NHS

Tees, Esk and Wear Valleys

NHS Foundation Trust

QUALITY ACCOUNT

2018 - 2019

making a difference together

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

I am pleased to present the Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) Quality Account for 2018/19. This is the 11th Quality Account that we have produced and it details what the Trust have done to improve the quality of our services in 2018/19 and how we intend to make further improvements during 2019/20.

The Trust provides a range of mental health, learning disability and autism services for around two million people living in County Durham, Darlington, Teesside, North Yorkshire (with the exception of Craven District) and York[1].

Our specialist services such as Child and Adolescent Mental Health Services (CAMHS) inpatient wards, adult eating disorder inpatient wards and forensic secure adult inpatient wards serve patients from elsewhere in the North East, Cumbria, Yorkshire and the Humber and further afield.

Our Mission, Vision and Strategy

The Mission of the Trust is:

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

The Trust's Vision is:

'To be a recognised centre of excellence with high quality staff providing high quality services that exceed people's expectations'

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

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

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

- We will provide care which is patient, carer and staff co-produced, recovery-focused and meets agreed expectations

[1] The Trust's community and inpatient services are also accessed by people living in Wetherby (West Yorkshire / Leeds CCG) and Pocklington (East Yorkshire / Vale of York CCG)

- We will provide care which is sensitive to the distress and needs of patients, carers and staff. Staff will respond with kind, intelligent and wise action to enable the person to flourish
- Care will need to be flexible and proactive to clinical need and provided by skilled and compassionate staff with the time to care
- Care will be consistent with best practice, delivered efficiently, and where possible, integrated with the other agencies with whom we work
- We will support staff to deliver high-quality care and will provide therapeutic environments which maintain safety and dignity

The Quality Strategy contains three goals, which are:

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

Each goal has high-level measures which the Trust monitors for assurance that the Trust's vision for quality is being delivered. These measures are scrutinised by our Quality Assurance Committee (QuAC) and Board.

A Profile of the Trust

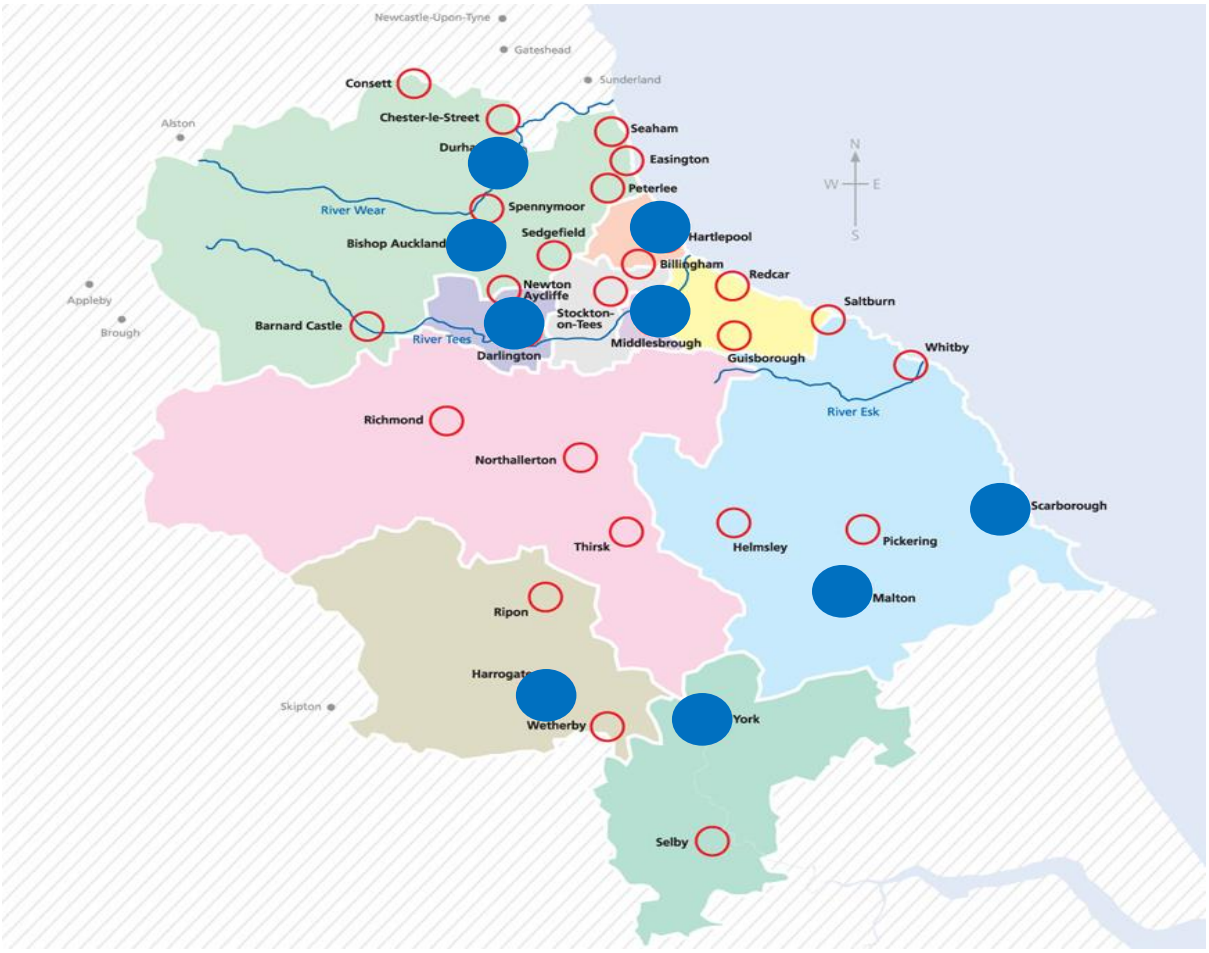
The Trust provides a range of Mental Health, Learning Disability and autism services for around two million people living in County Durham, Darlington, Teesside, North Yorkshire (with the exception of Craven District) and York.

This area covers 4,000 square miles (10,000 square kilometres). A map showing this region is provided on the following page – ***See Figure 1***. The Trust also provides some regional specialist services (e.g. Forensic Services, Children and Young person's inpatient ("tier four") Services and specialist Eating Disorder Services) to the North East and Cumbria region and beyond. The Trust is also commissioned as part of a national initiative to provide inpatient care to Ministry of Defence personnel, and provides mental health treatment to prisoners in North East England and also in parts of the North West.

Services commissioned by Clinical Commissioning Groups (CCGs) are managed within the Trust on a geographical basis. From 1st April 2019 this will be through three Localities, the first covering Durham and Darlington, the second Teesside, and the third North Yorkshire and York. There is also a non-geographic "Locality" which manages Forensic and Offender Health services. Each is led by a Director of Operations, Deputy Medical Director, Head of Nursing and Professional Lead for Psychology, who report to the Chief Operating Officer, Medical Director, Director of Nursing and Governance and Director of Therapies respectively.

- Our income in 2018/19 was **£356.1m**
- On 31st March 2019 **58,426** people had received care from TEWV during 2018/2019
- During 2018/19, on average we had **743** patients occupying an inpatient bed each day - this equates to an average occupancy rate of **86.62%** (This occupancy refers to all TEWV beds, not just to Assessment and Treatment beds where the occupancy rate is higher than this average figure)
- Our Community staff made more than **2.3 million** contacts with patients during 2018/19 (including IAPT Services)
- We have a total of **6,090** whole time equivalent employees or **6,854** permanently employed whole time equivalents

Figure 1: Map of TEWV Trust area showing main towns and locations of inpatient beds



Key				
Main Towns	O		Main town and location of TEWV inpatient beds	●

What we have achieved in 2018/19:

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

- Continued to work with our Experts by Experience ensuring that the work we do across the Trust is co-produced with them as far as possible
- Developed and rolled out the Mental Health Services for Older People (MHSOP) frailty Clinical Link Pathway (CliP) Trust-wide. This means that Baseline Visual Falls Assessment is completed within 12 hours of admission and a full Frailty Assessment within two weeks of admission. All new patients are discussed in Multi-Disciplinary Team (MDT) frailty meetings which take place at least once a week; these meetings are given priority and are attended by the physiotherapist, occupational therapist, pharmacist, physical care practitioner, medic, nurse, psychologist and admin staff
- Produced example scenarios for staff regarding safeguarding around abuse disclosures. These will be used to support good practice and reduce staff worries around having conversations about trauma with service users
- Received a Stage One award from The Carers Trust recognising commitment to becoming an organisation that involves and supports carers through implementation of the Triangle of Care (ToC). The Carer's Trust said the progress made by services over the past year has been impressive and encouraging. Work continues to embed ToC across all services, including roll-out to community teams over the next year
- Commenced construction of the new purpose-designed 72-bed hospital, Foss Park, located off Haxby Road in York. It will provide two adult single-sex wards and two older people's wards – one for patients with dementia and one for those with mental health conditions such as psychosis, severe depression or anxiety
- Introduced a new community perinatal mental health services across County Durham and Darlington, North Yorkshire and the Vale of York. Services are supporting local women who are experiencing mental health difficulties during pregnancy or in the first year after they have had their baby. Additionally, we have expanded services that the Trust already provides in Teesside
- Won the Liaison & Diversion Tenders for the Durham, Cleveland and North Yorkshire Police Force areas. In North Yorkshire and York this is a new service; our contract commenced on 1st April 2019. TEWV is working in partnership with HumanKind and Spectrum Community Health to deliver this service
- Launched an area on our Recovery College Online for young people providing information and resources, including for parents and carers
- Trained several Forensic Services patients in quality improvement techniques so that they can participate in improvement events

- Held an Annual Recovery event for Forensic wards in February 2019, enabling service users, friends and family and staff to celebrate service user achievements, recognising individual small steps
- Held a Rapid Process Improvement Workshop (RPIW) which reviewed the current Care Planning Approach, to make the process more patient-focused
- Held a family conference in relation to Preventable Deaths in March 2019, in line with the Trust's commitment to quality and involvement
- Undertaken a Mortality Review Process each month as part of the wider agenda of the Patient Safety Group. The majority of service users reviewed were over the age of 80 and the highest primary diagnosis was that of dementia – many had resided in care homes. The most notable learning point from the reviews so far is that of good practice/care and this has been fed back to the clinical teams involved. Emerging areas for improvement would appear to be similar to those from some of the incidental findings from our serious incident investigations (communication to/from GP, family involvement, early warning score monitoring and multi-agency working). In conjunction with other regional mental health organisations the Trust is trialling or mortality review tool from the Royal College of Psychiatrists and this will be evaluated throughout 2019/20
- Developed a zero inpatient suicide plan based upon the recommendations from the latest National Confidential Inquiry into Suicide and Homicide in Mental Health report (2018). It covers such areas as undertaking a follow-up to discharged patients within 72 hours rather than seven days, reducing alcohol and drug misuse and guidance on depression. Progress against the plan will be monitored by the Patient Safety Group
- Developed a steering group for the STOMP (Stopping Over-Medication of People with a Learning Disability, Autism or Both Project) and invited representatives to join from across the Trust. STOMP awareness sessions have been held with relevant services and also with student nurses at Teesside University, embedding practice for the future. A Communication Plan to promote good practice has also been developed via TEWV social media. Further work will be ongoing during 2019/20
- Held a Kaizen Quality Improvement Event to develop an autism reasonable adjustment Clinical Link Pathway (CLiP), with the aim of embedding a culture of Reasonable Adjustments across our general mental health services. The CLiP products have been launched at selected pilot sites throughout 2018 and we have received funding (from April 2019 to March 2020) to roll out the CLiP to all adult mental health teams across the Trust. Eventually we plan to seamlessly integrate the CLiP products with the Trust's forthcoming new Electronic Patient Record System, CITO
- Officially launched our Trust Autism Framework in March 2018 and held an event to showcase our work so far and plans for the future
- Delivered the face-to-face *Understanding Autism* training to 1,173 TEWV staff with a further 1,500 TEWV staff viewing our *Autism Awareness* video. We

have received further funding to allow us to continue to deliver the face-to-face training across the Trust

- Reviewed the Learning Disability Specialty Positive Behavioural Support (PBS) CLiP. This has enabled the pathway to be aligned more closely with standards published by the PBS Academy in 2017 and new NICE guidance (NG93) which was published in 2018. The pathway now has an even greater focus on improving quality of life for people with learning disabilities. There is ongoing work to develop a quality of life tool which can be used with service users who have a more significant level of disability to involve them more actively in quality of life assessments. There is also a significant piece of work taking place to develop and deliver an internal programme of competency-based PBS training for staff at the foundation and intermediate levels of the PBS competency framework. It is expected that the first cohort of staff will start this training at the end of May 2019
- Enhanced our Medicines Optimisation and Pharmacy Services by:
    - Developing a new series of lessons learned and safety bulletins designed to encourage reporting, supporting a 'fair blame' culture and enabling learning
    - Significantly improving compliance with our monthly Medicines Management Assessment process which looks at ten key safety standards; over 80% of wards now regularly achieve 100% compliance and improvements in all areas
    - Building upon the success of our monthly Medicines Management Assessments by launching regular Medicines Optimisation targeting clinical standards

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

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

TEWV's 2018 Community Mental Health Survey Results

- The response rate of **25%** was lower than the national response rate of **28%** (This is a decrease of **4%** from the response rate of **29%** in 2017/18, which was higher than the national response rate)
- TEWV scored *'better'* than the other Trusts in the question - *'Were you given information about your medicines in a way that you were able to understand?'* – the score in all other questions was *'about the same'* as the majority of other Trusts
- The highest scoring section for the Trust was *Planning Care* which scored **7.3** against the highest national score of **7.5**. Each of the three individual questions in this section scored relatively highly against the national results and also showed good improvement on 2017 Trust scores
- The overall rating on care experience has declined to **66.4%** compared to **70.9%** in 2017 and **74.3%** in 2016
- There was one question which was marked as a statistically significant improvement on that achieved in 2017 – *'Do you know who to contact out of office hours if you have a crisis?'* – 2017 score **6.4**, increased to **7.4** in 2018
- The section with the lowest overall scores for TEWV was once agai *'Support and Wellbeing'* – scoring **4.5** against the highest national score of **5.2**. When comparing the 2018 scores for the six individual questions in this section, all had deteriorated from those achieved in 2017
- The overall results for the Trust for 2018 present a mixed picture, with scores across the top, intermediate and lower ranges of the data. Unfortunately scores have decreased over the last two years, although the Trust's performance is still in line with national norms across all sections

TEWV's National NHS Staff Survey Results 2018*

*This data covers the calendar year 2018

Previously, the Trust only invited a sample of staff to complete the National NHS Staff Survey. However from 2018 this invitation was extended to include all TEWV staff.

