Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Our Quality Account 2015/16

making a difference together

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

I am pleased to be able to present Tees, Esk and Wear Valleys NHS Foundation Trust's (TEWV) Quality Account for 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 **page 45-46**).

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 higher scores than any other Mental Health and Learning Disability Foundation Trust in **14** 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 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, liaising with the relevant Head of Service 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 **192** complaints. During 2015/16 **78%** of complaints were resolved satisfactorily.

As a result of these complaints **58** action plans to learn the lessons were generated. At the end of February 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

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
Positive practice in Mental Health	Innovation in Child, Adolescent and Young Peoples Mental Health	CAMHS Crisis team
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.

Chief Executive
Tees, Esk and Wear Valleys NHS Foundation Trust

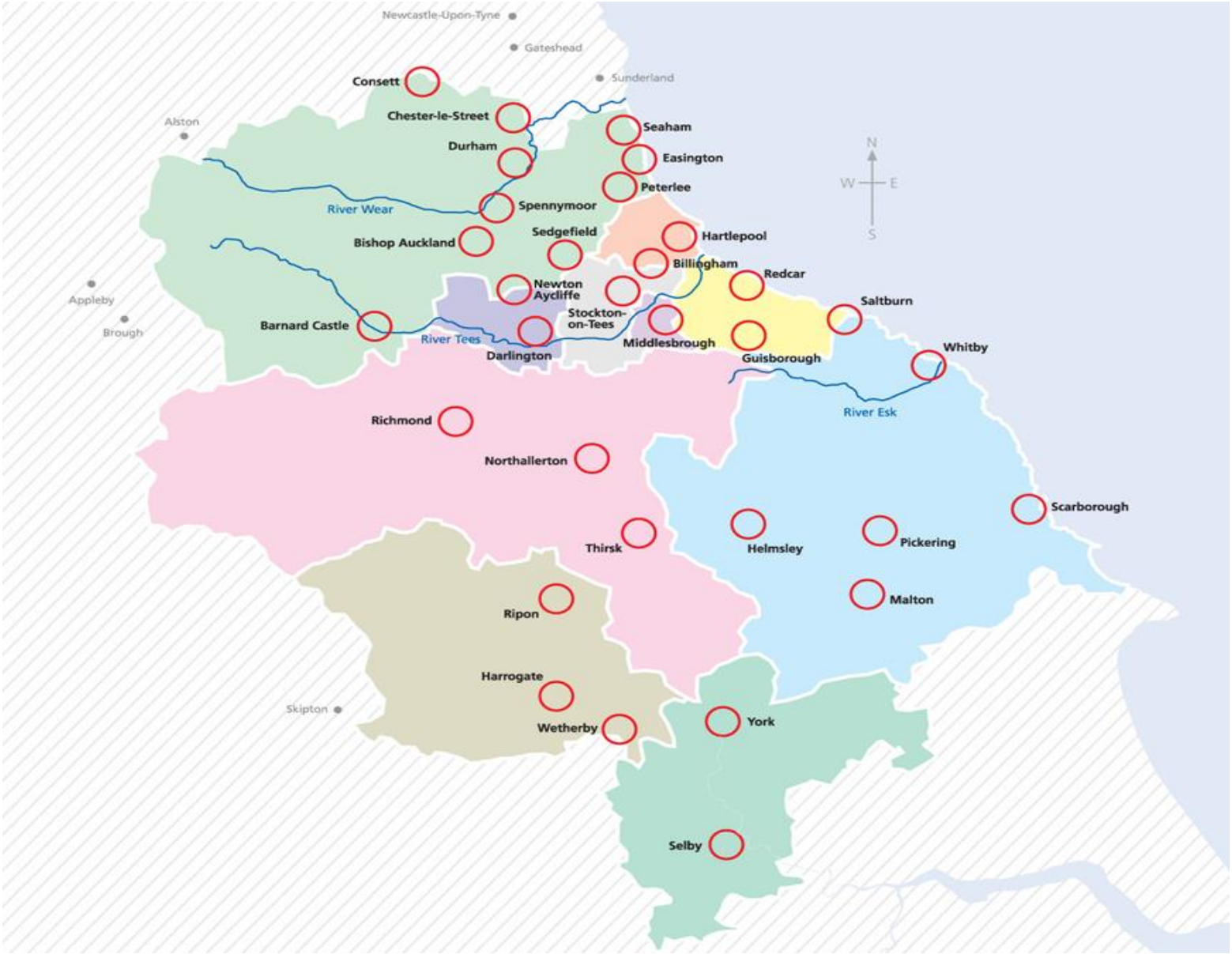
A Profile of the Trust

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. 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 **£279.5m***.
- On 31 March 2016 there were almost **52,000*** people receiving care from TEWV.
- During 2015/16 on average we had **778*** patients occupying an inpatient bed each day (this equates an average occupancy rate of 88%).
- Our community staff made more than **1.5 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).

