Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

AGENDA FOR THE MEETING OF THE COUNCIL OF GOVERNORS

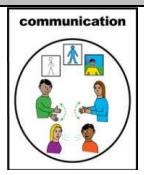
30 November 2017, 2.00pm

(Governor registration and hospitality available between 1.00pm and 1.45pm)
Holiday Inn, Scotch Corner, Darlington DL10 6NR

NOTE: Cllr Ann McCoy, Lead Governor will be available to meet with Governors during hospitality

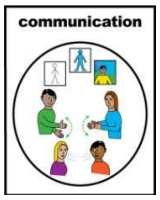
Agenda:

No		What we will talk about	Why are we talking about this	Lead Person	Supporting Paper / Spoken report
2.00pm Standard Items					
1.	 	Welcome and apologies for absence	**For information** To make sure that we have enough Governors present to be quorate and introduce any new attendees. To advise of housekeeping arrangements	Lesley Bessant, Chairman 	Spoken
2.		Minutes of the meeting of the Council of Governors held on 28 September 2017	**To agree** To check and approve the minutes of this meeting	Lesley Bessant, Chairman	Attached
3.		Public Council of Governors' Action Log	**To discuss** To update on any action items	Lesley Bessant, Chairman	Attached
4.		Declarations of Interest	**To agree** The opportunity for Governors to declare any interests with regard to any matter being discussed today	Lesley Bessant, Chairman	Spoken

No		What we will talk about	Why are we talking about this	Lead Person	Supporting Paper / Spoken report
5.	 	Chairman's activities	**For information** To hear from the Chairman on what she has been doing since the last meeting. There will be an opportunity to ask any questions	Lesley Bessant, Chairman	Spoken
6.		Questions from Governors	**To discuss** To consider any questions raised by Governors which are not covered elsewhere on the agenda (*Governors are asked to provide the Trust Secretary with at least 24 hours written notice if they wish to receive a formal answer to their questions at the meeting.*)	Lesley Bessant, Chairman	Spoken
		1. <u>Gary Emerson, Public Governor Stockton on Tees</u> *'Can TEWV please confirm how many Psychiatrist vacancies there are currently within the Trust and what is this as a percentage of the whole numbers of Psychiatrists employed? Has any vacancy been unfilled for more than twelve months and what steps are being taken to recruit into these posts.'* 2. <u>Gary Emerson, Public Governor Stockton on Tees</u> *'Given the significant reductions over the last 12-24 months in the number of children awaiting a mental health assessment in some localities, I am concerned that tightening the referral criteria is just moving the problem somewhere else. There also seems to be low numbers of children being signposted to other agencies - in some instances as few as just 13.5% signposted elsewhere. Can we establish better tracking mechanisms to ensure children with mental health issues are supported and a clear pathway is mapped.'*			

No		What we will talk about	Why are we talking about this	Lead Person	Supporting Paper / Spoken report
		3. <u>Stockton Public Governors</u> *'Following a meeting held with representatives from a local carer group, a number of issues were discussed about the support provided to carers. One of the concerns raised by the group which the Governors within the Stockton Constituency would like to seek information on is around the number of referrals made for Carer Assessments and, if available, how many of these referrals have been carried out with the average wait time since April 2017.* 4. <u>Sarah Talbot Landon, Public Governor Durham</u> *'I'm interested to know the Trust's view on how many bottled water machines we pay out for and if they have been considered essential based on the location of each individual machine, can these be changed to mains supply to reduce costs?'* *5.* <u>Catherine Haigh, Public Governor Middlesbrough</u> *'Can the Trust explain what is happening in Rehabilitation services across Teesside. Are there plans to reduce inpatient beds and where. If so what new community services are being planned to replace them and will these teams have the full complement of dedicated psychologists and occupational therapists.'*			
2.15pm Governance Related Items					
7.		Summary of the discussions held at meetings of the Board of Directors from September 2017 – October 2017	**For information** An opportunity to read through the key areas discussed at recent meetings of the Board of Directors	Lesley Bessant, Chairman	Attached
8.		Governor Appointments	**For agreement** To appoint, from nominations received to the: i. Board of Directors Mental Health Legislation Committee ii. Patient Experience Working Group	Phil Bellas, Trust Secretary 	Spoken

No		What we will talk about	Why are we talking about this	Lead Person	Supporting Paper / Spoken report
2.25pm Quality Related Items					
9.		i. Compliance activity in relation to the Care Quality Commission ii. An update on any items of relevance following contact with the Care Quality Commission not contained in the report at i.	**For information** To receive a briefing on the latest information from Care Quality Commission Inspections of the Trust	Elizabeth Moody Director of Nursing and Governance 	Attached
10.		Service changes	**For information** To receive a briefing on changes and improvements to services in the Trust	Brent Kilmurray Chief Operating Officer 	Attached
11.		Quality Account 2017/18	**For information** To receive the Q2 progress on the Trust's Quality Account for 2017/18	Sharon Pickering, Director of Planning, Performance and Communication 	Attached
2.35pm Performance Related					
12.		The Trust's Performance Dashboard as at end September 2017	**For information** To review the performance of the Trust key indicators	Sharon Pickering, Director of Planning, Performance and Communication	Attached

No		What we will talk about	Why are we talking about this	Lead Person	Supporting Paper / Spoken report
13.		The Trust's Finance report as at end September 2017	**For information** To receive information and review the current financial position of the Trust	Drew Kendall, Interim Director of Finance 	Attached
2.45pm Standing Committees					
14.		Involvement and Engagement Committee	**For information** i. To receive information on the work of this committee ii. To provide comments on the proposed ladder of participation for the Trust.	Vanessa Wildon, Chairman of Committee	Spoken Attached
15.		Task and Finish Group: Involvement	**For information** To receive information on the work of the task and finish group	Dr Hugh Griffiths, Non Executive Director	Spoken
2.55pm Additional Urgent Business					
16.		To raise any additional matters of business	**To discuss** To consider any other business matters raised by Governors which are not covered elsewhere on the agenda *(All business to be taken under this item must be approved by the Chairman. Governors must*	Lesley Bessant, Chairman	Spoken

No		What we will talk about	Why are we talking about this	Lead Person	Supporting Paper / Spoken report
			therefore give the Trust Secretary at least 24 hours written notice of any matters they wish to raise. No decisions shall be taken unless they are matters of urgency agreed by the Chairman)		
3.00pm Procedural					
17.		Date and Time of next meeting: 22 February 2018, 2.00pm Holiday Inn, Scotch Corner, Darlington, DL10 6NR			
18.		<u>Confidential Motion</u> *"That representatives of the press and other members of the public be excluded from the remainder of this meeting on the grounds that the nature of the business to be transacted may involve the likely disclosure of confidential information as defined in Annex 9 to the Constitution as explained below:* *Information relating to a particular employee, former employee or applicant to become an employee of, or a particular office-holder, former office-holder or applicant to become an office-holder under, the Trust.* *Any terms proposed or to be proposed by or to the Trust in the course of negotiations for a contract for the acquisition or disposal of property or the supply of goods or services.*			

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Statement of values and behaviours

Commitment to quality

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

Behaviours:

- Put service users first.
- Seek and act on feedback from service users, carers and staff about their experiences.
- Clarify people's needs and expectations and strive to ensure they are exceeded.
- Improve standards through training, experience, audit and evidence based practice.
- Learn from mistakes when things go wrong and build upon successes.
- Produce and share information that meets the needs of all individuals and their circumstances.
- Do what you / we say we are going to do.
- Strive to eliminate waste and minimise non-value adding activities.

Respect

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

Behaviours:

- Be accessible, approachable and professional.
- Consider the needs and views of others.
- Be open and honest about how decisions are made.
- Observe the confidential nature of information and circumstances as appropriate.
- Be prepared to challenge discrimination and inappropriate behaviour.
- Ask for feedback about how well views are being respected.
- Consider the communication needs of others and provide a range of opportunities to access information.

Involvement

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

Behaviours:

- Encourage people to share their ideas.
- Engage people through effective consultation and communication.
- Listen to what is said, be responsive and help people make choices.
- Provide clear information and support to improve understanding.
- Embrace involvement and the contribution that everyone can bring.
- Acknowledge and promote mutual interests and the contributions that we can all make at as early a stage as possible.
- Be clear about the rights and responsibilities of those involved.

Wellbeing

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

Behaviours:

- Demonstrate responsibility for our own, as well as others, wellbeing.
- Demonstrate understanding of individual and collective needs.
- Respond to needs in a timely and sensitive manner or direct to those who can help.
- Be pro-active toward addressing wellbeing issues.

Teamwork

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

Behaviours:

- Be clear about what needs to be achieved and take appropriate ownership.
- Communicate well by being open, listening and sharing.
- Consider the needs and views of others.
- Be supportive to other members of the team.
- Be helpful.
- Fulfil one's own responsibilities.
- Always help the team and its members be successful.

MINUTES OF THE COUNCIL OF GOVERNORS MEETING HELD ON 28 SEPTEMBER 2017, 5.30 PM AT HOLIDAY INN, SCOTCH CORNER, DARLINGTON

PRESENT:
Lesley Bessant (Chairman)
Cliff Allison (Durham)
Mary Booth (Middlesbrough)
Phil Boyes (Staff - Durham and Darlington)
Della Cannings QPM (Hambleton and Richmondshire)
Bernard Cole (Scarborough and Ryedale)
Dr Martin Combs (York)
Hilary Dixon (Harrogate and Wetherby)
Mark Eltringham (Stockton on Tees)
Gary Emerson (Stockton on Tees)
Chris Gibson (Harrogate and Wetherby)
Glenda Goodwin (Staff - Forensic)
Sandra Grundy (Durham)
Catherine Haigh (Middlesbrough)
Dr Peter Harrison (York)
Dr Judith Hurst (Staff - Corporate)
Gary Matfin (Staff - York and Selby)
Cllr Ann McCoy (Stockton Borough Council)
Jacci McNulty (Durham)
Keith Mollon (Durham)
Gillian Restall (Stockton on Tees)
Lesley Robertson (Darlington)
Graham Robinson (Durham)
Zoe Sherry (Hartlepool)
Cllr Helen Swiers (North Yorkshire County Council)
Ailsa Todd (Hambleton & Richmondshire)
Mac Williams JP (Durham)

IN ATTENDANCE:
Phil Bellas (Trust Secretary)
Angela Grant (Administrator)
Dr Hugh Griffiths (Non Executive Director)
David Jennings (Non Executive Director)
Wendy Johnson (Secretary)
Drew Kendall (Interim Director of Finance)
Brent Kilmurray (Chief Operating Officer)
Elizabeth Moody (Director of Nursing and Governance)
Paul Murphy (Non Executive Director)
Donna Oliver (Deputy Trust Secretary)
Kathryn Ord (Deputy Trust Secretary)
Sharon Pickering (Director of Planning, Performance and Communications)
Shirley Richardson (Non Executive Director)
Richard Simpson (Non Executive Director)

17/60 APOLOGIES

Colin Martin (Chief Executive)
Lee Alexander (Durham County Council)
Gemma Benson (Selby)
Rachel Booth (Staff - Teesside)
Dr Nathaniel Drake (York)
Dr John Drury (CCG representative for Hartlepool, Stockton on Tees and South Tees)
Wendy Fleming-Smith (Selby)
Elizabeth Forbes-Browne (Scarborough and Ryedale)
Marion Grieves (Teesside University)
Hazel Griffiths (Harrogate and Wetherby)
Marcus Hawthorn (Non Executive Director)
Dr Suresh Joseph (Newcastle University)
Kevin Kelly (Darlington Borough Council)
Dr Nick Land (Medical Director)
David Levy (Director of Human Resources and Organisational Development)
Cllr Ashley Mason (City of York)
Dr Lakkur Murthy (Durham)
Lisa Pope (representative for North Yorkshire Clinical Commissioning Groups)
Maureen Powles (Darlington
Jean Rayment (Hartlepool)
Prof Angela Simpson (University of York)
Cllr Kaylee Sirs (Hartlepool Borough Council)
Dr David Smart (CCG representative for Co Durham and Darlington)
Sarah Talbot-Landon (Durham)
Judith Webster (Scarborough & Ryedale)
Vanessa Wildon (Redcar and Cleveland)
Alan Williams (Redcar and Cleveland)

Prior to the commencement of the meeting the Chairman recognised, and reflected on the work Janice Clark, former Governor had undertaken within the Trust following the sad news of her recent death. A minute's silence was held in her memory.

17/61 WELCOME

The Chairman opened the meeting and noted apologies.

17/62 MINUTES OF PREVIOUS MEETINGS

The Council of Governors considered the minutes from the public meeting held on 13 July 2017 and the Annual General and Members meeting held on 19 July 2017.

Agreed

1. ***That the public minutes of the meeting held on 13 July 2017 be approved as a correct record and signed by the Chairman.***
2. ***That the minutes of the Annual General and Members meeting held on 19 July 2017 be approved as a correct record and signed by the Chairman.***

17/63 PUBLIC ACTION LOG

Consideration was given to the public action log.

Arising from the report:

1) Minute 16/82 – work of external audit
It was noted that this was due to be considered under the private element of the agenda of the meeting.

Action closed

2) Minute 17/04 – collaborative approach to access to welfare advice
Cllr McCoy advised that Stockton Citizen Advice Bureau would welcome partnership working with the Trust and would await contact.

Action closed

3) Minute 17/07 – physical health and well-being group
It was noted that service users and carers had been asked to nominate to join the steering group on 14 July 2017. A selection process had been undertaken with an appointment made.

Action closed

4) Minute 17/07 – patient safety annual report
It was noted that this was included on the agenda for the Governor Development Day planned for 25 October 2017.

Action closed

5) Minute 17/25 – CQC action plan
It was noted that this was due to be considered under agenda item 10 of the meeting.

Action closed

6) Minute 17/26 – patient absconsions
It was noted that a briefing had been provided within the agenda for the meeting.

Arising from questions Mrs Moody confirmed that the definition of an absconsion:
1) Did not include a specific time element.
2) Was very dependent on the type of leave being taken.
3) Required an element of professional judgement in terms of appropriateness to report as absconsion.

Action closed

7) Minute 17/32 – GP survey
It was noted that briefings had been provided by Directors of Operations during discussions held with Governors in November 2016.

Action closed

8) Minute 17/46 – occupational therapy services
It was noted that a response had been circulated to Governors on 26 July 2017.

Action closed

17/64 DECLARATIONS OF INTEREST

There were no declarations of interest.

17/65 CHAIRMAN'S REPORT

The Chairman reported on her activities since July 2017. She had:

1) Opened Reed Marsh House in Redcar which was a community service for Mental Health Services for Older People.
2) Presented Living the Values Awards to:
   - Staff within Deerbolt Prison.
   - Farnham Ward at Lanchester Road Hospital.

She advised that following a number of recommendations and commendations received from Governors she wished to present the Trust Secretary's Department with a Living the Values Award for the support and advice consistently provided.

17/66 GOVERNOR QUESTIONS

1. Cllr Ann McCoy, Appointed Governor Stockton Borough Council

   'a) What was the longest time a patient who had been assessed as able to leave hospital waited for discharge and what was the average time patients wait for discharge when no suitable accommodation could be found?

   b) Was TEWV confident that if a young person being discharged from prison or young offender facility, who had mental health issues, appropriate treatment and accommodation can be found?'

The Chairman confirmed that a full written response to both questions had been provided and had been circulated with the agenda.

Cllr McCoy thanked the Trust for the information which she had discussed with the Stockton Health and Wellbeing Board. Some figures were concerning and she recommended that this should be highlighted more with other Clinical Commissioning Groups and Health and Wellbeing Boards.

2. Keith Mollon, Public Governor Durham

   'With reference to the service update report (page 3, item number 11). A statement was made that Commissioners from Clinical Commissioning Groups and Local Authorities were currently completing a strategic review of the autism provision. What would be the best outcome from the report and how would it benefit the service users in the Durham and Darlington area?'

Mr Kilmurray advised that:

1) It was helpful that partners were prioritising this service.
2) The best outcome for the Trust would be an increased investment for this service provision which would assist:
   - The reduction of wait times.
   - Increased staffing resource.
   - Better coordination with other agencies.

In addition, Cllr McCoy advised that the Stockton Health and Wellbeing Board had been concerned with waiting times reported as being 17 to 44 months following a Freedom of Information request by a local doctor. As a result the Clinical Commissioning Group had been requested to attend a meeting of the Health and Wellbeing Board to discuss the prioritisation of services.

Mrs Pickering confirmed that the information referred to had been previously shared with Governors and had been issued as part of the Freedom of Information response from the Trust.

Mr Emerson rasied concern at recent press articles reporting the amount of mental illness of staff within Mental Health Trusts.

Mr Kilmurray confirmed that within the Trust, staff that did require treatment for mental ill health were offered treatment outside of their own team and work base, or if deemed appropriate outside of the Trust.

17/67 BOARD OF DIRECTORS FEEDBACK

Consideration was given to the Board of Directors roundup summaries from May 2017 to July 2017.

Arising from discussion points the following was noted that:
1) The content of the report could raise more questions rather than answers.
2) It did not include detail about what action/discussion points held in terms of providing informative assurances.

In response to the reporting of issues around medication Mrs Moody advised:
1) That all incidents of medication errors were reviewed by the Director to ensure appropriate grading of harm had been recorded.
2) All incidents reported had been of no harm directly to patient.
3) The majority of incidents were in relation to storage and recording errors.

Agreed – The Council of Governors received and noted the content of the Board round up from May 2017 to July 2017 inclusive.

17/68 REGISTER OF INTERESTS

The Council of Governors received and noted the Register of Interests of Governors, as at September 2017.

The Chairman requested that any further amendments be notified by 5 October 2017, the register would then be made public.

Agreed - That the Council of Governors' Register of Interest's be updated with further declarations received and uploaded to the Trust website after 5 October 2017.

Action: Mrs Ord

17/69 GOVERNOR APPOINTMENTS

The following appointments were agreed by the Council from the nominations received:

Agreed that:

i) Della Cannings QPM, (Public Governor for Hambleton and Richmondshire) be appointed to the Council of Governors' Nomination and Remuneration Committee until 30 November 2020.

ii) Mac Williams, JP (Public Governor for Durham) be appointed to the Council of Governors' Nomination and Remuneration Committee until 30 November 2020.

iii) Cllr Ann McCoy, (Appointed Governor Stockton Borough Council) be re-appointed as the Lead Governor until 30 September 2020.

iv) Della Cannings QPM, (Public Governor Hambleton and Richmondshire) be nominated by the Council to the NHS Providers Governor Advisory Committee upon the invitation of nominations from NHS Providers.

