Tees, Esk and Wear Valleys
NHS Foundation Trust

Quality Account 2021/22

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Part One: Introduction & Context

What is a Quality Account?

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

What are the aims of the Quality Account?

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

Who reads the Quality Account?

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

What information can be found in the Quality Account?

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

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

Structure of this Quality Account document

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

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

A Profile of the Trust

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

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

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

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

Our Quality Account. Quality Governance and Quality Issues

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

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

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

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

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

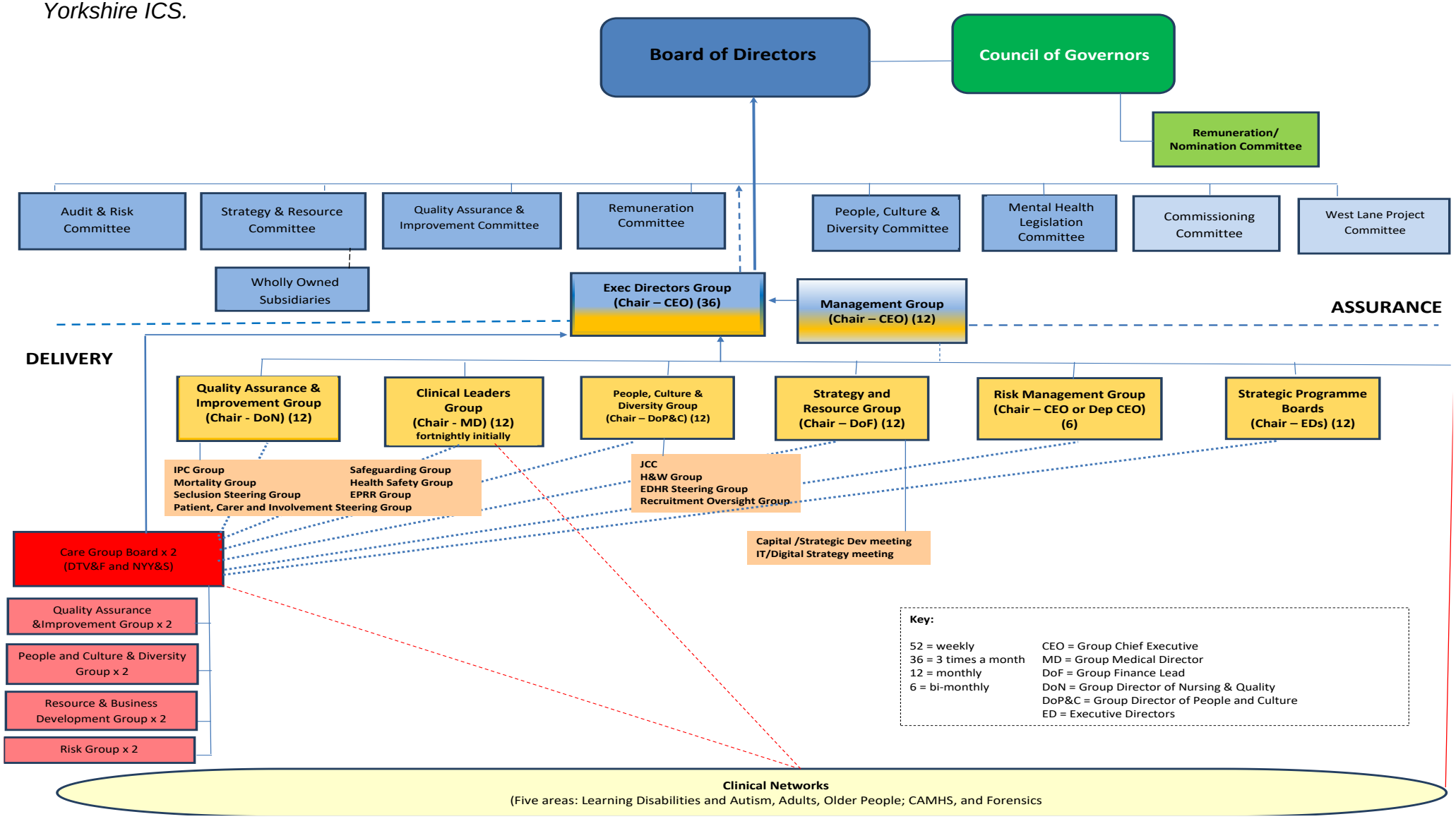
The new structure is shown in ***Figure 1*** the next page. However, the data and commentary contained in this document were produced using the governance structures and processes in place prior to April 2022. The key features of this were that In line with our previous Clinical Assurance Framework the review of data and information relating to our services was undertaken monthly by the relevant Quality Assurance Group (QuAG) for each service. A monthly report is produced for each QuAG which includes information on:

- **Patient Safety:** Including information on incidents, serious incidents, levels of violence and aggression, infection prevention and control and health and safety
- **Clinical Effectiveness:** including information on the implementation of NICE guidance and the results of clinical audits
- **Patient Experience:** Including information on patient satisfaction, carer satisfaction, the Friends and Family Test (FFT); complaints; and contact with the Trust's patient advice and liaison service (PALS)
- **Care Quality Commission:** Compliance with the essential standards of safety and quality, and the Mental Health Act

Figure 1: Summary of the Trust Journey to Change

Figure 2: Trust Governance from 1st April 2022

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



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

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

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

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

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

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

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

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

The CQC also highlighted positive practice in the report including:

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

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

Issues that the CQC found in their inspection included:

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

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

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

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

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

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

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

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

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

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

A full statement of Director's responsibilities in respect of the Quality Account is included in **Appendix 1.** I hope you find this report interesting and informative.

If you would like to know more about any of the examples of Quality Improvement or have any suggestions on how we could improve our Quality Account, please contact:

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

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

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

What we have achieved in 2021/22

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

Trust achievements in 2021/22 include:

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

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

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

National Awards – Won or Shortlisted

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

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

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

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

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

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

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

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

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

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

Our Progress on implementing our 2021/2022 Quality Improvement Priorities

Priority One: Making Care Plans more personal

Why this is important:

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

Feedback from service users shows that our current approach to Care Planning does not always promote a personalised approach, hence this being identified as a priority in 2021/22.

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

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

What we did in 2021/22:

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

How do we know we have made a difference?

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

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

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

Priority Two: Safer Care

Why this is important:

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

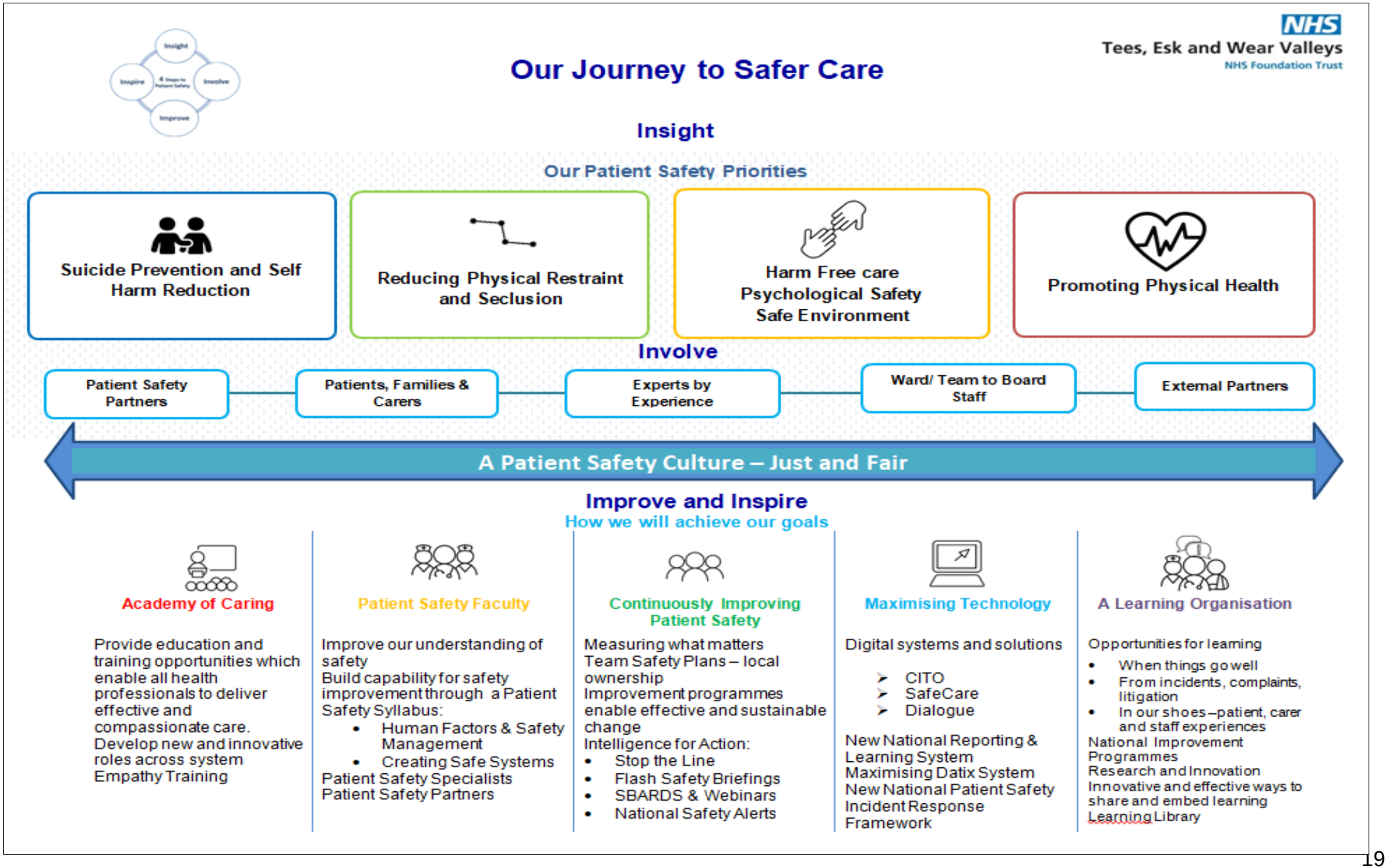
- Suicide prevention and self-harm reduction
- Reducing physical restraint and seclusion
- Promoting harm-free care, improving psychological and sexual safety (allowing staff and patients to speak out safely by fostering an open and transparent culture), providing a safe environment
- Promoting physical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

