Quality Account 2022/23

Part one

1.1 Welcome to the Quality Account and its purpose

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 achieving our quality goals.

It also looks forward to the year ahead and defines what our priorities for quality improvement will be and how we expect to achieve and monitor them.

The aims of the Quality Account

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

Who reads the Quality Account?

Lots of different people read the Quality Account. Some are people who we support through our services, their loved ones, colleagues, 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 improvement 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 the Quality Account

The structure of this Quality Account is in line with guidance 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 2022/23, our priorities for improvement in 2023/24 and the required statements of assurance from the Board
- **Part 3:** Further information on how we have performed in 2022/23 against our key quality metrics and national targets and the national quality agenda

1.2 Chief Executive's statement on quality

Welcome to our Quality Account 2022/23. It sets out the quality of our services highlighting our achievements and where we must continue to make progress.

High quality patient care is the core of what we do every day and goes hand in hand with our unrelenting focus on patient safety and clinical excellence.

Our priorities are clear:

- improvements in patient safety supported by a positive culture
- safe, kind and compassionate care informed by evidence with outcomes that matter
- empowering patients and carers to be equal partners and help address barriers in care
- co-creating holistic, responsive and integrated models of care
- supporting people to be active members of their community
- being inclusive, trauma-informed and recovery-focused
- a skilled workforce supported to provide high quality care

You will read more about Our Quality Journey in this report and our commitment to a great experience for patients in our care and for patients and carers who want to work with us for better mental health in our region. Indeed, much of our focus now is working within communities, alongside our partners, to support people to get help early on and close to home – all part of the community mental health framework.

Nationally and regionally, organisational changes to the NHS mean we are closely linked with the two Integrated Care Boards that cover our patch. We'll continue to build these partnerships to benefit the health and wellbeing of people living in our areas.

While we are making progress, we continue to see unprecedented demand for services and recognise the impact that the pandemic continued to have last year on patients, carers and colleagues – a picture reflected nationally.

I must also acknowledge the publication of the independent reports into the tragic deaths of three young women in our care and the safety and quality of children and adolescent mental health inpatient provision at West Lane Hospital in Middlesbrough in 2019/20. They remind us we must remain fully committed to being a listening organisation and putting patient and carer experience at the heart of everything we do.

The reports make it clear that at the time of the tragedies there were shortfalls in care and leadership – both of which have changed significantly during the last three years. This includes our new governance structure, embracing patient and carer experience and using their insights to continually improve, as well as our unrelenting focus on patient safety – all underpinned by Our Journey to Change.

We welcomed the Care Quality Commission into our services with inspectors acknowledging that improvements are being made following inspections of our children and adolescent mental health community service and our secure inpatient services.

In October 2022 we acted quickly on concerns raised about our adult learning disability and autism wards to make the positive changes that were needed.

You will see in this report the awards that colleagues have won and been shortlisted for – it is testament to the hard work and commitment of individuals and teams who I am proud to work alongside. I witness people living our values of compassion, respect and responsibility every single day to deliver safe and kind care to those we support.

As we move into the new financial year, we will continue to put quality and safety above all else, working with patients and carers and our partners to support people in our region to live their best possible lives.

Brent Kilmurray
Chief Executive
30 June 2023

1.3 About our Trust

We are the mental health and learning disability NHS foundation trust for more than 2 million people living across County Durham and Darlington, Teesside, North Yorkshire, York and Selby. We provide a range of inpatient and community mental health, learning disability and eating disorders services.

We are also a catchment area for the largest concentration of armed forces personnel in the UK – Catterick Garrison – and our adult inpatient eating disorder services and adult secure (forensic) wards serve the whole of the North East and North Cumbria.

From education and prevention, to crisis and specialist care – our talented and compassionate teams work in partnership with patients, communities and partners to help the people of our region feel safe, understood, believed in and cared for.

We nurture the recovery journey of people in our care. Patients and carers have a say in how they are supported and treated because we know how important it is to listen and treat people as individuals. Our patients, their families and carers work together with us towards better mental health.

We also provide mental health care within prisons, and an immigration removal centre, located in the North East, Cumbria and parts of Lancashire.

Around 7,800 staff work across more than 90 sites, including Foss Park, a state of the art 72-bed hospital and research space in York which opened in 2020.

On 1 April 2022 our new leadership and governance structure came into effect with the creation of two Care Group Boards – one covering Durham, Tees Valley and Forensic services and one for North Yorkshire, York and Selby.

Our new organisational and governance structure:

- Simplifies governance processes – this gives nurses and other healthcare professionals more time to care, supports clinical teams to make decisions with the people they care for and makes it easier for everyone to understand their role and responsibilities.
- Strengthens reporting from teams through our two new care groups directly to our Trust Board.
- Embeds increased line of sight and oversight from ward to Board

We deliver care under six clinical directorates across our Care Group Boards:

- Adult mental health services
- Mental health services for older people
- Children and young people's mental health services
- Learning disabilities
- Health and justice
- Secure inpatient services

1.4 Our Journey to Change

Everything we do is guided by Our Journey to Change and our values. Our Journey to Change sets out where we want to be and how we'll get there. It includes our goals that we co-created with patients, carers, colleagues and partners:

- To co-create a great experience for our patients, carers and families.
- To co-create a great experience for our colleagues
- To be a great partner

"I've found that the staff members who I've worked with have been keen to hear our views and include us in decision making.

"I'm optimistic that TEWV's new way of co-creating services, which relies on developing trust, relationships and equalising power, can and will improve lives.

"It will take time and require much reflection but is an exciting journey to be on. Everyone needs to feel that their experiences are important and that they are valued."
Ros, carer

1.5 Co-creation

We're embracing patient and carer experience and using their insights to continually improve; working in close partnership with patients, families and carers to provide the best possible experience and outcomes. We also work in partnership with our partners and regulators to ensure we understand what good looks likes so we bring meaningful change to the care we provide.

We refer to this partnership-style of working as co-creation.

It is at the heart of Our Journey to Change and is fundamental to how we improve the care we provide to the communities we serve.

We want this to run through everything we do, so that it becomes the normal way of doing things from:

- Care plans written in partnership, where patients and families have choice about their care and make shared decisions with their clinician.
- A thriving and diverse involvement community that supports co-creation across all areas of our Trust from policy to research, recruitment to quality improvement.
- A growing and diverse peer workforce across all services, underpinned by peer values and driven by peer leadership.
- Innovative and diverse methods to really hear the experience of all patients and families and understand the relationship between patient experience, complaints and serious incidents.
- Lived experience leadership roles supporting transformation and culture change. By lived experience we mean people who have experience of mental illness as a patient or carer and who are using their experiences and insights to help others.

We are making progress. We recruited two lived experience directors into our leadership team in 2022 to make sure the patient voice is heard at the very highest level in the organisation.

A number of our trainers have experience of mental illness and are supporting staff to put themselves in the shoes of both patients and their families so that we show true empathy in the care we deliver.

We also employ peer support workers, who have lived experience of mental illness either themselves or as a carer.

"To me, being a peer is about being your authentic self; and that is enough. Having lived experience and using that experience to build meaningful relationships is making a difference to people's lives, to my own life too. The validation you stir up when someone knows you really get it is so rewarding and really helps to form mutual relationships with people which is the key to people feeling empowered. When someone is empowered – look out world!"
Rachel, peer worker

Examples of co-creation and lived experience in action

- CAMHS team in Northallerton are working on a newspaper with young people about mental wellbeing.
- The crisis team have co-produced information for young people who are accessing intensive home treatment.
- A Mental Health Older Peoples Service User and Carer Participation Group have been involved in many projects and service developments.
- Our Tees Valley Community Mental Health Transformation lived experience board members have guided the programme that is now working with partners to develop community hubs.
- We have worked with carers to develop a carers' hub – a one stop shop for people who have a loved one in our services, providing a range of support and information.
- The learning disability shadow quality assurance group in North Yorkshire continue to enhance governance in this area.
- Stockton Occupational Therapy Community Team have worked with patients and colleagues to design and grow the Ideal House allotment, transforming it into a calming green space.

1.6 Involvement member story

A veteran and one of our involvement members is using his skills to help develop our services and has also created paintings for patients and staff to enjoy.

Veteran Bob Etherton signed up to the army in 1959 and became a special operator in the Royal Corps of Signals as well as joining the regiment's band as a piper. Serving in Germany, Singapore, Borneo, Cyprus, Australia and the Falkland Islands, to name a few, he had many adventures and a rewarding and progressive career until his retirement in 1992.

When Bob spent time in our care, he was approached to become a Trust involvement member, and now works with us to help develop our services.

"I thought I'd give it a try," said Bob, "I knew it would be challenging, but I was able to draw on my army experience. I take part in workshops, focus groups, meetings, interview boards and much more that has all been positive experiences. My contributions are valued as are those of other service users and carers and working with the Trust has very much helped my recovery and personal development.

"I also found a talent for art, painting and drawing and it's something I find most therapeutic. I wanted to pay tribute to the wonderful life and 70 years of service of Queen Elizabeth II and create something that the patients and staff can enjoy."

Bob's paintings are on display at our mental health services for older people at Cross Lane Hospital in Scarborough and Foss Park Hospital in York.

1.7 The services we provide

We deliver care under six clinical directorates across our Care Group Boards:

- Adult mental health services
- Mental health services for older people
- Children and young people's mental health services
- Learning disabilities
- Health and justice
- Secure inpatient services

There is further detail about our Trust and the services we deliver in section 1.3.

1.8 Our CQC ratings

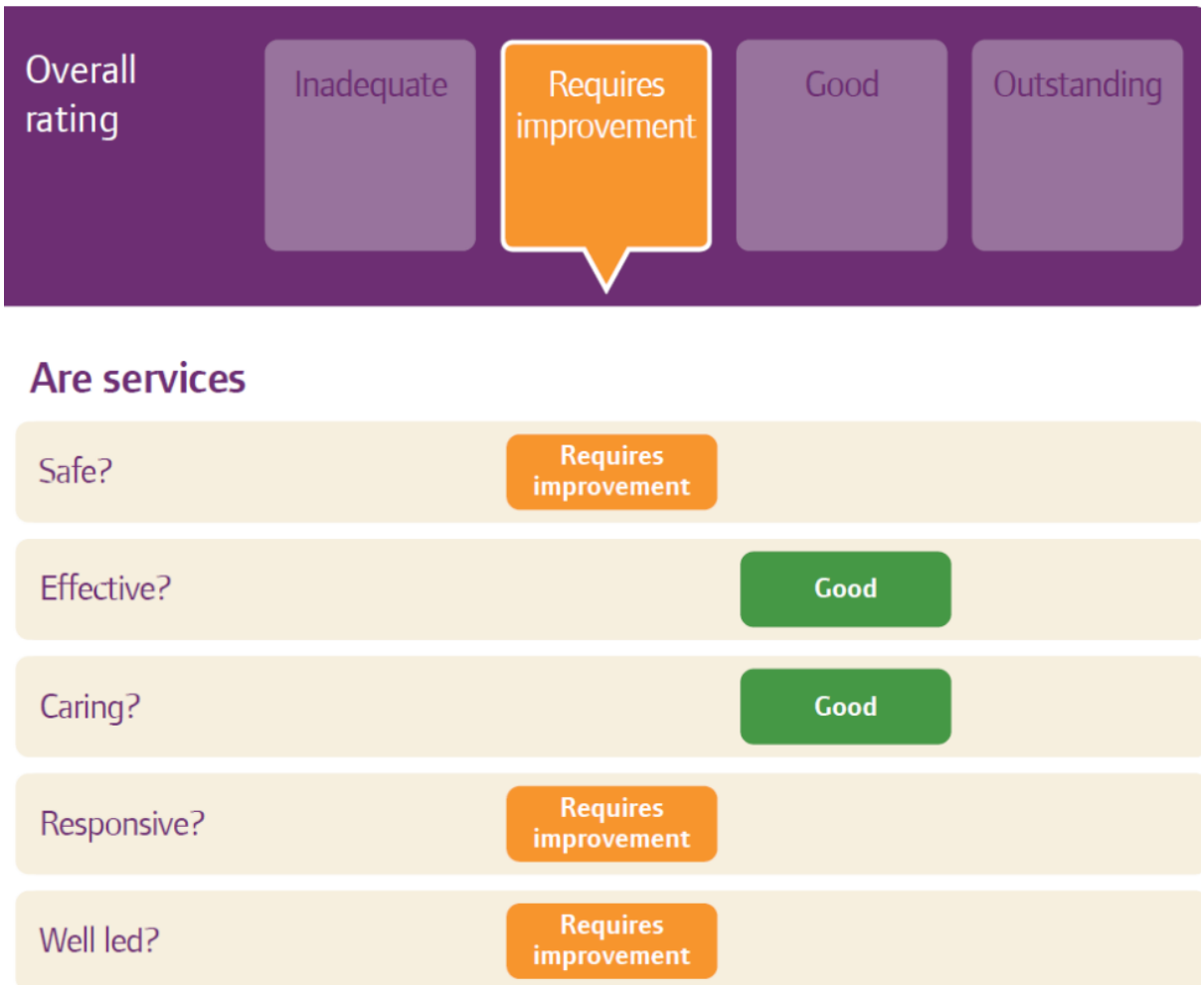
The CQC's current ratings for our Trust overall and for each key domain is as follows:

Overall rating: Requires improvement

For each key domain our Trust is rated:

- Safe: Requires improvement
- Effective: Good

- Caring: Good
- Responsive: Requires improvement
- Well-led: Requires improvement



Further information can be viewed within section 2.13, What the Care Quality Commission (CQC) says about us.

1.9 What we have achieved in 2022/23

We're making progress on our goals and working together to deliver a great experience for patients, carers and families, for colleagues and to be a great partner.

How we're co-creating a great experience for patients, carers and families

- £5m spent on making our wards safer since 2019, and almost £3m more planned in 2023.
- Waiting lists down by nearly 50% for children accessing mental health support.
- Carers Charter launched and being embedded in the Trust. It sets out our commitment to working with and supporting carers.

- Investing in our estates by opening a new community mental health hub in Northallerton and a new centre for young people in York.

- Installing innovative patient safety technology on some of our wards.

- Supporting members of the Armed Forces and showing our commitment to them by signing the Armed Forces Covenant.

- 46% more people helped to find work by our Individual Placement Service

- Putting patient experience at the heart of what we do.

- Peer support workers on our wards who are trained to use the knowledge and expertise that comes from their own lived experience of mental health services to support patients.

- Two lived experience directors bringing their own knowledge, understanding and compassion to the strategic leadership of our Trust.

"The team tried lots of different approaches and medications, and really listened to me."

"They were so helpful, so supportive, which helped me come out of myself a lot more."
James, patient, North Yorkshire

How we're co-creating a great experience for colleagues

- Recruiting 700 more staff since start of COVID in 2020.

- Introducing large scale recruitment events for healthcare assistants and nurses.

- We're on an international recruitment drive too.

- Streamlining our process making it quicker to recruit new people.

- Giving people a voice in our Trust by strengthening our staff networks.

- Investing in the health and wellbeing of our people.

- Introducing a staff awards and recognition scheme.

- Supporting teams to put patient experience at the heart of decision making.

"We have a really nice team. There is always somebody that you can check things with, that you can talk through issues with. It does feel like a big family really, where people look after each other and look out for each other."
Adele, Manager

How we're working with our partners

- More mental health nurses are working in GP surgeries across our region – supporting people to get the right help early on and close to home.

- 27 more schools are part of our mental health support programme helping young people and training teachers.

- Our innovative and world-class research team is part of a vital COVID-19 vaccine trial along with NHS partners and the University of York.

- Together with Hartlepool Borough Council we supported rough sleepers with their mental health.

- Our apprenticeship team has developed a strong partnership with Derwentside College to deliver a range of apprenticeship training to colleagues.