As no nominations had been received from Governors to be a member of the Mental Health Legislation Committee, this would be carried forward until the November 2017 meeting. Cliff Allison and Mark Eltringham had both expressed an interested and accepted an offer to attend a future meeting to observe proceedings.

Action Item – Mrs Ord

17/70 COMPLIANCE ACTIVITY RELATING TO THE CARE QUALITY COMMISSION (CQC)

Mrs Moody presented a summary and position statement of the key requirements of the CQCs action plan which had been produced following the Trustwide inspection held in 2015. A copy of the presentation can be found at Appendix 1.

Arising from questions the following was noted:

1) There was no requirement to have a built in patient alarm system in premises where patients were mobile. Patients were individually risk assessed and personal alarms were available if deemed appropriate. This was in line with other Mental Health Trusts.
2) There was more variation across the Trust in the provision of Mental Health Services for Older People, this was a result of individual practices and leadership. Environmental issues also played a part in the variances seen.
3) Any new areas identified that required action compared to previous inspections were generally due to the acuteness of patients and changes in environment.

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

1) The Ofsted registration of Holly and Baysdale units.
2) An update on inspections under the Mental Health Act.
3) Feedback from meetings of the:

- Quality Compliance Group.
- Fundamental Standards Group.
- CQC Engagement meetings.

Mrs Moody confirmed that consideration would be given to the extension of invitations for the CQC Engagement meetings in future.

Agreed – The Council of Governors received and noted the presentation on the position of the CQC action plan and the report in relation to compliance with Care Quality Commission requirements.

17/71 SERVICE CHANGES

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

Arising from questions the following was noted:

1) That the intention was to fill any vacancies within the Street Triage service as soon as possible, vacancies would not be held over. A number of other schemes were in place working with the police across the Trust which were delivered in a variety of different ways from staff within control rooms, liaison and diversion services, through to assisting police on patrol.
2) The packages of care available for patients on discharge especially within Teesside for older people, was reducing due to the lack of available care homes. However, a suggestion to expand the Trust's arms length body, PIPs was not appropriate due to its infancy in terms of diversifying its services.
3) The Trust was delivering liaison into care homes.

The Council of Governors congratulated the Trust on the number of teams and services who had been shortlisted for the Royal College of Psychiatry Awards.

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

17/72 QUALITY ACCOUNT

Mrs Pickering presented the Quarter 1 position of the Trust's Quality Account 2017/18.

Arising from questions Mr Kilmurray clarified that where incidents of self-harm had been reported (19 on Cedar Ward in Harrogate) the detail would not be made available as this could identify a patient. Not all cases resulted in the patient being taken from the ward.

Agreed – The Council of Governors received and noted the Quarter 1 position of the Quality Account 2017/18.

17/73 PERFORMANCE DASHBOARD

The Council received and noted the Performance Dashboard report as at 31 July 2017 and the availability of the supporting information pack.

Agreed – That the Council of Governors received and noted the Performance Dashboard report as at end of July 2017.

17/74 FINANCE REPORT

Consideration was given to the finance report for the period up to 31 July 2017.

Agreed – That the Council of Governors received and noted the Financial position of the Trust as at end of July 2017.

17/75 COMMITTEE UPDATE

Mr Bellas on behalf of the Committee updated the Council on the work of the Involvement and Engagement Committee which last met on 30 August 2017 including:

1) An update on Q1 involvement and engagement activity which included the position as at 31st July 2017. There were no areas of concern.
2) A briefing on the use of social media within the Trust with consideration as to how it could be used by Governors. Guidance was recommended to be issued around the safe use of social media and a request made for the delivery of training and support to Governors.
3) A review of the latest edition of Insight magazine.
4) A review of the delivery of the Annual General and Members Meeting 2017.

Future priorities for the Committee had been identified as the:

- Recruitment of new members.
- Encouragement of representation of Governors on the Committee to ensure that Constituency areas had a direct representative.
- Continuation of monitoring the delivery of the Involvement and Engagement Framework and the scorecard.
- Delivery of the Trust's Annual General and Members Meeting 2018 with an agreement of the theme and content.
- Further exploration of the use of social media by Governors.

Agreed – That the Council of Governors received and noted the update on the work of the Involvement and Engagement Committee.

17/76 TASK AND FINISH GROUP – Involvement

Dr Griffiths advised the Council that the second meeting of the task group had been held where:

1) Data had been received on the amount and activity type of involvement within the Trust.
2) It had been identified that interviews would be requested with the following people over the next 2-3 meetings:
    - Service users and carers from the Involvement Register.
    - Recovery Experts by Experience.
    - Directors of Operations for Teesside and Durham and Darlington.
    - Involvement and Engagement Officers.

Agreed - That the update of the Task and Finish Group on Involvement was received and noted.

17/77 FUTURE MEETINGS

The meetings in 2018 were agreed as:

- Thursday, 22 February 2018, 2pm
- Wednesday 16 May 2018, 6pm
- Thursday, 12 July 2018 6pm (special meeting if required)
- Wednesday 18 July 2018, 6pm (Annual General and Members Meeting)
- Wednesday, 19 September 2018, 6pm
- Thursday 29 November 2018, 2pm

All meetings to be held at Scotch Corner Hotel with the exception of the July meetings.

The Chairman confirmed the next meeting would be held on 30 November 2017 at 2pm at Holiday Inn Scotch Corner, Darlington, DL10 6NR.

17/78 CONFIDENTIAL RESOLUTION

> ***Agreed***– *that representatives of the press and other members of the public be excluded from the remainder of this meeting on the grounds that the nature of the business to be transacted may involve the likely disclosure of confidential information as defined in Annex 9 to the Constitution as explained below:*
>
> *Information relating to the financial or business affairs of any particular person (other than the Trust).*
>
> *Any advice received or information obtained from legal or financial advisors appointed by the Trust or action to be taken in connection with that advice or information.*

The Chairman closed the public session of the meeting at 6.45pm.

Appendix 1 – Presentation from Elizabeth Moody, Director of Nursing and Governance on the Care Quality Commission action plan.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Update on action plan following CQC inspection

Elizabeth Moody

Executive Director of Nursing &Governance

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

CQC Inspections – November 2016 and January 2017

November 2016

- All Adult Mental Health and MHSOP inpatient wards visited (Unannounced Inspection)

January 2017

- Well Led Review (Announced Inspection)
- Learning Disability Community Teams (Announced Inspection)
- All Rehabilitation Wards (Unannounced Inspection)

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Location	Overall	Safe	Effective	Caring	Responsive	Well Led
Trust overall (2017)	Good	Requires Improvement	Good	Good	Good	Good
Trust overall (2015)	Good	Requires Improvement	Good	Good	Good	Outstanding
Acute AMH Wards/PICU (2017)	Good	Requires Improvement	Good	Good	Good	Good
Acute AMH Wards/PICU (2015)	Good	Requires Improvement	Good	Good	Good	Good
MHSOP Wards (2017)	Requires Improvement	Requires Improvement	Requires Improvement	Not sufficient evidence to rate	Not sufficient evidence to rate	Requires Improvement
MHSOP Wards (2015)	Good	Requires Improvement	Good	Good	Good	Good
AMH Rehab Wards (2017)	Good	Requires Improvement	Good	Good	Good	Good
AMH Rehab Wards (2015)	Good	Requires Improvement	Good	Good	Good	Good
LD Community Teams (2017)	Good	Good	Good	Outstanding	Good	Good
LD Community teams (2015)	Not rated due to insufficient service user feedback collected					
Forensic Wards (2015)	Good	Good	Good	Outstanding	Good	Good
Child and Adolescent Wards (2015)	Good	Good	Good	Good	Good	Good
LD and Autism Wards (2015)	Good	Outstanding	Good	Good	Requires Improvement	Good
Child and Adolescent Community Teams (2015)	Good	Good	Good	Good	Good	Good
AMH Community teams (2015)	Good	Good	Good	Good	Good	Good
MHSOP Community teams (2015)	Good	Good	Good	Good	Good	Good
Crisis teams and Health Based Places of Safety (2015)	Good	Good	Outstanding	Good	Good	Good
Durham & Darlington Crisis House-Social Care	Good	Good	Good	Outstanding	Good	Good
367 Thornaby Road – LD Social Care	Good	Good	Good	Good	Good	Good

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Tees, Esk and Wear Valleys NHS
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CQC Actions Identified as "Must Do's"

Trustwide	MHSOP Wards
1. To exercise responsibilities under the duty of candour that a notification by given in writing to the person or their representatives or a written record of attempts to contact or speak to the relevant person.	1. Staff must ensure that all care plans are personalised and reflect the involvement of the patient showing that their views and opinions have been taken into account.
2. Ensure compliance with the Department of Health guidance on mixed sex accommodation with the provision of female lounges.	2. Staff must complete mandatory training
AMH Acute and PICU Wards	3. Ensure that all wards are included in the annual audit programme and checks on wards are completed in a timely manner i.e. medication cards etc.
1. All wards must have a suicide prevention environmental survey which is reviewed annually and staff must be aware of ligature risks and blind spots on wards and be able to identify how they mitigate for these.	4. All wards must participate in the annual audit programme when requested to do so.
2. Ensure that relevant staff are up to date with mandatory training in life support for staff that deliver or are involved in rapid tranquilisation, physical restraint and seclusion	5. Ensure that staff monitor and record physical observations following the administration of rapid tranquilisation
3. Ensure that staff monitor and record physical observations following the administration of rapid tranquilisation and that staff are trained in rapid tranquilisation	6. Make improvements to the environment at Cherry Tree House to ensure patient privacy and dignity
4. Ensure that staff recognise when a patient is being secluded in a room other than a seclusion room and that this is recorded appropriately in line with Trust Policy	7. Staff must be trained in the use of the safety summary tool and ensure that risk assessments are updated regularly to reflect current risk
AMH Rehabilitation Wards	8. Ensure that staff are appraised and supervised according to Trust policy and this is adequately recorded
1. To ensure that patients and staff at The Orchards have an alarm call system that can be easily accessed to summon assistance.	9. Clinic rooms must be clean, tidy and allow staff quick access to equipment and medication that is stored correctly and safely.
	10. Ensure regular review of staffing levels to ensure the observation of patients takes place and that staffing levels meet with the level of patient need.
	11. Must ensure that all staff comply with medicines management policies and procedures and that medication administration is documented correctly.
	12. To ensure that patients have a specific plan relating to how they needed support in a crisis in place
	13. All wards must have a suicide prevention environmental survey which is reviewed annually and staff must be aware of ligature risks and blind spots on wards and be able to identify how they mitigate for these.

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NHS Foundation Trust

CQC Actions Identified as "Should Do's"

AMH Acute and PICU Wards
1. Equipment in the resuscitation bags in date and ready to use
2. Staffing establishment levels to comply with national guidance.
3. Ensure staff are trained in the use of the safety summary tool
4. Ensure intervention plans are in place and fully documented to manage identified risks and are individual to each patient.
5. The safety summary tool should reflect the current patient risk.
6. Ensure there is a clear process in place to review blanket restrictions.
7. To maximise the privacy and dignity of patients on Ward 15
8. To control the temperature in the de-escalation room on Cedar Ward, Briary Unit.
AMH Rehabilitation Wards
1. Ensure clinic room temperatures are within acceptable limits
2. Ensure that monitoring of blood collection tubes and blood spillage kits takes place to ensure out of date equipment is replaced
3. Ensure there are no trip hazards in the courtyard at Fulmar Ward
4. Ensure patient care plans at The Orchards are personalised
5. Expired section 17 leave forms on The Orchards should be archived
6. Ensure clear plans are in place to support patients discharge planning and these are documented on patient electronic record

LD Community
1. Ensure fire drills are carried out at the York service
2. Ensure effective systems in place at the York service to allow staff to call for help in the event of an emergency
3. To ensure all patient risk assessments are continually updated
4. Ensure that the York and Selby service meets the excellent practice of other services in relation to patients involvement in their care and taking patients views and opinions into account.
5. Meetings at South Durham service should incorporate all relevant staff
6. Give consideration to running patient activities within all its services
7. All staff at the service are aware of their risk register so that any risks identified can be centrally recorded and managed.

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CQC Actions Identified as "Should Do's"

MHSOP Wards
1. To embed falls procedure on all wards and review wards with high numbers of falls
2. To have a clear review process in place to review blanket restrictions e.g. locked doors
3. Ensure that patients' at Worsley Court have access to snacks and drinks
4. The trust should ensure that staff attach leave risk assessments to leave forms to record that staff have considered risks when they authorise leave
5. Patient belongings to be stored securely at Worsley Court
6. To review of the use of bed bays at Friarage and Rowan (Briary Unit)
7. Attach certificates authorising medication to medication cards of detained patients
8. Ensure female patients at Rowan ward have access to the female only lounge and provide adequate communal facilities for male patients
9. Ensure female only lounge on Wingfield Ward is being used as a female lounge
10. Patients of both sexes able to use the assisted bathroom at Ward 14
11. Where wards have no space available for examination couches, that patients have a choice of areas for examination other than their bedroom
12. Improve the privacy and cleanliness of the visitors' room at Cherry Tree House
13. Ensure that they deep clean equipment at Worsley Court
14. Staff to record all physical health observations on one system where they can be easily located

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Key areas of focus-action plan

- Staffing levels on PICU adjusted in line with national guidance
- Environmental surveys reviewed and updated
- Improved focus and attendance to improve mandatory training trajectories
- Compliance audits-medication management, care-planning, safety planning
- Personalised care-planning-standard work, guidance, review format and training

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Implementation and monitoring of the action plan

- A report outlining outstanding CQC compliance actions is reported to EMT on a monthly basis
- There are currently no outstanding actions
- Annual programme of peer visits. Template includes key areas of focus from CQC compliance and MHA inspection visits
- Quality Compliance group

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NHS Foundation Trust
Thank you
Any questions?
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ITEM NO. 3

FOR GENERAL RELEASE

COUNCIL OF GOVERNORS

DATE:	**30 November 2017**
TITLE:	**Public Action Log**
REPORT OF:	**Phil Bellas, Trust Secretary**
REPORT FOR:	**Assurance**

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

Executive Summary:

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

Recommendations:

The Council of Governors is asked to received and note this report

Council of Governors Action Log

Item 3

RAG Ratings:

	Action completed/Approval of documentation
	Action due/Matter due for consideration at the meeting.
	Action outstanding but no timescale set by the Council.
	Action outstanding and the timescale set by the Council having passed.
	Action superseded
	Date for completion of action not yet reached

Date	Minute No.	Action	Owner(s)	Timescale	Status
29/09/2016	16/56	To provide an update on the impact of the removal of student nurse bursaries.	Elizabeth Moody	November 17	
17/11/2016	16/82	To provide an update on the use of PARIS and impact on staff time and patient care.	Brent Kilmurray	November 17	
23/02/2017	17/07	To arrange for the presentation of the annual report on patient safety to a governor development day following consideration by QUAC.	Jennifer illingworth	October 2017	Completed - briefing held at Governor Development Day 25/10/17
25/05/2017	17/25	To circulate the outcome of the PLACE inspections to Governors, service users and carers involved in the process.	Brent Kilmurray	~~October 2017~~ February 2018	Report will not be considered by EMT until December 2017
28/09/2017	17/69	To include an agenda item for the November 2017 Council meeting for the appointment to the Mental Health Legislation Committee	Kathryn Ord	November 2017	

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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Ref: BK/KA
21 November 2017

To: Council of Governors

Dear Colleagues

Further to discussion at the Council of Governors meeting on 17 November 2016, I am writing to give you further information with regard to the work being done to reduce the time taken in clinical record keeping on PARIS.

The attached note provides an update on the work being done to date and sets out some of the potential benefits we hope to see through a service wide implementation of work piloted in older people's services on Teesside.

I'd be happy to take any further queries or questions when we meet.

Yours sincerely

Brent Kilmurray
Chief Operating Officer & Deputy Chief Executive

Question

To provide an updated on the use of PARIS and the impact on staff time and patient care.

Reply

The issue of record keeping and its impact on staff time to deliver care has been an issue ever since clinical staff have had a requirement to record patient information. This was as relevant an issue in the days of written care notes and has continued into the current era of electronic patient records. The primary aim of we are striving to deliver is to ensure that the admin burden of the process (i.e. non value added activity) is minimised and that clinical interaction is maximised (value added time) and that the clinical record complies with Trust and Professional standards. In order to deliver this the Trust has undertaken extensive work in the last 12-18 months in order to understand the impact of clinical record keeping on staff time. This has been undertaken as a core element of the Purposeful and Productive Community Services (PPCS) programme, and has been led by the IT work stream.

This work has involved extensive observations of clinical practice in relation to record keeping, with the initial focus being on the initial assessment elements of the clinical pathway in MHSOP services.

This work was developed using the Quality Improvement System (QIS) methodology and tools.

It considered, a range of issues such as:

- Clinical staff recording practices
- What clinical information was recorded
- How clinical activity was recorded in PARIS.
- What if any change is required in PARIS to support practice.

What the work identified was:

- Clinicians had significant interruptions to their clinical recording.
- That clinical record keeping included extensive duplication of information due to clinical practices.
- There was wide variation in clinical recording on PARIS.

As a result, changes were made that included standard work for recording PARIS information. It also identified that recording of the clinical record with the service user present resulted in a reduction in PARIS recording time with no effect on the quality of the records. This was tested for 90 days and implemented across Teesside MHSOP services. This work has resulted in significant reduction in clinical time spent inputting clinical information into PARIS. The level of improvement to date

across the MHSOP teams in Teesside has been a reduction of PARIS inputting time of between 30% to 52%

As a result of this initial piece of work, the IT work stream are now planning the next phase of work which will roll out over the coming months across the Trust for all MHSOP services for initial assessments. The work will be further extended to include all specialities and pathways across all localities and will also encompass the key clinical areas of work that generate the most PARIS recording activity i.e.:

- Initial assessment.
- Review/treatment appointments.
- CPA reviews.

