DARLINGTON
Borough Council

Tees Valley Joint Health Scrutiny Committee Agenda

11.00 am
Wednesday, 8 June 2022
Roseberry Park, Marton Rd, Middlesbrough TS4 3AF

Members of the Public can view a live stream of the meeting at: https://www.youtube.com/user/middlesbroughcouncil/videos
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1. Appointment of Chair for the purpose of the meeting

2. Introductions/Attendance at Meeting

3. Declarations of Interest

4. Minutes of the Meeting held on 18 March 2022 (Pages 3 - 14)

5. Protocol for the Tees Valley Joint Health Scrutiny Committee (Pages 15 - 20)

6. Tees, Esk and Wear Valley NHS Foundation Trust - Quality Account 2021/2022 – Presentation by the Associate Director of Strategic Planning and Programmes and Director of Quality Governance, Tees, Esk and Wear Valley NHS Foundation Trust (Pages 21 - 114)

7. Tees, Esk and Wear Valley NHS Foundation Trust - CQC Inspection Update – Report of the Chief Executive, Tees, Esk and Wear Valley NHS Foundation Trust (Pages 115 - 134)

8. Work Programme –
Report of the Assistant Director Law and Governance
(Pages 135 - 140)

9. SUPPLEMENTARY ITEM(S) (if any) which in the opinion of the Chair of this Committee are of an urgent nature and can be discussed at the meeting.

Luke Swinhoe
Assistant Director Law and Governance

Friday, 27 May 2022

Town Hall
Darlington.

Membership
Councillors Mary Layton, Councillor Rob Cook, Councillor Rachel Creevy,
Councillor Angela Falconer, Councillor Dorothy Davison, Councillor Alma Hellaoui,
Councillor Dan Rees, Councillor Sandra Smith, Councillor Anne Watts,
Councillor Evaline Cunningham, Councillor Clare Gamble, Councillor Lynn Hall and Vacancies

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TEES VALLEY JOINT HEALTH SCRUTINY COMMITTEE

A meeting of the Tees Valley Joint Health Scrutiny Committee was held on Friday 18 March 2022.

PRESENT:	Councillors A Hellaoui (Chair), D Davison, M Layton (Vice-Chair), B Clarke, Richardson, E Cunningham, C Gamble, L Hall and V Rider (Substitute for S Smith)
PRESENT BY INVITATION:	Councillor D Coupe
ALSO IN ATTENDANCE:	B Kilmurray (Chief Executive) (TEWV), D Gallagher (TVCCG), C Blair (Director Of Commissioning Strategy and Delivery) (TVCCG), M Cotton (NEAS), B Cranna (Head of Hospitals Inspection Mental Health and Community Health Services (North Region)) (Care Quality Commission), A Bridges (Executive Director of Corporate Affairs and Involvement) (Tees, Esk & Wear Valley NHS Foundation Trust), P Murphy (Chair) (Tees, Esk & Wear Valley NHS Foundation Trust), S Gill (Head of Service for Adult Learning Disabilities) (Tees, Esk & Wear Valley NHS Foundation Trust), H Ray (Chief Executive) (North East Ambulance Service (NEAS)), A Monk (Medicines Optimisation Pharmacist) (North of England Commissioning Support (NECS)) and C Riley (Executive Director from North East and North Cumbria ICS) (NENC ICS)
OFFICERS:	C Breheny, A Pearson, G Woods, J Stevens, H Fay and S Bonner
APOLOGIES FOR ABSENCE:	Councillors I Bell, J Bartch, S Smith, D Rees, B Cook and D Loynes

20 **DECLARATIONS OF INTEREST**

There were no declarations of interest at this point in the meeting.

21 **MINUTES - TEES VALLEY JOINT HEALTH SCRUTINY COMMITTEE - 24 SEPTEMBER 2021**

The minutes of the Tees Valley Joint Health Scrutiny Committee held on 24 September 2021 were approved as a correct record.

22 **MINUTES - TEES VALLEY JOINT HEALTH SCRUTINY COMMITTEE - 10 DECEMBER 2021**

The minutes of the Tees Valley Joint Health Scrutiny Committee held on 10 December 2021 were approved as a correct record.

23 **TEES, ESK & WEAR VALLEYS NHS VALLEYS NHS FOUNDATION TRUST - RESPONSE TO RECENT CQC INSPECTION**

The Chief Executive at Tees, Esk and Wear Valley NHS Foundation Trust (TEWV), the Chair at TEWV NHS Foundation Trust and the Lead Inspector from the Care Quality Commission (CQC) were in attendance to provide an update in respect of the CQC's recent inspection report findings.

The Chief Executive thanked the Committee for providing the opportunity to update Members on the action that had been taken by the Trust in response to the CQC's recent report. In terms of the presentation, a copy of which had been provided to the Committee in advance of the meeting, it was advised that information on the following would be covered at today's meeting:-

• Our Journey To Change and key improvements.
• An overview of our recent Care Quality Commission (CQC) core service inspection (Jul-Aug 2021).
• An update on our secure inpatient service – key actions, improvements and impact. • An

update on our community child and adolescent mental health services – key actions, improvements and impact.
• Other services inspected and the feedback from the CQC.
• Adult mental health and psychiatric intensive care unit (PICU) follow up inspection progress.
• Wider challenges and how we're addressing them.
• Continuing Our Journey To Change.

In terms of the Trust's Journey to Change it was noted that a number of improvements had been made following the CQC inspection including; an organisational restructure, the introduction of improved governance arrangements, an increased leadership capacity - including the appointment of two lived experience directors, additional Board development work, increased oversight of the work of the Board and its sub-groups, the introduction of revised risk management arrangements, numerous recruitment and retention initiatives – resulting in a 5 per cent increase in FTE equivalents in the Trust's overall headcount, the implementation of enhanced quality assurance programmes, the development of an improved organisational learning infrastructure – development of a learning library and an increase in compliance with statutory and mandatory training.

With regard to the report itself, the CQC inspection had been held between June and August 2021 and the report had been published in December 2021. An action plan, as produced by the Trust was submitted to the CQC in January 2022 and the Trust had been working collaboratively with the CQC, colleagues in NHSEI, the CCG's, staff, patients and carers to bring about improvements. The improvement plan submitted to the CQC was co-created and frontline staff and patients were directly involved in its development. The Chief Executive stated that the Trust was confident in the approach it had adopted to bring about improvements. In terms of its CQC overall rating the Trust remained at requires improvement. The Trust had been rated as being good for caring and effective and required improvement for being well-led, responsive and safe. The Chief Executive advised that since the CQC inspection significant progress had been made and that the focus now was on embedding and sustaining those changes.

The Chief Executive advised that he wished to focus specifically on the delivery of secure inpatient services (SIS) as this was one of the main areas of concern alongside the delivery of child, adolescent and mental health services (CAMHS). It was advised that the SIS was a regional, specialised service and the concerns raised by the CQC in respect of this service had related to staffing, safeguarding and the governance systems in place to ensure quality and safety. In terms of progress the Trust had undertaken a number of measures including; undertaking reviews of safety plans and safety summaries to ensure they accurately reflected the current and real risks faced by individuals, improved compliance with safeguarding training, the embedding of a safeguarding expert within the service to deliver a more timely and responsive approach to safeguarding issues, the introduction of SafeCare to ensure the Trust maintained safe staffing levels, improvements to the flow of patient safety information through revised governance structures and a new model of care and professional practice had recently been launched (February 2022).

The Chief Executive stated that at the heart of some of the challenges faced by the secure inpatient service were issues around culture, which had been well documented within the CQC report. Secure inpatient services were by definition a closed environment and the Trust needed to ensure that it addressed any pockets of poor culture or behaviour issues that could influence the experience and safety of patients and colleagues that worked in this service. In terms of progress made since the inspection it was highlighted that very few requests for leave were now cancelled owing to staffing constraints and there had been positive impacts in terms of recruitment, with more offers of work progressing through the Trust's employment channels that were due to come to fruition in May / June 2022. In addition there had been a reduction in the use of bank staff, which was proving effective in addressing some of the cultural challenges.

In terms of the delivery of CAMHS it was advised that this another key area of improvement for the Trust and the areas of focus were as follows; ensuring staffing levels met the demands of the service, reviewing young people waiting for treatment including specialist assessments and ensuring mandatory training compliance. The Chief Executive advised that the Trust had made significant inroads in respect of CAMHS. All of the young people waiting for treatment had been reviewed, the Trust had been in touch with all young people and their families waiting for treatment and they were being contacted regularly in line with their individual risk.

Risks could now be reassessed and if an individual's level of risk changed and was heightened, for example, they could be prioritised and brought forward. In terms of the concerns raised in respect of the level of caseloads clinicians were managing significant progress had been made. The Trust had 'level loaded' through detailed caseload review and ongoing supervision so that in a number of teams now, including in the Tees Valley, how some of those caseloads can be reduced. It was advised that staffing was a key issue and there were currently 111 job offers in the system at the moment and in May / June 2022 these appointments would begin to impact on caseloads.

It was highlighted that workforce and transformation were particularly important for the Trust and work had been undertaken with the Director of Children Services in Stockton, on behalf of his colleagues across the other Tees Valley authorities, to develop approaches around early intervention, schools and the VCS's, as well as those children with some of the most acute needs. A significant amount of work was being undertaken in this whole area of children's services transformation in conjunction with Local Authority colleagues. Stockton had served as a pilot and caseloads within Stockton had reduced by approximately 37 per cent. It was envisaged that this work would be rolled out to other areas by September 2022. Improvements in waiting times had been made and the Trust had on Teesside the average wait for a first appointment was 6 days and the average wait for a second appointment was 20 days.

Another area covered in the CQC inspection report related to crisis services and health based places of safety. It was advised that the CQC rated this area as good and a number of areas of good practice were highlighted within the inspection report including that staff treated patients with compassion and kindness, they respected patients' privacy and dignity and leaders had the skills, knowledge and experience to perform their roles. Given that the crisis service received 250,000 to 300,000 calls per year this was a really positive outcome.

In respect of community based mental health services for adults of working age the CQC inspection had highlighted a number of areas of good practice. This included that staff assessed the mental health needs of all patients. They worked with patients and families and carers to develop individual care plans and updated them as needed. Care plan reflected the assessed needs, were personalised, holistic and recovery orientated. In terms of areas identified for improvement these included timely access to services and consistency of approach to caseload management. The community adult mental health service received an overall rating of required improvement.

Reference was made to an area that had been subject to a CQC report following a visit to TEWV in January 2021 in relation to care provided by the adult mental health acute inpatient admissions and psychiatric intensive care units. In terms of the concerns raised by the CQC these had been fundamentally focused on the complex systems that had been in place in respect of risk assessments and risk management. In terms of progress made a huge amount of work had been undertaken to redesign the systems used for the recording of risk assessment and risk management. In total 50,000 care plans, safety plans and safety summaries had been reviewed and updated. Through quality assurance and audit work the Trust was able to reassure itself that the improvements made were being maintained. A follow up inspection was undertaken by the CQC in May 2021 and the service was re-rated as required improvement.

In terms of the wider challenges and how the Trust was addressing these the Chief Executive advised all the work discussed was ongoing but it was acknowledged that there was still a significant amount of work to undertake. Workforce, recruitment and retention remained a challenge and the omicron phase of the Covid-19 pandemic had proved the most challenging for TEWV as an organisation. Thankfully, the impact of the pandemic was now reducing and staff absences were falling. Demand remained high and wards were often at full capacity, with patients needing to remain in hospital for longer due to their acuity of need. There had been a real focus on workforce with some significant successes. The volume of recruitment had resulted in the need to expand TEWV's recruitment team and support had been provided by a business services agency.

Further measures in respect of workforce included introducing incentives for people to come and work for TEWV, an online recruitment process that had been undertaken with Sussex University, which included an automated screening approach, work to refresh the induction and ongoing supervision processes and work to ensure TEWV's reward and recognition

package was favourable compared with that offered by other Trusts. As part of the organisational restructure TEWV was set to go live with its new operational, clinical restructure on 1 April 2022. Work was currently being undertaken with the corporate teams – people and culture directorate and support provided to staff in terms of workforce planning, health and wellbeing and staff engagement.

Reference was made to TEWV's plan on a page document and it was advised that the Trust had spent a lot of time over the last 18 months listening to people to get a sense of what was important, how TEWV could drive the improvement agenda before bringing that together to identify TEWV's vision and purpose. It was highlighted at stage 4 that TEWV had also developed a set of values – Respect, Compassion and Responsibility that were driving the organisation's Journey To Change. It was emphasised that it was not simply a case of improving services to satisfy the CQC, TEWV as an organisation wanted to deliver the highest quality services where patients had the best experience and this would be achieved through the sustained work being undertaken to achieve these goals.

Following the presentation Members were afforded the opportunity to ask questions and the issues below were raised:-

- Reference was made to the involvement of Health Care Assistants and people with lived experience in TEWV's Journey To Change and a Member queried whether the two Directors with lived experience were yet in post. In response it was advised that although they were not yet in post both had been recruited to and offered the positions. In addition a new Head of Co-Creation post had been established to further strengthen the involvement of patients in the development of service delivery. Work was also being undertaken to expand TEWV's Peer workforce so that the voice of lived experience would be working alongside all of TEWV's professionals. A concerted and thorough approach was being adopted. It was advised that significant investment had been put into these senior leadership roles to bring patient voice and patient leadership to the heart of TEWV's service delivery. It was anticipated that both of the lived experience were due to join the organisation in June 2022.
- Reference was made to sickness levels and the impact that the pandemic had had on staff. A Member queried whether any work had been undertaken to measure levels of stress amongst staff. It was advised that although no specific piece of work had been undertaken in relation to this issue. However, when recording staff absence the reasons were recorded and mental health / well-being was probably the second highest reason for staff absences. Psychological support was available to staff via the regional resilience hub and TEWV also had its own psychology service that staff could access. Good support systems were in place. In terms of the secure inpatient services sustained efforts had been made to ensure staff were now able to take their breaks whilst on shift. It was anticipated that the stresses would continue, even after the pressures caused by the pandemic. This was an area that TEWV would continue to prioritise.
- An area that remained of concern to Members was the toxic culture, as referenced by the CQC, in relation to the delivery of inpatient secure services. A Member queried how that issue was being addressed and what specific progress had been made to date. The Chief Executive advised that culture was a challenge for big organisations and that some of the work undertaken involved bringing the patients' voice into services through the lived experiences initiatives. Engaging with staff was another important factor and the development of the Health and Care Assistant Forum provided an opportunity for them to air any concerns and discuss with staff proactively how TEWV could create a better environment / positive culture for everyone to work within. A significant amount of work was being undertaken with regard to leadership in the area of inpatient secure services. It was emphasised that the comments made by the CQC in relation to a toxic culture related solely to this particular service area and was not endemic throughout the organisation. It was a focussed approach in this specific area. It was important to provide opportunities for staff to be able to raise any concerns and overt conversations were being held around accountability where there were any pockets of bad behaviour. Where such practices were found and evidenced then the leadership would challenge and deal with any issues.
- Reference was made to the statistical data, as referred to in the CQC report, in relation to a decrease in satisfaction amongst staff who identified as Black, Asian and Minority Ethnic (BAME) or as having a disability. In addition the CQC report had highlighted that a greater proportion of BAME staff had stated that they were victims of bullying, abuse and hate crime and that the management responses were variable. A Member of the Committee queried as to what reassurances could be provided in relation progress being made by

TEWV in respect of addressing these issues. In response it was advised that engagement work had been undertaken with a number of protected characteristics groups to ensure their perspectives were being heard and acted concerns raised acted upon. Reverse mentoring schemes had been introduced around the disciplinary processes, with representatives from BAME staff on those to ensure that there was no undue bias in any of those processes. Where issues did arise it was also a case of ensuring that there was fair accountability and demonstrating that these issues would be dealt with proactively. Talking to representatives from those networks it was felt that the Trust was making positive steps forward in respect of that agenda.

- A Member made reference to a recent presentation on TEWV's 'Journey To Change', as given by the Chief Executive at a recent Stockton Borough Council Adult Social Care and Health Select Committee meeting. It was stated that having had the opportunity to reflect on that presentation Members in Stockton felt that what was lacking was any information in respect of the impact the changes were having. It was also queried as to whether given that no work had been undertaken by the Trust to measure staff stress levels whether any wider staff survey had been conducted. Finally, reference was made to the Chief Executive's staff blog and comments made in relation to dismissals. It was queried as to the number of dismissals that had taken place? As well as to how many bank staff shifts had been used in Forensic Services in 2022 compared with the 2021 figures? In addition, how much overtime had been used and what were the current Covid/non-Covid sickness levels? It was stated that the Health Care Assistant Council referenced in the presentation, as a mechanism via which staff would be able to raise any concerns was not yet in operation and would only come into effect later this month. This initiative was applauded, although it was felt that it should have been introduced earlier. The reference to 3 per cent of leave being cancelled did not provide sufficient information in respect of the impact. It was queried as to what this meant in terms of numbers of people impacted. The CQC report had been very damning right up to Board level and it was queried as to what changes had been made at Board level in terms of the Medical Director and Safeguarding Lead. It was questioned as to whether it was felt that the Trust in its current size was simply too big.
- In response to the numerous questions posed above the Chief Executive advised that work was currently being undertaken within the Trust to split the Trust into two parts. One part to cover Durham and the Tees Valley and the other to cover North Yorkshire and York. It was felt that this would help to reduce the complexity of managing an organisation of that scale. In terms of the numbers these could be provided and the information would be forwarded to Members following the meeting. In terms of accountability the Chief Executive advised that the references made in his recent organisational blog demonstrated the Trust's commitment to ensuring that where any issues of concern were identified action would be taken.
- The Chair of TEWV responded to the query raised in terms of the changes introduced at Board level. The Chair stated that he was a lay Member and the majority of those that served on the Board were Non-Executive Directors. There had been an almost complete turnover of the personnel on that Board in the last 18 months. It was very much a new Board focused on how to make services better. The Trust was currently out to recruitment for a new Medical Director, as the previous Medical Director was leaving the Trust and leaving the NHS. The Board continued to both support and challenge the Chief Executive and staff within the Trust on a daily basis. The Chair offered his reassurance to the Committee that the lay people on the Board, on behalf of the patients and populations they served, ensured that the Chief Executive and his colleagues were absolutely focussed on improving services for our communities.
- The Chair of the Trust offered the opportunity for Members of the Board to undertake a visit to the Trust and any of the services being provided, including the secure inpatient service. It was stated that there was very much a willingness from the Trust to be open and transparent. The Trust had no hesitation in inviting Members of the Committee to visit its services and see first-hand the delivery of service provision. The Trust would be delighted to welcome Members to meet staff and patients and see for themselves the improvements being made. The Chair of the Trust acknowledged that there were some pockets of bad practice but they were absolutely a handful compared with the nearly 8000 members of staff employed across the Trust. It was emphasised that there were multiple areas of good practice compared with any areas of concern.
- Reference was made to the issues raised in the CQC report in respect of culture and Members expressed the view that there was no quick fix. It would take a long time to change the culture of the organisation and evidence from staff surveys would demonstrate whether that shift in culture was starting to take place. It was queried whether there were

any specific changes on the ground that could be reported in relation to this issue. The Chief Executive advised that there was no evidence to suggest that the issue in respect of culture was endemic and where there were issues action was being taken. The progress that had been made in terms of recruitment was encouraging, the fall in staff sickness rates in areas where there had been concerns was a further positive and the improved engagement in training. It was acknowledged that it was challenging, particularly in light of the impact of the pandemic. The Trust was due to undertake some pulse survey work over the next few weeks and it was anticipated that this would provide some evidence in respect of staff feedback. The offer was provided to update Members on this work at a future meeting of the Committee.

The Chair introduced the CQC's Lead Inspector and invited him to make any comments in respect of the information provided to the Committee and the discussion that had been held. The Lead Inspector advised that he wished to highlight a number of points. The first was in relation to the senior leadership within TEWV, as there had been significant changes in the leadership team. At the time of the inspection TEWV had developed plans to strengthen the leadership team to address the governance issues it had identified and this would be an area that would be revisited in the CQC's follow up inspection. In an effort to ascertain whether those changes had had the desired impact on strengthening the governance processes within the organisation and making the necessary improvements in leadership.

The Committee was advised that the CQC continued to have regular engagement with the organisation. TEWV provided it with regular updates and information and the CQC participated in the additional oversight processes in place. These included the Quality Improvement Board, which was chaired by NHS England Improvement (NHSEI) and regular conversations with the provider collaborative, which had responsibility for the monitoring of the secure services in particular. The CQC had seen that action had been taken by TEWV to address the areas of concern raised. However, from a regulatory position ultimately the CQC's assessment of whether it had received sufficient reassurance on improvement would be at the point it undertook a re-inspection and spoke to staff, patients and carers about what impact the changes had had for them.

The Lead Inspector advised that the re-inspection would be unannounced and the CQC generally re-inspected services within a six month period. If, however, any information came to light, which suggested that the level of risk had changed the CQC would be responsive and re-evaluate its timescales. The CQC had a range of enforcement powers available to it, both civil and criminal, but clearly the CQC's hope was that the action taken by the TEWV resulted in an improvement in the safety and quality of care people received.

AGREED as follows:-

i) That an additional meeting be arranged, if practical, given that purdah was scheduled to commence shortly, followed by each local authorities' AGM, where membership of the Committee would be subject to change.
ii) That the next meeting of the Committee be held at Roseberry Park Hospital and a visit to services, including the secure inpatient service, be undertaken following that meeting.
iii) That a copy of the key questions Members still had in relation to the CQC inspection report be forwarded to TEWV, in advance of the next meeting, for a written response to be provided.
iv) That information in respect of the pulse survey work undertaken with staff be provided to Members at the next meeting of the Committee.

24 **LOCAL NHS / PUBLIC HEALTH RESPONSE TO COVID-19**

The Director of Health was unable to attend the meeting and the Chair requested that in his absence this item be deferred for consideration at the next meeting of the Tees Valley Joint Health Scrutiny Committee.

AGREED that the item be deferred.

25 **NORTH EAST AMBULANCE SERVICE (NEAS) PERFORMANCE UPDATE**

The Chief Executive and the Assistant Director of Communications at the North East

Ambulance Service (NEAS) were in attendance to provide a performance update to the Committee.

In terms of 111 call handling it was advised that the call volumes coming into the service had spiked dramatically at the start of the Covid-19 pandemic. In respect of the calls received at that time, the average time to answer was within usual boundaries until April 2021. At that time call response times began to deteriorate and the service was impacted by waves of Covid-19 on the NEAS's workforce. There was a very large scale recruitment campaign, which was current at the moment to recruit 152 health advisors into the 111 and 999 service. NEAS was on target to meet demand and this month alone the service had welcome 53 new health advisors into the control room. A third call handling site was also opening on Teesside and the centre would handle both 111 and 999 calls. In particular there had been a large increase in the number of patients contacting the 111 service looking for dental help and NEAS had been working hard with NHS England to double the number of dental appointments the service was able to offer to patients each week, where they had an urgent dental concern.

The 111 outcomes chart (December 2021) showed that almost half of the calls (46 per cent) received by the service were referred back into Primary Care services (including the patient's own GP). Dental calls made up approximately 10 per cent of all calls to the 111 service. It was noted that although the outcome figure for calls to the 111 service where an ambulance was required indicated 17 per cent it was explained that the actual ambulance response figure was closer to 7 or 8 per cent. The reason for the difference was that these calls were revalidated by clinicians, which included a call back, to check on the level of need. The remaining specialist services included, for example, eye services, children's A&E and maternity suite referrals.

In respect of the 999 calls there had been a significant increase in the call volumes. Before the Covid-19 pandemic call volumes were quite high. During the first lock down in 2020 999 calls actually eased off a little bit. Over the last year or so the volume of 999 calls had started to increase again. A key mechanism to monitor the number of patients being handed over to A&E services was the 'hear and treat' rates. These were patients that were either treated on the phone or passed onto an alternative service. The 'hear and treat' rates both for the ambulance service as a whole and for the Tees Valley were almost identical. The rates had increased significantly over the last year.

Where an ambulance response was required it was noted that the service was measured against four different categories. The first category was average response standards to life threatening calls and the response data was provided for the Tees Valley and across NEAS. Category 1 calls needed to be responded to in an average of seven minutes and over the last year the graph indicated that this had very much been achieved on the vast majority of occasions. It was advised that a significant amount of attention was given to this category, as it included the most serious calls. Over the period January 2021 to January 2022 NEAS was the only ambulance service, alongside the London Ambulance Service to achieve the seven minute target. NEAS was one of the best ambulance services in the country for responding to Category 1 calls.

The second measure was response standards to 90 per cent of life-threatening calls within 15 minutes. It was advised that NEAS had achieved that target for the Tees Valley and across NEAS. There were 5 ambulance services across the country that had achieved this response target for the period January 2021-22. While that news was very positive there had been significant challenges for NEAS in respect the average response standards to Category 2 calls. There were emergency calls but not necessarily life threatening calls and this category accounted for a large proportion of NEAS's overall activity. This target had not been achieved for quite some time and over the last year that NEAS's response rates had deteriorated over the summer. The rates were now improving as the volume and demand were beginning to return to some sort of normal level. However, NEAS was still above the 18 minute target for an average response time for all of those particular cases. The Tees Valley area was in line with the response time across the whole of the service and in some months was outperforming the rest of the service as a whole.

It was advised that no Ambulance Trust in the country was currently achieving the Category 2 target. Whilst NEAS had not achieved the target, which was regrettable, it was at least the fourth best performing ambulance Trust nationally. There was a further target of response standards to 90 per cent of emergency calls within 40 minutes and performance was similar to

the previous Category 2 target. Similarly there was no Ambulance Trust in the country that was achieving this target. However, NEAS was again one of the better performers in respect of that particular standard.

The third target on which the service was measured related to Category 3 calls i.e. urgent calls. These were non-emergency or life threatening calls and the response target was that 90 per cent of urgent calls had to be responded to within 2 hours. Demand coupled with winter pressures had resulted in poor response times in relation to Category 3 calls. However, there had been significant improvements in respect of this standard over the last two months. It was noted that again there was no Ambulance Trust in the country that was achieving this standard. NEAS remained one of the fastest Trust's in the country at responding to Category 3 calls.

In terms of Category 4 calls – i.e. non urgent calls NEAS was the only Ambulance Trust in the country to be achieving the target of 90 per cent of non-urgent calls to receive an ambulance within 3 hours.

Reference was made to the see and treat rates and it was noted that the rates in the Tees Valley were approximately 5 per cent higher than the rates across the whole of the NEAS service area. Another option for the ambulance service was to convey patients directly to a ward, rather than an emergency department, and again conveyance rates to non-emergency departments in the Tees Valley was considerably higher than it was across the rest of the area. This was good, as it demonstrated direct admission for patients into the place where they needed to receive their care.

The Committee was advised that in terms of handover at hospital the standard was that a patient should be handed over by the ambulance within 15 minutes of arrival at hospital. The ambulance crew then have a further 15 minutes after arrival to clean, restock their vehicle and be ready to respond to the control room for the next call. However, average handovers had increased and consequently NEAS' handover to clear time had decreased. The most recent data showed that the average handover time, as recorded for these figures in December 2021, was 23 minutes 19 seconds against the standard 15 minute target. The most recent figures for the average handover to clear time was 13 minutes and 54 seconds against the standard 15 minute target.

