NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Our Quality Account 2017/18

making a difference together

Table of Contents

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

I am pleased to be able to present Tees, Esk and Wear Valleys NHS Foundation Trust's (TEWV) Quality Account for 2017/18. This is the 10th Quality Account we have produced and it details what we have done to improve the quality of our services in 2017/18 and how we intend to make further improvements in 2018/19.

TEWV primarily serves the populations of:

- County Durham;
- Darlington;
- North Yorkshire (not including Craven district, but including Wetherby);
- Teesside (the boroughs of Hartlepool, Middlesbrough, Redcar & Cleveland and Stockton);
- The Vale of York (which includes York, Easingwold, Pocklington, Tadcaster and Selby).

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:

- 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 three 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 2017 Community Mental Health Survey results show:

- The response rate of 29% was above the national response rate of 26%.
- When comparing TEWV survey results with those of the other organisations the scores were identified as being 'about the same' as other organisations across all 10 sections.
- Whilst there were no questions identified as scoring 'better' than other Trusts, TEWV scored well in three questions.
- TEWV scored 'about the same' as most other Trusts in all but one of the individual questions, which scored 'worse' (question 31: *Were these treatments or therapies explained to you in a way you could understand?)*.
- The overall rating on care experience was 70.9% in 2017 which has declined from the 2016 score of 74.3%. To improve this position, the Trust will examine the data to identify questions which scored low and concentrate improvement activity on these areas.

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 (QuAC) and Board. In addition, we have identified a number of supporting actions, established and new, which will each be monitored.

What we have achieved in 2017/18

- We have continued to work to deliver new services to meet the needs of those who use our services. For example we have:
  - Established a 24/7 Adult Learning Disability crisis access service across the Vale of York and North Yorkshire.
  - Set up an Adult Learning Disability Enhanced Crisis Preventative Community Service in Durham, Darlington and Teesside.

- Improved the number of people with Learning Disabilities seen in collaboration with Adult Mental Health (AMH) services under Greenlight arrangements in York and Selby, both inpatient and outpatient. We also now have champions for Positive Behavioural Support in our York Adult Learning Disability teams.
- Co-produced a vision for the future of services for people with autism and developed a training programme for staff.
- Introduced a new care planning process and format for Children and Young People's services, which are now written during an appointment with the service user, and written in the first person.
- Been granted planning permission for a new mental health hospital serving adult and older people at Haxby Road in York.
- Received Clinical Commissioning Group (CCG) agreement on a preferred model for the future mental health services for people living in Hambleton and Richmondshire. This will lead to investment into community services that will help to reduce admissions. It also means that there will no longer be mental health beds at The Friarage Hospital. Residents of this area who require inpatient treatment will be admitted to West Park, Roseberry Park or Auckland Park hospitals. These wards provide purpose built modern accommodation that supports the delivery of high quality care.
- Further increased the number of paid and voluntary experts by experience at the Trust. This is having a positive impact on staff culture and practice. Increasingly policies are being co-produced and recovery-friendly language is in use.
- Started work to establish the key features of a recovery oriented community team, enabling a TEWV recovery accreditation scheme to be developed.
- Expanded the range of courses at our Durham Recovery College.
- Launched an online Recovery College, accessible by service users as well as staff across the whole TEWV area.
- Achieved Investors in People (IiP) Gold Accreditation using the revised and more challenging IiP standard, and the Care Quality Commission (CQC) rated the Trust's leadership as "Good" in their most recent Well Led Review.

In the 2017 national NHS Staff Survey, the Trust had a response rate of 52% (3354 of 6402 eligible staff), the average response rate for Mental Health and Learning Disability Trusts.

The Trust scored the same or better than average on 30 of the 32 areas covered by the staff survey, two of which were the best score for Mental Health.

- We have also worked to improve our quality through staff training and, communication. For example we have:
  - Commenced the delivery of Trauma Informed Care (TiC) training.
  - Introduced training for all new inpatient staff in relation to patient leave and time away from the ward.

- 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 2017/18 are that we have:

- Redesiged many of our clinical pathways and clinical link pathways (CLiPs).
- Spread the existing Purposeful Inpatient Admissions (PIPA) approach from our Adult wards to our Older People's wards. This reduces delays in assessment, treatment and discharge, encourages multi-disciplinary team working and reduces inconsistenices in approach between different localities within TEWV.
- Improved and standardised practice across our two adult Psyciatric Intensive Care Units (PICUs) leading to a more recovery oriented approach and better arrangments for transfer back to assessment and treatment wards.
- Agreed Crisis Team triage and assessment standards, and criteria for admission and home based treatment interventions by these teams.
- Agreed Visual Control Boards (VCB) for the home-based treatment component of care (including extended assessment where indicated).
- Brought about improvements in the psychological input to the treatment of older people in our services (by improving the processes for referral to psychology). This is reducing waiting times from initial referral to first contact, improving the standard process for formulation, and ensuring more equity in length of time in therapy.
- Observed the daily practice of community mental health teams in all specialities and piloted new ways of entering patient information into our electronic patient record (Paris). This has increased the proportion of time that clinicians can spend with service users.
- Following a patient safety incident, utilising QIS principles, our Durham and Darlington Learning Disabilities service has implemented a new system to make sure that physical health and other checks for people taking lithium is taking place. It also ensures that there are timely reviews of care and intervention.
- Our Children and Young People's Services (CYPS) reviewed their existing care pathways to make them more Learning Disability compatible. This included ensuring any information gathering in the early stages would feed into a decision on whether a Leaning Disability assessment was needed and also contribute to that assessment. These new arrangements were piloted in Durham and Redcar.

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

- 81% are likely or highly likely to recommend treatment at TEWV.
- 70% would recommend TEWV as a place to work.
- 83% agree that they are able to make suggestions for improvement.

- In addition we have worked with our partners to improve services. For example we have:
  - Established a Service Level Agreement (SLA) with a local acute Trust to provide tissue viability advice, support and training for staff (for any pressure ulcer of grade 2 or above).
  - Supported the development of the voluntary and community sector's (VCS) adult learning disability workforce. We have done this by training TEWV staff in an Active Support 'train the trainer' Programme and mentoring other

providers' staff through Positive Behavioural Support BTEC (Business and Technology Council) courses.

- Developed good informal research relationships with the higher education sector in York and with potential new providers of medical and nursing / Allied Health Professional (AHP) training.
- Continued to organise the TEWV Learning Disability Quality conference. This has now been running for 11 years and each year it has become more successful and popular with over 200 people now attending. It showcases engagement and collaborative working. Service users are at the heart of the conference and are involved in the development, production and delivery of the conference.
- Worked with NHS England (NHSE), Northumberland, Tyne and Wear NHS Foundation Trust (NTW) and other providers to progress our pilots that are testing our provider-led management of NHSE commissioning budgets. We have active projects in adult secure (forensic) and CYPS specialist inpatient services. The CYPS work is most advanced and has led to investment in Crisis / Intensive Home Treatment teams across the area served by the Trust, and a reduction in admissions. We have also developed an Accountable Care Partnership (ACP) with the CCGs across Durham, Darlington and Teesside. In its first phase this has carried out reviews into over 60 Adult Learning Disability NHS funded placements and brought about many improvements in both the quality and value for money of these.

In 2017/18 the Trust was also recognised externally in a number of national awards where we won or were shortlisted. Awards won / highly commended by TEWV teams or staff members are shown in the table below:

Awarding Body	Award status	Name / Category of Award	Team / individual
British Medical Journal (BMJ) Awards 2017	Highly commended	Education category	Delirium team / Dr Mani Santhanakrishnan
Division of Forensic Psychology	Winner	2017 Senior Award for Distinguished Contributions to Professional Practice in Forensic Psychology	Ruby Bell
Yorkshire Personal Assistant (PA) awards	Runner-up	Best team	Community Learning Disabilities team - secretaries, York
Faculty for the psychology of older people in the British Psychological Society	Awarded	Mid-career - Bill Downes award	Sarah Dexter-Smith
Royal College of Psychiatrists' Centre for Quality Improvement	Awarded	Enabling Environment award	The PIPE (Psychologically Informed Planned Environment) team at HMP/YOI Low Newton
Royal College of Psychiatrists	Awarded	AIMS (Accreditation for Mental Health Inpatient Services)	Esk and Danby wards at Cross Lane Hospital, Scarborough
	Awarded	CCQI (College Centre for Quality Improvement) Quality Network for Inpatient CAMHS Accreditation	Westwood Centre

Awarding Body	Award status	Name / Category of Award	Team / individual
Royal College of Psychiatrists	Winner	Psychiatric Communicator of the Year	Dr Mani Santhanakrishnan
	Winner	Psychiatric Team of the Year: Non age-specific	Women's Forensic Learning Disabilities Secure Service
	Winner	Foundation Doctor Category	Dr Megan Brown
Positive practice in mental health awards 2017	Highly commended	Specialist Services category	Rollercoaster (parent support group)
	Highly commended	Co-production of care	Rollercoaster (parent support group)
	Highly commended	Innovation in Children and Young People's MH	Rollercoaster (parent support group)
	Winner	Psychological Therapies for People with 'Common Mental Health Problems'	Mindfulness team
	Highly commended	Mental wellbeing of staff	The TEWV Employee Support Service
	Highly commended	Integration of physical and mental healthcare	Harrogate Vanguard team
Australian College of Mental Health Nurses	Awarded	Research award 2017	David Ekers
The Investing in Children (IiC) Membership Award Scheme	Awarded	IiC Accreditation - Investing in Children Membership Award	CAMHS Hartlepool
Positive practice in mental health awards 2017	Winner	Carer / Parent / Sibling award	Rollercoaster (parent support group)

Awards where TEWV or one of its teams / staff were shortlisted for an award but did not win that award in 2017/18 were:

Awarding Body	Name / Category of Award	Team / individual
Student nursing times awards 2017	Mentor of the year	Claire Baird
	Student nurse of the year: learning disabilities	Catherine Thompson
BMJ awards 2017	Prevention team	Suicide prevention training
Royal College of Nursing (RCN) Nursing awards 2017	Mental health practice award	Perinatal mental health pathway team at HMP/YOI Low Newton
Health Service Journal (HSJ) Value in Healthcare Awards	Improving the value of NHS support services	Workforce development team
Patient Safety Awards 2017	Mental health	Mental Health Services for Older People, suicide prevention training team

Awarding Body	Name / Category of Award	Team / individual
Nursing Times awards	Nursing in Mental Health	Developing a perinatal mental health pathway within a female prison - a collaborative, cross-agency approach
Royal College of Psychiatrists	Specialty Doctor / Associate Specialist of the Year	Dr Ajith Suryadevara
	Psychiatric Team of the Year: Working-age adults	Teesside Crisis Service / Crisis Assessment Suite
		Teesside Rehabilitation Services
	Psychiatric Team of the Year: Older-age adults	Mental Health Services for Older People, Durham and Darlington
	Psychiatric Team of the Year: Quality Improvement	Adult Learning Disability Unit, Durham
		Durham and Darlington Child and Adolescent Mental Health Services Senior Management Team
	Carer Contributor of the Year	Sheena Foster
		Hazel Griffiths (Governor for the Trust)
NHS innovations North Bright ideas in Health	Research Delivery Impact	An innovative method of delivering RESEARCH AWARENESS to TEWV service users, carers and staff
Health Heroes Awards 17	Clinical Support Worker of the Year	Cheryl Young
Dementia Friendly Awards 2017	Dementia Friendly Community of the Year	Dementia Friendly Hartlepool
Health Business Awards	NHS Collaboration Award	Tees, Esk and Wear Valleys NHS Foundation Trust / Durham Constabulary - Street Triage
Patient Experience Network National Awards (PENNA)	Measuring, Reporting and Acting	Tees, Esk and Wear Valley NHS Foundation Trust - Making best use of technology to collect, report and use feedback to improve services

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 2017/18, the required statements of assurance from the Board and our priorities for improvement in 2018/19.
- **Part 3** – Further information on how we have performed in 2017/18 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 2017/18 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 or have any suggestions on how we could improve our Quality Account please contact:

- 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

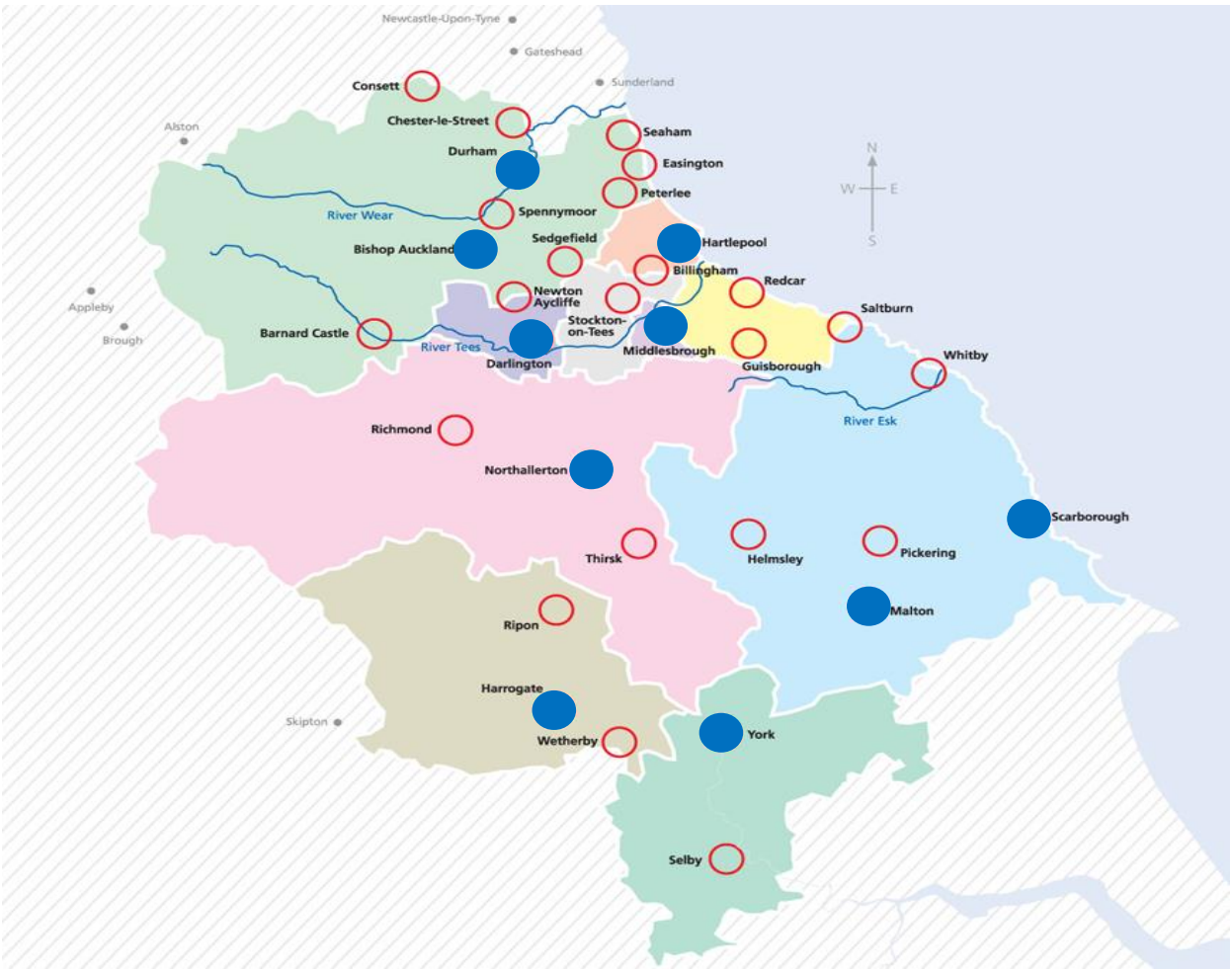
A Profile of the Trust

The Trust provides a range of mental health, learning disability and autism services for around two million people living in County Durham, Darlington, Teesside, North Yorkshire (other than Craven district) and the Vale of York. This area covers 4,000 square miles (10,000 square kilometres). A map showing this area is provided on the following page. The Trust also provides some regional specialist services (e.g. forensic services, children and young people tier 4 services and specialist eating disorder services) to the North East and Cumbria region and beyond. The Trust is also commissioned as part of a national initiative to provide inpatient care to Ministry of Defence personnel, and provides mental health treatment to prisoners in North East England and parts of the North West.

Services commissioned by 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 2017/18 was **£342m**.
- On 31st March 2018 there had been **153,271** people who had received care from TEWV during 2017/18.
- During 2017/18 on average we had **2,348** patients occupying an inpatient bed each day (this equates an average occupancy rate of **86%**[1]).
- Our community staff made more than **2.19 million** contacts with patients during 2017/18.
- We have **6,711** employees. Some of these employees work part-time hours, therefore the whole time equivalent workforce of the Trust is **5,951**.

[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	●

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

Update on 2016/17 quality priorities

In last year's Quality Account we reported on our progress with our quality priorities for 2016/17. Within this we also noted some further actions for 2017/18. In some cases, these actions were to be included within the quality priorities for 2017/18, 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 2017/18.

Implement and embed the revised harm minimisation and risk management approach	The Harm Minimisation Project was formally closed down at the end of March 2017. In April 2017 the mandatory Clinical Risk Assessment and Management e-learning was replaced with the new Harm Minimisation e-learning package. The e-learning was co-developed with experts by experience and allows the learner to provide reflective accounts of the harm minimisation and recovery agenda. These reflections are printed off and can be used for supervision / appraisal and as evidence for professional revalidation where appropriate. Given its central importance to good clinical practice, this training will be required every 2 years. Feedback on the e-learning has been mostly positive with staff commenting that doing reflections rather than questions is better and that the service user's narrative within the training is extremely powerful. It was recognised however that to enable the Trust to achieve the cultural change required to move toward recovery orientated harm minimisation which focuses on narrative development and co-production of recovery / safety plans, face to face training would need to continue for at least another year. Therefore during 2017/18 face to face training has continued to be provided by the established project training team consisting of one nurse and two part time experts by experience. The aim for 2017/18 was to deliver training (either face to face or e-learning) to 90% of all clinical staff by the end of quarter four 2017/18. To date 91% of all clinical staff have completed harm minimisation training. Of these, 79% have completed face to face training and the remainder e-learning. Of the 79% who have attended face to face training 67% have attended centrally booked training and the remaining 33% team training. Quarterly progress reports are sent to the recovery programme board and weekly updates to the Chief Operating Officer and Director of Nursing and Governance.

Further implementation of the nicotine replacement programme and smoking cessation project	Work has progressed well for the Nicotine Management Project with 2,971 staff receiving training to date and a full training programme available for staff for 2018/19. The Project Lead has presented at a number of national conferences and is part of the newly formed North East "Smoke free NHS / Treating Tobacco Dependency Taskforce" to further support the smoke free agenda in the region. As part of the work for 2017/18 the team reviewed the Nicotine Management Policy which is planned to be available for internal consultation around May / June 2018. The yearly audit looking at Trustwide smoking rates has been completed and once the final data and draft report are available future actions will be identified. The initial data highlights a reduction in smoking rates in all services Trustwide with Children and Young People Service (CYPS) and adult Learning Disabilities (LD) services having 0% smokers at the time of the audit. With regards to the Project Lead's support for the North East Prisons going smoke free, all eight North East prisons have now safely gone smoke free. Work will continue within 2018/19 to develop new training packages for delivery to prison staff and the development of a "train the trainer" model which will support the sustainability of prison smoke free services for the future.

2017/18 Priorities for improvement – how did we do

As part of our 2016/17 Quality Account following consultation with our stakeholders, the Board of Directors agreed five quality priorities to be addressed via the Quality Account during 2017/18:

Priority 1: Implement phase two 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.

Progress has been made against these five 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: Implement phase two 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 three 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 was made, both internal and external stakeholders had identified that further work was required to further embed a recovery and wellbeing approach within all our services. The Trust recognised that this remains a key priority and has been committed to large scale change, ensuring all systems and processes are reviewed from a recovery perspective and as described within our 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 we aimed to deliver for our patients and their carers were:

- That the care they receive is 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 is valued and the services they receive are both designed and delivered alongside them.
- To receive support that identifies and acknowledges the impact of previously experienced adversity and trauma, responding to this with compassion.
- To be supported to come to an understanding of their difficulties that is meaningful to them.

What we did in 2017/18:

The following is a summary of the key actions we have completed in 2017/18:

What we said we would do	What we did
• Recovery College Online available online to people living in the TEWV area by Q1 2017/18.	Recovery College Online was launched in March 2017 and made available to staff, service users, carers and the public. It has continued to be developed throughout the year and now has 85 self-management pages available to the public worldwide with six self-management courses and a tutorial course available to: 1. Individuals living in the TEWV catchment areas; 2. Trust staff. We have linked developments with other strategic priorities, for example we have an online introduction to Trauma course. There are a further nine courses in development. We have secured funding from the Academic Health Science Network to support a pilot in which we will offer Cumbria and Northumberland, Tyne and Wear NHS Trusts access to the resource. Additionally TEWV has provided funding for the next financial year to specifically support the development of CYPS resources. This is further being supported by some additional funding from commissioners in CYPS. The online college will continue to be developed and delivered as a 'business as usual' development.
• 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.	A significant piece of work has been conducted to set up a Recovery Demonstration site in adult services. Work with two teams has identified core areas which will further support the delivery of recovery and wellbeing orientated services. Core areas identified and being developed include: • The need for leaders to create socially safe environments for staff teams including supporting teams to understand team member working style preferences and strengths. • The embedding of shared decision making within practice. • The introduction of peer workers into clinical services. • Expanding levels of participation and aspiring to co-production at individual service level. • The need to enhance relational elements of care and create a framework to support validation and listening. • Embedding of a different language with language guide in development. Additional areas identified as essential is our organisations ability to review and implement a Care Programme Approach (CPA) process that supports recovery and wellbeing. The demonstration site work will be expanded into the next financial year in parallel with progressing the roll out of training of leaders and will inform the design of a recovery accreditation scheme.

• Development of a Recovery for Leaders training programme by Q4 2017/18.	Essential areas of content for the recovery for leaders programme have been identified via the demonstration site work. Some core training materials are in development. The Trust has embedded a programme approach to manage interdependencies across several strategic programmes and priorities over the last year. This has identified the need to co-ordinate all programme requirements relating to leadership teams resulting in the timeline for agreeing and developing the final recovery for leaders programme being extended into the next financial year.
• Continue to expand Involvement Peer roles by having at least 15 new roles in place by Q4 2017/18.	We have continued to set up new Involvement Peer Roles within the Trust but were unable to meet the final quarter four target due to the need for additional resource allocation to sustain this development. The Trust has funded half of a full time staff member to support this expansion in the next financial year and this post is due to go out to be recruited to in April 2018. It is anticipated that this will support future expansion.
• Develop an infrastructure for embedding a trauma informed approach by Q4 2017/18.	A large scale project to embed Trauma Informed Care (TIC) has been set up and the year one project plan is on target to be delivered. The project has delivered a large programme of training across a range of specialities which will continue into next year. One to one and group trauma informed psycho-education materials have been developed with a plan in place to pilot these interventions. A range of resources have been developed including an online course on Recovery College Online. The development of networks and consultations / supervision networks has progressed and remains an ongoing development. A research plan is in place for a number of research projects. Work has commenced and progressed on guidelines for planning in the event of a disaster and work has commenced on identifying needs of staff in relation to working with and experiencing trauma. Funding for the next financial year is in place and year two action plans are in development.

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
• To continue to expand the number of paid lived experience / peer roles within the Trust (we currently have 6 of these).	5 new	3*	Q4 2017/18
• Number of newly registered involvement peer roles (we currently have 23 of these).	15 new	10*	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	85* 6 + 1* tutorial	Q4 2017/18 Q4 2017/18

Indicator	Target	Actual	Timescale
• Increase the number of staff receiving trauma informed care training (from 100 to 300).	300	Exceeding 300*	Q4 2017/18

*Position as at the end of February 2018.

What we plan to do in 2018/19:

We will:

- Peer support - first training course recruited to and delivered by Q1 2018/19.
- First Peers recruited by Q1 2018/19.
- Commence harm minimisation training to serious incident and safeguarding teams by Q1 2018/19.
- Extend recovery to all specialties - identify and employ recovery leads and undertake baseline assessment by Q1 2018/19.
- Work with other leadership programmes in TEWV to ensure an integrated approach by Q2 2018/19.
- Deliver to a minimum of 60 additional super-cell leads (recovery for leaders training) by Q3 2018/19.
- Develop CYP materials for the Recovery College Online by Q4 2018/19.
- Develop team / service accreditation pack and gain initial approval by Q4 2018/19.
- Develop a draft recovery / TIC team / service accreditation tool by Q4 2018/19.
- Develop a research plan to improve the evidence base for TIC to allow TEWV to lead nationally / internationally by Q4 2018/19.
- Develop a culture measurement via a 3 year PhD programme of work by Q4 2018/19.

What we plan to do in 2019/20:

- Commence pilot implementation by Q1 2019/20.
- Develop and seek approval for Phase 3 of the Recovery strategy (sign off by December 2019) by Q3 2019/20.

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 and / 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. In 2017 there was a publication of specific guidance for Learning Disability and Mental Health services. Our stakeholders and Board of Directors 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[2] 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, AHPs 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.

The benefits / outcomes we aimed to deliver for our patients and their carers were:

- That 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.
- That the Trust robustly thinks through what staff with what skills will be needed when service changes are planned.
- That 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.
- More staff recruited externally to the Trust.
- To increase staff retention rates.
- That the Trust will develop new roles (such as Nursing Associates) to make sure that all our clinicians' skills are being used to the maximum extent to benefit patients.

[2] 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

What we did in 2017/18:

What we said we would do	What we did
• Establish governance structures by Q1 2017/18.	The programme board is now fully functional with regular reports / updates provided to the Trust's Strategic Change Oversight Board (SCOB) and Executive Management Team (EMT) as a result of this.
• Agree the Programme Plan which will include benefits and work-streams by Q1 2017/18.	The initial programme plan, benefits and workstreams were in place by quarter one. These have subsequently been revised due to the restructure and extended scope of the programme. An updated programme plan has been established, workstreams identified and benefits reviewed.
• Further actions and metrics will be developed for 2017/18 and 2018/19 upon set-up of programme board by Q2 2017/18.	After the increase in scope of the programme, actions were reviewed and developed further; these metrics have been identified to measure the benefits of the programme.
• Implement the agreed actions for 2017/18 by Q4 2017/18.	Actions have been agreed and are in place. Revised actions due to restructure and extended scope were developed and agreed, all of which have been achieved.
• Introduce a new report for ward managers which brings together data on staffing and other quality and safety indicators [*timescale to be confirmed as dependent upon information technology issues*].	Monthly and 6-monthly reports are in place (based on safe staffing levels). There remains a technical issue due to the supplier not being able to provide what we require. Mitigations have been put in place locally to support local gathering of information until a solution can be found. Discussions with the IT supplier continue to be explored.