In order to support the work of clinical staff, a range of further technology improvements are planned, these include:

- The availability or all clinicians to undertake routine working via access to appropriate devices such as Laptops; Smart Phones where required.
- Access to video conferencing clinical and business use.
- Improvements to the system infrastructure to speed up systems (PARIS included).
- Introduction of e-referrals, e-discharge and e-communications that will reduce clinical staff time using PARIS.

ITEM NO 7

FOR GENERAL RELEASE

COUNCIL OF GOVERNORS

DATE:	**30 November 2017**
TITLE:	**Board round-up**
REPORT OF:	**Phil Bellas**
REPORT FOR:	**Assurance/Information**

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

Executive Summary:

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

Recommendations:

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

MEETING OF:	**COUNCIL OF GOVERNORS**
DATE:	**30 November 2017**
TITLE:	**Board round-up**

1. INTRODUCTION & PURPOSE:

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

2. BACKGROUND INFORMATION AND CONTEXT:

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

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

3. KEY ISSUES:

3.1 Copies of the Board round-ups for the meetings held during September and October 2017 are attached to this report.

4. IMPLICATIONS:

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

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

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

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

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

5. CONCLUSIONS:

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

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

6. RECOMMENDATIONS:

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

Phil Bellas,
Trust Secretary

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

Feedback from Board of Directors meeting held 26 September 2017

Chairman's report
The Chairman reported that she had officially opened Reed Marsh House (a community team base for older people in Redcar). She noted that the event had been well attended and guests included the Mayor of Redcar and Cleveland along with the chairman of the council's health and wellbeing board.

Quality assurance committee (QuAC)
The board received and noted the QuAC report. They approved the recommendation to submit the self-assessments against the standards of the Triangle of Care to the Carers Trust and to support the implementation of the Triangle of Care across other areas of the Trust.

Nurse staffing report
The Board received and discussed the monthly report. Key issues discussed were:

- reporting of the lack of a registered nurse on duty - this had been escalated, according to the procedure, but not reported on Datix (it was noted that the incident was currently being investigated)
- the establishment of a duty nurse coordinator – the Board welcomed this new post and hoped that it would have a positive impact on registered nurse cover and lead to a reduction in missed breaks
- the newly qualified nurses due to start at TEWV in September and October 2017 - how we would make sure they had a positive experience of working for the Trust, including bespoke preceptorship programmes
- Newberry ward – there was a discussion about the support the Trust is providing for staff on this ward who were caring for a number of young people with very complex needs.

Learning from deaths policy
The Board discussed the draft policy which had been approved by EMT. They noted that the policy had been developed in collaboration with eight other mental health trusts and that it was likely to evolve further (eg in response to further guidance and/or to reflect the needs of the Trust). The Board ratified the policy (which would be published on the Trust's website), subject to an equality analysis screening.

Mental health legislation committee
The Board received and noted this report.

Nursing strategy – 2017-2020
The Board members were impressed with the draft nursing strategy. They felt it was comprehensive and patient focussed. They also welcomed the use of technology as a decision making tool. They approved the strategy.

Compliance with core standards for emergency preparedness, resilience and response
The Board approved the self assessment and statement of compliance for submission to NHS England.

Finance report
The Board received the finance report as of 31 August 2017 and noted that the Trust was ahead of plan. Drew Kendall also advised the Board that discussions were ongoing at EMT about the phasing of the CRES programme and that a detailed report on the Trust's CRES position and plans would be presented to the Board at the end of October.

Performance
The Board received and discussed the performance dashboard report.
There was a discussion about sickness levels across the Trust and David Levy noted that the Trust was struggling to consistently achieve its target for sickness absence. He also said there had been a significant increase in numbers of referrals to the Trust's health and wellbeing support services and that a comprehensive review of our approach to staff and health and wellbeing would be worthwhile.

The Board also received and discussed the strategic direction performance report which included changes to the Trust business plan along with revised metrics, which were approved.

Membership of committees
The Board agreed the proposed appointment of non-executive directors to Board Committees. They also agreed that, following Jim Tucker's retirement from the Board, a recommendation should be made to the council of governors' nomination and remuneration committee to appoint Hugh Griffiths as deputy chairman of the Trust.

Feedback from Board of Directors meeting held 31 October 2017

Chairman's report
Lesley reported that, with the exception of forensic services she had now completed her visits to locality senior management teams. She said the meetings had been very interesting and had given her the opportunity to talk to management teams about the issues they're facing. She said there were some consistent messages about CRES and the resulting pressures. However, she noted that staff had been very positive, were showing resilience and were proud of what they were doing. The chairman also fed back about the recent long service awards, which she said had been inspiring as well the recent governor development day which had been well attended.

Briefing on York and Selby
Ruth Hill, director of operations for York and Selby gave an update on what's happening across the locality. Some of the key topics of her presentation were:

- The significant improvements that have been made to the quality of our estate including the opening of Peppermill Court and the new community hubs that were bringing teams together under one roof and improving communications
- Some of the pressures facing the Trust and the wider health and social care system including challenges in reducing waiting times and recruitment issues

When asked about her biggest worry or challenge Ruth said it was about managing money and maintaining safety.

The Board recognised the significant progress which had been made in the relatively short period of time since the Trust had become responsible for the provision of services in the locality and passed on their thanks to the teams.

Guardian of safe working
The Board received and discussed the quarterly report presented by Julian Whaley. This included a discussion about taxi firms and the potential risk to staff and governors (following an alleged incident between a doctor and a taxi driver). The Board asked for a report on the Trust's taxi contracts including the incidence of alleged inappropriate behaviour by taxi drivers and the measures in place to protect vulnerable people.
The Board also discussed the level of junior doctor vacancies and the risk to the Trust in managing rotas. Dr Land assured the Board that action was been taken to mitigate the risks.

Freedom to speak up guardian
The Board received the report from Dewey Williams, the Trust's freedom to speak up guardian. Colin Martin thanked Dewey for his commitment and noted that it had been a positive first year which had clearly demonstrated the benefits of the role.

Quality Assurance Committee
The Board received and noted this report

Nurse staffing report
The Board received the monthly report

Temporary staffing service
The Board received and noted the annual report. There was a discussion about mandatory training levels among bank staff which led to a discussion about the use of the pay penalty for those staff not compliant with mandatory training requirements. The chairman considered that the pay penalty should be applied consistently and robustly.

Mental health legislation committee
Richard Simpson, chairman of the committee, reported that concerns about the interpretation and application of Deprivation of Liberty Safeguards (DOLS) by local authorities had been discussed at the meeting in October. The Board had a further discussion about this and the risks for TEWV and noted that a letter was being drafted that would provide guidance on the correct interpretation of the legislation. The Chairman asked for a further report to be provided to the Board once the local authorities had responded to the solicitors' letter.

Finance
Drew Kendall presented the finance report and the Trust's quarter 2 submission to NHS Improvement (which the Board approved).

Performance
The Board received and discussed the dashboard report. A main focus of their discussions was the issues relating to IAPT recovery indicator and it was agreed that the Board would receive a further report in January 2018 to include actions being taken to improve performance against the IAPT recovery indicator.

Medical education annual report
The Board received and noted this report.

Single oversight framework
The Board received the report for quarter 2 17/18. They noted that the quarterly review meeting in October with NHS Improvement had been very complimentary about the Trust's open and transparent approach.

ITEM NO. 9

FOR GENERAL RELEASE

COUNCIL OF GOVERNORS
PUBLIC AGENDA

DATE:	**30 November 2017**
TITLE:	**To assure the Council of Governors on the position of compliance with the Care Quality Commission registration requirements**
REPORT OF:	**Elizabeth Moody, Director of Nursing and Governance**
REPORT FOR:	**Information**

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

Executive Summary:

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

- **Ofsted Registration – Holly Ward took place 13th of October 2017**
- **CQC Mental Health Act Inspections – a total of 7 MHA Review inspections to wards have taken place across the Trust since the last report**
- **Quality Compliance Group – a summary of discussions from the meeting held in September 2017 is included within this report (section 2.3)**
- **Peer Review Programme – commenced July 2017**
- **CQC Engagement meetings – a summary of discussions from the meeting held 27th September 2017 is included within this report (section 2.6)**

Recommendations:

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

MEETING OF:	**COUNCIL OF GOVERNORS**
DATE:	**30 November 2017**
TITLE:	**To assure the Council of Governors on the position of compliance with Care Quality Commission registration requirements.**

1. INTRODUCTION & PURPOSE

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

2. KEY ISSUES:

2.1 Ofsted Registration – Holly and Baysdale

Ofsted registration has now been approved for Holly and Baysdale Units. The Units are registered as a social care based children's home residence. Under Regulation 44 the Trust will conduct monthly review inspections which commenced in September 2017.

The most recent review inspection was undertaken by representatives from the Nursing and Governance Directorate on the 13th of October 2017.

Overall findings from the visit concluded that Holly Unit is a very well run and well led unit for children and young people with special needs. It is very patient focussed and works in collaboration with parents.

2.2 CQC Mental Health Act Inspections

There have been 7 unannounced MHA inspections since the last report to the Council of Governors:

Ward	Date of inspection
Farnham Ward (D&D, AMH)	31st August 2017
Ebor (Y&S, AMH)	15th September 2017
Bedale PICU (Tees, AMH)	10th September 2017
Danby Ward (NY, AMH)	19th September 2017
Acomb Garth (Y&S, MHSOP)	1st October 2017
Westerdale North (Tees, MHSOP)	9th October 2017
Willow Ward (D&D, AMH	14th October 2017

2.3 Quality Compliance Group

Since the publication of the previous report, the Quality Compliance Group has met on one occasion (September 2017). The meetings continue to be well attended by Senior Managers from across the Trust. The main focus of the group is to ensure delivery of the CQC action plan and to share learning from CQC visits and internal peer review inspections across the Trust.

Discussion and review took place of the overarching CQC compliance action plan to secure and ensure progress updates from localities and specialities.

The group focused on planned improvements with respect to CPA and Care Planning Principles.
Findings and themes from the Mental Health Act reports received in August and September were reviewed and discussion took place regarding remedial actions.

Further planning and discussion took place around the Peer Review Programme which commenced in July 2017. Findings and themes from the Peer Review visits took place and actions to address issues raised were discussed. Full details are provided in the section below.

2.4 Peer Review Programme

The peer review programme (previously known as CQC mock inspections) commenced in July 2017 with a schedule of inspections that cover all Directorates and Specialties across the Trust. The inspection teams are made up of clinical staff, representatives from Nursing and Governance and where possible a member of the Fundamental Standards Group. The inspection team use a standard peer review tool and records tool which has been collaboratively developed based on issues previously raised during CQC compliance inspections, MHA Review visits and any pertinent issues which are arising nationally.

An information pack is provided by the Compliance Team which replicates the intelligence information that CQC may have gathered. An overview report will be provided to reviewed wards/teams as part of the peer review visit to include; good practice, key issues and actions. To ensure continued Trust wide learning takes place, good practice and issues identified from these visits are cascaded through locality governance groups and discussed at the Quality Compliance Group meetings.

2.5 Fundamental Standards Group

The Fundamental Standards Group met on 01 September 2017. The Mental Health Act Policy and Training Manager attended to present and discuss the Deprivation of Liberty Safeguards (DoLS) and the group shared and discussed personal scenarios surrounding this.

A Clinical Audit Facilitator from the Trust Clinical Audit and Effectiveness Team attended to discuss national audit findings from audits that have taken place during the past year:

- An overview of the prescribing valproate for Bipolar Disorder was presented to the group and discussed the areas where the Trust had performed well and those areas where improvements were required.
- The results of the audit of Monitoring of Patients Prescribed Lithium were shared and discussed

The Peer Review Programme was shared and the group expressed an interest in offering their expertise and involvement in the inspection visits.

2.6 CQC Engagement Meetings

Senior staff from Nursing and Governance and CQC met on 27 September 2017. Key points of discussion are detailed below:

- Update on the Trust-wide action plan following the compliance inspections and well-led review. Agreement to realign action plan metric with current Trust workstream regarding harm minimisation training being 90% complete by the end of March 2018 (Trustwide action plan indicated 95% by end September 2017).

- The Insight (CQC online intelligence portal) is due to go live immanently with staggered roll out to providers. The aim is to ensure intelligence monitoring is more sophisticated to reduce the burden on information requests from Trusts by using Trust data already obtained via other sources. At this point Trusts will have the capability to view their own dashboard and submit updated information.

- The new phase of regulation has now commenced. Trusts that have been inspected to date have provided positive feedback on the new process.
  For a well-led announced inspection, a PIR (Provider Information Request) will be issued requesting specific data with a 12 weeks submission deadline. Within this period Trusts should expect unannounced core services inspections. Community services are likely to receive a day's notice to ensure that staff are available during inspection.

- The CQC Lead Inspector and Relationship Owner attended Trust Board and reported back positively on the experience.

- An update was provided around planned ward changes following works required at Roseberry Park Hospital and consequent changes to the Statement of Purpose.

- A review of specific updates on safeguarding, serious incidents' and individual placements took place.

3. IMPLICATIONS:

3.1 **Compliance with the CQC Fundamental Standards:** Provision of safe and effective high quality services is a strategic priority for the Trust and the Fundamental Standards of Quality and Safety that underpin CQC registration support and facilitate those quality services. Ongoing full registration reinforces the position of the Trust in

maintaining high quality service delivery – any loss of registration has significant implications for the reputation of the Trust as a quality provider.

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

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

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

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

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

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

Jennifer Illingworth
Director of Quality Governance

ITEM NO. 10

FOR GENERAL RELEASE

COUNCIL OF GOVERNORS

DATE:	**30 November 2017**
TITLE:	**Service Changes Report**
REPORT OF:	**Brent Kilmurray, Chief Operating Officer**
REPORT FOR:	**Information**

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

Executive Summary:

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

Recommendations:

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

MEETING OF:	**Council of Governors**
DATE:	**30 November 2017**
TITLE:	**Service Changes Report**

1. INTRODUCTION & PURPOSE:

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

2. BACKGROUND INFORMATION AND CONTEXT:

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

3. KEY ISSUES:

3.1 Durham and Darlington

Adult Mental Health and Substance Misuse

Acute Services

The single sex wards at West Park Hospital are now embedded and working well, with particularly positive impact being seen on the female ward where lengths of stay have drastically reduced. Work is almost complete for the seclusion facilities on Cedar Ward and staff training is progressing well. An excellent local artist will be working with us over the coming months to incorporate the artwork produced by staff and service users into the building.

Our Street Triage Service has been operational since the start of September, with the final staff due to come into post in December. We have been able to provide at least 2 practitioners within the force control room, working from 2pm until 12am, with an increasing amount of face to face triages being undertaken as the staffing complement increases. Feedback from police and other stakeholders has been overwhelmingly positive. Next steps for the team will include increasing integration with stations in Darlington and Durham (eg Bishop Auckland and Spennymoor).

Purposeful and Productive Community Services

We have had two sets of leadership sessions with community teams since the last update, which have demonstrated real benefits and progress in realising the benefits of PPCS phase 1 and have been invaluable at helping us share practice across teams. These will be crucial in providing wider support to the phase 2 pilot teams.

Drug and Alcohol Services

Unfortunately we were unsuccessful in the re-tender exercise for drug and alcohol services in County Durham despite a very strong bid being submitted in partnership with Changing Lives. We will now be focusing on supporting

staff and clients through this transition period in anticipation of the new provider being in place by 1st February 2018.

Mental Health Services for Older People

Purposeful and Productive Community Services (PPCS)

Durham and Chester-Le-Street community team is one of the Trust 12 pilot teams for the Purposeful and Productive Community Services (PPCS) refresh. As part of this work over the next 6 months, we will be reviewing our clinical pathways, workforce, team roles, use of information technology and ensuring that all quality improvement work to date is fully embedded. We are seeking new ways to work with and involve service users and carers in developing a new model of service.

Admissions to Organic wards

August and September saw an increase in organic admissions across the Trust and we had a number of patients from out of Durham and Darlington locality admitted to our wards. We managed to maintain admissions within our locality, though needed to accommodate some organic patients on Oak ward at West Park Hospital. The ward staff worked hard to ensure the needs of patients were met safely and liaised with the organic inpatient teams via the daily lean management call, which includes ward managers, matron and senior managers from the locality.

Purposeful In-Patient Admissions (PIPA)

We participated in the Trust-wide MHSOP Purposeful In-Patient Admissions (PIPA) refresh RPIW in June 2017 and Hamsterley, our female organic ward, is a pilot for this. The 60 day report out in September highlighted areas for further improvement and the ward team continued implementing the process despite the rise in admissions and high level of patient observations during August and September.

Patient and carer experience

We continue to consider the feedback provided from the Meridian system at QuAG and in order to gain more narrative information to help us understand why patients and carers rate us in a particular way we developed our own Team Objective, to seek constructive feedback from patients and carers in a more robust way. Each of our teams had a target number of patients/carers to have a conversation with and the two questions asked were:

- What did we do well?
- What could we do better?

We received 383 completed feedbacks and 381 of these gave positive feedback on what we do well. There were 111 comments about things that could be improved and we will use this to inform our future quality improvement plan. A large number of comments were around the desire for more ‘face to face’ contacts and more frequent daily visits, extended treatments and groups.

Falls and Frailty

The revised, combined Falls and Frailty Clinical Link Pathway (CLiP) pilot has been extended and we continue to achieve compliance of 100% of assessments completed within 6 hours of admission. We have started to roll the CLiP out in community services.

Reducing the time between referral and diagnosis of dementia

Our Commissioners have agreed to help resolve the issues regarding delays in CT and MRI head scans, as patients still experience significant problems and we have been unable to make improvements to this during the RPIW held in May, or in previous work with the County Durham & Darlington NHS Foundation Trust Radiology team. Patients and carers have asked us to resolve this and believe that they are receiving a poor service. Most recently patients are being sent appointments to hospitals not of their choice and some receive appointments in the evenings or at weekends when transport becomes a problem. These problems combine to cause lengthy delays from referral to diagnosis for people with dementia in Durham and Darlington.

Children and Young People's Services

The service continues to sustain waiting time targets for CAMHS, with young people being seen within 4 weeks of referral and offered a second appointment within 9 weeks of referral.