In terms of handover delays at Darlington Memorial Hospital it was noted that in February 2022 NEAS lost 282 ambulance hours for the handover delays that occurred. There had been over 100 ambulance delays over the course of the month with a small proportion waiting for over 2 hours. Reference was made to the handover delays experienced at James Cook Hospital in Middlesbrough, which was a much bigger hospital and accepted patients from a wider area. Since June 2021 the handover delays at James Cook Hospital had gradually increased and in February 2022 NEAS had lost 517 ambulance hours as a result of the delays. At North Tees and Hartlepool Trust the picture was much better. In February 2022 NEAS lost 64 ambulance hours due to handover delays on 10 occasions.

Reference was made to the patient transport service and the Trust's level of activity over the last 2 years was highlighted. In terms of the impact of Covid on staff sickness absences it was noted that this had been significant. It had probably been one of the hardest winters in living memory for the ambulance service. The issues that had impacted on performance had included increases in both the demand and acuity of patients presenting to the service. The impact of Covid particularly sickness, shielding and cleaning. In addition there were other risk factors that would continue to put pressure on the service including the wider system pressures, primary care capacity and the long Covid impact on staff and wellbeing.

It was noted that NEAS had refreshed and refocussed its vision, mission and goals. NEAS's vision was to deliver unmatched quality of care and its mission was to deliver safe, effective and responsive care for all. The organisational values were CARE - Compassion, Accountable and responsible, Respect and Excellence and innovation. Underpinning the strategy were nine plans including those relating to planning and finance, quality and safety, clinical model and operations and performance.

In relation to the issue of assaults on ambulance staff it was advised that work continued and it was sad to report that during Covid those numbers increased significantly. A campaign had been undertaken in the North East in 2021 to tackle this issue and in the last month a

nationwide campaign had been launched to raise the profile on this issue and let staff know they were fully supported.

Following the presentation Members were afforded the opportunity to ask questions and the following points were raised:-

- Members expressed their thanks to all of the staff at NEAS for the amazing work they had undertaken in the most challenging of times over the last year.
- In response to a query regarding staff training the Chief Executive of NEAS advised that the organisation had endeavoured to maintain all core clinical training throughout the pandemic to maintain staff skill levels. Staff had been amazing, many had undertaken training in their own time to minimise any reduction in ambulance hours. NEAS continued to recruit and from a qualified paramedic perspective the organisation was over established. A decision was taken to employ at risk, which had paid dividends over the last several months. There was a higher turnover in terms of call handlers, which was a relatively young workforce when compared with qualified paramedics. Members were very encouraged to know that a full establishment had been achieved.
- In terms of the campaign to prevent abuse to ambulance staff and the support available to staff to deal with any abuse they faced was available to everyone included call handling staff. A full time Psychologist was employed within NEAS to support staff's mental well-being and NEAS was extremely focussed on providing staff with the appropriate support. Debrief opportunities were available for call handlers. Currently all areas were being upgraded to ensure that a quiet area was available for any staff that may have experienced a difficult clinical or abusive call.
- In terms of tracking patients that were treated via hear and treat it was explained that the systems were not available to track whether a patient attended their GP in place of a local pharmacist. However, where there were recurrent calls from the same patient these were monitored and tracked in case anything had been missed. In addition patients were regularly surveyed about their treatment experience. Satisfactions levels amongst patients that had received a 'hear and treat', see and treat service or ambulance dispatch service was very high. Despite the long delays that had recently been experienced by patients, which NEAS was working hard to rectify.
- Sustained efforts were being made with the acute hospital trusts to reduce delays in ambulance handover times. The Chief Executive reassured the Committee that NEAS had extraordinarily good relationships with each of the Trusts.

The Chair thanked the Chief Executive and Assistant Director of Communications at NEAS for all of the hard work undertaken and requested that the Committee's appreciation be passed onto all staff.

26 **TVCCG - UPDATE**

Representatives from TVCCG were in attendance at the meeting to provide an update to the Committee in respect of a number of items. The first of which was the development of the North East and North Cumbria Integrated Care System (NECS ICS), the Integrated Care Board (ICB) and the proposed sub-regional Integrated Care Partnership's (ICP's). The Chief Executive of the Tees Valley CCG and the Executive Director at NENC ICS were in attendance to provide this aspect of the update.

The Chief Executive of the Tees Valley CCG advised that Samantha Allen, the Chief Executive Designate of the NENC ICS, would welcome the opportunity to attend a future meeting of the Committee to discuss its establishment in more detail. It was advised that recruitment to the ICB had commenced and work was underway to describe the operating model of the ICB. Feedback had been sought, particularly from CCG staff who were affected by the change, as the CCG's morphed into the ICB, as well as a range of partners and stakeholders. A number of issues were being considered particularly in terms of what would happen at what level. For example, there would be issues that would be addressed at ICB level, either because it was high level commissioning i.e. the North East Ambulance Service, which worked across the whole of the North East but not the North East and Cumbria but also the annual report and annual accounts, which again would be produced at an ICB level.

A new organisational structure was being drawn up for discussion with staff, as the ICB would

take over formally from the CCGs on 1 July 2022. Consideration was currently being given to a number of issues including whether all the functions presently undertaken by the CCG's would continue to be delivered by the ICB, were there any issues of concern around safety, was there anything specific that needed to be considered in terms of the committee structure and what aspects of work would be undertaken more locally and fed into the ICB?

Reference was made to the white paper on integration and it was advised that efforts were being made to pick up on the links in that white paper to ensure these were implemented as part of the establishment of the ICB. The good news was that the overriding proposal in the white paper was for there to be a focus on place (13 upper tier local authorities in the NENC ICS). In the new ICB proposed organisational structure place was key and having leadership of place was included, along with oversite of budgets and working with existing Health and Well-Being Boards were also included.

The Executive Director advised that she was really keen to work with the Chair of the TVJHSC and Scrutiny Officer to consider the Committee's forward work programme and how the ICB's attendance at future meetings would be really helpful from a system perspective.

The second element of the update focussed on the opioid prescribing rates across the Tees Valley and the actions taken to reduce overprescribing by GPs. A Medicines Optimisation Pharmacist for North East Commissioning Support (NECS) was in attendance to provide an update to the Committee.

In terms of the work being undertaken across the TVCCG to reduce the high levels of opioid prescribing it was advised that a significant amount of work had been undertaken by both GP practices and Foundation Trusts. It was noted that number of initiatives had taken place including the CROP initiative – the Campaign to Reduce Opioid Prescribing, which originally commenced in Leeds. The North East Academic Network had adapted that programme and all of the GP practices within the Tees Valley had taken part in that initiative. A series of report had been produced for GP practices to highlight where they sat both locally and nationally in terms of opioid prescribing. This initiative had originally been due to commence in April 2020, however, owing to the Covid-19 pandemic was delayed until June 2020. In November 2020 a couple of four hour education sessions had been delivered to PCN and practice employees, pharmacy staff and GP's by Professor Eldabe from South Tees NHS FT's pain clinic, alongside specialist Nurses, a pain Pharmacist and Behavioural Psychologist from Warwick University. The education session was based on the i-watch programme, which was a national opioid reduction pilot. There had been 40 Pharmacists on the calls, together with consultants from North Tees NHS FT and specialist Nurses who were keen to replicate the work undertaken by the pain clinic in respect of opioid reduction clinics at South Tees NHS FT.

In addition to the education session the CCG had funded a one day per week specialist pain reduction Pharmacists resource to assist Primary Care Prescribers. This had led to a reduction in the waiting time for patients to access the opioid reduction clinics from 11 weeks to 4 weeks, which had a huge impact on the delivery of care to more complex patients requiring opioid reduction input. The CCG funding would be continued into 2022/23, which was fantastic to maintain that level of support for Primary Care Clinicians. Work continued in respect of drug related deaths across the Tees Valley and it was hoped that some further revision education sessions would be provided. A trend graph for the national indicator for high dose opioid prescribing volume showed there had been a 47 per cent decrease in prescribing rates across the Tees Valley compared with a 39 per cent decrease nationally.

The final aspect related to the Learning Disability Respite Review and the Head of Service for Adult Learning Disabilities in Tees at Tees, Esk and Wear Valley NHS Foundation Trust was in attendance to provide the committee with an update.

Reference was made to the current review and current arrangements for respite, which it was acknowledged was challenging for families and service users. It was advised that in January 2020, following the CQC inspection, the Trust had received a must do action relating to compliance with the Mixed Sex Accommodation (MSA) regulation. The Covid-19 pandemic had then hit and owing to the vulnerability of service users had impacted significantly on the provision of respite offer. It was explained that currently the two respite units Aysgarth in Stockton and Unit 2 in Middlesbrough were open and functioning. However, a reduced bed base was in operation. In autumn 2021 families were consulted about a range of options available, which resulted in a varying number of respite nights the families were able to

access.

Architects were subsequently commissioned to explore various options and this work was completed in January 2022. Subsequently an options paper was developed by the project group and the paper was due to be considered by the Board in April 2022. Further consideration was currently being given to how respite was being delivered at present to optimise capacity. Families were fully involved in the discussions and efforts were being made to build in additional flexibility. It was noted that pre-pandemic if a service user attended Aysgarth they would have received an average of 41 nights within a twelve month period. Those that attended Unit 2 at Bankfields would have received 33 nights. It was highlighted that in respect of the modelling work that was currently taking place regarding future respite provision some of the options would enable service users to receive additional days, as well as added flexibility. The immediate goal was to achieve stability for the families.

AGREED that an invite be extended to the Chief Executive of the NENC ICB to attend a future meeting of the TVJHSC.

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Protocol for the Tees Valley Health Scrutiny Joint Committee

1. This protocol provides a framework for carrying out scrutiny of regional and specialist health services that impact upon residents of the Tees Valley under powers for local authorities to scrutinise the NHS outlined in the NHS Act 2006, as amended by the Health and Social Care Act 2012, and related regulations.

2. The protocol will be reviewed as soon as is reasonably practicable, at the start of each new Municipal year. Minor amendments to the protocol that do not impact on the constitutions of the constituent Tees Valley Authorities will be determined by the Joint Committee at the first meeting in each Municipal year. An amended protocol, following agreement from the Tees Valley Health Scrutiny Joint Committee will be circulated for information to:-

Tees Valley Local Authorities

3. Darlington; Hartlepool; Middlesbrough; Redcar and Cleveland; Stockton-on-Tees (each referred to as either an “authority” or “Council”).

NHS England Area Teams

4. Durham, Darlington and Tees Area Team

NHS Foundation Trusts

5. County Durham and Darlington Trust; North Tees and Hartlepool Trust; South Tees Hospitals Trust; Tees, Esk & Wear Valleys NHS Trust; North East Ambulance Service.

Clinical Commissioning Group

6. Tees Valley CCG

Tees Valley Health Scrutiny Joint Committee

7. A Tees Valley Health Scrutiny Joint Committee (“the Joint Committee”) comprising the five Tees Valley Authorities has been created to act as a forum for the scrutiny of regional and specialist health scrutiny issues which impact upon the residents of the Tees valley and for sharing information and best practice in relation to health scrutiny and health scrutiny issues.

Membership

8. When holding general meetings, the Joint Committee will comprise 3 Councillors from each of the Tees Valley Local Authorities (supported by appropriate Officers as necessary) nominated on the basis of each authority’s political proportionality, unless it is determined by all of the constituent Local Authorities that the political balance requirements should be waived.

9. The terms of office for representatives will be one year from the date of their Authority’s annual council meeting. If a representative ceases to be a Councillor, or wishes to resign from the Joint Committee, the relevant council shall inform the Joint Committee secretariat and a replacement representative will be nominated and shall serve for the remainder of the original representative’s term of office.

10. To ensure that the operation of the Joint Committee is consistent with the Constitutions of all Tees Valley Authorities, those Authorities operating a substitution system shall be entitled to nominate substitutes. Substitutes (when not attending in place of the relevant Joint Committee member, and exercising the voting rights of that member) shall be entitled to attend general or review meetings of the Joint Committee as non-voting observers in order to familiarise themselves with the issues being considered.

11. The Joint Committee may ask individuals to assist it on a review by review basis (in a non-voting capacity) and may ask independent professionals to advise it during a review.

12. The quorum for general meetings of the Joint Committee shall be 6, provided that 3 out of 5 authorities are represented at general meetings. The quorum for Tees-wide review meetings, in cases where some Authorities have chosen not to be involved, shall be one third of those entitled to be present, provided that a majority of remaining participating authorities are represented. Where only 2 authorities are participating both authorities must be represented.

13. The Joint Committee will conduct health reviews which impact upon residents of the whole of the Tees Valley. If however one or more of the Councils decide that they do not wish to take part in such Tees-wide reviews, the Joint Committee will consist of representatives from the remaining Councils, subject to the quorum requirements in paragraph 12.

14. Where a review of a 'substantial development or variation' will only affect the residents of part of the Tees Valley, Councils where residents will not be affected will not take part in any such review. In such cases, the Joint Committee will liaise with the Councils where residents will be affected, in order to assist in establishing a separate joint body (committee) to undertake the review concerned. The composition of the committee concerned may include representatives from other Local Authorities outside the Tees Valley, where the residents of those Authorities will also be affected by the proposed review. The chairmanship, terms of reference, member composition, procedures and any other arrangements which will facilitate the conducting of the review in question will be matters for the joint body itself to determine.

15. It is accepted, however, that in relation to such reviews, the relevant constituent authorities of the committee concerned may also undertake their own health scrutiny reviews and that the outcome of any such reviews will inform the final report and formal consultation response of the committee.

Chair and Vice-Chair

16. The Chair of the Joint Committee will be rotated annually between the Tees Valley Authorities in the following order:-

Stockton
Hartlepool
Redcar & Cleveland
Middlesbrough
Darlington

17. The Joint Committee shall have a Vice-Chair from the Authority next in rotation for the Chair. At the first meeting of each municipal year, the Joint Committee shall appoint as Chair and Vice-Chair the Councillors nominated by the relevant Councils. If the Chair and Vice-Chair are absent from a meeting, the Joint Committee shall appoint a member to act as Chair for that meeting. The Chair will not have a second or casting vote.

18. Where the Authority holding the Chair or Vice-Chair has chosen not to be involved in a Tees-wide review, the Chair and Vice-Chair of the Joint Committee for the duration of that review will be appointed at a general meeting of the Joint Committee.

Co-option of other local authorities

19. Where the Joint Committee is to conduct a Tees-wide scrutiny review into services which will also directly impact on the residents of another local authority or authorities outside the Tees Valley, that authority or authorities will be invited to participate in the review as full and equal voting Members.

Terms of Reference

20. The Joint Committee shall have general meetings involving all the Tees Valley authorities:-

- To facilitate the exchange of information about planned health scrutiny work and to share information and outcomes from local health scrutiny reviews;

- To consider proposals for scrutiny of regional or specialist health services in order to ensure that the value of proposed health scrutiny exercises is not compromised by lack of input from appropriate sources and that the NHS is not over-burdened by similar reviews taking place in a short space of time.

21. The Joint Committee will consider any proposals to review regional or specialist services that impact on the residents of the whole Tees Valley area. The aim will be for the Joint Committee to reach a consensus on the issues to be subject to joint scrutiny, but this may not always be possible. In these circumstances it is recognised that each council can conduct its own health scrutiny reviews when they consider this to be in the best interests of their residents.

22. In respect of Tees Valley-wide reviews (including consideration of substantial developments or variations), the arrangements for carrying out the review (eg whether by the Joint Committee or a Sub-Committee), terms of reference, timescale, outline of how the review will progress and reporting procedures will be agreed at a general meeting of the Joint Committee at which all Tees Valley Authorities are represented.

23. The Joint Committee may also wish to scrutinise services provided for Tees Valley residents outside the Tees Valley. The Joint Committee will liaise with relevant providers to determine the best way of achieving this.

24. The basis of joint health scrutiny will be co-operation and partnership within mutual understanding of the following aims:-

- to improve the health of local people and to tackle health inequalities;

- ensuring that people's views and wishes about health and health services are identified and integrated into plans and services that achieve local health improvements;

- scrutinising whether all parts of the community are able to access health services and whether the outcomes of health services are equally good for all sections of the community.

25. Each Local Authority will plan its own programme of health scrutiny reviews to be carried out locally or in conjunction with neighbouring authorities when issues under consideration are relevant only to their residents. This programme will be presented to the Joint Committee for information.

26. Health scrutiny will focus on improving health services and the health of Tees Valley residents. Individual complaints about health services will not be considered. However, the Joint Committee may scrutinise trends in complaints where these are felt to be a cause for concern.

Administration

27. The Joint Committee will hold quarterly meetings. Additional meetings may be held in agreement with the Chair and Vice-Chair, or where at least 6 Members request a meeting. Agendas for meetings shall be determined by the secretariat in consultation with the Chair.

28. Notice of meetings of the Joint Committee will be sent to each member of the Joint Committee five clear working days before the date of the meeting and also to the Chair of the constituent authorities' relevant overview and scrutiny committees (for information). Notices of meetings will include the agenda and papers for meetings. Papers "to follow" will not be permitted except in exceptional circumstances and as agreed with the Chair.

29. Minutes of meetings will be supplied to each member of the Joint Committee and to the Chairs of the constituent authorities' relevant overview and scrutiny committees (for information) and shall be confirmed at the next meeting of the Joint Committee.

30. Meetings shall be held at the times, dates and places determined by the Chair.

Final Reports and Recommendations

31. The Joint Committee is independent of its constituent Councils, Executives and political groups and this independence should not be compromised by any member, officer or NHS body. The Joint Committee will send copies of its final reports to the bodies that are able to implement its recommendations (including the constituent authorities). This will include the NHS and local authority Executives.

32. The primary objective is to reach consensus, but where there are any matters as regards which there is no consensus, the Joint Committee's final report and formal consultation response will include, in full, the views of all constituent councils, with the specific reasons for those views, regarding those matters where there is no consensus, as well as the constituent authorities' views in relation to those matters where there is a consensus.

33. The Joint Committee will act as a forum for sharing the outcomes and recommendations of reviews with the NHS body being reviewed. NHS bodies will prepare Action Plans that will be used to monitor progress of recommendations.

Substantial Developments or Variations to Health Services

34. The Joint Committee will act as a depository for the views of its constituent authorities when consultation by local NHS bodies has under consideration any proposal for a substantial development of, or variation in, the provision of the health service across the Tees Valley, where that proposal will impact upon residents of each of the Tees Valley Local Authorities.

35. In such cases the Joint Committee will seek the views of its constituent authorities as to whether they consider the proposed change to represent a significant variation to health provision, specifically taking into account:-

- changes in accessibility of services
- impact of proposal on the wider community
- patients affected
- methods of service delivery

36. Provided that the proposal will impact upon residents of the whole of the Tees Valley, the Joint Committee will undertake the statutory review as required under the Local Authority (Public Health, Health and Wellbeing Boards and Public Health) Regulations 2013. Neighbouring authorities not normally part of the Joint Committee, may be included where it is considered appropriate to do so by the Joint Committee. In accordance with paragraph 22, the Joint Committee will agree the arrangements for carrying out the Review.

37. Where a review does not affect the residents of the whole of the Tees Valley the provisions of paragraphs 14 and 15 will apply and the statutory review will be conducted accordingly.

38. In all cases due regard will be taken of the NHS Act 2006 as amended by the Health and Social Care Act 2012, and the Local Authority (Public Health, Health and Wellbeing Boards and Public Health) Regulations 2013.

Principles for Joint Health Scrutiny

39. The health of Tees Valley residents is dependent on a number of factors including the quality of services provided by the NHS, the local authorities and local partnerships. The success of joint health scrutiny is dependent on the members of the Joint Committee as well as the NHS.

40. The local authorities and NHS bodies will be willing to share knowledge, respond to requests for information and carry out their duties in an atmosphere of courtesy and respect in accordance with their codes of conduct. Personal and prejudicial and/or disclosable pecuniary interests will be declared in all cases in accordance with the code of conduct and Localism Act 2011.

41. The scrutiny process will be open and transparent in accordance with the Local Government Act 1972 and the Access to information Act 1985 and meetings will be held in public. Only information that is expressly defined in regulations to be confidential or exempt from publication will be considered in private and only if the

Joint Committee so decide. Papers of the Joints Committee can be posted on the websites of the constituent authorities as determined by each authority.

42. Different approaches to scrutiny reviews may be taken in each case. The Joint Committee will seek to act as inclusively as possible and will take evidence from a wide range of opinion including patients, carers, the voluntary sector, NHS regulatory bodies and staff associations. Attempts will be made to ascertain the views of hard to reach groups, young people and the general public.

43. The Joint Committee will work to continually strengthen links with the other public and patient involvement bodies such as local HealthWatch.

44. The regulations covering health scrutiny require any officer of an NHS body to attend meetings of health scrutiny committees. However, the Joint Committee recognises that Chief Executives and Chairs of NHS bodies may wish to attend with other appropriate officers, depending on the matter under review. Reasonable time will be given for the provision of information by those asked to provide evidence.

45. Evidence and final reports will be written in plain English ensuring that acronyms and technical terms are explained.

46. The Joint Committee will work towards developing an annual work programme in consultation with the NHS and will endeavour to develop an indicative programme for a further 2 years. The NHS will inform the secretariat at an early stage on any likely proposals for substantial variations and developments in services that will impact on the Joint Committee's work programme. Each of the Tees Valley authorities will have regular dialogue with their local NHS bodies. NHS bodies that cover a wide geographic area (eg mental health and ambulance services) will be invited to attend meetings of the Joint Committee on a regular basis.

47. Communication with the media in connection with reviews will be handled in conjunction with each of the constituent local authorities' press officers.

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

TEWV Quality Account 2021/22 including Quality Improvement priorities planned for 2022/23

Tees Valley Joint Health Overview and Scrutiny Committee

8th June 2022

Agenda Item 6

journey to change

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Purpose

- To look back at progress made on the Quality Account improvement metrics and priorities in 21/22
- To outline proposed quality improvement priorities for 22/23 (to be included in the Quality Account 21/22 document)
- To remind the Committee about the deadline for responding to the formal consultation and explain the next steps

journey to change

Quality Metrics Slides

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

- The next few slides show our performance against the metrics that we use to assess our overall quality levels
- Red = target not achieved
- Green = target achieved
- We deliberately set stretching targets
- The way TEWV was structured in 21/22 means that our data covers the following geographies:
  - D&D = Darlington and County Durham
  - Tees = Hartlepool, Stockton, Middlesbrough, Redcar & Cleveland (not including specialist regional services such as the Secure Inpatient Services wards at Roseberry Park)
  - Trust = above + North Yorkshire and York + specialist regional services such as Secure Inpatient Services or prison-based services

journey to change

Quality Metrics (1)

Tees, Esk and Wear Valleys NHS Foundation Trust

	Quarter 4 21/22				Trend	Comments	Whole Trust 20/21
	D&D Actual	Tees Actual	Target	Whole Trust Actual			
1: Percentage of patients who report 'yes, always' to the question 'Do you feel safe on the ward?'	**72.48%**	**65.96%**	88.00%	**64.37%**	↑	This is the best position over the last five years but we still remain a long way from target. We are committed to improving patient safety and will keep this as a Quality Account priority during 2022/23	64.66%
2: Number of incidents of falls (level 3 and above) per 1000 occupied bed days (OBDs) – for inpatients	**0.06**	**0.21**	0.35	**0.07**	↓		0.13
3: Number of incidents of physical intervention/ restraint per 1000 occupied bed days	**36.34**	**75.62**	19.25	**37.66**		Although this metric is a long way from the target, these incidents relate largely to a small number of patients who. are acutely unwell and have very complex needs	20.90

Quality Metrics (2)

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

	Quarter 4 21/22						
	D&D Actual	Tees Actual	Target	Whole Trust Actual	Trend	Comments	Whole Trust 20/21
4: Existing percentage of patients on Care Programme Approach who were followed up within 72 hours after discharge from psychiatric inpatient care	86.46%	**93.91%**	>80%	**88.51%**	**N/A**	This is a revised metric for 2021/22, where follow-up was previously within 7 days. The reasons why this target is not being achieved are largely due to difficulties in engaging with the patient after discharge or breakdown in internal processes	N/A
5: Percentage of Quality Account audits completed	**N/A**	**N/A**	**N/A**	**N/A**	→	No Quality Account audits were scheduled for completion during Q4 2021/22	**100%**
6: Patients occupying a bed over 90 days	**N/A**	**N/A**	<61	**60**	**N/A**	This is a new metric for 2021/22	N/A

Quality Metrics (3)

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

	Quarter 4 21/22						Whole Trust 20/21
	D&D Actual	Tees Actual	Target	Whole Trust Actual	Trend	Comments	
7: Percentage of patients who reported their overall experience as excellent or good	**93.88%**	**92.42%**	94.00%	**94.34%**	↑	This is the first time that the Trust has achieved this target; the Durham and Tees Localities are also very close to achieving the target. Patient Experience is one of the three goals of Our Journey to Change	93.21%
8: Percentage of patients that report that staff treated them with dignity and respect	**89.53%**	**91.73%**	94.00%	**89.14%**	↑	The results against this metric have remained essentially static over the past few years. Work on this is underway throughout our service delivery linked to the Trust values of respect, compassion and responsibility	86.77%
9: Percentage of patients that would recommend our service to friends and family if they needed similar care or treatment	**93.00%**	**94.34%**	94.00%	**91.08%**	↑	There has been a consistent improvement in performance against this metric throughout the year	91.60%

Actions we've taken in response to our performance on Quality Metrics

NHS Tees, Esk and Wear Valleys NHS Foundation Trust

- Developed a business case for the further roll-out of body cameras on wards
- Undertaken a robust exploration of the data and intelligence influencing the Friends and Family Test; the Patient Experience Team have worked with operations to implement more robust governance and to set up Patient Experience Groups
- Shared key successes and learning from a review of patient safety and promoted the role of the Trust Patient Safety Specialist
- Gathered views of families and involved them in improving the Serious Incident Process
- Implemented a process to capture informal concerns and complaints that enabled us to identify any key themes where patients have raised issues

Quality Metrics for 2022/23

- We are going to review the suite of metrics to align them more closely with our new *quality journey to change*
- We also want to align them more closely to our improvement priorities
- Some of the metrics may still be the same
- We will analyse our data in a more sophisticated way, so that we can see where things are really improving or getting worse

Quality Account Improvement Priorities during 2021/22

Our 3 improvement priorities were:

- Improve the personalisation of Care Planning
- Safer Care
- Compassionate Care

- 46 actions sat under these headlines
- **30** of those **46** were achieved or on track at the end of 2021/22

Reasons for delays in implementation

- Covid
  - Some public events, such as conference with bereaved families to help us learn from their experiences could not be held
  - Staff diverted to infection prevention control work
  - Staff diverted to the vaccination programme
  - Restrictions on entering wards slowed down some key “feeling safe” initiatives such as installation of vital signs sensor technology (Oxehealth)
- Non-Covid
  - National policy changes on Care Programme Approach have meant some of our proposed actions are not relevant now, so we did not complete them.

Improvement priorities during 2022/23

- The Trust has identified the following **three** priorities for the new Quality Account:

  - Care Planning
  - Implementation of the new Patient Safety Incident Reporting Framework
  - Feeling Safe

In addition to these, the Trust also has a Business Plan with many other improvement actions.

