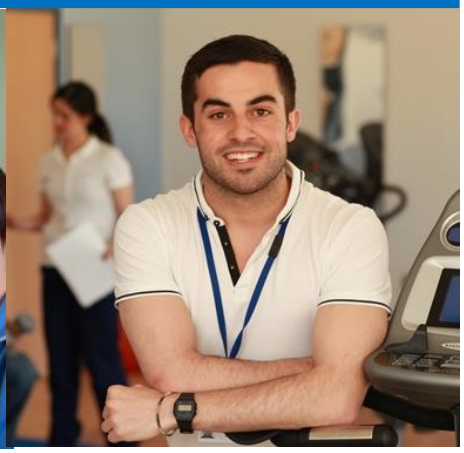
NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust



QUALITY ACCOUNT 2019-2020





making a difference together

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

I am pleased to present the Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) Quality Account for 2019/20. This details what the Trust has done to improve the quality of our services in 2019/20 and how we intend to make further improvements during 2020/21.

The Trust provides a range of Mental Health, Learning Disability and Autism Services for around two million people living in County Durham, the Tees Valley and North Yorkshire (with the exception of Craven District) and the Vale of York[1].

Our specialist services such as adult eating disorder inpatient wards and forensic secure adult inpatient wards serve patients from elsewhere in the North East and Cumbria, Yorkshire and the Humber and further afield.

Our Mission, Vision and Strategy

The Mission of the Trust is:

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

The Trust's Vision is:

'To be a recognised centre of excellence with high quality staff providing high quality services that exceeds peoples' expectations'

Our commitment to delivering high quality services is support by our second Strategic Goal:

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

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

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

- Care will be consistent with best practice, delivered efficiently, and where possible, integrated with the other agencies with whom we work
- We will support staff to deliver high-quality care and will provide therapeutic environments which maintain safety and dignity

Our current Quality Strategy contains three goals, which are:

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

Each goal has high-level measures which the Trust monitors for assurance that the Trust's vision for quality is being delivered. These measures are reported through the Patient Safety Group, Patient Experience Group and Clinical Effectiveness Group, and scrutinised by our Quality Assurance Committee (QuAC).

A Profile of the Trust

The Trust provides a range of Mental Health, Learning Disability and Autism services for around two million people from Stanley and Seaham in the north to Selby and Wetherby in the south, and from Hartlepool and Whitby in the east to Harrogate and Weardale in the west The area we serve incudes the cities of York, Durham and Ripon, and the towns such as Middlesbrough, Darlington, Northallerton, Bishop Auckland and Scarborough.

The area covers 4,000 square miles (approximately 10,000 square kilometres). The Trust also provides some regional specialist services (for example, Forensic Services and Specialist Eating Disorder Services to the North East and North Cumbria and beyond. The Trust is also commissioned as part of a national initiative to provide inpatient care to Ministry of Defence personnel, and provides mental health treatment to prisoners in North East England and also in parts of the North West.

Services commissioned by Clinical Commissioning Groups (CCGs) are managed within the Trust on a geographical basis. This is through three geographic Locality based services; Durham and Darlington, Teesside and North Yorkshire and York. There is also a non-geographic 'Locality' which manages Forensic and Offender Health services. Each is led by a Director of Operations, Deputy Medical Director, Head of Nursing and Professional Lead for Psychology, who report to the Chief Operating Officer, Medical Director, Director of Nursing and Governance and Director of Therapies respectively.

- Our income in 2019/20 was **£365.8m**
- On 31st March 2020, **102,635** people had received care from TEWV during 2019/20
- During 2019/20 on average we had **667** patients occupying an inpatient bed each day –this equates to an average occupancy rate of **86.81%** (This

occupancy refers to all TEWV beds, not just to Assessment and Treatment beds where the occupancy rate is significantly higher than this average figure)
- Our community staff made more than **1.8 million** contacts with patients during 2019/20 (including IAPT Services)
- We have a total of **5,587** whole time equivalent employees, and **7,065** employees in total

What we have achieved in 2019/20:

We have continued to work to improve the quality of our services and to develop new services to meet the needs of those who use our services. For example, we have:

- Secured additional funding for urgent care services and 'places of safety' across the Trust; plans for each locality are as follows:

    - North Yorkshire: over £500,000 worth of funding from local CCGs will be used to reduce the impact of mental health crisis on individuals and wider services, such as the police, ambulance and accident and emergency departments. Funding has also been secured for Harrogate Core 24 liaison service which will be deployed at wards in Harrogate and District General Hospital, including A&E

    - Durham and Darlington and Teesside: More than £2 million will be invested over the next two years to strengthen the services that are available for people in a mental health crisis and to help reduce the impact on wider public services. Plans are in progress so that Crisis Services in this area will be extended to support older people with complex needs as well as people living with dementia. Individuals with lived experience of mental ill health will also be recruited into peer support roles to help others on their journey to recovery. There is also additional support in each locality. In Teesside, a mental health helpline will be introduced. Dedicated psychology staff will also be employed and work with partner agencies to develop alternative emergency support arrangements. In Durham and Darlington, services have been funded to provide high-intensity work with people who regularly attend urgent care services. Telephone support will be available to those in distress through the introduction of a 111 (Option 2) service and the further development of local community initiatives such as safe havens will be supported

- Secured further funding to continue the rollout of the Autism Pathway to Adult Mental Health Services and to deliver further staff training on 'Autism Awareness' and 'Understanding Autism'

- Held an event to celebrate the end of our second year of developing coaching across the Trust. A recent evaluation showed that the impact of the coaching work has improved staff wellbeing, confidence, ability to goal set and ability to lead or manage teams

- Held an awards ceremony celebrating Adult Secure Service Users' recovery achievements (sponsored by Rethink Mental Illness) for the fifth year running, recognising individuals for their charitable efforts, health improvements, skills development and steps towards their recovery

- Completed significant progress in relation to the building of our new hospital, Foss Park in York. The new hospital opened in April 2020

- Worked in partnership with the British Institute for Human Rights, exploring ways to empower Service Users to know and claim their rights

- Been successful in partnership with Spectrum in securing the tender for healthcare services across the seven North East prisons from 1st April 2020

- Secured transformation funding for the perinatal service which has been used to procure a mobile app for fathers and partners to support mothers throughout pregnancy and after the birth of their child

- Been successful in the children's trailblazer funding bids in Teesside, Durham and Scarborough and Selby areas. This ensures that Mental Health Support Teams, supervised by NHS Children and Young People's Mental Health staff, will provide specific extra capacity for early intervention and ongoing support within an education setting

- Continued work on the Whole Pathway Commissioning for Children and Young People. This means coming together with our external partners to improve children and young people's emotional health and wellbeing. Events were held in November 2019 (Durham, Darlington and Teesside) and January 2020 (North Yorkshire) with different stakeholders, young people and their parents to ask what their vision for the future would be, and to identify key improvements to services for children, young people and families. An action plan will be developed to take these key priorities forward

- Developed specific additional recovery and trauma-informed training to complement the Trust Leadership Programme

- Conducted a Trust-wide establishment review to assess whether we have the right numbers and skill mix of staff for the numbers and complexity of service users on each ward. Further actions will be undertaken in relation to this over the coming year

- Undertaken two 'Trust-wide conversations' for staff using an online discussion platform, with 1,264 staff taking part and generating 8,661 ideas, comments and votes about how we can improve the well-being and the voice of staff. They have been independently analysed and findings have enabled the Trust to draft a series of actions to be taken forward, which we are discussing further with staff

- The Positive Practice in Mental Health collaborative presented key recommendations to the government for improving and delivering high-quality

mental health crisis care. Within their report, the Child and Adolescent Mental Health Service Crisis, Liaison and Intensive Home Treatment in County Durham and Darlington and the Crisis Assessment Suite at Roseberry Park in Middlesbrough were identified as examples of positive practice in action

Detailed information on the achievements related to our quality improvement priorities is included in **Part Two** of this document

However, it has also been a challenging year for the Trust. We faced difficulties in maintaining the desired quality of services in our inpatient wards serving Children and Young People. There were two deaths of inpatients on those wards. The CQC took regulatory action to close this service. TEWV will fully support the NHS England investigation into these events as we want to learn as much as we can and implement changes which can reduce the risk of such a situation reoccurring. In the meantime we have worked very hard with partners and families to support more young people at home with intensive treatment and crisis services.

The year ended with the Trust mobilising all our resources in response to the Coronavirus pandemic. This meant that we stopped work on quality improvement actions as staff were redeployed to support clinical services within TEWV and the wider NHS. This means that there are some gaps in end of year data in this document, and accounts for some (though not all) delays in achieving our 2019/20 improvement

The Trust is committed to gathering information to find out how we are performing from a wide range of Stakeholders and sources. This includes results from the Community Mental Health Survey, the national NHS Staff survey and the Trust Staff Friends and Family Test. A summary of the results from these surveys can be found in the following section.

TEWV's 2019 Community Mental Health Survey Results

- The response rate of **29%** was higher than the national response rate of **27%.** This is an increase of **4%** from the response rate of **25%** in 2018/19 (which was lower than the national response rate)
- TEWV scored **'better'** than other Trusts in the questions relating to medication – involved in decisions, purpose, side effects, getting on with medications – the score in all other questions was **'about the same'** as the majority of other Trusts
- Of the 29 questions, **15** reported TEWV as scoring in the **top 20%** of Mental Health Trusts, **14** scored in the intermediate range. There were no questions in bottom 20%
- The overall rating on care experience has improved to **71.1%** compared to **66.4%** in 2018, **70.9%** in 2017 and **74.3%** in 2016
- Respondents left narrative feedback resulting in **273** individual categories of which **51%** were positive. The categories with the highest proportion of negative comments **(88%)** were coded against the *Number of Staff Available*
- The section with the lowest overall scores for TEWV was the *Feedback* section, in particular in relation to the following question: *Q37:Aside from this questionnaire, in the last 12 months, have you been asked by NHS Mental Health services to give your views on the quality of your care?* (mean score **2.8** out of ten)

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

- Explore service user's views on how frequently they feel they need to see someone from NHS Mental Health Services

- Consider advanced communications training for key staff, as a way of addressing issues of trust and confidence voiced by service users

- Consider reviewing existing staffing structures and processes for managing referrals, triage and assessment, and local capacity and demand for interventions, to ensure that efficiency is optimised and access objectives are met

- Ensuring that all patients have a hard copy of their care plan. Use consistent language so that service users know that what they have been given is their care plan

- Ensure that health care professionals use and adapt the person-centred approach to meet the needs of individual patients so that all patients have the opportunity to be involved in decisions about their care at the level they wish

- Implement systems and undertake audit to proactively measure service user experience

- Promote shared decision-making and self-management so that people using mental health services are actively involved in shared decision-making and supported in self-management

- Continue to monitor the arrangements for ensuring patients know who to contact out of office hours if they have a crisis. Ensure the ways of making this accessible and understandable remain

- Continue to monitor the range and level of support provided by the out of hours service. Consider more detailed engagement with patients to understand better what help they needed and their response to the help that was available

- Continue to improve participation of service users in decisions about their medication, paying attention to establishing what level of involvement indecision-making the patient would like. This may include healthcare professionals reviewing their consultation style and adapting this to the needs of the individual service user

- Continue to provide information to service users when they are prescribed a new medication, including information about possible side effects. Establish the most effective way of communicating with each service user and, if necessary, consider ways of making information accessible and understandable (for example, using pictures, symbols, or an interpreter)

- Continue to assess arrangements for the regular review of patient medication and its' effectiveness. Be aware that service users' concerns about medicines, and whether they need them, affect how and whether they take their prescribed medication

- Review arrangements for access to treatment or therapies, other than medication, such as talking therapies

- Continue to review how we offer advice, information and access for meeting service users' physical health needs, e.g. disability, long-standing condition, injury, accessing social security, benefits and other financial advice, finding work or keeping work and access to employment services

- Further ensure that service users have access to support and aftercare pathways that provide a link to a range of organisations that promote social inclusion and offer meaningful activities locally

- Continue to review the reasons why there are a high number of people who said they wanted support from people with similar experiences of the same mental health needs and why they are not receiving this

- Examine the reasons for poor scores on overall experience. Drill down into data to look for areas of care which are scored low and for any pockets of poor ratings from different groups or locations. Examine patient experience FFT response rates and focus support on teams with low or zero responses

TEWV's National NHS Staff Survey Results 2019*

*This data covers the calendar year 2019

- In the 2019 National NHS Staff Survey, the Trust had a response rate of **45% (2,971 out of 6,602 eligible staff)**. The median response rate for Mental Health and Learning Disability Trusts was **54%**
- The Trust scored better than average on **three** of the eleven themes covered by the Staff Survey (Equality, Diversity and Inclusion; Health and Wellbeing, and Safe Environment – Bullying and Harassment)
- The Trust scored worse than average on the sections Immediate Managers; Quality of Appraisals; and Quality of Care
- The Trust scores on the other five sections were the same as the national average

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

- Take a positive approach to staff wellbeing – plans to improve staff wellbeing are led by the Health and Wellbeing Group. The Trust is using questionnaires to find out more about how we can support staff wellbeing, which will feed into the Health and Wellbeing Group work plan

- Hold an online conversation with staff around building psychological safety in order to encourage staff to speak up, and then established a working group to take forward actions identified from this feedback

- Implement a campaign to tackle mental health stigma

- Review the Trust flexible working policy and guidance, considering feedback received from staff during our online conversation about different ways of working

- Agree further support offers to improve the mental, physical and financial wellbeing of our staff

- Ensure our staff know about the support that is available to them through better use of the Trust intranet and the Vivup employee benefits scheme

TEWV's Staff Friends and Family Test Results

The information below relates to the results at the end of Quarter Two 2019/20, which covers the period April to September 2019. Results for the Staff Friends and Family Test are collated every six months; the data at Quarter Four 2019/20 has not been reported due to the ongoing Covid-19 pandemic.