The service is holding an RPIW week commencing 6th November 2017 to consider the "THRIVE" model. The "THRIVE" model has been advocated by NHS England and included in our local transformation plans with commissioners. This model focuses on the wider children's workforce to implement early help and prevention strategies. Within CAMHS we will need to look at how our services fit into the model with the focus on removing tiers. The RPIW will focus on removal of the tiers with young people accessing the right pathway and intervention. The model should reduce "hand offs" between Tier 2 and Tier 3 services, reducing reassessment and supporting timely interventions. We will report the findings in future updates.

The service's main concern is around the continuing increased wait for an Autism assessment, with the longest being two years in North Durham. As you recall the service used non-recurrent funding to make a significant impact on these waits however since this ended the waiting times have continued to increase. This is linked to an increase in demand, no increase in capacity and TEWV CAMHS not operationally managing the whole of the pathway. The service is working closely with Clinical Commissioning Groups (CCGs) to seek further investment. A paper was submitted to support both recurrent and non-recurrent funding in October however we have not yet had confirmation from CCG on their commissioning intentions. Locally the CCG and Local Authority are carrying out a strategic review of both the assessment and post diagnostic provision for Autism Spectrum Disorder (ASD); we are involved in this review. The CCG have also proposed to hold a kaizen event in December to review the interface between the Multi Agency Autism Team (MAAT). The Board has requested further detail on this for its December meeting.

The locality continues to support a single occupancy placement in Bankfields Court. We had expected the care to be transferred to Positive Individual Proactive Support (PIPS). However this has been delayed as we wait for PIPs to complete their OFSTED registration. This is currently being processed by OFSTED and we expect this transition to take place in January 2018. The impact of this continues to place additional stress on staffing levels across Durham and Darlington CAMHS relying on Crisis/Liaison, Holly and Community Teams to support.

Learning Disability Service

The key priority in Learning Disability Services remains the Transforming Care Agenda and the plans to reduce beds alongside the development of an enhanced community service. Durham & Darlington need to reduce from eleven to six beds by the end of March 2018 and this is something that we have been working towards over the last year. A paper outlining a range of options for the reduction in Adult Learning Disability beds was presented to LMGB in October and a final preferred model has been identified. The development of Purposeful In-patient Admission processes and an enhanced community service model have enabled this to be achieved safely and for local people to still receive the support they need when they're in crisis without the need for a hospital admission and where an admission to hospital is required, this should be for the shortest possible time.

As mentioned previously the Transforming Care plans also include the development of an Adult Learning Disability and Forensic Learning Disability 'hub' in the Lanchester Road Hospital. Plans for this have been approved by EMT and work is due to start next month on Talbot. It is envisaged that the hub will be operational from April 2018.

The Enhanced Community Service model is progressing well though still not fully operational due to recruitment difficulties. There are plans in place to address this. The crisis function of this service is currently working out of Lanchester Road Hospital with in patient and community based staff working together to maintain people in the community and prevent placement breakdown that would result in a person being admitted to hospital.

Positive Behavioural Support (PBS) is seen as a key enabler for better community support and this is well embedded in practice. The PBS pathway is currently being reviewed and updated to ensure it is aligned with the Regional TCP workforce plan and can support individuals and other providers in the locality.

The eleventh annual Learning Disability Conference entitled 'The Bigger Voice' was held at the Xcel Centre, Newton Aycliffe on Tuesday 17th October. The focus this year was on advocacy and enabling people with a learning disability to have a stronger voice. It was a vibrant and energising event with over 200 people in attendance. Feedback from delegates was very positive and overall the day was a huge success.

3.2 Tees

Adult Mental Health and Substance Misuse

Following the announcement about the need to undertake work at Roseberry Park Hospital there have been some changes to bed configuration on Tees to enable a decant to be started. Patients have been moved from Lincoln Ward in Hartlepool to allow older people's services to decant into Hartlepool as mentioned below.

Although there can be pressures on beds for either women or men and uneven requirements for admission, so far this has been managed and recently there have been both vacant beds and useable leave beds. Delayed discharges are the biggest risk and so bed use is being monitored closely at the moment.

The development of the rehabilitation plans of Tees are being progressed and a positive meeting has taken place with 13 Housing to look at the possible ways of supporting people in tenancies.

Mental Health Services for Older People

Nursing home places for older people with challenging behaviour continues to be our greatest problem and a risk to managing the beds in Tees. The inpatient services will move to Sandwell Park in early December and functional beds will require tight management.

A recent peer review of the acute care system in South Tess highlighted the positive impact of the liaison services. This was described by both the staff at James Cook and by the reviewers.

There have been really positive projects, as part of PPCS, looking at the time to input assessments onto PARIS and in particular to enter information whilst with the patient and their family members. This has saved a lot of time and not had any negative impacts.

Children and Young People's Services

The New Models of Care pilot for inpatient CYPS, led by Tees locality, has continued to show positive results in terms of reduced distance from home to inpatient unit for young people needing a bed, reduced length of stay and reduced number of people occupying a bed at the end of the first six months. Financially the model is ahead of target too.

H&ST CCG are considering our proposals to meet the continuing rising demand in CYP community services but have not responded to our detailed paper, after supplementary information was requested and provided. H&ST have also not published their plan for meeting the requirements of 'Future in Mind' at the end of October.

Increasing the use of Routine Outcome measures (ROMs) remains a priority and there will be an RPIW in January to accelerate progress.

Learning Disability Service
The difficulties for providers in the community and our teams are spending more time assisting with CQC identified quality issues with other providers.

The PIPS unit at The Dales should be able to take the first patient in December, the opening will be this month. There are six patients who will be cared for in packages provided by PIPS, from the original Winterbourne cohort.

3.3 North Yorkshire

Adult Mental Health and Substance Misuse
Following the closure of the Hambleton and Richmondshire transforming mental health services consultation, the CCG's Governing Body met in October and voted to progress option two. This proposal included the closure of Ward 14 and 15 at the Friarage Hospital Northallerton and inpatient provision being moved to West Park Hospital Darlington and Roseberry Park Hospital Middlesbrough. It also outlined a programme to enhance community based services in the locality.

EMT is supporting NY AMH proposal to restructure teams in the community. This will be managed through the Purposeful and Productive Community Services (PPCS) working group. The planned structure change is not due to go live until quarter one 2018.

Work continues with Kaizen Promotion Office (KPO) support to embed the principles of PPCS to the wider community teams including crisis and primary care. The new NY AMH community pathway is being rolled out across NY as part of PPCS phase two. In addition, this work is being supported by a locality wide focus on QIS for Leaders training.

The North Yorkshire IAPT Service has now received two Intensive Support Team reports from NHS Improvement. Discussions are taking place with North Yorkshire Commissioners to identify how the future access standard aspirations outlined in the Five Year Forward View are to be realised.

Mental Health Services for Older People
Scarborough Whitby Ryedale has welcomed individuals into critical posts including Physical Healthcare Nurse Practitioner to support our inpatient wards, a Clinical Psychologist and Consultant Psychologist. We are also reviewing how we work as part of the Purposeful and Productive Community Services (PPCS) refresh and developing an options appraisal about how community teams will work to improve our productivity and efficiency to meet the demand for the memory service.

As part of the wider transformation agenda in Harrogate, the Trust continues to play a critical part in the New Care Model programme which officially ends March 2018. In October the Service received a highly commended award as

part of the National Positive Practice in Mental Health Awards. Conversations as to what learning can be taken forward into 2018/19 is under way and will complement the discussion about how mental health services should be delivered across Harrogate and Rural for older people with a mental health need.

Harrogate Community Services are re-evaluating their approach to managing people in care homes and have also recently volunteered to be a pilot site for the PPCS re-fresh. This will assist with looking at how a community team should be modelled against capacity, demand and skill mix.

The Memory services continue to be proactive with addressing the increasing demand. The biggest challenge is the access to clinic space and a medic or advanced nurse practitioner who can diagnose. A robust recovery plan is in place over a 6 month period and monitored frequently for slippage.

The public consultation in Hambleton and Richmondshire is now also complete with the outcome being announced on 26th October 2017 by the CCG to provide inpatient services for residents of this area in West Park and Roseberry Park for functional patients and Auckland Park for organic patients. We continue to work in partnership with staff, service users and carers to refine the enhanced community model in preparation for implementation in 2018/2019.

Children and Young People's Services

In 2016 North Yorkshire County Council's Children and Young People's Service was designated as a DfE Partner in Practice (PiP) (one of eight Local Authorities nationally). This designation means the Local Authority will support and work alongside other authorities to share best practice and, as a result, develop more sustainable high performance in children's social care across the country.

As part of this initiative there has been an extension to the methodology behind the Children's Social Care Innovation Programme No Wrong Door project to the government's priority areas of care leavers and children and young people with mental health issues in residential schools and pupil referral units. North Yorkshire CAMHs are working in partnership with the Local Authority to provide clinical psychologist into the current and planned No Wrong Door project. This methodology has seen an increase in adolescents remaining at home through the successful out-of-care support, with a reduction in crisis presentations and young people being remanded into custody.

Referrals to community teams continue to rise. Further work is currently being undertaken to considering our proposals to meet the continuing rising demand.

Learning Disability Service

NYLD are currently building relationships with Coventry University through workshop sessions as part of the protected learning time for Practices Nurses

around Health Checks and Health Action Planning. This includes role play sessions by people who use our service providing a powerful insight into how a positive experience of having a GP Health Checks can feel, and the impact a poor experience can have on the individual. It's important both for networking with Coventry as a provider of future nurse education but also to raise awareness directly about the importance of health checks given the national rate for screening remains low for people with learning disabilities.

We have recruited existing staff into the Positive Behaviour Support (PBS) champion roles, one for each team which will critically support the work undertaken by the Community Crisis Intervention Specialist pilot through the NY TCP. In addition to this we have managed to access accredited training on Active Support - a train the trainer programme which the PBS champions will access in the New Year to further develop their knowledge and skills regarding PBS strategies. We've also offered places to colleagues in Y&S LD.

Greenlight – we have been invited to join colleagues from Y&S as part of the bed re-configuration planning and discussions in York, in particular about developing super greenlight options and increasing the admission rate into AMH under Greenlight and what this could mean for people requiring admission within NYLD.

3.4 York and Selby

Adult Mental Health and Substance Misuse
Peppermill Court inpatient services have now been open over a year. Continued evidence of a reduction in out of locality admissions, reduction in number of incidents of violence and aggression and reduced length of stay following the successful implementation of Purposeful Inpatient Admission (PIPA).

Ongoing challenges related to the demand on Access & Wellbeing service, significant reduction in 'waiters' related to management restructure and refining the clinical model to identify role specific interventions. There is current evidence of improved performance including meeting the 28 day target following the above changes. The team is due to complete an RPIW week commencing 13th November to further refine processes.

Improving Access to Psychological Therapies (IAPT) – A diagnostic review was undertaken by NHS England Intensive Support Team (IST) (Feb 2017). This has resulted in ongoing support from the IST and the development of an action plan formulated in conjunction with IST & CCG colleagues. The service has developed and implemented a new pathway with oversight from the IST. Ongoing challenges locally and nationally related to recruitment and retention.

Assertive Outreach, Early Intervention Psychosis, Community Mental Teams, Access & Wellbeing, and IAPT teams have all successfully moved into Huntington House.

The two adult CMHTs (Community Mental Health Teams) have been selected as part of the twelve teams Trust-wide to lead on the PPCS refresh and attended the recent Trust-wide launch event.

Mental Health Services for Older People
Male dementia bed availability remains the principal challenge to MHSOP services with 100% occupancy over the past 3 months. There is an increasing number of delayed transfers of care within this occupancy and the management of this position has been reviewed resulting in an invigorated approach to discharge planning. The report out system has been reviewed in line with this approach and discharge dates have been identified for all patients.

The Out Of Locality position has been affected by our high occupancy levels both in male dementia and in functional illness. Close monitoring of this situation is in place via a daily sit-rep call and patients are repatriated to York-based services at the earliest opportunity.

The Huntington House community hub is now fully operational bringing together the North East CMHT, Memory and Care Homes and Dementia teams into one base to the north of the city.

The Adult Liaison team based at York District Hospital has been enhanced by the CORE 24 funding secured via NHS England. The recruitment process has been successful and we will have a fully established team in place by November 2017. Links with the MHALT team are being strengthened in line with the CORE 24 work.

The Memory service has worked hard to reduce the number of people waiting for assessment and is on track to deliver a successful outcome to the waiting list initiative by the end of November 2017. Following an Intensive Support Team (IST) visit by NHS England, the memory service has begun to implement a series of changes to improve the patient experience and to enhance performance. This work is being shared on a collaborative basis with GP practices and the CCG.

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

The implementation of the Purposeful and Productive Community Services (PPCS) phase one products across all community teams is progressing well and is reflected in the dashboard. The next phase (Phase 2) of PPCS is now being implemented across all teams.

Work has commenced to transfer existing services managed under the Humber contract back to TEWV. The transfer date has been agreed as 01 February 2018.

Children and Young People's Services

The Single Point of Access Service continues to function well and is managing all new referrals to the service in a timely fashion, 92% receiving contact within 4 weeks in October and 82% receiving their second contact within 9 weeks. As predicted there has been the seasonal peak of referrals in October/November. The SPA has been staffed to accommodate this but inevitably the increase in referrals has also led to a higher demand for Initial Comprehensive Assessment slots. Staff have therefore been focussing resource on the front end of the service. Following the SPA review, staff job plans have been adjusted to ensure a smaller core number of staff work in the SPA, improving consistency of practice and processes. It has also led to highly motivated staff working in parts of the service they feel committed to.

Progress against waiting times for the intervention arm of the service continues to be a challenge. The service is looking at how to maximise the resources available, for example increasing the range of groups offered, in order to deliver interventions in a group setting rather than on an individual basis but as mentioned previously focussing on the front end of the service inevitably leads to longer waiting times for interventions.

As reported previously, the CCG are concerned about the level of reporting in relation to waiting times for secondary/intervention waits. The Trust and the commissioners have now reached an agreement, whereby service held intelligence will be reported on, on a monthly basis. The Trust has agreed to this with clear guidance that the data is not validated or has been subjected to the same degree of rigour as corporately produced data.

The York and Selby Crisis and Home Treatment team officially launched on 1st September 2017.Operating hours are between 10 am to 10pm in the first phase of this development. This will be extended as more funding is released either from a CCG led Crisis bid or the New Models of Care (NMOC) pilot.

Work has commenced to transfer existing services managed under the Humber contract back to TEWV. The transfer date has been agreed as 01 February 2018.

Learning Disability Service

Greenlight training continues to be delivered in Adult Mental Health Services with further sessions booked. People with learning disabilities now have access to the Crisis team, liaison, home based treatment and street triage as required.

The Core LD pathway is under review as part of the Purposeful and Productive Community Services (PPCS) refresh. The LD Community Team is part of the twelve teams Trust-wide to lead on the PPCS refresh and attended the recent Trust-wide launch event.

There are now physical health check clinics for people on antipsychotic medication

Transforming Care is moving slowly forward. The inpatient provision is under review and the future model is being considered as a both part of a Trust-wide provision and local need. There is a proposal for an enhanced community team model that includes an improved behavioural support team and transition post. This will be presented to the local Transforming Care board at the end of December.

There is Trust wide pressure on LD beds as transforming care is implemented. Oak Rise is experiencing high acuity, which in turn creates an increased work load for the community team.

3.5 Forensic Services

Estate/Security Issues
The Forensic service commissioned a review of the access and egress procedures at Ridgeway Reception and an investigation into the circumstances surrounding a potential key compromise at Ridgeway, Roseberry Park hospital, January 2017 with the final report discussed at LMGB April 17.

The recommendations of the report have been considered and a security action plan developed. The plan is now incorporated and monitored within the Forensic LMGB and bi-monthly updates provided by the Forensic Security Manager to LMGB.

Over the previous three months the following areas have been developed:

- Works Co-ordinator has been appointed and commenced duty July 17. This is progressing well
- Process commenced to collate all small works requests in an effort to centrally record all requests and track timescales within Ridgeway.
- We have used our annual table top exercise to test out a ward based fire scenario (October 2017) and the fire service have carried out a semi live evacuation of 1 of our empty wards using our staff as patients and dressed in full breathing apparatus kit (October 2017). Plans are being formulated to do a further test in early 2018.
- The key tracker system was installed in August 2017 but has been held up in testing and ultimate usage due to software issues. The Trust and Key Tracker are working on the issues to resolve the situation. Key Tracker engineers are attending ridgeway on 4th December to rectify the issues. Once the issues have been resolved a new go live date will be identified, finger prints will be collated and the security briefing issued to all staff

Model Ward

The Model Ward programme continues to progress. An away day took place on 15th November to review the programme and agree year 2 priorities. The scope of the away day included a review of the past year, the vision; intended benefits; designation of work streams and revised timescales for intended outputs. The event also focused on proactive opportunities to mitigate some of the challenges faced by the programme over the last 12 months, including staffing and building issues; to ensure progression continues at scale and pace.

The RPIW on Daily planning and co-ordination from February continues to show positive results. The 1st new ward to test the product went live on the 4th of July. Five wards now have the process operational with an additional five wards expected in the next phase due to complete by the end of 2017.

A Kaizen event on Bed management took place in August. The outputs have been received well showing an efficiency saving of 1002 minutes per week of senior managerial time. FMH and FLD now have a joint bed management and discharge planning meeting, this has put the service in a positive position for changes being suggested as part of New Care Models.

A two day innovation event looking at daily MDT meetings took place in September. The scope of the event was to design an effective daily MDT meeting, being piloted on our male medium secure autism service. Using feedback from staff away days, a new process has been designed ensuring maximum input from all ward professionals. The new meeting focusses on what we did yesterday; and what our plan for today is, for meeting our client's clinical needs and moving them towards recovery. Feedback so far has been very positive; a number of metrics including observation levels and sickness absence are being monitored to see if the process leads to improvement in these areas.

QIS for leaders cohort 1 was completed in September with some fantastic results, and great evidence of collaborative working with patients to enhance the care they receive. QIS projects included:

- Improving patient 1:1s
- Collaborative patient daily overview
- Patient information at a glance
- Improving information flows into MDT

Cohort 2 commenced September with 12 new trainees. Attendance at training is still an issue and is being reviewed as a risk through the programme board.

An inpatient learning collaborative event is being planned for the 12th December; this showcase will inform the wider Trust of the work being undertaken in Model Wards. The event will also be an opportunity for other localities to showcase work they have been on their inpatient areas.