Care Planning

Tees, Esk and Wear Valleys NHS Foundation Trust

Q1 22/23

- Establish working groups linked to outputs from the Care Planning event in March 2022, all of which link to Cito implementation (Cito is our new patient record interface)
- Care planning patient and carer information: review existing patient and carer information that refers to/is about care planning
- Care planning training and guidance: develop and approve package around goal setting and solution-focused approaches
- Care planning monitoring and embedding: agree metrics around care planning – to link into caseload management work
- Care planning in Secure Inpatient Services: to agree piloting of the use of DIALOG and DIALOG+ as a replacement for 'my shared pathway'
- Review everything that refers to CPA and agree how to change language and processes in line with community transformation and iThrive (in light of national guidance on replacement of CPA)
- Establish Care Planning Steering Group to report into Quality and Safe and Clinical Journey Boards
- Develop goal setting training and resources to complement move to DIALOG
- Introduce DIALOG and DIALOG+ to all inpatient services to further embed individualised goal based-plans

Care Planning (2)

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Q2 22/23

- Develop, approve and publish new patient and carer information in line with new approaches to care planning
- Deliver training on goal setting and solution-focused approaches that will further strengthen and support Cito training and guidance
- Gather data for baseline position using agreed metrics that will be transferable to Cito
- Test use of DIALOG and DIALOG+ in agreed wards within SIS
- Develop new policies and procedures in relation to CPA winding down
- Continue with inpatient work around understanding, implementation and embedding of DIALOG and DIALOG+

Care Planning (3)

Tees, Esk and Wear Valleys NHS Foundation Trust

Q3 22/23

- Go live date for Cito: it is envisaged that much of Quarter 3 will be the supporting of staff in the use of DIALOG, DIALOG+ and individualised care planning elements of Cito (including training and guidance refining and development)
- Publish new policies and procedures in relation to care planning and new ways of working (linked to Community Mental Health Framework)
- Embed processes for gathering key care planning metrics
- Review Secure Inpatient Services testing of DIALOG and DIALOG+ and agree next steps/roll out

Q4 22/23

- Continue with Cito support
- Next steps/roll out of DIALOG and DIALOG+ in Secure Inpatient Services
- Continue measurement of metrics

Care Planning (3)

Tees, Esk and Wear Valleys NHS Foundation Trust

Q3 22/23

- Go live of Cito: it is envisaged that much of Quarter 3 will be the supporting of staff in the use of DIALOG, DIALOG+ and individualised care planning elements of Cito (including training and guidance refining and development)
- Publish new policies and procedures in relation to care planning and new ways of working (linked to Community Mental Health Framework)
- Embed processes for gathering key care planning metrics
- Review SIS testing of DIALOG and DIALOG+ and agree next steps/roll out

Q4 22/23

- Continue with Cito support
- Next steps/roll out of DIALOG and DIALOG+ in SIS
- Continue measurement of metrics

Feeling Safe

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

In 2022/2023 we will:

- Review the information we have available from patient surveys, incidents and complaints from adult inpatient services to identify any new emerging themes that may help inform our programme of improvement work in this area
- Increase the visibility of staff within adult inpatient areas
- Focus on reducing patient-on-patient violence through exploring further use of Information Technology solutions
- Continue to implement the Safe Wards initiative (an evidence-based tool to reduce violence and support a safe ward environment)

Implementation of the new Patient Safety Incident Reporting Framework

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

In 2022/2023 we will:

- Roll out the two-part incident approval process across all areas of the Trust. This involves operational staff taking responsibility for reviewing and approving incidents that have occurred within their service before submitting centrally
- A triage process for incidents that have been categorised as moderate and serious harm to determine quickly the appropriate route for review
- Develop the daily patient safety huddle to include service staff and subject matter experts to ensure we can effectively review reported incidents in a timely way and where rapid reviews can be undertaken where appropriate that lead to immediate actions and improve safety
- A Serious Incident Review process that is robust and utilises evidence-based tools and that involve families to the level of their satisfaction
- Provide updates for staff on the duty of candour to ensure all have a full understanding
- Improve the quality and oversight of action plans
- Refresh the Terms of Reference for the Director Assurance Panels

What next?

- The closing date for comments on our Quality Account document is noon on Monday 13th June
- The document will go to the TEWV Board of Directors on Thursday 16th June
- Publication of the final document on 30th June
- We will be happy to bring six-monthly update on progress during 2022/23 to this Committee

Tees, Esk and Wear Valleys
NHS Foundation Trust

Quality Account 2021/22

DRAFT

Table of Contents

Part One: Introduction & Context

What is a Quality Account?

A Quality Account is an annual report describing the quality of services provided by an NHS healthcare organisation. Quality Accounts aim to increase public accountability and drive quality improvements in the NHS. Our Quality Account looks back on how well we have done in the past year at our achieving our quality goals. It also looks forward to the year ahead and defines what our priorities for quality improvements will be and how we expect to achieve and monitor them.

What are the aims of the Quality Account?

1. To help patients and their carers make informed choices about their healthcare providers
2. To empower the public to hold providers to account for the quality of their services
3. To engage the leaders of the organisation in their quality improvement agenda

Who reads the Quality Account?

Lots of different people read the Quality Account. Some are people who use our services, their carers, staff, commissioners, partners and regulating bodies. We produce our report for anyone who wants to know more about the quality of our services, and how we plan to maintain and improve them.

What information can be found in the Quality Account?

In this document, you will find information about how we measure and review the quality of services that we provide. You will also find our priorities for improvements for the year ahead. Like all NHS healthcare providers, we focus on three different aspects or “domains” of quality:

- Patient **safety**
- Clinical **effectiveness**
- Patient **experience**

Structure of this Quality Account document

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

- **Part 1** Introduction and Context
- **Part 2:** Information on how we have improved in the areas of quality we identified as important for 2021/22, our priorities for improvement in 2022/23 and the required statements of assurance from the Board and
- **Part 3:** Further information on how we have performed in 2021/22 against our key quality metrics and national targets and the national quality agenda

A Profile of the Trust

Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) is a TEWV is a large and complex organisation with around 7,800 employees who provide a range of inpatient and community mental health and learning disability services for approximately 2 million people of all ages living in

- County Durham
- The five Tees Valley boroughs of Darlington; Hartlepool, Stockton, Middlesbrough and Redcar and Cleveland

- The Scarborough, Whitby, Ryedale, Hambleton, Richmondshire, Selby and Harrogate areas of North Yorkshire
- The City of York
- The Pocklington area of East Yorkshire; and
- The Wetherby area of West Yorkshire

In addition, our adult inpatient eating disorder services, and our Secure Inpatient (Forensic) wards serve the whole of the North East and North Cumbria. TEWV also provides mental health care within prisons located in North East England, Yorkshire and the Humber, and North West England.

Our Quality Account. Quality Governance and Quality Issues

TEWV has changed its governance arrangements from 1st April 2022.

This is because it has become clear that the way we were structured, and the way our governance operated, needed to change so we provide well-governed clinical care alongside partners across our systems.

Our new governance structure will help us achieve 'Our Journey to Change' (see next page) by making sure the Trust is:

- Clinically led and operationally enabled
- Better able to align around the regional changes in the form of the two Integrated Care Systems in which we provide services
- Able to deliver on individual and collective system wide accountability effectively and consistently, by making all roles clearer and manageable for post holders
- Organised in a more simple, less complex way formally incorporating patient leadership into our structures.

The changes do not save money because their aim is to provide safe, high quality, effective clinical services, and the best possible experience for people in our care, families and carers, our colleagues, and our partners.

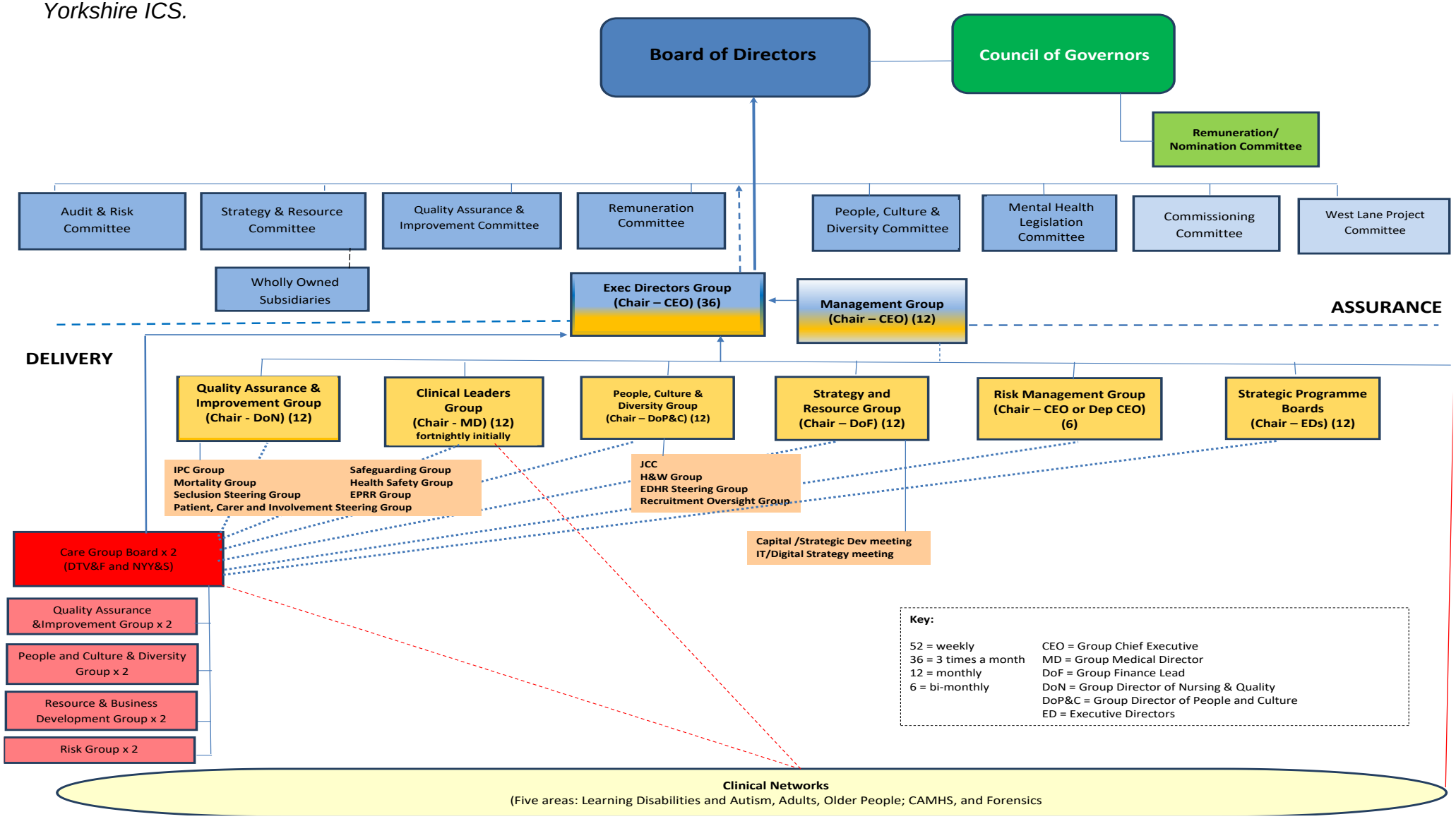
The new structure is shown in ***Figure 1*** the next page. However, the data and commentary contained in this document were produced using the governance structures and processes in place prior to April 2022. The key features of this were that In line with our previous Clinical Assurance Framework the review of data and information relating to our services was 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 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 contact with the Trust's patient advice and liaison service (PALS)
- **Care Quality Commission:** Compliance with the essential standards of safety and quality, and the Mental Health Act

Figure 1: Summary of the Trust Journey to Change

Figure 2: Trust Governance from 1st April 2022

This diagram shows the new structures and governance within TEWV. An important feature is the creation of two Care Groups – one for services serving the population of the North East North Cumbria ICS and one for services serving the Humber and North Yorkshire ICS.



Following discussion at the QuAG any areas of concern were escalated to the relevant Locality Management and Governance Board (LMGB) and from there to the Trust Board's Quality Assurance Committee (QuAC). The QuAC received formal Quality and Learning reports from each of the LMGBs on a monthly basis, as well as a Trust level report.

We also implemented a Quality Assurance programme that focused on the quality of patient risk assessments, safety summary and safety plans as well as broader care standards. A range of methods were used to gather this information and involved Trust staff as well as some of our CCG colleagues. This was supported by other activities such as clinical audits and leadership walkabouts.

Some normal aspects of governance were disrupted by the restrictions related to the Covid-19 pandemic. Peer review and Board visits to wards and teams, for example, were affected with some only taking place virtually via Microsoft Teams.

However, as staff updated the electronic patient record, online incident log, complaints database and other systems we were increasingly able to triangulate different sources of data and intelligence and to report/act on a holistic (whole) picture. Our Integrated Information Centre is a key tool in enabling this.

We also regularly provide our commissioners with information on the quality of our services. This includes holding regular Clinical Quality Review meetings with commissioners where we review key information on quality that we provide, with a particular emphasis on providing assurance on the quality of our services. At these meetings, we also provide information on any thematic analyses or quality improvement activities we have undertaken and on our responses to national reports that have been published.

In last year's Quality Account, we noted that, following an unannounced inspection from the Care Quality Commission (CQC), our acute wards for Adults and Psychiatric Intensive Care Units were rated as 'inadequate' for both 'safe' and 'well-led'. During 2021/22 we have made significant achievements in implementing the resulting CQC Action Plan.

Following further CQC inspections, our CQC core service and well-led inspection report was issued on 10th December 2021. The Trust's overall rating remained at 'requires Improvement'. CQC rated the 'safe', 'responsive' and 'well-led' domains as "requires improvement", and the effective and caring domains as 'good'.

In the inspection report the CQC acknowledged that TEWV had embarked on a significant change programme to change our governance and organisational arrangements. They also acknowledged that Our Journey to Change showed we had a strategy, co-created with service users, staff and stakeholders which would help the organisation to address the changes which needed to be made.

The CQC also highlighted positive practice in the report including:

- Further workforce investment and recruitment into inpatient services
- A strategic approach to people and culture within the trust, good record

of developing staff and engagement with staff side
- Robust systems in place in relation to the effective management of medicines and controlled drugs.
- More effective systems in place to comprehensively assess and manage patient risks

Issues that the CQC found in their inspection included:

- A variable culture across some services within the Trust
- Systems to identify, understand, monitor, and reduce or eliminate risks were not always effective and required further development
- Improvements were needed to safeguarding policies and processes, particularly in Adult Mental Health Services
- Insufficient staffing levels for the Trust's Community CAMHS caseload
- Some areas of poor compliance with mandatory training
- TEWV's approach to equality and diversity could be improved
- Investigations into complaints and serious incidents were not always carried out in line with trust policies.

A further action plan has been developed. Some of the actions have already been delivered but others will be delivered during 2022/23. There is more detail about the CQC's findings, inspection rating and our action plan on page **37**

During 2020/21 we have reported to and been support by an external Quality Board chaired by the North East North Cumbria ICS Lead Officer.

Unfortunately, the Trust is not always successful in preventing patients from ending their lives. We are very grateful to those relatives who have worked with us to help us better understand the root cause of these serious incidents and what we could do to reduce risk in the future. Inquests are also a chance to reflect on what has gone wrong and what could be done better in the future.

Our newly developed Clinical Journey to Change (Clinical Strategy) describes our ambition to be an outward looking, modern Mental Health, Learning Disability and Autism service by providing a roadmap through co-created transformation. The purpose is to improve the overall health and wellbeing of people with mental health issues, a learning disability or autism in our region. Our approach is to consider the whole person, whole life, whole system to deliver personalised care sooner, safer, and more holistically.

We have also developed Our Journey to Safer Care that sets out our key safety priorities and enablers. This forms part of the new Quality Strategy that is in development and will also include our ambitions for improving the experience of our patients.

The Trust fully acknowledges that our services are not always of the quality our patients require and the public (who fund the NHS) deserve. But we are absolutely committed to improving and Our Journey to Change which we developed in 2020/21 is starting to move us in the right direction.

In addition to the quality improvement priorities included within this Quality Account, the Trust also has a Business Plan which summarises all of our change plans. You can find this on the internet at **[weblink to be added once plan finalised]**

We think it is essential to highlight the good work that Trust staff have achieved as well as highlighting the issues that we still need to tackle. Therefore, we have included a short section on the following pages which highlights the positive progress made by the Trust and the individuals who work for us.

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

A full statement of Director's responsibilities in respect of the Quality Account is included in **Appendix 1.** 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:

- Elizabeth Moody (Director of Nursing & Governance) at: elizabeth.moody1@nhs.net
- Avril Lowery (Director of Quality Governance) at a.lowery1@nhs.net

This document has been shared for comment with Trust Governors, local Clinical Commissioning Groups (CCGs), Healthwatch Organisations and Local Authority Health Overview and Scrutiny Committees (including the Tees Valley Joint Health Scrutiny Committee). Responses to this consultation are included in ***Appendix 4.***

Brent Kilmurray
Chief Executive
Tees, Esk and Wear Valleys NHS Foundation Trust

What we have achieved in 2021/22

In his introduction on the previous pages, the Chief Executive notes the importance of highlighting the positive progress made by the Trust as a whole and by individuals who work for it. Some of these positives are presented below. By doing this we hope to give our staff and stakeholders confidence that we will overcome the ongoing quality issues that still face the Trust in the months and years ahead.

Trust achievements in 2021/22 include:

- TEWV lived experience members were successful in receiving an award for 'Leading Change' from South Tees Healthwatch as part of their role within the programme to create a new vision for how services will work in the future
- We reviewed our process for Freedom to Speak Up and Whistle Blowing and produced standard work to ensure consistency across the trust, and continued to encourage staff to speak out when they see unacceptable quality
- We implemented an improved waiting list process including an initial risk assessment for every child and a robust Keeping in Touch process.
- Over 4,000 Trust staff have been trained in how to use our new electronic patient record system (cito), which will go live in late summer/early autumn 2022
- In September 2021, Children and Young People's Mental Health Services in York moved to new premises at Orca House, on the Link Business Park is Osbaldwick, just outside York City Centre. Young people and their parents and carers were involved at every stage and level, from the naming of the premises to the look and feel of the main reception area and the clinical/therapy rooms
- The Trust has supported the creation and operations of the North East North Cumbria and Humber, Coast and Vale Resilience Hubs launched in February 2021 in response to the Covid-19 pandemic. These offer a wide range of emotional and wellbeing support to the health, care, and emergency services workforce across the area we serve. As well as providing outreach support and training, therapeutic interventions and assessments, the Hub has also implemented a range of support groups. The Humber Coast and Vale Hub's Long Covid Support Programme has been recognised as a national exemplar
- The new Care Home Liaison service in Durham recruited a variety of multi-disciplinary professionals to work closely with care home staff to prevent placement breakdown and which in turn improved outcomes for patients in these settings (e.g., removal from 'behaviours that challenge' Clinical Link Pathway (CLiP)
- In August 2021, the Trust opened a new community mental health hub at North Moor House in Northallerton. This hub houses mental health and learning disability services under one roof and provides modern outpatient facilities for local people of all ages who need to access these services. It also contains community team offices and increased consulting room space, supporting improved access to services and allowing more people to be seen as quickly as possible
- The 'Wellbeing in Mind' service, which supports young people and helps education establishments to develop a 'whole school approach' to wellbeing has received additional funding and now covers Harrogate, York and Hambleton and Richmondshire, supporting a further 27 schools and colleges to evaluate and develop their current wellbeing provision, to deliver staff training, co-facilitate student/pupil workshop and assemble and support student forums, campaigns and events to help raise awareness about the common problems young people experience and how to deal with them
- A successful partnership between Scarborough Survivors and TEWV helped Accident & Emergency workers during peak times in the winter period by providing support to people attending Scarborough General Hospital A&E department who presented with a suspected

mental health condition; helping improve communication between A&E and mental health services and strengthening the multi-agency approach to mental health care in the area

- The Trust have taken a proactive approach to national nurse recruitment issues by launching an international nurse recruitment programme overseen by a dedicated programme co-ordinator, and provides dedicated pastoral care and support with accommodation and education for those joining the Trust
- The Memory Service in Hambleton and Richmondshire has maintained its Memory Service National Accreditation Programme status for the 9th year. The team were commended for maintaining the same level of service throughout the pandemic by adapting and using virtual appointments and post-diagnostic sessions for individuals and groups, including virtual clinical environments to include families who live away from their loved ones and improving access for those who find it hard to travel
- The Care Home Wellbeing service in Durham and Darlington was set up to improve the wellbeing of care home residents and staff and to support recovery from the impacts of the Covid-19 pandemic
- We have co-created workshops to discuss our new values and how they can support new works of working together. A number of workshops have been delivered and will now be running on an ongoing basis. Evaluation data is demonstrating significant improvement in understanding of values and confidence in having conversations about them
- We have also co-created the first module of the collective leadership programme with service users and staff, which has now been piloted and rolled out
- The Trust signed the Armed Forces Covenant in March 2022; the Covenant is a pledge that together we understand that serving personnel, veterans, their families, and service leaders should be treated with fairness in respect in the communities, economy, and society they serve with their lives
- The Trust has developed two lived experience director roles for people with lived experience of mental illness, to ensure that services continue to be developed and improved by working closely with our network of patients and carers, local communities, and colleagues in other lived experience roles
- The Trust has established an Enhanced Physical Health Facilitation Team – a proactive and preventative approach to supporting physical health needs in our learning-disabled population in the Tees Valley, alongside further developments to the Specialist Health Teams enhanced capabilities in Durham
- A new role has been introduced – a STOMP (Stopping Over Medication of People with learning disabilities) lead nurse in Tees, who will work with the PCN pharmacists and GP Practices to raise knowledge and understanding and support structured medication reviews
- We introduced a new listening service in Teesside to provide a 24/7 telephone call line to support service users prior to the need to access crisis services

National Awards – Won or Shortlisted

In addition to the Trust achievements listed above, external bodies have recognised the work of individuals or teams through the award shortlisting, or award wins listed in the two tables below.

Awarding Body	Award Status	Name/Category of Award	Team/Individual
Positive Practice Mental Health Collaborative	Highly Commended	All Age Crisis and Acute Mental Health Care	Crisis & Assessment Suite: Roseberry Park
Positive Practice Mental Health Collaborative	Highly Commended	Addressing Inequalities in Mental Health	Westerdale North Inpatient Team: Sandwell Park
Patient Experience Network	Won	Transformer of Tomorrow Award	Dementia-friendly Village Project: Easington
NEPACS	Awarded	Ruth Cranfield Awards 2021	Speech & Language Therapy Team: HMP Holme House
Building Better Healthcare	Won	Best Interior Design (2020)	Foss Park Hospital
Building Better Healthcare	Highly Commended	Best Healthcare Development £10m+ (2020)	Foss Park Hospital
Healthcare Financial Management Association – Northern Branch	Won	Apprenticeship of the Year	Alex Pederson
Healthcare Financial Management Association – Northern Branch	Won	Chair's Unsung Hero Award	Andrea Reid
Bright Ideas in Mental Health	Won	Innovation Champion Award	Dr Mani Santhanakrishnan
The Dizzy's Life on the Level	Won	Best Balance Friend	Tracey Marston
Royal College of Psychiatrists (RCP)	Awarded	Enabling Environment Award	Primrose Service, HMP Low Newton

Awards where TEWV as an organisation, or one of our teams/staff members were nominated or shortlisted for an award but did not win that award during 2021/22 were:

Awarding Body	Award Status	Name/Category of Award	Team/Individual
Royal College of Psychiatrists (RCP)	Shortlisted	Care Contributor of the Year	Patient & Carer Participation Group: Tees-wide MHSOP Community Services
Royal College of Psychiatrists (RCP)	Shortlisted	Psychiatric Team of the Year: Quality Improvement	Research & Development: ECG Project
Royal College of Psychiatrists (RCP)	Shortlisted	Psychiatric Team of the Year: Older-age adults	MHSOP Inpatient Services: Lustrum Vale
Royal College of Psychiatrists (RCP)	Shortlisted	Psychiatrist of the Year	Dr Mani Santhanakrishnan
Royal College of Psychiatrists (RCP)	Shortlisted	Higher Psychiatric Trainee of the Year	Dr Sundar Gnanavel
Dynamo North East	Shortlisted	Tech for Good & People's Choice	TEWV & NENC AHSN
Health Service Journal	Shortlisted	NHS Communications Initiative of the Year	Preventing Suicide (Tees)

Awarding Body	Award Status	Name/Category of Award	Team/Individual
Bright Ideas in Mental Health	Shortlisted	Development of an Innovative Device or Technology	Anti-Psychotic Medication Monitoring
Bright Ideas in Mental Health	Shortlisted	Demonstrating an Impact upon Patient Safety and/or Quality Improvement	Remote Autism Assessments
Bright Ideas in Mental Health	Shortlisted	Helping our Workforce to recover from the Pandemic	Humber, Coast & Vale Resilience Hub
Health Technology Newspaper	Shortlisted	Health Tech Leader of the Year	Kam Sidhu

Part 2: Quality Priorities for 2021/22 and 2021/22 and required statements of assurance from the Board

2021/2022 and 2022/2023 Priorities for Improvement – How did we do and our future plans

In this first section of part 2, we look backwards at the progress we made in implementing our quality priorities during 2021/22 and the impact this had. Following this, we set out our quality improvement priorities for 2022/23.

Where we look back at 21/22, we use colours to show how much progress we made. The key for this is:

	Action completed by time of publication of this Quality Account
	Action not completed.

Our Progress on implementing our 2021/2022 Quality Improvement Priorities

Priority One: Making 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, hence this being identified as a priority in 2021/22.

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

- To have their personal circumstances viewed as a priority when planning care and treatment
- To have an accessible, understandable, and personalised care plan (including a 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 personal circumstances, and what is most important to the person and those closest, viewed as a priority when planning care and treatment

What we did in 2021/22:

What we said we would do	Did we achieve this?	Comment
Develop and implement a communications plan to ensure all relevant stakeholders are aware of changes to CPA processes, primarily via the introduction of DIALOG and other Cito developments		
Work with IT and other key stakeholders to ensure finalised, working version of DIALOG is embedded within CITO		Cito, the Trust's new electronic patient record interface, goes live in Autumn 2022
Develop multi-media guidance and training to support the implementation of DIALOG in a variety of clinical settings and scenarios		
Undertake a current state assessment to identify how many patients/agreed others receive a care plan, and to understand key elements of safety, quality, timeliness, and accessibility to inform a plan to address the issues identified		This wasn't needed because an existing baseline assessment gave enough information to allow the Cito plan to be developed
Produce a plan to address the issues identified in the above current state assessment		This was addressed in the design of the care planning elements into Cito
Review and revise local CPA policy in line with system changes and national guidance – especially in relation to guidance around the implementation of the Community Services Framework for Adults and Older Adults		We are still waiting for updated, clearer national guidance before reviewing and revising our CPA policy
Review and update care planning training to include a co-created and co-delivered explanation of the legal requirements set out by the Human Rights Act		This has not been progressed as we want to wait for national clarity on care planning requirements. We also need to consider the implications of the commitment given by government in December 2021 to abolish the Human Rights Act
Assess additional actions and priorities to remove barriers to care planning, including skills, clinical capacity, right staffing and mandatory training		
Work with teams and commissioners to ensure sufficient capacity is built into clinic scheduling to properly co-create and develop care plans, and that is reflected in efficiency requirements within our CCG contracts		To be completed in Quarter 1 2022/23; a one-day event will be held in May 2022 to set the principles and interim position and two workshops will then be held in June 2022 to look forward and work out how to build in sufficient capacity, and in particular look at what Cito can do to help with this

How do 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 2021/22	Actual 2021/22	Timescale
Patients know who to contact outside of office hours in times of crisis	84%	80%	Q4 21/22
Patients were involved as much as they wanted to be in what treatments or therapies, they received	85%	85%	Q4 21/22
Patients were involved as much as they wanted to be in terms of what care they received	85%	73%	Q4 21/22

The measures for the above come from the NHS Community Mental Health Survey which is administered by the CQC. The targets we set were very aspirational targets, and the experience that our service users reported relates to their experiences in the Trust as a whole, rather than in relation to their experience of care planning alone. Evidence also suggests that service users are more likely to complete this questionnaire if they have had a negative rather than a positive experience. It is pleasing to see that we have achieved good standards of service, however involving patients as much as they want to be in the care that they received is an area that we need to improve upon.