In the 2018 national NHS Staff Survey, the Trust had a response rate of **30.5%** (**1,988** of **6,518** eligible staff). The average response rate for Mental Health and Learning Disability Trusts was **54%**

The Trust scored better than average on nine of the 10 themes covered by the Staff Survey, two of which were the best score for Mental Health providers (Equality, diversity and inclusion; and Safety Culture). Our score on the Quality of Care theme was equal to the national average.

TEWV's Staff Friends and Family Test Results

Our *Staff Friends and Family Test (FFT)* results include (from **2,172** responses)*:*

- **81%** are likely or highly likely to recommend treatment at TEWV
- **69%** would recommend TEWV as a place to work
- **83%** agree that they are able to make suggestions for improvement

National Awards – Won or Shortlisted

In 2018/19 the Trust was recognised externally in a number of national awards where we won or were shortlisted. Awards won or highly commended by TEWV teams or staff members are shown in the table below:

Awarding Body	Award Status	Name/Category of Award	Team/Individual
The Carers Trust	Awarded	Stage 1 Award (Triangle of Care)	TEWV
Royal College of Psychiatrists	Awarded	Memory Services National Accreditation Programme	Harrogate Memory Service
Love York Awards (University of York)	Winner	Honorary Contribution to Student Life Award	IAPT Team (York, Selby, Tadcaster & Easingwold)
Student Nursing	Winner	Student Nurse of the	Joe Atkinson

Times		Year: Mental Health	
CYPS Celebrating Good Practice Awards	Winner	Team Achievement of the Year	Rachel Orr
			Katy Philips
Durham & Tees Valley GP Training Programme	Awarded	Clinical Supervisor of the Year	Mani Krishnan
HSJ Patient Safety Awards	Winner	Maternity & Midwifery Services	Perinatal MDT, HMP YOI Low Newton
Healthwatch York Making a Difference	Winner	Excellence in Health and Social Care Services	MHSOP Team, Acomb Garth, York
NEPACS	Awarded	New approach to management and therapeutic support of prisoner with mental health issues	Integrated Support Unit, I Wing, HMP Durham
Positive Practice in Mental Health Awards	Winner	Mental Health & Emergency Services/Criminal Justice	All-age Liaison & Diversion Service, Middlehaven Police Station
Positive Practice in Mental Health Awards	Awarded	Outstanding initiatives to improve patient care	Older Person's Functional Community Mental Health Team, Lustrum Vale
Royal College of Psychiatrists Awards	Winner	Team of the Year – Quality Improvement Category	MHSOP, Teesside
Cavell Star Award	Winner	For nurses, midwifes and health care assistants who shine bright and show exceptional care to either their patients, patient's families or colleagues	Jenny Trowsdale
			Stacey Daniels
			Kali Penfold
			Sarah Waite
			Linda Schumacher
			Deborah Jeffery
Royal College of Psychiatrists Awards	Winner	Specialty Doctor of the Year	Thandar Win
Teesside University	Awarded	Certificate of Excellence	North Tees Liaison Psychiatry Team, Farnedale
Durham Constabulary	Awarded	Wow! Award	Rebecca Stainsby
HSJ Partnership Awards	Winner	Legal Services Provider of the Year	TEWV & Ward Hadaway

Autism Professionals Awards	Winner	Outstanding Health Services	Trust-wide Autism Project Team
Autism Professionals Awards	Winner	Outstanding Health Services	The Northdale Centre, Roseberry Park

Awards where TEWV as an organisation, or one of our teams/a member of staff were shortlisted for an award but did not win that award in 2018/19 were:

Awarding Body	Award Status	Name/Category of Award	Team/Individual
BBC One Show NHS 70 Awards	Shortlisted	Lifetime Achievement Awards	Dr Muthukrishnan
Nursing Times	Shortlisted	Learning Disabilities Nursing Category	Learning Disabilities Service, North Yorkshire
		Team of the Year	MHSOP Community Team, Harrogate
Positive Practice in Mental Health Awards	Highly Commended	Older Adult Functional Mental Health Service	Stockton Community Mental Health Team
Royal College of Psychiatrists	Finalists	Older Adults Team of the Year	Stockton Community Mental Health Team
Great British Care Awards	Shortlisted	N/A	Deborah Jeffery
			Lynne Taylor
NHS70 Parliamentary Awards	Nominated	Excellence in Mental Health Care	Sarah McGeorge
HSJ Awards	Shortlisted	Improved Partnerships between Health & Local Government	Durham Liaison & Diversion Team

Structure of this Quality Account Document

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

- **Part 2:** Information on how we have improved in the areas of quality we identified as important for 2018/19, the required statements of assurance from the Board and our priorities for improvement in 2019/20
- **Part 3:** Further information on how we have performed in 2018/19 against our key quality metrics and national targets and the national quality agenda

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

A full statement of Director's responsibilities in respect of the Quality Account is included in **Appendix 1**. This is further supported by the signed limited assurance report provided by our external auditors on the content of the 2018/19 Quality Account which is included in **Appendix 2**.

I hope you find this report interesting and informative.

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

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

Mr Colin Martin
Chief Executive
Tees, Esk and Wear Valleys NHS Foundation Trust

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

2018/19 and 2019/20 Priorities for Improvement – How did we do and our future plans

During 2018/19 we held two events inviting our stakeholders to take part in our process of identifying quality priorities for 2019/20 to be included in the Quality Account. These events took place in July 2018 and February 2019; further information can be found in **Part 3, Our Stakeholders' Views** section. The five quality priorities which we identified from this engagement also sit within TEWV's 2019/20-2021/22 Business Plan. The Business Plan includes a further 13 priorities all of which have a positive impact on the quality of Trust services. Details of these priorities can be found in **Appendix 5.**

Our five agreed 2019/20 priorities for inclusion in the Quality Account are:

Priority 1: Improve the clinical effectiveness and patient experience in times of transition from Child to Adult Services
Priority 2: Reduce the number of Preventable Deaths
Priority 3: Making Care Plans more personal
Priority 4: Develop a Trust-wide approach to Dual Diagnosis which ensures that people with substance misuse issues can access appropriate and effective mental health services
Priority 5: Review our Urgent Care Services and identify a future model for delivery

Priorities 1 - 4 were priorities in 2018/19 and the section below includes information on what we have done during 2018/19 and what we will do in 2019/20. Priority 5 is a new priority which we have developed for 2019/20.

Priority 1: Improve the Clinical Effectiveness and Patient Experience in times of transition from Child to Adult Services

Why this is important:

We define Transitions for this Quality Account Priority as a purposeful and planned process of supporting young people to move from Children's to Adult Services. Young people with ongoing or long-term health or social care needs may be required to transition into Adult services, other service provision or back to their GP. The preparation and planning around moving on to new services can be an uncertain time for young people with health or social care needs. There is evidence of service gaps where there is a lack of appropriate services for young people to transition into, and evidence that young people may fail to engage with services without proper support.

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

The particular importance of improving the transition from children and young people's services to adult services was recognised by our Quality Account in 2015. We initially agreed to put a two-year quality improvement priority in place, focusing on this specific transition. The paragraphs below show what we achieved in 2018/19.

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

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

What we did in 2018/19:

What we said we would do:	What we did:
• Implement actions from the thematic review (conducted at the end of 2017/18) of patient stories by Q1 2018/19.	• Only three stories were received in the first nine months of the year which was not enough to complete a thematic review. This action was therefore changed to 'Share and embed best practice from the stories received so far'. We have now collated feedback/views from 11 young people who have moved from CAMHS to AMH services. It provides a varied picture of their experiences ranging from excellent to poor. This information has been shared with CAMHS and AMH Heads of Service and relevant Service Development Managers to use as learning with their teams
• Registered CAMHS and Adult Services staff to undertake further specific training on the Transitions process by Q1 2018/19	• Registered CAMHS and Adult Services staff have undertaken further specific training on the Transitions process. There are plans to roll out a training presentation until the end of May 2019

• Review Transitions panels already in place (set up during 2017/18), gain additional service user perspective and set relevant targets and metrics by Q3 2018/19	• Transitions panels have been observed and reviewed and service user perspective was gained from 11 young people. These panels are in place in all localities; however the format and attendees remain slightly different in each. We will use the data to inform improvement metrics in 2019/20
• Produce an engagement plan to involve family and carers in the process by Q4 2018/19	• An engagement plan has been produced by the CAMHS Head of Service for Durham & Darlington and the Trust CAMHS Service Development Manager

How do we know we have made a difference?

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

Indicator	Target	Actual	Timescale
• Percentage of joint agency transition action plans in place for patients approaching transition	**80%**	**94.2%**	Q4 2018/19
• Percentage of patients who reported feeling prepared for transitions at the point of discharge	**80%**	**76%**	Q4 2018/19
• Percentage of patients who have transitioned to AMH from CYPS who indicate that they have met their personal goals as agreed in their transition plan	**70%**	**69%**	Q4 2018/19

At the Quality Account event held in July 2018 to discuss priorities for 2019/20 it was agreed that transitions remain an area of concern and that this should be carried forward for at least another year. The actions below are those for the third year of this priority to further embed the improvements already undertaken.

What we will do in 2019/20:

We will:
• Use available data from Q4 2018/19 to undertake a gap analysis of numbers of transitions occurring and numbers of transitions panels occurring per locality (including attendance by Adult Services and CAMHS staff) by Q1 2019/20

- Set improvement trajectories for the remainder of 2019/20 based on outcomes of the analysis above during Q1 2019/20 and report on these trajectories during Q2, Q3 and Q4 2019/20

- Review the Healthcare Safety Investigation Branch report 'Transition from child and adolescent mental health services to adult mental health services' and identify any action or learning for the Trust during Q1 2019/20 and report on progress during Q3 and Q4 2019/20

- Hold a joint CYPS & Adult Services Engagement Event during Q2 2019/20 and report on the actions from this event during Q3 and Q4 2019/20

- Establish any potential barriers to successful transitions and consider how these could be overcome
    - Establish agreed models for transition panels
    - Include Experts by Experience sharing their experiences of transitions
    - Include presenting case studies of difficult to manage transitions and the learning regarding how to overcome difficult to manage transitions
    - Include partners from other organisations

- Evaluate the effectiveness of transition panels across the Trust during Q4 2019/20

How will we know we are making a difference?

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

Indicator:	Target:	Timescale:
• Percentage of young people (who are moving to adult services) who have a transition plan in place	**100%**	Q4 2019/20
• Percentage of joint agency transition action plans in place for patients approaching transition	**80%**	Q4 2019/20
• Percentage of patients who reported feeling prepared for transitions at the point of discharge	**80%**	Q4 2019/20

Priority 2: Reduce the number of Preventable Deaths

Why this is important:

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

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

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

In order to reduce preventable deaths, it is also important that learning from deaths is shared and acted on with an emphasis on engaging families and carers in this learning. During 2017/18, through our investigation process, we identified a number of preventable deaths of inpatients which took place while they were on leave. We put actions in place for improvements in this area and it is important that we continue this work to ensure our patients do not suffer preventable harm.

In addition to the work done under our Quality Account priority, TEWV has also been supporting the work of the Cumbria and North East Integrated Care System to tackle issues related to the physical health of people with a mental health condition. This has been focussing on collecting service user stories, promoting physical activity and weight loss and improving the knowledge of non-mental health NHS workers about the needs of their services users who also have mental health needs.

