Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

AGENDA FOR THE MEETING OF THE COUNCIL OF GOVERNORS

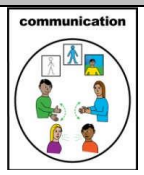
19 May 2016, 6.00pm

(Governor registration and hospitality available between 5pm and 5.45pm)
Middlesbrough Football Club

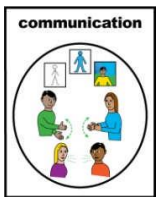
NOTE: Cllr Ann McCoy, Lead Governor will be available from 5.40pm to meet with Governors

Agenda:

No		What we will talk about	Why are we talking about this	Lead Person	Supporting Paper / Spoken report
6.00 – 6.20 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 meetings of the Council of Governors held 25 February 2016 and 16 March 2016	**To agree** To check and approve the minutes of these meetings	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>Catherine Haigh, Public Governor Middlesbrough</u> What are the guidelines for service user and carer involvement in RPIWs and other lean methodology service improvement events? How is involvement in service events monitored to ensure it takes place and that it is appropriate? Can this information be made available to Governors?			
6.20 – 6.25 Governance Related Items					
7.		Summary of the discussions held at meetings of the Board of Directors from February 2016 until March 2016.	**For information** An opportunity to read through the key areas discussed at recent meetings of the Board of Directors	Lesley Bessant, Chairman	Attached

No		What we will talk about	Why are we talking about this	Lead Person	Supporting Paper / Spoken report
8.		NHS Improvement Risk Assessment Framework	**For information** To receive information which is provided to Monitor, the regulator on how the Trust is performing	Phil Bellas, Trust Secretary 	Attached
6.25 – 6.40 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	Jennifer Illingworth Director of Quality 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 2015/16	**For information** To receive the Trust's draft Quality Account for 2015/16	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
6.40 - 7.00 Performance Related					
12.		The Trust's Performance Dashboard as at end March 2016	**For information** To review the performance of the Trust key indicators	Sharon Pickering, Director of Planning, Performance and Communication	Attached
13.		The Trust's Finance report as at end March 2016	**For information** To receive information and review the current financial position of the Trust	Drew Kendall, Acting Director of Finance 	Attached
14.		Payment By Results	**For information** Further to minute 15/74 to receive an update on the position of payment by results in the Trust	Drew Kendall, Acting Director of Finance	Spoken
15.		Development Plan	**To approve** To sign off the 2015/16 Council of Governors' development action plan and to approve the development plan for 2016/17	Phil Bellas, Trust Secretary	Attached
7.00 – 7.10 Standing Committees					
16.		Involvement and Engagement Committee	**For information** To receive information on the work of this committee and approve any recommendations made	Sandy Taylor, Chairman of Committee	Spoken

No		What we will talk about	Why are we talking about this	Lead Person	Supporting Paper / Spoken report
17.		Task and Finish Group: Member and Stakeholder Engagement and Representation	**For information** To receive information on the work of the task and finish group	Sandy Taylor, Chairman of Committee	Spoken
7.10 – 7.15 Procedural					
18.		Date and Time of next meeting: 13 July at 6pm. Middlesbrough Football Club, Riverside Stadium, Middlesbrough, TS3 6RS			Spoken
19.		<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
Contact: Phil Bellas, Trust Secretary Tel. 01325 55 2001/Email: p.bellas@nhs.net

MINUTES OF THE COUNCIL OF GOVERNORS MEETING HELD ON 25 FEBRUARY 2016, 2.00 PM AT MIDDLESBROUGH FOOTBALL CLUB

PRESENT:
Lesley Bessant (Chairman)
Cliff Allison (Durham)
Mary Booth (Middlesbrough)
Janice Clark (Durham)
Paul Emerson-Wardle (Stockton on Tees)
Betty Gibson (Durham)
Andrea Goldie (Darlington)
Glenda Goodwin (Staff, Forensic)
Marion Grieves (Teesside University)
Catherine Haigh (Middlesbrough)
Cllr Tony Hall (North Yorkshire County Council)
Simon Hughes (Staff, Teesside)
Dr Judith Hurst (Staff, Corporate)
Cllr Ann McCoy (Stockton Borough Council)
Gary Matfin (Staff, York and Selby)
Jean Rayment (Hartlepool)
Gillian Restall (Stockton on Tees)
Sandy Taylor (Harrogate and Wetherby)
Richard Thompson (Scarborough and Ryedale)
Vanessa Wildon (Redcar and Cleveland)
Colin Wilkie (Hambleton & Richmondshire)

IN ATTENDANCE:
Martin Barkley (Chief Executive)
Phil Bellas (Trust Secretary)
Marcus Hawthorn (Non Executive Director)
Wendy Johnson (Team Secretary)
Brent Kilmurray (Chief Operating Officer)
David Levy (Director of Human Resources and Organisational Development)
Elizabeth Moody (Director of Nursing and Governance)
Tina Shann (Membership Administrator)
Colin Martin (Director of Finance)
Donna Oliver (Deputy Trust Secretary)
Kathryn Ord (Deputy Trust Secretary)
Sharon Pickering (Director of Planning and Performance)
Patrick Scott (Director of Operations, Durham and Darlington)

OBSERVERS

Student Nurses - Clare Lumley, Michaela Mangan, Kathleen McGill, Matthew Moore, James Morgan, Coleen Nettleton, Kayleigh O'Donnell, Helen Pattinson, Allison Peggs, Megan Tansey, Nicolle Thraxton, Emily Whitelock

16/01 APOLOGIES

Cllr Stephen Akers-Belcher (Hartlepool Borough Council)
Dr Mina Bobdey (Rest of England)
Richenda Broad (Middlesbrough Council)
Hilary Dixon (Harrogate and Wetherby)
Dr John Drury (CCG representative for Hartlepool, Stockton on Tees and South Tees)
Jacqui Dyson (Staff, Durham and Darlington)
Gary Emerson (Stockton on Tees)
Claire Farrell (Redcar and Cleveland)
Chris Gibson (Harrogate and Wetherby)
Dr Hugh Griffiths (Non Executive Director)
Dennis Haithwaite (Darlington)
Prof Pali Hungin (Durham University)
Lesley Jeavons (Durham County Council)
David Jennings (Non Executive Director)
Kevin Kelly (Darlington Borough Council)
Dr Nick Land (Medical Director)
Keith Marsden (Scarborough and Ryedale)
Barbara Matthews (Non Executive Director)
Debbie Newton (representative for North Yorkshire Clinical Commissioning Groups)
Wendy Pedley (Staff, North Yorkshire)
Zoe Sherry (Hartlepool)
Richard Simpson (Non Executive Director)
Dr David Smart (CCG representative for Co Durham and Darlington)
Angela Stirk (Hambleton and Richmondshire)
Sarah Talbot-Landon (Durham)
Jim Tucker (Deputy Chairman)
Prof Ian Watt (University of York)
Judith Webster (Scarborough & Ryedale)
Mark Williams (Durham)

16/02 WELCOME

The Chairman opened the meeting and noted apologies. Gary Matfin, Staff Governor representing York and Selby was welcomed to his first meeting. Dr Mina Bobdey had been elected as Public Governor representing the Rest of England Constituency. Vince Crosby, Public Governor Durham had provided notice of resignation due to other commitments.

It was noted that a number of Non Executive Directors had submitted apologies for the meeting; this was due to illness and was unavoidable.

Patrick Scott, newly appointed Director of Operations for Durham and Darlington was introduced to the Council.

16/03 MINUTES OF PREVIOUS MEETING

The Council of Governors considered the minutes from the public meeting held on 17 November 2015.

Agreed – That the minutes of the meeting held on 17 November 2015 be approved and signed by the Chairman subject to an amendment of minute 14/78 to record Vanessa Wildon not Vanessa Wilson as a nomination to the Governor Oversight Committee.

16/04 PUBLIC ACTION LOG

Consideration was given to the Public Action Log noting the relevant updates provided at the meeting including:

Requests for extension for the following actions:

1) The introduction of Governor appraisals (minute15/32 refers).
2) Provision of guidance on Payment by Results to May 2016 as the national guidance had not yet been made available (minute 15/74 refers).
3) The consideration of a Governor annual report (minute 15/74) refers as this would fall within the remit of the Governor task and finish group on member and stakeholder representation and engagement.
4) The appointment of a Staff Governor to the Governor task and finish group on member and stakeholder representation and engagement due to the first meeting being delayed (minute 15/79 refers).

The following actions were noted as being completed:

5) Minute 15/74 – an update on the provision of learning disability beds at a Governor Development Day.
6) Minute 15/74 – to circulate the Trust's Associate Hospital Manager policy to Governors.

Agreed - The Council of Governors agreed to amend the timescales as noted within the Action Log.

Action: Mrs Ord

16/05 DECLARATIONS OF INTEREST

There were no declarations of interest.

16/06 CHAIRMAN'S REPORT

The Chairman reported on her activities since November 2015. She had:

1) Made a number of visits to services and teams including:
    a. Completion of her visits to the estates and housekeeping teams where she had been particularly impressed with how food was moved around the buildings and the excellent standard of cleanliness.
    b. Attendance at a Schwartz round which allowed staff to talk about issues in a safe environment. The topic for discussion was the Care Quality Commission and how staff felt on the receiving end of inspections.
2) Presented:
    a. Living the Value Awards to staff and teams at:
        - Westerdale South.
        - Harrogate's Briary Wing RICE team.
    b. Recovery Awards to service users at Ridgeway

3) Participated in the appointment process for the new Director of Operations for Durham and Darlington.
4) Visited with Non Executive Directors, the new outpatient area at Bootham Park Hospital in York which was opening on a phased basis. The new environment was a significant improvement for staff and patients.
5) Met with the Chairman of York's Health and Wellbeing Board who reported positively on the work of the Trust and was keen to continue building effective partnership working.

16/07 GOVERNOR QUESTIONS

1. Cllr Ann McCoy, Appointed Governor Stockton Borough Council

'Following the recent report in the press on 2/2/16. I would like to request that Governors are given an update on what procedures have been put in place following this unfortunate death in 2014?'

Mrs Moody apologised to the Council as she was not in a position to answer the question at that time. A response would be provided to Cllr McCoy outside of the meeting. Cllr McCoy requested that the response was also circulated to all Governors.

Action Item – Mrs Moody

2. Cliff Allison, Public Governor Durham

'Can the opening hours of café/restaurants in TEWV be confirmed?'

Mr Kilmurray confirmed the opening hours of café areas within the Trust as:

Lanchester Road Hospital - Monday to Friday 8.30am – 3.00pm
West Park Hospital – Monday to Friday 8.30am – 3.00pm
Auckland Park Hospital – Monday to Friday 10.00am – 2.30pm
Flatts Lane Centre – Monday to Friday 9.00am to 3.45pm
Roseberry Park Hospital – Monday to Friday 8.30am to 4.00pm

Mr Allison expressed concern that outside of these hours limited alternatives were available that included vending machines with no healthy choices, no weekend facilities and requested the opening hours was re-visited along with the cost of purchasing items which was reported to be high.

Mr Kilmurray agreed to re-visit the availability of directly provided facilities, but this very much depended on the demand. It was noted that changes were planned to the environment at West Park Hospital in the area of the café/reception.

Action Item – Mr Kilmurray

3. Cliff Allison, Public Governor Durham

'*What was the role, recruitment process and mandatory training requirements of volunteers?*

Mr Levy responded in that:

1) The number of volunteer roles was increasing and included:
   - Voluntary Driving.
   - Dining Assistance.
   - Gardening.
   - Supporting intervention groups.
   - Accompanying staff on home visits.
2) Recruitment of volunteers had changed over the last two years, with services now identifying roles for volunteers and a volunteer being sought through NHS Jobs.
3) There was a desire to double the number of volunteers within the Trust.
4) Work was still being undertaken to improve the process and an improvement event was planned for April 2016.
5) The Trust had to adhere to national guidelines for volunteers which included requirements for statutory training.

In response it was raised that:

1) Posters describing what volunteers could get involved in for staff and the public would assist awareness.
2) Through a personal experience of volunteering concerns were around:
   a. Requirement to complete an Occupational Health assessment resulting in a number of months delay in the receipt of a response to the assessment.
   b. Gardening tasks being undertaken, when clearly this was not appropriate as a volunteer due to physical medical conditions which had been highlighted with Occupational Health.
   c. Potential volunteers being put off getting involved due to the application and interview process.
   d. Requirements to undertake mandatory training without any consideration as to previous experience/ knowledge/training and that training was not tailored to the role being undertaken.

Mr Taylor, as the Governor representative on the Trust's Workforce Working Group, advised that the role of volunteers had been discussed, the views raised by Governors were recognised and that the process of having volunteers within the Trust which was much more rigorous than in the past, whilst also meeting the need to be sensitive to both the Trust and the volunteer.

4. Catherine Haigh, Public Governor Middlesbrough

'*The Crisis Assessment Suite (CAS) at Roseberry Park Hospital was accessible by walking along a pathway next to the inpatient windows. People on the way to and from the CAS could easily see into rooms, this issue had been raised previously but so far nothing had been done in nearly a year of the CAS existence to ensure the privacy and dignity of patients. What was the Trust going to do to ensure privacy for patients?*'

Mr Kilmurray advised that work had commenced at Roseberry Park Hospital on addressing the issues raised to ensure the privacy and dignity of patients.

5. Sandy Taylor, Public Governor Harrogate and Wetherby

'Service users and carers had raised the issue of communicating with CMHT and particularly their key worker along with the issue of leaving messages with administrative staff. In particularly, they would like to know if the Trust has any plans to use SMS messaging?'

Mr Kilmurray advised that:

1) A SMS facility did exist to allow the Trust to send a message to remind a service user of appointment.
2) No facility was currently available to allow service users to SMS to the Trust.
3) The use of staff email addresses was encouraged to allow communication between staff and service users.
4) Some staff did choose to share their work mobile number with service users.
5) Work was taking place within the Trust through purposeful and productive community work, this matter would be raised through this process. This would include providing clarity on the issuing of mobile numbers to patients.

Action Item – Mr Kilmurray

6. Sandy Taylor, Public Governor Harrogate and Wetherby

'Service users and carers have requested if formal processes exist to ensure involvement at the earliest possible stage in planning of new service development and particularly capital developments?'

Mr Martin responded in that:

1) Service user and carer involvement was managed through the Patient and Public Involvement team of the Trust.
2) In relation to the Harrogate Development two design workshops had been held covering Adult and Older People's services for which there had been service users and carer attendance.
3) The matter had been raised with the Head of Capital Design to investigate how further linkages could be made with service user and carer groups during the process.

7. Sandy Taylor , Public Governor Harrogate and Wetherby

'The most recent six month nurse staffing report, reference was made to data referring to ten incidents in respect of pressure ulcers and 410 incidents of medication errors. Could Governors receive further information on these two areas and the further action agreed by the Board?'

In response, Mrs Moody informed the Council that:

1) The staffing report looked at the numbers of staff on duty over/under the predicted establishment.

2) As part of the report and analysis, a range of other quality indicators were considered to identify whether staffing of wards was a factor to be considered.
3) The ten reported incidents of pressure ulcers were all level two incidents. The severity is scored between one and four with four being of the highest nature which required notification to NHS England.
4) The Trust was working to ensure that all staff were grading pressure ulcers consistently and correctly.
5) Full investigations were undertaken in relation to medication errors by the patient safety team. The majority of incidents had been reported as low or no harm and managed locally. This had been included within the report as a quality indicator to ensure that staffing levels against incidents reported was fully reported and analysed.
6) The Board, on reviewing the six month report had requested that further triangulation of staffing data against quality incidents should continue.

8. Wendy Pedley, Staff Governor North Yorkshire

'Is there a way that the Trust can offer staff a rationale as to why they are unable to park at the Briary Unit (within Harrogate District Hospital) free of charge where this is their dedicated workbase? This could also be used as an incentive for recruiting to staff vacancies'.

Mr Kilmurray advised that as the Trust was not the owner of the Briary Unit site it was not possible to remove car parking charges. A number of free parking spaces was available for those members of staff classed as frequent users but there were limitations on this.

16/08 BOARD OF DIRECTORS FEEDBACK

Mr Bellas presented the report containing the Board roundup summaries from November 2015 to January 2016 for information and to allow questions and clarification of any matters.

In response to a question it was noted that:
1) Culture metrics were in place for each of the Trust values and behaviour statements

Agreed – The Council of Governors received and noted the content of the Board round up from November 2015 to January 2016 inclusive.

16/09 MONITOR RISK ASSESSMENT FRAMEWORK

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

It was noted that:
1) The Board of Directors had agreed (on 26 January 2016) the Quarter 3 2015/16 submission to Monitor of:

a) A Financial Sustainability Risk Rating (replacing the Continuity of Service Risk Rating) of '4' in line with plan with a declaration that the Trust would maintain a rating of at least '3' for the next 12 months.
b) Confirmation that capital expenditure for the remainder of the financial year would not materially differ from plan.
c) Confirmation that no subsidiaries were included within the financial results.
d) Confirmation of the two governance statements.
d) A reported governance rating of 'green'.
e) Exception reports in relation to:
    - The inspection of Forensic Learning Disability wards at Roseberry Park Hospital, for which a follow up review by the CQC was still awaited in response to the completion of action plans.
    - The Trustwide CQC inspection. It was noted that all actions had been completed with the exception of an extension to the timescale for one action relating to the implementation of mental capacity monitoring systems from January 2016 to May 2016.
    - A progress report on the expansion of the Trust into York and Selby including:
        - The reopening of the Section 136 Suite on 16 December 2015 following an inspection by the CQC.
        - Negotiations with the CQC relating to the return of outpatient services to Bootham Park, with an expected timescale of February 2016.
        - Discussions around compliance issues identified during an inspection of Bootham Park in September 2015.
        - The provision of a corporate governance statement and statement on quality governance in accordance with the undertaking provided in September 2015.
        - The planned commencement of the refurbishment of Peppermill Court.
        - The action taken by the Trust as one of four organisations named in a Judicial Review in relation to the closure of Bootham Park Hospital.

Agreed – The Council of Governors received and noted the content of the Monitor Risk Assessment Framework for Quarter 3, 1 October 2015 – 31 December 2015.

16/10 COMPLIANCE ACTIVITY RELATING TO THE CARE QUALITY COMMISSION (CQC)

Arising from the report Mrs Moody advised that:

1) The Trust was still awaiting feedback from the Judicial Review in relation to the closure of Bootham Park Hospital.
2) The Section 136 suite (place of safety) had re-opened following an inspection by the CQC on 7 December 2015.
3) A phased return of outpatient services to Bootham Park Hospital was expected from mid February 2016.

4) The latest intelligence report on the Trust published by the CQC had provided the Trust with an overall risk score of 4 (2.76%) out of a maximum possible risk score of 145.
5) The compliance team and heads of service for adult and older people's services within York were working on addressing issues raised in the inspection carried out by the CQC in September 2015.
6) The Trust had received 21 inspections under the Mental Health Act since November 2015.
7) An unannounced inspection by the CQC had been undertaken for Forensic Learning Disability Services, verbal feedback had reported noticeable improvements, the final report was awaited.
8) The compliance team were continuing with their programme of mock inspections.

In response to questions it was noted that:

1) The Trust was working towards Ofsted registration for Holly Unit and Baysdale Unit. This may result in duplicate reporting requirements but as this was the first time the Trust had been required to do this, the impact was not yet known. Mrs Moody agreed to report the outcome back to a future meeting.

Action Item – Mrs Moody

2) The number of deaths had increased for those patients detained under the Mental Health Act, but as more older people fell under the safeguards of the Act rather than being informal patients, it was expected that the number of deaths would increase due to the age profile of those patients. It was not seen as a significant risk in the Trust.

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

16/11 UPDATE ON SERVICE CHANGES

Consideration was given to the service update report including:

1) The completion of the final phase of West Lane Hospital with open days for staff planned for 7 and 8 March. Governors would be invited to attend.

Action Item – Mrs Ord

Following a question, Mr Kilmurray advised that he was not aware of implications for the Trust's transforming care programme as a result of the press reports of problems with housing associations providing accommodation for learning disability patients.

Miss Haigh thanked the Trust for the information on Forensic Services and the inclusion of service users.

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

16/12 CRISIS SERVICE UPDATE

Further to minute 15/71 a summary report on the provision of Crisis Services was considered.

Arising from discussion the following points were noted:

1) That data for North and South Durham should be broken down to Durham and Darlington to allow Governors to obtain an overall picture for their area. Mrs Pickering confirmed that a breakdown by GP practice should be available.

Action Item – Mr Kilmurray / Mrs Pickering

2) A crisis expert clinician had been appointed who would be looking at training locally and nationally for crisis care. This would ensure that good practice was shared within the Trust.
3) The figures showed a high number of referrals for Darlington compared to other areas. Mr Kilmurray advised that no specific discussions had been held with the Clinical Commissioning Group (CCG) around this but work was underway reviewing the services within Darlington. This would report to the Executive Management Team (EMT) in March 2016.
4) The Middlesbrough crisis service had access to two crisis beds provided by the Richmond Fellowship.
5) There appeared to be a low number of face to face contacts for Middlesbrough compared to other areas. The reason for this would need to be investigated.

Action Item – Mr Kilmurray

6) Feedback from service users involved in the Crisis Care Concordat covering Harrogate was that it was unproductive. Mr Kilmurray advised that the Trust was doing more to engage with the police and other stakeholders led by the Director of Operations for North Yorkshire.

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

16/13 AUTISM SERVICE UPDATE

Mr Kilmurray advised of work in respect of autism services including:

1) The limited availability of adult autism services across the Trust.
2) An event was planned for May 2016 to develop a vision for the service with representatives from adult and learning disability service staff and service users and carers. The event would look at the statutory guidance, current pathways and capacity issues taking into account that conducting one assessment required approximately 40 hours work.
3) Once diagnosis was made, there needed to be consideration as to what type of service could be made available whilst taking into account views of commissioners and expectations of service users and carers.

The Council requested an update following the event to at a future meeting.

Action Item – Mr Kilmurray

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

16/14 CARER STRATEGY UPDATE

Mrs Moody advised that:

1) Following the submission of a business case, EMT had agreed to fund a position for a period of a year working within the Patient Experience Team to deliver the requirements of the Carers Strategy. This would include:
   - Re-engaging the carer link workers.
   - Developing training for staff.
   - Taking forward feedback received from service users and carers.
   - Implementing the Triangle of Care requirements and monitoring.
2) In order to achieve the requirements, 80% of services need to achieve the required standards.

Arising from questions:

1) It was recognised that carers could be young people as well as adults; Stockton Borough Council was seen as an exemplar for young carer services. A priority for the Trust was to work to deliver a young carer strategy in conjunction with Local Authorities.
2) As the Trust did sign up to the Triangle of Care in 2014, there was no requirement to re-sign, the key message for Governors to acknowledge was that:
   a. The Trust was signed up to the Triangle of Care.
   b. Investment had been made to resource work in support of the Carers Strategy and Triangle of Care.
   c. The Trust's aim was to achieve 80% assessment over the next year.

Agreed – The Council of Governors received and noted the update on the Carer Strategy.

16/15 PERFORMANCE DASHBOARD

Mrs Pickering presented the key issues as contained within the report and advised that a detailed information pack had been made available to Governors to support the performance summary.

In receiving the report the following was noted from discussions:

1) That the full report did not include data from York and Selby as this was not yet available through the Integrated Information Centre. The exception to this was three workforce indicators.
2) It was expected that reporting on York and Selby would be integrated from April 2016.
3) Two indicators relating to access to services usually showed a dip in December, however there had been an increase in January.
4) Improvements had been seen during December for out of locality admissions, this trend had continued into January.

As a result of discussion clarification was provided on the following:

1) The action plan to support children and young people's services was to reduce the staff vacancies, that once in post, the service would welcome support from Organisational Development.

2) In relation to indicator 14 – number of instances where a patient had three or more admissions in the past year to assessment and treatment wards. As this was a downward trend and was a concern of the Board all cases had been reviewed by the Speciality Development Group to provide assurance as to whether admissions had been appropriate. The Quality Assurance Committee would be continuing to oversee this with a report expected for submission to the Board in April 2016.
3) For the indicator relating to unexpected deaths (indicator 17) a breakdown for Durham and Darlington would be included in future reports. The trajectory was increasing against the target however this mirrored the national trend. It was noted that all deaths were suicides.

Action Item – Mrs Pickering

4) Mrs Moody reported that within the national data for unexpected deaths there was an increase in deaths of males between 45 and 54 years of age. Research was being undertaken to identify if this was a trend within the Trust.

   A more comprehensive report to be provided on unexpected deaths to a future meeting (July).

Action Item – Mrs Moody

5) That Indicator 21, percentage sickness absence rate would include reasons that incorporated instances of bullying and harassment. Each locality regularly considers instances of sickness and reasons with the Board receiving a fully report each quarter.

   Mr Levy advised that correlation of trends does take place and there were some linkages to sickness.

   Support for staff was available through the employee support service, and where there were high risk grievance cases, this support was sourced.
6) The indicator that was of the highest concern to the Board was in relation to waiting times and particularly the children and young people's service within Durham and Darlington.

Agreed – That the Council of Governors received and noted the Performance Dashboard report as at end of December 2015.

16/16 FINANCE REPORT

Consideration was given to the finance report for the period up to 31 December 2015.

In response to a question it was noted that:

1) 80% of the total provider sector was in deficit with the majority being acute trusts. This position was on a deteriorating trend.
2) Trusts within the mental health sector were in the main managing their financial position.
3) The combined surplus of trusts was relatively small.
4) The priority for 2016/17 was to ensure all trusts were in a balanced financial position.

5) The Trust needed to be mindful that there may, in future years be restrictions on capital provision.
6) There was no current indication that any surplus monies would be taken from Trusts who were in a financial surplus.

Agreed - The Council of Governors received and noted the Finance report as at end December 2015.

16/17 COMMITTEE UPDATE

The Chairman invited Mr Taylor to update the Council of Governors on the work of the Making the Most of Membership Committee.

It was noted that the Committee:

- Considered a draft report from North East Mental Health Development (NEMHDU) Unit who had been commissioned by the Chief Executive to review service user involvement within Teesside, Durham and Darlington. Key findings from the report were that involvement:
    - Was important for delivering high quality services and promoting recovery.
    - Should start at first contact with health (commissioners and providers), social or voluntary sector.
    - Required a co-ordinated multi-agency approach.
    - Was everybody's responsibility.
    - Should be embedded in the culture of the organisation
    - Needed to be understood by all staff in relation to their individual role.

  The final report would be submitted to the Chief Executive for onward consideration by EMT.
- Reviewed the current position of the Trust membership, a net increase of 957 public members against a target of 250 as at 31 January 2016. This increase included a recruitment exercise within York and Selby and parts of North Yorkshire. Overall membership of the Trust was at a satisfactory level.
- Considered the strategic metrics in support of the Involvement and Engagement Framework scorecard, a number of metrics required a baseline which would be set during 2016/17. The Committee requested approval of the Scorecard.
- Revised its Terms of Reference as a result of the Involvement and Engagement Framework. The Committee requested approval of the revised Terms of Reference.
- Discussed plans for the 2016 Annual General and Members Meeting and proposed a theme topic of "Service User and Carer Involvement and Engagement".
-

Agreed – The Council of Governors:

1. ***Received and noted the update from its Making the Most of Membership Committee.***
2. ***Approved the:***
    a. ***Involvement and Engagement Framework Scorecard.***

b. ***Draft Terms of Reference and the change of the Committee's name to Involvement and Engagement Committee.***
c. ***Theme for the 2016 Annual General and Members meeting of "Service User and Carer Involvement and Engagement".***

16/18 CONFIRMATION FUTURE MEETING DATES

The Chairman confirmed the next meeting as 19 May 2016, 6pm at Middlesbrough Football Club.

A special meeting of the Council of Governors would be held on 16 March 2016, 4.30pm at West Park Hospital to consider the appointment of the Chief Executive.

16/19 CONFIDENTIAL RESOLUTION

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

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

Any terms proposed or to be proposed by or to the Trust in the course of negotiations for a contract for the acquisition or disposal of property or the supply of goods or services.

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

The Chairman closed the public session of the meeting at 3.40pm.

MINUTES OF THE SPECIAL COUNCIL OF GOVERNORS MEETING HELD ON 16 MARCH 2016, 4.30 PM AT WEST PARK HOSPITAL, DARLINGTON

PRESENT:
Lesley Bessant (Chairman)
Cliff Allison (Durham)
Mary Booth (Middlesbrough)
Janice Clark (Durham)
Hilary Dixon (Harrogate and Wetherby)
Gary Emerson (Stockton on Tees)
Betty Gibson (Durham)
Chris Gibson (Harrogate and Wetherby)
Andrea Goldie (Darlington)
Glenda Goodwin (Staff, Forensic)
Catherine Haigh (Middlesbrough)
Dennis Haithwaite (Darlington)
Simon Hughes (Staff, Teesside)
Prof Pali Hungin (Durham University)
Dr Judith Hurst (Staff, Corporate)
Cllr Ann McCoy (Stockton Borough Council)
Jean Rayment (Hartlepool)
Gillian Restall (Stockton on Tees)
Sandy Taylor (Harrogate and Wetherby)
Judith Webster (Scarborough & Ryedale)
Vanessa Wildon (Redcar and Cleveland)
Mark Williams (Durham)
Colin Wilkie (Hambleton & Richmondshire)

IN ATTENDANCE:
Phil Bellas (Trust Secretary)
Tina Shann (Membership Administrator)
Kathryn Ord (Deputy Trust Secretary)

16/20 APOLOGIES
Cllr Stephen Akers-Belcher (Hartlepool Borough Council)
Dr Mina Bobdey (Rest of England)
Richenda Broad (Middlesbrough Council)
Dr John Drury (CCG representative for Hartlepool, Stockton on Tees and South Tees)
Jacqui Dyson (Staff, Durham and Darlington)
Paul Emerson-Wardle (Stockton on Tees)
Claire Farrell (Redcar and Cleveland)
Marion Grieves (Teesside University)
Cllr Tony Hall (North Yorkshire County Council)
Lesley Jeavons (Durham County Council)
Kevin Kelly (Darlington Borough Council)
Keith Marsden (Scarborough and Ryedale)
Gary Matfin (York and Selby)
Debbie Newton (representative for North Yorkshire Clinical Commissioning Groups)

Wendy Pedley (Staff, North Yorkshire)
Zoe Sherry (Hartlepool)
Dr David Smart (CCG representative for Co Durham and Darlington)
Angela Stirk (Hambleton and Richmondshire)
Sarah Talbot-Landon (Durham)
Richard Thompson (Scarborough and Ryedale)
Prof Ian Watt (University of York)

16/21 WELCOME

The Chairman opened the meeting and noted apologies.

16/22 DECLARATIONS OF INTEREST

There were no declarations of interest.

16/23 CONFIRMATION FUTURE MEETING DATES

The Chairman confirmed the next meeting as 19 May 2016, 6pm at Middlesbrough Football Club.

16/24 CONFIDENTIAL RESOLUTION

> ***Agreed***– *that representatives of the press and other members of the public be excluded from the remainder of this meeting on the grounds that the nature of the business to be transacted may involve the likely disclosure of confidential information as defined in Annex 9 to the Constitution as explained below:*
>
> *Information relating to the financial or business affairs of any particular person (other than the Trust).*
>
> *Any terms proposed or to be proposed by or to the Trust in the course of negotiations for a contract for the acquisition or disposal of property or the supply of goods or services.*
>
> *Information which, if published would, or be likely to, inhibit -*
> *(a) the free and frank provision of advice, or*
> *(b) the free and frank exchange of views for the purposes of deliberation, or*
> *(c) would otherwise prejudice, or would be likely otherwise to prejudice, the effective conduct of public affairs.*

The Chairman closed the public session of the meeting at 4.35pm.

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
19/05/2015	15/32	Introduction of Governor appraisals.	Phil Bellas	~~Feb-16~~ ~~March -16~~ July 16	
17/11/2015	15/74	To arrange the delivery of a training event including role play exercise for Associate Hospital Managers at a future Governor Development Day.	Kathryn Ord	Jul-16	
17/11/2015	15/74	To provide an update on the 2016 guidance on payment by results.	Colin Martin	~~Feb-16~~ May -16	see agenda item 14.
17/11/2015	15/74	To refer the suggestion of the production of a Governor annual report to the Task and Finish Group on Member and Stakeholder Representation and Engagement.	Phil Bellas/Kathryn Ord	~~Feb-16~~ March -16	Completed
17/11/2015	15/79	To seek a nomination for the appointment of a staff governor to the task and finish group for member and stakeholder representation.	Kathryn Ord	~~Jan-16~~ March -16	Completed
25/02/2016	16/04	To update the Public Action Log following the meeting held on 25/2/16	Kathryn Ord	May-16	Completed
25/02/2016	16/07	To provide a response to the question form Cllr Ann McCoy following the recent press coverage	Elizabeth Moody	Mar-16	Completed
25/02/2016	16/07	To review the provision of directly provided café/restaurant facilities.	Brent Kilmurray		
25/02/2016	16/07	To seek clarity on the issuing of staff mobile numbers to patients in relation to a recent SBard communication.	Brent Kilmurray		
25/02/2016	16/10	To update on reporting requirements as a result of OfSted registration	Elizabeth Moody		
25/02/2016	16/11	To advise Governors of the West Lane open days	Kathryn Ord	Mar-16	Completed

Date	Minute No.	Action	Owner(s)	Timescale	Status
25/02/2016	16/12	To break down the data within the Crisis Service update report for Durham and Darlington and circulate	Sharon Pickering / Brent Kilmurray	May-16	
25/02/2016	16/12	To investigate and report on the low number of face to face contacts for crisis service within Middlesbrough	Brent Kilmurray	May-16	
25/02/2016	16/12	To provide an update following the event to look at the provision of autism services within the Trust.	Brent Kilmurray	May-16	
25/02/2016	16/15	To breakdown the performance indicator 17 - unexpected deaths for Durham and Darlington and circulate.	Sharon Pickering	May-16	included within report under agenda item 12.
25/02/2016	16/15	To provide a comprehensive report to the Council on unexpected deaths.	Elizabeth Moody	Jul-16	

ITEM NO 7

FOR GENERAL RELEASE

COUNCIL OF GOVERNORS

DATE:	**19 May 2016**
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:	**19 May 2016**
TITLE:	**Board round-up**

1. INTRODUCTION & PURPOSE:

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

2. BACKGROUND INFORMATION AND CONTEXT:

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

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

3. KEY ISSUES:

3.1 Copies of the Board round-ups for the meetings held from 23 February 2016 to 22 March 2016 are attached to this report. The round up from the meeting held on 26 April is not yet available. This will be included within a future report.

4. IMPLICATIONS:

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

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

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

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

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

5. CONCLUSIONS:

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

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

6. RECOMMENDATIONS:

6.1 The Council of Governors is asked to note the key matters considered by the Board of Directors at its meetings held from 23 February 2016 to 22 March 2016 (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 23 February 2016

The key items on this month's agenda were

Chairman's report
The Chairman highlighted a number of visits and meetings. For instance:

- She was full of praise for the Ridgeway Recovery Awards event that she'd attended in February.
- She briefed the Board on a positive meeting with the Chairman of York's Health and Wellbeing Board and noted that the Council were keen to work with TEWV.
- She attended the equality and diversity steering group in January which included a very interesting discussion with one of the Trust chaplains, Ibrahim Meah.

Quality Assurance Committee
The Board received and noted the Quality Assurance Committee report. They noted the work that was being undertaken by the patient safety group to make sure we implement applicable recommendations from the Southern Health NHS Foundation Trust independent review.

Nurse staffing report
The Board discussed the nurse staffing report, which included the information requested on missed breaks and incidents that referenced staffing levels. Board members noted that although the numbers of missed breaks remained high there were no patterns and therefore it was difficult to draw any conclusions. The Board were informed that a safe staffing task and finish group was been established, focussing initially on inpatient services. There was also a discussion about the planned recruitment campaign for York and Selby, in advance of the reopening of Peppermill Court as an adult inpatient unit.

Mental Health Legislation Committee
The Board received this report and noted the 'significant assurance' provided by the internal auditors on Mental Health Act compliance.

Smoking cessation and nicotine management
Nick Land presented the progress report which demonstrated that the Trust was on track for becoming 'smoke free' on 9 March. Board members noted that there was a level of anxiety amongst staff. However, they also recognised that although complicated and challenging it was the right thing to do. Nick explained some of the measures that were being put in place to support staff and service users.

Staff survey
David Levy gave a presentation on the results of the staff survey and noted that overall, the results were positive. The Trustwide action plan will be presented to the Board in May and locality plans will be produced by June.

Finance report
Colin Martin presented the finance report and noted that there was no significant changes to the Trust's present or forecast financial position.

Performance dashboard
The board made a number of amendments and then approved the proposed performance dashboard for 2016/17; this included introducing ‘amber’ traffic lights to provide greater clarify on the level of risk.

Strategic direction performance report
The Board received the report and agreed the proposed changes to the business plan.

Feedback from Board of Directors meeting held 22 March 2016

The key items on this month's agenda were

Chairman's report
The Chairman had attended the service user and carer conference in Scarborough. She fed back to the Board that it had been a popular event with lots of positive comments and feedback from participants.

Lesley also reported on a visit to Birch Ward and said she was really impressed with positive changes to the ward since her previous visit. She said the team were really enthusiastic and proud of what they'd achieved.

The Board congratulated Colin Martin on his appointment as Martin Barkley's successor.

Locality briefing – forensic services
Levi Buckley, director of operations, gave a presentation on the key issues facing the directorate which was well received by the Board. Board members asked Levi to pass on their thanks to his staff for their hard work.

Quality Assurance Committee
The Board received the report of the quality assurance committee.

Nurse staffing
The Board received and discussed the nurse staffing report. They also asked to receive a briefing on the Trust's approach and longer term plans for recruitment, training and retention of nurses in May or June.

Equality objectives 2016 – 2020
The Board received a progress report from David Levy on equality objectives set in 2012 and proposals for equality objectives for 2016-20, which had been developed with the localities. The Board approved the objectives.

Finance report
Colin Martin presented the finance report and noted that the Trust was on track to meet targets.

Performance
Sharon Pickering presented the performance dashboard report and the Board noted the improving position with an increase in the number of 'greens' on the dashboard compared to earlier in the year.

Information governance toolkit
The Board approved the submission of the information governance toolkit.

ITEM NO. 8

FOR GENERAL RELEASE

COUNCIL OF GOVERNORS

DATE:	**19th May 2016**
TITLE:	**Risk Assessment Framework Report**
REPORT OF:	**Phil Bellas, Trust Secretary**
REPORT FOR:	**Information/Assurance**

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

Executive Summary:

This report seeks to provide assurance that the Trust was compliant with the requirements of NHS Improvement's Risk Assessment Framework for Quarter 4, 2015/16.

Recommendations:

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

MEETING OF:	**Council of Governors**
DATE:	**19th May 2016**
TITLE:	**Monitor Risk Assessment Framework Report**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to provide the Council of Governors with information on the Trust's position against the requirements of the Risk Assessment Framework (RAF) for Quarter 4, 2015/16 (1st January 2016 to 31st March 2016).

2. BACKGROUND INFORMATION AND CONTEXT:

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

2.2 At Quarter 3, 2015/16 the Trust had a Financial Sustainability Risk Rating of 4 ("no evident concerns") and a Governance Risk Rating of "green".

3. KEY ISSUES:

3.1 At its meeting held on 26th April 2016 the Board of Directors approved the submission of information to NHS Improvement for Quarter 4, 2015/16 in accordance with the Risk Assessment Framework based on:

(a) A Financial Sustainability Risk Rating of 4.

Details of the Trust's financial performance are provided under agenda item 13.

(b) Confirmation that the Board anticipates that the Trust will continue to maintain a Financial Sustainability Risk Rating of at least 3 for the next 12 months.

(c) Confirmation that the Board anticipates that capital expenditure for the remainder of the financial year will not materially differ from the forecast in the financial return.

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

(e) Confirmation of the following Governance Declarations:

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

- "The Board confirms that there are no matters arising in the quarter requiring an exception report to Monitor (per the Risk Assessment Framework, Table 3) which have not already been reported."

