Middlesbrough moving forward

**Finance, Governance and Support**

# TEES VALLEY JOINT HEALTH SCRUTINY COMMITTEE

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| **Date:** | **Tuesday 22nd June, 2021** |
| **Time:** | **10.30 am** |
| **Venue:** | **Virtual meeting** |

## AGENDA

Please note: this is a virtual meeting.

The meeting will be live-streamed via the Council's Youtube channel at 10.30 am on Tuesday 22nd June, 2021


1. Appointment of the Chair

2. Appointment of Vice Chair

3. Apologies for Absence

4. Declarations of Interest

5. Minutes of the Meeting held on 19 March 2021 — 3 – 8

6. Protocol for the Tees Valley Joint Health Scrutiny Committee — 9 – 14

7. Tees, Esk and Wear Valleys NHS Foundation Trust - Quality Account 2020/2021 — 15 - 94

   Presentation by Avril Lowery, Director of Quality Governance and Dr Chris Lanigan, Head of Planning and Business Development

8. Any urgent items which in the opinion of the Chair can be considered

9. Date & Time of next meeting - Friday, 24 September 2021 at 10.30am


Charlotte Benjamin
Director of Legal and Governance Services

Town Hall

Middlesborough
Date Not Specified

MEMBERSHIP

Councillors I Bell, B Donoghue, Layton, G Hall, B Harrison, B Loynes, Cook, A Hellaoui, B Clarke, D Rees, S Smith, E Cunningham, D Davison and D Coupe

**Assistance in accessing information**

**Should you have any queries on accessing the Agenda and associated information please contact Caroline Breheny, (01642) 729752, caroline_breheny@middlesbrough.gov.uk**

# TEES VALLEY JOINT HEALTH SCRUTINY COMMITTEE

## MINUTES

19 March 2021

The meeting commenced at 10:00 am via Microsoft Teams.

**Present:**

Redcar and Cleveland Borough Council: Councillors Sandra Smith (Chair) and B Clarke;
Darlington Borough Council: Councillor I Bell and B Donaghue;
Hartlepool Borough Council: Councillor G Hall;
Middlesbrough Borough Council: Councillors A Hellaoui and B Hubbard; and,
Stockton-on-Tees Borough Council: Councillors E Cunningham, C Gamble and L Hall.

Also Present: A Armstrong, Hartlepool Borough Council
C Breheny, Middlesbrough Borough Council
G Woods, Stockton-on-Tees Borough Council
M Crutwell, D Gardner, B Kilmurray, C Lanigan, A Lowery, S Mayo and Dr R Shah , Tees, Esk and Wear Valleys NHS Foundation Trust

Officers: S Fenwick RCBC Principal Democratic Services & Scrutiny Officer
A Pearson RCBC Governance Manager

## 24. Apologies for Absence

Apologies were submitted on behalf of Councillors D Rees (Redcar and Cleveland Borough Council), B Harrison and B Loynes (Hartlepool Borough Council) and, E Polano (Middlesbrough Borough Council).

## 25. Declarations of Interest

None.

## 26. Minutes of the meeting held on 29 January 2021

The minutes of the meeting held on 29 January 2021 were approved as a correct record.

## 27. Community Mental Health Service Framework - Update

Representatives from Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) gave a presentation on the Community Mental Health Framework and Developments in Mental Health Urgent Care Services.

The presentation highlighted the vision and outcomes for the Community Mental Health Framework which would be sustainable and joined up high quality mental health and care services that maximised the health and well being of the local population. It also set out the current structure of the Trust, key developments to date, the community model principles, and the next steps for 2021-22.

As part of the ensuing discussions the following points/questions were raised:

- Members felt that although the presentation was excellent it should have been circulated earlier as it contained a lot of information.
- The £600,000 awarded to Communities – was there any criteria and does it have to be applied for or was it awarded? Members were advised that a generic standard proposal form will be produced, there will be a general criterion in terms of aims and objectives and there will be an application process. Each area had a set amount as it was population base awarded. The aim of the funding was grassroots interventions at the VCS;
- A Member commented on the Marmot report on poverty and asked how the findings of that report would be incorporated into this framework, was there any capacity to spend in a preventative way and would greater awards be given to areas where the hot spots were in deprived areas. Members were advised that this will present opportunities to link to the population health management work that was taking place and will identify local needs, target those needs and invest in those areas;
- Members welcomed working together with clients and patients, but with regards to having named workers for each client a Member asked if there was a timescale. Members were advised that the arrangements for a named worker were currently being designed, the challenge would be the governance arrangements.
- A Member commented on 10 work streams and suggested it would be a benefit to have further information on the Local Authority work streams.
- A Member commented that the Trust did not do a very good job in dealing with armed forces veterans, it did not know how many veterans were in our areas annually as it was not included on the census. He asked whether consideration could be given to how they get assistance from Community Health. Members were advised that the Community Health Framework was at the start of its journey which would help to gain an understanding of what the local population needs were in each area. As part of this TEWV would also be working with groups like the British Legion, and this would be an opportunity for this to be included.

- A Member commented on support workers who were working with the Police and on an evening and asked if they also work with local voluntary agencies i.e. Stockton Pastors to help people who are in distress on an evening. Members were advised that the Trust were currently looking at this and welcomed any thoughts on how to shape this service for the future.

**RESOLVED** that the information in the presentation be noted and information on TEWVs work with veterans be circulated

## 28. Tees, Esk & Wear Valleys NHS Foundation Trust: Our Big Conversation – Draft Strategic Framework

The Chief Executive of the Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) reminded Members that at the last meeting Members were presented with the Draft Strategic Framework, which set out the 3 goals the TEVW were committed to over the next five years. Members were advised that following consultation and work that had been carried out over the last six months the Strategic Framework had now been agreed.

**RESOLVED** that the information in the presentation be noted.

## 29. Tees, Esk and Wear Valley NHS Foundation Trust Quality Account Update

Representatives from Tees, Esk and Wear Valley NHS Foundation Trust (TEWV) presented the Quality Accounts for 2020/21 and 2021/22.

The presentation looked back at progress made on the priorities this year, the Quality Accounts improvement metrics and the action taken in response to those metrics in Teesside.

Members were advised that detailed plans were currently being drafted for 3 proposed quality improvements priorities for 2021/22 namely: -

- Care Planning;
- Feeling Safe, and;
- Compassionate Care.

As part of the ensuing discussions the following points/questions were raised:

- Even though all targets have not been met it was encouraging to see there was an increase in the percentages towards the targeted figures.

- A Member expressed concern that the number of incidents of restraint had remained high and was similar to last year's figures. Last year Members were advised it was because of the eating disorder clinic, this year it was learning disabilities and people suffering from autism.
- Members commented that this is not just about individuals it was about staff, as the impact can also be traumatic for them too. Members were advised that a positive and safe program ran across the whole Tees, Esk and Wear Valley NHS Foundation Trust which was focussed on supporting staff to provide interventions. The Burdett program was also being introduced.
- Too much restraining was being used and it should one of the priorities for next year. Members were advised that the numbers had reduced in Teesside but the figure were high with children with eating disorders as a lot of nasogastric feeding was taking place under restraint. It was suggested that this be discussed in detail at a future meeting.
- A Member commented that it was pleasing to hear the push on respect, compassion and dignity but asked in terms of data and statistics, how many people where behind the percentages and how many interviews have taken place in the categories to get the percentage responses. She commented that analysis of the data was important to know what sector of the population was affected and their particular challenges.

**RESOLVED** that:

1. The information in the presentation be noted.
2. That Representatives from the Tees, Esk and Wear Valley NHS Foundation Trust (TEWV) be invited to a future meeting to discuss in detail the target around physical intervention/restraint.

## 30. Work Programme and Future Meetings

The Governance Manager presented a report which advised of the annual handover arrangements for the Chair and administrative support for the Joint Committee and the work-programme items to be carried over into 2021-22.

Members were reminded that the terms of reference provided for the Chairing and administrative support of the committee to be rotated between all five Tees Valley Local Authorities on an annual basis. For the 2021/22 municipal year Middlesbrough Borough Council would take on this role.

The report also advised that at the first meeting of the Committee in the new municipal year the Chair and Vice Chair will be appointed and the remaining items on the work programme will be carried forward.

**RESOLVED** that the information in the report be noted.

### Any other business

The Chair agreed that the following item could be discussed as any other business.