Our *Staff Friends and Family Test (FFT)* results include (from **1,973** responses):

- **76%** are 'likely' or 'highly likely' to recommend treatment at TEWV
- **68%** would recommend TEWV as a place to work

National Awards – Won or Shortlisted

In 2019/20 the Trust was proud to be recognised externally in a number of national awards

Awards won or highly commended by TEWV teams or staff members are shown in the following table:

Awarding Body	Award Status	Name/Category of Award	Team/Individual
Royal College of Psychiatrists	Winner	Duncan Macmillan Award	Sundar Gnanavel
Cavell Nurses' Trust	Winner	Cavell Star Award	Jacqueline Lynas
North East Better Health at Work	Approved	Inspiring People Awards – Health & Wellbeing in the Workplace	North Learning Disabilities Team, Chester-le-Street
Healthcare Financial Management Association	Winner	Student of the Year	Arran Scott
Healthcare Financial Management Association	Winner	Chairman's Award	Louise Ferguson
Royal College of Psychiatrists	Winner	Psychiatric Educator of the Year	Jim Boylan
Royal College of Psychiatrists	Winner	Service User/Patient Contributor of the Year	John Venable
Royal College of Psychiatrists	Winner	Team of the Year for Intellectual Disability	North Tees Adult Learning Disabilities Team
Nursing Times	Winner	Mental Health Nursing Award	Cleveland Liaison & Diversion Team

NEPACS	Winner	Ruth Cranfield Award for Good Practice in Rehabilitation	Mental Health Team, HMP Holme House
Cavell Nurses' Trust	Winner	Cavell Star Award	Adult Learning Disability Team, Flatts Lane
The Northern Care Alliance NHS Group	Winner	Chief Nursing Officer Award (Silver)	John Savage
NHS England	Winner	Chief Allied Professionals Chief Officer Award: AHP Public Health Champion	Jo-Anne Smith
Positive Practice in Mental Health	Winner	National Older People MH and Dementia: OPMH/Dementia individual staff of the year (including voluntary staff)	Corrine Walsh
Health Education England	Winner	Durham & Tees Valley GP Training Programme: Clinical Supervisor (Hospital Specialist) Award of the Year	Venkatraghavan Ramaswamy
British Psychological Society	Winner	Division of Forensic Psychology: 2019 Excellence in Forensic Psychology	Claire Bainbridge
North East Better Health at Work	Approved	Bronze Level	Talking Changes (IAPT – Durham & Darlington)
National Open College Network (NOCS)	Winner	Outstanding Provision of One Awards Learning	Keith Powles
Cavell Nurses' Trust	Winner	Cavell Star Award	Kay Wood

Awards where TEWV as an organisation, or one of our teams/staff members were shortlisted for an award but did not win that award during 2019/20 were:

Awarding Body	Award Status	Name/Category of Award	Team/Individual
Durham County Council	Shortlisted	Inspiring People in the Workplace: Health and Wellbeing in the Workplace	Adult Integrated Learning Disabilities Team
Healthcare Financial Management Association	Shortlisted	Small Team of the Year	Durham, Darlington and Teesside Mental Health

			Partnership Finance Team
Healthcare Financial Management Association	Shortlisted	Technician of the Year	Louise Ferguson
Healthcare Financial Management Association	Shortlisted	Accountant of the Year	Jamie Roberts
Royal College of Psychiatrists	Shortlisted	Psychiatric Team of the Year: Quality Improvement	Dual Diagnosis Team
Royal College of Psychiatrists	Shortlisted	Psychiatric Team of the Year: Working-Age Adults	Adult Mental Health Acute Care Services, Roseberry Park
Royal College of Psychiatrists	Shortlisted	Carer Contributor of the Year	Ros Savage
Health Services Journal	Shortlisted	Partnership Award of the Year	TEWV/Ward Hadaway
Health Tech Awards	Shortlisted	Best Use of Data	Currency & Tariff Development Team
Chartered Institute of Personnel & Development	Shortlisted	CIPD People Management Awards: Best coaching & mentoring initiative	TEWV ThinkOn
Royal College of Nursing	Shortlisted	Health Care Assistant	Diane Smyth
Health Service Journal	Shortlisted	HSJ Values Awards: Financial or Procurement Initiative of the Year	An innovative project using coaching methods to identify cash-releasing efficiency savings
BAFTA	Shortlisted	Director: Factual	Paddy Wivell (Prison – Spring Films/Channel 4)
Health Service Journal	Shortlisted	Mental Health Service Redesign Initiative	North Yorkshire & York Learning Disabilities Services

Structure of this Quality Account Document

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

- **Part 2:** Information on how we have improved in the areas of quality we identified as important for 2019/20, the required statements of assurance from the Board and our priorities for Improvement in 2020/21
- **Part 3:** Further information on how we have performed in 2019/20 against our key quality metrics and national targets and the national quality agenda

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

A full statement of 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:

- Sharon Pickering (Director of Planning, Performance and Communications) at: sharon.pickering1@nhs.net
- Elizabeth Moody (Director of Nursing & Governance) at: elizabeth.moody@nhs.net

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

Part 2: Priorities for Improvement and Statements of Assurance from the Board

2019/20 and 2020/21 Priorities for Improvement – How did we do and our future plans

During 2019/20 we held two events inviting our Stakeholders to take part in our process of identifying quality priorities for 2020/21 to be included in the Quality Account. These events took place in July 2019 and February 2020; further information can be found in **Part 3, Our Stakeholders' Views** section. The four Quality priorities for 2020/21 which we identified from this engagement also sit within TEWV's 2020/21–2022/23 Business Plan. The Business Plan includes a further 13 priorities, all of which have a positive impact on the quality of Trust services. Details of these priorities can be found in **Appendix 5.**

Our four agreed 2020/21 priorities for inclusion in the Quality Account are:

Priority 1: Improve the clinical effectiveness and patient experience in times of transition from Child to Adult Services
Priority 2: Reduce the number of Preventable Deaths
Priority 3: Making Care Plans more personal
Priority 4: Increase the percentage of inpatients feeling safe on the ward

Priorities 1-3 were priorities in 2019/20 and the section below includes information on what we have done during 2019/20 and what we will do in 2020/21. Priority 4 is a new priority which we have developed for 2020/21.

Priority 1: Improve the Clinical Effectiveness and Patient Experience in times of Transition from CYP to AMH Services

Why this is important:

We define Transition in this Quality Account priority as a *purposeful and planned process of supporting Young People to move from Children's to Adult's Mental Health Services*.

Young people with ongoing or long-term health or social care needs may be required to transition into adult services, other service provision or back to their GP. The preparation and planning around moving on to new services can be an uncertain time for young people with health or social care needs. There is evidence of service gaps where there is a lack of appropriate services for young people to transfer into, and evidence that young people may fail to engage with services without proper support.

This transition takes place at a pivotal time in the life of young person. It is often at a time of cultural and developmental changes that lead them into adulthood. Individuals may experience several transitions simultaneously. A loss of continuity in care can be a disruptive experience, particularly during adolescence, when young people are at enhanced risk of psychosocial problems.

The particular importance of improving the transition from Children and Young People's Services to Adult Services has been recognised for a number of years. We initially agreed to put a two-year Quality Improvement priority in place, focusing on this specific transition. We have extended this as the full extent of the work required has become apparent. The paragraphs below show what we achieved in 2019/20.

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

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

What we did in 2019/20:

What we said we would do:	What we did:
• Hold a joint CYPS & Adult Services Engagement Event during Q2 2019/20 and report on the actions from this event during Q3 and Q4 2019/20	• The Trust is now part of an NHS England Transitions Collaborative; although plans were originally made to hold a local event, this was superseded by a similar national event held by NHS England. The event included AMH, CAMHS and EIP – a pilot of this work will be rolled out during 2020/21 (see future plans section)
• Use available data from Q4 2018/19 to undertake a gap analysis of numbers of transitions occurring and numbers of transitions panels occurring per locality (including attendance by Adult Services and CAMHS staff) by Q1 2019/20	• A gap analysis has been undertaken in relation to the number of transitions and transition panels occurring per locality; the findings were reported through the Trust Transitions Steering Group. This will form a baseline of evidence around what each panel is doing
• Set improvement trajectories for the remainder of 2019/20 based on the outcomes of the analysis above during Q1 2019/20 and report on	• Improvement trajectories have been set and progress has been monitored by the Trust Transitions Steering Group. These are separate

these trajectories during Q2, Q3 and Q4 2019/20	trajectories to those listed in the indicator below; and the specialty has continued to consolidate progress throughout the year with improvements towards targets
• Review the 'Transition from Child and Adolescent Mental Health Services to Adult Mental Health Services' by the Healthcare Safety Investigation Branch and identify any actions or learning for the Trust during Q1 2019/20 and report on progress during Q2, Q3 and Q4 2019/20	• The report has been reviewed; although the six recommendations in the report are aimed at regulatory and commissioning bodies to action, the principles of the learning have been shared with the Service Development Groups (AMH and CAMHS) and the Transitions Steering Group. The report has been discussed at the Trust Patient Safety Group, with actions decided and learning has been shared
• Establish any potential barriers to successful transitions and consider how these could be overcome	• Work has been undertaken looking at Transitions Serious Incidents and identify potential barriers to successful transitions, to consider how these could be overcome
○ Establish agreed models for Transition Panels	○ Models for Transition Panels have been agreed and will be implemented during 202/21
○ Include Experts by Experience sharing their experiences of transitions	○ Experts by Experience have been involved in sharing their experiences of Transitions; co-produced resources are still being developed
○ Including presenting case studies of difficult to manage transitions and the learning regarding how to overcome difficult to manage transitions	○ Case studies have been presented at various forums in relations, and the learning relating to these issues
○ Include partners from other organisations	○ Partners from other organisations have also been involved in this work
• Evaluate the effectiveness of transitions panels across the Trust during Q4 2019/20	• The effectiveness of transition panels across the Trust has also been evaluated; a review has been undertaken around what works well and what doesn't

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	Actual	Timescale
• Percentage of Young People (who are moving to AMH Services) who have a transition plan in place	100%	**86%**	Q4 2019/20
• Percentage of joint agency transition action plans in place for patients approaching transition	80%	**94%**	Q4 2019/20
• Percentage of patients who reported feeling prepared for transitions at the point of discharge	80%	**70%**	Q4 2019/20

At the Quality Account event held in July 2019 to discuss priorities for 2020/21 it was agreed that transitions remain an area of concern and that this should be carried forward for at least another year. The actions below are those for the next year of the priority to further embed the improvements already undertaken.

What we will do in 2020/21:

We will:
• Extend the work of the NHS Improvement Transitions Collaborative project into an internal three-year project that oversees the development and delivery of key quality improvement learning from the original pilot and take this work forward. This will include learning from the thematic review, including CPA/Process/Case Management/Escalation, Reasonable Adjustments and Assertive Engagement in complex cases in Quarter 3 2020/21 • This 'Preparing for Adulthood Collective' will develop an action plan to implement key learning in the first year of the project, and will establish strategies and targets for Year Two and Year Three in Quarter 3 2020/21 • Sustain and maintain improvements in the clinical effectiveness and patient experience at times of transition from CAMHS to AMH throughout the year; this will be informed by the collaborative work and 'plan, do, study, act' cycle via the Steering Group and audit activities • Report on progress against plans agreed by the Transitions Collaborative in Quarter 4 2020/21

- Sustain and maintain improvement targets for 2020/21 based on the outcomes of the analyses carried out in 2019/20 throughout the year

- Instigate Quality Improvement plans for the effectiveness of the panel process following the evaluations of transition panels which has taken place in Quarter 4 2019/20 throughout the year

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:	Target:	Timescale:
• Percentage of CYP who have a transition plan by age 17 years and 4 months	100%	Q4 2020/21
• Percentage of CYP who have their transition plan discussed at Panel	100%	Q4 2020/21
• Percentage of CYP who have completed transitions questionnaire on leaving CAMHS Services	90%	Q4 2020/21
• Percentage of CYP who have a positive transitions experience	100%	Q4 2020/21
• Percentage of CYP who have an unplanned discharge from AMH with 3-6 months	0%	Q4 2020/21
• Percentage of people who have a '6P' Formulation when presented at transitions panel	100%	Q4 2020/21

Priority 2: Reduce the number of Preventable Deaths

Why this is important:

It is recognised that people with a mental health problem, autism and/or a learning disability are likely to experience a much earlier death than the general population; therefore a key focus for the Trust will be on mortality review processes. Not all deaths of people receiving mental health services from the Trust will represent a failing or a problem in the way that person received care. However, sometimes healthcare teams can make mistakes, or parts of the system do not work as well together as well as they could. This means that when things go wrong, a death may have been preventable. In December 2016, the CQC published their report 'Learning, Candour and Accountability', which made recommendations for the

improvements that need to be made in the NHS to be more open about these events.

The Trust already has systems in place to review and investigate deaths in line with national guidance in order to learn from them. We believe it is important to continue to strengthen the way we identify the need for investigations into the care provided and the way that we carry these out.

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

In order to reduce preventable deaths, it is also important that learning from deaths is shared and acted on with an emphasis on engaging families and carers in this learning by involving them further in incident reviews.

TEWV has also been supporting the work of the North East and Cumbria Integrated Care System to focus upon issues related to both the physical health of people with a mental health condition and parity of esteem. This has been focussing on collecting service user stories, promoting physical activity and weight loss and improving the knowledge of non-mental health NHS workers about the needs of their service users who also have mental health needs.

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

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

What we did in 2019/20:

What we said we would do:	What we did:
• Produce an Action Plan from the March 2019 Family Conference by Q1 2019/20 and implement this plan by Q4 2019/20	• An Action Plan has been produced based on feedback from families and actions have been implemented throughout 2019/20; including introducing a Family Liaison Officer, developing personalised condolence letters and setting up a supportive compassionate group for services for

	dealing with bereaved families
• Commence circulation of a new guidance booklet to families who have lost a loved one during Q1 2019/20, and review and evaluate the impact of this booklet by Q4 2019/20	• A new leaflet and guidance booklet were circulated, and a review and evaluation of the impact of these booklets was undertaken. This review identified that the booklet was the preferable option and this is now with service to share with families
• Review the Trust-wide policy in relation to Preventable Deaths and make necessary amendments during Q1 2019/20, including implementing any new national guidance throughout the year	• The Trust-wide policy on Preventable Deaths has been reviewed and amended in line with new national guidance and best practice
• Participate in all of the regional Mental Health Learning from Deaths Forum meetings during 2019/20	• The Trust has participated in all of the regional Mental Health Learning from Deaths Forum meetings during 2019/20

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	Actual	Timescale
• Increase the number of deaths that are reviewed as part of the mortality review process (this is in addition to the existing Serious Incident Process)	300	**149***	Q4 2019/20
• Eliminate preventable Deaths of inpatients (including during periods of leave)	0	**7***	Q4 2019/20
• Reduce the number of Serious Incidents where it was identified that the Trust contributed to the incident	30	**21***	Q4 2019/20

***The figures above are the figures reported for the end of Quarter 3 2019/20; the introduction of an improved process for reviews of Serious Incidents coincided with

the Covid-19 pandemic. This has led to some delays in the processing of information and the completion of some reviews; therefore full data is not available

What we will do in 2020/21:

At the Quality Account event held in July 2019 to discuss priorities for 2019/20 it was agreed that Reducing Preventable Deaths remains a priority and this should be carried forward for at least another year. The actions below are those for the next year of this priority to further embed the improvements already undertaken.