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

(g) The following information on Executive team turnover (as at 31st March 2016) which NHS Improvement uses as a potential indicator of quality governance concerns:

Executive Directors	Actual
Total number of Executive posts on the Board (voting)	5
Number of posts currently vacant	0
Number of posts currently filled by interim appointments	0
Number of resignations in quarter	1
Number of appointments in quarter	1

(h) The report on the elections held on 24th March 2016 to the City of York Public Constituency.

(i) The provision of an exception report covering CQC compliance, the York and Selby transaction and changes to the Trust's Executive Team as at 31st March 2016.

A copy of the exception report is attached as Annex 1.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** Information provided by the CQC is used by NHS Improvement to assess organisational and financial governance, including service performance and care quality.

4.2 **Financial/Value for Money:** This issue is covered in the report of the Acting Director of Finance under agenda item 13.

4.3 **Legal and Constitutional (including the NHS Constitution):** The Trust is required to hold a Licence in order to provide NHS services.

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

4.5 **Other implications:** There are no other implications associated with the report.

5. RISKS:

5.1 There are risks that NHS Improvement will take regulatory action if the Trust's Risk Ratings deteriorate.

6. CONCLUSIONS:

6.1 The Board informed NHS Improvement that it considered that the Trust was compliant with the requirements of the Risk Assessment Framework for Quarter 4, 2015/16.

7. RECOMMENDATIONS:

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

Background Papers:
NHS Improvement's Risk Assessment Framework (August 2015)

Annex 1

Risk Assessment Framework

Exception Report – Quarter 4, 2015/16

(1) **CQC Compliance:**

(a) At Quarter 4, 2014/15 the Trust advised Monitor that it had declared its Forensic Learning Disability services at Roseberry Park, Middlesbrough to be fully compliant with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 following action taken to address compliance issues and "moderate concerns" raised by the Care Quality Commission (CQC) arising from an inspection in March 2014.

The CQC re-inspected the services on 22nd February 2016 and its report is awaited.

(b) On 11th May 2015 the CQC published its reports on the inspection of the Trust in January 2015.

Whilst the overall rating provided to the Trust was "Good", the CQC issued requirement notices with regard to compliance with regulations 10, 12, 16, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

A copy of the Trust's Action Plan to address the CQC's requirements has been provided to Monitor.

As at the end of Quarter 4, all actions have either been completed or are on track for completion in accordance with the Action Plan.

(c) The Trust has developed an action plan to address the compliance actions which it has inherited from Leeds and York Partnership NHS Foundation Trust following its expansion into York and Selby on 1st October 2015.

It has been agreed that the York and Selby Action Plan and the overarching Trust Action Plan (see (b) above) will be amalgamated.

(NOTE: A copy of this amalgamated Action Plan has been provided to the Trust's Relationship Manager at NHS Improvement).

(2) **York and Selby Transaction:**

Further to the exception report provided at Quarter 3, 2015/16:

(a) Notification has been received that the Judge in the High Court of Justice Queen's Bench Division Administrative Court has refused permission for the

claimants to apply for judicial review against the Trust in relation to the closure of Bootham Park Hospital in September 2015.

(b) All actions included in the Quality Governance Memorandum and Plan, provided to Monitor on 27th January 2016, which were due to be completed by the end of Quarter 4, have been completed or are on track for completion in accordance with plan.

(c) At its meeting held on 25th April, 2016 the Health and Adult Social Care Policy and Scrutiny Committee of the City of York Council considered an update report on the closure of Bootham Park Hospital which also introduced the following reports:

- A Reflections, Learning and Assurance Report commissioned by NHS England to examine the transfer of services between Leeds & York Partnership NHS Foundation Trust and this Foundation Trust.
- The preliminary conclusions of an independent expert adviser appointed by the Committee.
- A report from Healthwatch York entitled "Bootham Park Hospital: What next for mental health in York?"

(3) Changes to the Executive Team

NHS Improvement has been notified that Mr. Martin Barkley is due to retire as the Chief Executive of the Trust at the end of April 2016 and that Mr. Colin Martin, the Trust's Director of Finance and Information, has been appointed as his successor.

Mr. Martin will start in his new role on 1st May 2016.

The recruitment of a new Director of Finance and Information has commenced. The position will be filled on an interim basis until a substantive appointment is made.

ITEM 9

COUNCIL OF GOVERNORS
PUBLIC AGENDA

DATE:	**19 May 2016**
TITLE:	**To assure the Council of Governors on the position of compliance with Care Quality Commission registration requirements**
REPORT OF:	**Jennifer Illingworth, Director of Quality Governance**
REPORT FOR:	**Compliance/Performance**

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

Executive Summary:

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

- **A CQC visit to Roseberry Park Hospital, Forensic Learning Disability Service to inspect against restrictive practices was undertaken on 22nd February 2015; the report has not yet been received.**
- **The CQC report from their unannounced inspection to 367 Thornaby Road has been received. It shows an overall rating of the service as "Good" and scored "Good" in all five domains.**
- **The Bootham Park Judicial Review: The Trust will be required to attend a hearing towards the end of May in which the Judge will decide if TEWV has a case to answer.**
- **The CQC's 2014 Inspection of Leeds and York Partnership NHS Foundation Trust and their subsequent action plan has been developed into a TEWV action plan for York and Selby.**
- **The Bootham Park Hospital outpatients are now open.**
- **The Trust is currently waiting to receive permission to open the ECT Suite at Bootham Park Hospital ECT Suite following a change of name to the registration.**
- **TEWV's Intelligent Monitoring report has now been published on the CQC Website.**
- **The CQC have carried out twelve MHA Inspections and the Trust has ten Provider Action Statements (PAS's) for monitoring since the previous COG report.**
- **The Compliance Team have carried out three internal mock CQC compliance inspections.**
- **The Compliance Team has a planned three week Trust wide programme of mock inspections planned; the mock inspection teams include clinical, corporate, estates as well as service users and carers.**
- **The Compliance Team were asked to carry out a week long programme of mock inspections for Northumberland Tyne and Wear (NTW) in March this year. A full report of the inspection programme was provided and this was well received by NTW.**
- **The Executive Director of Nursing & Governance held a meeting on 9th February 2016 with Chris Watson, CQC Inspection Manager, in which TEWV was informed of their respective relationship managers for each Locality.**

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

MEETING OF:	**COUNCIL OF GOVERNORS**
DATE:	**19 MAY 2016**
TITLE:	**To assure the Council of Governors on the position of compliance with Care Quality Commission registration requirements.**

1. INTRODUCTION & PURPOSE

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

2. KEY ISSUES:

2.1 Unannounced Visit to Forensic Learning Disability Service

The Trust had an unannounced CQC inspection to Forensic Learning Disability Services on 22 February 2016 to follow up on issues from the March 2014 inspection where compliance actions were raised in respect of restrictive practices.

The informal feedback received following the visit appeared positive.

The CQC thanked the staff for their support, particularly in accessing information. They described the staff as “fantastic and welcoming” and had given open and honest feedback when interviewed.

The CQC said they could see the staff had embedded the changes away from restrictive practices in their day to day working and that governance structures were seen to address/evaluate and review restrictive practices.

The CQC Inspectors noted that there have been clear and significant changes and improvements since March 2014 and that both staff and patients could clearly describe the changes they had made and could see the progress in many areas. They described the cultural changes that both staff and patients demonstrated and discussed the potential to remove more restrictions in the future. The CQC noted the CQUIN target in relation to Restrictive Practice that TEWV are likely to perform against in 2016/17.

However there were two areas for improvement identified:

1) The CQC request that the Trust assess the restrictions for patient’s access to Mobile phones, laptops and access to social media more rapidly.
    a. The CQC were informed of the Trusts Mobile Phone Pilot and the report that is due at the end of the month, and the likely recommendation to extend the pilot into other low secure areas.

2) The CQC cited counting knives and forks in and out after meals as an example of a restrictive practice.
    a. The Trust responded that they were not in a position to remove this restriction as it is currently a standard required by commissioners.

Additionally, it was discussed with CQC about the safety aspect of as there is a potential of cutlery being used as weapons.

The CQC noted that TEWV's Restrictive Practice Framework was due for review in April 2016 and requested that TEWV should consider CQC feedback within this review.

The CQC also noted that the RCP Quality Network had stated that TEWV were leading on reducing restrictive practice compared with other providers. The draft report is not expected for at least two months.

2.2 CQC unannounced inspection to 367 Thornaby Road

During the Trust's CQC Inspection of January 2015, this service was given a low rating; a follow up unannounced Social Care inspection was carried out on 29th January 2016. Following the re-inspection an overall rating of "good" and a rating of "good" for each of the five domains was received by the Trust. The final report (see appendix 1) was published on the CQC website on 21st March 2016.

2.3 Judicial Review – provision of acute mental health services in York and Selby

The Trust initially received an Order from the High Court which granted permission to the Claimants to proceed against the CQC in respect of the Judicial Review, but refused permission against TEWV and LYFPT. However the Claimants have made an application to review the Judge's decision and a hearing for this will take place later in May.

2.4 CQC Inspection at Bootham Hospital in October 2014 and September 2015

An action plan for the York and Selby Locality from the CQC inspection of Leeds and York Partnership NHS Foundation Trust's inspections in October 2014 has been produced. This has been agreed at EMT and this action plan will form part of the Trust's Overarching CQC Action Plan and monitored by EMT on a monthly basis. A copy has been requested to be sent to both CQC and Monitor for their information.

2.5 ECT Suite and Outpatient Clinics at Bootham Park Hospital

Following a meeting between CQC and TEWV on 4th February 2016 at Bootham Park Hospital where the request was made for the ECT suite to be re-opened at Bootham Park, the Trust has been advised to register a change of name for the location of Bootham Park Hospital to Bootham Park 136 and ECT Suite. The CQC advised they would undertake a visit to the ECT Suite prior to allowing the suite to be opened.

2.6 CQC Intelligent Monitoring report

The Trust has received the final version of the CQC Intelligent Monitoring report which was published on CQC website on 25th February 2016. The report is available on the CQC website at the following link:

https://www.cqc.org.uk/sites/default/files/RX3_103v6_WV.pdf.

In summary there were three risks identified by CQC:

- Composite indicator showing Trusts flagging for risk in relation to the number of deaths of patients detained under the Mental Health Act - MHA database/MHLDD
- Composite indicator to assess bed occupancy - MHA Database/KH03

- Fully and partially upheld investigations into complaints – PHSO

CQC gave TEWV an overall risk score of 3 (2.08%) out of a maximum possible risk score of 144 in the intelligent monitoring report. There were no elevated risks identified.

2.7 Mental Health Act Inspections

There have been twelve MHA inspections and ten PAS monitoring reports received since the last report to Council of Governors:-

- Acomb Garth, York (AMH Rehabilitation Y&S) 17th December 2015
- Lustrum Vale, The Dales, Stockton (Tees AMH Rehabilitation) 18th January 2016
- Oak Rise, 4-6 Oak Rise, York, (York and Selby LD) 21st January 2016
- Westerdale North, Roseberry Park Hospital (Tees, MHSOP) 26th January 2016
- Harrier/Hawk (Ridgeway FLD) 1st February 2016
- Bedale Ward, Roseberry Park Hospital (Tees, AMH) 5th February 2016
- Robin, Roseberry Park Hospital (Forensic LD) 15th February 2016
- Ivy/Clover, Roseberry Park Hospital (Forensic LD) 23rd February2016
- Cherry Tree House, York and Selby MHSOP 22nd March 2016
- The Orchards, North Yorkshire AMH 22nd March 2016

The following wards that have had a recent MHA visits await their reports:

- Springwood, Malton, North Yorkshire MHSOP 23rd March 2016
- Ward 15, Friarage, Northallerton, North Yorkshire AMH, 20th April 2016

2.8 Meeting between TEWV and CQC

A meeting was held on 9th February 2016 with Chris Watson, CQC Inspection Manager and the Executive Director of Nursing & Governance. The key issues from the meeting were:-

- The Trust was informed of imminent visit to Forensic Services to follow up on the compliance actions in March 2014 around restrictive practice. As reported this occurred on 22nd February 2016.

- The CQC will re-inspect the Trust against the “requires improvement” compliance actions identified during their January 2015 Inspection. It was suggested that this visit would occur towards the end of the next financial year (January – March 2017). The CQC will expect to see the Trust action plan being extended to include York and Selby, and to include the actions which were inherited by TEWV from the Leeds and York Partnership NHS Foundation Trust CQC October 204 and the re-inspection of services in September 2015. Such an action plan is being developed and will be included in the Trust wide CQC action plan and monitored by EMT.

- Chris Watson shared with the Trust that TEWV registered locations had been split into localities and each locality had its own CQC Relationship Owner. These are:-

  - Teesside Michelle Martin
  - Durham and Darlington Alma O’Rourke
  - North Yorkshire Gemma Berry
  - York and Selby Gemma Berry

- The Executive Director of Nursing and Governance provided an update to Chris Watson in relation to work being undertaken within the York and Selby locality and also discussed actions being taken in relation to themes arising from Mental Health Act visits namely CCTV notices and staff training in the Code of Practice.

2.9 Trustwide Programme of Mock Inspections

The Compliance Team have carried out a Trust wide programme of Mock Inspections, which were supported by a Trust wide series of Briefings on the Fundamental Standards including Duty of Candour. There was 44 services inspected bewteen18th April to 6th May 2016. The inspectors included clinical and corporate staff working across the Trust including Ward and Team managers, members from Estates and also service user and carer representation from the Fundamental Standards Group. The inspections highlighted many areas of good practice that indicate high standards have been maintained since the CQC inspection in January 2015. Where an issue has been identified, which could result in a compliance issue, this has been escalated to the Head of Service.

2.10 Compliance Team Mock Inspections

The Compliance Team have undertaken three mock inspections since reporting in the February Council of Governors reports -

a. Affective Disorder Service, Derwent Clinic, Shotley Bridge –
b. Durham and Darlington Crisis and Recovery House –
c. Wingfield Ward, (MHSOP) Hartlepool

Issues identified have been rectified within short timescales and a report will be sent to the relevant QuAGs for monitoring purposes.

A revisit to Worsley Court at Selby, Meadowfields in York and Cedar Ward in Harrogate was also undertaken to monitor actions identified in a previous internal mock inspections. An issue identified around medicines management has been raised and is currently being actioned.

The Compliance Team were requested by NTW to participate in a collaborative mock inspection with Leeds and York Partnership NHS Foundation and Capsticks (solicitors) as part of NTWs preparation for their Trust wide CQC inspection in May/June 2016. TEWV carried out eight mock inspections in two days at Northgate Hospital at Morpeth and Hopewood Park at Ryehope with the support of nursing staff from TEWV's Nursing and Governance Directorate. This work involved pre work in the preparation for the mock inspections and the writing of a report for NTW in a tight timescale, which was achieved. The report was sent to NTW for which TEWV were thanked and feedback has been received to say the report was well received.

IMPLICATIONS:

3.1 **Compliance with the CQC Fundamental Standards:** Provision of safe and effective high quality services is a strategic priority for the Trust and the Fundamental Standards of Quality and Safety that underpin CQC registration support and facilitate those quality services. Ongoing full registration reinforces the position of the Trust in maintaining high quality service delivery – any loss of registration has implications for the reputation of the Trust as 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 Foundation Trust – complete loss of registration therefore would have disastrous business impact**.** There are financial implications in maintaining CQC registration – the annual fee structure, the corporate infrastructure required to maintain the evidence base and relationship with CQC and the costs of addressing any challenges to compliance with changing services.

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

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

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

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

6. **RECOMMENDATIONS:** The Committee are asked to note the CQC registration and information assurance update.

Jennifer Illingworth
Director of Quality Governance

Background Papers:
- **Appendix 1: CQC report from 367 Thornaby Road**

Appendix 1

CareQuality Commission

Tees, Esk and Wear Valleys NHS Foundation Trust

367 Thornaby Road

Inspection report

Thornaby
Stockton On Tees
Cleveland
TS17 8QW

Tel: 01642892003
Website: www.tewv.nhs.uk

Date of inspection visit:
29 January 2016
22 February 2016

Date of publication:
15 March 2016

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

We carried out this inspection on the 29 January 2016 and 22 February 2016. The first day of inspection was unannounced which meant the staff and registered provider did not know we would be visiting. Due to people who used the service being out throughout the day we returned early evening on the second day to observe.

367 Thornaby Road is a small home providing personal and nursing care for five people with learning disabilities and additional support needs. The bungalow is purpose built, and each room has an en-suite bathroom. Two of the bedrooms are adapted to meet the needs of people with a physical disability.

The home had a registered manager in place who has been registered with the Care Quality Commission since November 2014. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection January 2015 we asked the registered provider to take action to make improvements in the management of medicines, good governance, assessing and monitoring the risks relating to the health and safety and welfare of service users, seeking and acting on feedback from relevant persons, acting on complaints and supporting staff through supervision and appraisals. The registered provider sent us an action plan stating they would be compliant by 31July 2015.

During this inspection we found that the registered provider had put systems in place to manage medicines safely. The registered provider was now assessing, monitoring and improving the quality of the service. Risk assessments were now in place to protect the health, safety and welfare of people who used the service and others. The registered provider was now seeking and acting on feedback from relevant persons. Complaints were now acted on and recorded effectively and staff were receiving regular supervision and an appraisal.

Staff we spoke with understood the principles and processes of safeguarding, as well as how to raise a safeguarding alert with the local authority. Staff said they would be confident to whistle blow (raise concerns about the home, staff practices or provider) if the need ever arose.

The registered manager had knowledge of the Mental Capacity Act [MCA] 2005 and Deprivation of Liberty Safeguards [DoLS]. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The registered manager understood when an application should be made, and how to submit one. At the time of our visit all five

people living at the service were subject to a DoLS authorisation.

Accidents and incidents were monitored each month to see if any trends were identified. At the time of our inspection the accidents and incidents were too few to identify any trends.

Staff received relevant training and competency assessments took place in subjects such as safe handling of medicines..

Staff were observed to know people well and to be caring and respected people's privacy and dignity.

People were supported to access healthcare professionals and services.

Activities took place more on a one to one level with the occasional group outing to the beach. People who used the service had a busy social life.

People's care records were person centred. Person centred planning (PCP) provides a way of helping a person plan all aspects of their life and support, focusing on what's important to the person. Care plans provided evidence of access to healthcare professionals and services. Care plans contained relevant risk assessments.

We found people were cared for by sufficient numbers of staff. Recruitment and selection procedures were in place and appropriate checks had been undertaken before staff began work.

We saw that the service was clean and tidy and there was plenty of personal protection equipment (PPE) available.

People were provided with a meal choice and enjoyed the food on offer.

Staff were supported by the registered manager and were able to raise any concerns with them.

We saw safety checks and certificates that were all within the last twelve months for items that had been serviced and checked such as fire equipment and water temperature checks.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe
Staff were knowledgeable in recognising signs of potential abuse and knew how to report any concerns.

Assessments were undertaken to identify risks to people using the service and others. Risk assessments were in place.

Medicines were stored securely and administered safely.

There were sufficient numbers of staff to care for people's needs.

Is the service effective?

Good

The service was effective.
Staff had the knowledge and skills to support people who used the service.

People were supported to have their nutritional needs met.

Staff understood the requirements of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards [DoLS]

People were supported to access healthcare professionals and services.

Is the service caring?

Good

The service was caring.
Staff were caring and respected people's privacy and dignity.

Staff knew people who used the service well.

Wherever possible independence was promoted.

Is the service responsive?

Good

The service was responsive.
People's needs were assessed and their care planned, care plans were person centred.

People had access to opportunities for social stimulation or

activities that met their individual needs and wishes.

A complaints and compliments process was in place

Is the service well-led?

Good

The service was well-led.
Staff said they were supported by their registered manager and felt they were open and honest.

Issues and learning were raised at regular staff meetings.

A wide range of regular audits were completed to monitor and assess the
quality of the service provided.

Care Quality Commission

367 Thornaby Road

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 28 January 2016 and 22 February 2016 and the first day was unannounced. Due to people who used the service being out throughout the day we returned early evening on the second day to observe.

The inspection team consisted of one adult social care inspector.

Before our inspection, we reviewed the information we held about the home. We looked at statutory notifications that had been submitted by the home. Statutory notifications include information about important events which the provider is required to send us by law. This information was reviewed and used to assist us with our inspection.

The registered provider was not asked to complete a provider information return [PIR]. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

People who used the service were unable to communicate verbally, therefore during the visit we observed the five people who used the service, the registered manager, the house coordinator and three staff members on the first day and three staff members on the second day. We also spoke on the telephone with two relatives of people who used the service. We undertook general observations and reviewed relevant records. These included three people's care records, four staff files and other relevant information such as policies and procedures.

Good

Is the service safe?

Our findings

At our last inspection in January 2015 we found the registered provider was not protecting people against the risks associated with the unsafe use and management of medicines, as appropriate arrangements were not in place for the recording, handling, using, safe keeping and safe administration of medicines. During this inspection we looked at medicines. Medicines were safely managed and securely stored in appropriate conditions. For example locked cupboards. The service had installed an air conditioning unit where they store the medicines to ensure safe and effective storage. We examined records of medicines received, administered, disposed and looked at a random sample of medicines held against records and did not find any discrepancies. Weekly and monthly medicine audits were now in place. Medicines' training was up to date and we saw evidence of staff competency checks. This meant that medicines were now managed safely.

At our last inspection the registered provider was not assessing, monitoring and mitigating the risks relating to the health, safety and welfare of people who used the service. We saw risk assessments were now completed as part of people's care and support plans which identified a range of social and healthcare needs and risks. Risk assessments covered general areas such as medicines compliance, self-harm and specific areas that were relevant to each individual person. For example one person had an eating disorder that meant they were at risk of eating inedible things such as stones and coins etc. There was fully documented guidance to reduce this risk and what to do in the event of the person eating an inedible object. Staff could explain well how they worked with this risk such as keeping small objects out the way, tidying up straight away after personal care took place. Assessments included positive risks that were deemed appropriate and acceptable for the promotion of recovery and independence. For example one person loved attending the theatre. Staff and the persons relative ensured this person had the same seat each time they attended, this made them feel safe and secure, as well as helping to maintain the persons safety and the people around them. Staff were knowledgeable about each person, including risks and recognised triggers and signs of deteriorating well-being.

The service promoted positive risk taking. The registered manager said, "One resident had not had successful overnight stays and last year went instead on days out, which they enjoyed. Their key workers feel that if we can address some of the issues from their last holiday attempt they could have a better chance of enjoying a break away on their own for several days. There has been careful planning around the venue and activities on offer to try to ensure, as best as possible, a positive and successful outcome for them."

There were five people who used the service who had lived together for nearly 30 years. None of the people could communicate verbally, therefore we observed people and staff interactions and spoke to peoples relatives. Most people who used the service were out throughout the day with one person returning on the afternoon. Therefore we observed the care provided to this person. We asked peoples relatives if they felt the person who used the service was safe. One relative said, "My [relative] could not be safer, I am very very pleased with the situation." Another relative said, "[Relative] is without a doubt safe, doors are locked, they have to be as they [relative] have no sense of danger."

We asked staff if they thought that people living there were safe. One staff member said, "They [people who used the service] are very safe, we keep the front door locked but they have the back door open and access to garden, the home is big enough for them to walk around safely." Another staff member said, "We [staff] are all aware of keeping things safe, [person who used the service] has no sense of danger and would walk in and pick a potato out of a boiling pan to eat, therefore we keep the kitchen door locked whilst cooking, it is open every other time of the day and they can enter whenever they want."

We looked at the arrangements that were in place for safeguarding vulnerable adults. The service had policies and procedures for safeguarding vulnerable adults, whistle blowing, accidents and incidents. Staff answered our questions about safeguarding which showed they understood the different types of abuse, how to report, escalation of concerns and whistle blowing procedures. They were confident that any safeguarding concerns raised would be dealt with appropriately. Staff were also aware of how to raise concerns with external agencies such as the Local Authority or Care Quality Commission (CQC).

We saw safety checks and certificates that were all within the last twelve months for items that had been serviced and checked such as fire equipment and we saw evidence of water temperature checks being taken weekly and at bathing. We saw evidence of Personal Emergency Evacuation Plans [PEEP] for all of the people living at the service. The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency. The registered provider should note that the last fire evacuation test had taken place in March 2015, there was no time recorded, therefore we could not establish if any night staff had been involved. We recommend that the registered provider looks at the latest guidance from the Cleveland Fire Brigade regarding staff training for both day and night shift staff.

Accidents and incidents involving people were appropriately recorded providing information about what happened and any actions taken at the time and subsequently. Staff told us that handovers took place between each shift. The handover gave staff the opportunity to be made aware of any incidents on the previous shift and how people were feeling or behaving.

The service had an up to date business continuity plan which contained arrangements that the Trust had in place to ensure effective management of a disruption. This meant if an emergency was to happen the service was prepared.

We found people were cared for by sufficient numbers of suitably qualified, skilled and experienced staff. The registered manager said staffing was flexible and if people wanted to do a group activity such as attend a show, extra staff would be brought on shift.

We looked at the recruitment records for four members of staff. The majority of staff had worked at the service for a number of years some as long as nearly 30 years. Recruitment and selection procedures were in place and appropriate checks had been undertaken before staff began work. We saw the registered manager had obtained references from previous employers and we saw evidence that a Disclosure and Barring Service [DBS] check had been completed before they started work in the home. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to minimise the risk of unsuitable people from working with children and vulnerable adults.

We saw that the service was well maintained, clean and tidy and there was plenty of personal protection equipment [PPE] available.

Good

Is the service effective?

Our findings

At our last inspection we found that the staff did not receive appropriate support through supervision and appraisal. Supervision is a process, usually a meeting, by which an organisation provide guidance and support to staff. During this inspection we found evidence to show that staff now received regular supervision and yearly appraisals. The four staff files we looked at showed that staff had received five supervisions since the last inspection and one appraisal. Topics covered in supervision were training, health and wellbeing and roles and responsibilities. The yearly appraisal consisted of two sections one was for the staff member to complete showing what they had learnt and how they reflected on their experiences. Section two was objectives, outcome of past objectives and date new objectives were to be completed by. We asked staff if they found the supervisions useful. One staff member said, "Yes they are useful, you can share concerns or receive updates, we all help each other." Another staff member said, "They are times to have a good discussion."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager told us they had worked with relevant authorities to apply for DoLS for people who lacked capacity. This ensured people received the care and treatment they needed and there was no less restrictive way of achieving this. At the time of our inspection five people living at the service were subject to a DoLS. Staff had received training in MCA and DoLS and demonstrated a clear understanding

People were supported by staff with the knowledge and skills they required to carry out their role.

We saw the training chart and matching certificates. All mandatory training was up to date in subjects such as moving and handling, health and safety and safeguarding. Staff had also received training in specialist subjects such as epilepsy, autism, information governance and equality and diversity.

We were told that new staff undertake a thorough induction process. The service had recently employed a house coordinator who was in the process of looking through policies and familiarising themselves with the people who used the service. The service had not employed any new care staff or nurses for a number of years but the registered manager said, "There is an induction process for all staff and they also need to carry out mandatory and statutory training for their role alongside training that is required and desirable for our service. Their compliance and competence in this is managed and monitored through the supervision of that person with any issues being dealt with an appropriate and supportive manner. The induction process ensure the confidence of the new staff member and the supervisor prior to taking full responsibility."

The service supported people to have sufficient food to eat and drink. A few people who used the service

could go into the kitchen and point to a cupboard or take out a box of cereal for example to show what they wanted to eat at that time. the majority of staff had worked with the people who used the service for about 27 years and knew people's likes and dislikes well. This information was also documented in each person's care plan. For example some people needed their food cut up small, or mixed with moisture such as a sauce, cream or gravy. Peoples likes and dislikes were documented such as one person loved spicy food and another liked their first cup of tea in the morning. The service used the eatwell plate. The eatwell plate highlights the different types of food that make up a diet, and shows the proportions that should be eaten to have a healthy, balanced diet. Staff we spoke with said, "[Person who used the service] chokes on rice, so we avoid it," Another staff member said, "We try to give a variety of meals, but know their likes and dislikes." On the second day of inspection Italian beef casserole with mashed potato and vegetable was planned for the evening meal. One staff member said, "They all love Italian beef casserole." We asked how people tell staff if they were not happy with the meal. A staff member said, "They can soon tell us, such as turning their face away, or keeping lips tightly shut if they do not want the meal provided, we would then find an alternative or try something later." The staff member explained how they [staff] have to show patience, the staff member said, "They may not want to eat at that time, so we respect that and try at different times or with different food."

Health monitoring was in place such as monthly weight recording. The registered manager said that they liked to keep an eye on people's weights to keep people at a healthy weight.

People were supported by staff to appointments with external healthcare professionals such as the community psychiatrist, GP and optician, evidence of visits were documented in their care files. Care plans included a health action plan which included information on the person's health and wellbeing, vision, hearing, nutrition and medicines. The health action plan also included dates of annual health checks, dental checks and visits to the GP. Each file we looked at included a hospital passport, this provides important information for hospital staff which includes, current medicines, medical history, things that are important to that person and likes and dislikes.

The premises were in very good condition and people had space for times they may want to be alone other than in their own rooms. The back garden was always available and the service had laid astro turf which made the garden suitable for all weathers. The registered manager said, "We are continuing to seek, with the help of our volunteer gardener, to develop the space at the back of the residence, ease the access and make better use of the land for the benefit of our residents. We have plans around putting a 'poly tunnel' in place so that residents can, as they like, take part and experience growing their own crops – even if that may only mean sharing the rhubarb crumble." They also said, "We have installed a new more accessible bath improving the bath time experiences of our residents." And "We aim to make further environmental improvements in the home with the addition of a patio door in the bedroom of one resident. Not only will this allow them to access the garden, but in a way, it also means the garden is 'brought indoors'. Additionally it means that the bungalow will have a fire resistant 'compartment' that the residents can horizontally evacuate to in the event of a fire, which means that the experience will be less traumatic for them and safer for the staff to support."

Good

Is the service caring?

Our findings

We observed the care between staff and the five people who used the service. Staff knew people well. For example they knew when one person wanted company, when to leave alone and what their current needs were. Another person liked to have coffee on their return from the day centre, staff would have this ready. Another staff member said, "They [people who used the service] all have different expressions or different noises that mean different things, and we know what they are."

We spoke with two relatives of people who used the service. One relative said, "I cannot stress enough how brilliant the staff are, I could not wish for anything better for my relative." And "All my relatives needs are met, they [staff] do a marvellous job." And "I have a lot of respect for the staff, they treat [relatives name] as if she were one of their own." Another relative said, "The care to my relative could not be any better." And "The staff are very very caring."

Staff we spoke with said, "I love it here, we all get along very nicely, we have all been here a while." Another staff member said, "We are very client focussed, the care all evolves around each person as an individual, it is what they want." And another staff member said, "I love it here, I love my job, I have been here 27 years, I look after them [people who used the service] like I would my own family." And "I give them [people who used the service] the best care they need."

We were told by staff that independence was fully encouraged. Staff we spoke with said, "We know what each person is capable of, for example they can put their arms into clothes so we encourage them to do this." Another staff member said, "We have to be patient, one person chooses their own clothes but may take a while putting them on, they may want to walk around their room for a while, this is fine, as long as door is closed and their privacy is protected they can take as long as they want." Another staff member said, "We encourage them all to be as independent as possible, we encourage people to eat and drink on their own, everyone has different capabilities."

Care plans also documented how to promote independence. For example one care file stated, "I will help to get dressed and undressed, I can step out of clothes, I like to wear fashionable clothes."

We saw through observation that people were treated with dignity and respect, we saw staff were polite and caring and were guided by the person and what they wanted rather than what the staff member wanted. Staff explained how they promoted this. One staff member said, "We have a shower curtain as well as a shower door as some people don't like the door shutting so we can then close the curtain."

People were able to make choices. We saw staff walking with a person who used the service and at each room they asked would they like to watch a video, would they like to go in the garden, would they like to sit on the rocking chair. The staff member also knew when the person wanted some alone time and although staff could still observe them, the person was left alone.

We were told that two people who used the service had access to an advocate. This advocate was an

Independent Mental Capacity Advocates ('IMCAs'). The IMCA visited the person for half a day each month to check if they were okay. We were told that the IMCA sits with the person who used the service and they have built up a relationship and close bond. We evidence of the IMCA's visits and they had made a comment which said, "The visit has made my day, it has restored my faith in care homes."

The registered manager said, " We are advocating on behalf of one of our residents and with the agreement of their family, to procure an electric wheelchair – this will be a benefit to them in having readier, easier access to the community, opening up a greater range of venues and locations."

Good

Is the service responsive?

Our findings

At our last inspection we found that the registered provider was failing to listen, act on and record complaints effectively. At this inspection the registered manager had a complaints, concerns and compliments file. The service had received one complaint since the last inspection and we saw this was fully documented with an outcome to show the person who made the complaint was happy. The service had received numerous compliments. We asked relatives of people who used the service if they had made a complaint and if they knew how to make a complaint. One relative said, "I have never complained but I know how to." Another relative said, "I did have problems in the past, which was mentioned at the last inspection, but everything is all sorted now, I am a lot happier now."

The care plans also contained relevant risk assessments for each person and focussed on people as an individual. Individual choices and decisions were documented in the care plans and they were reviewed monthly. Staff were aware of people's needs and preferences and demonstrated their knowledge in conversations with us.

The registered manager said, "We have been successful in making our care planning and risk assessment process more person centred and meaningful."

We looked at care plans and saw they were person centred and addressed a wide range of people's needs. Person-centred planning is a way of helping someone to plan their life and support, focusing on what's important to the person. The care files documented any medical alerts, for example allergies and recent operations. The care files also contained a 'pen picture.' A pen picture is a life story and captures all the important information about a person. Care files documented non verbal signs to show if a person was uncomfortable, how a person likes to look and communication needs. For example one care file stated, "I do not speak but I understand a lot." Another persons communication plan said, "I like to hum, I love it when staff hum along with me." During observation we saw the person who used the service stand by the door to suggest they wanted to enter the garden. The staff member quickly open the door and went out into the garden with the person.

Daily records were kept separately in a file to discuss at handover, these included information on what was needed for that day for example how people were feeling, who is going out, who is staying in and any specific appointments to attend.

Staff explained that due to people's different capabilities and needs, activities were mainly one to one, such as the sensory room, massages and music. One staff member said, "They [people who used the service] all enjoy different things, we do some group activities such as we will all go to the coast, to Whitby or Seaton Carew and have fish and chips." Another staff member said, "This is their home, their sanctuary for relaxing, they come back from day centre, shoes off, have a meal and we go from there, whether it is a movie, music." And "We did try activities such as finger painting, but they have done things like that all day, when they come home they just wan to sit back and relax." Another staff member said, "It is great when the light nights come, we are out all the time then."

One person who used the service liked going to the theatre and would go at least once a month. Staff we spoke with said, "[Person's name] loves the theatre, they go a lot and always have the same seats, it needs to be at the front circle as they like to rest their arms on the banister." We were told they all go on holidays to places like the Lake District or Blackpool, a staff member said, "We usually go to Haven sites as the entertainment is great." Another person enjoyed going to the Edinburgh Tattoo. One staff member said, "[persons name] is going to a log cabin with a hot tub, they love talking about it." We observed the staff member chatting about this holiday and explaining what there was to do when they got there.

One staff member said, "We always take them [people who used the service] out for a meal for their birthday, one person is not keen on noise so if we stop at a pub, one staff member runs in to make sure it is not too noisy before we all enter." Another staff member said, "It is all about making their lives as pleasant as possible, we do what they want, they soon tell us such as [person's name] will go and stand by the door so we know they want to go out, [another person] will get their coat and bring it to you."

Relatives we spoke with said, "In the summer it is hard to find them in, they are always off out to places like Whitby for fish and chips." Another relative said, "They do what they can for [person's name] they bring them home to have tea with me, they take them on lovely holidays, I could not ask for more."

The registered manager said, "We have completed all of the environmental enhancements on the gardens and now have open space for our residents to enjoy. We now have three volunteers in the service; two of whom are adults with learning disabilities. Our volunteers enrich our environment with the skills they bring to the garden, to the house and musically."

Good

Is the service well-led?

Our findings

At the time of our inspection the service had a registered manager who had been registered with the Care Quality Commission since November 2014.

At our last inspection the registered provider was not assessing, monitoring and improving the quality and safety of the services provided. The registered provider was not seeking and acting on feedback from relevant persons to continually evaluate and improve the services.

At this inspection we found audits were now regularly undertaken to assess and monitor the quality of the service. We saw evidence of weekly and monthly audits carried out by both staff and the registered manager, as well as monthly service audit carried out by the Matron. For example, staff carried out a weekly medicines audit on stock levels. The registered manager also completed a series of audits once a month. These audits covered areas such as the kitchen, medicines, staff files, cleaning, infection control, health and safety and care records. The monthly matrons service audit checked on the greeting they received, appearance of staff, people who used the service and environment, safety, staffing and supervisions. The trusts hotel services also carried out a quarterly infection prevention and control audit. All audits produced an action plan with dates of when an action had to be done by and who was responsible. These actions plans were checked before the start of the next months audit. This meant that the registered provider was now analysing information about the quality and safety of the service.

The registered provider was now seeking and acting on feedback from relatives and staff. They had completed a staff and relatives survey. The staff survey showed that staff felt valued. The relatives survey had not been successful due to non being returned. The registered manager was trying different ways to obtain relatives views. One of the ways they were trying at the time of inspection was quarterly visits to family members.

We asked relatives what they thought of the service, the registered manager and the staff. One relative said, "The manager always keeps in touch with me, they communicate well, it is a home from home, I can turn up anytime and I am always welcome." And "I have put them forward for awards." Another relative said, "[Registered managers name] is lovely, they have a caring soul, they were ace from the start." And "I have no qualms they provide the best care, my relatives support worker is unbelievable, he is a really good bloke, he does sign language with them and everything. I love my relative being there, I would fight to keep them there."

The registered manager said, "Our residents needs are paramount to staff and this is demonstrated through the behaviour & actions of the staff. We receive and collate feedback from family members, visitors and other agencies that ensure we are demonstrating the values & behaviours that are important in delivering a quality service. We observe our residents in their day to day lives to ensure that they appear to be happy with the care they are offered and if this were found not to be the case then we would make all efforts to rectify this."

We asked staff if they felt supported by the registered manager. Staff we spoke with said, "[The registered manager] is very supportive, brilliant, nothing is a problem at all they are very approachable." Another staff member said, "[The registered manager] is a really good manager, best manager I have ever had, very supportive, understanding, kind, caring and they listen. They listen to everybody."

We asked the registered manager how they promote the services visions and values, they said, "We have held training days with the staff around values and behaviours run by a local advocacy group including some service user supporters, who were able to offer us insight into their experiences of the care they have received."

Staff we spoke with thought that the service had an open and honest culture. One staff member said, "Nothing is hidden here, what you see is what you get."

We saw records to confirm that staff meetings had taken place every other month. Topics discussed were any updates, lessons learnt, care plans and any other business." Staff we spoke with said, "The staff meetings are good, we can voice opinions and these get acted on, such as we were struggling to get staff in to go to the theatre, we have sorted this now."

We asked the registered manager what links they have with the community. They said, " We access many local services and venues including the local pub, local cafes and restaurants, the GP's, chiropodist & dentist. Our residents also have links into their community supported by their day service, who we work closely with in order to ensure that those links are maintained."

The law requires providers send notifications of changes, events or incidents at the home to the Care Quality Commission and they had complied with this regulation.

ITEM NO 10

FOR GENERAL RELEASE

COUNCIL OF GOVERNORS

DATE:	**19 May 2016**
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.

Key themes to note:

- Progress with several key service areas as set out in the business plan.
- The ongoing work on Transforming Care.
- Some services that have transferred between localities.

Recommendations:

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

MEETING OF:	**Council of Governors**
DATE:	**19 May 2016**
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

We have now begun implementation of the practice aligned CPN model within the DDES Clinical Commissioning Group (CCG) area. We have four staff now in post, with additional staff to join the team following further recruitment. Although it is still very early days, initial indications are that this is being very positively received and will have a helpful impact on service provision.

Since the last COG, we have successfully completed the merger of Willow and Earlston Wards, completing phase 3 of our rehabilitation and recovery strategy. This transition went very well overall and individuals are reported to be well settled and content in their new placements.

Mental Health Services for Older People

We have completed the public consultation on changes to the way we deliver inpatient services for people living with organic conditions. The outcomes of the consultation are with CCGs and will also go before Durham and Darlington's Overview and Scrutiny Committees. Subject to the views of CCGs and the overview and Scrutiny Committee, we expect the move from three 10 bedded wards to two 15 bedded wards will occur over the summer.