The benefits/outcomes we aimed to deliver for our patients and their carers in 2018/19 were:

- That our processes reflect national guidance and best practice which will ensure we are delivering the best, evidence-based care and treatment to our patients
- A reduction in the number of preventable harm incidents and deaths of inpatients on leave from hospital
- To feel listened to during investigations of death and are consistently treated with kindness, openness and honesty

- Increased confidence that investigations are being carried out in accordance with best-practice guidelines and in a way that is likely to identify missed opportunities for preventing death and improving services
- That the Trust learns from deaths, including identifying any themes early so that actions can be taken to prevent future harm

What we did in 2018/19:

What we said we would do:	What we did:
• Develop a co-produced family and carer version of the Learning from Deaths policy by Q1 2018/19	• A co-produced family and carer version of the Learning from Deaths policy has now been produced
• Produce an engagement plan to involve family, carers and non-Executive Directors within the review process by Q2 2018/19	• An engagement plan to involve family, carers and non-Executive Directors within the review process has now been developed
• Implement the engagement plan by Q3 2018/19	• The engagement plan is now being implemented
• Hold a family conference in conjunction with Leeds & York Partnership NHS Foundation Trust. This will allow us to share good practice and continue to develop the further involvement of families and carers in the preventable deaths process by Q3 2018/19	• A family conference was held on 8th March 2019 which included gathering feedback from families/carers and staff about how they can be better engaged in the process moving forward. The conference was organised by TEWV and attended by representatives from TEWV, Northumberland, Tyne & Wear (NTW), Leeds & York Partnership, and Sheffield Health & Social Care NHS Trust
• Evaluate the level and effectiveness of engagement with families, carers and Non-Executive Directors (NEDs) by Q4 2018/19	• Using findings from the above we have completed an evaluation of progress and created an action plan to move forward which will be monitored throughout 2019/20. The NEDs have provided their support for this approach with an agreement that they may become more involved with the mortality review process in future

How do we know we have made a difference?

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

Indicator	Target	Actual	Timescale
• Increase the proportion of deaths that are reviewed as part of the mortality review processes (this is in addition to the existing Serious Incident process)	**120**	**204**	Q4 2018/19
• Eliminate preventable deaths of inpatients during periods of leave	**0**	**1**	Q4 2018/19
• Reduce the number of Serious Incidents where it was identified that the Trust contributed to the incident	**37**	**39**	Q4 2018/19

What we will do in 2019/20:

At the Quality Account event held in July 2018 to discuss priorities for 2019/20 it was agreed that reducing preventable deaths remains a priority and that this should be carried forward for at least another year. The actions below are those for the next year of this priority to further embed the improvements already undertaken.

We will:

- Produce an action plan from the March 2019 Family Conference by Q1 2019/20, and implement this plan by Q4 2019/20
- Commence circulation of a new guidance booklet to families who have lost a loved one during Q1 2019/20, and review and evaluate the impact of this booklet by Q4 2019/20
- Review the Trust-wide policy in relation to Preventable Deaths and make necessary amendments during Q1 2019/20
- Participate in all of the regional Mental Health Learning from Deaths Forum meetings during 2019/20
- Implement any new national guidance once released – by Q4 2019/20

How will we know we are making a difference?

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

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

Priority 3: Making Care Plans more personal

Why this is important:

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

Feedback from services users shows that our current approach to care planning does not always promote a personalised approach, hence this being identified as a priority in 2018/19.

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

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

What we did in 2018/19:

What we said we would do:	What we did:
• Co-produce an action plan with service users, carers and staff teams based on the findings and recommendations of the 2017/18 audit by Q1 2018/19	• An action plan has now been co-produced
• Co-produce guidance about what Personalised Care Planning means and how to demonstrate this through clinical records by Q1 2018/19	• Guidance has now been co-produced
• Co-develop training and development packages, aligning these to, and incorporating where possible, the training and development work of other programmes, projects and business as usual – these must include evaluation measures by Q2 2018/19	• Training packages have been co-developed and in conjunction with the Recovery Programme which links with audit findings and focus group themes; it will now be rolled out for delivery
• Co-deliver training and development packages – Trustwide by Q3 2018/19	• Training is now being delivered across the Trust which enabled approximately 200-300 people to be trained by the end of Q4 2018/19
• Re-audit and report as per Q4 2017/18 by Q4 2018/19	• The original audit and subsequent report did not take place until Q3 2018/19 and so the re-audit and report has been pushed back to Q3 2019/20

How do we know we have made a difference?

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

Indicator	Target	Actual	Timescale
The following indicators are for TEWV from the National Mental Health Community Survey 2018 (% for 2017)			
• Do you know who to contact out of office hours if you have a crisis? (64%)	**74%**	**74%**	

• Were you involved as much as you wanted to be in deciding what treatments or therapies to use? (68%)	**78%**	**76%**	All Q4 2018/19
• Have you been given information by NHS Mental Health Services about getting support from people who have experience of the same mental health needs as you? (32%)	**42%**	**31%**	
• Do the people you see through NHS mental health services help you with what is important to you? (66%)	**76%**	**69%**	
• Were you involved as much as you wanted to be in agreeing what care you will receive? (71%)	**81%**	**76%**	
• Were you involved as much as you wanted to be in discussing how your care is working? (75%)	**85%**	**71%**	
• Does the agreement on what care you will receive take your personal circumstances into account? (75%)	**85%**	**79%**	

What we will do in 2019/20:

At the Quality Account Stakeholder event held in July 2018 to discuss priorities for 2019/20 it was agreed that Care Planning remains an area where further improvement is needed and that this should be carried forward for at least another year. The actions below are those for the next year of this priority to further embed the improvements already undertaken.

We will:

- Complete appropriate impact assessments in relation to DIALOG and seek approval via the relevant channels (DIALOG is a clinical tool that allows for assessment, planning, intervention and evaluation in one procedure) by Q1 2019/20
- Involve experts by experience in care planning training workshops to provide feedback on the training and the process in general by Q4 2019/20
- Review the training package and produce an options appraisal regarding how to proceed (including non-face-to-face resources) by Q1 2019/20

- Continue with training package roll-out as per the agreement following options during Q2 and Q3 2019/20
- Test DIALOG within existing IT systems during Q2 2019/20
- Re-audit and report as per Q4 2017/18 during Q3 2019/20 (booked with Clinical Audit for October 2019)
- Compare and contrast review of Patient Experience during Q4 2019/20

How will we know we are making a difference?

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

Indicator:	Target:	Timescale:
• Do you know who to contact out of office hours if you have a crisis?	**84%**	All Q4 2019/20
• Were you involved as much as you wanted to be in deciding what treatments or therapies to use?	**86%**	
• Have you been given information by NHS Mental Health Services about getting support from people who have experience of the same mental health needs as you?	**41%**	
• Do the people you see through NHS mental health services help you with what is important to you?	**79%**	
• Were you involved as much as you wanted to be in agreeing what care you will receive?	**86%**	
• Were you involved as much as you wanted to be in discussing how your care is working?	**81%**	
• Does the agreement on what care you will receive take your personal circumstances into account?	**89%**	

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

Why this is important:

Service users with severe mental health problems who are also misusing substances (known as dual diagnosis) have high risks of harm to themselves or others, poor outcomes and high treatment costs. Changes in commissioning arrangements of substance misuse services could lead to increased risk of service gaps for patients with dual diagnosis. The Trust has recognised the importance of adapting to these changes and becoming more proactive in developing services that address the specific needs of this group of service users. In addition, the feedback we received from stakeholders identified that this should be a priority for 2018/19.

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

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

What we did in 2018/19:

What we said we would do:	What we did:
• Circulate Dual Diagnosis CliP to all localities, specialities and specialty sub-groups for them to agree the most appropriate place to integrate within their pathways by Q1 2018/19	• The CLiP has been circulated to relevant directorates, specialties and sub-groups
• Establish a process with the Patient Safety Team that incorporates Dual Diagnosis in investigations/reviews by Q1 2018/19	• A process has been established so that Dual Diagnosis is now formally considered within investigation/ review processes
• Directorate specialties to confirm their use of the Dual Diagnosis CliP (proportionate to their need) within relevant pathways by Q2 2018/19	• The Dual Diagnosis CLiP has now been fully rolled out and is confirmed to be in use by directorates and localities where this is appropriate

• Introduce a Training Needs Analysis (TNA) which includes Dual Diagnosis and identify those staff with dual diagnosis capabilities by Q2 2018/19	• The TNA has been undertaken and has identified a list of leads who have Dual Diagnosis capabilities
• Establish a training structure linked to Locality and Specialty requirements by Q3 2018/19	• This Training Structure has now been agreed
• Ensure all services have at least one person trained in Dual Diagnosis issues or have access to a trained clinician (proportionate to each directorate's needs) as a contact regarding Dual Diagnosis issues by Q4 2018/19	• There is at least one Dual Diagnosis champion in each locality but not within each service in all localities; however these champions provide cross-cover and allow services to access their expertise wherever it is needed
• Complete an annual thematic review of risks and Serious Incidents involving service users with Dual Diagnosis by Q4 2018/19	• A thematic review was completed in November 2018 and has been presented to the appropriate forums; all Serious Incidents involving service users with dual diagnosis are reviewed at the Extraordinary Drug Related Incidents Directors panel
• Establish links with the confidential enquiry process and identify whether there are any potential missed mental health factors in recorded drug-related deaths by Q4 2018/19	• All drug-related deaths are reviewed at the Extraordinary Drug Related Incidents Directors panels to identify whether there have been any missed MH factors and where lessons can be learnt - links are now established with the confidential enquiry process but these need to be made more robust and reliable
• Engage partners and stakeholders to agree a future approach and produce the framework/document which outlines the forward view for Dual Diagnosis by Q4 2018/19	• Due to the Trust-wide Dual Diagnosis lead acting into another role and no permanent replacement being appointed as yet this has not been completed. Therefore this will now be completed during Q1 2019/20

How do we know we have made a difference?

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

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

*AMH, CYPS, MHSOP, Learning Disabilities and Forensics

What we will do in 2019/20:

At the Quality Account Stakeholder event held in July 2018 to discuss priorities for 2019/20 it was agreed that Dual Diagnosis remains an area of concern and that this should be carried forward for at least another year. The actions below are those for the next year of this priority to further embed the improvements already undertaken.

We will:
• Review how current Dual Diagnosis networks across the Trust work to ensure they are effective, sustainable and fit for purpose during Q2 2019/20
• Review attendance at these Dual Diagnosis networks across the Trust and identify additional attendees to target to ensure these networks are truly multi-agency during Q3 2019/20
• Implement new reporting procedures via Datix (the Trust's internal incident logging system) so incidents that are drug/alcohol related are flagged by Q1 2019/20
• Undertake a qualitative evaluation into how the new Datix reporting procedure is working and whether these incidents are being picked up and recorded correctly by Q4 2019/20
• Explore how peer workers can be better involved with Dual Diagnosis work across the Trust area; including consideration of how a Peer Leadership Network could be established by Q4 2019/20
• Complete a further survey of staff Dual Diagnosis capabilities and skills and produce strategy paper by Q1 2019/20
• Complete further follow up work that is identified via the above survey and related strategy paper by Q4 2019/20

How will we know we are making a difference?

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

Indicator:	Target:	Timescale:
• Maintain Dual Diagnosis networks with at least quarterly meetings in every locality	**100%**	Q4 2019/20
◦ AMH Community Teams in attendance at one or more Dual Diagnosis network meetings	**80%**	Q4 2019/20
◦ Inpatient representatives to attend Dual Diagnosis meetings	**50%**	Q4 2019/20
• Each of the four localities to have at least one peer worker in place with a dedicated role in Dual Diagnosis	**100%**	Q4 2019/20

Priority 5: Review our Urgent Care services and identify a future model for delivery

Feedback from our stakeholders during 2018/19 has indicated that they see urgent care as very important and so we have agreed to include this as our fifth quality priority for 2019/20. This is also identified as a priority for Trusts in the NHS Long-Term Plan (2019). In this case, Urgent Care refers to crisis, acute liaison and street triage services across the Trust. In the short-term our focus is on crisis services, with longer-term focus on urgent care more widely.

Why this is important:

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

Along with our Stakeholders we therefore identified this as a 'new' priority for 2019/20. Although this was not a Quality Account priority during 2018/19, the Trust has been taking action to review and improve urgent care services over the past year. For example, we have:

- Produced a new Crisis Operational Policy in March 2018
- Produced guidance and standards in relation to alcohol and substance misuse
- Held the first Trust-wide Urgent Care Conference in May 2018
- Reviewed patient and carer information – 'Your stay in hospital', 'Crisis Teams' and 'What to do in a Crisis'
- Conducted an RPIW post-implementation audit of triage, assessment and intensive home treatment quality standards between May and October 2018
- Held an RPIW refresh event in October 2018 (which built on a previous event held in 2017)
- Held a CITO (electronic patient record) launch event in December 2018
- Introduced a Regional Suicide Prevention Strategy and local groups
- Completed Phase 1 of national benchmarking in conjunction with NHS England
- Established a Trust-wide Crisis Network and Acute Care Group
- Supported commissioner-led reviews in Durham & Darlington and Teesside

The benefits/outcomes our patients and carers should expect:

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

What we will do in 2019/20:

We will:
• Review the current Crisis Operational Policy by Q2 2019/20 • Host a Trust-wide Urgent Care Conference by Q3 2019/20 • Undertake internal Trust-wide peer review visits in line with Home Treatment Accreditation Scheme (HTAS) / TEWV standards by Q4 2019/20 • Ensure ambulance services can check whether any person they are called to see has a Mental Health crisis plan in place by Q1 2019/20 • Agree CITO (electronic patient record) pathway/journey for crisis services by Q4 2019/20

- Implement a new Crisis Operational Model for Durham and Darlington Crisis Teams by Q1 2019/20
- Implement the agreed actions arising from the Teesside urgent care review by Q4 2019/20
- Develop key principles and future vision for future urgent care model by Q3 2019/20

How will we know we are making a difference?

