Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Our Quality Account 2016/17

making a difference together

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

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

TEWV primarily serves the populations of:

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

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

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

Our Mission, Vision & Strategy

The purpose of the Trust is:

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

and our vision is:

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

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

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

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

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

The Quality Strategy contains 3 Goals which are:

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

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

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

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

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

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

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

What we have achieved in 2016/17

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

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

- Brought together all of our Middlesbrough adult community mental health teams into one new, purpose built location (Parkside) which offers an improved patient experience.
- Introduced an option for children and their parents to choose a telephone referral rather than face to face referral in our Durham and Darlington CAMHS service. This has proved very popular and has also helped us to reduce waiting times.
- Been chosen by NHS England as one of two national pilots where providers manage how specialist CAMHS budgets are spent. This went live on 1st April 2017 This will mean that more children will be able to receive care close to their home.

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

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

- Developed a multidisciplinary physical health team that works within our Forensic Secure Adult wards at Roseberry Park which includes doctors, nurses and physiotherapy. This has enabled delivery of general primary care initiatives including national screening programmes, vaccination programmes and long term condition management.
- Developed and delivered nurse education programmes which focused specifically on improving the skill set in relation to providing physical health care to patients in our Forensic Secure Adult wards (many of whom will be a resident on our secure wards for several years).

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

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

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

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

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

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

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

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

Awarding Body	**Name / Category of Award**	**Team / individual**
Positive Practice in Mental Health awards 2016	Mental Wellbeing of Staff	Staff Mindfulness Service
	The MINDset Quality Improvement Award	TEWV Quality Improvement System (QIS) teams in Hartlepool and Stockton
NHS Innovations North Bright Ideas in Health awards 2016	Service Improvement	The Recovery Focused Care Transfer (ReFleCT) service
Royal College of Psychiatry annual awards	Psychiatric Team of the Year – older age adults	The North Tees liaison psychiatry team part of a wider generic liaison team delivering care to patients presenting at the University Hospital of North Tees in Stockton
	Psychiatric Communicator of the Year	Dr Paul Blenkiron, consultant psychiatrist, AMH services, York
	Patient / Patient Contributor of the year	TEWV Experts by Experience Group
North East NHS Leadership Recognition awards 2016	Emerging leader	Thomas Hurst, ward manager, Overdale ward, Roseberry Park, Middlesbrough
	Inspirational leader	Mani Krishnan, consultant psychiatrist, MHSOP, Teesside
	Inclusive leader	Lisa Taylor, head of service, offender health
NHS England Friends and Family Test (FFT) awards (**Highly Commended**)	Best FFT Initiative in Other NHS Funder Services	Patient and carer experience team

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

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

Structure of this Quality Account document

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

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

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

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

I hope you find this report interesting and informative.

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

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

A Profile of the Trust

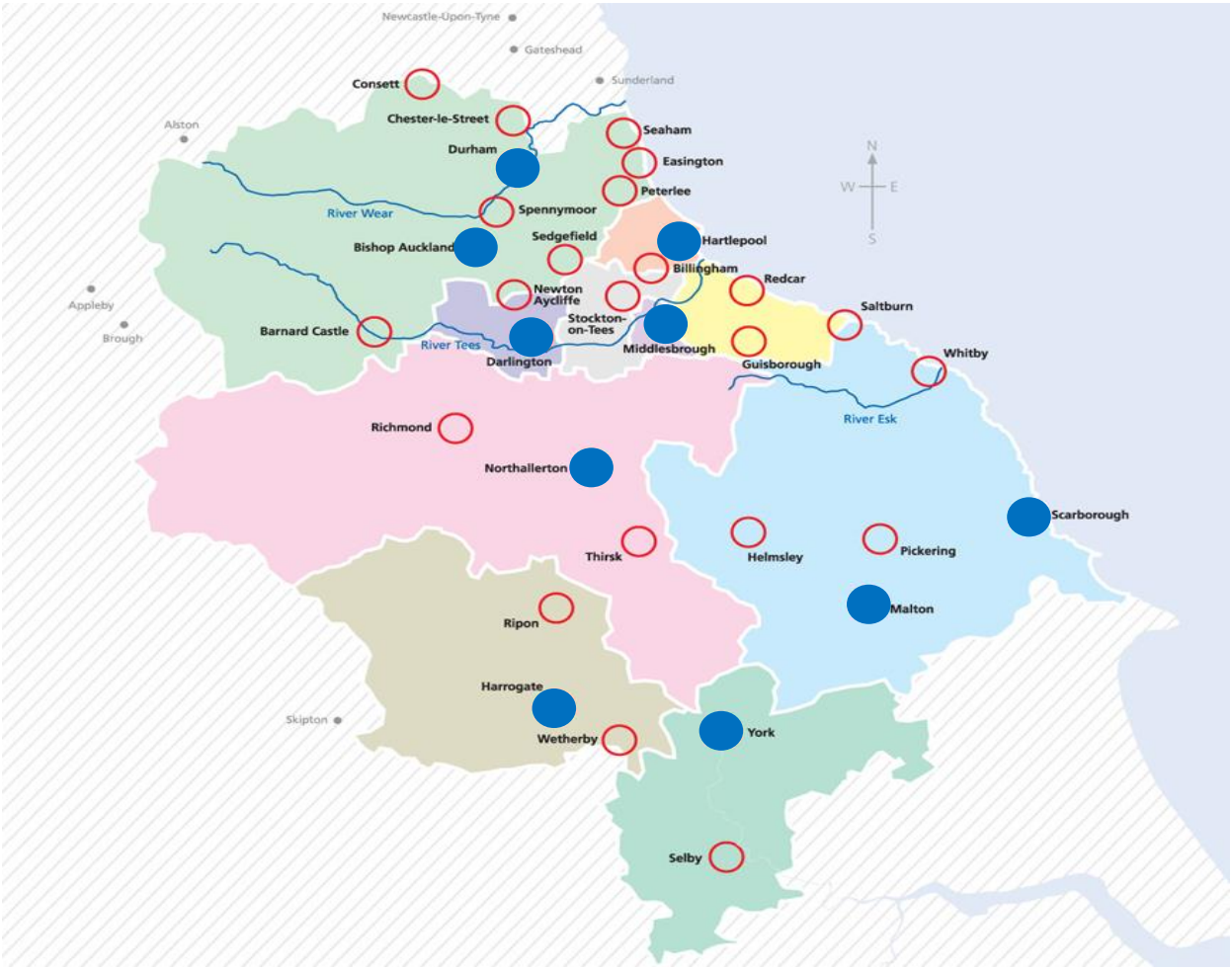
The Trust provides a range of mental health, learning disability and autism services for around two million people across a wide geographical area. Within this area our main towns and cities are: Bishop Auckland, Darlington, Durham, Hartlepool, Harrogate, Malton, Middlesbrough, Northallerton, Redcar,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

Services commissioned by 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 2016/17 was **£340.6m***.
- On 31 March 2017 there were **55,919** people receiving care from TEWV.
- During 2016/17 on average we had **809** patients occupying an inpatient bed each day (this equates an average occupancy rate of **89%**[1]).
- Our community staff made more than **2.16 million** contacts with patients during 2016/17.
- We have **6,586** employees. Some of these employees work part-time hours, therefore the whole time equivalent workforce of the Trust is **5,842.01**.