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

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

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

Figure 3: Our Journey to Safer Care



What we did in 2021/2022:

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

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

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

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

How do we know we have made a difference?

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

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

Priority Three: Compassionate Care

Why this is important:

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

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

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

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

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

What we did in 2021/22:

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

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

How do we know we have made a difference?

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

Quality Improvement Priorities for 22/23

Developing the Priorities

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

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

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

Priority One: Care Planning

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

What we will do	When we will complete it by

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

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

How will we know we are making things better?

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

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

Priority Two: Feeling Safe

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

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

How will we know we are making things better?

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

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

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

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

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

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

How will we know we are making things better?

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

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

Monitoring Progress

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

Conclusion and links to the next section of this document

Pages 16 to 28 have explained:

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

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

TEWV's 2021 Community Mental Health Survey Results

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

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

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

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

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

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

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

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

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

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

The areas where service user experience is best are:

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

The areas where service user experience could improve are:

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

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

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

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

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

TEWV's 2021 National NHS Staff Survey Results

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

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

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

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

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

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

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

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

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

Areas where the Trust scored low compared to national average:

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

Areas where the Trust scored better than the national average:

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

Review of Services

During 2021/22 the Trust provided and/or subcontracted **20** relevant health services. The Trust has reviewed all the data available to them on the quality of care in **20** of these relevant health services.

The income generated by the relevant health services reviewed in 2021/22 represents **100%** of the total income generated from the provision of relevant health services by the Trust for 2021/22.

Participation in clinical audits and national confidential inquiries

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

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

During 2021/22, TEWV participated in **100% (seven out of seven)** of the national clinical audits and **100% (three out of three)** of national confidential inquiries which it was eligible to participate in.

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

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

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

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

The national clinical audits and national confidential inquiries that TEWV participated in, **and for which data collection was completed during 2021/22** are listed below alongside the number of cases submitted to each audit or inquiry as a percentage of the number of registered cases required by the terms of the national audit or inquiry.

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

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

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

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

In addition to those local clinical audits reviewed (i.e., those that were reviewed by our Quality Assurance Committee and Clinical Effectiveness Group), the Trust undertook a further **72** clinical audits in 2021/22 which include clinical effectiveness projects undertaken by Trainee Doctors, Consultants, or other Directorate/Specialty Groups. These clinical audits were led by the services and individual members of staff for reasons of service improvement and professional development and were reviewed by specialities. Over the next year the Trust intends to use clinical audit applications to make clinical audits more efficient and to make it easier for teams to review their clinical quality information in a live format and to make any changes needed to improve practice and ultimately the quality of care and experience of our patients and their families.