We will:

- Hold a Family Involvement Event (previously planned for March 2020 but postponed due to the coronavirus pandemic) and produce evaluation report and recommendations and an action plan following the event during 2020/21 (exact timescale to be confirmed)

- Produce evaluation report and recommendations from the Safety Summit that was held in February 2020 in Quarter 1 2020/21

- Review the Trust Zero Suicide Plan in view of the Family Involvement Event and Safety Summit in Quarter 2 2020/21; a task and finish group will be set up to be an umbrella Steering Group around preventing harm and deaths. This will be chaired by the Trust Medical Director

- Produce 'Safer Care' action/improvement plan in Quarter 2 2020/21; progress was initially delayed due to the Covid-19 pandemic as external contractor staff were furloughed and appropriate hardware was not made available. Further work will be undertaken during Quarter 2 2020/21 to look at how risks are managed

- Implement actions from the 'Safer Care' action/improvement plan throughout the year

- Implement actions from the external review of unexpected deaths of adult, forensic and older persons services inpatients throughout the year

- Fully introduce 48-hour follow-up for all AMH patients after discharge from inpatient wards in Quarter 1 2020/21

- Involve a lived experience Service User/Carer Representative in the Environmental Risk Group in Quarter 1 2020/21 (and going forward)

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:	Target:	Timescale:
• Increase the number of mortality reviews in relation to deaths (this is in addition to the existing Serious Incident Process) and identify actionable learning	**TBC***	Q4 2020/21
• Eliminate Preventable Deaths of inpatients (including during periods of leave)	0	Q4 2020/21
• Reduce the number of Serious Incidents where it was identified that the Trust contributed to the incident	**TBC***	Q4 2020/21

*****The targets for 2020/21 will be based on achievements for these metrics during 2019/20; as the introduction of an improved process for reviews of Serious Incidents coincided with the Covid-19 pandemic. This has led to some delays in the processing of information and the completion of some reviews.

Priority 3: 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 2019/20.

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 2019/20:

What we said we would do:	What we did:
• Complete appropriate impact assessments in relation to DIALOG and seek approval via the relevant channels (DIALOG is a clinical tool that allows for assessment, planning, intervention and evaluation in one procedure) by Q1 2019/20	• Completed appropriate impact assessments in relation to DIALOG and approvals obtained via the relevant channels in Q3 2019/20 (due to changes in the Trust-wide format of these impact assessment documents)
• Involve Experts by Experience in Care Planning training workshops to provide feedback on the training and the process in general by Q4 2019/20	• The Trust completed and evaluated seven full-day trial 'personalising care planning' workshops, involving Experts by Experience during Q4 2018/19 and Q1 2019/20. Around 90 people in total attended each workshop. The feedback provided at these events was that the trainers, content and audience were appropriate, but that the timing of the events was perhaps too early, given the need to attach the new CPA to the Trust IT systems
• Review the training package and produce an options appraisal regarding how to proceed (including non-face-to-face resources) by Q1 2019/20	• The training package has been reviewed and has been found not to be as effective as anticipated; it is also not sustainable without additional resource. Although the training package was useful for developing basic skills in working with distress, goal setting and shared decision making, it did not meet the desired outcomes of allowing full personalisation of care planning.
• Continue with training package roll-out as per the agreement following options during Q2 and Q3 2019/20	• However, this has allowed sufficient direct contact with front line services to identify what is needed. This has been an ongoing review throughout 2019/20, as and when training has been conducted . A Trust-wide

	training package is being developed which is more focused on needs and goal setting. There are mandated items that the Trust needs to record (for the CQC, commissioners, etc.) which do not fit with our plans for personalisation so need to be recorded elsewhere rather than in clinical plans
• Test DIALOG within existing IT systems during Q2 2019/20	• The first testing of DIALOG has been pushed back to Q1 2020/21, due to interdependencies with the new Trust-wide IT system, CITO, which has experienced delays. Non-live User Assurance Testing (UAT) has taken place during Q4 2019/20
• Re-audit and report as per Q4 2017/18 during Q3 2019/20 (booked with Clinical Audit for October 2019)	• The re-audit took place via the Central Audit team during Q4 2019/20. All cases that were audited were a repeat audit from the previous sample. The report from this re-audit is still in draft form but preliminary findings indicate improvements in personalisation, although there are issues with clinical language and goal setting largely lacks direction – this will be addressed via the training package
• Compare and contrast review of Patient Experience during Q4 2019/20	• Due to redeployment of key staff, the compare and contrast review of Patient Experience was not undertaken during 2019/20 and will be carried forward to 2020/21

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	**Actual 19/20**	**Target 19/20**	**Actual 18/19**
• Do you know who to contact out of office hours if you have a crisis?	**75%**	84%	74%
• Were you involved as much as you wanted to be in deciding what treatments or therapies to use?	**71%**	86%	76%

• Have you been given information by NHS Mental Health Services about getting support from people who have experience of the same mental health needs as you?	**32%**	41%	31%
• Do the people you see through NHS mental health services help you with what is important to you?	**77%**	79%	69%
• Were you involved as much as you wanted to be in agreeing what care you will receive?	**72%**	86%	76%
• Were you involved as much as you wanted to be in discussing how your care is working?	**79%**	81%	71%
• Does the agreement on what care you will receive take your personal circumstances into account?	**77%**	89%	79%

The measures for the above come from the NHS Community Mental Health Survey which is administered by the CQC. The targets we have set are very aspirational targets, and the experience that our service users report relates to their experiences in the Trust as a whole, rather than in relation to their CPA 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.

What we will do in 2020/21:

At the Quality Account Stakeholder event held in July 2019 to discuss priorities for 2020/2 - it was agreed that Care Planning remains an area where further improvement is needed and that this should be carried forward for at least another year. The actions below are those for the next year of this priority to further embed the improvements already undertaken.

We will:
• Develop and implement a communications and engagement plan to ensure all relevant stakeholders are aware of changes to the CPA and introduction of DIALOG, and review this plan with key stakeholders (staff, service users, carers, local authorities and GPs) during Quarter 1 2020/21 • Continue User Acceptance Testing (UAT) of DIALOG and wider CITO developments (moving from artificial to real-life testing) during Quarter 1 2020/21 • Work with TEWV Information Technology team to ensure a finalised, working version of DIALOG is embedded within CITO during Quarter 2 2020/21

- Review and revise local CPA policy in line with national guidance when published during 2020/21
- Develop guidance to support the implementation of revised CPA processes including DIALOG in Quarter 3 2020/21
- Develop training and supporting materials in relation to the implementation of revised CPA processes including CITO pilot (this may not include the final version of DIALOG) by Quarter 3 2020/21
- Pilot training to support staff to implement the revised CPA processes during Quarter 3 2020/21
- Evaluate the pilot CPA training, making revisions where necessary, during Quarter 4 2020/21
- Roll out the revised CPA training across the Trust by the end of Quarter 1 2021/22

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 **(NB: targets for 2020/21 are based on a 10% increase to the scores achieved during 2019/20)**

Indicator:	**Target 20/21:**	**Timescale:**
• Do you know who to contact out of office hours if you have a crisis?	85%	All Q4 2020/21
• Were you involved as much as you wanted to be in deciding what treatments or therapies to use?	81%	
• Have you been given information by NHS Mental Health Services about getting support from people who have experience of the same mental health needs as you?	42%	
• Do the people you see through NHS mental health services help you with what is important to you?	87%	
• Were you involved as much as you wanted to be in agreeing what care you will receive?	82%	
• Were you involved as much as you wanted to be in discussing how your care is working?	89%	

• Does the agreement on what care you will receive take your personal circumstances into account?	87%	

Priority 4: Increasing the proportion of inpatients who feel safe on our wards

A common theme among mental health inpatients is that they do not feel safe on their wards; feedback from our Stakeholders 2019/20 has indicated awareness of this issue and so we have agreed to include this as our fourth Quality Account priority for 2020/21. This is also identified as a priority for Trusts in the NHS Long-Term Plan (2019).

Why this is important:

This is one of our key quality strategy targets – but of all the key targets it is the one where our actual performance is regularly the furthest away from our desired performance. It is also an area where the current processes to encourage improvement have not had sufficient impact and so we think a renewed and concentrated focus on it is required.

We already collect information in relation to the percentage of our inpatients who feel safe on our wards. Analysis has shown that the main reason that patients do not feel safe is due to other patients on the ward. This may be linked to the increased levels of need of service users in our inpatient environments. Going forward, further work will be undertaken looking into the detail around why patients do not feel safe and what actions can be taken by the Trust to improve the experience of inpatients.

What we plan to do going forward:

We have put in place a robust plan that aims to increase the percentage of our inpatients who feel safe on our wards. We will undertake a ‘deep dive’ piece of work to further understand the reasons why our patients might not feel safe, and focus specifically on the environments where support is most needed, developing an action plan to implement specific improvements.

Another reason why our patients may not feel safe appears to be due to the increased use of drugs and other illicit substances on our inpatient wards. We therefore aim to train two new drug detection dogs and introduce them into Trust service during the next financial year. These dogs will be shared between TEWV and Cumbria, Northumberland Tyne and Wear (CNTW) NHS Foundation Trust. Further work will also be undertaken in relation to enhancing monitoring technology in inpatient environments.

What we did in 2019/20:

Although this was not a Quality Account priority during 2018/19, the Trust has been taking action to review and improve levels of patient safety over the past year. For example, we have:

- Analysed Friends and Family Test results through the Executive Management Team
- Agreed technical solutions to support the delivery of care, such as the Oxehealth Digital Health Care Assistant, which is a digital monitoring system to assist with remote patient observations such as pulse and respiration rates, and a pilot of the use of staff body cameras

The benefits/outcomes we aim to deliver for our patients and their carers are:

- 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

What we will do in 2020/21:

We will:
• Use existing data to identify priority wards and actions; collate existing Friends and Family test and other data during Quarter 1 2020/21 • People with lived experience to talk to people currently on the TEWV inpatient wards with the highest and lowest current FFT scores and produce a 'lessons learned' report during Quarter 2 2020/21 • Develop a plan for each ward identified as a priority by Quarter 3 2020/21 • Deliver actions from this plan by Quarter 4 2020/21 • Complete training of two new drug detection dogs by Quarter 3 2020/21 and introduce them into Trust service in Quarter 4 2020/21 • Undertake work to improve liaison with the Police by Quarter 3 2020/21 • Continue monitoring of Key Performance Indicators (KPIs) during the pilot phase of body cameras (Quarter 2 2020/21) and develop a Business Case for further roll-out of these cameras in Quarter 3 2020/21 (if supported by monitoring of benefit KPIs) • Install the technology required for sensor technology in five wards during Quarter 2 2020/21 and develop required governance in relation to this pilot work; a benefits realisation of the pilot will be undertaken during Quarter 4 2020/21

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:	Target:	Timescale:
Percentage of inpatients who report feeling safe on our wards Percentage of inpatients who report that they were supported by staff to feel safe	**88%** (62% in 2019/20) **65%**	Quarter 4 2020/2021

Priorities from 2019/20 not being carried forward into 2020/21

The following two priorities were identified as being Quality Improvement priorities during 2019/20; however after consultation with Stakeholders at our event in July 2019 it was agreed that they are now embedded in 'business as usual' and, although work would continue in these areas going forward, they would not be carried forward into the Quality Account priorities for 2020/21

Develop a Trust-wide approach to Dual Diagnosis which ensures that people with substance misuse issues can access appropriate and effective mental health services

Why this is important:

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

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

- Service users with mental health and co-existing substance misuse get the same level of care as people without substance misuse problems
- Staff treat every service user with the same level of respect, without judgement
- Support for family and carers of service users with dual diagnosis improves
- Staff work collaboratively across organisations, with a creative, flexible and proactive approach
- Staff will consider the whole picture when considering the discharge of service users who have started/increased their misuse of substances
- The organisation will learn from incidents if things go wrong

What we did in 2019/20:

What we said we would do:	What we did:
• Review how current Dual Diagnosis networks across the Trust work to ensure they are effective, sustainable and fit for purpose during Q2 2019/20	• A review of Trust-wide Dual Diagnosis networks has been undertaken to ensure that they are effective, sustainable and fit for purpose during 2019/20
• Review attendance at these Dual Diagnosis networks across the Trust and identify additional attendees to target to ensure these networks are truly multi-agency during Q3 2019/20	• Attendance at these Dual Diagnosis networks has been reviewed, gaps identified and actions implemented to encourage attendance from under-represented groups, to ensure that these networks are truly multi-agency during Q3 2019/20
• Implement new reporting procedures via Datix (the Trust's internal incident logging system) so incidents that are drug/alcohol related are flagged by Q1 2019/20	• New reporting procedures are now in place via Datix, so that incidents involving drugs and/or alcohol are appropriately flagged (Q1 2019/20)
• Undertake a qualitative evaluation into how the new Datix reporting procedure is working and whether these incidents are being picked up and recorded correctly by Q4 2019/20	• A formal review has not been completed as planned; however feedback has been obtained informally through daily huddles and Head of Service reviews which have indicated that the procedure is working well.
• Explore how peer workers can be better involved with Dual Diagnosis work across the Trust area, including consideration of how a Peer	• Work has been undertaken to explore how peer workers can be better involved with Dual Diagnosis work across the Trust

Leadership Network could be established by Q4 2019/20	area, including consideration of how a Peer Leadership Network could be established, during Q4 2019/20. It has been confirmed that there are peer workers and voluntary workers in place in Durham and Darlington (although there have been difficulties recruiting), but not yet in Teesside or North Yorkshire and York
• Complete a further survey of staff Dual Diagnosis capabilities and skills and produce a paper by Q1 2019/20	• The initial survey was delayed due to staff capacity issues; this is still planned to take place during 2020/21
• Complete further follow-up work that is identified via the above survey and related strategy paper by Q4 2019/20	• Further follow-up work will be undertaken as identified via the above survey and related paper by Q2 2020/21