Priority Two: Safer Care

Why this is important:

Patient Safety continues to be the key priority for the Trust, and we have already identified four Patient Safety priority areas that we will focus upon going forward:

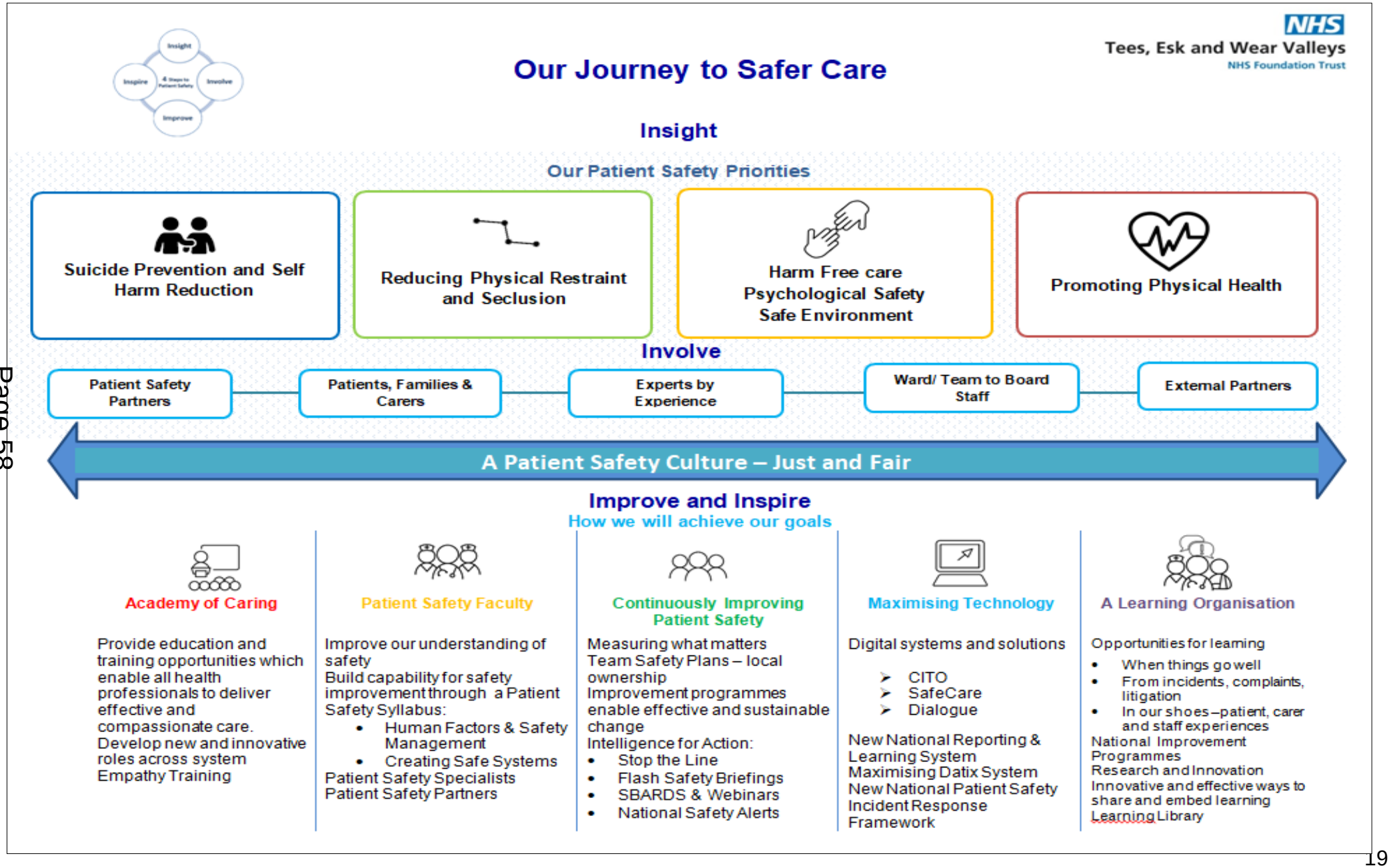
- Suicide prevention and self-harm reduction
- Reducing physical restraint and seclusion
- Promoting harm-free care, improving psychological and sexual safety (allowing staff and patients to speak out safely by fostering an open and transparent culture), providing a safe environment
- Promoting physical health

These are illustrated in ***Figure 3 - 'Our Journey to Safer Care'.*** This provides an overview of our approaches and key enablers.

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

- Improved patient safety and reduction of patient harm
- Increased capability for patient safety improvement
- Increased confidence that investigations are being carried out in accordance with best-practice guidelines and in a way that is likely to optimise learning opportunities
- An increase in the percentage of our service users feeling safe when they are in a Trust inpatient setting
- Increased collaboration between service users, staff, and peers
- A reduction in incidents e.g., violence and aggression, absence without leave, drug misuse
- Improved understanding of ward environments and why service users feel unsafe
- Increased opportunity to use digital technology to support the delivery of care

Figure 3: Our Journey to Safer Care



What we did in 2021/2022:

What we said we would do	Did we achieve this?	Comment
Implement 'Our Journey to Safer Care'		
Determine the programmes of work for each of the four patient safety priorities		
Identify process and outcome KPIs for each of the four patient safety priorities		This will be completed in 22/23; will be revisited in line with programme to ensure they are correct and fit with the programme priorities
Assess current baseline for each performance indicator identified and set incremental targets for improvement throughout 2022/23		
Promote the role of the Trust's Patient Safety Specialist		
Work in collaboration with the ISC 'Better Tomorrow programme: learning from deaths, learning from lives' to improve our processes for identifying lessons learned using information to improve future care and to develop support networks in undertaking mortality reviews within a wider community of practice		
Review and update Learning from Deaths Policy		
Increase the percentage of our inpatients who feel safe on our wards:		
Work proactively within the newly formed Regional Patient Experience Network; maximise opportunities for benchmarking patient experience data		
Use existing data to identify priority wards/teams and actions: collating existing Friends and Family Test (FFT) and other data		Robust exploration of the data and intelligence influencing the FFT scoring completed. Patient Experience Team have worked with services to implement more robust governance and setting up of Patient Experience Groups.
Develop a plan for each ward/team identified as a priority, with involvement from clinical staff, management and service users and deliver actions throughout the year		This has been rescheduled for 22/23
People with lived experience to talk to people currently on wards with highest and lowest current FFT scores		This was not possible due to Covid restrictions
Further review information from patient experience surveys and concerns raised from patients and carers through PALS contact and complaints and use this to feed into report and action plan, and deliver actions throughout the year		
Seek ideas as part of the 'mutual help' meetings that take place on the wards on what we can do to make patients feel safe - roll out across the Trust		

Review current 'ward orientation' process for patients being admitted onto our wards and incorporate into personal safety plans - roll out across the Trust (currently in Tees only)		
Continue existing pilot of body cameras to a further six wards and an additional 60 cameras		It was initially agreed to commence the body camera project in April 2020; however, delays occurred due to the pandemic. The project commenced in November 2020 with four wards. Following an initial review in April 2021, Senior Leadership Group agreed to a six-month extension of the pilot and an increase in participation to ten services across the Trust Since implementation in November 2020 staff have reported the use of cameras as a positive addition to the ward environment that improves staff safety. Patients have highlighted no concerns from the use of the cameras on wards however it is acknowledged that further co-creation and lived experience is needed to gain a greater appreciation within this sensitive area. The data currently available shows no significant impact on the use of restrictive interventions, however delays in implementation due to safety concerns or technical issues may have limited effectiveness. Further embedding and review of footage needs to be undertaken to fully evaluate the impact of the body worn cameras. Learning from other Trusts that have successfully embedded the approach has identified that it can take several years to fully embed systems and skills required to fully access the ability of this technology and achieve the benefits for patient care
Develop a business case for further roll-out of body cameras (if supported by monitoring of benefit Key Performance Indicators		See above with reference to extension of pilot project
Strengthen organisational learning, including learning from deaths:		
Implement an Organisational Learning Group (OLG)		Relatives/carers were invited to join this group to talk about their experiences and discuss how

		we could embed learning Trust-wide
Deliver the four organisational learning work programmes that aim to strengthen and embed robust systems for the identification and sharing of learning (infrastructure and governance, systems for communication of immediate patient safety concerns, development and launch of a Learning Library and share learning from West Lane Hospital	*	These workstreams were implemented and have made good progress: Infrastructure & Governance: developed the terms of reference for the OLG and developed the strategic infrastructure for 1) the identification and capture of learning from patient safety events, 2) communication of learning and actions to be taken, 3) assessing the impact of actions taken as a consequence of learning Systems for communication of immediate patient safety concerns: the work has focused on the development of Safety Briefings, and these are now well-embedded in the organisation The creation of a learning library: a learning library has been developed and is hosted on the Trust Intranet site. It contains a wide range of information for staff to access from across the organisation. This includes safety briefings, learning bulletins, medication safety information, safeguarding information, and information related to the Trust's improvement work relating to patient safety and quality *This action was placed in our Quality Account in the expectation that the independent review into West Lane would report during 2021/22 but this is now anticipated to be late summer or early autumn of 2022. The Trust will of course closely study the findings and learn from them
Have in place an Integrated Organisational Learning Report with an initial focus on learning from patient safety issues		
Have in place a mechanism assessing the impact of organisational learning		

Increase the percentage of our inpatients who feel safe on our wards:		
Work proactively within the newly formed Regional Patient Experience Network; maximise opportunities for benchmarking patient experience data		The Trust are members of the newly formed Regional Patient Experience Network, sharing ideas and best practice. Work is underway to benchmark our feeling safe data with the network. This has been slightly delayed due to capacity in services
Further review information from patient experience surveys and concerns raised from patients and carers through PALS contact and complaints and use this to feed into report and action plan, and deliver actions throughout the year		All patient experience surveys have a developed action plan and is displayed on trust notice boards in the form of 'you said, we did'. Learning from Patient Experience, PALS and Complaints is captured within a learning database. Further work is needed to ensure that these are shared more robustly across the Trust

How do 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 2021/22	Actual 2021/22
Expand the pilot use of staff body cameras to include a further five wards	Body cameras in place in a further five wards	Roll-out extended to ten sites across the Trust
Percentage of inpatients who report feeling safe on our wards	88%	64.37%
Percentage of inpatients who report that they were supported by staff to feel safe	65%	68.04%

Priority Three: Compassionate Care

Why this is important:

'Our Journey to Change' (see page **6**) describes the kind of organisation we want to be:

We will co-create safe and personalised care that improves the lives of people with mental health needs, a learning disability or autism, involving them and their carers as equal partners. We will listen, learn, improve, and innovate together with our communities and will always be respectful, compassionate, and responsible.

Fundamental to achieving this is by living these three values, one of which is Compassion, and through ensuring our systems and processes support these.

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

- Personalised, compassionate care
- Co creation of care that optimises and improves life experiences
- Feeling involved and listened to when there is a serious incident investigation
- Responses to complaints and concerns that are underpinned by an empathetic and compassionate approach

What we did in 2021/22:

What we said we would do	Did we achieve this?	Comment
Serious Incident reviews		
Develop the Serious Incident review process to take account of feedback from patients and families regarding a more collaborative and informed approach		This will be further developed and embedded during 2022/23
Undertake an evaluation of the new process		As above
Refresh current improvement plan related to responses to complaints		
Embed the new Trust Values and Behaviours within the Trust:		
Hold engagement events with staff at all levels to develop our new ways of working together, with involvement of service users and carers		Engagement sessions with staff began in May 2022; there is consideration of making these sessions mandatory for new staff
Share outputs of initial engagement events so all staff, service users and carers can access tools and resources which help to describe our new ways of working		We are developing a section on the Trust intranet to share tools and resources; however, this is still work in progress. It is anticipated that this will be completed during Q1 2022/23
Further roll-out of engagement events, to be attended by all staff		These are ongoing and are being led by the Trust Organisational Development Team
Work with staff, service users and carers to identify work which has already been developed which supports the new values.		The Trust Organisational Development Team run a service user leadership course annually; 'Our Journey to Change' will play a prominent role in the content. Specific training has also been undertaken with service users who attend our Programme Boards – these were very well received
Agree how we will learn from and build on this work		As above
All teams to co-create their ways of working and development plans		This now sits under People and Culture – there is an ongoing project to roll out a new digital solution called 'Workpal' which will help align personal objectives, team, service, and organisational level goals – this will be implemented by Q2 2022/23
Roll out empathy and compassion training across locality and corporate services		
Establish a baseline of those requiring training		A programme of training has been delivered throughout 2021/22 to staff

		within the localities and corporate services
Undertake a formal evaluation of training		

How do we know we have made a difference?

Indicator:	Target 2021/22:	Actual 2021/22	Timescale:
Percentage of patients reporting that they felt treated with dignity and respect	94%	87.98%	Q4 2021/22
Percentage of patients who were involved as much as they wanted to be in the planning of their care	70%	75.53%	Q4 2021/22
Percentage of patients who report being listened to and heard by staff	76%	79.64%	Q4 2021/22
Reduction in the number of complaints that request a further local resolution	18%	9% (27 out of 293 complaints)	Q4 2021/22

Quality Improvement Priorities for 22/23

Developing the Priorities

Following initial discussion and a review of quality data, risks, and future innovation, we developed our priorities in collaboration with our staff, service users and carers. Our priorities will support the Trust as we continue with our mission to make sure that safe, quality care is at the heart of all we do.

TEWV did not hold our traditional quality account stakeholder workshops in 2021/22. This was partly due to the risks associated with Covid infection which meant that large public face-to-face events could not take place. However, it also reflected our belief that:

- We have improved day to day, continuous engagement with service users, carers and stakeholders and should use what we learn from this to inform our Quality Account, rather than hold special one-off events
- The extensive engagement undertaken (mostly online) during the creation of Our Journey to Change has given a strong sense of where TEWV needs to improve, and the large number of participants (e.g., over 300 service users and carers) gives this feedback and data particular weight in considering priorities

Priority One: Care Planning

Information on why this is important and the benefits/outcomes that we aim to deliver for our patients and their carers can be found earlier in this document on page 16

What we will do	When we will complete it by

• Establish working groups linked to outputs from the Care Planning event in March 2022, all of which link to Cito implementation
  • Care planning patient and carer information: review existing patient and carer information that refers to/is about care planning
  • Care planning training and guidance: develop and approve package around goal setting and solution-focused approaches
  • Care planning monitoring and embedding: agree metrics around care planning – to link into caseload management work
  • Care planning in Secure Inpatient Services: to agree piloting of the use of DIALOG and DIALOG+ as a replacement for 'my shared pathway'
  • The CPA wind-down: review everything that refers to CPA and agree how to change language and processes in line with community transformation and iThrive
• Establish Care Planning Steering Group to report into Quality and Safe and Clinical Journey Boards
• Develop goal setting training and resources to complement move to DIALOG
• Introduce DIALOG and DIALOG+ to all inpatient services to further embed individualised goal-based plans
	All
	Quarter 1 2022/23

• Develop, approve, and publish new patient and carer information in line with new approaches to care planning • Deliver training on goal setting and solution-focused approaches that will further strengthen and support Cito training and guidance • Gather data for baseline position using agreed metrics that will be transferable to Cito • Test use of DIALOG and DIALOG+ in agreed wards within SIS • Develop new policies and procedures in relation to CPA winding down • Continue with inpatient work around understanding, implementation and embedding of DIALOG and DIALOG+	All Quarter 2 2022/23
• Go live of Cito: it is envisaged that much of Quarter 3 will be the supporting of staff in the use of DIALOG, DIALOG+ and individualised care planning elements of Cito (including training and guidance refining and development) • Publish new policies and procedures in relation to care planning and new ways of working (linked to Community Mental Health Framework) • Embed processes for gathering key care planning metrics • Review SIS testing of DIALOG and DIALOG+ and agree next steps/roll out	/ All Quarter 3 2022/23
• Continue with Cito support • Next steps/roll out of DIALOG and DIALOG+ in SIS • Continue measurement of metrics	Quarter 4 2022/23

How will we know we are making things better?

To demonstrate that we are making progress against this priority we will measure and report on the following metrics

Indicator	Actual 2021/22	Target for end 22/23
Patients know who to contact outside of office hours in times of crisis	80%	90%
Patients were involved as much as they wanted to be in what treatments or therapies they received	85%	95%
Patients were involved as much as they wanted to be in terms of what care they received	73%	83%

Priority Two: Feeling Safe

Information on why this is important and the benefits/outcomes that we aim to deliver for our patients and their carers can be found earlier in this document on page 18

What we will do
In 2022/23 we will: • Review the information we have available from patient surveys, incidents, and complaints from adult inpatient services to identify any new emerging themes that may help inform our programme of improvement work in this area • Increase the visibility of staff within adult inpatient areas • Focus on reducing patient-on-patient violence through exploring further use of Information Technology solutions • Continue to implement the Safe Wards initiative (an evidence-based tool to reduce violence and support a safe ward environment)

How will we know we are making things better?

To demonstrate that we are making progress against this priority we will measure and report on the following metrics

Indicator	Actual 2021/22	Target for end 22/23
Percentage of inpatients who report feeling safe on our wards	64.37%	88%
Percentage of inpatients who report that they were supported by staff to feel safe	68.04%	75%

Priority Three: Implementation of the new Patient Safety Incident Reporting Framework

We have made excellent progress on this work over the past few months; following the event that was held in July 2021, in relation to reviewing the current reporting and learning processes from the perspective of patients, carers and families, our

staff and our external colleagues. We have used this information to design the way that we work, and this has been in collaboration with service colleagues and families. Our new processes set out how we will respond to patient safety incidents reported by staff and patients, their families, and carers as part of the work to continually improve the quality and safety of the care provided. The plan sets out the ways the Trust intends to respond to patient safety incidents to learn and improve through Patient Safety Incident Investigations and Patient Safety Reviews. The new processes are in line with the requirements of the new National Patient Safety Incident Reporting Framework that will go live in 2022.

What we will do
In 2022/23 we will implement the revised systems and processes as below: • Roll out the two-part incident approval process across all areas of the Trust. This involves operational staff taking responsibility for reviewing and approving incidents that have occurred within their service before submitting centrally • A triage process for incidents that have been categorised as moderate and serious harm to quickly determine the appropriate route for review • Develop the daily patient safety huddle to include service staff and subject matter experts to ensure we can effectively review reported incidents in a timely way and where rapid reviews can be undertaken where appropriate that lead to immediate actions and improve safety • A Serious Incident Review process that is robust and utilises evidence-based tools and that involve families to the level of their satisfaction • Provide updates for staff on the duty of candour to ensure all have a full understanding • Improve the quality and oversight of action plans • Refresh the Terms of Reference for the Director Assurance Panels

How will we know we are making things better?

To demonstrate that we are making progress against this priority we will measure and report on the following metrics

Indicator	Actual 2021/22	Target for end 22/23
To be confirmed		

Monitoring Progress

The Trust will monitor its progress in implementing these priorities at the end of each quarter and will report to our Quality Assurance Committee, our Council of Governors and, on request to Overview and Scrutiny Committees.

Conclusion and links to the next section of this document

Pages 16 to 28 have explained:

- The progress made in implementing our 2021/22 Quality Improvement priorities and the impact this has had
- Our quality improvement plans for 2022/23

The rest of Part 2 of this Quality Account document summarises a number of data sources which together paint a picture of the quality of services in our Trust. We have followed the national Quality Account guidance in the selection of this material and have included the mandatory text where required.

TEWV's 2021 Community Mental Health Survey Results

- There were 311 completed surveys returned within the Trust, a response rate of 26%. This is the same as the national response rate, and compares with a rate of 28% in 2020

The following table shows how the Trust performed for each section of the Survey in comparison to the national average (all scores are out of 10)

Section	Trust Score	Comparison
Section 1: Health and Social Care Workers	7.3	About the same
Section 2: Organising Care	8.6	
Section 3: Planning Care	6.7	
Section 4: Reviewing Care	7.6	
Section 5: Crisis Care	7.1	
Section 6: Medicines	7.4	
Section 7: NHS Talking Therapies	7.6	
Section 8: Support and Wellbeing	4.8	
Section 9: Feedback	2.3	
Section 10: Overall views of care and services	7.1	
Section 11: Overall experience	7.1	
Section 12: Care during the Covid-19 pandemic	6.6	

The Trust did not score significantly better or worse than comparable Trusts for any of the individual questions or sections as a whole; however, the Trust did score somewhat better than expected on *Q12: Do you know how to contact this person [person in charge of their care] if you have a concern about your care?*

The Trust's top five scores against the national average were for the following questions:

- Q19: Would you know who to contact out of office hours within the NHS if you had a crisis? This should be a person or team within NHS mental health services
- Q17: In the last 12 months, have you had a specific meeting with someone from NHS mental health services to discuss how your care is working?
- Q23: Have the possible side effects of your medicines ever been discussed with you?
- Q32: In the last 12 months, did NHS mental health services support you with your physical health needs (this might be an injury, a disability, or a condition such as diabetes, epilepsy, etc?
- Q10: Have you been told who is in charge of organising your care and services? (This person can be anyone providing your care, and may be called a 'care coordinator' or 'lead professional')

The Trust's bottom five scores against the national average were for the following questions:

- Q34: In the last 12 months, did NHS mental health services give you any help or advice with finding support for finding or keeping work (paid or voluntary)?
- Q20: Thinking about the last time you tried to contact this person or team, did you get the help you needed?
- Q35: Have NHS mental health services involved a member of your family or someone else close to you as much as you would like?
- Q3: In the last 12 months, do you feel you have seen NHS mental health services often enough for your needs? (This includes contact in person, via video call and telephone)
- Q33: In the last 12 months, did NHS mental health services give you any help or advice with finding support for financial advice or benefits?

The following questions demonstrate where there was a statistically significant change in the Trust's results between 2020 and 2021:

- Q33: In the last 12 months, did NHS mental health services give you any help or advice with finding support for financial advice or benefits? ↓
- Q3: In the last 12 months, do you feel you have seen NHS mental health services often enough for your needs? ↓

The areas where service user experience is best are:

- ✓ Crisis care contact: service users knowing who to contact out of hours in the NHS if they have a crisis
- ✓ Review of care: service users meeting with NHS mental health services to discuss how their care is working
- ✓ Side effects: possible side effects of medicines being discussed with service users
- ✓ Support with physical health needs: service users being given support with their physical health needs
- ✓ Who organises care: service users being told who is in charge of organising their care and services

The areas where service user experience could improve are:

- × Support with work: service users being given help or advice with finding support for finding support for finding or keeping work
- × Crisis care help: service users getting the help needed when they last contacted the crisis team
- × Friends/Family involvement: service user's family/someone close to them is involved in their care as much as they like
- × Seen often enough: service users being seen by NHS mental health services often enough for their needs
- × Support with financial advice: service users being given help or advice with finding support for financial advice

Full results of the Survey for the Trust can be found at:

https://nhssurveys.org/all-files/05-community-mental-health/05-benchmarks-reports/2021/

In order to take forward these results in relation to improving our patient experience, we will:

- Circulate the National Community Mental Health Survey report and findings across the Trust for discussion at local governance groups and add this report to the agendas for discussion at patient and service user involvement groups
- Develop a further action plan with particular emphasis on the availability of services, people being involved as much as they wanted to be, the help provided by crisis teams and help finding support for finding or keeping work

TEWV's 2021 National NHS Staff Survey Results

The National NHS Staff Survey is commissioned by the Picker Institute on behalf of TEWV and 24 other Mental Health and Learning Disabilities Trusts. All Trust staff were invited to participate, and returned 3,747 completed questionnaires, which is a response rate of 50%, compared to a median response rate of 52%. This is a significant increase on the response rate in 2020 (38%). TEWV were ranked 20 out of 24 compared to 11 out of 27 back in 2020

The 2021 annual NHS staff survey results for TEWV show that the Trust's overall results are around average to a little below average for mental health providers.

The questions for the 2021 survey onwards are aligned to the NHS People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements.

The following table shows how the Trust performed on each of the seven aspects of the People Promise, compared to the highest, lowest, and mean scores from similar Trusts. The domains of staff engagement and morale were also measured and have also been included here

Section	TEWV	Mean	Highest	Lowest
We are compassionate and inclusive	7.4	7.5	7.9	7.1
We are recognised and rewarded	6.2	6.3	6.8	5.9
We each have a voice that counts	6.9	7.0	7.4	6.4
We are safe and healthy	6.2	6.2	6.6	5.8
We are always learning	5.4	5.6	6.1	4.8
We work flexibly	6.3	6.7	7.1	6.1
We are a team	6.9	7.1	7.4	6.6
Staff engagement	6.8	7.0	7.4	6.5
Morale	5.9	6.0	6.5	5.5

The most improved results compared to 2020 are shown in the following table. They mostly relate to values and behaviours and suggest that work over the last couple of years to encourage positive leadership and management behaviours, and to put effective processes in place to encourage and investigate concerns raised by staff who 'speak up' is starting to have a positive impact

Question	2021	2020
Q13d: Last experience of physical violence reported	92%	87%
Q11e: Not felt pressure from manager to come to work when not feeling well enough	82%	78%
Q14c: Not experienced harassment, bullying or abuse from other colleagues	86%	84%
Q14b: Not experienced harassment, bullying or abuse from managers	92%	90%
Q14d: Last experience of harassment/bullying/abuse reported	59%	57%

The scores that declined the most between 2020 and 2021 are shown below. The impact of increased demand for mental health services and workforce availability linked to Covid can clearly be seen.

Question	2021	2020
Q3i: Enough staff at organisation to do my job properly	28%	42%
Q21c: Would recommend organisation as place to work	52%	66%
Q21d: If friend/relative needed treatment would be happy with standard of care provided by organisation	54%	65%
Q4b: Satisfied with extent organisation values my work	43%	53%
Q11d: In last three months, have not come to work when not feeling well enough to perform duties	45%	55%

Areas where the Trust scored low compared to national average:

- Support from immediate manager
- Would recommend Trust as a place to work or receive care
- Making adequate adjustments
- There is a significant piece of work to do looking at improving appraisals and linking them to feeling valued and improve how we undertake our roles

Areas where the Trust scored better than the national average:

- Career development
- Not working additional hours
- Experiencing musculoskeletal problems as a result of work

Review of Services

During 2021/22 the Trust provided and/or subcontracted **20** relevant health services. The Trust 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 2021/22 represents **100%** of the total income generated from the provision of relevant health services by the Trust for 2021/22.