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
Monitoring of escalation processes.	100%	100%	Q2 2017/18
Staffing review using the national evidence based Hurst[1] tool.	100%	100%	Q3 2017/18
Review of rostering process to ensure best use of existing resources.	100%	100%	Q3 2017/18

[1] 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

What we plan to do in 2018/19:

We will:
• Produce improved training packages on effective rostering by Q1 2018/19. • Build Right Staffing* intranet (InTouch) website by Q1 2018/19. • Develop an operational plan and procedure for effective rostering and data quality improvements by Q2 2018/19. • Develop an extended plan to support staff recruitment and retention by Q2 2018/19. • Develop a plan and framework for ongoing and regular establishment reviews annually for all wards by Q2 2018/19. • Evidence-based staffing establishments: Delivery of proposed plan - phase two by Q3 2018/19. • Develop strategy and plan for Training & Development and Workforce Roles by Q3 2018/19. • Enhance and update the plan and framework for establishment reviews based on clinical pathways (linked with work on model wards) by Q4 2018/19. • Begin implementation of Training & Development and Workforce Roles plan by Q4 2018/19.

*This priority has been renamed 'Right Staffing / Workforce'.

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 to 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[3]; Singh 2009[4]).

Transition takes place at a pivotal time in the life of a young person. It is often at a time of the cultural and developmental changes that lead them into adulthood. Individuals may be experiencing several transitions simultaneously. 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

[3]Watson AR (2005) Problems and pitfalls of transition from paediatric to adult renal care. Paediatric Nephrology 20: 113–7
[4] Singh SP (2009) Transition of care from child to Adult Mental Health services: the great divide. Current Opinion in Psychiatry 22: 386–90

second year of this priority to further embed the improvements commenced in 2016/17.

The benefits / outcomes we aimed to deliver for our patients and their carers were:

- An improvement in the experience of young people 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[5] (National Institute for Clinical Excellence) evidence-based guidelines, which will result in better clinical outcomes.

What we did in 2017/18:

What we said we would do	What we did
• Using the audit action plan, further embed the Safe Transitions and Discharge Protocol by monitoring the agreed actions and timescales by Q2 2017/18.	The Commissioning for Quality and Innovation (CQUIN) Steering Group members ensured that the audit action plan was monitored and actioned within the agreed timescales. This included: • Evidence of transitions panel meetings taking place. • Transition plans developed, agreed and shared with the young person. • The GP / referrer being informed of the discharge and provided with a copy of the plan.
• Undertake an additional audit of the protocols to include further collection of patient and carer experience feedback by Q2 2017/18.	The audit undertaken within quarter two showed successful implementation of the protocol. Patient surveys were developed in quarter two and are given to those young people who transitioned out of CAMHS during their last appointment within CAMHS. Young people are encouraged by the clinician to complete the questionnaire and return it to the service.
• Establish mechanisms to provide stakeholders and staff with regular feedback by Q2 2017/18.	The use of inTouch (the Trust's intranet site for staff), e-bulletins and attendance by the CQUIN Team at locality meetings (CAMHS and AMH) has ensured staff members have been given feedback. Other meetings where feedback to staff have been provided are: • CQUIN Steering Group; • Service Development Groups (SDGs); • Quality Assurance Groups (QUAGs). The use of Facebook and attendance at parent support group meetings and young people's meetings has ensured stakeholders have been given feedback.

[5] 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

• Review the outcome of the audit, updating the current action plan by Q3 2017/18.	Following the audit an action plan was developed which included the following: • Panel meeting to take place 6 months (or within one month if new to service) prior to transition; • Transition plan to be developed, agreed and shared with the young person in 100% of cases; • The GP/referrer to be informed of the transition/discharge plan and the discharge plan will be shared with the GP. This has been shared with members of the CQUIN Steering Group and at locality meetings.
• Collect patients' stories in writing to gain detailed accounts of young people's experiences by Q3 2017/18.	There have been very few young people and / or parent / carers who are willing to share their experiences. To overcome this, the CQUIN team have a system in place whereby those young people who have transitioned from CAMHS to AMH and are still in service are being given the opportunity to complete a post transitions survey. The case worker is being asked if the young person would be willing to share their experiences by way of phone call with the CQUIN transitions Project Manager. The CQUIN transitions Project Manager will attend the parent / carer and young people's meetings asking for them to share their experience. The feedback we receive is then used to help us learn, adapting our services accordingly.
• Complete an evaluation report on the effectiveness of implementation of the new protocol and feedback to relevant stakeholders by Q4 2017/18.	An evaluation report has been completed. It evaluates the effectiveness of implementation of the new protocol using both quantitative review of the audit data and qualitative feedback from patient stories and staff. Feedback will be provided to stakeholders within quarter one of 2018/19.
• Continue to use patient surveys to gain feedback from young people (ongoing each quarter during 2017/18).	Since July 2017 young people who have transitioned out of CAMHS are given the opportunity to complete a transitions survey. As of 9th March 2018 a total of 35 transitions surveys and 2 post transitions surveys have been returned.

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 joint agency transition action plans in place for patients approaching transition.	80%	**Data will be available in April 2018**	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

What we plan to do in 2018/19:

This will continue to be an improvement priority for us. Our plans for 2018/19 are set out in **Part 2, 2018/19 Priorities for Improvement section**.

Priority 4: Reduce the number of preventable deaths

Why this is important:

Normally death is a naturally occurring event. Therefore 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. 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 2016 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. We believe it is important to continue 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 on 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. During 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 we aimed to deliver for our patients and their carers were:

- That 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.

- That the Trust learns from deaths, including identifying any themes early so that actions can be taken to prevent future harm.

What we did in 2017/18:

What we said we would do	What we did
• 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.	As a result of several Serious Incidents which were related to people who took their own lives or suffered serious harm while on a period of leave from inpatient care the EMT commissioned an independent thematic review into this matter. The scope of the review was to consider whether there were any specific themes apparent relating to these incidents and to identify any learning opportunities. The North of England Mental Health Development Unit (NEMHDU) was requested to carry out this review which was completed in February 2017 (thematic review of 15 Serious Incidents relating to patients on leave during the period February 2015-October 2016). The completed report from this review was presented at the Patient Safety Group on 19th June 2017 where the action plan was agreed and is being subsequently monitored. In January 2018 the group were provided with the quarter three update regarding the Trustwide action plan for episodes of planned leave. The group noted that one action relating to training for bank / new staff remained outstanding, however further training dates have now been provided. The group will continue to receive quarterly updates regarding progression. It is pleasing to note that within the Patient Safety Report (at quarter one and quarter two 2017/18) leave planning did not appear as a theme in the deaths that had been investigated. This was felt to be very positive.

What we said we would do	What we did
• Evaluate the current pilot process of reviewing mortality, revising it accordingly following the review by Q1 2017/18.	TEWV now has a mortality review policy and process which builds on the pilot of work completed across the region and remains under review as new advice / guidance is published. The Mazars report into the investigation of Serious Incidents by Southern Health NHS Foundation Trust was published in December 2015. The most significant piece of work for Trusts to undertake as a result of this report is to commence a process of mortality review, over and above the usual Serious Incident Review processes that are already in place. Several regional meetings were held throughout 2017/18 in conjunction with Mazars to progress the findings of the report. Key pieces of work from this group are as follows: • Drafting a North of England charter which sets out the common values and identifies the key work streams required to meet them. • Working towards common terms of reference for mortality review processes. • Drafting a 'Responding to Deaths' policy in line with NQB guidance. Whilst the regional work continues, within the Trust the Patient Safety Group monthly reviews all deaths of service users on CPA (other than those that result in a Serious Incident) and decides whether or not the circumstances fit the criteria for a mortality review. Following the draft 'regional' Policy, TEWVs version was ratified on the 27th September 2017, with appendix 1 outlining the mortality review process within TEWV. For those cases which require a mortality review a member of the Patient Safety group currently carries out a structured judgement case review using the methodology guidance developed by the Royal College of Physicians and the findings are taken back to the next Patient Safety Group for discussion. A discussion will then be had regarding availability of death / learning and good practice. Whilst the pilot has proved successful this process is under continual review as new advice/guidance is published.
• Establish quarterly reporting mechanisms for mortality review processes by Q1 2017/18.	NHSE produced a mortality dashboard as a tool to aid the systematic recording of deaths and learning from the care provided by all NHS Trusts and there is a requirement that Trusts publish this data on a quarterly basis. The TEWV dashboard continues to evolve based on learning from other Trusts across the region as well as nationally with the principle aim of enhancing future learning and the continuous improvement of patient care. We have developed this approach and reported formally to the Board of Directors mortality information for quarters one, two, three and four of 2017/18.

What we said we would do	What we did
• 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.	All new inpatient staff have received training in relation to leave and time away from the ward and will continue to do so via the Mental Health Act (MHA) team. As of April 2018 this has become part of the new mandatory MHA e-learning package. Whilst there are systems in place to monitor the training being delivered the information is not as yet available on the Trust IIC (Integrated Information Centre) which would enable us to more easily identify who has accessed the training. There is a work programme to make this happen.
• 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.	Audits have been completed regarding Section 17 (S17) leave by the audit team alongside the MHA team. Audits are currently underway by the audit team regarding those with time away from the ward i.e. patients who are not detained under the MHA and therefore not subject to S17 leave.
• 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.	Each quarter the QuAC receives a quarterly assurance report which identifies the key themes from root and contributory causes and identifies the key pieces of work to address them. The report also provides a Trustwide overview of the incidental findings and each locality also receives a locality specific version of this information.
• Undertake a review of the national guidance in relation to mortality each quarter by Q4 2017/18.	As a result of the Learning from Deaths requirements following the Southern Health report there is ongoing review of any national guidance in relation to mortality – any updates are discussed at the Patient Safety Group and incorporated into the TEWV processes as required. This includes for example NHS Improvement provider weekly bulletins which identify any new guidance and learning / case studies from other Trusts.
• Participate quarterly in the regional provider forum focused on learning from preventable deaths by Q4 2017/18.	Several regional meetings have been held throughout the year in conjunction with Mazars to progress the findings of their report (as mentioned above). Key pieces of work from this group are as follows: • Drafting a North of England charter which sets out the common values and identifies the key workstreams required to meet them. • Working towards common terms of reference for mortality review processes. • Drafting a 'Responding to Deaths' policy in line with NQB guidance.
• Report quarterly to the QuAC on progress of the reviewed mortality review processes to enhance learning by Q4 2017/18.	The Trust QuAC now receives a quarterly assurance report from the Trust monthly Patient Safety Group. The report identifies the key areas for learning within the Trust which corresponded with the themes identified from audit.

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
• 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).	90 cases	90*	Q4 2017/18
• To eliminate preventable deaths of inpatients during periods of leave.	0 deaths	1**	Q4 2017/18

*As this is a new process 90 is the baseline figure of case record reviews, deaths reviewed as part of the mortality process by 28/02/2018.
**Whilst there has been one preventable death of inpatients during periods of leave this is in comparison to 12 that occurred in 2015/16.

What we plan to do in 2018/19:

This will continue to be an improvement priority for us. Our plans for 2018/19 are set out in **Part 2, 2018/19 Priorities for Improvement section**.

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 within our premises and grounds have risen (but severity of harm has reduced). 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 we aimed to deliver for our patients and their carers were:

- 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 guideline 161 *'Falls: assessment and prevention of falls in older people*' (2013)[6] 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)[7].

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

- Care 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 did in 2017/18:

What we said we would do	What we did
• Undertake a baseline assessment of preventable falls by severity, completed by Q1 2017/18.	Each locality undertook a review of their own data which determined that the majority of falls occur within MHSOP. This data formed a baseline assessment of the number of preventable falls. The improved revised Trustwide Falls report is produced quarterly, the data and information is shared with each locality who then analyse their own data adding narrative quarterly. The Falls report now identifies: • category of falls; • severity of falls; • time of day of fall; • identifies multiple fallers and across multiple locations.
• Complete a thematic analysis by Specialty completed including direct observations of practice by Q1 2017/18.	Falls data analysis completed, this information was shared and accepted by Durham, Darlington and Tees Clinical Quality Reference Group (CQRG).
• Develop an action plan developed in line with outcome of thematic analysis by Q2 2017/18.	There was a 'Kaizen' event held to review the falls CLiP within quarter two 2017/18. As a result of this there was an action to progress with a frailty CLiP which incorporates falls as a frailty syndrome. This is in line with the outcome of the thematic review.
• 'Plan, Do, Study, Act' (PDSA) cycles agreed to address key issues identified via observations by Q2 2017/18.	There are five wards piloting frailty syndrome CLiP with full roll out planned following the outcome of the pilot. This will determine the next plans. As part of the pilot process, PDSA cycles have been agreed to address any key issues identified.
• Complete a Trustwide implementation of new processes based on PDSA cycles by Q3 2017/18.	A focused implementation will form part of the roll out of the all age frailty CLiP. Other specialities CLiPs are awaiting the outcome of the pilot of the frailty CLiP.
• Undertake a baseline assessment of falls by severity and theme reassessed by Q4 2017/18.	There is ongoing work as part of the Falls Executive Group and ownership and scrutiny of information by service which is included in the Trustwide quarterly falls report and compared to the baseline assessment identified at the beginning of 17/18.