Forensic Learning Disability - Transforming Care and Secure Outreach and Transitions Team (SOTT)

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

The local community model – Secure Outreach and Transitions Team (SOTT) is being progressed with further recruitment taking place. The extended 8am – 8pm, 7 day per week service has been operational from 1st May 2017 and this is providing a very valuable service to users out with of normal hours and has supported several individuals through crisis and prevented admissions. The SOTT has recruited further staff and welcomed two advanced practitioners as well as a psychologist to the team.

The service continues to face significant pressures on its registered nurse workforce and recruitment challenges none of which will be reduced with the announcement of further bed reductions. Overall the inpatient workforce is struggling under the pressure and this as well as TCP is impacting on staff morale. The service is working to minimise this and looking at a range of interventions. Six new registered nurses joined the service which should ease the pressure slightly.

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

The women's FLD secure service won the Team of the Year (non-specific age group) at the RCPsych awards.

The service is reviewing its restrictive practice work and there is an event scheduled for 1st December 2017.

Work on the New Care Models (NCM) programme continues in conjunction with NTW. Amanda Whiles (previously Oakes) has taken up a fixed term post as Project Lead for NCM.

Forensic Learning Disability and Forensic Mental Health Inpatient Service

15 newly recruited staff nurses to the service commenced post in October 2017 and completed a 4 week induction programme incorporating statutory and mandatory training as well as training specific to the service prior to commencing clinical work on the wards. This initiative across the inpatient forensic service provided staff with knowledge and skills development as well as the opportunity to build a peer support network at the start of their careers.

It was also felt to be a worthwhile investment from wards to ensure staff start their roles with all the necessary training and early development. It is currently being evaluated from both the attendees and the wards perspective.

The inpatient service has undertaken its self-assessment in relation to Triangle of Care and after submission received extremely positive feedback from the National Policy Lead. There are a number of areas identified within the self-assessment where focussed work is taking place to improve carers experience and action to achieve this is underway.

Update on the Kaizen relating to the bed management processes within Forensic Services which took place on the 7th and 8th August 2017. The sixty day report out took place on the 31st October 2017 and the metrics show improvement in all target areas. The lead time has shown a 58% improvement against the base line. However, the lead time has increased from the thirty day report out and this is due to the expanding agenda which was needed to incorporate a more detailed service wide view on discharges and approaching indicative dates of discharge. The quality defects also show a significant improvement in the time taken to receive report and reports received on time.

Offender Health and Community

The Integrated Support Unit within HMP Durham went live on the 4th October for a two week training/induction programme for clinical and prison staff. The first patients were admitted on the 16th October, the Unit reports full bed occupancy. The Unit and mental health team at HMP Durham demonstrated its commitment to high level patient centred care, when an offender was identified with acute mental illness and was transferred within five days to Roseberry Park, the national good practice guidelines is 14 days.

Due to the changes within HMP Durham a RPIW event was held looking at the referral and assessment process. This was extremely well attended, with Commissioners and the Prison participating. The 30 day report was completed in October with positive outcomes being achieved.

HMP Holme House, HMP Preston, HMP Lancaster farms and HMP Kirkham hosted visits from TEWV Directors, giving the opportunity to tour the establishments and meet the teams. The next visit will take place at HMP Durham.

The directorate successfully held its 2nd annual Offender Health conference. This year's event focussed on personality difficulties within the criminal justice system and guest speakers include Dr Caroline Logan, Consultant Forensic Clinical Psychologist & Associate Director in Forensic Mental Health at the University of Manchester, and Alan Bisset, awarding winning play write and author. The event sold out and feedback from the day was very positive.

4. IMPLICATIONS:

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

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

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

4.4 **Equality and Diversity:** None

4.4 **Other implications:** None

5. RISKS:

None

6. CONCLUSIONS:

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

7. RECOMMENDATION:

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

Brent Kilmurray
Chief Operating Officer

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO. 11

MEETING OF THE COUNCIL OF GOVERNORS

DATE:	**30 November 2017**
TITLE:	**Quality Account 2017/18 Quarter 2 Performance Report**
REPORT OF:	**Sharon Pickering, Director of Planning, Performance & Communications** **Elizabeth Moody, Director of Nursing & Governance**
REPORT FOR:	**Assurance**

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

Executive Summary:

This is the second progress report for the Quality Account during 2017/18 covering the period July to September 2017 (quarter 2).

This report presents updates against each of the five key quality priorities for 2017/18 identified in the Quality Account as well as performance against the agreed quality metrics.

The delivery of all five quality priorities for 2017/18 is on-track.

In terms of quality metrics, 3 of 9 (33%) are reporting green. We are reporting red on 6 of 9 metrics (67%). All three patient experience domain metrics are currently below target and two of these, along with patient reported perceptions of safety would need significant improvement if the full-year target is to be achieved.

Recommendations:

The Council of Governors are asked to receive and comment on the progress made against the Quality Account as at quarter 2 2017/18.

MEETING OF:	**MEETING OF THE COUNCIL OF GOVERNORS**
DATE:	**30 November 2017**
TITLE:	**Quality Account 2017/18 Quarter 2 Performance Report**

1. INTRODUCTION & PURPOSE:

1.1 This is the second progress report for the Quality Account during 2017/18 covering the period July to September 2017 (quarter 2).

1.2 This report presents an update against on the five key quality priorities for 2017/18 identified in the current Quality Account as well as performance against the agreed quality metrics.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The Trust is required each year to produce a Quality Account - a report about the quality of services provided by the Trust during the previous year and what quality priorities the Trust has committed to for the forthcoming year. The aim of the Quality Account is to enhance accountability to the public and engage the leaders of the Trust and its stakeholders in the quality improvement agenda.

3. KEY ISSUES:

3.1 The quality metrics for 2017/18 have been updated to reflect those within the Quality Strategy.

Progress on the five Quality Priorities for 2017/18

3.2 Within the 2016/17 Quality Account the Trust agreed the following five quality priorities for completion in 2017/18:

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

3.3 **37 of the 37** (100%) quality improvement actions related to these priorities were **Green** at 30/09/17.

Performance against Quality Metrics at quarter 2

3.4 Members may wish to note that due to an administrative error the target for metric 7 (ppercentage of patients who reported their overall experience as excellent or good)

was misstated in last quarters report and performance on this metric should have been reported as red rather than green.

3.5 There are 6 out of 9 quality metrics reporting RED at quarter 2 2017/18 (this is an improvement on the quarter 1 position where 7 out of 9 quality metrics reported RED). These are:

- **Metric 1: Percentage of patients reported 'yes 'always' to the question, 'do you feel safe on the ward?':** The Trust position for quarter 2 2017/18 is 62.37% which is 25.63% below the target of 88%. This relates to 552 positive out of 885 responses.

  All localities are below the target with Durham and Darlington performing highest with 74.46% (172 out of 231 responses) and Forensic Services lowest with 48.77% (79 out of 162 responses).

  In quarter 2 the most common reason for people not feeling safe on the ward was 'other patients' with the exception of York & Selby where the most common reason was 'own illness'. This is explored in detail each month by EMT during the Patient Experience performance report and is taken back for wider discussion and action within locality management teams.

- **Metric 3: Number of incidents of physical intervention / restraint per 1000 occupied bed days:** The Trust position for quarter 2 2017/18 is 34.17 which is 14.92 above the target of 19.25, and is a deterioration on the position reported for Q1. This relates to 2,440 restraints out of 71,415 occupied bed days.

  North Yorkshire is the only locality achieving the target. Of the underperforming localities Durham and Darlington are performing highest with 23.07 (389 restraints out of 16,860 OBD) and Teesside are performing lowest with 56.36 (1,127 restraints out of 19,995 ODB).

  Teesside's high number of physical interventions can partly be attributed to the position in Tier 4 CYP service where 2 patients (one in Newberry and one in Evergreen) accounted for 324 of the 1,127 incidents in Teesside. Although the actual number of restraint incidents increased in quarter 2 the number of prone restraints has reduced. Work is on-going across the Trust to ensure appropriate staff are trained and report incidents of restraint correctly on Datix.

- **Metric 6b: Average length of stay for patients in Mental Health Services for Older People Assessment & Treatment Wards:** The Trust position for older people has been worse than target since 2013/14, however the position for quarter 2 is reporting 59.38, which compares to a median length of stay of 45 days. This position is a significant improvement on the 70.69 days which was reported in quarter 1 2017/18.

  55% of lengths of stay were between 1-50 days with 33% between 51 – 100 days. Six patients had a length of stay greater than 200 days (an improvement

on the eleven patients at quarter 1), all patients have been investigated and the lengths of stay were appropriate due to patient need.

The median length of stay in older people was 45 days, which is better than the target of 52 days, and demonstrates that a small number of patients that had very long lengths of stay have a significant impact on the mean figures reported.

- **Metric 7: Percentage of patients who reported their overall experience as excellent or good:** The Trust position for quarter 2 2017/18 is 91.01% which is 2.99% below the target of 94%. This relates to 1,660 positive out of 1,824 responses.

  Teesside are the only locality achieving the target. Of the underperforming localities North Yorkshire are performing highest with 93.62% (323 out of 345 responses) and Forensic Services lowest with 74.68% (115 out of 154 responses).

  Wards and teams with low scores for this question are advised to review their other survey questions scores alongside the narrative comments to see where improvements can be made. By improving these scores, the score for patients reporting their overall experience as excellent or good is more likely to be higher if they have answered the other questions positively.

- **Metric 8: Percentage of patients that report that staff treated them with dignity and respect:** The Trust position for quarter 2 2017/18 is 85.48% which is 8.25% below the target of 94%. This relates to 2,472 positive out of 2,892 responses.

  All localities are underperforming with North Yorkshire performing highest with 88.82% (596 out of 671 responses) and Forensic Services the lowest with 66.52% (147 out of 221 responses). This is a decrease on quarter 1 and will be highlighted via the Patient Experience Group as an area for improvement across the organisation.

- **Metric 9: Percentage of patients that would recommend our service to friends and family if they needed similar care or treatment:** The Trust position for quarter 2 2017/18 is 87.71% which is 6.29% below the target of 94%. This relates to 2,684 positive out of 3,060 responses.

  All localities are not achieving the target with Teesside performing highest with 91.05% (946 out of 1,039 responses) and Forensic Services the lowest with 75.22% (170 out of 226 responses).

  Work continues to promote the completion of the patient FFT by the Patient and Carer Experience Team and clinical services. There is a direct correlation between the responses to this question and the responses received to Metric 1 - Percentage of patients reported ‘yes ‘always’ to the question, ‘do you feel safe on the ward?’ which suggests that some patients would not recommend our

services if they do not feel safe. The Forensics locality is undertaking targeted work to explore the issues that particularly lead to their service users not feeling safe.

4. IMPLICATIONS:

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

4.2 **Financial/Value for Money:** There are no direct financial implications associated with this report, however, there may be some financial implications associated with improving performance where necessary. These will be identified as part of the action plans as appropriate.

4.3 **Legal and Constitutional (including the NHS Constitution):** There are no direct legal and constitutional implications associated with this paper, although the Trust is required each year to produce a Quality Account and this paper contributes to the development of this.

4.4 **Equality and Diversity:** All the action and project plans will be impact assessed for the equality and diversity implications associated with the Quality Account.

5. RISKS:

5.1 There are no specific risks associated with this progress report.

6. CONCLUSIONS:

6.1 The delivery of all quality priorities for 2017/18 is on-track.

6.2 In terms of quality metrics, 3 of 9 (33%) are reporting green. We are reporting red on 6 of 9 metrics (67%). All three patient experience domain metrics are currently below target and two of these, along with patient reported perceptions of safety would need significant improvement if the full-year target is to be achieved.

7. RECOMMENDATIONS:

7.1 The Council of Governors are asked to receive and comment on this report on the progress made against the Quality Account as at quarter 2 2017/18.

Phillip Darvill,
Planning and Business Development Manager

Background Papers: 2016/17 Quality Account

Item 12

FOR GENERAL RELEASE

COUNCIL OF GOVERNORS

DATE:	**30th November 2017**
TITLE:	**Board Dashboard as at 30th September 2017**
REPORT OF:	**Sharon Pickering, Director of Planning, Performance & Communication**
REPORT FOR:	**Assurance**

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

Executive Summary:

The purpose of this report is to provide the Council of Governors with the Board Dashboard as at 30th September 2017 (Appendix A) in order to identify any significant risks to the organisation in terms of operational delivery.

As at the end of September 2017, 5 (26%) of the indicators reported are not achieving the expected levels and are red. This is a slight increase on the 4 that was reported as at the end of August. One of these indicators is showing an improving position over the previous 3 months and further detail is provided in key issues below.

There are a further 5 indicators which whilst not completely achieving the target levels are within the amber tolerance levels (which is the same number as reported for July and August).

Recommendations:

It is recommended that the Council of Governors receive this report for information.

MEETING OF:	**Council of Governors**
DATE:	**30th November 2017**
TITLE:	**Board Dashboard as at 30th September 2017**

1. INTRODUCTION & PURPOSE:

1.1 To present to the Council of Governors the Trust Dashboard as at 30th September (Appendix A). Further detail for each indicator, including trends over the previous 3 years, will be available within the information pack available at the Council of Governors meeting or can be provided electronically on request from the Trust Secretary's department tewv.ftmembership@nhs.net .

2. KEY ISSUES:

2.1 The key issues are as follows:

- As at the end of September 2017, 5 (26%) of the indicators reported are not achieving the expected levels and are red. This is a slight increase on the 4 that was reported as at the end of August. One of these indicators is showing an improving position over the previous 3 months.

  It should be noted that none of the indicators within the 'Quality' domain are rated as red at the end of September and the one finance indicator rated red for September is still reporting green in terms of the year to date performance.

  There are a further 5 indicators which whilst not completely achieving the target levels are within the amber tolerance levels (which is the same number as reported for July and August).

  In terms of the year to date position there are 3 indicators that are reporting red.

- In respect of performance against the key NHSI operational indicators in September the Trust did not achieve the IAPT recovery target of 50%, set by NHSI. In September we achieved 49.0% which whilst an improvement on the August figure of 48.6% still means that we failed the target for Quarter 2 achieving 49.51% in total. In terms of YTD the position is slightly above target at 50.2%.

2.2 The key risks are as follows:

1. Referrals (KPI1) – The number of referrals received in September remains considerably above the expected numbers however it should be noted that the trend in previous years of the reduction in August being followed by an increase in September has not been seen this year. The total number of

referrals in the first six months is 11% more than the expected figure (5,388 more referrals).

2. Number of instances of patients who have 3 or more admissions in a year (KPI 6) – The performance against this indicator continued to worsen in September compared to the expected position and is at the highest number/worst position in the past three years. Durham and Darlington account for almost half of the total 3 or more admissions. All admissions were appropriate, range of issues causing readmission and all on appropriate pathways.
3. Percentage of patients surveyed reporting their overall experience as excellent or good (KPI 10) – The performance reported in September is worse than target and is a decline compared to the position reported in August. Whilst the decline follows the same trend as the previous year it does mean that the position is the worse position since that reported in April 2016. Only Durham and Darlington are achieving the target with North Yorkshire, York and Selby and Forensic all reporting below 90%.
4. Sickness (KPI 20) – There has been a further increase in the amount of sickness reported in September to 5.48% (compared to 5.38% reported in August) which is the highest it has been since January 2016. Whilst the rate of increase in the figures reported in September has slowed compared to that reported in August it is still of significant concern. An event is being planned for November to get greater understanding of the reasons for the increase in sickness together with looking at what more we can do to support the health and well-being of staff.

2.3 Appendix B provides the data quality scorecard.

2.4 Appendix C provides further details of unexpected deaths including a breakdown by locality.

2.5 Appendix D provides a glossary of indicators.

3. RECOMMENDATIONS:

3.1 It is recommended that the Council of Governors receive this paper for information.

Sharon Pickering
Director of Planning, Performance and Communications

Background Papers:

Appendix A - Trust Dashboard Summary for TRUST

Activity

	September 2017				April 2017 To September 2017			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
1) Total number of External Referrals into Trust Services	7,542.00	8,420.00			46,005.00	51,393.00		91,759.00
2) Caseload Turnover	1.99%	-1.53%			1.99%	-1.53%		1.99%
3) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	85.00%	87.30%			85.00%	86.18%		85.00%
4) Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH and MHSOP A&T Wards)	75.00	64.00			75.00	64.00		75.00
5) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - rolling 3 months	10.00%	7.79%			10.00%	8.89%		10.00%
6) Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP) Rolling 3 months	20.00	29.33			119.00	149.00		237.00

Quality

	September 2017				April 2017 To September 2017			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
7) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral.	90.00%	90.95%			90.00%	90.58%		90.00%
8) Percentage of (Clinic) appointments cancelled by the Trust	10.00%	10.19%			10.00%	9.19%		10.00%
9) The percentage of Out of Area Placements (Postvalidated)	20.00%	13.29%			20.00%	12.96%		20.00%
10) Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind)	92.45%	90.15%			92.45%	91.97%		92.45%
11) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	0.67			6.00	5.49		12.00

Trust Dashboard Summary for TRUST

Workforce

	September 2017				April 2017 To September 2017			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
14) Actual number of workforce in month (Establishment 95%-100%)	100.00%	93.08%			100.00%	93.08%		100.00%
15) Percentage of registered healthcare professional jobs that are advertised two or more times	15.00%	25.00%			15.00%	20.15%		15.00%
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	95.00%	92.76%			95.00%	92.76%		95.00%
17) Percentage compliance with ALL mandatory and statutory training (snapshot)	90.00%	85.89%			90.00%	85.89%		90.00%
18) Percentage Sickness Absence Rate (month behind)	4.50%	5.48%			4.50%	4.92%		4.50%

Money

	September 2017				April 2017 To September 2017			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
19) Delivery of our financial plan (I and E)	-787,000.00	-731,000.00			-5,059,000.00	-5,076,000.00		-10,076,000.00
20) CRES delivery	523,680.00	605,700.00			3,142,080.00	3,276,023.93		8,230,080.00
21) Cash against plan	60,861,000.00	63,037,000.00			60,861,000.00	63,037,000.00		56,376,000.00