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

Participation in Clinical Research

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

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

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

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

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

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

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

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

What the Care Quality Commission (CQC) says about us

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

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

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

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

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

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

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

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

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

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

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

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

Improvement Plan

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

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

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

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

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

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

Information Governance

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

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

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

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

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

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

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

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

The Trust has the following policies linked to data quality:

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

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

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

Freedom to Speak Up

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

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

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

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

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

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

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

Reducing Gaps in Rotas

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

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

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

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

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

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

Bolstering staffing in adult and older adult community mental health services

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

Examples of service improvements enabled by additional staffing include:

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

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

Learning from Deaths

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

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

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

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

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

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

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

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

The following were Learning Disability Deaths (reported to LeDer)

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

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

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

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

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

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

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

Recurring themes relate to:

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

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

Practice Development Group (PDG)

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

Organisational Learning Group (OLG)

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

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

Patient Safety Priorities

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

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

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

Suicide Prevention and Harm Minimisation

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

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

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

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

Harm-Free Care – Safe Environment

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

Promoting Physical Health

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

Safeguarding

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

Serious Incident Investigation Process

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

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

Better Tomorrow Programme

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

Training

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

Clinical Strategy

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

Patient Safety Specialist

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

The definitions used by the Trust are as follows:

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

PALS and Complaints

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

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

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

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

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

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

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

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

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

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

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

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

Introduction to Part 3

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

Mandatory Quality Indicators

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

Care Programme Approach 72-hour follow-up

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

Crisis Resolution Home Treatment team acted as gatekeeper

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

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

The figures we have included are from the CQC website

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

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

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

Patient Safety incidents including incidents resulting in severe harm or death

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

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

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

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

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

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

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

Our performance against our quality metrics

The Quality Account has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report. The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report

Quality Metrics 21/22

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

Notes on selected Metrics

1. Data for CPA 72-hour follow-up is taken from the Trust's patient systems and is aligned to the national definition
2. The percentage of Quality Account audits of NICE Guidance completed is based on the number of audits of NICE guidelines completed against the number of audits of NICE guidelines planned. Data for this metric is taken from audits undertaken by the Clinical Directorates supported by the Clinical Audit Team
3. Data for average length of stay is taken from the Trust's patient systems

Comments on areas of under-performance

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

The end of **2021/22** position was **64.37%** which relates to **402** out of **625** surveyed. This is **23.63%** below the Trust target of **88.00%.** All localities underperformed this year. Durham & Darlington was closest to the target with 67.66% and Forensic Services was furthest away with 59.31%

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Quality Metrics for 2022-23

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

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

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

Our Performance against the System Oversight Framework Targets and Indicators

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

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

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

Notes on the System Oversight Framework Targets and Indicators

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

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

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

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

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

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

External Audit

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

Our Stakeholders' Views

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

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

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

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

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

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

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

APPENDICES

Appendix 1: 2021/22 Statement of Director's Responsibilities in respect of the Quality Account

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

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

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

- The content of the Quality Account/Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2021/22 and supporting guidance

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

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

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

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

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

controls are subject to review to confirm that they are working effectively in practice

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

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

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

By order of the Board:

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

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

Appendix 2: Glossary

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

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

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

Board/Board of Directors: The Trust is run by a Board of Directors made up of the Chairman, Chief Executive, Executive and Non-Executive Directors. The Board is responsible for ensuring accountability to the public for the services in manages. It is overseen by a Council of Governors and monitored by NHS Improvement. It also:

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

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

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

Care Planning: See Care Programme Approach (CPA)

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

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

Children and Young People's Services (CYPS): Mental Health Services for children and young people under the age of 18 years old. This includes community mental health services, inpatient services and learning disability services

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

Clinical Commissioning Groups (CCGs): NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England. CCGs are clinically led groups that include all GP practices in their geographical area. The aim of this is to give GPs and other clinicians the power to influence commissioning decisions for their patients. CCGs are overseen by NHS England

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

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

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

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

Confidential Inquiry: A national scheme that interviews clinicians anonymously to find out ways of improving care by gathering information about factors which contributed to the inability of the NHS to prevent each suicide of a patient within its care. National reports and recommendations are then produced

Co-production/Co-creation: This is an approach where a policy or other initiative/action is designed jointly between TEWV staff and service users, carers, and families