Participation in clinical audits and national confidential inquiries

A clinical audit is the process by which the quality of care and services provided are measured against agreed standards. Where services do not meet the agreed standard, the audit provides a framework where suggestions for improvements can be made. A third party conducts national audits. Participating in these audits gives organisations the opportunity to compare their results with other organisations. Local audits are conducted by the organisation itself. Here they evaluate aspects of care that the healthcare professionals themselves have selected as being important to their team. The statements on a clinical audit demonstrate the healthcare provider is concerned with monitoring the quality of their services and improving the healthcare provided.

During 2021/22, **seven** national clinical audits and **three** national confidential inquiries covered the health services that TEWV provides.

During 2021/22, TEWV participated in **100% (seven out of seven)** of the national clinical audits and **100% (three out of three)** 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 2021/22 were as follows:

- Prescribing Observatory for Mental Health (POMH):
  - POMH Topic 10b: Prescribing for depression in adult mental health services
  - POMH Topic 14c: Prescribing for substance misuse: alcohol detoxification
- National Clinical Audit of Psychosis (NCAP)
  - Spotlight re-audit in EIP Services
  - AMH Community Services
- National Audit of Inpatient Falls (NAIF)
- Facilities Audit
- National Audit of Care at the End of Life (NACEL)
- National Audit of Dementia (NAD)
- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD):
- Physical Healthcare in Mental Health Hospitals
- Transition from Child to Adult Services Study

The national clinical audits and national confidential inquiries that TEWV was **participated in** during 2021/22 were as follows:

- Prescribing Observatory for Mental Health (POMH):
  - POMH Topic 10b: Prescribing for depression in adult mental health services
  - POMH Topic 14c: Prescribing for substance misuse: alcohol detoxification
- National Clinical Audit of Psychosis (NCAP)
  - Spotlight re-audit in EIP Services
  - AMH Community Services
- National Audit of Inpatient Falls (NAIF)
- Facilities Audit
- National Audit of Care at the End of Life (NACEL)
- National Audit of Dementia (NAD)
- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD):
- Physical Healthcare in Mental Health Hospitals
- Transition from Child to Adult Services Study

The national clinical audits and national confidential inquiries that TEWV participated in, **and for which data collection was completed during 2021/22** 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 number of registered cases required**
POMH Topic 19b: Prescribing for depression in adult mental health services	Sample provided: 89	100%
POMH Topic 14c: Prescribing for substance misuse: alcohol detoxification	Sample provided: 11	100%
National Clinical Audit of Psychosis (NCAP): Spotlight re-audit in EIP	Sample provided: 510	100%
National Clinical Audit of Psychosis (NCAP): AMH Community	Sample provided: 100	100%
National Audit of Inpatient Falls (NAIF): Facilities Audit*	Not applicable – organisational questionnaire only	Not applicable
National Audit of Care at the End of Life (NACEL)*	Sample provided: 9	100%
National Audit of Dementia (NAD): Spotlight audit of Community-Based Memory Services*	Sample provided: 512	100%
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)	27 questionnaires sent to the Trust; 22 returned	81%
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) – Physical Healthcare in Mental Health Hospitals*	27 clinician questionnaires sent; 10 submitted questionnaires	37%
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) – Transition from Child to Adult Services Study	Not applicable – organisational questionnaire only	Not applicable

** The Trust was eligible to also participate in organisational/hospital level questionnaires for these national clinical audits/confidential inquiries. These were completed in all cases*

Due to the timings of the national audits, the Trust had not received and reviewed the reports for all 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 them and agree actions to improve the quality of healthcare provided.

The reports of **106** local clinical audits were reviewed by the Trust in 2021/22 and TEWV intends to take actions to improve the quality of healthcare provided. **Appendix 3** includes the actions the Trust is planning to take against the **five** key themes from these local clinical audits reviewed in 2021/22

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 **72** clinical audits in 2021/22 which include clinical effectiveness projects undertaken by Trainee 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 and were reviewed by specialities. Over the next year the Trust intends to use clinical audit applications to make clinical audits more efficient and to make it easier for teams to review their clinical quality information in a live format and to make any changes needed to improve practice and ultimately the quality of care and experience of our patients and their families.

The Trust implemented an extensive Quality Assurance Programme during 2021/22. This programme has delivered ongoing assurance for key quality and risk issues identified within the Trust. Significant improvements in practice and patient safety have been facilitated through this programme.

Participation in Clinical Research

The Trust participates in research activity to help provide new knowledge that has the potential to be valuable in improving care for patients. It is important that such research is open to critical examination and open to all that would benefit from it.

The number of patients receiving relevant health service provided or sub-contracted by TEWV in 2021/2022 that were recruited during that period to participate in research approved by a Research Ethics Committee was **806**. Of the 806 participants, 768 were recruited to 27 National Institute for Health Research (NIHR) portfolio studies. This compares with 826 patients involved as participants in NIHR research studies during 2020/21.

During 2021/2022, the Trust has continued to focus on successful continuation and delivery of the BASIL+ study. The Basil C19 study examines the use of behavioural activation in older adults with low mood or loneliness and long-term health conditions during Covid-19. Sponsored by TEWV, 435 participants were recruited across 12 sites in the UK, with TEWV recruiting 60 participants to the trial.

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

- We continue to work closely with the NIHR Clinical Research Network North Est and North Cumbria to support large scale national portfolio research studies, and to measure patient research experience when taking part in studies with feedback and any actions reported to our Research Governance Group.
- We were involved in conducting **66** clinical research studies in mental health, dementias and neurodegeneration, health services research and infection, during 2021/22; 49 of these studies were supported by the NIHR through its networks

- **45** members of our clinical staff participated as researchers in studies approved by a Research Ethics Committee, with **31** of these in the role of Principal Investigator for NIHR supported studies
- **371** members of our staff were also recruited as participants to NIHR portfolio studies
- We continue to collaborate with a wide range of universities and other NHS providers to deliver large multi-site research studies for the benefit of our service users, carers, and staff, through these collaborations, we have been awarded a further two NIHR Research for Patient Benefit grants during this year.

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

Due to the ongoing Covid-19 pandemic NHS England and NHS Improvement stood down all CQUIN requirements

What the Care Quality Commission (CQC) says about us

The Care Quality Commission (CQC) is the independent regulator for health and social care in England. It ensures that services such as hospitals, care homes, dentists and GP surgeries provide people with safe, effective, compassionate, and high-quality care, and encourages these services to improve. The CQC monitors and inspects these services, and then publishes its findings and ratings to help people make choices about their care.

Tees, Esk and Wear Valley NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is **registered without conditions for services being delivered by the Trust**. The Trust is therefore licensed to provide services.

The CQC **has** taken enforcement action against TEWV during 2020/21. TEWV **has** participated in a special review/investigation by the CQC during the reporting period.

Between 14th June 2021 and 5th August 2021, the Trust received a series of unannounced core service inspections from the CQC. This included inspection of Secure Inpatient Services, Adult Mental Health Crisis Services and Health-Based Places of Safety, Adult Mental Health Community Services and Community Child and Adolescent Mental Health Services. Core service inspections were also followed by a well-led inspection of the Trust.

Following the inspection, the CQC raised several areas for improvement with a Section 29A notification received for Secure Inpatient and Community Child and Adolescent Mental Health Services.

Inspections of the Secure Inpatient Services observed some issues with staffing levels, safeguarding processes and governance arrangements. Inspections of the Community Child and Adolescent Mental Health Services observed some issues with staffing, the size of caseloads and systems and processes for monitoring patients

Immediate action was taken in response to these concerns and a comprehensive action plan was developed to ensure these areas of risk were being adequately addressed. Implementation has been well progressed with robust weekly reporting and oversight through the Trust's Quality Improvement Board. The deadline for implementation was 1st March 2022. It is however recognised by the CQC that fully embedding some of these actions and the impact will require longer timescales. Further plans are in place to ensure that improvements are sustained, and that service delivery continues to be safe and effective.

Section 29A issues were subsequently encompassed by the CQC with the 'Must Do' regulatory actions included within the Trust CQC inspection report issued on 10th December 2021. The Trust was rated as 'Requires Improvement'

The follow-up CQC inspection of the Adult Mental Health Inpatient Services in June 2021 noted significant improvements in risk assessment and management processes and subsequently re-rated the service as 'Requires Improvement'

In addition to clearly evidencing delivery of the required actions, the Trust continues to implement a wider programme of change and improvement. During 2021, this has included restructuring how services are delivered, strengthening governance arrangements, increasing leadership capacity and oversight, improving staffing establishments and improving mandatory training, expertise, clinical supervision, and sustainable support to our clinical teams. Work has also been achieved to enhance and embed organisational learning from a range of internal and external sources. This has included reviewing, strengthening, and developing mechanisms for capturing and communicating learning and importantly gaining assurance of the impact of our actions to improve care for service users and their families. This work continues to support the Trust in nurturing a culture of patient safety and continuous quality improvement.

Since the inspections, we have sustained a quality assurance schedule that includes a review of the quality of care documentation. This has provided ongoing assurance that patient's risks are assessed and that they have care, safety and observation plans in line with their needs.

A 'Quality Improvement Board' chaired by the Chief Executive with executive team attendance with responsibility for ward/team to board reporting on implementation has been sustained to oversee quality assurance standards including regular audit and direct observation on wards and to provide assurance to the Trust Board that appropriate actions are being taken to address improvements in patient safety.

Improvement Plan

A Regional Quality Board was established where TEWV reports on progress to other partners such as NHS England and the Integrated Care Systems as well as the CQC. The Trust is also accessing expert external support for rapid improvement and embedding actions.

In addition to the attainment of all recommendations and conditions related to the Section 29A warning notice issued by the CQC in March 2021, an umbrella improvement plan is being implemented with overarching workstreams including:

- Implementation of the Trust's new strategy – 'Our Journey to Change'
- Board development
- Strengthening 'Ward/Team to Board governance flow' and focus on the Board Assurance Framework/Risk Registers
- Embedding organisational learning including reviewing the involvement of families and carers in Serious Incident reviews
- Simplification of management and governance structures to support the line of sight, communication, and flow of information
- Development of new Board integrated assurance performance report and strengthening capacity and capability in corporate and locality/specialist governance roles
- Training and professional development for clinical staff
- Sustainability of improvements including leadership and development and strengthening lines of accountability
- Technological improvements including the development of a new electronic patient record system

We are confident that we will continue to improve services and will work with staff, service users, carers, volunteers, governors, commissioners, and partners to address the areas where standards were not as expected.

The Trust has retained an overall rating of 'Requires Improvement' with a number of actions being taken to improve the quality and safety of our services.

Further information can be found at: https://www.cqc.org.uk/provider/RX3

Information Governance

Information Governance requires the Trust to set a high standard for the handling of information. The aim is to demonstrate that it can be trusted to maintain the confidentiality and security of personal information, by helping individuals to practice good information governance.

Due to the ongoing Covid-19 pandemic, NHS Digital has delayed submission of the Data Security and Protection Toolkit 2021-22 until 30th June 2022. Of the **110** mandatory evidence items and **38** assertions, we anticipate publishing the Toolkit with all except one evidence item provided and assertions met.

Similar to many other Trusts, the Trust is currently experiencing a higher than usual sickness absence rate making the mandatory requirement to ensure at least 95% of all staff have completed their annual Data Security Awareness Training problematic.

Not achieving an evidence item would require an action plan to be submitted that identifies the actions and timescales to achieve compliance.

Due to cyber security risk, NHSE/I have advised there is no appetite to reduce the mandatory 95%

In mitigation, the Trust issues monthly cyber security eLearning to all staff; all new staff complete mandatory Data Security and Protection Training for New Starters, and we have undertaken a number of phishing simulations with the findings and learning shared Trust-wide.

The following steps have been put in place to ensure that appropriate controls are in place to ensure the accuracy of data:

- The Trust has in place an internal group which has the responsibility for ensuring data quality within the Trust; this was put on-hold during the COVID-19 response but is set to be reinstated as part of the Trust's revised governance structure
- Data quality is included within the Corporate Risk Register which is used by the Board of Directors to monitor the risk of incomplete and inaccurate data.

The Trust has the following policies linked to data quality:

- Data Quality Policy
- Minimum Standards for Record Keeping
- Policy and Procedure for PARIS (Electronic Patient Record/Information System)
- Data Management Policy
- Information Governance Policy
- Information Systems Business Continuity Policy
- Confidentiality and Sharing Information Policy

These policies incorporate national standards where available and are regularly reviewed. All the policies are held on the staff intranet and are available to staff at all times. When policies have been reviewed (or new ones published) there is a mechanism to inform staff through monthly policy bulletins and other cascade mechanisms.

- As part of performance reporting to the Board, real-time data is used to forecast future positions, thus improving the decision-making process. Trust dashboards are available via the Integrated Information Centre (IIC) to support and enhance decision-making
- All data returns are submitted in line with agreed timescales

Freedom to Speak Up

Following a review by Sir Robert Francis in 2015, a national standard 'Freedom to Speak Up' policy was published by NHS Improvement and NHS England. This policy has the aim of developing a more open and supportive culture for staff to raise any issues of patient care, quality, or safety. The Trust has subsequently adopted this standard policy in its own policy.

The Trust has a policy which details how staff can speak up about risk, malpractice, or wrongdoing. Most of the time staff will choose to raise their concerns with their line manager. However sometimes they may feel this is inappropriate. They then have the option to 'Speak Up' anonymously using our Raising Concerns email address (which can be found on the Trust Intranet) or by contacting the Trust's Freedom to Speak Up Guardian via mobile telephone or dedicated email address.

Part of the role of the Freedom to Speak Up Guardian is to ensure that staff receive feedback on how their concerns are being addressed e.g., who is conducting the service review or investigation, what they found and what, if any, subsequent actions are being taken. Depending on the case, this feedback can be verbal or written. It often forms part of regular feedback aimed at developing a trusting relationship.

Ensuring that people who speak up do not experience detriment is a central commitment of the Guardian's role. It is also clearly stated within the Trust policy. Staff are also regularly reminded that they should not tolerate any negative consequences of their speaking up. At the end of their involvement, staff are asked to answer two questions – "Would you feel confident to speak up in the future?" and "Did you feel you experienced any detriment?"

The Trust has little evidence of overt actions leading to detriment. However, some staff have felt a loss of trust in the organisation to keep them safe. This loss of trust has on some occasions resulted in staff feeling unable to remain in their current post. Many have moved to another post within the organisation and have reported their satisfaction with this outcome.

The Freedom to Speak Up guardian attends the Trust Board on a twice-yearly basis to deliver their report. This report contains numbers of new cases taken on, the number closed, the broad category of the concern, and any feedback. It also contains anonymised case studies/examples and any lessons learnt.

During 2021/22, there were **78** cases referred to the Freedom to Speak Up Guardian. Of these, **25** were submitted anonymously. **34** of the concerns related to culture of bullying, and **38** related to patient safety and **15** to staff safety. The remainder related to other issues such as culture or systems/processes. We are committed to creating an open and transparent culture where every member of staff can speak out safely. Over the next year we will continue to raise the profile of the Freedom to Speak Up Guardian and triangulate the information we have with other sources to ensure the best and safest care for our service users.

Reducing Gaps in Rotas

The Guardian of Safe Working for Junior Doctors within the Trust produces quarterly reports to the Trust Board that focus on gaps in medical rotas and safety issues. The role sits independently from the management structure, with a primary aim to represent and resolve issues related to working hours. The work of the Guardian is subject to external scrutiny of doctors' working hours by the Care Quality Commission and by the continued scrutiny of the quality of training by Health Education England.

The Guardian is required to levy a fine against a department(s) if a Junior Doctor:

- Works on average over 48 hours/week
- Works over 72 hours in seven days
- Misses more than 25% of required rest breaks
- On non-residential on call (NROC) does not have a minimum of continuous rest for five hours between 22:00 and 07:00
- Does not have the minimum eight hours total rest per 24-hour NROC shift
- Has more than the maximum 13-hour residential shift length
- Does not have the minimum 11 hours rest between resident shifts

The Guardian of Safe Working for Junior Doctors within the Trust produces quarterly and annual reports to the Trust Board that focus on gaps in medical rotas and safety issues.

The Trust's Board received the Guardian's annual report for 2021/22 at its meeting of 26th May 2022. During the year, the most common reasons for needing short-term/locum cover was due to vacancies on the rotas, staff sickness (short/long term) and COVID-19 related absences (sickness or self-isolation).

Exception reports received related mostly to claiming additional hours whilst on Non-Residential On-Call, having to stay later than normal working hours or shift end time or missing teaching/training due to staff shortages. Discussions on these issues have taken place where appropriate and additional staffing put in place where possible.

Bolstering staffing in adult and older adult community mental health services

One of the consequences of the additional investment into mental health services in recent years (and the Trust's decision to invest in clinical posts to address the Covid surge in demand) has been an increase in our workforce. During 2021/22 this trend has continued and our workforce in January 2022 was 206 whole time equivalent posts higher than at the start of the financial year (although workforce size peaked in November 2021). Through Commissioners, national transformation investment and Covid surge monies, the Trust has increased staffing across all clinical services, including adult and older adult community mental health services.

Examples of service improvements enabled by additional staffing include:

- Additional Healthcare Assistants appointed to combat increased demand for physical health monitoring
- Additional staff recruited into Mental Health Support Teams to allow the full target population to be able to access support, particularly in relation to issues surround Covid/Covid lockdowns
- Allied Health Professionals (Speech and Language Therapy, Physiotherapy, Occupational Therapy) plus Pharmacist recruited into the Care Home Liaison Team in Durham
- Increased staffing across Perinatal teams in Durham, Darlington, and Tees to support further delivery of the NHS Long-Term Plan
- Increased staffing within Tees AMH Community Teams to provide additional support for service users with Autism/ADHD and also into Early Intervention in Psychosis

The Trust is currently agreeing with Commissioners their investment plans for 2021/22, which it is anticipated will be mobilised to implement a range of roles in both Inpatient and Community-based -Services.

Learning from Deaths

Following publication of the Southern Health report in 2015 there has been enhanced national scrutiny on how all NHS organisations respond to deaths of service users in their care. This culminated in the release of a 'Learning from Deaths Framework' which was published by the National Quality Board in 2017. The Trust collects data on all known deaths and has processes in place to determine the scope of deaths which require further review or investigation. The Board of Directors (meeting in public) receive a quarterly Learning from Deaths dashboard and report summarising learning. As well as being included in this Quality Account, information is also included in the annual Patient Safety report.

In Mental Health and Learning Disability Services we have a significant number of older people who are cared for in the community and their needs are such they only require minimal contact with us. Many of these people who die do so through natural

causes as happens in the wider population. This explains the difference between the total number of deaths (from all causes including natural causes) and the numbers we go on to investigate further. To support staff in their decision making regarding the investigation of deaths, staff have clear policy guidance, setting out criteria for categories and types of review. This is currently being reviewed as part of development work in preparation for the new Patient Safety Incident Response Framework which will be implemented gradually during 2022/23 in line with national guidance.

Despite the pressures of COVID-19, good progress has been made to improve both the quality and the number of Serious Incident and Mortality reviews completed over the year, notably the number of Learning Disability Deaths that have been reviewed internally and reported to LeDeR (Learning Disabilities Mortality Review).

It is recognised that team development and skilled staff are key to the delivery of high quality, safe care, and high functioning teams to minimise the risk of incidents occurring. Community Matrons, Practice Development Practitioners and Peer Workers appointed to support co-creation, recovery and involvement are embedding their roles which has enhanced senior clinical leadership during 2021/22.

In 2019, a family conference was held with bereaved families who had experienced the serious incident process. One of the aims of the conference was to identify how we could improve the way we engage with families. May 2021, an improvement event was held to consider how we could further improve involvement with families to facilitate a more equal partnership in the Serious Incident Investigation process. (Further information can be found in relation to our new priority for 2022/23 on pages 27 to 28). The Trust was due to hold its second annual family conference in March 2020; this was put on hold due to the COVID-19 pandemic and is regularly under review.

Any death of a person open to Trust services, which is reported through our Incident Management System, is subject to an initial review by the Central Approvals Team. During 2021/22 **2,163** TEWV patients died; this comprised the following number of deaths which occurred in each quarter of that reporting period:

- **486** in the first quarter
- **556** in the second quarter
- **638** in the third quarter
- **483** in the fourth quarter

The following were Learning Disability Deaths (reported to LeDer)

- **18** in the first quarter
- **26** in the second quarter
- **23** in the third quarter
- **19** in the fourth quarter

There were 26 inpatient deaths; 22 of these deaths related to physical health, 3 deaths were potential patient safety incidents; 1 cause of death remains unknown.

In Q1, 31 serious incidents resulting in death were reported. 23 serious incidents were reviewed. Of those 23 cases, 14 had lapses in care/service delivery

In Q2, 15 deaths were reported. 18 serious incidents were reviewed. Of those 18 cases, 11 had lapses in care/service delivery

In Q3, 23 deaths were reported. 15 serious incidents were reviewed. Of those 15 cases, 12 had lapses in care/service delivery

In Q4, 31 deaths were reported. 21 serious incidents were reviewed. Of those 21 cases, 8 had lapses in care/service delivery

By 31st March 2022, in relation to unexpected and expected physical health deaths, 430 mortality reviews, including 71 structured judgement reviews had either been carried out or requested

Recurring themes relate to:

- Risk assessment/safety summaries/safety plans
- Care Programme Approach (CPA), care plans/interventions plans/formulations
- Relative/carer involvement
- Record keeping

Detailed below are some of the structures to support and embed learning in response to what we have learned from reviews of deaths during 2021/22:

Practice Development Group (PDG)

The Practice Development Teams (PDT) overseen by the PDG are addressing the areas of learning as identified by lapses of care during 2021/22, namely safety summaries/safety plans, care planning and relative/carer involvement as detailed above. Practice Development Practitioners (PDP) have been appointed and continue to develop in their posts across inpatient wards. They are also offering training in relation to risk assessment and safety summaries Trust-wide, including to community staff.

Organisational Learning Group (OLG)

The Trust continues to strengthen its arrangements for organisational learning via the Organisational Learning Group. As part of the work undertaken by this group, urgent patient safety briefings are now circulated Trust-wide. Examples of these urgent safety messages relate to new anchor points/ligature risks identified within the Trust and how these risks are to be addressed. The briefings are specific about any assurance required from services; on receipt of completed actions these are stored

in the learning database. ‘Learning from Serious Incidents Bulletins’ are also regularly distributed across the Trust. The bulletins have shared key learning and good practice highlighted in serious incident reports presented at the Director’s assurance panel. All briefings and bulletins are stored in the learning library on the Trust’s intranet for easy access. A quality improvement event is planned for August 2022 to focus on how we can further improve the communication and impact of learning in front line services.

Patient Safety Priorities

The Journey to Safer Care as part of the Trust’s ‘Journey to Change’ highlights four key patient safety priorities:

- Suicide Prevention and Self-Harm Reduction
- Reducing Physical Restraint and Seclusion
- Harm Free Care, Psychological Safety including sexual safety and a Safe Environment
- Promoting Physical Health

The Service Development Managers (SDMs) who are members of the Patient Safety Campaign steering group have been tasked to map out work that is taking place across services in relation to these priorities. This will be used to inform the work plan for the Quality and Safety Programme Board.

Suicide Prevention and Harm Minimisation

A period of engagement has been carried out with staff, service users, carers/relatives, and partners to help shape the Trust’s draft Preventing Suicide Strategy, Leadership for suicide prevention is through the Clinical Strategy Lead supported by a multi-disciplinary Preventing Suicide and Self-Harm Reduction Group which will monitor progress against the strategy’s action plan. All actions will be aligned to our ‘Our Journey to Change’

In support of the above strategy, the preventing suicide project leads continue to work closely with the Patient Safety Team and our partners by:

- Sharing information from the early alerts system in areas where this is available. This applies to suspected suicides (not just people open to the Trust) to facilitate shared learning with partners
- Attending and working with partners in all localities where there have been multiple suicides in a particular area or site (not just people open to the Trust)
- Targeted work with rail network, to work closer together with shared protocols for preventing suicides
- Providing direct support and guidance to teams on completing Rapid Reviews, reflecting on lessons learnt and how the project workers can support clinical services
- Identifying emerging themes within their locality then engaging with those services directly to share the learning and provide guidance and support on best practice

The Trust is participating in the National Collaborative Work on reducing restrictive practices

Harm-Free Care – Safe Environment

The Environmental Risk Group receives monthly incident reports involving ligatures and other risks where environmental factors may have contributed to harm as well as progression of initiatives to reduce harm. Any urgent learning from this group is disseminated Trust-wide via Patient Safety Briefings or SBARDS. As part of the ligature reduction programme, in inpatient areas, ensuite doors and main bedroom doors are currently being replaced. Main bedroom doors are being replaced with sensor doors in designated wards. The roll-out of Oxehealth continues to support patient safety through enhanced observation. An early learning report has been undertaken and will go through various governance routes over the next month to highlight progress and areas for further development. Environmental surveys with input from estates, health and safety and clinical services have been recommenced. Completion of these has been impacted by Covid.

Promoting Physical Health

Work continues in relation to improving the physical health of people with mental health problems, in keeping with ICS priorities when learning from deaths. This includes weight management, care of the deteriorating patient, reducing alcohol and drug use, reducing falls.

Safeguarding

Despite improvement work already undertaken to embed the principles of ‘think family’ and the use of the PAMIC tool, it continued to be a finding in serious incident investigations. It was agreed that the issue is above the qualitative aspect of how parental mental health impacts on children and that this should be considered as part of a comprehensive risk assessment under the category of risk to others. Having this as a narrative in the risk assessment has enabled fuller information to be shared/documented about what has been considered from a ‘think family’ perspective. Outcomes of this improvement work will be triangulated with evidence from the Central Approvals Team, Patient Safety Team, and the Safeguarding Team to determine the impact of changes made on patient safety. Links between the Patient Safety Team and the Safeguarding Team continue to be strengthened with joint working on serious incident cases and in the Patient Safety Team huddle.

Serious Incident Investigation Process

A quality improvement event ‘Improving the Experience of Patients, Families and Staff during Serious Untoward Incident Reviews (SIRs)’ commissioned by the Director of Quality Governance, built on existing work already being carried out to improve the SI investigation process. A further event was held in February 2022 where four additional workstreams relating to the SI process and incident reporting were identified. A Project Manager is in place to drive delivery of this improvement work as well as the wider standards in keeping with ‘Our Journey to Change’, and event has been planned for the 20th of May 2022 to facilitate full engagement with all

relevant stakeholders. Improvement work has continued to identify early learning/themes from rapid reviews ensuring that clinical services embed early actions into practice. This work has been supported by Serious Incident Reviewers and the Preventing Suicide project leads. A more proactive approach to learning from deaths has been taken by facilitating closer working relationships between clinical services and the Patient Safety Team. In some cases, clinicians, and where required subject matter advisors, are invited into the Patient Safety Team huddle to discuss early learning and immediate actions required. Reviewers are now working with clinicians in areas such as perinatal services, suicide prevention, physical health and health and safety to share Trust-wide learning at these groups. This is promoting a more 'wrap-around' approach to learning between corporate and organisational services. All newly appointed Serious Incident Reviewers are attending serious incident investigation training which is being provided by the Healthcare Safety Investigation Branch (HSIB)

Better Tomorrow Programme

The Trust is working with the Better Tomorrow Programme to review current Mortality Review Systems and processes to help identify and support with potential areas of development. This work was put on hold due to the pandemic but has recently recommenced.

