any matters. He reminded Governors that:

(1) Copies of private Board of Director's minutes were available for viewing at each Council of Governors' meeting.
(2) Dates of Board of Directors meetings had been circulated to allow Governors to express their interest in observing. These would be re-circulated.

**Action Item – Mrs Ord**

Arising from a question, Mr Barkley clarified that the Malcolm Rae action plan was:
(1) As a result of four deaths occurring during February 2013 in the Derwentside Affective Disorder Team.
(2) Mr Rae had been appointed by the Trust to investigate the circumstances of the deaths and identify opportunities for improvement.
(3) The Board of Directors received an initial report in July 2013 containing an action plan as a result of each death and one overarching action plan in relation to the outcome of the investigations.
(4) The action plan referred to in the Board of Directors discussions was the progress against the overarching action plan developed by Mr Rae.

***Agreed – The Council of Governors received and noted the content of the Board round up from November 2014 to January 2015 inclusive.***

**15/09 MONITOR RISK ASSESSMENT FRAMEWORK**

The Council of Governors received a report on the Trust's position against the requirements of Monitor's Risk Assessment Framework.

It was noted that:
(1) The Board of Directors had agreed (on 27 January 2015) the Quarter 3 2014/15 submission to Monitor of:
  (a) A continuity of service risk rating of '4' in line with plan with a declaration of that the Trust would maintain a continuity of service risk rating of at least '3' for the next 12 months.
  (b) Confirmation that no subsidiaries were included within the financial results. The Council noted that although the Trust had established a subsidiary no trading had been undertaken.
  (c) Information on the Trust's performance against the governance targets as contained within the report.
  (d) Confirmation of the two governance statements.

(e) A reported governance rating of 'green'.

(f) An exception report was being provided to Monitor as a result of the compliance issues and 'moderate' concerns' arising from the CQCs inspection of Forensic Learning Disability wards at Roseberry Park Hospital, Middlesbrough in March 2014.

(g) The action plan in response to previous compliance actions arising from the CQCs inspection of The Dales in Stockton on Tees had now been signed off by the CQC.

(h) One reported resignation within the quarter, Mrs Stanbury, Director of Nursing and Governance's intention to retire in July 2015.

(2) Monitor had issued a consultation document on proposed changes to its Risk Assessment Framework.

***Agreed – The Council of Governors received and noted the content of the Monitor Risk Assessment Framework for Quarter 3, 1 October 2014 – 31 December 2014.***

**15/10 TASK AND FINISH GROUP – Review of the Conduct of Council of Governors' Business**

Mrs Booth, Governor Sponsor reported on the work of the Governor Task and Finish Group which was undertaking a review of the conduct of Council of Governors' business.

(1) Two meetings had been held looking at:

- How other Foundation Trusts structured their meetings.
- Locations and seating arrangements for meetings.
- How reports were currently presented based on Governor requirements.
- The work undertaken by Committees and Governor Development Days.

(2) A number of proposals would be presented and consulted on at the Governor Development Day on 17 March 2015.

***Agreed – The Council of Governors received and noted the update on the work of the Governor Task Group - review of the conduct of Council of Governors' business.***

**15/11 ENGAGEMENT AND INVOLVEMENT STRATEGY 2015/18**

Mr Bellas presented the Trust's proposed Engagement and Involvement Strategy and advised that:

(1) The Making the Most of Membership Committee had, in the past, developed and monitored the Trust's Membership Strategy.

(2) Within a previous version of the Trust's Membership Strategy, a recommendation had been made to bring together Patient and Public Involvement (PPI) and Membership 'databases' to provide greater inclusiveness. This had not been achieved due to the division of teams and remits.

(3) Following an organisational change in December 2014, the role of PPI transferred into the Trust Secretary's Department, this would now allow the previous views of the Council of Governors to be re-visited in terms of aligning PPI with Membership.

(4) Key areas addressed within the draft strategy were as a result of:
  (a) No current overarching Strategy for involvement.
  (b) A requirement to review the current Membership Strategy.
  (c) Differing methods and payment structures.
  (d) No central mechanism for recording interests and involvement, as a result more than one database in place to record personal information.
  (e) Opportunities available not necessarily coordinated.
  (f) Demand for involvement and engagement growing.

(5) The Making the Most of Membership Committee had been initially consulted on the draft and would discuss in detail at their meeting on 4 March 2015.

The following questions were raised:

(1) How would the views of the public, service users and carers be sought if they were not members of the Trust?
(2) How could those service users who do not wish to be a member of the Trust but who still wish to participate in involvement activity be included?
(3) The strategy implied that the general public were the same as service users and carers. It does not emphasise involvement of service users and carers.
(4) How have service users and carers been involved in the Strategy development?
(5) How would younger people be encouraged to be involved?
(6) How would this affect the volunteering service and its register of volunteers?
(7) What process would be undertaken in terms of future consultation?
(8) The consultation was welcomed as personal difficulties had been encountered in trying to volunteer and how to get involved in key pieces of work undertaken by the Trust.
(9) How would an easy read version of the Strategy be developed.

In response Mr Bellas advised that:

(1) It was not always possible for involvement and engagement to be undertaken with members and targeted which would need to be carried out in certain circumstances eg with regard to patients on individual wards.
(2) Engagement and Involvement would not just be limited to membership, there would clearly be times when wider ranging 'public' consultation for example would be required.
(3) Development of a single register for involvement would provide greater confidence and assurance and provide greater equity of opportunities and ensure that the appropriate people were involved in the relevant areas, based on their skills and experience.
(4) There was recognition that not everyone would wish to become a member of the Trust. The key area to overcome was why someone would not wish to be a member. It was important to ensure that the right message was conveyed.
(5) The development of a single database would assist in recruiting members for the Trust, whilst enabling aspirations of those involved members to be identified.
(6) The Strategy did aim to address service users and carers whilst also addressing the statutory duty of the Governors in terms of the general public.
(7) The Strategy sought to expand the number of service users and carers involved, and for those service users and carers to be identified, where

required, to have 'recent' experience of services. This would help address the current concerns that experiences were not necessarily recent.

(8) The consultation process was only in its initial stages and further discussions would be held with the Making the Most of Membership Committee to define requirements.

The Chairman thanked the Council for their comments and asked the Making the Most of Membership Committee to review the Strategy whilst addressing the comments and concerns of the Council.

***Agreed - That the Making the Most of Membership Committee review the Trust's Involvement and Engagement Strategy, determine any future consultation requirements and report back to the Council of Governors at a future meeting.***

**15/12 CANCELLED APPOINTMENTS**

Further to minute 14/79 Mrs Pickering advised that:

(1) In determining the average number of cancelled appointments, due to the time difference within the reporting period (8 months compared to 5 months) an overall average position had been calculated as shown within the report.

(2) The average had been calculated using the monthly average number of cancellations per 10,000 open cases.

(3) Improvement had been seen over the time periods in question in all services, with the exception of Children and Young People.

(4) The largest improvement had been seen within Adult Mental Health Services.

(5) Mental Health Services for Older People was improving but remained the highest service cancelling appointments within North Yorkshire and also higher than the rest of the Trust.

(6) Staff sickness, maternity leave and administrative support have all been issues within the area. Work was underway to see if this had impacted on appointments.

Clarification was sought on the following:

(1) What actions had been undertaken to result in the improvements seen.

Mrs Pickering advised that she was not aware of any particular actions. Researching the data and speaking to services may have raised the awareness of the number of cancellations that were occurring, which in turn has resulted in improvements. The Director of Operations would be asked if any specific changes in staffing, service provision had been undertaken.

**Action Item – Mrs Pickering**

(2) Cancelled appointments reported on were confirmed as being cancelled appointments by the Trust.

Cllr Hall acknowledged the improvements seen and requested a further report be presented including information on any staffing implications.

***Agreed – A further report on the position of cancelled appointments for the Hambleton, Richmondshire and Whitby CCG area to be provided in September.***

**Action Item – Mrs Pickering**

**15/13 COMPLIANCE ACTIVITY RELATING TO THE CARE QUALITY COMMISSION (CQC)**

Arising from the report Mr Kilmurray advised that:

(1) The Trust had undergone its inspection by the Care Quality Commission (CQC) which commenced on 19 January 2014 in North Yorkshire.
(2) All inpatient and rehabilitation wards and a third of community teams had been inspected.
(3) Leading up to the inspection the Trust had established a CQC Project Board to assist the Trust to prepare for the inspection.
(4) Mock inspections had been undertaken in all areas in preparation and work/actions put in place to address any concerns prior to the CQC inspection.
(5) CQC had met with detained patients and spoken with a number of Carers.
(6) Focus groups had been held by CQC with a range of staff groups, stakeholders and partners. All had been well attended with the exception of Approved Mental Health Practitioners.
(7) Verbal feedback had been provided at the conclusion of the inspection by the CQC highlighting some areas of concern and notable practice.
(8) A draft report was expected by the Trust on 2 April 2015 for which there would be 10 working days to respond.
(9) A quality summit would be held by the CQC on 5 May 2015 to which the Trust and external partners would be invited to.
(10) The final report was expected to be published a few days following the Quality Summit meeting.
(11) In addition to the Trust's CQC inspection, a further seven Mental Health Act monitoring reports had been received and the report following the visit of the CQC in relation to Seclusion and Segregation and management of Section 120 of the Mental Health Act.

Arising from a question Mr Barkley confirmed that the Trust researched other Trust inspections in order to learn lessons and identify trends and themes.

***Agreed – The Council of Governors received and noted the report submitted to the Quality and Assurance Committee in relation to the Care Quality Commission.***

**15/14 UPDATE ON SERVICE CHANGES**

Mr Kilmurray updated on key service changes including:

(1) Durham and Darlington
- The Trust had been successful in its bid with Lifeline to provide drug and alcohol services from 1 April 2015.
- A dedicated Section 136 suite at Lanchester Road Hospital would be provided from resilience funding received.

- Increased referrals were being received within Adult Mental Health, with an average of 1000 referrals compared to 600 for the same population in Teesside.
- The reduction of dementia care beds (5) had been completed.
- Funding had been provided for an additional 6 staff to meet increasing needs within Children and Young People's Services.
- Work was taking place within Learning Disability Services to provide individual flats for patients with complex needs, a new service model had been designed for those patients on the Winterbourne list and a business case had been submitted to commissioners for a specialist community learning disability model service.

(2) Teesside

- Agreement had been given by commissioners to provide a single access point for crisis services.
- The roll out of the model lines approach in psychosis teams had been successful within Hartlepool.
- Problems were still being experienced in meeting the demand for autism assessment and adults with ADHD, although waiting times were being managed.
- Occupancy on Westerdale South had been manageable but increases had been seen in the acuity of patients.
- A delirium screening service had been established as a result of problems occurring within acute trusts, with funding up until March.
- Children and Young People's (CYP) Crisis Services was expected to commence prior to March following the recruitment of staff.
- CYP service waiting times were being managed, however due to referral levels further reductions were proving difficult.

(3) North Yorkshire

- A new chaplain had been appointed, Graham Peacock who was due to start work in March 2015.
- The Orchards Rehabilitation Unit in Ripon was due to open in May 2015.
- An improvement event across Hambleton and Richmondshire was held in January 2015 to develop a single point of access across adult and older people's services. Full implementation was expected in April 2015.
- Transfer of the eating disorder service had been successful in October 2014 with all posts now fully established.
- Three locality manager posts had been appointed to.
- The Scarborough hospital liaison service commenced in January 2015.
- New clinical appointments had been made in Children and Young People's Services.
- Service users and carers had contributed to an improvement event to look to remodel the Learning Disability service.

(4) Forensic

- Significant progress had been made in reducing restrictive practice within secure services.
- Prison service mobilisation plans had continued to be developed.

- A further tender for Liaison and Diversion services had been submitted.
- Individual reviews of patients had been undertaken in Forensic Learning Disability services which had been extremely time consuming. Initial feedback was that care plans and discharge plans had been appropriate.
- A national audit office report had been received for Forensic Learning Disability service.

Clarification was sought on the following:

(1) Where are patients admitted to within North Yorkshire Eating Disorder Services?

Mr Barkley confirmed that inpatient services were provided from the Retreat in York, and under 18's were admitted to the Limetrees in York.

(2) Was there any further information for Autism Services and ADHD services for Teesside?

Mr Barkley advised that the main issue was as a result of capacity. Discussions were taking place with the Clinical Commissioning Groups (CCGs).

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

**15/15 QUALITY ACCOUNT 2014/15 QUARTER 3**

Mrs Pickering presented the Quarter 3 update of the Quality Account 2014/15 including:

(1) Four priorities had been identified for 2014/15.
(2) Various metrics were in place (24) for the Trust to report progress against linked to the four priorities.
(3) The Trust was reporting 'green' against 15 of the 24 metrics.
(4) In relation to the management of falls, the Trust had reinstated its Trustwide Falls Management Group.

***Agreed – The Council of Governors received and noted the Quarter 3 update of the Quality Account 2014/15.***

**15/16 FINANCE REPORT**

With regard to the finance report for the period up to 31 December 2014 it was noted that:

(1) The comprehensive income outturn showed a deficit of £2,921k equivalent to -1.4% turnover due to the unplanned impairments. Excluding the impact of those impairments the Trust had a surplus of £7,301k, £1,346 ahead of plan.
(2) Cash Releasing Efficiency Savings (CRES) were £607k ahead of plan with schemes continuing to be identified to meet the required level for 2015/16 and 2016/17.
(3) The continuity of services risk rating remained as 4.

Following a request for clarification Mrs Pickering advised:

Debt Service Cover:
i.) This was a Monitor indicator.
ii.) The purpose of the indicator was to ensure that the Trust could afford to pay its debts.
iii.) The Trust's current performance was '3'.
iv.) A £2m reducing in surplus would need to occur for the Trust to move to a position of '2'.

Liquidity:
i.) This was an indicator that looked at how much money was in the bank.
ii.) It focussed around if no other income was received by the Trust, how long could the Trust continue to operate for.
iii.) the Trust was currently at a '4'. To move to a '3' rating the Trust would need a £24m reduction.

Mr Barkley confirmed that the total amount of receivables reported (8%) which were over 90 days past their due date were likely to be from CCGs or NHS England and linked to issues around payment methods.

***Agreed - The Council of Governors received and noted the Finance report as at end of December 2014.***

**15/17 PERFORMANCE DASHBOARD**

In receiving the report the following issues were raised:

(1) In terms of the waiting times for Early Intervention in Psychosis (EIP), and the number of referrals, was the Trust expecting those targets not being met?

Mrs Pickering advised that a baseline had previously been taken in terms of target setting. A national recommendation had now been received for which the Trust needed to re-consider targets. The Trust's expectation was for this target to be achieved.

(2) In terms of performance, was there any breakdown available for locality areas, specifically Redcar and Cleveland?

Mrs Pickering advised that as some services cut across localities it would be difficult to drill down to a particular area. If there was a particular service that was of concern, then this could be provided, however it would be easier to do this outside of the standard performance dashboard at Council meetings.

(3) In terms of key indicator number 18, *Recovery Rate – Adult IAPT: the percentage of people who complete treatment who are moving to recovery*. What constitutes recovery? And how does the Trust's performance compare to national benchmarking

Mrs Pickering confirmed that NHS England have a detailed definition for Recovery in relation to IAPT services which is measured by two clinical outcome tools within the service.

In terms of performance the Trust is one of the highest performers. In addition:

i.) Consideration of including this target within the contract for Any Qualified Provider (AQP) contractors was underway.
ii.) There were some patients who attended the service, with a high level of clinical need who did make a good recovery, but not at the level that was significant enough to meet the threshold within the reporting tool.
iii.) North Yorkshire CCGs have requested analysis of where ii.) above occurs.

(4) For those patients who had waited longer than four weeks, was patient choice to wait longer included within the figures?

Mrs Pickering confirmed that the current reporting systems used within the Trust did not allow for the exclusion of patient choice. The target set takes into account that in some instances, some patients through choice, would wait longer than four weeks.

(5) How was the Trust working on improving the achievement of staff appraisals? The same level had now been achieved since April 2014?

Mr Levy advised that the Trust had introduced a new appraisal system which encouraged staff participation. Staff survey results indicated that appraisals held resulted in 92% achievement but the Trust was currently reporting at 80% against a target of 95%. The same had been seen for mandatory training which had impacted on Fire and Infection Control training.

The introduction of pay progression had resulted in an impact on improving the number of appraisals and mandatory training undertaken.

***Agreed - The Council of Governors received and noted the Performance Dashboard report as at end of December 2014.***

**15/18 COMMITTEE UPDATES**

The Chairman invited the Chairmen of the thematic Governor Committees to update the Council of Governors on their work.

**1. <u>Promoting Social Inclusion and Recovery, Cllr Ann McCoy, Chairman, Miss Catherine Haigh, Vice Chairman</u>**

The Committee met on 5 December 2014, items discussed were around:

- World Mental Health Day plans and feedback from events held in Newcastle, Middlesbrough and Gateshead led by North East Together.

- The feedback received from the Murton Mams in relation to the Connecting Communities project which had been highly positive around their achievements. A letter of thanks had been sent to the group.
- TEWV Arts - The Committee had supported Ripon Cathedral as the host venue for this year's exhibition. Information was also provided on the creation of Arts link volunteers.
- NICE Guidance audit plans which had been developed for Bipolar disorders and with audit programme for Schizophrenia had now been completed.

Future work priorities focussed around:

- An update on the volunteer strategy.
- TEWV Arts.
- Recovery project.
- World Mental Health day plans.
- Training provided to Associate Hospital Managers.
- NICE Guidance for physical health.
- Recovery college update.

**2. Making the Most of Membership, Mr Sandy Taylor, Chairman, Mrs Betty Gibson, Vice Chairman**

The Committee met on 1 December 2014, items discussed were around:

- Engagement events that had been held.
- Annual General and Members Meeting with agreement of Young Carers as a theme.
- Planning of future engagement events and further trials of information showcase events.
- Insight magazine review and planning for Spring issue.

Future work priorities focussed around:

- Planning for the Annual General and Members Meeting.
- Developing the Involvement and Engagement Strategy.
- Monitoring membership levels.
- Establishing requirements for engagement activities.
- Insight magazine content.

**3. Improving the Experience of Service Users, Miss Catherine Haigh, Chairman, Miss Vanessa Wildon, Vice Chairman**

The Committee met on 6 November 2014, items discussed were around:

- The outcome of a food tasting exercise by the Committee, where a range of dishes were served within a setting similar to a ward for sampling. Feedback was:
    - Generally positive.
    - The temperature of some dishes was not hot enough.
    - The colour and appearance of certain dishes was not inspiring.

- The latest position on the friends and family test
- The future of the committee in terms of taking forward work.

**Recommendation:** The Committee requested that the current Task and Finish group reviewing the conduct Council of Governors' business look at the current Committee structure and recommend whether this continued to meet the Council's need.

Mr Barkley responded to the Council on the recommendation to review the Thematic Committees of the Council of Governors and agreed that it was an appropriate time to conduct this. The Committees had been in place for over 6 years now, but a key element was to ensure that key feedback continued to be captured and Governors remained informed and involved.

***Agreed - That the:***

1. ***Council of Governors received and noted the updates from its thematic Committees.***
2. ***That the Governor Task and Finish group reviewing the conduct of business by the Council of Governors includes within its remit a review of its four Thematic Committees:***
   - ***a.) Improving the Experience of Service Users***
   - ***b.) Improving the Experience of Carers***
   - ***c.) Promoting Social Inclusion***
   - ***d.) Making the Most of Membership***

**15/19 APPOINTMENT TO THE NHS PROVIDERS GOVERNOR POLICY BOARD**

***Agreed – The Council of Governors supported the submission of the nomination from Mrs Mary Booth, Public Governor Middlesbrough to become a member of the NHS Providers Governor Policy Board.***

**15/20 CONFIRMATION OF NEXT MEETING**

The Chairman confirmed the next meeting as 19 May, 6pm at Middlesbrough Football Club.
NOTE: DUE TO VENUE AVAILABILITY THIS HAS NOW CHANGED TO THE ACKLAM CENTRE IN MIDDLESBROUGH.

**15/21 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 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.*

*Information which, if published would, or be likely to, inhibit -*
*(a) the free and frank provision of advice, or*
*(b) the free and frank exchange of views for the purposes of deliberation, or*
*(c) would otherwise prejudice, or would be likely otherwise to prejudice, the effective conduct of public affairs.*

The Chairman closed the public session of the meeting at 3.35pm.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

**Item 6**

# COUNCIL OF GOVERNORS

**Date of Meeting:** 19th May 2015

**Title:** Board round-up

**Lead:** Phil Bellas

**Report for:** Assurance/Information

## This report includes/supports the following areas:

| STRATEGIC GOALS: | ✓ |
|---|---|
| To provide excellent services working with the individual users of our services and their carers to promote recovery and well being | |
| To continuously improve the quality and value of our work | |
| To recruit, develop and retain a skilled and motivated workforce | |
| To have effective partnerships with local, national and international organisations for the benefit of our communities | |
| To be an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of our communities | ✓ |

| CQC REGISTRATION: Outcomes (✓) | | | | | |
|---|---|---|---|---|---|
| **Involvement and Information** | | | | | |
| Respecting & Involving Service Users | | Consent to care and treatment | | | |
| **Personalised care, treatment and support** | | | | | |
| Care and welfare of people who use services | | Meeting nutritional needs | | Co-operating with other providers | |
| **Safeguarding and safety** | | | | | |
| Safeguarding people who use services from abuse | | Cleanliness and infection control | | Management of medicines | |
| Safety and suitability of premises | | Safety, availability and suitability of equipment | | | |
| **Suitability of staffing** | | | | | |
| Requirements relating to workers | | Staffing | | Supporting workers | |
| **Quality and management** | | | | | |
| Statement of purpose | | Assessing and monitoring quality of service provision | | Complaints | |
| Notification of death of a person who uses services | | Notification of death or AWOL of person detained under MHA | | Notification of other incidents | |
| Records | | | | | |
| **Suitability of Management** (only relevant to changes in CQC registration) | | | | | |
| **This report does not support CQC Registration** | | | | | ✓ |

| **NHS CONSTITUTION:** The report supports compliance with the pledges of the NHS Constitution (✓) | | | | | |
|---|---|---|---|---|---|
| **Yes** | | **No** (Details must be provided in Section 4 "risks") | | **Not relevant** | ✓ |

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

**COUNCIL OF GOVERNORS**

**Date of Meeting:** **19th May 2015**

**Title:** **Board Round-up**

## 1. INTRODUCTION AND 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

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 on 24th February 2015, 24th March 2015 and 28th April 2015 are attached to this report.

## 4. IMPLICATIONS / RISKS:

4.1 **Quality:** No risks have been identified.

4.2 **Financial:** No risks have been identified.

4.3 **Legal and Constitutional:** No risks have been identified.

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

4.5 **Other Risks:** No other 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 on 24th February 2015, 24th March 2015 and 28th April 2015 (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".*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

# Briefing

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## Board round-up

All of our Board meetings are held in public and you will find copies of the agenda and all the public papers on our website at **www.tewv.nhs.uk/boardmeetings**

### Feedback from Board of Directors meeting held 24 February 2015

**Quality Assurance Committee (QuAC) report**
The Board received the report and noted one additional issue discussed at the 5 February meeting. This related to a request for further analysis of the number of unexpected deaths in Durham and Darlington, compared to other areas of the Trust. This will be discussed again at the next QuAC.

**Nurse staffing report**
Chris Stanbury presented this monthly report, which the Board found very informative. Directors discussed the continued high use of bank staff and were reassured that a high level of bank staff did not appear to have any adverse impact on the numbers of incidents. The bank is well-established and it was noted that this meant there was consistency of staffing.

**Durham and Darlington crisis recovery house**
Brent Kilmurray gave the Board an update on the crisis recovery house in Shildon. The Board were pleased with the positive progress that had been made over the last six months.

**County Durham and Darlington organic beds**
Brent Kilmurray presented this report. The Board noted the progress and requested information on occupancy levels, admissions and lengths of stay following the reduction of 15 organic beds in County Durham.

**Finance report**
Colin Martin reported there had been contract delays on the refurbishment of the Orchard in Ripon which could mean that capital expenditure would fall below tolerance levels. This will be closely monitored. Otherwise the Trust's financial plan will be achieved.

**Performance report**
Sharon Pickering presented this report, noting that the Trust had met the out of locality admissions indicator for the first time since this was reported on over two years ago (the actual number of out of locality admissions was 29 against a target of 35).

**Proposed targets for Trust dashboard indicators 15/16**
The Board approved the indicators detailed in the report.

**Integrated governance framework**
The Board approved the new framework with a few minor amendments. This will be posted on the Trust's website.

**Staff survey**
David Levy presented the headlines results and initial analysis of the national NHS staff survey. The Board were pleased with our overall position nationally, recognising that there are a number of areas that we need to address. It was agreed that further analysis was required and they requested further information to show trends over the last few years.

Lesley Bessant
Chairman

## Feedback from Board of Directors meeting held 24 March 2015

**Quality Assurance Committee (QuAC) report**
The Board received the report. The Board looked forward to hearing in future updates other ways we can monitor compliance as well as through the clinical audit programme.

**Nurse staffing report**
Chris Stanbury presented this monthly report, which the Board found very informative. The Board noted that the issue of temporary staffing use will receive detailed consideration at a Board Seminar.

**Mental health legislation committee**
Richard Simpson and Chris Stanbury gave the Board an update on the work of the mental health legislation committee. The Board noted that the number of admissions under the Mental Health Act are levelling off.

**Culture metrics**
David Levy presented this report. The Board noted that actions arising from these metrics will be included in the Trust's overall staff experience action plan including the staff survey and friends and family test. The main issue of concern was a reduction in the staff wellbeing metric.

**Finance report**
Colin Martin reported continued contract delays on the refurbishment of the Orchard in Ripon may mean that capital expenditure would fall below tolerance levels and will result in a report being sent to Monitor. This will continue to be closely monitored. Otherwise the Trust's financial plan will be achieved.

**Performance report**
Sharon Pickering presented this report. It was noted that sickness rates given in the report are similar to other Trusts in the region.

**Integrated governance strategy and information governance toolkit**
The Board received this report and approved the information governance toolkit results for 2014/15.

**Quality and assurance audit committee**
Due to Mike Newell's upcoming retirement from the Board, memberships were agreed until a fuller review of all committee memberships in September. Lesley Bessant, Chair, took this opportunity to thank Mike Newell for his contribution and work for the Trust over the last nine years.

Lesley Bessant
Chairman

## Feedback from Board of Directors meeting held 28 April 2015

### Chairman's report
Lesley Bessant reported that she had opened the Trust's second neuropsychology conference, held in conjunction with Teesside University, which had included powerful presentations by service users and their families.

### Quality Assurance Committee report
The Board received this report and discussed the key issues including staffing levels in forensic services and the agreement to retain the current protocol for admitting patients from 'out of area' into our children's inpatient beds

### 'Hard Truths' nurse staffing report
Chris Stanbury presented this monthly report, noting that we have submitted a further set of data to the national benchmarking exercise on the use of control and restraint. The use of bank staff was also discussed and David Levy reported that during the previous month we had reported the lowest number of requests for bank staff. An annual report on the use of bank staff will be brought to the Board in June.

### Finance
Colin Martin presented the finance report. This included details of our year-end position, which was on plan. The Board recognised the efforts required to achieve this and thanked everyone for their contributions.

### Performance
The Board noted our end of year position and discussed the key issues that continue to be a challenge for TEWV, including waiting times and out of locality admissions. Brent Kilmurray is to revisit the action plan to reduce waiting times (we did not achieve our four week target). He will also provide the Board with an update on the action plan to reduce out of locality admissions. There was also an in depth discussion about appraisals and mandatory training. The Board recognised there had been an improvement in the percentage of staff who had received an appraisal over the past year but noted that there was still work to do to improve levels of mandatory training.

### Workforce report
David Levy presented this report which included the revised workforce strategy. The strategy was approved along with the indicators to be included in the score card against which the implementation of the strategy will be monitored. There was also a discussion about workforce planning, specifically relating to the impact of changes to the NHS pension scheme. We expect to see a peak in the number of staff (with Mental Health Officer status) leaving in 2018 and the Board agreed that we needed to plan for this as well as for the impact of people working longer.

### Business plan
Sharon Pickering reported that we had achieved over 94% of our business plan milestones at the end of March 2015. This was a significant achievement and the Board thanked everyone for their efforts.

### Risk assessment framework
This was approved by the Board subject to an update to some of the figures.

### Governance actions
The Board received the positive quarterly progress report and approved the amendments.

Lesley Bessant
Chairman

**Item 7**

## FOR GENERAL RELEASE

## COUNCIL OF GOVERNORS

**Date of Meeting:** 19th May 2015

**Title:** Monitor Risk Assessment Framework Report

**Lead:** Phil Bellas

**Report for:** Assurance/Information

### This report includes/supports the following areas:

| STRATEGIC GOALS: | ✓ |
|---|---|
| To provide excellent services working with the individual users of our services and their carers to promote recovery and well being | ✓ |
| To continuously improve the quality and value of our work | |
| To recruit, develop and retain a skilled and motivated workforce | |
| To have effective partnerships with local, national and international organisations for the benefit of our communities | |
| To be an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of our communities | ✓ |

| CQC REGISTRATION: Outcomes (✓) | | | | | |
|---|---|---|---|---|---|
| **Involvement and Information** | | | | | |
| Respecting & Involving Service Users | | Consent to care and treatment | | | |
| **Personalised care, treatment and support** | | | | | |
| Care and welfare of people who use services | ✓ | Meeting nutritional needs | | Co-operating with other providers | |
| **Safeguarding and safety** | | | | | |
| Safeguarding people who use services from abuse | | Cleanliness and infection control | | Management of medicines | |
| Safety and suitability of premises | | Safety, availability and suitability of equipment | | | |
| **Suitability of staffing** | | | | | |
| Requirements relating to workers | | Staffing | | Supporting workers | |
| **Quality and management** | | | | | |
| Statement of purpose | | Assessing and monitoring quality of service provision | ✓ | Complaints | |
| Notification of death of a person who uses services | | Notification of death or AWOL of person detained under MHA | | Notification of other incidents | |
| Records | | | | | |
| **Suitability of Management** (only relevant to changes in CQC registration) | | | | | |
| **This report does not support CQC Registration** | | | | | |

| **NHS CONSTITUTION:** The report supports compliance with the pledges of the NHS Constitution (✓) | | | | | |
|---|---|---|---|---|---|
| **Yes** | | **No** (Details must be provided in Section 4 "risks") | | **Not relevant** | ✓ |

**COUNCIL OF GOVERNORS**

**Date of Meeting:** **19th May 2015**

**Title:** **Monitor Risk Assessment Framework Report**

## 1. INTRODUCTION & PURPOSE

1.1 The purpose of this report is to provide the Council of Governors with information on the Trust's position against the requirements of the Risk Assessment Framework for Quarter 4, 2014/15 (1st January 2015 to 31st March 2015).

## 2. BACKGROUND INFORMATION

2.1 Monitor undertakes in-year monitoring, in accordance with its Risk Assessment Framework, to measure and assess a Foundation Trust's actual performance against its Annual Plan. The intensity of monitoring is based on Monitor's assessment of the risks (its "risk ratings") of a significant breach of the Trust's Licence conditions.

2.2 Copies of the Risk Assessment Framework have been provided to Governors.

2.3 At Quarter 3, 2014/15 the Trust had a Continuity of Service Risk Rating of 4 ("no evident concerns") and a Governance Risk Rating of "green".

## 3. KEY ISSUES:

3.1 At its meeting held on 28th April 2015 the Board of Directors approved the submission of the following information to Monitor in accordance with the Risk Assessment Framework:

(a) A Continuity of Service Risk Rating (CoSRR) of 4.

The Council of Governors is asked to note that:

- The CoSRR remains in line with plan.
- Details of the Trust's financial performance are provided under agenda item 15.

(b) Completion of the declaration that capital expenditure was less than 85% of the latest plan for the year to date.

The Council of Governors is asked to note that this arose, principally, from some slippage on the redevelopment of The Orchards in Ripon as a result of contractor delays.

(c) Confirmation that the Trust will maintain a CoSRR of at least 3 for the next 12 months.

(d) Confirmation that no subsidiaries were included in the financial results.

(e) Confirmation of the following Governance Declarations:

- "The Board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards." (Statement A)

- "The Board confirms that there are no matters arising in the quarter requiring an exception report to Monitor (per Risk Assessment Framework page 22 Diagram 6) which have not already been reported." (Statement B)

(f) A Governance Risk Rating of "green" based on achievement of all the governance targets and indicators included in the Risk Assessment Framework.

In accordance with Monitor's requirements, the Trust provided an exception report with regard to the compliance issues and "moderate concerns" arising the CQC's inspection of forensic learning disability services wards at Roseberry Park in March 2014.

The Council of Governors is asked to note that Monitor was informed that:

- Following a review of progress against the action plan developed in response to the CQC's requirements the Trust has now declared that it considers these services to be fully compliant with the regulations.
- The Trust has invited the CQC to undertake a follow up inspection of the services so that the compliance issues and "moderate concerns" can be formally signed off.
- The CQC has yet to confirm the arrangements for this re-inspection.

The Board also agreed that, as a matter of courtesy, the Trust should advise Monitor of the receipt of the draft confidential report from the CQC on its inspection undertaken in January 2015; the expected timetable for its publication; and the Trust's process for responding to any compliance issues which might be identified.

(g) The following information on Executive team turnover which Monitor uses as a potential indicator of quality governance concerns:

| Executive Directors | Actual for Quarter ending 31/3/15 |
|---|---|
| Total number of Executive posts on the Board (voting) | 5 |
| Number of posts currently vacant | 0 |
| Number of posts currently filled by interim appointments | 0 |
| Number of resignations in quarter | 0 |
| Number of appointments in quarter | 1 |

## 4. IMPLICATIONS / RISKS:

4.1 **Quality:** The findings of the CQC inspection of forensic learning disability wards at Roseberry Park were reported to the Council of Governors at its meeting held on 24th July 2014 (minute 14/57 refers).

4.2 **Financial:** This issue is covered in the report of the Director of Finance under agenda item 15.

4.3 **Legal and Constitutional:** No other risks have been identified.

4.4 **Equality and Diversity:** There are no equality and diversity risks or implications arising from this report.

4.5 **Other Risks:** No other risks have been identified.

## 5. CONCLUSIONS

5.1 The Council of Governors is asked to note that the Trust assessed its risk ratings as 4 for Continuity of Service and “green” for Governance for Quarter 4 2014/15.

## 6. RECOMMENDATIONS

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

**Phil Bellas**
**Trust Secretary**

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

**Item 8**

# COUNCIL OF GOVERNORS

**Date of Meeting:** **19th May 2015**

**Title:** **Task and Finish Group Report on the Review of the Conduct of the Council of Governors' Business**

**Lead:** **Mary Booth, Public Governor for Middlesbrough – Sponsor of the Review**

**Report for:** **Decision**

## This report includes/supports the following areas:

| **STRATEGIC GOALS:** | ✓ |
|---|---|
| **To provide excellent services working with the individual users of our services and their carers to promote recovery and well being** | |
| **To continuously improve the quality and value of our work** | |
| **To recruit, develop and retain a skilled and motivated workforce** | |
| **To have effective partnerships with local, national and international organisations for the benefit of our communities** | |
| **To be an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of our communities** | ✓ |

| **CQC REGISTRATION: Outcomes (✓)** | | | | | |
|---|---|---|---|---|---|
| **Involvement and Information** | | | | | |
| Respecting & Involving Service Users | | Consent to care and treatment | | | |
| **Personalised care, treatment and support** | | | | | |
| Care and welfare of people who use services | | Meeting nutritional needs | | Co-operating with other providers | |
| **Safeguarding and safety** | | | | | |
| Safeguarding people who use services from abuse | | Cleanliness and infection control | | Management of medicines | |
| Safety and suitability of premises | | Safety, availability and suitability of equipment | | | |
| **Suitability of staffing** | | | | | |
| Requirements relating to workers | | Staffing | | Supporting workers | |
| **Quality and management** | | | | | |
| Statement of purpose | | Assessing and monitoring quality of service provision | | Complaints | |
| Notification of death of a person who uses services | | Notification of death or AWOL of person detained under MHA | | Notification of other incidents | |
| Records | | | | | |
| **Suitability of Management** (only relevant to changes in CQC registration) | | | | | |
| **This report does not support CQC Registration** | | | | | ✓ |

| **NHS CONSTITUTION:** The report supports compliance with the pledges of the NHS Constitution (✓) | | | | | |
|---|---|---|---|---|---|
| **Yes** | | **No** (Details must be provided in Section 4 "risks") | | **Not relevant** | ✓ |

# COUNCIL OF GOVERNORS

**Date of Meeting:** **19th May 2015**

**Title:** **Task and Finish Group Report on the Review of the Conduct of the Council of Governors' Business**

## 1. INTRODUCTION AND PURPOSE

1.1 The purpose of this report is to:
(a) Report the findings of the Task and Finish Group review of the conduct of Council of Governors' business.
(b) Seek the Council of Governors' support for the Task and Finish Group's recommendations.

## 2. BACKGROUND INFORMATION

2.1 There has been very little change to the way the Council of Governors operates since it was established in 2008.

2.2 Feedback had been received from some Governors that they found meetings difficult and unfulfilling. In addition, there were concerns that meetings of the Council of Governors, in their current form, could be intimidating for new Governors.

2.3 The Council of Governors, at its meeting on 24th September 2014, approved the establishment of a task and finish group to review the conduct of its business (minute 14/71 refers). As part of the review, at its meeting on 17th February 2015 (minute 15/10 refers) it was agreed that the work of its Committees should be included within this review.

2.4 A workshop was held at the Governor Development Day on 17th March 2015 to consult on the initial findings of the review.

2.5 The proposed recommendations have taken into account the outcome of the performance evaluation of the Council of Governors presented at the Governor Development Day on 17th March 2015.

2.6 The scoping paper for the Task and Finish Group review is attached as Appendix1.

## 3. KEY ISSUES:

3.1 The report of the Task and Finish Group including its recommendations is attached as Appendix 2 to this report.

3.2 The Council of Governors is asked to approve the recommendations arising from the review and to:
(a) Seek the support of the Board of Directors for recommendations 11-13 with regard to the style of reports provided to the Council of Governors.
(b) Agree that actions to implement the recommendations should be included in the Council of Governors' Development Plan for 2015/16.

## 4. IMPLICATIONS / RISKS:

4.1 **Quality:** No risks have been identified.

4.2 **Financial:** No financial risks have been identified.

4.3 **Legal and Constitutional:** The recommendations of the review are compliant with the Trust's Constitution.

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

4.5 **Other Risks:** No other risks have been identified.

## 5. CONCLUSIONS

5.1 It is considered that the Group has met its objectives and that its findings and recommendations will improve the way in which the Council of Governors conducts its business.

## 6. RECOMMENDATIONS

The Council of Governors is asked to:

(a) Formally receive the report of its Task and Finish Group reviewing the conduct of Council of Governors' business.
(b) Approve the recommendations contained within the report.
(c) Seek the support of the Board of Directors for recommendations 11-13 with regard to the style of reports provided to the Council of Governors.
(d) Agree that actions to implement the recommendations should be included in the Council of Governors' Development Plan for 2015/16.

**Phil Bellas,**
**Trust Secretary**

**Background Papers:**
*Responses to the self-assessment questionnaires for 2013/2014*
*Council of Governors Development Day, 17 March 2015*
*Updates provided to the Council of Governors at its establishment on 24 September 2014.*

**Appendix 1**

## Council of Governors

## Task and Finish Group Scoping Paper

| | |
|---|---|
| **Title of Review:** | Review of the way in which the Council of Governors' conducts its business. |
| **Governor Sponsor** | To be determined. |
| **Background:** | There has been very little change to the way in which the Council of Governors conducts its business since the authorisation of the Foundation Trust.<br><br>Feedback has been received that some Governors find meetings of the Council to be difficult and unfulfilling. |
| **Terms of Reference:** | Taking into account its statutory duties and powers to consider and bring forward recommendations with regard to:<br>(1) How the transaction of business by the Council of Governors should be improved with the aims of:<br>▪ Reducing the length of meetings.<br>▪ Improving the balance between formal business, developmental sessions and issues of interest to Governors.<br>▪ Increasing participation by all Governors in discussions and debates.<br>▪ Improving the operation of the Council of Governors' Committees and their reporting arrangements.<br>(2) Any changes required to facilitate the improvements identified under (1) above including:<br>▪ The number of meetings held each year and their spread throughout the year.<br>▪ The timing and location of meetings.<br>▪ Seating arrangements.<br>▪ The format of meetings including the use of informal briefings and developmental sessions. |
| **Group Membership:** | The Chairman of the Trust<br>The Trust Secretary<br>Four Members of the Council of Governors (with representation from each type of Governor).<br><br>(Note: The Executive Management Team will be asked to nominate a member of the Group if it considers it appropriate). |
| **Research Methodology:** | 1. Review of present arrangements.<br>2. Identification of the options for improvement.<br>3. Testing of the options e.g. through surveys or focus group |

| | |
|---|---|
| | discussions.<br>4. Option appraisal.<br>5. Formulation of preferred options and reporting. |
| **Budget:** | Not applicable. It is considered that the costs of the review can be contained within current budgets. |
| **Resource Implications:** | Four meetings of the Group (3 hours per meeting).<br>Administrative and research support from the Trust Secretary's Department (10 days). |
| **Review Overview:** | To be determined by the Group; however, the report and recommendations of the review to be provided to the Council of Governors for consideration in February 2015. |
| **Expected Outcomes:** | ▪ A revised framework for how the Council of Governors conducts its business.<br>▪ Increased Governor satisfaction and fulfilment in their role. |

**Council of Governors' Task and Finish Group Appendix 2**

# A report on the review of the conduct of the Council of Governors Business

## 1. Introduction and Foreword

The Council of Governors was established in 2008 upon the attainment of Foundation Trust status. Since that time there has been very little change to the way it operates in terms of undertaking its business.

Feedback from Governors through the annual performance appraisal of the Council of Governors has, over the last couple of years, highlighted that some Governors find participation in meetings difficult and unfulfilling.

At its meeting on 24 September 2014, the Council of Governors approved the establishment of a task and finish group to review how its business was conducted and to formulate recommendations for improvement.

This report sets out the findings and recommendations of this review.

## 2. Scope and Terms of Reference of the Review

The Council of Governors established the task and finish group, taking into account its statutory duties and powers to consider and bring forward recommendations with regard to:

How the transaction of business by the Council of Governors should be improved with the aims of:

- Reducing the length of meetings.
- Improving the balance between formal business, developmental sessions and issues of interest to Governors.
- Increasing participation by all Governors in discussions and debates.
- Improving the operation of the Council of Governors' Committees and their reporting arrangements.

The Group was tasked to present a report which provided recommendations on:

- Location and timings of Council of Governors' Meetings
- Format and Style of Agenda's
- Style and content of reports

In addition to the above, the group felt that as part of the review it was important to look at the committees established by the Council and how Governors receive information briefings through the current Governor Development Days.

## 3. Membership of the Task and Finish Group

The review was undertaken by:

| | |
|---|---|
| Mrs Mary Booth | Public Governor for Middlesbrough, Governor Sponsor of the Review |
| Mr Cliff Allison | Public Governor for Durham |
| Mr Stuart Fawcett | Public Governor for Durham |
| Mrs Judith Hurst | Staff Governor for Corporate Services |
| Prof Paul Keane | Appointed Governor for Teesside University until his resignation at the end of February 2015 |
| Cllr Ann McCoy | Appointed Governor for Stockton Borough Council, Lead Governor, replacement appointment for Prof Keane. |
| Mrs Lesley Bessant | Chairman |
| Mr Phil Bellas | Trust Secretary |
| Mrs Kathryn Ord | Deputy Trust Secretary |

## 4. Methodology

The review consisted of:

Stage 1 - Workshop of group members looking at positive and negatives of current conduct of business.

Stage 2 - Researching how other Trusts manage their Council meetings.
Gaining views from Governors through Governor Brief issued December 2014
The outcome of performance evaluation of the Council of Governors 2014.

Stage 3 - Consultation workshop with Governors on draft findings from research undertaken held at the Governor Development Day on 17 March 2015.

## 5. Key Findings and Recommendations

## 1. Council of Governor Meetings

The Trust holds a minimum of four Council of Governors' meetings per year which are chaired by the Trust Chairman. These meetings are open to members of the public, however members of the public may be excluded from all or part of any meeting.

The current composition of the Council of Governors consists of 47 seats with 43 currently occupied and 4 vacant. The Board of Directors are invited to attend meetings. The administration is provided by the Trust Secretary's Department.

In total the usual maximum attendance of Governors, administration and Board of Directors is 66 people (47 Governors, 15 Board members, 4 administration staff). In addition to this seating made available for public observers.

## 1.1 Meeting Location

Generally attendance at Council of Governors' meetings is good. Governors are aware that their attendance is recorded for the purpose of meeting their duty to attend at least two meetings per year (dependant on any dispensations granted for special reasons). This is published in the Trust's annual report.

In considering our recommendations, we noted that:

- Most Governors were familiar with the previously used Middlesbrough Teaching and Learning Centre and now Middlesbrough Football Club.

- Accessibility to Middlesbrough Football Club was good, well signposted and near to major commute routes.

- Teesside and in particular Middlesbrough remained central to the geographic area of the Trust.

- The distance travelled by Governors ranged from Durham villages, Consett in Co Durham, Harrogate and Scarborough and Ryedale.

- Governors were generally happy with the Middlesbrough location and the venue of Middlesbrough Football Club. It is acknowledged that there were still some issues to address around domestic arrangements (such as heating) and preferences around seating styles.

We conducted research focussing with Middlesbrough as a central meeting venue. No alternative venues could be found that could provide the range of requirements needed:

- Free parking
- Easy access of main roads
- Disabled access and facilities
- Presentational equipment
- Sound systems
- Hearing Loops
- Catering
- Seating for up to 66 people in various styles

In addition alternative venues were researched outside of the Middlesbrough catchment area but we felt that this would create greater difficulty in access and provided no better facilities that that presently available.

Consultation findings resulted in the majority of Governors being happy with Middlesbrough Football Club as a venue. We therefore recommend that meetings of the Council of Governors continue to be held at Middlesbrough Football Club. We are however mindful that following the tender submission for services in the York and Selby area, this recommendation may need to be re-visited in the future in terms of whether Middlesbrough is still an appropriate area for all to access.

**Recommendation:**

1. *To retain Middlesbrough Football Club as the venue for meetings of the Council of Governors unless no resolution can be found in terms of seating and domestics. (see recommendation 2), or another venue is identified which more effectively meets the Council of Governors' requirements.*

## 1.2 Seating Style

Since 2008 the seating style generally provided at Council of Governors' meetings has been a formal board room style around tables.

However, since the appointment of the current Chairman, discussions have been held over whether this is the most appropriate style of seating to aid facilitation, inclusion and involvement of attendees.

Following the closure of the Middlesbrough Teaching and Learning Centre in 2014, the opportunity arose to revisit the seating style to address the points above and to fit better within the accommodation available at Middlesbrough Football Club.

At its meeting on 17 February 2015 a trial was undertaken of theatre/auditorium style seating. Following and through the Governor workshop consultation, this was not supported due to:

- Inability to view the front panel table.
- Inability to hear discussions and see who was raising points.
- Attendees did not feel included in meeting.

We recognise that seating arrangements will not suit every person due to personal preferences however the key points to achieve are to:

- Provide a table.
- To facilitate viewing of other attendees and panel table.
- To allow easy access to microphones.
- To be able to view any presentations.
- To facilitate inclusiveness and a more informal feel to the meeting.
- Ambient temperature setting.