		Data Source					Data Reliability					KPI Construct/Definition					Total Score	% as at October 2016	% as at July 17	Notes
		A (5)	B (4)	C (3)	D (2)	E (1)	5	4	3	2	1	5	4	3	2	1				
		Direct Electronic transfer from System	Data extracted from Electronic System but data is then processed manually	Other Provider System	Access database or Excel Spreadsheet	Paper or telephone collection	Always reliable	Mostly reliable	Sometimes reliable	Unreliable	Untested Source	KPI is clearly defined	KPI is defined but could be open to interpretation	KPI is defined but is clearly open to interpretation	KPI construction is not clearly defined	KPI is not defined				
1	Total number of external referrals into trust (same)services	5					5					5					15	**100%**	**100%**	
2	Caseload Turnover (same)	5					5					5					15	**100%**	**100%**	
3	Bed occupancy (AMH & MHSOP A&T wards) (same)	5					5					5					15	**100%**	**100%**	
4	Number of patients occupying a bed with a length of stay (from admission) over 90 days (AMH & MHSOP A&T wards)	5					5					5					15	**100%**	**100%**	This KPI has been amended to include patients currently occupying a bed, rather than those subject to discharge. This allows for more pro active monitoring of patients with a longer length of stay to enable a review of the appropriateness of the length of impatient spell and this is monitored in the report out process. The change to this KPI does not impact on the score previously applied, which remains unchanged.
5	Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)	5						5				5					15	**93%**	**100%**	Historic data for York and Selby prior to 1st April 2016 was not on Trust systems and this impacted on the reliability score applied to this KPI. However due to the new reporting year this concern no longers applies. T and therefore the scoring of this KPI has improved from 93% to 100%
6	Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP)	5						5				5					15	**93%**	**100%**	The previous comments about the lack of historic data on the system with regards to York and Selby data no longer applies and therefore the scoring of this KPI has improved from 93% to 100%
7	Percentage of patients who have not waited longer than 4 weeks following an external referral	5						4				5					14	**93%**	**93%**	Data reliability is remains at 4 due to issues over the recording of DNA's. Although this continues to improve issues are still reported, particularly in the North Yorkshire locality and these are being addressed through the report out process

		Data Source					Data Reliability					KPI Construct/Definition					Total Score	% as at October 2016	% as at July 17	Notes
		A (5)	B (4)	C (3)	D (2)	E (1)	5	4	3	2	1	5	4	3	2	1				
		Direct Electronic transfer from System	Data extracted from Electronic System but data is then processed manually	Other Provider System	Access database or Excel Spreadsheet	Paper or telephone collection	Always reliable	Mostly reliable	Sometimes reliable	Unreliable	Untested Source	KPI is clearly defined	KPI is defined but could be open to interpretation	KPI is defined but is clearly open to interpretation	KPI construction is not clearly defined	KPI is not defined				
8	Percentage of clinic appointments cancelled by the Trust	5					5					5					15	**87%**	**100%**	This KPI has been changed to clinic appointments as the previous use of community contacts was unreliable as you could not future date appointments, and therefore clinicians were likely to record these inaccurately. This KPI now uses the outpatients module on PARIS and there are no concerns of the reliability of this data. The use of a drop down menu to clearly state cancellation reasons provides a high degree of confidence in data quality.
9	The percentage of Out of Area Placements (post validated)		4				5								5		14	**N/A**	**93%**	Data is imported back into the IIC following manual validation. This increases reliability however introduces a manual element into the process. Validation for all breaches must be completed within the timeframe to support a national return, which prevents concerns about some breaches being inappropriately discounted. Therefore the data reliability has been amended from 4 to 5. A change to PARIS with the inclusion of drop downs to eradicate the manual element of the process is planned.

		Data Source					Data Reliability					KPI Construct/Definition					Total Score	% as at October 2016	% as at July 17	Notes
		A (5)	B (4)	C (3)	D (2)	E (1)	5	4	3	2	1	5	4	3	2	1				
		Direct Electronic transfer from System	Data extracted from Electronic System but data is then processed manually	Other Provider System	Access database or Excel Spreadsheet	Paper or telephone collection	Always reliable	Mostly reliable	Sometimes reliable	Unreliable	Untested Source	KPI is clearly defined	KPI is defined but could be open to interpretation	KPI is defined but is clearly open to interpretation	KPI construction is not clearly defined	KPI is not defined				
10	Percentage of patients surveyed reporting their overall experience as excellent or good.				2		5					5					12	**80%**	**80%**	Questionnaires continue to be are a mix of paper and electronic. All inpatient wards are electronic data collection, however there is also a number of kiosks in a range of services which complement the paper collection. A new provider (Optimum Health Technology) is in place and data collection commenced on 1st April 2017 . Paper surveys are sent to the new provider and entered into their Meridian system. There is a manual upload of the data accessed from Meridian into the IIC (this was the case for the most recent data by the Data Quality Team) but work is ongoing to integrate this data with the IIC.
11	Number of unexpected deaths classed as a serious incident per 10,000 open cases		4				5					5					14	**93%**	**93%**	Data continues to be directly extracted from Datix into the IIC; however, this process is not fully embedded. IAPT caseload is a manual upload.
16	Percentage Sickness Absence Rate (month behind)	5						4				5					14	**93%**	**93%**	Sickness absence data for inpatient services is taken directly from the rostering system which helps to eliminate inaccuracies, the remainder of the Trust continue to input directly into ESR and there continues to be examples where managers are failing to end sickness in a timely manner or inaccurately recording information onto the system. These issues are picked up and monitored through sickness absence audits that the Operational HR team undertake.

		Data Source					Data Reliability					KPI Construct/Definition					Total Score	% as at October 2016	% as at July 17	Notes
		A (5)	B (4)	C (3)	D (2)	E (1)	5	4	3	2	1	5	4	3	2	1				
		Direct Electronic transfer from System	Data extracted from Electronic System but data is then processed manually	Other Provider System	Access database or Excel Spreadsheet	Paper or telephone collection	Always reliable	Mostly reliable	Sometimes reliable	Unreliable	Untested Source	KPI is clearly defined	KPI is defined but could be open to interpretation	KPI is defined but is clearly open to interpretation	KPI construction is not clearly defined	KPI is not defined				
14	Actual number of workforce in month		4				5					5					14	**93%**	**93%**	Data continues to be extracted electronically but processed manually
15	Percentage of registered health care professional jobs that are advertised two or more times				2			4				5					11	**73%**	**73%**	The form to capture this information is still reliant on recruiting managers completing the section of the form. The recruitment team are more proactive in recording on the tracking spreadsheet where they are aware it is a readvertisement because they know this is being reported through a KPI. The recording of the information is a manual input into a spreadsheet which has the potential for human error.
19	Are we delivering our financial plan (I and E)		4				5					5					14	**93%**	**93%**	Information is extracted from and electronic system but is then subject to a manual process.
16	Percentage of staff in post more than 12 months with a current appraisal – snapshot	5						4				5					14	**93%**	**93%**	Issues with appraisal dates being entered to ESR continue to improve - there appears to be greater confidence in the data being reported and operational clinical services have incorporated the monitoring of compliance into the daily lean management process. Performance has improved and the Trust compliance rate has consistently been above 90%
17	Percentage compliance with mandatory and statutory training – snapshot **	5						4				5					14	**93%**	**93%**	The key issue that impacts on the reliability of the data is that staff do not follow the correct procedures to ensure training is recorded accurately on the source system as being completed and this is being addressed. In terms of training requirements there have been issues with Resus and PAT training and work is underway to resolve these issues
20	Delivery of CRES against plan				2		5					5					12	**80%**	**80%**	Data continues to be collected on Excel with input co-ordinated and controlled by the Financial Controller and version control in operation.
21	Cash against plan		4				5					5					14	**93%**	**93%**	An extract continues to be taken from the system then processed manually to obtain actual performance.

APPENDIX C - Number of unexpected deaths and verdicts from the Coroner April 2017 - March 2018

	Number of unexpected deaths in the community					Number of unexpected deaths of patients who are an inpatient and took place in the hospital					Number of unexpected deaths where the patient is an inpatient but the death took place away from the hospital					Number of unexpected deaths where the patient was no longer in service					Total
	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	
Accidental death																					**0**
Natural causes																					**0**
Hanging																	1				**1**
Suicides																					**0**
Open																					**0**
Drug related death																					**0**
Drowning																					**0**
Misadventure																					**0**
Awaiting verdict	8	6	6	1	3		1									3		2		2	**32**
Total	**8**	**6**	**6**	**1**	**3**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**3**	**1**	**2**	**0**	**2**	**33**

Number of unexpected deaths classed as a serious untoward incident											
April	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**
4	3	2	8	12	4						

Number of unexpected deaths total by locality				
Durham & Darlington	**Teesside**	**North Yorkshire**	**Forensics**	**York & Selby**
11	8	8	1	5

Number of unexpected deaths and verdicts from the Coroner 2016 / 2017

This table has been included into this appendix for comparitive purposes only

	Number of unexpected deaths in the community					Number of unexpected deaths of patients who are an inpatient					Number of unexpected deaths where the patient is an inpatient but the					Number of unexpected deaths where the patient was no longer					Total
	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	
Accidental death																					**0**
Natural causes	1	1															1				**3**
Hanging					1												1				**2**
Suicides	5	2	2		2							1	2					1			**15**
Open			1																		**1**
Drug related death																					**0**
Drowning													1								**1**
Misadventure			1																		**1**
Awaiting verdict	7	2	7	2	6	1					1						1	1	2	1	**31**
Total	**13**	**5**	**11**	**2**	**9**	**1**	**0**	**0**	**0**	**0**	**1**	**1**	**3**	**0**	**0**	**0**	**3**	**2**	**2**	**1**	**54**

Number of unexpected deaths classed as a serious untoward incident											
April	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**
5	4	3	7	5	3	1	6	7	5	3	5

Number of unexpected deaths total by locality				
Durham & Darlington	**Teesside**	**North Yorkshire**	**Forensics**	**York & Selby**
15	9	16	4	10

Y&S recorded in old Datix not included

Glossary of Indicators

Table no.	Description	Comment
1	Total number of External Referrals into the Trust Services	This indicator counts the number of external referrals received into Trust services (GP and other); all external referrals to all services are included.
3	Bed Occupancy (AMH and MHSOP Assessment & Treatment Wards)	This indicator reports the number of occupied bed days in AMH and MHSOP Assessment and treatment wards in the month against the number of available occupied bed days
4	Number of patients admitted with a length of stay (admission to discharge) greater than 90 days (A&T wards)	This indiccator reports the number of patients admitted to Assessment & Treatment Wards with a length of stay greater than 90 days that have been discharged in the month
5	Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - Rolling 3 months	This indicator reports the total number of admissions to AMH and MHSOP Assessment and Treatment wards in the rolling 3 months period and, of those, the percentage that were readmissions within 30 days of a discharge from any Trust ward.
6	Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP) - Rolling 3 months	This indicator counts the number of patients who were admitted in the month that had previously been admitted on 2 or more occasions during the previous 12 months
7	Percentage of patients who were seen within 4 weeks for a first appointment following an external referral	These waiting times are in relation to patients being referred from external sources (for example GPs). They relate to patients seen in the month, and of those, the percentage who were seen within four weeks.
8	Percentage of appointments cancelled by the Trust	This indicator counts the number of direct (face to face or telephone) appointments regardless of the outcome of the appointment and, of those, measures the percentage that were cancelled by the Trust.
9	Percentage of out of locality admissions to assessment and treatment wards (AMH and MHSOP) - post- validated	Out of locality admissions relates to people who need to be admitted into a ward which is not in the same locality as their GP. Localities have reviewed all wards and a template has been developed to show where patients from each commissioning area would be expected to be admitted to. This indicator measures the percentage of patients that were not admitted to the assigned wards. E.g. an Adult Mental Health patient within Durham City should be admitted to Lanchester Road Hospital, and if the patient has then been admitted to West Park, this will be recorded as 'out of locality admission.'
10	Percentage of patients surveyed reporting their overall experience as excellent or good (mth behind)	This indicator reports the number of patients who have scored "excellent" or "good" in the patient survey to the Question: "Overall how would you rate the care you have received?" of those total patients who responded to this question.
11	Number of unexpected deaths classed as a serious incident per 10000 open cases - post validated	This KPI measures the number of unexpected deaths classed as a serious incident per 10,000 open cases. The total number of open cases on the Paris system is divided by 10,000 to obtain the correct ratio for this calculation.
14	Actual number of workforce in month (Establishment 90-95%)	This KPI reports the actual number of contracted whole time equivalent staff in the month
15	Percentage of registered healthcare professional jobs that are adversided two or more times	This KPI Reports the number of registered healthcare professional jobs advertised for the second (or more) time in the reporting month
16	Percentage of staff in post more than 12 months with a current appraisal (snapshot)	Staff employed by the trust must have completed an appraisal with their supervisor, and informed the workforce information department Information is entered onto ESR at least once a year.
17	Percentage compliance with mandatory and statutory training (snapshot)	This indicator reports the number of courses completed for compliance with the 7 core mandatory and statutory training as a percentage of the number of courses to be completed for compliance. Bank staff and non-Trust staff are excluded
18	Percentage Sickness Absence Rate (month behind)	This indicator measures the number of days lost within the month due to sickness absence, as a percentage of the number of days available.
19	Delivery of financial plan (I and E)	This indicator measures the Income and Expenditure plan at TRUST LEVEL, reporting the actual "surplus or deficit" compared to the "planned surplus" (target). If the figure is plus (positive) this denotes a deficit; if the figure is minus (negative) this denotes a surplus.
20	CRES Delivery	This indicator reports the value of CRES delivered.
21	Cash against plan	This indicator reports actual cash balance

Item 13

FOR GENERAL RELEASE

COUNCIL OF GOVERNORS

DATE:	**30th November 2017**
TITLE:	**Finance Report for Period 1 April 2017 to 30 September 2017**
REPORT OF:	**Drew Kendall, Interim Director of Finance and Information**
REPORT FOR:	**Assurance and Information**

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

Executive Summary:

The comprehensive income outturn for the period ending 30 September 2017 is a surplus of £5,076k, representing 3.0% of the Trust's turnover and is £17k ahead of plan.

Identified Cash Releasing Efficiency Savings at 30 September 2017 are £268k ahead of plan for the year to date. The Trust continues to identify and develop schemes to ensure full delivery of CRES for current and future years.

The Use of Resources Rating for the Trust is assessed as 2 for the period ending 30 September 2017 and is behind plan, with agency expenditure being £39k higher than planned. The Use of Resources Rating is forecast to remain a 2 at the end of the financial year.

Recommendations:

The Council of Governors is requested to :

- Receive the report, to note the conclusions in section 6 and to raise any issues of concern, clarification or interest.

MEETING OF:	**Council of Governors**
DATE:	**30 November 2017**
TITLE:	**Finance Report for Period 1 April 2017 to 30 September 2017**

1. INTRODUCTION & PURPOSE

1.1 This report summarises the Trust's financial performance from 1 April 2017 to 30 September 2017.

2. BACKGROUND INFORMATION

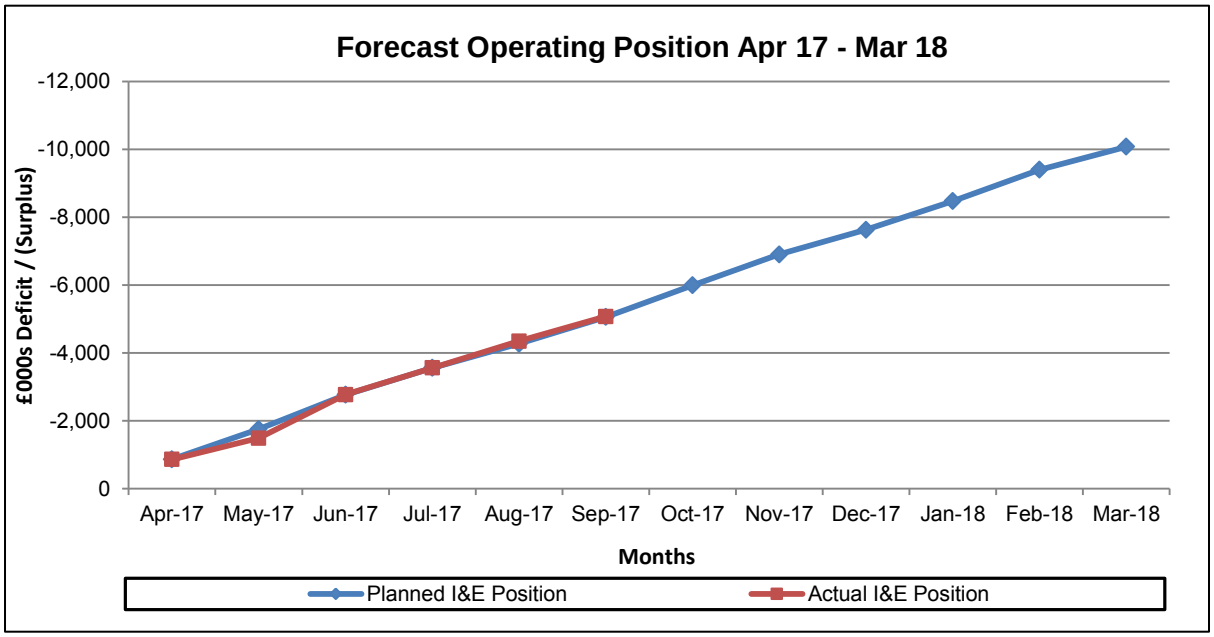
2.1 The financial reporting framework of a Foundation Trust places an increased emphasis on cash and the statement of financial position as well as the management of identified key financial drivers. The Board receives a monthly summary report on the Trust's finances as well as a more detailed analysis on a quarterly basis.