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	Actual
• Maintain Dual Diagnosis networks with at least quarterly meetings in every locality	100%	**100%**
○ AMH Community Teams in attendance at one or more Dual Diagnosis network meeting	80%	**100%**
○ Inpatient representatives in attendance at one or more Dual Diagnosis network meeting	50%	**100%**
• Durham and Darlington, Teesside and North Yorkshire and York to have at least one peer worker in place with a dedicated role in Dual Diagnosis*	100%	**100%**

*This does not apply in Forensic Services due to the way that patients are admitted in this Locality and the way that their drug and alcohol issues usual present

Review our Urgent Care services and identify a future model for delivery

Why this is important:

- Feedback from our service users, carers and families and our stakeholders has suggested that crisis/urgent care services across the Trust are not fully meeting patient needs
- Staff are often perceived to operate under high pressure and are unable to meet service user expectations
- Service users are sometimes unable to access crisis/urgent care services in a timely way; there are also differences across the Trust in the provision of 'pre-crisis' brief interventions, which would help individuals before they reach a 'crisis' state and would reduce demands on crisis teams

The benefits/outcomes our patients and carers should expect:

- To receive the right care at the right time by the right person
- Fewer service users reach a 'crisis' state because of improved access to 'pre-crisis' services
- To always be able to contact mental health urgent care services
- To have their complex needs and experience of trauma taken into account when they come into contact with crisis services
- Staff will always be caring and compassionate
- The role of the Trust urgent care teams to be clear and understood by service users and their families

What we did in 2019/20:

What we said we would do:	What we did:
• Review the current Crisis Operational Policy by Q2 2019/20	• The second Trust Crisis Operational Policy has been reviewed and released for use during Q2 2019/20
• Hold a Trust-wide Urgent Care Conference by Q3 2019/20	• A Trust-wide Urgent Care Conference was held in May 2019
• Undertake internal Trust-wide peer review visits in line with Home Treatment Accreditation Scheme (HTAS)/TEWV Standards by Q4 2019/20	• Trust-wide peer review visits in line with HTAS/TEWV Standards have been carried out with some teams throughout the year. Some very positive feedback was provided in relation to implementation of the quality standards

• Ensure ambulance services can check whether any person they are called to see has a Mental Health Crisis Plan in place by Q1 2019/20	• Ambulance services are now able to check whether any person they are called to see has a Mental Health condition and/or a Crisis Plan in place
• Agree CITO (electronic patient record) pathway/journey for crisis services by Q4 2019/20	• The CITO pathway/journey for Crisis and Urgent Care has now been agreed and is expected to be implemented in line with the rollout of DIALOG across the Trust –
• Implement a new Crisis Operational Model for Durham and Darlington Crisis Teams by Q1 2019/20	• The two teams in Durham and Darlington merged to form a single service in Q3 2019/20; however the new Crisis Operational Model (hub-and-spoke model) was delayed to Q4 2019/20 due to issues with identifying a suitable base and car parking facilities
• Implement the agreed actions arising from the Teesside Urgent Care review by Q4 2019/20	• The agreed actions arising from the Teesside Urgent Care review have been implemented throughout the year and are being supported using the Crisis Transformation funds from NHS England. This includes (amongst other actions) recruiting to peer support roles, implementing a 24/7 support telephone line and single point of access for all
• Develop key principles and future vision for future urgent care model by Q3 2019/20	• Key principles and a future vision for the future urgent care model have been developed during 2019/20 and include for example establishing one Trust-wide number for a single point of access, and implementing a peer support offer across Durham, Darlington and Teesside

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	Actual
• Percentage of patients triaged via the Crisis Team assessed within four hours of referral	100%	**96.53%**
• Percentage of patients with a crisis and recovery plan devised and shared with the patient/carer following an episode of Intensive Home Treatment (IHT)	100%	**N/A***

*It has not been possible to provide a figure across all teams for 2019/20 due to the current Covid-19 situation this data collection has been suspended; there had also been issues identified previously in the way that different teams record this information. There are plans to add this to the PARIS system so that this percentage can be audited in the future

Monitoring Progress

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

We will also feedback progress made during Quarter 1 2020/21 at our July Quality Account Stakeholder event, send a six-monthly update to all our Stakeholders, and provide a further update on the position as of 31st December 2020 at our February 2021 Quality Account stakeholder workshop.

Statement of Assurances from the Board 2019/20

The Department of Health and NHS Improvement require us to include our position against a number of mandated statements to provide assurance from the Board of Directors on progress made on key areas of quality in 2019/20. These statements are contained within the blue boxes. In some cases, additional information is supplied and where this is the case this is provided outside of the boxes.

Review of Services

During **2019/20** TEWV provided and/or sub-contracted 20 relevant health services, including Adult Mental Health Services, Mental Health Services for Older People, Children and Young People's Services and Adult Learning Disability Services in four localities, Forensic Learning Disability Services, Forensic Mental Health Services, Offender Health Services and Children's Tier 4 Services

TEWV has reviewed all the data available to them on the quality of care in 100%of these relevant health services

The income generated by the relevant health services reviewed in 2019/20 represents 100% of the total income generated from the provision of the relevant health services by TEWV for 2019/20

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

- **Patient Safety:** Including information on incidents, serious 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
- **Care Quality Commission:** Compliance with the essential standards of safety and quality, and the Mental Health Act

Following discussion at the QuAG any areas of concern are escalated to the relevant Locality Management and Governance Board (LMGB) and from there to the Trust Board's Quality Assurance Committee (QuAC). The QuAC receives formal reports from each of the LMGBs on a bi-monthly basis.

We also undertake an internal peer review inspection programme; the content of which is based on the Fundamental Standards of Quality and Safety published by the CQC. These inspections cover all services and a typical inspection team will include members of our Compliance Team, patient and carer representatives from our Fundamental Standards Group and peers from other services. In advance of the visit the inspection team review a range of information on the quality of the service being inspected, for example: incident data, Patient Advice and Liaison Service (PALS), complaints data, CQC compliance reports and Mental Health Act visit reports as well as any whistleblowing information. At the end of each internal inspection, verbal feedback is given to the ward or team manager, and any issues escalated to the Head of Service, Head of Nursing and Director of Quality Governance. An action plan is produced and implementation is assured via the

QuAGs, LMGBs and QuAC, as described above, and in line with the Trust's Clinical Assurance Framework.

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

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

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

Participation in clinical audits and national confidential inquiries

During 2019/20, **4** national clinical audits and **2** confidential inquiries covered the health services that TEWV provides

During 2019/20, TEWV participated in **100% (4 out of 4)** of national clinical audits and **100% (2 out of 2)** of national confidential inquiries which it was eligible to participate in.

The national clinical audits and national confidential inquiries that TEWV was **eligible to participate in** during 2019/20 were as follows:

- POMH Topic 19a: Prescribing for depression in adult mental health
- POMH Topic 17b: Use of depot/LA antipsychotic injections for relapse prevention
- POMH Topic 9d: Antipsychotic prescribing in people with a learning disability
- National Clinical Audit of Psychosis (NCAP): Early Intervention in Psychosis re-audit
- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD): Mental Healthcare in Young People and Young Adults

The national clinical audits and national confidential inquiries that TEWV **participated in** during 2019/20 are as follows:

- POMH Topic 19a: Prescribing for depression in adult mental health
- POMH Topic 17b: Use of depot/LA antipsychotic injections for relapse prevention
- POMH Topic 9d: Antipsychotic prescribing in people with a learning disability
- National Clinical Audit of Psychosis (NCAP): Early Intervention in Psychosis re-audit
- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH);
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD): Mental Healthcare in Young People and Young Adults

The national clinical audits and national confidential inquiries that TEWV participated in, and for which data collection was completed during 2019/20, are listed below alongside the number of cases submitted to each audit or inquiry as a percentage of the number of registered cases required by the terms of the national audit or inquiry.

Audit Title	Cases Submitted	% of the number of registered cases required
POMH Topic 19a: Prescribing for depression in adult mental health	Sample provided: 100	100%
POMH Topic 17b: Use of depot/LA antipsychotic injections for relapse prevention	Sample provided: 199	100%
POMH Topic 9d: Antipsychotic prescribing in people with a learning disability	Sample provided: 51	100%
National Clinical Audit of Psychosis (NCAP): Early Intervention in Psychosis re-audit	Sample provided: 392	100%
National Confidential Inquiry into Suicide & Homicide by People with Mental Illness	Sample provided: 47*	77%
National Confidential Enquiry into Patient Outcome and Death	Unknown**	Unknown**

* The NCISH no longer send out homicide questionnaires from April 2018 and figures represent response rate for suicide questionnaires returned from the provider during the reporting financial year.
**Cases are submitted confidentially and directly by individual consultants, and therefore, the number of cases submitted is unknown.

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

The reports of **184** local clinical audits were reviewed by the provider in 2019/20 and TEWV intends to take actions to improve the quality of healthcare provided. **Appendix 4** includes the actions we are planning to take against the **10** key themes from these local clinical audits reviewed in 2019/20.

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 **49** clinical audits in 2019/20 which include clinical effectiveness projects undertaken by Junior Doctors, Consultants or other Directorate/Specialty Groups. These clinical audits were led by the services and individual members of staff for reasons of service improvement and professional development and were reviewed by the Specialty Clinical Audit Subgroups.

Participation in Clinical Research

The number of patients receiving relevant health service provided or sub-contracted by TEWV in 2019/20 that were recruited during that period to participate in research approved by a Research Ethics Committee was **658**.

Of the **658** participants, **542** were recruited to **39** National Institute for Health Research (NIHR) portfolio studies. This compares with 664 patients involved as participants in NIHR research studies during 2018/19.

We had feedback from **39** research participants in TEWV about their experience of taking part in research. **87%** of participants strongly agreed or agreed that they had a good experience of taking part in research. **76%** indicated their reason for taking part in research was to help others.

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

- We were involved in conducting **85** clinical research studies during 2019/20, **42** of these studies were supported by the NIHR through its networks
- **68** members of our clinical staff participated as researchers in studies approved by a Research Ethics Committee, with **17** of these in the role of Principal Investigator for NIHR supported studies
- **223** 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

Key Achievements

TEWV has joined the Northern Health Science Alliance (NHSA), which brings together 24 research-active NHS Trusts and Universities across the North of England and the four Northern Academic Health Science Networks. It works closely with members to promote the North's life science sector to increase awareness of and drive investment into the Northern Powerhouse. As an Associate Member, TEWV will benefit from a range of opportunities through the NHSA's joint research partnerships, advocacy, business development and international and national programmes.

We have increased the number of trials we are sponsor for and will be opening a further sponsored trial this year (COMBAT). We are continually refining and updating our quality management system to ensure the Trust meets the requirements of clinical trial regulation.

In collaboration with our partners at the University of York, a new clinical research facility is operational within the new Foss Park Hospital, which provides a high quality environment for service users and carers to take part in our commercial research trials.

Goals agreed with Commissioners

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

A proportion of TEWV's income in 2019/20 was conditional on achieving quality improvement and innovation goals agreed between TEWV and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Further details on the agreed goals for 2019/20 and for the following 12-months is available electronically at:

https://www.tewv.nhs.uk/about-us/how-are-we-doing/

As part of the development and agreement of the 2018/20 (which ran from 1st April 2018 to 31st March 2020) mental health contract, we were provided with a list of nationally mandated CQUINs and then were given an option to add one further local CQUIN which the Trust opted to do in agreement with the commissioners. This included indicators around physical healthcare, staff health and wellbeing and discharge and resettlement within specialist services. These are monitored at meetings every quarter with our commissioners.

An overall total of £3,944,568 was available for CQUIN to TEWV in 2019/20, conditional upon achieving quality improvement and innovation goals across all of its CQUINs. A total of £3,413,478 (86%) is estimated to be received for the associated payment in 2019/20; however this will not be confirmed until May 2020. The CQUIN schemes make up all of 1.25% of the available funding with each national indicator having a minimum weighting of 0.25%.

This represents 1% of the Trust income rather than 1.9% as in previous years. The basis for this reduction was that 1.25% of CQUIN was built into provider contract baselines recurrently from 2019/20, and therefore no longer linked to CQUIN schemes.

This compares to £7,086,733 (95%) in 2018/19, £7,240,867 in 2017/18 (98.1%), £6,418,793 in 2016/17 (92.19%) and £6,452,069 in 2015/16 (99.2% from the TEWV CQUIN prior to the Vale of York contract and 100% from the Vale of York CQUIN). (The estimate for 2019/20 has still to go through all the required governance processes for full approval).