"They didn't need to take the partnership working approach they did but have chosen to. It's delivered a new and effective way of working."
Martin, Stockton Council

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

1.10 National awards – won and 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 table below.

Award body	Awarding status	Name / category of award	Team / individual
Health Watch Middlesbrough	Won	Leading Change Award	Tees Valley community mental health transformation lived experience members - Sophie Richardson, Michael Moorhouse and Sandra Bell
British Psychological Society's Division of Forensic Psychology	Won	Excellence in Forensic Psychology Practice Award	Alison Hodgson
Hull York Medical School Teaching Excellence	Shortlisted	Medicine Phase II and III Tutor of Excellence Award	Dr Meena Inasu, Dr Ioana Varvari and Dr Dan Whitney
Healthcare Financial Management Association (HFMA) - Northern Branch	Shortlisted	Accounting Technician of the Year	Emma Cruttenden and Laura Gittins
We Are NHS People	Won	NHS international HR Day	Michelle Lockwood

Hospitality Assured	Awarded	Covid Resilience Award - Premier Accreditation	Hotel services
British Institute of Learning disabilities (BILD)	Won	Positive Behavioural Support Coach of the Year	Steven Wilson
Nepacs' Ruth Cranfield Awards 2022	Won	Certificate of Excellence	Integrated Support Unit and PiPE team, HMP YOI Low Newton and TEWV
North of England Reserve Forces and Cadets Association	Awarded	Employer Recognition Scheme Silver Award 2022	Tees, Esk and Wear Valleys NHS Foundation Trust
Healthcare People Management Association	Shortlisted		Michelle Lockwood
LGBT Alliance	Awarded	Positive impact on LGBT Health	Roseberry Park
BBC Tees Making a Difference	Shortlisted	Together	Stephanie Addison
Northumbria in Bloom	Won	Best Grounds of a Hospital - Gold Award	Lanchester Road Hospital
Royal College of Nursing	Shortlisted	Commitment to Carers Award	Laura Blake
Positive Practise in Mental Health Awards	Won	Non-Clinical Team of the Year Mental health rehab and/or recovery Outstanding Leadership Forensic Mental Health Services (including Criminal Justice and Prisons)	Voluntary services team Recovery and outcomes support team Tom Hurst Cook healthy, eat, repeat ‘A recipe for a healthier lifestyle’
Positive Practise in Mental Health Awards	Highly commended	Complex Needs Mental Well-being of Workforce	Primrose Service - HMP & YOI Low Newton Employee support service

Royal Society for Public Health's prestigious Health and Wellbeing	Shortlisted	Arts and Health	York St John University - Converge
Nursing Times	Won	Nurse Leader of the Year	Judith-Marie Rose
Nursing Times	Shortlisted	Clinical Research Nursing	Nurses leading research
RC Psyche	Shortlisted	Psychiatric Team of the Year: Older-age adults	Mental health services for older people, inpatient organic service
Perinatal Quality Network (RC Psyche)	Awarded	Accreditation	Tees perinatal mental health team
Cavell Star	Won	Award	Suzanne Spence
Bright Ideas in Health Awards	Shortlisted	Cross-organisation Working to Deliver Research	Food Insecurity in Adults with Severe Mental Illness
Better Health at Work Awards	Awarded Awarded	Silver and Gold standard Bronze standard	Talking Changes IAPT service in Durham and Darlington Wellbeing team

Part 2: Quality priorities for 2022/23 and required statements of assurance from the Board

2.1 Introduction – purpose of this section

In part two of our Quality Account, we outline our planned quality improvement priorities for 2023/24 and provide a series of statements of assurance from the Board on mandated items, as outlined in the Detailed requirements for quality reports 2019/20 from NHSI.

In this section, we will also review the progress we have made in relation to the quality priorities we set ourselves in the 2022/23 Quality Account.

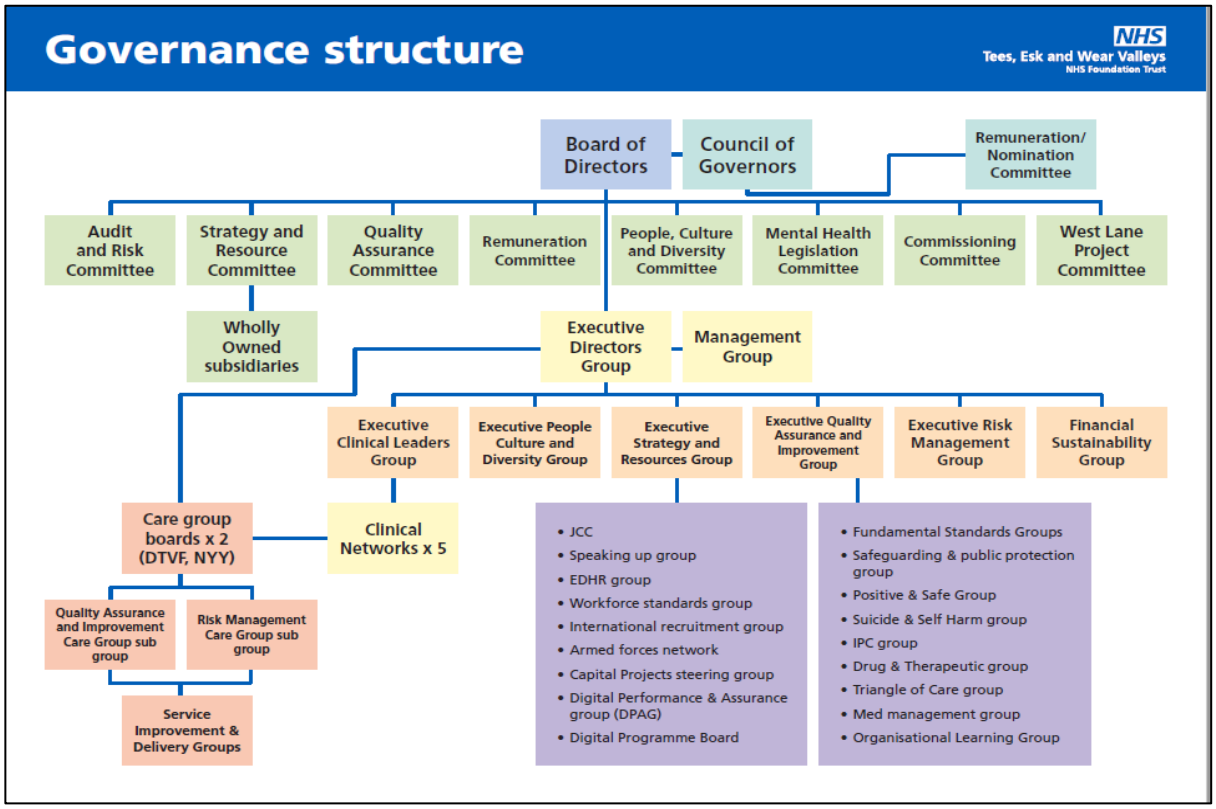
2.2 Our approach to quality governance and improvement

Our Trust has a robust governance infrastructure, with new arrangements put in place as part of the organisational restructure from 1 April 2022. The new governance structure is focused on enhanced oversight and accountability and is supported by the Trust's Accountability Framework.

Our new governance structure supports the delivery of Our Journey to Change by making sure we are:

- 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.

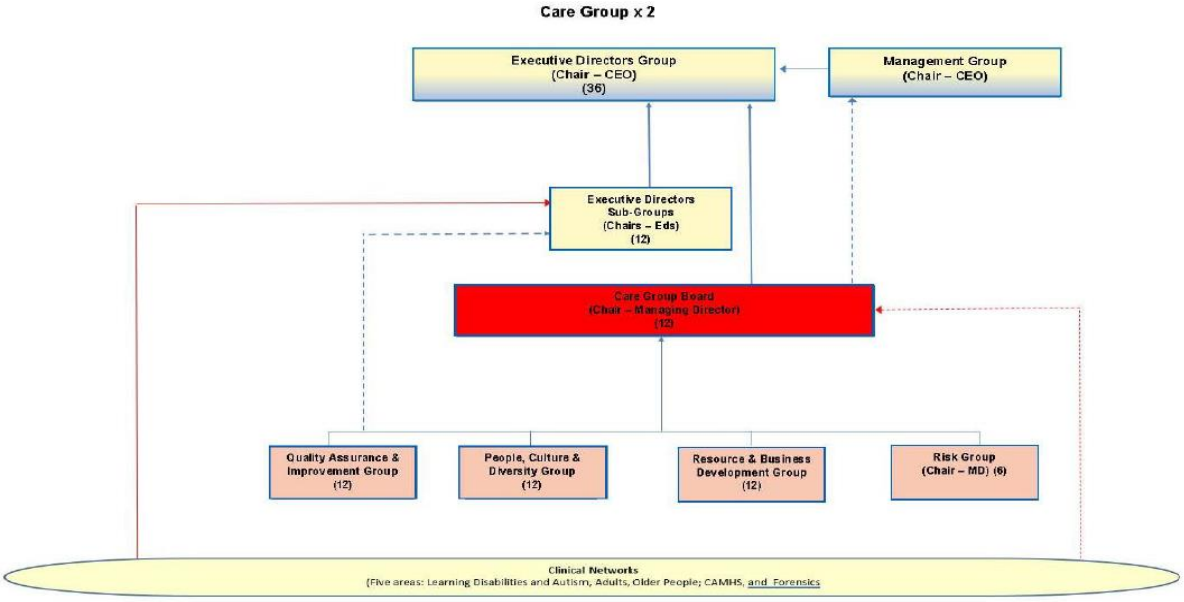
The new structures have been under review and evaluation to support us to provide safe, high quality, effective clinical services, and the best possible experience for people in our care, families and carers, our colleagues, and our partners. We continue to adapt and develop our governance process to achieve this aim. The structure in place during 2022/23 is shown in the figure below*.*



Our Trust Board ensures robust quality governance through the Quality Assurance Committee, a committee of the Board.

The Quality Assurance Committee is chaired by a non-executive director. Its strategic purpose is to provide assurance to the Board on the quality, safety and effectiveness of clinical and operational services through effective systems, structures and processes.

Each Care Group has quality governance arrangements to address the key elements of quality and safety. These are outlined in the figure below. Each Care Group reports directly to the Executive Quality Assurance and Improvement Group monthly, and to the Executive Directors Group weekly on quality performance issues that require executive oversight and/or escalation. Each Care Group is required to provide assurance to the Quality Committee against its quality improvement plans.



Quality Assurance and Improvement

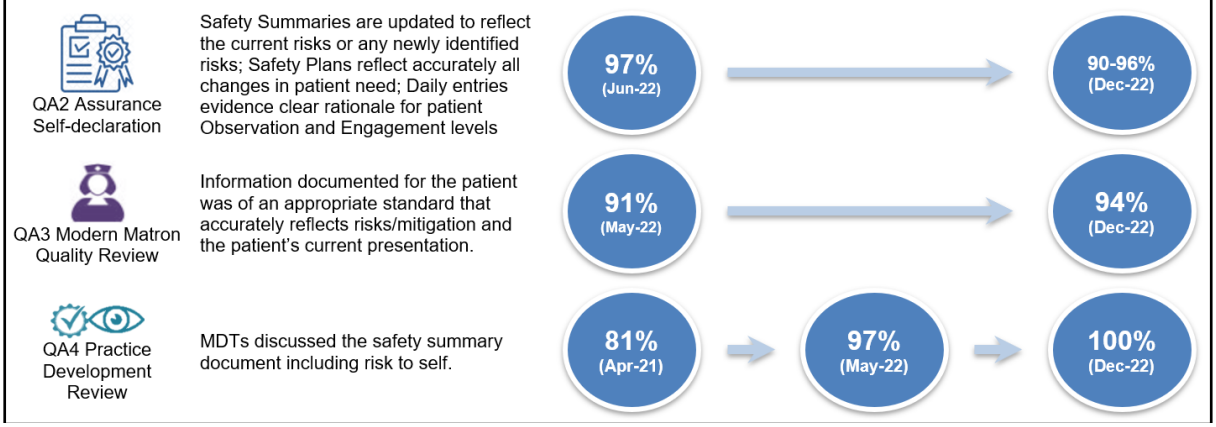
We have a well-established Quality Assurance and Improvement Programme which was first initiated in April 2021. This is focused partly on patient care documentation, recognising that high quality documentation is an enabler of high-quality patient care, as well as observation of practice and talking to teams in clinical areas.

The Programme comprises of a range of quality assurance tools that are used to gain a holistic assessment of the quality of patient care. These tools are subject to review to ensure they are informed by current areas of risks where further assurance is required.

- QA2: Assurance MDT self-declaration
- QA3: Modern matron quality review
- QA4: Practice development reviews
- QA5: Community Quality review
- QA6: Peer review
- QA7: MDT walkabout
- QA12: Directors visits

The Quality Assurance and Improvement Programme is an effective method of monitoring compliance against key standards of care related to patient safety, clinical effectiveness and patient experience. It has facilitated significant sustained practice improvements and provides the organisation with both quantitative and qualitative assurance evidence. Our Practice Development Practitioners continue to facilitate required practice improvements through supporting clinical staff via coaching, mentoring, education, and training.

Examples of Safety summary aspects indicating practice improvements from the QA programme – Quality Account



Key learning from incidents, patient surveys, complaints and other forms of intelligence helps to shape our Trust's quality improvement priorities and continues to be monitored using the Quality Assurance and Improvement Programme.

We have embedded an infrastructure and a range of approaches that support the delivery of high quality care and effective quality governance. Some examples are set out below:

- We have been using Quality Improvement (QI) since 2007 and, as a core element of Our Journey to Change, we will continue to use it in the future. Our QI approach gives people who access our services, who deliver our services and who partner with us to have a voice and to participate in QI activity to help make our Trust a great place to work and a great partner to work with, enabling people to live their best possible lives. Our dedicated Quality Improvement Team provides expertise and support across the Trust. To continue to build our capacity and capability QI training is provided at four different levels: foundation, intermediate, leader and expert.
- A wide range of staff training and development opportunities. We have implemented the National Patient Safety Syllabus at levels 1 and 2 as mandatory for all our staff.
- We have developed our training provision in relation to risk management and will be implementing a newly procured risk management system from July 2023 onwards. The system has a number of modules that provide digital solutions to incident reporting, risk registers, policies and procedures, complaints ad concerns, clinical audit and assurance and the CQC fundamental standards of care.
- Systems and structures that support organisation wide learning including rapid patient safety reviews, safety alerts, learning from serious incident bulletins and share and learn webinars.
- Working collaboratively with organisations on specific areas of practice and patient care e.g. sexual safety, implementing the HOPES model in adult learning disability services, suicide prevention and harm minimisation.

Co-creation is central to our overall approach. We work closely with patients, families and carers to identify and deliver our priorities. We are one of the first trusts nationally to create lived experience director roles for people with lived experience of mental illness and currently have two lived experience directors in post. These roles 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.

2.3 Our Progress on implementing our 2022/2023 quality improvement priorities

In this first section of Part 2, we look backwards at the progress we made in implementing our quality priorities during 2022/23 and the impact this had for patients and their families/carers. Following this, we set out our quality improvement priorities for 2023/24.

Priority 1 – Improving Care Planning

Why it is important:

In any health and social care organisation, care planning is a vital component of safe and effective patient care and treatment. In July 2021, NHS England published a formal statement advising all mental health trusts to move away from the Care Programme Approach (CPA) in favour of a community mental health framework. DIALOG+ as part of a wider piece of work, is the tool to enable the move away from CPA while providing a clear co-created, care plan for patients.