*to be update



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 project was opened. This has now become a quality priority within the Trust and included within this document. Further information can be found on **pages 47-48**.
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 on will continue through harm minimisation, recovery, relevant mandatory training and 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 they 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 get their lives back;
- 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 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 the Priorities for Improvement section on **pages 45-46**.

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 the Priorities for Improvement 2016/17 section on **page 49-50**. 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

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, we will continue to roll out the revised documentation to the teams in this area.

We will monitor the impact that the changes have on staff time 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 becoming 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/About-the-Trust/How-well-are-we-doing/CQUIN/. This is in development and the link will be updated for the final version

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 3, all area 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 opportunities for this are being investigated within North Yorkshire.
- Expanded peer worker roles throughout the Trust. The Trust is already exceeding the targets for three of the four agreed metrics with commissioners and on target for the final one. **10** involvement peers and **2** paid expert coordinator posts have been introduced. There are now **41** 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 **23** individuals with lived experience. **76** 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 3, **87%** 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 to 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 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 will be discontinued by end of March 2016.
- The Multi-Disciplinary Team will ensure all patients will be involved / consulted 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

- Due to management of change process across Locality and all services the consolidation of the bed base has allowed for staff to cover posts that were vacant.
- 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: **99.24**% for admitted patient care.
- Which included the patient's valid General Medical Practice Code was **98.85%** 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.
The areas highlighted in yellow will be updated for the final report.

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 and figure reported to Monitor: **98.19% (as at Feb 2016)**	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%**
	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 3 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, **43** 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;

- Services being unable to contact to arrange to see the service user; and
- Breakdown in processes.

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

- Monitoring this key performance indicator via the Trust's dashboard at team, service and Board level on a monthly basis.
- Investigating all breaches and identifying lessons to be learned at directorate and service level performance meetings.
- 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.
The areas highlighted in yellow will be updated for the final report.

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 and figure reported to Monitor: **96.3% (as at Feb 2016)** NHSIC reported: *Not yet available*	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%**
	Highest/best MH Trust = **100%**	Figure reported to Monitor: **96.57%**	Figure reported to Monitor: **97.24%**	Figure reported to Monitor: **98.13%**
	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, **47** 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 System 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 areas highlighted in yellow will be updated for the final report.

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 March 2016.

Note the data below does not include York and Selby services which joined the Trust on the 1 October 2015.

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 4 March 2016 **3377** incidents reported of which **61 (1.8%)** resulted in severe harm or death* NB: NRLS next reporting release is April 2016 *22 Severe Harm and 39 Death	NRLS Reported: National Average MH Trusts: incidents reported of which resulted in severe harm or death **Lowest MH Trust: **539** incidents reported of which **11 (2%)** resulted in severe harm and **12 (2.2%)** in death Highest MH Trusts: **5784** incidents reported of which **122 (2.1%)** resulted in severe harm and **0** in death. Alternatively the highest reported number of severe harm or deaths from **855** incidents was reported by one MH Trust as **8 (0.9%)** severe harm and **32 (3.7%)** death. (will be updated when available)	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 the figures reported. Incidents are now uploaded to NRLS on a weekly basis which can be seen in the consistency of performance in Q1 & Q2 of 2015/16.
- There is a necessity for each Trust to code their incident reporting system to NRLS in order to upload all patient safety incidents. However, different Trusts may choose

to apply different approaches. For example, the approach taken to determine a classification such as those 'resulting in severe harm' will often rely on clinical judgement which may, acceptably, differ between professionals. The classification of an incident may also be subject to a potentially lengthy investigation which may result in the classification being changed. The change may not be reported externally and the data held by a Trust may therefore not be the same as that held by the NRLS.