We therefore recommend that for the forthcoming meeting of the Council of Governors due to be held on 19 May 2015 that a cabaret style of seating around tables is trialled with feedback from Governors sought at the conclusion of the meeting. This proposal was supported at the workshop consultation with Governors. Liaison will continue with the venue to obtain ambient temperatures within the rooms utilised.

**Recommendation:**

2. *To trial a seating style of cabaret with approximately 8 delegates round a table with Board representative speakers to be seated at a panel table at the front of the room for the May 2014 meeting of the Council of Governors.*

3. *That the Council of Governors formally determines its preferred seating plan following the above trial.*

## 1.3 Timing of Meetings

Since 2008 timings of Council of Governors' meetings have alternated between a 2pm and 6pm start with afternoon meetings taking place in the autumn/winter months (November to February) and evening meetings taking place in the spring/summer months (May to September). This decision was taken to:

- Allow alternate meeting times to aid those Governors who had personal commitments either during the day or evening to attend at least two meetings per year as per the constitutional requirements.
- Try and ensure that those Governors who needed to drive to meetings did so in daylight hours where possible and to avoid adverse weather conditions in winter.

Through our own discussions and those raised at the Governor workshop consultation it is essential that there is a fixed meeting end time in place. This is to ensure that:

- Appropriate travel arrangements can be made in order that those who need assistance do not need to leave prior to the meeting conclusion.
- That the end time of evening meetings is at an appropriate time for the safety and wellbeing of attendees who need to travel long distances.
- All attendees are aware of time constraints and commitment they need to give.

We therefore recommend that meetings should not last longer than 3 hours in duration with a particular emphasis on those meetings starting at 6pm concluding no later than 8pm (2 hour duration). To aid the management of agenda's. Timings should be included for sections within the agenda, although this is recommended as a guide only and should not be used to curtail important discussions that are relevant to the item.

In addition to section timings, it is felt that holding a break in between the public and private elements of the meeting, allows attendees to refresh themselves and creates an opportunity speak to any members of the public present prior to their departure. This was trialled at the meeting of the Council in February and received good feedback both on the day and at the Governor consultation workshop.

**Recommendations:**

4. *To continue to start meetings at 6pm in the spring/summer and 2pm in the autumn/winter months to facilitate attendance of two meetings and allow travelling to be undertaken in daylight hours where possible.*
5. *For meetings of the Council of Governors to last no longer than 3 hours in duration with meeting starting at 6pm finishing no later than 8pm.*
6. *To include timings for each agenda section as a guide only to allow the*

*Chairman to manage the duration of the agenda.*

7. *For the inclusion of a comfort break between public and private agenda discussions.*

### 1.4 Agenda Style

From our research into the way other Trust's manage their Council meetings there was a significant range of styles of agenda. The key elements found were:

- Easy read style including the use of symbols to identify an item.
- Greater explanation of what the item was and why it was on the agenda including whether:
  - questions should be asked.
  - it was for information only.
  - it was for agreement.
- Embedded documents within the agenda's.
- Agenda's with all items following on after each other.
- Photographs of lead person for items.
- Timings of sections with agenda's.
- Inclusion of vision / values at end of agenda.

We commissioned a sample mock up agenda to be developed based on the meeting held on 17 February 2015 and asked the views of Governors at the workshop consultation held in March 2015.

There was a mixed review in terms of how this was received but general consensus was obtained on the inclusion of:

- Section timings (see Recommendation 6).
- Photographs of speakers. A debate was held as to whether these should only feature once but it was felt more appropriate to meet the needs of those this was designed to aid that photographs appeared each time. The size of photograph could be adjusted to aid an easier presentation style. It was also felt that this must be optional as some photographs would not be held on file, or through personal choice, some speakers may not wish this to appear. In this case, a standard 'shadow style' photograph should be used.
- Items for information to be at the end of an agenda and marked appropriately in terms of for information only.
- Access to electronic versions of documents for those that wish this.
- Agenda items to be linked where appropriate

A suggestion of having blank column area was not supported by the group due to the room available on the page.

**Recommendations:**

8. *The style of agenda's for meetings of the Council of Governors should include:*
   - *easy read symbols to facilitate understanding and inclusion against each*

*item.*

- *optional photographs of speakers for each item.*
- *full descriptions of items including, what the item is, why it is on the agenda and the expected outcome.*
- *items for information to appear at the end of the agenda.*
- *similar linked items to be grouped together.*
- *The Trust's vision values and objectives to feature at the end of an agenda.*

*9. Agendas to be developed and made available in a PDF format with each item following on after the previous item. Public agenda's to be published in this format on the Trust website.*

*10. Governors to be allowed the choice of:*

*9.1 Receiving electronic agenda's only.*

*9.2 Receiving postal agenda's only.*

*9.3 Receiving both electronic and postal agenda's*.

## 1.5 Style of Reports

Through our research and feedback from the performance evaluation of the Council of Governors a common theme we found was in relation to the content and style in which reports were written and presented to the Council of Governors.

Generally, we found that the majority of reports presented were indeed the same report as that presented to the Board of Directors, but 'tweaked' slightly to meet why presented to Governors. Examples of this include the Board Performance Dashboard, the Finance Report and Quality Account.

We found the reports did not provide a clear and upfront view as to the key areas that Governors should be highlighted to in terms of concerns or achievements and what the plans in place were to address these. In addition there was a lack of written and verbal information available identifying what matters had been discussed and challenged at the Board of Directors and subsequent outcomes.

Reports also contained a significant amount of data / information which was helpful to some Governors but meaningless to others.

In order to establish the views of Governors a mock up style performance dashboard report was commissioned and presented to Governors at the consultation workshop. The outcome of which generally supported the following:

- Data style information to be contained outwith the report in an information pack. This would be for all reports.
- Reports should identify up front, critical areas of concern or achievement and actions in place to address.
- Issues already addressed by the Board of Directors should be included where possible, or provided verbally during the presentation of a report.
- Although views around the front page where that this was not meaningful for Governors, it was acknowledged that this was a requirement for the Trust. It

was also acknowledged that this may be changed in future to meet new requirements.

In taking these views into account we acknowledge that any recommendation to change the style of the report could have a resource impact on report authors. We were made aware that discussions were underway with the Chief Executive and Directors on their ability to meet this requirement. Whilst mindful of this resource impact we are also aware that a similar discussion had been held with the Board of Directors in terms of identifying more clearly critical areas upfront within reports. Any changes undertaken in the Board requirements may also have a positive impact on the provision of reports to Governors and aid a smoother transition to a new style of report for Governors.

**Recommendations:**

11. *Reference information and data to be included within an information pack for Governors and not contained within the body of the report.*

12. *Reports to highlight key areas in an easily identifiable way at the beginning of the report. This should address areas of concern, achievement and actions in place to address.*

13. *Areas already addressed or challenged by the Board of Directors should be highlighted within the body of the report or reported verbally at the meeting.*

***NOTE: Recommendations 11-13 above are subject to the approval of the Board of Directors.***

## 1.6 Work of Committees

Although this area of work was not specifically detailed within the scope of the task and finish group. It was felt that Committees of the Council of Governors, Governor Development Days and the use of task and finish groups should be reviewed as all of these assist the Council of Governors in the overall conduct of business and the achievement of statutory duties.

Thematic Committees

The four main thematic committees, (Improving the Experience of Service Users, Improving the Experience of Carers and the Promoting Social Inclusion and Recovery, Making the Most of Membership) have been in place since the establishment of the Council of Governors in 2008. They were developed following feedback from Governors as to what would add value to their roles and contribute to the Trust. This was and still is common practice amongst Trusts although the topic areas do vary.

Nomination and Remuneration Committee

In addition to the thematic committees above, the Council of Governors established a Nomination and Remuneration committee to oversee the appointment and appraisal of the Chairman and Non Executive Directors.

Summary

Our view is that the Nomination and Remuneration Committee and the Making the Most of Membership Committee have functions that fall outside of information sharing and establishing best practice.

The Making the Most of Membership Committee assists the Council in ensuring that the membership of the Trust is representative and engaged and provides that assurance for reporting into Monitor; duties of the Council of Governors under the Constitution.

The Nomination and Remuneration Committee holds specific responsibilities to recommend their findings to the Council on matters relating to the Chairman and the Non Executive Directors that must be undertaken and fall under statutory duties of the Council.

Our recommendation is therefore that no change is made to these two committees.

In terms of the three remaining thematic committees, a review was undertaken to look at the topic areas of discussion and membership over the last year which identified:

- a significant cross over across a number of committees per agenda items discussions.
- Items being discussed which should be of general interest to all Governors.
- Majority of agenda items were information sharing items / briefings which did not result in any recommendations.
- Membership of committees was fairly static with a very similar membership which has gradually seen lower attendance levels over the last year.
- The resource implications of running committees from lead officer support and administration purposes as well as time commitment for Governors.

The findings from the consultation workshop supported the above points and there was general consensus to disband the three committees as mentioned above on the basis that alternative ways of working and information sharing was introduced.

Task and Finish Groups

Task and finish groups have been used on a number of occasions for time limited pieces of work such as Constitutional reviews, the appointment of the external auditor and more recently review how Non Executive Directors are held to account for the performance of the Board.

Reports from those who have attended task and finish groups have been positive, outcomes in terms of recommendations have been made, work had been undertaken in a timely fashion and Governors had found that their participation was a positive experience.

From the consultation workshop with Governors, there was a keenness to develop this way of working, as it was seen that:

- There was a clear goal in terms of work plan and recommendations required.

- Governors have experienced greater involvement and satisfaction from work undertaken.
- Recommendations put forward were generally support by the Council and implemented with changed effected.

Areas of concern that were made know to us were:

- Assurance wanted that the opportunity to be involved would not be reduced following any introduction of this way of working as a replacement for thematic committees and the amount of information made available to Governors not distilled.

Our findings demonstrated that in order to have task and finish groups there must be a Task and Finish Oversight Committee which would be appointed by the Council of Governors. The role of this committee would be to prioritise the items and develop the scope of any task and finish group and to recommend the findings of task and finish groups to the Council of Governors.

Governor Development Days

At present there are two days allocated per year where a range of briefings/ topics and items of interest are delivered for Governors. These days also provide an opportunity for Governors to network and get to know each other.

Our research and findings into the work of Committees found that a number of the agenda items such as updates on Volunteers, Recovery, Care Programme Approach, Advocacy, etc were areas where it was felt that the information provided would have benefitted all Governors rather than just those who were members of a particular committee.

In order to ensure that appropriate meaningful and timely information is provided to Governors which is relevant to the Governor role we recommend that Governor Development Days should be increased to four per year on the basis of the disbanding of the three thematic committees. We would also recommend that Governors have a greater input into agenda setting for these events to ensure that content is tailored to need. This view was supported by Governors at the consultation workshop.

**Recommendations:**

*14. That the Nomination and Remuneration Committee of the Council of Governors remains unchanged.*

*15. That the Making the Most of Membership Committee of the Council of Governors remains unchanged.*

*16. Subject to the approval of recommendations 16 -18 below that following committees area disbanded:*

*15.1 The Improving the Experience of Carers Committee*
*15.2 The Improving the Experience of Service Users Committee*
*15.3 The Promoting Social Inclusion and Recovery*

*It is anticipated that the use of Task and Finish Groups and more Governor Development Days would allow greater opportunities and involvement of Governors across a wider range of topics, briefings and discussions.*

17. *To establish a Task and Finish Oversight Committee with the Terms of Reference and Membership to be agreed by the Council of Governors.*

18. *That in view of capacity issues a maximum of four task and finish groups to be established per year.*

19. *Increase Governor Development Days to four per with Governors contributing to the development of agendas.*

**Annex's from consulation workshop 17 March 2015**

**Annex 1 - sample mock up agenda**
**Annex 2 - workshop notes**

Annex 1

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

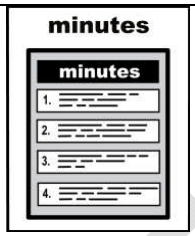
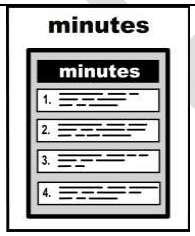
# AGENDA FOR THE MEETING OF THE COUNCIL OF GOVERNORS

## 17 February 2015, 2.00pm

(registration and hospitality available between 1pm and 1.45pm)

**Riverside Suite, Middlesbrough Football Club**

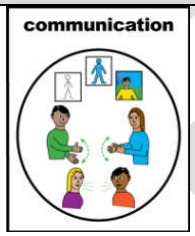
NOTE: Cllr Ann McCoy, Lead Governor will be available from 1. 40pm to meet with Governors

| No | | What we will talk about | Why are we talking about this | Lead Person | Supporting papers / Verbal report |
|---|---|---|---|---|---|
| Standard Items | | | | | |
| 1 |   | Welcome and apologies for absence Housekeeping | For information<br><br>To make sure that we have enough Governors present to be quorate and introduce any new attendees. | Lesley Bessant, Chairman  | Spoken |
| 2 |  | Minutes of last meeting held on 27 November 2014 | Paper to read for agreement<br><br>To check and approve the minutes of this meeting | Lesley Bessant, Chairman  | Attached  2014 11 27 PUBLIC MINUTES.pdf |
| 3 |  | Matters arising from the meeting held on 27 November 2014 | To discuss<br><br>To update on any action items and matters arising. | Lesley Bessant, Chairman  | Spoken |

| | | | | | |
|---|---|---|---|---|---|
| **4** | Declarations of Interest | | To agree<br><br>The opportunity for Governors to declare any interests that link to the agenda items being discussed today. | Lesley Bessant, Chairman<br>  | Spoken |
| **5** |  <br>  | Report on the Chairman's activities | For information<br><br>To hear from the Chairman on what she has been doing since the last meeting. There will be an opportunity to ask a question | Lesley Bessant, Chairman<br>  | Spoken |
| **6** |  | Questions from Governors | To discuss<br><br>To consider any questions raised by Governors which are not covered elsewhere on the agenda.<br>(*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.*) | Lesley Bessant, Chairman<br>  | Spoken |
| Question | | 1<br>i. Cllr Ann McCoy, Appointed Governor Stockton Borough Council:<br><br>*With regards to the recent case of a nurse who was struck off by the Nursing and Midwifery Council following a charge of harassment and criminal damage. The report stated that the Panel Chairman commented that their behaviour had put staff and patients at risk. The report also states that they had not* | | Cllr Ann McCoy | Reply attached<br>Item 5i 2015 01 19 response to Cllr McCc |

| | | | |
|---|---|---|---|
| | *informed the Trust of the charges faced. Considering Adult Safeguarding is there anything in the Terms and Conditions of employment that require an employee to inform the Trust of any charges they face that could impact on the safety of staff and patients.* | | |
| Question | 2<br>*ii.* Cllr Ann McCoy, Appointed Governor Stockton Borough Council:<br><br>*Is it mandatory for Trust staff to attend Mental Health Act and/or Mental Capacity Act training, and how does this compare against other Mental Health Trusts.* | Cllr Ann McCoy | Reply attached<br>Item 5ii 2015 02 15 response to Cllr McCc |
| Question | 3<br>*Janice Clark, Public Governor Durham*<br><br>a. How does the Trust record the number of data breaches that occur?<br>b. How does the Trust record the outcome of investigations into these data breaches?<br>c. Can the Trust explain why it did not respond to a Freedom of information request sent to all NHS trusts in April 2014 by Big Brother Watch?<br>d. Can the Governors be provided with the information that was requested by Big Brother Watch in April 2014? | Janice Clark | Spoken |

**Governance related items**

| | | | | | |
|---|---|---|---|---|---|
| **7** |  | Board of Directors meetings from November 2014 until end January 2015 | Paper to read for information<br><br>An opportunity to read through the key areas discussed at recent meetings of the Board of Directors | Lesley Bessant, Chairman<br>  | **Paper attached**<br>Item 6 Board Roundup.pdf |
| **8** |  | Monitor Risk Assessment | Paper to read<br><br>To receive information which is provided to Monitor, the regulator on how the Trust is performing | Phil Bellas, Trust Secretary | **Paper attached**<br>Item 7 Risk Assessment Framewc |

| | | | | | |
|---|---|---|---|---|---|
| **9** |  | Update on Task and Finish Group on how the Council of Governors conducts its business | For information<br><br>To hear what the task and finish group have been working on and their future plans. | Mary Booth, Governor Sponsor | **Spoken** |
| **10** |  | Trust's Engagement and Involvement Strategy 2015/18 | Paper to read and provide comments on<br><br>To be consulted on the plans for a new Strategy for engagement and involvement of staff, the public including service users and carers | Phil Bellas, Trust Secretary | **Paper attached**<br>Item 9 engagement and involvement strat<br>Item 9 Appendix 1 engagement and invc |

Annex 2

Task and Finish Group workshop at Governor Development Day 17/3/15

## 1. Seating

Negative

- Theatre did not work – seeing and hearing difficulties
- Depended where seated as to how could contribute and see what was happening
- Seats too low for some people
- Concerns around sitting at a round table
- Cabaret – concern that some people may focus into the table discussion all the time

Positive

- Happy to try cabaret
- Looking forward to compare board room to cabaret style of seating
- Allowed quicker access to microphone

Suggestions

- Do need a table to rest papers on
- Name plates to have names printed on both sides

## 2. Location

Positive

- Most people like MFC as a venue

Negative

- Queens campus – previous event poor room set up
- No hearing loop in queens campus - no microphone system
- Heating to be improved as been a concern over last 2 meetings

Suggestions

- Theatre style offset by herringbone type of seating

## 3. Timing

Positive

- Has improved over last couple of meetings
- Break good idea and is needed

Suggestions

- Should have set timings per agenda items to ensure everyone is aware of any time restraints
- Set finish time for the end of the meeting
- End time no later than 8pm

4. **Agenda Style – mock up**

Positive

- Some like it
- Like idea of easy read symbols
- Some governors have difficulty reading and makes easier for public to understand
- Overall general consensus to include symbols
- Like the what and why being included

Negative

- Some hate it
- Easy read distracting for some people
- Limited amount of images available

Suggestions

- LD services may be able to assist with image use
- One picture of speaker then don't repeat
- Agreement of overall agenda mock up
- All people to have pictures
- Would like to see timings included
- Governors to have blank column for notes (landscape)
- Highlight items for information only at end of agenda
- Photos should be optional Ensure options for electronic - people can open documents

**5. Report example**

**Positive**

- Happy with basic snapshot within example

**Negative**

- Don't like front page not necessary - General support for the removal of front sheet
- Acronym use needs to be looked at
- Is there a capacity issue to produce reports of this style by officers

**Suggestions**

- Still want option to have full paper
- Don't think need tables as appendix as narrative included
- Should be able to access electronically
- Some would like break down of local area performance

- Felt accessible – more information to hand
- Shredding issues of papers
- More meaningful, more narrative explains
- Full paper should be accessible
- Knowing what has already been challenged by board is important – should this be in the report or reported verbally
- NEDs should tell CoG what they have challenged on – included within report – perhaps this needs to be drawn out a little better

## 6. Committees

**Positive**

- Can see benefits for Task and Finish group work and increased governor development days
- Membership and Nomination and Remuneration should remain as committees
- Generally in favour disbanding 3 committees
- Task and finish groups have an end point, there is more involvement and more action as a result
- All Governor Development Days should be included and Governors choose what to be involved in
- Governor Development Days extending them is a good idea
- Agree task and finish groups that are topic dependant is a good idea
- Suggestion to streamline meetings to reduce costs incurred
- Agreement that N+R and membership should remain
- Can see benefits in briefings and information being shared with all Governors not just committee members

**Negative**

- Concern that there could there be loss of continuity over time changing from one type to the other
- Majority of people member of 3 committees – should be limited to 2 and be time served limited
- Too much duplication for committees looking at social inclusion and services user experience suggestions to merge these two
- Concern that change should not reduce activity in terms of involvement – info sharing
- Current committees are endless
- Concern over governor availability for more governor development days and task and finish groups

**Suggestions**

- Should have better locality focussed areas of work
- Use time prior to Council meeting to conduct/deliver briefings
- Locality task and finish groups

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

**Item 10**

# COUNCIL OF GOVERNORS

**Date of Meeting:** 19 May 2015

**Title:** Council of Governors' Development Plan 2014/15

**Lead:** Phil Bellas

**Report for:** Decision

## This report includes/supports the following areas:

| STRATEGIC GOALS: | ✓ |
|---|---|
| To provide excellent services working with the individual users of our services and their carers to promote recovery and well being | |
| To continuously improve the quality and value of our work | |
| To recruit, develop and retain a skilled and motivated workforce | |
| To have effective partnerships with local, national and international organisations for the benefit of our communities | |
| To be an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of our communities | ✓ |

| CQC REGISTRATION: Outcomes (✓) | | | | | |
|---|---|---|---|---|---|
| **Involvement and Information** | | | | | |
| Respecting & Involving Service Users | | Consent to care and treatment | | | |
| **Personalised care, treatment and support** | | | | | |
| Care and welfare of people who use services | | Meeting nutritional needs | | Co-operating with other providers | |
| **Safeguarding and safety** | | | | | |
| Safeguarding people who use services from abuse | | Cleanliness and infection control | | Management of medicines | |
| Safety and suitability of premises | | Safety, availability and suitability of equipment | | | |
| **Suitability of staffing** | | | | | |
| Requirements relating to workers | | Staffing | | Supporting workers | |
| **Quality and management** | | | | | |
| Statement of purpose | | Assessing and monitoring quality of service provision | | Complaints | |
| Notification of death of a person who uses services | | Notification of death or AWOL of person detained under MHA | | Notification of other incidents | |
| Records | | | | | |
| **Suitability of Management** (only relevant to changes in CQC registration) | | | | | |
| **This report does not support CQC Registration** | | | | | ✓ |

| **NHS CONSTITUTION:** The report supports compliance with the pledges of the NHS Constitution (✓) | | | | | |
|---|---|---|---|---|---|
| **Yes** | | **No** (Details must be provided in Section 4 "risks") | | **Not relevant** | ✓ |

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

**COUNCIL OF GOVERNORS**

**Date of Meeting:** **19 May 2015**

**Title:** **Council of Governors' Development Plan**

## 1. PURPOSE

1.1 The purpose of this report is to enable the Council of Governors to sign off the end of year position on its Development Plan for 2014/15.

## 2. BACKGROUND INFORMATION

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.

2.3 A development plan was approved by the Council of Governors at its meeting held on 22 May 2014 (minute P/14/18 refers) in response to issues identified from the self-assessment undertaken in late 2013 . A progress report was provided to the meeting held on 27 November 2014 (minute P/14/37 refers).

## 3. KEY ISSUES:

3.1 The end of year position against the Development Plan 2014/15 is provided in Annex 1 to this report.

## 4. IMPLICATIONS / RISKS:

4.1 **Quality:** No risks to patient safety, patient experience or clinical quality have been identified.

4.2 **Financial:** No financial risks have been identified.

4.3 **Legal and Constitutional:** The Annual Review supports compliance with the Foundation Trust Code of Governance.

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

4.5 **Other Risks:** No other risks have been identified.

## 5. CONCLUSIONS

5.1 Significant progress has been made in delivering the 2014/15 Development Plan.

## 6. RECOMMENDATIONS

The Council of Governors is asked to sign-off the end of year position on its Development Plan for 2014/15 (as set out in Annex 1 to this report).

**Phil Bellas,**
**Trust Secretary**

**Background Papers:**
*Council of Governors Development Day, February 2014 outcome*
*Council of Governors Development Plan 2014/15*
*Council of Governors report on progress November 2014*
*Foundation Trust Code of Governance*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Annex 1

# COUNCIL OF GOVERNORS PERFORMANCE EVALUATION ACTION PLAN

**PLAN DEVELOPED BY: Council of Governors** **DATE: 19 May 2015**
**PLAN AGREED: 22 May 2014**

| NO. | RECOMMENDATION/FINDING | INTENDED OUTCOME/RESULT | ACTION | ACTION OWNER | TARGET DATE | EVIDENCE | PROGRESS UPDATE |
|---|---|---|---|---|---|---|---|
| **THEME: Roles and Responsibilities** | | | | | | | |
| **1** | Holding the Non-Executive Directors to Account individually and collectively for the performance of the Board of Directors | • A better understanding of the roles of Non-Executive Directors | • To consider how Non-Executive Directors can participate in formal and informal meetings with Governors | Trust Secretary's Department | November 2014 | Report of the Governor Task and Finish Group to the Council Governors and approval of its recommendations on 26/9/14 (minute reference 14/70).<br><br>Action Plan to implement the Report's recommendations subsequently approved on 27/11/14 (minute reference 14/93). | **Completed**<br><br>A progress report on the action plan of the Task and Finish Group Review on "Holding the Non-Executive Directors to account for the performance of the Board" to be provided in September 2015. |
| | | • Governors to be more informed about the processes by which they can hold the Board and Non-Executive Directors to account | • Governors to utilise the information available to triangulate work of Non-Executive Directors/Board. This may involve observing meetings and researching papers as well as discussion | Council of Governors | November 2014 | | |

Annex 1

| NO. | RECOMMENDATION/FINDING | INTENDED OUTCOME/RESULT | ACTION | ACTION OWNER | TARGET DATE | EVIDENCE | PROGRESS UPDATE |
|---|---|---|---|---|---|---|---|
| **1** | Holding the Non Executive Directors to Account individually and collectively for the performance of the Board of Directors | | • Report and guidance to be produced by the Governor Task and Finish Group with a focus of holding Non-Executive Directors to account | Task and Finish Group members | September 2014 | | |
| | | • Awareness of the key issues of the Board of Directors | • A summary to be provided at each Council of Governors meeting of the key issues considered by the Board during the last quarter delivered by the Chairman | Chairman | September 2014 | Issue included in the action plan agreed by the Council of Governors on 27/11/14 (minute reference 14/93).<br><br>Board Round-up report provided to the Council of Governors meeting on 17/2/15. | **Completed** |

Annex 1

| NO. | RECOMMENDATION/FINDING | INTENDED OUTCOME/RESULT | ACTION | ACTION OWNER | TARGET DATE | EVIDENCE | PROGRESS UPDATE |
|---|---|---|---|---|---|---|---|
| **THEME: Training** | | | | | | | |
| **2** | To re-consider the provision of IT training to Governors | • Governors more proficient in IT literacy as a mechanism of communication and research | • Information Governance/ Training and IT to be consulted to establish if resource available and security issues can be overcome for the delivery of training | Deputy Trust Secretary | December 2014 | No requests have been received from Governors. | No requests have been received from Governors. |

Annex 1

| NO. | RECOMMENDATION/FINDING | INTENDED OUTCOME/RESULT | ACTION | ACTION OWNER | TARGET DATE | EVIDENCE | PROGRESS UPDATE |
|---|---|---|---|---|---|---|---|
| **THEME: Membership** | | | | | | | |
| **3** | Governors understanding their role for recruiting and representing the views of their membership and/or organisation | • To develop a mechanism and guidance as to the role of a Governor in the recruitment and engagement of public members<br>• For staff governors to have a better understanding of how they can represent their members<br>• For appointed Governors to understand their role in representing their organisation | • To consider the establishment of a Task and Finish Group with a focus on membership recruitment and engagement development | Trust Secretary | March 2015 | - | The Council of Governors has supported the creation of a Task and Finish Group to review how it undertakes is statutory duty to represent Members of the Trust and the Public.<br><br>However, this matter was deferred to enable the review of the operation of the Council of Governors.<br><br>It is now planned that the review will commence in September 2015. |

**FOR GENERAL RELEASE** **ITEM 11**

# COUNCIL OF GOVERNORS

**Date of Meeting:** 19 May 2015
**Title:** Service Update
**Lead Director:** Brent Kilmurray
**Report for:** Information

## This report includes/supports the following areas:

| STRATEGIC GOALS: | ✓ |
|---|---|
| To provide excellent services working with the individual users of our services and their carers to promote recovery and well being | ✓ |
| 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 our communities | ✓ |
| To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of our communities | ✓ |

| CQC REGISTRATION: Outcomes (✓) | | | | | |
|---|---|---|---|---|---|
| **Involvement and Information** | | | | | |
| Respecting & Involving Service Users | | Consent to care and treatment | | | |
| **Personalised care, treatment and support** | | | | | |
| Care and welfare of people who use services | | Meeting nutritional needs | | Co-operating with other providers | |
| **Safeguarding and safety** | | | | | |
| Safeguarding people who use services from abuse | | Cleanliness and infection control | | Management of medicines | |
| Safety and suitability of premises | | Safety, availability and suitability of equipment | | | |
| **Suitability of staffing** | | | | | |
| Requirements relating to workers | | Staffing | | Supporting workers | |
| **Quality and management** | | | | | |
| Statement of purpose | | Assessing and monitoring quality of service provision | | Complaints | |
| Notification of death of a person who uses services | | Notification of death or AWOL of person detained under MHA | | Notification of other incidents | |
| Records | | | | | |
| **Suitability of Management** (only relevant to changes in CQC registration) | | | | | |
| **This report does not support CQC Registration** | | | | | |

| **NHS CONSTITUTION:** The report supports compliance with the pledges of the NHS Constitution (✓) | | | | | |
|---|---|---|---|---|---|
| **Yes** | | **No** (Details must be provided in Section 4 "risks") | | **Not relevant** | |

**COUNCIL OF GOVERNORS**

**Date of Meeting:** **19 May 2015**

**Title:** **Service Update Report**

## 1. INTRODUCTION & PURPOSE

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

## 2. BACKGROUND INFORMATION

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

Substance Misuse services –The partnership service with Lifeline successfully commenced on the 1 April 2015.

The service has received 'Resilience' monies to improve year round service delivery. The funding has been used to establish a dedicated hospital Section 136 suite at Lanchester Road Hospital which also supports the Trust commitment to the Crisis Concordat to respond quickly to people experiencing a mental health crisis. These services have continued in April and May 2015.

The service is seeing an increasing demand on teams, with a month on month increase in referrals. Currently the service is receiving circa 1000 referrals each month, compared to circa 600 referrals in an equivalent population (Tees). The service has increased each Affective team by 1 wte nursing staff to manage this demand. DDES CCG have agreed to fund attached professionals into primary care to meet demand at source which will reduce pressure on the access assessment process.

#### Mental Health Services for Older People

The Dementia Care bed reduction of 5 beds across the 3 wards has been completed with the 3 existing wards (2 at Auckland Park and 1 at Bowes Lyon Unit, LRH) each providing 10 beds. The service will develop a Business case to identify the best way to provide these services in the most appropriate accommodation.

**Children and Young People's Services**

COG has previously been made aware of the increasing demand on community teams with an increase in the number of referrals received. The establishment of the crisis and self-harm service has provided some additional capacity. A review identifying the success of this service will be presented to commissioners in the next month or so.

The Trust has agreed to fund an additional 6 permanent CAMHS staff to meet the increasing demand and ensure timely access to services as well as reinvest some of the efficiencies made back into the service in the form of additional nurses.

We continue to discuss the increasing demand with commissioners in light of their review of CAMHs services.

**Learning Disability Service**

Work is under way on a plan to provide individual flats for three people in one of the wards at Bek, Talbot and Ramsay so that individuals with very complex needs can be cared for on their own. COG will be aware that we have submitted a proposal to Commissioners to provide the individual flats, which was rejected by Commissioners and we are now reconsidering our options.

The service has been instrumental in designing a new service model for patients on the Winterbourne list so they can be cared for in a tenancy model. This work has been undertaken in partnership with Durham County Council and health commissioners and commissioners are looking to develop a new service on this model. A business case has been developed which will be submitted against a national fund of capital.

A new service model for specialist community learning disability services in Durham has been agreed with a business case submitted to commissioners. Commissioners are looking to fund this using savings made from reducing assessment and treatment beds.

3.2 **Tees**

**Adult Mental Health Services**

The Crisis Assessment Centre has commenced operations and has been successful in its first 70 assessments. The Police have already written describing the benefits and we are sure this will continue as more staff come into post.

The Crisis Assessment Centre has been an important part of the Trust's contribution to the Crisis Concordat. An action plan is being established by NEMDU, the organisation commissioned to project manage the improvements and this will be circulated when it is complete and agreed

Although all services are managing waiting times for referrals, there are still problems in meeting the demand for autism assessments and also adults with suspected ADHD.

**Mental Health Services for Older People**

Bed occupancy on Westerdale South, for patients with an organic illness, has been high following a number of admissions from Hartlepool. This took place following CQC reviews of nursing homes in the area and reviews by the Local Authority of additional payments made for managing patients needing one to one staffing.

The CCG have praised the Intensive Community Liaison service for their speed of response when Admiral Court Nursing Home was inspected by the CQC and action was required to improve care. They also highlighted the level of additional support they offered as part of an action plan.

**Children and Young People's Services**

Waiting times for assessments have remained below 9 weeks but the number of referrals is making further reductions difficult.

A 3P event is taking place to look at provision of early intervention for 0 -4 year olds in conjunction with Stockton Borough Council. We would hope to roll this out to all four areas in Tees but will focus on one initially.

The Crisis and Liaison service has successfully recruited, and is now taking cases of self harm in acute hospitals before moving to full implementation as all staff come into post during the month.

**Learning Disability Services**

The transition of patients from our inpatient facilities to new providers is nearing completion. This will result in assessment and treatment being focussed on Bankfields and staff will be able to take up posts in the community teams where the service has been enhanced to support patients in the community and prevent admissions where possible.

There are new demands on Adult LD services particularly from patients moving on from Forensic Services and we are planning to ensure that changes in specialist commissioning arrangements will be managed safely

3.3 **North Yorkshire**

**Adult Mental Health Services**

We have successfully recruited a new, permanent Head of Service for Adult Mental Health, Mr Patrick Scott. He joined us on 4th May and his main office base will be in Scarborough. Patrick brings a wealth of experience and the service is looking forward to working with him. Patrick will replace Mr Paul Hyde who, after many

years of loyal public service, is retiring in June. We also wish Paul every happiness for his future.

There has been a slight delay in completion of the Orchards Rehabilitation Unit in Ripon that will replace Abdale House. The completed building will be handed over in June and we expect our service users to move in early July.

The North Yorkshire Crisis Concordat delivery plan was agreed and signed off in March 2015. Implementation is now being led by local delivery groups monitored through a multiagency steering group.

IAPT performance has improved significantly since we took over the operational management of the service in July 2014. There was a huge effort to achieve the prevalence targets. Whilst this was achieved in Hambleton, Richmondshire & Whitby, the performance in Harrogate & Rural District and Scarborough & Ryedale was slightly below. Commissioners have complimented the Trust on a significant improvement. A capacity and demand analysis is under way to ensure we can remodel the service in order to maximise productivity within the resources available.

**Mental Health Services for Older People**

Rowan Ward has successfully moved back to Briary Wing in Harrogate in March following repairs to the floor.

Hospital Liaison Services are now operating in full across the three main acute hospital sites across North Yorkshire. Activity is increasing month on month with positive feedback from service users and Emergency Department colleagues.

We are working closely with partners in Harrogate in support of the health and social care community Vanguard award to help design a new model of care for, in the first instance, frail older people. The Trust has been asked to lead initial work on developing a shared care plan for patients, their families and care staff.

**Children and Young People's Services**

In order to support the development of the local CAMHS we have temporarily enhanced the Head of Service capacity and appointed Dr Liz Herring as Head of Service for Tier 3 services. Liz will be with us for 12 months on secondment from her role as Director of Nursing, Quality & Development at North Durham CCG.

**Learning Disability Services**

The service has had its first success with 'Project Choice' across Scarborough - a partnership scheme between ourselves, the acute hospital and education to support people with a learning disability into work experience.

3.4 **Forensic Service**

**Restrictive practice/CQC**

The CQC inspection has highlighted significant progress with reducing restrictive practices within secure services. Inspectors identified that staff and patients were able to articulate the changes and that patient notes reflected the reduced restrictions and individual risk assessments.

A service wide event took place on the 4th February to extend the learning into forensic mental health. All patients now have individualised risk assessments in place which are regularly reviewed in relation to rub down searches, room searches, supervised visits and supervised opening of post. The status of these risk assessments is displayed on visual control boards in each ward office.

CQC stated they wished to see all of these developments rolled out across FMH, specifically in relation to individualised risk assessments. The CQC reviewed the position against the FLD compliance action plan and were very happy with progress made in the FLD service.

**Liaison and Diversion**

The Trust was successful in the Tender process for Liaison and Diversion services within Cleveland Police and Durham Constabulary areas.

The Liaison and Diversion mobilisation plans are developing well.

As L & D services were in place in Middlesbrough, services continue within Middlehaven Police Station, whilst recruitment has commenced for additional staff for the Middlehaven team and for services within Durham Constabulary.

A recruitment event has taken place in April whereby 42 staff were interviewed and successful applicants were appointed to the new service.

## 4. IMPLICATIONS / RISKS:

4.1 **Quality:**
None.

4.2 **Financial:**
None.

4.3 **Legal and Constitutional:**
None.

4.4 **Equality and Diversity:**
None.

4.5 **Other Risks:**
None.

## 5. CONCLUSION

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

## 6. RECOMMENDATION

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

**Brent Kilmurray**
**Chief Operating Officer**

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

**ITEM 12**

# COUNCIL OF GOVERNORS
# PUBLIC AGENDA

**Date of Meeting:** 19th May 2015

**Title:** A report on compliance activity in relation to the Care Quality Commission and an update on any items of relevance following contact with the Care Quality Commission

**Lead Director:** Chris Stanbury, Director of Nursing and Governance

**Report for:** Assurance

## This report includes/supports the following areas:

| **STRATEGIC GOALS:** | ✓ |
|---|---|
| **To provide excellent services working with the individual users of our services and their carers to promote recovery and well being** | ✓ |
| **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 our communities** | |
| **To be an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of our communities** | ✓ |

| **CQC REGISTRATION: Outcomes (✓)** | | | | | |
|---|---|---|---|---|---|
| **Involvement and Information** | | | | | |
| Respecting & Involving Service Users | ✓ | Consent to care and treatment | ✓ | | |
| **Personalised care, treatment and support** | | | | | |
| Care and welfare of people who use services | ✓ | Meeting nutritional needs | ✓ | Co-operating with other providers | ✓ |
| **Safeguarding and safety** | | | | | |
| Safeguarding people who use services from abuse | ✓ | Cleanliness and infection control | ✓ | Management of medicines | ✓ |
| Safety and suitability of premises | ✓ | Safety, availability and suitability of equipment | ✓ | | |
| **Suitability of staffing** | | | | | |
| Requirements relating to workers | ✓ | Staffing | ✓ | Supporting workers | ✓ |
| **Quality and management** | | | | | |
| Statement of purpose | | Assessing and monitoring quality of service provision | ✓ | Complaints | ✓ |
| Notification of death of a person who uses services | ✓ | Notification of death or AWOL of person detained under MHA | ✓ | Notification of other incidents | ✓ |
| Records | ✓ | | | | |
| **Suitability of Management** (only relevant to changes in CQC registration) | | | | | ✓ |
| **This report does not support CQC Registration** | | | | | |

| **NHS CONSTITUTION:** The report supports compliance with the pledges of the NHS Constitution (✓) | | | | | |
|---|---|---|---|---|---|
| **Yes** | ✓ | **No** (Details must be provided in Section 4 "risks") | | **Not relevant** | |

**COUNCIL OF GOVERNORS**
**PUBLIC AGENDA**

**Date of Meeting:** **19th May 2015**

**Title:** **A report on compliance activity in relation to the Care Quality Commission and an update on any items of relevance following contact with the Care Quality Commission**

## 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 to maintain registration.

## 2. KEY ISSUES:

2.1 Following the CQC inspection in January a draft report was received on the 10th April, a week later than anticipated. The Trust had 10 working days to submit a factual inaccuracy report and to challenge any findings. The overarching and core service reports were circulated to Directors of Operations and relevant senior managers for each respective core service report and to report back any inaccuracies and/or challenges. The final factual inaccuracy report was submitted to CQC on 24th April and the Trust has now received the final report which will be discussed at the Quality Summit on 5th May. The Trust has been given an overall rating of good. Five breaches were identified against four regulations and CQC have asked for an action plan to be submitted to CQC by 18th May. The final report will be published on the CQC website on 11th May 2015, following the Quality Summit.

2.2 On 17th April, the Director of Nursing and Governance received a letter from Jenny Wilkes, Head of Inspections (Hospitals – Mental Health) at CQC, requesting that CQC be allowed access to some further information regarding the Trust's learning disability services. This followed a telephone conversation between Jenny Wilkes and the Trust stating that CQC is now taking a more prominent role in relation to the transforming care agenda.

When CQC inspected the Trust's Learning Disability services, CQC stated they could clearly see that the Trust had taken their role and responsibilities, post Winterbourne, very seriously. CQC identified that the care the patients in these services were receiving is good. CQC suggested the evidence they saw showed a lack of effective arrangements in the health and social care economy to a level that is responsible for preventing the timely discharge of these patients into community based settings. The evidence suggested that the patients have been assessed as requiring a different form of care and treatment to meet their needs than that which is currently available. CQC therefore needed further evidence to corroborate these findings.

The letter stated that CQC were proposing a small team of inspectors visit the Learning Disability services week commencing the 27th April 2015 to undertake the following:

- Review all patients' clinical records and mental health act records.
- Liaise with the local CCG's, Local Authorities and community learning disability teams.
- Meet with the clinical teams to discuss each individual patient.
- Meet with the patients and their carers.

The reviewed started on 28th April 2015 at Bankfields Court, with further reviews to be undertaken at Roseberry Park on 29th and 30th April and Lanchester Road Hospital on 1st May 2015.

2.3 Mental Health Act monitoring reports have been received in respect of thirteen inspections:-

**Linnet Ward – 20/01/15**

Two issues were identified:-

- The ward operated the following blanket rules and restrictions to which the patients objected.
    - Patients were only allowed access to the courtyard at 12 set times during the day to smoke. The last time was at 7.10 pm and the period between the last and first access was over 12 hours. During this time they were supervised by two members of staff.
    - Patients were not allowed access to the courtyard outside of these times.
    - Patients could only access the assessment kitchen, the laundry, the de-escalation lounge and the activity room when they were supervised by staff.
    - The patients' bedroom windows were locked and patients were not allowed to slide them from the sealed glass to the meshed section to allow in fresh air without asking a member of staff.
    - Patients were not permitted to meet with their visitors in private. A member of staff would sit in on each visit.
    - Staff regularly search each patient's room and perform a rubdown search on each patient.
    - Patients returning from unescorted leave from either outside or within the secure perimeter were subjected to a rubdown search.
    - Patients were asked to open their personal mail in front of staff and show them the contents.
    - The information provided to patients on searching did not accurately describe the practice on the ward.

- The patients we spoke with had only a superficial knowledge of their intervention plan and no awareness of the outcomes that needed to be achieved in order for them to be either transferred to another ward or to be discharged.
  Patients were not involved in the formulation of their care plans.
  The case notes and other records contained mainly objective accounts of the patients behaviours and actions each day; very few records were found of the patients own views or of their participation in their care.

**Nightingale – 27th January 2015**

Two issues were identified:-

- That every patient CQC spoke with said that there had been occasions when their leave had been cancelled because the ward had insufficient staff to provide an escort.

- That the ward operated the following blanket rules and restrictions to which the patients objected.

    - Patients were only allowed to access to the courtyard at 12 set times during the day to smoke. The last time was at 7.20 pm and the period between the last and first access was almost 12 hours. During this time the patients were supervised by two members of staff and were not allowed access to the courtyard outside of these times.

    - Patients could only access the assessment kitchen and the laundry when they were supervised by staff.

    - The patients' bedroom windows were locked and patients were not allowed to slide them from the sealed glass to the mesh section to allow in fresh air without asking a member of staff.

    - Twice a day the staff would enter the patients bedrooms, whether the patient was present or not and check the integrity of the perimeter wall and the condition of the en suite.

    - Staff routinely searched each patient's room and performed a rubdown search on each patient irrespective of the patient's assessed risks.

    - Patients returning from unescorted leave were subjected to a rubdown search irrespective of the patient's assessed risks.

    - Two information leaflets on searching were available to the patients which contained conflicting information, only one of which was consistent with the Code of Practice.
    - Patients were not permitted to meet with their visitors in private; a member of staff would sit in on each visit irrespective of the patient's assessed risks.

    - Patients were asked to open their personal mail in front of staff and show them the contents.

**Ward 15 – 30th January 2015**

Seven issues were identified:-

- There had been some improvements to the environment since our last visit and the ward had been refurbished to a high standard. However, we were concerned that some aspects of the environment did not promote patient privacy and dignity. These were:

- The mixed sex nature of the ward; whilst the male bedrooms are along one corridor and the female bedrooms along another, patients need to walk through all areas of the ward in order to access the communal areas. This was a particular concern along the female corridor where the female bathrooms are located in close proximity to the communal lounge.

- In the four-bedded bays, there was only a curtain to divide the area between beds.

- The seclusion room did not appear to provide the patient with any means of calling for attention or an intercom system. The nurse in charge confirmed that patients would be expected to shout through the door if they wanted to speak to the observing staff. The observation panels were placed in such a way that staff would be unable to observe a secluded patient without standing up and peering through the panels, which may prove quite intrusive for the patient.

- That the seclusion records were difficult to extract from the patient's case notes on the PARIS system. Notes which should have been contemporaneous were found in the entries from the following day. We were unable to find a recording system which contained a separate, step by step account of the seclusion procedure.

- That in the case of one patient, the leave form was ambiguous as the parameters and conditions of leave were not clear.

- We reviewed a sample of the patient records and found that where the T2 authorised treatment with an antipsychotic from the British National Formulary (BNF) category 4.2.1, the RC had not identified whether or not this included clozapine for three patients. We also noted that one patient appeared to be being prescribed two antipsychotics when only one had been authorised by the T2 and that treatment with Hyoscine Hydrobromide had not been included.

- It was not possible to find evidence that the outcome of leave had been fully documented in accordance with the CoP paragraph 21.22 in some cases and we were unable to find evidence that the patient's own view of their leave had been sought or recorded.

- Each patient had a number of different intervention care plans in place to address different areas of need but the patient's view was not evident within the care plans. Intervention plans recorded the aim of each intervention but were written very much from a nursing perspective and did not reflect some of the more collaborative work which occurs during the one to one sessions. Within the care plans we were unable to find any information about the patient's strengths, progress, or their view of their treatment or ideas for the future.

**Cedar Ward, Briary Unit, Harrogate 21/01/15**

Six issues were identified:-

- That detained patients were generally informed of their rights in accordance with section 132 on admission, although some patients reported that there had been a delay in providing them with this information.
- That one patient had not received a fresh explanation of his rights when his detention was renewed.
- That some patients were not clear about their legal status or rights under section 132 of the Act. Some patients informed us that staff had just read out the rights leaflet when attempting to give this information and did not offer any further explanation or check understanding.
- Old and superseded leave forms in the current files that need to be removed or struck through. Patients informed us that there were occasions when they were unable to access escorted leave that had been authorised as there were insufficient numbers of regular staff available to escort them.
- Each patient had a number of different intervention care plans in place to address different areas of need but the patient's view was not evident within the care plans. Intervention plans recorded the aim of each intervention but were written very much from a nursing perspective and did not show evidence of collaboration. Within the care plans we were unable to find any information about the patient's strengths, progress, views of their treatment or ideas for the future.
- That in one case there were no care plans in place to address specific risks and disturbed behaviour that had been identified within the risk assessment.

**Stockdale – 29/01/15**

One issue was identified:-

- One patient had medication authorised by Form T2 dated 10 December 2014. However he had been receiving one type of medication not covered by Form T2. The medication was stopped for clinical reasons on 27 January 2015 but the mistake had not been discovered by the audit system in place.

**Overdale – 28/01/15**

Six issues were identified:-

- Patients did not have access to the internet while on the ward.
- The ward had not had a recent trust environmental risk assessment. However, we noted that some potential ligature risks were present such as length of electrical cabling on equipment, mobile telephone ear phones and phone chargers. We discussed these points with the ward manager and suggested these matters be included in the ward risk register.
- No Care Quality Commission (CQC) information rights leaflets for detained patients were available on the ward.