The DIALOG+ process approach allows healthcare professionals to have supportive and meaningful conversations with patients about the aspects of their lives that are most important to them such as family, relationships, leisure activities and accommodation, in addition to their mental and physical health. It uses a person centred and patient rated scale that measures patient reported outcomes as well as a measure of patient experience. The output of the DIALOG+ assessment will be a care plan that the patient and health professional create together that is specific, co-created and clear. The care plan will be digital easy to change and updated regularly as agreed with the service user.

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

- Personal circumstances, and what is most important to the person and those closest to them, are viewed as a priority when planning care and treatment.
- 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.
- Discussions that lead to shared decision-making and co-creation of meaningful care plans.
- Agreed plans recorded in a way that can be understood by the patients and everybody else that needs to have this information.
- Information about support from people who have experience of the same mental health needs.

What we said we would do and what we did:

Record all care plans on our new Cito electronic patient record (EPR) system
Due to unforeseen circumstances, we have not been able to go live with the Cito system as anticipated and this has prevented us from achieving this action. However, we are pleased to report that Cito will go live on 1 July 2023 which will enable us to meet our ambition of recording all patient care plans in this system from this point onwards.

Ensure all clinical staff are trained in our new DIALOG+ care planning system
This action was aimed at adequately preparing and training our staff in the use of the digital care planning tool DIALOG+. However, due to the delays in launching Cito, we have had to adapt our approach to preparation. We have introduced a paper-based version of DIALOG+ and have taken an incremental approach to its introduction. We have successfully

implemented this in adult mental health services and mental health services for older people supported by staff education and training. Roll out of the paper-based version is continuing and this will converge toward the one plan approach embedded within Cito. However, now that Cito online training has commenced, DIALOG+ training will start at the end of May 2023.

Publish new policies and procedures in relation to care planning and new ways of working (linked to Community Mental Health Framework)
This action is linked to system wide changes and is dependent on working with system wide partners to agree on the future approach. There have been several meetings with our senior leaders about how best to move away from the Care Planning Approach (for most services) and how this links to the wider community transformation of mental health services. Following an initial scoping meeting, a series of multiagency engagement events workshops are being held, the first took place in March 2023.

Introduce improvements to care planning in Secure Inpatient Services
Work started in October 2022 to move away from My Shared Pathway to goal based plans, in line with DIALOG+. A three-phase work programme was developed. Phase one focused on decluttering and organisation of current intervention plans, with a view of removing any duplication and also to assess if information would sit more suitably elsewhere such as within Safety Summary/Safety Plans.

A range of staff workshops have been held, led by the CPA lead and Practice Development Practitioners to facilitate this work. Good progress has been made. Currently approximately 75% of plans have transitioned to the new goal-based approach, with work continuing to complete the remainder. An assessment of the quality of care plans is being undertaken by the Practice Development Practitioner. Work will continue over the coming year to transition to the Cito based DIALOG+.

Update all patient and carer information resources about care planning
This has not yet been done but will be part of the work to move toward personalising care/advancing the CPA in our Trust that has started as this information should be co-created. Ideally this will be completed in conjunction with the autism project - at an event in 2022 it was agreed that if we made all information autism/neuro-divergent friendly then it would prevent the need to produce separate resources. It is worth noting that during 2022 getting inpatient services up and running with DIALOG+ and changing the approach to care planning in Secure Inpatient Services were the priority issues. In addition, the information available now is not wrong it just needs to be updated to be in line with system and culture changes.

Have data collection and monitoring systems in place to assess the impact of our clinical interventions on the goals set out in patient care plans
This work is directly linked to the Cito development, outcomes, and caseload management work that is ongoing. Cito has much improved data collection capabilities and has been designed so that care plan goals are at the front and centre of the system. DIALOG+ (badged as shared decisions in Cito) ensures that the process used to agree these goals is a personalised experience and that the goals are realistic and achievable. The measurement of the impact of the interventions against the goals will be via the DIALOG+ rating system, in conjunction with other outcome measures such as ReQoL-10 and GBO (or others for non adult mental health or mental health for older people services). All of this is against the backdrop of increasing communication and emphasis on the move toward a more interventionist approach that is expected as part of the wider community transformation and CPA position statement.

What was the outcome/impact:

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

Indicator	Target 2021/22	Actual 2021/22	Actual 2022/23
Patients know who to contact outside of office hours in times of crisis	84%	80%	78%
Patients were involved as much as they wanted to be in what treatments or therapies, they received	85%	85%	75%
Patients were involved as much as they wanted to be in terms of what care they received	85%	73%	73%
Percentage of patients who were involved as much as they wanted to be in the planning of their care	70%	75.53%	83%

Question	May 2022	March 2023
Inpatient		
Were you involved as much as you wanted in the planning of your care?	78%	74%
Were your family/carers involved in your care as much as you wanted?	81%	72%
Community		
Were you involved as much as you wanted in the planning of your care?	91%	92%
Were your family/carers involved in your care as much as you wanted?	84%	80%
Carer Survey		
Have you been asked to provide your experiences and history of the person you care for?	83%	84%
Do you feel that you are actively involved in decisions about the person you care for?	90%	88%

Priority 2 – feeling safe

Why it was important:
Patient safety continues to be our key priority. Our Quality Journey (the quality strategy) identifies a number of patient safety priorities that we will continue to focus on going forward.

Patients feeling safe on our inpatient wards is a key area for improvement for us. It is acknowledged nationally that some patients report not feeling safe while in the care of mental health services. A survey, undertaken in 2020 by the Parliamentary and Health Ombudsman, examined people's experiences of NHS mental health care in England, reporting that one in five patients reported feeling unsafe.

On a monthly basis patients on our wards are asked: do you feel safe on the ward?

The data from our survey is telling us that on average 56% of patients feel safe within our inpatient areas against a target of 75% which is frequently not met, however there is a lack of data nationally to allow any benchmarking comparisons to be made.

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

- Improved patient safety and reduction of patient harm.
- An increase in the percentage of our patients feeling safe when they are in an impatient setting.
- Increased collaboration between patients, staff, and peers.
- A reduction in incidents e.g. violence and aggression, absence without leave, drug misuse.
- Improved understanding of ward environments and why patients feel unsafe
- Increased opportunity to use digital technology to support the delivery of care

What we said we would do and what we did:

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

From the review undertaken we were able to identify the following themes:

- Environmental – missing bedroom keys, uncertainty around ward routine, doors banging, ward generally noisy, should feel homely.
- Staffing – patients value their relationships with staff, not enough staff around, staff are not always visible, lack of engagement from agency staff, staff don't feel safe due to low staffing, turnover of staff resulting in lack of consistent support, training of staff, lack of empathy, poor communication, staff sleeping whilst on duty, staff attitude.
- Ward based activities – should continue to be enhanced and there should be more productive use of courtyard areas.
- Patient safety – inadequate searches taking place on the ward, care planning, assessments not taking place in a timely manner, out of area admissions, medication reviews not being timely, sexual safety, assaults and patients being violent, dual diagnosis, timeliness of intervention and support, leave arrangements.
- Waiting times – for neurodevelopmental pathways, ADHD, ASD and autism assessments.
- Unsafe discharge – no care package in place, too early.
- Communication – patients not being able to get through to the team, calls not being returned, patients not being listened to, meeting the needs of the patient.
- Concerns being raised by MPs or via CQC rather than being reported directly to the Trust, repeated contacts from patients.

These themes have informed Our Quality Journey and further development of our Quality Assurance and Improvement Programme. In addition, the Patient and Carer Experience team (PaCE Team) have undertaken a series of focus groups between July 2022 and March 2023 across all inpatient wards. This was to understand what feeling safe means to our patients and staff and ask them what they feel would improve safety.

What did we ask patients and staff?

Patient questions

- What does feeling safe mean to you?
- During your stay on the ward have you felt safe?
- When you don't feel safe, what has caused this?
- What things help you when you don't feel safe?
- What does a safe day on the ward look like to you?
- When was the last time you felt safe?
- What was happening to make you feel like that?

Staff questions

- What does feeling safe mean to patients?
- During their stay on the ward have patients felt safe?
- When they don't feel safe what has caused this?
- What things help them when they don't feel safe?
- What does a safe day on the ward look like to you?

What patients said

- Peer support – talking to other patients on the ward.
- Staff support – getting reassurance from staff who listen and are adequately trained with the right skills and experience.
- Being able to easily identify staff members from patients.
- Being able to go to my bedroom when there are incidents on the ward.
- Accessing a place on the ward that is quiet.
- Listening to music, arts and crafts and access to the gym.
- Doing something productive, planting things looking after an allotment.
- PAT therapy animals on the ward.
- Doing activities, keeping myself occupied during the day.
- Being able to access leave, if I can't get out on my own having enough staff to escort me.

What staff said

- Access to patient alarms on the ward.
- Accessing one to one support and time with staff to offer them reassurance.
- Familiar faces and consistent staff on shift.
- Coping mechanisms and distraction techniques.
- Knowing the patients care plan, risks and offering debriefs when incidents happen.

Some of the things we have done in response to what our patients and staff have said:

Safe and visible staffing

- Introduced health care assistant and registered nurse councils to ensure that staff have a voice in our secure inpatient services.
- Introduced the SafeCare system (a nurse rostering system). This enables efficient allocation of staff and has inbuilt patient safety triggers to support patient safety.
- Improved the skill mix of staff on duty by investing in band 6 staff and recruiting advanced nurse practitioners and a positive and safe lead - this role focuses on adherence to best practice regarding restrictive interventions. There is also improved

clinical leadership through the introduction of practice development practitioners (PDPs) to support service improvement.
- Improved the continuity of care and safety on the wards by improving recruitment and retention within the service to provide consistent staffing.
- Invested in staff break areas to support wellbeing in the workplace.
- We are introducing an Agency Passport to improve competencies, training and induction of agency staff prior to them working on the wards.
- Supported block booking agency staff to ensure consistent staffing on the wards.
- Practice development practitioners are supporting improvements to the induction process for agency staff.

Patient leave
- Introduced a dedicated leave team to support patients to access leave.
- Patient access to leave is consistently discussed in the daily ward huddles

Patient activities
- An annual timetable of activities and health promotion activities has been produced and is offered across our secure impatient services.
- Recruited to a number of activity coordinators who work on our wards across a seven day week.
- Introduced pet therapy animals within some wards.
- Recruited gym instructors for both PICUs.
- Support from the arts at Foss Park Hospital and Cross Lane Hospital with projects, co-created with patients, that are creating a better environment.

Patient environment
- Improvements to Roseberry Park Hospital courtyard areas including decorating feature walls and installing new planters which are managed by activity coordinators on the wards.
- Allocated lifecycle funds to replace outside furniture.
- Improved the safety of the internal space by introducing heavy duty furniture onto wards. On some wards there is ongoing estates work to improve the ward environment with daily (ward managers) and weekly (matron) walkabouts to ensure issues are addressed.
- Installed anti-ligature doors within Tunstall ward.
- Continue to review the use of carpets in collaboration with the IPC team and acoustics have been considered as part of the Roseberry Park Hospital rectification works.
- A number of actions in place as part of the environmental ligature reduction work with regular reporting through estates and facilities management.

Each care group has developed a patient experience improvement plan that incorporates actions related to a range of patient feedback and includes those actions related to patients feeling safe on our wards. The plans are reported and monitored through the care group quality assurance meetings and reported for assurance to the Executive Quality Assurance and Improvement Group. This area of patient safety will continue as a priority over the coming year.

Increase the visibility of staff within adult inpatient areas

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Review of the ward clerk and administrative roles: The introduction of seven day a week administrative support to wards is supporting the provision of an increase in the clinical time available to clinical staff. The impact of these developments has increased the quality of care and patient safety within our Trust and also aims to improve staff wellbeing and retention.

Introduction of new roles: The introduction of peer support and activity workers on our wards increase engagement and improve meaningful and diversional activity on the wards.

Focus on reducing patient-on-patient violence through exploring further use of information technology solutions

A pilot of body worn cameras: Ten wards are testing the use of body worn cameras. The aim is to prevent violence on acute mental health wards by recording audio and video footage of interactions between staff and patients. This is based on evidence around the impact of their use on police and public behaviour. The aim of the initiative is to assess the impact on patient aggression.

As the pilot has progressed there has been a range of emerging challenges. These include IT issues and the need for additional training to further progress the pilot.

Wards and teams can then explore ways in which they can develop sustained local processes focused upon maintenance and reviewing footage. Although the prime expected benefit of this technology is a reduction in restraint, national studies have also suggested that incidents (which include patient-patient violence) should be reduced.

Oxevision: Oxevision is a tool that helps colleagues care for patients more safely and was developed in collaboration with patients. The system has been designed specifically for mental health care and includes a regulated medical device which operates with an infrared-sensitive camera. It helps staff visually confirm a patient is safe through measuring their pulse and breathing rate - without disturbing their sleep.

The evaluation of the Oxevision pilot has reported some positive outcome for patients to date as shown below. Our Trust has also supported a national review of the use of vision-based patient monitoring systems (VBPMS) in mental health wards and is disseminating the resulting guidance to relevant wards. Oxevision is being rolled out to further wards across our Trust following the success observed to date. This includes:

Improved safety on the wards

- Over 90% of staff reported Oxevision improves safety on the ward and helps them identify falls they may otherwise not have known about. 90% of staff reported the system enabled them to prevent potential incidents and 86% reported the system made it easier to monitor the physical health of patients.
- 83% of patients felt the system kept them safer and 88% felt that it allowed staff to respond to them more quickly.

Older adults (Rowan Lea ward)

- 16% relative reduction in falls in bedrooms when compared to the control ward
- 25 - 40% relative reduction in assaults across the bedroom and ward respectively when compared to the control ward.

Acute (Elm ward)

- 7% relative reduction in self-harm in bedrooms when compared to the control ward.
- Harmful self-harm in the bedroom had a relative reduction of 85% when compared to the control ward.
- Ligatures also had a relative decrease when compared to the control ward.

Psychiatric Intensive Care Units (Cedar ward)

- 25% reduction in self-harm in bedrooms compared to its baseline.

- 17% and 10% increase in assaults bedrooms and across the ward, respectively, compared to its baseline.

Improved patient experience

- 100% of patients felt the system reduced disturbance at night-time.
- 89% of patients felt that the system improved their wellbeing and 92% felt it enabled staff to care for them better.
- Patients felt the system helps them get better sleep (80%), gives them a greater sense of privacy (83%) and dignity (90%) and improved their relationship with staff (88%).

Positive impact on risk management and restrictive practice levels

- 90% staff reported that the system enables them to better manage patient risk.

Improved care quality

- 79% of staff reported that the system enables them to provide better care for patients.
- 72% of staff reported that the system provides them with more information to help make better care or clinical decisions.

Continue to implement the Safewards initiative (an evidence-based tool to reduce violence and support a safe ward environment)

Use of the Safewards model and its 10 core interventions remains a key part of our overall strategy for reducing restrictive interventions. Its implementation is documented within our policy for supporting behaviours that challenge and the annual Positive and Safe Report 22/23.

Each ward has identified champions for implementing the approach in their wards. Training on the Safewards model is included in our Restrain Reduction Network accredited courses and must be completed by all staff working across inpatient services.

All inpatient wards complete a Safewards self-assessment checklist each month. Compliance is shared and discussed via local Positive and Safe Groups each month.

Additional workshops for staff in champion or ward leadership roles are available each month for staff to focus upon specific ward implementation issues. We hold a Trustwide Safewards Sharing Practice Group every three months for ward staff to network and share good practice.

Wards can seek specific support regarding the Safewards model anytime through our Positive and Safe team.

What was the outcome / impact?

Indicator	Target	Actual 2021/22	Actual 2022/23
Percentage of inpatients who report feeling safe on our wards	75%	64.37%	56%
Percentage of inpatients who report that they were supported by staff to feel safe	66%	68.04	85%

Priority 3 - implementation of the new Patient Safety Incident Reporting Framework

Why it was important
The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

The PSIRF is a contractual requirement under the NHS Standard Contract and as such is mandatory for services provided under that contract, including acute, ambulance, mental health, and community healthcare providers. This includes maternity and all specialised services.