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

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



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

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

Update on 2015/16 quality priorities

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

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

2016/17 Priorities for improvement – how did we do

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

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

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

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

Priority 1: Continue to develop and implement Recovery focused services

Why this is important:

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

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

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

The benefits / outcomes we aimed to deliver were:

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

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

What we did in 2016/17:

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

What we said we would do	What we did
• Ensure Recovery Principles are embedded within the Trust's Harm Minimisation project by including them within the training being implemented by the project by Q2 2016/17.	The central Recovery Programme team and the Harm Minimisation project team have worked in close partnership throughout the year to both review and set up a new Harm Minimisation Policy and to ensure that recovery and wellbeing values and principles have been embedded within both the face to face and e-learning training packages. The process has followed a co-production approach with individuals with lived experience co-designing the training packages throughout.
• Expand Peer involvement within the Trust, having 6 new peer roles by Q3 2016/17.	We have worked to expand both paid and unpaid lived experience roles during this financial year. This has included employing 3 paid Expert Trainers as part of the Harm Minimisation project, 1 Peer within the Outcomes teams and a further Peer Trainer to work within the development of the Recovery College Online. We have also registered 24 Involvement Peers with 20 new Involvement Peer roles being commenced. Throughout expanding developments we have identified that our Involvement Peer handbook can be enhanced. We are currently in the process of reviewing this. We have also identified, that not all Involvement Peers that initially register go on to actively engage in a role. This is for a variety of reasons such as moving into paid work, deciding this is not the right time for them to engage in this role and/or service changes. Evaluations of Peer roles both paid and unpaid indicate that they are highly valued by both staff and patients.
• Continue to implement Phase 1 of the Recovery Project with an interim evaluation report presented to the Executive Management team (EMT) providing an update on progress to date by Q3 2016/17.	In August 2016 we implemented a process to review both the Phase 1 Recovery and Wellbeing Strategy and the Recovery Programme business case. As part of the development of a new 2017- 2020 Recovery and Wellbeing strategy we completed an interim evaluation of Phase 1 achievements and this was submitted to the Board of Directors in January 2017. We have achieved the majority of our targets and actions that were set out in the initial strategy. The interim summary evaluation is available within the appendix of our new Recovery and Wellbeing strategy.
• Develop a business case for Phase 2 of the Recovery project and submit for approval by Q3 2016/17.	A new 3 year Recovery and Wellbeing Strategy and Business Case for Recovery and Wellbeing was developed. A Business Case was submitted and approved in November 2016.

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

How we know we have made a difference:

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

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

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

What we plan to do in 2017/18:

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

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

Why this is important:

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

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

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

were regular findings of incident reviews. There was also an emerging picture of disconnection with identification of risk and subsequent development of a plan to mitigate and manage the risk.

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

The benefits / outcomes we aimed to deliver:

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

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

What we did in 2016/17:

What we said we would do	What we did
• Complete a review of the current Harm Minimisation and Risk Management practice across the Trust by Q1 2016/17	Information was collected directly from services regarding which risk tools they were using, including any that related to engagement and observation. In addition to this we also collected information from other Trusts (e.g. Northumberland Tyne & Wear NHS Foundation Trust). Furthermore, we collected best practice research regarding recovery and harm minimisation principles. An internally completed review identified that there are a number of bespoke 'approved' Risk Assessment tools in use across Trust services. Evidence from audit and post incident investigations suggested that it is often the case that there is minimal inputting into these tools and that a 'ticking the box' culture has evolved. Additionally there was evidence of 'cutting and pasting' from previous assessments when risk assessments are updated, all of which is suggestive of a defensive and risk averse approach.

• Develop and agree Harm Minimisation principles including engagement guidelines by Q1 2016/17	We used the information gleaned from the review to inform the development of a new Recovery Orientated Harm Minimisation Policy and also a new Supportive Engagement and Observation Procedure which are based on 7 agreed principles. Development days were held with representatives from all specialities as well as Experts by Experience to draft the Policy and Procedure. The documents were then finalised by the Harm Minimisation Steering Group and Recovery Project Team, including Experts by Experience, before going out for 6 week Trust wide consultation. The 7 main principles agreed are: 1.Our aim is to promote recovery; 2 Collaborative working and shared decision making; 3 Achieving a shared understanding; 4 Positive care planning; 5 Open and clear communication; 6 Timely reviews; 7 Support and training.
• Develop and complete Harm Minimisation training materials and training plan which will include a Recovery focused approach by Q2 2016/17	We used the information from the review and the Policy & Procedure development to inform the training. A 4 day workshop event was held 31st May to 3rd June 2016 to develop the face to face training programme. Attendees represented all clinical specialities as well as the following projects/teams: Harm Minimisation, Force Reduction, Recovery, PARIS, Management of Violence and Aggression, Workforce Development, Experts by Experience, Shared Decision Making, Medicines Management, and Equality & Diversity. The 4 day workshop produced the outline of the training with workgroups set up to finalise the detail. The Harm Minimisation Steering Group then drafted the training which was approved via the Steering group and the Recovery Programme Board. Regular updates were also given to the QuAC.
• Commence face to face training which includes Expert by Experience input / delivery by Q2 2016/17	Face to face training commenced on Friday 22nd July 2016. The training was available for booking places both via the Education Department and also by managers requesting team training to be delivered within the workplace. We employed three Experts by Experience trainers to co-produce and co-deliver the training. From April 2017 the updated e-learning training will be available which is the mandatory component to be completed by all clinical staff every 2 years.
• Develop an e-learning package which will include a competency framework by Q3 2016/17	In order to ensure expertise at producing a professional and interactive training module, we identified two IT trainers from NHS North of England Commissioning Support Unit to develop the e-learning package.

	The training will be in 3 parts with parts 1 and 2 forming the mandatory component of the training: • Part 1 – core training for all staff covering the principles of recovery orientated harm minimisation; • Part 2 – briefings (e.g. Trust process to follow when informal patients going on unescorted leave or national NCISH 20 year review); • Part 3 – speciality based training. Parts 1 and 2 of the e-learning packages were co-developed with Experts by Experience. The material for all 3 parts are currently with the developers with the aim of launching the mandatory element of the 1st May 2017.
• Have sufficient staff trained in priority areas by Q4 2016/17.	From the 22nd July 2016 to the end February 2017 we trained 39% of all clinical staff which equates to 1870 members of staff. Of these 596 attended training directly delivered to teams. The teams and members of staff trained via centrally booking with the training department are from a range of teams including inpatient and community as well as a range of disciplines including nursing, medics and allied health professionals. The main delay impacting staff training has been due to the demand on clinical staff stopping them from being able to be released for training. Additional funding has been made available for the training to continue into 2017/18 which aims to ensure the target of 65% of staff trained is achieved.
• Evaluate the project and develop options for future delivery by Q4 2016/17.	A report was completed which included the findings from the training participant's evaluation forms, this informed the Trusts project evaluation form.