Teams are actively involved in the purposeful and productive community services work and are beginning to embed some of the new processes and systems and are monitoring the impact of this.

Children and Young People's Services

We continue to experience an increase in referrals. The service has several work streams aligned to the purposeful and productive community services agenda to ensure we are using our resources as effectively as possible:

- RPIW planned for the 6th June to develop a single point of access across the locality
- 3P event on 20th June, commissioned by Darlington CCG, to review with wider children's workforce and provision for young people with emotional difficulties
- Engagement with CCG to ensure local transformation plans are implemented

We are awaiting confirmation from Commissioners regarding recurring funding for the CYP Crisis Service and to develop this model as part of the Core 24 All Age Liaison Service model. As part of the Future in Minds transformation plans we have now received funding from Commissioners to further develop the Eating Disorder service to enable us to increase capacity and enhance service delivery.

Learning Disability Service

Work continues to progress options for future service design across Adult Learning Disability Services in response to national requirements around bed provision within the Transforming Care agenda. The new enhanced community service model to support the changes to bed provision is being refined and will be implemented shortly once additional staff have been recruited.

The Specialist Health Teams (SHT) in Durham have implemented daily huddles to improve the flow of information across the teams and between the units. The Physical Health part of the SHT (formerly health facilitation) has liaised with local CCG leads to agree how they can support health priorities for people with learning disabilities locally including improving access and uptake of cancer screening and flu jabs.

The Autism pilot is progressing well and the project team has participated in a Trust wide event to scope the development of Autism services.

Following the successful Daily Lean Management Kaizen event in AMH earlier in the year, ALD services are currently planning a similar event with Children's services to be held in June.

3.2 Tees

Adult Mental Health and Substance Misuse

New services transferred to Tees, Kirkdale ward and Autism Services as well as ECT from Durham and Darlington.

Work is progressing well on the purposeful and productive community services, building on work carried out developing the model line in psychosis teams and on work developed by the affective collaborative.

Mental Health Services for Older People

There have been 15 nursing homes in special measures meaning additional meetings for the Intensive Community Liaison Service (ICLS) and then expectations of supporting work to maintain difficult situations. Hartlepool is particularly problematic, but impacting everywhere, it is becoming essential for organic patients to continue to go further outside Tees for long term care.

The Dementia Collaborative is in its fourth year North of Tees. Work is now targeted on nursing and residential homes. Dementia Awareness week starts on 14th May.

There has been an extension to the ICLS team in Stockton, funded through the Better Care Fund, for 12 months to enable closer working with physical healthcare teams.

Children and Young People's Services

The 24/7 Crisis and Home Treatment Service is now in place, with funding received recurrently from CCGs.

Waiting times have now stabilised and new appointments are now being offered within 3 weeks.

West Lane services have transferred to Tees Locality and will be part of CYPS.

Learning Disability Service

There has been a slowing pace of transformation as there remains a lack of clarity on dowry funds for patients which is creating difficulties for local authorities.

NECS are currently undertaking a review of the extended community teams.

New complex patients are being admitted to Bankfields Court.

3.3 North Yorkshire

Adult Mental Health and Substance Misuse

The Service User and Carer conference on 4th March 2016 in Scarborough was well received and helped us to understand how our service is received. From this we developed a "you said – we did" document.

All Scarborough Whitby Ryedale (SWR) AMH Team Managers and Clinical Leads are engaged in a training programme for Police staff across North Yorkshire – this forms part of a research project (RCT).

Mentorship by Police Inspector in SWR for Crisis Manager is under way, and for Locality Manager in SWR to mentor a Police Inspector is also under way. This is part of an approach to grow the relationships between the 2 providers.

Scarborough Locality Manager (Martin Dale) meets with Governors three-monthly and this is hugely beneficial in updating each other.

Caroline Knott has been appointed as an Approved Clinician on Cedar Ward, Harrogate.

Mental Health Services for Older People

Springwood and Rowan Lea have implemented My Life Software and it will be rolled out to Rowan Ward, Harrogate.

New Consultant Psychiatrist, Dr Sabrina Leigh Hunt, has been appointed in Ryedale.

Children and Young People's Services

The new North Yorkshire and York CAMHS Eating Disorder team has commenced; recruitment having started to fill newly funded posts. The new team will work across North Yorkshire and York using a hub and spoke model which provides an exciting opportunity to work across two localities.

A new part-time Consultant Psychiatrist has been successfully appointed to Harrogate CAMHS and he will commence in post once recruitment checks have been completed.

The North Yorkshire Looked After Children's Team has had its contract extended to cover the Selby area of North Yorkshire. This was following successful discussions with North Yorkshire County Council. Previously this area had been covered by York CAMHS.

Learning Disability Service

In response to the Council of Governors challenge to involve carers and service users North Yorkshire Learning Disabilities (NYLD) team have included a Carer on a recent Kaizen Event in the Scarborough, Whitby and Ryedale Area and looking forward into the involvement of carers and service users at KPO events ie Report Outs.

The newly formed NYLD Shadow QuAG has been developed to replicate the NYLD QuAG. The meeting is run with a group of service users from across North Yorkshire to challenge the quality of services delivered and improve systems.

New Appointments:

- New Health Facilitation structure in NYLD
- New Psychologist in Harrogate and Craven
- New Service Manager in Harrogate and Craven
- 2 New ANP Posts across NYLD

3.4 York and Selby

Overview

NHS England published its report in April 2016, outlining the lessons learnt following the closure of Bootham Park Hospital (BPH - York). In parallel HealthWatch summarised the issues and concerns from service users, carers and stakeholders perspective.

Work commenced in February 2016 to upgrade Peppermill Court, York. This unit will provide 24 beds and the 136 suite and will enable the reinstatement of adult beds back to York. Work is anticipated to take approximately 6 months with the unit being operational by Summer 2016. A number of service users have contributed to the design solution.

A work stream around the development of community hubs has begun. This is exploring the optimal configuration of community teams. This will improve clinic and patient facing environments, address the need to consolidate a number of separate community bases, which in turn will improve team effectiveness. The plans for hubs are interdependent on various service solutions and availability of sites/ buildings. Plans are developing and should be identified by Autumn 2016.

Plans for the new hospital are progressing. TEWV are currently in discussions with the Clinical Commissioning Group (CCG) to develop a Strategic Outline Case that will consider options for the procurement of a new hospital and include options on potential sites.

From 1 April 2016 the locality transitioned IT systems from Leeds & York Partnership Foundation NHS Trust (LYPFT) to TEWV. There was considerable work required to support the transition and enable the smooth transfer of systems.

Dr Stephen Wright has been appointed at Deputy Medical Director for York and Selby, starting on 1st May 2016.

Adult Mental Health and Substance Misuse

Work has been completed in moving the service from an all age model to MHSOP and AMH services.

A symposium facilitated by the International Mental Health Collaborating Network (IMHCN) was held in April focused on recovery; “whole life whole

system". This enabled participants to explore recovery approaches and learn from best practice elsewhere.

As part of the estate changes to Acomb Gables the temporary closure of the rehabilitation beds occurred in March 2016. A quality improvement event (3P) was held in March which reviewed the service model, involving a number of service users/ carers and a range of stakeholders including housing, voluntary and community sector, local authority partners as part of this work. There are a number of work streams which have been developed as part of this work which will consider the next steps for rehabilitation and recovery approaches within the service.

Dr Stephen Wright has led a multi-agency stakeholder session around student mental health.

Mental Health Services for Older People

Work has been completed in moving the service from an all age model to MHSOP and AMH services.

Work is progressing around expanding the care home liaison service with an aim to move to a 7 day a week model from August 2016.

Cherry Tree House held its first Rapid Process Improvement Workshop (RPIW) around Purposeful Inpatient Admission (PIPA) in April.

Children and Young People's Services

TEWV has recruited to new primary care mental health worker posts which will increase the staffing and enable the development of a crisis service working closely with the liaison and A&E service. It is anticipated that this service will be operational in June 2016.

The service continues in its participation in the Children's IAPT programme which will increase the skills and transformation of the CAMHS service in York & Selby.

Additional funding has been confirmed by the CCG to invest in a North Yorkshire and York wide Eating Disorders Service. Recruitment to these posts is progressing.

Learning Disability Service

As part of the national 'Transforming Care' agenda work is under way to address the key elements of this plan – reducing inpatient beds and enhancing community services to reduce the need for hospital admission. As part of this work the facility at White Horse View in Easingwold closed in April 2016.The savings from closing the unit will be reinvested, primarily in learning disability services in York and Selby.

The service held a "*have your say*" day in March which was well attended by service users, carers and advocates. This was an opportunity to enable feedback on our services, understand issues and influence our reinvestment plans for the community teams.

3.5 Forensic Services

Transforming Care (Assuring Transformation)

As previously reported, the implementation of NHS England's Assuring Transformation programme continues to be the most significant issue facing the service. The service has delivered the plans to reduce inpatient beds by 8 by 31st March 2016. Further reductions are planned in the 2016-17 financial year and staff consultations are under way. There is more clarity on funding and recruitment for the Secure Outreach & Transitions Team (SOTT). This will involve investment in staff and training for DBT (Dialectical Behaviour Therapy) and PBS (Positive Behaviour Support). Current plans are in development for the innovative use of DBT for people with autism and also offence specific treatment. Uncertainty remains regarding the future role of the rehabilitation units in the service. Care and Treatment Reviews have increased in frequency to once every six months, creating an additional pressure for clinical staff.

The service continues to work with staff, commissioners, providers, patients and advocates to develop alternative models of care to reduce length of stay and reduce future admissions. We are involving service users in the development of these models.

Recruitment & Retention Issues.

Recruitment into the service remains a concern and every effort is being made to fill existing vacancies. Staff retention also remains a concern, as the service is seeing nursing and Allied Health Professionals leave for roles elsewhere. The uncertainty over the Transforming Care agenda has played a part in this, as has service developments in other areas of the Trust. Morale and workload pressures are being monitored by the senior team.

FLD Development Group

Karen Picking Associates has commenced involvement with the senior leadership with the service in conducting a diagnostic phase. This is to support the organisational development of the service. Interviews have commence and the outcome of the diagnostic phase will be revealed soon, with a set of recommendations and actions.

Forensic Nursing Awards

Joanna Yarker (Modern Matron) has organised a Nursing Awards Event on the 12th May to celebrate International Nurses Day. There are a range of

categories for nominations. This is to recognise the valuable contributions registered nurses, health care assistants and associate practitioners make to the service.

Offender Health Directorate

The Offender Health Directorate has recently arranged two Positive Practice events with Durham Police and Cleveland Police. Lord Bradley attended each and both received excellent feedback.

Durham Liaison & Diversion team are piloting a scheme with Durham police to assess people arrested for sex offences. Cleveland police will commence a similar pilot shortly. The Offender Health Directorate are facilitating "Working with sexual offenders" training to equip staff with the requisite skills and knowledge.

The Independent Monitoring Board report for HMP Durham gave very good feedback to mental health services working into the prison, the report also highlighted standards within the segregation unit and waiting times for external beds which have been increased due to a lack of available secure beds.

The service has timetabled three improvement events to take place over the coming months: These will focus on:

- Social Worker roles and responsibilities
- CPA within prison teams.
- Discharge process with prison teams.

Forensic Mental Health Directorate

Dr Phil Brown has stepped down from his post as Clinical Director for Forensic Mental Health services. He will continue to work as a Consultant Psychiatrist within the service. Dr Pratish Thakkar was appointed to the Clinical Director post and interviews will take place to fill his vacated post of Clinical Director for Offender Health in May.

The management of Kirkdale Locked Rehabilitation ward transferred from the Forensic Mental Health service to Teesside Adult Mental Health service in April 2016.

The service is experiencing a very high level of demand for male acute admission beds both low and medium secure. This is leading to a delay in prisoners being transferred into secure beds.

The Forensic Mental Health service led the Forensic service wide Smoke Free initiative which saw all inpatient areas go completely smoke free in March of this year. Our service users have adapted extremely well to going

smoke free with many individuals now engaged in reducing programmes of nicotine replacement therapy.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:**
No implications identified.

4.2 **Financial/Value for Money:**
No implications identified.

4.3 **Legal and Constitutional (including the NHS Constitution):**
No implications identified.

4.4 **Equality and Diversity:**
No implications identified.

4.4 **Other implications:**
None identified.

5. RISKS:

None identified.

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

ITEM NO. 11

COUNCIL OF GOVERNORS

DATE:	**19th May 2016**
TITLE:	**Quality Account/Report 2015/16**
REPORT OF:	**Sharon Pickering, Director of Planning, Performance and Communications and Elizabeth Moody, Director of Nursing and Governance**
REPORT FOR:	**Assurance**

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

Executive Summary:

This report contains the final draft of the 2015/16 Quality Account / Report including all end of year data. However, any stakeholder feedback received after the submission of this report, and the Auditor's Limited Assurance Report will be added to the final version of the Quality Account / Report which will be considered by the Trust Board on 24th May.

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

Recommendations:

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

MEETING OF:	**Council of Governors**
DATE:	**19th May 2016**
TITLE:	**Quality Account / Report**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to present to the Council of Governors the final version of the Quality Account/Report which will be presented to the Board at its meeting on 24th May.

2. BACKGROUND INFORMATION AND CONTEXT:

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

2.2 The Quality Account has been developed with regard to the views of stakeholders and the Council of Governors Task and Finish Groups (which met on 16th March and 13th April to discuss the draft QA).

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

3. KEY ISSUES:

3.1 The final draft of the Quality Account includes all end of year data.

3.2 The section of the Quality Account that reproduces our stakeholders' comments is not complete in this draft because the deadline for their comments to be received was 15th May. Only those comments received before this paper was submitted are included. Comments that were received later than this will be included in the final draft verbatim once received.

3.3 The Quality Report will be included within the Annual Report which will be published in July 2015 at the Annual Members Meeting. The Quality Account will be published in June on NHS Choices as per the guidance from the Department of Health.

3.4 The draft Quality Account has been subject to external audit and their limited assurance report will be included within the document as an Appendix.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** The CQC will view and digest Quality Report documents as part of its intelligence monitoring operations.

4.2 **Financial/Value for Money:** The priorities for improvement within this Quality Account / report are also within the TEWV Business Plan and taken account of in our financial plan.

4.3 **Legal and Constitutional (including the NHS Constitution):** The Quality Account / Report has been produced to meet the requirements of Department of Health / Monitor guidance

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

4.4 **Other implications:** none

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

6. CONCLUSIONS:

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

7. RECOMMENDATIONS:

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

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

Background Papers:
Monitor, *Detailed Requirements for Quality Reports*
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/496542/Consultation_on_requirements_for_content_and_assurance_for_quality_reports.pdf

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Our Quality Account 2015/16

making a difference together

TABLE OF CONTENTS

PART 1: STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE OF THE TRUST

I am pleased to be able to present Tees, Esk and Wear Valleys NHS Foundation Trust's (TEWV) Quality Account for 2015/16. This is the 8th Quality Account we have produced and it tells you what we have done to improve the quality of our services in 2015/16 and how we intend to make further improvements in 2016/17.

Our Mission, Vision & Strategy

The purpose of the Trust is:

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

and our vision is:

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

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

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

It is also supported by our Quality Strategy 2014-2019. This outlines what the Trust expects from all staff as we work towards our vision of delivering high quality services that exceed people's expectations.

In delivering quality we believe our services must:

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

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

TEWV's 2015 Community Mental Health Survey *results led to CQC highlighting the Trust as one of 5 across the country performing better than expected* when compared to other Trusts.

There were 4 areas the Trust was significantly better than most other Trusts, these were:

- Organising Care
- Planning Care
- Reviewing Care
- Crisis Care

Areas where our performance was similar to other Trusts and which we will focus improvement on were:

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

These types of support are amongst those that will be improved by our Recovery improvement priority (see **Part 2, 2016/17 Priorities for Improvement section**).

On 1 October 2015 TEWV took over responsibility for providing Mental Health and Learning Disabilities for the whole of the Vale of York CCG area. Since then we have undertaken work to understand these services better and to identify where quality is high and where we believe we can improve this further. The majority of the information provided in this report for 2015/16 therefore does not include the services in the Vale of York but where we can we have provided this and made this clear. The priorities identified for 2016/17 will apply across the organisation, including services serving the Vale of York.

What we have achieved in 2015/16

In the 2015 national NHS Staff Survey, the Trust had high scores compared to other Mental Health and Learning Disability Foundation Trust's in **29** of the **32** areas covered.

- We have continued to work with our commissioners to deliver new services to meet the needs of those who use our services. For example we have:
  - Provided a new "place of safety" (also known as Section 136 Suites) in Harrogate resulting in their now being a place of safety in each locality served by the Trust. This means that police forces can avoid using police station cells for people arrested due to behavour triggered by a mental health crisis across the whole Trust area.
  - Opened a Crisis Assessment Suite (CAS) at Roseberry Park Hospital on Teesside. For patients and carers, the CAS has meant a reduction in the time they wait for assessments to commence as the facility is staffed on a 24/7 basis. In addition, the project has enabled a more sensitive and suitable environment to be provided for both patients and families. Overall patient experience has improved. There have also been benefits for our partners such as Cleveland Police and accident and emergency departments.
  - Opened a new rehabilitation service in North Yorkshire at The Orchards in Ripon. This provides a modern, fit-for-purpose therapeutic environment that will assist patients' recovery and reduce readmissions to acute assessment and treatment beds.
  - Completed the transformation of West Lane Hospital, our children and young people's inpatient site, resulting in the facility providing a modern therapeutic environment.
  - Expanded our Child and Adolescent Mental Health Services (CAMHS), using additional funding from commissioners to implement a 24/7 crisis service for under 18s in Teesside (in addition to the Durham service that commenced in 2014/15).
  - Implemented a peri-natal service in Teesside with clinics established at North Tees & Hartlepool NHS Foundation Trust and South Tees NHS Foundation Trust sites and an agreed training plan for midwives and health visitsors.
  - Introduced an enhanced community learning disability service in Teesside that is available 7 days a week from 8am until 8pm. This has resulted in capacity and flexibility to meet the needs of people with complex needs and behaviours that challenge, prevented unnecessary admissions and facilitated effective timely discharge.

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

- Agreed a Learning Culture Framework and implemented processes for learning from reportable incidents (RIDDOR), Safeguarding, Serious Incidents, Complaints, Claims and Quality Reviews. We have also disseminated Learning Lessons Bulletins to staff about these topics and received positive feedback about the impact of these on front-line-staff and their practice.
- Improved the way that we record, collate and report quality-related information and statistics.
- Established a group that feeds into the Learning Disability Services Quality Board in North Yorkshire, where people who use our services give us meaningful feedback and clear actions for future improvement.
- Piloted the "Safewards" model in 10 Forensic wards and are now extending this to our remaining Forensic wards given the evidence from the pilot that incidents have decreased.
- Facilitatated secure wards' service user attendance at the regional Forensic Recovery & Outcomes meeting in Wakefield (quarterly). In July 2015, five service users attended the National Service User Conference in Birmingham. One service user has also attended two National Recovery & Outcomes Steering Group meetings in Birmingham.
- Improved the way we manage complaints from patients and carers. This enables us to acknowledge and investigate complaints more effectively, including reviewing clinical records and Trust policies, consulting with clinical staff involved in the complaint, seeking expert clinical advice as required, and producing a response.

The Trust has had the highest number of Friends and Family responses for a mental health Trust for ten of the eleven months between December 2015 and January 2016.

In January the number of respondents who would recommend the Trust's services was **86%**.

- In addition we have worked with our partners to improve services. For example we have:
  - Extended access to the Arch Recovery College in Durham by developing on-line access for people that cannot physically attend the courses (including patients being treated in secure settings). These courses help service users develop strategies to help them live the life that they want to live.
  - Established York and Selby Mental Health Connects which provides a platform that enables TEWV to build on existing relationships with third sector organisations and to develop new relationships that promote improved service quality and enables all partners to jointly work toward increasing investment in mental health services within York and Selby.
  - Extended our pilot of locating Mental Health Services for Older People (MHSOP) community staff in GP surgeries from the initial site at Blackhall, County Durham more widely across Durham Dales, Easington and Sedgefield (DDES) CCG area. The aim of this is to simplify the referral process so that people registered with the GP practice can access mental health services quickly and conveniently.
  - Worked with Middlesbrough and Stockton MIND to make advice and signposting sessions available to inpatients at Roseberry Park and their carers.

TEWV scored the 4th highest out of all 230 NHS acute, mental health and community Trusts in the Learning form Mistakes league table published by Monitor in March 2016.

As well as the examples above, we have also continued to drive improvements in the quality of our services through using the TEWV Quality Improvement System (QIS). This is the Trust's approach to continuous quality improvement and uses tried and tested techniques to improve the way services are delivered. Some notable examples of what we have achieved in 2015/16 are that we have:

- Reduced the variation in practice among our community psychosis and Early Intervention in Psychosis (EIP) teams, ensuring that patients receive the same quality of intervention wherever they live across the area served by the Trust.
- Developed our "Unified Affective Disorders Pathway" and are rolling this out across the Trust following a successful pilot. We have also developed a new pathway for MHSOP service users with a "Functional" illness (i.e. an illness not related to dementia or other degenerative brain changes).
- Improved processes in Durham and Darlington MHSOP, which have released nurse time for direct patient contact and improving recovery.
- Reduced the time taken for Scarborough Memory Service patients to receive a diagnosis and also increased capacity to deal with an increase in referrals for memory services.
- Developed a protocol to enable service users within low secure services to be able to use mobile phones whilst within the ward environment.
- Replicated the successful "For Us" Forensic Learning Disability service user group in Forensic Mental Health.

In 2015/16 the Trust received **200** complaints. During 2015/16 **79%** of complaints were resolved satisfactorily.

As a result of these complaints **59** action plans to learn the lessons were generated. At the end of March 2016, the Trust had no action plans that were outstanding more than one month beyond their originally agreed timescale.

In 2015/16 the Trust was also recognised externally in a number of national awards where we were shortlisted and / or won. Awards won by TEWV teams or staff members are shown in the table below:

Awarding Body	Name / Category of Award	Team/individual
NHS Friends and Family Test (FFT) Awards 2016	Best Staff Friends and Family Test Initiative award	Kerry Jones, Staff Experience Project Manager
	Awarded highly commended at these awards for best FFT initiative in any other NHS-funded service. The team was recognised for putting a Trustwide system in place for the collection, analysis and dissemination of patient and carer experience feedback.	Patient and Carer team
Nursing Times Awards	Child and Adolescent Mental Health Services (CAMHS)	Durham and Darlington CAMHS Crisis Team (for Person Centred Care Planning for Young People with Emerging Personality Disorders)

Royal college of Psychiatrists	Psychiatric team of the year: working age adults	Ward 15, Friarage Hospital
North East Leadership Academy	NHS Inspirational Leader of the Year	Amy Colling
Positive practice in Mental Health	Innovation in Child, Adolescent and Young Peoples Mental Health	CAMHS Crisis team
	Partnership working	Talking Changes (Durham and Darlington)

Awards where TEWV or one of its teams / staff were shortlisted for an award but did not win that award in 2015/16 were:

Awarding Body	**Name / Category of Award**	**Team/individual**
Nursing Times Awards	Child and Adolescent Mental Health Services (CAMHS)	CAMHS Scarborough, Ryedale and Whitby for working with young people to develop videos about services
	Team of the year	
Patient Safety Awards	Clinical Leadership (highly commended)	Karen Atkinson for improving quality/efficiency in the patient safety department
	Mental Health category	Durham CAMHS Crisis and liaison team for person centre care planning for young people with emerging personality disorder
		Eating Disorders Services
Royal College of Psychiatrists	Psychiatric trainer of the year	Dr Mani Santhanakrishnan
	SAS doctor of the year	Dr Sagrika Nag
	Carer contributor of the year	Pam Elliott
Health Service Journal Awards	Staff engagement	Whole organisation
	Board leadership	Whole organisation
North East Leadership Academy	NHS Development Champion of the year	Sarah Dexter-Smith and Jenny Oddy

Structure of this Quality Account document

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

- **Section 2** – Information on how we have improved in the areas of quality we identified as important for 2015/16, the required statements of assurance from the Board and our priorities for improvement in 2016/17.
- **Section 3** – Further information on how we have performed in 2015/16 against our key quality metrics and national targets and the national quality agenda.

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

A full statement of Directors' responsibilities in respect of the Quality Account is included in **appendix 1**. This is further supported by the signed limited assurance report provided by our external auditors on the content of the 2015/16 Quality Account which is included in **appendix 2**.

I hope you find this report interesting and informative.

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

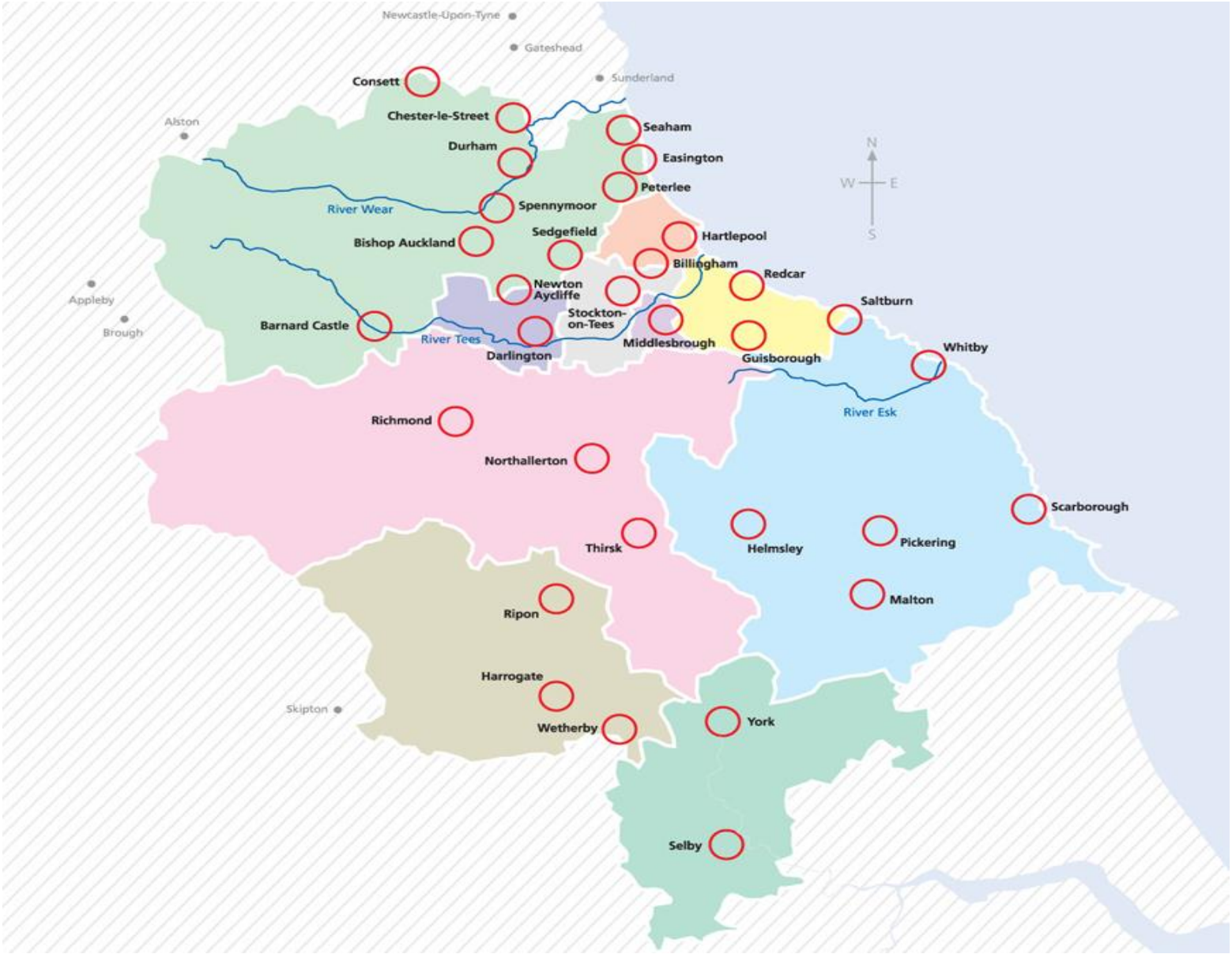
Mr. Colin Martin
Chief Executive
Tees, Esk and Wear Valleys NHS Foundation Trust

A Profile of the Trust

The Trust provides a range of mental health, learning disability and autism services for 2.0 million people across a wide geographical area. Within this area our main towns and cities are: Durham, Darlington, Hartlepool, Stockton, Middlesbrough, Redcar, Scarborough, Whitby, Ripon, Harrogate, Malton, York and Selby and there are numerous smaller seaside and market towns scattered throughout the Trust's geography. We are also in the catchment area for the largest concentration of armed forces personnel in the UK (Catterick Garrison). A map showing this area is provided on the following page. The Trust also provides learning disability services to the population of Craven and some regional specialist services (e.g. Forensic services, Children and Young People tier 4 services and Specialist Eating Disorder services) to the North East and Cumbria region and beyond.

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

- Our income in 2015/16 was **£311.9m**.
- On 31 March 2016 there were almost **59,789** people receiving care from TEWV.
- During 2015/16 on average we had **832** patients occupying an inpatient bed each day (this equates an average occupancy rate of **86%**).
- Our community staff made more than **1.3 million** contacts with service users during 2015/16.
- We have **6,653** (includes York and Selby locality) whole time equivalent staff working in the organisation (March 2016).



KEY:

O = main towns

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

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

Update on 2014/15 quality priorities

In last year's Quality Account we reported on our progress with our quality priorities for 2014/15. Within this we also noted some further actions for 2015/16. In some cases, these actions were to be included within the quality priorities for 2015/16, and therefore, are reported within this Quality Account. In other cases, these quality priorities were discontinued in the Quality Account but remained a priority for the Trust. The following is a brief summary of our progress with the quality priorities that were not continued in the Quality Account priorities for 2015/16.

To have more staff trained in specialist suicide prevention and intervention	During 2015/16 the Trust realised that in order to support this priority in the long term we needed to take a wider approach. This means that we needed to incorporate all aspects of harm minimisation that could impact on a service user's life. A fundamental part of this is suicide presentation and intervention. Due to this, our suicide prevention project was closed and a new harm minimisation and risk management project was opened. This has now become a quality priority within the Trust and included within this document. Further information can be found in **Part 2, 2016/17 Priorities for Improvement section**.
To implement the recommendations of the Care Programme Approach (CPA) review, including, - Improving communication between staff, patients and other professionals - Treating people as individuals	The recovery focused care planning training that commenced in 2014/15 continued during 2015/16 and we achieved the following targets at the end of March 2016. • All Trust Psychosis and EIP teams to have received recovery focused care planning training (100% achieved). • 95% of staff attending training reporting an improved information / knowledge of recovery focused care planning (82% achieved) – i.e. more than 8 out of 10 people who have attended this training have improved their knowledge. • 95% of staff attending training report they are clear about intended action to take to improve care planning (91% achieved). • 95% of staff satisfied with the recovery focused care planning training (92% achieved). • 95% of staff would recommend this training to staff, patients and carers (95% achieved). Further work continued in 2015/16 to streamline all recording and documentation relating to CPA and standard care on the Trusts electronic patient record (Paris). Alongside this, there has been joint work with the new Harm Minimisation framework and risk assessment process to ensure this is incorporated into CPA and care planning. Training will continue through harm minimisation, recovery, relevant mandatory training and our new staff induction in 2016/17.

To manage the pressure on acute inpatient beds	During 2015/16 a Crisis team training package was devised and piloted with team members from every crisis team. In addition to this, a crisis team manager support event was held resulting in an established network for the crisis leadership team. The crisis training was evaluated, and an appraisal of options for future training has been sent to the crisis network and acute care forum for consideration. Crisis / contingency plans were reviewed and tested as part of an improvement event. The format has since been used in redesigning shaping this element of service users electronic care record. We will continue to understand relationships between community care teams and crisis and intensive home treatment, to maximise opportunities for viable alternatives to hospital admission. This will be discussed/ planned through the crisis network and the Acute Care Forum.

2015/16 Priorities for improvement – how did we do

As part of our 2014/15 Quality Account following consultation with our stakeholders, the Board of Directors agreed four quality priorities to be addressed during 2015/16.

Priority 1: Delivery of the recovery project in line with the agreed plan.
Priority 2: Nicotine Management and Smoking Cessation.
Priority 3: Expand the use of Positive Behavioural Support in our Learning Disabilities Services.
Priority 4: Implementation of age appropriate risk assessments and care plans for Children and Young People Services.

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

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

Priority 1: Delivery of the recovery project in line with the agreed plan

Why this is important:

This is a continuation of the priority identified in 2014/15 and recognises that delivery of recovery focused services is critical but will take a number of years. Our stakeholders and Board therefore agreed it was important that this remained a key priority in 2015/16.

The three year recovery strategy within TEWV aims to embed recovery values and principles in services for adults and older adults and ensure we are delivering care that is in line with service users' and carers' needs.

The 2014 national community patient survey shows that TEWV's scores for providing health and advice to patients about their physical health needs, financial / benefit advice and support for staying in or finding work, or taking part in a local activity are all relatively low (between 4.7 and 5.2 out of 10) compared to other groups of questions in the survey. While these are in line with the scores achieved by other mental health Trusts, they do demonstrate the need for a long term commitment to moving to recovery-oriented services.

The benefits / outcomes we aimed to deliver were:

- Care designed to support service users to achieve their own goals;
- Staff genuinely believing that service users can lead fulfilling lives;
- Service users genuinely feeling listened to, heard and validated;
- Views and personal expertise by experience of service users and carers being valued;
- Staff working in partnership with service users and carers at every level of service delivery;
- Service users being supported to take charge of their lives, promoting choice and self-management.

What we did in 2015/16:

The following is a summary of the key actions we have completed in 2015/16:

What we said we would do	What we did
• Expand the number of experts by experience to 24 within TEWV by quarter 2 2015/16.	The recovery programme has now trained four cohorts of experts by experience. Each cohort provided a five day training programme led by Jacqui Dillon, an international consultant on lived experience and the chair of the UK's Hearing Voices Network alongside the Trusts Recovery Programme Clinical Lead. The training prepares individuals to use their own personal lived experience in recovery/service development projects within TEWV. We currently have 31 experts by experience.
• Develop and deliver peer training to 10 potential peers by quarter 3 2015/16.	We have run 2 introductory peer training courses for a total of 10 people. Additional funding from Health Education North has been used to procure Sutton Mental Health Foundation as a provider to deliver accredited peer training which commenced in Q4 2015/16 and will be completed in June/July 2016/17 – 14 people are taking part, 7 of which took part in the introductory course, 7 are new.
• Develop 6 new peer roles within TEWV by quarter 4 2015/16.	Over the last year 14 new peer roles have been established in the Trust with an increasing recognition of the value of these roles within teams.

• Expand the number of Recovery College courses delivered to 28 and identify options for roll out into other areas by quarter 3 2015/16.	The ARCH recovery college in Durham * has continued to expand its provision with more students signing up and attending courses. We were able to exceed our expectations being able to deliver 40 courses in comparison to the planned 28 courses. As at the end of March 2016 the number of new people enrolled at the Recovery College stood at 188. In addition, TEWV is now developing a Virtual Recovery College to allow all service users and carers across the Trust's geography to have access to self-management training and education.
• Roll out recovery training to a further 250 TEWV staff and embed recovery principles into core mandatory training by quarter 4 2015/16.	In the last year the recovery project team have delivered a substantial amount of recovery related training across the Trust, with 531 attendances from Trust staff. This includes: Adult Mental Health teams involved in a Trust-wide quality improvement work-stream, Children's and Young People's Services, Mental Health Services for Older People, the Trust induction programme and training designed to help those diagnosed with a personality disorder. A Trust recovery conference was held in March 2016. Recovery principles have been embedded in much of TEWV's mandatory training and work continues to embed it within the remaining mandatory training courses.
• Work with the Health Foundation and using their methodology to embed shared decision making principles within the recovery programme by quarter 4 2015/16.	We have continued to work with the Health Foundation throughout 2015/16 to ensure the principles of Shared Decision Making are integrated with other recovery related training including Harm Minimisation.

*Only patients resident within County Durham are served by the ARCH recovery college because it is commissioned by Durham Dales, Easington and Sedgefield (DDES) and North Durham CCGs. However there are other recovery colleges in Teesside and York provided by other organisations, and TEWV co-operates with these.

How we know we have made a difference:

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

Indicator	Target	Actual	Timescale
• Number of courses delivered at ARCH Recovery College.	28	40	Q3 2015/16
• Number of individuals receiving peer support training.	10	10	Q3 2015/16
• Number of new peer roles established in TEWV.	6	14	Q4 2015/16
• Number of TEWV staff receiving recovery related training.	250	531*	Q4 2015/16

*total number of people receiving training, some people could be duplicated if attended more than one session/conference.

What we plan to do in 2016/17:

This will continue to be an improvement priority for us. Our plans for 2016/17 are set out in **Part 2, 2016/17 Priorities for Improvement section**.

Priority 2: Nicotine Management and Smoking Cessation

Why this is important:

Research suggests that people with severe mental illness die 15-20 years earlier than the general population. A significant contributor to this is that people with mental health problems also have poorer physical health, with many more smoking when compared to the average population.

People who smoke and have mental health problems are no less likely to want to quit smoking than those without, but it is suggested that they are more likely to be heavily addicted to smoking and anticipate difficulty quitting smoking, and be less likely to succeed. However, as in the general population, smokers with mental health problems are more likely to quit if they are provided with behavioural support and alternatives.

The benefits / outcomes we aimed to deliver:

- Encouragement to commit to giving up smoking for both service users and staff;
- Effective support to give up smoking including access to Nicotine Replacement Therapy (NRT) for both service users and staff;
- Access to trained staff able to provide advice around smoking cessation for service users;
- Improved physical health in the longer term and life expectancy (for both staff and service users).
- Reduced exposure to smoke for staff, which will improve their wellbeing

What we did in 2015/16:

What we said we would do	What we did
• Appoint a Project Manager for the Nicotine Management and Smoking Cessation Project by quarter 1 2015/16.	We appointed a Project Manager in April 2015 (Quarter 1) to lead the Trust's project in order to implement the plans to go smokefree on 9 March 2016.
• Develop a communications plan to inform staff and service users of the Trust's plans to implement its policy on Nicotine Management and Smoking Cessation by quarter 1 2015/16.	A detailed communications plan was developed in Quarter 1 2015/16 to ensure service users, carers and staff were kept informed on the progress of the project. A key part embedded within the communications plan was to ensure service users and staff were informed of the developments of the Nicotine Management and Smoking Cessation project including the revised policy which ultimately details the Trusts smokefree standards.

• Identify potential/available alternatives to smoking/nicotine and understand mechanisms for prescribing by quarter 1 2015/16.	A 'Pharmacy' group was developed in Quarter 1 to look at all available products to support a smoker to become smokefree inclusive of the prescribing pathway. This group also looked at the options for temporary abstinence and also the options available should the service user wish to set a quit date. Additional behavioural support and advice was made available to staff who set themselves a quit date. This was provided following a comprehensive assessment by a Level 2 trained member of staff. Such staff also received a direct referral to community stop smoking services at the end of the Trust's own support.
• Have used the Baseline Assessment Tool (identified within the NICE Public Health guidance 48 (PH48) on smoking cessation) to ensure that the Trust's practice is in line with recommended NICE guidance by quarter 1 2015/16.	The Baseline Assessment Tool was used to ensure all areas of Trust clinical practice, as identified by NICE nicotine management and smoking cessation guidelines were introduced as common practice within every day service user care for those that smoke.
• Complete a benchmarking exercise to understand the number of staff smokers in order to set targets for reduction by quarter 2 2015/16 and then monitor performance against those targets in future quarters.	A benchmarking exercise was undertaken to identify the numbers of staff who currently smoke across the Trust (not including York and Selby). This showed that various percentages of staff identified themselves as a smoker at any given time. This has made it difficult to set a target; however, the Trust has maintained that they will continue to support Trust staff in their efforts to stop smoking.
• Work with our Local Authority Smoking Cessation services to host clinics at key Trust localities (such as Roseberry Park or Lanchester Road) by quarter 2 2015/16.	A 'Local Authority Commissioners' group was set up to look at the provision of services for staff across Trust premises. Lloyds Pharmacies at Lanchester Road Hospital, West Park Hospital and Roseberry Park have been commissioned to provide support to staff wishing to stop smoking from 9 March 2016. Other smoking cessation services will also be contacted as the project continues into 2016/17 to look at the possibility of providing drop-ins for staff within other areas of the Trust such as Scarborough and York.
• Advertise, promote and maximise the opportunity provided by Stoptober 2015 by quarter 3 2015/16.	Multiple Stoptober events were held across the Trust to advertise the support available for those wishing to stop smoking.
• Review our No Smoking Policy to incorporate Nicotine Management and Smoking Cessation by quarter 3 2015/16.	A full policy review took place and the newly ratified Nicotine Management Policy is now available Trustwide for staff to access.