What we said we would do and what we did

- **Roll out the two-part incident approval process across all areas of our Trust. This involves operational staff taking responsibility for reviewing and approving incidents that have occurred within their service before submitting centrally.** Roll-out of this programme continues and 150 clinical areas have adopted the two-part approval of incidents. Significant training and staff support have been required to reach this point and we are closely monitoring progress with the approval of incidents. To facilitate this, daily reports are provided to services to enable them to have oversight of incident occurrence, stage of review and approval. Twice weekly sit rep meetings take place to enable strategic oversight and performance and weekly reports are provided to the Executive Directors Group.

- **Introduce a triage process for incidents that have been categorised as moderate and serious harm to quickly determine the appropriate route for review.** We have successfully implemented the incident triage process implemented

- **Develop the daily patient safety huddle to include service staff and subject matter experts so 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.** The Patient Safety Huddle is now embedded as routine practice and is operating effectively.

- **Improve our Serious Incident Review process so it is robust and uses evidence-based tools and involves families to the level of their satisfaction.** We have a continued focus on improving the quality of incident reporting, investigation, and identification of key learning. A strategic project manager, with additional support from the NHSE/I's System Improvement Team initially provided support for this workstream. Key improvements across the incident reporting and investigation pathway have been implemented incrementally and we continue to develop and embed these changes ensuring that they are compliant with the requirements of the National NHS Patient Safety Strategy and the PSIRF. This improvement workstream forms part of our key quality priorities within the Quality Journey and our Quality Strategy, with formal governance reporting routes in place. The Incident Reporting and Serious Incident Policy has also been fully reviewed and consulted upon. Further review of the policy is planned as PSIRF implementation progresses. PSIRF is to be fully implemented by 30 September 2023

- **Provide updates for staff on the duty of candour to ensure all have a full understanding.** As part of the improvement work related to learning from deaths, several training needs for staff Trustwide 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 Trustwide training needs analysis event.

An internal audit of the Duty of Candour Policy identified some areas for improvement. We have since reviewed the policy and updated it in line with current best practice to support staff understanding of the standards to be met. We have also held listening events to gain a better insight of staff understanding and application of the duty of candour. We will be using this to make improvement over 2023/24.

- **Improve the quality and oversight of action plans.** We continue to work on this improvement action. We have developed a standard action plan template for use across our Trust. However, the quality of some actions plans continue to be less than expected. We will continue to focus on this over the coming months.

- **Refresh the terms of reference for the Director Assurance Panels.** The Directors Assurance Panel terms of reference have now been revised and implemented. The function and performance of the review panel is under continual review to ensure continuous improvement.

2.4 Our Quality Journey

We focused on five areas to support Our Journey to Change. During 2022 we worked with patients, carers, partners and colleagues to create strategies – that we're calling journeys – to show what we will do and how each area will enable us to achieve Our Journey to Change.

The five journeys are:

- Clinical – how we will provide high quality, safe, kind, effective and personalised clinical care to the people we support
- Quality – how we will make our services safer and improve patient experience through evidence-based care
- Co-creation – how we will seek out and act upon the voices of the people we work with to improve care
- Infrastructure – how the places we work, such as our hospitals and offices, the equipment we use, the information we gather and the systems and processes we put in place will support excellent patient care
- People – how we will ensure everyone who works and volunteers with us has a great experience, whether they're permanent employees, people working as bank staff or through an agency, students or volunteers

The journeys set out specific ambitions and principles that support the mission, values and goals of Our Journey to Change and will drive both incremental and large-scale improvement initiatives. The journeys will be delivered through a series of programmes and workplans that make up our 2023/24 delivery plan.

The journeys create a strong framework and strategic vision that allow our Trust to prioritise key work. They will introduce rigour and support through a programme management approach and allow the Trust Board to receive assurance that we are making sufficient progress and achieving the outcomes and impact required.

Our Quality Journey sets out our quality ambitions for the next three to five years showing where we want our journey to take us. It sets out key principles and explains how our

objectives connect to the national NHS Patient Safety Strategy. It also outlines our key strategic quality objectives.

Our ambition is that by 2028, we will achieve the specific aims and measurable improvements set out in Our Quality Journey, through continuous learning and improvement using a range of tools and enablers. This Journey has been shaped by our other journeys; Clinical, Co-creation, People and Infrastructure.

We will continue to have an unrelenting focus on patient safety and are committed to:

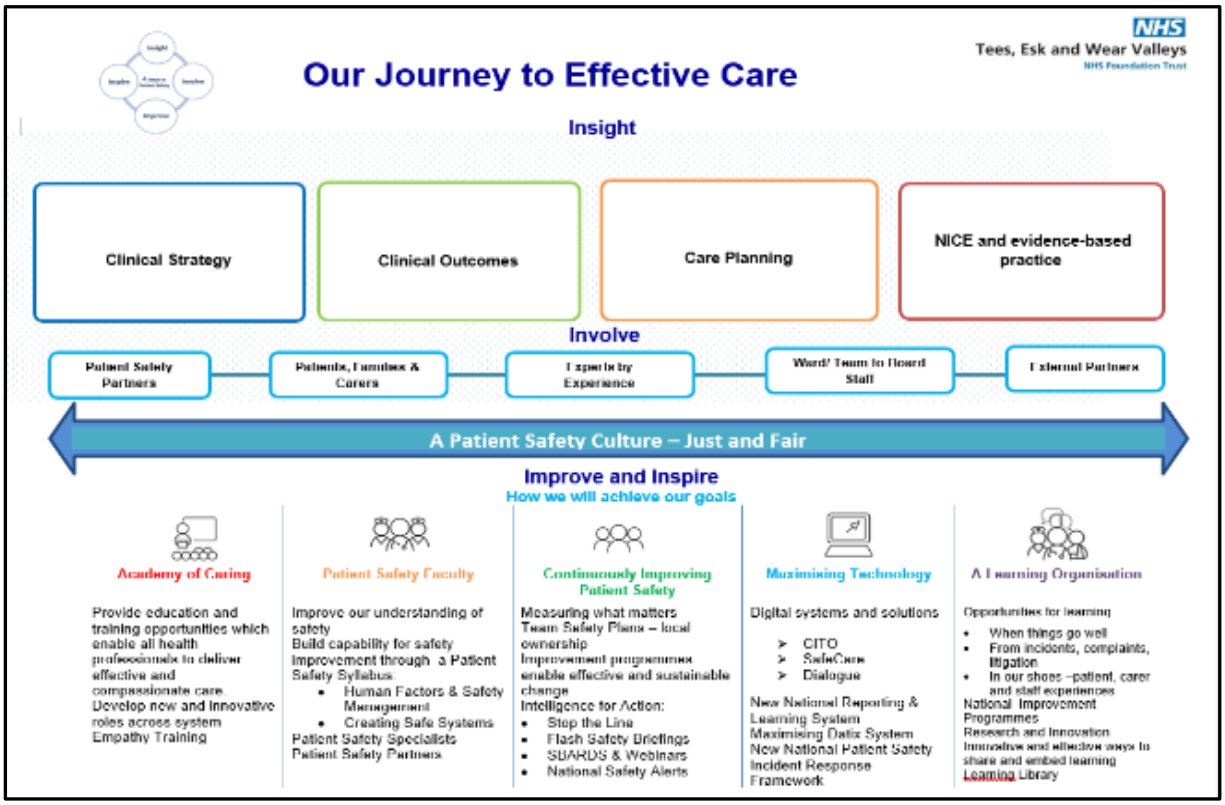
- Driving improvements in patient safety across our Trust, together with patients, carers and families, colleagues, and partners, and supported by a positive culture.
- Providing a great experience for patients in our care and for patients, carers and families who want to work with us for better mental health in our region.
- Providing safe and kind care that's based on evidence and has outcomes that matter to people

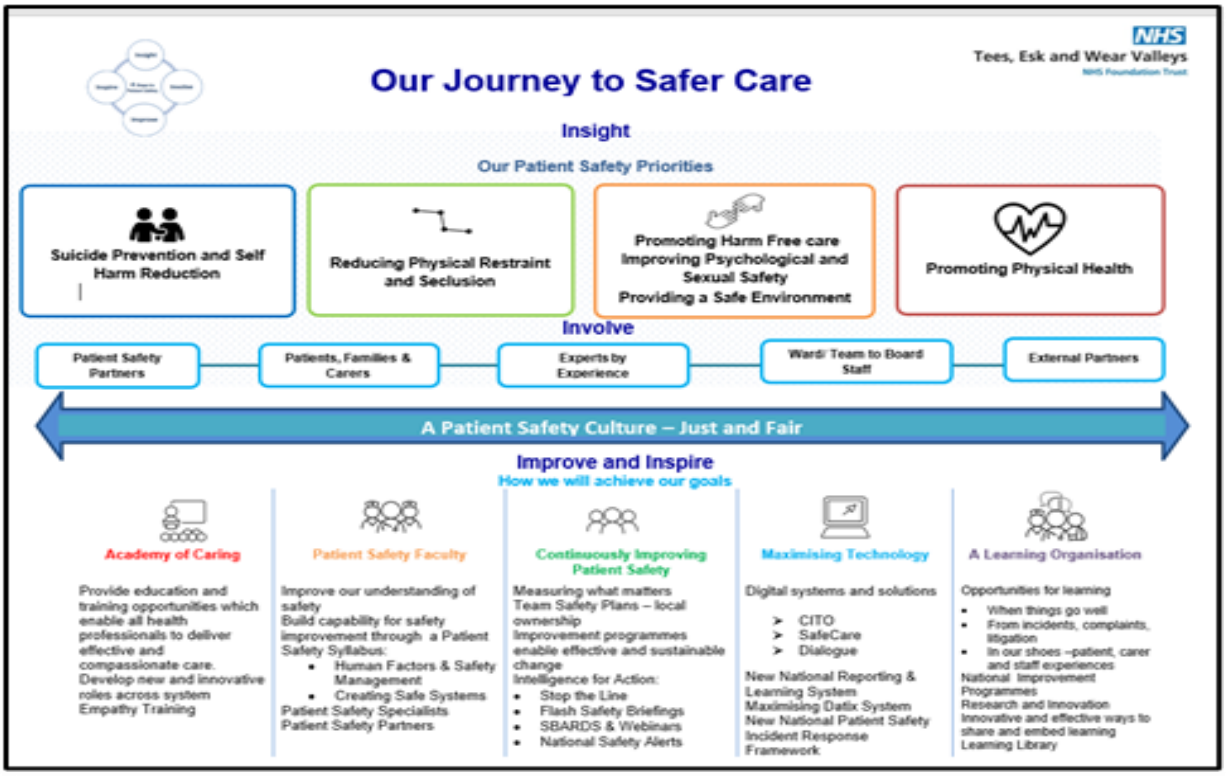
It is often important to make quick changes to tackle quality issues, and our governance system will promote a culture and processes where data is analysed holistically, and changes implemented swiftly. This means that not everything we need to improve will have a detailed, long-term plan around it.

However, there will be some potential changes which will require lengthy development and implementation periods. These will be governed as projects, grouped into programmes, and be backed by clear business cases which set out the benefits (improvements) that should be seen and when they should be expected to occur.

During 2023/24 the initial set of quality related programs will be:

- Personalised care planning, including implementing the DIALOG+ model. This is a shared ambition with the Co-creation Journey.
- Harm free care, including psychological safety, feeling safe on our wards, sexual safety, self-harm / suicide / misadventure reduction, safeguarding, environmental risk minimisation.
- Patient safety, including electronic risk management system procurement, patient safety incident reporting framework (PSIRF), rapid learning from serious incident investigations and sharing learning at every level.


Tees, Esk and Wear Valleys
NHS Foundation Trust
Our Journey to Effective Care
Insight
Clinical Strategy
Clinical Outcomes
Care Planning
NICE and evidence-based practice
Involve
Patient Safety Partners
Patients, Families & Carers
Experts by Experience
Ward/ Team to Board Staff
External Partners
A Patient Safety Culture – Just and Fair
Improve and Inspire
How we will achieve our goals
Academy of Caring
Provide education and training opportunities which enable all health professionals to deliver effective and compassionate care
Develop new and innovative roles across system
Empathy Training
Patient Safety Faculty
Improve our understanding of safety
Build capability for safety Improvement through a Patient Safety Syllabus
Human Factors & Safety Management
Creating Safe Systems
Patient Safety Specialists
Patient Safety Partners
Continuously Improving Patient Safety
Measuring what matters
Team Safety Plans – local ownership
Improvement programmes enable effective and sustainable change
Intelligence for Action:
Stop the Line
Flash Safety Briefings
SBARDS & Webinars
National Safety Alerts
Maximising Technology
Digital systems and solutions
CITO
SafeCare
Dialogue
New National Reporting & Learning System
Maximising Datix System
New National Patient Safety Incident Response Framework
A Learning Organisation
Opportunities for learning
When things go well
From incidents, complaints, litigation
In our shoes –patient, carer and staff experiences
National Improvement Programmes
Research and Innovation
Innovative and effective ways to share and embed learning
Learning Library


Tees, Esk and Wear Valleys
NHS Foundation Trust
Our Journey to Safer Care
Insight
Our Patient Safety Priorities
Suicide Prevention and Self Harm Reduction
Reducing Physical Restraint and Seclusion
Promoting Harm Free care
Improving Psychological and Sexual Safety
Providing a Safe Environment
Promoting Physical Health
Involve
Patient Safety Partners
Patients, Families & Carers
Experts by Experience
Ward/ Team to Board Staff
External Partners
A Patient Safety Culture – Just and Fair
Improve and Inspire
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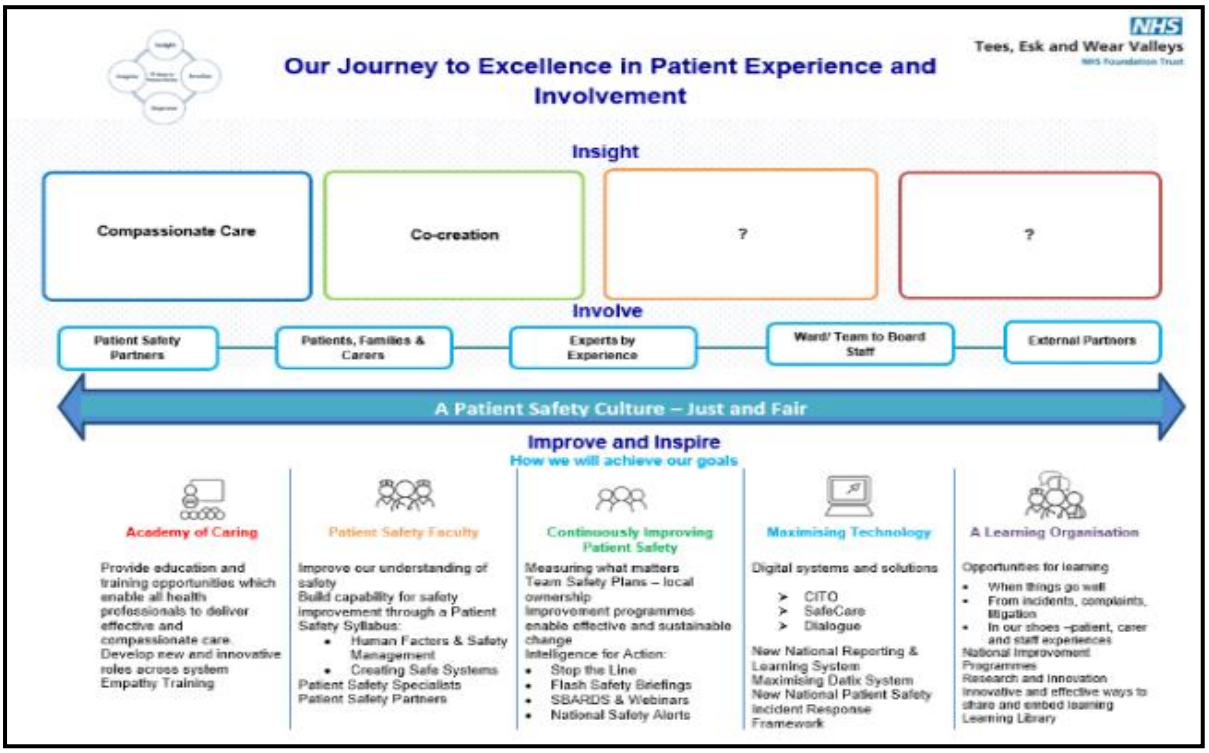
Tees, Esk and Wear Valleys
NHS Foundation Trust
Our Journey to Excellence in Patient Experience and Involvement
Insight
Compassionate Care
Co-creation
?
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Involve
Patient Safety Partners
Patients, Families & Carers
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2.5 Our priorities for 2023/24

Developing our priorities

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

We did not hold our traditional quality account stakeholder workshops in 2022/23, however considerable engagement has been undertaken during the creation of our journeys and particularly Our Quality Journey. This together with consideration of a range of patient safety and experience data and information, and the level of progress made against priorities in 2022/23, has given a strong sense of where we need to improve.