How we know we have made a difference:

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

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

What we plan to do in 2017/18:

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

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

Why this is important:

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

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

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

The benefits / outcomes we aimed to deliver:

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

What we did in 2016/17:

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

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

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

How we know we have made a difference:

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

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

What we plan to do in 2017/18:

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

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

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

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

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

Why this is important:

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

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

The benefits / outcomes we aimed to deliver:

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

What we did in 2016/17:

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

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

How will we know we are making a difference?

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

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

What we plan to do in 2017/18:

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

Statement of Assurances from the Board 2016/17

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

Review of services

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

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

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

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

- **Patient safety** – including information on incidents, serious untoward incidents, levels of violence and aggression, infection prevention and control and health and safety.
- **Clinical effectiveness** – including information on the implementation of 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 QuAC the sub-committee of the Board which has responsibility for Quality Assurance. The QuAC receives formal reports from each of the LMGBs on a bi-monthly basis.

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

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

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

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

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

Participation in clinical audits and national confidential inquiries

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

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

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

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

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

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

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

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

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

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

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

- No reports received*.

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

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

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

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

Participation in clinical research

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

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

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

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

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

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

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

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

Goals agreed with commissioners

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

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

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

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

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

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

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

What others say about the provider

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

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

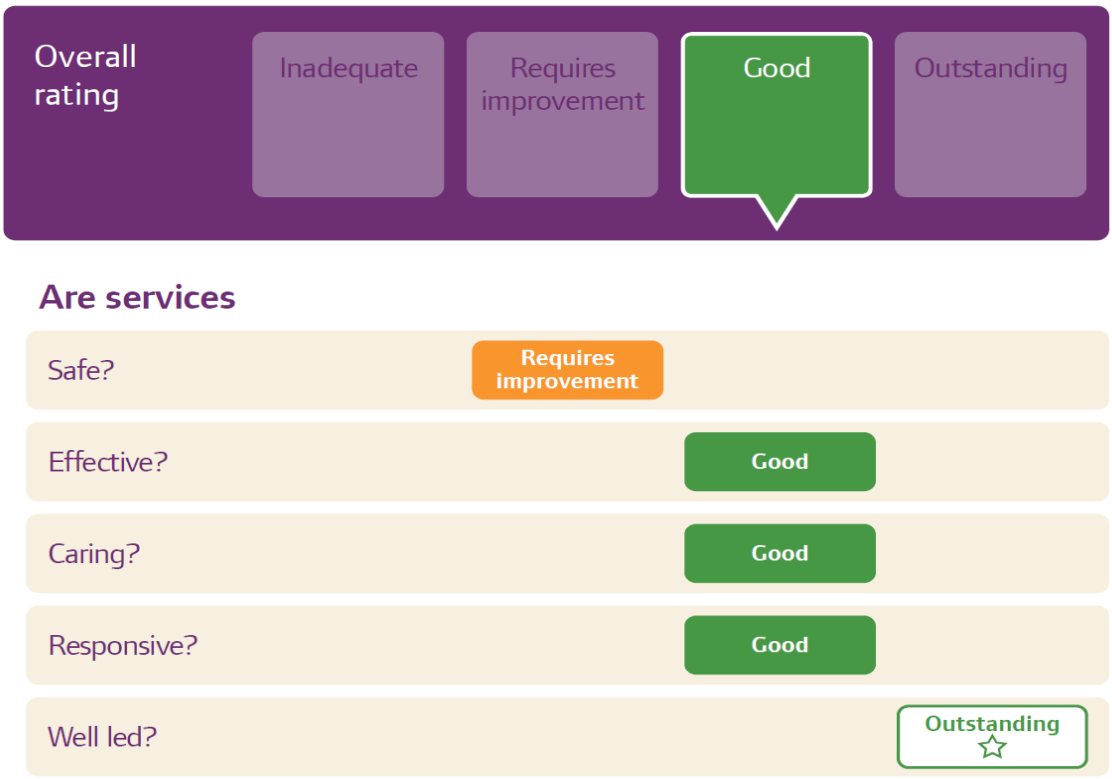
TEWV has not participated in any special reviews or investigations by the CQC during the reporting period.

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

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

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

CQC's rating for each key domain was:



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

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

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

CQC Follow up Visit to Forensic Services February 2016

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

Mental Health Act Inspections

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

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

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

Quality of data

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

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

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

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

The Information Governance Toolkit measures performance in the following areas:

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

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

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

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

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

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

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

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

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

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

Further work for 2017/18 includes:

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

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

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

Mandatory quality indicators

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

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

Care Programme Approach 7 day follow-up

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

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

TEWV Actual Quarter 4 2016/17	***National Benchmarks in Quarter 3 2016/17***	***TEWV Actual Quarter 3 2016/17***	***TEWV Actual Quarter 2 2016/17***	***TEWV Actual Quarter 1 2016/17***
Trust final reported figure: **98.41%** (as at February 2017)	NHSIC reported: Highest/best MH Trust = **100%**	Trust final reported figure: **96.67%**	Trust final reported figure: **97.93%**	Trust final reported figure: **96.95%**
Figure reported to NHSI: N/A**	National average MH Trust = **96.2%**	Figure reported to NHSI: N/A**	Figure reported to NHSI: **97.57%**	Figure reported to NHSI: **97.4%**
NHS Digital reported: **Not yet available**	Lowest/worst MH Trust = **73.3%**	NHS Digital reported: **96.8%**	NHS Digital reported: **97.8%**	NHS Digital reported: **97.5%**

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

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

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

were:

- Difficulty in engaging with the patient despite efforts of the service to contact the patient; and
- Breakdown in processes within the service.

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

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

Crisis Resolution Home Treatment Team acted as a gatekeeper

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

TEWV Actual Quarter 4 2016/17	***National Benchmarks in Quarter 3 2016/17***	***TEWV Actual Quarter 3 2016/17***	***TEWV Actual Quarter 2 2016/17***	***TEWV Actual Quarter 1 2016/17***
Trust final reported figure: **98.09%**	NHSIC Reported: National average MH Trust = **98.3%**	Trust final reported figure: **96.27%**	Trust final reported figure: **96.71%**	Trust final reported figure: **96.79%**
Figure reported to NHSI: N/A**	Highest/best MH Trust = **100%**	Figure reported to NHSI: N/A**	Figure reported to NHSI: **97.24%**	Figure reported to NHSI: **96.8%**
NHS Digital Reported: **Not available**	Lowest/worst MH Trust = **88.3%**	NHS Digital Reported: **96.3%**	NHS Digital Reported: **96.7%**	NHS Digital reported: **96.8%**

*Latest benchmark data available on NHS Digital at quarters 3 2016/17

** We are no longer required to report performance to NHSI following the change in the Regulatory Framework in October 2016.

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

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

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

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

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

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

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

An overall Trust score is not provided, due to the nature of the survey, therefore it is not possible to compare Trusts overall. For 2016, we have reported the Reviewing Care Section score which compiles the results from the questions used from the survey detailed below the table.