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

Indicator:	Target:	Timescale:
• Percentage of patients triaged via the Crisis Team assessed within four hours of referral	**100%**	Q4 2019/20
• Percentage of patients with a crisis and recovery plan devised and shared with the patient/carer following an episode of Intensive Home Treatment (IHT)	**100%**	Q4 2019/20

Monitoring Progress

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

We will also feedback progress made during quarter one at our July Quality Account stakeholder event, send a six-monthly update to all our stakeholders, and provide a further update on the position as of 31st December 2019 at our February 2020 Quality Account stakeholder workshop.

Statement of Assurances from the Board 2018/19

The Department of Health and NHS Improvement require us to include our position against a number of mandated statements to provide assurance from the Board of Directors on progress made on key areas of quality in 2018/19. These statements are contained within the blue boxes. In some cases, additional information is supplied and where this is the case this is provided outside of the boxes.

Review of Services

During **2018/19** TEWV provided and/or sub-contracted **20** relevant health services, including Adult Mental Health Services, Mental Health Services for Older People, Children and Young People's Services and Adult Learning Disability Services in four localities, Forensic Learning Disability Services, Forensic Mental Health Services, Offender Health Services and Children's Tier 4 Services

TEWV has reviewed all the data available to them on the quality of care in **20** of these relevant health services

The income generated by the relevant health services reviewed in 2018/19 represents **100%** of the total income generated from the provision of the relevant health services bv TEWV for 2018/19

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

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

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

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

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

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

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

Participation in clinical audits and national confidential inquiries

During 2018/19, **seven** national clinical audits and **two** confidential inquiries covered the health services that TEWV provides

During 2018/19, TEWV participated in **86% (6/7)** of national clinical audits and **100% (2/2)** of national confidential inquiries which it was eligible to participate in.

The national clinical audits and national confidential inquiries that TEWV was **eligible to participate in** during 2018/19 were as follows:

- POMH (Prescribing Observatory for Mental Health) Topic 7f: Monitoring of patients prescribed Lithium (ongoing)
- POMH Topic 6d: Assessment of the side effects of depot antipsychotics (ongoing)
- POMH Topic 18a: prescribing Clozapine (ongoing)
- National Clinical Audit of Anxiety and Depression (NCAAD) (ongoing)
- National Clinical Audit of Anxiety and Depression (NCAAD): Spotlight Audit in Psychological Therapies
- National Audit of Care at End of Life (NACEL) (ongoing)
- National Clinical Audit of Psychosis (NCAP): Spotlight Audit in Early Intervention in Psychosis (EIP) Services (ongoing)
- National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH)
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

The national clinical audits and national confidential inquiries that TEWV **participated in** during 2018/19 are as follows:

- POMH Topic 17f: Monitoring of Patients Prescribed Lithium (ongoing)
- POMH Topic 6d: Assessment of side effects of depot antipsychotics (ongoing)
- POMH Topic 18a: prescribing Clozapine (ongoing)
- National Clinical Audit of Anxiety and Depression (NCAAD) (ongoing)
- National Audit of Care at End of Life (NACEL) (ongoing)
- National Clinical Audit of Psychosis (NCAP): Spotlight Audit in Early Intervention in Psychosis (EIP) Services (ongoing)
- National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH)
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

The national clinical audits and national confidential inquiries that TEWV participated in, and for which data collection was completed during 2018/19, are listed below alongside the number of cases submitted to each audit or inquiry as a percentage of the number of registered cases required by the terms of the national audit or inquiry.

Audit Title	Cases Submitted	% of the number of registered cases required
POMH Topic 7f: Monitoring of Patients Prescribed Lithium (ongoing)	234	Not Applicable
POMH Topic 6d: Assessments of side effects of depot antipsychotics (ongoing)	270	Not Applicable
POMH Topic 18a: Prescribing Clozapine (ongoing)	133	Not Applicable
National Clinical Audit of Anxiety and Depression (NCAAD) (ongoing)	100	100%
National Audit of Care at End of Life (NACEL) (ongoing)	1*	100%
National Clinical Audit of Psychosis (NCAP): Spotlight Audit in Early Intervention in Psychosis (EIP) Services (ongoing)	370	100%
National Confidential Inquiry into Suicide & Homicide by People with Mental Illness	42**	82%
National Confidential Enquiry into Patient Outcome and Death	n/k***	Unknown

*Organisation Level data was required for Mental Health Services
** The NCISH no longer send out homicide questionnaires from April 2018 and figures represent response rate for suicide questionnaires returned from the provider
*** Cases are submitted confidentially and directly by individual consultants, and therefore, the number of cases submitted is unknown

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

The reports of **174** local clinical audits were reviewed by the provider in 2018/19 and TEWV intends to take actions to improve the quality of healthcare provided. **Appendix 4** includes the actions we are planning to take against the **seven** key themes from these local clinical audits reviewed in 2018/19.

In addition to those local clinical audits reviewed (i.e. those that were reviewed by our Quality Assurance Committee and Clinical Effectiveness Group) the Trust undertook a further **25** clinical audits in 2018/19 which include clinical effectiveness projects undertaken by Junior Doctors, Consultants or other Directorate/Specialty Groups. These clinical audits were led by the services and individual members of staff for reasons of service improvement and professional development and were reviewed by the Specialty Clinical Audit Subgroups.

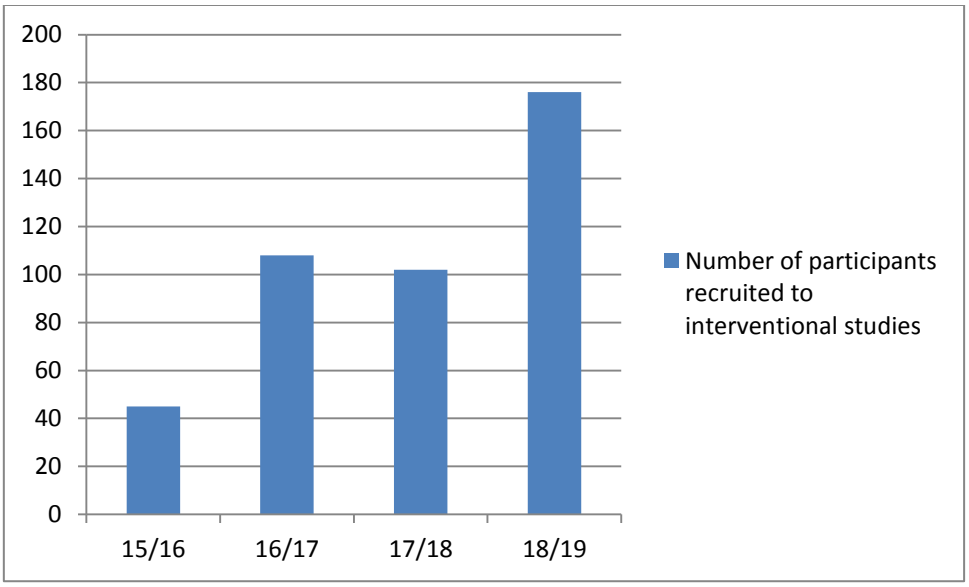
Participation in Clinical Research

The number of patients receiving relevant health services provided or subcontracted by TEWV in 2018/19 that were recruited during that period to participate in research approved by a Research Ethics Committee was **800**.

Of the **800** participants, **664** were recruited to **43** National Institute for Health Research (NIHR) portfolio studies. This compares with **1,299** patients involved as participants in NIHR research studies during 2017/18.

During 2018/19, we have successfully increased opportunities for participation in more complex interventional research studies which have lower recruitment targets than the large-scale observational studies recruited to in 2017/18. Although the overall number of participants in research has decreased, the chart below demonstrates the increase in recruitment to interventional studies which has grown from **45** participants in 2015/16 to **174** in 2018/19

Figure 2: Number of participants in interventional studies between 2015/16 and 2018/19



In 2018/19, we had feedback from **75** research participants in TEWV about their experience of taking part in research. **94%** of participants strongly agreed or agreed that taking part in research should be a normal part of NHS Healthcare. **91%** strongly agreed or agreed that they would be happy to take part in another research study

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

- We were involved in conducting **111** clinical research studies during 2018/19. **48** of these studies were supported by the NIHR through its networks
- **42** members of our clinical staff participated as researchers in studies approved by a Research Ethics Committee, with **21** of these in the role of Principal Investigator for NIHR supported studies, which is almost double the number in 2017/18
- **170** members of our staff were also recruited as participants to NIHR portfolio studies
- Following the success of identifying members of staff in the Clinical Teams in Mental Health Services for Older People to become Research Champions to promote opportunities for service users to participate in research, we have begun to roll out this model to other specialties to have Research Champions in place by the end of 2019/20
- 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

In December 2017, the Trust and the University of York (UoY) signed a long-term Memorandum of Understanding to collaborate on research, aiming for both local and global impact, with benefits for the people we serve

Key achievements from the TEWV/UoY partnership during 2018/19 are:

- Christina Van der Feltz-Cornelis has been appointed to the Department of Health Sciences at Hull York Medical School as Professor of Psychiatry and Epidemiology from July 2018, with an honorary clinical consultant appointment at the Trust as Liaison Psychiatrist. Her work focuses on common mental disorders such as somatic symptom disorders, depression and anxiety, and the promotion of mental and physical health amongst those with combined chronic medical conditions and mental disorders
- David Ekers was awarded an Honorary Visiting Professorship with the University in May 2018. He is the Trust's first Nurse Professor, having studied at York to gain his PhD and established a successful programme of research in Primary Care Mental Health in his Trust role as a Nurse Consultant
- Lina Gega from Health Sciences UoY has been appointed as an Honorary Nurse Consultant in Mental Health in TEWV
- Consultant Forensic Psychiatrist Anne Aboaja has been appointed as Honorary Visiting Fellow to the University and also an NIHR North East and

North Cumbria Clinical Research Network Lead for research career development in mental health

- The University has been successful in securing a Mental Health Network Plus programme grant from the UK's Research Councils to investigate new approaches to physical health in severe mental illness, entitled "Closing the Gap"
- The mental health charity MQ, identified the University as one of the top ten UK institutions receiving the highest levels of funding for mental health research
- The Trust has been successful in winning £2.4 million in its first hosted NIHR Programme Grant for Applied Research, developing and trialling psychological approaches to depression in older people with multi-morbidity
- A number of smaller grant successes including the development of a Patient and Public Involvement Network at York and an amalgam to share research findings on the completed workforce project have also been achieved and others are in development
- An Economic and Social Research Council-supported Knowledge Mobilisation Project led by Professor Rachel Churchill is working closely with library services across both TEWV and Northumberland, Tyne and Wear (NTW) Mental Health NHS Foundation Trusts to better implement research findings into practice. The project has developed seven new online critical appraisal skills resources which will develop the research skills of staff across the Trusts
- The Partnership identified a number of research priorities for the future including workforce mental health, common mental disorders, and improving physical health in severe mental illness

Goals agreed with Commissioners

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

A proportion of TEWV's income in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between TEWV and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Further details on the agreed goals for 2018/19 and for the following 12-month are available electronically at:

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

As part of the development and agreement of the 2017/19 (which ran from 1st April 2017 to 31st March 2019) mental health contract, we were provided with a list of nationally mandated CQUINs and then were given an option to add one further local CQUIN which the Trust opted to do in agreement with the commissioners. This included indicators around physical healthcare, staff health and wellbeing and discharge and resettlement within specialist services. These are monitored at meetings every quarter with our commissioners.

An overall total of **£4,992,919** was available for CQUIN to TEWV in 2018/19, conditional upon achieving quality improvement and innovation goals across all of its CQUINs. A total of **£4,634,789 (93%)** is estimated to be received for the associated payment in 2018/19; however this will not be confirmed until May 2019. This represents **1.5%** of the Trust income rather than 2.5% as in previous years; as 0.5% was allocated for engagement in STPs (Sustainability and Transformation Partnerships, now replaced by Integrated Care Partnerships) and a further 0.5% towards achieving our control total. Including the further 1% available, a total of **£7,458,346** was available and **£7,100,216 (95%)** is estimated to be achieved.