• Develop an implementation plan to support staff to stop smoking by quarter 3 2015/16.	An implementation plan was developed by the Human Resources department to support staff to stop smoking.
• Have sufficient staff trained in Nicotine Management and Smoking Cessation pilot sites in each of our localities to sustain the delivery of our smoke free agenda within the pilot sites by quarter 4 2015/16.	Over 1300 frontline staff have been trained to Level 1 (Very Brief Advice) to ensure service users are identified as smokers/non-smokers on admission and offered nicotine management support for temporary abstinence or to set a quit date. 200 staff have completed a more advanced Level 2 Practitioner Training which allows them to provide a detailed assessment of a smoker and then offer nicotine replacement products and behavioural support. Training of staff will continue into 2016/17 to ensure the Trusts standards are embedded throughout the organisation.
• Implement the Trust's standards on Nicotine Management and Smoking Cessation as per the new / revised approved policy by quarter 4 2015/16.	The newly revised policy has been ratified and approved which sets out the Trust's smokefree standards, which were implemented on the 9 March 2016. These standards will be further embedded as the project continues into 2016/17.

How we know we have made a difference:

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

Indicator	Target	Actual	Timescales
• Proportion of inpatient units that are smoke free.	75%	100%	2015/16 Q4
• Proportion of locally identified clinical staff that have been trained to smoking cessation level 2.	75%	95%	2015/16 Q4
• Delivered reduction in staff smoking in line with target agreed in quarter 2 2015/16.	90%	N/A	Unable to measure due to inconsistent survey data

A clinical audit of smoking prevalence within all Trust services was carried out in December 2015. The audit highlighted the following key points:

- 56% of all inpatients on the 28 December across the Trust are non-smokers;
- On the 28 December 2015 all specialities (except Forensic Mental Health (FMH)) reported having more patients who are non-smokers than patients who currently smoke;
- 43% of all inpatients on the 28 December across the Trust currently smoke;

- Smoking rates are noticeably higher amongst inpatients (on the 28 December) within FMH (68%) in comparison to other specialities.

Please note that these improvements have also been delivered in York and Selby inpatient units, which also went smokefree on 9 March along with other Trust hospitals.

What we plan to do in 2016/17:

This will continue to be an improvement priority for us. Our plans for 2016/17 are set out in **Part 2, 2016/17 Priorities for Improvement section**. A further audit will be conducted in December 2016 to review the smoking status of the service users within the Trust to highlight the impact of change since going fully smokefree within Trust inpatient sites on the 9 March 2016.

Priority 3: Expand the use of Positive Behavioural Support (PBS) in our Learning Disabilities Services

Why this is important:

Behaviour can be defined as "the actions or reactions of a person in response to external or internal stimuli" and can be:

- anything a person says or does;
- voluntary or involuntary;
- good, bad, desirable or undesirable;
- judged along degrees of 'appropriateness'.

The factors that determine behaviour are highly complex and much behaviour has multiple causes. Positive behavioural approaches are focused on **illumination** (understanding the meanings and purposes of the behaviour from the individual's point of view) rather than on **elimination**. Therefore, rather than seeking ways to control people (in the name of treatment and/or intervention), this approach seeks ways to better understand the person and the stimuli for their behaviour, to communicate with them, and to work with them toward achieving fulfilling lives.

There is a considerable evidence base which shows the clear benefits of Positive Behavioural Support as a strategy in terms of enhancing the quality of life of service users and also reducing behavioural challenges. It is widely recognised that Positive Behavioural Support offers the most ethically stringent, evidence-based intervention option for people with learning disabilities and challenging needs and that its use is key to the reduction of restraint and other restrictive practices (including physical, chemical, mechanical restraint and seclusion) in all health and social care settings.

The benefits / outcomes we aimed to deliver:

- A values led based, person centred approach;
- Improved quality of life, happiness and well-being;

- Service users being given the skills and coping capacities to be able to deal with the demands of everyday living;
- A reduction in restrictive practice including control and restraint and use of 'as-required' medication;
- An improved support structure in place for people whose behaviour is described as challenging.

What we did in 2015/16:

What we said we would do	What we did
• Ensure by quarter 4 2015/16 that all people who are referred to the Learning Disabilities Service receive an initial screening and if behavioural challenges are considered to need a functional assessment, place the person onto Tier 1 of the Positive Behavioural Support pathway. The Brief Behavioural Assessment Tool (BBAT) is a core component of Tier 1 therefore everyone who is placed onto Tier 1 automatically undergoes a Brief Behavioural Assessment.	Analysis of the use of the pathway demonstrates we have achieved all our targets. We have also achieved a reduction in intensity and frequency of concerning behaviours for 63% of the people in quarter 1 on the pathway and 20% of the people in quarter 2 on the pathway – 15 people having been successfully discharged with a PBS plan in place. Of those remaining, they continue on the pathway. Examples of Quality of Life Improvements Reported: Service user 1 – is now noticeably smiling more and observed to appear happy and content; now goes out every day somewhere he chooses, voluntarily links arms with others companiably – intensity of one of the priority behaviours of concern has gone from 'Severe' to 'Minor'. Service user 2 – Intensity / frequency of one of priority behaviours of concern has gone from 'Major / Hourly' to 'Negligible / Less (than weekly)' following the implementation of the PBS intervention plans. Service user 3 – All priority behaviours of concern have reduced following PBS intervention plans and the person has been discharged from the pathway – this service user has since been found to be terminally ill and is on an end of life pathway. The reduction of the impact of their behaviours on their quality of life surely has contributed to a more peaceful and dignified end.
• Ensure appropriate training is available in order to increase the number of community staff who are trained in Positive Behavioural Support by quarter 4 2015/16.	Training has continually been made available to staff which has enabled the achievement to meet and go above the target of 95%. This will continue into 2016/17 to ensure staff can receive the training they need to embed the Positive Behavioural Support approach.
• Maintain a register of all inpatient staff that have completed the Positive Behavioural Support training (including new employees) and ensure regular Positive Behavioural Support training sessions are provided for inpatient staff to ensure service remains at 95% by quarter 4 2015/16.	At the end of quarter 4 the service achieved 96% of staff trained. Training sessions will continue to be provided and the register maintained during 2016/17 to ensure the current target is met on an ongoing basis.

How we know we have made a difference:

The following table shows how we have performed against the targets we set ourselves for this priority. This data does not include York and Selby:

Indicator	Target	Actual	Timescale
• Percentage of people (of those identified as suitable from initial screening) placed onto the Positive Behavioural Support pathway and underwent a Brief Behavioural Assessment Tool (BBAT) assessment.	100%	100%	Q4 2015/16
• Percentage increase in staff training within community teams from 60% to 95%.	95%	96%	Q4 2015/16
• Percentage of staff training maintained in inpatient areas.	95%	96%	Q4 2015/16

Evidence has shown a reduction in restrictive practice that has been implemented across the service through the use of the PBS approach. It shows that there has been a clear reduction in behaviours of concern and very clear evidence of improvements of quality of life in all cases. These improvements in themselves demonstrate reductions in restrictive practice because if this had not been the case such positive outcomes would not have been achieved.

Less frequent and intense behaviour scores mean there has been less need to intervene and therefore adopt more restrictive practices.

Increased quality of life again means more positive practice is happening for people; this again implies very clearly that there is reduced need to intervene in more restrictive ways.

What we plan to do in 2016/17:

We will continue to use the PBS approach across the Adult LD Service. In 2016/17 we plan to purchase the Person Centred Active Support (PCAS) training which is an additional but integral part of the PBS approach. This will be delivered as a train the trainers approach across the service over the coming 2-3 years.

In addition to expanding the use of Positive Behavioural Support across our Learning Disabilities service we are also implementing it across our other specialities. This work will take place as part of a project within the Trust that will:

- Conduct Person-centred Behavioural Support Training within Adult Mental Health services and Mental Health Services for Older People pilot sites.
- Develop a Behavioural Support Plan template and debriefing tool for inpatients areas.
- Review the Trust's policies on behaviours that challenge.
- Revise current Management of Violence and Aggression training so that it includes Positive Behavioural Support.

Priority 4: Implementation of developmental age appropriate risk assessments and care plans for Children and Young People Services

Why this is important:

Children and Young People Services (CYPS) assess and treat children at different ages and development stages of their life. There is a vast difference between the verbal, cognitive and social interaction skills of a 4 year old child and a 17 year old adolescent. There are also different risks associated with different age groups or developmental stages.

The historic system for undertaking risk assessments and producing care plans in CYPS does not reflect the different risks and issues identified at each developmental stage and age group a child presents in. This can result in an ineffective use of staff time which affects the experience of service users and carers in a negative way.

The benefits / outcomes we aimed to deliver:

By creating age, and developmental, appropriate risk assessments and care plans, CYPS will be able to co-produce risk assessments and risk management plans with the young person and their family, which are responsive to their age, development and need. Children, young people and their carers will therefore:

- Be at the centre of care with an agreement in place on the identified risks;
- Have a shared care plan and risk assessment which will include a summary of the identified risks and interventions;
- Have more meaningful risk assessments and care plans based on needs, and less unnecessary documentation;
- Have a shorter wait for assessment and treatment because staff will have more time available for patient contacts (due to more focused assessments and care planning);
- Feel that the process is more tailored to the individual needs of the child / young person and more supportive to their wellbeing, safety and recovery;
- Experience a consistent high standard of practice across CYPS in assessing and managing risk.

What we did in 2015/16:

What we said we would do	What we did
• Draft age appropriate risk assessment and care plans for the revised risk management documentation created by quarter 1 2015/16.	Whilst the documentation was in development feedback was received from staff within the Children's Hubs (such as School Nurses, Health Visitors, Senior Educational Needs Co-ordinators (SENCO)) requesting that we align our revised documentation with the Children's Assessment Framework (CAF). The first sections of the revised documentation now match that of the CAF with the aim of supporting patient care and improve communication when linking with our partners whilst also saving Trust staff time. The draft documentation has been piloted across 2 Trust teams, one in North Durham and the other in Stockton. Feedback from staff taking part in the pilot teams was positive with relevant suggested changes made.

• Gather service user feedback on the revised risk management documentation and process by quarter 2 2015/16.	A questionnaire was developed to gather service user views on the revised documentation. Feedback from the questionnaire showed that no changes to the revised documentation were required.
• Ensure approval of the revised risk management documentation and process from relevant Trust governance groups including those involving patients and carers by quarter 2 2015/16.	The draft documentation was reviewed and approved within the Trusts Speciality Development Group for Children's services.
• Complete revisions to our risk management documentation and process based on feedback received from Trust governance groups by quarter 3 2015/16.	As no changes were required when reviewed by service users and the Trusts Children's Speciality Development Group, no revisions were completed. Following the upload of the documentation to Paris (our electronic patient record system), service user and Speciality Development Group views will be gathered with any requested changes being added to Paris to ensure the documentation reflects what is needed and required by our service users.
• Upload the approved documents on to Paris (our electronic patient record system) by quarter 4 2015/16.	The Paris system has been updated to make the system more user friendly. This means that the flow of how documentation is used on the system differs from when the risk assessments and care plans were originally revised. Currently the basic principles of the revised documentation have been uploaded within Paris. Further development is ongoing to adapt the documentation to flow in the same way as the updated version of Paris.
• Complete staff training on the new documentation and process by quarter 4 2015/16.	During January to March 2016 staff received training to enable them to seamlessly use the updated version of Paris. This training will continue during the ongoing developmental work being carried out on Paris as mentioned above.
• Ensure the revised risk management process is implemented across all teams by quarter 4 2015/16.	Whilst the staff training was taking place, the revised risk management process was implemented across all teams in preparation for the revised documentation being uploaded on to Paris.

How will we know we are making a difference?

The following table shows how we have performed against the targets we set ourselves for this priority (please note, this data does not include York and Selby):

Indicator	Target	Actual	Timescale
• Percentage of children offered a paper copy of their completed risk assessment.	100%	100%	Q4 2015/16
• Percentage of all staff trained on new documentation (inpatient and community).	100%	100%	Q4 2015/16
• Reduction in staff time inputting risk management documentation in to Paris.	50%	Will be reported during 2016/17	Q1 2016/17
• Patient and Carer satisfaction (metric and target to be developed).	90%		Q1 2016/17

Staff have received training on the revised documentation and how to use the updated version of Paris. Training will continue across the Trust into 2016/17 as Paris is updated.

What we plan to do in 2016/17:

During 2016/17 we will continue to use the revised risk assessments and care plans that have been uploaded on to Paris. The documentation will be reviewed at regular intervals to ensure they are meeting the needs of our service users, with any amendments being made when necessary.

As York and Selby will be able to access the TEWV version of Paris in 2016/17, however, they already use age appropriate risk assessments and care plans. Work will commence to review the strengths of both sets of forms which will lead to further improvement in the future.

We will monitor the impact that the changes have on time staff spend inputting risk management documentation into PARIS, and continue to gather the views of patients and their carers to ensure that our new arrangements are have the intended impact.

Statement of Assurances from the Board 2015/16

The Department of Health and Monitor require us to include our position against a number of mandated statements to provide assurance from the Board of Directors on progress made on key areas of quality in 2015/16. These statements are contained within the blue boxes. In some cases additional information is supplied and where this is the case this is provided outside of the boxes.

Review of services

During **2015/16** TEWV provided and/or sub-contracted **20** relevant health services.

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

The income generated by the relevant health services reviewed in 2015/16 represents **100%** per cent of the total income generated from the provision of the relevant health services by TEWV for 2015/16.

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

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

Following discussion at the QuAG any areas of concern are escalated to the relevant Locality Management and Governance Board (LMGB) and from there to the Quality and Assurance Committee (QuAC) the sub-committee of the Board which has responsibility for Quality Assurance. The QuAC receives formal reports from each of the Locality Management and Governance Boards on a 2 monthly basis.

We also undertake an Internal Inspection Programme, the content of which is based on the Fundamental Standards of Quality and Safety published by the CQC. These inspections cover all services and the inspection team includes members of our Compliance Team, service user and carer representatives from our Fundamental Standards Group and peers from other services. In advance of the visit the inspection team review a range of information on the quality of the service being inspected, for example: incident data, PALS /

complaints data, CQC compliance reports and Mental Health Act visit reports, and any whistleblowing information. At the end of the internal inspection verbal feedback is given to the ward/team manager and any issues are escalated to the Head of Service, Head of Nursing and the Director of Nursing and Governance. An action plan is produced and implementation is assured via the QuAGs, LMGBs and Quality Assurance Committee (QuAC), as described above, and in line with the Trusts Clinical Assurance Framework.

Each month the Board of Directors also undertakes a minimum of seven visits, to our wards and teams across the Trust. They listen to what service users, carers and staff think and feel about the services we provide.

In addition to the above the Trust has introduced an Integrated Information Centre (IIC) which is a data warehouse which integrates information from a wide range of source systems e.g. patient information, finance, workforce and incidents. The information within the IIC is updated regularly from the source systems and allows for the interrogation of the most up to date positions at any time of the day. This allows clinical staff and managers to access the information on their service at any time of day (or night) and to be able to 'drill' down to the lowest level of the data available (according to access rights). The IIC also sends prompts to staff which helps to improve the care and experience of our service users. For example, the IIC sends prompts to Care Coordinators on a weekly basis listing those patients whose care plan reviews are due in the next week, 2 weeks and 1 month. This ensures that staff can be proactive about ensuring these patients have review appointments scheduled in a timely manner thus improving patient safety.

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

The increase in services reported above compared to that reported in 2014/15 relates to the Trust becoming the provider of services in the Vale of York on the 1 October 2015. Since October we have replicated the governance processes, outlined above, within our York and Selby Locality and they have commenced the review of available data. It is expected that this will become further embedded during 2016/17.

Participation in clinical audits and national confidential inquiries

During 2015/16, **3** national clinical audits and **1** national confidential inquiry covered the relevant health services that TEWV provides.

During 2015/16, TEWV participated in **100%** of national clinical audits and **100%** of national confidential inquiries of the national clinical audits and national confidential inquiries which it was eligible to participate in.

The national clinical audits and national confidential inquiries that TEWV was **eligible to**

participate in during 2015/16 are as follows:

- National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH);
- POMH UK Topic 13b: Prescribing for ADHD in Children, Adolescents and Adults;
- POMH UK Topic 14b: Prescribing for substance misuse – alcohol detoxification;
- POMH UK Topic 15a: Prescribing valproate for bipolar disorder.

The national clinical audits and national confidential inquiries that TEWV **participated in** during 2015/16 are as follows:

- National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH);
- POMH UK Topic 13b: Prescribing for ADHD in Children, Adolescents and Adults;
- POMH UK Topic 14b: Prescribing for substance misuse – alcohol detoxification;
- POMH UK Topic 15a: Prescribing valproate for bipolar disorder.

A further internal Trust re-audit of POMH UK Topic 10c: Prescribing antipsychotics for children and adolescents was undertaken.

The national clinical audits and national confidential inquiries that TEWV participated in, and for which data collection was completed during 2015/16, are listed below alongside the number of cases submitted to each audit or inquiry as a percentage of the number of registered cases required by the terms of the national audit or inquiry.

Audit Title	Cases Submitted	% of the number of registered cases required
POMH UK Topic 13b: Prescribing for ADHD in Children, Adolescents and Adults.	99	Not applicable
POMH UK Topic 14b: Prescribing for substance misuse – alcohol detoxification.	27	Not applicable
POMH UK Topic 15a: Prescribing valproate for bipolar disorder.	197	Not applicable
National Confidential Inquiry into Suicide & Homicide by People with Mental Illness.	n/k*	99%

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

The report of **1** national clinical audit was reviewed by the provider in 2015/16 and TEWV intends to take the following actions to improve the quality of healthcare provided:

- POMH UK Topic 13b: Prescribing for ADHD in Children, Adolescents and Adults

Actions:

- Present audit report to Drugs and Therapeutics Committee, CYPS, LD and AMH Clinical Audit Subgroups.
- Disseminate audit report to relevant Team Managers and Consultants.

- Work by CAMHS / LD CAMHS Consultants to find out about access arrangements to centile charts.
- Identify a source of pulse centile charts and make them available to CAMHS / LD CAMHS teams.
- Project lead to liaise with Adult ADHD and CAMHS teams to introduce standardised rating scales for use in reviews for patients prescribed medication for ADHD.

The reports of **161** local clinical audits were reviewed by the provider in 2015/16 and TEWV intends to take actions to improve the quality of healthcare provided. **Appendix 4** includes the actions we are planning to take against the **8** key themes from these local clinical audits reviewed in 2015/16.

In addition to those local clinical audits reviewed (i.e. those that were reviewed by our Quality Assurance Committee and Clinical Effectiveness Group), the Trust undertook a further **66** clinical audits in 2015/16. These clinical audits were led by the services and individual members of staff for reasons of service improvement and professional development and were reviewed by the Specialty Clinical Audit Subgroups.

Participation in clinical research

The number of patients receiving NHS services provided or subcontracted by TEWV in 2015/16 that were recruited during that period to participate in research approved by a research ethics committee was **331**.

Of the **331, 314** were recruited to **22** National Institute for Health Research (NIHR) portfolio studies. This compares with **265** patients involved as participants in NIHR research studies during 2014/15.

Recruitment into research has increased this year due to a number of higher recruiting studies including the REQUOL (mental health) study which recruited 84 participants and the IDEAL (Dementia) study which recruited 60 participants. The Trust contributes to the overall Clinical Research Network: North East and North Cumbria targets for recruitment and the Mental Health, DeNDRoN and Health Service Delivery specialties that we contribute to have all exceeded recruitment targets for this year.

We continue to be involved with large scale national research across a variety of clinical disciplines such as psychosis, drug safety, forensic mental health, dementia, learning disabilities, personality disorder and children and young people services. Our ongoing participation in clinical research through 2015/16 reflects our firm commitment to improving the quality of care we provide, as well as contributing to the broader goals of mental health, learning disability and dementia research. The Trust has also supported national research into the implications of later retirement ages in the NHS.

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

- We were involved in conducting **61** clinical research studies during 2015/16. **27** of these studies were supported by the NIHR through its networks and **17** new studies approved through its coordinated research approval process.
- **28** members of our clinical staff participated as researchers in studies approved by a research ethics committee, with **16** of these in the role of principal investigator for NIHR supported studies.
- **875** members of our staff were also recruited as participants to both NIHR portfolio and non-portfolio studies that were undertaken within TEWV.
- **76** researchers from outside the organisation were granted access under the National Research Passport Scheme to perform research with us compared to **33** in 2014/15. This increased number was due to issuing 37 letters of access for research teams to access research participants in the York and Selby region which became part of our Trust in October 2015.
- We have a new 5 year R&D strategy with a strong focus on PPI engagement and academic collaborations which provide us with the aim of becoming a lead research site with further opportunities for research involvement for our service users. We continue to be co-applicants on large scale grant applications in collaboration with our university partners.
- We have setup a clinical trials pharmacy department which will provide the infrastructure to enable us to participate in future CTIMP studies.
- We have research champions embedded across all of our memory services which provides a link to ensure equality of access to research opportunities across the Trust. Our research champions promote the national Join Dementia Research system and we have been a pilot site for a 'JDR' on prescription scheme in collaboration with the Alzheimer's Society.

Goals agreed with commissioners

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

A proportion of TEWV's income in 2015/16 was conditional on achieving quality improvement and innovation goals agreed between TEWV and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2015/16 and for the following 12 month period are available electronically at http://www.tewv.nhs.uk/site/about/how-well-are-we-doing.

As part of the development and agreement of the 2015/16 mental health contract, discussions were held between the Trust and each of its commissioners to agree a set of goals and indicators that all parties felt were appropriate and relevant to local and national strategies. Indicators linked to physical healthcare, positive behaviour support and family support were key to both provider and commissioners. These are monitored at meetings every quarter with our commissioners.

An overall total of £6,874,344 was available for CQUIN to TEWV in 2015/16 conditional upon achieving quality improvement and innovation goals across all of its CQUINs, and a total of £6,544,915 (95% from the TEWV CQUIN prior to the Vale of York contract and 100% from the Vale of York CQUIN) is estimated to be received for the associated payment in 2015/16. This compares to £5,765,066 (98.02%) received in 2014/15, £5,777,218 (99.28%) in 2013/14 and £5,938,580 (100%) in 2012/13 (the estimate for 2015/16 has still to go through all the required governance processes for full approval). The Vale of York CQUIN consisted of a 1.57% scheme which was included within the contract in relation to services post October 2015.

Some examples of CQUIN indicators which the Trust made progress with in 2015/16 were:

- Improved response time for urgent assessments to North Yorkshire Acute Trust Emergency Departments Children's wards, Adult crisis teams and community services. Baseline data for March – May 2015 showed that 25% of urgent referrals within Scarborough were seen by a suitably trained practitioner within 4 hours of referral, 22% in Northallerton and 92% in Harrogate. As at quarter 4, all areas reported **100%**.
- To support parent/carers, young carers and siblings of young people in service, an evaluation of family support has been undertaken. Peer mentoring groups are being offered in Durham & Darlington and Teesside.
- Expanded peer worker roles throughout the Trust. The Trust exceeded the targets for the agreed metrics with commissioners. **14** involvement peers and **2** paid expert coordinator posts have been introduced. There are now **50** regular positions on steering and working groups for service users with lived experience and there are a further 3 Trust groups that are attended by an average number of **31** individuals with lived experience. **79** volunteering opportunities have been offered to individuals with lived experience.
- Improved care pathway journeys within CAMHS to ensure compliance with admission and discharge standard process descriptions. At quarter 1 60% of admissions were completed in line with the standard process description and 79% of discharges. As at quarter 4, **95%** of admissions and **100%** of discharges were completed in line.

What others say about the provider

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

TEWV is required to register with the Care Quality Commission (CQC) and its current registration status is **registered to provide services with no conditions attached**. The Care Quality Commission has not taken enforcement action against TEWV during 2015/16.

During 2015/16 TEWV were subject to one CQC Compliance inspection at Ridgeway, Roseberry Park but has not yet received formal feedback.

The Trust has had one social care inspection during 2015/16 at 367 Thornaby Road and a draft report has been received. The draft report states that 367 Thornaby Road is

good overall and no action plan was required.

CQC's rating for each key area for 367 Thornaby Road was:

Key area	Rating
Are services caring?	Good
Are services safe?	Good
Are services effective?	Good
Are services responsive?	Good
Are services well-led?	Good

The Trust has also had one joint CQC and HMPI 2015/16 inspection but are waiting for formal feedback.

The CQC also undertook a review of health services for Looked After Children and Safeguarding in the Middlesbrough, from 8 June to 15 June 2015. A recommendation for TEWV and the CCG was to ensure that early help services for children who require access to Tier One and Two services for emotional health and well-being are strengthened.

There has also been a Looked After Children and Safeguarding review in Hartlepool; however the final report is awaited.

York and Selby Services

In the mobilisation period leading up to the transfer of York and Selby services from Leeds and York Partnership Foundation Trust (LYPFT) to TEWV, a CQC Inspection was carried out at Bootham Park Hospital (BPH) on 8 and 9 September 2015. This was a follow up to the Trustwide CQC Inspection of LYPFT in October 2014 where compliance actions were raised.

During this inspection of BPH, the CQC identified specific concerns about the environment and in particular the fixture and fittings that posed potential ligature risk of suicide or serious harm for patients; LYPFT were not able to remove the fixtures and fittings because of BPH status as a listed building. As well as the ligature risk there was a problem with the water temperature and patients were believed to be at risk of scalding from high water temperatures.

On the two adult admission inpatient wards CQC Inspectors found that nursing staff were unable to observe all parts of the wards due to the layout, that there was a lack of call alarms for patients, there was poor hygiene and infection control as well as insufficient staffing levels.

On the 24 September 2015 LYPFT were given notice by CQC that they were to de-register BPH and formally served them notice under Section 64 of the Health and Social Care Act 2014. CQC stated that they required for no regulated activities to be carried on at the location BPH by midnight 30 September 2015.

On the 1 October 2015 the York and Selby services transferred to TEWV and a Notice of Decision to vary the conditions of TEWV Registration by CQC was received. This confirmed that they had registered all services with the exception of BPH. Since the

Notice of Decision was made CQC have allowed TEWV to reopen Bootham Park for outpatient services and the Section 136 Suite only.

The following requirements were found by CQC following their LYPFT inspection in September 2015 at Bootham Park Hospital and the actions taken by TEWV since the 1 October 2016 to address these issues raised by CQC are:

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Fundamental standards were not met as the provider (LYPFT) did not:

- take appropriate steps to ensure wards were safe to use for their intended purpose and were used in a safe way;
- assess the risk of infection and prevent and control the spread of infection;
- assess the risks to the health and safety of service users of receiving care or treatment. They did not include arrangements to respond appropriately and in good time to people's changing needs;
- have risk assessments that contained plans for managing risks;
- do all that was reasonably practicable to mitigate risk. The Trust (LYPFT) did not make the required adjustments to premises, process and practices to ensure the safety of people who used the service.

Actions and Progress by TEWV

- Inpatient wards have moved from Bootham Park Hospital. Peppermill Court and Acomb Garth are undergoing refurbishment. This will ensure that all York and Selby patients in beds within that Locality will be in wards / units that meet the safe care and treatment standards.
- Peppermill Court Environmental Risk assessment to be reviewed once refurbishment completed.
- Review all environmental risk assessments in line with TEWV policies. On completion of review of environmental risk assessments, consider unsafe areas and ensure doors locked where appropriate.
- A Trustwide review of ligature risk was undertaken in March 2016. Estates work identified will be completed.
- All Ward environments will be EMSA compliant following refurbishment.
- New Risk Assessment framework and new Paris (our electronic patient record system) training will be implemented together. FACE risk assessment and SAMP (Safety, Assessment Management Plan) will be discontinued by end of March 2016.
- The Multi-Disciplinary Team will ensure all patients will be involved in planning their care and treatment, including the observation and engagement care plan. This will be recorded daily in the clinical record and include the patients' views.
- Infection Prevention and Control (IPC) Audits to be undertaken in all inpatient wards in York and Selby Locality.

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Fundamental standards were not met as the provider did not:

- Ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in order to make sure they could meet people's care and treatment needs.

Actions and Progress by TEWV

- Ongoing programme of recruitment alongside management of change process.
- Process to manage staff in MHSOP and AMH service through business continuity and management of change process to support establishment of staff across both services.
- Review of shift systems and establishments and introduction of e-roster meetings across all wards and services.

The following requirements were found by CQC following their LYPFT inspection in October 2014 across York and Selby services. Below are the actions TEWV have identified to be taken and their progress against breaches and compliance issues raised by CQC which are not covered by the actions raised in the September 2015 actions listed above.

Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints

The systems for identifying, handling and responding to complaints made by service users were not effective across the Trust (LYPFT).

This is because the systems currently in place did not identify, handle and record complaints being resolved at local resolution or ward level, complaints were stored and handled within patient care records contrary to published guidance and it was not clear that complaints were fully investigated.

Actions and Progress by TEWV

- Complaints are recorded and managed centrally by the Complaints Department. Staff in York and Selby now adhere to TEWV Complaints Policy. Lessons learnt following complaints are shared in the York and Selby Locality QuAGs. TEWV Complaints Manager has attended Quality Assurance groups in York and Selby to discuss process for managing complaints. When complaints have been received discussions have taken place with relevant service managers and other clinical staff to enable responses to be provided.

Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff

The Trust (LYPFT) did not ensure that staff received mandatory training including Mental Capacity Act (MCA) and Deprivation Of Liberty Safeguards (DoLS), complaints

training and Mental Health Act training. The Trust did not ensure all staff received appropriate training, supervision and appraisal.

Actions and Progress by TEWV

- Monitoring of Mandatory Training is undertaken by the Education and Training Department and reported to Ward Managers, the York and Selby Locality Management and Governance Board and the Trust Board. Ward Managers ensure staff complete mandatory training as well as supervision and appraisal.

Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment

The registered provider (LYPFT) did not have suitable arrangements in place for obtaining and acting in accordance with, the consent of patients in relation to the care and treatment provided to them at Bootham Park Hospital ward 2 and the Becklin Centre ward 4 and 5 in accordance with the Mental Health Act (MHA), Code of Practice, Regulation 18.

Actions and Progress by TEWV

- The Rolling Programme of MHA training now includes the York and Selby locality. The programme has six modules ranging from an introduction to the MHA and MCA to modules including Consent and Capacity, MHA / DoLS interface. All of these modules are available to York and Selby staff of all levels and disciplines.
- TEWV have also provided specific training to each ward and unit around the MHA and MCA including TEWV policies, all of which have been implemented across York and Selby which reflect the requirements of both the MHA and MCA Codes of Practice.

Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records

The patients were not protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of an accurate record in respect of each service user which should include appropriate information and documentation in relation to their care and treatment.

Actions and Progress by TEWV

- Immediate review of care record documentation was reported as undertaken by LYPFT and improvements made.
- Physical health assessment on admission will be monitored as part of the audit on admission paperwork and care plan audit.

Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines

At Worsley Court the Trust (LYPFT) must ensure that there are no delays to the

administration of patients' medication.

Actions and Progress by TEWV

- Registered nurses now check all drug cards following medication rounds.
- Posters requesting non-interruption of medication rounds are now placed on the ward for visitors and staff.
- A meeting has taken place to look at improving systems and process around the management of medicines at all MHSOP services in York and Selby.
- Medication round observations are now undertaken within York MSHOP services and reported on by the lead nurse for medicines management.

TEWV has also participated in **43** Mental Health Act inspections by the Care Quality Commission to the following ward areas during 2015/16:

Ward	Service Type	Locality
Acomb Garth	Adult Mental Health Rehab	York
Bankfields Court	Learning Disabilities Assessment & Treatment	Middlesbrough
Bedale	Adult Mental Health Assessment & Treatment	Middlesbrough
Bek	Learning Disabilities Assessment & Treatment	Durham
Bilsdale	Adult Mental Health Assessment & Treatment	Middlesbrough
Birch	Adult Eating Disorders	Darlington
Brambling	Forensic Mental Health Low Secure	Middlesbrough
Bransdale	Adult Mental Health Assessment & Treatment	Middlesbrough
Cedar	Adult Mental Health Assessment & Treatment	Darlington
Ceddesfeld	Older Peoples Mental Health Assessment & Treatment	Bishop Auckland
Cherry Trees	Older Peoples Mental Health Assessment & Treatment	York
Danby	Adult Mental Health Assessment & Treatment	Scarborough
Eagle	Forensic Learning Disability Low Secure	Middlesbrough
Earlston House	Adult Mental Health Rehab	Darlington
Farnham	Adult Mental Health Assessment & Treatment	Durham
Harland	Forensic Learning Disability Low Secure	Durham
Harrier	Forensic Learning Disability Low Secure	Middlesbrough
Ivy/Clover	Forensic Learning Disability Low Secure	Middlesbrough
Jay	Forensic Mental Health Low Secure	Middlesbrough
Kirkdale	Low secure rehabilitation	Middlesbrough
Langley	Forensic Learning Disability Low Secure	Durham
Lark	Forensic Mental Health Low Secure	Middlesbrough
Lincoln	Adult Mental Health Assessment & Treatment	Hartlepool
Lustrum Vale	Adult Mental Health Rehabilitation	Middlesbrough
Mandarin	Forensic Mental Health Medium Secure	Middlesbrough
Maple	Adult Mental Health Assessment & Treatment	Darlington
Meadowfields	Older Peoples Mental Health Assessment & Treatment	York
Merlin Ward	Forensic Mental Health Low Secure	Middlesbrough
Newberry Centre	Child and adolescent service Assessment & Treatment	Middlesbrough
Oak Rise	Learning Disabilities Assessment & Treatment	York
Orchards	Adult Mental Health Rehabilitation	North Yorkshire
Park House	Adult Mental Health Rehabilitation	Middlesbrough
Primrose Lodge	Adult Mental Health Rehabilitation	Chester le Street

Robin	Forensic Learning Disability Low Secure	Middlesbrough
Roseberry	Older Peoples Mental Health Assessment & Treatment	Darlington
Sandpiper	Forensic Mental Health Medium Secure	Middlesbrough
Springwood	Older Peoples Mental Health Assessment & Treatment	North Yorkshire
Westerdale North	Older Peoples Mental Health Assessment & Treatment	Middlesbrough
Westerdale South	Older Peoples Mental Health Assessment & Treatment	Middlesbrough
Westwood Centre	Child and adolescent service low secure	Middlesbrough
White Horse View	Learning Disabilities Rehabilitation	Easingwold
Willow	Adult Mental Health Rehabilitation	Darlington
Worsley Court	Older Peoples Mental Health Assessment & Treatment	Selby

Quality of data

TEWV submitted records during 2015/16 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- Which included the patient's valid NHS number was: **99.99%** for admitted patient care.
- Which included the patient's valid General Medical Practice Code was **99.98%** for admitted patient care.

TEWV Information Governance Assessment Report overall score for 2015/16 was **89%** and was granted as **satisfactory***.

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

The Information Governance Toolkit measures performance in the following areas:

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

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

89% (satisfactory) means that we have achieved at least level 2 on all of the 45 requirements of the toolkit, however, in a significant number of elements we attained level 3 (the highest score).

TEWV was **not** subject to the Payment by Results clinical coding audit during 2015/16 by the Audit Commission.

Monitor, issued draft guidance at the end of 2014 for the 2015/16 financial year. This required organisations to share with commissioner's outcome measurements as a key requirement of developing the Mental Health Currency and Tariff. The areas for development are:

- **Clinically Reported Outcome Measure (CROM):** this is the Health of the Nation Outcome Score (HoNOS) and reported via the Mental Health Minimum Data Set (MHMDS). The reporting of this is now available to all clinicians and managers on their desktops via the IIC. The outcome reports are also routinely provided to commissioners. These reports are automatically generated by the IIC, other than in York and Selby, where moving data recording onto the electronic patient record system used in the rest of the Trust has to be completed first (this move will be taking place in 2016/17 Q1).
- **Patient Reported Outcome Measure (PROM):** the Trust has implemented the use of the patient reported wellbeing measure, the short version of the Warwick-Edinburgh Mental Well-being Scale (SWEMWBS). The reporting of this is now available to all clinicians and managers on their desktops via the IIC, other than in York and Selby (see above).

A training programme has been provided to clinical staff on the use and understanding of the outcome tools in day to day practice and how to access and interpret the IIC data in relation to PROMS and CROMS.

At the end of March 2016, excluding York and Selby:

- **97%** of service users on the Adult Mental Health (AMH) and **99%** of services users on the Mental Health Services for Older People (MHSOP) caseloads were assessed using the mental health clustering tool.
- **91%** of service users on the Adult Mental Health (AMH) and **91%** of services users Mental Health Services for Older People (MHSOP) caseloads were reviewed within the guideline timeframes.

Further work for 2016/17 includes:

- The testing of a currency model in Forensic Mental Health Services and Children and Young People Services.

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

- We have a Data Quality Group chaired by the Director of Finance and Information which meets on a monthly basis and addresses data quality issues in terms of

patient, staff, financial and risk information.

- We have a data quality strategy and scorecard to monitor improvement. The strategy aims:
  - To maximise the accuracy, timeliness and quality of all our data wherever and however it is recorded.
  - To ensure that every member of our staff understands that data quality is the responsibility of everyone and an integral part of their role.
  - To ensure we achieve compliance with all our statutory and regulatory obligations.
- A data quality working group (formed in late 2014/15) continues to identify areas of poor data quality, develop locality specific action plans in relation to data quality, and provide advice, support and education to teams. This group reports into the Trust Data Quality Group.
- We have established regular reports on key elements of data which show how well data is being recorded on the various information systems, particularly the patient information system and the staff information system.
- We report on data quality to the Board as part of our Strategic Direction Scorecard reports.
- Regular reports are available to all services so that they can target improvement work on areas where problems occur. Data quality is a key item for discussion in the monthly performance meetings that are held between the services and the Chief Operating Officer, the Director of Finance and Information and the Director of Planning, Performance and Communication.
- We have agreed Data Quality Improvement Plans (DQIPs) with our commissioners for key indicators, particularly those that require new data recording or collection systems to be put in place.

Mandatory quality indicators

The following are the mandatory quality indicators relevant to mental health Trusts, issued jointly by the Department of Health and Monitor and effective from February 2013. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127382/130129-QAs-Letter-Gateway-18690.pdf.pdf
For each quality indicator we have presented a mandatory statement and the data on the NHS Information Centre (NHSIC) for the most recent and the previous reporting period available.

Care Programme Approach 7 day follow-up

The data made available by the Health and Social Care Information Centre (NHSIC) with regard to the percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period.

Note the data for quarter 3 and Quarter 4 2015/16 **does** include York & Selby services which joined the Trust on the 1 October 2015.

TEWV Actual Quarter 4 2015/16	***National Benchmarks in Quarter 3 2015/16***	***TEWV Actual Quarter 3 2015/16***	***TEWV Actual Quarter 2 2015/16***	***TEWV Actual Quarter 1 2015/16***
Trust final reported figure: **97.75%**	NHSIC reported: Highest/best MH Trust = **100%**	Trust final reported figure: **97.8%**	Trust final reported figure: **97.5%**	Trust final reported figure: **98.1%**
Figure reported to Monitor: **98.76%**	National average MH Trust = **96.9%**	Figure reported to Monitor: **97.55%**	Figure reported to Monitor: **97.57%**	Figure reported to Monitor: **98.07%**
NHSIC reported: not yet available	Lowest/worst MH Trust = **50%**	NHSIC reported: **97.5%**	NHSIC reported: **97.6%**	NHSIC reported: **98.1%**

* latest benchmark data available on NHSIC at quarters 3 2015/16

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

- The discrepancy between the Trust final reported figure and the figure reported to Monitor in quarter 4 2015/16 is due to the fact the Trust final figure is refreshed throughout the year to reflect a validated position as data quality issues are resolved. The figure reported to Monitor is the position at quarter end and is not refreshed after submission.
- The discrepancy between the NHSIC and the Trust / Monitor figure in quarters 2 and 3 is due to the fact the NHSIC data is submitted at a Clinical Commissioning Group (CCG) level, and therefore, excludes data where the CCG is unspecified in the patient record.
- The few actual breaches, **50** in total in 2015/16, were a result of:
  - Difficulty in engaging with the service user despite efforts of the service to contact the patient; and

- Breakdown in processes.