- For one patient the online statutory consultee form had only been completed by one consultee. Also the RC had not completed part of the form to confirm the patient had been informed of the outcome of the SOAD visit.
- For one patient who had been subject to section 5(2) no copy of the form was present in the case file.
- Records did not confirm that all detained patients were being reminded of their rights under the MHA at key times during their detention such as managers hearings and renewal of detention.

**Wingfield 27/01/15**

Two issues were identified:-

- In the care plans of the patients whose notes we examined, we found that some patient views were recorded, but in a very minimal fashion.

- In some of the notes examined we could not find care plans to manage some of the identified risks.

**Evergreen Ward (CYPS Tier 4) – 27th January 2015**

No issues were identified

**Abdale House (AMH North Yorkshire) – 20th January 2015**

Eight actions were identified:-

i) There had been some improvements to the environment since CQC's last visit and this has created a warm and homely environment appropriate for a rehabilitation unit.

However, CQC were concerned that some aspects of the environment do not promote patient safety and privacy. These were as follows:

A number of ligature risks were observed throughout the building. CQC noted that the stairwell to the second floor was a ligature risk and were concerned about its isolated location relative to the patient areas. This risk had not previously been identified. CQC were informed that work would be undertaken immediately to address this risk.

Mixed sex accommodation was managed by having male bedrooms at one side of the building and female bedrooms at the other. However, there were places where male and female bedrooms and bathrooms were next to each other such as the ground floor bedrooms and the adjoining corridor bedrooms on the first floor. CQC also noted that there was no designated female only lounge

The staff office doubles as the clinic and we were informed that patients would be invited in to the office to receive their medication. CQC were concerned

about how this arrangement might impact on patient privacy particularly when there are other members of staff working in the office at the same time. CQC were also concerned about protecting confidential information in the staff office when patients come in for their medication.

ii) There was some evidence of restrictive practices on this unit which need to be reconsidered in the light of the rehabilitative nature of the facility. These included:

- Locking away all sharp knives because of historical risks associated with a patient who was discharged some time ago.
- Patients were not allowed to watch the television until after 4pm during the week.
- Patients were given £4.00 each afternoon to shop for their evening meal.

They were not able to pool money together and shop for a few days or put their own money towards their meal. This restricted their choice about what they could buy and did not support the development of budgeting skills.

iii) CQC found that patients were generally informed of their rights in accordance with section 132 of the Act on admission and at three monthly intervals thereafter. However, in the case of one patient it was not possible to identify when they had last been made aware of their rights.

iv) Patients were granted both escorted and unescorted leave on each section 17 leave proforma. The parameters of leave were not clearly set out and it was unclear under what circumstances a patient requiring escorted leave would be allowed to leave the facility unescorted.

v) The leave file did not contain the Ministry of Justice (MoJ) letter authorising leave, as well as the section 17 leave authorisation. CQC also noted that the old leave forms were present in the leave file which could lead to confusion about what leave had actually been granted.

vi) It was not possible to find evidence that the outcome of leave had been documented in accordance with the CoP paragraph 21.22 in some cases and CQC were unable to find evidence that the patient's own view of their leave had been sought or recorded.

vii) Each patient had a number of different intervention care plans in place to address different areas of need but the patient's view was not evident within the care plans. Patient wishes were captured as part of the recovery star, but this did not appear to be linked in any way to the intervention plans and therefore it was unclear how this would be used to plan, develop or review a patients care and treatment.

viii) CQC reviewed a sample of the patient records and found that treatment appeared to be being given under an appropriate legal authority. However, there was a form T2 in place for one patient which appeared to authorise treatment with a nutritional supplement which would fall outside the definition of

medical treatment for mental disorder as defined by section 145(4) of the Act and therefore the provisions of section 58 would not apply.

**Rowan Ward at Alexander House (MHSOP at North Yorkshire) – 02/02/15**

Three issues were identified:-

i) One patient detained under section 3 MHA who did not appear to have a nearest relative within the meaning of the Act.

ii) The conditions for leave for two patients did not set out how many staff should escort the patient or whether a specific designation of staff should act as escort.

iii) There was an over reliance on the use of standardised statements applicable to all patients in the care plans we reviewed.

**Springwood (MHSOP at North Yorkshire) – 10/02/15**

Two issues were identified:-

i) That while the staff had recorded how they had attempted to inform the detained patients of their rights, they had also recorded that every detained patient had not understood the information. The staff had only referred one detained patient to the advocacy service. No intervention plans had been developed to address either the patients' inability to comprehend the information or the action the staff should take to ensure that the patients' rights were upheld.

ii) The MCA1 forms used to record the assessment of the patient capacity did not state that the assessment was for the patients capacity to consent to their treatment.

**Mallard (FMH Roseberry Park) – 17th February 2015**

Three actions were identified:-

- To ensure that patient' clinical records contained an intervention plan with actions needed for the provision of information relating to MHA Section 132 ensuring that a patient's rights were upheld in relation to understanding their rights under the Mental Health Act or had refused to hear it.

  To implement a system/register to record which patients were referred to an advocate and which continued to be supported by an advocate. To ensure information about advocacy services displayed on the ward's notice board was up to date.

- That the ward risk assess patients individually to identify their risks and review the following blanket restrictions:
  - Staff regularly searched each patient's bedroom and performed a rubdown search on each patient. The Trust's information leaflet to patients on

searching patients, entitled "Ridgeway Searching of Persons and the Environment", did not comply with the MHA 1983 Code of Practice and needed to state that searching would be proportionate to any identified risk, patients would be informed how frequently they would be searched, that staff would ask their permission to carry out the searches and who they should contact if they had questions about the searching practice.
    - Patients were not permitted to meet with their visitors in private; a member of staff would sit in on each visit.
    - Patients were asked to open their personal mail in front of staff and show them the contents.
    - The patients' bedroom windows were locked and patients were not allowed to slide them from the sealed glass to the mesh section to allow in fresh air without asking a member of staff.
    - Twice a day the staff would enter the patients' bedrooms, whether the patient was present or not and check the integrity of the perimeter wall and the condition of the en-suite.

- That the responsible clinician must the feedback to the patient following the visit by the second opinion appointed doctor SOAD.

**Talbot (LD Lanchester Road Hospital) – 3rd March 2015**

No actions were identified in respect of monitoring the application of the Mental Health Act. However during the visit a patient raised specific issues regarding their care, treatment and human rights and an action statement has been submitted to address these issues.

2.4 The Care Quality Commission recently published a guide for care providers on how to display CQC ratings and a briefing is attached as appendix 1.

2.5 The Care Quality Commission recently published their **Final guidance on regulations (the fundamental standards)**. A briefing and summary of the fundamental standards are attached as Appendix 2.

2.6 England's Chief Inspector of Hospitals has published his first report on the quality of the services provided by Southern Health NHS Foundation Trust following an inspection by the Care Quality Commission.

Overall, the trust has been rated as Requires Improvement – although the trust was rated as Good for being caring and responsive. The specialist perinatal service based at Winchester was rated Outstanding in all areas.

Southern Health NHS Foundation Trust delivers a wide range of community healthcare, mental health, learning disability and adult social care services from locations in Hampshire, Oxfordshire and Buckinghamshire.

A team of CQC inspectors, expert specialist advisors and people who have experience of using services or caring for someone who uses services spent four days at the trust

in October. CQC has published 17 separate reports on the services provided by the trust in hospitals, in clinics, and in the community.

Full reports including ratings for all core services are available by this link :- http://www.cqc.org.uk/provider/RW1

At the time of the inspection, the trust was in the process of redesigning the way it delivers its services, and these changes were at a relatively early stage of development. Although the trust leadership had been strengthened by the appointment of new directors and senior managers, many had only been in post a short time.

The inspectors found a lack of consistency across the trust. While some community health and mental health services were good, there was significant variation in the quality of services.

The numbers of staff and skill mix on some mental health wards were a concern. Staff reported working longer than their contracted hours in order to deliver care to patients and said that the needs of patients was not always taken into account when deciding the numbers of staff.

Community healthcare services did not always have enough staff and the gaps were not always covered. This meant some missed visits to patients and long waiting times for treatment by a therapist.

At the time, inspectors raised their concerns about the safety of patients at Ravenswood House, a secure hospital at Fareham. Although there are plans to relocate the service, inspectors were concerned that the building was unfit for use. Some wards had ligature points that could endanger people at risk of suicide.

CQC has identified a number of specific areas where the trust must improve. As a first step, the trust must provide a plan setting out how it will address each requirement.

On the adolescent mental health wards and forensic services, the trust must ensure there is an appropriate policy for the use of restraint and that there is appropriate recording of this.

The trust must ensure appropriate measures are taken to mitigate and manage ligature risks that might endanger patients at risk of suicide, on forensic and secure wards at Ravenswood House and Southfield.

On wards for people with learning disabilities or autism, the trust must ensure that all staff are aware of adverse incidents that have taken place in the service and where relevant in other parts of the trust and the learning from these incidents

The trust must ensure there are sufficient numbers of suitably qualified, skilled and experienced staff to provide end of life care to all patients that need it.

Despite these problems, in all of the services visited, inspectors found kind, sensitive and caring staff who were passionate about their work and committed to delivering high quality care. Patients and families were positive about the way staff communicated with them, the time staff took to listen, and their caring nature. Inspectors also identified a

number of specific areas of good practice and some exceptional practice across the trust, including:

The mother and baby unit at Melbury Lodge in Winchester engaged in preventative work and raised awareness of the needs of women who experience mental health needs during and after pregnancy. They used a range of creative methods to engage and support women using the service.

The trust had introduced a 'recovery college' for people with mental health problems and staff working in mental health services. The college offers courses designed to increase knowledge of recovery and self-management

A leadership development programme called Going Viral had been developed, with the aim of supporting approximately 1,000 senior leaders across the trust to redesign and integrate their services to enhance every aspect of the patient experience.

The trust had a clear commitment to progressing research and had conducted 45 research studies between 2012/14 involving approximately 800 people

A system of peer review had recently been established. The process involved a small review team from another service or area within the trust visiting a ward or team and assessing it against set criteria.

Inspectors found a clear commitment to equality and diversity: the trust had won several national awards.

2.7 On 22nd April 2015 following an inspection by the Care Quality Commission England's Inspector of Hospitals published his first report on the quality of the services provided by Leeds Community Healthcare NHS Trust.

Overall, the Leeds Trust was rated as Requires Improvement. Inspectors found that services were caring, effective and well led, but that the trust required improvement to be safe and responsive, particularly in relation to its Community and Inpatient services, and Community Child and Adolescent Mental Health Services.

As part of this Community Healthcare Inspection the CQC inspected the core service of Child and Adolescent Mental Health Wards and rated them overall as good. However the Inspectors were concerned about the safety of the premises at Little Woodhouse Hall which provides inpatient services for children and young people with mental health needs. It was stated that not all the potential risks from fixtures were identified and patients could have self-harmed, the lay out of the building meant it was difficult for staff to observe all parts of all wards due to the layout of the building. The Leeds Trust had identified the premises were not suitable, but did not have a clear timescale for moving to new premises or have plans in place to improve the present premises whilst they waited for the move.

CQC identified some additional areas where the Leeds Trust should make improvements (for full details, see the report). These included ensuring that:

- People are protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them in their records. Staff had not always recorded peoples risk assessments on the computer system.
- Young people, children and families are able to access community child and adolescent mental health services they need within a reasonable time frame.
- Staffing levels in adult community teams are reviewed to ensure they are safe, especially at times of high vacancies.

A link to the report is attached below:-

http://www.cqc.org.uk/content/chief-inspector-hospitals-publishes-report-quality-care-provided-leeds-community-healthcare

## 3. IMPLICATIONS / RISKS:

3.1 **Quality:** Provision of safe and effective high quality services is a strategic priority for the Trust and the Essential 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:** 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:** 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 Essential Standards of Quality and Safety 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.

3.5 **Other 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.

## 4 CONCLUSIONS

4.1 The Trust continues to maintain full registration with the Care Quality Commission with no conditions and is gradually strengthening the validated evidence base that demonstrates compliance with the CQC's framework for regulating and monitoring services.

## 5 RECOMMENDATIONS

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

**Chris Stanbury,**
**Director of Nursing and Governance**

**Appendix 1**

## A guide for care providers on how to display CQC ratings

### Introduction

To help the public know how care services are performing, the Government has introduced a requirement for providers to display CQC ratings. The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided. The ratings tell the public whether a service is outstanding, good, requires improvement or inadequate.

The guidance details the following points:

- When the Trust has been awarded a CQC rating (outstanding, good, requires improvement or inadequate) we must display it in each and every premises where a regulated activity is being delivered, in the main place of business (West Park) and on website(s) to ensure people will be sure to see it. **This is a legal requirement from 1 April 2015.**
- CQC will assess whether or not your ratings are displayed legibly and conspicuously – not doing so may result in a fine and may impact on future inspection ratings.
- CQC will make posters for physical display of the ratings available to download from their website. Using their posters will ensure that we include all the information as set out in the Regulation.

    - At each premises you must show the ratings that relate to the service(s) provided at that location.

- Premises poster

    - This should **always** be displayed at the premises it relates to.
    - This is the only poster you need to display in adult social care.

- Provider poster

    - This should **always** be displayed if there is no premises level poster (for example, for community or mental health providers).
    - This should also be displayed if a premises level poster is not relevant (for example, at an NHS trust head office where that office is not in a rated location).

- Activity poster (core services / population groups)

  - This should **always** be displayed alongside either the premises poster or the provider poster.

- For Mental Health and Community Health Services, CQC expect the Trust will display our posters at the main entrances to all premises where we provide a regulated activity, where as many people as possible are able to see them.

- If some of the people who use Trust services do not have access to the entrance (for example, on a locked ward) the Trust must display the poster somewhere people who use that service can see it (for example on a notice board in the ward).

- For a community-based service it is our responsibility to ensure that the poster is visible to people who use that service when they come to use it.

- For specialist services eg Eating Disorders, that have not been rated, but have been given an overall provider rating, the Trust must display our overall provider rating and core service ratings.

- It is not a requirement, but the Trust may wish to consider displaying additional posters showing our ratings at the entrances to all wards / clinics where core services are delivered.
- The Trust must display ratings online on the websites. The Trust can use the CQC templates for online display to help us do so. These are available from www.cqc.org.uk/ratingsdisplaytoolkit.

**Website(s)**

  - The Trust must put ratings on every website that we operate that describes the services we offer.

**Webpage(s)**

  - The overriding principle is to place ratings on a permanent page(s) that the public (people who use services or those acting on their behalf) frequently visit.
  - Wherever possible, place ratings on a context-specific page. For example, a hospital rating should be included on the main page for that hospital. If the Trust does not have premises specific pages, we are still required to display premises ratings. The Trust should identify other appropriate pages that meet the principles outlined here.
  - The ratings should be on a page that can be reached via the main navigation. Pages that can only be reached by using a web search facility are not conspicuous.

- When placing the ratings on a page, put it above the fold so that the user does not need to scroll down to see it.

- The Trust has a maximum of 21 calendar days to display ratings from the date the Trust's inspection report is published on the CQC website.

**How will the new Regulation be enforced?**

If CQC assess that the Trust's rating is not displayed legibly and conspicuously, or it has been displayed inaccurately (for example, it does not reflect your most recent ratings or does not contain all the information required) CQC will discuss this with the Trust. CQC will tell the Trust why they think it is not meeting the Regulation and ask the Trust to take appropriate action.

**Appendix 2**

## Final guidance on regulations (the fundamental standards)

CQC have published the finalised regulations guidance, including the remaining regulations which they consulted on in January. This guidance forms part of the *CQC guidance for providers on regulations* which they published in February.

The guidance and consultation response document are available on their website.

CQC are still to publish all remaining information to support the guidance later this month, including further details on meeting the Fit and proper person requirement for directors and the Duty of candour.

The guidance will help to ensure that providers, people who use services, the public and other stakeholders are clear about our expectations and judgements, the action we will take to ensure that we protect people from poor care and highlight good care, and our role in encouraging improvement in care quality.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 make important changes to health and social care standards which are regulated by the Care Quality Commission. They represent one of the main ways in which the Government is responding to the Francis Inquiry, which recommended the enforcement of fundamental standards to prevent problems like those at Mid Staffordshire, Winterbourne view and elsewhere.

There are now 12 fundamental standards. They replace the previous essential standards and apply to all health and social care providers save for the new duty of candour which at present applies only to health service bodies. The other new requirement is the fit and proper persons test for all directors or those acting in an equivalent role within any service provider.

The fundamental standards come with the force of criminal law behind them. Previously essential standards were generally less onerous and the CQC had to give prior notice of any breaches before initiating a criminal prosecution, of which there have been relatively few.

**Key changes are the breaches of some fundamental standards are strict liability offences and (where breaches of fundamental standards are criminal offences) the CQC can now prosecute without given prior notice. The risk of prosecution and conviction is therefore significantly increased. Whilst fines can be imposed for breaches, the level is relatively modest and the real damage in the event of prosecution and conviction is likely to be reputational.**

The enforcement dates for the Regulations are:-

- The duty of candour (applicable only to health service bodies) – from 27 November 2014
- All other fundamental standards (applicable to all service providers) – from 1 April 2015
- The fit and proper persons test (applicable to NHS trusts and foundation trusts) – from 27 November 2014

- The fit and proper persons test (applicable to all other service providers) – from 1 April 2015.

The regulatory requirements and criminal sanctions (if any) are summarised below but please see Appendix 1 for full list of regulations and the action CQC will take for both Health and Social Care Act 2008 Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009:-

**Fundamental standards that carry risk of criminal prosecution without prior notice:-**

- The duty of candour (regulation 20)
- Need for consent (regulation 11)
- Receiving and acting on complaints (regulation 16)
- Good governance (regulation 17)
- Safe care and treatment (regulation 12)
- Safeguarding service users from abuse and improper treatment (regulation 13)
- Meeting nutritional and hydration needs (regulation 14)
- Requirement as to display of performance assessments (Regulation 20)

**Other fundamental standards**

- Staffing (regulation 18) and fit and proper persons employed (regulation 19)
- Person centred care (regulation 9) and dignity and respect (regulation 10)
- Premises and equipment (regulation 15)

**Fit and proper persons (regulations 9)**

# Summary of Requirements and Recommendations for Compliance

## THE DUTY OF CANDOUR (REGULATION 20)

### The requirement

A health service body must act in an open and transparent way in relation to care and treatment provided to patients. As soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred, a health service body must notify the relevant person and provide reasonable support to him or her in relation to the incident. The relevant person is the service user or a person acting on his or her behalf if the service user is death or under 16 years or lacks capacity.

Notification must comply with specific requirements: it must be given in person, provide an account which is true as to the facts the health service body knows about the incident, advise what further enquiries into the incident are considered appropriate, apologise and record all of these matters in a written record which must be kept by the health service body. Notification must be followed by written notification.

### The sanction

It is a criminal offence to fail to provide notification of a notifiable safety incident and/or comply with the specific requirements of notification. On conviction a health service body would be liable to a potential fine of £2,500.

### Achieving compliance

This is a wholly new requirement. Health service bodies will have to ensure they have systems in place to capture notifiable safety incidents and processes for notification to and support for relevant persons.

The concept of a notifiable safety incident is crucial. The regulations define such an incident as one where any unintended or unexpected incident occurs in respect of a service user during the provision of a regulated activity that in the reasonable option of a healthcare professional, could or appears to have resulted in death, severe or moderate harm, or prolonged psychological harm.

It is recommended that health service providers take account of the following key points in training their workforce on the duty of candour.

1. **Context** – make sure that staff understand that the new duty sits alongside existing professional responsibilities. Managers as well as clinical staff need to be aware of the GMC's *Good Medical Practice* and existing policies and procedures on Whistleblowing Raising Serious Concerns Procedure, Being Open briefing Sheet, Incident Reporting and Investigating Policy.

2. **Roles –** Staff have to understand their own obligations and the roles of those around them in relation to the duty. They have to be able to raise concerns where they think the duty has not been complied with by others and they need to understand their role in keeping the organisation compliant.

3. **Involve the Board –** As the obligation rests with the organisation it is important that the Board members are aware and kept informed about the duty and how it is being discharged. The focus of the Board should be on ensuring that systems are in place to deliver compliance. The Board should have periodic reports about how the duty is being met and the sort of events that are being reported. Boards also need to be informed about progress towards meeting the other fundamental standards

4. **Identifying a relevant incident –** Ensure that staff understand when the duty arises and how to identify when the harm threshold has been reached. Some of it is counter-intuitive, for example the inclusion of "unintended" events catches significant complications for which no-one could reasonably be blamed, and the definition of moderate harm includes numerous minor events provided they also cause significant temporary harm.

5. **Reporting arrangements -** Take staff through the organisational reporting requirements where the duty applies. It is in the interests of both parties and health service bodies themselves that ways are found to promote the reporting of incidents.

6. **Support** – Make clear the ways in which staff can receive support in complying with the duty and raising concerns once they identify a problem.

7. **Communication -** An essential part of training on the duty will include how to communicate with patients once the duty has arisen and, speficially, how to apology requires an expression of sorrow or regret – it does not require an admission of fault.

8. **Consequences -** it is important that staff understand the consequences of not complying with the duty. Staff need to know how non-compliance could affect the organisation and how it could lead to disciplinary proceedings / professional conduct issues for them personally. It is also important to emphasise that the organisation will look at the underlying causes of patient safety concerns (eg by root cause analysis, significant event audit) to ensure that the focus is not exclusively on the last individual to provide care.

9. **Investigation –** Although health service bodies will already have systems in place to investigate serious incidents it is important to review how investigations are currently carried out to ensure that further training to meet the duty of candour is provided if required.

## NEED FOR CONSENT (REGULATION 11)

### The requirement

Care and treatment of patients must be provided only with the consent of the relevant person – whether that be the patient, or whether consent needs to be obtained in accord with the requirements of the Mental Capacity Act 2005 (MCA 2005).

Care and treatment is plainly not confined to surgery: it catches everything from the application of a bandage.

### The sanction

Breach is a criminal offence, directly prosecutable (no warning notice required) and at present attracts a maximum fine of £50,000. Alternatively the CQC may issue a fixed penalty notice and fine a service provider £4,000 and registered manager £2,000.

There is no requirement in the Regulations that anyone needs to have come to any harm as a precursor to a criminal prosecution.

### Achieving compliance

The requirement to treat all patients with appropriate consent in place is a well-established common law principle. Under the essential standards a service provider had to have suitable arrangements in place for obtaining consent. What is new is that the service providers and registered managers are now at risk of a strict liability criminal offence if someone is treated without consent even if he or she suffers no harm.

Recommendations

1. Review all current policies relating to consent to ensure they are up to date and accurately reflect **current** legal requirements including those contained in the MCA 2005 and Mental Health Act 1983.

2. Include training about consent to all induction training and undertaken annual refresher training.
3. Establish clear documentation requirements to evidence the fact consent has been obtained in all cases. However given the petty nature of many occasions when consent will be obtained, providers are advised that such requirements should continue to be proportionate.
4. Audit compliance and act on failure when identified.
5. Support staff by ensuring they can access appropriate support and guidance

## RECEIVING AND ACTING ON COMPLAINTS (REGULATION 16)

### The requirement

Any complaint received must be investigated and necessary and proportionate action taken in response to any failures identified by the complaint or investigation: you must have an accessible system for identifying, receiving, recording, handling and responding to complaints: and you must provide to CQC, when requested to do so and by no later than 28 days beginning on the day after receipt of any such request, a summary of complaints made under your complaints system, responses to complaints and any other relevant information in relation to such complaints as CQC may request.

### The sanction

Failure to provide CQC, when requested to do so, a summary of complaints, responses and any other relevant information they seek is a criminal offence, directly prosecutable under the Regulations, maximum fine £2,500.

### Achieving compliance

It is vital all trust have a **well organised and appropriately resourced complaints department that is fit for purpose.** This should be a dedicated team responsible ofr the management of complaints. It is recommended that service providers ensure that they:-

1. Have clear processes in place for the investigation of complaints, and an investigatory process that is sufficiently robust such that it will get to the bottom of issues raised by complaints within a reasonable time frame.
2. Record information about complaints, including responses and follow up correspondence, in a system which is readily accessible in case it is required by CQC
3. Take necessary and proportionate action in response to identified failures and are able to provide evidence to CQC that such action has been taken.
4. Have systems and processes that monitor that actions have been taken and followed through. This may generally be beyond the remit of the complaints team and very specific.
5. Audit compliance and act on failure when identified.
6. Support staff by ensuring they can access appropriate support and guidance
7. Assign responsibilities to individuals to ensure actions are followed through within the relevant department/specialty. The action taken needs to be logged and recorded. Where there is a lack of evidence, CQC will be concerned that the organisation does not properly learn from complaints to minimise the risk of repeated failures occurring, which should be an important component of its overall clinical governance strategy.

## GOOD GOVERNANCE (REGULATION 17)

### The requirement

Service providers must have in place systems and processes that are operated effectively to ensure compliance with the fundamental standards: in particular, they need to be able to assess, monitor and improve the quality and safety of services provided, and be able to demonstrate they assess, monitor and mitigate the risks relating to the health, safety and welfare of patients and others who may be exposed to risk.

Service providers must securely maintain accurate, complete and contemporaneous medical records and personnel records; and they must seek and act on feedback received to demonstrate a commitment to on-going continual evaluation and improvement of services. They must be in a position to provide the CQC with a written report explaining how they are achieving good clinical governance, in particular how they assess, monitor and improve the quality and safety of services, and how they assess, monitor and mitigate the risks relating to the health, safety and welfare of any persons who may be at risk arising out of services they provide.

### The sanction

It is a criminal offence to fail to provide CQC with a written report within 28 days of their request of such a report – punishable by a fine of £2,500.

### Achieving compliance

It is recommended that :-

1. When dealing with claims, complaints and serious incidents, good record keeping should be a high priority.
2. Organisations should train staff and make clear their expectations as to record keeping on a regular basis. Employees' record keeping skills should form part of appraisal and performance assessment.
3. Boards must be completely satisfied that clinical governance operates effectively in assessing, monitoring and improving the quality and safety of services, and that feedback is continually sought from external sources to include service users, commissioners and others.
4. Boards must be able to demonstrate that such information is acted on having been analysed and responded to. Most if not all organisations will have such procedures in place, but these existing systems will need to be reviewed for compliance with the specific requirements for Regulation.
5. It is recommended that Boards should proactively prepare, approve and routinely update a report in the terms required by the standard so that it is ready or near ready in the event of the CQC request.

## SAFE CARE AND TREATMENT (REGULATION 12)

### The requirement

Care and treatment must be provided in a safe way for patients: there must be robust risk assessment procedures: persons providing treatment must have the qualifications, competence, skills and experience to do so safely; and premises equipment must be safe; management of medicines must be safe; infection control procedures must be in place and effective and appropriate arrangements must be in place to ensure safe handover where care is shared or passed to another.

### The sanction

A criminal offence punishable by a maximum fine of £50,000 where someone has come to harm or been exposed to the risk of harm as a result of breach. Alternatively the CQC may issue a fixed penalty notice and fine a service provider £4,000 and registered manager £2,000.

### Achieving compliance

It is recommended that serve providers take account of the following points:-

1. The requirement to provide safe care and treatment is extremely broad, and encompasses a large number of aspects of service delivery. The Regulation requires that care and treatment are provided in a safe way; to do this providers must assess the risks of delivering care, and must do all that is reasonably practicable to mitigate such risks. Where an accident occurs, and this Regulation is engaged, any defence would have to demonstrate reasonably practicable steps had been taken to prevent the accident happening. This will require documentary evidence.
2. There are specific requirements concerning premises, equipment and medication; all must be safe, and there is no qualification about taking reasonable precautions hence if something goes wrong, it will often create a strict liability offence because if someone has come to harm, it will usually prove the equipment or medicine has not been used in a safe way and guilt will be established as a result. Hospitals also need to ensure that they comply with other relevant legislation, for example, the Medicines Act 1968 and the Human Medicines Regulations 2012 concerning medication management; or the Health and Safety At Work etc. Act 1974 and associated regulations concerning the health and safety of people on the premises. In relation to infection control, service providers must assess and document the risk, and then prevent, detect and control their spread.
3. In relation to all these areas, are the service provider's systems and operating procedures supportive of staff in seeking to achieve safe care at all times? For example, do systems and policies in place concerning safe medicines managements effectively mitigate the risk that human error will result in unsafe treatment such as an incorrect dose? The Board might want to commission a review of its processes in some of these key areas, especially if there is any evidence of recurring issues through internal incident reporting: look for any themes and act on them, now and in the future.
4. The fact that regulations create a strict liability does not mean that there is not much to be gained by minimising risk. Evidence that all reasonable steps have been taken will

be useful both in persuading the CQC not to prosecute and the courts to impose a lower penalty.

## SAFEGUARDING SERVICE USERS FROM ABUSE AND IMPROPER TREATMENT (REGULATION 13)

### The requirement

Patients must be protected from abuse and improper treatment: there must be systems and processes in place which operate effectively to prevent such abuse: and where allegations or evidence of such abuse arise, there must be effective systems to investigate immediately: patients must not be treated in discriminatory fashion, any restraint must be strictly proportionate and patients must not be deprived on their liberty for the purpose of receiving care or treatment without lawful authority.

### The sanction

It is a criminal offence to fail to comply with most aspects of this Regulation, punishable by a maximum fine of £50,000 where someone has been harmed or exposed to the risk of harm: it is not a criminal offence, directly prosecutable on the face of the Regulations, to deprive someone of their liberty without lawful authority (but such would give rise to a claim for unlawful detention on the part of the individual so deprived). Alternatively the CQC may issue a fixed penalty notice and fine a service provider £4,000 and registered manager £2,000.

### Achieving compliance

It is recommended that:-

1. Service providers have robust safeguarding policies and processes – most will, but they must be fully understood by staff, and followed and implemented where indicated.
2. All staff should be trained in how they share patient information. Whilst there are some services where staff need to be particularly alert to the risk of abuse occurring, the requirement to have proper procedures in place to prevent, and if it does arise deal with abuse, applies to all staff. If something goes wrong, and a patient is subject to abuse but safeguarding procedures were not initiated, it will be difficult to argue compliance with the Regulation – as if such a scenario arises, it suggests that the systems and processes were not being operated effectively – which is what this Regulation demands.
3. Good working relationships with local authority colleagues are essential – are there well established links so that the provider can work with the Local Authority effectively where there are concerns about possible abuse?
4. Staff who care for patients on a regular basis who lack capacity need to be alerted to circumstances which could give rise to a deprivation of liberty, and know where to go for advice and support to ensure any deprivation of liberty is lawful

## MEETING NUTRITIONAL AND HYDRATION NEEDS (REGULATION 14)

### The requirement

Nutritional and hydration needs of patients must be met. This requires all patients to be provided with nutritious food and hydration which is adequate to sustain life and good health: the requirement extends to patients in receipt of paraenteral nutrition and dietary supplements prescribed by a healthcare professional. If required, patients must be provided with support to assist them in eating and/or drinking.

### The sanction

It is a criminal offence to fail to comply, punishable by a maximum fine of £50,000, where harm or risk of harm occurring arises as a result of a breach. Alternatively the CQC may issues a fixed penalty notice and fine a service provider £4,000 and registered manager £2,000.

### Achieving compliance

It is recommended that service providers ensure that:-

1. They seek assurance from a dietetic service that food provided to patients is nutritious, served at an appropriate temperature and provided in a manner that can be easily consumed.
2. Specific dietary requirements are met – whether through health needs eg a diabetic diet, or through cultural requirements of a particular individual
3. Appropriate support is provided to those that need assistance to eat or drink and this is properly care planned
4. They audit compliance with this standard: ask patients and carers if food and drink is being consumed, arrives hot, and that there is ready assistance to those that need it to eat and drink. Failure in any of these areas is a crime.

In relation to parenteral nutrition, an NCEPOD (National Confidential Enquiry Into Patient Outcome and Death) report entitled *"A Mixed Bag"* in 2010 found an alarming lack of good practice amongst the NHS. Parenteral nutrition is hazardous but necessary for some of the sickest patients in hospital. A good starting point for managers in seeking to reassure themselves as to their provision of parenteral nutrition would be to review the recommendations made as a result of the NCEPOD report and assess their services by reference to them. Other NCEPOD reports have criticised nutrition given to other groups of patients and this is likely to be an area of vulnerability for many providers.

## STAFFING (REGULATIONS 18) AND

## FIT AND PROPER PERSONS EMPLOYED (REGULATION 19)

### The requirement

There must be sufficient numbers of suitably qualified, competent, skilled and experienced persons to meet the requirements set out in the fundamental standards: they must be properly trained and supervised: and persons employed must be fit and proper namely of good character, have the requisite qualifications, be able by reason of their health after reasonable adjustments to carry out tasks intrinsic to their work and recruitment procedures must demonstrate a robust approach to ensuring staff are fit and proper for the work they are to be employed to undertake.

### The sanction

These requirements are not directly prosecutable in their own right but a lack of staff, or a lack of suitably qualified or competent staff is likely to lead to breach of other Regulations which are directly prosecutable, for example the requirement to provide safe care and treatment. Conditions could be placed upon a trust's registration by the CQC in relation to staffing and a failure to comply could ultimately result in a criminal prosecution.

### Achieving compliance

A recommendation is that service providers should:-

1. Demonstrate a systematic approach to determining the number of staff and range of skills required in each department/ward/location. CQC will not tell you how many staff you should have in any given service area, but will identify a lack of staff where they perceive that it is leading to poor care.

2. Ensure there are good contingency plans in place to deal with unexpected staff absences

3. Ensure full induction takes place so that new members of staff or locum or temporary members of staff are fully conversant with practice and procedure, and know where to look for and/or who to go to for guidance.

4. Ensure staff are supported to gain further qualifications and are in receipt of regular appraisal.

5. Ensure the HR Department monitor compliance with the requirements of good recruitment and retaining evidence on all files of this – in particular that written references are obtained from previous employer(s), and retained, and that DBS checks are undertaken and retained on file.

Whilst there are no directly prosecutable crimes arising out of this standard, it creates significant obligations for employers which will no doubt be seized upon by trade unions and employment lawyers, especially when things go wrong.

## PERSON CENTRED CARE (REGULATION 9)

## AND DIGNITY AND RESPECT (REGULATION 10)

### The requirement

All patients must receive care and treatment that is appropriate to meet their needs and reflects their preferences: they must be supported to make choices having received information as to the risks and benefits involved in particular courses of treatment: and patients must be treated with dignity and respect such that it ensures their privacy, and supports their autonomy and independence.

### The sanction

These requirements are not directly prosecutable under the terms of the Regulations, but care that is not person centred or that lacks respect for privacy and dignity risks breaching other Regulations that are directly prosecutable for example, the need for consent, or the need to provide safe care, or the need to prevent abuse.

### Achieve Compliance

Recommendations:-

1. Care and treatment must be appropriate, reflect individual preferences and meet the needs of patients. There is also a statutory duty to ensure the privacy of patients. It is not qualified by the word reasonable, nor is there any reference to using best endeavours to ensure privacy which is not always easy in the setting of a busy acute ward and there is little guidance to assist in this regard.

2. All care planning must ensure it reflects a patient's preferences and requirements, or that it complies with the terms of the Mental Capacity Act 2005 in relation to those that lack capacity, particularly in relation to assessing best interests. There must be evidence within the documentation that individual preferences and choices are specifically reviewed, considered and discussed with patients so it is possible to demonstrate a personal approach to care and treatment.

3. Patients must be helped to make choices by provision of all necessary information in a manner and form they can understand – whether or not they lack capacity in the legal sense.

4. Ensure accommodation is suitably private; for example, segregated accommodation for men and women is particularly important to some patients. Can you provide this? Do staff always ensure that sensitive discussions with patients and families take place in private? If patients are managed in a bed surrounded only by a curtain, are some conversations so sensitive that the patient should be moved for the purpose?

5. Where a patient makes specific requests as to how their care is delivered, are reasonable efforts made to comply, for example, a request that staff of a specified

gender deliver personal care? Such requests cannot simply be dismissed as impractical without any due consideration and all staff must realise they have to care consider any requests of this nature, and seek senior input from line managers if necessary, otherwise they risk breaching the requirements of the fundamental standards expected in relation to these issues.

## PREMISES AND EQUIPMENT (REGULATION 15)

### The requirement

Premises and equipment accessed and used by patients must be clean, secure, and suitable for purpose, properly used and maintained and appropriately located.

### The sanction

This requirement is not directly prosecutable under the terms of the Regulations, but premises or equipment that are not fit for purpose would probably lead to the provision of care which is potentially unsafe, which is a directly prosecutable criminal offence. CQC could impose conditions on registration in relation to premises and / or equipment and a failure to comply would potentially be a criminal offence. Additionally service providers would be at risk of criminal prosecution for any breaches of the Health and Safety at Work etc Act 1974

### Achieving compliance

It is recommended that service providers have audited systems to demonstrate:-

1. Cleaning schedules are appropriate and followed.

2. Where there are reports or complaints of a lack of cleanliness, they are acted on promptly and appropriately.

3. Requirements are followed for relevant legislation in relation to premises and equipment including health and safety, fire, electrical, building maintenance, portable appliance testing, infection control, environmental health, hazardous waste and medical devices regulations.

4. Systems are in place to assess and monitor such matters, and where issues arise, are there plans in place to address and deal with them. Are concerns in relation to medical devices and equipment appropriately reported and investigated with the assistance of the Medicines and Healthcare Products Regulatory Agency and manufacturers where necessary? Health & Safety and Estates teams can usefully assist in benchmarking compliance in this area.

## FIT AND PROPER TEST FOR DIRECTORS (REGULATION 5)

*Creating a fit and proper persons test for healthcare leaders was one of the key recommendations of the Francis Report. The test will apply to all health service bodies ie NHS Trusts, NHS Foundation Trusts and Special Health Authorities.*

The purpose is to require providers to take proper steps to ensure their directors (and equivalent) are fit and proper for the role. Providers will have separate responsibilities to ensure that the staff who they employ are fit and proper.

The fit and proper persons test will apply to directors (both executive directors and non-executive directors) and individuals *"performing the function of, or functions equivalent or similar to the functions of a director".* The test will therefore apply to senior managers who exercise function similar to the directors of the organisation. Such managers may, for example, attend Board meetings even though they are not members of the Board.

The Regulations provide that health service bodies must not appoint or have in place an individual as a director or equivalent unless:

- The individual is of good character
- The individual has the qualifications, competence, skills and experience which are necessary for the relevant office or position or work for which they are employed
- The individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed.
- The individual has not be responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity.
- None of the grounds of unfitness specified in Part 1 of Schedule 4 applied to the individual: bankruptcy; on a barred list, legal impediment.

<u>So what is new?</u>

Regulation 5 states that a provider must not **appoint** or **have in place** an individual:

a) As a director of the service provider, or
b) Performing the functions of, or functions **equivalent or similar to** the functions of, such a Director who:
    - Is not of good character
    - Does not have the necessary qualifications, competence, skills and experience
    - Is not physically and mentally fit (after adjustments) to perform their duties

Other than the introduction of an element of retrospection by imposing these requirements upon present as well as future incumbents many would say so far so good.

Matters however become more challenging because the new regulation 5(3)(d) decrees that directors or those exercising equivalent or similar functions cannot have: **been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity.**

This will enable the CQC to decide that someone is not fit to be a director on the basis of previous misconduct in a previous role. Going forward, it means that blame will be often not be confined to the primary players. Where nursing establishment numbers are insufficient the director of nursing may bear primary responsibility. But if they were sounding the alarm but prevented from increasing establishment numbers the chief executive and the other directors may also be *responsible for* the consequences. In an egregious case this provision may be deployed to clear out the whole Board, in practice it is likely to be construed far more narrowly.

## FIT AND PROPER PERSONS TEST FOR DIRECTORS (REGULATION 5)

***"Been privy to"***

This could catch anyone who knew things were wrong. However this guidance tells us that there is a second trigger – that of failing to take the appropriate action to ensure it was addressed.

Board members regularly receive papers describing problems. If they are assured that things are being satisfactorily dealt with the first time they fail to intervene they could hardly be criticised but at what point should a fellow director seek to intervene – and how? In governance terms NHS Boards are unitary Boards, in which each member is responsible for decisions even where they are voted against. This regulation underlines that responsibility. It is presumably intended to lead to greater challenge and demand for action.

***"Contributed to or facilitated"***

*Contributed to* is easy to recognise – be *facilitated* is much more difficult to define. Does a chair or other member of a Board facilitate mismanagement by not holding the executive properly to account? It would seem possible depending on the facts. In the criminal law offence of aiding and abetting, the criminal had to do something to advance the crime. Where a Board is seen as a watchdog that failed to bark, something much more passive may qualify.

*"Any serious misconduct or mismanagement"*

The CQC's consultation says that this means *behaviour that wound constitute a breach of any legislation / enactment.* However the regulations expressly say that something can constitute serious misconduct or mismanagement *whether unlawful or not.* Whilst the consultation document may provide a helpful pointer to how the CQC propose to assess breaches in practice, the wording of the regulation will permit a more onerous interpretation when the prosecutor deems it appropriate.

***"Whether unlawful or not"***

This is very wide. A basic tenet of the law is that the citizen should know what conduct puts them at risk of a penalty, and those found not to be a fit and proper people to serve as a director will pay a heavy penalty in loss of their role as a director and eligibility for other appointments.

**Where is the evidence of breach to come from?**

This will be straightforward in the case of acts or omissions after the person joined the Board. Much more problematic are events arising before the person joined the organisation. Chairs are required to confirm that fitness of all directors has been assessed in line with the regulations. The CQC themselves will cross check individuals against other information they hold and may require providers to remove a director.

Whilst the most reliable guide is what the CQC do in practice, Boards should consider the regulations and CQC guidance themselves.

**What action must the service provider take?**

Regulation 5(6) says where a person is no longer a fit and proper person the service provider **must:**

- Take such action as is necessary and proportionate to ensure that the office or position in question is held by an individual who meets such requirements.
- If the individual is a health care professional, social worker or other professional registered with a health care or social care regulator, inform the regulator in question.

The requirement to dismiss or demote points up a need for employers to amend employment contracts to give effect to this expectation. Healthcare bodies are well-used to reporting clinical staff to their professional regulators.

**Acknowledgement**

Hempsons, Solicitors, Newcastle.

# Appendix i – Offences Chart

This table shows the action CQC will take if they find a breach of the **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

| Reg no | Regulation | Action CQC will take |
|---|---|---|
| **4** | Requirements where the service provider is an individual or partnership | Regulatory action other than prosecution |
| **5** | Fit and proper persons: directors | Regulatory action other than prosecution |
| **6** | Requirement where the service provider is a body other than a partnership | Regulatory action other than prosecution |
| **7** | Requirements relating to registered managers | Regulatory action other than prosecution |
| **8** | General | Regulatory action other than prosecution |
| **9** | Person-centre care | Regulatory action other than prosecution |
| **10** | Dignity and respect | Regulatory action other than prosecution |
| **11** | Need for consent | Prosecuted directly |
| **12** | Safe care and treatment | Prosecution with qualifications* |
| **13** | Safeguarding service users from abuse and improper treatment | Prosecution with qualifications* |
| **13(1)** | 1. Service users must be protected from abuse and improper treatment in accordance with this regulation. | Prosecution with qualifications* |
| **13(2)** | 2. Systems and processes must be established and operated effectively to prevent abuse of service users. | Prosecution with qualifications* |
| **13(3)** | 3. Systems and processes must be established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse. | Prosecution with qualifications* |
| **13(4)** | 4. Care or treatment for service users must not be provided in a way that-<br><br>(a) includes discrimination against a service user on grounds of any protected characteristic (as defined in section 4 of the Equality Act 2010) of the service user, | Prosecution with qualifications* |

| Reg no | Regulation | Action CQC will take |
|---|---|---|
| | (b) includes acts intended to control or restrain a service user that are not necessary to prevent, or not a proportionate response to, a risk of harm posed to the service user or another individual if the service user was not subject to control or restraint,<br><br>(c) is degrading for the service user, or<br><br>(d) significantly disregards the needs of the service user for care or treatment. | |
| **13(5)** | 5. A service user must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority. | Regulatory action other than prosecution |
| **14** | Meeting nutritional and hydration needs | Prosecution with qualifications* |
| **15** | Premises and equipment | Regulatory action other than prosecution |
| **16(1)** | Receiving and acting on complaints<br><br>1. Any complaint received must be investigated and necessary and proportionate action must be taken in response to any failure identified by the complaint or investigation. | Regulatory action other than prosecution |
| **16(2)** | 2. The registered person must establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity. | Regulatory action other than prosecution |
| **16(3)** | 3. The registered person must provide to the Commission, when requested to do so and by no later than 28 days beginning on the day after receipt of the request, a summary of –<br><br>(a) complaints made under such complaints system,<br><br>(b) responses made by the registered person to such complaints and any further correspondence with the complainants in relation to such complaints, and<br><br>(c) any other relevant information in relation to such complaints as the Commission may request. | Prosecuted directly |

| Reg no | Regulation | Action CQC will take |
|---|---|---|
| **17(1)** | Good governance<br><br>1. Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. | Regulatory action other than prosecution |
| **17(2)** | 2. Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to–<br><br>(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);<br><br>(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of services users and others who may be at risk which arise from the carrying on of the regulated activity;<br><br>(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;<br><br>(d) maintain securely such other records as are necessary to be kept in relation to–<br><br>(i) persons employed in the carrying on of the regulated activity, and<br><br>(ii) the management of the regulated activity;<br><br>(e) seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services;<br><br>(f) evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e). | Regulatory action other than prosecution |
| **17(3)** | 3. The registered person must send to the Commission, when requested to do so and by no later than 28 days beginning on the day after | Prosecuted directly |

| Reg no | Regulation | Action CQC will take |
|---|---|---|
| | receipt of the request –<br><br>(a) a written report setting out how, and the extent to which, in the opinion of the registered person, the requirements of paragraph (2)(a) and (b) are being complied with, and<br><br>(b) any plans that the registered person has for improving the standard of the services provided to service users with a view to ensuring their health and welfare. | |
| **18** | Staffing | Regulatory action other than prosecution |
| **19** | Fit and proper persons employed | Regulatory action other than prosecution |
| **20(1)** | Duty of candour<br><br>1. Registered persons must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity | Regulatory action other than prosecution |
| **20(2)** | 2. As soon as reasonable practicable after becoming aware that a notifiable safety incident has occurred registered persons must- | Prosecuted directly |
| **20(2)** | a. notify the relevant person that the incident has occurred in accordance with paragraph (3), and | Regulatory action other than prosecution |
| **20(2b)** | b. provide reasonable support to the relevant person in relation to the incident, including when giving such notification. | Regulatory action other than prosecution |
| **20(3)** | 3. The notification to be given under paragraph (2)(a) must–<br><br>(a) be given in person by one or more representatives of the registered persons,<br><br>(b) provide an account, which to the best of the registered persons' knowledge is true, of all the facts the registered persons know about the incident as at the date of the notification,<br><br>(c) advise the relevant person what further enquiries into the incident the registered persons believe are appropriate, | Prosecuted directly |

| Reg no | Regulation | Action CQC will take |
|---|---|---|
| | (d) include an apology, and<br><br>(e) be recorded in a written record which is kept securely by the registered persons. | |
| **20(4)** | 4. The notification given under paragraph (2)(a) must be followed by a written notification given or sent to the relevant person containing—<br><br>(a) the information provided under paragraph (3)(b),<br><br>(b) details of any enquiries to be undertaken in accordance with paragraph (3)(c),<br><br>(c) the results of any further enquiries into the incident, and<br><br>(d) an apology. | Regulatory action other than prosecution |
| **20(5)** | 5. But if the relevant person cannot be contacted in person or declines to speak to the representative of the health service body—<br><br>(a) paragraphs (2) to (4) are not to apply, and<br><br>(b) a written record is to be kept of attempts to contact or to speak to the relevant person. | Regulatory action other than prosecution |
| **20(6)** | 6. The registered provider must keep a copy of all correspondence with the relevant person under paragraph (4). | Regulatory action other than prosecution |
| **20A** | Requirement as to display of performance assessments | Prosecuted directly |

* 'Prosecution with qualifications' shows the regulations that require qualification for prosecuting. These are Regulations 12, 13(1) to (4) and 14 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This qualification is given in Regulation 22(2) of those Regulations – namely, that the breach of the regulation results in people who use services being exposed to avoidable harm (physical or psychological), being exposed to a significant risk of such harm occurring or suffering a loss of money or property as a result of theft, misuse or misappropriation.