Priority 1 – 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.

By 31 March 2024 we will:

a) Ensure all clinical staff are trained in our new DIALOG+ care planning system.
b) Record all care plans on our new Cito patient record system using DIALOG+.
c) Have measurable goals in all patient care plans.
c) Publish new policies and procedures in relation to care planning and new ways of working (linked to Community Mental Health Framework).
e) Have data collection and monitoring systems in place to assess the impact of our clinical interventions on the goals set out in patient care plans.

How will we know we have made a difference / made an impact

Indicator	Target 2021/22	Actual 2021/22	Actual 2022/23
Patients know who to contact outside of office hours in times of crisis	84%	80%	78%
Patients were involved as much as they wanted to be in what treatments or therapies, they received	85%	85%	75%
Patients were involved as much as they wanted to be in terms of what care they received	85%	73%	73%
Percentage of patients who were involved as much as they wanted to be in the planning of their care	70%	75.53%	83%

Priority 2 – 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 xx

By 2023/24 Q4 we will:

a) Implement the range of actions identified from the Feeling Safe focus groups with patients and staff.
b) Continue to progress our body worn camera pilot work and evaluate its impact.
c) Continue to implement the Safewards initiative.

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	Actual 2022/23	Target for end 2023/24
Percentage of inpatients who report feeling safe on our wards	64.37%	56%	75%
Percentage of inpatients who report that they were supported by staff to feel safe	69.04%	85%	75%

Priority 3 – embed the new Patient Safety Incident Reporting Framework (PSIRF)
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 xx.

By 2023/24 Q4 we will:
a) Be compliant with the national requirements regarding PSIRF.
c) Increase the number of staff completing level 1 and 2 training within the national Patient Safety Syllabus training.
d) Introduce an annual patient safety summit.
e) Introduce the role of patent safety partners.
f) Complete the focused work we have initiated on the Duty of Candour through the delivery of an improvement plan

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 indicators:

- Full implementation of PSIRF.
- Compliance with level 1 and 2 national patient safety training.
- Delivered our Duty of Candour Improvement Plan.

2.6 Statement of assurances from the Trust

In this section of the Quality Account, the Trust is required to provide statements of assurance in relation to a number of key performance indicators which are as follows:

- Review of services provided by or contracted our Trust
- Our 2023 Community Mental Health Survey results
- Our 2023 National NHS Staff Survey results
- Clinical Audit: Participation in clinical audits and national confidential inquiries
- Clinical Research
- Use of the Commissioning for Quality and Innovation (CQUIN) Payment Framework
- What the Care Quality Commission (CQC) says about us
- Information governance
- Freedom to Speak Up
- Reducing gaps in rotas
- Learning from deaths
- PALS and complaints

- Data quality
- Mandatory quality indicators

2.7 Review of services provided by or contracted by our Trust

During 2022/23 our Trust provided and/or subcontracted 20 relevant health services. Our Trust reviewed all the data available to us on the quality of care in 20 of these relevant health services.

The income generated by the relevant health services reviewed in 2022/23 represents 100% of the total income generated from the provision of relevant health services by our Trust for 2022/23.

2.8 Our 2022 Community Mental Health Survey Results

There were 253 completed surveys returned within our Trust for the 2022 Community Mental Health Survey, a response rate of 20.69%. This is the same as the national response rate and compares with a rate of 20.9% in 2021.

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

Section	2022 score	Band
1: Health and Social Care workers	7.4	
2: Organising Care	8.2	
3: Planning care	7.0	
4: Reviewing care	7.5	
5: Crisis care	7.1	Somewhat better
6: Medicines	7.5	
7: NHS Talking Therapies	7.2	
8: Support and Wellbeing	5.2	
9: Feedback	2.2	
10: Overall view of care and services	7.2	
11: Overall experience	6.9	
12: Responsive care	7.9	

Our Trust did not score significantly better or worse than comparable Trusts for any of the individual questions or sections as a whole, however, we did score better and somewhat better than expected as set out below:

Better

- Has the purpose of your medicines ever been discussed with you?
- Have the possible side effects of your medicines ever been discussed with you?

Somewhat better

- Were you given enough time to discuss your needs and treatment?
- Would you know who to contact out of office hours within the NHS if you had a crisis? This should be a person or a team within NHS mental health services.

Our top five scores against the national average were for the following questions:

Top five questions	Score
Q13. Do you know how to contact this person if you have a concern about your care?	96.0%
Q6. Have you received your care and treatment in the way you agreed?	85.8%
Q38. Overall, in the last 12 months, did you feel that you were treated with respect and dignity by NHS mental health services?	83.6%
Q19. Did you feel that decisions were made together by you and the person you saw during this discussion?	83.2%
Q24. Has the purpose of your medicines ever been discussed with you?	82.7%

Our bottom five scores against the national average were for the following questions:

Bottom five questions	Score
Q39. Aside from in this questionnaire, in the last 12 months, have you been asked by NHS mental health services to give your views on the quality of your care?	21.9%
Q34. In the last 12 months, did NHS mental health services give you any help or advice with finding support for financial advice or benefits?	41.4%
Q35. In the last 12 months, did NHS mental health services give you any help or advice with finding support for finding or keeping work?	46.3%
Q33. In the last 12 months, did NHS mental health services support you with your physical health needs?	50.3%
Q3. In the last 12 months, do you feel you have seen NHS mental health services often enough for your needs?	60.1%

There are 13 areas where we are in the top 20% nationally and these are:

- Have you received your care and treatment in the way you agreed?
- Were you given enough time to discuss your needs and treatment?
- Did the person or people you saw understand how your mental health needs affect other areas of your life?
- Have you been told who is in charge of organising your care and services?
- Have you agreed with someone from NHS Mental Health Services what care you will receive?
- Did you feel that decisions were made together by you and the person you saw during this discussion?
- Do you know who to contact out of office hours if you have a crisis?
- Thinking about the last time you tried to contact this person or team, did you get the help needed?
- How do you feel about the length of time it took you to get through to this person or team?
- Has the purpose of your medicines ever been discussed with you
- Have the possible side effects of your medicines ever been discussed with you?

- In the last 12 months, did NHS Mental Health Services give you any help or advice with finding support for finding or keeping work?
- Have NHS Mental Health Services involved a member of your family or someone else close to you as much as you would like?

The areas where service user experience could improve are:

- Organising the care and services that individuals need
- Knowing who to contact when you have a concern about your care
- Receiving the help that they need
- NHS Talking Therapies explained in a way that is easily understood
- People are involved as much as you wanted to be in deciding what therapies to use

Full results of the survey for our Trust can be found at: https://nhssurveys.org/all-files/05-community-mental-health/05-benchmarks-reports/2022/

To take forward these results so we continue to improve our patient experience, we are:

Organising the care and services that individuals need.

- Included within the Service Improvement Plan for each Care Board

Ensuring patients know who to contact when they have a concern about their care.

- PALs and Complaints service is currently going through a whole service review. The team has introduced pop up clinics in hospital reception areas and are visiting wards to raise their profile and be more accessible.

Supporting people to receive the help that they need.

- An improvement event was held in June 2022 where the current Crisis line system and infrastructure were reviewed. This identified improvements that can be made.

Explaining NHS Talking Therapies in a way that is easily understood.

- Leaflets are available including easy read versions and translated into other languages.

Involving patients, as much as they want to be, in deciding what therapies to use.

- The IAPT team provide support in the way that feels best for the individual. For example, some people find guided self-help really suits them, others find counselling can help.

2.9 Our 2022 National NHS Staff Survey Results

All colleagues were invited to participate in the 2022 national NHS Staff Survey.

Guidance now states that colleagues have to be absent from work for at least 365 days before being considered as long term sick and not eligible for the survey. Previously this was 90 days. This meant that 304 people (3.5%) were unable to complete the survey.

The final response rate was 44% compared to 50% in 2021, 3330 participants in total.

We ranked 15th against the other 25 mental health trusts who commission Picker for the survey and first in overall positive score change.

Our overall staff engagement score remained seven out of 10.

The most improved results compared to 2021 are shown in the following table.

	2022	**2021**	**Increase**
Received appraisal in the past 12 months	84%	79%	5%
Feel organisation respects individual differences	74%	69%	5%
Organisation is committed to helping balance work and home life	51%	47%	4%
Feel supported to develop my potential	62%	57%	5%
Team members often meet to discuss the team's effectiveness	69%	65%	4%

The scores that declined the most between 2021 and 2022 are shown below.

	2022	**2021**	**Decrease**
Satisfied with level of pay	31%	38%	7%
Have adequate materials, supplies and equipment to do my work	62%	65%	3%
If friend/relative needed treatment would be happy with standard of care provided by organisation	51%	54%	3%
Don't work any additional unpaid hours per week for this organisation, over above contracted hours	40%	42%	2%
Organisation acts on concerns raised by patients/service users	74%	76%	2%

Areas where the Trust scored low compared to national average:

- If friend or relative needed treatment would be happy with standard of care
- Staff involved in a near miss or incident feel treated fairly
- Would recommend Trust as a place to work

Areas where the Trust scored better than the national average:

- Career progression

- Not experiencing musculoskeletal problems as a result of work
- Not experiencing discrimination from patients, carers and families

2.10 Clinical Audit: 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. For local audits, the Trust evaluates 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 2022/23, four national clinical audits and one national confidential enquiry covered NHS services that Tees, Esk and Wear Valleys NHS Foundation Trust provides.

- During that period, Tees, Esk and Wear Valleys NHS Foundation Trust participated in 100% of national clinical audits and 100% of the national confidential enquiries which it was eligible to participate in.

- The national clinical audits and national confidential enquiries that Tees, Esk and Wear Valleys NHS Foundation Trust was eligible to participate in during 2022/23 are as follows:

    - National Audit of Inpatient Falls (NAIF) – continuous audit
    - National Clinical Audit of Psychosis (NCAP) EIP Re-audit
    - POMH Topic 21a: The use of Melatonin
    - POMH Topic 20b: Valproate Prescribing in Adult Mental Health Services
    - National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)

- The national clinical audits and national confidential enquires that Tees, Esk and Wear Valleys NHS Foundation Trust participated in, and for which data collection was completed during 2022/23, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Audit Title	Cases Submitted	% of number of registered cases required
National Audit of Inpatient Falls (NAIF) – Continuous audit	3	100%
National Clinical Audit of Psychosis (NCAP) EIP re-audit	507 (and a further 7 contextual team level questionnaires)	100%
POMH Topic 21a: The use of Melatonin	Sample provided: 242	100%
POMH Topic 20b: Valproate Prescribing in Adult Mental Health Services	Sample provided: 197	100%
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)	69 questionnaires sent to the Trust with 46 returned	67%

- The reports of six national clinical audits were reviewed by the provider in 2022/23 and Tees, Esk and Wear Valleys NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

  - Existing procedures in relation to alcohol detoxification were re-circulated to all staff with a copy of the clinical audit report and the findings shared.
  - Our Deputy Chief Pharmacist and Cito Clinical Locality Lead collaborated to develop effective guidance and prompts which will be included as part of the Cito developments before this is launched.
  - As part of the depression medication pathway review, a checklist was added for annual reviews which cover assessment of medication adherence, side-effects (with example rating scales), alcohol and substance use and co-morbidities.
  - Barriers to performance in relation to the NCAP standards were explored and actioned within our EIP Steering Group. This included an identified plan and timeline for delivery of At Risk Mental State (ARMS) provision within the North Yorkshire, York and Selby Care Group.
  - A review was undertaken of the shared pathway between EIP and CAMHS.
  - The process and recording flowchart were disseminated to all teams via the adult mental health clinical network.
  - Key physical health Key Performance Indicators (KPIs) have been developed, led by our Physical Health Group, which facilitates the recommendations highlighted from the NCEPOD Physical Healthcare in Mental Health inpatient settings audit.

- The reports of 129 local clinical audits were reviewed by the provider in 2022/23 and Tees, Esk and Wear Valleys NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

  - Indication was added as a necessary field for antibiotics on the Electronic Prescribing and Medicines Administration (EPMA) system which is being piloted during 2023. Options were explored including using protocols for antibiotic regimens, mandating stop/review dates and having links to guidelines within the new prescribing system.
  - Training was provided for delivering Performance Development Reviews (PDR) to mental health team managers and assistant team managers and facilitated sessions included the appraisal process and how to identify measurable outcomes included throughout supervision sessions with staff.

- Briefings were shared (developed with the Practice Development Practitioner Group) including key areas requiring improvement highlighted from the NEWS2 clinical audit report.
- Amendments were made to the Quality Assurance and Improvement Programme QA tools following recommendations highlighted from clinical audit findings to facilitate regular monitoring and oversight.
- Educational videos were shared in relation to diabetes management.
- Assurance was gathered that mattress checklists were in place across the Trust and following the clinical audit, the Trust Infection Prevention and Control (IPC) Team developed and shared an educational video to demonstrate the correct full mattress checking process required.
- A clinical audit summary briefing was developed by the Safeguarding and Public Protection Team illustrating key findings from the Safeguarding Children's Policy audit. This was shared with teams and the Care Group Fundamental Standards Groups as well as being published within our Trust's weekly bulletin.
- Amendments were identified following clinical audit results in relation to our Trust's emergency equipment annual audit. This included the requirement that locations have clear signage to the emergency response bag/AED and oxygen, updates made in relation to items within three month of expiry requiring replacement, updates made to the checklists used for teams and explicit guidance as to which spare oxygen should be available for areas.
- The reporting of staff allegations, Making Safeguarding Personal (MSP), record keeping, and safeguarding supervision have been incorporated into the Safeguarding Level 3 Training for staff following the clinical audit results.
- All Infection Prevention and Control audits are continuously monitored by the IPC Team and any required actions are rectified collaboratively by the IPC Team and ward staff. Assurance of implementation of actions is monitored by the Clinical Audit and Effectiveness Team via the clinical audit action monitoring database. A total of 110 IPC clinical audits were conducted during 2022/23 across inpatient areas, prison teams, and applicable community teams where there are clinic facilities. 71% (78/110) of clinical areas achieved standards between 90-100% compliance. Local clinical audit action plans were implemented in collaboration with the IPC Team and the clinical team members to mitigate any areas of non-compliance.