3. KEY ISSUES:

3.1 Statement of Comprehensive Income

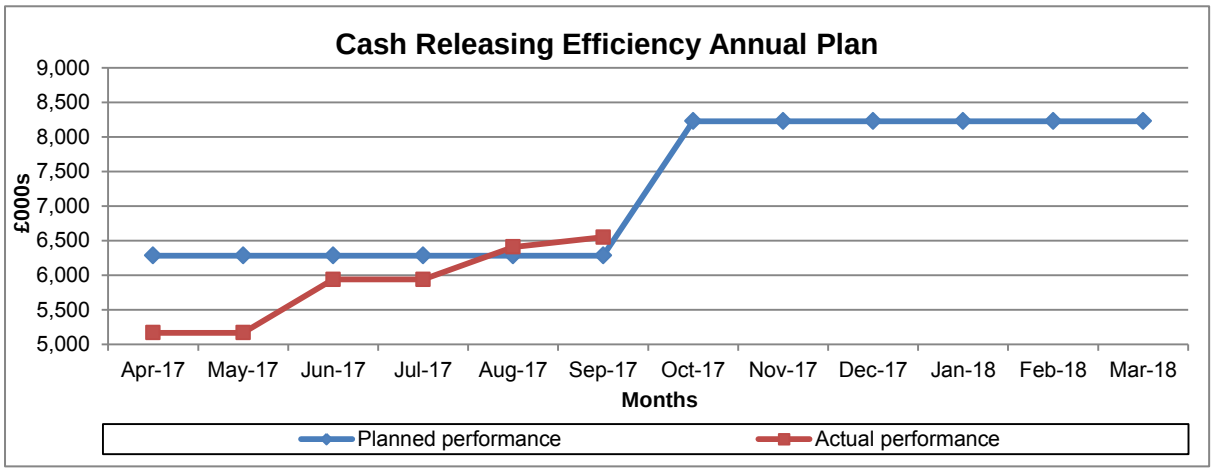
The comprehensive income outturn for the period ending 30 September 2017 is a surplus of £5,076k, representing 3.0% of the Trust's turnover and is £17k ahead of plan.

The graph below shows the Trust's planned operating surplus against actual performance.

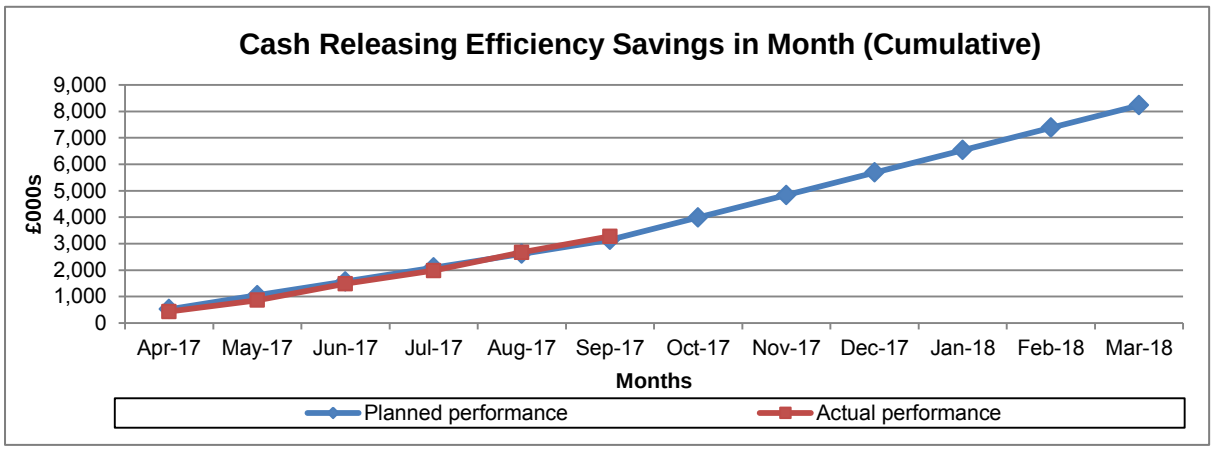


3.2 Cash Releasing Efficiency Savings

Total CRES identified at 30 September 2017 is £6,552k and is £268k ahead of plan for the year to date, and improved in month due to new schemes being identified. The Trust has, and continues to identify and progress schemes to deliver CRES in full for current and future years.

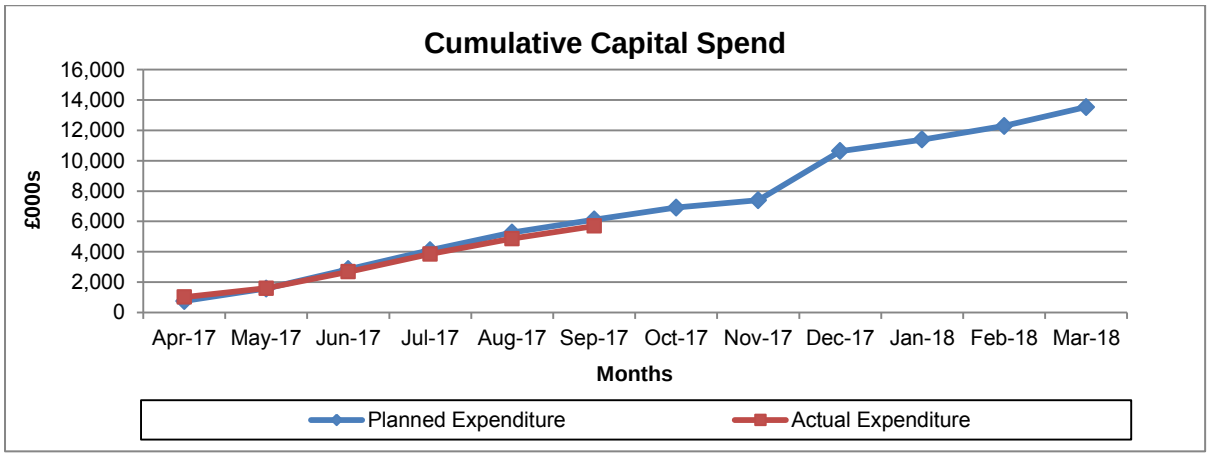


The monthly profile for CRES identified by Localities is shown below.



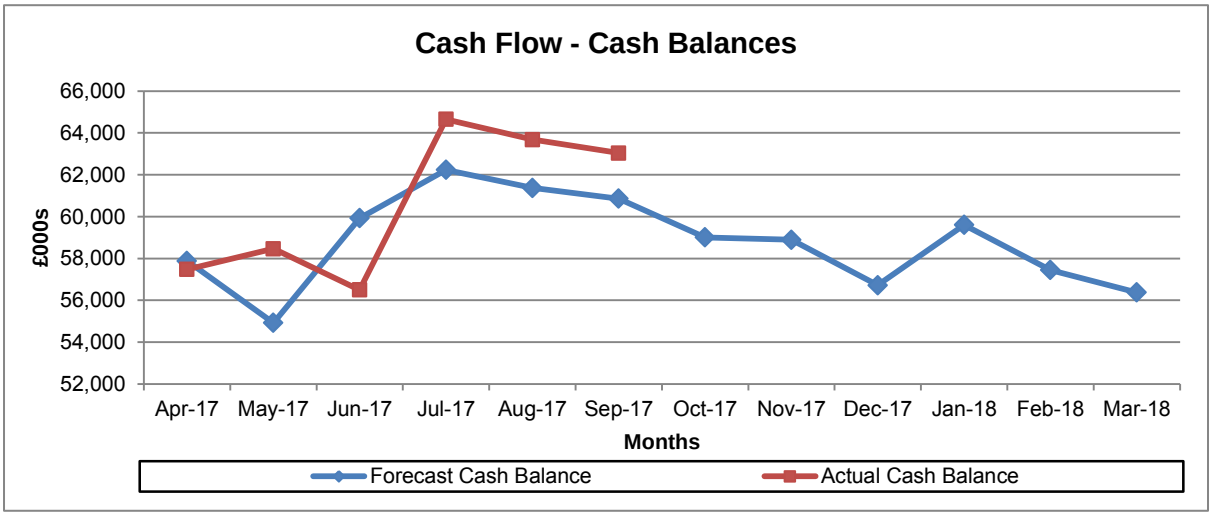
3.3 Capital Programme

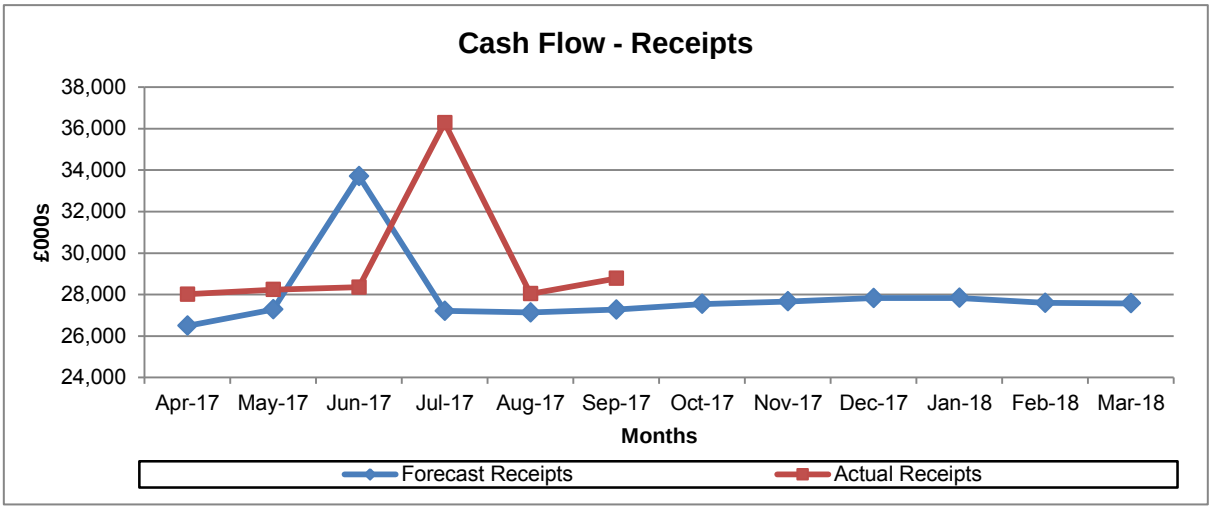
Capital expenditure to 30 September 2017 is £5,701k and is £415k behind plan due to minor delays against identified developments.

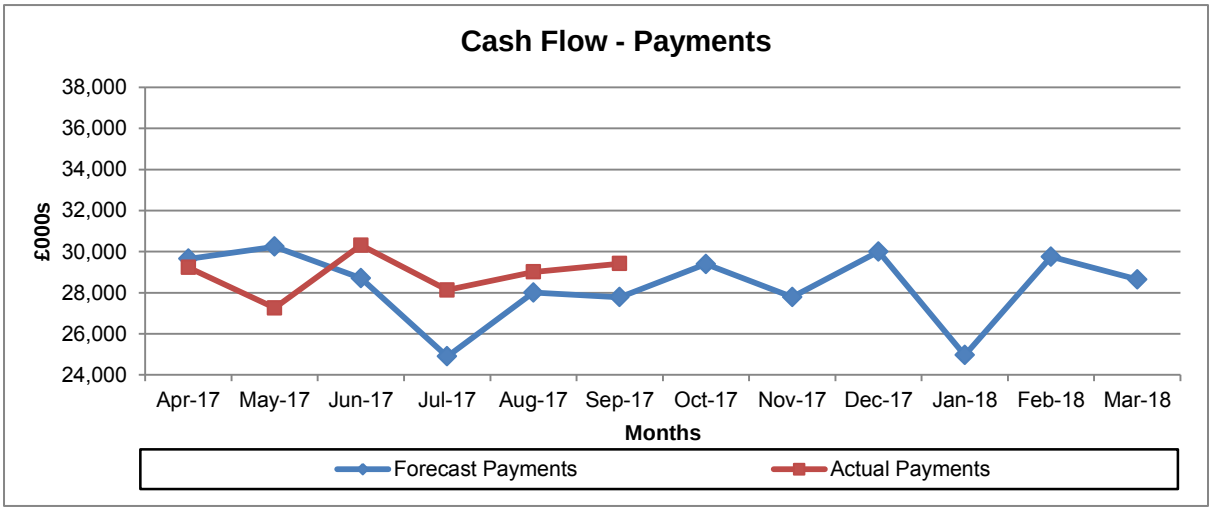


3.4 Cash Flow

Total cash at 30 September 2017 is £63,037k, and is £2,176k ahead of plan largely due to working capital variations.



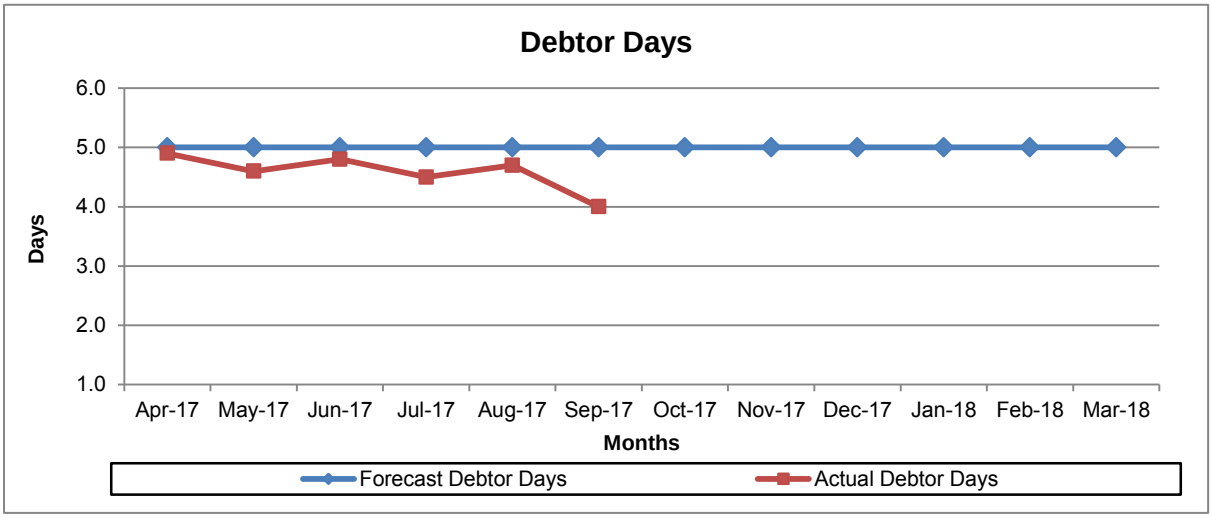




The receipts profile fluctuates over the year for 2016/17 Sustainability and Transformation Fund incentive scheme receipt. The payments profile fluctuates over the year for PDC dividend payments, financing repayments and capital expenditure.

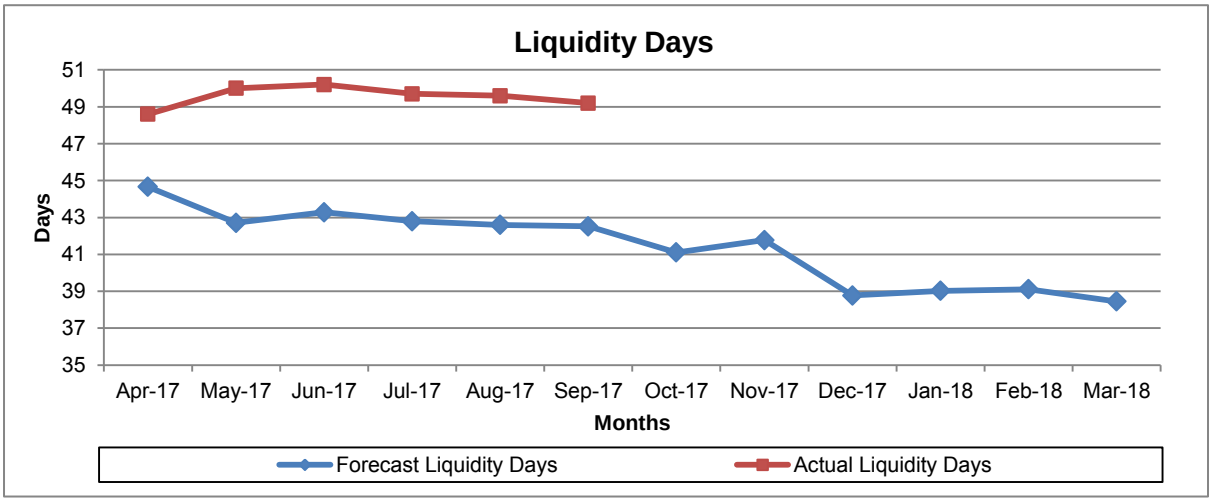
Working Capital ratios for period to 30 September 2017 are:

- Debtor Days of 4.0 days
- Liquidity of 49.2 days
- Better Payment Practice Code (% of invoices paid within terms)
  NHS – 60.0%
  Non NHS 30 Days – 97.1%



The Trust has a debtors' target of 5.0 days, and actual performance of 4.0 days at 30 September 2017, which is ahead of plan.

The liquidity days graph below reflects the metric within NHS Improvement's single oversight framework. The Trust's liquidity day's ratio is ahead of plan due to higher than planned net current assets.



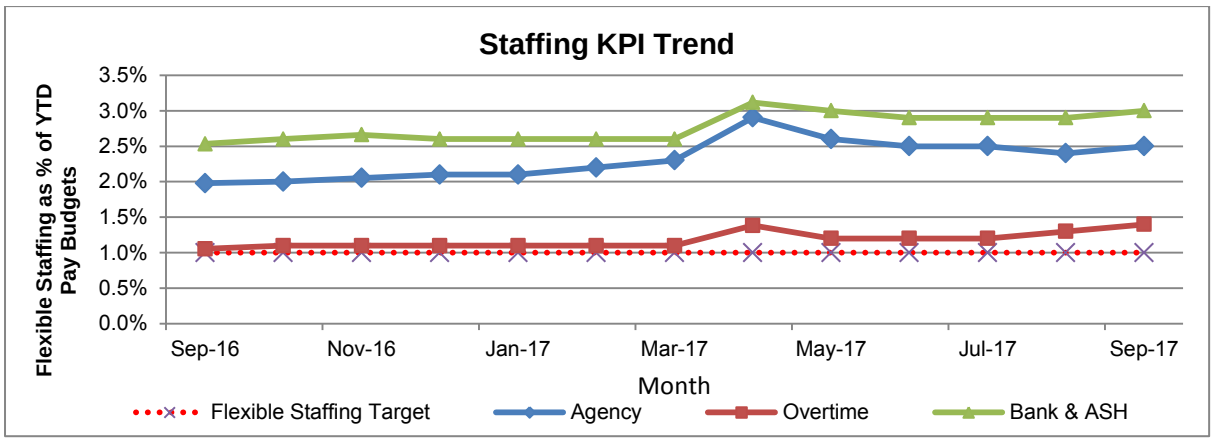
3.5 Financial Drivers

The following table and chart show the Trust's performance on some of the key financial drivers identified by the Board.