### Care Quality Commission (CQC) Report

The Chief Executive from Tees, Esk and Wear Valley NHS Foundation Trust (TEWV) gave an update on a recent report from the Care Quality Commission (CQC). Members were advised that the report was currently embargoed but further information will be circulated to members in due course. **- NOTED**

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## Protocol for the Tees Valley Health Scrutiny Joint Committee

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

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

**Tees Valley Local Authorities**

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

**NHS England Area Teams**

4. Durham, Darlington and Tees Area Team

**NHS Foundation Trusts**

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

**Clinical Commissioning Groups**

6. Darlington; Hartlepool and Stockton-on-Tees; South Tees;

**Tees Valley Health Scrutiny Joint Committee**

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

**Membership**

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

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

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

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

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

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

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

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

**Chair and Vice-Chair**

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

Stockton
Hartlepool
Redcar & Cleveland
Middlesbrough
Darlington

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

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

**Co-option of other local authorities**

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

**Terms of Reference**

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

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

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

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

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

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

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

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

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

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

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

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

**Administration**

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

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

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

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

**Final Reports and Recommendations**

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

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

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

**Substantial Developments or Variations to Health Services**

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

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

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

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

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

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

**Principles for Joint Health Scrutiny**

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

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

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

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

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

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

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

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

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

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

# QUALITY ACCOUNT 2020-2021

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# Part One: Introduction and About Us

## What is a Quality Account?

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

### What are the aims of the Quality Account?

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

### Who reads the Quality Account?

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

### What information can be found in the Quality Account?

In this report, you will find information about how we measure and review the quality of services that we provide. You will also find our priorities for improvements for the year ahead. Like all NHS healthcare providers, we measure the quality of our services by looking at:

- Patient Safety
- The effectiveness of treatments that patients receive
- How patients experienced the care provided

### Structure of this Quality Account document

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

- **Part 2:** Information on how we have improved in the areas of quality we identified as important for 2020/21, our priorities for improvement in 2021/22 and  the required statements of assurance from the Board and
- **Part 3:** Further information on how we have performed in 2020/21 against our key quality metrics and national targets and the national quality agenda

## A profile of the Trust

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

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

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

## Our Quality Account and Quality Governance

The Department of Health and NHS Improvement (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 2020/21.

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 (PALS)
- **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 monthly basis.

We have recently developed a Quality Assurance Framework focusing upon the patient's clinical risk assessment and management. Our assurance programme utilises a range of methods such as Matron Walkabouts and clinical audit and leadership visits, involving a range of personnel. We will continue to build on this and broaden our focus.

We also normally 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. Unfortunately we have been unable to undertake peer review inspections during 2020/21 due to the Covid-19 pandemic, however we plan to resume these as soon as restrictions allow.

In addition, each month members of the Executive Management Team (EMT) and non-Executive Directors undertake visits to our wards and teams across the Trust. They listen to what patients, carers and staff think and feel about the services we provide. As above, we have been able to only hold these visits virtually instead of in person due to the Covid-19 pandemic, however plan to resume face-to-face as soon as we are able to do so.

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 we review key information on quality that we provide, with a particular emphasis on providing assurance on the quality of our services. At these meetings, we also provide information on any thematic analyses or quality

improvement activities we have undertaken and on our responses to national reports that have been published.

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

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

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

- Elizabeth Moody (Director of Nursing & Governance) at: elizabeth.moody1@nhs.net
- Sharon Pickering (Director of Planning, Performance, Commissioning and Communications) at: sharon.pickering1@nhs.net
- Avril Lowery (Director of Quality Governance ) at a.lowery1@nhs.net

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

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

## What we have achieved in 2020/21:

The following provide some examples of where we have improved the quality of our services over the past year:

- We have opened Foss Park Hospital, our new 72-bed hospital located on Haxby Road in York. It provides two adult single-sex wards (Ebor Ward – female adult beds and Minster Ward – male adult beds) and two older people's wards (Wold View for people with dementia and Moor Croft for people with Mental Health conditions such as psychosis, severe depression or anxiety)
- The York Crisis Home Treatment team was accredited as providing an excellent service by the Royal College of Psychiatrists Home Treatment Accreditation Scheme (HTAS)
- The Tees CAMHS Single Point of Contact (SPoC) went live in 2020; SPoC provides a single telephone line (or email) for children and young people, their parents/carers, and professionals to talk to expert CAMHS trained staff about concerns regarding a child or young person's mental health. It provides an initial point of contact, triage, clinical decision making, access to mental health expertise, advice on self-help, signposting, referral and emotional containment for parents/professionals
- The Trust's care home liaison staff have been working closely with care homes in Teesside and County Durham to support the wellbeing of their residents and staff during the COVID-19 pandemic. In addition to providing telephone, video and face-to-face consultations, the teams have shared resources and guidance on supporting wellbeing
- The Trust has launched a new free-phone service for those in mental or emotional distress. The service, which has been developed as part of our long term ambition to transform mental health crisis services, is available 24 hours a day, seven days a week, providing an alternative to traditional crisis care and offering local people the opportunity to talk to trained mental health support workers
- Adult Learning Disabilities services in Durham & Darlington have secured additional funding to assist primary care colleagues to complete Annual Health Checks for people with a learning disability. The agreed protocol and model is being shared with colleagues in Tees Locality as they have been asked to provide similar support by commissioners
- TEWV's forecasting model, which was designed by TEWV clinicians and planners with the help of our CCG colleagues and our Director of Public Health has been recognised as one of the four best practice models nationally. It identifies the main drivers of increased need (direct impact of Covid 19, impact of the lockdown, and impact of the economic recession on a range of segments in our population). It also estimates how much of the additional mental health needs will translate into demand for secondary care services. TEWV staff will explain how the model works at a forthcoming national NHS England webinar. We will be refining our model in the light of recent research and the learning from the other models. This work has helped the Trust prepare for the expected Covid-related surge in mental health needs and informed our current surge-recruitment campaign

- Within Durham & Darlington Mental Health Services for Older People, work has commenced within the Care Home Liaison Wellbeing Service. This has made significant positive impact and feedback. Due to the extent of the demand and the continuing pandemic, we would hope to extend this service post-March 2021
- Michael Taylor, associate nurse consultant and Dr Paul Tiffin, consultant psychiatrist, have been supporting scriptwriters from the television soap Emmerdale on a storyline featuring a character's relapse in mental health following a traumatic episode. Working closely with scriptwriters the team have reviewed scripts and offered advice and guidance on symptoms, treatment and presentation to ensure an accurate representation is portrayed
- As part of Black History Month the North East regional BAME staff networks, including TEWV, held a virtual event in October called 'Action, allyship and antiracism – what do these mean for everyone?'
- Construction work is underway on the new community mental health hub being built on North Moor Road in Northallerton. North Moor House will provide state of the art facilities for local mental health and learning disability services and will accommodate outpatient services for people of all ages across Northallerton and the surrounding areas
- The Trust has purchased rights to DadPad, a free app that provides dads with advice on caring for a new baby as well as information on various topics including mental health
- The rollout of Attend Anywhere across all services during the Covid-19 pandemic, to enable remote virtual appointments to continue has been largely successful

## National Awards – Won or Shortlisted

Awards where TEWV as an organisation, or one of our teams/staff members were shortlisted for an award but did not win that award during 2020/21 were:

| Awarding Body | Award Status | Name/Category of Award | Team/Individual |
|---|---|---|---|
| Health Service Journal | Shortlisted | Transformation Category – Mental Health Service Redesign Initiative | North Yorkshire & York Community Learning Disability Service – initial assessments: more co-production, timely clinical documentation and improved staff wellbeing |
| Nursing Times | Shortlisted | Nursing in Mental Health | Health & Justice Mental Health Inreach Team: HMP Holme House |
| Healthcare Quality Improvement Partnership | Shortlisted | Clinical Audit Professional of the Year | Robert Redfern |
| Northern Echo Health & Care | Shortlisted | Mental Health Award | Chris Oakes |

| Awards | | | |
|---|---|---|---|
| Northern Echo Health & Care Awards | Shortlisted | Mental Health Award | Unforgettable Experiences |