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
• A reduction in the number of people who suffer serious harm as a result of a fall.	<9	3	Q4 2017/18

What we plan to do in 2018/19:

We will:
• The Falls Executive Group will continue to meet quarterly, with Trustwide / service user representation. • The work plan for 2018/19 has been developed and is in the process of being finalised. It will include Trust localities analysing their own data and action planning where appropriate. • Development of a root cause analysis report for fractured neck of femur with appropriate oversight within Nursing & Governance.

Statement of Assurances from the Board 2017/18

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 2017/18. 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 **2017/18** 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 2017/18 represents **100%** per cent of the total income generated from the provision of the relevant health services by TEWV for 2017/18.

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 NICE guidance and the results of clinical audits.
- **Patient experience** – including information on patient satisfaction; carer satisfaction; the Friends and Family Test (FFT); 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 peer review 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 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 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 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 '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 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 2017/18, **5** national clinical audits and **2** national confidential inquiries covered the health services that TEWV provides.

During 2017/18, TEWV participated in **80%** (4/5) of national clinical audits and **100%** (2/2) of 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 2017/18 were as follows:

- POMH Topic 17a: Use of depot/long-acting antipsychotic injections for relapse prevention (ongoing);
- POMH Topic 15b: Prescribing Valproate for Bipolar Disorder (ongoing);
- POMH Topic 16b: Rapid Tranquilisation;
- EIP National Self-Assessment Audit 2017/18 (ongoing);
- National Clinical Audit of Psychosis (NCAP) (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 2017/18 are as follows:

- POMH Topic 17a: Use of depot/long-acting antipsychotic injections for relapse prevention (ongoing);
- POMH Topic 15b: Prescribing Valproate for Bipolar Disorder (ongoing);
- EIP National Self-Assessment Audit 2017/18 (ongoing);
- National Clinical Audit of Psychosis (NCAP) (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 2017/18, 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 17a: Use of depot/long-acting antipsychotic injections for relapse prevention	241	Not applicable
POMH Topic 15b: Prescribing Valproate for Bipolar Disorder	191	Not applicable
EIP National Self-Assessment Audit 2017/18	889	Not applicable
National Clinical Audit of Psychosis (NCAP)	272	91%
National Confidential Inquiry into Suicide & Homicide by People with Mental Illness.	57	TBC*
National Confidential Enquiry into Patient Outcome and Death	n/k*	Unknown

*To be confirmed within final version.
**Cases are submitted confidentially and directly by individual consultants, and therefore, the number of cases submitted is unknown.

Due to the timings of the national audits, the provider 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 the Trust will formally receive these reports and agree actions to improve the quality of healthcare provided.

The reports of **163** local clinical audits were reviewed by the provider in 2017/18 and TEWV intends to take actions to improve the quality of healthcare provided.

Appendix 4 includes the actions we are planning to take against the **8** key themes from these local clinical audits reviewed in 2017/18.

*To be confirmed within final version.

In addition to those local clinical audits reviewed (i.e. those that were reviewed by our Quality Assurance Committee and Clinical Effectiveness Group), the Trust undertook a further **12** clinical audits in 2017/18 which include clinical effectiveness projects undertaken by Junior Doctors, Consultants or other Directorate / Specialty Groups.

These clinical audits were led by the services and individual members of staff for reasons of service improvement and professional development.

Participation in clinical research

The number of patients receiving relevant health services provided or subcontracted by TEWV in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was **1341**.

Of the **1341, 1299** were recruited to **32** National Institute for Health Research (NIHR) portfolio studies. This compares with **952** patients involved as participants in NIHR research studies during 2016/17.

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 2017/18 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 **96** clinical research studies during 2017/18. **53** of these studies were supported by the NIHR through its networks and **16** new portfolio studies approved through the Health Research Authority approval process.
- **29** 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.
- **50** members of our staff were also recruited as participants to NIHR portfolio studies.
- **40** researchers from outside the organisation were granted access under the National Research Passport Scheme to perform research with us compared to **28** from 2016/17. 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 Research & Development Strategy with a strong focus on Patient and Public Involvement (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 (JDR) 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 (CQUIN) Payment Framework

A proportion of TEWV's income in 2017/18 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 2017/18 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 2017/19 mental health contract, we were provided with a list of nationally mandated CQUINs and then were given an option to add one further local CQUIN which the Trust opted to do in agreement with the commissioners. This included indicators around physical healthcare, staff health and wellbeing and discharge and resettlement within specialist services. These are monitored at meetings every quarter with our commissioners.

An overall total of £4,896,824 was available for CQUIN to TEWV in 2017/18 conditional upon achieving quality improvement and innovation goals across all of its CQUINs. A total of £4,472,231 (91.32%) is estimated to be received for the associated payment in 2017/18; however this will not be confirmed until May. This represents 1.5% of the Trust income rather than 2.5% as in previous years; as 0.5% was allocated for engagement in STPs and a further 0.5% towards achieving our control total. Including the further 1% a total of £7,328,422 was available and £6,903,829 (94.26%) is estimated to be achieved. This compares to £6,418,793 in 2016/17 (92.19%), £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 2017/18 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 2017/18 were:

- Improving the uptake of flu vaccinations for frontline clinical staff. This was a CQUIN in 2016/17 as well as going forward into the 2017/19 scheme. Before this became a CQUIN, the 2015/16 Trust uptake of the flu jab was 39%. Over the last two years the Trust has committed to a flu vaccination scheme, introducing staff incentives. In 2016/17 we achieved a 16% increase of staff taking up the offer of a flu jab in 2017/18 achieved a further 11% increase. This gives us an overall increase of 27% over the two years which is a real achievement and helps to keeping our staff and patients safe from flu. We aim to further increase this uptake in 18/19.
- Virtual Recovery College. This was our local scheme agreed with the commissioners and one that we felt very important. The Trust has a physical recovery college based in Durham; however acknowledged that due to the geography of the Trust this was not accessible to a lot of our patients and therefore the decision was made to set up a virtual recovery college (known as recovery college online). Since its launch at the start of the year the site now hosts over 80 pages, which are accessible to all internet users and 7 courses, which are accessible to people within the Trust's geographical area and there are over 1000 people viewing the site every month.
- Discharge and Resettlement within specialist services. This CQUIN spans all specialist services and looks to reduce delayed discharges by ensuring that discharge planning is started right from the point of the patients admission by setting an expected discharge date. This CQUIN involved setting up a whole new system within each service and devising a two year strategy on how the services were going to look to reduce delayed discharges. During its first year services have successfully embedded all of the processes required to ensure the success of the CQUIN. All patients have had an expected discharge date set within the required 12 weeks of admission and there have been some cases of patients being discharged before their expected discharge date.
- Patient Experience within Street Triage. This is the first year that we have had a CQUIN from the Health and Justice contract. The Street Triage team already had a patient experience measure in place as part of the Trust monitoring; however work has been undertaken to assess how best to offer the patient experience surveys, as it is acknowledged that due to the nature of the work it is not the best time when the patient is being seen. The team has seen satisfaction scores increase from 82% at the start of the year to 100% by the end of the year. The team have also, as an additional measure, developed an experience survey for the police who are involved in the cases they worked with and have received very positive feedback via this.

What others say about the provider

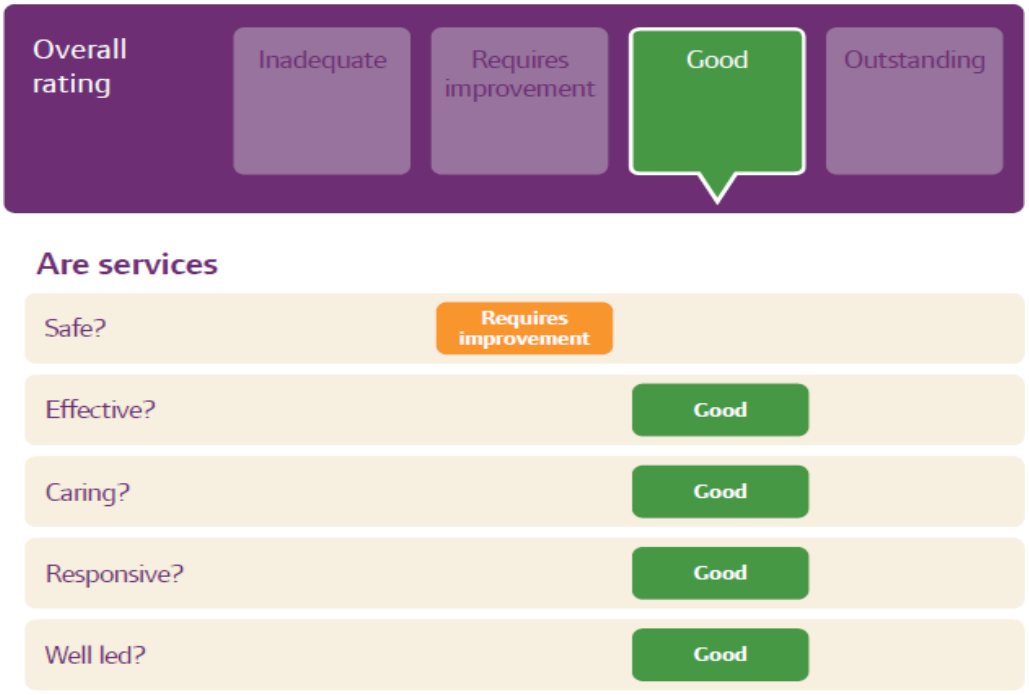
Registration with the Care Quality Commission (CQC) and periodic / special reviews

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 2017/18.

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

The Trust has not received any CQC compliance inspections during 2017/28 and the overall Trust rating remains **Good**.

The Trust CQC ratings for each domain are currently as follows:



In July 2017, Her Majesty's Inspectorate of Prisons conducted an unannounced inspection of Holme House Prison, a category B local prison near Stockton-On-Tees. Following inspection the CQC issued the Trust with a Requirement Notice regarding Regulation 9: Person Centred Care. This states that 'The care and treatment of service users must be appropriate, meet their needs and reflect their preferences'. In response, the Trust reviewed processes and put in place required improvement actions to ensure that appropriate care was consistently provided to meet the needs of patients and reflect their preferences.

The Trust also has two premises that are registered with Ofsted. The two Units are classified by Ofsted as children's home premises. The Units provide care and accommodation for children and young people who have a learning and/or physical disability for short breaks. Following registration with Ofsted in August 2017, both units received their first inspections with one unit being rated as 'Good' and the other as 'Requires Improvement'. All improvement requirements have been met and formal responses submitted to Ofsted to ensure compliance with statutory guidance and the requirements of the Care Standards Act 2000.

Mental Health Act Inspections

34 Mental Health Act inspections were undertaken by the Care Quality Commission during 2017/18:

Ward	Service Type	Location
Acomb Garth	Wards for older people with mental health problems	York
Bankfields Court	Wards for people with learning disabilities or autism	Middlesbrough
Bedale Ward	Acute wards for adults of working age and psychiatric intensive care units	Teesside
Birch Ward	Acute wards for adults of working age and psychiatric intensive care units	Darlington
Brambling Ward	Forensic inpatient (low/medium)	Middlesbrough
Bransdale Unit	Acute wards for adults of working age and psychiatric intensive care units	Middlesbrough
Cedar (PICU)	Acute wards for adults of working age and psychiatric intensive care units	Darlington
Cherry Trees	Wards for older people with mental health problems	York
Danby Ward	Acute wards for adults of working age and psychiatric intensive care units	Scarborough
Ebor Ward	Acute wards for adults of working age and psychiatric intensive care units	York
Eagle/Osprey	Forensic inpatient (low/medium)	Middlesbrough
Elm Ward	Acute wards for adults of working age and psychiatric intensive care units	Darlington
Farnham Ward	Acute wards for adults of working age and psychiatric intensive care units	Durham
Hamsterley Ward	Wards for older people with mental health problems	Bishop Auckland
Harland Ward	Ward for people with learning disability or autism	Durham
Ivy/Clover Ward	Forensic inpatient (low/medium)	Middlesbrough
Jay Ward	Forensic inpatient (low/medium)	Middlesbrough
Kirkdale Ward	Long stay/rehabilitation mental health wards for working age adults	Middlesbrough
Langley Ward	Forensic Learning Disability Low Secure	Durham
Lark Ward	Forensic inpatient (low/medium)	Middlesbrough
Lincoln Ward	Acute wards for adults of working age and psychiatric intensive care units	Hartlepool
Mandarin Ward	Forensic inpatient (low/medium)	Middlesbrough
Maple ward	Acute wards for adults of working age and psychiatric intensive care units	Darlington
Merlin Ward	Forensic inpatient (low/medium)	Middlesbrough
Newtondale	Forensic inpatient (low/medium)	Middlesbrough
Northdale Centre	Forensic inpatient (low/medium)	Middlesbrough
Oak Ward	Wards for older people with mental health problems	Darlington
Ramsey Ward	Wards for people with learning disabilities or autism	Durham
Rowan Lea Ward	Wards for older people with mental health problems	Scarborough
Sandpiper Ward	Forensic inpatient (low/medium)	Middlesbrough
Westerdale North	Wards for older people with mental health problems	Middlesbrough
Westerdale South	Wards for older people with mental health problems	Middlesbrough
Westwood Centre	Child and adolescent mental health wards	Middlesbrough
Willow Ward	Long stay/rehabilitation mental health wards for working age adults	Darlington

Quality of data

TEWV submitted records during 2017/18 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 **100.00%** for admitted patient care.
- Which included the patient's valid General Medical Practice Code was **98.68%** for admitted patient care.