Tolerance	Apr	May	June	July	August	Sept.
Agency (1%)	2.9%	2.6%	2.5%	2.5%	2.4%	2.4%
Overtime (1%)	1.4%	1.2%	1.2%	1.2%	1.3%	1.3%
Bank & ASH (flexed against establishment)	3.1%	3.0%	2.9%	2.9%	2.9%	2.9%
Establishment (90%-95%)	94.6%	94.0%	94.2%	93.1%	93.1%	93.1%
Total	**102.0%**	**100.8%**	**100.9%**	**99.7%**	**99.7%**	**99.7%**

The tolerances for flexible staffing expenditure are set at 1% of pay budgets for agency and overtime, and flexed in correlation to staff in post for bank and additional standard hours (ASH). For September 2017 the tolerance for Bank and ASH is 4.9% of pay budgets.

The following chart shows performance for each type of flexible staffing.



Additional staffing expenditure is 6.7% of pay budgets. The requirement for bank, agency and overtime is due to a number of factors including cover for vacancies (48%), enhanced observations (19%), service need (14%) and sickness (11%).

3.6 Use of Resources Rating and Indicators

3.6.1 The Use of Resources Rating is assessed as 2 at 30 September 2017, and is behind plan. The Use of Resources Rating is forecast to remain a 2 at the end of the financial year.

3.6.2 The capital service capacity rating assesses the level of operating surplus generated, to ensure Trusts are able to cover all debt repayments due in the reporting period. The Trust has a capital service capacity of 1.64x (can cover debt payments due 1.64 times), which is ahead of plan and rated as a 3.

3.6.3 The liquidity metric assesses the number of days operating expenditure held in working capital (current assets less current liabilities). The Trust liquidity metric is 49.2 days; this is ahead of plan and is rated as a 1.

3.6.4 The income and expenditure (I&E) margin assesses the level of surplus or deficit against turnover, excluding exceptional items e.g. impairments. The Trust has an I&E margin of 3.0% and is rated as a 1.

3.6.5 The I&E margin distance from plan ratio assesses the I&E Margin against plan, excluding STF income. The Trust I&E margin distance from plan is -0.1% and is behind plan and is rated as a 2.

3.6.6 The agency rating assesses agency expenditure against a capped target for the Trust. Agency expenditure is £39k higher than the cap and is rated as a 2.

The margins on Use of Resource Rating are as follows:

- Capital service cover - to improve to a 2 a surplus increase of £904k is required.
- Liquidity - to reduce to a 2 a working capital reduction of £41,729k is required.
- I&E Margin – to reduce to a 2 an operating surplus decrease of £3,401k is required.
- I&E margin distance from plan – to improve to a 1 an operating surplus increase of £110k is required.
- Agency Cap rating – to improve to a 1 a reduction in agency expenditure of £39k is required.

NHS Improvement's Rating Guide	**Weighting**	**Rating Categories**			
	%	**1**	**2**	**3**	**4**
Capital service Cover	20	>2.50	1.75	1.25	<1.25
Liquidity	20	>0	-7.0	-14.0	<-14.0
I&E margin	20	>1%	0%	-1%	<=-1%
Variance from control total	20	>=0%	-1%	-2%	<=-2%
Agency expenditure	20	<=0%	-25%	-50%	>50%

TEWV Performance	**Actual**		**YTD Plan**		**RAG**
	Achieved	Rating	Planned	Rating	**Rating**
Capital service cover	1.64x	3	1.56x	3	
Liquidity	49.2 days	1	43.1 days	1	
I&E margin	3.0%	1	3.1%	1	
Variance from control total	-0.1%	2	0.0%	1	
Agency expenditure	£3,123k	2	£3,084k	1	

Overall Use of Resource Rating	**2**	**1**	

3.6.7 17.3% of total receivables (£613k) are over 90 days past their due date; this is above the 5% finance risk tolerance. The Trust has received confirmation of payment for £265k of this debt. Excluding debts with confirmation to pay the ratio reduces to 9.8%, which represents 0.21% of the Trusts turnover at 30 September 2017. £233k of the remaining debt at risk is with other NHS organisations, and discussions are ongoing to arrange payment.

Internal controls have been reviewed and improved to ensure future issues are resolved before the 90 day threshold.

3.6.8 3.3% of total payables invoices (£407k) held for payment are over 90 days past their due date. This is within the 5% finance risk tolerance.

3.6.9 The cash balance at 30 September 2017 is £63,037k and represents 74.1 days of annualised operating expenses.

3.6.10 The Use of Resource Rating is forecast to remain a 2 at the end of the financial year.

4. IMPLICATIONS:

4.1 There are no direct CQC, quality, legal or equality and diversity implications associated with this paper.

5. RISKS:

5.1 There are no risks arising from the implications identified in section 4.

6. CONCLUSIONS:

6.1 The comprehensive income outturn for the period ending 30 September 2017 is a surplus of £5,076k, representing 3.0% of the Trust's turnover and is £17k ahead of plan.

6.2 Identified Cash Releasing Efficiency Savings at 30 September 2017 are £268k ahead of plan. The Trust continues to identify and develop schemes to ensure full delivery of CRES for current and future years.

6.3 The Use of Resources Rating for the Trust is a 2 for the period ending 30 September 2017 which is behind plan. The rating is forecast to remain a 2 at the end of the financial year.

7. RECOMMENDATIONS:

7.1 The Council of Governors is requested to:

- Receive the report, to note the conclusions in section 6 and to raise any issues of concern, clarification or interest.

Drew Kendall
Interim Director of Finance and Information

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM 14

COUNCIL OF GOVERNORS

DATE:	**30 November 2017**
TITLE:	**Defining levels of participation in TEWV**
REPORT OF:	**Involvement and Engagement Committee – prepared by the Recovery Team, KPO and Involvement and Engagement team**
REPORT FOR:	**Consideration and comments**

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

Executive Summary:

To advise the Committee of work that has taken place between the Recovery, Kaizan Promotion Office and the Involvement and Engagement teams (joint development team) to develop a proposed Ladder of Participation for the Trust including definition statements and examples of how this could be applied to Quality Improvement work (QIS) and Training for the Trust.

The Council of Governors is being consulted on the proposed ladder. The Recovery Programme Board is also being asked for their comments on the proposed ladder.

In the development of the work by the joint team, service users, carers were consulted as part of the Involvement Working Group (who developed the Involvement Matrix approved by the Council in 2017) alongside the Experts by Experience.

Recommendations:

The Council of Governor's is asked to consider and provide comments on the :

a. Proposed Ladder of Participation and the definitions (appendix 1 refers)
b. Examples provided of participation ladder in practice (appendix 2 refers).

Comments will be fed into the joint working group to consider prior to submission to the Trust for final approval via the Executive Management Team.

DATE:	**30 November 2017**
TITLE:	**Defining levels of participation in TEWV**
REPORT OF:	**Involvement and Engagement Committee – prepared by the Recovery Team, KPO and Involvement and Engagement team**
REPORT FOR:	**Consideration and comments**

1. INTRODUCTION & PURPOSE:

1.1 This report presents recent work conducted between the Recovery, Involvement and Engagement and the Kaizan Promotion Office (KPO) teams (the joint development team) to define the different levels of participation within the Trust.

1.2 The purpose of the report is to share a proposed ladder of participation and the associated definitions and an example of the different forms and types of participation that can take place within the Trust and seek comments from the Council of Governors

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 Objective 2 of the phase 2 Recovery and Wellbeing strategy 2016-2020 focusses upon further embedding structures to support a model of co-production within the organisation. In setting the phase 2 strategy it was recognised that there was a requirement for the organisation to determine how co-production was defined and implemented within TEWV. It was agreed that there was a requirement for a shared understanding of the different types and forms of participation that could take place within the organisations work.

2.2 It has been recognised that whilst we now regularly use the term ‘co-production’ across the organisation that there is work required to support the organisation and our staff to gain a greater understanding of the different types and levels of participation. This will form the foundation for supporting the progression of work in this area as it will enable the Trust and its staff and services to identify the various types of involvement and engagement.

2.3 There are many different ways in which people, including service users and carers, the public and stakeholders may participate in health service design and delivery. The ladder of participation is widely recognised nationally for understanding the different forms and degrees of involvement and engagement and what this entails especially around decision making. It is important to recognise that providing a voice and an opportunity for participation on every step of the ladder is valuable and important, but also that the level of involvement and the degree to which the organisation shares power with others increases as you move up the ladder.

2.4 Over the last three months work has been conducted between the Recovery, Involvement and Engagement and KPO teams to develop the Ladder of Participation and to determine how different types and forms of participation could

be defined. Work has also commenced to begin to describe examples of how this translates into practice within different pieces of work within the Trust.

2.5 During the development of the Involvement Matrix which was approved by the Council of Governors in July 2017 (minute 17/48) refers, the Involvement Working Group (consisting of 8 service users and carers and 3 Involvement and Engagement staff) considered the application of a ladder of involvement to go alongside each of the categories of involvement. The decision at that time was that it would be more appropriate to have a Trust authorised Ladder of Participation (Involvement) and that this needed to incorporate the requirements of the Recovery Phase 2 Strategy. This was therefore not included at that time.

2.6 The work of the Involvement Working Group has been taken into account and utilised during the development of the proposed Ladder of Participation.

3. KEY ISSUES:

3.1 Whilst the Recovery Strategy and associated work is promoting an increase in a co-production approach to service design and delivery, it is important for the organisation to recognise that all levels of participation hold a valuable role within the organisation. Striving to increase our levels of co-production does not equate to other forms of involvement being replaced.

3.2 A core foundation to moving this agenda forward pertains to the organisation and staff having a clear understanding of what the different forms/ types of involvement mean. At present there is a lack of shared understanding around forms / types of involvement making it difficult for staff and services to identify when we are supporting co-production and other forms of involvement and engagement. Without this understanding our services experience difficulties in progressing different forms of participation.

3.3 Work has been conducted to define different forms of involvement within TEWV but this requires Trust approval. The proposed definitions can be found in appendix 1.

3.4 Devolvement has been included within the ladder as there is some evidence of this within the Trust, particularly by the Council of Governors. However, as a Trust there is a requirement to agree whether, within our policies and procedures and governance, we are able to support service user led initiatives or to support partnerships between the organisation and user led initiatives. This matter will be taken forward through the Recovery Strategy and the Recovery Programme Board.

3.5 Once approval of the definitions is obtained, there is a need for the organisation to complete work to translate these definitions into what this means for our approaches to delivering and supporting involvement (eg governance arrangements, training, QIS activity, involvement in recruitment). Work has commenced to produce some guidelines based on the draft definitions as a mechanism for providing examples of what this work will include. Examples relating to improvement work (QIS) and training can be found in appendix 2.

3.6 The Council of Governors is being consulted on the proposed Ladder of Participate and associated definition and examples of this application to quality imporvement and training in the involvement of people. It seeks to gain comments from the Council of Governors which will then be considered alongside comments from the Recovery Programme Board who are also being consulted on the proposal prior to the recommendation of the joint development group to the Trust Executive Management Team (EMT) for approval and implementation.

4. CONCLUSIONS:

4.1 There is a requirement for the Trust to have a shared understanding of the different forms of involvement and an approved definition of what this means for TEWV as an organisation. Approval of Trust definitions will provide the foundation for future work to support developments in this area.

5. RECOMMENDATIONS:

The Council of Governor's is asked to consider and provide comments on the :

a. Proposed Ladder of Participation and the definitions (appendix 1 refers)

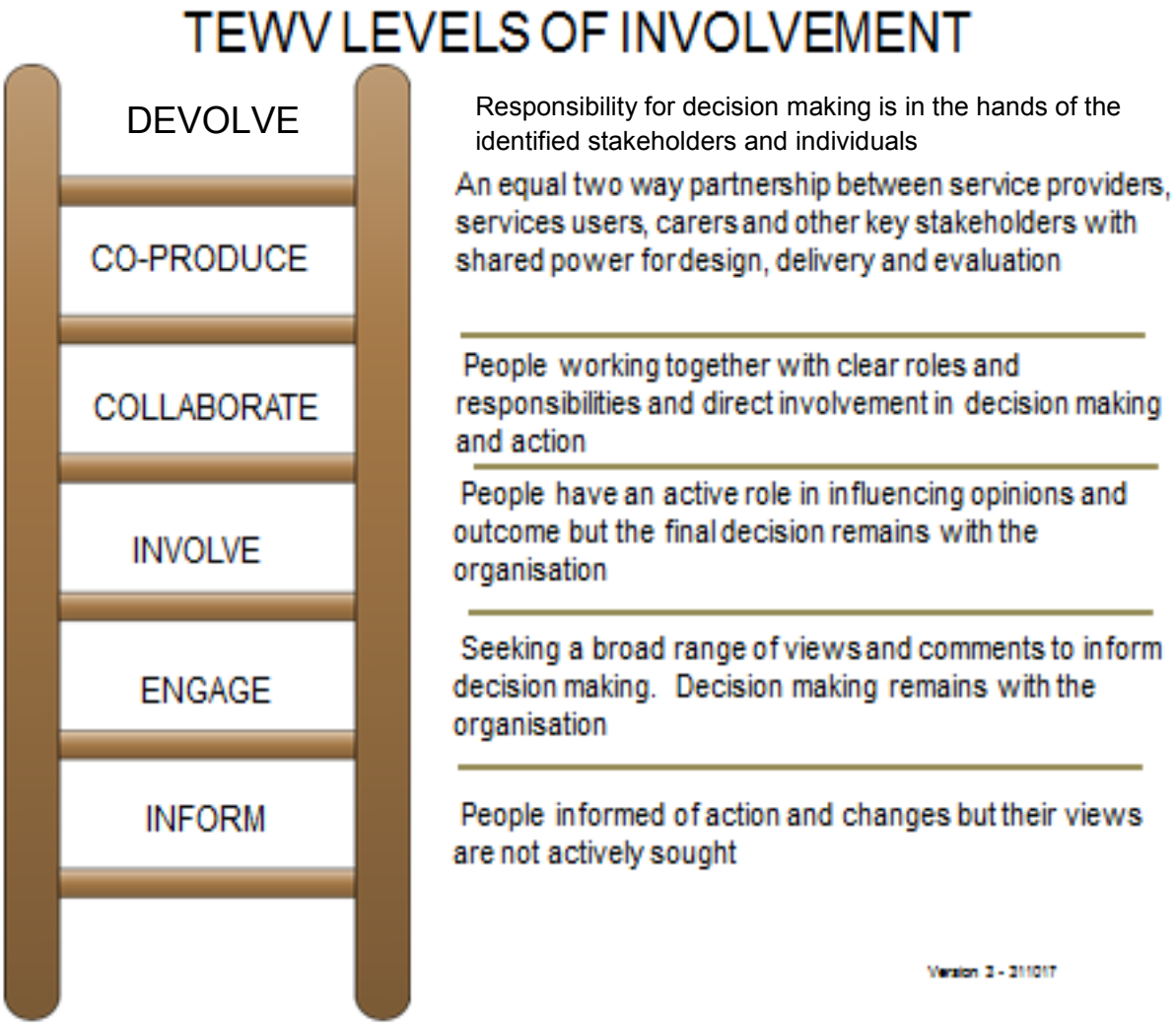
b. Examples provided of participation ladder in practice (appendix 2 refers).

Comments will be fed into the joint working group to consider prior to submission to the Trust for final approval via the Executive Management Team.

Authors: **Kate Hughes (Recovery Project Manager), Kathryn Ord, (Deputy Trust Secretary).**

Background Papers:
Recovery and Wellbeing strategy 2016-2020
Involvement and Engagement Framework
Involvement Working Group meeting actions / notes
Involvement Matrix

Appendix 1 **Proposed Ladder Participation and definitions within future TEWV work**



Examples of levels of participation in practice **Appendix 2**

DESCRIPTOR	LINKS TO QIS
CO-PRODUCE	• Service user / carer identifying topics for QIS • Service user / carer leading QIS projects within teams • Service user / carer having defined roles in the process e.g. as sponsor/process owner • Service user / carer leading the decision making process in conjunction with clinical staff • Service user / carer are partners in the scoping and planning meetings as well as 30/60/90/365 day follow up • Service user / carer are paid members of the KPO team
COLLABORATIVE	• Service user / carer are team members at QIS events • Service user / carer are fully briefed beforehand and clear links made as to their experience and the topic • Sponsor/Process Owner/Workshop Lead/Team Lead have a clear understanding of why service user / carers are in attendance, articulate their expectations of them and provide space for them to contribute and influence decision making • Involved in scoping and planning meetings • Evidence that ideas put forward by service user / carer has influenced decision making
INVOLVE	• Attendance of service user / carer at an improvement event either part-time or full-time • Service user / carer Given space within the event to tell their story / give an account of their experience relevant to the scope of the improvement project • Service User / carer assist in testing out products/outputs with other service users / carers and obtain feedback
ENGAGE	• Service user / carer asked for their ideas to improve services • Service user / carer involved in focus group discussions to obtains views prior or during improvement event • Questionnaires to service users to ask specific questions about their experience of the service under review
INFORM	• Inform service user /carer that improvement work is taking place • Inform service user / carer that changes are happening to services

DESCRIPTOR	LINKS TO training
CO-PRODUCE	• Service users/carers have an equal voice in identifying the need for training. • The outcomes of a training package would be determined by both service users/carers and professionals together. • Service users/carers would co-develop the content of the training. • Service users would/carers co-deliver the training. • Service users would/carers co-evaluate the training. • Service users/carers paid the same rate as professionals for their time.
COLLABORATIVE	• Service users/carers and staff may work together on developing the content or parts of the content. • Service users/carers may deliver sections of the training in partnership with staff. • Service users/ carers offered payment for their contributions. • Service user may be involved in evaluating the training.
INVOLVE	• Service users/carers might be invited to contribute to parts of the session for example sharing their story/ doing a question and answer • Service user/carer may be asked for feedback on the content of the training. • Service users invited to attend training and given relevant information beforehand • Reasonable adjustments considered and travel expenses covered in order to make training accessible for service users/carers.
ENGAGE	• Service users invited to attend and participate in training alongside staff e.g. contribute to workshops or discussion. • Service users/carers consulted for their opinion on what training should cover/how it should be delivered
INFORM	• Inform service users /carers that staff training is taking place and what it covers • Service users/carers to attend training to receive information.