In 2020/21 the Trust was proud to be recognised externally in a number of national awards. Awards won or highly commended by TEWV teams or staff members are shown in the following table:

| Awarding Body | Award Status | Name/Category of Award | Team/Individual |
|---|---|---|---|
| TheraNorth | Won | TheraNorth Award - October | Karen Cartmell |
| Royal College of Psychiatrists | Won | Psychiatric Team of the Year: Working Age Adults | Redcar & Cleveland Community Affective Disorders Service |
| Annual Medical Education Awards | Won | Clinical Supervisor of the Year | Steve Wright |
| Royal College of Psychiatrists: Northern & Yorkshire | Won | 25 Women in Psychiatry | Kim Barkas |
| The Irene Taylor Trust | Won | Koestler Award | Health & Justice PIPE and Primrose Services |
| Literati Award 2020 | Won | Literati Award | Sarah Dexter-Smith<br>Abi Tarran-Jones |

## Our Big Conversation

In July 2020, our Board of Directors considered a report about revising our overarching strategy. The Board agreed that we needed to review the Strategic Framework but that this needed to be informed by significant engagement with our service users, carers, staff and stakeholders. As a result of this we launched 'Our Big Conversation' as a means of gathering intelligence to inform our new Strategic Framework but also for testing the key messages that we heard from that intelligence.

Our Big Conversation has been undertaken and engaged a total of **2,183** staff, service users, carers and partners, who together shared over **35,800** ideas, comments and votes. This provided an ideal opportunity for the Board to listen to what people are saying about the organisation. The thoughts and ideas provided have been analysed. This analysis was then used to inform an emerging Strategic Framework.

Three Board planning workshops were held between October 2020 and January 2021 to discuss and develop the draft Strategic Framework and that led to the identification of key areas of focus for the 2021/22-2023/24 Business Plan and the actions for each of these key areas.

The new Strategic Framework will enable actions to be planned and implemented to address the issues revealed by the conversations.

## Quality Priorities

We have identified our three Quality Improvement priorities for 2021/22, based on our assessment of the quality data and intelligence available to us and feedback from service users and carers. The priorities are:

1. Making Care Planning more Personal (this is a continuation of our previous Quality Improvement priority)
2. Safer Care (this is an amalgamation of two of our previous Quality Improvement priorities – Reducing the number of Preventable Deaths and Increasing the percentage of our inpatients who feel safe on the wards)
3. Compassionate Care

The following section includes our proposed actions for these priorities during 2021/22

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

## 2020/21 and 2021/22 Priorities for Improvement – How did we do and our future plans

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

**Due to the ongoing Covid-19 pandemic, it was not possible to undertake our normal Quality Account stakeholder engagement events. Consideration was given as to whether it would be possible to hold stakeholder engagement activities virtually, for example, via Microsoft Teams. It was however agreed that as the original priorities for 2019/20 were developed by our stakeholders during previous engagement sessions, and the fact that there has been little progress against the actions identified for these priorities during the previous year because of the pandemic, it would not be necessary to undertake further engagement at this time.**

The three Quality priorities for 2021/22 which we have identified also sit within TEWV's 2021/22–2023/24 Business Plan.

One of our priorities for 2020/21 – **Improve the Clinical Effectiveness and Patient Experience in times of Transition from CYP to AMH Services** – has not been carried forward to 2021/22 due to the work of this priority being superseded by the Trust-wide project 'Improving Transitions and Service Provision for People aged 16 to 25 years in Tees, Esk and Wear Valleys NHS Foundation Trust' which is linked to the Trust's wider work around the NHS England CAMHS Whole Pathway Commissioning. This means that many of the actions in relation to this Quality Improvement priority were removed from our Quality Account to ensure there was no duplication or divergence.

**Priority 1** – **Making Care Planning more Personal -** has been a priority for the Trust several years; however whilst some improvement has been made we still have some way to go to truly co-create care plans in line with our new goals and service user and regulator's expectations. **Priority 2 –Safer Care** this is an amalgamation of - priorities from the Trust Quality Account – Reducing Preventable Deaths and Increasing the Percentage of Inpatients who feel Safe on our Wards (now known as Safer Care). For these priorities, the section below including information on what we have done during 2020/21 and what we will do in 2021/22. **Priority 3 – Compassionate Care** – is a new priority which we have developed for 2021/22.

# Our Progress during 2020/21

## Making Care Plans more personal

**Why this is important:**

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

Feedback from service users shows that our current approach to Care Planning does not always promote a personalised approach, hence this being identified as a priority in 2020/21.