Some examples of CQUIN indicators which the Trust made progress with in 2019/20 were:

- Improved Discharge Follow Up: 72 hour follow up is a key part of the work to support the Suicide Prevention Agenda within the Long-Term Plan. The National Confidential Inquiry into Suicide and Safety in Mental Health (2018) found that the highest number of deaths occurred on day three post-discharge. By completing follow-up within three days we support the Suicide Prevention Agenda, ensuring patients have both a timely and well-planned discharge. The aim of this CQUIN is to achieve 80% of Adult Mental Health patients receiving a follow-up within 72 hours of discharge from a CCG – commissioned service. Ensuring timely and well-planned discharge over 80% of our patients have been followed-up within three days thus supporting the suicide prevention agenda and improving patient and experience and outcomes. 72 hour follow-up is now fully embedded within the Trust as a quality standard and will replace the current standard of following up our patients within seven days of discharge from psychiatric inpatient care

- Prevention of ill health through Alcohol and Tobacco Screening and Brief Advice: The aim of this CQUIN is to deliver screening and provide Brief Advice to tobacco and alcohol users which forms a key component of their path to cessation

    - Over 90% of patients on our wards are now being comprehensively screened for the use of both alcohol and tobacco
    - Over 90% of eligible patients who have been recorded as smokers during screening are being given Brief Advice as outlined in the Alcohol and Tobacco Brief Interventions e-Learning Programme – including an offer of Nicotine Replacement Therapy
    - Over 95% of eligible patients who have been recorded as drinking above the low risk levels have been given advice as outlined in the Alcohol and Tobacco Brief Interventions e-Learning Programme, or offered a specialist referral if the patient is potentially alcohol dependent

- Health and Justice: Personalised Care and Support Planning with Liaison and Diversion Services: This is a two-year CQUIN; the aim of the first year is to increase partnership working with a variety of agencies e.g. the Police, Probation, CRCs, etc.; embedding personalised care and support planning for people vulnerabilities. During this year, activity has been focused on agreeing and putting in place systems and processes to ensure that the relevant patient population can be identified, the relevant workforce receives appropriate training, and that personalised care and support planning conversations can

be incorporated into consultations with service users, carers (where appropriate) and partner agencies

- Prevention of ill health through Healthy Weight in Adult Secure Services: This is a two-year CQUIN; the aim of the first year is to deliver a healthy service environment in adult secure services. A sophisticated staged approach to healthy weight management has been created offering a bespoke range of interventions to all patients irrespective of whether or not they have an unhealthy weight through a co-produced lifestyle change programme and Lifestyle, Education, Activity and Nutrition (LEAN) programme for overweight and obese service users established by a specialist dietician and supported by the nursing team, ward managers and consultants. To reflect the changes made throughout the year and to obtain feedback from service users and a range of professionals an innovation day was organised. Additionally, feedback is also being sought from service users and staff through an electronic survey which will contribute to revision of the programme and introduction of a physical health and lifestyle passport in Year 2 of the CQUIN

What others say about the provider

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

TEWV is required to register with the Care Quality Commission and its current registration status is **registered to provide services with the exception of CAMHS Tier 4 Services.**

The CQC **has** taken enforcement action against TEWV during 2019/20 and has suspended Child and Adolescent Mental Health wards while concerns about this service are investigated

TEWV **has** participated in a special review/investigation by the CQC during the reporting period, in relation to the above

Following submission of the Provider Information Request (PIR) on 17 July 2019, the Trust received notification of core service inspections commencing 23 September 2019. The CQC made the decision to inform the Trust of the date of inspection given the number of services they wished to include. The following core services were inspected during the week 23 September–3 October 2019:

- Forensic Inpatient/Secure Wards
- Long stay/rehabilitation mental health wards for working age adults
- Acute wards for adults of working age and psychiatric intensive care units
- Wards for people with learning disabilities or autism
- Mental Health crisis services and health-based places of safety
- Community based Mental Health Services for Older People
- Specialist Community Mental Health services for children and young people
- Wards for older people with mental health problems

- Specialist Eating Disorder Services

A Learning from Deaths Review was also undertaken by the CQC on 22 October 2019, following which the Trust was provided with informal feedback that there were no immediate concerns raised.

In addition, the CQC undertook its inspection of whether the Trust as a whole is well-led on 5/6 November 2019. This included interviews with senior staff, focus groups, a review of documents and attendance at relevant governance and Board meetings.

The Trust received the draft report on 30 December 2019 and the factual accuracy response was submitted on the deadline of 14 January 2020. The CQC published their report and ratings on 3 March 2020.

The CQC's rating for each key domain overall was:

The Trust was changed to a 'Requires Improvement' rating overall with two elements being rated as inadequate – 'Safe' and 'Responsive'.

The CQC found that:

- Staff engaged with patients in a caring, compassionate and respectful manner. Feedback received from patients and carers was positive in relation to the care and treatment they received and they felt involved in care planning
- The Trust engaged positively with patients, carers and staff. This included a wide range of co-production work. The Trust was also extending the number of peer support workers. However, it would be helpful to have a Trust Strategy for user involvement to ensure this was embedded throughout the organisation
- The Trust had a values-based culture which was positive and open. There was a high degree of openness and transparency in the senior leadership team. Staff spoke about the positive culture during the inspections of services
- The Trust was making increasing use of digital technology to support the delivery of services to patients

- The Trust had a talented and experienced leadership team. The board was working together well to respond appropriately to the ongoing challenges following the closure of the wards for young people at West Lane Hospital
- The importance of the leadership team being visible and approachable was recognised
- The Trust continued to provide leadership development for staff, a strong focus was still placed on creating a coaching culture that supported recovery and wellbeing [and] the Trust continued with its leadership programme for staff from a black, Asian and minority ethnic background
- The Board and Senior Leadership Team had developed a clear strategy and staff were aware of what it was. It was evident that staff and patients had been engaged during the formation of the strategy. The Trust continued to embed the strategy as it developed its ongoing operational priorities

However, they also found that:

- Staffing did not always meet the needs of patients, leading to excessive caseloads and/or delays in assessments in some teams
- Medicines were not always effectively managed
- Where we have poor physical environments, these were adversely impacting on the safety, privacy and dignity afforded to patients
- Equality and Diversity for staff and patients was not fully integrated into all areas of the work of the organisation. This was particularly needed for people who are LGBT+
- Disciplinary and grievance processes were not always completed in line with Trust policy.

There are several actions the Trust will take in order to meet CQC regulatory requirements. The Trust has developed an Action Plan to address the Must Dos and Should Dos set out in the report. Progress on this will be monitored by clinical services with further reporting to the Quality Assurance Committee (QuAC) and the Trust's Board of Directors. Governors will also be kept informed of progress and any issues.

Other priorities and actions in the Trust's Business Plan which address the points made by CQC include:

- Development of a new inpatient model for Children and Young People
- Development of a coproduction and participation strategy
- Relocation of services to fit-for-purpose buildings (e.g. Redcar Community CAMHS, York and Selby Community CAMHS, all community services in Hambleton and Richmondshire

Mental Health Act Inspections

31 Mental Health Act inspections were undertaken by the Care Quality Commission during 2019/20, across a wide range of services in all localities.

There were several key themes identified from these inspections, including:

- Care Plans (20)
- MHA: Section 17 Leave (15)
- MHA: Capacity Assessments/Consent/Best Interests (13)
- MHA: Patient Rights (10)
- Restrictive Practices (9)
- Notices/Ward Information (8)
- Discharge Planning (7)
- MHA: IMHA Referral (7)
- Activities (6)
- Privacy and Dignity (6)

Where issues are identified there are action plans put in place to address them, with a monthly report to QuAGs and quarterly report to LMGBs.

Quality of Data

TEWV submitted records during 2019/20 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- Which included the patient's valid NHS number was **100%** for admitted patient care
- Which included the patient's valid General Medical Practice code was **100%** for admitted patient care

TEWV has provided **100** out of 100 mandatory evidence items and **40** out of 40 assertions have been confirmed for the Data Protection and Security Toolkit

The Trust has no unmet assertions.

The Data Security and Protection (DSP) Toolkit is an online tool that enables organisations to measure their performance against data security and information governance requirements which reflect legal rules and Department of Health policy.

The Toolkit has been developed in response to The NDG Review (Review of Data Security, Consent and Opt-Outs) published in July 2016 and the government response published in July 2017. The Data Security and Protection Toolkit is the successor framework to the Information Governance Toolkit.

Progress to evidence compliance is monitored weekly by our Information Governance Manager and reported monthly to the Trust's Digital Safety and Information Governance Board where progress is reviewed and action to mitigate slippage against targets is agreed.

TEWV **was** subject to an external clinical coding audit during 2019/20 by D&D Clinical Coding Consultancy (Private Sector) in line with the DS&P Toolkit Standard 1 and 3 (former Information Governance Toolkit requirements 505 and 514).The results were as follows:

Five specialties were audited:

- Learning Disabilities (LD) (700)
- Adult Mental Health (AMH) (710)
- Child and Adolescent Mental Health Services (CAMHS) (711)
- Forensic (712)
- Mental Health Services for Older People (MHSOP) (715)

Table of coding accuracy findings **% Diagnoses coded correctly**		
Specialty	**Primary**	**Secondary**
LD	100	96.58
AMH	100	95.42
CAMHS	100	94.16
Forensic	100	96.25
MHSOP	100	95.26
Overall	100	**95.26**

Data Security Standard 1: Data Quality
The Trust has achieved the following attainment level – Standards Exceeded

Data Security Standard 3: Training
The Trust has achieved the following attainment level – Standards Exceeded

There is growing emphasis within healthcare on the importance and relevance of clinical outcome collection and reporting (NHS England, 2014; 2019). Within TEWV we are working to embed meaningful, timely and accurate clinical outcome reporting for all clinical services in line with guidance within the NHS Long-Term Plan (NHS England, 2019) and Currency Tariff Development Guidance (NHS England and NHS Improvement 2016; 2019).

CAMHS Current View, HoNOSCA and PROM information from patients discharged between April 2019-December 2019

Specialty	Tool	Logic applied (forms the denominator)	Total left once logic has been applied (denominator)	What is being reported (forms the numerator)	Total number reported on (numerator)
CAMHS	Current View	Removed those who had not had a 2nd contact (proxy for entering treatment). Removed retrospective	5691	Those patients who are classed as entering treatment and are non-retrospective, who have a current view completed with a Needs-Based Grouping allocate (those with data quality issues are still reported here as long as they have a Needs-Based Grouping allocated)	5014 (88.1%)
CAMHS	HoNOSCA	Removed those who had not had a 2nd contact (proxy for entering treatment). Removed those that were under the age of 6 at the time of their first HoNOSCA and those that do not have a HoNOSCA completed but started their spell before they were 6 years old. Removed spells less than 2 weeks. Removed those who do not have a Needs-Based Grouping allocated	673	Those patients who are classed as entering treatment, who are non-retrospective, have a spell longer than 2 weeks, were either aged 6 or over when they entered treatment or their first HoNOSCA was completed once they were aged 6 or over, who have a fully complete pair with no data quality issues and have a Needs-Based Grouping allocated	215 (32%)
CAMHS	CORS/ORS/ RCADS/SCORE 15 /EDE-Q/SDQ	Removed those who had not had a 2nd contact (proxy for entering treatment). Removed retrospective. Removed those that were under the age of 6 at the start of their spell. Removed spells less than 2 weeks. Removed those who do not have a Needs-Based Grouping allocated	3223	Those patients who are classed as entering treatment, who are non-retrospective, have a spell longer than 2 weeks, were aged 6 or over when they started their spell, who have a paired PROM completed and have a Needs-Based Grouping allocated (one or both tools may have data quality issues)	1463 (45.4%)
CAMHS	CORS/ORS/RCADS/SCORE 15/EDE-Q/SDQ	As above	3223	As above but only those who have a fully completed paired PROM (data quality issues removed) NB This number is for patients who have had any paired PROM completed; a patient could have 1 fully complete pair and 3 pairs with DQ issues and they would still be flagged as having a fully complete pair	1422 (44.1%)

Forensic secure outcome

The following information relates to patients who have been discharged from a security level between April 2019-December 2019 (there is no logic in relation to spells lasting less than two weeks, retrospective, etc. applied to the data). The data only applies to those patients who have a paired HoNOS completed before their discharge.

	Numerator	Denominator	
	Of those in denominator, number of patients who had an improved HoNOS score recorded before discharge	Total number of patient discharges during reporting period	Percentage of patients with improved HoNOS score on discharge
LOW_SECURE	17	36	47%
MEDIUM_SECURE	18	29	62%
Grand Total	35	65	54%

Perinatal and LD PROM/CROM Information

The following information relates to non-retrospective patients, it shows initial information for those patients who had a referral made between April 2019 and December 2019, and discharge information for those patients who had a referral closed between April 2019 and December 2019 the same patients will not necessarily shown in the initial and the discharge information.

	Perinatal	Learning Disabilities
Number of patients with an initial CROM	246	618
% of patients with an initial CROM	32.49%	62.11%
Number of patients with an initial PROM	304	
% of patients with an initial PROM	40.16%	
Number of patients with a discharge CROM	13	188
% of patients with a discharge CROM	2.41%	22.09%
Number of patients with a discharge PROM	32	
% of patients with a discharge PROM	5.94%	

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

- Continuing to hold monthly Quality Working Group
- Continue with Data Quality Scorecard, focusing on main issues impacting on quality of data
- Automate as many reports as appropriate to reduce data quality issues
- Continue with annual data quality assessments for a range of KPIs and other metrics

Learning from Deaths

Following the 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. In Mental Health and Learning Disability Services the vast majority of our service users are cared for in the community and often we have very minimal contact with them. This means that most of our service users 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 which are generally deaths that are unexpected.

In line with the National Quality Board (NQB) guidance, the Trust has developed a Learning from Deaths policy along with a number of other Northern Mental Health and Community Trusts as part of a collaborative approach to learning from deaths. We have made it a priority to work more closely with families and carers of service users who have died and to ensure meaningful support and engagement with them at all stages, from notification of death right through to actions taken from investigation. A recent conference was held with bereaved families who have had experience of the serious incident process to identify how we can improve it.

The Trust has standardised its approach to reviewing deaths in line with the NHSI guidance and can demonstrate improved identification and reporting of deaths. The Trust collects data on all known deaths and has a process in place to determine the scope of deaths which require further review or investigation. The Trust has a Family Liaison Officer who works with families and supports them through the Serious Incident process.

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. 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, this information is also included in the annual Patient Safety report. We also ensure learning is cascaded to frontline clinical staff on a regular basis by use of Patient Safety Bulletins, Learning Lessons information and Incidental Findings thematic summaries.

The Trust has seen an increase in the number of serious incidents in 19/20. Some of these incidents related to deaths within inpatient services. In response, the Trust has:

- Continued to review all serious incidents in order to learn lessons and make relevant practice and environmental improvements;
- Commissioned an external thematic review of inpatient deaths and developed an action plan based on its recommendations;
- Revised and implemented a new Observation and Engagement Policy;

- Held a multi-agency/multi-disciplinary Safety Summit (Feb 2020), which reviewed our zero suicide ambition and plan, sought views on the implications of our data, discussed how to promote openness and learning when incidents take place, discussed how we can better learn from other Trusts and national best practice

All unexpected deaths which are reported through our incident management system (**273** in 2019/20) are subject to an initial review by a senior clinician in the Patient Safety Team. We would normally report on the average age of service users who died during the previous year, however due to the impact of the Covid-19 pandemic on the operational capacity of relevant teams, it has not been possible to provide this information at this time.

There is no agreed or validated tool to determine whether problems in the care of the patient contributed to their death within Mental Health or Learning Disability Service. We use the approach of considering a root cause being found in an incident review until a nationally agreed tool becomes available. This means that currently different Mental Health and Learning Disability organisations are using differing ways currently of assessing this.

During 2019/20 **745** TEWV patients died; this comprised the following number of deaths which occurred in each quarter of that reporting period:

- **383** in the first quarter
- **398** in the second quarter
- **477** in the third quarter
- **487** in the fourth quarter

By 31st March 2020, **224** case reviews and **67** investigations have been carried out in relation to **291** of the deaths included in the figures above

In **zero** cases a death was subject to both a case record review and an investigation. The number of deaths in each quarter for which a serious incident investigation was carried out was:

- **33** in the first quarter
- **40** in the second quarter
- **35** in the third quarter
- **38** in the fourth quarter

12, representing **0.69%** of the patient deaths during the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. The incident review has then been used as a way to determine if the patient death may have been attributable to problems with care provided.