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

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

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

Data Protection and Security Toolkit: A national approach that provides a framework and assessment for assuring information quality against national definitions for all information that is entered onto computerised systems whether centrally or locally maintained

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

Department of Health: The government department responsible for Health Policy

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

Forensic Adult and Mental Health and Learning Disability Services: Work mainly with people who are mentally unwell or who have a learning disability and have been through the criminal justice system. The majority of people are transferred to a secure hospital from a prison or court, where their needs can be assessed and treated

Formulation: When clinicians use information obtained from their assessment of a patient to provide an explanation or hypothesis about the cause and nature of the presenting problems. This helps in developing the most suitable treatment approach

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

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

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

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

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

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

Health and Wellbeing Boards: The Health and Social Care Act 2012 established health and wellbeing boards as a forum where key leaders from the health and care system (i.e., Local Authorities and the NHS) would work together to improve the health and wellbeing of their local population and to reduce health inequalities. Health and wellbeing board members collaborate to understand their local community's needs, agree priorities, and encourage commissioners to work in a more joined-up way

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

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

Hospital Episode Statistics (HES): The national statistical data warehouse for England of the care provided by NHS hospitals and for NHS hospital patients treated elsewhere. HES is the data source for a wide range of healthcare analysis for the NHS, Government and many other organisations and individuals

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

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

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

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

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

Local Authority Overview and Scrutiny Committee: Statutory committees of each Local Authority which scrutinise the development and progress of strategic and operational plans of multiple agencies within the Local Authority area. All Local Authorities have an OSC that focusses on Health, although Darlington, Middlesbrough, Stockton, Hartlepool and Redcar and Cleveland councils have a joint Tees Valley Health OSC that performs this function

Mental Health Act (1983): The main piece of legislation that covers the assessment, treatment, and rights of people with a mental health disorder. In most cases when people are treated in hospital or in another mental health facility they have agreed or volunteered to be there. However, there are cases when a person can be detained (also known as sectioned) under the Mental Health Act and treated without their agreement. People detained under the Mental Health Act need urgent treatment for a mental health disorder and are at risk of harm to themselves or others

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

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

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

National Institute for Clinical Excellence (NICE): NHS body that provides guidance sets quality standards and manages a national database to improve people's health and to prevent and treat ill health. NICE works with experts from the NHS, local authorities, and others in the public, private, voluntary and community sectors – as well as patients and carers – to make independent decisions in an open, transparent way, based on the best available evidence and including input from experts and interested parties

National Institute for Health Research (NIHR): An NHS research body aimed at supporting outstanding individuals working in world class facilities to conduct leading edge research focused on the needs of the patients and the public

National Reporting and Learning System (NRLS): A central (national) database of patient safety incident reports. All information submitted is analysed to identify hazards, risks, and opportunities to continuously improve the safety of patient care

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

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

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

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

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

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

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

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

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

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

Prescribing Observatory in Mental Health (POMH): A national agency led by the Royal College of Psychiatrists, which aims to help specialist mental health services improve prescribing practice via clinical audit and quality improvement interventions

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

Project: A one-off, time limited piece of work that produces a product (such as a new building, a change in service or a new strategy/policy) that will bring benefits to relevant stakeholders. Within TEWV, projects will go through a scoping phase, and then a Business Case phase before they are implemented, evaluated, and closed down. All projects will have a project plan and a project manager

Psychiatric Intensive Care Unit (PICU): A unit (or ward) that is designed to look after people who cannot be managed on an open (unlocked) psychiatric ward due to the level of risk they pose to themselves or others

Quality Account: A report about the quality of services provided by an NHS Healthcare Provider, the report is published annually by each provider

Quality Assurance Committee (QuAC): Sub-Committee of the Trust Board responsible for Quality and Assurance

Quality Assurance Groups (QuAG): Locality/divisional groups within the Trust responsible for Quality and Assurance

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

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

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

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

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

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

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

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

Serious Incident (SI): An incident that occurred in relation to NHS-funded services and care, to either patient, staff, or member of the public, resulting in one of the following – unexpected/avoidable death, serious/prolonged/permanent harm, abuse, threat to the continuation of delivery of services, absconding from secure care

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

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

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

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

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

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

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

TEWV: Tees, Esk and Wear Valleys NHS Foundation Trust

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

The Trust: see TEWV above

Trust Board: See Board/Board of Directors above

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

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

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

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

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

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

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

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

Appendix 4: Feedback from our Stakeholders

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