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

Some examples of CQUIN indicators which the Trust made progress with in 2018/19 were:

- Healthy food for NHS staff, visitors and patients – This CQUIN will help to reduce the consequence of excessive sugar consumption including obesity, dental decay and other health issues for our staff visitors and patients. Building on some of the achievements in 2016/17 and 2017/18, we have continued to be part of the national SSB (Sugar-Sweetened Beverages) reduction scheme; ensured that SSB are 10% or less of all litre drinks sold, that all confectionary and sweets do not exceed 250kcal; and we have achieved the standards in relation to reducing the calories for sandwiches and other savoury pre-packed meals

- Preventing ill health by risky behaviours – this CQUIN aims to incentivise and support healthier behaviour by encouraging smoking cessation and reduced alcohol consumption in patients, where appropriate. For both alcohol and smoking, this involves undertaking screening, providing brief advice, referral to specialist services (where appropriate) and the offer of stop smoking medication. We have achieved all targets across all localities during the year, supporting our patients to quit smoking and/or reduce their alcohol consumption to enable them to lead healthier lives

- Virtual Recovery College - This was our local scheme agreed with the commissioners and one that we felt was very important. The Trust launched the Virtual Recovery College two years ago and the site now hosts over 100 pages, an increase of 25% from last year. The site is accessible to all internet users and was visited 20,639 times during the two-year CQUIN period, between April 2017

and March 2018 by 15,666 users. Of these users 87.5% have been first-time users whilst 12.5% were returning visitors. The site contains 19 e-learning courses which have recently been made available to those in the geographical area of Northumberland, Tyne and Wear NHS Foundation Trust and Cumbria Partnership NHS Foundation Trust, as well as those within our Trust localities. The number of students, who have signed up for an account on the e-learning platform, has more than doubled over the past year, with a current total of over 1000 students

- Reducing Restrictive Practices within Adult Specialist Services – The overall aim of this CQUIN is to develop an ethos in which patients are able to fully participate in formulating plans for their wellbeing, risk management and care in a collaborative manner, reducing the need for restrictive interventions. Over the past three years, a framework has been put in place to review and reduce restrictive practices, where appropriate, to ensure more patient involvement and to provide staff training. Over the last year, work has been undertaken to further improve our practices and outcomes for patients, including an audit of our blanket restrictions (those routinely applied to all patients) and a system to identify and monitor patients who are involved in their treatment and discussions around individualised restrictive practices

- Patient Experience with Street Triage - This is the second year of this CQUIN which has again shown positive results throughout the year and continues to be a success. Results for Patient Experience Surveys during Quarter 4 (January-March 2019) show that 95% of patients were satisfied. Last year, the team also developed a measure regarding an experience survey for the police who are involved in the cases they worked with. Questionnaires are now available to be completed on electronic devices and to send via text messages

What others say about the provider

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

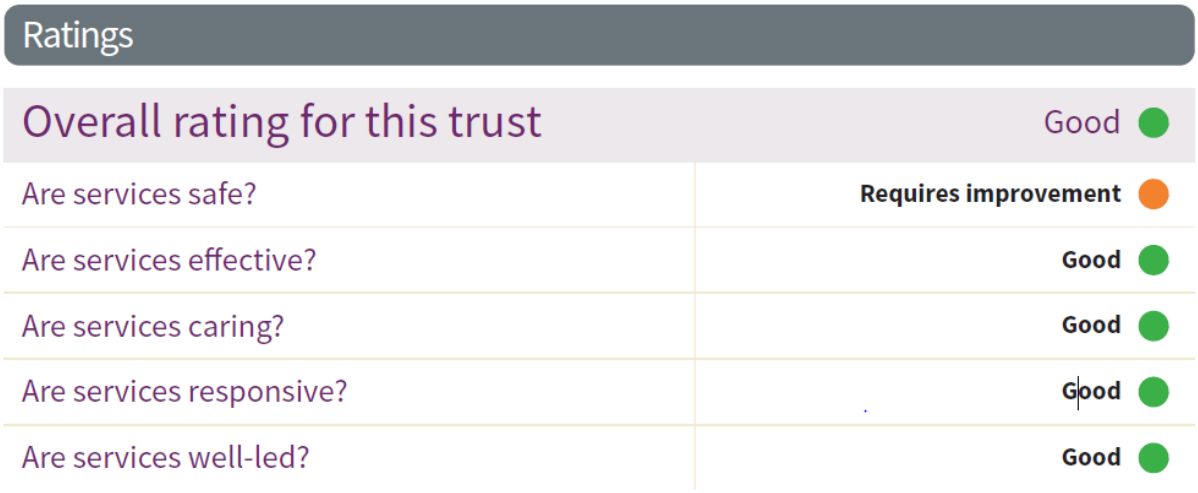
TEWV is required to register with the Care Quality Commission and its current registration status is **registered to provide services with no conditions attached.** The CQC **has not** taken enforcement action against TEWV during 2018/19

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

The CQC undertook an unannounced inspection during 2018 and inspected six core services, concluding with a 'Well-Led' review in July 2018. The core services inspected included Adult Mental Health wards, Mental Health Services for Older

People wards, Children and Young People's Services Tier 4 wards, Forensic, Adult Mental Health Community Teams and Adult Autism and Learning Disability Community Teams.

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



The Trust retained a 'Good' rating overall with no elements being rated as inadequate. The CQC found that without exception, all staff were enthusiastic, caring and compassionate. They particularly highlighted good medical engagement, professional nursing leadership and were impressed with the quality improvement activities including the daily lean management process which the Trust has implemented. On visiting the wards, the CQC noted that there were always good interactions between staff and patients and across many areas care plans were felt to be more person-centred which is a significant improvement from findings of the previous inspection.

Key areas highlighted for improvement were as follows (there were no 'must dos' relating to CAMHS)

'Must Do' issue highlighted by CQC	AMH	MHSOP	ALD	Forensic
Ligature risk assessments	x			
Privacy & Dignity	x			
Risk Assessments	x			
Physical Health recording after rapid tranquilisation	x	x		
Seclusion recording	x			
Staffing Levels	x			
Personalised Care Planning	x			
Blanket Restrictions/Restrictive Practices	x			x
Nurse call alarms		x		
Recording of covert medication		x		
Capacity to consent being considered and recorded			x	
Activities at weekends				x
Fridge and clinic room temperature recording				x

The Trust has looked carefully at the issues raised by the CQC as 'must dos' and 'should dos'. The Director of Quality Governance has then worked closely with Directors of Operations and Directors of Corporate Services to develop an action plan based on the CQC's findings. This action plan is reviewed and monitored by EMT on a monthly basis and is reported quarterly to the Board. There is engagement on a monthly basis between the CQC and the Trust. The Director of Quality Governance also holds an annual session with Governors to review the CQC findings. The deadline for completion of this action plan is the end of June 2019.

Mental Health Act Inspections

31 Mental Health Act inspections were undertaken by the Care Quality Commission during 2018/19, across a wide range of services in all localities.

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

- Issues with Capacity assessments/consent
- Issues with Care Plans
- Issues with Section 17 leave forms
- Issues with MHA section forms
- Issues with Patient's Rights

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

Quality of Data

TEWV submitted records during 2018/19 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- Which included the patient's valid NHS number was **100%** for admitted patient care
- Which included the patient's valid General Medical Practice code was **99.68%** for admitted patient care

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

The 2018/19 version of the toolkit is significantly different to the 2017/18 toolkit.

The new toolkit is called the Data Protection and Security Toolkit. There is no overall score for the new toolkit.

The toolkit assertions are based on the ten National Data Guardian Standards:

- Standard One: Personal Confidential Data (eight out of eight assertions met)
- Standard Two: Staff Responsibilities (two out of two assertions met)
- Standard Three: Training (four out of four assertions met)
- Standard Four: Managing Data Access (three out of three assertions met)
- Standard Five: Process Reviews (one out of one assertion met)
- Standard Six: Responding to Incidents (four out of four assertions met)
- Standard Seven: Continuity Planning (two out of two assertions met)
- Standard Eight: Unsupported Systems (three out of three assertions met)
- Standard Nine: IT Protection (three out of three assertions met)
- Standard Ten: Accountable Suppliers (two out of two assertions met)

The Trust has no unmet assertions.

The Data Security and Protection (DSP) Toolkit is an online tool that enables organisations to measure their performance against data security and information governance requirements which reflect legal rules and Department of Health policy. The Toolkit has been developed in response to The NDG Review (Review of Data Security, Consent and Opt-Outs) published in July 2016 and the government response published in July 2017. The Data Security and Protection Toolkit is the successor framework to the Information Governance Toolkit.

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

TEWV was **not** subject to any external clinical coding audits during 2018/19 by Public Sector Audit Appointments Ltd, the National Audit Office, Financial Reporting Council or Cabinet Office (replacements of the Audit Commission)

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

Service	Update
AMH & MHSOP (in-scope services)	Within AMH & MHSOP services we are mandated to report the following: • **Clinically Reported Outcome Measure (CROM):** Within in-scope AMH & MHSOP services we use the Health of the Nation Outcome Score (HoNOS). Completion of this is reported via the Mental Health Services Data Set (MHSDS) • **Patient Reported Outcome Measure (PROM):** Within in-scope MHSOP services we use the short version of the Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS) Of the patients discharged from services between November 2018 – January 2019, we were able to report outcome for the following: Within AMH Services – HoNOS (80%) and SWEMWBS (72%) Within MHSOP Services – HoNOS (82%) and SWEMWBS (45%) These figures do not include those patients we were unable to report outcome for due to them being in service prior to CROM/PROM collection, those whose care spell is less than 2 weeks, those discharged from a cluster 0 or those patients that died or disengaged prior to the second outcome measure being collected Within EIP Services all new patients from 1st March 2018 will have been offered the Process of Recovery Questionnaire (QPR) as a PROM rather than SWEMWBS. This change is in line with NHS England guidance for implementing the Early Intervention in Psychosis: Access and Waiting Time Standards (NHS England, 2016) Commissioners receive quarterly reports describing complexity of current caseload and clinical outcomes for discharged patients using an established model of clinical significance for both HoNOS and SWEMWBS. Discussions with commissioners will agree how QPR reporting will be integrated in to existing commissioner reports Internally outcome data is reported within the clinical outcomes dashboard. There are regular discussions within both OMT & EMT meeting exploring outcome performance Eating Disorder Examination Questionnaire (EDE-Q) may be collected and reported as a PROM across specialist in-patient eating disorder services An ongoing training programme is available to all clinical staff
CAMHS	• **Clinically Reported Outcome Measure (CROM):** CAMHS clinicians currently complete HoNOSCA (Health of the Nation Outcome Scale for Children and Adults) which is a broad-focused CROM and rates the general functioning of young people accessing services. Clinicians are currently required to complete HoNOSCA at the time of

	assessment, at review and at the end of a care episode • **Patient Reported Outcome Measure (PROM):** Child Outcome Rating Scale (CORS)/Outcome Rating Scale (ORS) were introduced into the CAMHS services from February 2018. Clinicians are expected to complete CORS/ORS with service users and carers at every session in a clinically meaningful way, in the context of collaborative working and shared-decision making • **Current view** is a data collection tool used to rate a number of presenting problems, complexity and contextual problems, school work or training difficulties according to a shared understanding of their presence/impact upon the child or young person at that time. The final step in following completion of the current view tool is assigning a needs-based grouping in collaboration with the service user and their parent/carer. Needs based groupings were developed as part of the national currency and tariff project in an attempt to define and categorise the work CAMHS does. The data contained in current view and the choice of needs based grouping not only informs the currency and tariff project at a national and trust level, but also guides service managers in structuring CAMHS teams and performance managing individual clinicians Performance reports are being managed via a CAMHS currency development steering group. Ongoing discussions with commissioners will agree the integration into existing reports An ongoing training programme is available to all clinical staff
Learning Disability	• **Clinically Reported Outcome Measure (CROM):** Learning disability services across Teesside, York and North Yorkshire have begun recording HoNOS -LD at initial assessment, review and discharge for new patients. Within Durham & Darlington services, roll out has been delayed due to identified data extraction problems as a result of care records being recorded within the social services IT system rather than TEWV's. Clinical groupings have been identified, and these were due to be added onto Paris (TEWV's electronic patient record system) at the beginning of March. This will help to work towards a model of clinical significance to report outcomes. In the short term compliance reports will be published identifying timely completion at initial assessment and discharge • **Patient Reported Outcome Measure (PROM):** No PROM has yet initiated with learning disability services, and discussion is required to find or develop a suitable PROM and begin rollout An ongoing training programme is available to all clinical staff
Perinatal	• **Clinically Reported Outcome Measure (CROM):** Since 1st April 2019, Perinatal Services complete HoNOS and indicate which

	perinatal pathway is appropriate. TEWV will report outcomes against the five perinatal pathways for Psychotic and Non Psychotic patients using a Reliable Change Index (RCI) developed for adult patients as a result of clustering and HoNOS model development • **Patient Reported Outcome Measure (PROM):** Since 1st April 2019, Perinatal Services complete CORE-10. Outcome for CORE-10 will be reported using a model of clinical significance An ongoing training programme is available to all clinical staff Outcome data will be reported within the clinical outcomes dashboard. Initially this will focus on timely completion of the CROM & PROM until outcome data starts to flow as patients are discharged from service
Forensic Inpatient	• **Clinically Reported Outcome Measure (CROM):** Since April 2018, forensic in-patient services have been using HoNOS secure or HoNOS LD as relevant

Further work for 2019/20 includes:

- Consideration of clinical outcome metrics for prison in-reach services
- Development of outcome data reporting within IIC

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

- A Data Quality Strategy and Scorecard was signed off by the Trust EMT in May 2018. The strategy has a broader remit than previous documents that have been developed by the Trust. We will continue to implement this strategy during 2019/29; it has five key objectives. These are:
  - We will improve the understanding and need for high quality data throughout the Trust
  - We will ensure that the clinical effort required for inputting accurate, complete data into systems will be minimal
  - We will reduce the volume of reports currently produced, improve consistency and standardisation
  - We will have systems in place that enable Trust staff to 'self-serve' their own information requirements
  - We will improve the satisfaction of partner organisations in regards to the information provided by the Trust

- A review of the governance arrangements to support the data quality agenda have been undertaken and this identified a need to revise the terms of reference for the Managing the Business Group and Data Quality Sub-Group. Both meetings now have a wider representation and are pro-actively working through a work plan aligned to the strategy
- Data Quality Improvement Plans (DQIPs) have been agreed with Commissioners during 2018/19. Over 18 DQIPs have either been delivered or are on track to be delivered this financial year. Additional DQIPs are in the final process of being agreed for 2019/20
- New reports continue to be developed within the IIC to allow services to easily identify data quality concerns and target improvement work. A data quality IIC dashboard has been developed and evidences data quality completeness of key data items within the clinical record. The IIC development plan for 2019/20 is currently in the process of being prioritised and approved

Learning from Deaths

Following the publication of the Southern Health report in 2015 there has been enhanced national scrutiny on how all NHS organisations respond to deaths of service users in their care. This culminated in the release of a 'Learning from Deaths Framework' which was published by the National Quality Board in 2017. In Mental Health and Learning Disability Services the vast majority of our service users are cared for in the community and often we have very minimal contact with them. This means that most of our service users who die do so through natural causes as happens in the wider population. This explains the difference between the total number of deaths (from all causes including natural causes) and the numbers we go on to investigate further which are generally deaths that are unexpected.