## Care Quality Commission (Registration) Regulations 2009

| Reg No | Regulation | Prosecuted directly | With qualifications | Unable to prosecute |
|---|---|---|---|---|
| **11** | General<br>A registered person must, insofar as they are applicable, comply with the requirements specified in regulations 12 to 20 in relation to any regulated activity in respect of which they are registered. | | | X |
| **12** | Statement of purpose | X | | |
| **13** | Financial position | | | X |
| **14** | Notice of absence | X | | |
| **15** | Notice of changes | X | | |
| **16** | Notification of death of service user | X | | |
| **17** | Notification of death or unauthorised absence of a service user who is detained or liable to be detained under the Mental Health Act 1983 | X | | |
| **18** | Notification of other incidents | X | | |
| **19** | Fees etc | X | | |
| **20** | Requirements relating to termination of pregnancies | X | | |

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

**ITEM 13**

# COUNCIL OF GOVERNORS

**Date of Meeting:** 19th May 2015

**Title:** Draft Quality Account/Report 2014/15

**Lead Director:** Sharon Pickering, Director of Planning, Performance and Communications and Chris Stanbury, Director of Nursing and Governance

**Report for:** Assurance

## This report includes/supports the following areas:

| STRATEGIC GOALS: | ✓ |
|---|---|
| To provide excellent services working with the individual users of our services and their carers to promote recovery and well being | |
| 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 our communities | |
| To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of our communities | ✓ |

| CQC REGISTRATION: Outcomes (✓) | | | | | |
|---|---|---|---|---|---|
| **Involvement and Information** | | | | | |
| Respecting & Involving Service Users | | Consent to care and treatment | | | |
| **Personalised care, treatment and support** | | | | | |
| Care and welfare of people who use services | | Meeting nutritional needs | | Co-operating with other providers | |
| **Safeguarding and safety** | | | | | |
| Safeguarding people who use services from abuse | | Cleanliness and infection control | | Management of medicines | |
| Safety and suitability of premises | | Safety, availability and suitability of equipment | | | |
| **Suitability of staffing** | | | | | |
| Requirements relating to workers | | Staffing | | Supporting workers | |
| **Quality and management** | | | | | |
| Statement of purpose | | Assessing and monitoring quality of service provision | | Complaints | |
| Notification of death of a person who uses services | | Notification of death or AWOL of person detained under MHA | | Notification of other incidents | |
| Records | | | | | |
| **Suitability of Management** (only relevant to changes in CQC registration) | | | | | |
| **This report does not support CQC Registration** | | | | | ✓ |

| **NHS CONSTITUTION:** The report supports compliance with the pledges of the NHS Constitution (✓) | | | | | |
|---|---|---|---|---|---|
| **Yes** | ✓ | **No** (Details must be provided in Section 4 "risks") | | **Not relevant** | |

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

**COUNCIL OF GOVERNORS**

**Date of Meeting:** **19th May 2015**

**Title:** **Draft Quality Account/Report 2014/15**

## 1. INTRODUCTION & PURPOSE

1.1 The purpose of this report is to present to the Council of Governors the final draft version of the Quality Account/Report which will be presented to the Board at its meeting on 26th May.

## 2. BACKGROUND INFORMATION

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 Monitor.

2.2 The Quality Account has been developed with regard to the views of stakeholders and the Council of Governors Task and Finish Groups (which met twice to discuss the draft QA).

2.3 The final draft of the Quality Account is attached at **Appendix 1**. This fulfils the requirement to produce a Quality Account and a Quality Report.

## 3. KEY ISSUES:

3.1 The final draft of the Quality Account includes all end of year data, and a summary of the recent CQC inspection report.

3.2 The section of the Quality Account that reproduces our stakeholders' comments is not included in this draft because the deadline for their comments to be received was 17th May. Their comments will be included in the final draft verbatim once received.

3.3 The Quality Report will be included within the Annual Report which will be published in July 2015 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.

3.4 The draft Quality Account has been subject to external audit and their limited assurance report will be included within the document as an Appendix following Audit Committee on 22nd May.

## 4. IMPLICATIONS / RISKS:

4.1 **Quality:** The Quality Account sets out our performance on key quality metrics and the 4 improvement priorities identified for 2014/15. There are 4 further quality priorities for 2015/16 included in the forward looking part of the Quality Account which are also contained within the Trust's Business Plan.

4.2 **Financial:** The proposals in this Quality Account are contained within our Business Plan 2015/16-2016/17 and are therefore included within our financial plan for the next two years.

4.3 **Legal and Constitutional:** The Quality Account has been produced to meet the requirements of Department of Health / Monitor guidance.

4.4 **Equality and Diversity:** There are no specific equality and diversity issues associated with this report.

4.5 **Other Risks:** None.

## 5. CONCLUSIONS

The Quality Account has been produced in line with statutory guidance, and in line with the views of stakeholders, as expressed in our engagement with them.

## 6. RECOMMENDATIONS

Governors are recommended to receive the final Draft Quality Account document and note the timescales for its approval by the Board and its publication.

**Author:** **Chris Lanigan**
**Title:** **Head of Planning and Business Development**

**Background Papers:**
Monitor: Detailed Guidance on the Requirements for Quality Reports
Stakeholders' formal response to the draft QA (to be tabled)

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

# Our Quality Account 2014/15

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 2014/15. This is the 7th Quality Account we have produced and it tells you what we have done to improve the quality of our services in 2014/15 and how we intend to make further improvements in 2015/16.

## 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'***

and our Quality Strategy 2014-2019.

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

In delivering quality we believe our services must:

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

Our four Quality Goals are:

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

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

In the Trust's own surveys in 2014/15, **74%** of wards scored greater than 80% for patient satisfaction.

In the Trust's own surveys 90.6% of our community patients say they have been involved in the development of their own care plan.

patients and clinicians.
- Our staff feel positively engaged with the Trust.

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

## What we have achieved in 2014/15

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

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

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

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

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

- We have also continued to invest in ensuring our buildings provide appropriate and therapeutic environments. In 2014/15 we saw the completion of refurbishment of the children's inpatient assessment and treatment unit at West Lane Hospital, Middlesbrough. Patients and staff also benefitted from

community team base improvements in Redcar and Cleveland Children and Young Peoples Services (CYPS) (The Ridings, Redcar) and East Durham Older People's Services (Seaham Old Vicarage). Work has commenced at Ripon on a new rehabilitation facility, and community bases in Chester-le-Street and Derwentside are also being improved.

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

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

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

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

- With the help of carers, who took part in an improvement event, we have redesigned our Serious Untoward Incident (SUI) investigation process.
- We have developed a new pathway, (including documentation and standard processes) for community psychosis / early intervention teams, piloted this and then commenced a phased Trustwide implementation.
- We used improvement techniques to design a new process and template for discharge letters that are sent to patients' GPs. GPs in the pilot area (South Durham) have reported that the new style letters are easier and quicker to read and help them to understand and digest important information about their patient's ongoing treatment needs.

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

- We have introduced a new "daily report out" process in our Learning Disability wards. As a result we now have quicker decision making regarding patient care and prompter adjustments to care and discharge plans. These changes are reducing length of stay.

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

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

## What did we learn in 2014/15

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

One area where we identified we needed to do things differently was in our approach to the investigation of Serious Untoward Incidents (SUIs). We recognised that the quality and timeliness of reviews was often not as good as we would have liked. As a result we have introduced an expert corporate team of dedicated SUI reviewers supported by a network of clinical experts. This new arrangement commenced in December 2014 and was fully in place by 1 April 2015.

We also held an improvement event which used all the feedback from staff and families about how to conduct the review in a more efficient and person centred way. As a result we now include relatives in SUI investigations from the beginning and we always give them copies of the investigation report. We audited this, found it was

not working as intended and so conducted further work to develop a standard process. All families and carers have the opportunity to be involved and to have a feedback session when the review is complete. We recognise that some families do not want to engage with this process and respect their wishes, but we now have processes to involve those who do want to be involved. This links to our work on establishing a "culture of candour" – see **section 3**.

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

Inspections are a useful source of learning for the Trust. To make the most of this learning, we have improved our post-inspection action planning and ensured that staff are trained in the new approach. We have also set up a performance management system to track progress against the actions. These changes have been audited by our internal audit service (Audit North) who have assessed them as being fit for purpose. We also use clinical audits to check that the actions have been effective in addressing the original problem. The findings of external inspections of the Trust are included in **section 2**. The CQC carried out an inspection of all Trust services and sites during January 2015 and the results from this were published in May 2015 (see **pages 35-41**).

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

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

## 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, Monitor, and contains the following information:

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

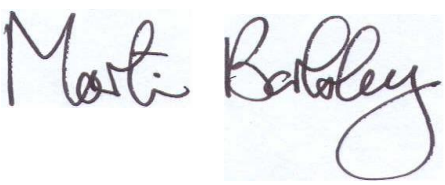
The information contained within this report is accurate, to the best of my knowledge.

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

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

I hope you find this report interesting and informative.

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



**Martin Barkley**
**Chief Executive**
**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 1.6 million people across a wide geographical area of approximately 3,600 square miles. The areas covered by the Trust include County Durham and Darlington, the four Teesside boroughs of Hartlepool, Stockton, Middlesbrough and Redcar & Cleveland; the Scarborough & Whitby, Ryedale, Hambleton & Richmondshire and Harrogate districts of North Yorkshire, and Wetherby Town in West Yorkshire. 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 (eg Forensic services, Children and Young People tier 4 services and Specialist Eating Disorder services) to the North East and beyond.

Services commissioned by Clinical Commissioning Groups (CCGs) are managed within the Trust on a geographical basis in three Localities covering, Durham and Darlington; Teesside; and North Yorkshire. 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 2014/15 was **£294.7m**.
- On 31st March 2015 there were **51,928** people on TEWV's caseload.
- During 2014/15 on average we had **778** patients occupying an inpatient bed each day (this equates an average occupancy rate of 88%)
- Our community staff made more than **1.2 million** contacts with service users during 2014/15.


KEY:

**O** = main towns

| | |
|---|---|
| | County Durham |
| | Darlington |
| | Stockton |
| | Hartlepool |
| | Middlesbrough |
| | Redcar & Cleveland |
| | N. Yorkshire – Scarborough and Ryedale |
| | N Yorkshire – Hambleton and Richmondshire |
| | N Yorkshire – Harrogate |

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

## Update on 2013/14 quality priorities

In last year's Quality Account we reported on our progress with our quality priorities for 2013/14. Within this we also noted some further actions for 2014/15. In some cases, these actions were to be included within the quality priorities for 2014/15, and therefore, are reported within this Quality 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 2014/15.

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

## 2014/15 Priorities for improvement – how did we do

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

**Priority 1:** To have more staff trained in specialist suicide prevention and intervention
**Priority 2:** To implement the recommendations of the Care Programme Approach (CPA) review, including,
- Improving communication between staff, patients and other professionals
- Treating people as individuals

**Priority 3:** To embed the recovery approach (in conjunction with CPA)
**Priority 4:** To manage the pressure on acute inpatient beds

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

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

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

#### Why is this important:

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

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

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

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

### What benefits / outcomes did we aim to deliver:

- Increased prevention of suicide across services.
- Increased safety for patients.
- Enhanced staff competency and confidence in suicide prevention and clinical risk management.
- An increase in the number of staff trained in specialist suicide prevention and intervention.
- Improved engagement and support for families and carers to promote safety and recovery.
- Care provided in a way that manages risk whilst promoting recovery and keeping our service users safe.
- Service users allocated the appropriate CPA level to support their identified needs.
- Promoting a culture of harm minimisation, working towards zero suicides, actively involving service users to develop resilience, control, choice, in safety planning.

- Carers, family members and workers in other public services will have more knowledge about behaviours that indicate an increased risk of suicide and what do to when they realise that the level of risk is increasing.

## What we did in 2014/15:

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

| What we said we would do | What we did |
|---|---|
| • Approve the project scope by quarter 1 2014/15. | • Project scope was approved in April 2014. |
| • Recruit the project team and establish the project group to take this forward by quarter 1 2014/15. | • Project Manager was appointed April 2014 but subsequently left. A replacement was appointed in February 2015. Given the delays with recruiting a new Project Manager, the immediate focus had been on developing a framework.<br>• A Project group was established in June 2014.<br>• 3 working groups were identified to take forward developments looking specifically at data / themes / trends and human factors of suicide which will then feed back into the framework and training development. A fourth proposed group will focus on the training aspect and this group will run once the pilot framework is developed. |
| • Review current practice within the Trust by quarter 1 2014/15. | • The review was completed in July 2014 and discussed at the Patient Safety Group in August 2014. |
| • Develop a suicide prevention framework and training and implementation plan that describes what training is required, who will provide it and what other support is necessary for staff to provide effective suicide prevention and intervention by quarter 2 2014/15. | • Feedback from clinical services was obtained throughout 2014/15 in relation to the utilisation of the framework. The feedback we received from the clinical services was very positive with minor amendments required.<br>• The framework was approved at the Suicide Mitigation steering group in February 2015. Following minor amendments it will be submitted to the Executive Management Team for approval in July 2015. |
| • Develop a training needs assessment and training plan which will describe who will receive training and how this will be rolled out across the Trust by quarter 3 2014/15. | • A plan for delivering training was initially agreed and has been rolled out within the MHSOP service. Given that the scope of the project has been extended Trustwide, further training and costing options are being explored by the Project Manager however a plan for training priority staff has been developed. |

| | |
|---|---|
| • Commence training for priority staff (eg crisis teams) by Q4 2014/15 (to be completed for all relevant staff in 2015/16). | • We have not commenced training all priority staff. The resignation of the original project manager and the time for a replacement to arrive in post contributed to the slower than anticipated start to the training. But it also reflects the decision by Trust Board to extend the project to cover other clinical specialities in order to ensure that all relevant Trust staff are given the same skills and information in relation to risk assessment and management. This decision also supports the information coming from the Confidential Enquiry Report relating to increase suicide rates in older people. Durham and Darlington training of priority staff will be completed by Q2 15/16, North Yorkshire and Forensic by Q4 Q15/16 and Teesside by Q2 16/17. |

## What we plan to do in 2015/16:

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

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

## How we know we will have made a difference:

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

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

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

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

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

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

### What benefits / outcomes did we aim to deliver:

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

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

### What we did in 2014/15:

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

| What we said we would do | What we did |
|---|---|
| • Implement actions relating to CPA from Model Lines pilot team by quarter 2 2014/15. | • Ensured close working with the Model Lines (see **appendix 3** for details) team to ensure the framework of CPA (assessment, risk assessment, care planning, contingency planning and reviews) is person centred and recovery focused.<br>• The CPA project lead and the Recovery project lead participated in events to raise awareness and engage with internal stakeholders on CPA and how this approach supports recovery.<br>• Completed care plan audits for each Psychosis and Early Intervention in Psychosis (EIP) teams within the roll out of Model Lines with specific findings presented to the teams to give an overview of recovery focused care planning and coproduction in the team. |

| | |
|---|---|
| | • Facilitated recovery focused care planning workshops for the Model Lines teams following on from the care plan audits to engage the staff and increase awareness about person-centred and co-produced care planning.<br><br>• Developed a model for training Trust staff in care planning along with service users and the ARCH (aspiration, recovery, confidence, hope) Recovery College in Durham for all teams across the Trust.<br><br>• Developed 'good care planning' guides for staff and services users.<br><br>• Developed a briefing sheet on the 'principles underpinning recovery focused care planning'. This is used within the care planning and CPA training and has been incorporated into the revised draft CPA policy. |
| • By quarter 4 2014/15, redesign CPA processes and documentation to ensure they fulfil the following:<br><br>  ◦ meeting mandatory requirements whilst reducing unnecessary burden on staff.<br>  ◦ ensuring the requirements of the Mental Health Act are met whilst reducing unnecessary burden on staff.<br>  ◦ development of standard work regarding Section 117 of the Mental Health Act – the statutory duty to provide health and social care to some service users following discharge from in-patient care. | • Standard care (for people not placed on CPA) review documentation on the electronic record system has been redesigned so that both the risk assessment and care plan can be viewed in the form of a letter to make it easier to read. This has been piloted and evaluated in our Mental Health Services for Older People (MHSOP) memory services. The benefits have been a reduction in administration time for clinical staff, which in turn has increased the direct face to face clinical time available with service users and their carers.<br><br>• Identified how we roll out the new process and documentation to all services in order to reduce unnecessary administration and increase direct clinical time. Using our electronic patient record (Paris) the delivery of this is contingent on the Paris Programme business case therefore some of this work will be delivered in 2015/16.<br><br>• Redesigned care documentation for CPA processes such as assessment and review, with an aim to ensure the requirements of the Trusts CPA policy and the Mental Health Act are met in the redesigned Paris in 2015/16.<br><br>• Aligned the new policy on Section 117 after-care legislation with the CPA policy and ensured staff are clear about the requirements of their role and the documentation of after-care needs and services.<br><br>• Supported all specialities to develop risk assessments that promote safety and link with care planning in a recovery orientated way that is meaningful to the person and their carer and families. |
| • Implement regular audit and case management / supervision systems to include monitoring of transfer processes within Paris (the electronic patient record) by quarter 4 2014/15. | • Conducted audits of CPA, transfers of care and care plans. The findings of these reports are in the process of being finalised and the results will be used to inform training and development action plans to improve CPA within the Trust in 2015/16. |

| | |
|---|---|
| | • Developed a CPA audit framework to combine the findings in the reports mentioned above and ensure this is conducted bi-annually to monitor compliance of CPA against the Trust policy.<br>• Developed a standard process for when patients are transferred between teams within the Trust that are aligned to the CPA policy and the protocols that relate to the transition of service users between specialities.<br>• Developed a checklist for use within case management and supervision (with Trust staff) to ensure transitions of service users between teams are as smooth as possible.<br>• Undertaken work to ensure transfers of patient care from one team to another are clearly recorded on our electronic patient record and communicated to GPs effectively. |

## How we know we have made a difference:

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

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

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

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

### What we plan to do in 2015/16:

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

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

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

### Why this is important:

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

Helping people to recover involves supporting them to;

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

These are known as the CHIME factors.

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

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

## What benefits / outcomes did we aim to deliver:

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

## What we did in 2014/15:

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

| What we said we would do | What we did |
|---|---|
| • Develop a programme of work to ensure the principles of recovery are embedded within all key programmes eg CPA, Model Lines, risk assessment & management (ongoing). | • In 2013/14 a recovery strategy and programme of work was developed for implementation throughout 2014/15. This programme recognised that we needed to ensure recovery principles were embedded into a number of different strategic projects / work streams. We have therefore embedded the recovery principles into the following areas of work:<br>◦ Model Lines Project<br>◦ CPA Project<br>◦ Values Based Recruitment Project<br>◦ Risk Framework<br>These projects are ongoing and recovery principles will continue to be integrated within these projects throughout 2015/16.<br>• Specific Recovery Training has been delivered to over 400 staff including clinical teams, senior medical staff and executive managers.<br>• An evaluation of the recovery training has shown that:<br>◦ 81% of those who attended the training and responded reported an increased knowledge and understanding of recovery. The remainder reported a high level of knowledge prior to training. |

| | |
|---|---|
| | • 94% of attendees rated 5-10, (medium – high) when asked if the training would improve their recovery focus within their clinical practice.<br><br>• We have delivered a number of recovery focused care planning workshops within adult clinical teams across localities.<br><br>• We have been successful in securing a project to work alongside the Mental Health Foundation (MHF) which will embed shared decision making. The MHF will support us to deliver training to staff in 2015/16 in shared decision making. |
| • Establish the current position on recovery action planning and devise an implementation plan by quarter 2 2014/15. | • 'Steps to Recovery' is a recovery action planning group intervention designed by a psychologist working within our MHSOP services. A pilot of this intervention has demonstrated a positive impact upon recovery outcomes. In 2014/15 we trained a further 95 Trust staff across MHSOP and Adult Mental Health services to support the delivery of this intervention across the Trust.<br><br>• Recovery action planning courses are also being delivered within the Durham Recovery College. 'Recovery - the New Me'. This course is delivered to college students and is facilitated by Peer Trainers with lived experience.<br><br>• Recovery action planning has also been embedded as a specific workbook within the Model Lines Project. |
| • Increase the opportunities for volunteering by quarter 4 2014/15. | • A review of our volunteering processes and procedures has taken place and new processes have been developed. A further business case to expand the volunteering opportunities has been approved for 2015/16.<br><br>• 7 new volunteering roles have been developed for individuals with lived experience within the Durham Recovery College.<br><br>• 23 further volunteers with lived experience have been given roles within a range of the Trust services. |
| • Investigate the role of peer support workers (staff with 'lived experience' providing care and support) by quarter 4 2014/15. | • The scoping of peer support roles has taken place.<br><br>• Draft role descriptions have been developed and possible models of delivery have been explored.<br><br>• A peer support steering group was set up in Q3 2014/15.<br><br>• Funding has been secured from Health Education North East to deliver our first peer support training in 2015/16 at the Durham Recovery College. |

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- An action plan to offer specific peer volunteer opportunities throughout 2015/16 has been put in place (and commenced development of an action plan to take forward paid peer roles).

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<tr><td>

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

</td><td>

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

<table>
<tr><th>Locality living / or received services</th><th>Number of current experts</th></tr>
<tr><td>Tees - Middlesbrough</td><td>1</td></tr>
<tr><td>Tees Stockton</td><td>2</td></tr>
<tr><td>Tees - Hartlepool</td><td>2</td></tr>
<tr><td>North Yorkshire – Harrogate Hambleton and Richmond</td><td>3</td></tr>
<tr><td>Durham and Darlington - South Durham</td><td>6</td></tr>
<tr><td>Durham and Darlington – North Durham</td><td>4</td></tr>
<tr><td>Out of area</td><td>1</td></tr>
</table>

- This group of experts have co-facilitated our recovery training, recovery development workshops, CPA care planning workshops.
- The group of experts have been consulted and provided feedback for a number of Trust developments including the bid for the Virtual Recovery College, the development of CPA documentation and IT projects.
- Members of the group also sit on a range of steering groups and work streams. Examples include;
  - Recovery steering group,
  - Recovery College steering group,
  - Force reduction steering group,
  - Peer support work stream group,
  - Culture work stream group,
  - Trauma work groups,
  - Values based recruitment fair planning and delivery group.
- We are in the process of setting up a new training programme for a 3rd cohort of experts by experience and aim to develop a minimum of 10 further expert roles in 2015/16.

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

### How we know we have made a difference:

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

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

### What we plan to do in 2015/16:

The Trust's Recovery Strategy and implementation plan were always intended to be in place for more than one year to enable the complex process and cultural changes required to take place. Our stakeholders were consequently keen to retain Recovery as one of the 15/16 priorities for this Quality Account. Therefore our future actions for this priority can be found on **pages 51-52** in the section on our new quality account improvement priorities.

## Priority 4: To manage the pressure on acute inpatient beds

### Why this is important:

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

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

- ensure their own sense of connectedness and familiarity is maintained;
- ensure family and carers can remain involved in their care and treatment;
- ensure consistent engagement of their community mental health team which provides continuity of care and supports early discharge;

- ensure we minimise disruption / stress for the service user and their family.

### What benefits / outcomes did we aim to deliver:

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

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

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

### What we did in 2014/15:

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

| What we said we would do | What we did |
|---|---|
| • Staff are skilled in the delivery of a range of home treatment | • Completed a skills analysis and identified training priorities. From this, e-learning packages for induction training materials have been developed and produced.<br>• Face to face training events have also been designed.<br>• Developed a Crisis Team Toolkit, which has provided staff with “at hand” resources for assessment, psychological formulation and risk assessment / management. It also provides crisis practitioners with the tools to refer to alternative or additional services appropriately and confidently. |
| • Service users have co-produced high quality care plans that seek to maintain treatment in the community rather than admission to hospital | • This action is linked to the CPA quality priority.<br>• Recovery focused care plan workshop and engagement events have been held, whilst ensuring this linked with the Model Lines Framework.<br>• There has been a redesign of CPA processes and documentation to ensure they fulfil the mandatory requirements whilst reducing an unnecessary burden on Trust staff.<br>• Ensuring the requirements of the Mental Health Act are met whilst reducing unnecessary burden on staff, inclusive of the development of standard work regarding Section 117 of the Mental Health Act – the statutory duty to provide health and social care to some service users following discharge from in-patient care. This has been piloted with a plan for phased implementation with briefings and training for Trust staff planned for May 2015. |

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

## What we plan to do in 2015/16:

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

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

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

# Statement of Assurances from the Board 2014/15

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

## Review of services

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

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

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

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

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

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

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

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

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

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

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

## Participation in clinical audits and national confidential inquiries

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

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

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

- National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH).

- POMH UK Topic 14a: Prescribing for substance misuse – alcohol detoxification.
- POMH UK Topic 12b: Prescribing for people with personality disorder.
- POMH UK Topic 9c: Antipsychotic prescribing for people with a learning disability.
- National Audit of Memory Clinics 2014.

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

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

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

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

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

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

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

- National Audit of Memory Clinics 2014

*Actions:*

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

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

  *Actions:*

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

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

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

## Participation in clinical research

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

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

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

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

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

SCIMITAR PLUS – a trial of smoking cessation intervention for people with severe mental ill health.

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

## Goals agreed with commissioners

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

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

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

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

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

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

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

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

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

  1. Smoking status;
  2. Lifestyle (including exercise, diet alcohol and drugs);

3. Body Mass Index;
4. Blood pressure;
5. Glucose regulation (HbA1c or fasting glucose or random glucose as appropriate);
6. Blood lipids.

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

## What others say about the provider

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

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

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

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

CQC's rating for each key area was:

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

The Trust received a rating of "requires improvement" for the key area "*Are services safe"* which was partially due to an issue CQC raised around privacy and dignity in respect of same sex accommodation in a rehabilitation ward. It is worth noting that the issues raised in respect of this key area relates to a small percentage of TEWVs services with all other areas performing effectively and safely. Further information on the improvement required for this key area can be seen on **pages 39-41**.

The report highlights several areas of good practice, including:

- The learning disability and autism service have a steering group and champions for positive behaviour support. The role and purpose of the group and

champions was to embed teaching and learning across the locations to ensure positive behaviour support was an effective tool to manage complex behaviours which challenged.

- The implementation of a programme, within the substance misuse services, to provide emergency medical treatment for those identified as high risk of opiate overdose. Staff had been told that the programme had prevented a number of deaths in the community.
- In the wards for the older people service, specifically on Springwood and Rowan Lea wards, staff were using specialist computer programmes to enable them to interact with people with memory problems in a positive way.
- Excellent examples of some crisis teams encouraging patients to develop advance directives to help them determine their future crisis care needs.
- The pharmacy team had worked with some of the wards to develop and implement robust 'step down' procedures to support patients in managing their own medicines in preparation for when they moved on from the ward.

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

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

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

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

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

- Explore the development and implementation of a consultant led peri-natal mental health pathway that also includes services for those women with mild to moderate mental health needs during pregnancy and postpartum.
- Ensure that there is effective liaison and sharing of expertise between health professionals in early intervention, child in need and child protection cases including the undertaking of joint visits as appropriate.

- Assure themselves that health practitioners are trained in writing referrals to children's social care and that those referrals appropriately assess and articulate risk to enable social workers to make well informed decisions.
- Assure themselves that health practitioners are trained and understand national and local guidance on record keeping and that local health records contain appropriate detail on concerns and action taken by practitioners when working with families.
- Ensure that paperwork relating to safeguarding and child protection is available as part of the electronic patient record to enable practitioners to access the complete record when working with their client.

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

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

| | | |
|---|---|---|
| Ward 15 | Adult Mental Health Assessment & Treatment | Northallerton |
| Willow | Adult Mental Health Rehab | Darlington |
| Wingfield | Older Peoples Mental Health Assessment and Treatment | Hartlepool |

The CQC Mental Health Act (MHA) Commissioners undertook a two day inspection in December 2014 in order to monitor under Section 120 of the Mental Health Act 1983 to look at the arrangements for assessment and application for detention that operated in Teesside and North Yorkshire. The primary issues are that within Teesside there are delays in ambulance transportation for conveying patients to hospital from the community. It was also identified there can be difficulty in securing a second Section 12 approved doctor for formal MHA assessments.

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

**Actions Taken**

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

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

**Actions and Progress**

- My Shared Pathway Intervention Planning training has been rolled out across service to all teams.
- Written copies of care plans are now readily available to all staff.
- Handover discussions and clinical supervision review actions taken by staff are used to implement individual care plans.
- Templates have been developed for daily recording on Paris which links with My Shared Pathway interventions and includes the patient's experience and feedback.
- Regular collaborative activity planning sessions with all patients and their named nurses have been established.
- The options of establishing a Recovery College accessible to forensic patients are progressing.
- A survey of patients and staff to determine whether discrimination is occurring is to be undertaken and a patient and staff reference group regarding equality and diversity meets monthly. Lesbian, Gay, Bisexual and Transgender (LGBT) information leaflets and antidiscrimination posters are available in clinical areas. Equality Champions have been identified for each ward.
- The appropriateness of admissions have been discussed regarding admission

criteria with commissioners for Forensic Learning Disability Low Secure services and NHS England Commissioners have agreed appropriate assessment information. An escalation framework for delayed transfers (externally to the Trust) has been developed.

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

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

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

**Actions and progress**

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

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

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

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

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

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

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

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

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

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

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

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

- A parabolic mirror in the seclusion room at Ward 15 has been installed to ensure there are no blind spots where patients cannot be observed.
- The estates escalation processes for inpatient staff, in hosted environments, has been reviewed to ensure the TEWV Director of Estates and Facilities

Management can resolve delays in environmental maintenance and improvement actions. We have briefed the matron and ward managers of those wards about the escalation process.

- The TEWV Director of Estates and Facilities Management has a quality monitoring process in place with partner NHS Trusts where services are provided from.
- All actions have been completed.

## Quality of data

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

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

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

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

The Information Governance Toolkit measures performance in the following areas:

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

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

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

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

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

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

At the end of March 2015:

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

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

Further work for 2015/16 includes:

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

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

- We have a Data Quality Group chaired by the Director of Finance and Information which meets on a monthly basis and addresses data quality issues in terms of patient, staff, financial and risk information.
- We have a data quality strategy and scorecard to monitor improvement. The strategy aims:
    - To maximise the accuracy, timeliness and quality of all our data wherever and however it is recorded.
    - To ensure that every member of our staff understands that data quality is the responsibility of everyone and an integral part of their role.
    - To ensure we achieve compliance with all our statutory and regulatory obligations.
- A data quality working group was formalised in late 2014/15 to identify areas of poor data quality, develop locality specific action plans in relation to data quality, and provide advice, support and education to teams. This group works to the Trust Data Quality Group.
- We have established regular reports on key elements of data which show how well data is being recorded on the various information systems, particularly the patient information system and the staff information system.
- We report on data quality to the Board as part of our Strategic Direction Scorecard reports.
- In 2015/16, the Trust is continuing to further implement an Integrated Information Centre. Within this there is a data quality function that now enables services and teams to assess and improve the quality of their data in real time, but further refinements and improvements to the system will take place over the year.
- Regular reports are available to all services so that they can target improvement work on areas where problems occur. Data quality is a key item for discussion in the monthly performance meetings that are held between the services and the Chief Operating Officer, the Director of Finance and Information and the Director of Planning, Performance and Communication.
- We have agreed Data Quality Improvement Plans (DQIPs) with our commissioners for key indicators, particularly those that require new data recording or collection systems to be put in place.

## Mandatory quality indicators

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

### Care Programme Approach 7 day follow-up

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

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

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

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

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

- Service being unable to access the service user; and
- Breakdown in processes.

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

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

## Crisis Resolution Home Treatment Team acted as a gatekeeper

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

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

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

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

- The discrepancy between the NHSIC and the Trust / Monitor figures is due to

the fact the NHSIC data is submitted at a Clinical Commissioning Group (CCG) level, and therefore, excludes data for patients from CCGs outside the Trust area or where the CCG is unspecified in the patient record.

- The few actual breaches, **19** in total in 2014/15, were a result of failure to follow the standard procedure.

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

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

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

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

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

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

*not directly comparable with previous years data

### Notes on metric

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

Thinking about the last time you saw this NHS health worker or social care worker for your mental health condition…
…Did this person listen carefully to you?

…Did this person take your views into account?
…Did you have trust and confidence in this person?
…Did this person treat you respect and dignity?

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

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

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

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

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

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

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

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

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

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

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

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

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

## Patient safety incidents including incidents resulting in severe harm or death

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

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

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

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

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

can say, however:

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

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

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

## 2015/16 Priorities for Improvement

During 2014/15 we held two events inviting our stakeholders to take part in our process of identifying quality priorities for 2015/16 to be included in the Quality Account. These events took place in July 2014 and February 2015: further information can be found in **pages 68-69**. In addition to the quality priorities identified by our stakeholders, we have a number of additional priorities to improve quality included within the Trusts business plan, details can be found in **appendix 6**.

Our four agreed priorities for inclusion in the Quality Account for 2015/16 are:

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

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

### Why this is important:

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

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

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

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

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

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

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

### What we will do in 2015/16:

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

### How will we know we are making a difference:

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

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

## Priority 2: Nicotine Management and Smoking Cessation

### Why this is important:

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

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

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

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

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

## What we will do in 2015/16:

**We will:**

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

### How will we know we are making a difference:

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

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

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

### Why this is important:

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

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

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

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

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

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

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

## What we will do in 2015/16:

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

## How will we know we are making a difference:

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

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

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

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

### Why this is important:

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

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

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

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

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

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

### What we will do in 2015/16:

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

### How will we know we are making a difference:

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

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

## Monitoring Progress

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

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

# PART 3: OTHER INFORMATION ON QUALITY PERFORMANCE 2013/14

## Our performance against our quality metrics

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

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

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

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

### Table 1: Quality Metrics

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

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

**Notes on selected metrics**

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

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

**Table 2: National Patient Survey historical performance**

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

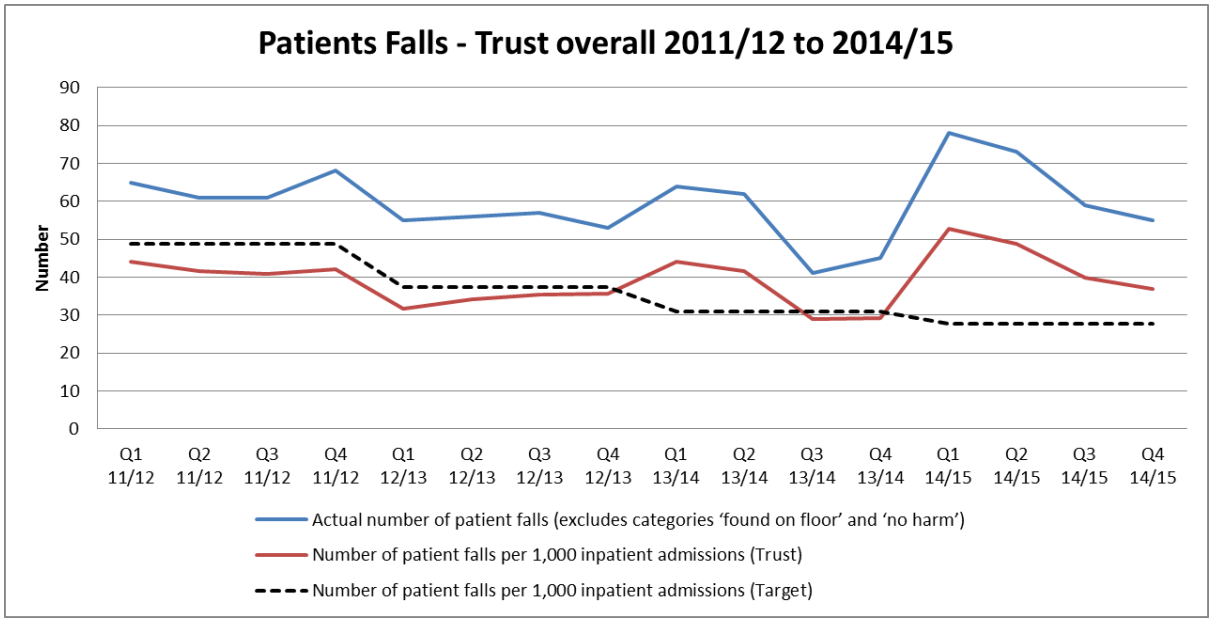
## Comments on Areas of Under-Performance

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

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

**Metric 3:** Patient falls per 1,000 admissions.

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




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

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

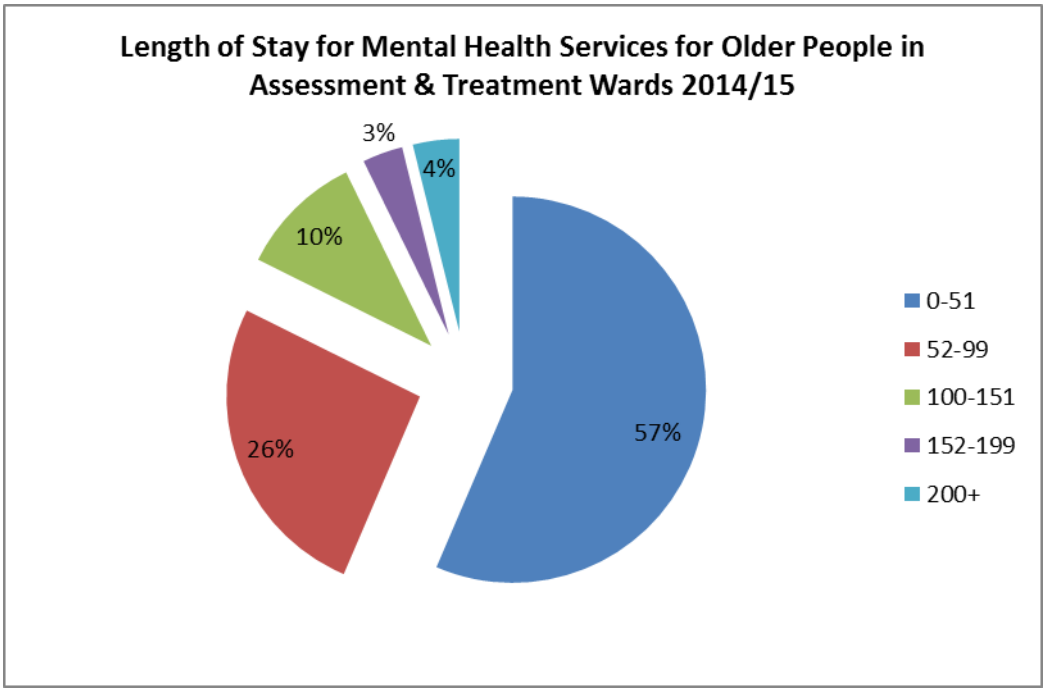
- The Trust 'Falls Executive Group' was reintroduced in January 2015 – this is the body that steers and monitors Trust falls management and will report into the Patient Safety Group (a sub group of the Quality Assurance Committee).
- We are analysing falls across the Trust comparing 2013/14 to 2014/15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

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

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

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

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




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

**Metric 8:** Percentage of complaints satisfactorily resolved.

The percentage of complaints satisfactorily resolved in 2014/15 was **75.38**% which is below the target of **90.00**% but an improvement on 2013/14. This relates to **195**

formal complaints received. Complaints are monitored by the Quality Assurance Committee and each is thoroughly investigated. Both the Patient Experience Department and Patient Advice and Liaison Services (PALS) strive to resolve as many concerns/complaints as possible informally.

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

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

**Table 3: Complaints Resolution 2014/15**

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

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

## Our performance against the Risk Assessment Framework Targets and Indicators

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

**Table 4: Risk Assessment Framework**

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

**Notes on Risk Assessment Framework Targets and Indicators**

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

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

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

## External Audit

For 2014/15, our external auditors have to provide a limited assurance report on whether two mandated indicators included in the Quality 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 2014/15 are:

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

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

## Progress against National Quality Issues/Reports

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

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

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

### Duty of Candour

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

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

## Review of Trust complaints process

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

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

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

## Safe Staffing Levels

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

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

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

## Raising Concerns

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

## Audit of Quality Governance

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

## Our stakeholders' views

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

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

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

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

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

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

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

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

In response the Trust will continue to make the production of the Quality 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 2014/15 to the following stakeholders:

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

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

The following are the general themes received from stakeholders in reviewing our Quality Account for 2014/15:

**To be added upon receipt of stakeholder feedback (deadline 17th May 2015).**

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

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

# APPENDICES

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

The Directors are required under the Health Act 2009 and the National Health Service (Quality Account) Regulations 2010 to prepare Quality Accounts / Report for each financial year.

Monitor has issued guidance to NHS foundation Trust boards on the form and content of annual Quality Account (which incorporate the above legal requirements) and on the arrangements that NHS foundation Trust boards should put in place to support the data quality for the preparation of the Quality 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 2014/15 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 2014 to May 2015;
    - Papers relating to Quality reported to the Board over the period April 2014 to May 2015;
    - Feedback from the commissioners dated XX and XX/XX/20XX;
    - Feedback from Governors dated 23 March, 13 April and 19 May 2015;
    - Feedback from Local Healthwatch organisations dated XX/XX/20XX;
    - Feedback from Overview and Scrutiny Committees dated XX/XX/20XX
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated XX/XX/20XX;
    - The latest national patient survey published 18 September 2014;
    - The latest national staff survey published 24 February 2015;
    - The Head of Internal Audit's annual opinion over the Trust's control environment dated 6 May 2015*;*
    - CQC Intelligent Monitoring Report dated 20 November 2014.

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

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

By order of the Board

NB: sign and date in any colour ink except black

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

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

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

To be included in the final version of this document following the receipt of the external auditor's report.

## APPENDIX 3: GLOSSARY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Coproduction:** This is an approach where a policy, and approach or other initiative / action is designed jointly by TEWV and a service user / service users.

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

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

**Crisis Care Concordat:** The Mental Health Crisis Care Concordat is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis.

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

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

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

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

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

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

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

**Drug and Therapeutics Committee:** This is a subcommittee of the Quality Assurance Committee. It's role is to provide assurance to the Board of Directors, through the monitoring of quality and performance indicator data, planned work streams, guideline development and system implementation that the use of medicines throughout the Trust is safe, evidence-based, clinically and cost effective.

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

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

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

**Electroconvulsive Therapy (ECT):** ECT is a treatment for a small number of severe mental illnesses. It was developed in the 1930s and was used widely during the 1950s and 1960s for a variety of conditions. It is now only used for fewer, more serious conditions. An electrical current is passed through the brain to produce an epileptic fit – hence the name, electro-convulsive. No-one is certain how ECT works. We do know that it can change patterns of blood flow through the brain and change the metabolism of areas of the brain which may be affected by depression. There is evidence that severe depression is caused by problems with certain brain chemicals. It is thought that ECT causes the release of these chemicals and, probably more importantly, makes the chemicals more likely to work and so help recovery.

**Equality Champions:** Staff within TEWV who have been appointed to promote good practice in equalities within their service and who attend the Trust-wide Equalities group.

**Experts by Experience:** experts by experience have been trained to work alongside the recovery team to develop and deliver recovery related training in supporting staff and service development in recovery related practice. Experts by experience work with Trust staff, they do not work with service users and carers (ie they are not acting in a peer role). These roles are managed via our Patient and Public Involvement process.

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

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

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

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

**Health and Social Care Information Centre (HSCIC):** The Health and Social Care Information Centre (HSCIC) was set up as an executive non-departmental public body in April 2013, sponsored by the Department of Health. It is the national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care**.**

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

**Health Education North East:** The Health and Social Care Act 2012 established Health Education England which is supported by 13 local education and training boards (LETBs) spread across the country. HENE is the LETB that covers the North East of England, north Cumbria and Richmondshire / Hambleton area of North Yorkshire. It is responsible for the education and training of the whole NHS north east workforce. The professions range from medics, dentists, nurses, dental nurses, allied health professionals and healthcare scientists, to a variety of support staff such as healthcare and nursing assistants, therapists and technical staff.

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

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

**Health Technology Assessment (HTA):** The HTA Programme is the largest of the National Institute for Health Research programmes. We fund independent research about the effectiveness, costs and broader impact of healthcare treatments and tests for those who plan, provide or receive care in the NHS. We fund our studies via a number of routes including commissioned and researcher-led workstreams

**Her Majesties Prison Inspectorate (HMPI):** The inspectorate reporting on the treatment and conditions for those in prison and other types of custody in England and Wales

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

**Human Resources:** This phrase is either shorthand for all the staff working for TEWV, or the corporate service within TEWV responsible for ensuring that we have policies, procedures and professional advice that help us to recruit and retain suitably qualified, skilled and motivated workers in our full range of jobs (in other organisations this might be known as the Personnel Department).

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

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

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

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

**Join Dementia Research (JDR):** is a new national system which allows anyone, with or without dementia, to register their interest in becoming involved in dementia research. People can register online, by phone or by post and the system aims to match people to studies they may be able to take part in.

**Learning Disabilities Service:** Services for people with a learning disability and mental health needs. TEWV has Adult Learning Disability (ALD) service in each of its 3 Localities and also specific wards for Forensic LD patients. TEWV provides Child LD services in Durham, Darlington and Teesside but not in North Yorkshire.

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

**Local Authority Overview and Scrutiny Committee:** All "upper-tier" and "unitary" local authorities are responsible for scrutinising health services in their area, and most have a Health Overview and Scrutiny Committee (OSC). Darlington, Hartlepool, Middlesbrough, Stockton and Redcar & Cleveland Councils have formed a joint Tees Valley OSC.

**Localities:** services in TEWV are organised around three Localities (ie County Durham & Darlington, Tees, North Yorkshire). Our Forensic services are not

organised as a geographical basis, but are often referred to a fourth "Locality" within TEWV.

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

**Mental Capacity Act:** is a framework to provide protection for people who cannot make decisions for themselves. It contains provision for assessing whether people have the mental capacity to make decisions, procedures for making decisions on behalf of people who lack mental capacity and safeguards. The underlying philosophy of the MCA is that any decision made, or action taken, on behalf of someone who lacks the capacity to make the decision or act for themselves must be made in their best interests**.**

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

**Mental Health and Learning Disabilities Data Set (MHLDDS):** This contains data about the care of adults and older people using secondary mental health, learning disabilities or autism spectrum disorder services**.** Data is submitted by all providers of NHS funded services (doing so is a contractual requirement). This used to be referred to as the Mental Health Minimum Data Set (MHMDS).

**Mental Health Foundation:** A UK mental health research, policy and service improvement charity.

**Mental Health Minimum Data Set (MHMDS)**: see *Mental Health and Learning Disabilities Data Set (MHLDDS)* above.

**Mental Health Research Network (MHRN):** is part of and funded by the National Institute for Health Research and provides the NHS infrastructure to support commercial and non-commercial large scale research in mental health including clinical trials.