This number has been estimated using the findings from Serious Incident investigations. Where there has been a root cause found from the incident review then this has been used to determine if the patient death may have been attributable to problems with care provided.

Root or contributory findings from serious incident reviews undertaken in 2019/20 have highlighted the following areas for learning and improvement:

- Multi-disciplinary/agency working
- Record keeping
- Communication
- Patient risk assessments
- Non-compliance with some elements of Trust policy

A thematic review into learning from deaths within the Trust identified the following five recommendations:

- An assurance review of the effectiveness of the revised risk assessment tool and associated training
- To include in the clinical audit plan for 2020/21 compliance around policies for clinical observation, physical healthcare and leave
- Clinical supervisors to include family and carers in the clinical supervision process
- To issue a Safety Bulletin to clinical staff around communications
- Investigating officers to consider compliance with NICE guidelines in respect of prescribed medication as well as staffing levels within the investigatory process
- Begun work to improve the Trust's electronic recording system to improve how we record, retrieve and consider patient risk information

The bullets below show the actions we have already taken, or will take during 2020/21 in response to what we have learned from reviews of deaths:

- Generated action plans from each Serious Incident, and developing our processes for monitoring these actions by setting up a robust governance database to assess the impact of learning from these incidents
- Introduced regular safety huddles and a ligature reduction programme
- Completed an up-to-date environmental audit for each ward
- Reviewed and updated relevant policies (e.g. Harm Minimisation) to reflect best practice and impact on patient safety
- Introduced a suicide prevention and self-harm reduction group
- Commenced a 'root and branch' review of ward communication structures

These key pieces of work will continue through 2020/21 in addition to ongoing service improvements across the organisation.

The impact of these case record reviews and investigations on the data submitted in our 18/19 Quality Account is as follows (the figures reported in our 18/19 Quality Account are stated in the brackets):

169 (106) case record reviews and **113** (126) investigations were carried out in relation to the 2,322 deaths of TEWV patients which TEWV was notified about in 18/19. **23** (11) representing **0.99%** (0.47%) of the patient deaths during the 18/19 reporting period are therefore now judged to be more likely than not to have been due to problems in the care provided to the patient.

PALS and Complaints

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 2019/20 PALS dealt with 2,369 concerns or issues from patients and carers, an increase of 522 when compared to 2018/19. 1,222 (52%) of the concerns raised were from AMH services across the Trust.

1,847 of the PALS concerns (78%) were closed within five working days although no formal target is set for this.

284 formal complaints were received and registered during 2019/20 compared to 263 for the same period last year.

Complaints across services,; 185 in AMH services, 44 in CYPS, 23 in MHSOP, 21 in Forensic Services, 4 in ALD services and 7 in Corporate Services.

The most common cause for complaint across the Trust each month relates to aspects of Clinical Care (178), followed by communication (63) and attitude (36). Complaints have also been received relating to discharge arrangements (6), general advice (4), environment (4) and equality and diversity (1).

267 responses were sent out during 2019/20, 211 (79%) were within timescales (60 working days).The number of complaints received and closed are published on the Trust's website.

Freedom to Speak Up

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 telephone number (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 via email. 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 provides a report to the Trust Board on a twice-yearly basis. 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 2019/20, there were **72** cases referred to the Freedom to Speak Up Guardian. Of these, **53** were submitted anonymously. **33** of the concerns related to culture of bullying, and **24** related to patient safety and **8** to staff safety. The remainder related to other issues such as culture or systems/processes.

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 Trust's Board received the Guardian's annual report at its meeting of 28th April 2020. The role sits independently from the management structure, with a primary aim to represent and resolve issues related to working hours. The Guardian is required to levy a fine against a department(s) if a doctor works on average over 48 hours/week, works over 72 hours in 7 days or misses more than 25% of required rest breaks. 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's Annual Report notes that: "The 2016 Junior Doctor Contract was implemented for psychiatry trainees starting new contracts in February 2017. Mandated monitoring processes for the year have not identified any breaches to terms and conditions of service requiring the levy of a fine. Exception Reports mainly reflect variation in work on non-resident rotas and a new process for this has been implemented and is under review. Processes are in place for ongoing scrutiny and review of work schedules to provide assurance of safe working environments and consideration of training and service needs. There has been extensive Junior Doctor engagement in planning & implementation of rota changes and recording activity. Junior Doctor Locality Forums are running in each area, including operational and educational leaders as well as the guardian, in order to find systemic solutions.

During the year, the most common reasons for needing short-term/locum cover was due to staff sickness and maternity/paternity leave. Towards the end of the reporting period there was an increasing requirement for short-notice cover due to staff self-isolating because of Covid-19.

Exception reports received related mostly to having to stay later than 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.

The Guardian attends the Medical Directorate Management meeting and the Trust Strategic Medical Education meeting. Actions captured in relation to reducing gaps in rotas of medical staffing are RAG rated and managed through these meeting cycles as part of the Medical Education Operating Framework. More substantial plans and strategic pieces of work are part of an ongoing Quality Improvement plan, which is overseen by Health Education England.

Mandatory Quality Indicators

The following are the mandatory quality indicators relevant to mental health Trusts, issued jointly by the Department of Health and NHS Improvement and effective from February 2013:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127382/130129-QAs-Letter-Gateway-18690.pdf.pdf

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

Care Programme Approach Seven-Day follow-up

The data made available by NHS with regard to the percentage of patients on Care Programme Approach (CPA) who were followed up within seven days after discharge from psychiatric inpatient care during the reporting period. As per NHS Oversight Framework guidance, this reports all patients discharged that were followed up within seven days.

TEWV Actual Q4 19/20	***National benchmarks in Q3 19/20***	***TEWV Actual Q3 19/20***	***TEWV Actual Q2 19/20***	***TEWV Actual Q1 19/20***
Trust final reported figure: **95.93%**	NHSIC reported - National average MH Trust: **95.48%**	Trust final reported figure: **97.43%**	Trust final reported figure: **98.23%**	Trust final reported figure: **97.22%**
Figure reported to NHSI: 0N/A*	Highest/Best MH Trust: **100.00%**			
NHS Digital reported: **Not available**	Lowest/Worst NHS Trust: **86.3%**	NHS Digital reported figure: **97.39%**	NHS Digital reported figure: **98.21%**	NHS Digital reported figure: **97.59%**

*Latest benchmark data available on NHS Digital

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

- The discrepancy between the NHS Digital and the Trust data is due to the fact the NHS Digital data is submitted at a CCG level, and therefore excludes data where the CCG is unspecified in the patient record. The Trust figure includes all discharges

- **72** people were not followed up within seven days during 2019/20; the key reasons for this were as follows:
    - Difficulty engaging with the patient despite efforts of the service to contact the patient **(27 patients)**
    - Breakdown in processes within the services **(26 patients)**
    - The impact of Covid-19 on data collection and operational performance prevented the validation of **12 patients**

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

- Investigating all cases that were not followed up and identifying lessons to be learned at service level
- Continuing to utilise the report-out process and Trust performance management system to proactively monitor performance and ensure compliance. Supporting the adherence to standard process to ensure patients discharged to other services (e.g. 24-hour care unit) are not overlooked, including the introduction of visual control boards
- Continuously raising awareness and reminding staff at ward/team meetings of the national requirement and why it is important to patient safety, the need to follow standard procedure and the need to record data accurately considering appropriate exclusions

Crisis Resolution Home Treatment team acted as gatekeeper

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

TEWV Actual Q4 19/20	****National benchmarks in Q3 19/20***	***TEWV Actual Q3 19/20***	***TEWV Actual Q2 19/20***	***TEWV Actual Q1 19/20***
Trust final reported figure: **89.81%**	NHSIC reported - National Average MH Trust: **97.13%**	Trust final reported figure: **98.2%**	Trust final reported figure: **98.03%**	Trust final reported figure: **97.33%**
	Highest/Best MH Trust: **100.00%**			
NHS Digital reported: **Not available**	Lowest/Worst NHS Trust: **79.96%**	NHS Digital reported figure: **98.17%**	NHS Digital reported figure: **98.01%**	NHS Digital reported figure: **97.3%**

*Latest benchmark data available on NHS Digital at Quarter 3 2019/20

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

- The discrepancy between the NHS Digital and the Trust is due to the fact the NHS Digital data is submitted at a CCG level, and therefore, excludes data where the CCG is unspecified in the patient record. The Trust figures include these cases

- **59** people during 2019/20 were not assessed by the Crisis Team prior to admission; the key reasons for this were as follows:
    - Breakdown in process due to failure to follow the standard procedures **(36 patients)**
    - High levels of demand on the Crisis Teams **(8 patients)**
    - Impact of Covid-19 on data collection and operational performance prevented the validation of **11 patients**

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

- Investigating instances where patients were not seen by a Crisis Team prior to admission and identifying lessons to be learned at service level
- Continuing to utilise the report-out process and Trust performance management system to proactively monitor performance and ensure compliance. Supporting the adherence to standard process, including the introduction of visual control boards
- Continuously raising awareness and reminding staff at ward/team meetings of this national requirement and why it is important, the need to follow the standard procedure and the need to record data accurately considering appropriate exclusions

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

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

An overall Trust score is not provided, due to the nature of the survey, therefore it is not possible to compare trusts overall. For 2019, 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 2019	***National benchmarks in 2019***	***TEWV Actual 2018***	***TEWV Actual 2017***	***TEWV Actual 2016***
Overall section score: 7.3 **(sample size 241)**	Highest/Best MH Trust: **8.3** Lowest/Worst MH Trust: **6.7** Average Score: **7.5**	Overall section score: **7.3** (sample size 209)	Overall section score: **7.7** (sample size 232)	Overall section scor**e:7.8** (sample size 234)

Notes on Metric

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

Thinking about the last time you saw this NHS health worker or social care worker for your mental health condition…

- Did this person listen carefully to you?
- Did this person take your views into account?
- Did you have trust and confidence in this patient?
- Did this person treat you with respect and dignity?

From 2014, the CQC (who design and collate the results of the survey) ceased the provision of a single overall rate for each NHS Trust and the following questioned replaced those previously asked around contact with an NHS health worker or social care worker:

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

Patient Safety incidents including incidents resulting in severe harm or death

The data made available by NHS Digital with regard to the number of patient safety incidents, and percentage resulting in severe harm or death, reported within the Trust during the reporting period. The next reporting period is March 2020

TEWV Actual Q3 19/20	***National Benchmark in Q1 & Q2 19/20***	***TEWV Actual Q1 & Q2 19/20***	***TEWV Actual Q3 & Q4 18/19***
Trust reported to NRLS: **3,312** incidents reported **40 (1.20%)** resulted in severe harm or death	NRLS Reported: National Average MH Trusts: **3,926** incidents reported of which **37 (0.94%)** resulted in severe harm or death Lowest MH Trust: **13** incidents reported of which **0** resulted in severe harm and **8 (61.54%)** resulted in death Highest MH Trust: **8,568** incidents reported of which **9 (0.11%)** resulted in severe harm and **31 (0.36%)** resulted in death The highest reported rate of death as a proportion of all incidents was **1.5%**	Trust reported to NRLS: **8,024** incidents reported of which **86 (1.1&)** resulted in severe harm or death* NRLS reported: **8,024** incidents reported of which **86 (1.1%)** resulted in severe harm or death* ***22** Severe Harm and **64** Death	Trust reported to NRLS: **8,154** incidents reported of which **72 (0.88%)** resulted in severe harm or death* NRLS reported: **8,154** incidents reported of which **72 (0.88%)** resulted in severe harm or death* ***11** Severe Harm and **61** Death

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

- The Trust reported and National Reporting and Learning Systems (NRLS) reported data for Quarters one and two 2019/20 indicate that TEWV were identified as the second highest Mental Health Trust

- The number of incidents reported by TEWV to the NRLS for Quarters one and two 2019/20 was slightly less than the previous two quarters. However, it is not possible to use the NRLS data to comment on a Trust's culture of incident reporting or the occurrence of incidents. The absolute numbers of incidents reported is a factor of the relative size of a Trust and the complexity of their case-mix. We have noted that:

    - The reporting of patient safety incidents in the Trust in Quarters one and two 2019/20 has considerably increased when compared to Quarters three and four 2018/19. This is due to the implementation of a new web-based version of our incident reporting process which has had the positive impact of raising staff awareness of recording
    - Amongst the most common themes reported are self-harming behaviour, patient accident, disruptive, aggressive behaviour and medication which account for three-quarters of all incidents leading to harm

- During 2019/20 TEWV reported **159** incidents as Serious Incidents, of which **119** were deaths due to unexpected causes
- TEWV is one of the largest Mental Health Trusts in England in terms of population served and caseload

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

- Analysis of all patient safety incidents. These are reported and reviewed by the Patient Safety Group which is a sub-group of the Trust's Quality Assurance Committee. A monthly report is circulated to the QuAC Safety incidents are reported to commissioners via the Clinical Quality Review Process

- Making permanent the central approval team which was put in place to ensure consistent grading of incidents and to improve the overall quality of reporting

- Ensuring all Serious Incidents (i.e. those resulting in severe harm or death) are subject to a Serious Incident review. This is a robust and rigorous approach to understand how and why each incident has happened, to identify any causal factors and to identify and share any lessons for the future
- Introducing mortality reviews on those deaths that are not classed as unexpected. We are following national guidance as it published in this area – the National Guidance on Learning from Deaths was released in March 2017 and have implemented its recommendations throughout 2019/20

Part 3: Other Information on Quality Performance 2019/20

Our performance against our quality metrics

During 2016/17 we reviewed and revised our Trust's Quality Strategy. In approving the new strategy, the Trust Board agreed a set of metrics to be routinely monitored each quarter to show the progress that is being made in delivering the objectives within the strategy. As a consequence, we revisited the quality metrics to be used in the 2019/20 Quality Account to ensure that they are aligned to the metrics in the Quality Strategy.

The following table provides details of our performance against our set of agreed quality metrics for 2019/20.