TEWV Information Governance Assessment Report overall score for 2017/18 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 2017/18 by the Audit Commission.

NHS England and NHS Improvement issued guidance in December 2016 for the contracting period 2017-2019. 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). Commissioners receive quarterly reports describing complexity of current caseload and clinical outcomes for discharged patients using an established model of clinical significance. The IIC will routinely report this information during 2018/19.
- **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). Commissioners receive quarterly reports describing complexity of current caseload and clinical outcomes for discharged patients using an established model of clinical significance. The IIC will routinely report this information during 2018/19. EIP services have replaced SWEMWBS with The Process of Recovery Questionnaire (QPR) for all new patients from 1st March 2018. Discussions with commissioners will agree how QPR reporting will be integrated in existing commissioner reports.
  A training program is ongoing with regards to cluster accuracy and factors affecting the ability to report outcomes effectively and accurately. Performance relating to clinical outcomes is monitored and managed throughout TEWV.
- **CAMHS services:** Child Outcome Rating Scale (CORS)/Outcome Rating Scale (ORS) were introduced into the CAMHS services from February 2018 and will be used to report clinical outcomes. Ongoing discussions with commissioners will agree the integration into existing reports.
  Performance reports are being managed via a CAMHS currency development steering group and training and support to staff is ongoing.

At the end of March 2018:

96% of service users on the Adult Mental Health (AMH) and **98%** of services users on the Mental Health Services for Older People (MHSOP) caseloads were assessed using the mental health clustering tool.
90% 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 2018/19 includes:

- Consideration of clinical outcome metrics for Learning Disability services.

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

- We are currently in the process of producing a revised Data Quality (DQ) Strategy and scorecard, with a plan for this to have a much broader focus than the previous version and be inclusive of all Trust data, rather than just patient focused data. The draft strategy has been written and engagement / consultation was conducted with a variety of groups within the Trust, including LMGB's, Operational Management Team (OMT) and service users. The draft strategy was submitted and approved at the Managing the Business April 2018 meeting - this group is chaired by the Director of Finance and Information and meets monthly. Other Directors also attend the meetings from Planning, Performance and Communication, Nursing and Governance and Human

Resources. It is expected that the Data Quality Strategy will be approved by EMT in quarter one 2018/19.

- The Trust has a new DQ working group which is a sub group of the Managing the Business Group. It is chaired by the Head of Supporting Users and has representation from Planning, Performance and Communications, Quality Data, Human Resources and Information attend. The DQ working group will focus on issues with data quality identified either by corporate or clinical services and attempt to provide resolutions. For example, this may be to help with training on how to enter information correctly in Paris or it may be working with services to provide clarity on recording of activity.
- Data Quality Improvement Plans (DQIPs) have been agreed with commissioners for 2017/18. Over 40 DQIPs have either been delivered or are on track for being delivered this financial year. Additional DQIPs are in the final process of being agreed for 2018/19.
- New reports continue to be developed within the IIC to allow services to easily identify data quality concerns and target improvement work. A data quality IIC dashboard has been developed and evidences data quality completeness of key data items within the clinical record. A development plan for the IIC for 2018/19 was finalised in April 2018.

Learning from deaths

During 2017/18 1,639* of TEWV patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 541 in the first quarter;
- 524 in the second quarter;
- 574 in the third quarter;
- **xx*** in the fourth quarter.

By 28th February 2018, 90* case record reviews and 89* investigations have been carried out in relation to 1,639* of the deaths included in the figures above.

In 179* cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 65 in the first quarter;
- 47 in the second quarter;
- 67 in the third quarter;
- **xx*** in the fourth quarter.

28* representing 1.7%* of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:

- 9 representing 1.7% for the first quarter;
- 7 representing 1.3% for the second quarter;
- 12 representing 2.1% for the third quarter;
- **xx*** representing **xx**%* for the fourth quarter.

These numbers have been estimated using the **xx***.

A summary of what TEWV has learnt from case record reviews and investigations conducted in relation to the deaths identified in item 27.3:

- **xx***

A description of the actions which TEWV has taken in 2017/18, and proposes to take following 2017/18, in consequence of what TEWV has learnt during 2017/18:

- **xx***

An assessment of the impact of the actions described above which were taken by the TEWV during 2017/18:

- **xx***

xx* case record reviews and **xx*** investigations completed after 1st April 2018 which related to deaths which took place before the start of 2017/18.

xx* representing **xx**%* of the patient deaths before 2017/18, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the **xx***.

xx* representing **xx**%* of the patient deaths during **xx*** are judged to be more likely than not to have been due to problems in the care provided to the patient.

*End of year data to follow.

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. As per Single

Oversight Framework guidance, this reports all patients discharged that were followed up within 7 days.

TEWV actual quarter four 2017/18	***National benchmarks in quarter three 2017/18***	***TEWV actual quarter three 2017/18***	***TEWV actual quarter two 2017/18***	***TEWV actual quarter one 2017/18***
Trust final reported figure: **Not available**	NHSIC reported: Highest/best MH Trust = **100%**	Trust final reported figure: **97.13%**	Trust final reported figure: **95.80%**	Trust final reported figure: **96.46%**
Figure reported to NHSI: N/A**	National average MH Trust = **95.9%**			
NHS Digital reported: **Not available**	Lowest/worst MH Trust = **69.2%**	NHS Digital reported figure: **97.2%**	NHS Digital reported figure: **95.2%**	NHS Digital reported figure: **96.4%**

*Latest benchmark data available on NHS Digital at quarter three 2017/18.
**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 NHS Digital and the Trust is due to the fact the NHS Digital data is submitted at a 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 **90** people during 2017/18 to date were not followed up within 7 days were:
  - difficulties in engaging with the patient despite efforts of the service to contact the patient (51 patients); and
  - breakdown in processes within the service (30 patients).

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

- Investigating all cases that were not followed up and identifying lessons to be learned at service level.
- Undertaking an improvement programme led by the Chief Operating Officer to improve proactive performance management and eliminate waste in both clinical and corporate services.
- Continuing to utilise 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 four 2017/18	***National benchmarks in quarter three 2017/18***	***TEWV actual quarter three 2017/18***	***TEWV actual quarter two 2017/18***	***TEWV actual quarter one 2017/18***
Trust final reported figure: **Not available**	NHSIC Reported: National average MH Trust = **98.3%**	Trust final reported figure: **96.57%**	Trust final reported figure: **97.55%**	Trust final reported figure: **97.58%**
Figure reported to NHSI: N/A**	Highest/best MH Trust = **100%**			
NHS Digital Reported: **Not available**	Lowest/worst MH Trust = **84.3%**	NHS Digital Reported: **96.3%**	NHS Digital Reported: **97.3%**	NHS Digital reported: **97.6%**

*Latest benchmark data available on NHS Digital at quarters 3 2017/18.
**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 NHS Digital and the Trust / NHSI figures is due to the fact the NHS Digital data is submitted at a 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 **45** people in 2017/18 were not assessed by the Crisis team prior to admission were:
  - breakdown in process due to failure to follow the standard procedure (28 patients); and
  - high levels of demand on the Crisis team (7 patients).

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 an improvement programme led by the Chief Operating Officer to improve proactive performance management and eliminate waste in both clinical and corporate services.
- Continuing to utilise 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 2017, we have reported the Health and Social Care Workers section score which compiles the results from the questions used from the survey detailed below the table.

TEWV actual 2017	***National benchmarks in 2017***	***TEWV actual 2016***	***TEWV actual 2015***	***TEWV actual 2014***
Overall section score: **7.7** (sample size 232)	Highest/Best MH Trust = **8.1** Lowest/Worst MH Trust = **6.4** Average Score**=7.6**	Overall section score: **7.8** (sample size 234)	Overall section score: **8.0** (sample size 239)	NHSIC Reported: **8.1** (sample size 188)

CQC design and collate the results of the community mental health patient experience survey. Since 2014 the survey has asked community service users the following questions about their contacts 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 **8.1**. The lowest national mean was 7.2 and the highest 8.7.
- *Were you given enough time to discuss your needs and treatment*: TEWV mean score of **8.0**. The lowest national mean was 6.2 and the highest 8.1.
- *Did the person or people you saw understand how your mental health needs affect other areas of your life*: TEWV mean score of **7.0**. The lowest national mean was 5.8 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. As with the 2016 survey, 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.

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

- Reviewing the way we do care planning in the Trust to make them more personal (a Quality Account priority for 2018/19).
- Recruiting experts by experience (including peer workers) to help make services think more about the patient experience.
- Taking action to re-provide care from outdated wards in York, Northallerton and Harrogate so that all inpatient wards will have single en-suite bedrooms by 2019/20.
- Continuing to carry out our local inpatient and community surveys with established mechanisms in place for action plan development and feedback.
- Transferring to the new external provider Optimum Health, which is a live system that enables managers to monitor level of feedback received and act upon any issues in a timely manner.
- A pilot of SMS/Web based surveying using staff smartphones is coming to an end and will be rolled out Trustwide in April.

In addition, patient experience kiosks are now installed in 31 sites where there is a high footfall of patients and carers, which enables them to complete the survey anytime, and a quarterly narrative audit is undertaken to ensure areas address issues from narrative feedback.

The Trust continues to carry out regular patient experience surveys across all services which includes the FFT. Between January 2017 and January 2018 the Trust received feedback from 19,791 patients with an average of 89% 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 2018.

TEWV actual quarters three & four 2017/18	****National benchmarks in quarters three & four 2016/17***	***TEWV actual quarters one & two 2017/18***	***TEWV actual quarters three & four 2016/17***
Trust Reported to NRLS: as at 31st January 2018 **5,504** incidents reported of which **63 (1.45%)** resulted in severe harm or death	NRLS Reported: National Average MH Trusts: incidents reported of which resulted in severe harm or death **Not yet available**	Trust Reported to NRLS: **7,372** incidents reported of which **47 (0.64%)** resulted in severe harm or death* NRLS reported: **7,372** incidents reported of which **47 (0.64%)** resulted in severe harm or death* *15 Severe Harm and 32 Death	Trust Reported to NRLS: **6,244** incidents reported of which **54 (0.86%)** resulted in severe harm or death NRLS reported: **6,244** incidents reported of which **54 (0.86%)** resulted in severe harm or death

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

- The Trust reported and National Reporting & Learning System (NRLS) reported data for quarters one and two 2017/18 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 one and two 2017/18 was improved compared to the previous two 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 one and two 2017/18 has considerably increased when compared to with quarters three and four 2016/17. 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 2017/18 TEWV reported 178 incidents as Serious Incidents, of which 156 were deaths due to unexpected causes (as at end of February 2018).

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 have implemented its recommendations throughout 2017/18.

2018/19 Priorities for Improvement

During 2017/18 we held two events inviting our stakeholders to take part in our process of identifying quality priorities for 2018/19 to be included in the Quality Account. These events took place in July 2017 and February 2018: further information can be found in **Part 3, Our Stakeholders' Views section**. The four quality priorities which we identified from this engagement also sit within TEWV's 2018/19-2020/21 Business Plan. The Business Plan includes a further 10 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 four agreed 2018/19 priorities for inclusion in the Quality Account are:

Priority 1: Reduce the number of preventable deaths;
Priority 2: Improve the clinical effectiveness and patient experience in times of transition from Child to Adult services;
Priority 3: Making Care Plans more personal;
Priority 4: Develop a Trust-wide approach to dual diagnosis which ensures that people with substance misuse issues can access appropriate and effective mental health services.

Priority 1: Reduce the number of preventable deaths

Why this is important:

As mentioned in **Part 2** (above) where we provided an update on our Quality Priorities for 2017/18, the Trust identified that this was an important priority for our Quality Account because:

- Sometimes healthcare teams can make mistakes or different teams / organisations do not work together as well as they could. This means that when things go wrong, a death may have been preventable.
- The CQC made recommendations for the improvements that need to be made in the NHS regarding deaths.
- 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 important that families and carers are fully involved in reviews and investigations following a death.
- To reduce preventable deaths, it is important that learning from deaths and near misses are shared and acted on with an emphasis on engaging families and carers in this learning.

The benefits / outcomes we aimed to deliver:

- 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.
- That patients and carers 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 2018/19:

We will:
• Develop a co-produced family and carer version of the learning from deaths policy by Q1 2018/19.
• Produce an engagement plan to involve family, carers and non-Executive Directors within the review process by Q2 2018/19.
• Implement the engagement plan by Q3 2018/19.
• Hold a family conference in conjunction with Leeds and York Partnership Foundation Trust. This will allow us to share good practice and continue to develop the further involvement of families and carers in the preventable deaths process by Q3 2018/19.
• Evaluate the level and effectiveness of engagement with families, carers and Non-Executive Directors by Q4 2018/19.