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

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



**What we did in 2020/21:**

| What we said we would do: | What we did: |
|---|---|
| • Re-audit and report as per Q4 2017/18<br>• Compare and contrast review of Patient Experience<br>• Develop and implement a communications and engagement plan to ensure all relevant stakeholders are aware of changes to the CPA and introduction of DIALOG (a clinical tool that allows for | • The Covid-19 pandemic has severely impacted progress against this priority over the past year. The lead for this piece of work has been redeployed for much of this time to support the patient and staff swabbing, antibody clinics, outbreak response and vaccination programme. However, aspects of the work have continued, for example, training has been delivered for trainee and newly qualified nurses on a variety of courses, but this has been to |

| | |
|---|---|
| more personalised Care Planning) and review this plan with key stakeholders (staff, service users, carers, local authorities and GPs)<br>• Continue User Acceptance Testing (UAT) of DIALOG and wider CITO developments (moving from artificial to real-life testing)<br>• Work with TEWV Information Technology team to ensure a finalised, working version of DIALOG is embedded within CITO<br>• Develop guidance to support the implementation of revised CPA processes including DIALOG<br>• Develop training and supporting materials in relation to the implementation of revised CPA processes including CITO pilot (this may not include the final version of DIALOG)<br>• Pilot training to support staff to implement the revised CPA processes<br>• Evaluate the pilot CPA training, making revisions where necessary<br>• Roll out the revised CPA training across the Trust | a much lesser extent than during previous years. Links have been maintained with the development group for Cito (a system which overlays the Trust's patient record to make it easier to record and view the patient's records), although this has also been impacted by the redeployment of the lead for this piece of work and key others within the group due to the Covid-19 pandemic. These actions have been rolled over into 2021/22 |



**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 2010/21: | Actual 2020/21: | Timescale: |
|---|---|---|---|
| • Do you know who to contact out of office hours if you have a crisis? | 85% | 74% | Q4 2020/21 |
| • Were you involved as much as you wanted to be in deciding what treatments or therapies to use? | 81% | 75% | Q4 2020/21 |

| | | | |
|---|---|---|---|
| • 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?<br><br>*This was added as a performance indicator as it was anticipated, when this part of the Quality Account was developed, that the Peer Support project would be well-established and would be supporting a different way of approaching care planning. It has been established more recently that this development opportunity will be progressed during 2021/22 with a Trust Lead overseeing recruitment and induction. Patient Experience Surveys will be expanded to include this measure from Q3 2021/22* | 42% | N/A | Q4 2020/21 |
| • Do the people you see through NHS mental health services help you with what is important to you?<br><br>*This is at the heart of care planning; the future state will place this front and centre of the approach to care planning. The use of DIALOG within Cito makes this very explicit, as it asks the questions 'do you need more help in this area' across 11 quality of life domains that will have been self-rated. Communications and basic introductory training and question/answer sessions have been running since November 2020 with support from the Cito team*<br><br>*This also links to current work that is underway to make sure that plans are 'needs led' and not being written because people feel that they have to. As such, the intervention plans, safety plans and care plans are being reviewed to establish what needs to remain and what can be moved to other parts of the system and processes (i.e. are the plans written because there is a personal need – needs-led)*<br><br>*The measurement of this indicator will be considered in future Patient Experience Surveys and DIALOG and is fully dependent on the new ways of working following the implementation of Cito in August 2022* | 87% | N/A | Q4 2020/21 |
| • Were you involved as much as you wanted to be in agreeing what care you will receive? | 82% | 75% | Q4 2020/21 |
| • Were you involved as much as you wanted to be in discussing how your care is | | | |

| | | | |
|---|---|---|---|
| working? | 89% | 79% | Q4 2020/21 |
| • Does the agreement on what care you will receive take your personal circumstances into account?<br><br>*This is linked to the questions above. Again, our intended future state addresses this directly, as there are parts of the process and systems that highlight what is important to the person and describes the context of the care planning. The measurement of this indicator will be considered in future Patient Experience Surveys and DIALOG and is fully dependent on the new ways of working following the implementation of Cito in August 2022* | 87% | N/A | Q4 2020/21 |

The measures for the above come from the NHS Community Mental Health Survey which is administered by the CQC. The targets we have set are very aspirational targets, and the experience that our service users report relates to their experiences in the Trust as a whole, rather than in relation to their CPA alone. Evidence also suggests that service users are more likely to complete this questionnaire if they have had a negative rather than a positive experience.