TEWV Actual 2016	*National Benchmarks in 2016*	*TEWV Actual 2015*	*TEWV Actual 2014*
Overall section score: **8.0** (sample size 234)	Highest/Best MH Trust = **8.1** Lowest/Worst MH Trust = **6.7** Average Score**=7.5**	Overall section score: **8.0** (sample size 239)	NHSIC Reported: **8.1** (sample size of 188)

Notes on metric

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

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

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

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

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

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

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

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

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

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

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

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

Patient safety incidents including incidents resulting in severe harm or death

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

TEWV Actual Quarters 3&4 2016/17	****National Benchmarks in Quarters 3&4 2016/17***	***TEWV Actual Quarters 1&2 2016/17***	***TEWV Actual Quarters 3&4 2015/16***
Trust Reported to NRLS: as at 31st March 2017 **XX**** incidents reported of which **XX** (XX)**** resulted in severe harm or death **data not yet available	NRLS Reported: National Average MH Trusts: incidents reported of which resulted in severe harm or death **Lowest MH Trust: **599** incidents reported of which **5** resulted in severe harm and **31 (5.2%)** in death Highest MH Trusts: **5572** incidents reported of which **49 (0.9%)** resulted in severe harm and **31 (0.6%)** in death. The highest reported rate of deaths as a proportion of overall incidents was **5.2%**	Trust Reported to NRLS: **4,971** incidents reported of which **88 (1.77%)** resulted in severe harm or death* NRLS reported: **4,971** incidents reported of which **88 (1.77%)** resulted in severe harm or death* *21 Severe Harm and 67 Death	Trust Reported to NRLS: **3,789** incidents reported of which **110 (2.9%)** resulted in severe harm or death NRLS reported: **3,789** incidents reported of which **110 (2.9%)** resulted in severe harm or death

*As of the end of February 2017.

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

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

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

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

2017/18 Priorities for Improvement

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

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

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

Priority 1: Implement Phase 2 of our Recovery Strategy

Why this is important:

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

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

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

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

The benefits / outcomes our patients and carers should expect:

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

What we will do in 2017/18:

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

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

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

How will we know we are making a difference?

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

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

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

Why this is important:

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

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

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

The Carter[3] productivity and efficiency report made it clear that improved workforce efficiency can benefit patient care through better recruitment and retention of permanent staff, better rostering, reduced sickness absence, matching work patterns to patient need and reducing reliance on agency staff.

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

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

The benefits / outcomes our patients and carers should expect:

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

What we will do in 2017/18:

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

How will we know we are making a difference?

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

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

• Outcomes related to the suggested workstreams of:
  • staffing review using the national evidence based Hurst[4] tool;
  • monitoring of escalation processes;
  • review of rostering process to ensure best use of existing resources.	

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

Why this is important:

We define transitions for this Quality Account Priority as a purposeful and planned process of supporting young people to move from children's to adults' services. Young people with ongoing or long-term health or social care needs may be required to transition into AMH services, other service provision or back to their GP. The preparation and planning around moving on into new services can be an uncertain time for young people with health or social care needs. There is evidence of service gaps where there is a lack of appropriate services for young people to transition into, and evidence that young people may fail to engage with services without proper support (Watson 2005[5]; Singh 2009[6]).

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

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

The benefits / outcomes our patients and carers should expect:

- An improvement in their experience during their transition from Children and Young People's to Adult services.
- Greater involvement in decisions about the care received when they transfer into Adult services.
- To receive care informed by NICE's[7] evidence-based guidelines, which will result in better clinical outcomes.

[4] https://hee.nhs.uk/hee-your-area/west-midlands/about-us/our-governance/our-letcs/mental-health-institute-letc/safe-staffing-tools-mental-health-learning-disability
[5] Watson AR (2005) Problems and pitfalls of transition from paediatric to adult renal care. Paediatric Nephrology 20: 113–7
[6] Singh SP (2009) Transition of care from child to Adult Mental Health services: the great divide. Current Opinion in Psychiatry 22: 386–90
[7] http://www.rcpch.ac.uk/system/files/protected/page/Transition%20from%20children%E2%80%99s%20to%20adults%E2%80%99%20services%20-%20FULL%20published_1.pdf

What we will do in 2017/18:

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

How will we know we are making a difference?

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

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

Priority 4: Reduce the number of preventable deaths

Why this is important:

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

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

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

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

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

The benefits / outcomes our patients and carers should expect:

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

What we will do in 2017/18:

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

How will we know we are making a difference?

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

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

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

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

Why this is important:

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

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

The benefits / outcomes our patients and carers should expect:

- A reduction in moderate and severe harm as a result of falls.
- More falls are prevented during hospital stays.
- To feel more informed about the risks and benefits around falls interventions.
- Their values and preferences informing care.
- That care is managed in line with NICE clinical guideline 161 *'Falls: assessment and prevention of falls in older people*' (2013)[8] and in line with actions from the National Patient Safety Agency '*how to guide for reducing harm from falls in mental health inpatient settings*' (2012)[9].
- Care is delivered by staff with the appropriate skills and competencies to prevent and manage falls.
- Appropriate assessment and treatment is given to people who have fallen.

What we will do in 2017/18:

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

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

How will we know we are making a difference?

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

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

Monitoring Progress

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

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

Part 3: Other information on Quality Performance 2016/17

Our performance against our quality metrics

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

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

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

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

Quality Metrics

	Quality Metrics	2016/17		2015/16	2014/15	2013/14	2012/13
		Target	Actual (as at Feb 17)	Actual	Actual	Actual	Actual
Patient Safety Measures							
1	Number of unexpected deaths classed as a serious incident per 10,000 open cases	<9.00*	**8.03**	14.68	12.16	11.88	15.91
2	Number of outbreaks of Healthcare Associated Infections	0	**0**	0	0	0	0
3	Patient Falls per 1,000 admissions	<28.79	65.58	46.69	44.54	35.99	34.09
Clinical Effectiveness Measures							
4	Percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care	> 95.00%	**97.42%**	97.75%	97.42%	97.86%	97.14%
5	Percentage of clinical audits of NICE Guidance completed	100%	**100%**	100%	100%	97%	89.47%
6	Average length of stay for patients in Adult Mental Health and Mental Health Services for Older People Assessment & Treatment Wards	AMH <30.2	**30.03**	26.81	26.67	31.72	35
		MHSOP <52	**79.38**	62.67	62.18	54.08	
Patient Experience Measures							
7	Delayed Transfers of Care	<7.50%	**4.91%**	1.69%	2.11%	1.89%	2.07%
8	Percentage of complaints satisfactorily resolved	> 90.00%	**73.56%**	79.00%	75.38%	65.77%	76.36%
National Patient Survey							
9	Number of questions where our mean score was within 5% of the highest mean scored Mental Health Trusts	Improvement on previous year	4	16**	10**		
	Number of questions where our mean score was within the middle 90% of mean scored Mental Health Trusts		32	17**	23**		
	Number of questions where our mean score was within 5% of the lowest mean scored Mental Health Trusts		0	0**	0**		

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

** Not directly comparable with 2016/17 figures

Notes on selected metrics

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

Comments on Areas of Under-Performance

Metric 3: Patient falls per 1,000 admissions.