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
• 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).	120	Q4 2018/19
• Eliminate preventable deaths of inpatients during periods of leave.	0	Q4 2018/19
• Reduce the number of Serious Incidents where it was identified that the Trust contributed to the incident.	37	Q4 2018/19

Priority 2: Improve the clinical effectiveness and patient experience in times of transition from Child to Adult services

Why this is important:

As mentioned in **Part 2** (above) where we provided an update on our Quality Priorities for 2017/18, the Trust identified that this was an important priority for our Quality Account because:

- 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 into new services can be an uncertain time for young people with health and / or social care needs.
- There is evidence of service gaps where there is a lack of appropriate services for young people to transition into. There is also evidence that without proper support young people may fail to engage with services (Watson 2005[8]; Singh 2009[9]).
- Transition takes place at a pivotal time in the life of a young person.
- 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.

The benefits / outcomes we aimed to deliver:

- An improvement in the experience of young people 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[10] evidence-based guidelines, which will result in better clinical outcomes.

What we will do in 2018/19:

We will:
• Implement actions from the thematic review (conducted at the end of 2017/18) of patient stories by Q1 2018/19. • Registered CAMHS and AMH staff to undertake further specific training on the transitions process by Q1 2018/19. • Review transition panels already in place (set up during 2017/18), gain additional service user perspective and set relevant targets and metrics by Q3 2018/19. • Produce an engagement plan to involve family and carers in the process by Q4 2018/19.

[8]Watson AR (2005) Problems and pitfalls of transition from paediatric to adult renal care. Paediatric Nephrology 20: 113–7
[9] Singh SP (2009) Transition of care from child to Adult Mental Health services: the great divide. Current Opinion in Psychiatry 22: 386–90
[10]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

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
• Percentage of joint agency transition action plans in place for patients approaching transition.	80%	Q4 2018/19
• Percentage of patients who reported feeling prepared for transitions at the point of discharge.	80%	Q4 2018/19
• 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 2018/19

Priority 3: Making our Care Plans more personal

Why this is important:

Personalisation is defined in the skills and education document by NHS England 'Person Centred Approaches' (2016) as *'Recognising people as individuals who have strengths and preferences and putting them at the centre of their own care and support. Personalised approaches involve enabling people to identify their own needs and make choices about how and when they are supported to live their lives'*.

Feedback from service users shows that our current approach to care planning does not always promote a personalised approach. By undertaking the actions agreed for 2018/19 we aim to improve the experience of service users and carers. For this to be sustainable a change in culture will be required.

The benefits / outcomes our patients and carers should expect:

- To have their personal circumstances viewed as a priority when planning care and treatment.
- To have an accessible, understandable and personalised crisis plan containing contact details of those people and services that are best placed to help when the need arises.
- To have discussions that lead to shared decision making and co-production of meaningful care plans.
- To have agreed plans recorded in a way that can be understood by the service user and everybody else that needs to have this information.
- To receive information about getting support from people who have experience of the same mental health needs.
- To have help with what is important to the service user and carers.

What we did in 2017/18:

We will:
• Completed and reported on an in-depth quality focused audit of the Care Programme Approach, including the care plan.

What we will do in 2018/19:

We will:
• Co-produce an action plan with service users, carers and staff teams based on the findings and recommendations of the audit by Q1 2018/19. • Co-produce guidance about what Personalised Care Planning means and how to demonstrate this through clinical records by Q1 2018/19. • Co-develop training and development packages aligning these to, and incorporate where possible, the training and development work of other programmes, projects and business as usual – these must include evaluation measures by Q2 2018/19. • Co-deliver training and development packages – Trustwide by Q3 2018/19. • Re-audit and report as per Q4 2017/18 by Q4 2018/19.

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
The following indicators are for TEWV from the National Mental Health Community service user Survey 2017 (% for 2017) • Do you know who to contact out of office hours if you have a crisis? (64.8%) • Were you involved as much as you wanted to be in deciding what treatments or therapies to use? (68%) • Have you been given information by NHS mental health services about getting support from people who have experience of the same mental health needs as you? (32.8%) • Do the people you see through NHS mental health services help you with what is important to you? (66.9%) • Were you involved as much as you wanted to be in agreeing what care you will receive? (70.8%) • Were you involved as much as you wanted to be in discussing how your care is working? (75.5%) • Does the agreement on what care you will receive take your personal circumstances into account? (74.9%)	All 2017 indicators to increase by 10% points minimum	Q4 2018/19

Priority 4: Develop a Trust-wide approach to dual diagnosis which ensures that people with substance misuse issues can access appropriate and effective mental health services.

Why this is important:

Service users with severe mental health problems who are also misusing substances (known as **dual diagnosis**) have high risks of harm to themselves or others, poor outcomes and high treatment costs. Changes in commissioning arrangements of substance misuse services could lead to increased risk of have service gaps for patients with a dual diagnosis. The Trust has recognised the importance of adapting to these changes and become more proactive in developing services that address the specific needs of this group of service users.

The benefits / outcomes our patients and carers should expect:

- That service users with mental health and co-existing substance misuse get the same level of care than people without substance misuse.
- Staff treat every service user with the same level of respect, without judging someone because they abuse drugs or alcohol.
- Support for family and carers of service users with dual diagnosis.
- Staff will work collaboratively across organisations, with a creative, flexible and proactive approach.
- The Trust will consider the whole picture when considering the discharge of service users who have started / increased their misuse of substances.
- The organisation will learn from incidents if things go wrong.

What we will do in 2018/19:

We will:
• Circulate Dual Diagnosis CLiP to all Localities, specialties and specialty sub-groups for them to agree the most appropriate place to integrate within their pathways by Q1 2018/19.
• Establish a process with the patient safety team that incorporates dual diagnosis in investigations / reviews by Q1 2018/19.
• Directorate specialties to confirm their use of Dual Diagnosis CLiP (proportionate to their need) within relevant pathways by Q2 2018/19.
• Introduce a Training Needs Analysis (TNA) which includes dual diagnosis and identify those staff with dual diagnosis capabilities by Q2 2018/19.
• Establish a training structure linked to Locality and speciality requirements by Q3 2018/19.
• Ensure all services have at least 1 person trained or have access to a trained clinician (proportionate to each directorate's needs) as a contact regarding dual diagnosis issues by Q4 2018/19.
• Complete an annual thematic review of risks and Serious Incidents involving service users with Dual Diagnosis by Q4 2018/19.
• Establish links with the confidential enquiry process and identify whether there are any potential missed mental health factors in recorded drug-related deaths by Q4 2018/19.

- Engage partner and stakeholders to agree a future approach and produce the framework/document which outlines the forward view for dual diagnosis by Q4 2018/19.

What we will do in 2019/20:

We will:
• Complete an audit of staff dual diagnosis capabilities and skills by Q4 2019/20, and then repeat this every two years.

How will we know we are making a difference?

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

Indicator	Target	Timescale
• Percentage of services* that have at least one person trained or have access to a trained clinician.	100%	Q4 2018/19
• Percentage of services* which have access to an identified staff member who has enhanced dual diagnosis capabilities.	100%	Q4 2018/19

*AMH, CYPS, MHSOP, Learning Disabilities and Forensics.

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 one at our July Quality Account stakeholder event, send a six monthly update to all of our stakeholders, and provide a further update of the position as of 31 December 2018 at our February 2019 Quality Account Stakeholder workshop.

Part 3: Other information on Quality Performance 2017/18

Our performance against our quality metrics

During 2016/17 we reviewed and revised our Trust's Quality Strategy. In approving the new strategy the Trust Board agreed a set of metrics to be routinely monitored each quarter to show the progress that is being made in delivering the objectives within the strategy. As a consequence we revisited the quality metrics to be used in the 2017/18 Quality Account to ensure they are aligned to the metrics in the Quality Strategy.

The following table provides details of our performance against our set of agreed quality metrics for 2017/18. As the majority of these metrics now align to the Trust Quality Strategy, they do vary from those we have reported in previous years.

The targets in the table below are taken from TEWV's Quality Strategy 2017/18 to 2020/21. We intend to achieve these targets by March 2021. In the first year we have started progress towards these, and we expect a year-on-year improvement in these figures as we get nearer to achieving these 3 year targets.

Quality Metrics

Quality Metrics		2017/18		2016/17	2015/16	2014/15	2013/14
		Target	Actual	Actual	Actual	Actual	Actual
Patient Safety Measures							
1	Percentage of patients reported 'yes always' to the question, 'do you feel safe on the ward'?	88%	**62.30%**	NA	NA	NA	NA
2	Number of incidents of falls (level 3 and above) per 1000 occupied bed days (for in patients)	0.35	**0.12**	0.37	NA	NA	NA
3	Number of incidents of physical intervention / restraint per 1000 occupied bed days	19.25	**30.65**	20.26	NA	NA	NA
Clinical Effectiveness Measures							
4	Existing Percentage of patients on Care Program Approach who were followed up within 7 days after discharge from psychiatric in-patient care	> 95.00%	**94.78%**	98.35%	97.75%	97.42%	97.86%
5	Percentage of clinical audits of NICE Guidance completed	100%	**N/A**	100%	100%	100%	97%
6a	Average length of stay for patients in Adult Mental Health and	AMH <30.2	**24.56***	30.08	26.81	26.67	31.72

Quality Metrics		2017/18		2016/17	2015/16	2014/15	2013/14
		Target	Actual	Actual	Actual	Actual	Actual
6b	Mental Health Services for Older People Assessment & Treatment Wards	MHSOP <52	**69.47***	78.06	62.67	62.18	54.08
Patient Experience Measures							
7	Percentage of patients who reported their overall experience as excellent or good	94%	**90.50%**	90.53%	NA	NA	NA
8	Percentage of patients that report that staff treated them with dignity and respect	94%	**85.90%**	NA	NA	NA	NA
9	Percentage of patients that would recommend our service to friends and family if they needed similar care or treatment	94%	**87.20%**	86.58%	85.51%	NA	NA

*Year to date as at the end of February 2018.

Notes on selected metrics

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.
   As at the 28th February, there were no NICE audits due for completion. There are three to be completed by the end of March 2018.
6. Data for average length of stay is taken from the Trust's patient systems.

Comments on Areas of Under-Performance

Metric 1: Percentage of patients reported 'yes always' to the question, 'do you feel safe on the ward'?

The end of year position was 62.33%, which relates to 2,290 out of 3,674 surveyed. This is 25.67% below the Trust target of 88.00%.

All localities underperformed this year. Durham and Darlington is closest to the target with 69.58% and Forensic Services are furthest away with 48.78%.

The Trust's Patient Safety Group is conducting a "deep dive" to better understand the data for this action and are developing an action plan to monitor and resolve any issues highlighted.

Metric 3: Number of incidents of physical intervention / restraint per 1000 occupied bed days.

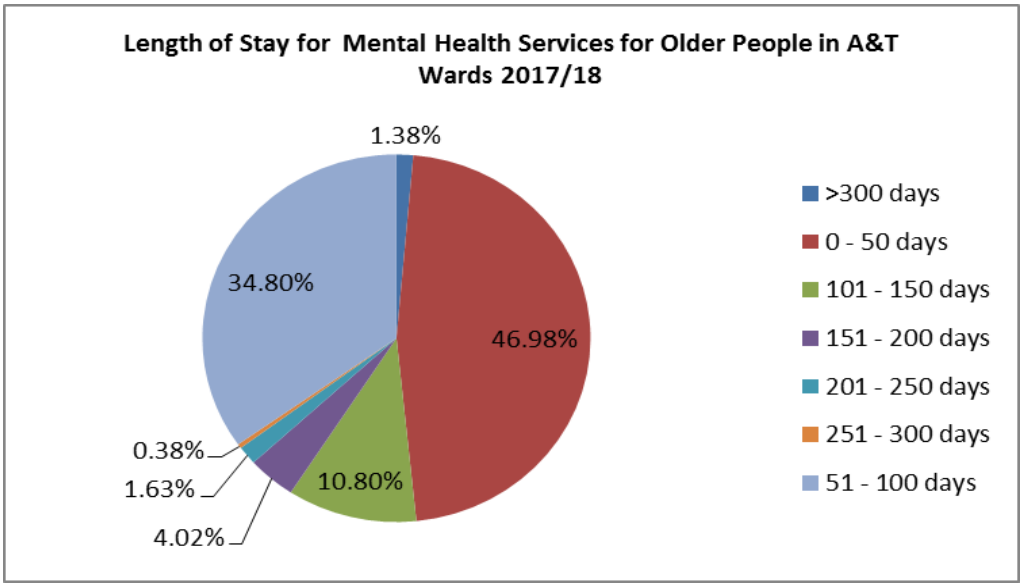
The end of year position was 30.65, which relates to 8,492 incidents out of 277,030 occupied bed days. This is 11.40 above the Trust target of 19.25.

Durham & Darlington and North Yorkshire achieved the target during year. Of the underperforming localities Forensic Services is closest to the target with 24.28 and Teesside are furthest away with 55.91.

Metric 6b: Average length of stay for patients in Mental Health Services for Older People assessment and treatment wards.