All deaths which are reported through our incident management system (1,414 in 2018/19) are subject to an initial review by a senior clinician in the Patient Safety Team. We have also undertaken some analysis of the average age of service users who died during 2018/19, which was found to be 81 years of age.

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

During 2018/19 **2,308** TEWV patients died; this comprised the following number of deaths which occurred in each quarter of that reporting period:

- **652** in the first quarter
- **578** in the second quarter
- **593** in the third quarter
- **485** in the fourth quarter

By 31st March 2019, **204** case reviews and **126** investigations have been carried out in relation to **330** of the deaths included in the figures above

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

- **89** in the first quarter
- **97** in the second quarter
- **75** in the third quarter
- **69** in the fourth quarter

10 representing **0.43%** of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. The incident review has then been used as a way to determine if the patient death may have been attributable to problems with care provided.

In relation to each quarter, this consisted of:

- **1** representing **0.15%** in the first quarter
- **4** representing **0.69%** in the second quarter
- **3** representing **0.51%** in the third quarter
- **2** representing **0.41%** in the fourth quarter

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

Root or contributory findings from serious incident reviews undertaken in 2018/19 have highlighted the following areas for learning and improvement:

- Risk Assessment
- Adherence to procedure/policy/pathway
- Family Involvement
- Access to services/referral processes
- Communication and information sharing
- Record keeping

The bullets below show the actions we have already taken, or will take during 2019/20 in response to what we have learned from reviews of deaths:

- Our Harm Minimisation policy and training for staff is a recovery-orientated approach to clinical risk assessment and management. Experts by experience were employed as part of the Harm Minimisation project team to co-produce and co-deliver face-to-face Harm Minimisation training and a mandatory e-learning Harm Minimisation training package is in place
- A new safety summary is being designed as part of the roll-out of CITO – an enhanced electronic care record
- Work is underway to improve personalised care planning by the Trust Care Programme Approach (CPA) Project Lead. Both the CPA and Harm Minimisation Projects support the principles of family involvement and shared decision making which are also core principles of the Trust Recovery Strategy
- TEWV held a Family Conference in March 2019 which included gathering feedback from families/carers and staff about how they can be better engaged in the Learning from Deaths process moving forward

These key pieces of work will continue through 2019/20 in addition to ongoing service improvements across the organisation. Improved family involvement will be a particular focus and we intend to launch family-friendly versions of some of our patient safety policies.

49 case record reviews and **37** investigations completed after 31st March 2018 which related to deaths which took place before the start of the reporting period.

Two representing **2.3%** 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 findings from Serious Incident investigations. Where there has been a root cause found from incident review then this has been used as a way to determine if the patient death may have been attributable to problems with care provided.

Freedom to Speak Up

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

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

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

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

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

Reducing Gaps in Rotas

The Guardian of Safe Working within the Trust oversees this issue and produces quarterly reports to the Trust Board that focus on gaps in rotas and safety issues. More broadly, the Guardian of Safe Working attends the Medical Directorate Management meeting and the Trust Strategic Medical Education meeting.

Actions captured in relation to reducing gaps in rotas of medical staffing are RAG rated and managed through these meeting cycles as part of the Medical Education Operating Framework.

More substantial plans and strategic pieces of work are part of an ongoing Quality Improvement plan, which is overseen by Health Education England.

Mandatory Quality Indicators

The following are the mandatory quality indicators relevant to mental health Trusts, issued jointly by the Department of Health and NHS Improvement and effective from February 2013:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127382/130129-QAs-Letter-Gateway-18690.pdf.pdf

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

Care Programme Approach Seven-Day follow-up

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

TEWV Actual Q4 18/19	****National benchmarks in Q3 18/19***	***TEWV Actual Q3 18/19***	***TEWV Actual Q2 18/19***	***TEWV Actual Q1 18/19***
Trust final reported figure: **98.09%**	NHSIC reported - Highest/Best MH Trust: **100.00%**	Trust final reported figure: **96.49%**	Trust final reported figure: **96.67%**	Trust final reported figure: **98.07%**
NHS Digital reported: **Not available**	National average MH Trust: **95.52%**			
	Lowest/Worst NHS Trust: **81.60%**	NHS Digital reported figure: **96.69%**	NHS Digital reported figure: **97.43%**	NHS Digital reported figure: **98.16%**

*Latest benchmark data available on NHS Digital at Quarter 3 2018/19

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

- **81** people were not followed up within seven days during 2018/19; the main reasons for this were as follows:
    - Difficulty engaging with the patient despite efforts of the service to contact the patient (**34** patients); and
    - Breakdown in processes within the service (**32** patients)

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

Crisis Resolution Home Treatment team acted as gatekeeper

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

TEWV Actual Q4 18/19	****National benchmarks in Q3 18/19***	***TEWV Actual Q3 18/19***	***TEWV Actual Q2 18/19***	***TEWV Actual Q1 18/19***
Trust final reported figure: **98.80%**	NHSIC reported - National Average MH Trust: **97.81%**	Trust final reported figure: **98.49%**	Trust final reported figure: **98.01%**	Trust final reported figure: **97.81%**
NHS Digital reported: **Not available**	Highest/Best MH Trust: **100.00%**			
	Lowest/Worst NHS Trust: **78.79%**	NHS Digital reported figure: **98.64%**	NHS Digital reported figure: **98.13%**	NHS Digital reported figure: **97.75%**

*Latest benchmark data available on NHS Digital at Quarter 3 2018/19

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

- The discrepancy between the NHS Digital and the Trust is due to the fact the NHS Digital data is submitted at a CCG level, and therefore, excludes data where the CCG is unspecified in the patient record. The Trust figures include these cases
- **36** people during 2018/19 were not assessed by the Crisis Team prior to admission; the main reasons for this were as follows:
    - Breakdown in process due to failure to follow the standard procedure (**22** patients)
    - High levels of demand on the Crisis Team (**seven** patients)

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

- Investigating instances where patients were not seen by a crisis team prior to admission and identifying lessons to be learned at a service level
- Continuing to utilise the report out process and Trust performance management system to proactively monitor performance and ensure compliance. Supporting the adherence to standard process to ensure patients discharged to other services (i.e. 24 hour care unit) are not overlooked, including the introduction of visual control boards

- Continuously raising awareness and reminding staff at ward/team meetings of this national requirement and why it is important, the need to follow the standard procedure and the need to record data accurately considering appropriate exclusions

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

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

An overall Trust score is not provided, due to the nature of the survey, therefore it is not possible to compare trusts overall. For 2018, we have reported the Health and Social Care Workers section score which compiles the results from the questions used from the survey detailed below in the table.

TEWV Actual 2018	***National benchmarks in 2018***	***TEWV Actual 2017***	***TEWV Actual 2016***	***TEWV Actual 2015***
Overall section score: 7.3 (sample size 209)	Highest/Best MH Trust: **7.7** Lowest/Worst MH Trust: **5.9** Average Score: **7.2**	Overall section score: **7.7** (sample size 232)	Overall section score: **7.8** (sample size 234)	Overall section score: **8.0** (sample size 239)

Notes on Metric

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

Thinking about the last time you saw this NHS health worker or social care worker for your mental health condition…
…Did this person listen carefully to you?
…Did this person take your views into account?
…Did you have trust and confidence in this person?
…Did this person treat you with respect and dignity?

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

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

However, during the development of the 2018 survey, stakeholders felt the question "Did the person or people listen carefully to you?" to be unnecessary and possibly misleading and therefore it was removed from the survey with no replacement introduced

Based on information derived from the NHS Patient Survey report the individual scores for TEWV in relation to the above are described as follows:

- *Were you given enough time to discuss your needs and treatment:* TEWV mean (average) score was **7.6** The lowest national mean (average) was **6.2** and the highest **8.0**
- *Did the person or people you saw understand how your mental needs affect other areas of your life:* TEWV mean (average) score of **6.9**. The lowest national mean (average) was **5.7** and the highest **7.5**

The report identified if Trusts perform 'better', 'about the same' or 'worse' based on a statistic called the expected range. When comparing TEWV survey results with those of the other organisations the scores were identified as being 'about the same' as other organisations across all 11 sections. As with the 2017 survey, there was no overall rating of 'better' or 'worse' than others for any section of the survey (in 2015 TEWV had four sections that were rated better than other organisations)

The CQC has published detailed scores for TEWV which can be found at: http://www.cqc.org.uk/provider/RX3/survey/6

Issues raised at the Patient Experience Group (PEG) are also often acted on immediately by the Group's members, often by taking an agreed course of action to each of the Trust's Locality Management and Governance Boards (LMGBs). An example is given in relation to inpatients reporting not feeling safe due to incidents where some patients have become aggressive due to their illness. The PEG discussed a number of suggestions on how patients who witness such incidents should be supported. It was agreed that the best ideas would be taken back to LMGBs, such as a 1:1 compassionate approach and offering debriefings

The Trust continues to carry out regular patient experience surveys across all services which includes the FFT. Between January 2018 and January 2019 the Trust received feedback from 18,536 patients with an average of 91% who would be extremely likely or likely to recommend TEWV services

Patient Safety incidents including incidents resulting in severe harm or death

The data made available by NHS Digital with regard to the number of patient safety incidents, and percentage resulting in severe harm or death, reported within the Trust during the reporting period. The next reporting period is March 2019

TEWV Actual Q3 & Q4 18/19	***National Benchmark in Q1 & Q2 18/19***	***TEWV Actual Q1 & Q2 18/19***	***TEWV Actual Q3 & Q4 17/18***
Trust reported to NRLS: **7,288** incidents reported of which **73 (1.00%)** resulted in severe harm or death	NRLS Reported: National Average MH Trusts: **3,494** incidents reported of which **83 (2.38%)** resulted in severe harm or death Lowest MH Trust: **16** incidents reported of which **0** resulted in severe harm and **1 (6.25%)** in death Highest MH Trust: **9,204** incidents reported of which **12 (0.13%)** resulted in severe harm and **65 (0.71%)** death The highest reported rate of death as a proportion of all incidents was **2.3%**	Trust reported to NRLS: **9,204** incidents reported of which **77 (0.84%)** resulted in severe harm or death* NRLS reported: **9,204** incidents reported of which **77 (0.84%)** resulted in severe harm or death* *__12__ Severe Harm and **65** Death	Trust reported to NRLS: **7,244** incidents reported of which **85 (1.17%)** resulted in severe harm or death NRLS Reported: **8,134** incidents reported of which **63 (0.77%)** resulted in severe harm or death* *__9__ Severe Harm and **54** Death

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

- The Trust reported and National Reporting & Learning System (NRLS) reported data for quarters one and two 2018/19 and TEWV were identified as the highest (worst) MH Trust. This improved position from last year is due to a significant amount of data quality improvement work the Trust has undertaken

- The number of incidents reported by TEWV to the NRLS for quarters one and two 2018/19 was improved compared to the previous two quarters. However, it is not possible to use the NRLS data to comment on a Trust's culture of incident reporting or the occurrence of incidents. The absolute numbers of incidents reported is a factor of the relative size of a Trust and the complexity of their case-mix. We have noted that:

    - The reporting of patient safety incidents in the Trust in quarters one and two 2018/19 has considerably increased when compared to with quarters three and four 2017/18. This is due to the implementation of a new web-based version of our incident reporting process which has had the positive impact of raising staff awareness of reporting
    - Amongst the most common themes reported are self-harming behaviour, patient accident, disruptive, aggressive behaviour and medication which account for three-quarters of all incidents leading to harm

- During 2018/19 TEWV reported 142 incidents as Serious Incidents, of which 126 were deaths due to unexpected causes
- TEWV is one of the largest Mental Health Trusts in England in terms of population served and caseload

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

- Analysis of all patient safety incidents. These are reported and reviewed by the Patient Safety Group which is a sub group of the Trust's Quality Assurance Committee. A monthly report is circulated to the QuAC. Safety incidents are reported to commissioners via the Clinical Quality Review Process
- Making permanent the central approval team which was put in place to ensure consistent grading of incidents and to improve the overall quality of reporting

- Ensuring all serious incidents (i.e. those resulting in severe harm or death) are subject to a serious incident review. This is a robust and rigorous approach to understand how and why each incident has happened, to identify any causal factors and to identify and share any lessons for the future
- Introducing mortality reviews on those deaths that are not classed as unexpected. We are following national guidance as it is published in this area – the National Guidance on Learning from Deaths was released in March 2017 and have implemented its recommendations throughout 2018/19

Part 3: Other Information on Quality Performance 2018/19

Our performance against our quality metrics

During 2016/17 we reviewed and revised our Trust's Quality Strategy. In approving the new strategy, the Trust Board agreed a set of metrics to be routinely monitored each quarter to show the progress that is being made in delivering the objectives within the strategy. As a consequence, we revisited the quality metrics to be used in the 2018/19 Quality Account to ensure that they are aligned to the metrics in the Quality Strategy.