The number of falls reported in 2016/17 is **65.58** per 1,000 admissions as at February 2017, which is significantly above the target of <28.79.

This relates to 371 falls this financial year to date: 81 (21.83%) in Durham and Darlington, 77 (20.75%) in Teesside, 54 (14.56%) Forensics, 98 (26.42%) North Yorkshire, 62 (16.71%) York and Selby.

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

Locality	No. of Falls in 2016/17	No. of Falls per 1000 admissions
Durham and Darlington	81	43.13
Forensics	54	1102.04*
North Yorkshire	98	161.98
Teesside	76	25.69
York and Selby	62	371.26
Grand Total	**371**	**65.58**

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

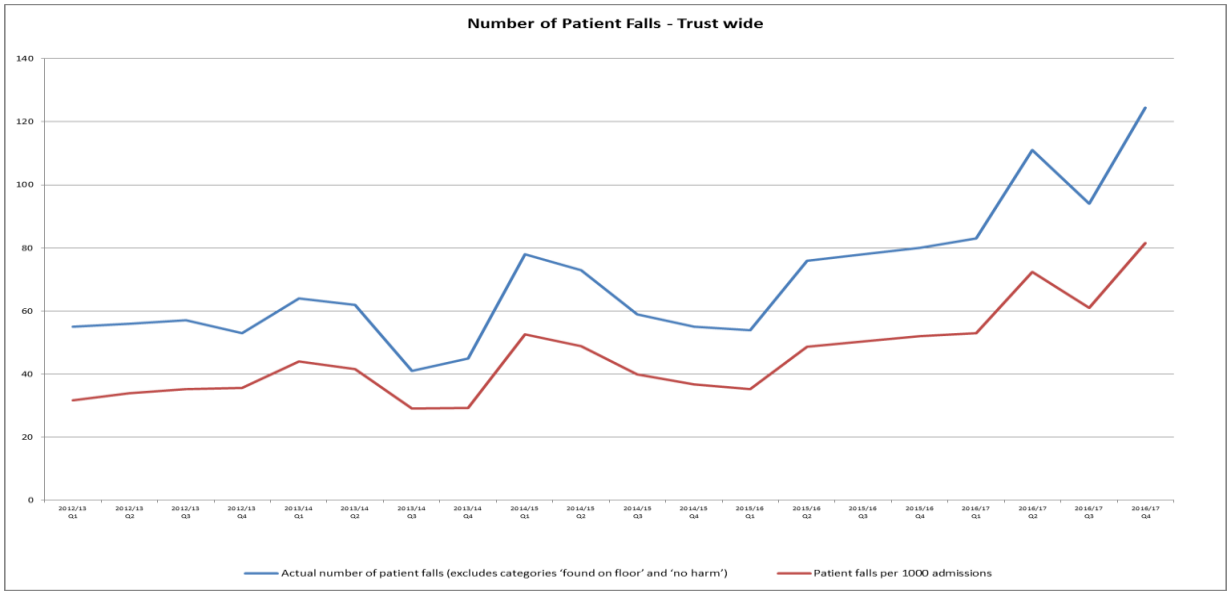
As shown in the table below the majority of falls in 2016/17 were recorded within MHSOP speciality:

Speciality	No. of Falls in 2016/17	No. of Falls per 1000 admissions
MHSOP	239	67.20
Forensics	54	1102.04*
Adults	50	18.47
Learning Disabilities	20	62.81
CYP	8	37.56
Grand Total	**371**	**8.84**

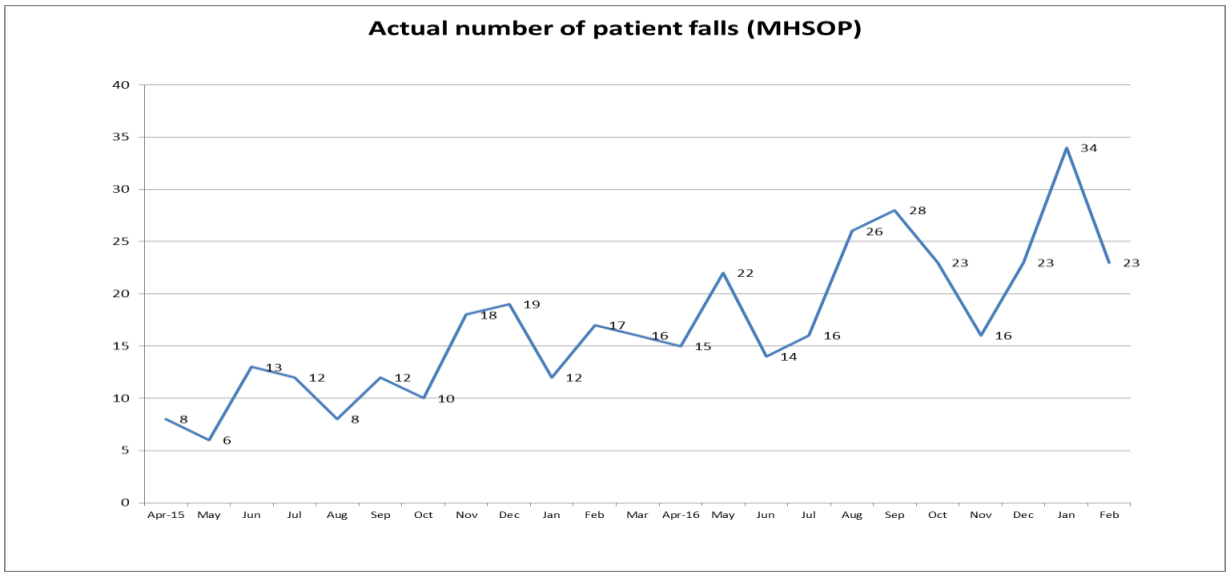
*note the low throughput of patients within forensic services skews this figure to an artificially high level.

Of the falls reported, 293 (78.76%) were classified low with minimal harm, 70 (18.82%) were reported as moderate short term harm, 7 (1.88%) were reported as severe, 1 (0.54%) was related to a patient's death due to physical health. This related to one patient who subsequently died after suffering a fracture due to a fall.

The graph below shows that the downwards trend at the end of 2013/14 has been replaced by an upwards trend from 2014/15, 2015/16 and 2016/17. During 2016/17 a significant increase is seen in quarters 2 and 3.



Of the 371 falls, 240 (64.69%) were reported within Mental Health Services for Older People. This is an increase on the 52.43% reported at the same point during 2015/16.