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

**Why this is important:**

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

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

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

The particular importance of improving the transition from Children and Young People's Services to Adult Services has been recognised for a number of years. We initially agreed to put a two-year Quality Improvement priority in place, focusing on this specific transition. We have extended this as the full extent of the work required has become apparent. The paragraphs below show what we achieved in 2020/21.

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

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

**What we did in 2020/21:**

| What we said we would do: | What we did: |
|---|---|
| • Extend the work of the NHSI Transitions Collaborative project into an internal 3-year project that oversees the development and delivery of key quality improvements – learning from the original pilot and the SI review undertaken in February 2020, taking the work forward. Including the learning form the thematic review – CPA/Process/Caseload Management/Escalation; Reasonable Adjustments & Assertive Engagement in complex cases<br>• Develop an action plan with this 'Preparing for Adulthood Collective' to implement key learning in the first year of the project, and will establish strategies and targets for Year Two and Year Three<br>• Instigate Quality Improvement plans for the effectiveness of the panel process following the evaluations of transition panels which has taken place in Quarter 4 2019/20 | • The majority of these actions were suspended due to the ongoing Covid-19 pandemic. Towards the end of 2020-21 the Trust began to implement the project 'Improving Transitions and Service Provision for People aged 16 to 25 years in Tees, Esk and Wear Valleys NHS Foundation Trust' which is linked to the Trust's wider work around the NHS England CAMHS Whole Pathway Commissioning. This means that many of the actions in relation to our Transitions Quality Improvement priority were superseded by this work and so were removed from our Quality Account to ensure there was no duplication or divergence |
| • Sustain and maintain improvements in the clinical effectiveness and patient experience at times of transition from CAMHS to AMH throughout the year; this will be informed by the collaborative work and 'plan, do, study, act' cycle via the Steering Group and audit activities | • We have however managed to maintain our improvement targets over this time period in terms of actual numbers; we saw an extra 703 young people through their transition period and completed a transition plan for an extra 784 during 2020/21 compared to 2018/19. This is positive especially against the backdrop of Covid-19 and extremely high caseload numbers |

**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 CYP who have a transition plan by age 17 years and 4 months<br><br>*This remains a high priority within clinical services; further work will be undertaken to better understand why all young people don't have a transition plan in place, and the actions required to ensure that a transitions plan is in place* | 100% | 87.4% | Q4 2020/21 |
| • Percentage of CYP who have their transition plan discussed at Panel<br><br>*This metric requires further review; at present we have been unable to extract the information required* | 100% | N/A | Q4 2020/21 |
| • Percentage of CYP who have completed transitions questionnaire on leaving CAMHS Services<br><br>*During the pandemic it has been more challenging to achieve feedback from young people; the service plans to expand the cohort of young people who they approach to complete the questionnaire to the 16-25 service. This will enable a greater number of questionnaires to be completed, providing more detailed feedback to improve services* | 90% | N/A | Q4 2020/21 |
| • Percentage of CYP who have a positive transitions experience<br><br>*Again during the pandemic it has been more challenging to achieve feedback from young people; the service plans to expand the cohort of young people who they approach to complete the questionnaire to the 16-25 service. This will enable a greater number of questionnaires to be completed providing more detailed feedback to improve services* | 100% | N/A | Q4 2020/21 |
| • Percentage of CYP who have an unplanned discharge from AMH within 3-6 | 0% | N/A | Q4 2020/21 |

| | | | |
|---|---|---|---|
| months<br><br>• Percentage of people who have a ‘6P*’ Formulation when presented at transitions panel<br><br>*Due to the Covid-19 pandemic, the audit that would encompass these two metrics has been delayed. It is now planned to publish this report during Quarter 3 2021/22* | 100% | N/A | Q4 2020/21 |

*A ‘6P’ formulation (also known as a Rethink formulation) uses a visual approach to organising information for formulation using the ‘6Ps’ as follows: presenting problem(s), predisposing factors which made the individual vulnerable to the problem, precipitating factors which triggered the problem, perpetuating factors such as mechanisms which keep a problem going or unintended consequences of an attempt to cope with the problem, protective factors and predictive factors