Training

'Connecting for people' suicide awareness training continues with plans for further Trust staff to be trained as trainers during 2022. The Trust's mandatory harm minimisation training continues to include updated headlines from serious incidents in relation to learning from deaths. As part of the improvement work around the serious incident process and learning from deaths, several training needs for staff Trust-wide have been identified. These include incident reporting, holding difficult conversations with bereaved relatives, duty of candour/culture of candour, report writing and writing smart action plans. These have been fed into the Trust-wide training needs analysis event. The Trust will be participating in patient safety training released as part of the National Patient Safety Strategy

Clinical Strategy

Learning from deaths during 2021/22 highlighted that patients with dual diagnoses were often not followed-up proactively by mental health services. This workstream will be picked up in the clinical strategy.

Patient Safety Specialist

The Trust's Patient Safety Specialist continues to attend the Patient Safety Specialist Improvement Programme Webinars, arranged by the National Patient Safety Team. These interactive forums connect over 700 Specialists from around the country. There is also the opportunity to discuss any issues relating to patient safety including learning from deaths on the Patient Safety Specialist's workspace both from a national and regional perspective.

The definitions used by the Trust are as follows:

- **Root Cause** - The prime reason(s) why an incident occurred: A root cause is a fundamental factor, an act or omission that had a direct effect on the incident occurring. Removal of these will either prevent or reduce the chances of a similar type of incident from happening in similar circumstances in the future**.**
- **Contributory Factor/Influencing Factor -** An act or omission that influences the likelihood of the incident occurring and hence contributed to the incident

PALS and Complaints

Complaints are managed following national guidance and we endeavour to respond to all of our formal complaints within 60 days. We have a complaints manager aligned to each locality area of the Trust who works with the relevant operational staff member, service user and/or carer to resolve the issue that has been raised.

The Trust's Policy and Procedure for the Management of Compliments, Comments, Concerns and Complaints outlines the Trust's approach to receiving valuable feedback and information from patients and their carers about the services provided by the Trust. When people raise concerns, they are given options by the Patient Advice and Liaison Service (PALS)/Complaints Team for taking their concerns forward. They may opt to have their concerns addressed by PALS staff liaising on their behalf with clinical staff or through meetings with the Clinicians.

People may also choose at any point to have their concerns registered under the NHS Complaints Regulations (2009) with a more formal investigation and a written response letter from the Chief Executive.

During 2021/22 PALS dealt with **2,279** concerns or issues from patients and carers, an increase of **152** when compared to 2020/21. **1,123 (49%)** of the concerns raised were around AMH services across the Trust.

1,800 of the PALS concerns (**79%**) were closed within 15 working days (although no formal target is set for this). Non-compliance was largely as a result of the Covid-19 pandemic where it has not always been possible to obtain timely feedback from operational services.

301 formal complaints were received and registered during 2021/22 compared to 265 for the same period last year.

Complaints across services: **196** in AMH services, **58** in CYPS, **17** in MHSOP, **22** in Secure Inpatient Services, **0** in Health and Justice, **2** in ALD services and **6** in Corporate Services.

The most common cause for complaints across the Trust related to aspects of clinical care (216 or 71.76%) followed by communication (36) and attitude (26). Complaints have also been received relating to discharge arrangements (8), environment (6), waiting times (4), medical records (2), Hotel Service (1) and Bereavement (1).

249 responses were sent out during 2021/22, **49** (**20%**) were within timescales (60 working days). Non-compliance was in respect of the complexity of the complaints being received and the Covid-19 pandemic. The number of complaints received and closed are published on the Trust's website.

The Trust continues to deliver specific training to support and empower a wide range of our staff to develop reasoned empathy emotional awareness and intelligence, compassion, and resilience to promote wellbeing and a just, caring culture. Learning is applied within the context of duty of candour, ensuring a person-centred approach to complaints, resilience, and leadership culture. The training is supporting our staff to understand vulnerability in themselves and others and prevent psychological harm. It does this in a thought-provoking, honest, and supportive learning environment. Learning the science and reality behind meaningful, empathic communication, as well as self-care and to build confidence in why empathy and emotional awareness is a key and important focus.

An example is the session of experimental learning; it not only identifies what empathy is, but enables those attending to 'feel' empathy, analyse, and understand it on a deeper level, and why it is so important within complaints. The session takes empathy out of the textbook and into real life as delegates go on a journey of empathy and emotional awareness and the importance of both these things when an incident occurs to support patients, loved ones and themselves.

Part 3: Further information on how we have performed in 2021/22

Introduction to Part 3

Part 3 of this document contains further information which the legal guidance requires us to include. This includes statutory statements. As with Part 2, this helps to develop an overall picture of quality at the Trust.

Mandatory Quality Indicators

Since 2012/13, all NHS Foundation Trusts have been required to report performance against a core set of indicators. Normally the Trust is required to present a mandatory statement and the data on NHS Digital for the most recent and the previous reporting period available. However, due to the ongoing Covid-19 pandemic, this mandatory collection was stood down by NHS Digital

Care Programme Approach 72-hour follow-up

327 people were not followed up within 72 hours during 2021/22. Given the unprecedented times, it has not been possible to gather the level of intelligence in terms of this area of underperformance that would normally be included within the report, as all efforts have been diverted to manage the Covid-19 situation and the need to ensure that the Trust's focus remains on this clinical priority

Crisis Resolution Home Treatment team acted as gatekeeper

In March 2020, the national collection of this measure by NHS Digital was suspended due to the Covid-19 pandemic and the need to release capacity across the NHS to support the response. Subsequently, a consultation on the Quarterly Mental Health Community Teams Activity return opened and the outcome was published on 15th April 2021 announcing the decision to retire this collection. A replacement for this measure will not be introduced immediately; time will be taken to explore developing an alternative indicator(s) to help measure meaningful contact with Crisis Resolution & Home Treatment Teams before admission.

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

The figures we have included are from the CQC website

An overall Trust score is not provided, due to the nature of the survey, therefore it is not possible to compare trusts overall. For 2021, we have reported the Health and Social Care Workers section score which compiles the results from the questions used from the survey detailed below in the table.

TEWV Actual 2021	***National benchmarks in 2021***	***TEWV Actual 2020***	***TEWV Actual 2019***	***TEWV Actual 2018***
Overall section score: 7.3 (Sample size 282)	*Highest/Best MH Trust: 7.7* *Lowest/Worst MH Trust: 6.0*	Overall section score: 7.34 (Sample size 340)	Overall section score: 7.3 (Sample size 209)	Overall section score:7.3 (Sample size 209)

For more information, please see the section on results of the NHS Community Mental Health Survey on pages 29 to 31

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.

TEWV Actual Q3 21/22	***National Benchmark in Q1 & Q2 21/22***	***TEWV Actual Q1 & Q2 21/22***	***TEWV Actual Q3 20/21***
Trust reported to NRLS: 4,297 incidents reported of which 29 (0.7%) resulted in severe harm or death* *7 Severe Harm and 22 Death	*Not available*	Trust reported to NRLS: 6,215 incidents reported of which 84 (1.35%) resulted in severe harm or death* *25 Severe Harm and 59 Death	Trust reported to NRLS: 3,105 incidents reported of which 27 (0.9%) resulted in severe harm or death

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

- Although this may seem like a large number of total incidents, this is in line with expected numbers for a Trust with a caseload the size of TEWV; the absolute numbers of incidents reported is a factor of the relative size of the Trust and the complexity of their case-mix

- The Trust is reporting 56.2 as the rate of incidents (calculated by dividing the number of incidents reported by the number of occupied bed days); the national average is 75.4 (the highest reported rate was 235.8 and the lowest 21.4)
- Amongst the most common themes reported are self-harming behaviour, patient accident, disruptive/aggressive behaviour, and medication errors which account for three-quarters of all incidents leading to harm

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

- The Trust introduced incident reporting in September 2021 as a mandatory training requirement with all staff across the Trust. This has led to an increased focus on incident reporting with an increase of incidents being reported
- To support the training, additional tools have been developed to support those reporters of incidents ensuring data quality of the incidents being reported

Our performance against our quality metrics

The Quality Account 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 Report

Quality Metrics 21/22

Quality Metrics		2021/22		2020/21	2019/20	2018/19	2017/18
		Target	Actual	Actual	Actual	Actual	Actual
Patient Safety Metrics							
1	Percentage of patients reported 'yes always' to the question 'do you feel safe on the ward'?	88%	65.30%	67.54%	62.39%	61.50%	62.30%
2	Number of incidents of falls (level 3 and above) per 1000 occupied bed days (for inpatients)	0.35	0.07	0.18	0.15	0.18	0.12
3	Number of incidents of physical intervention/restraint per 1,000 occupied bed days	19.25	37.66	26.27	30.45	33.81	30.65
Clinical Effectiveness Measures							
4	Existing Percentage of patients on Care Program Approach who were followed up within 72 hours after discharge from psychiatric inpatient care	>80%	88.51%	N/A*	N/A*	N/A*	N/A*
5	Percentage of Quality Account audits of NICE guidance completed	100%	N/A**	100%	100%	100%	100%
6	Patients occupying a bed over 90 days	<61	60	N/A*	N/A*	N/A*	N/A*
Patient Experience Measures							
7	Percentage of patients who reported their overall experience as excellent or good	94%	94.34%	90.32%	91.65%	91.41%	90.50%
8	Percentage of patients that report that staff treated them with dignity and respect	94%	86.04%	84.59%	85.80%	85.70%	85.90%
9	Percentage of patients that would recommend our service to friends and family if they needed similar care or treatment	94%	87.76%	89.94%	86.70%	86.90%	87.20%

Notes on selected Metrics

1. Data for CPA 72-hour follow-up is taken from the Trust's patient systems and is aligned to the national definition
2. The percentage of Quality Account 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
3. 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 **2021/22** position was **64.37%** which relates to **402** out of **625** surveyed. This is **23.63%** below the Trust target of **88.00%.** All localities underperformed this year. Durham & Darlington was closest to the target with 67.66% and Forensic Services was furthest away with 59.31%

When brief analysis has been undertaken of why patients do not feel safe in a ward environment, the most often cited cause has been due to the behaviour of other patients. It has also been noted that due to the acuity levels of patients who are admitted, they are likely to feel unsafe due to the fact that they are acutely unwell. As there is a persistent significant gap between our target and performance on this metric, improving safer care has been identified as a Quality Improvement priority for 2022/23 (see page **27**).

Metric 3: Number of incidents of physical intervention/restraint per 1,000 occupied bed days (OBDs)

The end of **2021/22** position was **23.02;** which relates to **1408** interventions and **61156** OBDs; this is **4.22** worse than the Trust target of **19.25**

Durham & Darlington were the only locality achieving the target with a rate of 17.7. Of the underperforming localities, Teesside had the highest number of incidents per 1000 OBD with 34.39

A large proportion of restrictive intervention usage across the Trust occurs in a small number of wards and is more likely to occur with a small group of patients with complex needs. Severe forms of physical restraint i.e., prone (face-down) have significantly reduced in recent years.

The Trust continues to work towards the long-term reduction of all forms of restrictive intervention. A range of actions are in progress across the Trust via our Restrictive Intervention Reduction Plan.

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

The end of **2021/22** position was **86.04%** which relates to **2997** out of **3484** surveyed. This is **7.96%** below the Trust target of **94.00%.**

All localities underperformed in 2021/22. Teesside were closest to the target with 87.98% and Forensic Services were furthest away from the target with 75.99%.

We continue to focus on this important area of patient experience; our patients tell us that treating people with dignity and respect includes staff treating people in a caring and compassionate way which will be strengthened by the work we are doing on our Trust values and empathy training for staff. It is also about involving people in

decisions around their care which will be supported by the ongoing quality priority around personalised care planning and our goal of co-creation. Having an environment that respects privacy and dignity is important and we are proud that we have eliminated all dormitory accommodation and all patient bedrooms are now single, many with ensuite facilities.

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

The end of **2021/22** position was **87.76%** which relates to **3238** out of **3690** surveyed. This is **6.24%** below the Trust target of **94.00%.**

Whilst the Trust has not met its own target, we are pleased that the majority of our patients would recommend our services and we continue to focus on a range of improvement work focused on providing high quality and responsive services that provide a good patient experience. Examples are given throughout this report.

All localities underperformed in 2021/22. **Teesside** were closest to the target with **89.59%** and **Forensic Services** were furthest away from the target with **79.86%.**

Quality Metrics for 2022-23

The current set of quality metrics have been in place for several years, but changes in the national and local quality agendas now require a revised set of metrics to be monitored.

Work is underway to review the suite of metrics to align them more closely with our new quality journey and our improvement priorities.

Some of the current metrics will remain the same; however, we will analyse our data in a more sophisticated way, so that it can be identified where things are really improving or getting worse

Our Performance against the System Oversight Framework Targets and Indicators

A new System Oversight Framework (SOF) was released in June 2021, setting out NHS England and NHS Improvement's approach to the oversight of Integrated Care Systems, CCGs, and Trusts, with a focus on system-led delivery of care.

Indicators	2021/22	
	Threshold	Actual
Total access to IAPT Services: Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy	N/A	28295
IAPT: The proportion of people who are moving to recovery	50%	52.22%
3.A1: The proportion of people who wait 6 weeks or less from referral to accessing IAPT against the number of people who finish a course of treatment in the reporting period	75%	99.04%
3.A2: The proportion of people who wait 18 weeks or less from referral to accessing IAPT against the number of people who finish a course of treatment in the reporting period	95%	99.92%
3.B1: The proportion of people who wait six weeks or less from referral to their first IAPT treatment appointment against the number of people who enter treatment in the reporting period	N/A (supporting measure)	99.01%
3.B2: The proportion of people who wait 18 weeks or less from referral to their first IAPT treatment appointment against the number of people who enter treatment in the reporting period	N/A (supporting measure)	99.90%
3.C1: Number of ended referrals in the reporting period who received a course of treatment against the number of ended referrals in the reporting period who received a single treatment appointment	N/A (supporting measure)	1.80
3.C2: IAPT: Average number of treatment sessions	N/A (supporting measure)	7.94
3.C3: IAPT: The proportion of people who waited less than 28 days from their first treatment appointment to their second treatment appointment	N/A (supporting measure)	50.49%
3.C4: IAPT: The proportion of people who waited less than 90 days from their first treatment appointment to their second treatment appointment	N/A (supporting measure)	91.52%
Percentage of people who have waited more than 90 days between first and second appointments	<10%	8.48%
Implementation of IAPT – Long-Term Condition pathways	N/A (CCG ambition)	No
Number of CYP aged under 18 supported through NHS funded mental health with at least one contact	N/A (CCG ambition)	31,796
The proportion of CYP with ED (routine cases) that wait four weeks or less from referral to start of NICE-approved treatment (rolling 12 months)	95%	53.82%
The proportion of CYP with ED (urgent cases) that wait one week or less from referral to start of NICE-approved treatment (rolling 12 months)	95%	50.91%
Number of people accessing Individual Placement Support (IPS) services as a rolling total each quarter	N/A (CCG ambition)	674
Number of people who receive two or more contacts from NHS or NHS-commissioned community mental health services for adults and older adults with severe mental illnesses	N/A (CCG ambition)	269,446
13a: Number of inappropriate OAP bed days for adults by quarter that are either 'internal' or 'external' to the sending provider	0 by Q4	701
13b: Number of inappropriate OAP bed days for adults by quarter that are 'external' to the sending provider	0 by Q4	701
Percentage of people who are admitted to hospital without having had any prior contact with community mental health services	N/A (CCG ambition)	14.79%

Indicators	2021/22	
	Threshold	Actual
Percentage of adults discharged from CCG-commissioned mental health inpatient services receive a follow-up within 72 hours	80%	90.21%
Number of women accessing specialist community Perinatal Mental Health services in the reporting period (12-month rolling)	N/A (CCG ambition)	1126
Percentage of women accessing specialist community Perinatal Mental Health services in the reporting period (12-month rolling)	N/A (CCG ambition)	5.41%
Data Quality Maturity Index	90%	98.10%

Notes on the System Oversight Framework Targets and Indicators

IAPT: The Trust does not have as many people accessing IAPT Services as is our ambition. This continues to be impacted by staff sickness and vacancies within our services, and recruitment is ongoing in all areas. The Trust level IAPT recovery is a positive position with the standard being achieved consistently.

OAP: The Trust continuing to see an increase in the number of patients that are being placed in external beds. Whilst this is a national issue due to current demand levels, the Trust remains concerned and are committed to eliminating out of area placements by Quarter 3 2022/23.

Eating Disorders: The Trust is concerned that Children and Young People with an eating disorder are not being treated in a timely manner. Whilst this is a pressure in terms of demand that is being experienced nationally, this has been greatly impacted by vacancies within our services. Recruitment continues and work has been undertaken to increase the number of appointments.

IPS: Whilst the Trust has not achieved the ambitions set nationally for each individual CCG, work has been undertaken with partners to develop a set of local trajectories for these measures as part of the 2022/23 operational planning round for mental health services. These have been submitted to NHS England and NHS Improvement for approval.

Perinatal Mental Health Services: Whilst the Trust has not achieved the ambitions set nationally for each individual CCG, work has been undertaken with partners to develop a set of local trajectories for these measures as part of the 2022/23 operational planning round for mental health services. These have been submitted to NHS England and NHS Improvement for approval.

General: Our sickness levels continue to be higher than we aspire to in all localities and whilst all sickness is managed in line with Trust policy and is closely monitored within operational services, this is impacting on the delivery of some of our services.

External Audit

Due to the COVID-19 pandemic, the external audit of the 2021/22 Quality Account was stood down.

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. Due to the Covid-19 pandemic we have been unable to hold our usual Stakeholder engagement events; however, we have sought views from our Stakeholders, service users, carers, and staff through a variety of other means throughout the year, including Our Big Conversation. We have used this feedback when formulating our priorities and actions for 2022/23.

In line with national guidance, we have circulated our draft Quality Account for 2021/22 to the following stakeholders:

- NHS England
- North East Commissioning Support
- Clinical Commissioning Groups (County Durham, Tees Valley, North Yorkshire, Vale of York)
- Local Authority Overview & Scrutiny Committees (x9 inc. Tees Valley Joint Committee)
- Local Authority Health & Wellbeing Boards (x7)
- Local Healthwatch Organisations (x8)

All the comments we have received from our stakeholders are included verbatim in **Appendix 4.**

The following are the general themes received from stakeholders in reviewing our Quality Account for 2021/22: [to be added upon receipt of Stakeholder Feedback]

The Trust will write to each stakeholder addressing each comment made following publication of the Quality Account 2021/22 and use the feedback as part of the annual lessons learnt exercise in preparation for the Quality Account 2022/23.

APPENDICES

Appendix 1: 2021/22 Statement of Director's 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 2021/22 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 2021 to May 2022
    - Papers relating to quality reported to the Board over the period April 2021 to May 2022
    - Feedback from the Commissioners dated
    - Feedback from local Healthwatch organisations dated
    - Feedback from Overview and Scrutiny Committees dated
    - Feedback from Health and Wellbeing Boards dated
    - The Trust's complaints information reported to its Quality Assurance Committee of the Board of Directors, which will be published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
    - The latest national patient survey published 3rd December 2021
    - The latest national staff survey published 11th March 2022
    - CQC inspection report dated 27th August 2021 and 10th December 2021

- 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 Account 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:

16th June 2021……. Paul Murphy (Interim Chairman)

16th June 2021 ……Brent Kilmurray (Chief Executive)

Appendix 2: Glossary

Adult Mental Health (AMH) Services: Services provided for people aged between 18 and 64 – known in some other parts of the country as 'working-age services. These services include 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 have Early Onset Dementia. Early Intervention in Psychosis (EIP) teams may treat patients less than 18 years of age as well as patients aged 18-64

Audit: An official inspection of records; this can be conducted either by an independent body or an internal audit department

Autism: This describes a range of conditions typically characterised by social deficits, communication difficulties, stereotyped or repetitive behaviours and interests, and in some cases cognitive delays. People with autism are sometimes known as "neuro-diverse". Autism cannot be "cured", but the mental illnesses which are more common for people with autism can be treated.

Board/Board of Directors: The Trust is run by a 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 in manages. It is overseen by a Council of Governors and monitored by NHS Improvement. It also:

- Ensure effective dialogue between the Trust and the communities it serves
- Monitors and ensures high quality services
- Is responsible for the Trust's financial viability
- Appoints and appraises the Trust's executive management team

Business Plan: A document produced once a year by the Trust to outline what we intend to do over the next three years in relation to the services that we provide

Child and Adolescent Mental Health Services (CAMHS): See Children and Young People's Services (CYPS)

Care Planning: See Care Programme Approach (CPA)

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

Care Quality Commission (CQC): The independent regulator of health and social care in England. They 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's Services (CYPS): Mental Health Services for children and young people under the age of 18 years old. This includes community mental health services, inpatient services and learning disability services

Cito: An information technology system which overlays the Trust's patient record system (PARIS) which makes it easier to record and view the patient's records

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 GP practices in their geographical area. The aim of this is to give GPs and other clinicians the power to influence commissioning decisions for their patients. CCGs are overseen by NHS England

Clinical Supervision: a supportive mechanism which involves clinicians meeting regularly to reflect on practice, with the intention of learning, developing practice and providing high quality, safe care to patients

Commissioners: The organisations that have responsibility for purchasing health services on behalf of the population in the area they work for

Commissioning for Quality and Innovation (CQUIN): A payment framework where a proportion of NHS providers' income is conditional on quality and innovation

Community Mental Health Survey: a survey conducted every year by the CQC. It represents the experiences of people who have received specialist care or treatment for a mental health condition in 55 NHS Trusts in England over a specific period during the year

Confidential Inquiry: A national scheme that interviews clinicians anonymously to find out ways of improving care by gathering information about factors which 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-creation: This is an approach where a policy or other initiative/action is designed jointly between TEWV staff and service users, carers, and families

Council of Governors: Made up of elected public and staff members and 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

Crisis Resolution & Home Treatment (CRHT) Team: Provide intensive support at home for individuals experiencing an acute mental health crisis. They aim to reduce both the number and length of hospital admissions and to ease the pressure on inpatient units

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 and Security Toolkit: 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

Data Quality Strategy: A TEWV strategy which sets out 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

Department of Health: The government department responsible for Health Policy

DIALOG: A clinical tool that allows for assessment, planning, intervention, and evaluation in one procedure and allows more personalised Care Planning

Forensic Adult and 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 a prison or court, where their needs can be assessed and treated

Formulation: When 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 to Speak Up Guardian: Provides guidance and support to staff to enable them to speak up safely within their own workplace

Friends and Family Test (FFT): A survey put to service users, carers and staff that asks whether or not they would recommend a hospital/community service to a friend or family member if they need treatment

Gatekeeper/Gatekeeping: Assessing the service user before admission to hospital to consider whether there are alternatives to admission and the involvement in the decision-making processes that result in admission

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

Guardian of Safe Working: Provides assurance that rotas and working conditions are safe for doctors and patients

Harm Minimisation: Our way of working to minimise the risks of sometimes multiple and conflicting harm to both service users and other people

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 (i.e., Local Authorities and the NHS) would work together to improve the health and wellbeing of their local population and to 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

HealthWatch: Local bodies made up of individuals and community groups, such as faith groups and resident's organisations 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

Home Treatment Accreditation Scheme (HTAS): Works with teams to assure and improve the quality of crisis resolution and home treatment services for people with acute mental illness and their carers

Hospital Episode Statistics (HES): 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

Improving Access to Psychological Therapies (IAPT): An NHS initiative to increase the provision of evidence-based treatments for common mental health conditions such as depression and anxiety by primary care organisations

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

Intranet: This is the Trust's internal website used for staff to access relevant information about the organisation, such as Trustwide policies and procedures

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

LeDeR: The learning from deaths of people with a Learning Disability (LeDeR) programme was set up as a service improvement programme to look at why people are dying and what we can do to change services locally and nationally to improve the health of people with a Learning Disability and reduce health inequalities

Local Authority Overview and Scrutiny Committee: 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 focusses on Health, although Darlington, Middlesbrough, Stockton, Hartlepool and Redcar and Cleveland councils have a joint Tees Valley Health OSC that performs this function

Mental Health Act (1983): 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 in 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 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 with a mental health problem. They can be treated for 'functional' illness, such as depression, psychosis, or anxiety, or for 'organic' mental illness (conditions usually associated with memory loss and cognitive impairment) such as dementia. The MHSOP Service sometimes treats people less than 65 years of age with organic conditions such as early-onset dementia

Mortality Review Process: A Trust process to review deaths, ensuring a consistent and coordinated approach, and promoting the identification of improvements and the sharing of learning

Multi-Disciplinary: This means that more than one type of professional is involved, for example, psychiatrists, psychologists, occupational therapists, behavioural therapists, nurses, pharmacists all working together in a Multi-Disciplinary Team (MDT)

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 to 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 the patients and the public

National Reporting and Learning System (NRLS): 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

NHS England (NHSE): leads the National Health Service in England

NHS Improvement (NHSI): The independent economic regulator for NHS Foundation Trusts – previously known as Monitor. This will be abolished if the current Health and Care Bill is passed by parliament, and its functions have already been subsumed into NHS England.

NHS Long-Term Plan (2019): A new plan for the NHS to improve the quality of patient care and health outcomes. It sets out how the £20.5 billion budget settlement

for the NHS, announced by the Prime Minister in summer 2018, will be spent over the next five years

NHS Staff Survey: Annual survey of staff experience of working within NHS Trusts

Non-Executive Directors (NEDs): Members of the Trust Board who act as a 'critical friend' to hold the Board to account by challenging its decisions and outcomes to ensure they act in the best interests of patients and the public

North Cumbria and North East Integrated Care System: Consists of four Integrated Care Partnerships – North, South, East, and West (see Integrated Care Partnerships)

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

Patient Advice and Liaison Service (PALS): A service within the Trust that offers confidential advice, support, and information on health-related matters. They provide a point of contact for patients, their families, and their carers

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

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

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

Project: A one-off, time limited piece of work that produces a product (such as a new building, a change in service or a new strategy/policy) that will bring benefits to relevant stakeholders. Within 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): A unit (or ward) that is designed to look after people who cannot be managed on an open (unlocked) psychiatric ward due to the level of risk they pose to themselves or others

Quality Account: A report about the quality of services provided by an NHS Healthcare Provider, the report is 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 and Assurance

Quarter One/Quarter Two/Quarter Three/Quarter Four: Specific time points within the financial year (1st April to 31st March). Quarter One is from April to June, Quarter Two is from July to September, Quarter Three is October to December and Quarter Four is January to March

Reasonable Adjustments: A change or adjustment unique to a person's needs that will support them in their daily lives, e.g., at work, attending medical appointments, etc.