The following table provides details of our performance against our set of agreed quality metrics for 2018/19.

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

Quality Metrics

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

Quality Metrics		2018/19		2017/18	2016/17	2015/16	2014/15
		Target	Actual	Actual	Actual	Actual	Actual
Patient Safety Metrics							
1	Percentage of patients reported 'yes always' to the question 'do you feel safe on the ward'?	**88%**	**61.50%**	**62.30%**	**N/A**	**N/A**	**N/A**
2	Number of incidents of falls (level 3 and above) per 1000 occupied bed days (for inpatients)	**0.35**	**0.16**	**0.12**	**0.37**	**N/A**	**N/A**
3	Number of incidents of physical intervention/restraint per 1,000 occupied bed days	**19.25**	**31.75**	**30.65**	**20.26**	**N/A**	**N/A**

Clinical Effectiveness Measures							
4	Existing Percentage of patients on Care Program Approach who were followed up within seven days after discharge from psychiatric inpatient care	**>95.00 %**	**96.49%**	**94.78%**	**98.35%**	**97.75%**	**97.42%**
5	Percentage of clinical audits of NICE guidance completed	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
6a	Average length of stay for patients in Adult Mental Health	**<30.2**	**24.70**	**27.64**	**30.08**	**26.81**	**26.67**
6b	Average length of stay for patients in Mental Health Services for Older People	**<52**	**66.53**	**67.42**	**78.06**	**62.67**	**62.18**
Patient Experience Measures							
7	Percentage of patients who reported their overall experience as excellent or good	**94%**	**91.41%**	**90.50%**	**90.53%**	**N/A**	**N/A**
8	Percentage of patients that report that staff treated them with dignity and respect	**94%**	**85.70%**	**85.90%**	**N/A**	**N/A**	**N/A**
9	Percentage of patients that would recommend our service to friends and family if they needed similar care or treatment	**94%**	**86.9%**	**87.20%**	**86.58%**	**85.51%**	**N/A**

Notes on selected Metrics

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

Comments on areas of under-performance

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

The end of year position was **61.5%** which relates to **1,980** out of **3,218** surveyed. This is **26.5%** below the Trust target of **88.00%.**

All localities underperformed this year. **North Yorkshire** was closest to the target with **68.6%** and **Forensic Services** was furthest away with **57.3%**

When brief analysis has been undertaken of why patients do not feel safe in a ward environment, the most often cited cause has been due to the behaviour of other patients. It has also been noted that due to the acuity level of patients who are admitted, they are likely to feel unsafe due to the fact that they are acutely unwell. The Trust's Patient Safety Group is conducting a 'deep dive' to better understand the data for this action and are developing an action plan to monitor and resolve any issues highlighted.

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

The end of year position was **31.75;** this is **12.5** above the Trust target of 19.25.

Durham and Darlington and Forensic Services achieved the target this year. Of the underperforming localities, North Yorkshire was closest to the target with **19.33** and Teesside was furthest away with **73.33**.

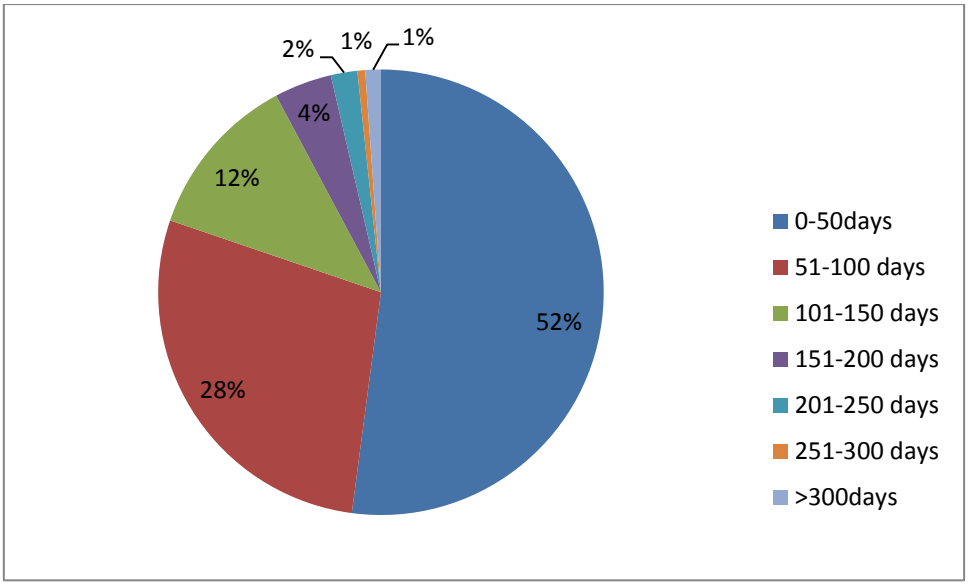
The high amount of physical restraints on Teesside reflects the high use of restraint within West Lane Hospital (CAMHS inpatient services) which is managed by the Trust's Teesside Locality, which however serves the whole Cumbria and North East England region and beyond due to the specialist services available. This high amount is largely due to restraint to enable nasogastric feeding. The rate of restraint in the Teesside Locality excluding this site is largely in line with the rest of the localities across the Trust.

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

The average length of stay for older people has been worse than target since quarter three 2013/14 reporting 66.53 days as at end March 2019, which is 14.53 worse than target but an improvement compared to the position reported in 2017/18. Figure 3 over the page shows the breakdown for the various lengths of stay during 2018/19.

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

Figure 3: Length of Stay for Mental Health Services for Older people in Assessment & Treatment Wards during 2018/19



The length of stay of patients (for both adults and older people) is closely monitored by all services within the Trust. The reasons for the increase in the average length of stay for patients is due to the small number of patients who were discharged after a very long length of stay, which has distorted the overall average. In total (across AMH and MHSOP) 79.79% of lengths of stay were between 0-50 days, with 13.21% between 51-100 days. There were 52 patients who had a length of stay greater than 200 days; the majority were attributable to the complex needs of the patients (including physical health problems) and/or delays in accessing suitable placements for patients subsequent to discharge.

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

The end of year position was **91.41%**, which relates to **18,412** out of **20,142** surveyed. This is **2.59%** below the Trust target of 94.00%.

All localities underperformed against this target in 2018/19. **Durham and Darlington** was closest to the target with **92.68%** and **Forensic Services** was performing furthest away from the target at **82.95%.**

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

The end of year position was **85.7%** which relates to **16,151** out of **18,848** surveyed. This is **8.3%** below the Trust target of 94.00%.

All localities underperformed in 2018/19. **North Yorkshire** was closest to the target with **88.9%** and **Forensic Services** was performing furthest away from the target with **72.4%.**

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

The end of year position was **86.9%** which relates to **17,722** out of **20,401** surveyed. This is **7.1%** below the Trust target of 94.00%.

None of our localities achieved this target in 2018/19. **Durham & Darlington** was closest to the target with **88.6%** and **Forensic Services** was performing furthest away from the target with **77.9%.**

Our Performance against the Single Oversight Framework Targets and Indicators

The following table demonstrates how we have performed against the relevant indicators and performance thresholds set out in Appendix Three of the Single Oversight Framework November 2017.

Single Oversight Framework

Indicators		2018/19		2017/18	2016/17	2015/16	2014/15	2013/14
		Threshold	Actual	Actual	Actual	Actual	Actual	Actual
A	Percentage of people experiencing a first episode of psychosis that were treated with a NICE approved care package within two weeks of referral*	50%	**64.89%**	**73.32%**	**70.04%**	**55.91%**	**N/A**	**N/A**
B	Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in inpatient wards*	90%	**92.00%**	**92.50%**	**N/A**	**N/A**	**N/A**	**N/A**
C	Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in early intervention in psychosis services**	90%	**91.55%**	**91.00%**	**N/A**	**N/A**	**N/A**	**N/A**
D	Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in community mental health services (people on CPA)*	65%	**78.00%**	**74.39%**	**N/A**	**N/A**	**N/A**	**N/A**
E	IAPT/Talking Therapies – proportion of people completing treatment who move to recovery (from IAPT minimum dataset)	50%	**51.29%**	**50.44%**	**48.32%**	**N/A**	**N/A**	**N/A**
F	Percentage of people referred to the IAPT programme that were treated within six weeks of referral	75%	**97.91%**	**95.49%**	**95.44%**	**84.01%**	**N/A**	**N/A**

G	Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral	95%	**99.73%**	**99.89%**	**99.14%**	**95.93%**	**N/A**	**N/A**
H	Percentage of patients on Care Programme Approach who were followed up within seven days after discharge from psychiatric inpatient care	>95.00%	**97.31%**	**96.52%**	**98.35%**	**97.75%**	**97.42%**	**97.86%**
I	Admissions to adult facilities of patients who are under 16 years old		**0**	**1**	**N/A**	**N/A**	**N/A**	**N/A**
J	Inappropriate out of area placements (OAPs) for adult mental health services		**874**	**1913**	**N/A**	**N/A**	**N/A**	**N/A**

*This figure is different to that published elsewhere for 2018/19 due to the timing of the data extracted
**The figures provided are based on a Trust assessment of the sample audit data

Notes on the Single Oversight Framework Targets and Indicators

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

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

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

Data collection using the College of Psychiatrists' Centre for Quality Improvement (CCQI) self-assessment tool was submitted to NHS England/Royal College of Psychiatrists during quarters three and four; this was based on a sample of data.

External Audit

For 2018/19, our external auditors are required to provide a limited assurance report on whether two of the mandated indicators included in the Quality Account have been reasonably stated in all material aspects. In addition the Council of Governors (CoG) have chosen one further local indicator for external assurance. Therefore the three indicators which have been included in the external assurance of the Quality Account 2018/19 are:

- Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE)-approved care package within two weeks of referral
- Inappropriate out-of-area placements for adult mental health services
- Percentage of patients who report 'yes, always' to the question 'Do you feel safe on the ward?'

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

Our Stakeholders' Views

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

How we involve and listen to what our stakeholders say about us is critical to this process. In producing the Quality Account 2018/19, we have tried to improve how we involved our stakeholders in assessing our quality in 2018/19.

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

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

- *Good mix of stakeholders on Group – OSC, Healthwatch, TEWV Governors, NECS*
- *Opportunity to network – share learning and information*
- *Informative*
- *A good range of speakers*

However, stakeholders also suggested that we allow more time for questions about our quality priorities and give attendees more time to feed back their thoughts, which we will take on board for our Stakeholder Events to be held during 2019/20.

In line with national guidance, we have circulated our draft Quality Account for 2018/19 to the following stakeholders:

- NHS England
- North East Commissioning Support
- Clinical Commissioning Groups (x9)
- Local Authority Overview & Scrutiny Committees (x8)

- Local Authority Health & Wellbeing Boards (x7)
- Local Healthwatch Organisations (x7)

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

The following are the general themes received from stakeholders in reviewing our Quality Account for 2018/19:

[To be inserted once feedback in received]

The Trust will write to each stakeholder addressing each comment made following publication of the Quality Account 2018/19 and use the feedback as part of the annual lessons learnt exercise in preparation for the Quality Account 2019/20.

In response to many stakeholders' requests, the Trust has agreed to continue providing all stakeholders with a half-year update in November 2019 on the Trust's progress with delivering its quality priorities and metrics for 2019/20.