In addition to those local clinical audits reviewed (i.e., those that were reviewed by our Quality Assurance Committee and Quality Assurance and Improvement Group), we undertook a further 52 clinical audits in 2022/23 including clinical effectiveness projects by trainee doctors, consultants and other professionals, in addition to those by directorates/specialty groups. These clinical audits were led by the services and individual members of staff to support service improvement and professional development and were reviewed by specialties.

Over the next year, our Trust intends to use an electronic clinical audit application to make clinical audits more efficient and 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 the experience of our patients and their families.

We continued to implement an extensive Quality Assurance and Improvement Programme during 2022/23. This provides ongoing assurance that key quality and risk issues identified are addressed. Significant improvements in practice and patient safety have been facilitated through this programme.

2.11 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 our Trust in 2022/2023 that were recruited during that period to participate in research approved by a Research Ethics Committee was 975. Of the 975 participants, 827 were recruited to 36 National Institute for Health Research (NIHR) portfolio studies. This compares with 806 patients involved as participants in 27 NIHR research studies during 2021/22.

As well as acting as a research site and participant identification centre, our Trust sponsors research including three major NIHR grant-funded multi-centre studies (COMBAT, MODS WP3&4 and CASCADE). As part of this role our research and development team are actively engaged in governance activities such as site set-up and performance tracking. As sponsor, during 2022/2023, our Trust oversaw the completion of the BASIL pilot study which showed the acceptability of behavioural activation intervention amongst older adults (https://bmjopen.bmj.com/content/13/3/e064694).

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 East 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.
- 23 different staff members took on the role of Principal Investigator for NIHR supported 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 grants this year.

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

A proportion of our Trust's income in 2022/23 was conditional on achieving quality improvement and innovation goals agreed between Tees, Esk and Wear Valleys NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2022/23 and for the following 12 month period are available on request from Ashleigh Lyons, Head of Performance, email Ashleigh.lyons@nhs.net.

2.13 What the Care Quality Commission (CQC) says about us

The 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 Valleys 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 took enforcement action against Tees, Esk and Wear Valleys NHS Foundation Trust during 2022/23. We have not participated in a special review/investigation by the CQC during the reporting period.

We are subject to periodic reviews by the CQC and a number of reviews have taken place this year. A comprehensive inspection of adult inpatient learning disability wards took place between 29 May to June 22.

A further focused inspection of community child and adolescent mental health services and secure inpatient services took place in July 2022. This considered review of the actions and improvements taken by these services in response to the Section 29a notification issued in August 2021.

The CQC's assessment of our Trust following these reviews remained requires Improvement. Changes to the core service areas inspected did however change, and the overall rating for adult inpatient learning disability wards moved from good to inadequate.

The outcome of the community child and adolescent mental health services inspection remained as requires improvement, with the safe domain improving from inadequate to requires improvement.

The outcome of the secure inpatient service inspection improved overall ratings, increasing from inadequate to requires improvement.

Inspections of the adult inpatient learning disability wards demonstrated that people's care and support was provided in a clean, well-equipped, well-furnished and well-maintained environment which mostly met people's sensory and physical needs. Some people made choices and took part in activities which were part of their planned care and staff supported them to achieve their goals.

However, some issues with care delivery were noted. The service did not meet all of the principles of Right Support, Right Care, Right Culture. Inspections of the service observed some issues with staffing levels, training, restrictive practices and safeguarding processes. Some people experienced delayed discharges due to there not being sufficient appropriate community provision.

Inspections of community child and adolescent mental health services were undertaken by the CQC to see if improvements had been made following the section 29a notification issued in June 2021. The CQC found that the senior management team had responded promptly to address issues identified at the previous inspection. Inspections demonstrated that the service was achieving its targets of maintaining contact with children and young people on waiting lists. It also observed that premises were clean, well maintained and well furnished.

Some issues were noted regarding a high number of vacancies and high caseloads in some teams. Improvements were also required in completion of mandatory training for some staff.

Inspections of the secure inpatient service were undertaken by the CQC to see if improvements had been made following the CQC section 29a notification issued in June 2021. The CQC found that the culture within the service had improved since the previous inspection, staff felt more supported by managers and there were mechanisms in place to

allow staff to escalate any staffing concerns. Staff actively involved patients, families and carers in care decisions and staff supported patients well to live healthier lives. The ward teams had access to a range of specialists required to meet the needs of patients and staff worked well together as a multi-disciplinary team.

Some issues were noted regarding staffing, safeguarding and restrictive practices and improvements were required in facilitating holistic activities for patients.

Tees, Esk and Wear Valleys NHS Foundation Trust intends to take the following action to address the points made in the CQC's assessment: Immediate action was taken in response to the inspection findings and a comprehensive action plan was developed to ensure that areas of risk were being adequately addressed. Implementation of the action plan has been well progressed with routine reporting and oversight through the Trust's Quality Improvement Board.

Tees, Esk and Wear Valleys NHS Foundation Trust has made the following progress by 31 March 2023 in taking such action: 68 of 74 actions (92%) must do actions within the action plan have now been completed. The remaining six actions were on track with little risk to delivery.

Actions have included:

- Implemented a programme that will increase the knowledge and skills of staff in relation to patient safety, improve incident reporting and enable learning from patient safety incidents.
- Undertaken a caseload deep dive in community child and adolescent mental health services to improve caseload management and reduce team's overall caseload size and to allow for more timely appointments.
- Developed Keeping In Touch processes for patients waiting for community child and adolescent mental health services.
- Improved recruitment to vacant posts.
- Implemented recruitment and retention programmes to attract new staff.
- Undertaken a staffing establishment review.
- Undertaken a review of the clinical model in adult learning disability services.
- Improving the staffing skill mix in adult learning disability wards.
- Increased leadership capacity and visibility.
- Improved staffing escalation processes in secure inpatient services and adult learning disability services.
- Developed and implemented adult learning disability specific post incident rapid review guidance to support rapid reflection and learning.
- Implemented Reducing Restrictive Practice Assurance Panels.
- Improving mandatory and statutory training compliance.
- Embedding the new governance structure.
- Implemented the revised Board Assurance Framework.
- Developed systems for learning from incidents and complaints.
- Developed and enhanced the Trust's corporate risk register.
- Review of the Safeguarding Policy.
- Reviewing the Speak Up and Whistle Blowing Policy.

In addition to clearly evidencing delivery of the required actions, we continue to implement a wider programme of change and improvement. During 2022/23 this has included, strengthening governance arrangements, increasing leadership visibility and oversight, improving staffing establishments and improving mandatory training and the quality of clinical supervision. Work has also been achieved to enhance organisational learning from a

range of internal and external sources. This has included strengthening and further developing mechanisms for capturing and communicating learning. In addition, significant progress has been made in implementing learning from the Quality Assurance and Improvement Programme to improve practice and gain assurance of the impact of our actions to improve care for patients, their families and carers.

This work continues to nurture a positive culture of patient safety and continuous quality improvement.

During 2022/23 we reported to and have been supported by an external Quality Board jointly chaired by the North East North Cumbria Integrated Care Board Lead Officer and the Regional Chief Nurse.

Tees, Esk and Wear Valleys NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

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

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

2.14 Information governance

The reporting deadline for the toolkit is now 30 June, so our position is as for our 2021/22 position which is 'approaching standards'.

We are currently at 91% completion of our information governance mandatory and statutory training.

Our Trust currently has a sickness rate of higher than 5% so our ability to achieve the 95% target has been impacted. Many other healthcare organisations are in the same situation, and NHS E have taken this on board for future iterations of the toolkit.

2.15 Freedom to Speak Up

There are a number of routes through which staff can raise concerns:

- Through their own management or professional structures.

- Through the Freedom to Speak Up team. This is as confidential as the person asks for it to be. Concerns are shared with the Director of People and Culture where possible to provide oversight of any ongoing or widespread themes, but where the person does not want this to happen, the Freedom to Speak Up team will support any investigation independently. Depending on the concern this may lead to a review commissioned by someone independent of the service or support given to the individual eg. through the Employee Support Service. Feedback is given to the person on a regular basis, in line with our revised process. As much feedback is given as appropriate although, by the nature of some concerns and investigations, full feedback is not always possible.

- Through the online raising concerns form which people can complete anonymously. Where the person leaves their name we respond directly to them. Where it is anonymous, the relevant director provides a written response to go on the staff intranet.

- Through our safeguarding team or directly to the CQC.

- Through our formal HR processes, the timescales of which vary and are laid out in the relevant policy.

- Through the Employee Support Service who will signpost and provide guidance on how to make best use of the options available.

- Through any trade union of which they are a member.

Any concerns of detriment are, in line with national guidance, dealt with through our normal HR processes. We have recently agreed that concerns will be passed to our Associate Director for Operations and Resourcing, with indication of who should not be involved in any review. They will provide the names of three people who could potentially look into it, so the person raising the concern has the opportunity to identify any conflicts of interest.

The Non-Executive Director Freedom to Speak Up lead has agreed that they will receive quarterly reports on these concerns and raise any issues with the Director of People and Culture and include their feedback in the Freedom to Speak Up reports to our Board.

2.16 Reducing gaps in rotas

Please note we are awaiting information on progress in bolstering staffing in adult and older adult community mental health services, following additional investment from local CCGs' baseline funding.

The role of Guardian of Safe Working for Postgraduate Doctors within our Trust 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 postgraduate 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 10pm and 7am
- 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 Postgraduate Doctors within our Trust produces quarterly and annual reports to the Board that focus on gaps in medical rotas and safety issues.

The Board received the Guardian's annual report for 2022/23 at its meeting of 27 April 2023. During the year, the most common reasons for needing short-term/locum cover was due to vacancies on the rotas and staff sickness (short/long term).

Exception reports received related mostly to claiming additional hours whilst on NROC, 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 at the relevant forums and additional staffing put in place where possible.

2.17 Learning from deaths

Please note we are still awaiting information to complete this section of the Quality Account – you will see the gaps below.

1. During 2022/23 2339 of patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 577 in the first quarter, 552 in the second quarter, 669 in the third quarter and 541 in the fourth quarter.

2. By the end of 2022/23 xx case record reviews and xx investigations were carried out in relation to 2339 of the deaths included in item 1.

In xx cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: xx in the first quarter; xx in the second quarter; xx in the third quarter; xx in the fourth quarter.

3. [xx] representing XX% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of: [Number] representing [number as percentage of the number of deaths which occurred in the quarter given in item 1]% for the first quarter; [Number] representing [number as percentage of the number of deaths which occurred in the quarter given in item 1]% for the second quarter; [Number] representing [number as percentage of the number of deaths which occurred in the quarter given in item 1]% for the third quarter; [Number] representing [number as percentage of the number of deaths which occurred in the quarter given in item 1]% for the fourth quarter.

These numbers have been estimated using the [name, and brief explanation of the methods used in the case record review or investigation].

4. Significant work was undertaken during 2022/2023 to identify learning and themes from both case record reviews and serious incidents investigations.

The top seven themes from serious incidents were identified as:

- Risk assessment and management (Safety Summary/Plan/contingency planning)
- Care planning
- Safeguarding (including use of PAMIC tool)
- Family involvement
- Record keeping
- Multi-agency working
- Records management

Themes from case record reviews were identified as:

- Risk assessment/risk management
- Communication between Trust teams
- Poor multi-agency working

- Poor consideration and management of risks related to medication and obesity
- Need to have a greater focus on review of service users mental state at depot clinics
- Poor physical health monitoring
- Poor record keeping

All learning in our Trust is now referred to as actionable learning which replaces previous categories of learning including root and contributory causes. This language supports our approach towards a just and learning culture in line with Our Journey to Change and a systems-based approach to learning.

Learning from all types of reviews is triangulated to identify emerging themes.

5. Learning from serious incidents, once reviewed, continues to be monitored against the themes identified in item 4 above. Our Quality Assurance Programme is regularly updated to reflect learning from patient safety incidents. It provides assurance that improvements are being made in relation to risk assessment, risk management, and contingency planning, care plans and carer involvement and that these improvements are being sustained in both inpatient and community settings.

Work around care planning and safeguarding forms part of our quality strategy in keeping with Our Journey to Change.

Practice Development Practitioners (PDPs) are addressing areas of learning within their teams through compliance audits, coaching and supervision of staff. PDPs are integrated into the Fundamental Standards group where wider learning is shared to inform improvements in other areas.

Findings from case record reviews are discussed within the clinical networks, where appropriate, to ensure that learning feeds into existing improvement work. Outcomes are captured in minutes at the following mortality review panel. Where the learning identified is related to the work of a specific professional group, for example pharmacy, the relevant mortality review panel member ensures this is actioned and shared Trustwide. Good examples of assurance can be evidenced from the workstreams related to Clozapine, Lithium and Depot Injections. Learning for individuals is also shared with operational teams where appropriate and addressed via supervision and local governance processes.

Previous learning from case record reviews and early learning reviews has suggested that a community frailty pathway to help staff in recognising the deteriorating patient in community settings should be actioned. Training has commenced in recognition of the physically deteriorating patient in community settings. Work is underway with key stakeholders including the primary care networks to create a pathway and guidance document.

Our Trust continues to strengthen arrangements for organisational learning via the Organisational Learning Group. The groups role is to gain assurance that:

a) we identify areas of learning
b) we are implementing change to address areas of learning, and
c) the actions we are taking are having the desired impact.

Agenda items have included analysis of the Quality Assurance and Improvement report to determine the effectiveness of the assurance tools used, identification of emerging themes, effectiveness of associated actions and the learning from deaths improvement work with the Better Tomorrow Programme.

Forty patient safety briefings have been circulated trust wide during 2022/23 as a result of learning.

Examples of these briefings include:

- Accurate documentation of observations and general observations/care rounds for all inpatient, respite, and residential settings.
- Ensuring all staff are aware of how to access anti-barricade doors especially if there may be pressure behind the door.
- The importance of bowel monitoring when patients are on high dose anti-psychotic therapy (HDAT), or any medications where constipation could cause significant issues such as Clozapine.
- Delivering compassionate care and the importance of raising concerns.
- Raising awareness of the importance of seamless transfers of care and service delivery when patients move between services/trusts.
- Door handles - potential ligature risks.
- Shower drain – potential ligature risk.
- Emergency rescue of a collapsed person.
- Observation and engagement/care rounds.
- Guidance to support the identification and management of safeguarding (adult/child) cases.
- Patient leave - sharing of relevant information and keeping in touch plans.

The briefings circulated are specific about any assurance required from services. On receipt of completed actions these are documented in the local safety alert and learning database.

Learning from Serious Incidents Bulletins are also regularly distributed across our Trust. The bulletins have shared key learning and good practice highlighted in serious incident reviews considered at the Directors Assurance Panels. All briefings and bulletins are stored in the learning library on our staff intranet and are accessible to all employees.

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. Environmental surveys with a multi professional input from estates, health and safety and clinical services were recommenced.

In relation to safeguarding, the Quality Assurance tool for practice development reviews has demonstrated improvements in relation to identification of risk to others and from others within the safety summaries being discussed within Multi-disciplinary Team. Peer reviews (Quality Assurance tool 6) have evidenced good examples of safeguarding procedures and staff knowledge. Training figures indicated that over 90% of staff are compliant with mandatory safeguarding training in both Care Groups.

Connecting for people, suicide awareness training, continues, and our mandatory harm minimisation training was revised. The harm minimisation training continues to include updated headlines from serious incidents in relation to learning from deaths. Training dates are available up to 2024. Training has been adapted for relevant specialties, for example CAMHS. The training considers completion of documentation/record keeping, patient/carer involvement and the importance of multi-agency working. Bespoke training sessions in hot spot areas are available on request. For example, in front line teams such as Crisis.

As part of the improvement work around the serious incident process and learning from deaths, several training needs for staff Trustwide were 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 were fed into the Trustwide training needs analysis event.