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

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

Key themes / issues under consideration include:

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

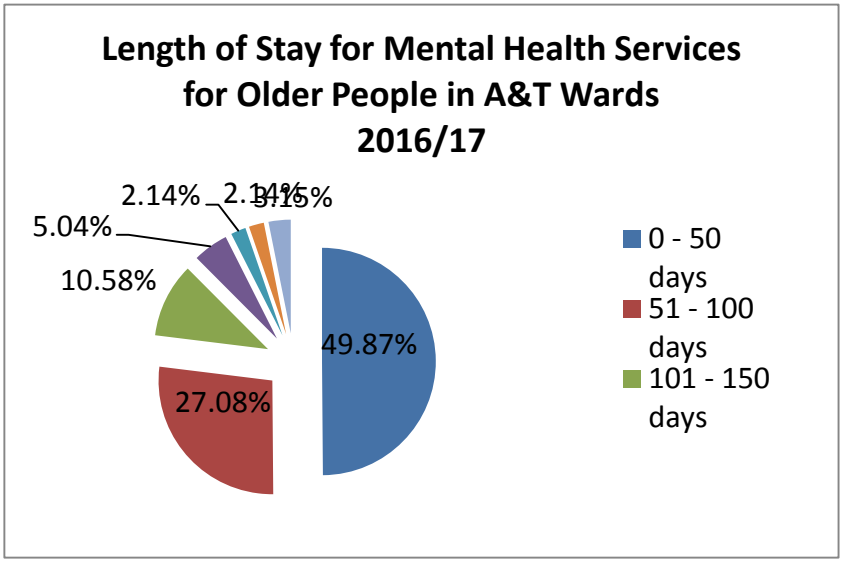
Speciality leads continue to co-ordinate and drive improvements as follows:

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

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

The average length of stay for older people has been worse than target since Q3 2013/14 reporting 79.38 days as at February 2016/17, which is 27.38 worse than target and a deterioration compared to the position reported in 2015/16. The pie chart below shows the breakdown for the various lengths of stay during 2016/17.

The median length of stay was **51** days, which is better than the target of 52 days and demonstrates that the small number of patients that had very long lengths of stay have a significant impact on the mean figures reported.



The length of stay of patients is closely monitored by all services within the Trust. The reasons for the increase in the average length of stay for patients are due to a small number of patients who were discharged after a very long length of stay, which has skewed the overall average. In total 49.87% of lengths of stay were between 0-50 days, with 27.08% between 51 – 100 days. There were 62 patients who had a length of stay greater than 200 days; the majority were attributable to the complex needs of the patients (such as co-morbidity with physical health problems).

Metric 8: Percentage of complaints satisfactorily resolved.

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

The percentage of complaints satisfactorily resolved as at February 2016/17 was 73.56%, which is below the target of 98% and a deterioration on both 2015/16 and 2014/15. This relates to **128** complaints being satisfactorily resolved. Complaints are monitored by the Quality Assurance Committee and each is thoroughly investigated.

There were **46** people who were not satisfied with our response to their complaint since April 2016 to February 2017. The subject of complaints or those that expressed dissatisfaction are varied but predominately are about clinical care, which covers a number of different subjects including ineffective treatment and care, medication and discharge/Transfer/continuity of care. Trust wide there were no specific trends or patterns identified in the reasons given for dissatisfaction.

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

Complaints Resolution 2016/17

	FYTD		
	Number of complaints resolution letters sent	**Number of dissatisfied responses received**	**Percentage satisfactorily resolved**
Durham & Darlington	**61**	**17**	**72%**
Adult Mental Health	48	15	69%
Mental Health Services for Older People	3	0	100%
Children & Young People's Services	9	2	78%
Learning Disabilities	1	0	100%
Tees	**40**	**13**	**67%**
Adult Mental Health	29	9	69%
Mental Health Services for Older People	1	1	100%
Children & Young People's Services	9	3	67%
Learning Disabilities	1	0	100%
North Yorkshire	**38**	**6**	**84%**
Adult Mental Health	28	5	82%
Mental Health Services for Older People	5	1	80%
Children & Young People's Services	4	0	100%
Learning Disabilities	1	0	100%
York and Selby	**25**	**7**	**72%**
Adult Mental Health	15	7	53%
Mental Health Services for Older People	8	0	100%
Children & Young People Services	2	0	100%
Learning Disabilities	0	0	N/A
Forensics	**9**	**3**	**67%**
Forensic Learning Disabilities	5	2	60%
Forensic Mental Health	3	1	67%
Forensic Offender Health	1	0	100%
Corporate	**1**	**0**	**100%**
TOTAL	**174**	**46**	**74%**

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

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

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

Risk Assessment Framework and Single Oversight Framework

Indicators		2016/17		2015/16	2014/15	2013/14
		Threshold	Actual*	Actual	Actual (exc Y&S)	Actual (exc Y&S)
a	CPA patients having formal review within 12 months	95%	**97.90%**	**98.76%**	97.75%	96.56%
b	Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams	95%	**96.89%**	**96.74%**	98.42%	98.58%
c	Meeting commitment to serve new psychosis cases by early intervention teams	95%	**481.33%****	**265%**	254%	239%
d	Percentage of people experiencing a first episode of psychosis that were treated with a NICE approved care package within two weeks of referral	50%	**71.23%**	**55.91%**		
e	Percentage of people referred to the IAPT programme that were treated within 6 weeks of referral	75%	**94.62%**	**84.01%**		
f	Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral	95%	**98.97%**	**95.93%**		

*As of the end of February 2017.
**Additional narrative to be included within final version.

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

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

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

There is an additional indicator contained within appendix A of the Risk Assessment Framework and the Single Oversight Framework that is relevant however this has been reported in the Quality Metrics table on **page 60**.

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

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

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

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

External Audit

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

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

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

Local Improvement Plans

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

Duty of Candour

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

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

Sign Up To Safety

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

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

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

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

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

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

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

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

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

NHS Staff Survey Results

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

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

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

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

Our stakeholders' views

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

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

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

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

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

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

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

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

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

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

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

[To be inserted following feedback from stakeholders]

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

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

APPENDICES

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

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

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

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

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

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

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

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

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

- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;

- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review;

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

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

By order of the Board.

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

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

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

APPENDIX 3: GLOSSARY

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

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

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.

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.

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

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

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

Children and Young People Service (CYPS): Services for people under 18 years old. These include community mental health services and inpatient services. In Durham, Darlington 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.

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 patient / carer.

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

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

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

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

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

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

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

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

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

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

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

Duty of Candour: From 27 November 2014 all NHS bodies are legally required to meet the Duty of Candour. This requires healthcare providers to be open and

transparent with those who use their services in relation to their care and treatment, and specifically when things go wrong.

Early Intervention in Psychosis (EIP): Early intervention in psychosis is a clinical approach to those experiencing symptoms of psychosis for the first time. It forms part of a new prevention paradigm for psychiatry and is leading to reform of mental health services especially in the United Kingdom. This approach centres on the early detection and treatment of early symptoms of psychosis during the formative years of the psychotic condition. The first three to five years are believed by some to be a critical period. The aim is to reduce the usual delays to treatment for those in their first episode of psychosis. The provision of optimal treatments in these early years is thought to prevent relapses and reduce the long-term impact of the condition.

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.

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

Forensic Services: Forensic Adult Mental Health and learning disability services work mainly with people who are mentally unwell or who have a learning disability and have been through the criminal justice system. The majority of people are transferred to 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. It is now called NHS Digital.

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 patients with severe mental illness are rated by clinical staff. The idea is that these ratings are stored, and then repeated- say after a course of treatment or some other intervention- and then compared. If the ratings show a difference, then that might mean that the patient's health or social status has changed. They are therefore designed for repeated use, as their name implies, as clinical outcomes measures.