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

- Monitoring this key performance indicator via the Trust's dashboard at team, service and Board level on a monthly basis.
- Investigating all breaches and identifying lessons to be learned at directorate and service level performance meetings.
- Undertaking a Quality Improvement System session to review the monitoring and validation process.
- Adhering to a standard process to ensure patients discharged to other services (e.g. 24 hour care unit) are not overlooked, including the introduction of visual control boards.
- Continuously raising awareness and reminding staff at ward / team meetings of this national requirement, the need to follow the standard procedure and the need to record data accurately.

Crisis Resolution Home Treatment Team acted as a gatekeeper

The data made available by the Health and Social Care Information Centre (NHSIC) with regard to the percentage of admissions to acute wards for which the crisis resolution home treatment team acted as a gatekeeper during the reporting period.

Note the data for Quarter 3 and Quarter 4 2015/16 does include York & Selby services which joined the Trust on the 1 October 2015.

TEWV Actual Quarter 4 2015/16	***National Benchmarks in Quarter 3 2015/16***	***TEWV Actual Quarter 3 2015/16***	***TEWV Actual Quarter 2 2015/16***	***TEWV Actual Quarter 1 2015/16***
Trust final reported figure: **97.18%**	NHSIC Reported: National average MH Trust = **97.4%**	Trust final reported figure: **96.6%**	Trust final reported figure: **97.2%**	Trust final reported figure: **97.9%**
Figure reported to Monitor: **96.74%**	Highest/best MH Trust = **100%**	Figure reported to Monitor: **96.57%**	Figure reported to Monitor: **97.24%**	Figure reported to Monitor: **98.13%**
NHSIC Reported: not yet available	Lowest/worst MH Trust = **61.9%**	NHSIC Reported: **96.5%**	NHSIC Reported: **97.0%**	NHSIC reported: **98.1%**

* latest benchmark data available on NHSIC at quarters 3 2015/16

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

- The discrepancy between the NHSIC and the Trust / Monitor figures is due to the fact the NHSIC data is submitted at a Clinical Commissioning Group (CCG) level, and

therefore, excludes data where the CCG is unspecified in the patient record.
- The few actual breaches, **49** in total in 2015/16, were a result of failure to follow the standard procedure.

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

- Monitoring this key performance indicator via the Trust's dashboard at team, service and Board level on a monthly basis.
- Investigating all breaches and identifying lessons learnt at director and service level performance meetings.
- Undertaking a Quality Improvement event session to review the monitoring and validation process.
- Continuously raising awareness and reminding staff at ward / team meetings of this national requirement, the need to follow the standard procedure and the need to record data accurately.

Patient's experience of contact with a health or social care worker

The data made available by the Health and Social Care Information Centre (NHSIC) with regard to the Trust's "patient experience of community mental health services" indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period. The figures we have included are from the CQC website but at the time of writing comparative figures were not available on the NHSCIC.

An overall Trust score is not provided, due to the nature of the survey, therefore it is not possible to compare Trusts overall. For 2015, we have reported the Section score which compiles the results from the questions used from the survey detailed below the table.

Note the data below does not include York and Selby services which joined the Trust on the 1 October 2015, which was after the survey was carried out.

TEWV Actual 2015	***National Benchmarks in 2015***	***TEWV Actual 2014***	***TEWV Actual 2013***
Overall section score: 8.0 (sample size 239)	Highest/Best MH Trust = 8.2 Lowest/Worst MH Trust = 6.8	NHSIC Reported: **8.1*** (sample size of 188)	NHSIC Reported: **89.40** (sample size of 217)

***not directly comparable with 2013 data**

Notes on metric

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

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

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

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

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

- The figures are derived from the NHS Patient survey report.
- The individual scores that this figure is based on were:

  - Did this person listen carefully to you: TEWV mean score of **8.4**. The lowest national mean was 7.6 and the highest 8.7.
  - Were you given enough time to discuss your needs and treatment: TEWV mean score of **7.7**. The lowest national mean was 6.8 and the highest 8.0.
  - Did the person or people you saw understand how your mental health needs affect other areas of your life: TEWV mean score of **7.7**. The lowest national mean was 6.0 and the highest 7.8.

To determine how the Trust is performing, a banding of better/worse/about the same was allocated to each Trust for each question, using a statistic called the 'expected range' which takes into account the number of respondents from each Trust as well as the scores for all other Trusts. Of the 33 questions rated, the CQC categorisation of TEWV result compared to other mental health Trusts was “Better” for 5 questions and “About the Same” for 28.

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

TEWV is taking the following actions to improve patient experience through:

- Further staff training on positive behavioural support. Full implementation of this approach should improve the experience for inpatients due to reduced use of restraint.
- Increasing the amount of time available for clinical staff to spend in direct contact with patients through improvements to other processes that they are involved with (including reducing the time taken to input essential information into our electronic care record).
- The Quality Improvement priorities set out in section 3, particularly the further

development of a Recovery Approach, Harm Minimisation and Transitions should have a positive impact upon community patient experience.

- Continuing to carry out our local inpatient and community surveys with established mechanisms in place for action plan development and feedback.

The Trust continues to carry out regular patient experience surveys across all services which includes the Friends and Family Test. Between April 2015 and January 2016 the Trust received feedback from 11,916 patients of which 86% would be extremely likely or likely to recommend the service and 5% would be unlikely or very unlikely to recommend.

Patient safety incidents including incidents resulting in severe harm or death

The data made available by the Health and Social Care Information Centre (HSCIC) with regard to the number of patient safety incidents, and percentage resulting in severe harm or death, reported within the Trust during the reporting period. The next reporting period is March 2016.

Note the data below includes York and Selby from the 1 October 2015 when these services which joined the Trust.

TEWV Actual Quarters 3&4 2015/16	****National Benchmarks in Quarters 3&4 2014/15***	***TEWV Actual Quarters 1&2 2015/16***	***TEWV Actual Quarters 3&4 2014/15***
Trust Reported to NRLS: *as at 31st March 2016 **3789** incidents reported of which **110 (2.9%)** resulted in severe harm or death	NRLS Reported: National Average MH Trusts: incidents reported of which resulted in severe harm or death **Lowest MH Trust: **840** incidents reported of which **0** resulted in severe harm and **11 (1.3%)** in death Highest MH Trusts: **6723** incidents reported of which **74 (1.1%)** resulted in severe harm and **0** in death. The highest reported rate of deaths as a proportion of overall incidents was reported by two MH Trusts at 3.2%.	Trust Reported to NRLS: **3,827** incidents reported of which **72 (1.88%)** resulted in severe harm or death* NRLS reported: **3,827** incidents reported of which **72 (1.88%)** resulted in severe harm or death *17 Severe Harm and 55 Death	Trust Reported to NRLS: **3,279** incidents reported of which **27** (**0.8%**) resulted in severe harm or death NRLS reported: **3921** incidents of which **31 (0.8%)** resulted in severe harm or death

** One Trust reported 8 incidents with 0 incidents of severe harm or death

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

- The Trust reported and National Reporting & Learning System (NRLS) reported data for Quarters 3 & 4 2014/15 showed a variance of 642 incidents. In considering the information it is acknowledged that at that time there was sometimes an identified delay in uploading incidents to NRLS which would account for the figures reported. Incidents are now uploaded to NRLS on a weekly basis. In Q1 & Q2 of 2015/16 there is a discrepancy of 172 incidents which relates to a data quality issue following a system upgrade in the reporting period.
- The number of incidents reported by TEWV to the NRLS for Quarters 1 and 2 2015/16 was just below the national average. However, it is not possible to use the NRLS data to comment on a Trust's culture of incident reporting or the occurrence of incidents. The absolute numbers of incidents reported is a factor of the relative size of a Trust and the complexity of their case-mix. We have noted that:
    - The reporting of patient safety incidents in the Trust was largely consistent when comparing Quarters 1 & 2 2015/16 with Quarters 3 & 4 2014/15.
    - Amongst the most common themes reported are self-harming behaviour, patient accident, disruptive, aggressive behaviour and medication which account for three-quarters of all incidents leading to harm.
    - During 2015/16 TEWV reported 119 incidents as Serious Incidents, of which 80 were deaths due to unexpected causes.

Ongoing work in TEWV continues to improve our reporting culture and the quality of our services through:

- Analysis of all patient safety incidents. These are reported and reviewed by the Patient Safety Group and sub group of the Trust's Quality Assurance Committee. A monthly report is circulated to the QuAC. Safety incidents are reported to commissioners via the Clinical Quality Review Process.
- The implementation of an enhanced web-based reporting system that enables timely and service-specific analysis and a transparent corporate overview including proactive identification of areas of risk, trends and themes across the whole of the Trust.
- A dedicated central approval team is in place to ensure consistent grading of incidents and to improve the overall quality of reporting.
- Analysis of areas of low reporting and trends in high risk incident categories. These are reviewed monthly by the responsible service with action plans developed and monitored as appropriate to address warning signs.
- Ensuring all serious incidents (ie those resulting in severe harm or death) are subject to a serious incident review. This is a robust and rigorous approach to understand how and why each incident has happened, to identify any causal factors and to identify and share any lessons for the future. Raising awareness of the importance and value of reporting and reviewing 'near misses'.
- Implementation of a revised policy in line with the NHS England Serious Incident Framework (2015). This new approach will promote an increased opportunity for learning lessons and improving the quality of services.

2016/17 Priorities for Improvement

During 2015/16 we held two events inviting our stakeholders to take part in our process of identifying quality priorities for 2016/17 to be included in the Quality Account. These events took place in July 2015 and February 2016: further information can be found in **Part 3, Our Stakeholders' Views section**. In addition to the quality priorities identified by our stakeholders, we have a number of additional priorities to improve quality included within the Trusts 2016/17 – 2018/19 Business Plan; details can be found in **appendix 5**.

Our four agreed 2016/17 priorities for inclusion in the Quality Account are:

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

Priority 1: Continue to develop and implement Recovery focused services

Why this is important:

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

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

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

The benefits / outcomes our service users and carers should expect:

- The care they receive to be designed to support and achieve their own personal goals;
- They feel really listened to and heard;
- Their views and personal expertise by experience are valued;
- They are supported to take charge of their lives, promoting choice and self-management;
- Our staff to work in partnership with them at every level of service delivery; genuinely believe that service users will benefit from an improved quality of life and reflect this in care plans.

What we will do in 2016/17:

We will:
• Ensure Recovery Principles are embedded within the Trust's Harm Minimisation project by including them within the training being implemented by the project by Q2 2016/17. • Expand Peer involvement within the Trust, having 6 new peer roles by Q3 2016/17. • Continue to implement Phase 1 of the Recovery Project with an interim evaluation report presented to the Executive Management team providing an update on progress to date by Q3 2016/17. • Develop a business case for Phase 2 of the Recovery project and submit for approval by Q3 2016/17. • Deliver Recovery training to 84% of new Trust staff as part of their induction by Q4 2016/17. • Develop and consolidate the Experts by Experience group ensuring their input into key Trust developments by Q4 2016/17. • Design and establish the Virtual Recovery College so that it available to access by Q4 2016/17. • Complete implementation of Phase 1 of the Recovery project with a final evaluation report presented to the Executive Management Team by Q1 2017/18. • If approved, implement Phase 2 of the Recovery project in line with agreed project plan.

How will we know we are making a difference?

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

Indicator	Target	Timescale
• Percentage of new Trust staff receiving recovery training as part of their Trust induction.	84%	Q4 2016/17
• To introduce new lived experience/ peer roles into the organisation.	6	Q4 2016/17
• Number of self-management pages available on Virtual Recovery College.	30	Q4 2016/17
• Number of new opportunities for individuals with lived experience to take part in service development / improvement initiatives.	20	Q4 2016/17

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

Why this is important:

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

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

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

The benefits / outcomes our service users and carers should expect:

- An increase in personal risk and safety plans that demonstrate clear formulation of risk and show direct correlation to the care and intervention plan;
- An increase in the number of current risk assessments which show evidence of *formulation*;
- An increase in the number of personal risk and safety plans that demonstrate co-production with service users, their families and/or carers;
- A reduction in the occurrence of inadequate risk management practice as a root or contributory finding in the review of serious incidents from the baseline;

- An agreed set of practice standards for the initiation, maintenance and termination of engagement and observation procedures based on the principles of harm minimisation intervention.

This project also supports delivery of the Recovery Project and Priority 1.

What we will do in 2016/17:

We will:
• Complete a review of the current Harm Minimisation and Risk Management practice across the Trust by Q1 2016/17.
• Develop and agree Harm Minimisation principles including engagement guidelines by Q1 2016/17.
• Develop and complete Harm Minimisation training materials and training plan which will include a Recovery focused approach by Q2 2016/17.
• Commence face to face training which includes expert by experience input / delivery by Q2 2016/17.
• Develop an e-learning package which will include a competency framework by Q3 2016/17.
• Have sufficient staff trained in priority areas by Q4 2016/17.
• Evaluate the project and develop options for future delivery by Q4 2016/17.

How will we know we are making a difference?

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

Indicator	Target	Timescales
• Face to face training to be developed and delivered alongside experts by experience. This will support recovery orientated harm minimisation practice which focuses on narrative formulation and co-production of recovery / safety plans.	65% of all clinical staff received face to face training	Q4 2016/17
• Set of outcome measures to be developed in conjunction with experts by experience/service users/carers.	Quantitative and qualitative measures developed and implemented	Q2 2016/17
• A measured increase in the number of current risk assessments which show evidence of formulation and a narrative from baseline.	To be confirmed as part of review of current Harm Minimisation practice taking place in Q1 2016/17	Q4 2016/17
• An increase in personal risk and safety plans that demonstrate clear formulation of risk and show direct correlation to the care and/or intervention plan.		Q4 2016/17
• An increase in the number of personal risk and safety plans that demonstrate co-production with service users, their families and/or carers.		Q4 2016/17

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

Why this is important:

This is a continuation of the priority identified in 2014/15 and recognises that delivery of the smokefree agenda is critical to improving the life expectancy and health of our service users and staff. Our stakeholders and Board therefore agreed it was important that this remained a key priority in 2015/16.

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

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

The benefits / outcomes our service users and carers should expect:

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

What we will do in 2016/17:

We will:
• Develop a communication plan for the prison services by Q1 2016/17.
• Further embed the Trusts policy on being smoke free within inpatient sites by conducting an audit to show if levels of nicotine replacement / management products have increasingly been prescribed across inpatient sites by Q2 2016/17.
• Further embed the Trusts policy on being smoke free within inpatient sites by reviewing levels (and maintenance) of staff trained in nicotine management and smoking cessation by Q2 2016/17.
• Following the above audit and review of training, if necessary, identify inpatient sites that require additional support and provide training / one to one visits by Q2 2016/17.
• Nicotine management policy and information leaflets developed for prison services by Q3 2016/17.
• Medication options identified inclusive of the use of disposable e-cigarettes for prison services by Q3 2016/17.

- Continue to monitor the implementation plan developed to support staff to stop smoking by Q3 2016/17.
- Implement nicotine management and smoking cessation training across Trust community teams by Q4 2016/17.
- Support staff to ensure a seamless pathway of support on admission / discharge for service users undertaking smoking cessation by Q4 2016/17.
- Support prison services with their plans to go smoke free by identifying prison trainers to deliver level 1 and level 2 smoking cessation and nicotine management training by Q4 2016/17.

In addition, a clinical audit will be conducted in December 2016 to review the smoking status of the service users within the Trust to highlight the impact of change since going fully smokefree within Trust inpatient sites on the 9 March 2016.

How will we know we are making a difference?

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

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

As mentioned above, an audit will be conducted during December 2016 to review the change in inpatient service user smoking levels since going smokefree on 9 March 2016.

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

Why this is important:

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

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

The benefits / outcomes our service users and carers should expect:

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

What we will do in 2016/17:

We will:
• Baseline the current experiences of service users through a review of transition in CAMHS which includes service user and carer experience feedback by Q1 2016/17.
• Review and develop a Safe Transition and Discharge Protocol for CAMHS by Q1 2016/17.
• Implement the Safe Transitions and Discharge Protocol by Q2 2016/17.
• Undertake an audit of the protocols to include a further collection of service user and carer experience feedback by Q3 2016/17.
• Review the outcome of the audit with the aim to develop and implement an action plan by Q4 2016/17.

What we will do in 2017/18:

- Using the audit action plan, further embed the Safe Transitions and Discharge Protocol by monitoring the agreed actions and timescales by Q2 2017/18.
- Undertake an additional audit of the protocols to include further collection of service user and carer experience feedback by Q2 2017/18.
- Review outcome of the audit, updating current action plan by Q3 2017/18.
- Complete an evaluation report on the effectiveness of implementation of the new protocol and feedback to relevant stakeholders by Q4 2017/18.

How will we know we are making a difference?

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

Indicator	Target	Timescale
• Implement new transitions protocol across CAMHS teams.	100%	Q3 16/17
• An improvement in the experience of service users going through transitions in CAMHS.	TBC	Q3 17/18

Monitoring Progress

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

We will also send a 6 monthly update to all of our stakeholders, and provide a further update of the position as of 31 December at our February 2016 Quality Account Stakeholder workshop.

PART 3: OTHER INFORMATION ON QUALITY PERFORMANCE 2015/16

Our performance against our quality metrics

The following table provides details of our performance against our set of agreed quality metrics for 2015/16.

Note: the data in this section does not include York and Selby services which joined the Trust on 1 October 2015 unless stated in the "Notes on selected metrics".

These metrics are the same as those we reported against in our Quality Account, 2014/15 and since 2011/12. This allows us to monitor progress over time. However, in some cases we have needed to change our metrics:

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

Please also note the National Patient Survey for 2015/16 is not directly comparable to previous surveys therefore the historical data has been moved from the tables below to the "notes on selected metrics".

During 2016/17 we will be reviewing our Trust's Quality Strategy. As part of this work we will be agreeing a set of Trust quality metrics. It is likely that future Quality Accounts will contain some of the most important of these revised quality metrics rather than those in this Quality Account.

Quality Metrics

	Quality Metrics	2015/16		2014/15	2013/14	2012/13	2011/12
		Target	Actual	Actual	Actual	Actual	Actual
Patient Safety Measures							
1	Number of unexpected deaths classed as a serious incident per 10,000 open cases	<12.00*	**14.68**	12.16	11.88	15.91	12.00
2	Number of outbreaks of Healthcare Associated Infections	0	**0**	0	0	0	0
3	Patient Falls per 1,000 admissions	<27.79	**46.69**	44.54	35.99	34.09	37.44
Clinical Effectiveness Measures							
4	Percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care	> 95.00%	**97.75%**	97.42%	97.86%	97.14%	98.08%
5	Percentage of clinical audits of NICE Guidance completed	100%	**100.0%**	100%	97%	89.47%	95.20%
6	Average length of stay for patients in Adult Mental Health and Mental Health Services for Older People Assessment & Treatment Wards	AMH <30.2	**26.81**	26.67	AMH: 31.72	35	37
		MHSOP <52	**62.67**	62.18	MHSOP : 54.08		
Patient Experience Measures							
7	Delayed Transfers of Care	<7.50%	**1.69%**	2.11%	1.89%	2.07%	1.60%
8	Percentage of complaints satisfactorily resolved	> 90.00%	**79.00%**	75.38%	65.77%	76.36%	
National Patient Survey							
9	Number of questions where our mean score was within 5% of the highest mean scored Mental Health Trusts	Improvement on previous year	**16**	10			
	Number of questions where our mean score was within the middle 90% of mean scored Mental Health Trusts		**17**	23			
	Number of questions where our mean score was within 5% of the lowest mean scored Mental Health Trusts		**0**	0			

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

Notes on selected metrics

1. Data for this metric is taken from Incident Reports which are then reported via the National Strategic Executive Information System (STEIS).
2. Outbreaks of healthcare associated infections relates to those of MRSA bacteraemia and C Difficile. The Infection Prevention and Control Team would be notified of any outbreaks direct by the ward and that would then be recorded on an 'outbreak' form before being reported externally.
3. Patient falls excludes the categories 'found on floor' and 'no harm'. Data for this metric is taken from Incident Reports which are then reported via the Trust's Risk Management System, DATIX.
4. Data for CPA 7 day follow up is taken from the Trust's patient systems and is aligned to the national definition. **Note** this data does include York & Selby services.
5. The percentage of clinical audits of NICE Guidance completed is based on the number of audits of NICE guidelines completed against the number of audits of NICE guidelines planned. Data for this metric is taken from audits undertaken by the Clinical Directorates supported by the Clinical Audit Team.
6. Data for average length of stay is taken from the Trust's patient systems.
7. Delayed transfers of care are based on Monitor's definition and therefore exclude children and adolescent mental health services. Data for this metric is taken from the Trust's patient systems.
8. The percentage of complaints satisfactorily resolved is based on the number of complaints where the complainant did not report dissatisfaction with the Trust's response expressed as a percentage of the total number of resolution letters sent out. Please note, if the complainant did not respond to the resolution letter it was assumed that the complainant was satisfied with the Trust's response.
9. The National Patient Survey for 2015/16 is not directly comparable to previous Community Surveys, although a comparative positon for 2014/15 has been provided. Also the National Patient Survey for 2009/10 is an inpatient survey which is not directly comparable to the community surveys.

National Patient Survey historical performance

National Patient Survey	2013/14	2012/13	2011/12
Number of questions where our score was within 5% of the highest scored Mental Health Trusts	12 (32%)	11 (29%)	12 (32%)
Number of questions where our score was within the middle 90% of scored Mental Health Trusts	26 (68%)	27 (71%)	23 (61%)
Number of questions where our score was within 5% of the lowest scored Mental Health Trusts	0 (0%)	0 (0%)	3 (8%)

Comments on Areas of Under-Performance

Metric 1: Number of unexpected deaths classed as a serious incident per 10,000 open cases.

The Trust position in 2015/16 is **14.68** which is 2.68 above the target of 12.00. The total number of unexpected deaths reported was **83** in 2015/16 compared to **61** unexpected deaths in 2014/15.

Unexpected Deaths 2015/16

	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Out of Trust Area	Total
Serious Incidents classed as unexpected deaths	32	25	17	4	4	1	**83***
Serious Incidents which did not result in death	10	11	7	2	4	2	**36**

* There were 83 unexpected deaths reported in year, however, one incident was subsequently downgraded by Commissioners as found to be from natural causes.

The definition of an unexpected death is one where 'natural causes are not suspected.' Table 2 above shows the number of unexpected deaths formally reported during 2015/16. Of the 83 reported deaths many are still awaiting a formal coroner's verdict, however 70 deaths would appear to be due to suicide related causes and 5 were definitely found to be from physical health related causes. These numbers are subject to change as more information is received from the coroner. Data from York and Selby relates to the period 1st October 2015 - 31st March 2016 only which is when the services were formally transferred to the Trust.

All unexpected deaths are robustly reviewed as Serious Incidents and reported externally to our commissioners. Family members and carers are included within the review process in keeping with the principles of Duty of Candour (being open and honest). An action plan of learning points is developed from each investigation and these are monitored until they are satisfactorily closed.

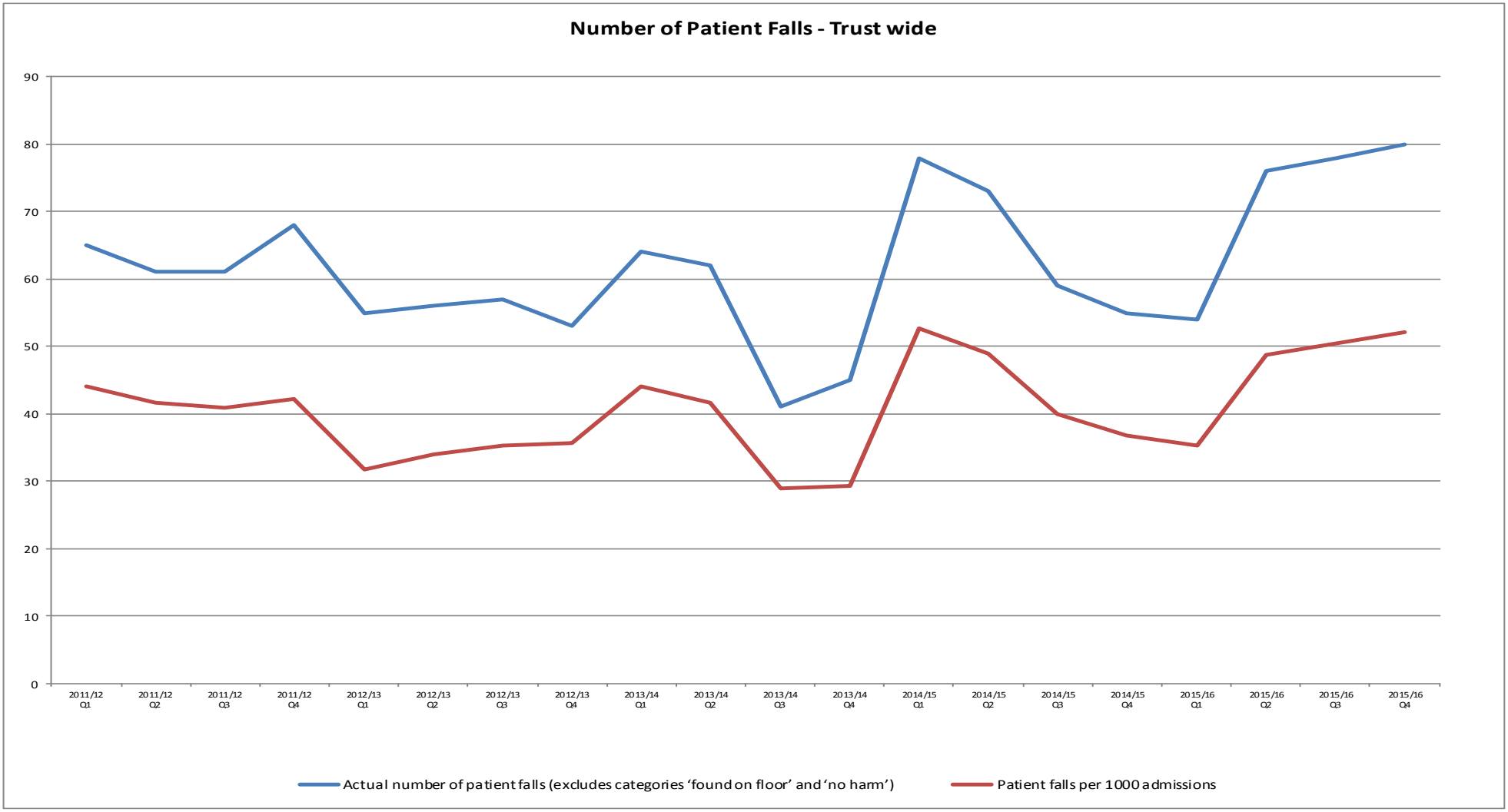
The 36 Serious Incidents reported which did not result in the death of a service user were mainly due to incidents of significant self-harm (including overdoses) and fractures relating to patient falls. These incidents are investigated with the same level of scrutiny as described above.

Metric 3: Patient falls per 1,000 admissions.

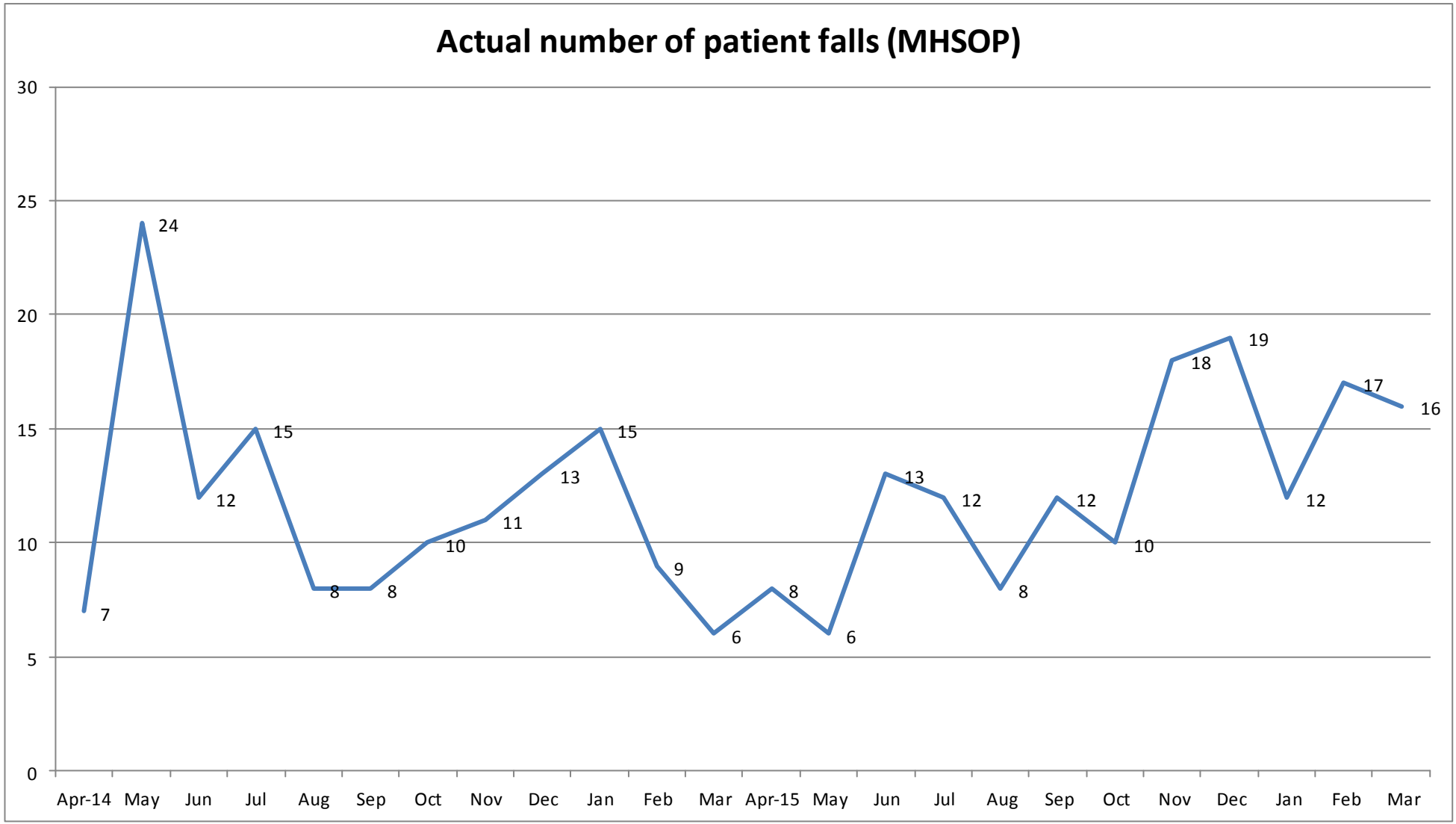
The number of falls reported in 2015/16 is **46.69** per 1,000 admissions, which is significantly above the target of <27.79.

This relates to 288 falls this financial year to date: 88 (30.56%) in Durham and Darlington, 93 (32.30%) in Teesside, 59 (20.49%) in Forensics, 47 (16.32%) in North Yorkshire and 1 (0.35%) other. Of the falls reported, 231 (80.21%) were classified low with minimal harm, 51 (17.71%) were reported as moderate short term harm, 5 (1.74%) were reported as severe. The 5 falls resulting in severe harm occurred on different wards. No patterns have been identified.

The graph below shows that the downwards trend between 2011/12 and the end of 2013/14 have been replaced by an upwards trend during 2014/15 and 2015/16.



Of the 288 falls, 151 (52.43%) were reported within Mental Health Services for Older People. This is comparable to the 132 reported at the same point during 2014/15.


Actual number of patient falls (MHSOP)
30
25
20
15
10
5
0
Apr-14 May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr-15 May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
7
24
12
15
8
8
10
11
13
15
9
6
8
6
13
12
8
12
10
18
19
12
17
16

The Trust 'Falls Executive Group' was reintroduced in 2015/16 and steers and monitors Trust falls management, reporting into the Patient Safety Group. Data on falls is now also available on the IIC.

Whilst the Group is still determining what regular data reports they and services require to facilitate ongoing monitoring, the group approved an audit tool for use in 2015/16, the use of the Audit Tool by each clinical speciality is as follows:

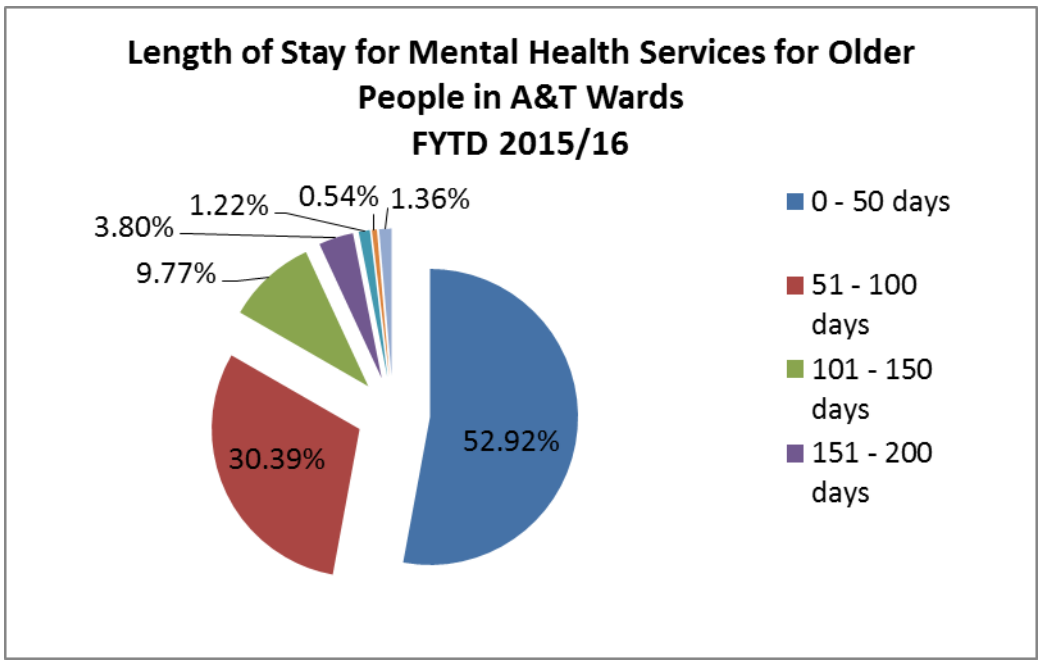
- MHSOP – the audit has been undertaken, using the audit tool. The results of the audit have led to (1) the production of guidance for junior doctors regarding falls assessment and management; (2) pain assessment and management training has been fully rolled out and (3) a pain medication algorithm has been developed. A review of ward level action plans was undertaken during March 2016 and a sleep hygiene share and spread event is planned for June 2016.
- Adult LD – the audit has been undertaken and the audit report has been compiled and is awaiting ratification. This will be included on the agenda of the May 2016 Falls Executive Meeting.
- Forensics MH & LD – The audit has been undertaken, an initial report has been drafted and will be included on the agenda for the May 2016 Fall Executive Meeting.
- Adult MH – the audit has been undertaken and a set of draft proposals produced. In addition, the specialty is currently reviewing the visual control boards supporting the PIpA (Purposeful Inpatient Admission) process in relation to physical health; actions to embed the decision tool will be part of this work. It is proposed that AMH wards will have a formalised input from Pharmacists in relation to the potential impact of medication on risk of falls, and it was agreed at the March Acute Care Forum that localities would share falls information to identify any issues and trends across the specialty.

All services are currently completing a skills gap analysis with the intention to commission targeted training. A report from this work was delivered at the March 2015 meeting of the Falls Executive Group.

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

The average length of stay for adults has remained steady throughout 2015/16, only reporting above target for two months. The average length of stay for older people has been above target since Q3 2013/14, with the exception of one month, reporting **62.67** days for 2015/16. This is 10.67 above target. The pie chart below shows the breakdown for the various lengths of stay during 2015/16.

The median length of stay was **48** days, which is better than the target of 52 days and demonstrates that the small number of patients that have very long lengths of stay have a significant impact on the mean figures reported.



The length of stay of patients is closely monitored by all services within the Trust. The reasons for the increase in the average length of stay for patients are due to a small number of patients with a very long length of stay, which has skewed the overall average. 52.92% of lengths of stay were between 0-50 days, with 30.39% between 51 – 100 days. 23 patients had a length of stay greater than 200 days; the majority were attributable to the complex needs of the patients (such as co-morbidity with physical health problems).

Metric 8: Percentage of complaints satisfactorily resolved.

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

The percentage of complaints satisfactorily resolved in 2015/16 was **79.00%**, which is below the target of 98% but an improvement on 2014/15 and 2013/14. This relates to **158** complaints being satisfactorily resolved. Complaints are monitored by the Quality Assurance Committee and each is thoroughly investigated.

There were **42** people who were not satisfied with our response to their complaint since April 2015 and as at 31st March, there was **1** still open awaiting a further response. The subject of complaints or those that expressed dissatisfaction are varied but predominately are about clinical care, which covers a number of different subjects including ineffective treatment and care, medication and discharge/Transfer/continuity of care. Trust wide there were no specific trends or patterns identified in the reasons given for dissatisfaction.

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

Complaints Resolution 2015/16

	FYTD		
	Number of complaints resolution letters sent	Number of dissatisfied responses received	Percentage satisfactorily resolved*
Durham & Darlington	**73**	**9**	**88%**
Adult Mental Health	53	6	89%
Mental Health Services for Older People	4	0	100%
Children & Young People's Services	14	3	79%
Learning Disabilities	2	0	100%
Tees	**52**	**16**	**69%**
Adult Mental Health	37	10	73%
Mental Health Services for Older People	8	3	63%
Children & Young People's Services	6	3	50%
Learning Disabilities	1	0	100%
North Yorkshire	**54**	**14**	**74%**
Adult Mental Health	43	11	74%
Mental Health Services for Older People	7	2	71%
Children & Young People's Services	4	1	75%
Learning Disabilities	0	0	N/A
Forensics	**21**	**3**	**86%**
Forensic Learning Disabilities	12	2	83%
Forensic Mental Health	8	1	88%
Forensic Offender Health	1	0	100%

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

Our performance against the Risk Assessment Framework Targets and Indicators

The following table demonstrates how we have performed against the relevant indicators and performance thresholds set out in appendix A of the Risk Assessment Framework.

Risk Assessment Framework

Indicators			2015/16		2014/15	2013/14	2012/13
			Threshold	Actual	Actual	Actual	Actual
a	Care Programme Approach (CPA) patients having formal review within 12 months	TEWV Inc Y&S for 15/16	95%	**98.76%**	97.75%	96.56%	96.90%
b	Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams		95%	**96.74%**	98.42%	98.58%	97.35%
c	Meeting commitment to serve new psychosis cases by early intervention teams		95%	**265%**	254%	239%	231%
e	Mental health data completeness: identifiers		97%	**99.61%**	99.61%	98.73%	99.18%
f	Mental health data completeness: outcomes for patients on CPA		50%	**90.22%**	94.09%	96.68%	96.73%
g	Certification against compliance with requirements regarding access to health care for people with a learning disability		**Compliant**	**Compliant**	Compliant	Compliant	Compliant
h	Percentage of people experiencing a first episode of psychosis that were treated with a NICE approved care package within two weeks of referral		50%	**55.91%**			
i	Percentage of people referred to the IAPT programme that were treated within 6 weeks of referral		75%	**84.01%**			
j	Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral		95%	**95.93%**			

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

Notes on Risk Assessment Framework Targets and Indicators

The figure reported for Percentage of people experiencing a first episode of psychosis that were treated with a NICE approved care package within two weeks of referral reflects the quarter 4 position. In quarter 3 the Trust reported 68.10% to Monitor; however this was based on a proxy indicator as the definition for this key performance indicator was not released until January.