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

**Model Lines:** A TEWV programme to support community teams to become recovery focused by using the quality improvement system philosophy and tools to maximise the time staff have available to work with patients, their families and

carers. It also seeks to standardise the approach taken by different staff within a team, and across the Trust as a whole.

**Monitor:** the independent economic regulator for NHS Foundation Trusts.

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

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

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

**My Shared Pathway:** My Shared Pathway is used in our Forensic (Adult Secure) wards. It focusses on *recovery*, identifying and achieving outcomes and streamlining the pathway for service users within secure settings. This way of working ensures that service users are treated as individuals by looking at each person's needs. They are encouraged to find new ways of meeting their needs by looking at the whole pathway through secure care, from the very start.

**National Audit of Psychological Therapies (NAPT):** funded by the Healthcare Quality Improvement Partnership (HQIP) and is an initiative of the College Centre for Quality Improvement (CCQI). Aims to promote access, appropriateness, acceptability and positive outcomes of treatment for those suffering from depression and anxiety.

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

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

**National Research Passport Scheme:** a scheme to streamline procedures associated with issuing honorary research contracts or letters of access to researchers who have no contractual arrangements with NHS organisations who host research, and who carry out research in the NHS that affects patient care, or requires access to NHS facilities.

**National Institute for Clinical Excellence (NICE):** NHS body that provides guidance, sets quality standards and manages a national database to improve

people's health and prevent and treat ill health. NICE works with experts from the NHS, local authorities and others in the public, private, voluntary and community sectors - as well as patients and carers - to make independent decisions in an open, transparent way, based on the best available evidence and including input from experts and interested parties.

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

**National Reporting and Learning System (NRLS):** an NHS led central database of information on patient safety incidents used to identify and tackle important patient safety issues at their root cause.

**National Research Passport Scheme:** a scheme to streamline procedures associated with issuing honorary research contracts or letters of access to researchers who have no contractual arrangements with NHS organisations who host research, and who carry out research in the NHS that affects patient care, or requires access to NHS facilities.

**National Strategic Executive Information System (STEIS):** a new Department of Health system for collecting weekly management information from the NHS.

**NHS England Commissioners:** The part of NHS England responsible for commissioning specialist mental health services – e.g. Adult Secure (Forensic), CAMHS Inpatients and Inpatient adult and CYP Eating Disorders.

**NHS England – Area Teams:** The teams with NHS England responsible for commissioning specialised services and monitoring our performance against our specialist services contracts.

**NHS Service User Survey:** the annual survey of service users' experience of care and treatment received by NHS Trusts. In different years has focused both on inpatient and community service users.

**NHS Staff Survey:** an annual survey of staffs' experience of working within NHS Trusts.

**Opting in to Clinical Research (OptiC):** This has recently been incorporated within our local electronic patient records system. Systems like this, which are embedded in NHS records, allow service-users to express an interest (or otherwise) in participating in clinical research and have the potential to enhance and streamline the recruitment of patients to studies.

**Out of Locality Action Plan:** The Trust wants all inpatients to be admitted to the normal hospital for the place where they live for their condition, unless they express a choice to be treated elsewhere. Sometimes we are unable to do that when there are no beds available in their local hospital in which case the patient would be admitted to another TEWV hospital, further away from where the patient lives. We have an action plan to reduce the number of times this happens.

**Overview & Scrutiny Committees (OSCs):** These are statutory committees of each Local Authority which scrutinise the development and progress of strategic and operational plans of multiple agencies within the Local Authority area. All local authorities have an OSC that focussed on Health, although Darlington, Middlesbrough, Stockton, Hartlepool and Redcar & Cleveland Councils have a joint Tees Valley Health OSC that performs this function.

**Paris:** the Trust's electronic care record, product name Paris, designed with mental health professionals to ensure that the right information is available to those who need it at all times.

**Paris Programme:** Ongoing improvement of the PARIS system to adapt it to TEWV's service delivery models and pathways.

**Patient Advice & Liaison Team (PALs):** The Patient Advice and Liaison Service (PALS) offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers. TEWV has its own PALS service as do all other NHS providers.

**Patient Safety Group:** The group monitors on a monthly basis the number of incidents reported, any thematic analysis and seeks assurances from operational services that we are learning from incidents. We monitor within the group any patient safety specific projects that are on-going to ensure milestones are achieved and benefits to service users are realised.

**Payment by Results (PBR):** a new system being implemented across the NHS, and piloted in mental health Trusts, to provide a transparent, rules-based system for paying NHS Trusts. The system aims to reward efficiency, support patient choice and diversity and encourage activity for sustainable waiting time reductions. Payment will be linked to activity, adjusted for case-mix, and outcomes. Importantly, this system aims to ensure a fair and consistent basis for hospital funding rather than being reliant principally on historic budgets and the negotiating skills of individual managers.

**Peer Trainer:** someone who is trained and recruited as a paid employee within the Trust in a specifically designed job to actively use their lived experience and to deliver training courses to other service users and carers. They work within the Recovery College.

**Peer Volunteer:** someone who gives their time freely to the Trust in a specifically defined unpaid role to actively use their lived experience (as a service user or carer) to support other carers and service users. They work alongside and support paid staff as well as providing support to specific groups / tasks.

**Peer Worker:** someone who is trained and recruited as a paid employee within the Trust in a specifically designed job, to actively use their lived experience (as a service user or carer) to support other service users, in line with the Recovery Approach.

**PPI:** Patient and Public Involvement.

**Prescribing Observatory in Mental Health (POMH):** a national agency, led by the Royal College of Psychiatrists, that aims to help specialist mental health services improve prescribing practice via clinical audit and quality improvement interventions.

**Prime Minister's Challenge on Dementia:** David Cameron's government's five year vision for the future of dementia care, support and research, which was launched in 2012 and updated in 2015. The overall ambition set by the vision is by 2020 for England to be:

- The best country in the world for dementia care and support and for people with dementia, their carers and families to live; and
- The best place in the world to undertake research into dementia and other neurodegenerative diseases.

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

**Purposeful Inpatient Admission and Treatment:** This is TEWV's method for ensuring that all patients receive assessments and treatments as quickly as possible so that their length of stay is kept as short as possible.

**Quality 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 Goals:** (see *Quality Strategy*, below).

**Quality Governance Framework (Monitor):** Monitor's approach to making sure NHS foundation trusts are well run and can continue to provide good quality services for patients.

**Quality Strategy:** This is a TEWV strategy. The current strategy covers 2014 – 2019. It sets a clear direction and outlines what the Trust expects from its staff to work towards our vision of providing excellent quality care. It helps TEWV continue to improve the quality and value of our work, whilst making sure that it remains clinically and financially sustainable

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

**Quality Risk Profile Reports:** The Care Quality Commission's (CQC) tool for providers, commissioners and CQC staff to monitor provider's compliance with the essential standards of quality and safety.

**Recovery Approach:** This is a new approach in mental health care that goes beyond the past focus on the medical treatment of symptoms, and getting back to a "normal" state. Personal recovery is much broader and for many people it means finding / achieving a way of living a satisfying and meaningful life within the limits of mental illness. Putting recovery into action means focusing care on what is personally important and meaningful, looking at the person's life goals beyond their symptoms. Helping someone to recover can include assisting them to find a job, getting somewhere safe to live and supporting them to develop relationships.

**Recovery College:** A recovery college is a learning centre, where service users, carers and staff enrol as students to attend courses based on recovery principles. Our recovery college, called *ARCH,* opened in September 2014 in Durham. This exciting resource is available to TEWV service users, carers and staff in the Durham area. Courses aim to equip students with the skills and knowledge they need to manage their recovery, have hope and gain more control over their lives. All courses are developed and delivered in co-production with people who have lived experience of mental health issues.

**Recovery Strategy:** TEWV's long term plan for moving services towards the *recovery approach* (see above).

**Research for Patient Benefit (RfPB):** provides funding for high quality research, inspired by patients and practice, for the benefit of users of the NHS in England. Its main purpose is to realise, through evidence, the huge potential for improving, expanding and strengthening the way that healthcare is delivered for patients, the public and the NHS.

**Resilience:** Resilience in the context of this Quality Account is the extent to which patients can cope, and maintain their own well-being when they can feel their mental health worsening. We work with patients to build up their resilience as part of the recovery approach, and often develop Resilience Plans with them.

**Ridgeway:** The part of Roseberry Park Hospital that houses our Adult Low Secure and Medium Secure wards (also known as Forensic wards).

**Root Cause Analysis (RCA):** a technique employed during an investigation that systematically considers the factors that may have contributed to the incident and seeks to understand the underlying causal factors.

**Safeguarding Adults / Children:** Safeguarding means protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect. It is fundamental to creating high-quality health and social care.

**Section 117 of the Mental Health Act:** This part of the Act provides for aftercare to be given to some people discharged from mental health inpatient beds to help them avoid readmission to hospital. The duty applies both to the NHS and to Social Services.

**Section 136 of the Mental Health Act:** The police can use section 136 of the Mental Health Act to take a person to a place of safety when they are in a public place. They can do this if they think the person has a mental illness and are in need of care. A place of safety can be a hospital or a police station. The police can keep the person under this section for up to 72 hours. During this time, mental health professionals can arrange for a Mental Health Act assessment.

**Section 136 Suite:** A "place of safety" where people displaying behaviours that are a risk to themselves or to the public can be taken by the Police pending a formal mental health assessment. This procedure is contained within Section 136 of the Mental Health Act.

**Serious Untoward Incidents (SUIs):** defined as an incident that occurred in relation to NHS-funded services and care, to ether patient, staff or member of the public, resulting in one of the following: unexpected / avoidable death, serious / prolonged / permanent harm, abuse, threat to the continuation of the delivery of services, absconding from secure care.

**Service User Focus Groups:** a discussion group made up of people who either are, or have been users of our services. The outputs from these groups inform management decisions.

**Stoptober:** This is a Public Health England initiative held in October each year. It is a programme designed to help people quit smoking based on evidence that if you quit for 28 days you are five times more likely to quit for good.

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

**SWEMWBS:** The shortened version of *WEMWBS* (see below).

**TEWV:** see 'The Trust'.

**TEWV Quality Improvement System (QIS):** the Trust's framework and approach to continuous quality improvement based on Kaizen / Toyota principles.

**Trust Board:** See 'Board / Board of Directors'.

**The Health Foundation:** is an independent national charity working to improve the quality of healthcare in the UK. The Health Foundation supports people working in health care practice and policy to make lasting improvements to health services. They carry out research and in-depth policy analysis, run improvement programmes to put ideas into practice in the NHS, support and develop leaders and share evidence to encourage wider change. Each year they give grants in the region of £18m to fund health care research, fellowships and improvement projects across the UK – all with the aim of improving health care quality.

**The Trust:** Tees, Esk and Wear Valleys NHS Foundation Trust.

**Trustwide:** This means across the whole geographical area served by the Trust's 3 Localities.

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

**Values Based Recruitment Project:** This is a recruitment method that does not just focus on the skills and experience but also on the values and likely behaviours of job applicants.

**Virtual Recovery College:** This is an initiative that would allow people to access recovery college materials and peer-support on-line.

**Visual Control Boards:** a technique for improving quality within the overall TEWV Quality Improvement System (QIS).

**Warwick-Edinburgh Mental Well-Being Scale (WEMWBS):** The Warwick-Edinburgh Mental Well-being Scale (WEMWBS) is a scale of 14 positively worded items, with five response categories, for assessing mental wellbeing. There is also a "short" version of this scale – where this is used it is called *SWEMWBS.*

**Youth Speak:** is a young people's group which aims to give young people a voice and skills in mental health research; reducing mental health stigma for young people through research; and shaping research to influence mental health services for young people.

# APPENDIX 4: ARCH DURHAM RECOVERY COLLEGE COURSES

**Courses Ran throughout 2014/15**

- Recovery – What's it all About? (Taster session plus enrolment)
- Recovery – The New Me (6 week course)
- Sleeping Well (3 week course)
- Lifestyle and Recovery (6 week course)
- Spirituality and Recovery (4 week course)
- Know your Medication:
  - Know Your Medication – Mood Stabilisers,
  - Know Your Medication – Anti-depressants,
  - Know Your Medication – Anti-psychotics.
- 'Diagnosis' workshops:
  - Understanding Bipolar Disorder,
  - Understanding Psychosis,
  - Understanding Personality Disorder,
  - Understanding Depression,
  - Understanding Eating Disorders.
- Getting the Best out of Mental Health Services
- Mindfulness Taster
- CPA Workshops
- Assertiveness
- Resilience
- Volunteering

**Most Popular Courses to date (in terms of sign-up and attendance)**

- Recovery – What's it all About
- Recovery – The New Me
- Mindfulness Taster
- Sleeping Well
- Understanding Psychosis/
- Understanding Bipolar Disorder

**Additional courses for delivery 2015/2016**

- Carers and CPA
- Dealing with others
- Finding your way around the benefits system
- Getting the best out of Mental Health Services
- An Introduction to Complementary Therapies
- Making use of community resources
- Managing money

- Managing stress
- Mental Health Act
- Mindfulness 8 weeks course
- Volunteering with TEWV
- Trauma and Mental Health
- Peer Support worker training
- Student residential mindfulness retreat

# APPENDIX 5: KEY THEMES FROM 64 LOCAL CLINICAL AUDITS (194 INDIVIDUAL AUDITS) REVIEWED IN 2014/15

| Audit Theme | Summary of Actions |
|---|---|
| Infection prevention and control audits | • All Infection Prevention and Control Audits are continuously monitored by the IPC team and any required actions are rectified collaboratively with the IPC team and ward staff. Assurance of implementation of actions is monitored by the Clinical Audit and Effectiveness team via the clinical audit database. |
| Physical Health audits | • Modern Matrons to emphasise to teams the process to be followed on admission and issue all ward staff with the Trust's Diabetes Guidelines.<br>• Modern Matrons to ensure e-learning is completed by all staff.<br>• Review current Psychotropic induced Hyperprolactinaemia Trust guidance to improve clarity and to remove ambiguity and communicate to staff.<br>• Incorporate assessment of red flags into annual assessment of practice for nurses.<br>• Areas for improvement to be disseminated to teams, including:<br>  ◦ Up to date care plans/discharge documents/letters with GPs with evidence this has been shared with GP at point of discharge and following care plan reviews.<br>  ◦ Medical Director to remind medical staff to record codes in relevant documents as outlined (via medical directors bulletin and consultant meetings).<br>  ◦ Modern Matrons to remind all clinical disciplines to include recovery interventions associated with physical health improvement within relevant documents/plans including:<br>  ▪ Lifestyle<br>  ▪ Social<br>  ▪ Employment<br>  ▪ Accommodation<br>• Ward managers to add to report out visual display board the status of EWS recording (daily or not daily) to remind the multidisciplinary team to discuss this at report out.<br>• Ward clinical leads and champions to be informed again of EWS procedure by email; and that ward staff to attend Trust training on physiological observations and the use of the EWS if they are identified as requiring this in appraisal. |

| | |
|---|---|
| Care Programme Approach audits | • Modern Matrons to:<br>  ◦ circulate briefing note to all staff via ward managers highlighting the issue of risk assessments not being reviewed weekly as per policy and emphasise the agreed minimum standards.<br>  ◦ audit 5 patients electronic care records across MHSOP inpatient units to assess compliance in relation to standard (risk assessments to be reviewed weekly).<br>  ◦ arrange for all staff to be issued with guidelines for correct completion of risk sections on face document by email.<br>• Team / Ward Managers to:<br>  ◦ arrange FACE risk training sessions for all qualified staff.<br>  ◦ review individual practice by measuring completion of FACE documentation against the audit tool.<br>  ◦ document discussions about FACE in supervision records.<br>  ◦ discuss care plan reviews prior to transfer/transition between services with staff in supervision.<br>  ◦ discuss with social care colleagues the FACs criteria to ensure team members are aware of this criterion during supervision and team meetings. |
| Audits with high risk factors | • Submit a list of areas affected by poor soundproofing to the Trust's CQC team for further assessment (with a view to securing funding for improvement, where needed).<br>• Record the previous family history of mental illness in comprehensive assessment.<br>• Clinical Skills team to increase emergency equipment spot checks across the trust and address areas of non-compliance. Initial spot checks post audit to be completed trust wide.<br>• Ward Managers and Modern Matrons will inform all members of staff of the requirement to comply with this standard and introduce a process for monitoring this clinical practice.<br>• Ensure robust SMART action plans are developed which mitigate all areas of non-compliance identified as part of the audit. |
| Positive Behavioural Support (PBS) audits | • Undertake staff training as part of PBS rollout.<br>• Design and implement a process to ensure detail of PBS work is captured without being too onerous for staff; process to be linked with record keeping and PBS plan requirements.<br>• Discuss with Consultant Clinical Psychologist the work he is doing on De-briefs and the Trust wide C&R Reduction group Lead as this is a trust wide issue; and develop a workable solution / process that allows teams to use supportive de-briefs or wider MDT input as part of the support process following an incident.<br>• Progress to be reviewed monthly at both the PBS Champions Group and the PBS Steering Group; and at Intervention Planning 60 / 90 day follow up meetings. |

| | |
|---|---|
| Medicines Management audits | • Update the Medicines Code with specific information on storage of controlled stationery.<br>• Briefing sheet on appropriate storage of, and access to, controlled stationery to be provided to teams.<br>• To produce a clinical algorithm to assist staff in understanding NICE guidance in relation to alcohol dementia.<br>• Controlled Drugs data is submitted on a quarterly basis and rolling chart is developed.<br>• Remind prescribers in Pharmacy Bulletin to complete and record in Paris a full cardiovascular assessment, including ECG when appropriate, prior to initiation of treatment with AChE inhibitor. |
| Record Keeping audits | • Green compliance was assigned as 100% compliance was achieved.<br>• All Mental Health Team Managers to confirm discussion consent documentation with staff during supervision and in staff meetings.<br>• Mental Health Team Managers to discuss clinical record keeping with staff within clinical supervision. |
| Violence and Aggression audits | • Highlight key messages in august AMH audit bulletin. Key messages to include capacity, trigger factors and preferred strategies.<br>• Coordinate a review of service users PARIS records to provide assurance to Modern Matrons that an advanced directive or case entry has been completed if required.<br>• Management of Violence and Aggression (MOVA) liaison team to request evidence from clinical teams on a monthly basis that post incident reviews have been completed if applicable. Outcome from MOVA liaison monthly ward visits to be fed back to appropriate ward manager and Modern Matron.<br>• Obtain the post incident review checklist and email the checklist to all teams.<br>• Discuss service user involvement when producing advance directives and undertaking post incident reviews with the My Shared Pathway work stream and service user groups to inform development. |
| Supervision audits | • New supervision matrix template to be drafted.<br>• Team managers to obtain a copy of the supervision matrix to utilise for their team.<br>• Standard email to be sent out to all preceptors and preceptees.<br>• Embed clinical supervision processes for Nurses.<br>• Establish agreed standard for professional portfolio template.<br>• Standard guidance to be issued around portfolio development. |

| | |
|---|---|
| Safeguarding audits | • A variety of communication methods will be developed to raise awareness of link professional contacts.<br>  ◦ e-bulletin<br>  ◦ InTouch<br>  ◦ Email to service managers for dissemination<br>• Training packages to be reviewed.<br>• Audit tool to be reviewed and revised ahead of re-audit.<br>• To review all current referral forms made by TEWV to children's social care to ensure staff have the most up to date version and all others archived. |

# APPENDIX 6: TRUST BUSINESS PLAN ADDITIONAL QUALITY PRIORITIES

**In addition to the 4 quality priorities for 2015/16 set out in this document, the Trust has also included additional quality priorities within out 2015-2017 Business Plan. These are:**

- Complete the delivery of our physical health care project
- Undertake a systematic review of current levels of community team productivity across the Trust with aim of increasing the amount of clinical time available for patient contact through the reduction of non-value added activity
- Implement recommendations of the CPA review to deliver effective and efficient care
- Develop the first model line to deliver clinical pathways and underpin service delivery and agree a programme of future model line development
- Review the Trust approach to suicide prevention and complete the implementation of changes required to improve this approach
- Complete the development of effective systems to ensure a learning culture is embedded through change in practice and behaviour
- Implement DH recommendations for the reduction of restrictive practice and improvement of a culture of positive behavioural support
- Introduce a revised risk assessment and management process, that incorporates best practice of co-produced risk information with service users and positive risk management to improve the person's health, wellbeing and quality of life to facilitate their recovery
- Review systems for planning and evaluating safe and clinically cost effective nurse staffing establishment
- Implement the agreed CQC action plan drawn up in response to the January 2015 whole-Trust inspection

In addition to these, many of the operational plans and the enabling priorities set out within our Business Plan underpin our quality improvement agenda. Our Business Plan can found on TEWV's website at http://www.tewv.nhs.uk/About-the-Trust/How-we-do-it/Business-Plans/

# APPENDIX 7: QUALITY PERFORMANCE INDICATOR DEFINITIONS

## The percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care

Data definition:

All patients discharged to their place of residence, care home, residential accommodation, or to non-psychiatric care must be followed up within 7 days of discharge. All avenues need to be exploited to ensure patients are followed up within 7 days of discharge*. Where a patient has been discharged to prison, contact should be made via the prison in-reach team.

Exemptions:

- Patients who die within 7 days of discharge may be excluded.
- Where legal precedence has forced the removal of the patient from the country.
- Patients transferred to NHS psychiatric inpatient ward.
- CYPS are not included.

The 7 day period should be measured in days not hours and should start on the day after discharge.

Accountability:

Achieving at least 95% rate of patients followed up after discharge each quarter.

* *Follow up may be face-to-face or telephone contact, this excludes text or phone messages*

## The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper

Data definition:

Gate-keeping: in order to prevent hospital admission and give support to informal carers, crisis resolution home treatment teams are required to gate-keep all admission to psychiatric inpatient wards and facilitate early discharge of service users. An admission has been gate-kept by a crisis resolution team if they have assessed** the service user before admission and if the crisis resolution team was involved in the decision making-process, which resulted in an admission.

Total exemption from crisis resolution home treatment teams gate-keeping:

- Patients recalled on a Community Treatment Order.
- Patients transferred from another NHS hospital for psychiatric treatment.
- Internal transfers of service users between wards in the Trust for psychiatry treatment.
- Patients on leave under Section 17 of the Mental Health Act.
- Planned admission for psychiatric care from specialist units such as eating disorder unit.

Partial exemption:

Admissions from out of the Trust area where the patient was seen by the local crisis team (out of area) and only admitted to this trust because they had no available beds in the local areas. Crisis resolution home treatment teams should assure themselves that gate-keeping was carried out. This can be recorded as gate-kept by crisis resolution home treatment teams.

** This indicator applies to patients in the age bracket 16-65 years and only applies to CYPS patients where they have been admitted to an adult ward.*
*** An assessment should be recorded if there is direct contact between a member of the team and the referred patient, irrespective of the setting, and an assessment made. The assessment should be face-to-face and only by telephone where face-to-face is not appropriate or possible.*

### Patient falls per 1000 admissions

Numerator:

The number of patient falls recorded on Datix across the Trust which are Finally Approved incidents.

Denominator:

The total number of inpatient admissions (all services) / 1000.

Exemptions:

- Found on floor
- No harm / injury

Indicator format:

Actual.

## APPENDIX 8: FEEDBACK FROM OUR STAKEHOLDERS

**TO BE ADDED UPON RECEIPT OF STAKEHOLDER FEEDBACK (DEADLINE 17TH MAY 2015).**

**Item 14**

# COUNCIL OF GOVERNORS

**Date of Meeting:** 19TH May 2015
**Title:** Board Dashboard as at 31st March 2015
**Lead Director:** Sharon Pickering, Director of Planning, Performance & Communications
**Report for:** Assurance

## This report includes/supports the following areas:

| STRATEGIC GOALS: | ✓ |
|---|---|
| To provide excellent services working with the individual users of our services and their carers to promote recovery and well being | ✓ |
| 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 our communities | ✓ |
| To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of our communities | ✓ |

| CQC REGISTRATION: Outcomes (✓) | | | | | |
|---|---|---|---|---|---|
| **Involvement and Information** | | | | | |
| Respecting & Involving Service Users | ✓ | Consent to care and treatment | | | |
| **Personalised care, treatment and support** | | | | | |
| Care and welfare of people who use services | ✓ | Meeting nutritional needs | | Co-operating with other providers | ✓ |
| **Safeguarding and safety** | | | | | |
| Safeguarding people who use services from abuse | ✓ | Cleanliness and infection control | | Management of medicines | |
| Safety and suitability of premises | | Safety, availability and suitability of equipment | | | |
| **Suitability of staffing** | | | | | |
| Requirements relating to workers | ✓ | Staffing | ✓ | Supporting workers | ✓ |
| **Quality and management** | | | | | |
| Statement of purpose | | Assessing and monitoring quality of service provision | ✓ | Complaints | ✓ |
| Notification of death of a person who uses services | ✓ | Notification of death or AWOL of person detained under MHA | ✓ | Notification of other incidents | |
| Records | | | | | |
| **Suitability of Management** (only relevant to changes in CQC registration) | | | | | |
| **This report does not support CQC Registration** | | | | | |

| **NHS CONSTITUTION:** The report supports compliance with the pledges of the NHS Constitution (✓) | | | | | |
|---|---|---|---|---|---|
| **Yes** | ✓ | **No** (Details must be provided in Section 4 "risks") | | **Not relevant** | |

**COUNCIL OF GOVERNORS**

**Date of Meeting:** **28th April 2015**

**Title:** **Board Dashboard as at 31st March 2015**

## 1 INTRODUCTION & PURPOSE

1.1 To present to the Council of Governors the Trust Dashboard (Appendix 1) as at 31st March 2015.

## 2. KEY RISKS/ISSUES

### 2.1 Key Issues/Risks

The key issues are as follows:

- All of the Monitor targets were met as at the end of March 2015.
- 13 of the 29 (45%) indicators reported have underperformed in March 2015 which is an deterioration on the February position when 11 indicators (37%) were red. Of the 13 indicators that are red 4 show an improving position compared to the February position.
- In terms of the full year 2014/15 14 indicators did not achieve the full year target. Of the 23 indicators where a comparison can be made with 2013/14 performance 18 (78%) show either an improvement or a similar level of performance to that achieved in 2013/14. Therefore whist we have not achieved all of the absolute targets we set ourselves at the start of the year it can be seen that we have improved performance in 2014/15 compared to that in 2013/14.

The key risks are as follows:

- Access - Both waiting time targets (KPIs 1 & 2) are showing an underperformance as at the end of March.

  KPI 1 (External Referrals) shows a decrease in performance in the month of March. This reflects the position in March 2014 however the rate of decrease in March 2015 is lower than that experienced in March 2014. The main area of concern is in Children and Young People's services across all three localities but particularly in Durham and Darlington where only 52.3% of patients were seen within 4 weeks (Teesside and North Yorkshire achieved 73.24% and 74.31% respectively).

  KPI 2 (Internal Referrals) shows a further improvement on that in February 2015 however again the main area of concern is in Children and Young People's services.

There have been vacancies within the Children and Young People's services which have contributed to the position although overtime was used wherever possible to mitigate the impact. Recruitment has now taken place and people are expected to take up posts over the coming months.

The Chief Operating Office is undertaking a review of the position at the end of March in order to identify the key reasons why the previous action plan did not deliver the expected position at the end of March. Following this he will produce a revised action plan to address the issues and improve performance in 2015/16.

- Out of Locality Admissions (KPI 14) – The position has deteriorated further in March with a further significant increase in the number of Out of Locality Admissions to the highest point since July 2014. Both Teesside and North Yorkshire underperformed in March whilst Durham and Darlington were below target.

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

  The action plan previously presented to the Board is approximately two thirds complete. Some delays have been experienced due to delays in recruiting an Advanced Practitioner. An update on the action plan will be presented to Board in May 2015

- Psychological Therapies (KPIs 17 and 18) – Both KPIs remain below target as at the end of March and both show a deteriorating position compared to February.

  In terms of KPI 17 (Access) this decrease mirrors that in March 2014 although performance across 2014/15 has been considerably better than that in 2013/14. There have been a number of vacancies within the Durham and Darlington services which have impacted on the performance. The IAPT Partnership Board for Durham and Darlington has decided to over recruit to the vacancies in order to manage the risk of future staff turnover (interviews are being held in April).

  In terms of KPI 18 (Recovery) all the CCGs are below the target. The staffing issues mentioned above have also impacted on the delivery of recovery in the Durham and Darlington locality. In Teesside there are significant numbers of patients that do not complete their treatment which impacts on the delivery of this target. The analysis of the reasons for this is to be expanded to see if there is any link between this and the different therapies.

- Appraisal (KPI 23) – Whilst there continues to be an underperformance against this KPI there has been a significant improvement in March 2015 with 89% of staff having had an appraisal in the past 12 months. This is the highest level of performance in 2013/14 and 2014/15. The use of ESR to record appraisals is now in place although it has been identified that there are still some issues with ESR (including that some staff are reporting difficulties in inputting the

information onto ESR). To address this a designated named contact has been identified in the Workforce Information team to support services to ensure staff who have had an appraisal are appropriately recorded on ESR. Further work is ongoing in terms of ensuring that the content of ESR is accurate. EMT have agreed to have a further detailed discussion on how the issues affecting delivery of this indicator, including those with ESR, can be resolved.

- Mandatory Training (KPI 24) – The performance in March has declined slightly in March 2015 although the Trust position remains at amber. North Yorkshire continues to be an outlier compared to the other localities and the Director of Operations having discussions with each locality manager within the service.

- Sickness Absence Rates (KPI 25) – There was a significant decrease in the sickness absence rate in March 2015 which reflects the same trajectory as in 2014/15, although the level for March 2015 was less than that reported in March 2014. Work continues to be undertaken by HR to support services in managing sickness appropriately however we are seeing an increase in the number of people commencing long term sickness. A revised Sickness Absence Management procedures has been approved by the Executive Management Team and will start to be implemented in May 2015.

2.3 Appendix 2 provides further details of unexpected deaths. The breakdown by locality is now included.

2.4 Appendix 3 provides a glossary of indicators.

## 3 RECOMMENDATIONS

It is recommended that the Council of Governors:

- Consider the content of this paper and raise any areas of concern/query.

**Sharon Pickering**
**Director of Planning, Performance & Communications**

# Trust Dashboard Summary for TRUST

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

| | March 2015 | | | April 2014 To March 2015 | | | Annual |
|---|---|---|---|---|---|---|---|
| | Target | Month | Status | Target | YTD | Status | Target |
| 1) Percentage of patients who have not waited longer than 4 weeks for a first appointment | 98.00% | 86.40% |  | 98.00% | 83.74% |  | 98.00% |
| 2) Percentage of patients who have not waited longer than 4 weeks following an internal referral | 98.00% | 87.16% |  | 98.00% | 85.80% |  | 98.00% |
| 3) Percentage CPA 7 day follow up (adult services only) - post validated | 95.00% | 96.80% |  | 95.00% | 97.42% |  | 95.00% |
| 4) Percentage of CPA Patients having a formal review documented within 12 months - snapshot (adult services only) | 98.00% | 97.75% |  | 98.00% | 97.75% |  | 98.00% |
| 5) Percentage of admissions to Inpatient Services that had access to Crisis Resolution Home Treatment Teams prior to admission (adult services only) - post validated | 95.00% | 100.00% |  | 95.00% | 98.42% |  | 95.00% |
| 6) Median number of days from when a patient is discharged as an inpatient to their next admission as an inpatient from community teams (AMH & MHSOP - CUM FYTD) | 138.00 | 136.00 |  | 138.00 | 136.00 |  | 138.00 |
| 7) Number of Early Intervention Teams (EIP) new cases (CUM FYTD) | 259.00 | 659.00 |  | 259.00 | 659.00 |  | 259.00 |
| 8) Percentage of wards who have scored greater than 80% satisfaction in patient survey (month behind) | 75.00% | 65.85% |  | 75.00% | 73.17% |  | 75.00% |
| 9) Percentage of community patients who state they have been involved in the development of their care plan (month behind) (AMH, MHSOP and LD) | 80.00% | 90.54% |  | 80.00% | 90.58% |  | 80.00% |
| 10) Number of patients who have 3 or more admissions in a year (AMH & MHSOP) | 28.00 | 9.00 |  | 331.00 | 210.00 |  | 331.00 |

# Trust Dashboard Summary for TRUST

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

| | March 2015 | | | April 2014 To March 2015 | | | Annual |
|---|---|---|---|---|---|---|---|
| | Target | Month | Status | Target | YTD | Status | Target |
| 11) Number of unexpected deaths classed as a serious incident per 10000 open cases (reported to NRLS) | 1.00 | 1.54 | | 12.00 | 12.16 | | 12.00 |
| 12) Data Completeness: Outcomes for patients on CPA (from MHMDS - snapshot) | 90.00% | 94.09% | | 90.00% | 94.09% | | 90.00% |
| 13) Data Completeness: Identifiers (MHMDS - snapshot) | 99.00% | 99.61% | | 99.00% | 99.61% | | 99.00% |
| 14) The number of out of locality admissions (AMH and MHSOP) post validated | 35.00 | 52.00 | | 413.00 | 510.00 | | 413.00 |
| 15) Percentage of HoNOS ratings that have improved in the non-psychotic and psychosis super classes for patients that are in scope (AMH and MHSOP) - Snapshot | 43.00% | 48.05% | | 43.00% | 48.05% | | 43.00% |
| 16) Percentage of HoNOS ratings that have improved in the organic super classes for patients that are in scope (AMH and MHSOP) - Snapshot | 30.00% | 31.16% | | 30.00% | 31.16% | | 30.00% |
| 17) Access to Psychological Therapies - Adult IAPT: The percentage of people that enter treatment against the level of need in the general population (treatment commenced) | 15.00% | 8.91% | | 15.00% | 11.82% | | 15.00% |
| 18) Recovery Rate - Adult IAPT: The percentage of people who complete treatment who are moving to recovery | 50.00% | 44.44% | | 50.00% | 47.64% | | 50.00% |
| 19) Mean level of improvement on SWEMWBS (AMH only) | 5.97 | 5.73 | | 5.97 | 5.66 | | 5.97 |
| 20) Mean level of improvement on SWEMWBS (MHSOP only) | 3.52 | 2.46 | | 3.52 | 2.81 | | 3.52 |
| 21) Number of reds on CQC action plans (including MHA action plans) | 0.00 | 0.00 | | 0.00 | 0.00 | | 0.00 |

# Trust Dashboard Summary for TRUST

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

| | March 2015 | | | April 2014 To March 2015 | | | Annual |
|---|---|---|---|---|---|---|---|
| | Target | Month | Status | Target | YTD | Status | Target |
| 22) Number of RIDDOR Incidents per 100,000 occupied bed days | 12.14 | 8.33 | | 12.14 | 16.00 | | 12.14 |
| 23) Percentage of staff in post more than 12 months with a current appraisal (snapshot) | 95.00% | 89.37% | | 95.00% | 89.37% | | 95.00% |
| 24) Percentage compliance with mandatory and statutory training (snapshot) | 95.00% | 88.11% | | 95.00% | 88.11% | | 95.00% |
| 25) Percentage Sickness Absence Rate (month behind) | 4.50% | 5.09% | | 4.50% | 5.15% | | 4.50% |

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

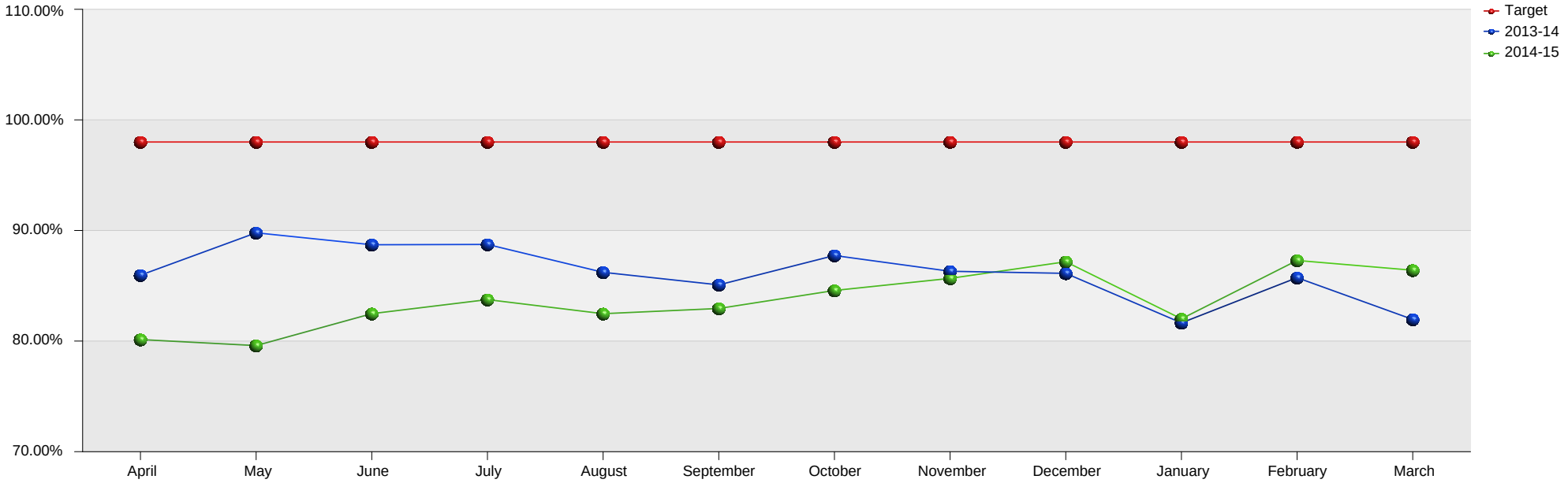
| | March 2015 | | | April 2014 To March 2015 | | | Annual |
|---|---|---|---|---|---|---|---|
| | Target | Month | Status | Target | YTD | Status | Target |
| 26) Percentage of non acute patients whose transfer of care was delayed | 7.50% | 1.80% | | 7.50% | 2.11% | | 7.50% |
| 27) Number of reds from each of the four locality dashboards - snapshot (month behind) | 32.00 | 44.00 | | 32.00 | 44.00 | | 32.00 |

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

| | March 2015 | | | April 2014 To March 2015 | | | Annual |
|---|---|---|---|---|---|---|---|
| | Target | Month | Status | Target | YTD | Status | Target |
| 28) Number of GP Referrals into Trust Services | 3,217.00 | 4,180.00 | | 37,879.00 | 40,654.00 | | 37,879.00 |
| 29) Number of other external referrals into Trust services excluding GP referrals | 2,293.00 | 2,671.00 | | 26,996.00 | 29,272.00 | | 26,996.00 |
| 30) Financial value of ward and teams below the average cost productivity baseline (AMH and MHSOP only in scope of PbR) | | | | | | | |

# Trust Dashboard Graphs for TRUST

## 1) Percentage of patients who have not waited longer than 4 weeks for a first appointment



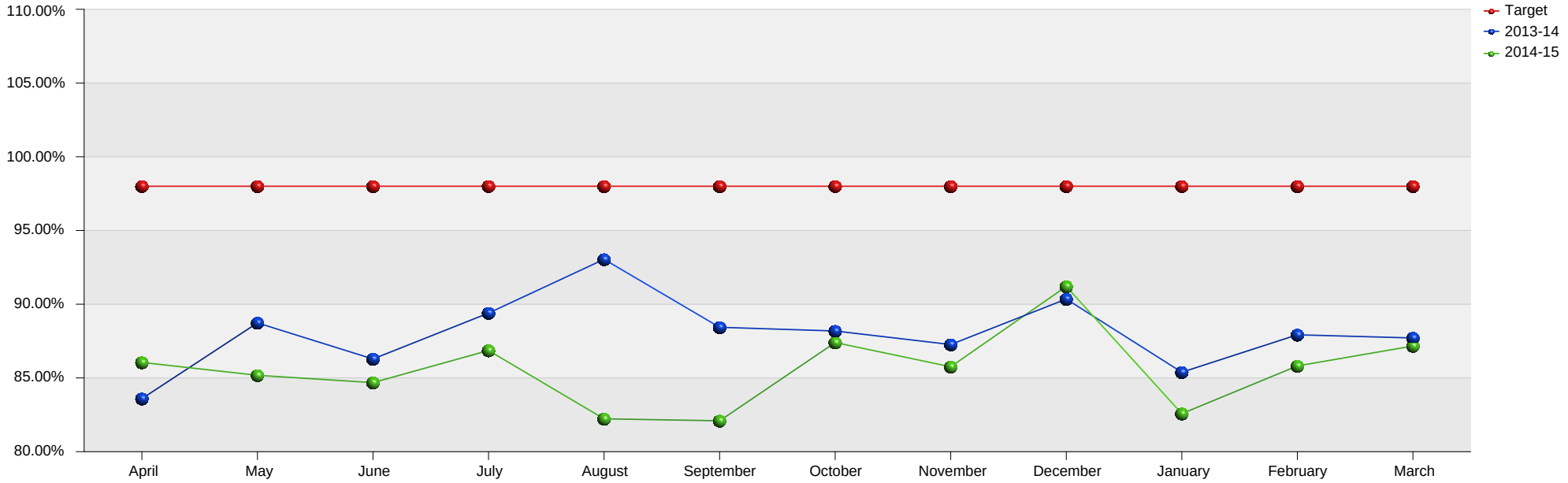

| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 1) Percentage of patients who have not waited longer than 4 weeks for a first appointment | 86.40% | 83.74% | 81.64% | 82.44% | 93.61% | 87.79% | 82.96% | 78.92% | 100.00% | 100.00% |

**Narrative**

The Trust position for March 2015 is 86.40%, with 529 patients out of 3891 having waited longer than 4 weeks for a first appointment. This is 11.60% below target and a deterioration on February performance.The areas of concern are:* Durham and Darlington Children and Young People's Service at 52.50% with 133 out of 280 patients breaching the 4 week target. * North Yorkshire Children and Young People's Services at 74.31% with 28 out of 109 patients not seen within 4 weeks.* Teesside Children and Young People's Services at 73.24% with 57 out of 213 patients not seen within 4 weeks.* North Yorkshire Learning Disabilities Services at 54.55% with 15 patients out of 33 not seen within 4 weeks.The annual outturn for 2014/15 is 83.74% and therefore the annual target of 98% has not been achieved.The annual outturn for 2013/14 was 85.70%. Performance for 2014/15 is slightly worse than for 2013/14.

# Trust Dashboard Graphs for TRUST

## 2) Percentage of patients who have not waited longer than 4 weeks following an internal referral

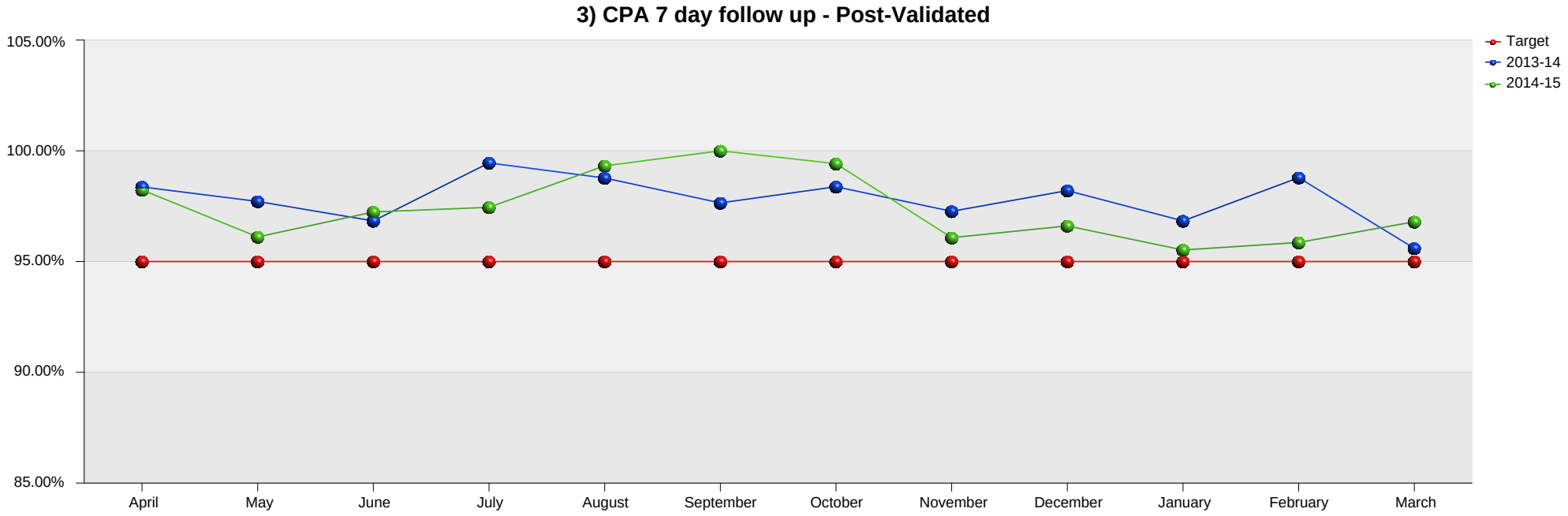



| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 2) Percentage of patients who have not waited longer than 4 weeks following an internal referral | 87.16% | 85.80% | 88.39% | 81.90% | 88.50% | 90.28% | 91.06% | 86.95% | 21.28% | 52.92% |

**Narrative**

The Trust position for March 2015 is 87.16%, which relates to 326 patients out of 2540 that were not seen within 4 weeks of an internal referral. This is 10.84% below target but an improvement on the February performance.The specific areas of concern are:* Durham and Darlington Children and Young People's Services at 67.80% (with 66 patients out of 205 not being seen within 4 weeks)* Teesside Children and Young People's Services at 55.06% (with 71 patients out of 158 not being seen within 4 weeks)* North Yorkshire Children and Young People's Services at 70.97% (with 9 patients out of 31 not being seen within 4 weeks)The annual outturn for 2014/15 is 85.80% therefore the annual target of 98% has not been achieved.The annual outturn for 2013/14 was 87.54%. Performance for 2014/15 is slightly worse than for 2013/14.