The Incident Reporting and Serious Incident Review policy was reviewed to incorporate improvement work which was co-produced with clinical services and bereaved families/carers. It also includes the Patient Safety Incident Response standards. A designated programme manager continues to work with the project team to implement the Patient Safety Incident Response Framework (PSIRF) which will gradually be introduced in line with national requirements during Autumn 2023.

The Learning from Deaths policy was also reviewed. Both policies are aligned to Our Journey to Change in that we will ensure carers and families receive compassionate care following the loss of a loved one. We will continue to work closely with families and carers of patients who have died to ensure meaningful support and engagement with them at all stages, from the notification of death through to actions taken following an investigation/review.

We continue to work collaboratively as part of the Better Tomorrow Programme to facilitate shared learning/good practice and valid comparisons with other trusts.

A replacement risk management system has been procured that will bring additional benefits in terms of triangulation of learning and oversight of serious incident action plans.

Deaths of people with a dual diagnosis are increasing. Community transformation work has facilitated collaborative pathways across the system it operates within. It aims to create a core mental health service which is aligned with primary care networks and voluntary sector organisations to ensure that services are accessible to the community it serves and inclusive of population need.

6. Our Quality Assurance Programme uses a range of tools to measure compliance with key areas of practice that relate to the seven key learning themes. This has provided quantitative evidence of sustained improvement Results show that improvements have been made across all seven learning themes.

MDT walkabouts have also identified that staff are aware of learning issued by patient safety briefings that are circulated across the Trust.

Good examples of assurance can be evidenced from the workstreams related to critical medications such as Clozapine and Lithium.

The national lead from the Better Tomorrow Programme indicated that improvement work carried out by our Trust will be used as a case study and have shared work completed as good practice.

7. [Number] case record reviews and [number] investigations completed after [date] which related to deaths which took place before the start of the reporting period.

8. [Number] representing [number as percentage of number in item 27.1 of the relevant document for the previous reporting period] % of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the [name, and brief explanation of the methods used in the case record review or investigation].

9. [Number] representing [number as percentage of number in item 27.1 of the relevant document for the previous reporting period] % of the patient deaths during [the previous reporting period] are judged to be more likely than not to have been due to problems in the care provided to the patient.

2.18 PALS and complaints

Complaints are managed following national guidance and we endeavour to respond to all our formal complaints within 60 days. We have a complaints manager aligned to each Care Group of our Trust who works with operational colleagues, patients and/or carers to resolve the issue that has been raised.

Our policy and procedure for the Management of Compliments, Comments, Concerns and Complaints outlines our approach to receiving valuable feedback and information from patients and their carers about the services we provide.

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 2022/23 PALS dealt with 2,438 concerns or issues from patients and carers, an increase of 157 when compared to 2021/22.

1,008 (41%) of the concerns raised were around adult mental health services.

1,950 of the PALS concerns (80%) were closed within 15 working days (although no formal target is set for this). Non-compliance was largely in relation to obtaining timely feedback from operational services.

338 formal complaints were received and registered during 2022/23 compared to 300 for the same period last year.

Complaints across services:

- 230 in adult mental health services
- 69 in children and young people services
- 1 in crisis
- 13 in mental health services for older people
- 8 in secure inpatient services
- 0 in Health and Justice
- 1 in adult learning disability services and
- 16 in corporate services

2.19 Data quality

The latest published Data Quality Maturity Index (DQMI) score is 97.4. This is for December 2022.

Our Trust did not submit records during 2022/23 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

Our Trust was not subject to the Payment by Results clinical coding audit during 2022/23 by the Audit Commission.

We did have a clinical coding audit for the Information Governance Toolkit. The results were 99% correct for primary diagnosis and 90.8% correct for secondary diagnosis.

We stopped making Commissioning Data Sets submissions that go to Secondary Uses Service and Hospital Episode Statistics about four years ago as the data was duplicated with the Mental Health Services Data Set. The Mental Health Services Data Set data quality for NHS Number and GP practice from the Data Quality Maturity Index publication for December 2022 were both 100%

2.20 Mandatory quality indicators

Please note we are awaiting information for this section on the following indicators:

- *The percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care during the reporting period*

- *The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period.*

- *The percentage of patients aged:*
  (i) 0 to 15 and
  (ii) 16 or over readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.

- *Our patient experience of community mental health services indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period.*

- *The number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.*

The indicators below were removed from national reporting and we are therefore not including these figures in this year's Quality Account:

- Care Programme Approach 72-hour follow-up
- Crisis Resolution Home Treatment team acted as gatekeeper

PART 3 – Further Information on how we have performed in 2022/23

3.1 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 our Trust.

3.2 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.

Please note we are awaiting information to complete the table below.

Quality metrics	Target	Whole Trust 22/23	Whole Trust 21/22	Whole Trust 20/21	National benchmark (where available)	
Patient safety indicators						
Percentage of patients who report 'yes, always' to the question 'do you feel safe on the ward?'	75.00%	55.57%	65.30%	64.66%	Not measured nationally	Please refer to section on Feeling safe. We are unable to benchmark with other mental health trusts as this is not universally collected. Intelligence gathered via the focus groups has informed the patient experience improvement plan and the work is being implemented. Delivery against the actions is being closely monitored via the care group and strategic governance routes. We also recognise that the feeling of safety is affected by some of an inherent aspect of some of our patient's mental health conditions. We will continue to focus on this important area of patient safety in 2023/24.
Number of incidents of falls (level 3 and above) per 1000 occupied bed days (OBDs) – for inpatients	0.35	0.28	0.17	0.13	The Royal College of Physicians discourage any benchmarking or comparisons due to the high number variables that exist that makes comparison unreliable.	Analysis of information suggests the slight increase in the rate of falls is associated with the increase in the acuity of patients accessing our services.

The number of incidents of physical intervention/ restraint per 1000 occupied bed days	19.25	33.27	28.84	20.9	Please refer to Further benchmarking data in section below.
The number of medication errors with a severity of moderate harm and above	2.5	13	12	7	TBC
The number of serious incidents reported on STEIS	-	144	141	142	TBC
Clinical Effectiveness Indicators	**Target**	**Whole Trust 22/23**	**Whole Trust 21/22**	**Whole Trust 20/21**	**National Benchmark**
Percentage of adults discharged from CCG-commissioned mental health inpatient services receive a follow-up within 72 hours	85%	88%	Previously reported indicator: (Existing percentage of patients on Care Programme Approach who were followed up within 72 hours after discharge from psychiatric inpatient care)		
Adults with a long length of stay over 60 for adult admissions	TBC	TBC			*Awaiting information*
Older adults with a long length of stay over 90 days for older adult admissions	TBC	TBC			

Patient experience indicators	Target	Whole Trust 22/23	Whole Trust 21/22	Whole Trust 20/21	National benchmark
Percentage of patients who reported their overall experience as very good or good	92.00%*	92.16%	94.34%	93.21%	87%
Percentage of patients that report that staff treated them with dignity and respect	94.00%	86.69%	84.72%	86.77%	TBC
Number of complaints raised	-	338	257	533	TBC

* *Previous target was 94% changed Dec 2023 to 92%*

Comments on areas for improvement

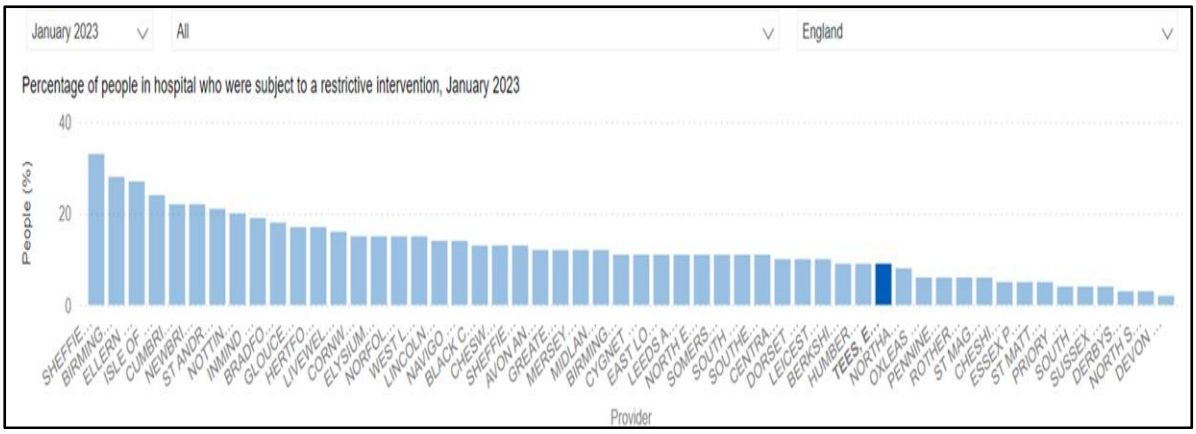
Percentage of patients reported 'yes always' to the question 'do you feel safe on the ward'?
The end of 2022/23 position was 55.57% which relates to 962 out of 1731 surveyed. This is 19.43% below our target of 75.00%. Both Care Groups have underperformed this year. Durham, Tees Valley and Forensics with 54.72% and North Yorkshire, York and Selby with 58.94%. This area continues to be a priority for 2023/24.

Number of incidents of physical intervention/ restraint per 1000 occupied bed days (OBDs) – for inpatients
The end of 2022/23 position was 33.27 which relates to 7873 incidents and 236,605 OBDs. This is 14.02 above our target of 19.25

North Yorkshire, York and Selby were the only Care Group achieving the target with a rate of **12.78**. Within Durham, Tees Valley and Forensics Care Group the actual rate was **38.23.** This higher rate is due to a large proportion of the restrictive intervention usage in a small number of wards in adult learning disabilities where this is more likely to occur in a small group of patients with complex needs.

We have been working with Mersey Care NHS Foundation Trust implementing the HOPES model, a care approach that reduces the use of long-term segregation sometimes experienced by autistic adults, adults with a learning disability and children and young people. We now have a dedicated HOPE(S) practitioner, to work in partnership with the national team and Mersey Care NHS Foundation Trust.

The graph below illustrates the Trusts positive position against other mental health trusts nationally. We continue to work towards the long-term reduction of all forms of restrictive intervention. A range of actions are in progress via our Restrictive Intervention Reduction Plan.



	Total mean 22/23	Total mean 22/23 (ALD inpatient services excluded)
Incidents involving restrictive interventions	578.56	321.20
Total number of restrictive interventions used	897.73	504.82
Use of prone restraint	10.08	8.04
Use of supine restraint	208.68	88.64
Use of rapid tranquilisation	107.32	91.12
Use of seclusion	82.82	14.64
Use of tearproof clothing	7.64	7.64
Use of mechanical restraint	2.48	2.48

Percentage of patients that report that staff treated them with dignity and respect
The end of **2022/23** position was **86.69%** which relates to **8718** out of **10057** surveyed. This is **7.31%** below our target of **94.00%.**

Broken down by Care Groups, we are pleased that the majority of our patients are treated with dignity and respect. North Yorkshire, York and Selby are closest to the target with **91.03%** with Durham, Tees Valley and Forensics **85.06%**.

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.

The number of medication errors with a severity of moderate harm and above
The end of **2022/23** position was **13** which is **10.5** above our target of **2.5.**

These 13 were split across the Care Groups. North Yorkshire, York and Selby had five and Durham, Tees Valley and Forensics had eight medication errors with a severity of moderate harm and above.

A review of incidents (moderate harm and above) identified medication errors occurring mainly in relation to medications such as Clozapine, Lithium and Depot Medication. In response to this, the Pharmacy Team has led workstreams focused on making practice improvements to reduce the number of incidents reported. The Safe Medication Practice Group has co-created action plans to address key issues. Actions delivered during 2022/23 have included changes to procedures, development of e-learning training packages for staff and the production of posters focused on patients to raise their awareness of the key side effects of medication.

These incidents occur in low numbers and are routinely reported to the Trust's Board through the Integrated Performance report to ensure robust monitoring and oversight.

3.3 Our Performance against the System Oversight Framework Targets and Indicators

The NHS Oversight Framework is built around five national themes:

- Quality of care, access and outcomes
- Leadership and capability
- People
- Preventing ill health and reducing inequalities
- Finance and use of resources

A sixth theme focusses on local strategic priorities.

The five themes are underpinned by 23 key performance measures and sub-measures and Trust and Integrated Care Board (ICB) performance is monitored via an allocation to a top, inter or bottom quartile. Typically, those within the top quartile indicate the higher performing Trusts.

To provide an overview of the level and nature of support and the oversight arrangements required across systems, Integrated Care Boards and Trusts are allocated to one of four segments, determined by the scale and nature of their support needs, ranging from no specific support needs (segment 1) to intensive support needs (segment 4).

Our Trust is currently placed within segment 3; bespoke mandated support, potentially through a regional improvement hub, drawing on system and national expertise as required.

There are a number of measures where we are placed in the lowest performing quartile which indicates a position of concern or where we are not achieving the Oversight Standard.

These are:

- Access rate for IAPT services (North East and North Cumbria)*
- Overall CQC rating
- NHS Staff Survey compassionate culture people promise element sub score
- NHS Staff Survey compassionate leadership people promise element sub score
- CQC well led rating
- Staff survey engagement theme score
- Proportion of staff in a senior leadership role who are from a BME background

*Please see the relevant sections within the Integrated Performance Report, Long Term Plan and Performance Improvement Plans

Further details on our performance are below:

1) Quality, access and outcomes: Mental health
There are four mental Health measures monitored as part of the 2022/23 Framework; 1 is monitored at Trust level and 3 are monitored at ICB level. Our achievement against these has been provided in the tables below.

TEWV	Oversight standard	Q1	Q2	Q3	Q4	Latest national position
Number of inappropriate OAP bed days for adults by quarter that are either internal or external to the sending provider	0	1094	1031	431	951	Interquartile ranges as at December 2022 (500) 23 out of 56 Trusts.