There are an additional two indicators contained within appendix A of the Risk Assessment Framework that are relevant however these have been reported in the Quality Metrics table:

- Care Programme Approach (CPA) patients receiving follow-up contact within seven days of discharge.
- Minimising mental health delayed transfers of care.

There are three new indicators that have been reported from quarter 3 (as at the 31 December) 2015/16:

- Percentage of people experiencing a first episode of psychosis that were treated with a NICE approved care package within two weeks of referral.
- Percentage of people referred to the IAPT programme that were treated within 6 weeks of referral.
- Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral.

Where available the historic information shown for 2013/14 has been taken from the Board Dashboard report at year end. The 2012/13 information has been taken from the “combined” Board Dashboard report at year end which included the Harrogate, Hambleton & Richmond services.

External Audit

For 2015/16, our external auditors have to provide a limited assurance report on whether two mandated indicators included in the Quality Account have been reasonably stated in all material respects. In addition the Council of Governors (CoG) have the option to choose one further local indicator for external assurance. The three indicators which have been included in the external assurance of the Quality Account 2015/16 are:

- the percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care;
- the percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper;
- complaints satisfactorily resolved (the local indicator chosen by the Council of Governors).

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

Local Improvement Plans

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

Duty of Candour

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

Additionally, TEWV have developed a draft Duty of Candour Policy: *Being Open, Honest and Transparent*, which outlines the legal responsibility to inform a patient and carer should anything go wrong that causes or has potential to cause harm and distress. This underpins the culture of candour. Briefing and consultation sessions on the draft policy have been held in Quarter 4 across the Trust in readiness for full implementation and embedding in practice of the policy in 2016/17.

Training in “Delivering Difficult Messages” is also in the process of being developed and will be rolled out in 2016/17 to ensure staff have the necessary level of skills and confidence to undertake this process.

Sign Up To Safety

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

What we have done:
A Trust Safety Improvement Plan was submitted based on the guidance provided by the Sign up to Safety campaign office. The Plan comprises the Trust Quality Strategy with Driver Diagrams identifying the three areas of patient safety (Harm

Minimisation, Force Reduction and Learning Lessons) which the Trust will focus on as part of the campaign. The National Sign Up To Safety Lead Suzette Woodward stated that it was one of the best she had seen.

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

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

Service users and carers have been approached to identify what safety means to them. Suicide/Harm minimisation update training which was initially developed for adult services Darlington and Durham has now been opened up to all services and includes a Sign up to Safety element.

The initial implementation of the Force Reduction project demonstrates positive assurance with regard to continued reductions in the use of restrictive interventions, notably Prone restraint.

What we will be doing:
The Learning Lessons, Force Reduction and Harm Minimisation projects and metrics are the focus of the implementation plan. 90 day plans have been developed and will continue to be updated. Learning Lessons bulletins have been produced monthly since October. Due to the close alignment between the principles of force reduction and harm minimisation an alliance between the two projects has been made to optimise skills/knowledge and resources. As such the two teams will be co-developing and co-delivering with experts by experience both recovery orientated harm minimisation, and positive behavioural support training supporting the reduction of restrictive practice. This will enable the Trust to achieve the cultural change required to move toward recovery orientated harm minimisation which focuses on narrative formulation and co-production of recovery / safety plans.

NHS Staff Survey Results

The NHS recognises that the percentage of staff reporting that they have been harassed, bullied or abused by managers / colleagues and the percentage reporting that they believe the organisation provides equal opportunities for career progression and promotion are important indicators that correlate with high quality patient care.

The 2015 NHS Staff Survey was distributed to randomly selected Trust staff before York and Selby services came into TEWV. Therefore the results do not include York and Selby staff. The results for these two indicators were:

- 16% of staff reported experiencing harassment, bullying or abuse from staff in the last 12 months. This was the lowest (best) score of any of the 29 NHS organisations that are solely focussed on mental health services.

- 92% of staff stated that they believed that the Trust provides equal opportunities for career progression. This is one of the best scores reported by a Mental Health Trust.

CQC Rating

As reported in the 2014/15 Quality Account, TEWV participated in one Trustwide inspection during January 2015 under the Care Quality Commission's new approach to inspections. This was before the Trust expanded to cover York and Selby. The overall findings during the inspection were rated as **GOOD**.

CQC's rating for each key area was:

Key area	Rating
Are services caring?	Good
Are services safe?	Requires Improvement
Are services effective?	Good
Are services responsive?	Good
Are services well-led?	Outstanding

The Trust received a rating of "requires improvement" for the key area "*Are services safe"*. The Trust has addressed the majority of the improvement actions required to meet the CQC Fundamental Standards where the inspectors found non-compliance with regulations.

1. To meet the 2014 Regulation 10 requirements, for Dignity and Respect: All the actions have been completed as follows

    - The en-suite female bedrooms have been relocated, that were adjacent to the male corridor in Earlston House, to create a new female zone upstairs.
    - A new clinic room has been created just off the main hall in Earlston House, away from both female and male bedroom areas.
    - The Trust Privacy and Dignity policy has been reviewed, clarifying the zoning advice and re-issued, with staff briefings, through the matron group.
    - All in-patient areas have been reassessed against the Regulation 10 requirements and guidance has been given to each ward regarding implementation of the zoning protocol.

2. To meet the 2014 Regulation 12 requirements, for Safe Care and Treatment: All the actions have been completed as follows:

    - The two cases on Hamsterley and Ceddesfeld wards have been reviewed and the required safeguarding processes regarding covert medication have been put into place.
    - The covert medication procedure has been reviewed and improved.

- The nurse who was observed to make an administration error was suspended until competency was achieved further to a retraining programme. A personal statement and learning plan was actioned.
- All the actions were completed and evidence submitted before the end of the inspection period.
- Learning lessons information is distributed across all MHSOP and monitoring of administration will continue with observation, audit and sampling.

3. To meet the 2014 Regulation 9 requirements, for Person Centred Care:

- The clinical risk management systems and processes have been reviewed on Ward 15, and plans have been put in place for both environmental and process improvements.
- The discharge planning processes for those inpatients in learning disability Assessment and Treatment units have been reviewed, through an Improvement Event with partners and we will implement a more commissioning specification approach to the formulation of discharge plans.

All actions have been completed with the exception of the improvement plans for the environment on Ward 15 at Friarage Hospital. An options appraisal is currently in development to determine timescales and a way forward to complete the plans for ward 15.

4. To meet the 2014 Regulation 12 requirements, for Safe Care and Treatment: All actions have been completed as follows:

- A parabolic mirror in the seclusion room at Ward 15 has been installed to ensure there are no blind spots where patients cannot be observed.
- The estates escalation processes for inpatient staff, in hosted environments, has been reviewed to ensure the TEWV Director of Estates and Facilities Management can resolve delays in environmental maintenance and improvement actions. We have briefed the matron and ward managers of those wards about the escalation process.
- The TEWV Director of Estates and Facilities Management has a quality monitoring process in place with partner NHS Trusts where estate services are provided by these organisations.

All actions have been completed.

Southern Health Report

This national report[1] is an independent review into practice at Southern Health NHS Foundation Trust regarding the preventable death of a patient, who had a learning disability, in 2013. The review covered all deaths of patients who had received care from their Mental Health and Learning Disability (MH & LD) services between April 2011 and March 2015

[1] https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2015/12/mazars-rep.pdf

The key findings of this report were:

- Lack of leadership, focus and sufficient time spent on carefully reporting and investigating unexpected deaths of MH&LD service users;
- Inadequate Serious Incident reporting processes and standards of investigation;
- Timeliness of those incidents that were investigated – average completion time of 10 months;
- Involvement of families and carers was very limited;
- That Southern Health Trust could not demonstrate a comprehensive, systematic approach to learning from deaths;
- That other service providers were not included in investigations when it would have been appropriate;
- That Southern Health Trust failed to use the data it had available to effectively understand mortality and issues relating to deaths of its service users.

We have reviewed the 23 recommendations and as a result is:

- Considering the scope and Terms of Reference of a mortality review process (to include reporting to the open Trust Board);
- Revising Patient Safety information reporting to ensure all patient groups can be easily identified, for example those patients with a learning disability
- Hosting a region wide event with Mazars (the authors of the report) on 21 April 2016 to discuss the wider implications of the report and agree a consistent response.

Force Reduction

The Trusts Force Reduction project is aimed at reducing the use of restrictive interventions across the Trust, encouraging a recovery focussed culture that is committed to developing therapeutic environments where physical interventions are only used as a last resort

In recent years a number of reports have focused on the use, or abuse, of restrictive interventions in health and care services. In 2012 the Department of Health published *Transforming Care: A national response to Winterbourne View Hospital* which outlined the actions to be taken to avoid any repeat of the abuse and illegal practices witnessed at Winterbourne View Hospital. A subsequent CQC inspection of over 150 learning disability services found some services having an over-reliance on the use of 'restraint' rather than on preventative approaches to 'challenging behaviour'. Analysis of the MIND report *Physical Restraint in Crisis*[2] (2013) raised concerns about the Trust's levels of prone (Face down) restraint.

Key areas of focus of the project include:

- **Data collection, analysis and reporting** – more transparent and focussed analysis of information on restrictive interventions which is reported to the trust Quality and Assurance Committee on a quarterly basis.

[2] https://www.mind.org.uk/media/197120/physical_restraint_final_web_version.pdf

- **Development and use of Behavioural Support Plans** – a standard template has been produced to ensure that aspects of the person's environment that they find challenging are identified and addressed, that quality of life is enhanced and that wherever possible people are supported to develop alternative strategies by which they can better meet their own needs.

- **Implementation of the Safewards model** – The safewards model promotes a new set of interventions to staff teams which have been proved to reduce conflict and levels of containment within inpatient settings .Implementation across inpatient sites is now complete with plans in place to train other ward areas across 2016.

- **Use of Debrief tools following use of restrictive intervention** – The project team have created and facilitated a working group to develop a debrief tool for both patients and staff to complete for the use of restrictive interventions.
  If effective, debrief training will be developed to support the pilot areas which could potentially be incorporated within the existing Trust Management of Violence and Aggression (MOVA) training programme as recommended within the recent changes to NICE guidance.

- **Management of Violence and Aggression Training (MOVA)** – Training in the management of violence and aggression is a pivotal intervention within the force reduction framework. Whilst this training cannot be categorised as a strategy to reduce the use of restrictive intervention, the context in which it is taught, monitored and clinically lead will require significant consideration long term as the organisation implements its restraint reduction plan.

- **Use of Medication in the management of behaviours that challenge** – A working group has been set up that includes representation from service users and staff. The group are currently exploring how we may define the use of 'Rapid tranquilisation' and the context of its use. A policy review to reflect changes to NICE guidance and the force reduction framework is nearly complete.

- **Use of Seclusion and Mechanical Restraint in the management of behaviours that challenge** – The project team are currently engaging with all services with allocated seclusion rooms to better understand staff perceptions of its use and how this may be incorporated in a wider preventive model of behaviour support. Training in the use of seclusion is emerging as a key theme within this work stream.

Whilst a number of the above approaches remain within the pilot phase, there have been significant reductions evident across the Trust. Available data at Q3 2015/16 in comparison to Q3 2014/15 highlighted that there had been an 81% reduction in Prone restraint across the trust. In order to understand whether prone restraint was being substituted for other restrictive interventions, analysis of other restrictive interventions such as seclusion (the supervised confinement of a person in a room which may be locked), supine (face up) restraint and rapid tranquilisation (administration of medicine to help quickly calm people) has also taken place. The results below highlight that the trust has seen a corresponding reduction across all types of restrictive interventions.

- 890 incidents involving restrictive interventions occurred during the quarter. Q3 14/15 highlighted 1114 incidents suggesting a **21% decrease**.
- 33 prone restraints during Q3 suggest an **81% decrease** based on the 173 that occurred during the same period in 14/15.
- 197 supine restraints suggest a **41% percent reduction** from the 329 incidents that occurred during the same period in 14/15.
- Q3 14/15 identified 37 uses of seclusion. Q3 of the current financial year identified 32 uses, highlighting a **14% decrease**.
- 115 administrations of rapid tranquilisation highlighting a **21% reduction** from the same time last year.

Tier 4 CAMHS services remains an outlier within the data, however reductions since training was delivered in Positive Behaviour Support and Safewards shows promise. Use of prone restraint has also significantly reduced.

Our stakeholders' views

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

How we involve and listen to what our stakeholders say about us is critical to this process. In producing the Quality Account 2015/16, we have tried to improve how we involved our stakeholders in assessing our quality in 2015/16.

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

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

- *Chance to talk to leads of all 4 quality improvement priorities and find out about services.*
- *Well facilitated session, where a clear quality story was presented and participants were not drowned in huge amounts of data and had sufficient time for discussions.*
- *Good mix of participants from Trust governors and voluntary, commissioning and local government sectors.*

However, some participants felt more time was needed to interact with the improvement leads, that we needed to keep the event within the parameters of the quality account, and that we need to amplify all presenters at the event.

Participants also wished that more of their colleagues from similar organisations would attend to further improve the representation from all sectors and geographies within the Trust.

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

In line with national guidance, we have circulated our draft Quality Account for 2015/16 to the following stakeholders:

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

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

The following are the general themes received from stakeholders in reviewing our Quality Account for 2015/16:

- *To add once received*

The Trust will write to each stakeholder addressing each comment made following publication of the Quality Account 2015/16 and use the feedback as part of an annual lessons learnt exercise in preparation for the Quality Account 2016/17.

In response to many stakeholders' requests, the Trust has agreed to continue providing all stakeholders with a half-year update in November 2016 on the Trust's progress with delivering its quality priorities and metrics for 2016/17.

APPENDICES

APPENDIX 1: 2015/16 STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE QUALITY ACCOUNT

The Directors are required under the Health Act 2009 and the National Health Service (Quality Account) Regulations 2010 to prepare Quality Accounts / Report for each financial year.

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

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

- the content of the Quality Account meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2015/16 and supporting guidance;

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

  - Board minutes and papers for the period April 2015 to May 2016;
  - Papers relating to Quality reported to the Board over the period April 2015 to May 2016;
  - Feedback from the commissioners dated xx May and xx May 2016;
  - Feedback from Governors dated 16 March, 13 April and 19 May 2016;
  - Feedback from Local Healthwatch organisations dated xx May and xx May 2016;
  - Feedback from Overview and Scrutiny Committees dated xx May and xx May 2016;
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 17 May 2016;
  - The latest national patient survey published 21 October 2015;
  - The latest national staff survey published 24 February 2016;
  - The Head of Internal Audit's annual opinion over the Trust's control environment dated 12 May 2016;
  - CQC Intelligent Monitoring Reports dated June 2015 and February 2016.

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

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

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

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

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

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

By order of the Board

NB: sign and date in any colour ink except black

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

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

APPENDIX 2: 2015/16 LIMITED ASSURANCE REPORT ON THE CONTENT OF THE QUALITY ACCOUNTS AND MANDATED PERFORMANCE INDICATORS

To be included in the final version of this document following the receipt of the external auditor's report.

APPENDIX 3: GLOSSARY

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

Alcohol Detoxification Pathway: This is the standard set of assessments that we use to identify alcohol dependency and a set of consequent interventions we use to address this.

ARCH (aspiration, recovery, confidence, hope): This is the name of our Durham *Recovery College*, and it reflects the impact that we intend our recovery work to have on our service users' lives.

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

Audit North: This is an Audit Consortium covering many health, local government and other bodies in the North East, Yorkshire, East Midlands and Cumbria. Audit North provider TEWV's internal audit service (the Trust's external auditors are Mazars).

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

Behavioural Activation: As a treatment for depression and other mood disorders, behavioural activation is based on the theory that, as individuals become depressed, they tend to engage in increasing avoidance and isolation, which serves to maintain or worsen their symptoms. The goal of treatment, therefore, is to work with depressed individuals to gradually decrease their avoidance and isolation and increase their engagement in activities that have been shown to improve mood. Many times, this includes activities that they enjoyed before becoming depressed, activities related to their values or even everyday items that get pushed aside.

Benchmarking: This is where data on how the same service / team performs clinically, financially or otherwise is compared against other similar services / teams in other places. Often this comparison will be against the average, median, upper or lower quartile position, which is worked out by ranking all of the services / teams. Benchmarking may be "internal" (comparing teams across TEWV) or "external" (comparing across the country).

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

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

C Difficile: a species of bacteria of the genus Clostridium that causes severe diarrhoea and other intestinal disease when competing bacteria in the gut flora have been wiped out by antibiotics.

CAMHS: Children and Young People's Mental Health services (see Children and Young People's Services).

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

Care Programme Approach (CPA) Policy: the Trusts policy on the Care Programme Approach.

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

Care UK: A major provider of NHS and private sector healthcare services, which until March 2015 held the contract for health services in the prisons in North East England, subcontracting the mental health elements of the contract to TEWV.

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

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

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

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

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

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

COBRA (cost and outcome of behavioural activation versus cognitive behaviour therapy for depression): is a research study comparing 2 psychological interventions for the treatment of depression in adults. The study aims to determine both the clinical and cost effectiveness of Behavioural Activation compared to Cognitive Behavioural Therapy for depression in adults within primary care.

Cognitive Behavioural Therapy (CBT): CBT is a "talking therapy." The therapist will talk with the patient about how they think about themselves, the world and other people and how what they do affects their thoughts and feelings. CBT can help patients change how they think ('Cognitive') and what they do ('Behaviour'). These changes can help the patient to feel better. Unlike some of the other talking treatments, it focuses on the 'here and now' problems and difficulties. Instead of focusing on the causes of your distress or symptoms in the past, it looks for ways to improve the patient's state of mind now.

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

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

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

Coproduction: This is an approach where a policy, and approach or other initiative / action is designed jointly by TEWV and a service user / service users.

Council of Governors: the Council of Governors is made up of elected public and staff members, and also includes non-elected members, such as the Prison Service, Voluntary Sector, Acute Trusts, Universities, Primary Care Trusts and Local

Authorities. The Council has an advisory, guardianship and strategic role including developing the Trust's membership, appointments and remuneration of the Non-Executive Directors including Chairman and Deputy Chairman, responding to matters of consultation from the Trust Board, and appointing the Trust's auditors.

Crisis Care Concordat: The Mental Health Crisis Care Concordat is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis.

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

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

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

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

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

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

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

Drug and Therapeutics Committee: This is a subcommittee of the Quality Assurance Committee. It's role is to provide assurance to the Board of Directors, through the monitoring of quality and performance indicator data, planned work streams, guideline development and system implementation that the use of medicines throughout the Trust is safe, evidence-based, clinically and cost effective.

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

Early Intervention in Psychosis (EIP): Early intervention in psychosis is a clinical approach to those experiencing symptoms of psychosis for the first time. It forms

part of a new prevention paradigm for psychiatry and is leading to reform of mental health services especially in the United Kingdom. This approach centres on the early detection and treatment of early symptoms of psychosis during the formative years of the psychotic condition. The first three to five years are believed by some to be a critical period. The aim is to reduce the usual delays to treatment for those in their first episode of psychosis. The provision of optimal treatments in these early years is thought to prevent relapses and reduce the long-term impact of the condition.

Electroconvulsive Therapy (ECT): ECT is a treatment for a small number of severe mental illnesses. It was developed in the 1930s and was used widely during the 1950s and 1960s for a variety of conditions. It is now only used for fewer, more serious conditions. An electrical current is passed through the brain to produce an epileptic fit – hence the name, electro-convulsive. No-one is certain how ECT works. We do know that it can change patterns of blood flow through the brain and change the metabolism of areas of the brain which may be affected by depression. There is evidence that severe depression is caused by problems with certain brain chemicals. It is thought that ECT causes the release of these chemicals and, probably more importantly, makes the chemicals more likely to work and so help recovery.

Equality Champions: Staff within TEWV who have been appointed to promote good practice in equalities within their service and who attend the Trust-wide Equalities group.

Experts by Experience: experts by experience have been trained to work alongside the recovery team to develop and deliver recovery related training in supporting staff and service development in recovery related practice. Experts by experience work with Trust staff, they do not work with service users and carers (ie they are not acting in a peer role). These roles are managed via our Patient and Public Involvement process.

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

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

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

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

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

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

Health and Social Care Information Centre (HSCIC): The Health and Social Care Information Centre (HSCIC) was set up as an executive non-departmental public body in April 2013, sponsored by the Department of Health. It is the national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care.

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

Health Education North East: The Health and Social Care Act 2012 established Health Education England which is supported by 13 local education and training boards (LETBs) spread across the country. HENE is the LETB that covers the North East of England, north Cumbria and Richmondshire / Hambleton area of North Yorkshire. It is responsible for the education and training of the whole NHS north east workforce. The professions range from medics, dentists, nurses, dental nurses, allied health professionals and healthcare scientists, to a variety of support staff such as healthcare and nursing assistants, therapists and technical staff.

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

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

Health Technology Assessment (HTA): The HTA Programme is the largest of the National Institute for Health Research programmes. We fund independent research about the effectiveness, costs and broader impact of healthcare treatments and tests for those who plan, provide or receive care in the NHS. We fund our studies via a number of routes including commissioned and researcher-led workstreams.

Her Majesties Prison Inspectorate (HMPI): The inspectorate reporting on the treatment and conditions for those in prison and other types of custody in England and Wales.

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

Human Resources: This phrase is either shorthand for all the staff working for TEWV, or the corporate service within TEWV responsible for ensuring that we have policies, procedures and professional advice that help us to recruit and retain suitably qualified, skilled and motivated workers in our full range of jobs (in other organisations this might be known as the Personnel Department).

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

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

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

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

Join Dementia Research (JDR): is a new national system which allows anyone, with or without dementia, to register their interest in becoming involved in dementia research. People can register online, by phone or by post and the system aims to match people to studies they may be able to take part in.

Learning Disabilities Service: Services for people with a learning disability and mental health needs. TEWV has Adult Learning Disability (ALD) service in each of its 3 Localities and also specific wards for Forensic LD patients. TEWV provides Child LD services in Durham, Darlington and Teesside but not in North Yorkshire.

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

Local Authority Overview and Scrutiny Committee: All "upper-tier" and "unitary" local authorities are responsible for scrutinising health services in their area, and most have a Health Overview and Scrutiny Committee (OSC). Darlington, Hartlepool, Middlesbrough, Stockton and Redcar & Cleveland Councils have formed a joint Tees Valley OSC.

Localities: services in TEWV are organised around three Localities (ie County Durham & Darlington, Tees, North Yorkshire). Our Forensic services are not organised as a geographical basis, but are often referred to a fourth "Locality" within TEWV.

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

Mental Capacity Act: is a framework to provide protection for people who cannot make decisions for themselves. It contains provision for assessing whether people have the mental capacity to make decisions, procedures for making decisions on behalf of people who lack mental capacity and safeguards. The underlying philosophy of the MCA is that any decision made, or action taken, on behalf of someone who lacks the capacity to make the decision or act for themselves must be made in their best interests.

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

Mental Health and Learning Disabilities Data Set (MHLDDS): This contains data about the care of adults and older people using secondary mental health, learning disabilities or autism spectrum disorder services**.** Data is submitted by all providers of NHS funded services (doing so is a contractual requirement). This used to be referred to as the Mental Health Minimum Data Set (MHMDS).

Mental Health Foundation: A UK mental health research, policy and service improvement charity.

Mental Health Minimum Data Set (MHMDS): see *Mental Health and Learning Disabilities Data Set (MHLDDS)* above.

Mental Health Research Network (MHRN): is part of and funded by the National Institute for Health Research and provides the NHS infrastructure to support commercial and non-commercial large scale research in mental health including clinical trials.

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

Model Lines: A TEWV programme to support community teams to become recovery focused by using the quality improvement system philosophy and tools to maximise the time staff have available to work with patients, their families and carers. It also seeks to standardise the approach taken by different staff within a team, and across the Trust as a whole.

Monitor: the independent economic regulator for NHS Foundation Trusts.

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

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

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

My Shared Pathway: My Shared Pathway is used in our Forensic (Adult Secure) wards. It focusses on *recovery*, identifying and achieving outcomes and streamlining the pathway for service users within secure settings. This way of working ensures that service users are treated as individuals by looking at each person's needs. They are encouraged to find new ways of meeting their needs by looking at the whole pathway through secure care, from the very start.

National Audit of Psychological Therapies (NAPT): funded by the Healthcare Quality Improvement Partnership (HQIP) and is an initiative of the College Centre for Quality Improvement (CCQI). Aims to promote access, appropriateness, acceptability and positive outcomes of treatment for those suffering from depression and anxiety.

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

National Reporting and Learning System (NRLS): The National Reporting and Learning System (NRLS) is a central (national) database of patient safety incident

reports. All information submitted is analysed to identify hazards, risks and opportunities to continuously improve the safety of patient care.

National Research Passport Scheme: a scheme to streamline procedures associated with issuing honorary research contracts or letters of access to researchers who have no contractual arrangements with NHS organisations who host research, and who carry out research in the NHS that affects patient care, or requires access to NHS facilities.

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

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

National Reporting and Learning System (NRLS): an NHS led central database of information on patient safety incidents used to identify and tackle important patient safety issues at their root cause.

National Research Passport Scheme: a scheme to streamline procedures associated with issuing honorary research contracts or letters of access to researchers who have no contractual arrangements with NHS organisations who host research, and who carry out research in the NHS that affects patient care, or requires access to NHS facilities.

National Strategic Executive Information System (STEIS): a new Department of Health system for collecting weekly management information from the NHS.

NHS England Commissioners: The part of NHS England responsible for commissioning specialist mental health services – e.g. Adult Secure (Forensic), CAMHS Inpatients and Inpatient adult and CYP Eating Disorders.

NHS England – Area Teams: The teams with NHS England responsible for commissioning specialised services and monitoring our performance against our specialist services contracts.

NHS Service User Survey: the annual survey of service users' experience of care and treatment received by NHS Trusts. In different years has focused both on inpatient and community service users.

NHS Staff Survey: an annual survey of staffs' experience of working within NHS Trusts.

Opting in to Clinical Research (OptiC): This has recently been incorporated within our local electronic patient records system. Systems like this, which are embedded in

NHS records, allow service-users to express an interest (or otherwise) in participating in clinical research and have the potential to enhance and streamline the recruitment of patients to studies.

Organic (MHSOP): Older people with a decreased mental function which is due to a medical or physical condition. This includes dementia-related conditions.

Out of Locality Action Plan: The Trust wants all inpatients to be admitted to the normal hospital for the place where they live for their condition, unless they express a choice to be treated elsewhere. Sometimes we are unable to do that when there are no beds available in their local hospital in which case the patient would be admitted to another TEWV hospital, further away from where the patient lives. We have an action plan to reduce the number of times this happens.

Overview & Scrutiny Committees (OSCs): These are statutory committees of each Local Authority which scrutinise the development and progress of strategic and operational plans of multiple agencies within the Local Authority area. All local authorities have an OSC that focussed on Health, although Darlington, Middlesbrough, Stockton, Hartlepool and Redcar & Cleveland Councils have a joint Tees Valley Health OSC that performs this function.

Paris: the Trust's electronic care record, product name Paris, designed with mental health professionals to ensure that the right information is available to those who need it at all times.

Paris Programme: Ongoing improvement of the Paris system to adapt it to TEWV's service delivery models and pathways.

Patient Advice & Liaison Team (PALs): The Patient Advice and Liaison Service (PALS) offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers. TEWV has its own PALS service as do all other NHS providers.

Patient Safety Group: The group monitors on a monthly basis the number of incidents reported, any thematic analysis and seeks assurances from operational services that we are learning from incidents. We monitor within the group any patient safety specific projects that are on-going to ensure milestones are achieved and benefits to service users are realised.

Payment by Results (PBR): a new system being implemented across the NHS, and piloted in mental health Trusts, to provide a transparent, rules-based system for paying NHS Trusts. The system aims to reward efficiency, support patient choice and diversity and encourage activity for sustainable waiting time reductions. Payment will be linked to activity, adjusted for case-mix, and outcomes. Importantly, this system aims to ensure a fair and consistent basis for hospital funding rather than being reliant principally on historic budgets and the negotiating skills of individual managers.

Peer Trainer: someone who is trained and recruited as a paid employee within the Trust in a specifically designed job to actively use their lived experience and to

deliver training courses to other service users and carers. They work within the Recovery College.

Peer Volunteer: someone who gives their time freely to the Trust in a specifically defined unpaid role to actively use their lived experience (as a service user or carer) to support other carers and service users. They work alongside and support paid staff as well as providing support to specific groups / tasks.

Peer Worker: someone who is trained and recruited as a paid employee within the Trust in a specifically designed job, to actively use their lived experience (as a service user or carer) to support other service users, in line with the Recovery Approach.

Pharmacotherapies: in smoking cessation aims to reduce the symptoms of nicotine withdrawal, thereby making it easier for a smoker to stop the use of cigarettes. Pharmacotherapies can also refer to the replacement of a person's drug of choice with a legally prescribed and dispensed substitute. As well as for those experiencing difficulties with a range of medical conditions.

PPI: Patient and Public Involvement.

Prescribing Observatory in Mental Health (POMH): a national agency, led by the Royal College of Psychiatrists, which aims to help specialist mental health services improve prescribing practice via clinical audit and quality improvement interventions.

Prime Minister's Challenge on Dementia: David Cameron's government's five year vision for the future of dementia care, support and research, which was launched in 2012 and updated in 2015. The overall ambition set by the vision is by 2020 for England to be:

- The best country in the world for dementia care and support and for people with dementia, their carers and families to live; and
- The best place in the world to undertake research into dementia and other neurodegenerative diseases.

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

Purposeful Inpatient Admission and Treatment: This is TEWV's method for ensuring that all patients receive assessments and treatments as quickly as possible so that their length of stay is kept as short as possible.

Quality Account: A Quality Account is a report about the quality of services by an NHS healthcare provider. The reports are published annually by each provider.

Quality Assurance Committee (QuAC): sub-committee of the Trust Board responsible for quality and assurance.

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

Quality Goals: (see *Quality Strategy*, below).

Quality Governance Framework (Monitor): Monitor's approach to making sure NHS foundation Trusts are well run and can continue to provide good quality services for patients.

Quality Strategy: This is a TEWV strategy. The current strategy covers 2014 – 2019, but will be refreshed during 2016/17. It sets a clear direction and outlines what the Trust expects from its staff to work towards our vision of providing excellent quality care. It helps TEWV continue to improve the quality and value of our work, whilst making sure that it remains clinically and financially sustainable.

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

Quality Risk Profile Reports: The Care Quality Commission's (CQC) tool for providers, commissioners and CQC staff to monitor provider's compliance with the essential standards of quality and safety.

Recovery Approach: This is a new approach in mental health care that goes beyond the past focus on the medical treatment of symptoms, and getting back to a "normal" state. Personal recovery is much broader and for many people it means finding / achieving a way of living a satisfying and meaningful life within the limits of mental illness. Putting recovery into action means focusing care on what is personally important and meaningful, looking at the person's life goals beyond their symptoms. Helping someone to recover can include assisting them to find a job, getting somewhere safe to live and supporting them to develop relationships.

Recovery College: A recovery college is a learning centre, where service users, carers and staff enrol as students to attend courses based on recovery principles. Our recovery college, called *ARCH,* opened in September 2014 in Durham. This exciting resource is available to TEWV service users, carers and staff in the Durham area. Courses aim to equip students with the skills and knowledge they need to manage their recovery, have hope and gain more control over their lives. All courses are developed and delivered in co-production with people who have lived experience of mental health issues.

Recovery Strategy: TEWV's long term plan for moving services towards the *recovery approach* (see above).

Research for Patient Benefit (RfPB): provides funding for high quality research, inspired by patients and practice, for the benefit of users of the NHS in England. Its main purpose is to realise, through evidence, the huge potential for improving, expanding and strengthening the way that healthcare is delivered for patients, the public and the NHS.

Resilience: Resilience in the context of this Quality Account is the extent to which patients can cope, and maintain their own well-being when they can feel their mental health worsening. We work with patients to build up their resilience as part of the recovery approach, and often develop Resilience Plans with them.

RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations): is the reporting requirement for work-related deaths and injuries. This requires deaths and injuries to be reported when there has been an accident which caused the injury, the accident was work-related and / or when the injury is of a type which is reportable.

Ridgeway: The part of Roseberry Park Hospital that houses our Adult Low Secure and Medium Secure wards (also known as Forensic wards).

Root Cause Analysis (RCA): a technique employed during an investigation that systematically considers the factors that may have contributed to the incident and seeks to understand the underlying causal factors.

Safeguarding Adults / Children: Safeguarding means protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect. It is fundamental to creating high-quality health and social care.

Safewards: is a set of interventions proven to reduce conflict within inpatient settings.

Section 117 of the Mental Health Act: This part of the Act provides for aftercare to be given to some people discharged from mental health inpatient beds to help them avoid readmission to hospital. The duty applies both to the NHS and to Social Services.

Section 136 of the Mental Health Act: The police can use section 136 of the Mental Health Act to take a person to a place of safety when they are in a public place. They can do this if they think the person has a mental illness and are in need of care. A place of safety can be a hospital or a police station. The police can keep the person under this section for up to 72 hours. During this time, mental health professionals can arrange for a Mental Health Act assessment.

Section 136 Suite: A "place of safety" where people displaying behaviours that are a risk to themselves or to the public can be taken by the Police pending a formal mental health assessment. This procedure is contained within Section 136 of the Mental Health Act.

Serious Untoward Incidents (SUIs): defined as an incident that occurred in relation to NHS-funded services and care, to ether patient, staff or member of the public, resulting in one of the following: unexpected / avoidable death, serious / prolonged / permanent harm, abuse, threat to the continuation of the delivery of services, absconding from secure care.

Service User Focus Groups: a discussion group made up of people who either are, or have been users of our services. The outputs from these groups inform management decisions.

STEIS: National system for reporting serious incidents.

Stoptober: This is a Public Health England initiative held in October each year. It is a programme designed to help people quit smoking based on evidence that if you quit for 28 days you are five times more likely to quit for good.

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

SWEMWBS: The shortened version of *WEMWBS* (see below).

TEWV: see 'The Trust'.

TEWV Quality Improvement System (QIS): the Trust's framework and approach to continuous quality improvement based on Kaizen / Toyota principles.

Trust Board: See 'Board / Board of Directors'.

The Health Foundation: is an independent national charity working to improve the quality of healthcare in the UK. The Health Foundation supports people working in health care practice and policy to make lasting improvements to health services. They carry out research and in-depth policy analysis, run improvement programmes to put ideas into practice in the NHS, support and develop leaders and share evidence to encourage wider change. Each year they give grants in the region of £18m to fund health care research, fellowships and improvement projects across the UK – all with the aim of improving health care quality.

The Trust: Tees, Esk and Wear Valleys NHS Foundation Trust.

Trustwide: This means across the whole geographical area served by the Trust's 3 Localities.

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

Values Based Recruitment Project: This is a recruitment method that does not just focus on the skills and experience but also on the values and likely behaviours of job applicants.

Virtual Recovery College: This is an initiative that would allow people to access recovery college materials and peer-support on-line.

Visual Control Boards: a technique for improving quality within the overall TEWV Quality Improvement System (QIS).

Warwick-Edinburgh Mental Well-Being Scale (WEMWBS): The Warwick-Edinburgh Mental Well-being Scale (WEMWBS) is a scale of 14 positively worded items, with five response categories, for assessing mental wellbeing. There is also a "short" version of this scale – where this is used it is called *SWEMWBS.*

Youth Speak: is a young people's group which aims to give young people a voice and skills in mental health research; reducing mental health stigma for young people through research; and shaping research to influence mental health services for young people.

APPENDIX 4: KEY THEMES FROM 161 LOCAL CLINICAL AUDITS REVIEWED IN 2015/16

Audit Theme	Key quality improvement activities associated with clinical audit outcomes

NICE	• The Self-Harm Pathway was piloted in a CAMHS community team prior to its planned roll out across the Trust. A clinical audit was undertaken to assess the compliance of the pilot team to the CYPS Self-Harm Pathway. Results indicated that further work is required to be undertaken to improve practice prior to further roll out to ensure all parameters of the pathway are delivered consistently, in particular:
	  ◦ Recording frequency of past self-harm, immediate risks and access to family/carers medications in the comprehensive assessment;
	  ◦ Identifying steps to achieve goals in the care plan;
	  ◦ Having formulation meetings;
	  ◦ Reviewing the risk assessment at discharge;
	  ◦ Giving the patient their discharge plan.
	• The Attention Deficit Hyperactivity Disorder (ADHD) Pathway was implemented across CAMHS and a clinical audit was undertaken to establish whether improvements were identified following initial baseline audit within the 2 community pilot sites in January 2015.
	• There have been several clinical audits which ascertained that the number of patients with Learning Disabilities on each Pathway, those who have completed a Pathway and those who are suitable to be placed on a Pathway but currently are not.
	• The Dementia Care Pathway aims to deliver person-centred services based on the most up to date evidence for delivering high standards of care. Early assessment and diagnosis are the key components of the Trust Pathway which was reviewed in June 2014. A clinical audit was undertaken in MHSOP memory and community teams involved in the diagnosis of patients with dementia. Results indicated that 91% of cases the comprehensive assessment was started on the date of the first face-to-face contact and in 85% of cases were completed within 28 days of starting it. In 84% the risk assessment was started on the date of the first face-to-face contact. Further work is required around the standard relating to the GP being sent a letter about the diagnosis within 5 days of the diagnostic meeting.
	• The clinical audit of POMH-UK Topic 13b – Prescribing for Attention Deficit Hyperactivity Disorder (ADHD) in Children, Adolescents and Adults showed that 100% of applicable patients on medication for ADHD had blood pressure, heart rate and weight/BMI (and height for under 16s) documented at baseline and within 3 months of starting medication for ADHD. 100% had a documented medication review in the last year. Improvements were required with the recording of monitoring parameters on centile charts in CAMHS / LD CAMHS services. Recording on centile charts enables clinicians to assess the risk:benefit ratio on ongoing treatment, and underpins safe and effective shared care of patients between specialist and primary care services. If recorded on the charts in the patient-held medication record, it provides assurance to both parties that required monitoring has been completed prior to prescriptions being issued. In adult services, recording of physical health parameters are being addressed as part of the Physical Healthcare Team's work on the implementation of the Lester Tool. Standardised rating scales for use in reviews for patients prescribed medication for ADHD will be introduced as a component of the pathway for adults with ADHD.

Physical Healthcare	• Current work programmes to drive forward improvements in physical healthcare include:
	  ◦ CQUIN 1 – Physical Health Care and Health Promotion for Service Users with psychosis.
	  ◦ National CQUIN 4 – Improving Physical Healthcare to Reduce Premature Mortality in People with Severe Mental Illness (Implementation of the Lester Tool reported via Royal College of Psychiatrists).
	  ◦ NHSIQ funded project/audit in 2 pilot sites in TEWV to improve the cardiovascular health of patients with a serious mental illness.
	• Audit activities supported CQUIN 1 and 4 which demonstrated significant improvements from the previous years' results.
	• These work programmes are currently led by the Physical Health/SMI Team and also link into other Trust initiatives including:
	  ◦ Kaizen work which has recently commenced to implement the physical health/monitoring of antipsychotic medication requirements of the NICE Guidance for Schizophrenia and Psychosis, 2014.