TEWV has noted a steady improvement in patient safety incident reporting. There is ongoing work to continue to improve this position, and in so doing, the quality of its services through:

- Analysis of all patient safety incidents. These are reported and reviewed by the Patient Safety Group a sub group of the Trust's Quality Assurance Committee. A monthly report is circulated to the QuAC. Safety incidents are reported to commissioners via the Clinical Quality Review Process.
- 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 (i.e. those resulting in severe harm or death) are subject to a serious incident review. This is a robust and rigorous approach to understand how and why each incident has happened, to identify any causal factors and to identify and share any lessons for the future. 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 **pages 73-74**. 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 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.

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. We also aim to provide a consistent approach across the Trust localities whilst having a tailored process dependent on clinical service.

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:
• Create a baseline of current experiences through a detailed review of transition e.g. patient feedback on their experience, incident reviews and other data to identify issues by Q1 2016/17.
• Using the above baseline data, identify the speciality with the most significant transition issues by Q2 2016/17.
• Develop and commence an action plan focusing on the speciality highlighted with the most significant issues by Q3 2016/17.
• Develop improved processes for priority speciality by Q4 2016/17.

What we will do in 2017/18:

- Evaluate effectiveness of action plan implementation by Q1 2017/18.
- Develop a roll out programme in collaboration with relevant clinical services that will focus on one speciality and a selection of teams based on the priority area identified within year 1 by Q1 2017/18.
- Develop a communication strategy which will include an agreement of reporting and feedback mechanisms by Q2 2017/18.
- Launch an improvement programme via facilitated training event(s) for identified teams to include team administrators to be able to report on transitions with new transitions procedures initiated within 50% of teams by Q2 2017/18.
- Implement new transitions process within remaining identified teams by Q3 2017/18.
- Complete an evaluation report on the effectiveness of implementation of the new procedure 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 process within identified teams initiated.	50%	Q2 17/18
• An improvement in the experience of service users going through transitions.	TBC	Q2 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 As at 29.02.2016		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*	**14.11**	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	**46.30**	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%	**97.86%**	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	**27.11**	26.67	AMH: 31.72	35	37
		MHSOP <52	**63.58**	62.18	MHSOP : 54.08		
Patient Experience Measures							
7	Delayed Transfers of Care	<7.50%	**1.70%**	2.11%	1.89%	2.07%	1.60%
8	Percentage of complaints satisfactorily resolved	> 90.00%	**78.80%**	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 classes as a serious incident per 10,000 open cases.

The Trust position as at the 29 February 2016 is **14.11** which is 2.11 above the target of 12.00. The total number of unexpected deaths was **81** in 2015/16 compared to **61** unexpected deaths in 2014/15.

Unexpected Deaths 2015/16

Number of unexpected deaths by locality					
Durham & Darlington	**Teesside**	**North Yorkshire**	**Forensics**	**York & Selby**	**Total**
30	**22**	**20**	**4**	**4**	**80***

* There were 81 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 reported during 2015/16. Of the 80 deaths, 44 are still awaiting a formal coroner's verdict, 36 deaths were due to suicide related incidents and 2 were found to be from physical health related causes. The 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.