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

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.

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

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

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

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 four Localities (ie County Durham & Darlington, Tees, North Yorkshire and York & Selby). Our Forensic services are not organised as a geographical basis, but are often referred to a fifth "Locality" within TEWV.

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

Mental 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.

NHS Improvement: 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).

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. Forensic Secure Adult, 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 Patient Survey: the annual survey of patients' experience of care and treatment received by NHS Trusts. In different years has focused both on inpatient and community patients.

NHS Staff Survey: an annual survey of staffs' experience of working within NHS Trusts.

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 focused on Health, although Darlington, Middlesbrough, Stockton, Hartlepool and Redcar & Cleveland Councils have a joint Tees Valley Health OSC that performs this function.

Paid Experts by Experience: Paid lived experience roles which offer input into strategic / service developments. These roles are focused on working with staff rather than patients and carers. Examples include Expert co-ordinator, expert trainer posts.

Paid Peer Workers: are paid members of staff who work within clinical / other support services within the Trust to offer peer support to other patients and carers within their process of care.

Paris: the Trust's electronic care record, product name Paris, designed with mental health professionals to ensure that the right information is available to those who need it at all times.

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 patients are realised.

Peer Trainer: someone who is trained and recruited as a paid employee within the Trust in a specifically designed job to actively use their lived experience and to deliver training courses to other patients and carers. They work within the Recovery College.

Peer Volunteer: someone who gives their time freely to the Trust in a specifically defined unpaid role to actively use their lived experience (as a patient or carer) to support other carers and patients. They work alongside and support paid staff as well as providing support to specific groups / tasks.

Peer Worker: someone who is trained and recruited as a paid employee within the Trust in a specifically designed job, to actively use their lived experience (as a patient or carer) to support other patients, in line with the Recovery Approach.

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.

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 (NHS Improvement): NHS Improvement's approach to making sure NHS foundation Trusts are well run and can continue to provide good quality services for patients.

Quality Strategy: This is a TEWV strategy. It sets a clear direction and outlines what the Trust expects from its staff to work towards our vision of providing excellent quality care. It helps TEWV continue to improve the quality and value of our work, whilst making sure that it remains clinically and financially sustainable.

Quality Strategy Scorecard: A set of numerical indicators related to all aspects of Quality, reported to Trust Board four times per year, that helps the Board ascertain whether the actions being taken to support the Quality Strategy are having the expected positive impact.

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 patients, carers and staff enrol as students to attend courses based on recovery principles. Our recovery college, called *ARCH,* opened in September 2014 in Durham. This exciting resource is available to TEWV patients, carers and staff in the Durham area. Courses aim to equip students with the skills and knowledge they need to manage their recovery, have hope and gain more control over their lives. All courses are developed and delivered in co-production with people who have lived experience of mental health issues.

Recovery Strategy: TEWV's long term plan for moving services towards the *recovery approach* (see above).

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 low and medium Forensic Secure Adult 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 Incidents (SIs): defined as an incident that occurred in relation to NHS-funded services and care, to ether patient, staff or member of the public, resulting in one of the following: unexpected / avoidable death, serious / prolonged / permanent harm, abuse, threat to the continuation of the delivery of services, absconding from secure care.

Patient 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.

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 4 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.

Recovery College Online: This is an initiative that would allow people to access recovery college materials and peer-support on-line.

Visual Control Boards: a technique for improving quality within the overall TEWV Quality Improvement System (QIS).

Warwick-Edinburgh Mental Well-Being Scale (WEMWBS): The Warwick-Edinburgh Mental Well-being Scale (WEMWBS) is a scale of 14 positively worded items, with five response categories, for assessing mental wellbeing. There is also a "short" version of this scale – where this is used it is called *SWEMWBS.*

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 95 LOCAL CLINICAL AUDITS REVIEWED IN 2016/17

Audit Theme	Key quality improvement activities associated with clinical audit outcomes
1. NICE/ Pathway Development	• A briefing sheet on the CYPS Depression Pathway was distributed to teams and plans were developed for roll-out in North Yorkshire, Tees and Durham and Darlington Localities. • To support compliance with NICE CG185 (Bipolar disorder), information resources on the use of valproate in bipolar disorder have been made available to all clinicians and links to information resources have been included in the Trust Bipolar Disorder Pathway. Monitoring requirements for patients prescribed valproate have been added to new Trust guidance. • To support compliance with NICE CG115 (Alcohol-use disorders), the Trust inpatient alcohol detoxification pathway/guidelines will be updated to include blood test that should be performed for patients undergoing detox. • The LD Core Pathway will be updated to include sleep resources and a Sleep CLIP will be developed.
2. Physical Healthcare	• VTE risk assessment guidance and eLearning have been promoted staff by Modern Matrons and via Medical Education. • In Forensic services, the admission checklist has been updated to include completion of the Falls CLIP within 72 hours of admission. • The Care Plan template for pregnant service users has been updated to include provision of health promotion information on blood borne viruses. • Results of the National CQuIN Safety Thermometer are reported to the Clinical Effectiveness Group quarterly.
3. Medicines Management	• Rapid tranquilisation (RT) audit results have been incorporated into a review of Medicines Management training and update of the Trust RT policy/procedure. RT eLearning has been developed. • To support good antimicrobial stewardship, a new Trust Antimicrobial Prescribing Policy has been developed and pharmacy training slides for Junior Doctors and Pharmacists have been updated. • A briefing on Lithium monitoring has been updated and shared with Trust staff and colleagues in Primary Care to emphasise the importance of recording the interval between last lithium dose and serum lithium tests. • The Trust medicines fridge monitoring form has been updated and all old paperwork replaced; a fridge monitoring bulletin was produced and distributed to clinical areas.
4. Risk Assessment/ Violence and Aggression/ Suicide Prevention	• Suicide prevention audit results will be incorporated into the relevant Harm Minimisation Training package and monthly Suicide Prevention update training. • In CYPS, training on collaborative recovery-focused care planning was delivered for relevant teams and the importance of timely risk assessment was promoted. • In CYPS, the Trust self-harm information leaflet for patients and carers was reviewed and made available. • Bespoke MAPPA training has been made available via InTouch; PARIS has been updated to facilitate MAPPA record keeping. • Following a strategic review of the way safeguarding activity and supervision is documented on PARIS, a new Safeguarding Care Document has been made available on PARIS.
5. Infection Prevention and Control (IPC)	• All Infection Prevention and Control Audits are continuously monitored by the IPC team and any required actions are rectified collaboratively with the IPC team and ward staff. Assurance of implementation of actions is monitored by the Clinical Audit and Effectiveness team via the clinical audit database. • A total of **87** IPC clinical audits were conducted during 2016/17 in inpatient areas in the Trust. **99% (86/87)** of clinical areas achieved standards between 80-100% compliance. • Clinical audits have been undertaken to assess compliance with Hand Hygiene standards and a monthly Essential Steps audit is completed in inpatient areas.