Audit Theme	Key quality improvement activities associated with clinical audit outcomes
	• Model Lines and Purposeful and Productive Community Services work currently being implemented in Psychosis/Early Intervention in Psychosis (EIP) teams. • Smoke Free project; all inpatient areas are smoke free from March 2016, and plans are in place to then enhance this work in community teams (including EIP Teams). • TEWV Physical Health Project; the associated work will impact on the physical health knowledge and skills of clinical staff. • Paris Programme work, including improvements to the recording mechanisms for physical health assessment and interventions following audit recommendations. • AEIP National Audit. The audit results within this report demonstrate a significant improvement in comparison to those captured within the AEIP national audit report written in 2015. This may be attributable to the ongoing support and monitoring provided by the CQUIN project team (including Clinical Audit input). • The Physical Healthcare Project Team has delivered bespoke training to implement the new Early Warning System (EWS) Procedure and Charts. Services that have been offered training, have been audited, identifying good practice points and areas for learning and improvement.
Medicines Management	• A process for debrief with patients after they have received As Needed (PRN) medication has been included in the Force Reduction Project work stream. The debriefing following rapid tranquilisation will be incorporated into the new debrief process which is currently in development. • Medicine management training is mandatory for all registered nurses with clinical contact. There has been an expectation that all registered nurses will complete an annual assessment in practice of their skills related to administration of medicines as part of the Trusts appraisal process. Following the annual assessment tool being updated to ensure nurses are able to demonstrate knowledge of high risk medicines, a clinical audit was required to be conducted to ascertain the proportion of permanent registered nurses who completed the medicine management assessment in practice between 1 April 2014 and 31 March 2015. The new assessment document has been developed and launched and all inpatient areas now have access to this as a reminder to complete this mandatory assessment and has been made available on the Trust Intranet. • An audit has been undertaken to evaluate supervision arrangements for Non-Medical Prescribers (NMP) against requirements set out in the Trust NMP Procedure to Practice. The availability of specialty supervision sessions is restricted in some areas. Planned restructuring of NMP supervision arrangements aims to promote and support improvements so that all NMPs can access supervision appropriately and a revised NMP Procedure to Practice has been launched. • Patient Group Directions (PGDs) provide a legal framework for the supply and/or administration of medicines to groups of patients. An audit was undertaken to assess compliance with the Trust PGD guidance specifically covering the following medications and doses supplied to adults by Crisis Teams: Diazepam 2mg, Diazepam 5mg and Zopiclone 7.5mg. 100% compliance was maintained/achieved in all 4 of the criteria relating to PGD supplies and access. Improvements were required with the recording of patient date of birth/NHS number, weekly stock checks, recording the time PGDs were supplied/administered and recording requisition number.
Violence and Aggression / Suicide Prevention	• A range of audits have been undertaken which support the Trust Projects for Harm Minimisation and Force Reduction. Audits around violence and aggression, training includes Force Reduction, PBS, Safe Wards, reduction in prone restraint, development of debrief process. • Clinical audits have informed the following developments: • The Harm Minimisation Policy has been drafted which includes supportive engagement and observation. The policy links with recovery principles and will also inform future Management of Violence and Aggression (MOVA) training. • Training package development. New training looks at being more proactive in the management of risk (suicide audits). • The 3 sign up to safety projects: Harm Minimisation, Force Reduction, and Learning Lessons. • Changes to the risk assessments on Paris. • Revision of Suicide Prevention Training.

Audit Theme	Key quality improvement activities associated with clinical audit outcomes

Positive Behavioural Support (PBS)	• The PBS project in adult learning disabilities was established in June 2013 and aimed to ensure that all service users whose behaviour is described as challenging receive evidence based and ethically sound assessment and intervention in line with nationally and internationally recognised best practice – positive behaviour support. The key elements of the PBS project include:
	  ◦ All senior managers and senior clinicians in adult learning disability services took part in sessions giving them an awareness and understanding of the principles and key characteristics of PBS to enable them to properly support frontline staff.
	  ◦ All frontline staff including senior clinicians where appropriate will be trained to gain the knowledge, skills and attitudes to deliver PBS practices across the adult learning disabilities service.
	• A PBS clinical pathway has been rolled out across the adult LD services and additional coaching and mentoring is also provided for frontline staff as part of the delivery of the PBS project from skilled and experienced behaviour practitioners.
	• Clinical audits have been undertaken to establish activity of the use of Functional Assessments and Formulations and their connection to PBS intervention plans, Environmental Adaption plans, Skills Teaching plans, Focussed Support Strategy and Reactive plans. Proactive interventions were also investigated which related to sensory interventions, community outings, skills teaching and meaningful in-house activity. All patients had evidence of functional assessment and baseline measures however improvements were required with documenting evidence of a formulation and PBS intervention plans linked to the outcome of functional assessment and formulation. Findings showed that the proactive and reactive interventions used by staff could be considered effective in avoiding episodes of behaviour escalating into an incident requiring a restrictive intervention.

Infection Prevention and Control (IPC)	• All Infection Prevention and Control Audits are continuously monitored by the IPC team and any required actions are rectified collaboratively with the IPC team and ward staff. Assurance of implementation of actions is monitored by the Clinical Audit and Effectiveness team via the clinical audit database. • A total of 91 IPC clinical audits were conducted during 2015/16 in inpatient areas in the Trust. 100% of clinical areas achieved standards between 80-100% compliance. • Clinical audits have been undertaken to assess compliance with Hand Hygiene standards and a monthly Essential Steps audit is completed in inpatient areas.
Supervision	• Clinical audit findings have informed the development of the new Trust Supervision policy and will also inform the training packages which support implementation. • There is an ongoing contract requirement which involves undertaking an audit for specialist services to establish the duration of clinical supervision which staff have achieved, with a target of a minimum of 2 hours. Results from the findings have informed the Trust Supervision Policy.
Records Management	• Clinical audit activities have assessed clinical record keeping and informed changes within the electronic patient record (Paris) for the Trust. • Examples of aspects which have been assessed against record keeping standards include physical health promotion documentation, physical examination documentation, and Trustwide compliance with the Minimum Standard in Clinical Record Keeping Trust policy.

APPENDIX 5: TRUST BUSINESS PLAN ADDITIONAL QUALITY PRIORITIES

In addition to the 4 quality priorities for 2016/17 set out in this document, the Trust has also included additional quality priorities within our 2016/17-2018/19 Business Plan. These are shown below.

Priority	Actions and Timescales
Ensure our current approach to addressing the physical healthcare needs of our patients is embedded and developed further	• Integrate physical health monitoring, assessment and management into daily practice (inpatients) (Q1 2016/17). • Include Physical Health principles and standards in relevant policies, procedures and strategies (Q2 2016/17). • Develop Physical Health and Wellbeing Policy for Community Services and an action plan for each Locality (Q3 2016/17). • Implement electronic physical health incident reporting system (Q4 2016/17). • Identify clinical staff training needs to monitor and manage the physical health care needs of their patients (Inpatient and community) Medical, Nursing and AHP (Q2 2017/18). • Embed physical health across all community services (Q3 2017/18). • Develop implementation plan and hand over responsibility for implementation to Operational Services (Q4 2017/18).
Build on the existing Learning Lessons project to ensure the process for learning lessons and making improvements are embedded in everyday practice	• Conduct baseline assessment in pilot teams to identify the prevailing culture (Q1 2016/17). • Include learning lessons framework and processes n relevant policies and processes (Q2 2016/17). • Re-measure the prevailing culture in the pilot clinical teams and share learning (Q3 2016/17).
Implement a TEWV programme to further reduce restrictive practice and increase use of Positive Behavioural Support	• Review Trust policies on behaviours that challenge, rapid tranquilisation, seclusion and mechanical restraint (Q1 2016/17). • Complete Positive Behavioural Support training in all pilot sites (Q1 2016/17). • Develop a Behaviour Support Plan template and debriefing tool for inpatient areas (Q1 2016/17). • Complete Safe Wards 'Train the trainer' sessions in all inpatient areas (Q1 2016/17).
Review and refresh the Quality Strategy	• Engage with stakeholders on revised draft strategy and its metrics (Q1 2016/17). • Revise strategy following on from consultation (Q2 2016/17). • Strategy approved and ratified by Trust Board (Q2 2016/17). • Complete communication of new Strategy throughout the organisation (Q4 2016/17).
Respond to the national guidance on safe staffing	• Review national guidance when published. • Develop action plan within 3 months of publication.
Further embed the TEWV Quality Improvement System (QIS) - including developing methods for share and spread,	• Deliver further QIS Training Programmes (ongoing). • Develop QIS Locality Boards in each Locality to encourage share and spread, maintenance of standard work and everyday lean management (Q1 2016/17).

maintenance of standard work and everyday lean management	• Fully embed monthly Locality Report Outs in practice (Q4 2016/17). • Ensure all Certified Leads recertify in 2016/17 (Q4 2016/17). • Deliver the Kaizen Production Team's work programme, particularly the Affective Disorders Unified Pathway within Adult community teams (Q4 2016/17).
Develop a new system for identifying and discussing emerging clinical treatments that assists early adoption	• Undertake a review of the current process (Q1 2016/17). • Implement a streamlined approach (Q2 2016/17). • Review effectiveness of new system making appropriate changes if necessary (Q4 2016/17).
Respond to relevant recommendations of the report into SUI Investigations at Southern Health	• Identify priorities, good practice, positive approaches and areas best served by continued collaboration across the region (Q1 2016/17). • Establish mortality review group with monthly meetings (Q2 2016/17), and 6 month progress reports (Q4 2016/17). • Establish reporting mechanisms relating to mortality review group (Q2 2016/17). • Review reporting systems to ensure relevant data is being produced (Q3 2016/17).

In addition to these, many of the operational plans and the enabling priorities set out within our Business Plan underpin our quality improvement agenda. Our Business Plan can found on TEWV's website at http://www.tewv.nhs.uk/About-the-Trust/How-we-do-it/Business-Plans/.

APPENDIX 6: QUALITY PERFORMANCE INDICATOR DEFINITIONS

The percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care

Data definition:

All patients discharged to their place of residence, care home, residential accommodation, or to non-psychiatric care must be followed up within 7 days of discharge. All avenues need to be exploited to ensure patients are followed up within 7 days of discharge*. Where a patient has been discharged to prison, contact should be made via the prison in-reach team.

Exemptions:

- Patients who die within 7 days of discharge may be excluded.
- Where legal precedence has forced the removal of the patient from the country.
- Patients transferred to NHS psychiatric inpatient ward.
- CYPS are not included.

The 7 day period should be measured in days not hours and should start on the day after discharge.

Accountability:

Achieving at least 95% rate of patients followed up after discharge each quarter.

* *Follow up may be face-to-face or telephone contact, this excludes text or phone messages*

The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper

Data definition:

Gate-keeping: in order to prevent hospital admission and give support to informal carers, crisis resolution home treatment teams are required to gate-keep all admission to psychiatric inpatient wards and facilitate early discharge of service users. An admission has been gate-kept by a crisis resolution team if they have assessed** the service user before admission and if the crisis resolution team was involved in the decision making-process, which resulted in an admission.

Total exemption from crisis resolution home treatment teams gate-keeping:

- Patients recalled on a Community Treatment Order.
- Patients transferred from another NHS hospital for psychiatric treatment.
- Internal transfers of service users between wards in the Trust for psychiatry treatment.
- Patients on leave under Section 17 of the Mental Health Act.
- Planned admission for psychiatric care from specialist units such as eating disorder unit.

Partial exemption:

Admissions from out of the Trust area where the patient was seen by the local crisis team (out of area) and only admitted to this Trust because they had no available beds in the local areas. Crisis resolution home treatment teams should assure themselves that gate-keeping was carried out. This can be recorded as gate-kept by crisis resolution home treatment teams.

** This indicator applies to patients in the age bracket 16-65 years and only applies to CYPS patients where they have been admitted to an adult ward.*
*** An assessment should be recorded if there is direct contact between a member of the team and the referred patient, irrespective of the setting, and an assessment made. The assessment should be face-to-face and only by telephone where face-to-face is not appropriate or possible.*

Complaints Satisfactorily Resolved

Numerator:

From the number of response letters sent during the month where there is no notification from the complainant that they are dissatisfied and requesting further action.

Denominator:

Number of resolution letters sent within the month.

APPENDIX 7: FEEDBACK FROM OUR STAKEHOLDERS

South Tees CCG and Hartlepool and Stockton CCG Feedback

NHS
Hartlepool and Stockton-on-Tees
Clinical Commissioning Group

Director of Nursing and Governance
06 MAY 2016

NHS
South Tees
Clinical Commissioning Group

North Ormesby Health Village
1st Floor
14 Trinity Mews
North Ormesby
Middlesbrough
TS3 6AL

Tel: 01642 263030
Email: stccg.enquiries@nhs.net
Website: www.southteesccg.nhs.uk

Date: 29th April 2016

Elizabeth Moody
Director of Nursing and Governance
Tees Esk and Wear Valleys NHS Foundation Trust
Trust Headquarters
West Park Hospital
Edward Pease Way
Darlington
County Durham
DL2 2TS

Dear Elizabeth

RE: Tees, Esk and Wear Valleys Quality Account 2015/16
Statement for NHS South Tees CCG and NHS Hartlepool and Stockton-On-Tees CCG

NHS South Tees Clinical Commissioning Group (ST CCG) and NHS Hartlepool and Stockton-On-Tees Clinical Commissioning Group (HAST CCG) commission healthcare services for the populations of Hartlepool, Stockton and South Tees. The CCGs welcome the opportunity to submit a statement on the annual Quality Account for Tees, Esk and Wear Valleys NHS Foundation Trust (TEWVFT).

The CCGs can confirm that to the best of their knowledge the information provided within the annual Quality Account is an accurate and fair reflection of the Trust's performance for 2015-16.

The Quality Account is clearly presented in the format required by NHS England and the information clearly represents the Trust quality profile.

improving health together

The CCGs would like to provide the following statement:
On behalf of NHS South Tees Clinical Commissioning Group (ST CCG) and NHS Hartlepool and Stockton-On-Tees Clinical Commissioning Group (HAST CCG), we would like to congratulate the Trust on the results of the Community Mental Health Survey which led to the Trust being highlighted by the CQC as one of 5 across the country performing better than expected when compared to other Trusts. It is reassuring to understand that the Trust was significantly better than most other Trusts in organising care; planning care; reviewing care and crisis care delivery. The survey also identified areas where care was similar to other Trusts and this has supported the Trust in identifying areas of care as the focus for continued improvement.

The Trust is also to be congratulated in scoring the 4th highest of all 230 NHS acute, mental health and community Trusts in the "Learning from Mistakes" league table published by Monitor in March 2016. This supports the focus the Trust has on making a difference to patients by being a learning organisation.

The development of services for patients requiring crisis support have benefited from the opening of the new Crisis Assessment Suite at Roseberry Park Hospital during 2015/16. This is now providing an improved service for people in crisis, as a result of reduced waiting time to assessment, 24 hours a day 7 days a week.

Further work undertaken by the Trust to implement the recommendations of the Care Programme Approach (CPA) across 2015/16 is acknowledged by the CCGs. This work has had a recovery focus and has resulted in a number of improvements including the development of a more streamlined approach to the documenting and recording of patient care.

The CCGs are encouraged to see the progress made across 2015/16 in relation to nicotine management and smoking cessation and would like to congratulate the Trust on achieving 100% smoke free inpatient units. It is encouraging to see that staff also benefit from this programme as they are also included in this initiative in terms of supporting them to stop smoking. It is equally encouraging to see that 95% of staff have been trained to smoking cessation level 2.

Throughout 2015/16 the CCGs have continued to hold quality and contract review meetings with the Trust and the Trust demonstrated openness and honesty in relation to quality concerns and provided assurance that safe and effective care is being delivered. The CCGs have also conducted a programme of commissioner led inspection visits to the Trust during 2015/16, to gain further insight and assurance of the quality of care provided for patients. This enhanced approach has been welcomed by the Trust.

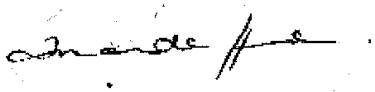
It was pleasing to see that the Trust has achieved a 100% participation rate in national clinical audits and confidential inquiries and the report provides details of the actions the Trust has taken in response to the findings of the audits. The CCGs acknowledge that the Trust has initiated appropriate actions in response to compliance against the key mandatory quality indicators in order to improve performance outcomes.

It was previously noted that the NRLS data for quarters 3&4 2014/15 demonstrates a variance in the incident data submitted to the National Reporting and Learning System. This was identified by the Trust as being due to delays in uploading the data. Remedial actions were put in place and the CCGs would like to acknowledge the improved position of quarters 1&2 in 2015/16 and increased confidence in the validity of these figures. The CCGs will continue to work with the Trust to improve the timeliness of reporting and management of these incidents. Whilst acknowledging that work is underway to improve the position they would like see further improvement in the quality and timeliness of the management of serious incident investigations.

Following the initiatives on suicide prevention undertaken during 2014/15 the Trust and their stakeholders recognised the need to take a wider approach to support this priority. This resulted in the development of the more comprehensive 'Harm Minimisation' Project during 2015/16 facilitating the cultural shift towards recovery focused harm minimisation and safety planning based on shared decision making with patients, and the joint development of personal safety plans. This is welcomed by the CCGs recognising that this will aid the reduction in service user safety incidents relating to self-harm and suicide.

The CCGs are supportive of the Trust priorities for 2016/17 particularly the focus on implementation and embedding the revised harm minimisation and risk management approach which will continue to increase the safety of our service users.
The CCGs look forward to continuing to work in partnership with the Trust to assure the quality of services commissioned on behalf of their population in 2016/17.

Yours sincerely,



Mrs Amanda Hume
Chief Officer
South Tees CCG

On behalf of NHS South Tees Clinical Commissioning Group (ST CCG) and NHS Hartlepool and Stockton-On-Tees Clinical Commissioning Group (HAST CCG)

Item 12

FOR GENERAL RELEASE

COUNCIL OF GOVERNORS

DATE:	**19th May 2016**
TITLE:	**Board Dashboard as at 31st March 2016**
REPORT OF:	**Sharon Pickering, Director of Planning, Performance & Communications**
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 Board Dashboard as at 31st March 2016 (Appendix A) in order to inform the Council of Governors of the end of year position. A separate appendix covering the York and Selby Locality is attached in Appendix B.

In terms of the Trust (excluding the York and Selby Locality) 14 of the 24 (58%) indicators are being reported as red in March 2016 which is a deterioration on the position in February when 10 (42%) of the indicators were red. Of those, 4 are showing an improving trend over the last 3 months. In terms of the York and Selby Locality report 7 of the 11 (64%) of the indicators reported are showing as red which is the same as the position in February.

The key issues/risks continue to be:

- Access – Waiting Times (KPIs 1 & 2)
- Early Intervention in Psychosis (KPI 3)
- Psychological Therapies – Access (KPI 6) and Recovery (KPI 7)
- Out of Locality Admissions (KPI 12)
- Appraisal (KPI 19)

Recommendations:
It is recommended that the Council of Governors consider the content of this paper and raise any areas of concern/query.

MEETING OF:	**COUNCIL OF GOVERNORS**
DATE:	**19th May 2016**
TITLE:	**Board Dashboard as at 31st March 2016**

1 INTRODUCTION & PURPOSE

1.1 To present to the Council of Governors the Trust Dashboard scorecard (Appendix A) as at 31stMarch 2016. 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 RISKS/ISSUES

2.1 Key Issues/Risks

The key issues are as follows:

- Given that the Trust took over as the provider of mental health and learning disability services to the Vale of York CCG on 1st October this report now includes the following 4 Appendices:
  - The usual Dashboard report produced from the IIC in Appendix A.

    As part of the preparation for the transfer of York and Selby Services onto TEWV PARIS a small amount of data relating to this locality was transferred into TEWV PARIS in March. This has therefore flowed into the IIC resulting in it being included within the Trust Dashboard figures in Appendix A. This has impacted slightly on 4 indicators (the two waiting times indicators (KPIs 1&2), the CPA 12 month review indicator (KPI 10) and the external referral indicator (KPI 23)).

    As in previous months the Mandatory training indicator (KPI 20) and Sickness Absence indicator (KPI21) includes the York and Selby services.
  - A separate dashboard for the locality of York and Selby is included within Appendix B where the information is available. It should be noted that until the services in York and Selby move over to the Trust's PARIS system in April 2016 (from the Leeds Partnership system) it will not be possible to report against all the indicators.
  - The Data Quality Scorecard is included in Appendix C. This does not include an assessment of the data quality relating to the York and Selby locality. It is proposed that a data quality assessment for this is undertaken at the start of 2016/17 when the services transfer to the Trusts PARIS system.
- The Trust (including York and Selby services) achieved all of the Monitor targets for Q4.
- For the Trust (excluding the York and Selby Locality) 14 of the 24 (58%) indicators are being reported as red in March 2016 which is an Improvement on the position in February. Of those, 4 are showing an improving trend over the last 3 months. In terms of the York and Selby report 7 of the 11 (63%) indicators reported are showing as red.

- At its meeting in November the Board of Directors asked for some detailed analysis on the following indicators:

  - Percentage of patients readmitted to Assessment and Treatment wards within 30 days (KPI 13)
  - Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (KPI 14)
  - Median number of days from when an inpatient is discharged to their next admission to an Assessment and Treatment ward (KPI 15).

  A detailed analysis was undertaken and the results of this considered by the Adult Speciality Development Group (SDG). The SDG did not find that the analysis highlighted any clinical concerns. The report and the SDG conclusions were shared with the Quality Assurance Group (QUAC) who discussed the findings at their meeting in April. The QUAC provided assurance to the Board, in April that the performance reported in the dashboard was not associated with any areas of clinical concern.

The key risks are as follows:

- Access - Both waiting time targets (KPIs 1 & 2) continue to show an underperformance as at the end of March although KPI2 has shown an improvement. Children and Young Peoples' (CYP) services continue to be the area of most concern. In Teesside all referrals that have been received in April are being allocated a first appointment within 4 weeks although there remains some referrals that are still waiting that have exceeded the 4 weeks. The service is taking steps to ensure these are seen as soon as possible. In Durham the level of staff vacancies and sickness in the CYP service continues to be a significant factor which is impacting on the position, however there has been some improvement in the staffing levels in the last few weeks of March which has increased the number of assessments being offered and there has been a reduction in the numbers of children waiting over 4 weeks during late March into April.

- Early Intervention in Psychosis – whilst the Dashboard shows that this target is being met this is based on an internal definition due to the delay in the publication of the national guidance. Using the national guidance the Trust achieved 60% of people being seen within 2 weeks in March which is also above target. Work is ongoing to ensure that the accurate recording of activity supports reporting against the final guidance. The 2016/17 Dashboard will use the national definition for this indicator.

- Psychological Therapies

  The Trust is reporting performance slightly below the target for the IAPT 18 week waiting time target, excluding York and Selby. (KPI 5). The most significant outlier is Teesside and this is linked to the Trust withdrawing from providing this service in Teesside. If the Tees figures are excluded the performance increases to 98.3% which is above target.

In terms of the Access indicator (KPI 6) the position, excluding York and Selby, is similar to that in February 2016. All CCGS across Durham and Darlington and North Yorkshire are achieving target with the exception of DDES CCG and Darlington CCG. Further work has been identified to improve efficiency and throughput of patients in these areas.

In terms of recovery (KPI7) there has been an improvement in the position in March, excluding York and Selby, although performance is still below the target. All three CCG areas in North Yorkshire have reported improvement and further deep dive work is planned to be carried out when the dedicated data analyst is in post.

In York and Selby Locality performance is below target for all four IAPT indicators. A key contributor to this position is the transfer to using PARIS as the electronic patient record (rather than IAPTUS) which took place during February. Significant time has been spent in March on training and transferring patients over onto PARIS which has impacted on the amount of clinical care that could be delivered. A comprehensive IAPT action plan has been developed to improve service delivery and this is being implemented, the service have also held an improvement event and a full time team manager is now in post.

- Out of Locality Admissions (OoL) (KPI 12). The position has remained above target with deterioration in March. The increase seen in March 2016 reflects that in the previous 2 years. The final year end figure is 17% which is 2% above the target.

- Appraisal (KPI 19) – Performance is under target for the Trust and has deteriorated slightly in March. The York & Selby Locality is reporting 48%. Services have been given until the end of April to ensure that all appraisals undertaken in 2015/16 are included within ESR before the final figures for the year are calculated.

2.3 Appendix D provides further details of unexpected deaths including a breakdown by locality as requested at the last Council of Governors meeting.

2.4 Appendix E provides a glossary of indicators.

3 RECOMMENDATIONS

It is recommended that the Council of Governors:

- Receive this paper and raise any areas of concern/query.

Sharon Pickering
Director of Planning, Performance & Communications

Trust Dashboard Summary for TRUST

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

	March 2016				April 2015 To March 2016			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
1) Percentage of patients who were seen within 4 weeks for a first appointment following an external referral.	98.00%	83.33%			98.00%	82.65%		98.00%
2) Percentage of patients who were seen within 4 weeks for a first appointment following an internal referral	98.00%	84.51%			98.00%	83.96%		98.00%
3) Percentage of people experiencing a first episode of psychosis that were treated with a NICE approved care package within two weeks of referral. (System)	50.00%	76.12%			50.00%	74.12%		50.00%
4) Percentage of people referred to the IAPT programme that were treated within 6 weeks of referral.	75.00%	87.77%			75.00%	84.77%		75.00%
5) Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral.	95.00%	94.54%			95.00%	94.78%		95.00%
6) Access to Psychological Therapies - Adult IAPT: The percentage of people that enter treatment against the level of need in the general population (treatment commenced)	15.00%	14.62%			15.00%	13.57%		15.00%
7) Recovery Rate - Adult IAPT: The percentage of people who complete treatment who are moving to recovery	50.00%	46.90%			50.00%	46.07%		50.00%
8) Percentage of admissions to Inpatient Services that had access to Crisis Resolution Home Treatment Teams prior to admission (adult services only) - post-validated	95.00%	95.91%			95.00%	97.18%		95.00%
9) Percentage CPA 7 day follow up (AMH) - post-validated	95.00%	96.37%			95.00%	97.75%		95.00%
10) Percentage of CPA Patients having a formal review documented within 12 months - snapshot (AMH)	98.00%	94.87%			98.00%	94.87%		98.00%
11) Percentage of community patients who state they have been involved in the development of their care plan (month behind)	85.00%	90.96%			85.00%	90.19%		85.00%

Trust Dashboard Summary for TRUST

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

	March 2016				April 2015 To March 2016			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
12) The percentage of Out of Locality Admissions to assessment and treatment wards (AMH and MHSOP) - post-validated	15.00%	18.08%			15.00%	17.01%		15.00%
13) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)	15.00%	26.44%			15.00%	24.16%		15.00%
14) Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP)	18.00	27.00			209.00	279.00		209.00
15) Median number of days from when an inpatient is discharged to their next admission to an Assessment and Treatment ward (AMH and MHSOP)	146.00	104.00			146.00	125.00		146.00
16) Percentage of appointments cancelled by the Trust	0.67%	1.24%			0.67%	1.10%		0.67%
17) Number of unexpected deaths classed as a serious incident per 10,000 open cases - Post Validated	1.00	0.19			12.00	14.68		12.00
18) Percentage of wards who have scored greater than 80% satisfaction in patient survey (month behind)	75.00%	77.78%			75.00%	75.28%		75.00%

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

	March 2016				April 2015 To March 2016			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
19) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	95.00%	81.32%			95.00%	81.32%		95.00%
20) Percentage compliance with mandatory and statutory training (snapshot)	95.00%	87.45%			95.00%	87.45%		95.00%
21) Percentage Sickness Absence Rate (month behind)	4.50%	4.89%			4.50%	4.62%		4.50%

Trust Dashboard Summary for TRUST

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

	March 2016				April 2015 To March 2016			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
22) Number of reds on CQC action plans (including MHA action plans)	0.00	0.00			0.00	0.00		0.00
23) Total number of External Referrals into the Trust Services	5,939.00	7,295.00			69,931.00	80,348.00		69,931.00
24) Delivery of our financial plan (I and E)	556,300.00	4,946,000.00			-4,784,000.00	-297,000.00		-4,784,000.00

Trust Dashboard Summary for York & Selby Locality

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

		Mar-16				October 2015 - March 2016			Annual
		Target	Month	Status	Change on previous month	Target	YTD	Status	Target
1	Percentage of patients who were seen within 4 weeks for a first appointment following an external referral								
2	Percentage of patients who were seen within 4 weeks for a first appointment following an internal referral								
3	Percentage of people experiencing a first episode of psychosis that were treated with a NICE approved care package within two weeks of referral	50.00%	55.56%	●	↑	50.00%	55.17%	●	50.00%
4	Percentage of people referred to the IAPT programme that were treated within 6 weeks of referral *	75.00%	39.05%	●	↓	75.00%	59.80%	●	75.00%
5	Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral*	95.00%	92.38%	●	↓	95.00%	94.10%	●	95.00%
6	Access to Psychological Therapies - Adult IAPT: The percentage of people that enter treatment against the level of need in the general population (treatment commenced)*	15.00%	4.50%	●	↑	15.00%	9.45%	●	15.00%
7	Recovery Rate - Adult IAPT: The percentage of people who complete treatment who are moving to recovery*	50.00%	23.68%	●	↓	50.00%	41.56%	●	50.00%
8	Percentage of admissions to Inpatient Services that had access to Crisis Resolution Home Treatment Teams prior to admission (adult services only)*	95.00%	86.67%	●	↓	95.00%	90.24%	●	95.00%
9	Percentage CPA 7 day follow up (AMH)*	95.00%	100.00%	●	–	95.00%	97.70%	●	95.00%
10	Percentage of CPA Patients having a formal review documented within 12 months - snapshot (AMH)	98.00%	98.06%	●	↓	98.00%	98.06%	●	98.00%
11	Percentage of community patients who state they have been involved in the development of their care plan (month behind)								

		Mar-16				April 2015 - March 2016			Annual
		Target	Month	Status	Change on previous month	Target	YTD	Status	Target
12	The percentage of Out of Locality Admissions to assessment and treatment wards (AMH and MHSOP)								
13	Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)								
14	Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP)								
15	Median number of days from when an inpatient is discharged to their next admission to an Assessment and Treatment ward (AMH and MHSOP)								
16	Percentage of appointments cancelled by the Trust								
17	Number of unexpected deaths classed as a serious incident per 10,000 open cases								
18	Percentage of wards who have scored greater than 80% satisfaction in patient survey (month behind)								
Strategic Goal 3: To recruit, develop and retain a skilled, compassionate and motivated workforce									
19	Percentage of staff in post more than 12 months with a current appraisal (snapshot)	95.00%	52.00%	🔴	🡻	95.00%	52.00%	🔴	95.00%
20	Percentage compliance with mandatory and statutory training (snapshot)	95.00%	64.00%	🔴	🡻	95.00%	64.00%	🔴	95.00%
21	Percentage Sickness Absence Rate (month behind)	4.50%	4.38%	🟢	🡹	4.50%	5.06%	🔴	4.50%
Strategic Goal 5: To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of the communities we serve									
22	Number of reds on CQC action plans (including MHA action plans)								
23	Total number of External Referrals into the Trust Services								
24	Delivery of our financial plan (I and E)								

*** Indicators 4 - 9 contain data for VoY CCG only**

Data Quality Assessment

Appendix C

		Data Source					Data Reliability					KPI Construct/Definition					Total Score	Percentage as at June 2015	Percentage	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	Percentage of patients who have not waited longer than 4 weeks for a first appointment	5						4				5					14	93%	93%	
2	Percentage of patients who have not waited longer than 4 weeks following an internal referral	5						4				5					14	93%	93%	
3	Percentage of people experiencing a first episode of psychosis that were treated with a NICE approved care package within two weeks of referral	5						4				5					14	87%	93%	The Trust has developed a local KPI pending publication of national construction. There is an issue identified with allocation of a care co-ordinator which was required for this indicator, which has been monitored through the Data Quality group, but has temporarily been removed from the logic. Work has been undertaken with the services to improve reliability, therefore the score for data reliability has increased from 3 to 4.
4	Percentage of people referred to the IAPT programme that were treated within 6 weeks of referral		4					4				5					13	87%	87%	
5	Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral		4					4				5					13	87%	87%	
6	Access to Psychological Therapies - Adult IAPT: The percentage of people that enter treatment against the level of need in the general population (treatment commenced)		4					4				5					13	87%	87%	
7	Recovery Rate – Adult IAPT: The percentage of people who complete treatment who are moving to recovery		4					4				5					13	87%	87%	
8	Percentage of admissions to Inpatient Services that had access to Crisis Resolution Home Treatment Teams prior to admission (adult services only)		4					4				5					13	87%	87%	Data is now imported back into IIC following manual validation. This increases reliability; however, there will be some discharges discounted because complete validation has not been possible within the time. These could subsequently be determined to be breaches.
9	Percentage CPA 7 day follow up (adult services only)		4					4				5					13	87%	87%	Data is now imported back into IIC following manual validation. This increases reliability; however, there will be some discharges discounted because complete validation has not been possible within the time. These could subsequently be determined to be breaches.
10	Percentage of CPA Patients having a formal review documented within 12 months – snapshot (adult services only)	5						4				5					14	93%	93%	
11	Percentage of community patients who state they have been involved in the development of their care plan (month behind)					1		4				5					10	67%	67%	All questionnaires are paper-based, except for some CAMHS units, where patients use a touch screen facility to record their comments. The manual questionnaires from Trust are sent to CRT and scanned into their system. Raw data files are received from CRT, which are accessed by IPT and uploaded into the IIC.
12	Percentage of out of locality admissions to assessment and treatment wards (AMH and MHSOP) - post validated		4					4				5					13	87%	87%	
13	Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)	5						4				5					14	93%	93%	

		Data Source					Data Reliability					KPI Construct/Definition					Total Score	Percentage as at June 2015	Percentage	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	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	100%	100%	
15	Median number of days from when an inpatient is discharged to their next admission to an Assessment and Treatment ward (AMH and MHSOP)	5					5					5					15	100%	100%	
16	Percentage of appointments cancelled by the Trust	5									1	5					11	87%	73%	Whilst data reliability has been tested, a number of data quality issues identified by the Patient Experience Group and the localities have raised a significant concern; therefore the Data Quality Group has assessed reliability at 1. For example: • appointments being incorrectly recorded as cancelled • not all cancelled appointments being recorded • appointments not having outcomes recorded A working party is to be established to investigate the problem and produce longer term recommendations
17	Number of unexpected deaths classed as a serious incident per 10,000 open cases					1		4				5					10	67%	67%	Different sources in calculation - lower one used which is a manual process including a telephone call and data entered onto Datix (unexpected deaths)
18	Percentage of wards who have scored greater than 80% satisfaction in patient survey (month behind)			3				4				5					12	80%	80%	Surveys for ward are via the hand held device. The devices are uploaded electronically (can sometimes be issues with the devices) direct to CRT. Patient Experience Team (PET) provided with ward based reports. PET open every ward report, identify the % and number completing, calculate the numerator manually then type this into the spreadsheet for each individual ward. Latter 2 processes open to human error.
19	Percentage of staff in post more than 12 months with a current appraisal – snapshot	5						4				5					14	93%	93%	
20	Percentage compliance with mandatory and statutory training – snapshot	5						4				5					14	93%	93%	
21	Percentage Sickness Absence Rate (month behind)	5							3			5					13	87%	87%	Whilst the sickness absence data for inpatient services is now being taken directly from the rostering system which should help to eliminate inaccuracies the remainder of the Trust continue to input directly into ESR and there are examples whereby managers are failing to end sickness in a timely manner or inaccurately recording information onto the system – this is picked up and monitored through sickness absence audits that the Operational HR team undertake.
22	Number of reds on CQC Action Plans (including MHA Action Plans)				2		5					5					12	73%	80%	Whilst static reports are emailed to the Trust, the information is maintained on an Excel spreadsheet. This is monitored and updated in conjunction with the services. Contingencies are now in place to ensure data is correctly reported and sourced on time and data is extracted from the spreadsheet onto the manual return for upload onto the IIC. Therefore, the score for data source has increased from 1 to 2.
23	Total number of External Referrals into the Trust Services	5					5					5					15	100%	100%	
24	Are we delivering our financial plan (I and E)		4				5					5					14	93%	93%	

Number of unexpected deaths and verdicts from the coroner April 2015 - March 2016

	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	1																				**1**
Natural causes	1					1															**2**
Hanging	3	1	2								1						1		1		**9**
Suicides	7	3	6										1				1				**18**
Open	1		1																		**2**
Drug related death	1	2																			**3**
Drowning																					**0**
Misadventure	1		1																		**2**
Awaiting verdict	11	8	7	2		2		1			1	2	2			1	4		1		**42**
Total	**26**	**14**	**17**	**2**	**0**	**3**	**0**	**1**	**0**	**0**	**2**	**2**	**3**	**0**	**0**	**1**	**6**	**0**	**2**	**0**	**79**

Number of unexpected deaths classed as a serious untoward incident											
April	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**
7	10	9	10*	5	4	9	9	5	5	5	1

** There was originally 11 reported within this month, however, one incident was subsequently downgraded by Commissioners*

Number of unexpected deaths total by locality				
Durham & Darlington	**Teesside**	**North Yorkshire**	**Forensics**	**York & Selby**
32	22	21	4	0
Rate of unexpected deaths total by locality				
12.86	13.45	17.91	47.57	0

Number of unexpected deaths and verdicts from the coroner 2014 / 2015

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 and took place in the hospital					Number of unexpected deaths where the patient is an inpatient but the death took place away from the hospital					Number of unexpected deaths where the patient was no longer in service					Total
	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	Durham & Darlington	Teesside	North Yorkshire	Forensics	York & Selby	
Accidental death																					**0**
Natural causes	1										1					1					**3**
Hanging	1	1	1													1					**4**
Suicides	14	8	3	1					1							1	3	2			**33**
Open																					**0**
Abuse of drugs																		1			**1**
Drowning																					**0**
Misadventure	1															1					**2**
Awaiting verdict	6	1	3			1	1				1					3	1				**17**
Total	**23**	**10**	**7**	**1**		**1**	**1**	**0**	**1**		**2**	**0**	**0**	**0**		**7**	**4**	**3**	**0**		**60**

Number of unexpected deaths classed as a serious untoward incident											
April	May	June	July	August	September	October	November	December	January	February	March
4	2	7	7	4	4	2	8	3	7	5	8

Number of unexpected deaths total by locality				
Durham & Darlington	**Teesside**	**North Yorkshire**	**Forensics**	**York & Selby**
33	15	10	2	0

Glossary of Indicators

Table no.	Description	Comment
1	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.
2	Percentage of patients who were seen within 4 weeks for a first appointment following an internal referral	These waiting times are in relation to patients being referred from internal sources (for example another Trust team). They relate to patients seen in the month, and of those, the percentage who were seen within four weeks.
3	Percentage of people experiencing a first episode of psychosis that were treated with a NICE approved care package within two weeks of referral	We are still awaiting national development of this indicator. Currently the indicator reports patients experiencing first episode psychosis who have been accepted onto caseload, had an EIP care coordinator allocated and a NICE concordant package* of care commenced and, of these, the percentage who attended a first appointment within 2 weeks of the date the referral was received.
4	Percentage of people referred to the IAPT programme that were treated within 6 weeks of referral	These waiting times relate to the number of ended referrals that finish a course of treatment in the reporting period and, of these, the percentage that received their first treatment appointment within 6 weeks of referral. To be counted within the denominator, the patient must have attended at least two treatment contacts and the referral must be coded as discharged.
5	Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral	These waiting times relate to the number of ended referrals that finish a course of treatment in the reporting period and, of these, the percentage that received their first treatment appointment within 18 weeks of referral. To be counted within the denominator, the patient must have attended at least two treatment contacts and the referral must be coded as discharged.
6	Access to Psychological Therapies - Adult IAPT: The percentage of people that enter treatment against the level of need in the general population (treatment commenced)	The Improving Access to Psychological Therapies (IAPT) programme aims to improve access to evidence based talking therapies in the NHS through an expansion of the psychological therapy workforce and service. This indicator is comprised of the number of people who have entered (i.e. received) psychological therapies, as a percentage of the number of people who are expected to have depression and or anxiety disorders.
7	Recovery Rate - Adult IAPT: The proportion of people who complete treatment who are moving to recovery	This indicator is comprised of the number of people who are moving to recovery of those who have completed treatment, as a proportion of the number of people who have completed treatment who are not at clinical caseness at treatment commencement.
8	Percentage of admissions to Inpatient Services that had access to Crisis Resolution Home Treatment Teams prior to admission (adult services only)	An admission has been gate kept by the Crisis Resolution Team if the Crisis Resolution Team have assessed the service user before admission and if they were involved in the decision-making process, which resulted in admission.
9	Percentage CPA 7 day follow up (adult services only)	All patients who are discharged to their place of residence, care home, residential accommodation, or to non-psychiatric care must be followed up within seven days of discharge. Follow up starts on the day following discharge and ideally should be made with the patient face to face.
10	Percentage of CPA Patients having a formal review documented within 12 months - snapshot (adult services only)	This indicator relates to the percentage of adults who have been on CPA for more than 12 months who have had at least one meeting with their Care Co-ordinator in the past 12 months.
11	Percentage of community patients who state they have been involved in the development of their care plan (month behind) (AMH, MHSOP and LD)	This indicator reports the number of community patients who state they have been involved in the development of their care plan against the number of community patients who have responded to the involvement/development of the care plan question in the patient survey. To facilitate this a new question was added to the hand held devices asking "Have you been involved in the development of your care plan?"
12	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.'
13	Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)	This indicator reports the total number of admissions to AMH and MHSOP Assessment and Treatment wards in the month and, of those, the percentage that were readmissions within 30 days of a discharge from any Trust ward.