APPENDICES

Appendix 1: 2018/19 Statement of Director's Responsibilities in respect of the Quality Account

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

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

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

- The content of the Quality Account/Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2018/19 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 2018 to May 2019
    - Papers relating to quality reported to the Board over the period April 2018 to May 2019
    - Feedback from the Commissioners dated **xx**
    - Feedback from Governors dated **xx**
    - Feedback from local Healthwatch organisations dated **xx**
    - Feedback from Overview and Scrutiny Committees dated **xx**
    - Feedback from Health and Wellbeing Board dated **xx**
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, received **xx**
    - The latest national patient survey published **xx**
    - The latest national staff survey published **xx**
    - The Head of Internal Audit's annual opinion over the Trust's control environment dated **xx**
    - CQC inspection reports 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:

-- May 2019……Chairman

-- May 2019……Chief Executive

Appendix 2: 2018/19 limited assurance report on the content of the Quality Accounts and mandated Performance Indicators

[To be inserted once received]

Appendix 3: Glossary

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

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

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

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

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

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

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

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

Care Planning: See Care Programme Approach (CPA)

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

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

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

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

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

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

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

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

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

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

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

Council of Governors: Made up of elected public and staff members, and includes non-elected members such as the Prison Service, Voluntary Sector, Acute Trusts, Universities and Local Authorities. The Council has an advisory, guardianship and strategic role including developing the Trust's membership, appointments and

remuneration of the Non-Executive Directors including Chairman and Deputy Chairman, responding to matters of consultation from the Trust Board, and appointing the Trust's auditors

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

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

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

Data Quality Improvement Plan (DQIP): A plan to improve the reliability/accuracy of data collected on a particular subject – often used where data has not been collected in the past and new systems to do this need to be established

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

Department of Health: The government department responsible for Health Policy

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

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

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

Executive Management Team (EMT): Individuals at the senior level of management within the organisation (e.g. Directors) who meet on a regular basis. They are responsible for the overall management of TEWV and the high-level decisions within the organisation

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

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

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

Freedom of Information Act (2000): A law that outlines the rights that the public have to request information from public bodies (other than personal information covered by the Data Protection Act), the timescales they can expect to receive the information, and the exemptions that can be used by public bodies to deny access to the information

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Involvement Peer Roles: Non-contracted unpaid roles which offer individuals with lived experience an opportunity to share their experiences to support other patients/carers wellbeing and recovery. They can input into courses or groups but always work alongside paid staff, who lead the sessions. They are managed under

the involvement and engagement process and are paid travel expenses and an honorarium

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

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

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

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

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

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

Mazars: An international, integrated and independent organisation specialising in audit, accountancy, tax, legal and advisory services. They are TEWV's current external auditors

Memorandum of Understanding: An agreement between two or more parties that expresses a convergence of will between them, indicating a common line of action

Managing the Business Group: A director-level group which means monthly and manages the operational corporate business of the Trust; similar to the Operational Management Team (OMT) however its focuses are on corporate services rather than clinical services. The Group holds overall responsibility for the Data Quality Strategy

Memory Services: Services for people who are experiencing memory difficulties, including the early onset of dementia

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

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

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

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

Multi-Agency Public Protection Arrangements (MAPPA): The process through which various agencies such as the police, the Prison Service and Probation work together to protect the public by managing the risks posed by violent and sexual offenders living in the community

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)

Multi-morbidity: Where an individual has two or more long-term health conditions

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

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

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

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

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

NHS Long-Term Plan (2019): A new plan for the NHS to improve the quality of patient care and health outcomes. It sets out how the £20.5 billion budget settlement for the NHS, announced by the Prime Minister in summer 2018, will be spent over the next five years

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Quality Strategy: This is a TEWV strategy. It sets a clear direction and outlines what the Trust expects from its staff to work towards our vision of providing excellent

quality care. It helps TEWV continue to improve the quality and value of our work, whilst making sure it remains clinically and financially sustainable

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

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

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

Rapid Process Improvement Workshop (RPIW): A workshop held over a number of days focusing on a particular process in which the people who do the work are empowered to eliminate waste and reduce the burden of work. It is designed around the plan-do-study-act (PDSA) method

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

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

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

Recovery College Online: An initiative that allows people to access Recovery College materials and peer support online (see above). This is available to service users and staff in all areas served by TEWV

Recovery Strategy: TEWV's long-term plan for moving services towards the Recovery Approach *(see above)*

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

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

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

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

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

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

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

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

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

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

STOMP (Stopping Over-Medication of People with a Learning Disability, Autism or Both Project): A national project involving many different organisations which are helping to stop the over use of psychotropic medications with people who

have a Learning Disability, Autism or both. STOMP is about helping people to stay well and have a good quality of life

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

SWEMWBS: Shortened version of WEMWBS *(see below)*

TEWV: Tees, Esk and Wear Valleys NHS Foundation Trust

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

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

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

The Trust: see TEWV above

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

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

Triangle of Care (ToC): A working collaboration, or 'therapeutic alliance' between the service user, professional and carer that promotes safety, supports recovery and sustains wellbeing

Trust Autism Framework: A document which sets out how the Trust aims to become more autism aware, informed and responsive to needs of people with autism through better access and clearer pathways to services

Trust Board: See Board/Board of Directors above

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

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

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

Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS): A scale of 14 positively-worded items which is used to measure changes over time in service user wellbeing

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

Year (e.g. 2018/19): These are financial years, which start on the 1st April in the first year and end on the 31st March in the second year

Appendix 4: Key themes from 174 Local Clinical Audits reviewed in 2018/19

Audit Theme	Key quality improvement activities associated with clinical audit outcomes
1. Infection Prevention and Control (IPC)	• All Infection Prevention and Control Audits are continually monitored by the IPC team and any required actions are rectified collaboratively with the IPC team and ward staff. Assurance of implementation of actions is monitored by the Clinical Audit and Effectiveness team via the clinical audit action monitoring database • A total of **101** IPC clinical audits were conducted during 2018/19 in inpatient areas in the Trust.**79% (80/101)** of clinical areas achieved standards between 80%-100% compliance • Clinical audits have been undertaken to assess compliance with Hand Hygiene standards and a monthly Essential Steps audit is completed in inpatient areas
2. Medicines Management	• Audit results have been used to help refine the wording regarding key labelling requirements in the Trust's medicines storage policy • Standards for prescription writing on Trust prescription and administration charts have been updated to include an instruction to state the indication for antimicrobials in the comments box and the Trust pharmacy junior doctor induction presentation regarding the need to record indication, dose, frequency, start date and review/stop dates for oral antimicrobials on PARIS as well as the prescription and administration chart • There has been a roll-out of a new formal prescription chart and compliance with key standards for prescription writing is monitored via the monthly Medicines Optimisation Assessments (MOA) • Further clinical audit results have influenced changes to be included within these monthly Medicines Optimisation Assessments including monitoring appropriateness of antimicrobial course length • National Prescribing Observatory for Mental Health (POMH) clinical audit results have been shared with prescribers highlighting the need for all patients on depot antipsychotics to have side effects and therapeutic response reviewed annually • A medication lessons learned bulletin has been produced following National audit results including aspects relating to provision of information, service user involvement, and the discussions regarding

	pros and cons of medication • A Medication Safety Series on the Valproate PPP (pregnancy prevention programme) was published • Changes have been made to Trust psychotropic monitoring guidance to add the broader physical health monitoring parameters (BP, glucose/HbA1c, lipids) from CG185 on valproate and other drugs used in bipolar disorder • Following the Trust's High Dose Antipsychotic Treatment (HDAT) audit, the Trust will be assessing the impact of electronic HDAT registers which have been implemented within specific teams with a view to share and spread this good practice • A regular Controlled Drugs newsletter was launched highlighting key lessons learned
3. Physical Healthcare	• Trust Nasogastric Tube Insertion Training has been delivered for relevant teams following clinical audit results • Results of the National CQUIN Safety Thermometer are reported to the Clinical Effectiveness Group quarterly • A VTE workstream has been established following clinical audit activities. Developments are ongoing around exploring changes in the admission pathway for medical staff and progress with the addition of new physical health admission documentation on PARIS. The workstream will be reviewing the current Trust VTE policy as well as the checklist document, in particular in relation to ensuring that history of VTE is considered • A briefing has been circulated to medical and nursing staff providing information about VTE assessment including bleeding risk factors and prescribing VTE prophylaxis wand why this is crucial in practice to ensure care is safe and effective • The Positive Approaches Training (PAT) programme curriculum has been amended to include training on reporting the use of physical intervention • A Soft-Restraint Device (SRD) physical health check form has been devised which will be completed by a medic prior to the implementation of SRDs
4. Records Management	• Work is ongoing around changing elements of the electronic patient record system including merging the care plan and intervention plan into one single plan and redesigning these documents in

	collaboration with the recovery programme and digital transformation team to promote the principles of CPA • A standard report has been made available within the Trust's Integrated Information Centre (IIC) to allow staff to review young people at the age of 17.25 to allow better planning for Transition meetings. In addition to this, a prompt sheet has been rolled out in CYPS and AMH services for discharge/transition planning • A policy review has been undertaken to standardise the way in which time taken away from the ward is documented by clinical staff/teams. In addition to this, changes have been made to the Trust approved Record Keeping/Abbreviation Document • Operational policies have been updated in MHSOP Services following clinical audit activities investigating compliance with age discrimination requirements of the Equality Act 2010 and the Trust Human Rights, Equality and Diversity Policy • Standard work is ongoing for reviewing the format for how evidence will be documented in the clinical record in AMH services in terms of managing risks posed by people with borderline personality disorder in the community mental health service as it is recommended that these should be managed by the whole multi-disciplinary team • The Safeguarding Team's MAPPA Standard Process Description will include a safety precaution and quality check to ensure actions from MAPPA meetings are completed
5. Risk Assessment/Patient Safety	• The admissions checklist has been updated and considers the assessment of pain in MHSOP inpatient services • DNA (Did Not Attend) risk assessment requirements have been clarified following clinical audit results in relation to what is meant by carrying out an assessment of risk in relation to DNA • Measures have been put in place to improve compliance in risk areas relating to Duty of Candour policy adherence including amending the 72 hour report form. Serious Incident Investigators now review the details provided on the 72 hour report form in relation to Duty of Candour and offer telephone support to ensure all fields are competed and the information is transferred to PARIS • Harm Minimisation Training resources programme content has been informed by findings from clinical audit activities. • The Clinical Audit and Effectiveness Team provided immediate feedback to clinical teams as appropriate to mitigate risks identified from clinical audit activities assessing Safety Summary

	documentation within patient electronic records • Guidance notes have been developed detailing where consent is documented within the electronic patient record system • The Positive and Safe Team have developed Behaviour Support Planning Masterclasses for all Registered Nursing Staff as well as drop in clinical support sessions for staff following Positive and Safe Practice clinical audit. As well as this, an incident reporting template has been developed and will be rolled out within the updated Rapid Tranquilisation Policy • The Trust's policy on the use of Global Restrictive Practices in inpatient units has been updated following clinical audit results to include the requirement to document plans to lift temporary blanket restrictions and a flow chart summarising the process staff should following when implementing a blanket restriction. Further developments are ongoing to ensure there is a process in place for Directorates to set a minimum frequency for review of blanket restrictions, to minute the reviews at ward-level meetings, and to review these in the Quality Assurance Groups • There is ongoing work for implementing a process with Modern Matrons to review Section 17 Leave forms each month and report this to Locality Quality Assurance Groups
6. Supervision	• There is an ongoing specialist contract requirement which involves undertaking an audit for specialist services to establish the duration of clinical supervision which staff have received, with a target of a minimum of 2 hours per quarter • Trust policy has been updated for CPD/supervision requirements so that it is clear what supervision is needed in the first 6 months as Level 1 Non-Medical Prescriber • Clinical Audit has facilitated documentation of supervision requirements within Offender Health, Prison and Liaison & Diversion Teams
7. NICE/Pathway Development	• Tier 4 CAMHS wards have included a section on the Visual Display Boards to identify which service users are on the Positive Behaviour Support (PBS) pathway for quick reference • MHSOP community teams have shared audit results to inform local improvements required as part of the Purposeful and Productive Community Services (PPCS) initiative • The dietetic leaflet within the Trust ADHD Pathway was updated • A review of the Falls CLiP was undertaken to determine whether the existing CLiP is suitable for use in LD services and to adapt this to make the CLiP more relevant to LD services • Guidance has been developed for staff in LD services to support "the who, when & how of 'routine

	inquiry'" in conjunction with the Trauma Informed Care Project • Autism Post-diagnostic interventions have been reviewed following clinical audit results and patients are now offered occupational therapy and social care assessment once an autism diagnosis is made. In addition to this, quality improvement work has been undertaken to reduce waiting times for autism assessments following referral and there is ongoing work with regards to improving care plan documentation through CPA work streams, and crisis plan development will be considered as part of this work

Appendix 5: Trust Business Plan additional Priorities

The Quality Improvement priorities set out in Part 2 of this Quality Account document are also included in the Trust's Business Plan (in which they are priorities 14-18). The other priorities in the Business Plan will all have a positive impact on the quality of Trust services, and are listed in the table below.

No	Title	Lead	To conclude by
Overarching Priorities			
0	Implement a recovery-focused approach across all services	Medical Director	Q4 21/22
Strategic Priorities			
1	Develop and implement a trauma-informed care approach across our services	Medical Director	Q4 21/22
2	Improve the purposefulness and productivity of our services	Chief Operating Officer	Q4 21/22
3	Ensure we have the right staffing for our services now and in the future	Director of Nursing & Governance	Q4 21/22
4	Make a Difference Together by embedding TEWV's values and behaviours throughout the organisation	Chief Executive	Q4 21/22
5	Deliver our Digital Transformation Strategy	Director of Finance & Information	Q4 21/22
6	Identify and reduce waste	Chief Executive	Q4 21/22
Operational Priorities			
7	Implement the Transforming Care agenda	Chief Operating Officer	Q4 19/20
8	Develop and implement a Trust-wide approach to enabling people who have autism to access mental health services	Chief Operating Officer	Q4 19/20
9	Complete the transformation of our York & Selby services	Chief Operating Officer	Q2 21/22
10	Implement the agreed future delivery model for people living in Harrogate and Rural District and Wetherby who require our services	Chief Operating Officer	Q2 20/21
11	Implement the agreed delivery model for people living in Hambleton and Richmondshire who require our services	Chief Operating Officer	Q4 20/21
12	Improve the physical environment at Roseberry Park Hospital	Chief Operating Officer	Q1 24/25
13	Implement the NHS Long Term Plan for Mental Health as agreed with each of our commissioners	Chief Operating Officer	Q4 21/11

In addition to these, many of the operational plans the enabling priorities set out within our Business Plan underpin our quality improvement agenda

Appendix 6: Quality Performance Indicator Definitions

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

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

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

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

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

Exemptions:

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

Accountability:

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

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

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

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

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

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

Data definition:

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

Exemptions:

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

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

Data definition:

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

Exemptions:

There are no exemptions for this indicator

Accountability:

QuAC and Patient Safety Group

Numerator:

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

Denominator:

The total number of responses to this question

Appendix 7: Feedback from our Stakeholders

[To be added once received]