# Trust Dashboard Graphs for TRUST

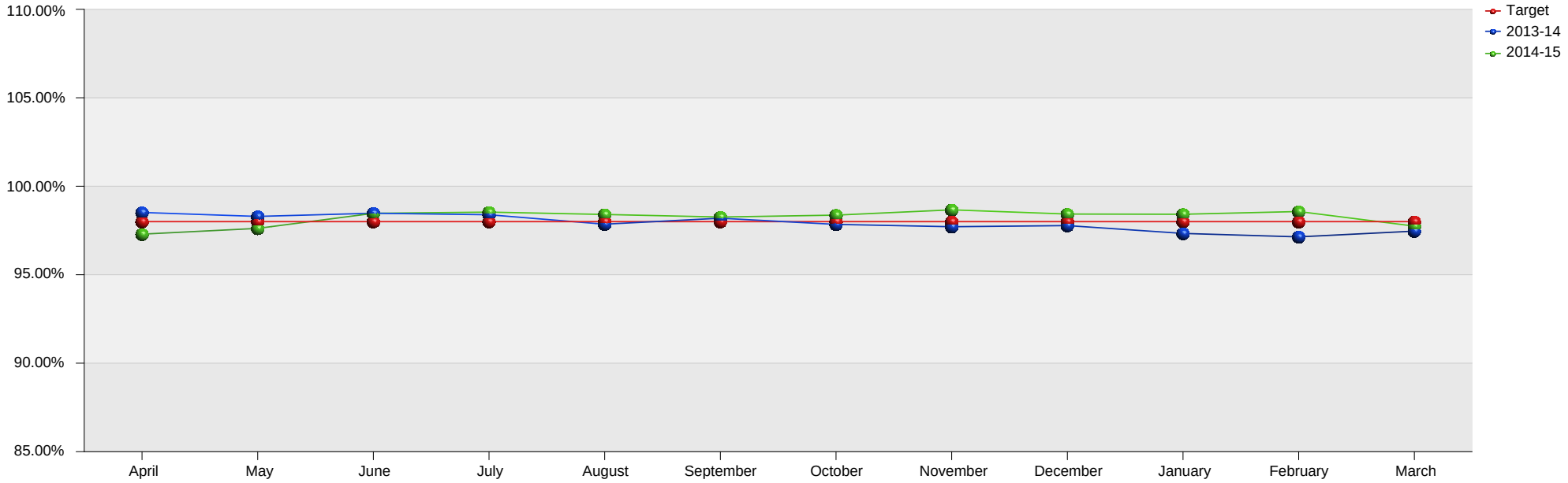



| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 3) Percentage CPA 7 day follow up (adult services only) - post validated | 96.80% | 97.42% | 96.55% | 97.61% | 96.72% | 97.95% | 97.30% | 96.13% | NA | NA |

| Narrative |
|---|
| The Trust post validated position for March 2015 is 96.79% which is 1.79% above the target and an improvement on February's position. The Trust post validated position for 2014/15 is 97.42% therefore the annual target of 95% has been achieved.The post validated annual outturn for 2013/14 was 97.86%. Performance for 2014/15 is similar to that for 2013/14. |

# Trust Dashboard Graphs for TRUST

## 4) CPA reviews completed within 12 months (AMH)

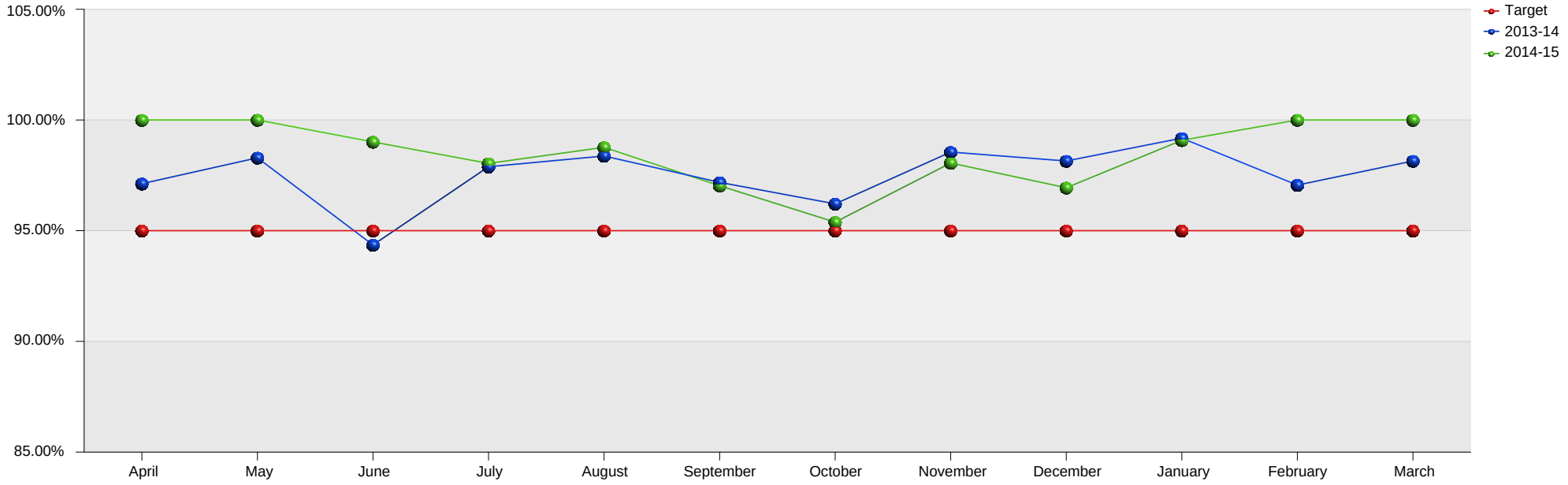



| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 4) Percentage of CPA Patients having a formal review documented within 12 months - snapshot (adult services only) | 97.75% | 97.75% | 96.91% | 96.91% | 99.27% | 99.27% | 97.31% | 97.31% | | |

| Narrative |
|---|
| The Trust position for March 2015 is 97.75% which relates to 98 patients out of 4349 that had not had a formal review documented within 12 months. Therefore the Monitor target of 95% has been achieved. The Trust target of 98% has not been achieved, reporting below target by 0.25%.The annual outturn for 2013/14 was 97.13%. Performance for 2014/15 is similar to that for 2013/14. |

# Trust Dashboard Graphs for TRUST

## 5) People seen by Crisis Services before admission - Post-Validated

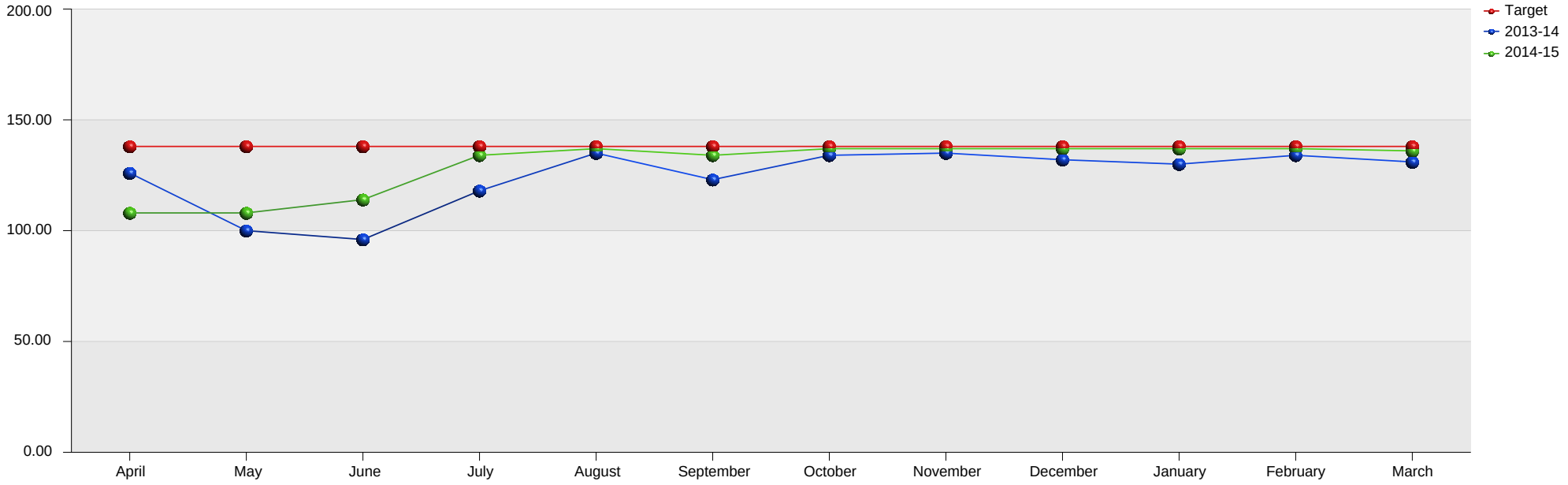



| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 5) Percentage of admissions to Inpatient Services that had access to Crisis Resolution Home Treatment Teams prior to admission (adult services only) - post validated | 100.00% | 98.42% | 100.00% | 97.35% | 100.00% | 98.22% | 100.00% | 99.31% | NA | NA |

| Narrative |
|---|
| The Trust post validated position for March 2015 is 100%, which is 5% above the target and consistent with February performance. The Trust post validated position for 2014/15 is 98.42%.Therefore the annual target of 95% has been achieved. The post validated annual outturn for 2013/14 was 97.58%. Performance for 2014/15 is better than for 2013/14. |

# Trust Dashboard Graphs for TRUST

## 6) Time between admissions (AMH & MHSOP)

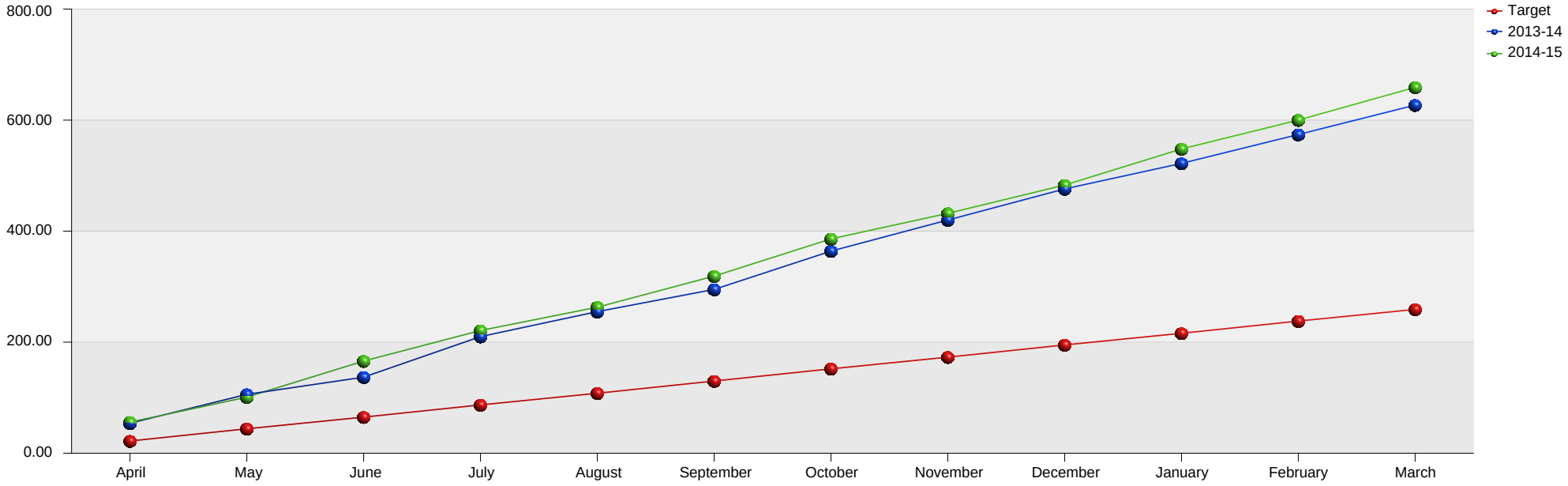



| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 6) Median number of days from when a patient is discharged as an inpatient to their next admission as an inpatient from community teams (AMH & MHSOP - CUM FYTD) | 136.00 | 136.00 | 155.00 | 155.00 | 137.00 | 137.00 | 118.00 | 118.00 | NA | NA |

| Narrative |
|---|
| The data for the month and year to date positions is the same, as this is a cumulative indicator. The Trust position for March 2015 is 136, which is 2 below the target of 138 and a very slight deterioration on February performance. The mean number of days from discharge to next admission for the financial year to date is 286.The annual target has not been achieved for 2014/15.The annual outturn for 2013/14 was 131. Performance for 2014/15 is better than for 2013/14. |

# Trust Dashboard Graphs for TRUST

## 7) EIP new cases

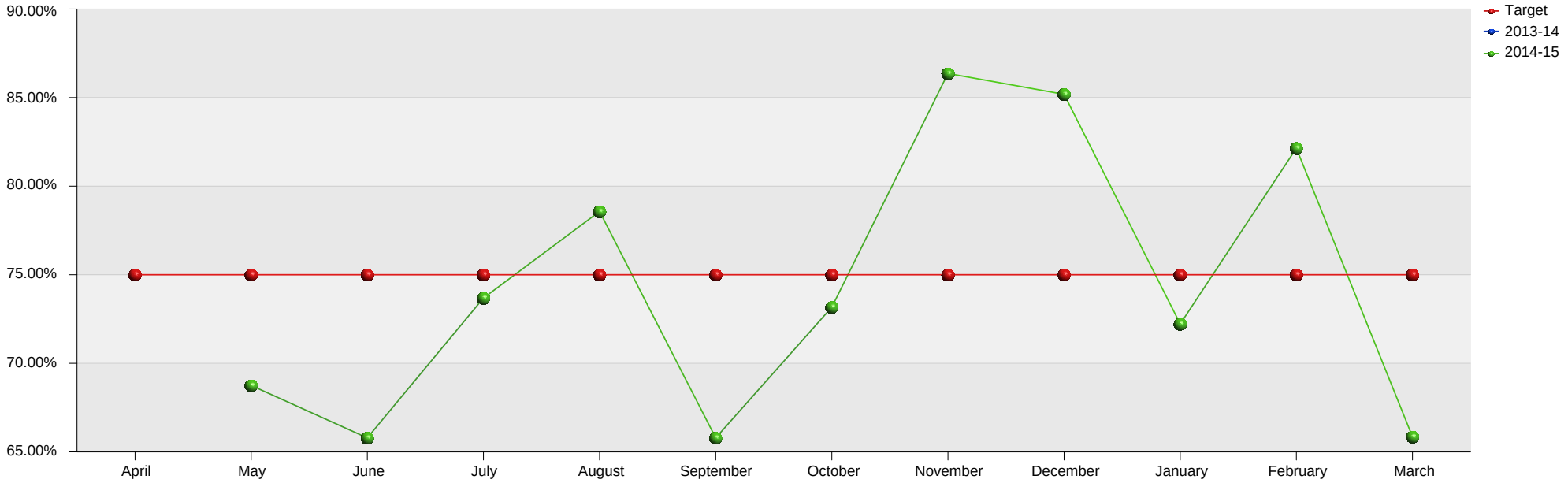



| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 7) Number of Early Intervention Teams (EIP) new cases (CUM FYTD) | 659.00 | 659.00 | 289.00 | 289.00 | 254.00 | 254.00 | 116.00 | 116.00 | NA | NA |

| Narrative |
|---|
| The Trust position for March 2015 is 659 which is 400 above the target of 259.The annual target has been achieved for 2014/15.The annual outturn for 2013/14 was 626. Performance for 2014/15 is better than for 2013/14. |

# Trust Dashboard Graphs for TRUST

## 8) Percentage of wards who have scored greater than 80% satisfaction in patient survey (month behind)



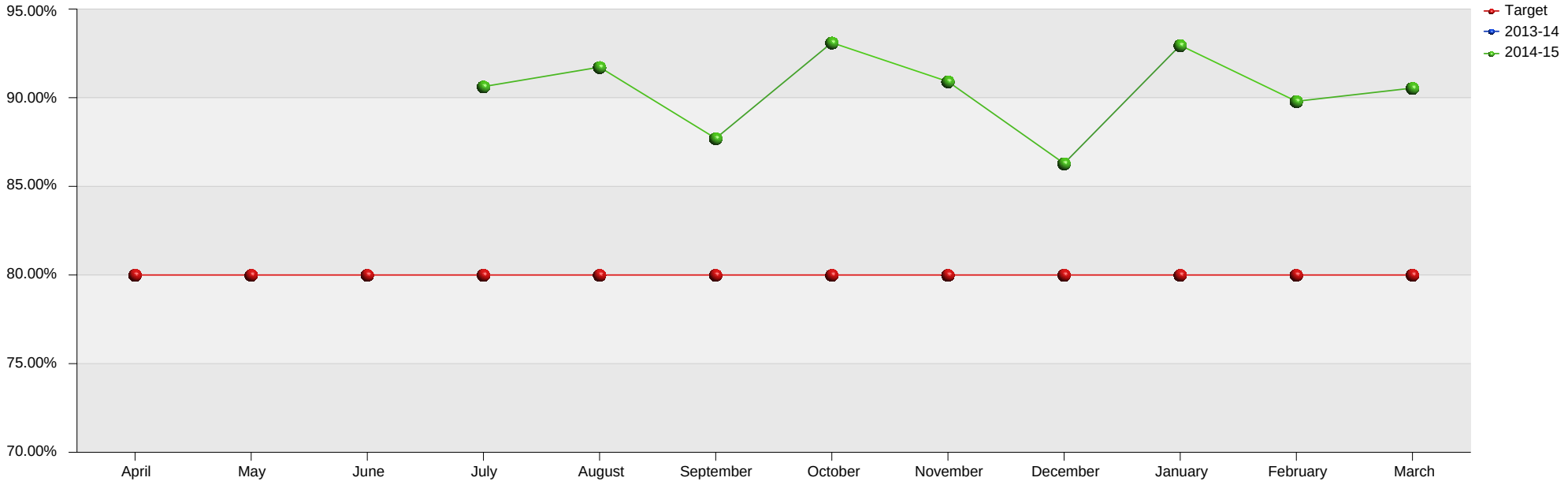

| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 8) Percentage of wards who have scored greater than 80% satisfaction in patient survey (month behind) | 65.85% | 73.17% | 90.00% | 81.45% | 100.00% | 84.69% | 71.43% | 81.43% | 21.43% | 36.11% |

**Narrative**

The Trust position reported in March relates to February performance. The Trust position for February 2015 is 65.85% with 14 wards out of 41 wards surveyed in February not scoring higher than 80%. This is 9.15% below the target of 75.00% and a significant deterioration on the previous month's position. North Yorkshire and Forensics are reporting below target.The annual outturn for 2014/15 is 73.17%, which is 1.83% below target. The annual outturn for 2013/14 was 70.31%. Performance for 2014/15 is better than for 2013/14.

# Trust Dashboard Graphs for TRUST

## 9) Community patients involved in the development of their care plan (month behind) (AMH, MHSOP and LD)

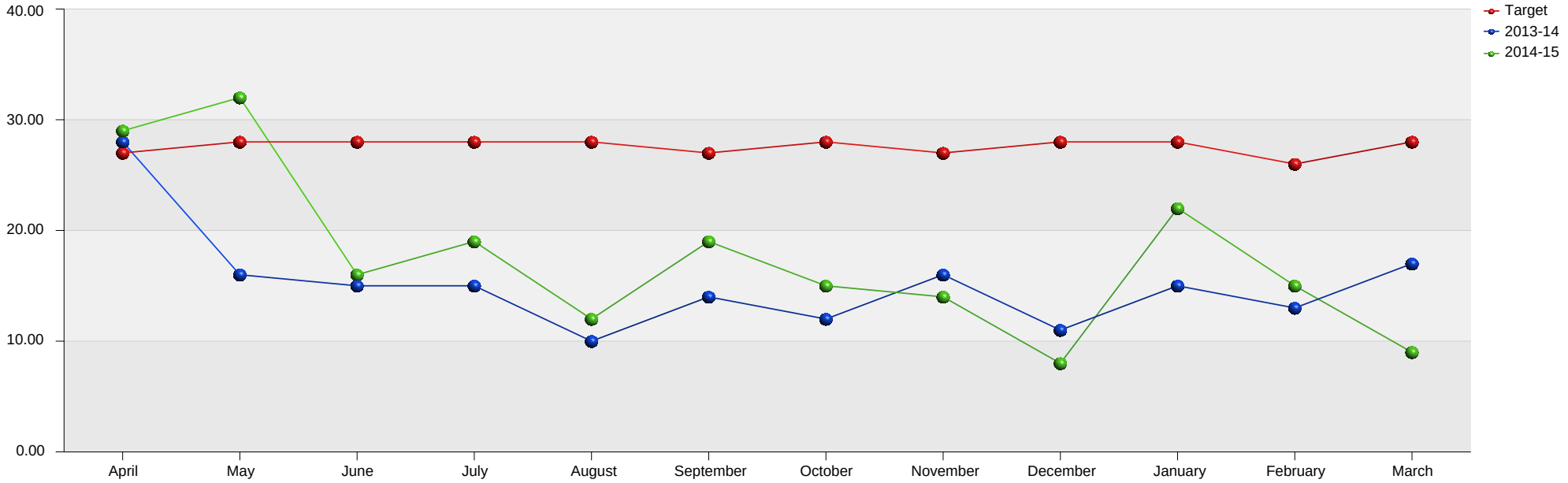



| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 9) Percentage of community patients who state they have been involved in the development of their care plan (month behind) (AMH, MHSOP and LD) | 90.54% | 90.58% | 90.51% | 90.55% | 93.55% | 92.18% | 84.54% | 87.55% | 83.33% | 83.33% |

| Narrative |
|---|
| The Trust position reported in March 2015 is 90.54%, which is 10.54% above the target of 80% and an improvement on the position reported in February. All Localities are achieving the target.The Trust position for 2014/15 is 90.58%; therefore we have achieved the target of 80%.Data only started being collected in July 2014; therefore we are unable to provide a comparison with 2013/14. |

# Trust Dashboard Graphs for TRUST

## 10) Number of patients who have 3 or more admissions in a year (AMH and MHSOP)

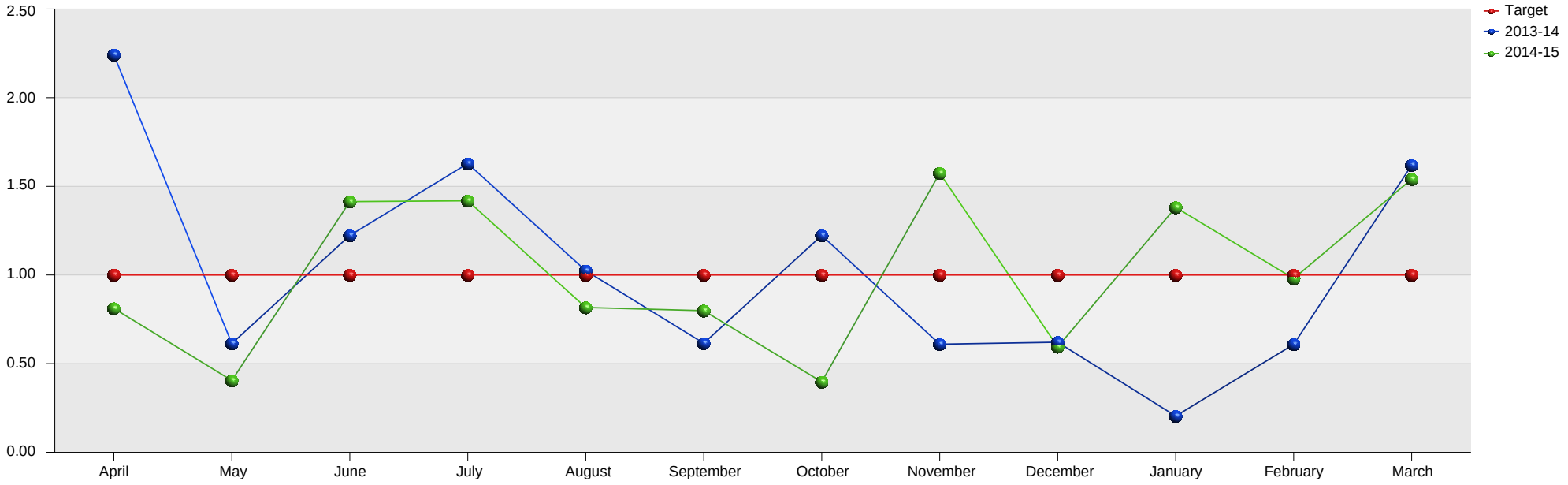



| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 10) Number of patients who have 3 or more admissions in a year (AMH & MHSOP) | 9.00 | 210.00 | 4.00 | 71.00 | 3.00 | 80.00 | 2.00 | 59.00 | 0.00 | 0.00 |

| Narrative |
|---|
| The Trust position for March 2015 is 9, which is 19 below the target of 28 and a significant improvement compared to February performance.The annual outturn for 2014/15 is 210; therefore we have achieved the target of 331.The annual outturn for 2013/14 was 358. Performance for 2014/15 is significantly better than for 2013/14. |

# Trust Dashboard Graphs for TRUST

## 11) Number of unexpected deaths classed as a serious incident per 10000 open cases



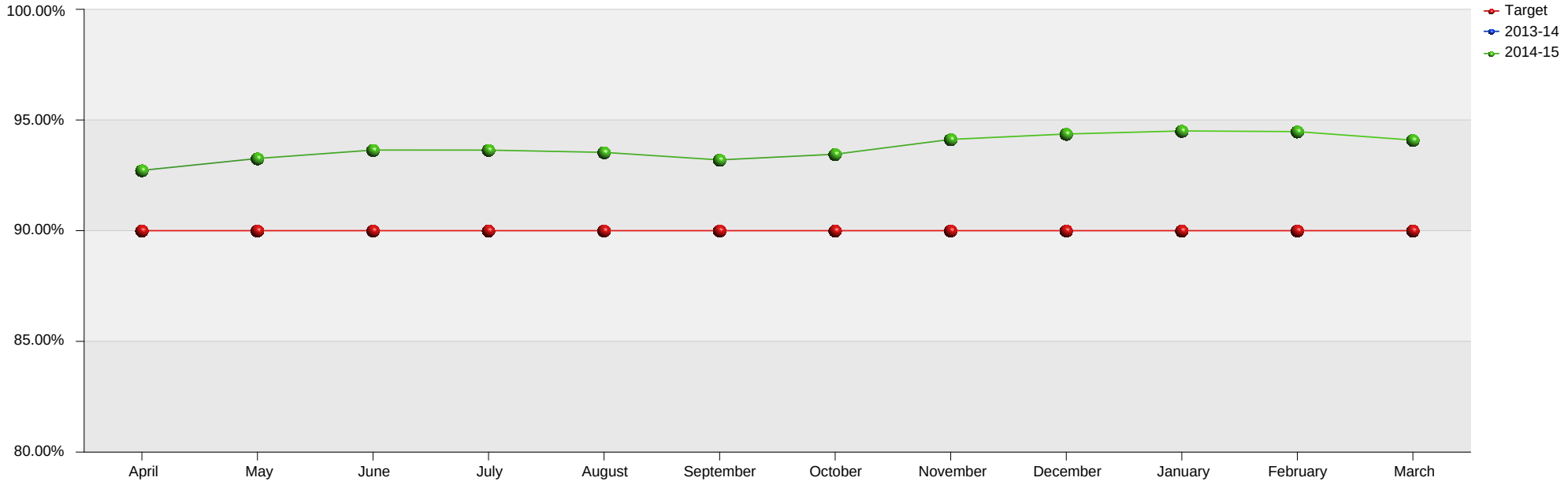

| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 11) Number of unexpected deaths classed as a serious incident per 10000 open cases (reported to NRLS) | 1.54 | 12.16 | 3.18 | 14.85 | 0.61 | 9.80 | 0.00 | 9.67 | 0.00 | 22.11 |

**Narrative**

The Trust position for March 2015 is 1.54, which is above the target of 1 and a deterioration on February performance. This rate relates to 8 unexpected deaths reported in March; 7 in Durham and Darlington and 1 in Teesside. 50% of the deaths this month occurred within IAPT services. No other patterns or trends have been identified. The total number of unexpected deaths reported in 2014/15 is 61, at the same point last year i.e. March 2013 we reported 60 deaths (Please refer to appendix 2).The annual outturn for 2014/15 is 12.16; therefore we have not quite achieved the annual target of 12.00.The annual outturn for 2013/14 was 13.15. Performance for 2014/15 is better than for 2013/14.

# Trust Dashboard Graphs for TRUST

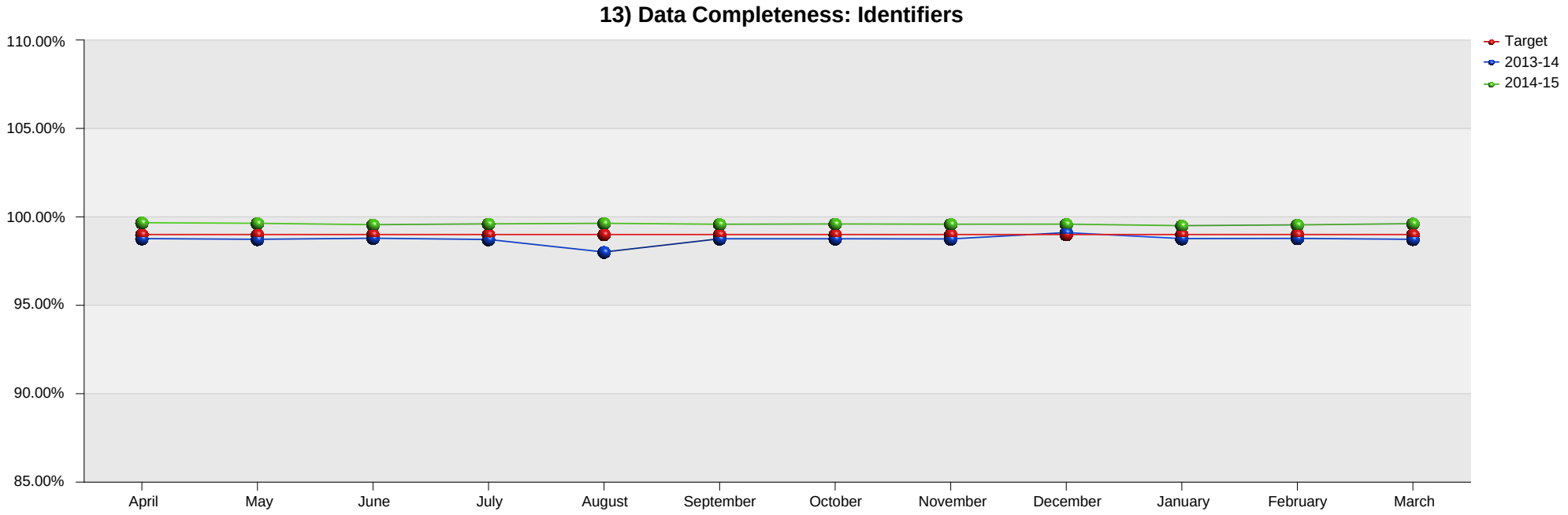
## 12) Data Completeness: Outcomes for patients on CPA




| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 12) Data Completeness: Outcomes for patients on CPA (from MHMDS - snapshot) | 94.09% | 94.09% | 93.01% | 93.01% | 97.07% | 97.07% | 96.05% | 96.05% | 90.52% | 90.52% |

| Narrative |
|---|
| The Trust position for March 2015 is 94.09%, with 1199 out of 20,289 records not being complete. Therefore we have achieved both the Trust target of 90% and the Monitor target of 50%.The annual outturn for 2013/14 was 92.44%. Performance for 2014/15 is better than for 2013/14. |

# Trust Dashboard Graphs for TRUST

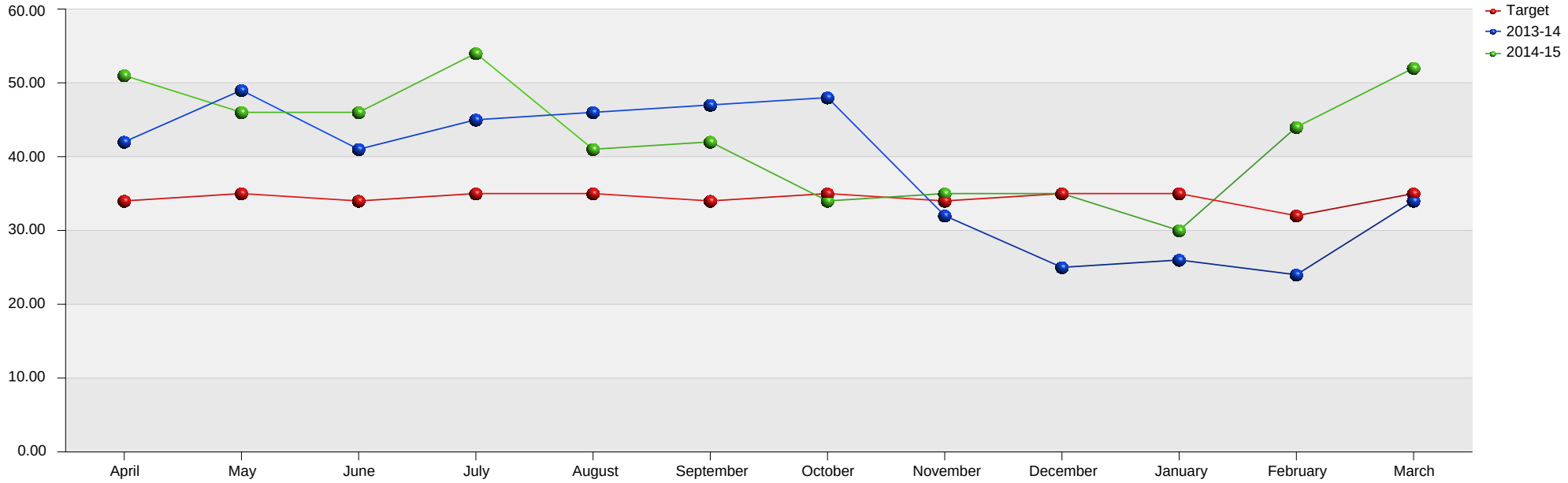



| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 13) Data Completeness: Identifiers (MHMDS - snapshot) | 99.61% | 99.61% | 99.55% | 99.55% | 99.72% | 99.72% | 99.60% | 99.60% | 99.50% | 99.50% |

| Narrative |
|---|
| The Trust position for March 2015 is 99.61% with 664 records out of 171,984 not being complete. This is 0.61% above the target of 99% and a slight improvement on February performance.Therefore we have achieved the annual target of 99%. The annual outturn for 2013/14 was 99.25%. Performance for 2014/15 is similar to that for 2013/14. |

# Trust Dashboard Graphs for TRUST

## 14) Out of locality admissions (AMH and MHSOP) post validated



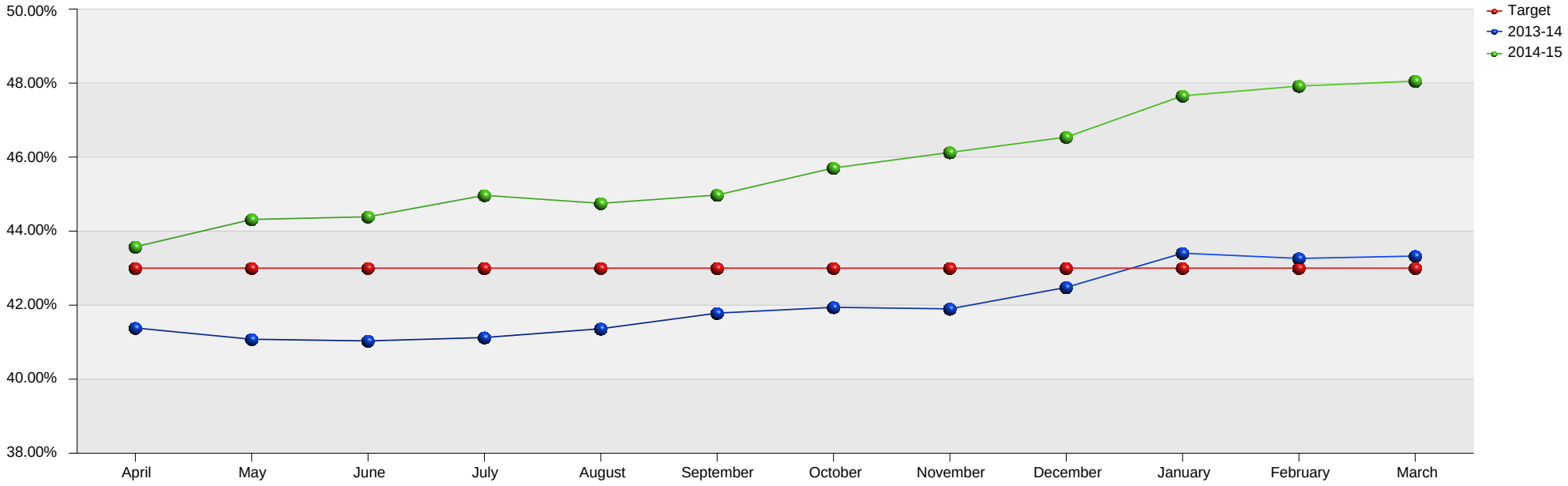

| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 14) The number of out of locality admissions (AMH and MHSOP) post validated | 52.00 | 510.00 | 12.00 | 231.00 | 17.00 | 143.00 | 23.00 | 136.00 | NA | NA |

**Narrative**

The Trust position for March 2015 is 52 ‘out of locality’ patients, which is above the target of 35. This is a deterioration on February’s performance. Only Durham and Darlington achieved target. North Yorkshire show the greatest level of underperformance with 23 Out of locality admissions compared to a target of 9. Teesside also under performed with 17 Out of locality compared to a target of 11.Of the 52 patients admitted to an ‘out of locality’ bed:* 51 (98.08%) were due to no beds being available at their local hospital – AMH 28, MHSOP 23* 1 (1.92%) breach was due to other reasons. This was within AMH Durham and Darlington localityThe annual outturn for 2014/15 is 510 and therefore the annual target has not been achieved.The annual outturn for 2013/14 was 459. Performance for 2014/15 is worse than for 2013/14.

# Trust Dashboard Graphs for TRUST

## 15) HoNOS ratings that have improved in non-psychotic and psychosis superclass (AMH & MHSOP) - Snapshot

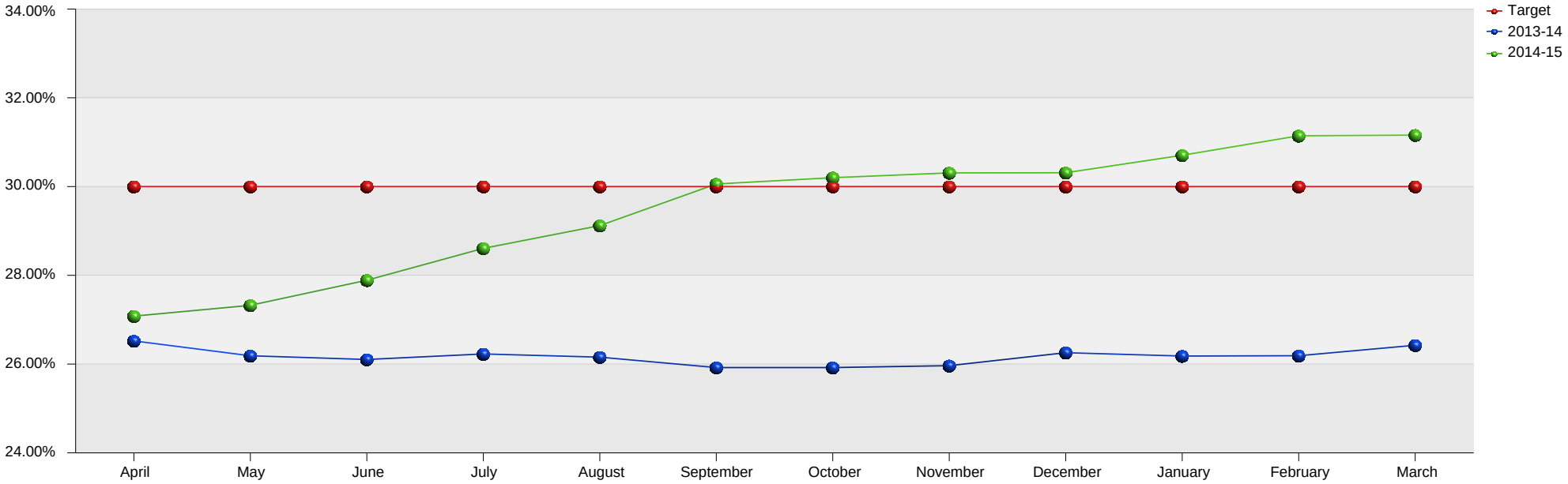



| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 15) Percentage of HoNOS ratings that have improved in the non-psychotic and psychosis super classes for patients that are in scope (AMH and MHSOP) - Snapshot | 48.05% | 48.05% | 43.59% | 43.59% | 50.27% | 50.27% | 53.70% | 53.70% | NA | NA |

| Narrative |
|---|
| The Trust position for March 2015 is 48.05% which is 5.05% above the target of 43% and a slight improvement on the February performance. All locality areas are achieving target.Therefore we have achieved the annual target of 43%. The annual outturn for 2013/14 was 40.13%. Performance for 2014/15 is significantly better than for 2013/14. |

# Trust Dashboard Graphs for TRUST

## 16) HoNOS ratings that have improved in the organic superclass (AMH and MHSOP) - Snapshot

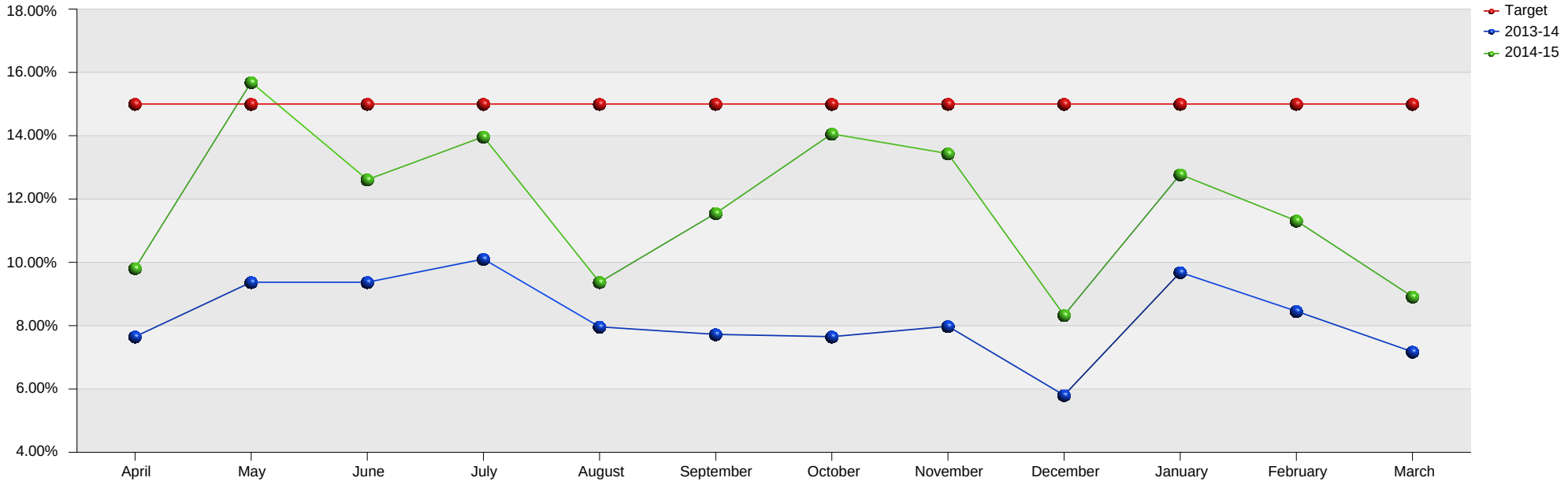



| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 16) Percentage of HoNOS ratings that have improved in the organic super classes for patients that are in scope (AMH and MHSOP) - Snapshot | 31.16% | 31.16% | 33.02% | 33.02% | 29.10% | 29.10% | 30.73% | 30.73% | NA | NA |

| Narrative |
|---|
| The Trust position for March 2015 is 31.16% which is 1.16% above the target of 30.00% but a slight deterioration on February performance. Only Teesside are not achieving the target.Therefore we have achieved the annual target of 30%.The annual outturn for 2013/14 was 25.78%. Performance for 2014/15 is significantly better than for 2013/14. |

# Trust Dashboard Graphs for TRUST

## 17) Access to Psychological Therapies - Adult IAPT

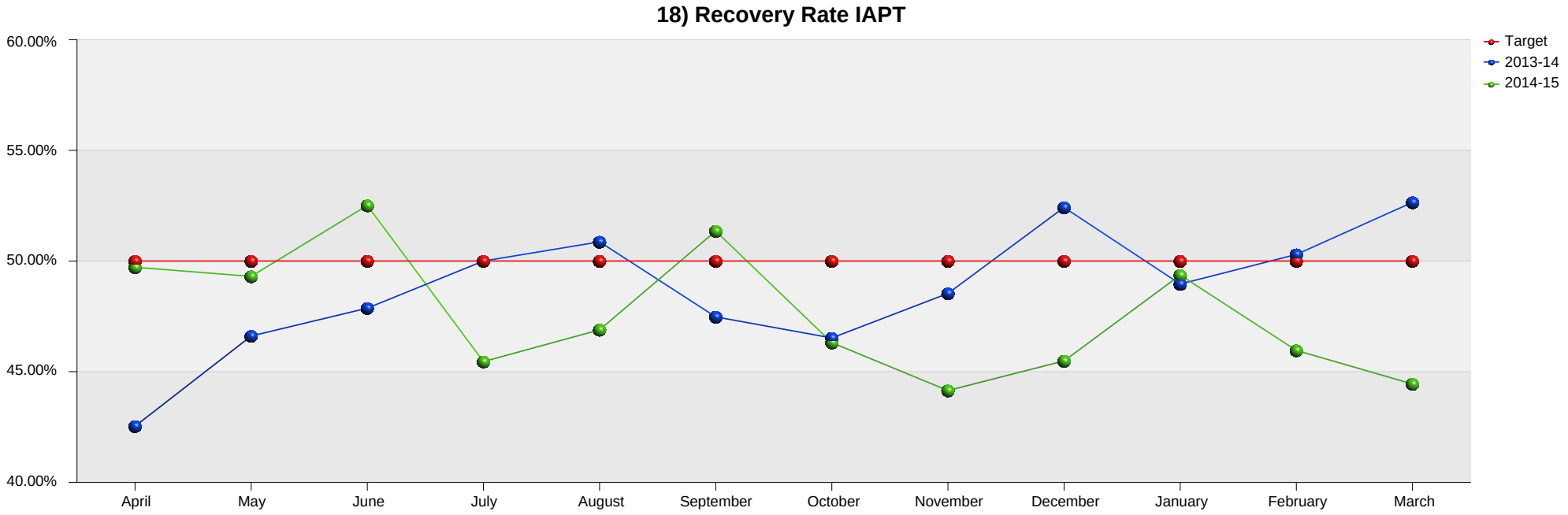



| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 17) Access to Psychological Therapies - Adult IAPT: The percentage of people that enter treatment against the level of need in the general population (treatment commenced) | 8.91% | 11.82% | 8.91% | 11.82% | NA | NA | NA | NA | NA | NA |

### Narrative

The Trust position for March 2015 is 8.91% which equates to 487 people entering treatment from 5463 of the general population. This is 6.06% below the target of 15% and is a deterioration on February performance.All 3 CCGS are below target with North Durham CCG (8.12%) and DDES CCG (9.31%) reporting a deterioration in performance from last month; Darlington (9.81%) have reported an improvement. Direct bookings are in place for Step 2a treatment (telephone guided self-help). Direct bookings for Step 2b treatment (face to face) has been put on hold due to large numbers of referrals for step 2a treatment. Resources are currently being allocated to manage this demand; however the service has been impacted by a large number of vacancies (12 across the service) in addition to staff sickness and maternity leave. Interviews for qualified staff will take place during April.The annual outturn for 2014/15 is 11.82% and therefore the annual target of 15% has not been achieved.The annual outturn for 2013/14 was 8.24%. Performance for 2014/15 is significantly better than for 2013/14.