North East and North Cumbria ICB	Oversight standard	Q1	Q2	Q3	Q4	Latest national position
Access rate for IAPT services	100%	93.23 %	71.93%	81.23%	88.50%	Lowest performing quartile (a position of concern) as at December 2022 32 out of 42 ICBs
Number of children and young people accessing mental health services as a % of population	100%	114.52 %	113.38 %	113.65 %	112.47 %	
Access rates to community mental health services for adult and older adults with severe mental illness	100%	211.2 %	211.49 %	214.24 %	217.97 %	

Humber and North Yorkshire ICB	Oversight standard	Q1	Q2	Q3	Q4	Latest national position

Access rate for IAPT services	100%	85.67 %	85.53%	97.43%	96.39%	Interquartile ranges as at December 2022 21 out of 42 ICBs
Number of children and young people accessing mental health services as a % of population	100%	148.9 %	153.31 %	153.10 %	154.21 %	
Access rates to community mental health services for adult and older adults with severe mental illness	100%	239.47 %	231.06 %	227.55 %	218.56 %	

Quality of care, access and outcomes: safe, high-quality care

Quality of care, access and outcomes: safe, high-quality care	**Oversight standard**	**Q1**	**Q2**	**Q3**	**Q4**	**Latest national position**
National Patient Safety Alerts not completed by deadline	0	0	0	0	0	Data as at January 2022
Consistency of reporting patient safety incidents	100.00%	100.00%	100.00%	100.00%	100.00%	Data as at January 2022 Highest performing quartile (a positive position) as at September 2022 (100%) 1 out of 71 Trusts
Overall CQC rating	N/A	Requires improvement				Lowest performing quartile (a position of concern) as at

						February 2023 53 out of 69 Trusts
NHS Staff Survey compassionate culture people promise element sub-score		6.9	6.9	6.9	6.8	Lowest performing quartile (a position of concern) as at 2021 survey 63 out of 70 Trusts
NHS Staff Survey raising concerns people promise element sub-score		6.7	6.7	6.7	6.7	Interquartile range as at 2021 survey 49 out of 70 Trusts
Adult acute length of stay over 60 days	0%	10.87%	13.43%	11.07%	12.93%	Highest performing quartile (a positive position) as at December 2022 (12.1%) 6 out of 50 Trusts
Older adult acute length of stay over 60 days	0%	33.59%	33.81%	40.15%	28.28%	Interquartile range as at December 2022 (32.4%) 15 out of 50 Trusts

Leadership and capability: leadership

Leadership and capability: leadership	**Oversight standard**	**Q1**	**Q2**	**Q3**	**Q4**	**Latest national position**
NHS Staff Survey compassionate leadership people promise element sub-score	As per staff survey benchmarking group results	7.17	7.17	7.17	7.3	Lowest performing quartile (a position of concern) as at 2021 survey 65 out of 70 Trusts
CQC well-led rating	N/A	Requires improvement				Lowest performing quartile (a position of concern) as at February 2023

			55 out of 69 Trusts

People: Looking after our people

People: Looking after our people	Oversight Standard	Q1	Q2	Q3	Q4	Latest national position
Staff survey engagement theme score	As per staff survey benchmarking group results	7.00	7.00	7.00	6.80	Lowest performing quartile (a position of concern) as at 2021 survey (6.79) 64 out of 70 Trusts
Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from managers	As per staff survey benchmarking group results	8.00%	8.00%	8.00%	7.00%	Interquartile range as at 2021 survey (8.33%) 32 out of 70 Trusts
Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from other colleagues	As per staff survey benchmarking group results	14.00%	14.00%	14.00%	14.00%	Interquartile range as at 2021 survey (13.80%) 28 out of 70 Trusts
Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from patients/service users, their relatives or other members of the public	As per staff survey benchmarking group results	25.00%	25.00%	25.00%	23.00%	Interquartile range as at 2021 survey (24%) 20 out of 70 Trusts
NHS staff leaver rate	None	13.87%	13.39%	12.91%	12.31%	Highest performing quartile (a positive position) as at December

						2022 (7.34%) 7 out of 71 Trusts
Sickness absence rate (working days lost to sickness)	None	6.44%	6.11%	6.16%	6.71%	Interquartile range as at October 2022 (6.33%) 51 out of 71 Trusts

People: Belonging in the NHS

People: Belonging in the NHS	**Oversight Standard**	**Q1**	**Q2**	**Q3**	**Q4**	**Latest national position**
Proportion of staff in senior leadership roles who a) are from a BME background b) are women c) disabled staff						
BME background	12%	1%	1%	1%	1%	Lowest performing quartile (a position of concern) as at 2021 calendar year (1.99%) 64 out of 69 Trusts
Women	62%	66%	67%	64%	65%	Interquartile range as at December 2022 (62.3%) 29 out of 47 Trusts
Disabled staff	3.20%	4%	4%	6%	6%	
Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual	As per staff survey benchmarking	56.00 %	56.00 %	56.00 %	63.00 %	Interquartile range as at 2021 calendar year (60.50%) 28 out of 70 Trusts

orientation, disability or age						

Finance and use of resources

There are 4 measures and sub measures monitored as part of finance and use of resources; of these, a Trust assessment has not been possible at this stage. Work is currently underway to develop the agency measures.

Finance and use of resources	Oversight Standard	Q1	Q2	Q3	Q4	Latest national position
Financial efficiency - variance from efficiency plan - Recurrent	N/A	£1,208,577	£3,871,945	£6,482,000	£9,963,681	Financial values with brackets indicate a (Surplus) or (Favourable) position, financial values without brackets indicate a deficit or adverse position.
Financial efficiency - variance from efficiency plan - non-recurrent	N/A	£361,173	£722,346	£1,044,000	£3,754,319	
Financial stability - variance from break-even	N/A	£1,296,930	£4,290,781	£4,718,089	-£1,207,855	
Agency spending: Agency spend compared to the agency ceiling	100%	Not currently available	208.23%	224.76%	221.14%	
Agency spending: Price cap compliance	100%	Not currently available	64%	64%	63%	

3.4 Learning from West Lane Hospital

On 2 November 2022, three NHS England independent investigation reports were published following the deaths of three young people in our care between 2019 and 2020.

The reports looked at the care and treatment of Christie Harnett, Nadia Sharif and Emily Moore at West Lane Hospital in Middlesbrough, and in addition for Emily, at Lanchester Road Hospital in Durham, as well as the actions for partner organisations. The investigation was commissioned by NHS England and carried out by Niche Health and Social Care Consulting.

In response to the findings of the three reports our Chief executive said:

“On behalf of the trust, I would like to apologise unreservedly for the unacceptable failings in the care of Christie, Nadia and Emily which these reports have clearly identified.

“The girls and their families deserved better while under our care. I know everyone at the trust offers their heartfelt sympathies and condolences to the girls’ family and friends for their tragic loss.

“We must do everything in our power to ensure these failings can never be repeated.

“However, we know that our actions must match our words. We accept in full the recommendations made in the reports – in fact the overwhelming majority of them have already been addressed by us where applicable to our services.

“It is clear from the reports that no single individual or group of individuals were solely to blame – it was a failure of our systems with tragic consequences.

“We have since undergone a thorough change in our senior leadership team and our structure and, as importantly, changed the way we care and treat our patients. However, the transformation needed is not complete. We need to get better and ensure that respect, compassion, and responsibility is at the centre of everything we do.”

The reports and our response to the identified recommendations is available as follows:

Report and our response to the recommendations: Christie Harnett
Report and our response to the recommendations: Nadia Sharif
Report and our response to the recommendations: Emily Moore

In addition to the three reports published, a further system-wide independent investigation report was published on 21 March 2023 looking into the concerns and issues raised relating to the safety and quality of CAMHS provision at West Lane Hospital.

The report included recommendations for our Trust as well as other organisations. The assurance statement is our response to the recommendations, and this was published at the same time.

The report and our response is available as follows:

Report and response to the recommendations: System-wide independent investigation

We stopped delivering inpatient CAMHS provision in September 2019 at West Lane Hospital.

Our Trust accepted in full the recommendations made in the reports and we reiterated how deeply sorry we are for the events that contributed to the deaths of Christie, Nadia and Emily.

In the three years since these tragedies, we've made significant improvements in our environments, how we organise staff and services and most importantly how we more closely involve families and loved ones themselves.

These improvements are being delivered through our five year change programme, Our Journey to Change, in line with our three big goals to co-create a great experience for our patients, carers and their families, for our staff and our partners. This includes an unrelenting focus on patient safety, supported by a robust quality assurance schedule.

3.5 Learning from Okenden- the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust

The consideration of learning from organisations across the health and social care system is essential to continuous improvement and the provision of high quality care. All trust boards have a duty to prevent failings found in the wider NHS from happening within their organisations and the local system. Our Trust is committed to applying such learning and to take action to mitigate any risks identified.

The independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust commenced in the summer of 2017. It was originally requested by the Rt Hon Jeremy Hunt MP when he was Secretary of State for Health and Social Care, and commissioned by NHS Improvement, to examine 23 cases of concern collated by the tireless efforts of the parents of Kate Stanton-Davies and Pippa Griffiths, who both died after birth at the Trust in 2009 and 2016 respectively.

The independent review examined the maternity care of 1,486 families, the majority of which were patients at the Trust between the years 2000 and 2019. The review found that consistently lessons were not learned, mistakes in care were repeated, and the safety of mothers and babies was unnecessarily compromised as a result.

There were a number of reviews carried out by external bodies, including local clinical commissioning groups and the Care Quality Commission, during the last decade. The review team was concerned that some of the findings from these reviews gave false reassurance about maternity services at the Trust, despite repeated concerns being raised by families, and therefore opportunities for improvement were lost.

The Ockenden report from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust was published on 30 March 2022 and is available as follows:

Ockenden review: summary of findings, conclusions and essential actions

NHSE/I wrote to all trusts to ask that the Ockenden report and its recommendations be considered at public board meetings and shared with all relevant staff. Trusts were expected to take action to mitigate any risks identified and develop robust plans against areas where services need to make changes, paying particular attention to the report's four key pillars:

1. Safe staffing levels
2. A well-trained workforce
3. Learning from incidents
4. Listening to families

In April 2022 a paper presenting the key learning from the Ockenden review was presented to our Trust Board. It recognised the wider implications for learning and improvement across our organisation in relation to the four key pillars.

Key learning from the four pillars has helped inform continuous improvement workstreams in our Trust, for example the ongoing work on safer staffing, implementation of the national Patient Safety Incident Review Framework, developing mechanisms for recognising and sharing learning from incidents, patient safety events, complaints and patient, family and carer feedback and involving families in the serious incident review process.

The Trust's Organisational Learning Group has reviewed the report further and agreed additional actions to mitigate any risks identified with specific reference to the four key pillars

3.6 Identifying closed cultures

Following findings of patient abuse at the Edenfield Centre at Greater Manchester Mental Health Foundation Trust, the National Director for Mental Health wrote to all NHS trusts to request specific areas of care were reviewed by trust boards. In addition to this, the Humber and North Yorkshire Integrated Care Board requested that providers within the Mental Health, Learning Disability and Autism Provider Collaborative review the mitigations in place to prevent closed cultures like that at the Edenfield Centre from developing.

The CQC has undertaken some significant work on defining and identifying closed cultures. They describe a closed culture as, "a poor culture in a health or care service that increases the risk of harm. This includes abuse and human rights breaches. The development of closed cultures can be deliberate or unintentional – either way it can cause unacceptable harm to a person and their loved ones."

Our Trust recognises that many of our services are at inherent risk of developing a closed culture because of the services provided, where some people are not free to leave and have multiple vulnerabilities. This includes all our inpatient services where people may be treated under the Mental Health Act.

In response to learning from the Edenfield Centre and the need to provide assurance both internally and to the ICB, the Nursing and Governance Directorate developed a cultural assessment tool or 'trigger tool'. This tool was informed by the characteristics of a closed culture identified through the project work of the CQC.

The first stage of our review involved a tabletop review of all inpatient wards using the cultural assessment tool. This allowed us to identify wards with the highest risk of developing a closed culture. Following this the 48 inpatient wards were independently visited.

We used the 'see, hear and feel' approach to test out, at patient care level, the factors that impact on patient and staff safety and experience and therefore impact on culture. Findings were reviewed for positive and negative themes. Any immediate concerns identified were escalated and remedial action was taken.

The exercise gave us improved visibility and there was positive feedback received from the Trust's Care Groups and visiting teams about this approach.

It should be acknowledged that quantitative, qualitative data and ward reviews alone will not inform the Trust of closed cultures, however they support the identification of early warning signs of poor cultures and therefore are effective at mitigating risks in conjunction with a wider quality assurance approach.

The majority of feedback from both staff and patients and from observations of practice suggested many aspects of good practice from compassionate and caring staff.

While teams and reviewers found this work to be worthwhile, no closed cultures were identified. We recognise that closed cultures are very difficult to spot, therefore this exercise has been seen as part of a need for wider and ongoing surveillance to identify risks and address poor cultures emerging at an early stage.

3.7 Reading the Signals - Maternity and Neonatal Services in East Kent

Following concerns raised about the quality and outcomes of maternity and neonatal care, NHS England and NHS Improvement (NHS E/I) commissioned Dr Bill Kirkup CBE to undertake an independent review into maternity and neonatal services at East Kent Hospitals University NHS Foundation Trust.

The final report Reading the Signals - Maternity and Neonatal Services in East Kent was published in October 2022.

It reviewed 202 cases of families who received care in East Kent between 2009 to 2020.

The review found a clear pattern. Over that period, those responsible for the services too often provided clinical care that was suboptimal and led to significant harm, failed to listen to the families involved, and acted in ways which made the experience of families unacceptably and distressingly poor.

The individual and collective behaviours of people providing the services were visible to senior managers and the Trust Board in a series of reports right through the period from 2009 to 2020 and lay at the root of the pattern of recurring harm. The report identified eight clear separate missed opportunities, both internally and externally, when these problems could and should have been acknowledged and tackled effectively.

It found that the Trust treated problems as limited one-off issues, rather than acknowledging the systemic nature of the challenges and confronting the issues head on. When issues were brought into public focus, it found the Trust focussed on reputation management, reducing liability through litigation and a ‘them and us approach’. This got in the way of patient safety and learning.

A copy of the full report is available as follows:

Reading the signals: Maternity and neonatal services in East Kent – the Report of the Independent Investigation

There were four key areas for action identified within the report as follows:

1. Monitoring safe performance and identifying poorly performing units – finding signals among noise.
2. Standards of clinical behaviour – giving care with compassion and kindness, technical care is not enough.
3. Team working with a common purpose – rather than flawed teamworking, pulling in different directions,
4. Organisational behaviour – looking good while doing badly. Responding to challenge with honesty rather than focussing on reputation management.

A paper was presented to our Trust Board in February 2023 that set out the key issues and learning from the national report, recognising that they are not unique to East Kent Trust or only trusts delivering maternity services. The paper provided details on how learning from

the report has been taken forward to mitigate risks to quality and safety and included an overview of assurance against the recommendations and potential delivery risks.

Our response reinforced the importance of culture and the need for patient safety to be a priority for the Board. The paper detailed the assurance mechanisms in place across our Trust including the recent use of team cultural assessments across all inpatient wards, the development of quality and safety dashboards to highlight hot-spots and track changes in quality and safety including safe staffing over time and improved systems for organisational learning.

In relation to culture and behaviours, the establishment of two lived experience directors as core members of the Care Group Boards as well as the continued recruitment of peer workers into our Trust seeks to positively influence culture and achieve our goals of co-creation in everything we do.

Work also includes improvements to risk management systems and the more effective use of the risk register to support enhanced oversight, assurance and management of risks. In addition, our dedicated Quality Assurance and Improvement Programme focuses on key quality and safety issues and is informed and regularly refreshed to take account of new learning.

We have also set out actions we will take to further triangulate workforce and quality information and to continuously improve teamwork with a common purpose. Due to the importance of the learning, an interactive discussion and presentation on the Kirkup review has continued to be delivered at multiple clinical and managerial leadership sessions across our Trust.

3.8 External audit

Under guidance from NHS England, the Quality Account 2022/23 is not subject to review by external audit.

3.9 Our stakeholders' views

Summary of stakeholders' views to be included

Appendix 1: 2023/24 Statement of directors' responsibilities in respect of the Quality Account

Please note we are awaiting some dates in this section.

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 2022/23 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 2022 to May 2023
  - Papers relating to quality reported to the Board over the period April 2022 to May 2023
  - Feedback from the integrated Care Boards *dated xx* and *dated xx*
  - Feedback from Healthwatch *dated xx*
  - Feedback from Overview and Scrutiny Committees *dated xx*
  - Feedback from Health and Wellbeing Boards *dated xx*
  - 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 xx*
  - The latest national staff survey *published xx*
  - CQC inspection report *dated xx*
  - 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.

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: Our 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 England. It also:

- Ensure effective dialogue between our Trust and the communities we serve
- Monitors and ensures high quality services
- Is responsible for our financial viability
- Appoints and appraises our executive management team

Business plan: A document produced once a year 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 our staff and patients, 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 our 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 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): Our 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 our 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. We have an Adult Learning Disability (ALD) service in each Care Group and also specific wards for Forensic LD patients. We provide 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 (OSC): 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 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 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: Our 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 our Trust that offers confidential advice, support, and information on health-related matters. The team provides 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 our Trust, 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 (1 April to 31 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.

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 us 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 Trustwide.

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

Trust Board: See Board/Board of Directors above

Trustwide: The whole geographical area served by our Trust.

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 our 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 1 April in the first year and end on the 31 March in the second year.

Appendix 3: Stakeholders' views

Feedback to be included