Audit Theme	Key quality improvement activities associated with clinical audit outcomes
6. Supervision	• Clinical audit findings have informed the development of the training packages to support the implementation of the new Trust Supervision Policy. • There is an ongoing specialist contract requirement which involves undertaking an audit for specialist services to establish the duration of clinical supervision which staff have achieved, with a target of a minimum of 2 hours per quarter. • The Trust Preceptorship Policy has been updated, a preceptor preparation session has been designed and delivered and standard scripts introduced to ensure meetings cover required content.
7. Records management	• Clinical audit activities have assessed clinical record keeping and informed changes within the electronic patient record (Paris) for the Trust. Examples of aspects which have been assessed against record keeping standards include the physical examination and harm minimisation documents. • The Trust approved abbreviation list has been reviewed and updated. • The Safeguarding Care Document on PARIS has been reviewed and updated to reduce the administrative burden on staff.
8. Environment and Equipment	• Summary guidance has been issued on the use and maintenance of posture safety belts for MHSOP wards. • Emergency bags have been checked to make sure all relevant equipment is available; work is underway to create an up to date asset register for emergency bags. • MHSOP wards have introduced weekly falls meetings.
9. Serious Incidents and Complaints	• The Clinical Audit and Effectiveness Team continued to validate SI action plans and findings have been fed back to the Patient Safety Group. • The Clinical Audit and Effectiveness Team continued to validate complaint action plans and findings have been fed back to the Patient Experience Group.
10. Transition, Transfer, Discharge and Leave	• In CAMHS a transitions flowchart has been developed and shared with teams along with a template to assist with correct completion of the Transition Care Document on Paris. The Transitions Protocol has been promoted and will be reviewed to include provision for young people who are new to CAMHS after 17.5 years of age. “My Passport” (a template to improve recording of information about patients’ transition/discharge plans) will be added to Paris. • To improve adherence to Trust Protocol for Section 17 leave, a standard flowchart has been developed for display on wards, a Leave Risk Assessment Tool has been developed for completion by the MDT following any changes to leave status. • The Trust Harm Minimisation Policy and supporting Observation and Engagement Procedure have been implemented. Standard work, detailing the process to be followed before facilitating leave, has been developed and implemented; this includes risk assessment and documentation of expectations, documentation on Paris and a Patient Leave Form.

APPENDIX 5: TRUST BUSINESS PLAN ADDITIONAL QUALITY PRIORITIES

The 5 quality priorities within this Quality Account, also sit within TEWV's 2017/18-2019/20 Business Plan. The Business Plan includes a further 10 priorities all of which will have a positive impact on the quality of Trust services. These are shown below.

No	Priority	To conclude by
1	Implement Phase 2 of the Recovery Strategy	2019/20 Q4
2	Develop and deliver the Purposeful and Productive Community Services Programme (PPCS)	2018/19 Q4
3	Improve the consistency and purposefulness of inpatient care across the Trust by implementing and building on the Model Wards work and implementation of the refreshed PIPA process	2019/20 Q4
4	Ensure we have Safe Staffing in all our services (this will address a wide number of factors including recruitment and retention, skill mix and optimisation).	2018/19 Q4
5	Ensure we address the issues with PARIS and clinical recording and maximise the benefits of existing Information Technology	2019/20 Q4
6	Refresh, communicate and implement 'The TEWV Way' across the whole organisation	2019/20 Q4
7	Implement the 5 Year Forward View for Mental Health as agreed with each of our commissioners	2018/19 Q4
8	Evaluate and agree future collaboration with universities on research, education and training	To be confirmed
9	Implement the Transforming Care agenda in Learning Disability Services	2018/19 Q2
10	Improve the clinical effectiveness and patient experience at times of transition	2017/18 Q4
11	Develop a Trustwide approach to delivering services to patients with Autism	2017/18 Q4
12	Deliver improvement to the inpatient estate in Harrogate and York	2019/20 Q2
13	Deliver a new model of care for Adult Mental Health and Mental Health Services for Older People in Hambleton and Richmondshire	2018/19 Q4
14	Reduce the number of preventable deaths	2017/18 Q4
15	Reduce occurrences of serious harm resulting from inpatient falls	2017/18 Q4

In addition to these, many of the operational plans and the enabling priorities set out within our Business Plan underpin our quality improvement agenda.

APPENDIX 6: QUALITY PERFORMANCE INDICATOR DEFINITIONS

100% of enhanced CPA patients receiving follow-contact within seven days of discharge from hospital

Data definition:

All patients discharged to their place of residence, care home, residential accommodation, or to non-psychiatric care must be followed up within 7 days of discharge. All avenues need to be exploited to ensure patients are followed up within 7 days of discharge*. Where a patient has been discharged to prison, contact should be made via the prison in-reach team.

Exemptions:

- Patients who die within 7 days of discharge may be excluded.
- Where legal precedence has forced the removal of the patient from the country.
- Patients transferred to NHS psychiatric inpatient ward.
- CYPS are not included.

The 7 day period should be measured in days not hours and should start on the day after discharge.

Accountability:

Achieving at least 95% rate of patients followed up after discharge each quarter.

* *Follow up may be face-to-face or telephone contact, this excludes text or phone messages*

Proportion of admissions to inpatient services which had access to crisis resolution home treatment teams

Data definition:

Gate-keeping: in order to prevent hospital admission and give support to informal carers, crisis resolution home treatment teams are required to gate-keep all admission to psychiatric inpatient wards and facilitate early discharge of patients. An admission has been gate-kept by a crisis resolution team if they have assessed** the patient before admission and if the crisis resolution team was involved in the decision making-process, which resulted in an admission.

Total exemption from crisis resolution home treatment teams gate-keeping:

- Patients recalled on a Community Treatment Order.
- Patients transferred from another NHS hospital for psychiatric treatment.
- Internal transfers of patients between wards in the Trust for psychiatry treatment.
- Patients on leave under Section 17 of the Mental Health Act.
- Planned admission for psychiatric care from specialist units such as eating disorder unit.

Partial exemption:

Admissions from out of the Trust area where the patient was seen by the local crisis team (out of area) and only admitted to this Trust because they had no available beds in the local areas. Crisis resolution home treatment teams should assure themselves that gate-keeping was carried out. This can be recorded as gate-kept by crisis resolution home treatment teams.

** This indicator applies to patients in the age bracket 16-65 years and only applies to CYPS patients where they have been admitted to an adult ward.*
*** An assessment should be recorded if there is direct contact between a member of the team and the referred patient, irrespective of the setting, and an assessment made. The assessment should be face-to-face and only by telephone where face-to-face is not appropriate or possible.*

Percentage of clinical audits of NICE Guidance completed

Data definition:

The percentage of clinical audits of NICE Guidance completed is based on the number of audits of NICE guidelines completed against the number of audits of NICE guidelines planned. Data for this metric is taken from audits undertaken by the Clinical Directorates supported by the Clinical Audit Team.

Numerator:

Number of NICE Guidance audits completed within the month.

Denominator:

Number of NICE Guidance audits scheduled for completion within the month.

APPENDIX 7: FEEDBACK FROM OUR STAKEHOLDERS