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

Quality Metrics

The following table demonstrates how we have performed against the relevant quality metrics

Quality Metrics		2019/20		2018/19	2017/18	2016/17	2015/16
		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%**	**62.39%**	**61.50%**	**62.30%**	**N/A**	**N/A**
2	Number of incidents of falls (level 3 and above) per 1000 occupied bed days (for inpatients)	**0.35**	**0.15**	**0.18**	**0.12**	**0.37**	**N/A**
3	Number of incidents of physical intervention/restraint per 1,000 occupied bed days	**19.25**	**30.45**	**33.81**	**30.65**	**20.26**	**N/A**

Clinical Effectiveness Measures							
4	Existing Percentage of patients on Care Program Approach who were followed up within seven days after discharge from psychiatric inpatient care	**>95.00 %**	**97.13%**	**96.49%**	**94.78%**	**98.35%**	**98.35%**
5	Percentage of clinical audits of NICE guidance completed	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
6a	Average length of stay for patients in Adult Mental Health (days)	**<30.2**	**25.55**	**24.70**	**27.64**	**30.08**	**26.81**
6b	Average length of stay for patients in Mental Health Services for Older People (days)	**<52**	**66.84**	**66.53**	**67.42**	**78.06**	**62.67**
Patient Experience Measures							
7	Percentage of patients who reported their overall experience as excellent or good	**94%**	**91.65%**	**91.41%**	**90.50%**	**90.53%**	**N/A**
8	Percentage of patients that report that staff treated them with dignity and respect	**94%**	**85.80%**	**85.70%**	**85.90%**	**N/A**	**N/A**
9	Percentage of patients that would recommend our service to friends and family if they needed similar care or treatment	**94%**	**86.70%**	**86.90%**	**87.20%**	**86.58%**	**85.51%**

Notes on selected Metrics

4. Data for CPA seven day follow-up is taken from the Trust's patient systems and is aligned to the national definition
5. The percentage of clinical audits of NICE Guidance completed is based on the number of audits of NICE guidelines completed against the number of audits of NICE guidelines planned. Data for this metric is taken from audits undertaken by the Clinical Directorates supported by the Clinical Audit Team
6. Data for average length of stay is taken from the Trust's patient systems

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 **2019/20** position was **62.39%** which relates to **1777** out of **2848** surveyed. This is **25.61%** below the Trust target of **88.00%.**

All localities underperformed this year. **Durham and Darlington** was closest to the target with **64.81%** and **Teesside** was furthest away with **57.14%**

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

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

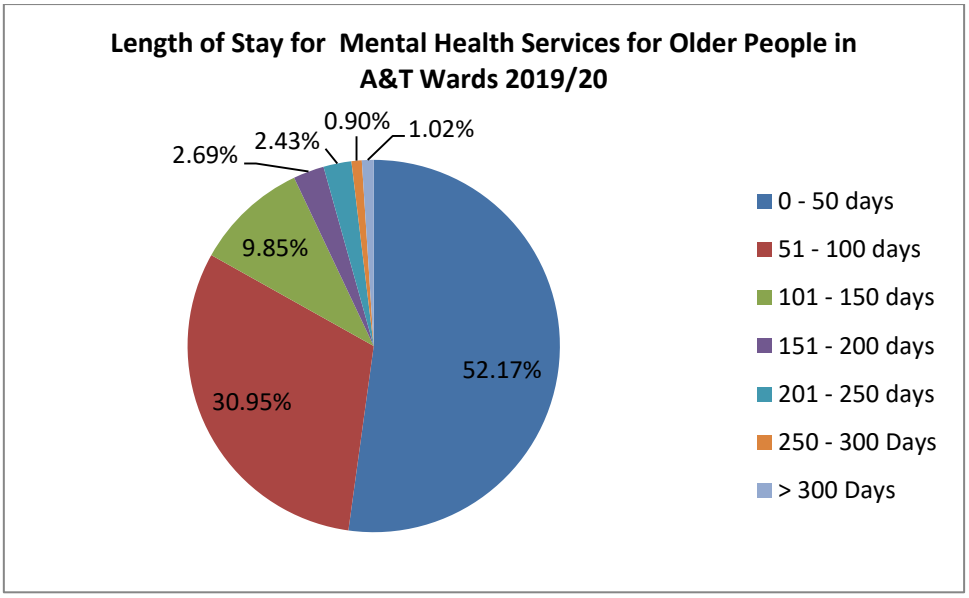
The end of **2019/20** position was **30.45;** which relates to **7625** interventions and **250426** OBDs; this is **11.19** above the Trust target of **19.25**.

Teesside were the only underperforming locality with a rate of **71.63** (**43.87** when CYPS Tier 4 are removed) this is attributed to complex patients both at West Lane Hospital and Bankfields Court. Of the localities that achieved the target, **Durham and Darlington** had the lowest number of incidents with **14.95** and Forensic Services the highest with**18.51.**

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

The average length of stay for older people has been worse than target since Quarter Three 2013/14 reporting **66.84** days as at end of **2019/20**. This is **14.84** worse than target but remains comparative to the position reported in 2018/19. The pie chart over the page shows the breakdown for the breakdown for the various lengths of stay during 2019/20.

The median length of stay was **49** days, which is 3 days better than the target of 52 days and demonstrates that the small number of patients who had very long lengths of stay have a significant impact on the mean figures reported.



The length of stay of patients (for both adults and older people) is closely monitored by all services within the Trust. The reasons for the increase in average length of stay for patients are due to a small number of patients who were discharged after a very long length of stay, which has skewed the overall average. In total (Adults and MHSOP) **80.97%** of lengths of stay were between 0-50 days, with **12.93%** between 51-100 days. There were 50 patients who had a length of stay greater than 200 days; the majority were attributable to the complex needs of the patients (including physical health problems) and delays in accessing suitable placements for patients subsequent to discharge.

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

The end of **2019/20** position was **91.65%** which relates to **14171** out of **15467** surveyed. This is **2.35%** below the Trust target of **94.00%.**

All localities underperformed against the target in 2019/20. **Teesside** were closest to the target with **92.72%** and **Forensic Services** was performing furthest away from the target at **86.70%.**

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

The end of **2019/20** position was **85.80%** which relates to **12451** out of **14512** surveyed. This is **8.2%** below the Trust target of **94.00%.**

All localities underperformed in 2019/20. **Teesside** were closest to the target with **88.14%** and **Forensic Services** were furthest away from the target with **81.61%.**

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

The end of **2019/20** position was **86.70%** which relates to **16292** out of **18791** surveyed. This is **7.3%** below the Trust target of **94.00%.**

All localities underperformed in 2019/20. Durham and Darlington were closest to the target with **88.27%** and **Forensic Services** were furthest away from the target with **79.68%.**

Our Performance against the Single Oversight Framework Targets and Indicators

The following table demonstrates how we have performed against the relevant indicators and performance thresholds set out in the NHS Oversight Framework2019/20 Annex 2, released in August 2019.

Single Oversight Framework

Indicators		2019/20		2018/19	2017/18	2016/17	2015/16	2014/15
		Threshold	Actual	Actual	Actual	Actual	Actual	Actual
A	Percentage of people experiencing a first episode of psychosis that were treated with a NICE approved care package within two weeks of referral*	**56%**	**77.53%**	**64.89%**	**73.32%**	**70.04%**	**55.91%**	**N/A**
B	Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in inpatient wards*			**92.00%**	**92.50%**			
C	Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in early intervention in psychosis services*			**91.55%**	**91.00%**			
D	Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in community mental health services (people on CPA)*			**78.00%**	**74.39%**			
E	IAPT/Talking Therapies – proportion of people completing treatment who move to recovery (from IAPT minimum dataset)	50%	**48.83%**	**51.29%**	**50.44%**	**48.32%**	**N/A**	**N/A**
F	Percentage of people referred to the IAPT programme that were treated within six weeks of referral	75%	**96.49%**	**97.91%**	**95.49%**	**95.44%**	**84.01%**	**N/A**
G	Percentage of people	95%	**99.84%**	**99.73%**	**99.89%**	**99.14%**	**95.93%**	**N/A**

	referred to the IAPT programme that were treated within 18 weeks of referral							
H	Percentage of patients on Care Programme Approach who were followed up within seven days after discharge from psychiatric inpatient care	>95.00 %	**97.56%**	**97.31%**	**96.52%**	**98.35%**	**97.75%**	**97.42%**
I	Admissions to adult facilities of patients who are under 16 years old		**0**	**0**	**1**	**N/A**	**N/A**	**N/A**
J	Inappropriate out of area placements (OAPs) for adult mental health services		**2367**	**874**	**1913**	**N/A**	**N/A**	**N/A**
K	Data Quality Maturity Index (DQMI) – Mental Health Services Data Set Data Score		**98.2**					

Notes on the Single Oversight Framework Targets and Indicators

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

Where available historic information shown for 2013/14 has been taken from the Board of Directors Dashboard report or the Monitor/Single Assessment Framework report at year end

*These metrics were not carried forward to form part of the NHS Oversight Framework, released in August 2019

Metric E: IAPT/Talking Therapies – proportion of people completing treatment who move to recovery (from IAPT minimum dataset)

Since August 2019 IAPT recovery rate has performed below target, only reporting above standard in February 2020. Whilst a number of CCGs did report an underperformance in some months, all areas in Durham and Darlington consistently performed below target. During this period, an action plan was agreed and implemented with commissioners and all three CCG areas reported improvements in the final three months of the year.

Metric I: Inappropriate out of area placements for Adult Mental Health Services

Out of area placements have reported above standard since January 2020, prior to which the standard had been achieved. The deterioration in performance was linked to increases in the bed occupancy levels. Specific work is being taken forward with regards to bed management as part of the Right Care Right Place Strategic

Programme and an action plan has been developed to try to ensure we proactively manage bed usage across the organisation.

Metric K: Data Quality Maturity Index (DQMI) – Mental Health Services Data Set Data Score

This measure was introduced as part of the Operational Performance Metrics in August 2019 and reported below the national standard for the first three months of the year. However, significant improvement work has been undertaken in line with the Commissioning for Quality and Innovation requirements and the Trust has reported consistently above standard since July 2019.

External Audit

Due to the COVID-19 pandemic, the external audit of the 2019/20 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. In producing the Quality Account 2019/20, we have tried to improve how we involved our stakeholders in assessing our quality in 2019/20.

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

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

[To add]

In line with national guidance, we have circulated our draft Quality Account for 2019/20 to the following stakeholders:

- NHS England
- North East Commissioning Support
- Clinical Commissioning Groups (x4)
- Local Authority Overview & Scrutiny Committees (x8)
- Local Authority Health & Wellbeing Boards (x9)
- Local Healthwatch Organisations (x8)

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

The following are the general themes received from stakeholders in reviewing our Quality Account for 2019/20:

[To add]

The Trust will write to each stakeholder addressing each comment made following publication of the Quality Account 2019/20 and use the feedback as part of the annual lessons learnt exercise in preparation for the Quality Account 2020/21.

APPENDICES

Appendix 1: 2019/20 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 2019/20 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 2019 to May 2020
    - Papers relating to quality reported to the Board over the period April 2019 to May 2020
    - Feedback from the Commissioners dated **[To add]**
    - Feedback from Governors dated **[To add]**
    - Feedback from local Healthwatch organisations dated **[To add]**
    - Feedback from Overview and Scrutiny Committees dated **[To add]**
    - Feedback from Health and Wellbeing Board dated **[To add]**
    - 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 14th February 2020
    - The latest national staff survey published 21st November 2019
    - The Head of Internal Audit's annual opinion over the Trust's control environment dated 19th June 2020
    - CQC inspection report dated 3rd March 2020

- 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:

24th September 2020……Chairman

24th September 2020……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 Services/Autistic Spectrum: This describes a range of conditions including autism, Asperger's Syndrome, Pervasive Developmental Disorder not Otherwise Specified (PDD-NOS), Childhood Disintegrative Disorder and Rett Syndrome, although usually only the first three conditions are considered part of the autism spectrum. These disorders are typically characterised by social deficits, communication difficulties, stereotyped or repetitive behaviours and interests, and in some cases cognitive delays

Benefits: This term is often used when describing and measuring the positive and negative (disbenefits) elements of a project or programme of work

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 Link Pathway (CLiP): a multidisciplinary management tool based on evidence-based practice for a specific group of patients with a predictable clinical course, in which the different tasks (interventions) by the professionals involved in the patient's care are defined, optimised and sequenced using the Trust's electronic patient record system (PARIS)

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-produced: 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

Directorate: TEWV's Corporate Services are organised into a number of directorates – Human Resources and Organisational Development; Finance and Information; Nursing and Governance; Planning, Performance and Communications; Estates and Facilities Management

Early Intervention in Psychosis (EIP): A clinical approach to those experiencing symptoms of psychosis for the first time. The approach centres on the early detection and treatment of symptoms of psychosis during the formative years of the psychotic condition. The first three to five years are believed by some to be a critical period. The aim is to reduce the usual delays to treatment for those in their first episode of psychosis. The provision of optimal treatment in these early years is thought to prevent relapses and reduce the long-term impact of the condition

Executive Management Team (EMT): 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

Experts by Experience: Non-contracted roles, to offer story-telling input into trainer and provide the opportunity to gain a broader perspective of lived experience views on a range of services developments. Experts by Experience have been trained to work alongside the Recovery Team to develop and delivery Recovery-related training and supporting staff and service developments in Recovery-related practice. Experts by Experience work with Trust staff, they do not work with patients and carers (i.e. they are not acting in a peer role)

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: Aims to prevent and reduce the myriad of harms associated with the use of psychoactive drugs in the community

Health and Wellbeing Boards: The Health and Social Care Act 2012 established health and wellbeing boards as a forum where key leaders from the health and care system (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

Healthcare Safety Investigation Branch: Undertakes investigations of accidents which have happened within the NHS

Health of the Nation Outcome Score (HoNOS): A way of measuring patients' health and wellbeing. It is made up of 12 simple scales on which patients with severe mental illness are rated by clinical staff. The idea is that these ratings are stored, and then repeated – for example, after a course of treatment or other intervention – and then compared. If the ratings show a difference, this might mean that the patient's health or social status has changed

Health Services Journal (HSJ): A peer-reviewed journal that contains articles on health care

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 Care Partnerships: An emerging NHS initiative to encourage integration and place-based planning

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

Intensive Home Treatment: See Crisis Resolution and Home Treatment Team above

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

Kaizen: A word used as part of the Quality Improvement System (QIS) process; it is a Japanese word that means 'change for the better' and is also known as 'continuous improvement'

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

Liaison & Diversion: A process whereby people of all ages with mental health problems, a learning disability, substance misuse problems and other vulnerabilities are identified and assessed as early as possible as they pass through the youth and criminal justice systems

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

Locality: Services in TEWV are organised around three localities (Durham and Darlington, Teesside and North Yorkshire & York). Forensic Services are not organised on a geographical basis, but are often referred to as a fourth 'Locality' within TEWV

Locality Management and Governance Board (LMGB): A monthly meeting held in each locality (see above) that involves senior managers and clinical leaders who work in that Locality and take key decisions

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

Ministry of Defence: The British government department responsible for implementing the defence policy set by Her Majesty's Government and is the headquarters of the British Armed Forces

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 Digital: Previously known as the Health and Social Care Information Centre (HSCIC) and set up as an executive non-departmental public body in April 2013, sponsored by the Department of Health. It is the national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care

NHS Improvement (NHSI): The independent economic regulator for NHS Foundation Trusts – previously known as Monitor

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 Patient Survey: Annual survey of patients' experience of care and treatment received by NHS Trusts. In different years has focused on both inpatient and community patients

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)

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

PARIS: The Trust's electronic care record, 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

Patient Safety Group: The group monitors on a monthly basis the number of incidents reported, any thematic analysis and seeks assurances from operational services that we are learning from incidents. We monitor within the group any patient safety specific projects that are ongoing to ensure milestones are achieved and benefits to patients are realised

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

Perinatal Mental Health Service: A service for any woman with mental health problems who is planning a pregnancy, is pregnant, or has a baby up to one year old

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

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

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

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

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

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

RAG rated: A measuring tool used to measure progress against a specific action; e.g. green if it has been achieved and red if it has not. Some scales also use amber ratings to indicate where an action has been delayed but will still be completed

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.