The average length of stay for older people has been worse than target since quarter three 2013/14 reporting 69.47 days as at February 2018, which is 17.47 worse than target but an improvement compared to the position reported in 2016/17. The pie chart below shows the breakdown for the various lengths of stay during 2017/18.

The median length of stay was **54** days, which is only two days above 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 distorted the overall average. In total 77.77% of lengths of stay were between 0-50 days, with 14.65% between 51 – 100 days. There were 56 patients who had a length of stay greater than 200 days; the majority were attributable to the complex needs of the patients (including physical health problems) and delays in accessing suitable placements for patients subsequent to discharge.

Metric 7: Percentage of patients who reported their overall experience as excellent or good.

The end of year position was 90.50%, which relates to 13,772 out of 15,218 surveyed. This is 3.50% below the Trust target of 94.00%.

All localities underperformed this year. Teesside is closest to the target with 91.98% and Forensic Services performing furthest away with 79.90%.

Metric 8: Percentage of patients that report that staff treated them with dignity and respect.

The end of year position was 85.94%, this relates to 14,567 out of 16,950 surveyed and is 8.06% below the Trust target of 94.00%.

All localities underperformed this year. North Yorkshire is closest to the target with 90.08% and Forensic Services performing furthest away with 64.45%.

Metric 9: Percentage of patients that would recommend our service to friends and family if they needed similar care or treatment.

The end of year position was 87.22%, which relates to 12,424 out of 14,244 surveyed. This is 6.78% below the Trust target of 94.00%.

All localities underperformed this year. Teesside is closest to the target with 89.08% and Forensic Services performing furthest away with 72.63%.

Our performance against the 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 three of the Single Oversight Framework November 2017, representing the position as at February 2018**.

Single Oversight Framework

Indicators		2017/18		2016/17	2015/16	2014/15	2013/14
		Threshold	Actual	Actual	Actual		
A	Percentage of people experiencing a first episode of psychosis that were treated with a NICE approved care package within two weeks of referral	50%	**73.67%**	70.04%	55.91%		
B	Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in inpatient wards*	90%	**92.31%**				

Indicators		2017/18		2016/17	2015/16	2014/15	2013/14
		Threshold	Actual	Actual	Actual		
C	Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in early intervention in psychosis services*	90%	**85.47%**				
D	Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in community mental health services (people on CPA)*	65%	**70.73%**				
E	IAPT/Talking Therapies - proportion of people completing treatment who move to recovery (from IAPT minimum dataset)	50%	**50.34%**	48.32%			
F	Percentage of people referred to the IAPT programme that were treated within 6 weeks of referral	75%	**95.13%**	95.44%	84.01%		
G	Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral	95%	**99.87%**	99.14%	95.93%		
H	Percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care	> 95.00%	**96.42%**	98.35%	97.75%	97.42%	97.86%
I	Admissions to adult facilities of patients who are under 16 years old		**1**				
J	Inappropriate out of area placements for adult mental health services		**2515****				

*The figures provided are based on a Trust assessment of the sample audit data.
**This is the rolling 3 month figure ending December 2017.

Notes on the Single Oversight Framework Targets and Indicators

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 or the Monitor/Single Assessment Framework report at year end.

Metric C: Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in early intervention in psychosis services

Data collection using the CCQI self-assessment tool was submitted to NHSE / Royal College of Psychiatrists on 30th January 2018; this was based on a sample of data, we believe that using this sample the compliance rate will be below target. However, analysis of the cumulative data collection period reported that 93% (354 / 381) of Early Intervention in Psychosis (EIP) service users who met the CQUIN inclusion criteria were screened and had associated interventions documented within the electronic care record (Paris).

Metric I: Admissions to adult facilities of patients who are under 16 years old

In July one patient aged 14 years old was admitted to an adult ward. The admission was the most appropriate option to keep the patient safe until a CAMHS learning disability bed became available; however this was not clinically appropriate and therefore a serious incident report was raised.

Metric J: Inappropriate out of area placements for adult mental health services

The Trust is currently seeking clarity from NHS Improvement on the calculation of this metric as it appears that the guidance issued for the Quality Account conflicts with that for the Single Oversight Framework (SOF) and we believe the two should align. In the interim the figure shown in the table is based on the calculation within the SOF and represents the rolling 3 month position ending December 2017. There were 2515 inappropriate out of area placement bed days in this period; however all of these were internal Out of Area Placements (OAPs) within the Trust as opposed to an external OAP.

An internal OAP is where the patient remains within their home organisation, but the location of the receiving unit disrupts their continuity of care. An external OAP is where the sending organisation is paying another provider to care for their patient, usually because they do not have an available bed. We have now agreed a trajectory with the CCGs to improve performance and we plan to reduce this figure by 10% each year which has been discussed with NHS England who are supportive of our approach. Representatives from the Trust have met with CCGs to develop action plans to support this delivery.

External Audit

For 2017/18, 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 2017/18 are:

- Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE)-approved care package within two weeks of referral.
- Inappropriate out-of-area placements for adult mental health services.
- Number of incidents of physical intervention / restraint per 1000 occupied bed days (Governor selected indicator).

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

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 2017/18, we have tried to improve how we involved our stakeholders in assessing our quality in 2017/18.

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.*
- *Table discussions work well.*
- *Good mix of knowledge on tables.*
- *Really positive information sharing exercise.*
- *Good range of topics covered.*
- *Interesting agenda and good speakers.*
- *Everything was excellent and very informative.*
- *Clear ideas and aims / decisions.*

In line with national guidance, we have circulated our draft Quality Account for 2017/18 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 organisations (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 2017/18:

- [Insert when received].

The Trust will write to each stakeholder addressing each comment made following publication of the Quality Account 2017/18 and use the feedback as part of an annual lessons learnt exercise in preparation for the Quality Account 2018/19.

In response to many stakeholders' requests, the Trust has agreed to continue providing all stakeholders with a half-year update in November 2018 on the Trust's progress with delivering its quality priorities and metrics for 2018/19.

APPENDICES

APPENDIX 1: 2017/18 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 Accounts) 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/Reports (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/Report.

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

- the content of the Quality Account/Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18 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 2017 to May 2018;
  - Papers relating to quality reported to the Board over the period April 2017 to May 2018;
  - Feedback from the Commissioners dated 12 May and 15 May 2017;
  - Feedback from Governors dated 8 March and 13 April 2018;
  - Feedback from Local Healthwatch organisations one dated May 2017 and one undated but received on 9 May 2017;
  - Feedback from Overview and Scrutiny Committees one dated 11 May 2017 and two undated but received on 12 May 2017;
  - Feedback from Health and Wellbeing Board dated 17 May 2017;
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 17 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 18 May 2017;
  - CQC inspection reports dated 23 February 2017.

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

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

- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account/Report, 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/Report.

By order of the Board.

..22 May 2018...Date.....Chairman

..22 May 2018...Date.....Chief Executive

APPENDIX 2: 2017/18 LIMITED ASSURANCE REPORT ON THE CONTENT OF THE QUALITY ACCOUNTS AND MANDATED PERFORMANCE INDICATORS

To be included within final version.

APPENDIX 3: GLOSSARY

Academic Health Science Network (AHSN): There are 15 AHSNs across England; they focus on two main areas: improving population health and generating economic growth. AHSNs have also been established to deliver a 'step-change' in the way healthcare providers identify, develop, adopt and spread new technologies.

Accountable Care Partnership (ACP): are alliances of NHS providers that work together to deliver care by agreeing to collaborate rather than compete. These providers include hospitals, community services, mental health services and GPs. Social care and independent and third sector providers may also be involved.

Acute Trust: provide physical healthcare services within hospitals, with some providing services within the community.

Adult Mental Health Service (AMH): Services provided for people aged 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.

Allied Health Professional (AHP): is the term used for a range of professional roles such as Dietitians, Occupational Therapists, Physiotherapists and Speech and Language Therapists.

Audit: is an official inspection of records. This can be conducted either by an independent body or an internal audit department.

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.

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 characterised by social deficits, communication difficulties, stereotyped or repetitive behaviours and interests, and in some cases, cognitive delays.

Bank Staff: This is a pool of staff that can be called upon to cover vacant shifts on inpatient wards. These staff are employed by the Trust.

Benefits: This term is often used when describing and measuring the positive and negative (dis-benefits) elements of a project or programme.

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 NHS Improvement.

Business as usual: This is a way of describing day to day business.

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 Planning: see Care Programme Approach (CPA).

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, Teesside and York 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.

College Centre for Quality Improvement (CCQI): works with the majority of mental health Trusts in the UK focusing on quality networks, accreditation, national clinical audits and research.

Clinical pathway: is a multidisciplinary management tool based on evidence-based practice for a specific group of patients with a predictable clinical course, in which the different tasks (interventions) by the professionals involved in the patient care are defined, optimised and sequenced.

CLiP (Clinical Link Pathway): Completed on the Trust's electronic patient record (Paris) for Falls allowing them to be monitored effectively.

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.

Community Mental Health Survey: is conducted every year by the CQC. It represents the experiences of over 13,000 people who received specialist care or treatment for a mental health condition in 55 NHS Trusts in England during a specified time each year.

Confidential Inquiry: 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.

Co-production / co-produced: 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.

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 (DQIPs): 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.

Data Quality (DQ) 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 data. It helps TEWV continue to improve the quality and value of our work, whilst making sure that it remains clinically and financially sustainable.

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.

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.

Executive Management Team: A regular meeting of individuals at the senior level of management within the organisation (e.g. Directors) who are responsible for the overall management of TEWV; they are responsible for the high-level decisions within the organisation.

Expert by Experience Groups and members: Non 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 a 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 (FFT): A survey question put to patients, carers or staff that asks whether they would recommend a hospital / community service to a friend of family member if they needed that kind of treatment.

General Medical Practice Code: is the organisation code of the GP Practice that the patient is registered with. This is used to make sure that our patients' GP practice is recorded correctly.

Greenlight: is a framework and self-audit toolkit for improving mental health support for people with learning disabilities.

Harm Minimisation: aims to prevent and reduce the myriad harms associated with the use of psychoactive drugs in the community.

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 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.

Health Research Authority (HRA): In accordance with the provision of the Care Act 2014, the HRA was established as an executive non-departmental public body sponsored by the Department of Health. Its purpose is to regulate different aspects of health and social care research.

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.

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.

IAPT (also known as 'Talking Therapies'): IAPT stands for "Increasing Access to Psychological Therapies" and was introduced in the last.

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.

inTouch: This is the Trusts internal website used for staff to access relevant information about the organisation, such as Trustwide policies and procedures.

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.

Join Dementia Research: is a national service that enables individuals to register their interest and be matched to take part in suitable research studies.

Kaizen: is a word used as part of the QIS process, it is a Japanese word that means 'change for the better' and is known as 'continuous improvement'.

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, Selby, Teesside and York but not in North Yorkshire.

Lived Experience: A member of the public or staff who has been treated for MH issues in the past and so has special insight into the patient perspective of having a mental illness and receiving treatment.

Local Authority Overview and Scrutiny Committee (OSC): 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.

Localities: services in TEWV are organised around four Localities (i.e. County Durham & Darlington, Teesside, 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.

Mazars: is an international, integrated and independent organisation specialising in audit, accountancy, tax, legal and advisory services.

Memorandum of understanding: is an agreement between two or more parties. It expresses a convergence of will between the parties, indicating an intended common line of action.

Managing the Business Group: is a director level group which meets monthly and manages the operational corporate business of the Trust. Similar to the Operational Management Group (OMT), however its focus is corporate services rather than clinical services. The group holds overall responsibility for the Data Quality Strategy.

Memory Services: are for people who may be experiencing memory difficulties, which includes the early onset of dementia.

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 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.

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 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 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 Quality Board (NQB): The purpose of the NQB is to provide coordinated leadership for quality on behalf of the Department of Health, Public Health England, NHS England, the Care Quality Commission, NHS Improvement and the National Institute for Care Excellence.

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.

NHS Digital: Previously known as 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.

NHS Improvement: the independent economic regulator for NHS Foundation Trusts – previously known as Monitor.

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.

North of England Mental Health Development Unit (NEMHDU): offers health and social care consultancy.

Operational Management Team (OMT): work on a localised level and are responsible for the day-to-day management of TEWV; they report to the Executive Management Team.

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.

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 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.

Positive Behavioural Support: is a person-centred approach to people who display or are at risk of displaying behaviours with challenge. It involves understanding the reasons for behaviour and considering the person as a whole including their life history, physical health and emotional needs, to implement ways of supporting the person. It focuses on creating physical and social environments that are supportive and capable of meeting people's needs and teaching people new skills to replace the behaviours which challenge.

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.

Pressure Ulcer: also known as pressure sores are localised damage to the skin and / or underlying tissue that usually occur over a bony prominence as a result of pressure or pressure in combination with shear and / or friction.

Professional Revalidation: is the process that all Nurses and Midwives need to go through in order to renew their registration with the Nursing and Midwifery Council (NMC).

Programme: A set of coordinated group of projects and change management activities designed to achieve outputs and / or changes that will benefit the organisation.

Programme Board: A group of individuals established to meet and discuss a particular programme, providing input, discussions and / or approval on issues affecting the progress of the programme, setting tasks, actions and deadlines.

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.

Psychiatric Intensive Care Unit (PICU): are units (or wards) that are designed to look after patients who cannot be managed on open (unlocked) psychiatric wards due to the level of risk they pose to themselves or others.