# Trust Dashboard Graphs for TRUST



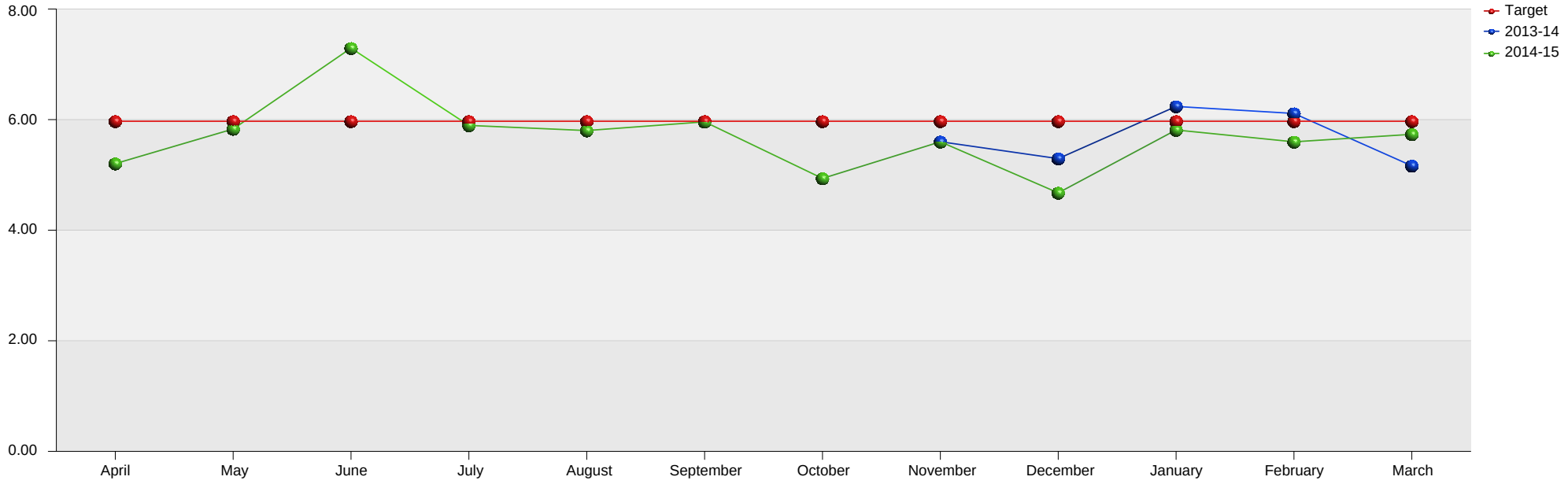

| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 18) Recovery Rate - Adult IAPT: The percentage of people who complete treatment who are moving to recovery | 44.44% | 47.64% | 45.06% | 48.82% | 42.52% | 44.55% | NA | NA | NA | NA |

**Narrative**

The Trust position in March 2015 is 44.44%, with 290 people out of 522 not achieving recovery. This is 5.56% below the target of 50% and a slight deterioration on February.All CCGS are below target. North Durham CCG (47.74%) and DDES CCG (44.25%) have reported a deterioration in performance compared to last month, whereas Darlington CCG (40.91%) has improved. The service has been impacted by vacancies, in addition to staff sickness and maternity leave. Interviews for qualified staff will take place during April. Hartlepool and Stockton CCG (37.50%) is reporting an improvement on the February position, but South Tees CCG (46.48%) is reporting a deterioration. The service continues to monitor each patient who has not achieved recovery and the action plan that was completed in response to the performance notice, is ongoing. A significant number of patients drop out of treatment therefore not achieving recovery. Analysis undertaken to determine at what point this occurs, is to be further developed to include the type of therapy the patient was attending when the drop out occurred. This will be produced by the end of April for discussion at the May meeting to identify if further actions can be identified to reduce drop outs.The annual outturn for 2014/15 is 47.64% and therefore the annual target of 50% has not been achieved.The annual outturn for 2013/14 was 48.77%. Performance for 2014/15 is slightly worse than for 2013/14.

# Trust Dashboard Graphs for TRUST

## 19) Mean level of improvement on SWEMWBS (AMH only)

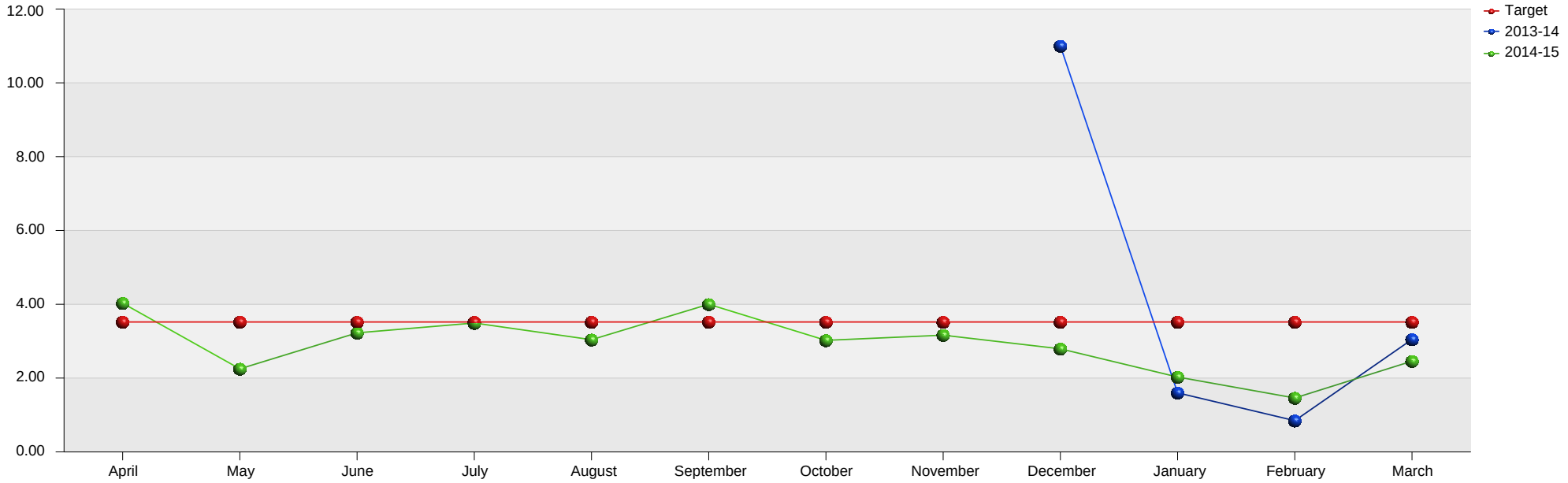



| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 19) Mean level of improvement on SWEMWBS (AMH only) | 5.73 | 5.66 | 6.10 | 4.64 | 4.63 | 5.45 | 6.37 | 5.95 | NA | NA |

| Narrative |
|---|
| The Trust position for March 2015 is 5.73 which is 0.24 below the target of 5.97 but an improvement on February performance. Only Teesside failed to achieve target in March.Data only started being collected in November 2013 hence the gap in data for the period April – October 2013.The annual outturn for 2014/15 is 5.66 and therefore the annual target of 5.97 has not been achieved.The annual outturn for 2013/14 was 5.3. Performance for 2014/15 is similar to that for 2013/14. |

# Trust Dashboard Graphs for TRUST

## 20) Mean level of improvement on SWEMWBS (MHSOP only)

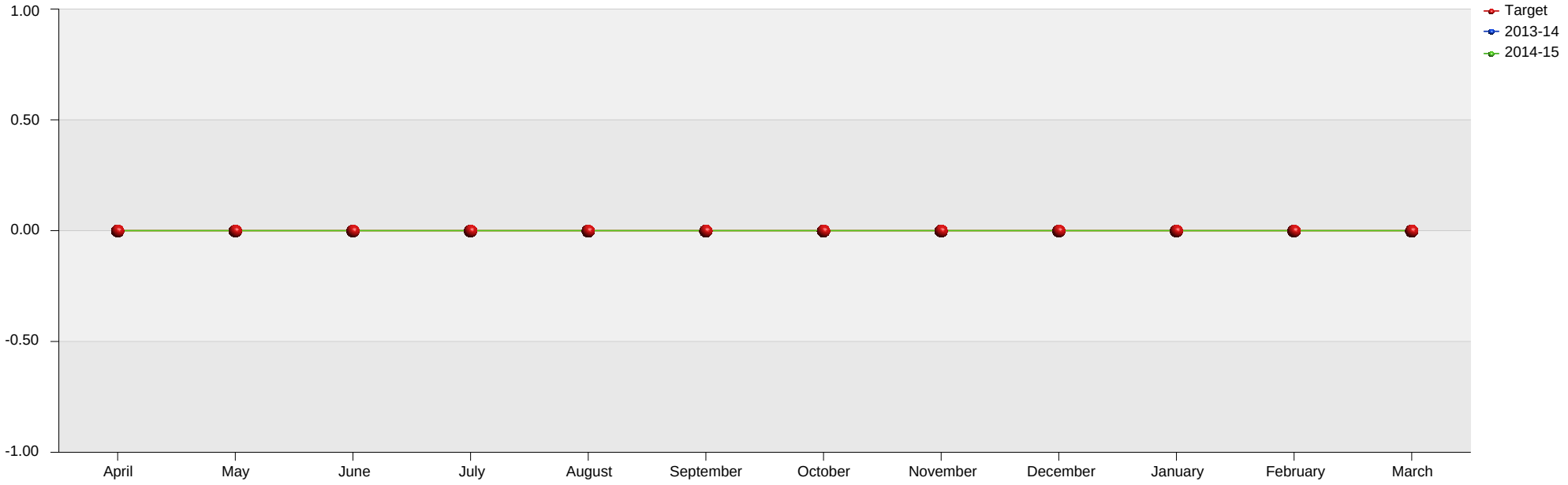



| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 20) Mean level of improvement on SWEMWBS (MHSOP only) | 2.46 | 2.81 | 2.72 | 2.88 | 2.18 | 2.76 | 2.40 | 2.72 | NA | NA |

| Narrative |
|---|
| The Trust position for March 2015 is 2.46 which is 1.53 below the target of 3.52 but an improvement on February performance. All localities are failing to achieve target.Data only started being collected in November 2013 hence the gap in data for the period April – October 2013.The annual outturn for 2014/15 is 2.81 and therefore the annual target of 3.52 has not been achieved.The annual outturn for 2013/14 was 3.09. Performance for 2014/15 is worse than for 2013/14. |

# Trust Dashboard Graphs for TRUST

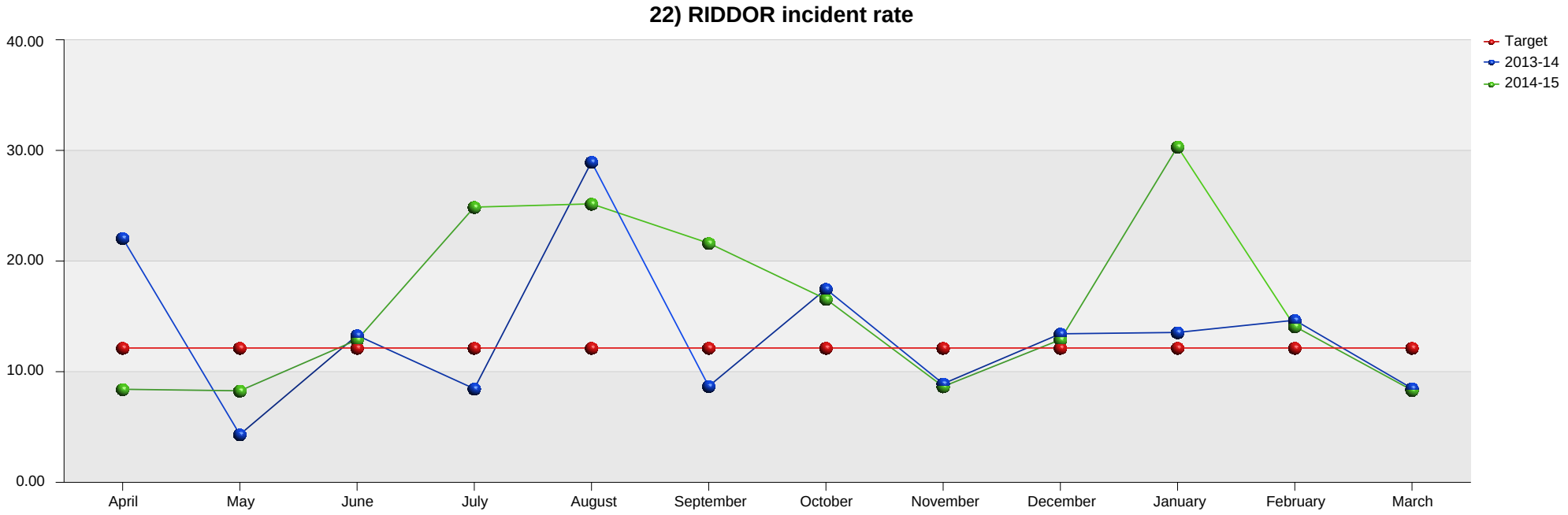
## 21) Number of reds on CQC action plans (including MHA action plans)




| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 21) Number of reds on CQC action plans (including MHA action plans) | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |

| Narrative |
|---|
| The Trust position for 2014/15 is zero; therefore the target has been achieved. |

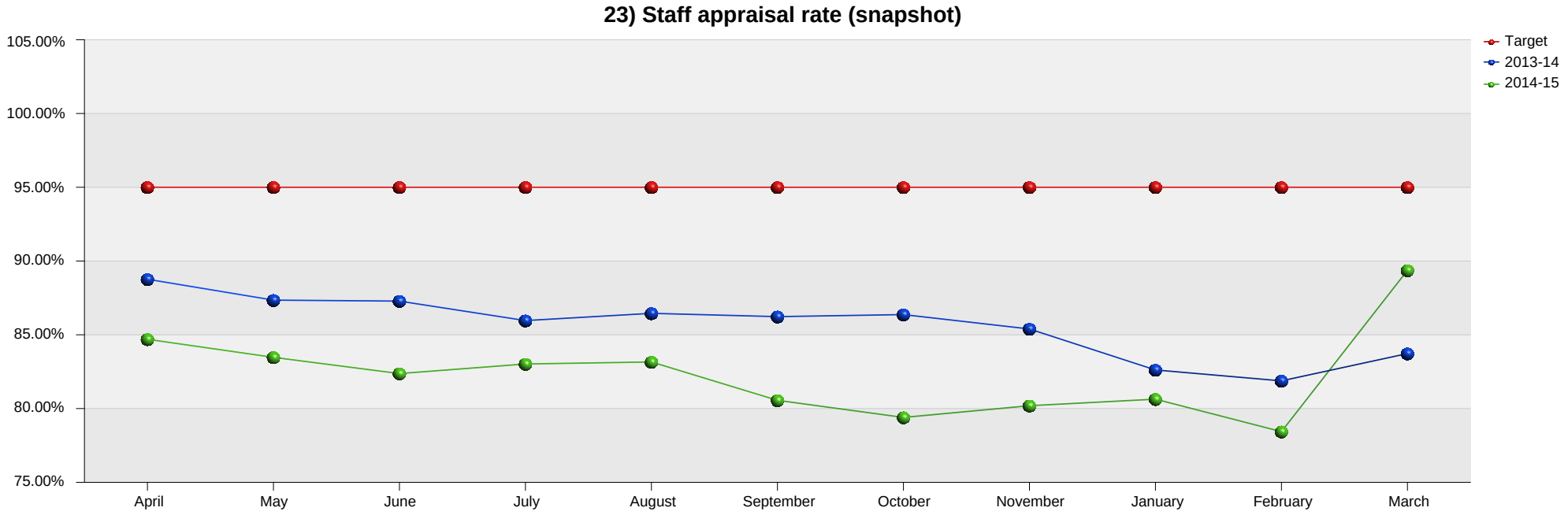
# Trust Dashboard Graphs for TRUST




| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 22) Number of RIDDOR Incidents per 100,000 occupied bed days | 8.33 | 16.00 | 0.00 | 3.84 | 0.00 | 17.80 | 0.00 | 12.23 | 13.59 | 20.78 |

| Narrative |
|---|
| The Trust position for March 2015 is 8.33, which is below the target of 12.14. This is an improvement on the February performance. The position reflects 2 RIDDOR incidents, one in Forensic Services and one in Estates and Facilities Management.The annual outturn for 2014/15 is 16; therefore we have not achieved the annual target of 12.14. The annual outturn for 2013/14 was 13.78. Performance for 2014/15 is worse than for 2013/14. |

# Trust Dashboard Graphs for TRUST

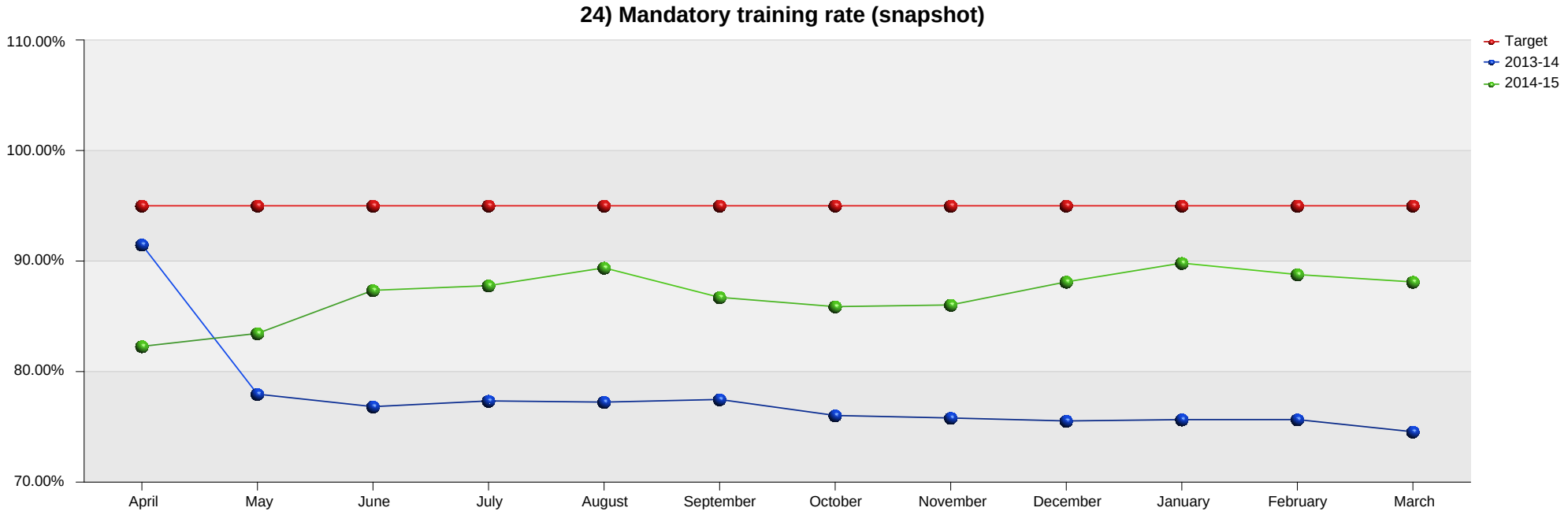



| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 23) Percentage of staff in post more than 12 months with a current appraisal (snapshot) | 89.37% | 89.37% | 87.05% | 87.05% | 92.02% | 92.02% | 85.59% | 85.59% | 89.47% | 89.47% |

## Narrative

The Trust position for March 2015 is 89.37% which relates to 541 members of staff out of 5088 that do not have a current appraisal. This is 5.63% below the target of 95% but a significant improvement on the February 2015 position.Managers are able to directly input into ESR via Manager Self Service when an appraisal has been completed. Some managers have experienced problems with accessing ESR and have reported not being able to input the appraisal information. Following a discussion at EMT it has been agreed that a designated named contact within the Workforce Information Team will be available to input appraisal information into ESR. Regular monthly compliance reports are produced for Heads of Service and line managers to monitor performance against the target of 95%. 17 staff had their pay progression withheld at the end of March due to non-compliance of mandatory training and/or appraisal and there are 16 staff due to have their pay progression withheld at the end of April.The annual outturn for 2014/15 is 89.37% and therefore the annual target of 95% has not been achieved.The annual outturn for 2013/14 was 85.47%. Performance for 2014/15 is better than for 2013/14.

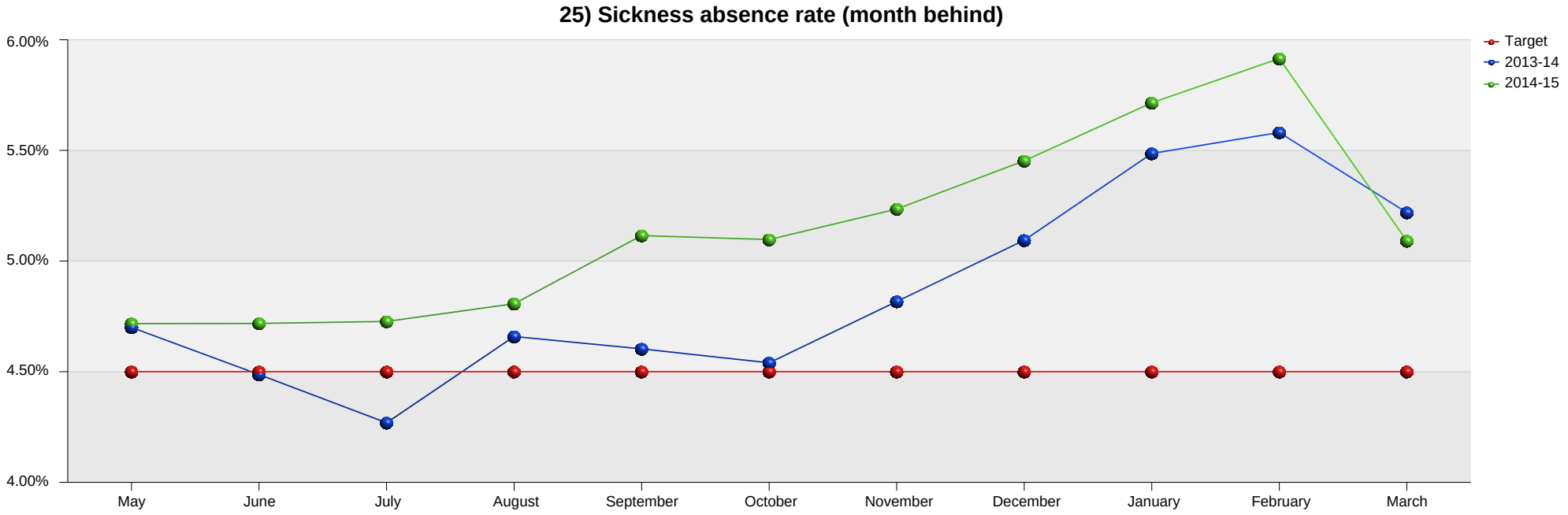
# Trust Dashboard Graphs for TRUST




| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 24) Percentage compliance with mandatory and statutory training (snapshot) | 88.11% | 88.11% | 88.14% | 88.14% | 88.37% | 88.37% | 82.45% | 82.45% | 87.23% | 87.23% |

| Narrative |
|---|
| The position for March 2015 is 88.11%. This is 6.89% below the target of 95% and a slight deterioration on February 2015 performance.Regular monthly reports are produced for Heads of Service and line managers to monitor performance against the target of 95%. Operational Services have regular monthly performance monitoring meetings to consider the compliance rate in relation to the target. Access to ESR Self Service is available to some staff allowing them to complete the core mandatory and statutory training requirements online, and in these cases, successful completion of the training automatically updates the personal training record.The annual outturn for 2014/15 is 88.11% and therefore the annual target of 95% has not been achieved.The annual outturn for 2013/14 was 87.93%. Performance for 2014/15 is similar to that for 2013/14. |

# Trust Dashboard Graphs for TRUST

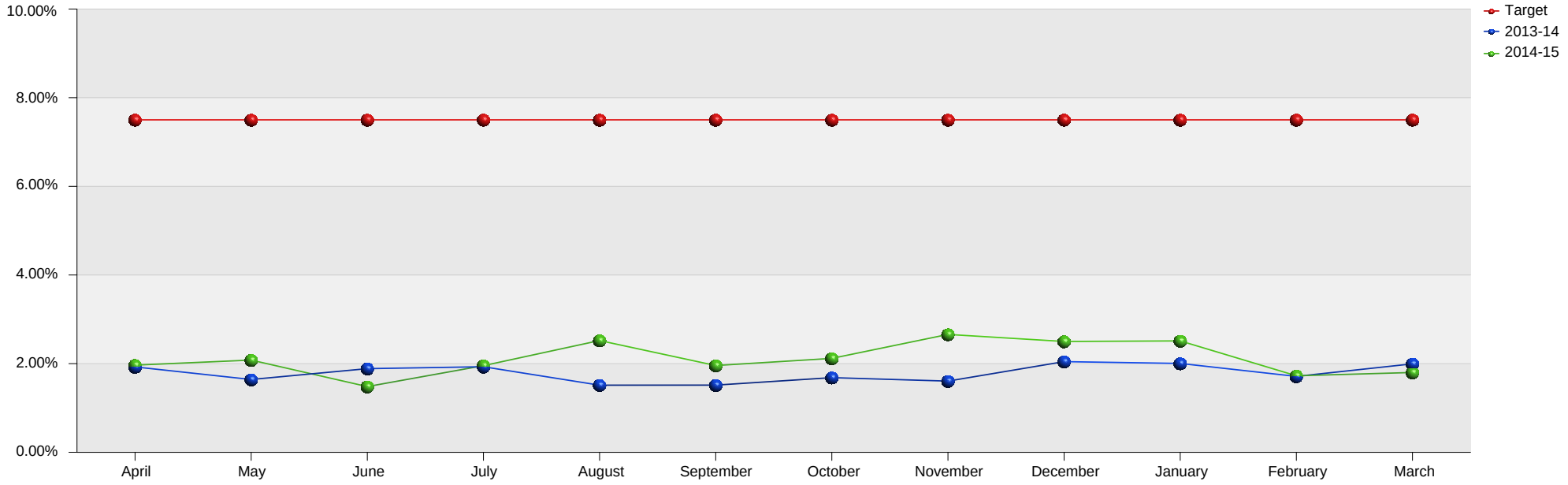



| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 25) Percentage Sickness Absence Rate (month behind) | 5.09% | 5.15% | 5.40% | 5.11% | 5.67% | 6.02% | 4.81% | 4.30% | 5.56% | 6.40% |

| Narrative |
|---|
| The Trust position reported in March relates to the February sickness level. The Trust position reported in March 2015 is 5.09%, which is 1.09% above the target of 4.50% but a considerable improvement on the position reported in February. The Operational HR team continues to proactively support line managers to manage staff that are experiencing episodes of short term persistent absence, and the long term sickness absence team continues to successfully support line managers and staff experiencing long term absence to facilitate a speedy return to work. Whilst we are reducing the amount of time people with long term sickness are away from work more staff are commencing long term sickness than in the previous year. An improvement event took place in November to review the current Sickness Absence Management Procedure. The revised procedure was considered and approved by EMT and will begin to be implemented.The annual outturn for 2014/15 is 5.15% and therefore the annual target of 4.5% has not been achieved.The annual outturn for 2013/14 was 5.09%. Performance for 2014/15 is similar as that for 2013/14. |

# Trust Dashboard Graphs for TRUST

## 26) Delayed transfers of care

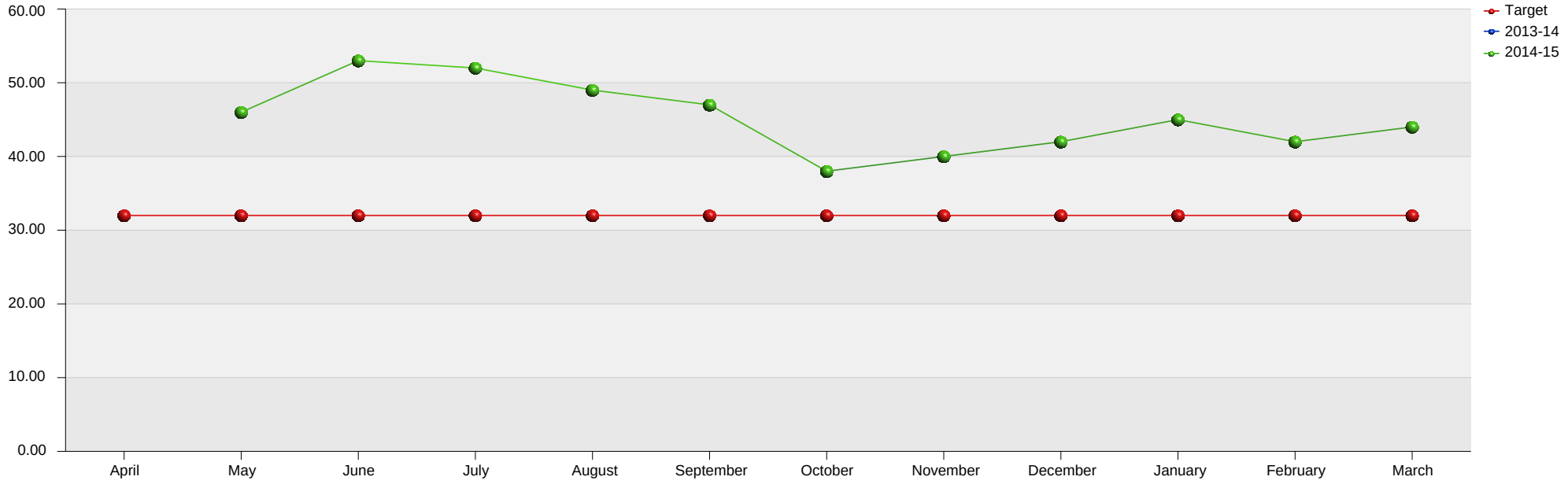



| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 26) Percentage of non acute patients whose transfer of care was delayed | 1.80% | 2.11% | 1.32% | 2.10% | 2.28% | 2.37% | 5.87% | 5.15% | 0.00% | 0.66% |

| Narrative |
|---|
| The Trust position for March 2015 is 1.80% which is 5.70% under the target of 7.5% and a slight deterioration on February performance.The annual outturn for 2014/15 is 2.11% therefore we have achieved the annual target of 7.5%. The annual outturn for 2013/14 was 1.89%. Performance for 2014/15 is similar to that for 2013/14. |

# Trust Dashboard Graphs for TRUST

## 27) Number of reds from each of the four locality dashboards - snapshot (month behind)

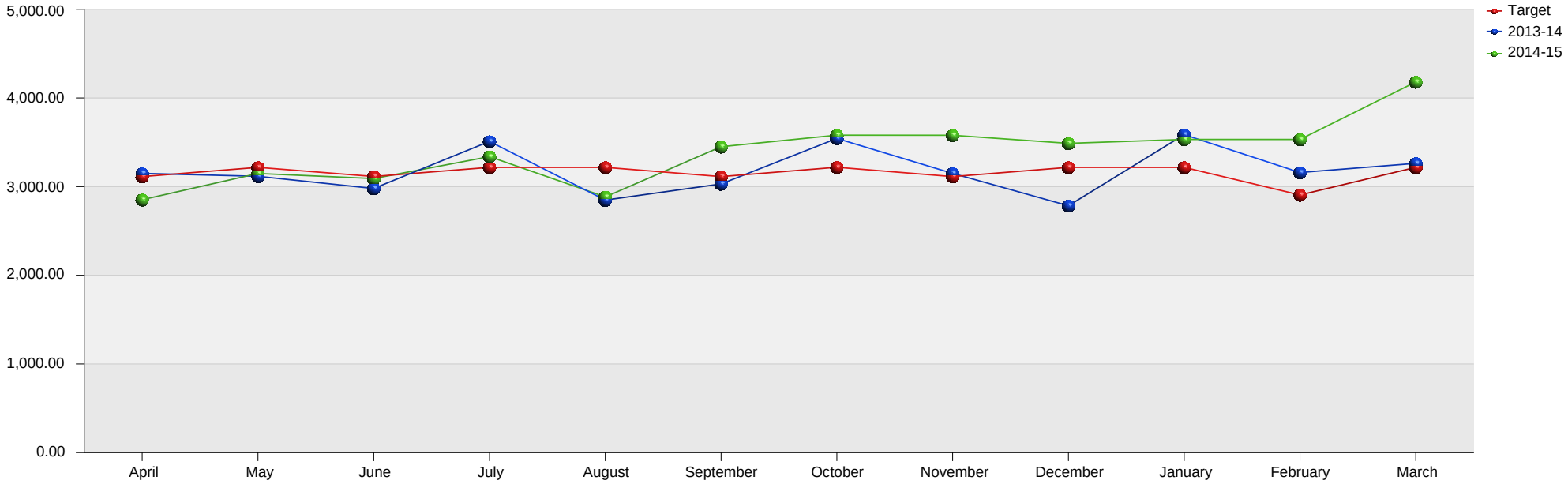



| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 27) Number of reds from each of the four locality dashboards - snapshot (month behind) | 44.00 | 44.00 | 12.00 | 12.00 | 14.00 | 14.00 | 12.00 | 12.00 | 6.00 | 6.00 |

| Narrative |
|---|
| The Trust position reported in March relates to the performance in February. In February there were 44 reds in the locality dashboard, which is 12 above the Trust target and a deterioration on the position in January. No locality has achieved the target for February.March's locality dashboard attached at the back of this report shows the annual outturn for 2014/15 is 38 and therefore the annual target of 32 has not been achieved.The annual outturn for 2013/14 was 38. Performance for 2014/15 is the same as that for 2013/14. |

# Trust Dashboard Graphs for TRUST

## 28) GP referrals received

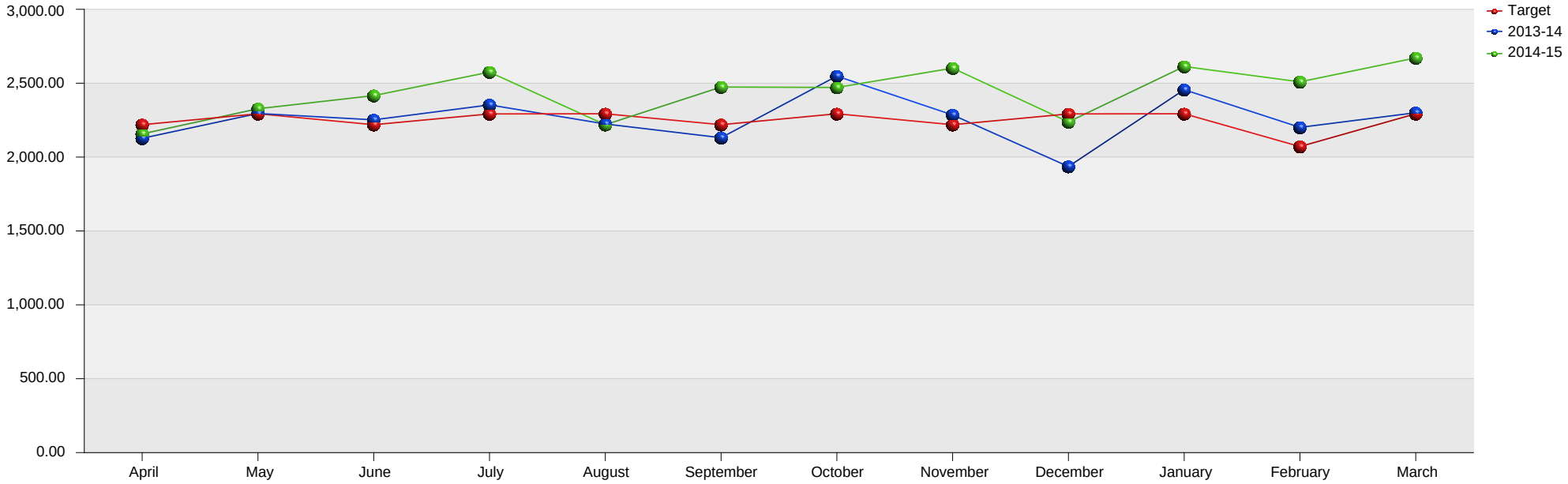



| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 28) Number of GP Referrals into Trust Services | 4,180.00 | 40,654.00 | 1,310.00 | 12,486.00 | 1,075.00 | 11,280.00 | 1,759.00 | 15,989.00 | 0.00 | 0.00 |

| Narrative |
|---|
| The Trust position for March 2015 is 4180 which is 963 above the Trust target of 3217 and an increase on February's position.The annual outturn for 2014/15 is 40,654 which is above the annual target of 37,879. We therefore received 2766 or (7.3%) more referrals from GPs in 2014/15 compared to 2013/14. This equates to approximately 56 additional referrals per week across all our teams.The annual outturn for 2013/14 was 37,888. |

# Trust Dashboard Graphs for TRUST

## 29) Total of other external referrals into the Trust Services

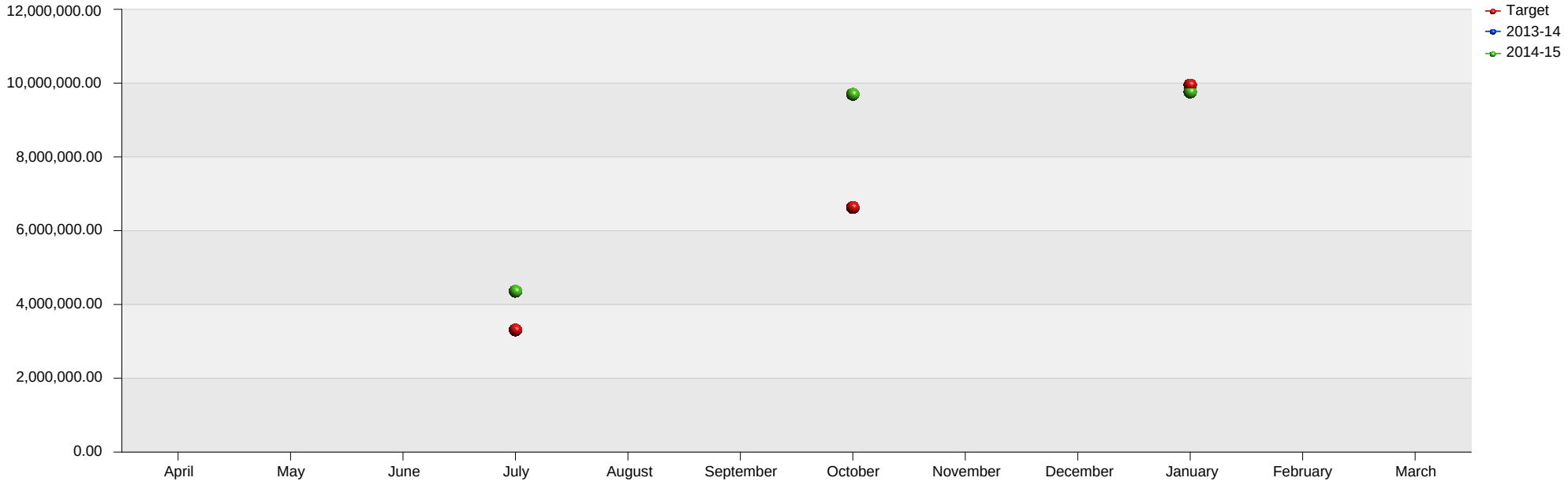



| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 29) Number of other external referrals into Trust services excluding GP referrals | 2,671.00 | 29,272.00 | 922.00 | 9,404.00 | 1,111.00 | 11,987.00 | 440.00 | 5,512.00 | 191.00 | 2,211.00 |

| Narrative |
|---|
| The Trust position for March 2015 is 2671 which is 378 above the Trust target of 2293 but a deterioration on the February position. The annual outturn for 2014/15 is 29,272 therefore we have achieved the annual target of 26,996. We therefore received 2276 (or 7.8%) more referrals from other sources in 2014/15 compared to 2013/14. This equates to approximately 44 additional referrals per week across all our teams. The annual outturn for 2013/14 was 26,996. |

# Trust Dashboard Graphs for TRUST

## 30) Financial value of ward and teams below the average cost productivity baseline (AMH and MHSOP only)




| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD | Current Month | YTD |
| 30) Financial value of ward and teams below the average cost productivity baseline (AMH and MHSOP only in scope of PbR) | | | | | | | | | NA | NA |

| Narrative |
|---|
| This Key Performance Indicator is reported quarterly (a month behind) therefore there is no data for inclusion in this report. |

## Trust Dashboard - Locality Breakdown for TRUST

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

| | March 2015 | | | | | | | | | | April 2014 To March 2015 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
| | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual |
| 1) Percentage of patients who have not waited longer than 4 weeks for a first appointment | 98.00% | 86.40% | 98.00% | 81.64% | 98.00% | 93.61% | 98.00% | 82.96% | 98.00% | 100.00% | 98.00% | 83.74% | 98.00% | 82.44% | 98.00% | 87.79% | 98.00% | 78.92% | 98.00% | 100.00% |
| 2) Percentage of patients who have not waited longer than 4 weeks following an internal referral | 98.00% | 87.16% | 98.00% | 88.39% | 98.00% | 88.50% | 98.00% | 91.06% | 98.00% | 21.28% | 98.00% | 85.80% | 98.00% | 81.90% | 98.00% | 90.28% | 98.00% | 86.95% | 98.00% | 52.92% |
| 3) Percentage CPA 7 day follow up (adult services only) - post validated | 95.00% | 96.80% | 95.00% | 96.55% | 95.00% | 96.72% | 95.00% | 97.30% | NA | NA | 95.00% | 97.42% | 95.00% | 97.61% | 95.00% | 97.95% | 95.00% | 96.13% | NA | NA |
| 4) Percentage of CPA Patients having a formal review documented within 12 months - snapshot (adult services only) | 98.00% | 97.75% | 98.00% | 96.91% | 98.00% | 99.27% | 98.00% | 97.31% | 98.00% | | 98.00% | 97.75% | 98.00% | 96.91% | 98.00% | 99.27% | 98.00% | 97.31% | 98.00% | |
| 5) Percentage of admissions to Inpatient Services that had access to Crisis Resolution Home Treatment Teams prior to admission (adult services only) - post validated | 95.00% | 100.00% | 95.00% | 100.00% | 95.00% | 100.00% | 95.00% | 100.00% | NA | NA | 95.00% | 98.42% | 95.00% | 97.35% | 95.00% | 98.22% | 95.00% | 99.31% | NA | NA |
| 6) Median number of days from when a patient is discharged as an inpatient to their next admission as an inpatient from community teams (AMH & MHSOP - CUM FYTD) | 138.00 | 136.00 | 138.00 | 155.00 | 138.00 | 137.00 | 138.00 | 118.00 | NA | NA | 138.00 | 136.00 | 138.00 | 155.00 | 138.00 | 137.00 | 138.00 | 118.00 | NA | NA |
| 7) Number of Early Intervention Teams (EIP) new cases (CUM FYTD) | 259.00 | 659.00 | 108.00 | 289.00 | 102.00 | 254.00 | 49.00 | 116.00 | NA | NA | 259.00 | 659.00 | 108.00 | 289.00 | 102.00 | 254.00 | 49.00 | 116.00 | NA | NA |
| 8) Percentage of wards who have scored greater than 80% satisfaction in patient survey (month behind) | 75.00% | 65.85% | 75.00% | 90.00% | 75.00% | 100.00% | 75.00% | 71.43% | 75.00% | 21.43% | 75.00% | 73.17% | 75.00% | 81.45% | 75.00% | 84.69% | 75.00% | 81.43% | 75.00% | 36.11% |
| 9) Percentage of community patients who state they have been involved in the development of their care plan (month behind) (AMH, MHSOP and LD) | 80.00% | 90.54% | 80.00% | 90.51% | 80.00% | 93.55% | 80.00% | 84.54% | NA | 83.33% | 80.00% | 90.58% | 80.00% | 90.55% | 80.00% | 92.18% | 80.00% | 87.55% | NA | 83.33% |
| 10) Number of patients who have 3 or more admissions in a year (AMH & MHSOP) | 28.00 | 9.00 | 11.00 | 4.00 | 9.00 | 3.00 | 8.00 | 2.00 | 0.00 | 0 | 331.00 | 210.00 | 132.00 | 71.00 | 106.00 | 80.00 | 90.00 | 59.00 | 3.00 | 0 |

## Trust Dashboard - Locality Breakdown for TRUST

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

| | March 2015 | | | | | | | | | | April 2014 To March 2015 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
| | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual |
| 11) Number of unexpected deaths classed as a serious incident per 10000 open cases (reported to NRLS) | 1.00 | 1.54 | 1.00 | 3.18 | 1.00 | 0.61 | 1.00 | 0.00 | 1.00 | 0.00 | 12.00 | 12.16 | 12.00 | 14.85 | 12.00 | 9.80 | 12.00 | 9.67 | 12.00 | 22.11 |
| 12) Data Completeness: Outcomes for patients on CPA (from MHMDS - snapshot) | 90.00% | 94.09% | 90.00% | 93.01% | 90.00% | 97.07% | 90.00% | 96.05% | 90.00% | 90.52% | 90.00% | 94.09% | 90.00% | 93.01% | 90.00% | 97.07% | 90.00% | 96.05% | 90.00% | 90.52% |
| 13) Data Completeness: Identifiers (MHMDS - snapshot) | 99.00% | 99.61% | 99.00% | 99.55% | 99.00% | 99.72% | 99.00% | 99.60% | 99.00% | 99.50% | 99.00% | 99.61% | 99.00% | 99.55% | 99.00% | 99.72% | 99.00% | 99.60% | 99.00% | 99.50% |
| 14) The number of out of locality admissions (AMH and MHSOP) post validated | 35.00 | 52.00 | 14.00 | 12.00 | 11.00 | 17.00 | 9.00 | 23.00 | NA | NA | 413.00 | 510.00 | 168.00 | 231.00 | 135.00 | 143.00 | 110.00 | 136.00 | NA | NA |
| 15) Percentage of HoNOS ratings that have improved in the non-psychotic and psychosis super classes for patients that are in scope (AMH and MHSOP) - Snapshot | 43.00% | 48.05% | 43.00% | 43.59% | 43.00% | 50.27% | 43.00% | 53.70% | NA | NA | 43.00% | 48.05% | 43.00% | 43.59% | 43.00% | 50.27% | 43.00% | 53.70% | NA | NA |
| 16) Percentage of HoNOS ratings that have improved in the organic super classes for patients that are in scope (AMH and MHSOP) - Snapshot | 30.00% | 31.16% | 30.00% | 33.02% | 30.00% | 29.10% | 30.00% | 30.73% | NA | NA | 30.00% | 31.16% | 30.00% | 33.02% | 30.00% | 29.10% | 30.00% | 30.73% | NA | NA |
| 17) Access to Psychological Therapies - Adult IAPT: The percentage of people that enter treatment against the level of need in the general population (treatment commenced) | 15.00% | 8.91% | 15.00% | 8.91% | NA | NA | NA | NA | NA | NA | 15.00% | 11.82% | 15.00% | 11.82% | NA | NA | NA | NA | NA | NA |
| 18) Recovery Rate - Adult IAPT: The percentage of people who complete treatment who are moving to recovery | 50.00% | 44.44% | 50.00% | 45.06% | 50.00% | 42.52% | NA | NA | NA | NA | 50.00% | 47.64% | 50.00% | 48.82% | 50.00% | 44.55% | NA | NA | NA | NA |
| 19) Mean level of improvement on SWEMWBS (AMH only) | 5.97 | 5.73 | 5.97 | 6.10 | 5.97 | 4.63 | 5.97 | 6.37 | NA | NA | 5.97 | 5.66 | 5.97 | 4.64 | 5.97 | 5.45 | 5.97 | 5.95 | NA | NA |
| 20) Mean level of improvement on SWEMWBS (MHSOP only) | 3.52 | 2.46 | 3.52 | 2.72 | 3.52 | 2.18 | 3.52 | 2.40 | NA | NA | 3.52 | 2.81 | 3.52 | 2.88 | 3.52 | 2.76 | 3.52 | 2.72 | NA | NA |
| 21) Number of reds on CQC action plans (including MHA action plans) | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |

## Trust Dashboard - Locality Breakdown for TRUST

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

| | March 2015 | | | | | | | | | | April 2014 To March 2015 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
| | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual |
| 22) Number of RIDDOR Incidents per 100,000 occupied bed days | 12.14 | 8.33 | 12.14 | 0.00 | 12.14 | 0.00 | 12.14 | 0.00 | 12.14 | 13.59 | 12.14 | 16.00 | 12.14 | 3.84 | 12.14 | 17.80 | 12.14 | 12.23 | 12.14 | 20.78 |
| 23) Percentage of staff in post more than 12 months with a current appraisal (snapshot) | 95.00% | 89.37% | 95.00% | 87.05% | 95.00% | 92.02% | 95.00% | 85.59% | 95.00% | 89.47% | 95.00% | 89.37% | 95.00% | 87.05% | 95.00% | 92.02% | 95.00% | 85.59% | 95.00% | 89.47% |
| 24) Percentage compliance with mandatory and statutory training (snapshot) | 95.00% | 88.11% | 95.00% | 88.14% | 95.00% | 88.37% | 95.00% | 82.45% | 95.00% | 87.23% | 95.00% | 88.11% | 95.00% | 88.14% | 95.00% | 88.37% | 95.00% | 82.45% | 95.00% | 87.23% |
| 25) Percentage Sickness Absence Rate (month behind) | 4.50% | 5.09% | 4.50% | 5.40% | 4.50% | 5.67% | 4.50% | 4.81% | 4.50% | 5.56% | 4.50% | 5.15% | 4.50% | 5.11% | 4.50% | 6.02% | 4.50% | 4.30% | 4.50% | 6.40% |