Recovery Approach: A new approach in mental health care that goes beyond the past focus on the medical treatment of symptoms, and getting back to a 'normal' state. Personal recovery is much broader and for many people it means finding/achieving a way of living a satisfying and meaningful life within the limits of what is personally important and meaningful, looking at the person's life goals beyond their symptoms. Helping someone to recover can include assisting them to find a job, getting somewhere safe to live and supporting them to develop relationships

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

Recovery College Online: An initiative that allows people to access Recovery College materials and peer support online (see above). This is available to service users and staff in all areas served by TEWV
Recovery Strategy: TEWV's long-term plan for moving services towards the Recovery Approach *(see above)*

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

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

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

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

Specialties: The term that TEWV uses to describe the different types of clinical services that we provide (previously known as Directorates). The Specialties are Adult Mental Health Services, Mental Health Services for Older People, Children and Young People's Services and Adult Learning Disabilities

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

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

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

TEWV: Tees, Esk and Wear Valleys NHS Foundation Trust

TEWV Quality Improvement System (QIS): The Trust's framework and approach to continuous quality improvement based on Kaizen/Virginia Mason principles

Tier 4 Children's Services: Deliver specialist inpatient and day patient care to children who are suffering from severe and/or complex mental health conditions that cannot be adequately treated by community CAMHS services

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

Transitions: For the Transitions Quality Account priority we define a transition as a purposeful and planned process of supporting young people to move from Children's to Adult Services

Trauma-Informed Care: Involves understanding, recognising and responding to the effects of all types of trauma

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

Year (e.g. 2019/20): These are financial years, which start on the 1st April in the first year and end on the 31st March in the second year

Appendix 3: Key themes from action plans produced in response to 184 Local Clinical Audits in 2019/20

Audit Theme	Key quality improvement activities associated with clinical audit outcomes
1. Infection Prevention and Control (IPC)	• 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 by the Clinical Audit and Effectiveness Team via the clinical audit action monitoring database • A total of **118** clinical audits were conducted during 2019/20 in inpatient areas in the Trust; **90% (106/118)** of clinical areas achieved standards between 80%-100% compliance. Local clinical audit action plans were implemented in collaboration with the IPC team and the clinical team members to mitigate all areas of non-compliance • Clinical audits have been undertaken to assess compliance with Hand Hygiene standards, Mattress Assessments and a monthly Essential Steps audit which is completed in inpatient areas. Actions taken in response to these areas include removal and replacement of relevant mattresses and promotion of correct procedures regarding hand hygiene
2. Medicines Management	• An annual review of Clozapine Initiation Checklist was developed. This took into account current guidelines and was publicised via the Trust Pharmacy newsletter • The Pharmacy Leadership Team has considered appropriate options for monitoring GP records in terms of Clozapine prescribing which includes a Task and Finish Group to improve organisation and relevant communication • The Trust psychotropic monitoring guidelines have been amended to include a section for assessment of monitoring side effects including extrapyramidal side effects, weight, sexual side effects and menstrual irregularities • The Trust developed and distributed guidance on side effect monitoring scales for antipsychotic medications • Further promotion of local antipsychotic medication monitoring spreadsheets will be undertaken for all services • The Trust amended the Controlled Drugs Register to clearly explain the process for making corrections to the register and the regular Controlled Drugs newsletter encouraged regular actual measurements of Controlled Drug liquids to be undertaken as opposed to visual checks • The Trust reviewed and adapted the electronic initiation/discontinuation proforma used for patients prescribed lithium. There are mandatory field options for pre-initiation tests and further options to support monitoring for those patients identified on established lithium treatment. The Pharmacy Team will be reviewing options for pathology laboratories to check calcium/bone chemistry as default on all samples received for lithium levels and will be developing an annual review checklist/GP communication sheet for those prescribed lithium

3. Records Management	• The Eating Disorders Teams have publicised to all staff the requirements in relation to Safeguarding referral documentation • Services have been promoted to complete consistent documentation of outcomes, and to use the PAMIC (Parental Adult Mental Health Impact on Children). Tool has been facilitated through a Safeguarding Toolkit illustrating information regarding procedures and how to complete the documentation • The Trust Safeguarding Team has developed a document guide for staff to support when formal best interests meetings are held and how these should be managed and recorded • Clinical audits have been undertaken to support Health and Justice Prison Services which have facilitated new standardised care plan documentation. Regular care plan spot check audits have been put in place to allow consistent local monitoring
4. Service Provision	• Following the National Clinical Audit of Psychosis (NCAP) spotlight audit in EIP Services, there have been developments within the North Yorkshire and York Locality to agree Individual Placement Support (IPS) service provision as well as to identify a plan to deliver Family Interventions
5. Physical Healthcare	• Promotion of available e-ELCA (End of Life Care for All) resources was completed across the Trust in response to the National Audit of Care at End of Life • A Diabetes Working Group was established to review current guidelines and to clarify what is required upon admission, diagnosis and annual review. The working groups also reviewed the essential training requirements and updated Trust guidelines; including advice for when to monitor ketones, standards for intervention planning, and the management of hypoglycaemia • A standard process for physical health monitoring for under 18 year olds was agreed following the National Clinical Audit of Psychosis Spotlight Audit in EIP Services • A Standard Process Description was developed and embedded across all services illustrating the process for completing current patient Physical Examination sheets • Clinical Audit work has facilitated key quality improvement activities relating to the physical health of patients with severe mental illness (SMI). Work is ongoing on developments to ensure that all groups of service users who experience SMI are included • Clinical Audit has supported the implementation of the Nutritional Screening Tool 'SANSI' across all inpatient areas • Clinical Audit has evidenced key quality improvements for compliance with the Emergency Response bag equipment and associated daily monitoring
6. Policy and Pathway Developments	• It was identified following clinical audit findings that an amendment was required to the Trust Claims Management Policy. This is scheduled to be completed to clarify that the Claims and Legal Services Manager should provide comments on liability to NHS Resolution within six to eight weeks of the receipt of the claim • Following clinical audit findings, the Serious Incident Policy is undergoing further review relating to the process

	involved when reviewing moderate harms • The Children and Young Person specific Was Not Brought (WNB) flowchart and procedure were updated within the Trust Did Not Attend (DNA) Policy • The Challenging Behaviour MHSOP Clinical Link Pathway will be updated following clinical audit findings to provide clearer guidance on the need for debrief, the manner in which debrief should take place, and the evidence that should be recorded
7. Supervision	• There is an ongoing specialist contract requirement which involves undertaking an audit for specialist services to establish the duration of clinical supervision which staff have received (with a target of a minimum of two hours per quarter and relevant formal one-to-one clinical supervision sessions). Local actions have been progressed within Locality Performance Improvement Groups in collaboration with Team Managers and Modern Matrons • Clinical Audit has facilitated documentation of supervision requirements within Health and Justice, Prison and Liaison and Diversion Teams. This is being enhanced Trust-wide through recording of all types of supervision sessions electronically from October 2019 • Recommendations have been made to consider changes to Governed Psychological Therapy (GPT) supervision • Promotion has been completed to reiterate key supervision requirements associated with Safeguarding Children Supervision and the need to document appropriately where relevant sessions could not be facilitated
8. Transitions from CAMHS to AMH	• The Trust has participated in the NHSI Improving Healthcare Transition Collaborative and clinical audit data has been used to demonstrate significant improvements, including increasing the focus on the quality of transition plans in place. Key actions undertaken included understanding the barriers experienced throughout the transition process, clarifying what is required for staff and responsiveness reporting of key quality indicators. Developments were progressed with improving the number of '5P' formulations and the transition plans in place for young people prior to discussion at the transition panels. The learning from this collaborative approach will be expanded upon and rolled out across the Trust
9. Systems Development	• Services have been working in collaboration with Information Services to enhance the Trust electronic patient record system and clinical audit results have demonstrated improvements to be considered. Examples of developments associated with this include considering centile charts for relevant physical health parameters, self-harm assessment template developments and embedding a clozapine initiation checklist
10. Training	• The Safeguarding Adults Level 2 Training package has been adapted to place increased emphasis on Making Safeguarding Personal and the process that surrounds this from the outset of training • The Trust Behavioural Clinical Link Pathway (CLiP) Lead will be delivering training with identified trainers to individual MHSOP Liaison Teams to support Behaviour Support Plan training • The Mental Health Legalisation Team continue to provide bespoke face-to-face training for individual

	teams/staff groups where requested and identified a need around implementation of the Mental Capacity Act. Requirements for MCA were incorporated into clinical supervision in relation to caseloads for staff and training needs identified and addressed • Changes have been made to the Safety Summary/Harm Minimisation Training as well as e-learning documentation • Specific bespoke training has been provided for staff relating to adherence with the Trust Search policy and the Safe and Secure Handling of Medicines in Crisis Teams

Appendix 4: Trust Business Plan additional Priorities

The Quality Improvement priorities set out in Part 2 of this Quality Account document are also included in the Trust's Business Plan (in which they are priorities 14-17). The other priorities in the Business Plan will all have a positive impact on the quality of Trust services, and are listed in the table below.

No	Title	Lead	To conclude by	Strategic Goal
	OVERARCHING PRIORITIES			
O	Implement a recovery-focussed approach across all services	Medical Director	22/23 Q4	1
	STRATEGIC PRIORITIES			
1	Develop and implement a trauma-informed care approach across our services	Medical Director	22/23 Q4	1
2	Ensure we deliver the right services in the right place	Chief Operating Officer	tbc	2
3	Ensure we have the right staffing for our services now and in the future	Director of Nursing and Governance	22/23 Q4	3
4	Make a Difference Together by ensuring TEWV is an organisation where everyone values each other and feels valued	Chief Executive	21/22 Q4	3
5	Deliver our Digital Transformation Strategy	Director of Finance and Information	Currently 20/21 Q4 but new strategy in development	5
6	Identify and reduce waste	Chief Executive	ongoing	5
	OPERATIONAL PRIORITIES			
7	Develop a new Children and Young People's inpatient model	COO	tbc	4
8	Complete the transformation of services in North Yorkshire and York	DoO (NY&Y)	Tbc when Selby proposals developed and agreed	1
9	Implement the Transforming Care agenda	COO	ongoing	4
10	Develop and implement a Trust-wide approach to enabling people who have autism to access mental health services	Medical Director	20/21 Q4	1
11	Improve the physical environment at Roseberry Park Hospital	Director of Finance and Information	24/25 Q1	1
12	Relocate the Redcar CYP team	DoO (Tees)	20/21 Q3	1
13	Implement the NHS Long Term Plan for Mental Health as agreed with each of our commissioners	DoOs	ongoing	4
	QUALITY ACCOUNT PRIORITIES			
14	Reduce the number of preventable deaths	Director of Nursing and Governance	20/21 Q4	2
15	Increase the proportion of inpatients who feel safe on our wards	COO	20/21 Q4	2
16	Introduce personalised care planning	Director of Nursing and Governance	20/21 Q4	2
17	Improve CYP to AMH transitions	Director of Nursing	20/21 Q4	2

		and Governance		
	ADDRESSING CQC'S INSPECTION FINDINGS			
18	Implement TEWV's CQC Action Plan within the agreed timescales	Director of Nursing and Governance	20/21 Q3	2

Shortly after this Business Plan was agreed, the Trust had to concentrate all of its resources onto our response to the Covid-19 pandemic. This has led to significant delays to the implementation of our Business Plan. As a Trust, we also intend to consider what we have learnt from the NHS response to the pandemic and so we expect to review and revise our plans for 2020/21 and beyond during Autumn 2020

Appendix 5: Quality Performance Indicator Definitions

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

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

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

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

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

Exemptions:

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

Accountability:

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

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

- Performance against the RTT waiting-time element of the standard is being measured via MHSDS and UNIFY2 data submissions
- Performance against The National Institute for Health and Care Excellence concordance element of the standard is to be measured via:
    - A quality assessment and improvement network being hosted by the College Centre for Quality Improvement at the Royal College of Psychiatrists; all providers will be expected to take part in this network and submit self-assessment data, which will be validated and performance-

scored on a four-point scale at the end of the year. This assessment will be used to track progress against the trajectory set out in Implementing the Five Year Forward View for Mental Health: www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf

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

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

Data definition:

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

Exemptions:

All beds except for acute mental health care – Assessment and Treatment, Acute Older Adult Mental Health Care (Organic and Functional) Assessment and Treatment and PICU. The age range excludes anyone who is under 18 years

Percentage of patients who reported 'yes, always' to the question 'Do you feel safe on the ward?'

Data definition:

Percentage of patients who answer 'yes, always' to the question on the FFT 'Do you feel safe on the ward?'

Exemptions:

There are no exemptions for this indicator

Accountability:

QuAC and Patient Safety Group

Numerator:

The actual percentage of patients who answer 'yes, always' to this question

Denominator:

The total number of responses to this question

Appendix 6: Feedback from our Stakeholders

[To add]