Research Ethics Committee: An independent committee of the Health Research Authority, whose task it is to consider the ethics of proposed research projects which will involve human participants, and which will take place, generally, within the NHS

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

Safeguarding: Protecting vulnerable adults or children from abuse or neglect, including ensuring such people are supported to get good access to healthcare and stay well

Secondary Uses Service: The single, comprehensive repository for healthcare data in England which enables a range of reporting and analysis to support the NHS in the delivery of healthcare services

Section 29a Notice: This is a warning notice served by the CQC where concerns are identified across either the whole or part of an NHS Trust and where it is decided that there is a need for significant improvements in the quality of healthcare

Senior Leadership Group (SLG): Individuals at the senior level of management within the organisation (e.g., Directors) who meet on a regular basis. They are responsible for the overall management of TEWV and the high-level decisions within the organisation

Serious Incident (SI): An incident that occurred in relation to NHS-funded services and care, to either 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 delivery of services, absconding from secure care

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

Staff Friends and Family Test: A feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. It helps the Trust to identify what is working well, what can be improved and how

Statistical Process Control (SPC) charts: a graph used to show how a process changes over time and to see whether a situation is improving or deteriorating,

whether the system is likely to be capable to meet the standard and whether the process is reliable or variable

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

Strategic Framework: primarily intended as a framework for thinking about the future and a guide to inform the investment and disinvestment decisions by those tasked with future planning

Substance Misuse Services: Clinical services who work with people who abuse alcohol, illegal drugs or over the counter or prescription medications in a way that they are not meant to be used

TEWV: Tees, Esk and Wear Valleys NHS Foundation Trust

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 Trust-wide

The Trust: see TEWV above

Trust Board: See Board/Board of Directors above

Trustwide: The whole geographical area served by the Trust's localities

Unexpected Death: A death that is not expected due to a terminal medical condition or physical illness

Urgent Care Services: Crisis, Acute Liaison and Street Triage services across the Trust

Whistleblowing: this is a term used when a worker highlights a concern about their organisation and/or services to the Freedom to Speak Up Guardian or NHS Regulators. This will normally be regarding something they have witnessed at work

Year (e.g., 2022/23): These are financial years, which start on the 1st of April in the first year and end on the 31st of March in the second year

Appendix 3: Key themes from action plans produced in response to 130 Local Clinical Audits in 2021/22

Audit Theme	Key quality improvement activities associated with clinical audit outcomes
1. Infection prevention and control	• All infection prevention and control (IPC) audits are continuously monitored by the IPC Team and any required actions are rectified collaboratively by the IPC team and ward staff. Assurance of implementation of actions is monitored using the Clinical Audit and Effectiveness Team via the clinical audit action monitoring database • A total of 76 IPC clinical audits were conducted during 2021/22 in inpatient areas, prison teams, and community teams where there is a clinic. 74% (56/76) of clinical areas achieved standards between 90-100% compliance. Local clinical audit plans were implemented in collaboration with the IPC Team and the clinical team members to mitigate any areas of non-compliance
2. Medicines Management	• The Pharmacy Team has a central mechanism to scrutinise quarterly controlled drugs (CD) audit data as it comes in. Where audits show any areas for improvement, the CD accountable officer will contact the ward manager • The Pharmacy Team will explore the feasibility of introducing electronic controlled drugs registers • A valproate initiation and monitoring chart will be developed to prompt staff to record indication/target symptoms for valproate treatment, discussions around off-label prescribing, baseline and ongoing physical health monitoring for people prescribed valproate for bipolar disorder • The Pharmacy Team will develop a valproate Pregnancy Prevention Programme (PPP) register to help teams give relevant guidance and track timely Annual Risk Acknowledgement Form (ARAF) completion • The Pharmacy Team will review all identified instances of women under 55 years of age being prescribed valproate without an ARAF in their clinical record • Following the National Clinical Audit of Psychosis (NCAP) audit, cases where patients with first episode psychosis had not been offered clozapine (after failed trials of two antipsychotics) were reviewed. This included exploration of barriers for patients commencing clozapine medication • A request will be submitted for a change to the new electronic record system to support prescribers in offering clozapine and documenting the offer to patients • A flowchart will be developed to enhance staff knowledge around offering clozapine to patients • Wards with a medicines omission rate >0.5% have implemented a ‘second checker’ process to ensure that no doses of medication are omitted unintentionally • Amendments and additions will be made to the Clozapine Initiation Checklist and Annual Review Checklist • The Pharmacy Team will develop and implement a sub-process for adding clozapine to the GP record if this is not present at the clinical check of 6-month prescriptions

Audit Theme	Key quality improvement activities associated with clinical audit outcomes
3. Safeguarding	• Safeguarding Adults Procedure audit findings were fed into the Datix task and finish group to improve reporting • Updated guidance on how to raise and complete a safeguarding concern on PARIS was shared via a Staff Briefing and also shared with staff when disseminating the audit findings • Safeguarding duty workers were reminded to follow standard processes to support safeguarding adult referrals • Safeguarding supervision details were updated within the Trust's Clinical Supervision Policy • An action briefing has been developed to be shared with staff. This reminds practitioners of their responsibility to ensure that service users' wishes, and feelings are part of the safeguarding process and are recorded • Regular reminders of the Safeguarding process will be incorporated within the Safeguarding Team's briefing • The Safeguarding Team will review a sample of records every three months to monitor compliance with the Safeguarding processes • The Safeguarding Adults Flow Chart, PARIS briefing, and eLearning package has been promoted via a Staff Briefing and the Safeguarding Link Professionals • The Safeguarding Adults intranet page will be updated to include links to PARIS briefings and eLearning packages to increase ease of access for practitioners • A briefing will be produced specifying the requirements of the Safeguarding Children Policy and this will be shared with Community Modern Matrons. A review will be undertaken with the Community Modern Matrons and learning from this will be shared focusing on the positive practice observed as well as implementing improvements to sustain high quality practice standards
4. Risk assessment and CPA	• Assessment packs will be developed for the Health and Justice service to include useful guidance in relation to the Care Programme Approach (CPA), neurodevelopmental assessments prompts, a trauma leaflet, and a leaflet about the team • Outcomes measures training will be provided to all Health and Justice Teams and a recording system will be developed for all screening tools • All Age Liaison and Diversion Teams will be developing aide memoire cards for staff and updating the visual control boards in order to improve recording of assessment and consent documentation
5. Physical Health	• The Trust-wide Physical Health Group will be reviewed and recommenced in order to provide further support to improve assessment and recording of relevant physical health activities. This will be chaired by a Clinical Director • Staff will be reminded to ensure that when physical health measures are unable to be obtained due to patients declining these, this must be recorded within the electronic patient record • The Tissue Viability and Physical Health Specialist Nurse in collaboration with Ward Managers will produce a flowchart which shows the agreed process for ensuring that all patients have a Waterlow Pressure Ulcer Risk Assessment completed and updated, along with documented evidence of interventions for those identified with a pressure ulcer (in line with the Assessment, Prevention and Management of Pressure Ulcers Procedure)

Appendix 4: Feedback from our Stakeholders

This Appendix consists of letters from our Stakeholders which will be posted into this section of the document once received at the end of the consultation period (mid-June)

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Report to

Tees Valley Joint Health Scrutiny Committee - 8 June 2022

1 Introduction

Tees Valley Joint Health Scrutiny Committee has sought assurances on a number of issues from Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) ahead of their meeting 8 June 2022. The Committee have asked for a general update and progress in relation to the CQC inspection report since their last meeting in mid-March. This report provides an update on progress since then and outlines the Trust's response to these questions.

2 Update and general progress

2.1 Strengthened leadership and governance: capacity, oversight and accountability

Since the Committee last received an update from TEWV's leadership team on 18 March 2022, the Trust has implemented a new governance and organisational structure on 1 April 2022, to ensure we provide well-governed care that is clinically led. It has been developed following feedback from our staff, patients, families and carers, our governors and our partners, as well as consultation with staff whose roles were affected.

We have simplified the organisation by establishing two Care Groups, which will enable the Trust to be better aligned to the two Integrated Care Systems (ICS) in which we provide services, and better play our part in transforming care across the communities we serve. This is a critical element of Our Journey to Change and will enable us to focus on place-based care, meet population needs, influence change and strengthen local relationships.

The two Care Groups cover the Integrated Care Systems (ICS) that we serve:

- Durham, Tees Valley and Forensic Care Group will align with the North East and North Cumbria ICS.
- North Yorkshire, York and Selby Care Group will align with the Humber, North Yorkshire Health and Care Partnership (ICS).

To co-create a great experience for our patients, carers and their families, it is vital that our leaders include people with lived experience of mental illness, who can bring a new level of perspective and understanding to our organisation and how we develop our services.

As part of our new structure, we have appointed two lived experience directors for each care group, who will join the Trust in June and July this year, and who will be supported by a new Head of Co-creation, who has championed trauma informed care and peer support for a number of years. We believe we are one of the first NHS Trusts in the country to make this significant change to our senior leadership team, which will ensure lived experienced voices are heard at all levels of the organisation and make a major contribution to changing the culture of the Trust. They will play a key part in developing and improving our services by working closely with our patients and carers, local communities, and colleagues in other lived experience roles.

We have also increased the number of peer workers across our services and at the end of the recruitment period we will have more than 20 new peers providing support to patients; using the knowledge and expertise that comes from their own lived experience of mental health services. These are hugely important additions to our wards, and the benefits of peer support workers can include

improved experience of services and levels of satisfaction with care. It can also help lead to improved outcomes for service users and support cultural change.

These revised governance arrangements have been developed to strengthen our leadership structure and capacity. This will improve line of sight from ward to Board, improve the flow of assurances and enable greater oversight of risk. We have made the collective leadership model clearer so responsibility and ownership is more transparent. We have also increased clinical leadership significantly and given parity to allied health professions (AHPs) within the structure.

We have also introduced a new integrated performance Board Assurance Framework to support oversight, monitoring and reporting of key measures to demonstrate the delivery of the quality of services and provide assurance to the Board through its sub-committee structure.

We are making improvements to risk management with work to design and prepare to establish risk groups at both executive and care group levels in 2022/23, and improved reporting to the Board and its committees through a new risk escalation framework.

2.2 Workforce and culture

We have an overarching People plan aligned to our Board Assurance Framework built around three key strands of recruitment and retention, staff wellbeing and experience, and culture.

In terms of recruitment, the Trust is growing in numbers of employees, with an increase of 5% in the last 18 months. From 1 January 2022 to 18 May 2022, we have published 2,277 adverts, offered 1,189 jobs, and 873 candidates have started in post. However, we still face recruitment challenges, which are being felt regionally and nationally. As a Trust, we are working extremely hard to streamline and speed up our recruitment processes and offer incentives for prospective candidates.

As well as recruitment, retaining our existing staff remains a high priority for the Trust. We have introduced new ‘intention to leave’ and ‘should I stay’ groups, which are allowing us to gain a better understanding of our teams and any issues that arise.

Our Autumn 2021 staff survey response rate increased from 38% to 50%, and we have improved in the following areas:

- bullying/ abuse from colleagues had improved;
- not feeling pressure to come in to work when ill; and
- feeling able to raise concerns.

We recognise that there is still work to do, and there were declining rates in the following areas, which are being addressed through our ongoing culture change, reward and recognition and staff experience programmes, and our CQC action plans:

- Enough staff at organisation to do my job properly
- Would recommend as a place to work
- In last 3 months (Jun-Aug 2021) have not come to work when not feeling well enough to perform duties

Staff survey action plans have been developed, and ongoing quarterly pulse surveys allow the Trust to take a temperature check on how the organisation is doing, and staff are feeling. The important insight is being used to shape and develop our plans around leadership competency, culture change, and staff experience.

We have reviewed our staff reward and recognition offering, and have established a new group, including five staff-side colleagues, to oversee our retention offers in the broadest sense. Our current staff offers are very favourable compared to other NHS Trusts, such as free car parking at Trust sites and reservist training days, and we've introduced a monthly staff prize draw, which is proving really popular.

Staff wellbeing is also one of our top priorities, and we are currently restructuring our People and Culture Directorate to put an increased focus on workforce planning, health and wellbeing and staff engagement.

We hold regular staff engagement sessions which include virtual 'lunch and learn' sessions with guest speakers covering a range of topics including equality and diversity subjects, monthly coffee breaks and a month senior leadership webinar.

Additional information is provided on our staff survey, staff networks and equality and diversity improvements – see section 3.3 Great Place to work.

Staff sickness remains a challenge and much like recruitment, remains a national issue. However, we have retained a lower absence rate than other local Trusts for the last two months, which is around 6-7%.

2.3 CQC Action Plan

The Care Quality Commission (CQC) is likely to revisit us soon to review the progress we're making. This will be an opportunity for us to show the progress we have made, particularly within Secure Inpatient Services (SIS) and CAMHS, and we know that members of this Committee were particularly concerned about these issues too.

Our key areas of focus within SIS are staffing and culture, safeguarding and governance systems for quality and safety.

We have made significant progress with the development of a Healthcare Assistant (HCA) Council, our largest workforce in SIS. Meetings have started to take place, which has strengthened the staff voice in the service and ensured that the team is heard at the highest level. The meeting is chaired by an HCA and supported by the Associate Director of nursing and Quality, reporting into the Care Group so the voice of the HCA is heard and responded to. The council meeting will meet in the morning and then spend the afternoon on the SIS site engaging and feeding back as well as gaining agenda items for the next meeting. The first two meetings have included teaching as requested by the council around BAME, unconscious bias, listening skills and resilience.

We are working hard to improve the culture of the service and make changes based on direct staff feedback and what is most important to them. The service has undertaken a review of shift start and finish times, and we have invested in facilities for staff in order to enable breaks to be taken comfortably within the secure perimeter. We are also reviewing the policy in relation to the use of mobile phones by staff within the perimeter and developing a 'safe area' where staff can use electronic devices.

One of the key concerns highlighted by staff has been movement within the service to pathways they feel unfamiliar with (i.e. staff being moved around the service). We have introduced daily leadership groups that are focused on minimising this type of movement. We have also included this as a key component of SafeCare, so we are able to monitor the impact of this on an ongoing basis.

The Trust's organisational development team are working closely with ward managers in SIS to ensure service managers and modern matrons are visible and offering support to staff on the wards.

In CAMHS we have implemented a Keeping Touch Process (KIT) whilst families are waiting for their assessment (or treatment). Families should as minimum expect to receive a letter from the team as a way of touching base on a quarterly basis (RAG rated green) and monthly contact for those RAG rated amber. We have also taken action to address waiting for young people to access our services. The whole waiting list has undergone a full data validation exercise and we undertake daily monitoring of waiting lists.

An anonymous poll within our children and young people's services discovered that 86% of staff felt that the service was heading in the right direction.

Whilst we recognise there is more work to do, we do feel we have made significant progress to address areas of concern and welcome the opportunity to update the Committee on 8 June 2022.

More specific information on SIS and CAMHS are provided in the responses in Appendix 1.

APPDENDIX 1

3 Responses to questions

3.1 Quality and Performance Assurance and Improvement

3.1.1 What new performance measures do locality leaders now use to have oversight and ensure good quality care?

As part of the continuous improvement of the Trust's Performance Management Framework, we have been developing a more integrated approach to quality and performance assurance and improvement across the Trust during 21/22. We have implemented a new Integrated Performance Dashboard (IPD) in 22/23 which enables us to have oversight, and monitor and report key measures that demonstrate the delivery of the quality of services we provide, and provide assurance to the Board through its sub-committee structure. The measures for the new IPD were identified by the relevant Board Sub-Committees and agreed by the Board of Directors (see list below). All the measures have been aligned to one of our three strategic goals and where appropriate, support the monitoring of the Board Assurance Framework risks.

The IPD is produced and discussed monthly at Care Group level then Board level as part of the information and assurance process. The data for each measure will be available to the lowest level possible (i.e. ward/team level) in order to better understand, and where necessary, help improve the quality of services we provide.

Some of the measures have previously been reported through a variety of reports/formats. We will now have a suite of "integrated" dashboards available for leaders to have oversight of the care being provided.

Our Quality Measures	
1	Percentage of patients surveyed reporting their recent experience as very good or good
2	Percentage of carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for
3	Percentage of inpatients reporting that they feel safe whilst in our care
4	Percentage of CYP showing measurable improvement following treatment - patient reported
5	Percentage of adults and older persons showing measurable improvement following treatment - patient reported
6	Percentage of CYP showing measurable improvement following treatment - clinician reported
7	Percentage of adults and older persons showing measurable improvement following treatment - clinician reported
8	Bed occupancy (AMH & MHSOP assessment & treatment wards)
9	Number of inappropriate OAP bed days for adults that are 'external' to the sending provider
10	The number of Serious Incidents reported on STEIS
11	The number of Service Reviews relating to incidents of moderate harm and near misses
12	The number of Restrictive Intervention Incidents
13	The number of Medication Errors with a severity of moderate harm and above
14	The number of unexpected inpatient unnatural deaths reported on STEIS
15	The number of uses of the Mental Health Act
Our People Measures	

16	Percentage of staff recommending the Trust as a place to work
17	Percentage of staff feeling they can make improvements happen in their area of work
18	Staff Leaver Rate
19	Percentage Sickness Absence Rate
20	Percentage compliance with all mandatory and statutory training
21	Percentage of staff in post with a current appraisal
Our Activity and Finance Measures	
22	Number of new unique patients referred
23	Unique Caseload (snapshot)
24	Financial Plan: SOCI - Final Accounts - Surplus/Deficit
25	Underlying Performance - run rate movement
26	Use of Resources Rating - overall score
27	CRES Performance – Recurrent
28	CRES Performance - Non-Recurrent
29	Capital Expenditure (CDEL)
30	Cash balances (actual compared to plan)

In addition to the development work on the integrated approach to performance, we have continued to develop a suite of 'waiters' reports, so that we have oversight of our patients that are waiting for assessment. Oversight of local waiting times will now be part of our Care Groups' governance arrangements with escalation to our Executive Team where required. These locally developed reports follow a patient journey from referral to the point where they first receive an assessment (not a contact), irrespective of the service into which they were first referred. We have already completed testing on the following reports, which are shared monthly with our commissioners:

- Children & Young People's waits for assessment
- Children & Young People's waits for autism assessment
- Mental Health Services for Older People waits for assessment

We are in the final stages of testing Adult Mental Health waits for assessment and Adult Learning Disabilities waits for assessment which we hope to release in the coming months. We have also developed a local waiting time for "treatment" for Children & Young People's services however this is still in development and testing stage. This development is our priority going forward in respect of waiting lists at the current time pending the release of the new National Access Standards.

3.2 Recruitment, Retention and Staffing

3.2.1 Numbers of bank staff and agency staff being used (not just percentages that, in isolation, are not really helpful).

This table shows the number of bank and agency workers **working** per month by contract status across the Trust:

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
Dual (bank & substantive)	493	501	509	543	551	539	522	523	503	652	516	546	540
Bank Only	304	322	369	368	394	395	430	426	453	470	443	443	447
Agency	95	102	113	124	125	144	147	149	169	185	213	245	245

3.2.2 Are staffing levels in community teams now sufficient to meet the demands of the service for both Adults and Children?

Vacancy rates across the Trust are currently around 7-8%.

In terms of recruitment, the Trust is growing, with an increase of 5% in the last 18 months. From 1 January to 18 May 2022, we published 2,277 adverts, offered 1,189 jobs, and 873 candidates started in post. However, we still face recruitment challenges, as is the case regionally and nationally. We are working extremely hard to streamline and speed up our recruitment processes and offer incentives for prospective candidates.

Within adult mental health, we are in line with the community mental health framework investing in excess of £5 million in community mental health provision across Tees Valley (2021-2024), this is being invested in system wide developments including direct investment in community teams. Investment to date in these teams includes the introduction of community navigator roles, increase in psychology provision, Primary Care Network first contact mental health workers and planned introduction of peer support workers. Over the last 12 months we have had a number of unfilled vacancies in our care coordinator posts, however we have worked to mitigate this with a notable increase in appointments of newly qualified nurses (September cohort) alongside consideration of our teams' skill mix.

Within children and young people's services workforce challenges do remain in some specific CAMHS teams. The primary concern is, as with adult services, the availability of experienced community psychiatric nurses. Where we do have gaps in teams for these roles we have rolling programmes of recruitment and both HR and recruitment teams are prioritising CAMHS recruitment episodes. The rolling recruitment provides ongoing opportunities to attract experienced nurses when they become available and, in parallel to this, we are utilising vacant post funding to recruit alternative roles that still add value to community CAMHS teams. Examples of this include newly qualified nurses, support workers and assistant psychologists. These alternative roles are being used to help facilitate different ways of working to help teams meet the increases in demand, the facilitation of groups for young people with similar needs is a good example.

The Trust has also committed funding at risk to temporarily employ nurses via agencies to help fill some of these gaps in the most affected teams whilst still progressing with the actions detailed above.

Currently our staffing levels remain challenging, with increased demands on our services. For context, our modelling (backed up by national research) suggests that demand will grow at an unprecedented rate: by 20% for older people; 30-40% for adults; and over 60% for children and young people.

3.2.3 In respect of the community based mental health services of adults of working age, are all teams now meeting the Trust target of 28 days for an assessment and/or to start treatment?

The percentage of patients seen within four weeks for a first appointment, following external referral (90% standard) in April 2022 was 87.2% for the Durham and Tees Valley Care Group.

For context please note:

The Trust doesn't have a "target" of 28 days for an assessment and/or to start treatment. We previously monitored first contact within four weeks (as a proxy for assessment) and second contact within 6 weeks (as a proxy for treatment), however that report was retired in April 2022.

Throughout 2021/22, our Associate Director of Performance has led on the development of a new Integrated Performance Report, incorporating an Integrated Performance Dashboard (IPD). The IPD includes a set of measures that have been identified by our Executive Subcommittees as being the

priorities we need to focus on through 2022/23. That report does not include any local waiting times measures, although it will include a section on the System Oversight Framework on a quarterly basis which includes the following national LTP measures:

Over the last few years, we have developed a suite of 'waiters' reports, so that we have oversight of our patients that are waiting for **assessment**. Oversight of local waiting times will now be part of our Care Groups governance arrangements with escalation to our Executive Team where required. These locally developed reports, follow a patient journey from referral to the point whether they first receive an assessment (not a contact), irrespective of the service into which they were first referred. We have already completed testing on the following reports, which are shared monthly with our commissioners:

- Children & Young People's waits for assessment
- Children & Young People's waits for autism assessment
- Mental Health Services for Older People waits for assessment

We are in the final stages of testing Adult Mental Health waits for assessment and Adult Learning Disabilities waits for assessment which we hope to release in the coming months. We have also developed a local waiting time for "treatment" for Children & Young People's services however this is still in development and testing stage. This development is our priority going forward in respect of waiting lists at the current time. We are now awaiting the release of the National Access Standards which we understand are imminent, which will provide the opportunity to benchmark with other providers.

Our community mental health services have been significantly impacted by covid-related sickness and an increased level of vacancies over the last 12 months, which has had a direct impact upon waiting times. Current average waiting from referral to assessment for routine appointments is 44 days with 41% of patients assessed within 28 days. All referrals are reviewed by a duty worker within 24 hours of referral with any urgent referrals to our community teams prioritised. In addition to this the service achieves above 90% compliance for crisis referrals assessed within 4hrs.

3.3 Great Place to Work

3.3.1 How has continued improvement in the Trust's approach to equality and diversity been demonstrated in 2021/2022?

A revised Equality, Diversity and Human Rights Strategy for 2020–2023 was approved by the Board of Directors in January 2020 to better align with our vision, mission, and strategic goals. Progress on the associated action plans is reported to the equality, diversity and human rights steering group and from there to the people, culture and diversity committee, which is a subcommittee of the Board.

The Trust also completes the workforce race equality standard (WRES), workforce disability equality standard (WDES) and workforce sexual orientation equality standard (SOWES). These measure differences in outcomes and experience between staff in the three protected groups referred to and those not in those groups. The associated plans are approved by the Trust Board and progress is reported through the same process outlined above.

There have been the following improvements in the WRES, WDES and SOWES data during the year 21/22:

Year	Black, Asian, and Minority Ethnic (BAME) staff in the organisation	BAME staff in bands 8a-8d
2021	359 (4.7%)	13
2022	387 (5.1%)	18

Staff survey results show improvements in the following questions:

BAME staff		
Year	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	Percentage of staff who have personally experienced discrimination at work from any of the following in the last 12 months- Manager/team leader or other colleagues
2020	25%	15% (national benchmark 15.1%)
2021	21.4%	10.3% (national benchmark 14.4%)

Staff with Long Term Health Conditions		
Year	Percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months	Percentage of staff experiencing harassment, bullying or abuse from colleagues in the last 12 months
2020	15.1%	23.1% 23.1% (national benchmark 21.3%)
2021	12.6%	19.7% (national benchmark 20.2%)

Staff survey results show that there have been improvements for bisexual staff in the following staff survey questions:

Bisexual staff		
Year	Percentage of staff experiencing harassment, bullying or abuse from colleagues in the last 12 months	Percentage of staff who have personally experienced discrimination at work from any of the following in the last 12 months- Manager/team leader or other colleagues
2020	30%	23.3% (national benchmark 15.1%)
2021	20%	12.7% (national benchmark 13.8%)

Staff Networks

The Trust currently has four staff networks which provide safe spaces for staff who identify with these protected groups. Staff feel they belong and are listened to, support is given, and actions and changes are made. We have the follow networks:

- Black, Asian and minority ethnic staff
- Staff with long term health conditions
- Lesbian, Gay, Bisexual, Trans and Questioning staff
- Neurodivergent staff

Members of the executive team regularly attend the network sessions, which are well attended, and feedback has been very positive:

"*I feel the network gives people the safe space to speak and share issues or suggestions without being judged and it makes me feel seen and heard. There is also great support from the equality and diversity team, as well as higher management.*" – **BAME network member**

In addition to the four networks currently running, we are now in the process of establishing a new Armed Forces network, a health and wellbeing board, and are exploring thoughts and suggestions around a menopause network.

To highlight the work that is happening around the Trust, we have invited our protected groups to share their voice in our staff weekly blog, which is usually written or vlogged by chief executive, Brent Kilmurray. Each network will write their own piece and raise awareness of any issues, challenges, and changes.

Lunch and Learn

The equality and diversity team have recently started to run monthly lunch and learn sessions for staff. Topics which have been covered are, hate crimes, Gypsy, Romany and Traveller communities, racism, and Ramadan. Each session has been well attended and positive feedback has been widely received.

Gary is very powerful in educating through story telling. No PowerPoint slides, just telling it as it is. Authentic. Open. Honest. Easy style. I could listen to him all day. Thanks so much for organising this, it's been an inspirational session.	- Racism session
What a good insight into Ramadan, interesting, informative, and moving, thank you.	- Ramadan session
Thank you so much for such an interesting session, brilliant and we all enjoyed it! There were five of us from our ward that tuned in, and we all gained so much from attending.	- Gypsy, Romany and Traveller communities

Refugee and Asylum Seeking work in Teesside

Research and consultation was undertaken in Teesside which identified that the refugee and asylum-seeking population had specific mental health needs. This was because of fleeing and post migration stressors, such as language barriers, lack of knowledge of services available and how to access mental health pathways. As a result, several actions have been taken over the last 12-18 months to help make this process more accessible.