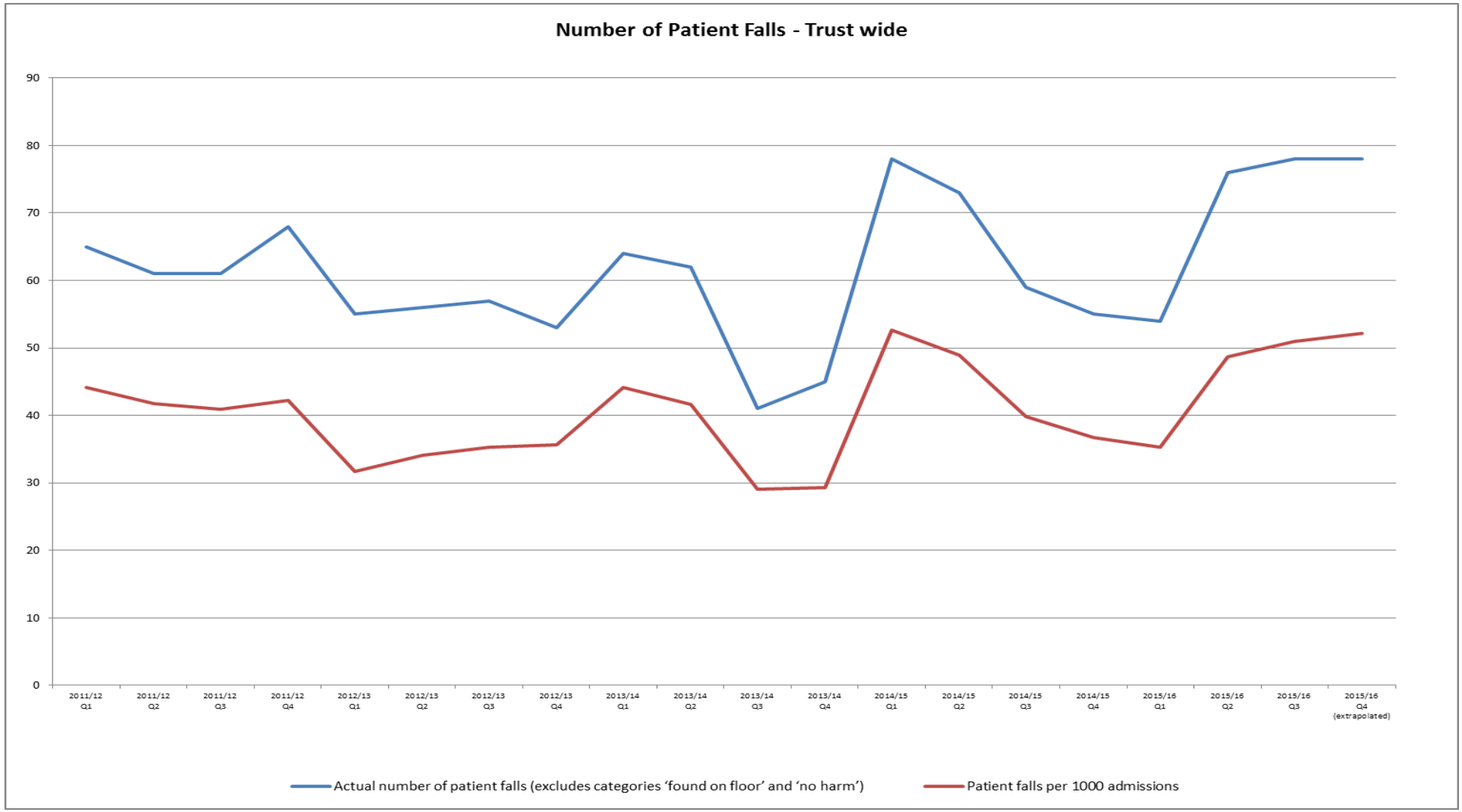
All unexpected deaths are robustly reviewed as Serious Incidents and reported externally to our commissioners. Family members and carers are included within the review process in keeping with the principles of Duty of Candour (being open and honest). An action plan of learning points is developed from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

Metric 3: Patient falls per 1,000 admissions.