Purposeful Inpatient Admission (PIPA) 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 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.

Quarter one (Q1) / quarter two (Q2) / quarter three (Q3) / quarter four (Q4): These refer to specific points within the financial year (1st April to 31st March). Quarter one is the period of time from April until June. Quarter two is the period of time from July to September. Quarter three is the period of time from October to December. Quarter four is the period of time from January to March.

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

Recovery focused: see Recovery Approach.

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

Ridgeway: The part of Roseberry Park Hospital that houses our low and medium Forensic Secure Adult wards (also known as Forensic wards).

Royal College of Psychiatrists: is the professional body responsible for education and training, and setting and raising standards in psychiatry.

Section 17 (S17): This is a Section within the Mental Health Act (1983) which allows the Responsible Clinician (RC) to grant a detained patient leave of absence from hospital. It is the only legal means by which a detained patient may leave a secure hospital site when they are detained under 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.

Service Development Group (SDG): A group of individuals established to review how changes can be made to improve patient care.

Single Oversight Framework: sets out how NHS Trusts and NHS Foundation Trusts are over overseen.

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.

Steering Group: These are made up of experts who oversee key pieces of work to ensure that protocol is followed and provide advice / troubleshoot where necessary.

Strategic Change Oversight Board (SCOB): A meeting of members of EMT to oversee and discuss and / or approve development and improvement of the Trust’s services.

Strategic Programme: A programme that considers the ‘big picture’, overseeing how they can benefit the Trust as a whole in order to help improve services and patient experience.

Substance Misuse: A pattern of psychoactive substance use (including illegal drugs, alcohol, smoking and misuse of prescription drugs) that is causing damage to health or has adverse social consequences. Substances can be misused on a regular or intermittent basis (e.g. binge drinking).

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.

Thematic Review: A piece of work to identify and evaluate Trustwide practice in relation to a particular theme. This may be to identify where there are problems / concerns or to identify areas of best practice that could be shared Trustwide.

The Process of Recovery Questionnaire (QPR): is a 15 item measurement tool developed from service users' accounts of recovery from psychosis in collaboration with local service users.

The Trust: Tees, Esk and Wear Valleys NHS Foundation Trust.

Tissue Viability Advice: is advice provided to healthcare professionals who are involved in the management of complex wounds such as pressure ulcers.

Transitions: For the transitions Quality Account Priority we define a transition as a purposeful and planned process of supporting young people to move from children's to adults' services.

Trauma informed care (TiC): involves understanding, recognising and responding to the effects of all types of trauma.

Trust Board: See 'Board / Board of Directors'.

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.

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.*

Workstreams: is the progressive completion of tasks completed by different groups which are required to complete a single project or programme.

Years 2015/16 / 2016/17 / 2017/18 / 2018/19 / 2019/20 / 2020/21: These are financial years, which start on the 1st April of the first part of the year and end on the 31st March on the second part of the year on each of the years shown.

APPENDIX 4: KEY THEMES FROM 163 LOCAL CLINICAL AUDITS REVIEWED IN 2017/18

Audit Theme	Key quality improvement activities associated with clinical audit outcomes
1. 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 **99** IPC clinical audits were conducted during 2017/18 in inpatient areas and a sample of community areas in the Trust. **96% (95/99)** 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.
2. Supervision	• Supervisory staff and Durham County Council (DCC) employees have been provided with details of DCC training requirements and provision. Local Authority staff have been given access to and registered on ESR and IIC so all can access training information for supervision. • A Task and Finish Group is scheduled to be developed which includes Team Managers from both DCC and TEWV to work locally to develop common documentation for recording staff supervision. The goals for the team that reflect DCC and TEWV required outcomes are to be identified by a leadership team and will be incorporated into individual appraisals. • 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.
3. Records management	• There have been newly established work streams to rectify documentation recording within Prison patient systems and subsequent clinical audit re-audits have identified high compliance within Offender Health services documentation showing significant improvements made. • In CYPS Tier 4 Services, there have been developments following clinical audit activities which have influenced the recording of incidents of restraint within the TEWV Datix system. The developments related to including prompts for staff to document the appropriate information as required. Additional information posters were also displayed in clinical areas. • In MHSOP Services, clinical audits have identified outdated guidance and reference to age of 65 within operational policies for Age and Discrimination. These have been updated to specify 'older people' and referenced by the RCP guidance. • Following a clinical audit investigating the Claims Management Policy, the Claims and Legal Services Manager have reviewed the process of sharing lessons learnt from the claim to relevant Heads of Services. • In CYPS new guidelines and a flowchart have been developed around the requirements for documentation in a transition plan and panel meetings.
4. NICE/ Pathway Development	• Adult Mental Health services have reviewed and updated the Positive Behaviour Support (PBS) Pathway, linking to the Force Reduction Team, and awareness sessions have taken place for staff around PBS. • The Forensic Service has developed PBS awareness sessions for carers to support their involvement when service users express a wish for their involvement during behaviour support or intervention plan development. • In CYPS services, a checklist was rolled out for assessment of low mood to support compliance with NICE Guidance for Depression and this was incorporated into the CYPS Pathway shared area to be accessible. • A Memory Clinic Initial Assessment crib sheet was included within the Dementia Care Pathway document.
5. Physical Healthcare	• A new frailty CLiP has been introduced following clinical audit activities considering Falls assessment and management in MHSOP services. • AMH Teams have been provided with additional support from the Nicotine Management Team to continue to further reduce smoking rates. A Toolkit has been developed to support implementation of the Nicotine Management policy and this has been cascaded by the Smoking Cession Project Lead during ward visits to support smokers on admission. • The Trust Rapid Tranquilisation (RT) and Early Warning Score (EWS) policies have been updated to clarify the need for EWS total scores to be

Audit Theme	Key quality improvement activities associated with clinical audit outcomes
	transferred from the paper EWS chart to the post Rapid Tranquilisation physical health case note. The RT policy has also been updated to include instructions to complete the post-Rapid Tranquilisation paper form which has been developed to provide a single place to record incident details and debrief and to provide a prompt to record EWS as per policy. • RT clinical audit findings have influenced updates to the Health Care Assistant physiological observation training detailing more information on RT and EWS, and also influenced updates to the Trust Incident reporting system to allow reporting of RT without physical intervention and to prompt recording of EWS post RT. • Trust Nasogastric Tube Insertion training materials were updated following clinical audit findings to emphasise the correct tests to check NG tube positioning and the intended use for the Cortrak system. • Results of the National CQuIN Safety Thermometer are reported to the Clinical Effectiveness Group quarterly.
6. Medicines Management	• Covert medicine checklist was updated to include space in which to indicate who is responsible for reviewing covert administration. Covert medicines Standard Process Description was amended to include the option to make reference to covert administration instructions set out in the covert medicines plan, rather than recording instructions in the comments section in the prescription and administration chart. • The Trust's High Dose Antipsychotic Treatment (HDAT) monitoring sheet was updated to include reminders for documenting the reason for HDAT, consent/T3, and Paris medication alert. • There have been updates made to the lithium initiation proforma and lithium register recording patient weight/BMI and the requirement to inform women of childbearing age of lithium's teratogenic potential. • A monitoring information sheet has been produced for GP practices as part of the new lithium shared care guidelines.
7. Risk Assessment/ Patient Safety	• Harm Minimisation Training resources programme content have been influenced from findings from clinical audit activities. • The Clinical Audit and Effectiveness Team provided immediate feedback to clinical teams as appropriate to mitigate risks identified from clinical audit activities assessing Safety Summary documentation within patient electronic records. • Guidance notes have been developed detailing requirements for Safety Summary documentation following clinical audit findings. • Safeguarding clinical audits have resulted in points of contact for the Team published on the Trust Intranet and electronic posters shared in clinical teams. A Rapid Process Improvement Workshop (RPIW) has also been arranged with a focus on addressing improvements to the process following findings from the clinical audits. • MCA/DoLS training has been made mandatory within the Trust and bespoke briefing sessions and ward visits have been facilitated to support practice delivery following a MCA assessment audit.
8. Environment and Equipment	• The Trust Resuscitation policy has been updated following clinical audit findings to comply with new training requirements. • As part of ongoing improvement work regarding improving the state and readiness of Emergency Equipment in the Trust, a process has been developed by Nursing and Governance to implement a new monitoring process for this equipment. Modern Matrons and Service Managers will receive completed daily checklists on a 4 week basis and validation checks undertaken by these will provide assurance to the Quality Assurance Groups.

APPENDIX 5: TRUST BUSINESS PLAN ADDITIONAL QUALITY PRIORITIES

The 4 quality priorities within this Quality Account also sit within TEWV's 2018/19-2020/21 Business Plan. The Business Plan includes a further 15 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 Trust's Recovery Strategy (years 4-6 of 10) and develop Phase 3	Q4 2020/21
2	Develop and deliver the Purposeful and Productive Community Services Programme (PPCS)	Q4 2020/21
3	Improve the consistency and purposefulness of inpatient care across the Trust	Q4 2020/21
4	Ensure we have the right staffing for our services now and in the future	Q4 2018/19
5	Deliver our Digital Transformation Strategy	Q4 2020/21
6	Refresh, communicate and implement Making a Difference Together across the whole organisation	Q4 2018/19
7	Develop and implement New Care Models	Q4 2020/21
8	Evaluate and agree future collaboration with universities on research, education and training	Q4 2018/19
9	Implement the Transforming Care agenda in Learning Disability Services	Q4 2018/19
10	Develop a Trust-wide approach to enabling service users with autism to access Trust mental health services	Q4 2018/19
11	Complete the transformation of our York and Selby services	Q3 2019/20
12	Agree and implement future service delivery model for service users from Harrogate and Rural District CCG and Wetherby area	Q3 2019/20
13	Deliver the agreed new model of care for Adult Mental Health and Mental Health Services for Older People in Hambleton and Richmondshire	Q4 2018/19
14	Improve the physical environment at Roseberry Park	Q4 2020/21
15	Implement the 5 Year Forward View for Mental Health as agreed with each of our commissioners	Q4 2020/21

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

Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE)-approved care package within two weeks of referral

Data definition:
Percentage of people with a first episode of psychosis beginning treatment with a NICE-recommended care package within two weeks of referral. The clock stops at the start of the first definitive treatment for 2 different patient cohorts:

a) those experiencing first episode psychosis - when a person has been accepted onto caseload, an EIP care coordinator allocated and a NICE concordant package* of care commenced - this will need to be incorporated into the KPI when details are published. ALL THESE CONDITIONS MUST HAVE BEEN MET;

UNTIL THE NICE CARE PACKAGE DETAILS ARE KNOWN, THE CLOCK WILL STOP WHEN PATIENT HAS HAD A FIRST SUCCESSFUL FACE TO FACE CONTACT AFTER NEW REFERRAL RECEIVED DATE

b) for those possibly at risk mental state (ARMS) - when the person has been accepted onto caseload, an EIP care coordinator allocated and a specialist ARMS assessment commenced by an appropriately qualified EIP clinician - ALL THESE CONDITIONS MUST HAVE BEEN MET.

Exemptions:
The only suspected cases of first episode psychosis exempt from this KPI will be referrals of individuals who are experiencing psychotic symptoms in the context of organic illness e.g. dementia.

Accountability:
This standard applies to anyone with a suspected first episode of psychosis who is aged 14 to 65. People aged over 35 who may historically not have had access to specialist early intervention in psychosis services should not be excluded. Technical guidance is available at: www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/02/tech-cyped-eip.pdf.

Provider boards must be fully assured that RTT data submitted is complete, accurate and in line with published guidance. Both ‘strands’ of the standard must be delivered:

- performance against the RTT waiting-time element of the standard is being measured via MHSDS and UNIFY2 data submissions.
- performance against The National Institute for Health and Care Excellence concordance element of the standard is to be measured via:
    - a quality assessment and improvement network being hosted by the College Centre for Quality Improvement at the Royal College of Psychiatrists; all providers will be expected to take part in this network and submit self-assessment data, which will be validated and performance-scored on a four-point scale at the end of the year. This assessment will be used to track progress against the trajectory set out in Implementing the Five Year Forward View for Mental Health: www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf.

- submission of intervention and outcomes data using SNOMED-CT codes in line with published guidance. Provider boards must be fully assured that intervention and outcomes data submitted is complete and accurate.

Inappropriate out-of-area placements for adult mental health services

Data definition:
An out of area placement that is solely or primarily necessitated because of the unavailability of a local acute bed will not meet the criteria for being appropriate. The total number of OAP days is the number of bed days associated with open OAPs in the rolling 3 month period.

Exemptions:
All beds except for acute adult mental health care - Assessment & Treatment, Acute older adult mental health care (Organic and Functional) Assessment & Treatment and PICU. The age range excludes anyone who is under 18 years.

Number of incidents of physical intervention / restraint per 1000 occupied bed days

Data definition:
Number of incidents of physical intervention / restraint per 1000 occupied bed days

Exemptions:
There are not any exemptions for this indicator.

Accountability:
QuAC and Patient Safety Group

Numerator:
The actual number of incidents of physical intervention / restraint .

Denominator:
The total number of responsible ward / team occupied bed days divided by 1000.

APPENDIX 7: FEEDBACK FROM OUR STAKEHOLDERS

To be included within final version verbatim.