We have an additional role reimbursement scheme mental health practitioner based in the Primary Care Network (PCN) that covers arrival in Stockton and Middlesbrough. Specialist GP practices are provided for asylum-seekers who have just newly arrived, and the practitioners provide input to each practice on a weekly basis	- Longer appointments are automatically facilitated to make reasonable adjustments for any language barrier
Both Teesside PCN staff and Tees liaison psychiatry staff have had specialist contextual knowledge training on refugees and asylum-seekers, this training was provided by Refugees Voices.	- The same training is due to be delivered to the Tees crisis and intensive home treatment teams next week

A BAME link worker role has been created specifically to address the mental health of refugees and asylum-seekers. They will work with the mental health access teams and within primary care practices with the highest population of asylum-seekers in Tees Valley. The Trust aims to improve services through active engagement and collating input and feedback on barriers, gaps in knowledge of mental health pathways and interventions.	- Discussions are ongoing about recruiting a specialist refugee and asylum-seeker mental health practitioner for Teesside
The link worker aims to build relationships and trust with local communities to ensure health needs are met and early intervention is delivered before crisis point. They will also work to co-produce effective communication tools, helping to improve our service offering. The link worker will cultivate strong working partnerships with diverse community-based support groups, with an awareness that people seeking asylum are not a homogeneous population.	- Asylum-seekers and refugees come from different countries and cultures and have had experiences that rely on responses that are person centred in their approach and are both trauma and culturally informed

3.3.2 Has the Trust's target of 90 per cent for mandatory training compliance in relation to safeguarding level three, raising concerns/whistleblowing, medicines management, rapid tranquilisation and manual handing been achieved in 2021/22?

We are committed to providing high quality, safe services and environments for patents, carers, families and staff. To do this it's essential that staff have access to appropriate levels of training and that this training is up to date.

We have met the Trustwide target for Safeguarding Level 3 and Raising concerns/whistleblowing. As of March 2022, 86.7% of staff were compliant with their training across the Trust. (92,998 training courses out of 107,306).

	Trust	Children & Young People	Secure Inpatient Services	Health & Justice Services
Full Mandatory Training	86.67%	89.80%	87.06%	93.90%
Safeguarding Level 3	90.85%	94.97%	95.98%	97.33%
Raising concerns/Whistleblowing	90.81%	93.36%	92.49%	98.48%
Medicines Management Annual Module	77.95%	68.75%	80.00%	100%
Rapid Tranquilisation (1-3)	83.74%	N/A	88.92%	100%
Manual Handling (part 1 and part 2 updates)	64.48%	92.59%	67.24%	-

We continue to monitor training and actively encourage staff to complete outstanding training requirements as soon as possible, with new targets in place. However, we been impacted by covid, ongoing service pressures and staffing levels.

Face-to-face training is making good progress back to pre-covid levels.

To ensure that staff have the necessary time to complete their training, services have provided trajectories to improve compliance by the following dates:

- Forensic Services – 31 July 2022
- Durham & Darlington, North Yorkshire & York – 30 June 2022
- Tees – 30 September 2022

3.4 Secure Inpatient Services

3.4.1 Has the issue of unsafe staffing numbers in forensic inpatient wards now been fully resolved?

Our staffing levels are safe. We now use SafeCare as part of Health Roster to ensure we are safely staffed on a daily basis. SafeCare is clinician-rated and is used to ensure rapid escalation and mitigation of concerns. A review of our staffing is carried out in three formal meetings per day, and is monitored via the designated Duty Nurse Coordinator system to ensure immediate response to any issue that may arise. All services are safe and no service is left uncovered.

In terms of recruitment, the Trust is growing in size, with an increase of 5% in the last 18 months. From 1 January to 18 May 2022, we have published 2,277 adverts, offered 1,189 jobs, and 873 candidates have started in post. However, we still face recruitment challenges, which are being felt regionally and nationally. As a Trust, we are working extremely hard to streamline and speed up our recruitment processes and offer incentives for prospective candidates.

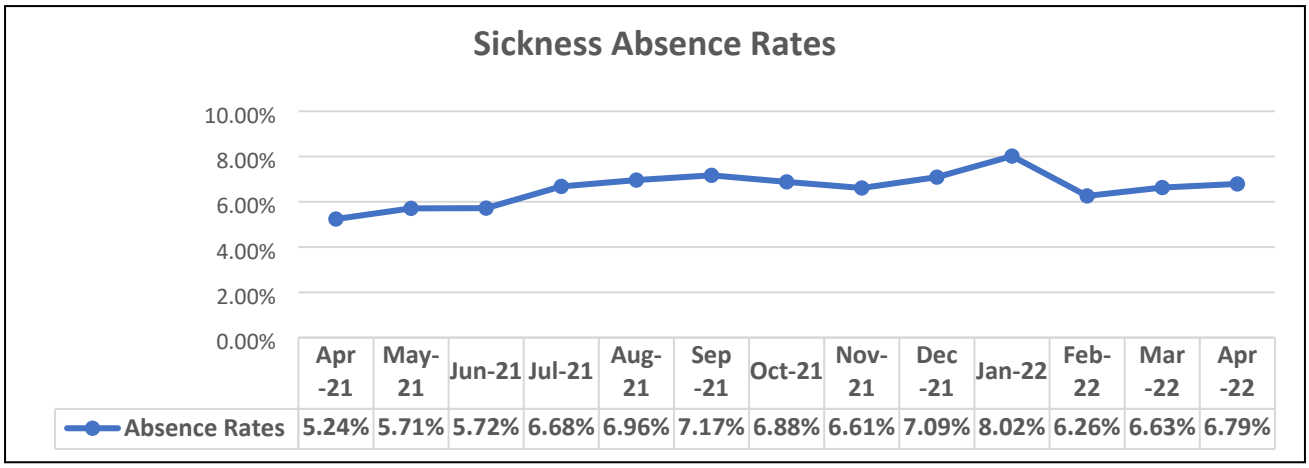
We also have a focus on the retention of current staff, and have made significant progress with the development of a Healthcare Assistant (HCA) Council, our largest workforce in SIS. Meetings have started to take place, which has strengthened the staff voice in the service and ensured that the team is heard at the highest level.

3.4.2 Has the average sickness rating within the forensic inpatient service reduced from the reported rate of 9.83% over the 12 month period up to 18 June 2021?

We have had some challenges with sickness for the period July 21 – March 22. We saw particular challenges during December and January when Omicron was at its peak

The average sickness rate for the period in question within SIS is 13.2%. However, Trustwide, our sickness is stabilising around 6-7%, which is lower than neighbouring Trusts.

We have dedicated HR clinics to manage and support staff sickness and wellbeing. We also have a clear focus on staff wellbeing initiatives and have a range of wellbeing activities that are available within the service.



	Apr -21	May-21	Jun-21	Jul-21	Aug-21	Sep -21	Oct-21	Nov-21	Dec -21	Jan-22	Feb-22	Mar -22	Apr -22
Absence Rates	5.24%	5.71%	5.72%	6.68%	6.96%	7.17%	6.88%	6.61%	7.09%	8.02%	6.26%	6.63%	6.79%

3.2.3 What action has been taken to address poor culture within the forensic inpatient wards and how has the impact been measured?

Significant work has taken place with regard to the development of an overall model of care and professional development within the service. The model of care describes the key underpinning principles and requirements of staff in terms of values and approach. There is a continued focus on staff retention within the service as well as robust induction processes for new staff. We have invested in our safeguarding, boundaries and values training as well as freedom to speak up processes, so staff feel safe to speak up and are supported. We have also ensured that we monitor levels of clinical supervision.

There is a monthly focus on wellbeing and we have established the healthcare assistant (HCA) and Investing in our People Councils as well as ensuring ward improvement groups and staff meetings regularly take place. In addition, the service has recently partnered with a production company to create a film, 'Diamonds in the Rough', which dramatises the experience of living in a secure inpatient service from the patient perspective. This was cocreated with our patients in the service. The film comes with a series of clips and exercises and will form a key part of induction and training processes for our staff in the future. In addition, all ward managers are undertaking a development programme to support them in the key role they play in shaping culture. Clips from the film can be viewed on the following links:

https://www.youtube.com/watch?v=0uR4hpAFF54
https://www.youtube.com/watch?v=8TZ9ESCTXSk
https://www.youtube.com/watch?v=drFnOCmLZiQ
https://www.youtube.com/watch?v=Hbud3UozVeM

The focus on safeguarding has been particularly important. We have had a member of the corporate safeguarding team based within the service offering direct support, supervision and involvement in clinical care. Positively, we have seen the number of safeguarding concerns being raised within the service almost double. However, the number of formal referrals to the Local Authority has remained at a similar level. This indicates that staff are more vigilant and aware of potential safeguarding issues and are actively discussing these with the Trust safeguarding team. The new leadership team will continue to support staff wellbeing and address these issues.

3.4.4 Have any of the improvements made been embedded in the inpatient forensic service?

The use of Safecare to assess, escalate and mitigate any safe staffing concerns is embedded within our secure inpatient service.

We have also introduced a number of daily, weekly and monthly management processes. These ensure consistent oversight of the key areas of quality, including use of restrictive interventions and associated debriefs for staff and patients, use of restrictive practices, availability and delivery of psychological interventions, availability and delivery of AHP interventions, delivery of leave and meaningful activities.

In addition, we have demonstrated consistent improvements in levels of mandatory and statutory training, and safeguarding training. We have introduced quality assurance processes in relation to completion and accuracy of care records.

3.4.5 How many incidents of escorted leave have been cancelled between May 2021 and May 2022 due to insufficient staff at the start of shift? (Figure for May 2020 to May 2021 257 instances)

Between June 21 – April 22:

	Medium Secure units	Low Secure units
No of episodes of escorted leave delivered	5,467	5,391
No of episodes of escorted leave were cancelled due to staffing	137	248
Cancellation rate (%)	1.1%	2.2%

It is not possible to state that all of these cancellations were due to insufficient staff at the start of the shift. Incidents can occur during the course of a shift that require the re-prioritisation of staff resources (e.g. hospital escorts, acuity of patients).

We have taken a number of steps to minimise cancelled leaves, including implementing a clear escalation process via daily staffing huddles to try and prevent cancellations wherever possible. We have also recruited to a Leave Team which is already having an impact.

3.4.6 Are all of the nine wards inspected, holding team meetings? How often do these take place?

Yes, all wards are now holding meetings. The meetings take place on a monthly basis and this is monitored via the Inpatient Fundamental Standards group covering Durham and Tees Valley.

3.5 Children and Young People's Mental Health Services

3.5.1 What percentage of children waiting for support from CAMHS have not received "keep in touch (KIT) calls" as per protocol since July 2021?

Previously teams manually created, maintained and kept in contact with their own waiting lists. Now, all team waiting lists are centrally generated from the IT system giving much greater visibility and accuracy across the Trust.

Whilst families are waiting for their assessment or treatment, we have a keeping in touch (KIT) process. This means quarterly contact for children and young people who are waiting and who are RISK-RAG rated GREEN and monthly contact for those RISK-RAG rated AMBER. Anyone rated RED for risk will be receiving active support. Not everyone will receive a call; GREEN RISK-RATED patients receive a letter, as is our protocol. AMBER RISK-RATED young people receive a telephone call and RED-RAG RATED cases will receive support.

We monitor compliance with this process on a daily basis within teams and three times per week on a Trust-wide basis. All staff at clinical and senior management levels have oversight of the same waiting list, containing the same KIT information and it is held in the same place; this data is always a 'live' position. This means 'compliance' fluctuates on a daily basis but is measured as part of the three-times-weekly Trust-wide compliance check.

Since monitoring of this new process began in November 2021, compliance has been between 91%-99%, as of today it is 97%. This means that 97% of people currently on the Trust-wide CAMHS waiting list have had a contact within the timeframe in accordance with their risk level.

For any young person who becomes 'overdue' for a contact; these will be flagged up within the three-times per week Trust-wide compliance huddles and action taken to make contact. Due to the regularity of the team-level and Trust-wide compliance checks within this process and the 'live' nature of the data, usually no young person remains 'overdue' for more than 24 hours. This is a much better position than at the time of the inspection when the majority of breaches remained overdue for longer than this. Our regular communication as part of these contacts reiterates to families what other support is available in their communities and how to contact our 24/7 crisis line if needed.

3.6 Autism Services

3.6.1 What improvements have been put in place to ensure children and adults waiting for an autism assessment receive support whilst they are waiting?

Children and Young People's Services

Whilst families are waiting for their assessment with the neurodevelopmental team, we have a keeping in touch (KIT) process. Families should as minimum expect to receive a letter from the team as a way of keeping in contact on a quarterly basis. In some of our localities a newsletter is produced and we want to work towards this being a co-production opportunity with our parent/carer forum across the localities.

There are services that are commissioned to offer a 'bubble of support' which is provided by our partners, for families and there is work underway by the CCG to continue to develop services to offer a menu of options. Bubble of Support is needs-led and for any CYP/family who have an ASC presentation – whether they are formally on the specialist pathway or not.

The Trust works with our partners in delivering the ITHIRVE framework that encompasses a systems approach in supporting families with their emotional wellbeing and mental health needs, the provision of which will be different in different areas.

The i-THRIVE framework includes:

- Thriving: prevention and promotion in the community
- Getting Advice and Signposting: signposting, self-management and one-off contact
- Getting Help: goals focused, evidence informed, outcomes focused intervention
- Getting More Help: Extensive treatment
- Getting Risk Support: Focus of intervention is providing risk management

There is a monthly Emotional Wellbeing and Mental Health Steering Group, with local provider task & finish groups – to identify the direction of transformation and work. This steering group is chaired by North of England Commissioning Support and has key providers and Local Authority leaders as core members. At a clinical level there are clinical huddles at all levels to get the right child to the right place at the right time.

At any time (whether waiting for assessment or during assessment) where a mental health need is identified, the young person is referred into the most appropriate service that will support them with their mental health (which may/may not be TEWV).

Adult Mental Health Services

Adult Mental Health services have developed bespoke principles around keeping in touch. These principles apply from the point that someone is allocated onto caseload.

In AMH there are occasions when a person is waiting for a specific assessment or treatment. However, this does not mean that the service user will be left 'waiting' - this is in effect stage 1 of assessment/treatment and it is important that there is an initial assessment that informs the safety summary and safety plan. This will be co-produced wherever possible and will set out the identified ongoing support, help and guidance that will be available during this period.

When identified as being in stage 1 there will be an initial assessment of need to cover the 'waiting' period. This will be documented in the safety summary and safety plan, regardless of whether the agreement is about interim interventions such as self-help guidance or how to keep in touch.

The safety plan should therefore reflect the following:

- A likely timescale agreed with the service user/carer to have the specific assessment /treatment they are waiting for
- Who will keep in touch
- How often
- By which preferred method
- If appropriate what interventions will take place (e.g. self-help, recovery college)
- What to do/who to contact if there are any concerns or changes in circumstances

There may be occasions where there are no interventions identified as being required during this stage but there will always be an agreed minimum review period, of no more than six months, as well as an escalation route if there are concerns/changes in circumstances.

3.6.2 How many people, children and adults, are on the waiting list for an autism assessment and long is the current wait time for an assessment?

Children and Young People's Services

Waiting time to access Children and Young People's Services specialist autism assessments are typically around 2 years. This is due to a lockdown backlog. In addition, a recent review with CCG partners shows demand has increased by 300% post COVID-19.

Each week we provide an internal report which provides oversight of the numbers of children and young people waiting for a specialist autism assessment and the length of time waited. We also provide assurance in relation to the status of each of the long waiters and the actions being taken.

In addition, each month we provide the same report to Commissioners which also includes a Patient Tracker List (PTL) for the longest waiters.

On 16 May 2022, we had 3,391 children and young people waiting for a specialist autism assessment.

- Within Durham and Tees Valley we had 3,166 children and young people waiting for a specialist autism assessment (Durham and Darlington 1829 and Teesside 1337).
- Within North Yorkshire, York & Selby we had 225 children and young people waiting for a specialist autism assessment. TEWV do not have a commissioned service in North Yorkshire; only York & Selby.

Within Durham and Tees Valley we have 10 children and young people recorded as more than 2 years.

- Nine of our children and young people are genuine waiters, due to demand for autism assessments exceeding capacity within the team. They are all due to be seen between May and July 22. The longest wait is 805 days (2 years, 3 months)

Within North Yorkshire, York & Selby we have eight children and young people between 1-2 years.

Adult Mental Health Services

There are currently 371 patients on the waiting list to be allocated for diagnostic assessment. The longest waiter is 770 days.

3.7 Patient Safety

3.7.1 Has a trust-wide policy for safeguarding adults been developed?

A policy has been developed and is now undergoing a six-week staff consultation from 19 May-30 June 2022.

3.7.2 Who is the named doctor for adult safeguarding?

A job description is currently being developed for a new role within the Trust as a named doctor for safeguarding adults. In the Interim, the Medical Director covers these responsibilities.

3.7.3 How are the level of restrictions placed on patients' freedom measured? Does the level of restrictions in place remain high?

There will be occasion where in order to keep our patients safe, staff will need to use certain restrictions as part of the overcall care and treatment we provided.

The types of restrictions that will be put into place will vary depending on the patient's needs at that time, and these can range from preventing a patient from having access to certain items i.e. mobile phones to using a physical restraint technique to prevent a patient from harming the self or staff member.

All forms of restriction should always be carried out as a last resort using the least restrictive approach that is available in order to keep a patient safe.

Any use of these types of interventions are recorded as incidents and will be subject to comprehensive reviews at ward, local and senior levels within the Trust. The nature and number of restrictions are overseen by the Quality Assurance Committee, the quality sub-committee of the Trust Board.

Ward teams continue to implement a range of approaches to reduce restrictive interventions through the Trusts positive and Safe plan. Specialist support in Positive Behaviour Support is in place across SIS. The CQC routinely undertake Mental Health Act inspections of inpatient wards to monitor compliance

3.7.4 Has the level of restrictions reduced since the inspection was held?

The Trust has seen significant reductions in the use of physical intervention in the last 12 months and we remain committed to reducing this further across all of our services. The use of physical intervention is only implemented when the safety of our patients or staff is at risk, and when all other practical means of managing a challenging situation have been unsuccessful. Between 2020/21 and 2021/22 there has been:

- 50% reduction in prone restraint
- 68% reduction in mechanical restraint
- 25% reduction in seclusion usage

The Trust has clear aims in place to reduce all forms of restrictive practices across our inpatient areas. We have invested in developing human rights training for supporting people in our care; and introduced clinical frameworks focused on improving ward spaces and developing individualised approaches for managing risk and behaviours that challenge. Whilst these approaches continue to have a positive impact across our service, we recognise that there is further work to consider and areas for further development that we want to explore.

We have developed a robust process for open and transparent reporting of restrictions across our services. We have seen significant reductions in different types of restrictions we use i.e. restraint. We regularly monitor our usage as part of national bench marking programmes and report similar to other Trust's nationally.

3.7.5 How many safeguarding issues in relation to the protection of patients have been referred to the local authority adult safeguarding team since December 2021?

	20-21	21-22			
	Q4	Q1	Q2	Q3	Q4
Trustwide	147 (27.5%)	167 (27%)	170 (26%)	175 (27%)	144 (21%)
Durham and Darlington	29 (20%)	45 (27%)	46 (27%)	36 (22%)	34 (19%)
Forensic	18 (26.5%)	24 (38%)	11 (16%)	24 (23.5%)	23 (18%)
Teesside	47 (33%)	64 (27%)	72 (29%)	53 (27%)	53 (25%)

The table above shows 21% of the safeguarding concerns recorded were referred to the Local Authority. 79% of the concerns did not meet the requirement for a referral and were managed by the clinical teams.

3.7.6 What quality and assurance systems are in place to ensure information within care records are kept accurate and up to date?

The Trust has a range of quality and assurance systems in place which support services to ensure that care records are kept accurate and up to date.

The Trust's electronic care system supports clinicians to ensure care records are up to date and accurate by monitoring and flagging when care and treatment reviews are due to take place. This includes reviews of key care documents, such as care and safety plans. There are quality and performance management systems in place to ensure senior level oversight of clinical teams is maintained.

We've invested in a new electronic patient information management system (CITO), which has been developed in partnership with teams and in line with service delivery plans. The new system is due to go live in Autumn 2022 and will further support the patient journey, ensuring actions take place in a timely and efficient manner and records are updated and accurate.

The Trust has in place a Quality Assurance Schedule. This includes a range of clinical audits, many of which focus on reviewing care documents to ensure that these are up to date and to provide assurance regarding the quality of their content. Services have a range of senior professionals who support with the delivery of the quality and assurance systems which are in place. This includes Modern Matrons and Practice Development Practitioners who provide coaching and mentoring to ensure continuous quality improvement with regard to the quality of clinical practice (including record keeping practices).

The Quality Assurance Schedule reports into Trust governance forums as part of the quality assurance system and has supported significant improvements in practice since its introduction.

Clinical staff also undertake clinical supervision sessions with a designated clinical supervisor. Sample clinical cases are reviewed during these sessions, which supports peer review and checks that clinical recording is accurate and up to date.

3.7.8 How many serious incidents have there been in the last 12 months?

We have undertaken significant improvement work to learn from serious incidents and prevent harm to patients. There were 145 serious incidents reported on the national data base (StEIS) from the beginning of May 2021 to the end of April 2022. This includes both community and inpatient services. The Trust currently has more than 56,200 patients open to services, which includes over 630 inpatients.

A patient safety event was held on 20 May 2022 around improving the experience of patients and families during serious incident reviews. The 'journey to safer care' event provided an update on the significant work we have been undertaking to modernise our incident reporting processes and how these align to the forthcoming national requirements outlined in the Patient Safety Incident Reporting Framework (NHSE/I).

It also looked at the incident reporting and investigation process from start to finish, and how we will use information from 'low' harm to 'catastrophic' harm incidents to ensure that we identify themes, and actionable learning, how we will embed learning, and how we propose to monitor the impact and outcome of actions on patients and the quality of our services.

We are also transforming and improving incident reporting and incident reviews from the perspective of patients, families, carers, staff and external partners.

3.7.9 What improvements have been made to ensure learning from serious incidents is shared with the whole team and wider service to prevent future serious incidents?

The Trust continues to strengthen its arrangements for organisational learning via the Organisational Learning Group. Urgent patient safety messages identified when incidents have occurred are shared Trustwide via patient safety briefings and assurance is obtained confirming that the information has been shared with the clinical teams within a given timescale. 'Learning from serious incidents' bulletins are distributed across the Trust, which share key learning and good practice highlighted in serious incident reports presented at the Directors' Assurance Panel. A quality Improvement event will be held in August 2022 to focus on how we can improve the communication and impact of learning in front line services.

ENDS

TEES VALLEY JOINT HEALTH SCRUTINY COMMITTEE
8 JUNE 2022

WORK PROGRAMME

SUMMARY REPORT

Purpose of the Report

1. To consider and agree the Committee's work programme for 2022/2023 and to agree the future meeting dates for the Tees Valley Joint Health Scrutiny Committee.

Summary

2. The Committee is required to agree its work programme annually and in doing so consider matters that are of a Tees Valley and sub-regional nature.

3. A number of issues have been introduced to the Committee's agenda as standing items. These include monitoring of the performance of the North East Ambulance Service and the consideration of the Tees, Esk and Wear Valleys NHS Foundation Trust Quality Account, enabling the Committee to provide a view on behalf of the Tees Valley area.

4. A suggested work programme is set out at Appendix 1. In addition to those topics set out, Members may wish to suggest additional, or alternative, work programme topics and should also bear in mind the Committee may need capacity to deal with any emerging issues during the year (for example, proposals for NHS service change).

5. A request has been received for Members to consider the inclusion of Children's mental health on the work programme for 2022/2023 (Appendix 2).

6. The protocol provides for meetings of the Tees Valley Joint Health Scrutiny Committee on a quarterly basis. These can be supplemented with additional meetings if required.

7. The proposed meeting dates for remainder of the 2022/2023 Municipal Year are:

   - 23 September 2022
   - 16 December 2022
   - 17 March 2023

Recommendation

8. It is recommended that :-

   (a) Members consider and agree the proposed work programme for the Joint Committee for 2022/2023.

(b) Members agree the proposed meeting dates for remainder of the 2022/2023 Municipal Year.

Luke Swinhoe
Assistant Director Law and Governance

Background Papers
No Background papers were used in the preparation of this report.

Author : Hannah Miller 405801

Appendix 1

Meeting Date	Work programme topic
8 June 2022	• Appointment of Chair and Vice Chair • Tees Valley Health Scrutiny Joint Committee – Protocol • Work Programme/Meeting timetable • Community Diagnostics Centres • Tees, Esk and Wear Valley NHS Foundation Trust Quality Accounts 2021/2022 • Tees, Esk and Wear Valley NHS Foundation Trust - CQC Inspection Update
23 September 2022	• Opioid prescribing and dependency across the Tees Valley • North East and North Cumbria Integrated Care Board and System implementation • Vaccination (Covid) response at an 'above organisation' level
16 December 2022	• North East Ambulance Service (NEAS) Performance Update • Urgent and Emergency Care and Primary Care Access • Palliative and End of Life Care strategy development and implementation • TEWV Quality Accounts – Q1 Update
17 March 2023	• Breast symptomatic services • Tees Valley Clinical Services Strategy • TEWV Quality Accounts

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Select Committee Work Programme

Suggested Review – Pro Forma

Summary of issue you wish to be scrutinised, including key concerns and outcome for scrutinising the topic?

Children's mental health and the transition

The pandemic has had a detrimental effect on children's mental health. Increased stress and anxiety has obvious demands on mental health services and possible delays in support. Is there a shortfall in professional help in schools and what is the extent of provision from the Council and the NHS. What systems are in place to ensure "joined up services", has the support for schools been reduced over time.

Outcomes desired:- To ensure the Council and members have a better understanding of the perceived or real shortfalls in support for the mental health wellbeing of our children Throughout their school life and into transition into secondary, further and higher education

Please be clear about the focus of the review and desired outcome.

NOTE: ENTRIES BELOW RELATE TO ISSUE CATEGORIES OF THE PICK PROCESS.

PLEASE REFER TO THE EXPLANATION NOTES TO THIS FORM FOR FURTHER INFORMATION.

Public interest justification:

Increase in home schooling has led to more parents spending time with their children and noticing changes in behaviour. When returning to school notable differences in behaviour in some is eluded to by parents and staff. Educational Psychologists consultation waiting times maybe unknown to members or the public in general. There appears to be growing concern among many about the mental health and wellbeing of pupils. Coupled with this is the alarming rise in suicide and self-harm attributed by some as the effects of social isolation from their peer group.

Impact on the social, economic and environmental well-being of the area:

Early interventions can impact on later more intense costly and time consuming treatments.

Skilled analysis can enhance the child's attainment and behaviour preventing the need for specialist educational placement. This may lead to family beak up, anti-social behaviour and a more vulnerable group of young people.

Council performance, efficiency (identification of savings and reducing demand) in this area:

Early intervention may reduce demands on social services and demands on provision for looked after children.

Keep in Context (are other reviews taking place in this area?):
How does the topic support delivery of the Council Plan? To hopefully review the changes as proposed last April in children's services and help develop a healthy more cohesive society.
What would you want the outcome of the review to be? Improve where necessary the provision of mental health services in schools and the community as a whole. Also to ensure as far as possible a more joined up and holistic approach to the mental health of our young people.
Signed:  **Date:** 18/02/2022
Please return to: Judy Trainer Scrutiny Section Democratic Services Municipal Buildings Church Road Stockton on Tees TS18 1LD Email: judith.trainer@stockton.gov.uk Tel: 01642 528158