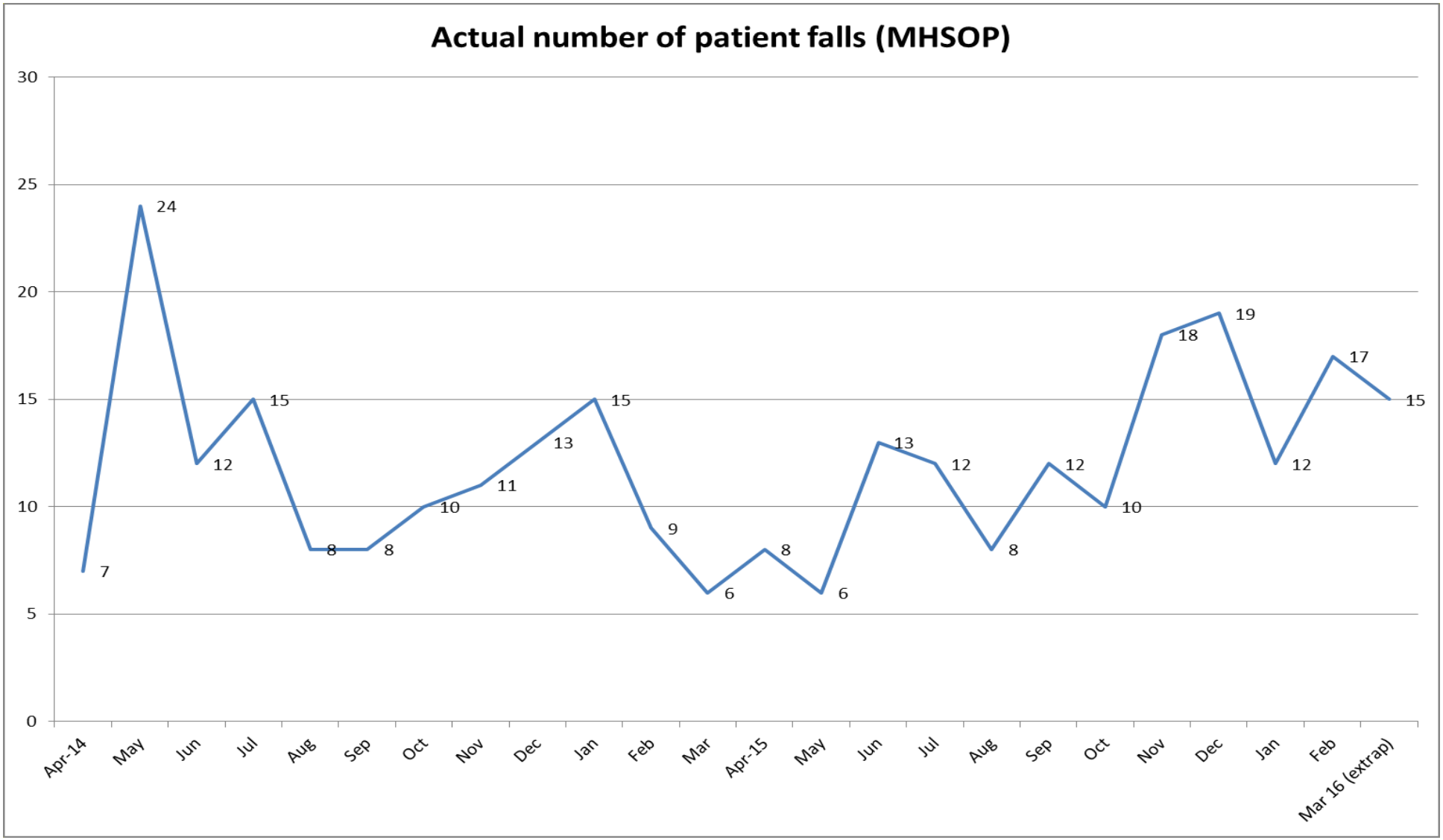
The number of falls reported as at the 29 February 2016 is **46.30** per 1,000 admissions, which is significantly above the target of <27.79.

This relates to 260 falls this financial year to date: 81 (31.15%) in Durham and Darlington, 80 (30.77%) in Teesside, 56 (21.54%) in Forensics, 42 (16.15%) in North Yorkshire and 1 (0.39%) other. Of the falls reported, 209 (80.38%) were classified low with minimal harm, 45 (17.31%) were reported as moderate short term harm and 5 (1.92%) 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. The final quarter figure has been extrapolated based on January and February actual data.



Of the 260 falls, 135 (51.92%) 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
7
24
12
15
8
8
10
11
13
15
9
6
8
6
13
12
8
12
10
18
19
12
17
15
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 16 (extrap)

The Trust 'Falls Executive Group' was reintroduced in January 2015 and steers and monitors Trust falls management, reporting into the Patient Safety Group. Data on falls is now 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:

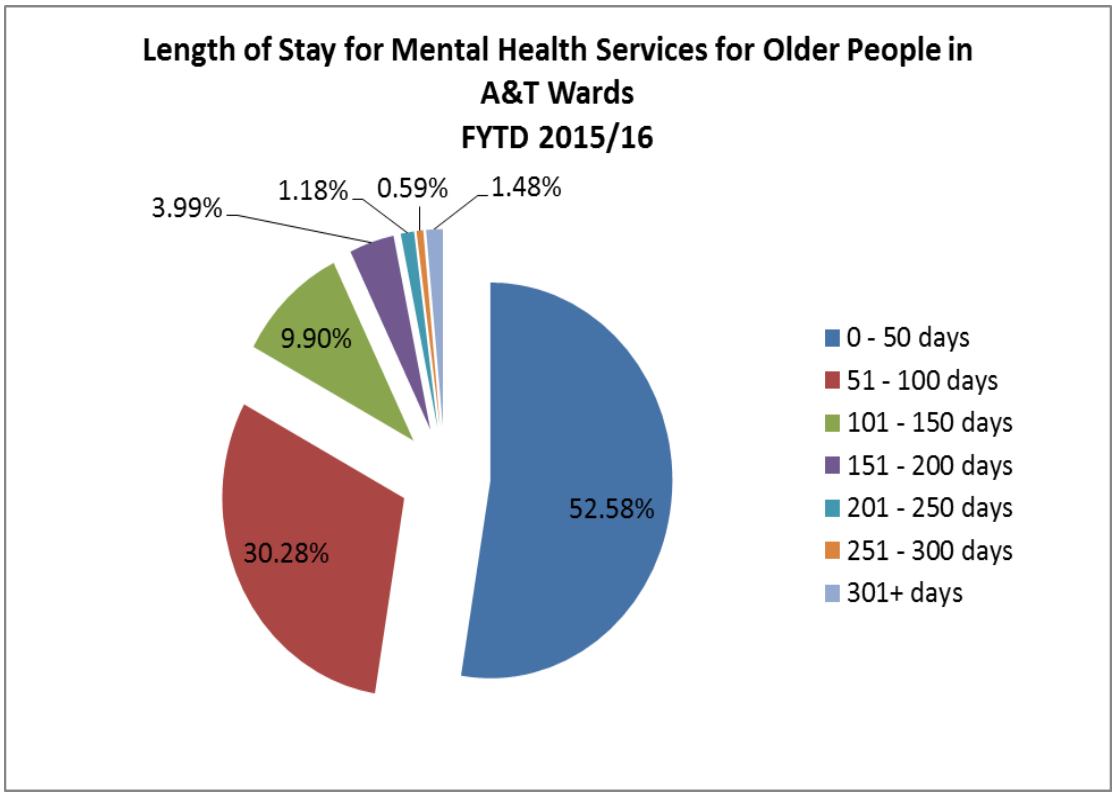
- MHSOP – the audit has been undertaken, using the audit tool. The results of the audit have led to (1) the production of guidance for junior doctors regarding falls assessment and management; (2) pain assessment and management training has been fully rolled out to all Specialities and (3) a pain medication 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, reporting **63.58** days for 2015/16. This is 11.58 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 outliers have a significant impact on the mean figures reported.



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. 52.58% of lengths of stay were between 0-50 days, with 30.28% between 51 – 100 days. 22 patients had a length of stay greater than 200 days; all of these were attributable to the complex needs of the patients (such as co-morbidity with physical health problems). They were not due to bed blocking.

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 it is assumed that the complainant was satisfied with the Trust's response.

The percentage of complaints satisfactorily resolved as at the 29 February 2015 was **78.80%**, which is below the target of 98% but an improvement on 2014/15 and 2013/14. This relates to **184** complaints resolved. Complaints are monitored by the Quality Assurance Committee and each is thoroughly investigated.

There were **39** dissatisfied complaints reported since April 2015 and as at the 29 February, there were **13** 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	**65**	**8**	**88%**
Adult Mental Health	47	7	85%
Mental Health Services for Older People	3	0	100%
Children & Young People's Services	13	1	92%
Learning Disabilities	2	0	100%
Tees	**50**	**14**	**72%**
Adult Mental Health	35	9	74%
Mental Health Services for Older People	8	2	75%
Children & Young People's Services	6	3	50%
Learning Disabilities	1	0	100%
North Yorkshire	**52**	**13**	**75%**
Adult Mental Health	42	11	74%
Mental Health Services for Older People	6	1	83%
Children & Young People's Services	4	1	75%
Learning Disabilities	0	0	N/A
Forensics	**17**	**4**	**76%**
Forensic Learning Disabilities	10	2	80%
Forensic Mental Health	7	2	71%

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%	**98.60%**	97.75%	96.56%	96.90%
b	Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams		95%	**97.06%**	98.42%	98.58%	97.35%
c	Meeting commitment to serve new psychosis cases by early intervention teams		95%	**254%**	254%	239%	231%
e	Mental health data completeness: identifiers		97%	**99.10%**	99.61%	98.73%	99.18%
f	Mental health data completeness: outcomes for patients on CPA		50%	**90.48%**	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%	**74.44%**			
i	Percentage of people referred to the IAPT programme that were treated within 6 weeks of referral		75%	**86.14%**			
j	Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral		95%	**96.24%**			

***As at end February**

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 (January – February 2016) 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.

The trust has 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 trusts 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.
- **Development and use of Behavioural Support Plans** - a standard template has been produced to ensure that aspects of the person's environment that they

[2] https://www.mind.org.uk/media/197120/physical_restraint_final_web_version.pdf

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 2014/16 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.

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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 xx 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 xx 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

To be added once received.