14	Number of instances where a patient has had 3 or more admissions in the past year to Assessment and Treatment wards (AMH and MHSOP	This indicator counts the number of patients who were admitted in the month that had previously been admitted on 2 or more occasions during the previous 12 months
15	Median number of days from when a patient is discharged as an inpatient to their next admission as an inpatient	This indicator measures the median (mid point from a range of data) time, in days, from a patient being discharged from an Assessment & Treatment ward to readmission back into an Assessment & Treatment ward. It is intended that this indicator will monitor the effectiveness of the discharge process as well as the robustness of the community services maintaining patients within the community. A higher number of days would suggest that the discharge process was more effective and the community teams interventions more successful.
16	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.
17	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 b 10,000 to obtain the correct ratio for this calculation.
18	Percentage of wards who have scored greater than 80% satisfaction in patient survey (month behind)	This indicator reports the number of wards who have scored greater than 80% satisfaction in the patient survey against the number of wards who have had responses to the satisfaction question in the patient survey. It uses the question "Overall, rate the care you have received" and counts Excellent and Good responses as being satisfied.
19	Mean level of improvement on SWEMWBS (AMH only)	This indicator is a patient related outcome measure (PROM), which looks at the score taken at the referral to service and then again at the discharge point from TEWV (start of spell to end of spell) for new patients and calculate the improvement. A mean improvement score is the calculated as an overall figure for Adult Mental Health. New patients would be reported in the month they were discharged but only if their referral was after 4th November due to commencement of this PROM.
20	Mean level of improvement on SWEMWBS (MHSOP only)	This indicator is a patient related outcome measure (PROM), which looks at the score taken at the referral to service and then again at the discharge point from TEWV (start of spell to end of spell) for new patients and calculate the improvement. A mean improvement score is the calculated as an overall figure for Mental Health Services for Older People. New patients would be reported in the month they were discharged but only if their referral was after 4th November due to commencement of this PROM.
21	Percentage of HoNOS ratings that have improved in the non-psychotic and psychosis super classes for patients that are in scope (AMH and MHSOP) - Snapshot	This indicator is a clinician related outcome measure (CROM), which reports the number of in scope patients in the non-psychotic and psychosis super classes whose most recent HoNOS score is lower than their referral HoNOS score as a percentage of the number of in scope patients in those super classes on an active case load within the month who have more than one HoNOS rating.
22	Percentage of HoNOS ratings that have improved in the organic super classes for patients that are in scope (AMH and MHSOP) - Snapshot	This indicator is a clinician related outcome measure (CROM), which reports the number of in scope patients in the organic super classes whose most recent HoNOS score is lower than their referral HoNOS score as a percentage of the number of in scope patients in those super classes on an active case load within the month who have more than one HoNOS rating.
23	Percentage of staff in post more than 12 months with a current appraisal (snapshot)	Staff employed by the trust must have completed an appraisal with their supervisor, and informed the workforce information department Information is entered onto ESR at least once a year.
24	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
25	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.
26	Number of reds on CQC action plans (including MHA action plans)	This indicator counts the number of reds detailed on Care Quality Commission action plans, including Mental Health Act action plans.
27	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.
28	Are we delivering our 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.

ITEM NO 13

FOR GENERAL RELEASE

COUNCIL OF GOVERNORS

DATE:	**19 May 2016**
TITLE:	**Finance Report for Period 1 April 2015 to 31 March 2016**
REPORT OF:	**Colin Martin, Director of Finance**
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.	✓

The comprehensive income outturn for the period ending 31 March 2016 was a deficit of £297k, representing 0.1% of the Trust's turnover and was behind plan. The variation of £5,086k was largely due to the impairment of Trust properties being £10,983k above plan. Excluding impairments the Trust was ahead of plan by £5,897k largely due to a non-recurrent surplus within projects and higher than planned contract income.

Identified Cash Releasing Efficiency Savings at 31 March 2016 were in line with plan.

The Trust has identified schemes to deliver CRES in 2016/17 whilst plans continue to be progressed for future years.

The Financial Sustainability Risk Rating for the Trust was 4 for the period ending 31 March 2016.

The Trust's annual accounts are subject to external audit and any findings may alter the financial outturn position and associated financial risk rating indicators.

The Council of Governors are requested to receive the report, to note the conclusions in section 5 and to raise any issues of concern, clarification or interest.

MEETING OF:	**Council of Governors**
DATE:	**19 May 2016**
TITLE:	**Finance Report for Period 1 April 2015 to 31 March 2016**

1. INTRODUCTION & PURPOSE

1.1 This report summarises the Trust's financial performance from 1 April 2015 to 31 March 2016.

2. BACKGROUND INFORMATION

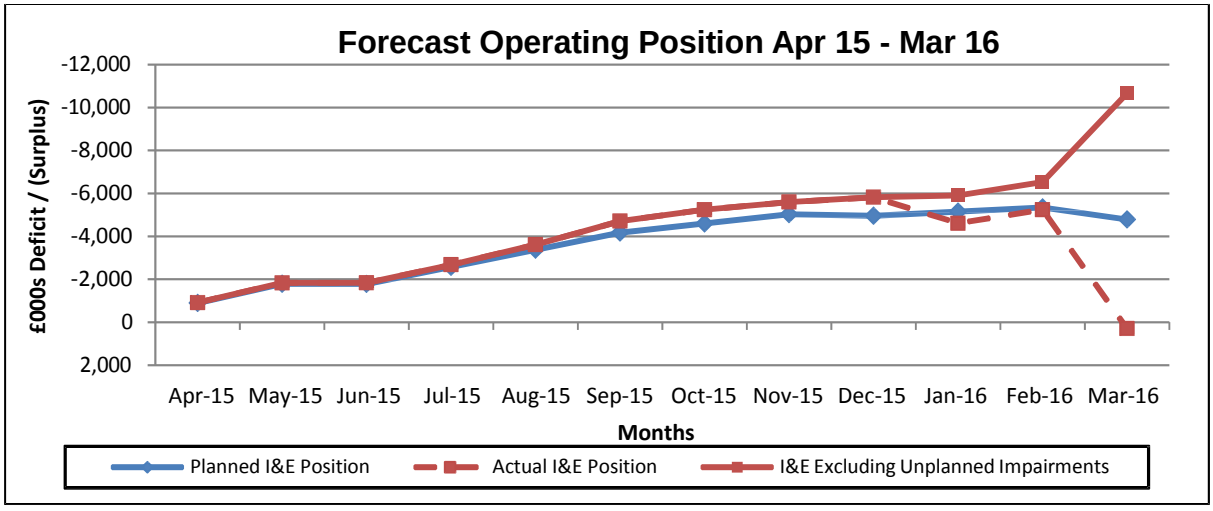
2.1 The financial reporting framework of a Foundation Trust places an increased emphasis on cash and the statement of financial position as well as the management of identified key financial drivers. The Board receives a monthly summary report on the Trust's finances as well as a more detailed analysis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

3. KEY ISSUES:

3.1 Statement of Comprehensive Income

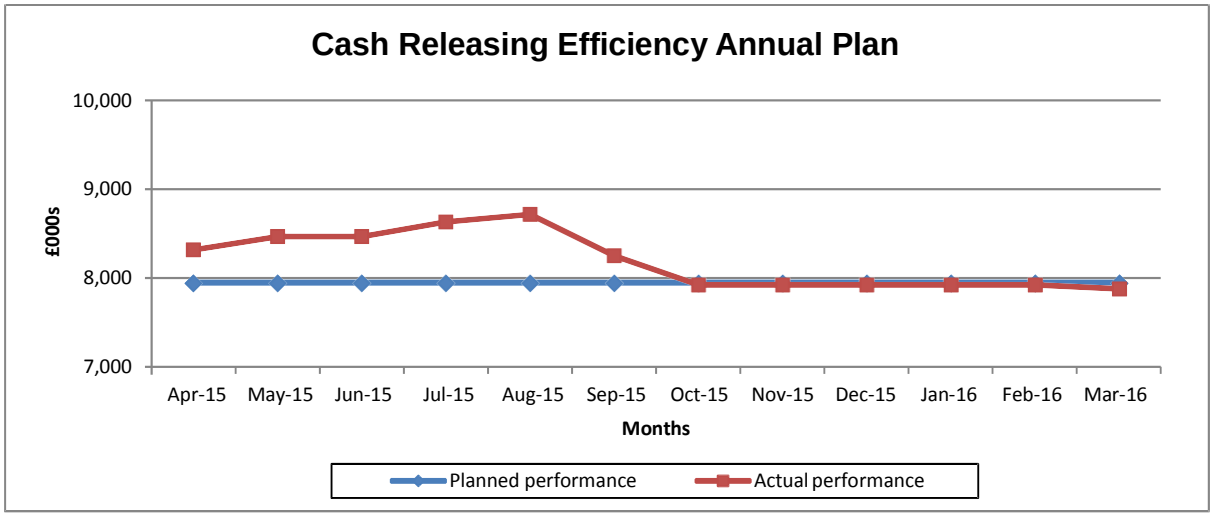
The comprehensive income outturn for the period ending 31 March 2016 was a deficit of £297k, representing 0.1% of the Trust's turnover and was behind plan. The variation of £5,086k was largely due to the impairment of Trust properties being £10,983k above plan. Excluding impairments the Trust was ahead of plan by £5,897k largely due to a non-recurrent surplus within projects and higher than planned contract income.

The graph below shows the Trust's planned operating surplus against actual performance and the Trusts position excluding impairments.

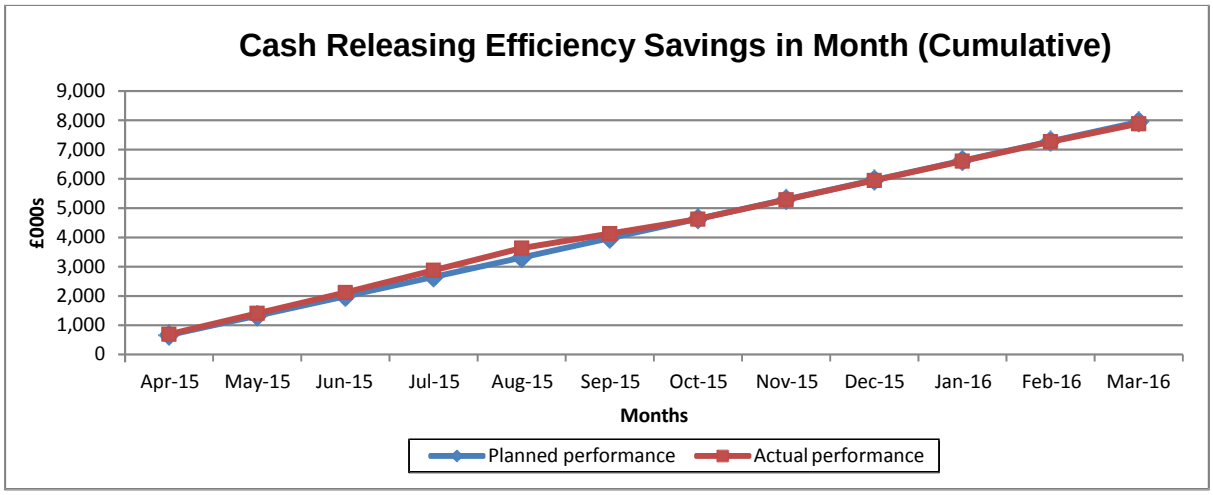


3.2 Cash Releasing Efficiency Savings

Total CRES identified at 31 March 2016 was £7,930k and was in line with plan. The reduction in September and October was due to some schemes being deferred to 2016/17.

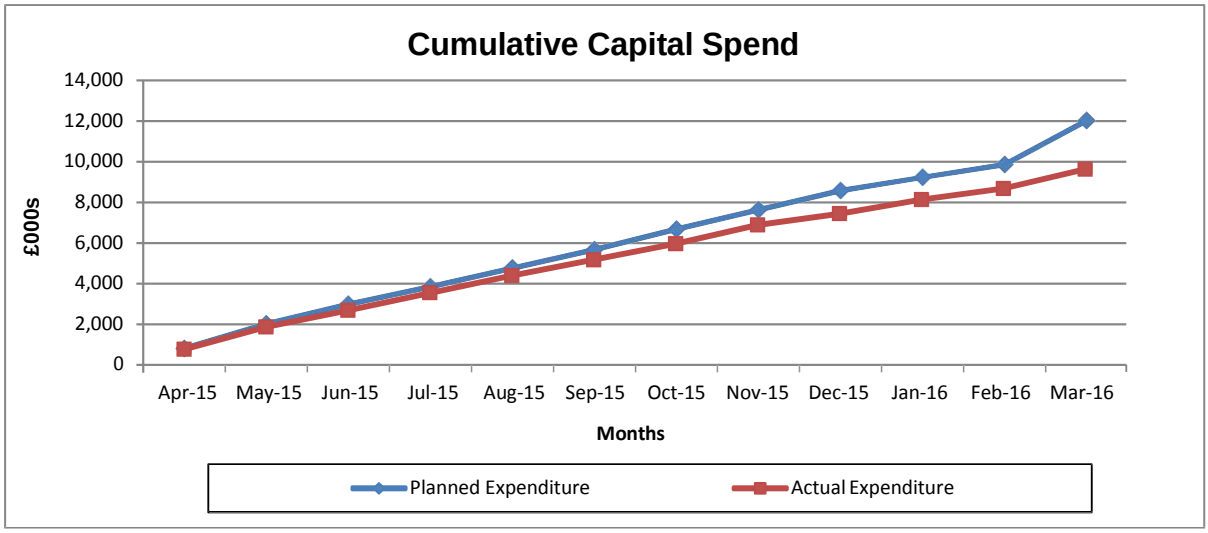


The monthly profile for CRES identified by Localities is shown below.



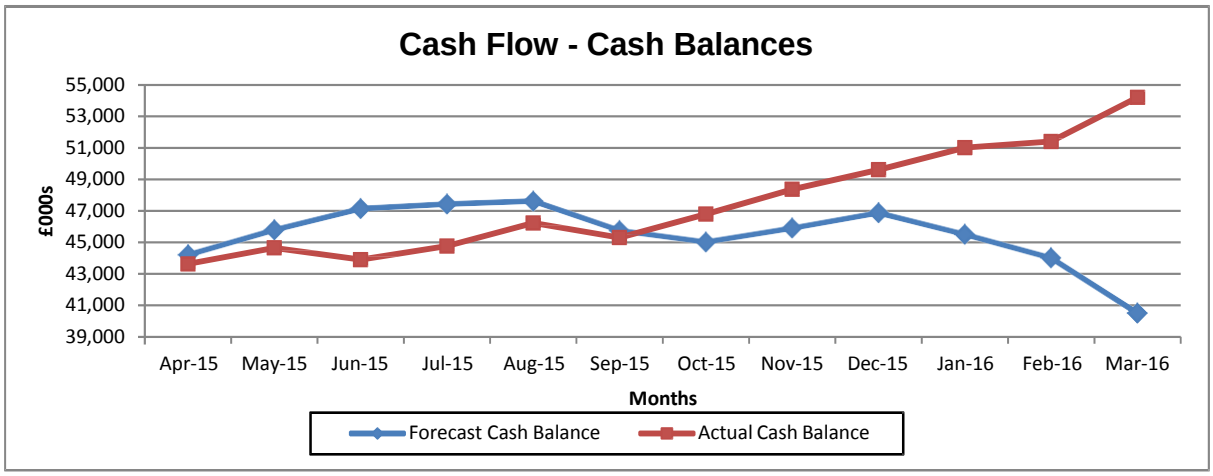
3.3 Capital Programme

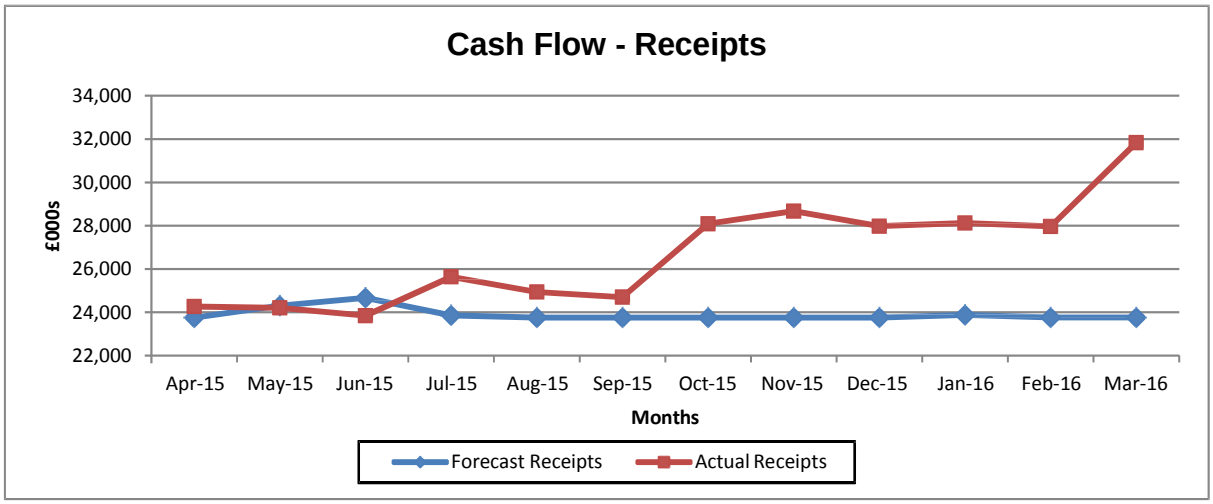
Capital expenditure to 31 March 2016 was £9,635k, and was behind plan at the financial year end due to the planned deferral of schemes into 2016/17.

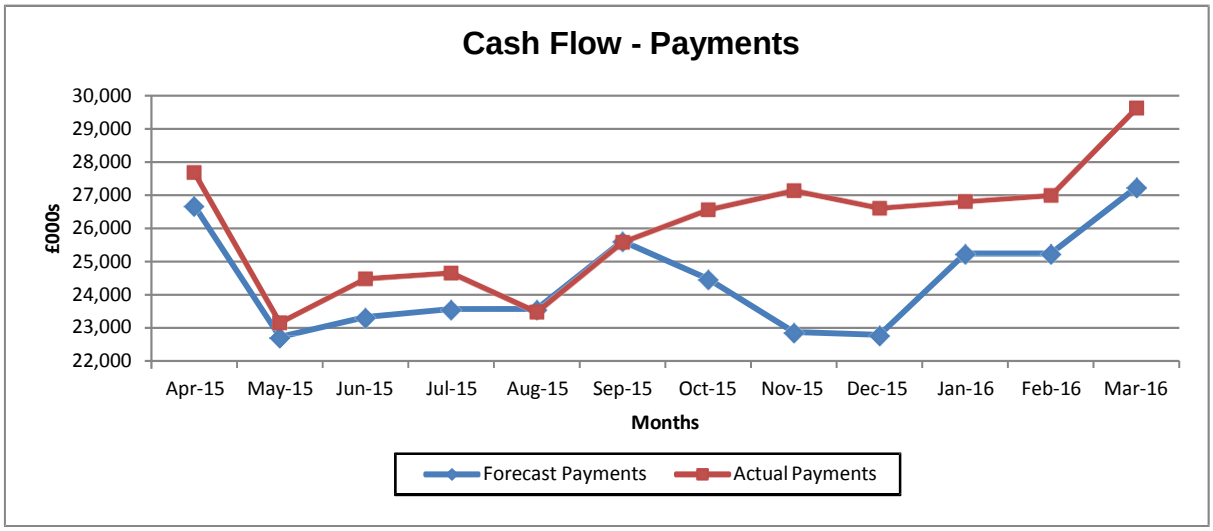


3.4 Cash Flow

Total cash at 31 March 2016 was £54,148k and was ahead of plan due to the planned deferral of capital schemes, the higher than planned surplus position (excluding impairments) and working capital cycle variations following the start of the Trust's contract to provide MH & LD Services to the York and Selby locality.





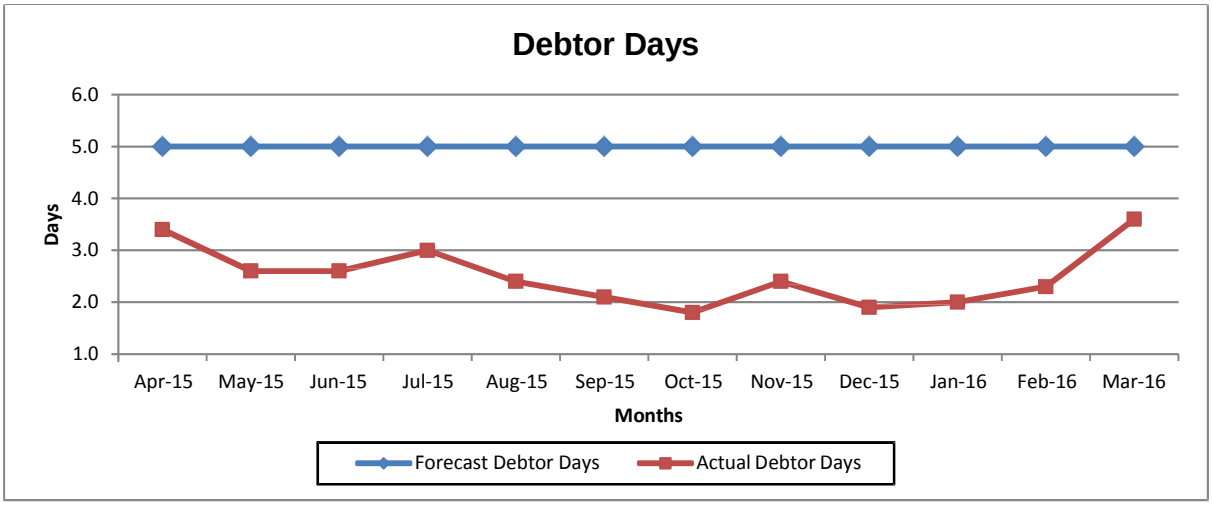


The increase within receipts and payments from October 2015 was due to additional revenue streams related to the York and Selby locality.

Other payment profile fluctuations over the year are for PDC dividend payments, financing repayments and payments for capital expenditure.

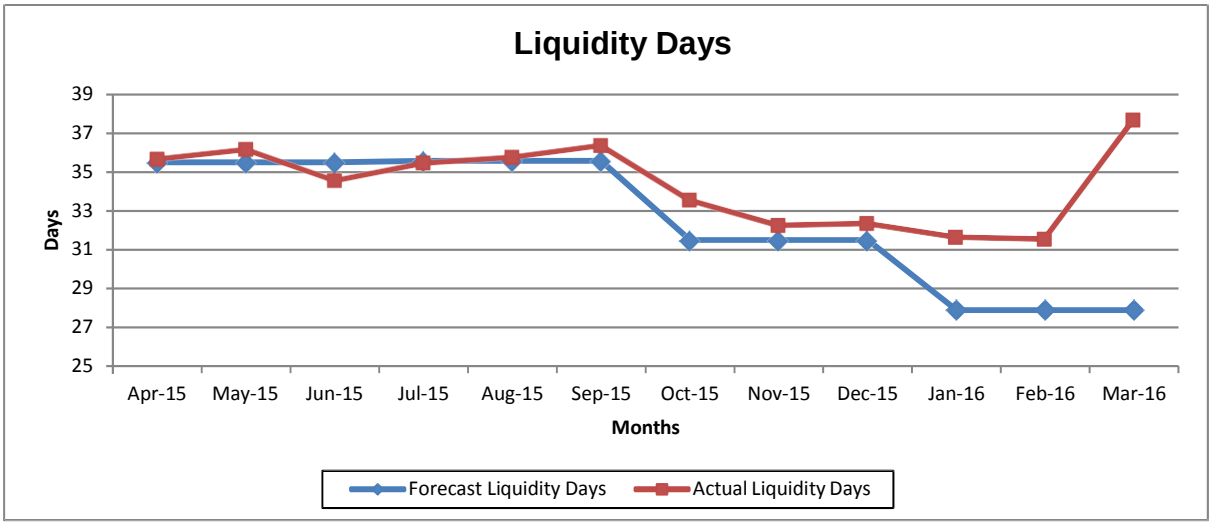
Working Capital ratios for period to 31 March 2016 were:

- Debtor Days of 3.6 days
- Liquidity of 37.7 days
- Better Payment Practice Code (% of invoices paid within terms)
  NHS – 78.09%
  Non NHS 30 Days – 96.84%



The Trust had a debtors' target of 5.0 days and actual performance of 3.6 days for March. The average debtor days throughout the financial year were 2.5, which was ahead of plan.

The liquidity days graph below reflects the metric within Monitor's risk assessment framework. The Trust liquidity days ratio was marginally ahead of plan throughout the financial year and further head at the yearend due to higher than anticipated cash receipts.



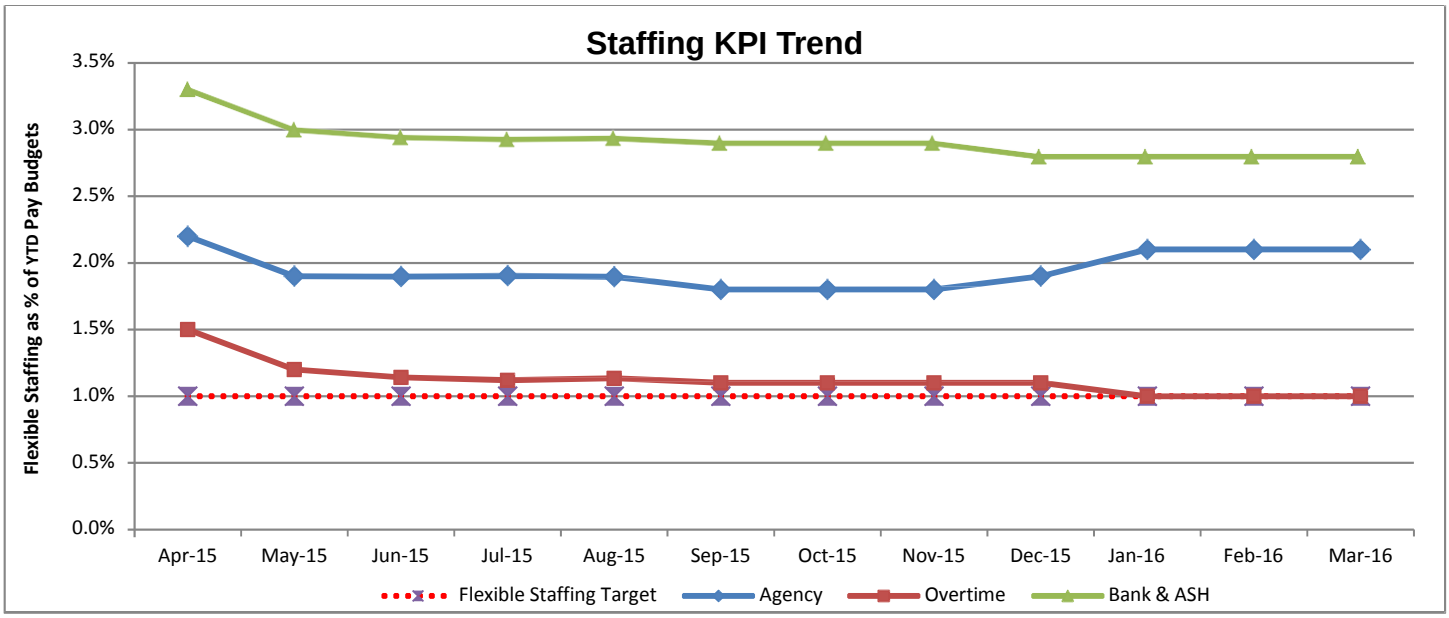
3.5 Financial Drivers

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

Tolerance	Nov	Dec	Jan	Feb	Mar
Agency (1%)	1.8%	1.9%	2.1%	2.1%	2.1%
Overtime (1%)	1.1%	1.1%	1.0%	1.0%	1.0%
Bank & ASH (flexed against establishment)	2.9%	2.8%	2.8%	2.8%	2.8%
Establishment (90%-95%)	93.7%	93.0%	94.2%	93.1%	92.7%
Total	**99.5%**	**98.8%**	**100.1%**	**99.0%**	**98.6%**

The tolerances for flexible staffing expenditure were set at 1% of pay budgets for Agency and Overtime, and flexed in correlation to staff in post for Bank & ASH. For March 2016 the tolerance for Bank and ASH is 5.3% of pay budgets.

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



Additional staffing expenditure is 5.9% of pay budgets. The requirement for bank, agency and overtime was due to a number of factors including cover for vacancies (51%), enhanced observations (17%) and sickness (15%).

3.6 Monitor Risk Ratings and Indicators

3.6.1 The Financial Sustainability Risk Rating was assessed as 4 at 31 March 2016, and was in line with the restated planned risk rating.

3.6.2 Capital service capacity rating assesses the level of operating surplus generated, to ensure a Trust is able to cover all debt repayments due in the

reporting period. The Trust has a capital service capacity of 1.80x (can cover debt payments due 1.80 times), which was in line with 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 was 37.6 days, this was in line with plan and was rated as a 4.

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 4.2% and was rated as a 4.

3.6.5 The variance from plan assesses the level of surplus or deficit against plan, excluding exceptional items e.g. impairments. The Trust surplus was 1.8% ahead of plan and was rated as a 4.

The margins on Financial Sustainability Risk Rating were as follows:

- Capital service cover - to reduce to a 2 a surplus decrease of £757k was required.
- Liquidity - to reduce to a 3 a working capital reduction of £29,723k was required.
- I&E Margin – to reduce to a 3 an operating surplus decrease of £9,725k was required.
- Variance from plan – to reduce to a 3 an operating surplus decrease of £5,876k was required.

Financial Sustainability Risk Rating at March 2016

Monitors Rating Guide	Weighting	Rating Categories			
	%	4	3	2	1
Capital service Cover	25	2.50	1.75	1.25	<1.25
Liquidity	25	0.0	-7.0	-14.0	<-14
I&E Margin	25	1%	0%	-1%	<=-1%
Variance from plan	25	0%	-1%	-2%	<=-2%

TEWV Performance	Actual		Annual Plan		RAG
	Achieved	Rating	Planned	Rating	Rating
Capital service Cover	1.80x	3	1.36x	2	1
Liquidity	37.6 days	4	27.9 days	4	0
I&E Margin	4.2%	4	2.4%	4	0
Variance from plan	1.8%	4	0%	4	0

3.6.7 6.3% of total receivables (£161k) were over 90 days past their due date. This is above the 5% finance risk tolerance set by Monitor, but is not a cause for concern as negotiations are ongoing to resolve.

3.6.8 3.9% of total payables invoices (£423k) held for payment were over 90 days past their due date. This is below the 5% finance risk tolerance set by Monitor.

3.6.9 The cash balance at 31 March 2016 is £54,148k and represents 69.5 days of annualised operating expenses.

3.6.10 Actual capital expenditure was 80% of planned expenditure at the financial year end which was due to the planned deferral of schemes into 2016/17.

3.6.11 The Trust does not anticipate the Financial Sustainability Risk Rating will be less than 3 in the next 12 months.

4. IMPLICATIONS:

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

4.2 The Trust's annual accounts are subject to external audit.

5. RISKS:

5.1 Any findings from the external audit may alter the financial outturn position and associated financial risk rating indicators.

6. CONCLUSIONS:

6.1 The comprehensive income outturn for the period ending 31 March 2016 was a deficit of £297k, representing 0.1% of the Trust's turnover and was behind plan. Excluding impairments the Trust was ahead of plan by £5,897k largely due to a non-recurrent surplus within projects and higher than planned contract income.

6.2 Identified Cash Releasing Efficiency Savings at 31 March 2016 were in line with plan.

The Trust has identified schemes to deliver CRES in 2016/17 whilst plans continue to be progressed for future years.

6.3 The Financial Sustainability Risk Rating for the Trust was 4 for the period ending 31 March 2016.

7. RECOMMENDATIONS:

7.1 The Council of Governors are requested to receive the report, to note the conclusions in section 5 and to raise any issues of concern, clarification or interest.

.

Drew Kendall

Acting Director of Finance and Information

ITEM NO 15

FOR GENERAL RELEASE

COUNCIL OF GOVERNORS

DATE:	**19 May 2016**
TITLE:	**Council of Governors' Development Plan**
REPORT OF:	**Phil Bellas**
REPORT FOR:	**Assurance/Information**

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

Executive Summary:

For the Council of Governors to receive an update on its Development Plan for 2015/16 and approve its achievement.

For the Council of Governors to review the findings of the 2015 self assessment undertaken during January 2016 and approve its Development Plan for 2016/17.

Recommendations:

The Council of Governors is asked to receive and approve the sign off of the 2015/16 Development Plan and approve its 2016/17 Development Plan.

MEETING OF:	**COUNCIL OF GOVERNORS**
DATE:	**19 May 2016**
TITLE:	**Council of Governors' Development Plan**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to enable the Council of Governors to:
a) Sign off the end year position on its Development Plan for 2015/16.
b) Approve its Development Plan for 2016/17.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 In accordance with the Foundation Trust Code of Governance the Council of Governors should periodically review its collective performance and should regularly communicate to members and the public details on how it has discharged its responsibilities including its impact and effectiveness on:

- Holding the Non Executive Directors individually and collectively to account for the performance of the Board of Directors.
- Communicating with their member constituencies and transmitting their views to the Board of Directors.
- Contributing to the development of forward plans of NHS Foundation Trusts.

2.2 In June 2009 the Council of Governors decided to undertake a review by self assessment using a similar approach to that adopted for the performance evaluation of the Board of Directors. This process has been repeated in subsequent years.

3. KEY ISSUES:

3.1 A Development Plan was approved by the Council of Governors at its meeting held on 22 September 2015 (minute 15/61 refers) in response to issues identified from the self-assessment undertaken during 2014.

3.2 The end of year position against the 2015/16 Development Plan is provided at Annex 1 to this report.

3.3 The Council of Governors is asked to note that all actions have been fully achieved within the 2015/16 Development Plan.

3.4 A self assessment questionnaire was issued to all Governors in post in January 2016. The full summary of the responses received is available within the Information Pack for the meeting.

3.5 A workshop to discuss the findings of the self assessment was held with Governors on 19 April 2016.

3.6 The draft Development Plan for 2016/17 is attached at Annex 2 to this report.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** Not applicable.

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

4.3 **Legal and Constitutional (including the NHS Constitution):** The Annual Review supports compliance with the Foundation Trust Code of Governance

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

4.5 **Other implications:** None.

6. CONCLUSIONS:

6.1 There are no issues of significant concern arising from the self assessment. The workshop held with Governors identified that where scores were marginally lower than in previous years, this was not significant enough to cause concern and in most cases it was a result of responses stating don't know / not applicable to questions.

7. RECOMMENDATIONS:

7.1 The Council of Governors is asked to:

a) Sign-off the end of year position on its Development Plan for 2015/16 (as set out in Annex 1 to this report).

b) Approve its Development Plan for 2016/17 (as set out in Annex 2 to this report).

Phil Bellas,
Trust Secretary

Background Papers:
Council of Governors workshop findings 19/4/16
Council of Governors Development Plan 2015/16
Foundation Trust Code of Governance

Annex 1

ACTION PLAN

PLAN LOCATION/TEAM: COUNCIL OF GOVERNORS **DATE PLAN AGREED: 22 September 2015**
PLAN DEVELOPED BY: KATHRYN ORD

NO	RECOMMENDATION/ FINDING	INTENDED OUTCOME/RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
1	Holding the Non Executive Directors to Account individually and collectively for the performance of the Board of Directors	Greater awareness and understanding of roles of Board members and	Delivery of the Task and Finish Action Plan '*Holding the Non Executive Directors to Account individually and collectively for the performance of the Board of Directors'*	Trust Secretary's Department	November 2015	• 2016 Governor Meeting Schedule • Governor Central diary to record bookings	**Meeting schedule issued and updated** **Governor representation meetings and visits is recorded.**
2	Raising awareness of services and staff and patient views	Greater understanding of services and evidence that Board members are visiting services talking to staff, service users and carers	The bi-monthly Board visit schedule to be issued for Governors to book a place on a visit (1 governor per visit)	Trust Secretary's Department	December 2015	• Schedule of visits • Governor Central diary	**Bi Monthly schedule of visit publicised** **Details of attendance of Governors recorded within diary**

NO	RECOMMENDATION/ FINDING	INTENDED OUTCOME/RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
3	Improve the way the Council of Governors conducts its business	More interactive and purposeful meetings of the Council of Governors Less duplication of business Governors to feel they can interact more within business proceedings	The establishment submission and delivery of the Task and Finish Action Plan '*Review of the Conduct of Council of Governors Business'*	Trust Secretary's Department	November 2015	• Implementation plan	**Task and Finish Group established and recommendations approved by Council with implementation plan agreed.**
4	To review how Governors can engage and represent members and stakeholders	Clarity on what engagement and representation means and how it can be achieved by Governors	The establishment of a Task and Finish Group to review engagement and representation of members and stakeholders	Trust Secretary's Department	October 2015	• Terms of Reference • Membership • Recommendations • Action Plan	**Task and Finish Group established and currently in progress**
5	More structured briefing processes around key Trust developments and issues	Governor Development Days to be more around briefings and training delivery	Move to quarterly Government Development Days with a mix of briefings and training delivery	Trust Secretary's Department	January 2016	• Meeting Schedule • Agendas	**Governor Development days now scheduled four times per year. Agenda items are sought from Governors**

Annex 2

DRAFT ACTION PLAN

PLAN LOCATION/TEAM: COUNCIL OF GOVERNORS DEVELOPMENT PLAN **DATE PLAN AGREED: 19/5/16**
PLAN DEVELOPED BY: KATHRYN ORD

NO	RECOMMENDATION/ FINDING	INTENDED OUTCOME/RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
1	To refresh the Governor Training programme.	Tailored training internal and external available to Governors.	To issue a schedule of internal training events. To issue a schedule of Governwell (external) training events.	Kathryn Ord	July 2016	Training Programme and schedule. Record of training undertaken by Governors.	
2	To have greater contact with Non Executive Directors.	To facilitate greater understanding of the role of a Non Executive Director.	Non Executive Directors invited to: • Governor Development Days. (4 per year) • Council of Governor Meetings (5 per year) • Meetings with Directors of Operations (2 per year) Governors invited to attend Board and	Kathryn Ord / Governors	June 2016	• Schedule of meetings. • Diary records of Governors attending visits. • Meeting with the Chairman July 16	

NO	RECOMMENDATION/ FINDING	INTENDED OUTCOME/RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
			EMT visits to services (approx. 7 visits on a bi monthly basis) To examine opportunities for Governors and Non Executive Directors to enter into dialogue. To explore with the Chairman other opportunities for Governors and NEDs to interact.		July 2016 July 2016		
3	Governors to influence the agenda setting for Governor Development Days.	Greater ownership of items being discussed that are relevant and timely for Governors. Raising awareness and providing briefings on key initiatives within the Trust.	Governors to continue to suggest items for future agendas of Governor Development Days.	Kathryn Ord	June 2016	• Governor Development Day agenda's	
4	Raising awareness of the work of the Council of Governors.	Clarity on what being a Governor on the Council of Governors means.	For the Task and Finish Group looking at Member and Stakeholder	Task and Finish group members.	November 2016	• Recommendations from Task and Finish Group	

NO	RECOMMENDATION/ FINDING	INTENDED OUTCOME/RESULT	ACTION	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION	EVIDENCE (TO BE RETAINED BY ACTION OWNER)	PROGRESS UPDATE
		Showcasing what work Governors undertake and how this influences the work of the Trust which in turn benefits service users and carers.	representation and engagement to consider and recommend to the council of Governors a proposed booklet.				
5	To ensure that the Council of Governors is fully representative in terms of its membership	To ensure that that the positions of Appointed Governors on the Council are filled and encourage Appointed Governors to attend Council meetings and events.	To contact appointing organisations to seek representation. To include within induction events the importance of involvement of those Governors appointed by stakeholders.	Phil Bellas / Kathryn Ord	August 2016	• Membership of the Council of Governors	