## Trust Dashboard - Locality Breakdown for TRUST

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

| | March 2015 | | | | | | | | | | April 2014 To March 2015 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
| | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual |
| 26) Percentage of non acute patients whose transfer of care was delayed | 7.50% | 1.80% | 7.50% | 1.32% | 7.50% | 2.28% | 7.50% | 5.87% | 7.50% | 0.00% | 7.50% | 2.11% | 7.50% | 2.10% | 7.50% | 2.37% | 7.50% | 5.15% | 7.50% | 0.66% |
| 27) Number of reds from each of the four locality dashboards - snapshot (month behind) | 32.00 | 44.00 | 9.00 | 12.00 | 9.00 | 14.00 | 9.00 | 12.00 | 5.00 | 6.00 | 32.00 | 44.00 | 9.00 | 12.00 | 9.00 | 14.00 | 9.00 | 12.00 | 5.00 | 6.00 |

## Trust Dashboard - Locality Breakdown for TRUST

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

| | March 2015 | | | | | | | | | | April 2014 To March 2015 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | | TRUST | | DURHAM AND DARLINGTON | | TEESSIDE | | NORTH YORKSHIRE | | FORENSIC SERVICES | |
| | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual |
| 28) Number of GP Referrals into Trust Services | 3,217.00 | 4,180.00 | 1,090.00 | 1,310.00 | 1,015.00 | 1,075.00 | 1,111.00 | 1,759.00 | 0.00 | 0 | 37,879.00 | 40,654.00 | 12,833.00 | 12,486.00 | 11,955.00 | 11,280.00 | 13,087.00 | 15,989.00 | 4.00 | 0 |
| 29) Number of other external referrals into Trust services excluding GP referrals | 2,293.00 | 2,671.00 | 807.00 | 922.00 | 989.00 | 1,111.00 | 373.00 | 440.00 | 124.00 | 191.00 | 26,996.00 | 29,272.00 | 9,504.00 | 9,404.00 | 11,641.00 | 11,987.00 | 4,387.00 | 5,512.00 | 1,464.00 | 2,211.00 |
| 30) Financial value of ward and teams below the average cost productivity baseline (AMH and MHSOP only in scope of PbR) | | | | | | | | | NA | NA | | | | | | | | | NA | NA |

***Number of unexpected deaths and verdicts from the coroner April 2014-March 2015***

| | 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 | Durham & Darlington | Teesside | North Yorkshire | Forensics | Durham & Darlington | Teesside | North Yorkshire | Forensics | Durham & Darlington | Teesside | North Yorkshire | Forensics | |
| **Accidental death** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| **Natural causes** | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **1** |
| **Hanging** | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | **4** |
| **Suicides** | 8 | 7 | 3 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | **21** |
| **Open** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| **Abuse of drugs** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | **1** |
| **Drowning** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| **Misadventure** | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **1** |
| **Awaiting verdict** | 11 | 3 | 4 | 0 | 1 | 1 | 0 | 0 | 2 | 0 | 0 | 0 | 5 | 4 | 2 | 0 | **33** |
| **Total** | **22** | **11** | **8** | **1** | **1** | **1** | **0** | **1** | **2** | **0** | **0** | **0** | **7** | **4** | **3** | **0** | **61** |

| Number of unexpected deaths classed as a serious untoward incident | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| April | May | June | July | August | September | October | November | December | January | February | March |
| 4 | 2 | 7 | 7 | 4 | 4 | 2 | 8 | 3 | 7 | 5 | 8 |

This table has been included into this appendix for comparitive purposes only

***Number of unexpected deaths and verdicts from the coroner 2013 / 2014***

| | 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 | Durham & Darlington | Teesside | North Yorkshire | Forensics | Durham & Darlington | Teesside | North Yorkshire | Forensics | Durham & Darlington | Teesside | North Yorkshire | Forensics | |
| **Accidental death** | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | **3** |
| **Natural causes** | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **2** |
| **Hanging** | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **1** |
| **Suicides** | 8 | 5 | 5 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 2 | 0 | 0 | 1 | **23** |
| **Open** | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **2** |
| **Abuse of drugs** | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **1** |
| **Drowning** | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **1** |
| **Misadventure** | 2 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | **3** |
| **Awaiting verdict** | 4 | 10 | 2 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 1 | 0 | **20** |
| **Total** | **14** | **20** | **10** | **0** | **1** | **1** | **1** | **1** | **0** | **2** | **0** | **0** | **5** | **0** | **1** | **1** | **57** |

| Number of unexpected deaths classed as a serious untoward incident | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| April | May | June | July | August | September | October | November | December | January | February | March |
| 9 | 3 | 6 | 8 | 4 | 3 | 6 | 3 | 3 | 1 | 3 | 8 |

## Glossary of Indicators

| Table no. | Description | Comment |
|---|---|---|
| 1 | Percentage of patients , seen in the month, who have not waited longer than 4 weeks for a first appointment | 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. |
| 2 | Percentage of patients who have not waited longer than 4 weeks following an internal referral | These waiting times relate to patients seen in the month, and of those, the percentage who have been seen within 4 weeks of being referred from another service within the Trust. |
| 3 | Percentage CPA 7 day follow up (adult services only) | All patients who are discharged to their place of residence, care home, residential accommodation, or to non-psychiatric care must be followed up within seven days of discharge. Follow up starts on the day following discharge and should be made with the patient face to face. Only where this is not possible should contact be made by telephone. |
| 4 | Percentage of CPA Patients having a formal review documented within 12 months (adult services only) | This indicator relates to the percentage of adults who have been on CPA for more than 12 months who have had at least one meeting with their Care Co-ordinator in the past 12 months. |
| 5 | Percentage of admissions to Inpatient Services that had access to Crisis Resolution Home Treatment Teams prior to admission (adult services only) | An admission has been gate kept by the Crisis Resolution Team if they have assessed the service user before admission and if they were involved in the decision-making process, which resulted in admission. |
| 6 | Median number of days from when a patient is discharged as an inpatient to their next admission as an inpatient | This indicator measures the median (mid point from a range of data) time, in days, from a patient being discharged from an Assessment & Treatment ward to readmission back into an Assessment & Treatment ward. It is intended that this indicator will monitor the effectiveness of the discharge process as well as the robustness of the community services maintaining patients within the community. A higher number of days would suggest that the discharge process was more effective and the community teams interventions more successful. |
| 7 | Number of new EIP cases | This is a national indicator which monitors cases of first episode psychosis which have been taken on by dedicated Early Intervention Teams for treatment and support since 1 April 2009. Patients who are being monitored for a limited period because they are suspected cases should not be included in this count. |
| 8 | Percentage of wards who have scored greater than 80% satisfaction in patient survey (month behind) | This indicator reports the number of wards who have scored greater than 80% satisfaction in the patient survey against the number of wards who have had responses to the satisfaction question in the patient survey. It uses the question "Overall, rate the care you have received" and count as 'satisfied' in terms of the Excellent and Good positive responses |
| 9 | Percentage of community patients who state they have been involved in the development of their care plan (month behind) (AMH, MHSOP and LD) | This indicator reports the number of community patients who state they have been involved in the development of their care plan against the number of community patients who have responded to the involvement/development of the care plan question in the patient survey. To facilitate this a new question was added to the hand held devices asking "Have you been involved in the development of your care plan?" |
| 10 | Number of patients who have 3 or more admissions in a year (AMH & MHSOP) | 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 past 12 months |
| 11 | Number of unexpected deaths classed as a serious incident per 10000 open cases (reported to NRLS) | This KPI measures the number of unexpected deaths classed as a serious incident per 10,000 open cases against the number of unexpected deaths classed as a serious untoward incident (SUI) The total number of open cases on the Paris system is divided by 10,000 to obtain the correct ratio for this calculation. |
| 12 | Data completeness: outcomes | This indicator relates to measurable outcomes for adults and reports the percentage of valid entries on patient records for employment status, in settled accommodation and if they have had a Health of the Nation Outcome Scales ( HoNOS) assessment in the last 12 months. |
| 13 | Data completeness: identifiers | This indicator relates to the completeness of patient records and counts the number of valid entries for the following; NHS number, Date of Birth, Postcode, Gender, GP Practice code, Commissioner Organisation code. |
| 14 | Number of 'out of locality' admissions | 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 should be admitted. This indicator measures the percentage of patients that were not admitted to the assigned wards. E.g. an Adult Mental Health patient within Durham 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.' |
| 15 | Percentage of HoNOS ratings that have improved in the non-psychotic and psychosis super classes for patients that are in scope (AMH and MHSOP) - Snapshot | This indicator is based on the number of affective and psychosis patients within the scope of PbR who are on an active caseload |

| | | |
|---|---|---|
| 16 | Percentage of HoNOS ratings that have improved in the organic super classes for patients that are in scope (AMH and MHSOP) - Snapshot | This indicator is based on the number of organic patients within the scope of PbR who are on an active caseload |
| 17 | Access to Psychological Therapies - Adult IAPT: The proportion of people that enter treatment against the level of need in the general population | The Improving Access to Psychological Therapies (IAPT) programme aims to improve access to evidence based talking therapies in the NHS through an expansion of the psychological therapy workforce and service. This indicator is comprised of the number of people who have entered (i.e. received) psychological therapies / the number of people who have depression and or anxiety disorders. |
| 18 | Recovery Rate - Adult IAPT: The proportion of people who complete treatment who are moving to recovery | This indicator is comprised of the number of people who are moving to recovery of those who have completed treatment / the number of people who have completed treatment who are not at clinical caseness at treatment commencement. |
| 19 | Mean level of improvement on SWEMWBS (AMH only) | This indicator looks at the score taken at the referral to service and then again at the discharge point from TEWV (start of spell to end of spell) for new patients and calculate the improvement. A mean improvement score is the calculated as an overall figure for Adult Mental Health. New patients would be reported in the month they were discharged but only if their referral was after 4th November due to commencement of this PROM. |
| 20 | Mean level of improvement on SWEMWBS (MHSOP only) | This indicator looks at the score taken at the referral to service and then again at the discharge point from TEWV (start of spell to end of spell) for new patients and calculate the improvement. A mean improvement score is the calculated as an overall figure for Mental Health Services for Older People. New patients would be reported in the month they were discharged but only if their referral was after 4th November due to commencement of this PROM. |
| 21 | Number of reds on CQC action plans (including MHA action plans) | This indicator counts the number of reds detailed on Care Quality Commission action plans, including Mental Health Act action plans. |
| 22 | Number of RIDDOR Incidents per 100,000 occupied bed days | The occupied bed flag is set to 1 to only include patients who were in a bed at midnight during the reporting period. The 'Default' ward is also excluded from the measure. The information is grouped by inpatient bed days date on a month on month basis. The number of RIDDOR incidents. This data is currently captured manually via the DATIX system from the Risk Management team. The number of occupied bed days on the Paris system divided by 100,000 to obtain the correct ratio (sum of the occupied bed flag/100,000). |
| 23 | 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 month. |
| 24 | Percentage compliance with mandatory and statutory training (snapshot) | Compliance is measured by staff completing the 7 core competencies by either faced to face training or e-learning within the relevant renewal periods. On completion of e-learning, e-mail is automatically sent to education and training. Education and training then manually update ESR. Face to face training – registers completed and entered into ESR Information is entered onto ESR at least once a month. If doing e-learning, ensure that you have MS Outlook open when doing your training so that the email can be sent to Education & Training team. If there are any discrepancies in the information:<br>1. Allowed for reasonable entering of information<br>2. Contact education & training team in first instance<br>If still inaccurate, escalate to local HR Manager |
| 25 | Percentage Sickness Absence Rate (month behind) | This KPI measures the Trust percentage sickness absence rate (monthly in arrears). Results are grouped on a month by month basis and depicted at Cost Centre Level. Currently, information is updated by Finance, using information from the Staff Variation Sickness Lists Where services who are using ESR Self Service, managers enter the data directly into ESR |
| 26 | Percentage of non acute patients whose transfer of care was delayed | Delayed transfers of care relates to those patients (other than children) who are medically fit enough to be discharged but who remain on the ward as there is no identified package of care/place for them to be discharged to. |
| 27 | Number of reds from each of the four locality dashboards - snapshot (month behind) | This KPI reports the number of reds in the previous month being reported so, for example, if the month being reported is December the KPI 'December' figure for the KPI will be the number of reds reported for November in each of the dashboards. |
| 28 | Number of GP Referrals into Trust Services | This KPI measures the number of GP referrals into Trust services. This measure counts patient Paris IDs grouped on a month on month basis by referral received date/referral sent date |
| 29 | Number of other external referrals into Trust services excluding GP referrals | This KPI measures the number of referrals into Trust services, other than those received from GPs. This measure counts patient Paris IDs grouped on a month on month basis by referral received date/referral sent date |
| 30 | Financial value of community teams below the average cost productivity baseline (AMH and MHSOP only in scope of PbR) | This indicator measures the financial cost variance (£) of the community teams that are below the average cost productivity baseline (AMH and MHSOP only) |

**ITEM 15**

**FOR GENERAL RELEASE**

**Council of Governors**

**Date:** **19 May 2015**

**Title:** **Finance Report for Period 1 April 2014 to 31 March 2015**

**Lead Director:** **Colin Martin, Director of Finance**

**Report for:** **Assurance and Information**

## This report includes/supports the following areas:

| **STRATEGIC GOALS:** | ✓ |
|---|---|
| **To provide excellent services working with the individual users of our services and their carers to promote recovery and well being** | |
| **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 our communities** | |
| **To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of our communities.** | ✓ |

| **CQC REGISTRATION: Outcomes (✓)** | | | | | |
|---|---|---|---|---|---|
| **Involvement and Information** | | | | | |
| Respecting & Involving Service Users | | Consent to care and treatment | | | |
| **Personalised care, treatment and support** | | | | | |
| Care and welfare of people who use services | | Meeting nutritional needs | | Co-operating with other providers | |
| **Safeguarding and safety** | | | | | |
| Safeguarding people who use services from abuse | | Cleanliness and infection control | | Management of medicines | |
| Safety and suitability of premises | | Safety, availability and suitability of equipment | | | |
| **Suitability of staffing** | | | | | |
| Requirements relating to workers | | Staffing | | Supporting workers | |
| **Quality and management** | | | | | |
| Statement of purpose | ✓ | Assessing and monitoring quality of service provision | | Complaints | |
| Notification of death of a person who uses services | | Notification of death or AWOL of person detained under MHA | | Notification of other incidents | |
| Records | | | | | |
| **Suitability of Management** (only relevant to changes in CQC registration) | | | | | ✓ |
| **This report does not support CQC Registration** | | | | | |

| **NHS CONSTITUTION:** The report supports compliance with the pledges of the NHS Constitution (✓) | | | | | |
|---|---|---|---|---|---|
| **Yes** | ✓ | **No** (Details must be provided in Section 4 "risks") | | **Not relevant** | |

# COUNCIL OF GOVERNORS

**Date of Meeting:** **19 May 2015**

**Title:** **Finance Report for period 1 April 2014 to 31 March 2015**

## 1. INTRODUCTION & PURPOSE

1.1 This report summarises the Trust's financial performance from 1 April 2014 to 31 March 2015.

## 2. BACKGROUND INFORMATION

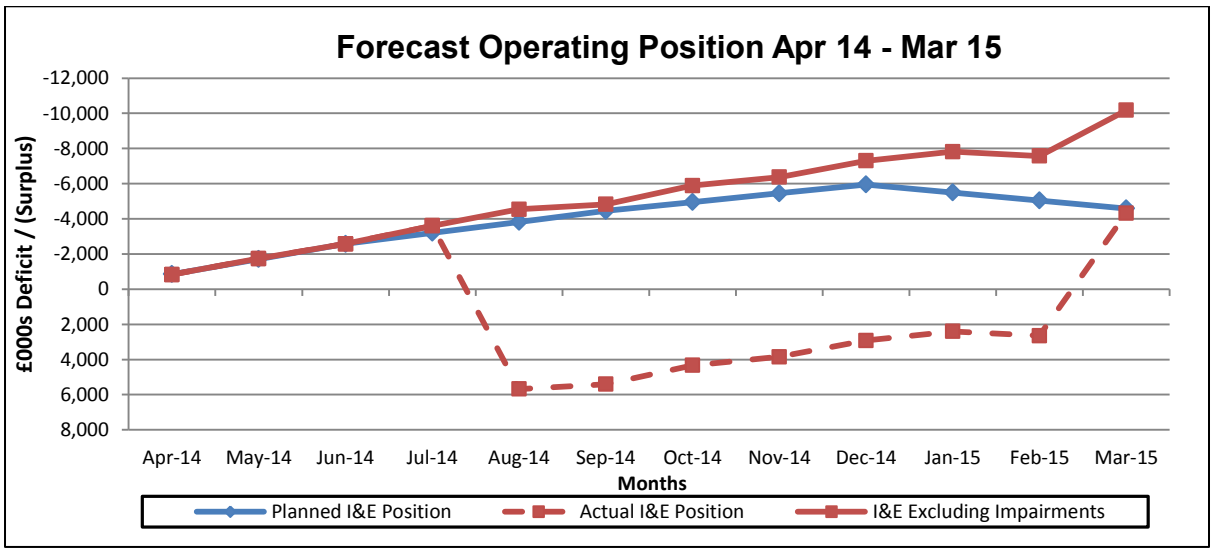
2.1 The financial reporting framework of a Foundation Trust places an increased emphasis on cash and the statement of financial position as well as the management of identified key financial drivers. The Board receives a monthly summary report on the Trust's finances as well as a more detailed analysis on a quarterly basis.

## 3. KEY ISSUES:

3.1 Statement of Comprehensive Income

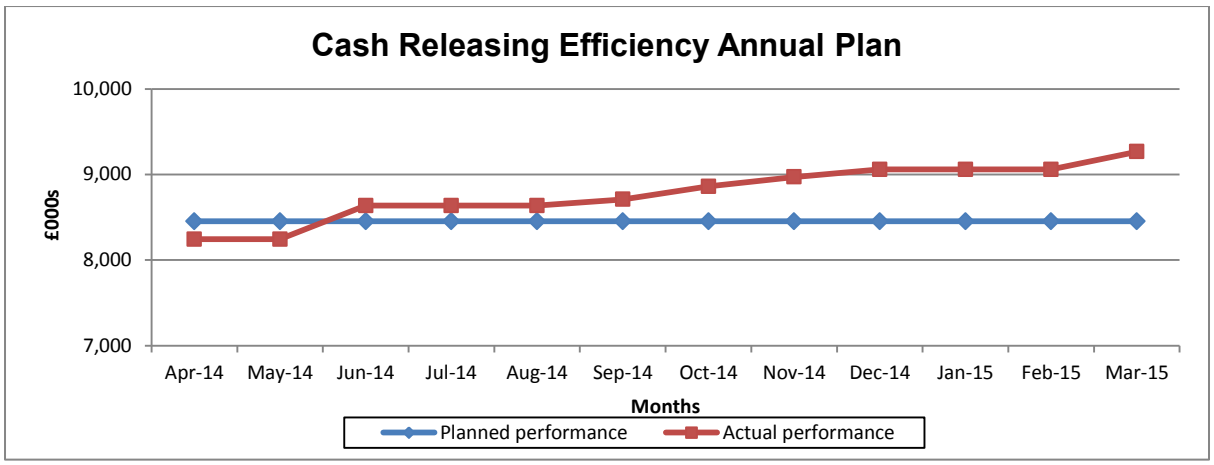
The financial position was a surplus of £4,321k for the period 1 April 2014 to 31 March 2015, representing 1.5% of the Trust's turnover and was marginally behind plan. This variation of £270k was due to fixed asset impairments that occurred during the year, which were largely offset by end of year asset revaluations, additional contract income and slippage on some projects.

The graph below shows the Trust's planned operating surplus against actual performance, and the Trust's position excluding impairments.

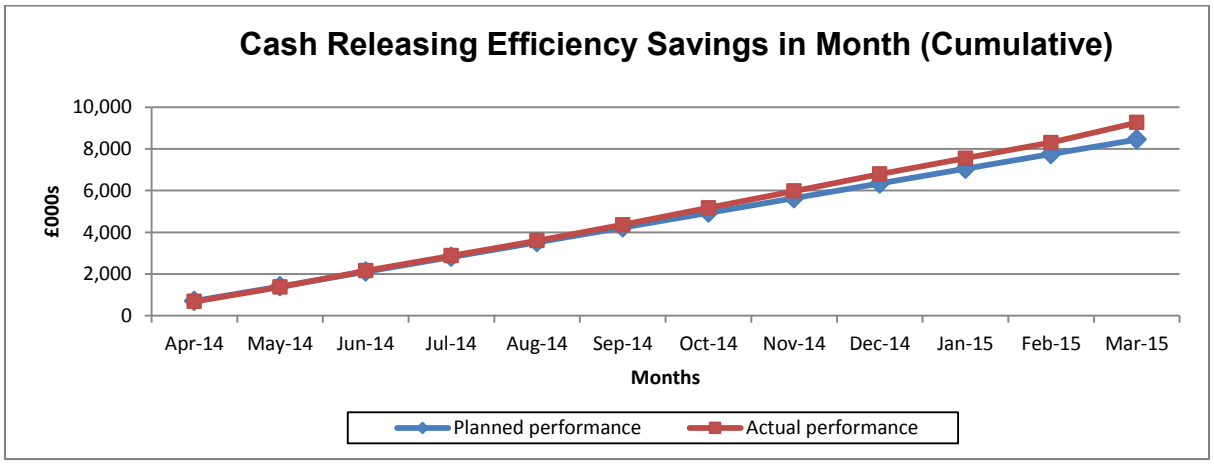


## 3.2 Cash Releasing Efficiency Savings

Total CRES achieved at 31 March 2015 was £9,267k and was £815k ahead of plan.

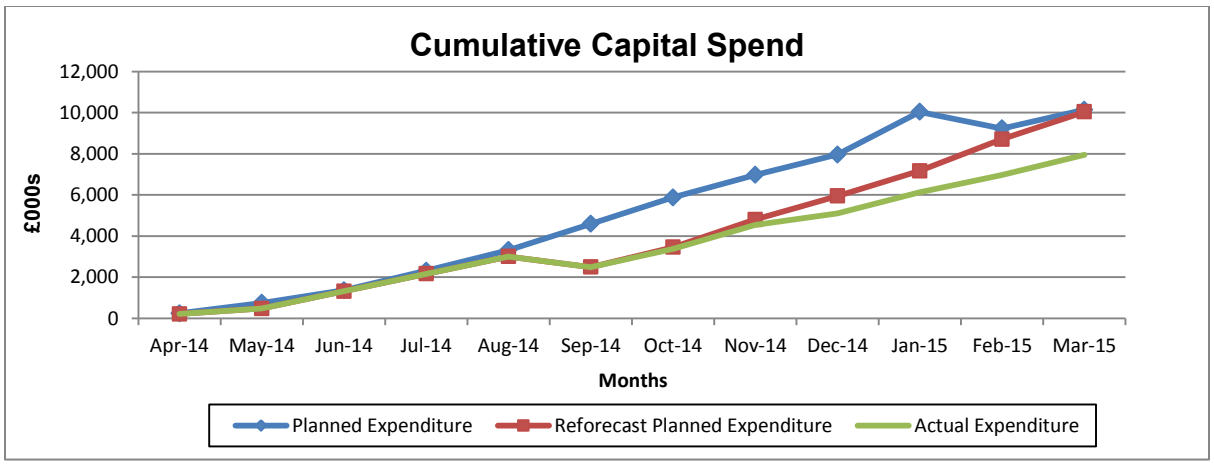



The monthly profile for CRES achieved by Localities is shown below.



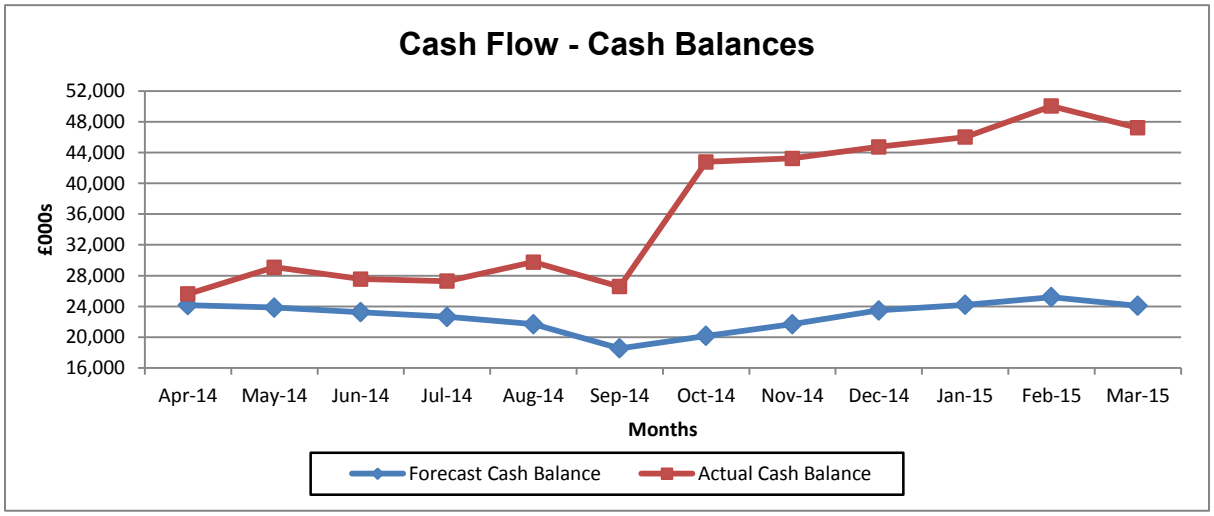

## 3.3 Capital Programme

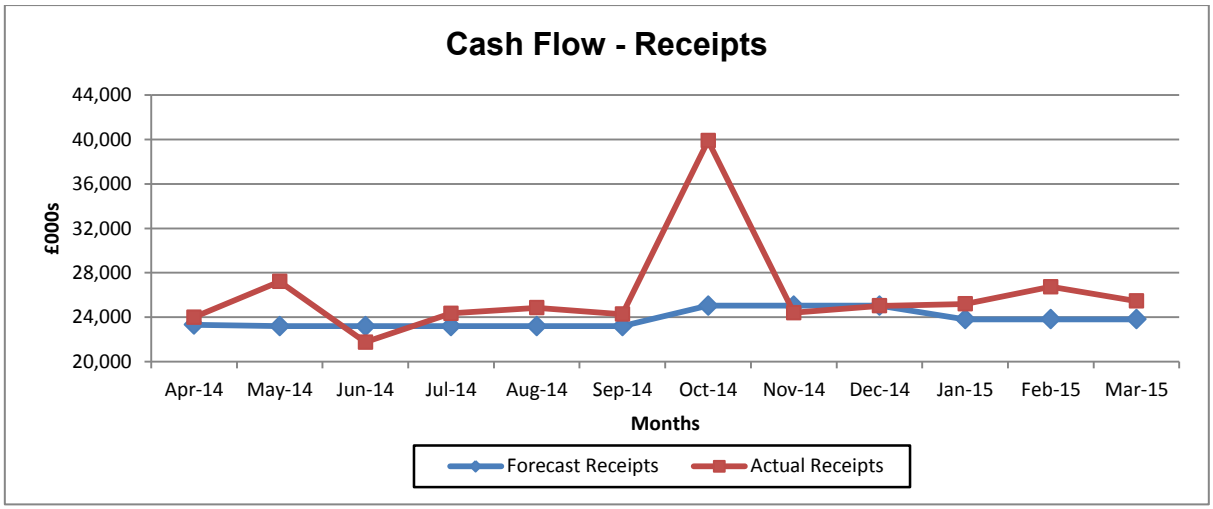
Capital expenditure to 31 March 2015 was £7,950k, which was behind the reforecast plan submitted to Monitor due to further delays in some schemes.

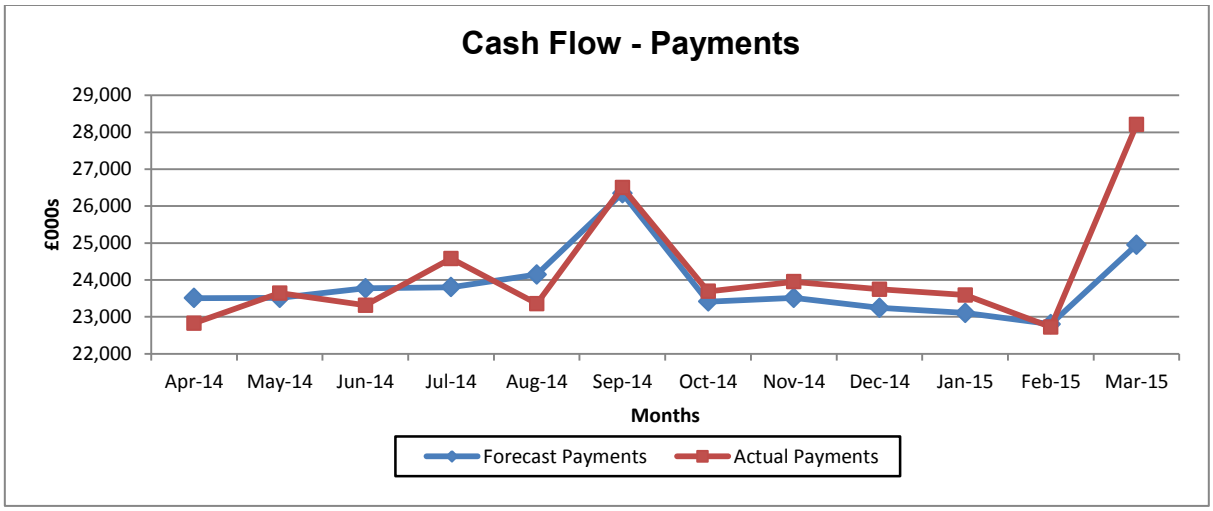


## 3.4 Cash Flow

Total cash at 31 March 2015 was £47,147k and was ahead of plan. This was largely due to the Trust receiving a £15,000k loan repayable over 5 years from the Independent Trust Finance Facility (ITFF), which was used to support the Trust's capital programme. The additional liquidity also enabled the Trust to reduce its PDC dividend payable by more than the interest charged on the loan, which improved the operating surplus.



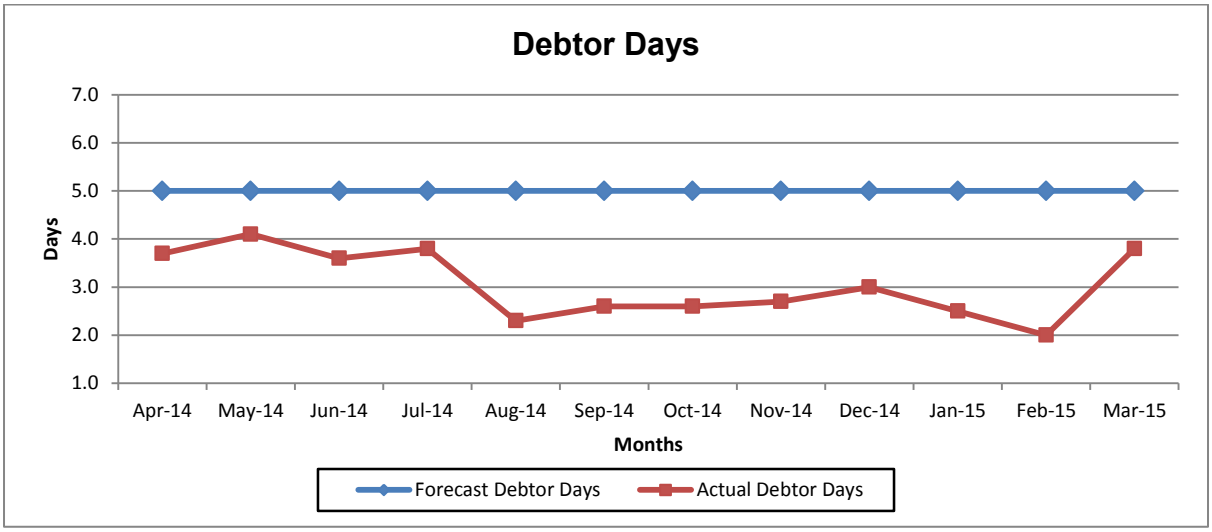



The payments profile fluctuated for PDC dividend payments which occurred in September and March. In addition during March there were a number of high value project payments which were anticipated, but approved after the submission of the forecast plan.

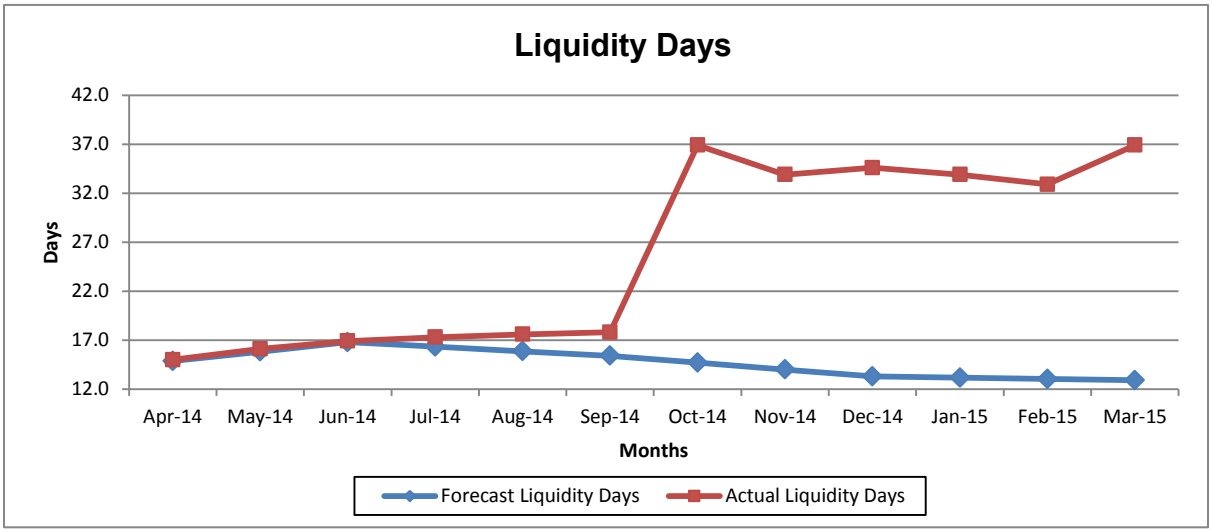
Working Capital ratios for the period to 31 March 2015 were:

- Debtor Days of 3.8 days
- Liquidity of 36.9 days
- Better Payment Practice Code (% of invoices paid within terms)
  NHS – 78.09%
  Non NHS 30 Days – 98.12%




The Trust had a debtors' target of 5.0 days and actual performance of 3.8 days, which was ahead of plan.

The liquidity days graph below reflects the metric within Monitor's risk assessment framework. The Trust liquidity day's ratio was ahead of plan following receipt of the ITFF loan.

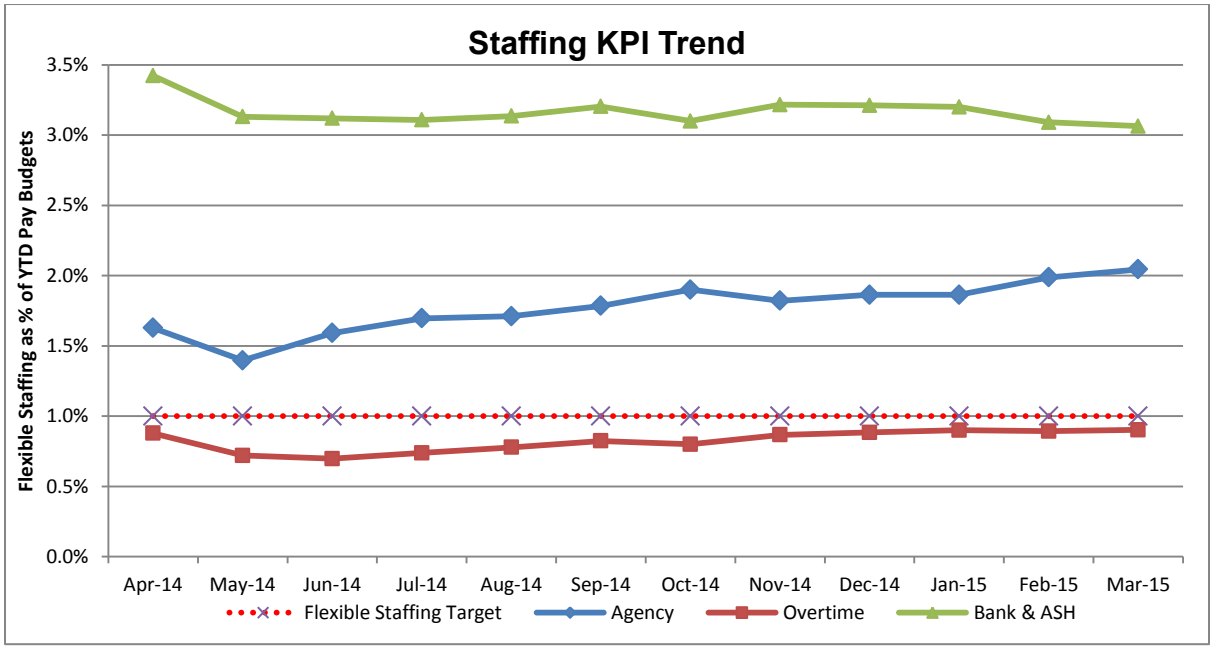


3.5 Financial Drivers

The following table and chart show the Trust's performance on some of the key financial drivers identified by the Board.

| Tolerance | November | December | January | February | March |
|---|---|---|---|---|---|
| Agency (1%) | 1.8% | 1.9% | 1.9% | 2.0% | 2.0% |
| Overtime (1%) | 0.9% | 0.9% | 0.9% | 0.9% | 0.9% |
| Bank & ASH (flexed against establishment) | 3.2% | 3.2% | 3.2% | 3.1% | 3.1% |
| Establishment (90%-95%) | 93.5% | 93.8% | 93.1% | 93.4% | 92.8% |
| **Total** | **99.4%** | **99.8%** | **99.1%** | **99.3%** | **98.8%** |

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 & ASH. For March 2015 the tolerance for Bank and ASH was 5.2% 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 (41%), enhanced observations (22%) and sickness (21%).

3.6 Continuity of Service Risk Rating and Indicators

3.6.1 The Continuity of Service Risk Rating was assessed as 4 at 31 March 2015 and was in line with plan.

3.6.2 Debt service cover assesses the level of operating surplus generated to ensure a Trust is able to cover all debt repayments due in the reporting period.

The Trust had a debt service cover of 2.12x (can cover debt payments due 2.12 times), which was in line with plan and was rated as a 3 in the CoSRR metrics.

3.6.3 The liquidity position was 36.9 days which was ahead of plan and rated as a 4 in the CoSRR metrics.

3.6.4 The margins on CoSRR risk ratings are as follows:

- Debt service cover - to reduce to a 2 a surplus reduction of £4,395k was required.
- Liquidity - to reduce to a 3 a working capital reduction of £27,070k was required.

**Continuity of Services Risk Rating at 31 March 2015**

| Monitors Rating Guide | Weighting | Rating Categories | | | |
|---|---|---|---|---|---|
| | % | 4 | 3 | 2 | 1 |
| Debt Service Cover | 50 | 2.50 | 1.75 | 1.25 | < 1.25 |
| Liquidity | 50 | 0 | -7 | -14 | <-14 |

| TEWV Performance | Weighting | Rating Categories | | | |
|---|---|---|---|---|---|
| | % | 4 | 3 | 2 | 1 |
| Debt Service Cover | 50 | | 2.12x | | |
| Liquidity | 50 | 36.9 Days | | | |

**Overall Finance Continuity of Services Risk Rating** **4**

3.6.5 4.2% of total receivables (£130k) were over 90 days past their due date which is within the 5% tolerance set by Monitor.

3.6.6 0.8% of total payables invoices (£95k) held for payment were over 90 days past their due date. This was within the 5% finance risk tolerance set by Monitor.

3.6.7 The cash balance at 31 March 2015 was £47,147k and represents 65.2 days of annualised operating expenses.

3.6.8 Actual capital expenditure was 79% of the reforecast plan and was 6% (£600k) under Monitor tolerances due to further slippage in a few schemes.

3.6.9 The Trust does not anticipate the quarterly Continuity of Services Risk Rating will be less than 3 in the next 12 months.

## 4. IMPLICATIONS / RISKS

4.1 There are no direct quality, legal or equality and diversity implications associated with this paper.

## 5. CONCLUSIONS

5.1 The comprehensive income outturn for the period ending 31 March 2015 was a surplus of £4,321k, which was equivalent to 1.5% of turnover and was £270k behind plan. Excluding the impact of technical accounting items linked

to asset revaluations and impairments the Trust has achieved its financial plan for 2014/15.

5.2 The Trust was ahead of plan for Cash Releasing Efficiency Savings at 31 March 2015. The Trust has identified schemes to deliver the required level of CRES in 2015/16 whilst plans continue to be progressed for 2016/17.

5.3 The Continuity of Services Risk Rating for the Trust was 4 for the period ending 31 March 2015.

## 6.0 RECOMMENDATIONS

6.1 The Council of Governors are requested to receive the report, to note the conclusions in section 5 and to raise any issues of concern, clarification or interest.

**Colin Martin**
**Director of Finance**

**ITEM 17i**

**Report for Information only.**

**Patient Experience Group, Tuesday 21 April 2015**

**Key points for Council of Governors Sub Group Improving the Experience of Service Users**

The Trust is to work more closely with CCGs when placing patients with challenging behaviour. The Trust is exploring the possibility of monitoring and reporting whether patients who have been discharged into care homes are readmitted to inpatient wards. PEG and locality managers are maintaining an awareness of the results CQC inspections of care homes within Trust boundaries.

Pressure on MHSOP beds which may result in out of locality placements is being monitored and positive practice highlighted to QuAC.

Ongoing work to ensure care plans are completed with the service user and that they receive copies is taking place across the Trust.

Work is continuing in North Yorkshire to ensure cancelled appointments are recorded correctly on PARIS (this is part of the response to concerns raised at CoG). Standard work will be shared across the Trust. There is ongoing work in all localities on cancelled appointments.

Quality issues have been raised as a result of patient experience data. Mitigating factors and actions taken to resolve issues are reported to PEG by locality managers. PEG agreed to continue to challenge adequacy and speed of these responses.

Feedback was sent from PEG members to QuAC that the group has made progress in achieving clarity of purpose, ability to challenge and explore patient experience issues and overall effectiveness.

Durham and Darlington LMGB continues to investigate why patients have reported not feeling safe on ward. Reasons include noise, other patients and feeling unsafe of their condition.

Forensic services have been engaging patients with their Head of Housekeeping in improving food choices. Temperature of food has not been raised as an issue. Theme nights are popular.

The lack of information about when smoking in inpatients is to be stopped is causing concern in adult forensic services.

**Quality Strategy Scorecard**

There is an overall reduction in the quality scores monitored by PEG. There is no obvious reason for this so the figures for March will be closely monitored.

The Trust Carer Strategy Scorecard to measure the Carer Strategy was discussed – see attachment. The Patient Experience team have received funding to roll out surveys of carer experience. The PEG expressed concern that without CQUIN funding for raising carer awareness it is not expected that scores in developing carer experience will improve over time.

**CQC update** – see bulletin

**CQUIN targets**

CQUIN targets implementation of the Friends and Family Test and improving carer support and engagement have been achieved.

**Complaints**

The number of complaints have gone up. A possible explanation is that more complaints are being received through MPs and CQC. There is an expectation that the introduction of smoking cessation will raise the number of complaints. TEWV is not receiving more complaints than expected for at Trust of its size.

PEG is monitoring ongoing work to complete outstanding Complaint Action Plans.

**Quality Visit**

Trust quality visits have restarted. Between February and March 2015 42 visits have taken place with 88% receiving a green score. During the 2014/15 year 88 visits took place and 92% received a green score. An increasing number of areas are now displaying feedback prominently and there are some excellent examples of easy read display boards.

Community teams have highlighted the difficulty of feeding back to patients who do not visit a Trust base for appointments. The Patient and Carer Experience Team (PaCE) intends to introduce a quarterly newsletter that teams could utilise to feed back. A Patient Experience Lead network is to be established to improve communication between the corporate team and clinical teams.

**Catherine Haigh,**

**Public Governor, Middlesbrough**

**Appointed to Patient Experience Group.**

# TRUST CARER STRATEGY SCORECARD

| No | Metric | Baseline 2014/15 | Target 15/16 | Target 16/17 |
|---|---|---|---|---|
| **1) Ensure carers receive timely information to support them and the person they care for** | | | | |
| 1 | Given/offered information - how to raise concerns (survey) | | | |
| 2 | Given/offered information - how to give feedback (survey) | | | |
| 3 | Given/offered information - carer support services (survey) | | | |
| **2) Treat carers as individuals and with dignity and respect for their cultural, communication, physical and mental health needs** | | | | |
| 4 | Staff treat you with dignity and respect (survey) | | | |
| 5 | Number of carers assessments completed | | | |
| **3) Actively involve carers in decisions about the care and treatment of the person they care for wherever possible** | | | | |
| 6 | Actively involved - decisions about care & treatment of person you care for (survey) | | | |
| **4) Develop and implement carer awareness training for staff to ensure carers needs are recognised** | | | | |
| 7 | Percentage of staff who have completed carer awareness training | | | |
| 8 | Percentage of inpatient wards that have a carers champions | | | |
| 9 | Percentage of community teams that have a carers champions | | | |
| **5) Actively involve carers by consulting and seeking views when planning, developing, delivering and improving services** | | | | |
| 10 | Number of carers who have been involved in recruitment | | | |
| 11 | Number of carers who are working as Trust volunteers | | | |
| 12 | Number of carers involved in service improvement activities | | | |
| 13 | Number of carer surveys completed | | | |

**Item 17ii**

**FEEDBACK FROM BETTY GIBSON, PUBLIC GOVERNOR, DURHAM**

Equality, Diversity and Human Rights Steering Group – Meeting 15th April 2015

1. Some time was spent on reading and discussing the 2013/14 Equality Data report. It was agreed that the only area of concern was the disability section. Work needs to be undertaken to address this with both staff and service users – i.e. understanding etc

2. Research shows that Black/Caribbean communities have higher use of Mental Health services than others.

3. Asian communities have little concept of Mental Health seeing Dementia as a happening of old age.

4. The Trust publishes more data than many others.

5. The bi-annual spirituality event will not take place this summer because of lack of uptake of places.

6. Work with the travelling communities continues and all involved are satisfied with the progress made.

7. It was noted during their visit to Forensic Learning Disabilities service in January this year that CQC commented on the good practice staff provided. CQC quoted 'No blanket restrictive procedures were in use' and documentation was provided in easy read format. This meets Equality and Diversity and Human Rights guidelines.

8. Durham Pride event is being supported jointly by Equality and Diversity and the Trust Secretary's team.

9. Service user representatives have now been agreed for membership of the group.

Betty Gibson,

Public Governor, Durham

Appointed to Equality, Diversity and Human Rights Steering Group