## Reduce the number of Preventable Deaths

**Why this is important:**

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

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

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

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

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There have been 11 Patient Safety Briefings disseminated to wards and teams from January to April 2021 to support early learning from incidents. These have covered issues and information including: Assessment and management of risks including updates on clinical risk management improvements to record keeping and environmental risk awareness; management of ligature risks in assisted bathrooms and toilet areas; defibrillation battery indicators; and keeping patients safe through carrying out of care rounds and supportive observations. Staff awareness of these briefings has been enhanced through improved ward communication structures and the inpatient practice development team.

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

- Increased confidence that investigations are being carried out in accordance with best-practice guidelines and in a way that is likely to identify missed opportunities for preventing death and improving services
- That the Trust learns from the reviews of deaths, including identifying any themes early so that actions can be taken to prevent future harm
- That our process reflect national guidance and best practice which will support the delivery of 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
- Patients and families feel listened to during serious incident investigations are consistently treated with kindness, openness and honesty

**What we did in 2020/21:**



| **What we said we would do:** | **What we did:** |
| --- | --- |
| • Fully introduce 48-hour follow up for all AMH patients after discharge from inpatient wards | • We have fully introduced 48-hour follow-up processes for all AMH patients after discharge from inpatient wards (previously 72 hours) |
| • Produce report, recommendations and evaluation from Family Conference<br>• Produce action plan from Family Conference and implement these actions | • The Family Conference held in March 2019 was to be followed on by March 28th 2020 by a second event. However the Covid-19 lockdown prevented this from going ahead. This was a disappointment for families who wanted to be part of the event but they were appreciative of why it was cancelled. Due to the sensitive nature of the Family Conference it was not the type of event that could be held remotely. One of the reasons for the success of the 2019 event was due to the support that was in place for the families that attended who were still grieving and distressed about the loss of their loved one |
| • Involve a lived experience Service User/Carer Representative in the Environmental Risk Group | • We have invited a Service User/Carer Representative with lived experience to be a member of the Trust's Environmental Risk |

| | |
|---|---|
| | Group and they have attended one meeting so far. The Environmental Risk Group have overseen a comprehensive programme to reduce the risk of ligatures across inpatient services; this has included the fitting of new, safer, ensuite showers, toilets and hand basins as well as the pilot of the Oxehealth Digital Care Assistant in three wards. This is a system that detects movement in bedroom areas and seclusion rooms through the measurement of a patient's vital signs and can send alerts to staff where risks to the patient may be arising |
| • Implement actions from the external review of unexpected deaths of Adult, Forensic and Older Person's Services inpatients | • We have implemented the actions from the external review of unexpected deaths of Adult, Forensic and Older Person's Services inpatients |
| • Review the Trust Zero Suicide Plan in view of the Family Involvement Event and Safety Summit in Quarter 2 2020/21; set up a task and finish group to be an umbrella Steering Group around preventing harm and deaths, chaired by the Trust Medical Director | • The Suicide Prevention and Self Harm Reduction Group, chaired by the Medical Director, was established as planned. The group continues to develop a framework to ensure that the Trust is supported in coordinating activities designed to reduce the risk of suicide and frequency of suicide attempts. The group also focuses on dissemination of learning and good practice around suicide prevention and self-harm. |



**How do we know we have made a difference?**

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

| Indicator | Target | Actual | Timescale |
|---|---|---|---|
| • Increase the number of mortality reviews in relation to deaths (this is in addition to the existing Serious Incident Process) and identify actionable learning | 400 | 326 | Q4 2020/21 |
| • Eliminate Preventable Deaths of inpatients (including during periods of leave) | 0 | 1* | Q4 2020/21 |
| • Reduce the number of Serious Incidents where it was identified that the Trust contributed to the incident | <30 | 55 | Q4 2020/21 |

*There is one other inpatient death in the process of review, which will not be complete until August 2021*

The purpose of reviews of deaths is to understand where problems in care might have contributed to that death. The mortality review process remains under review and is focusing on proportionate investigations to ensure that learning and themes are identified and acted upon Trust-wide and wider. A more robust multi-disciplinary mortality review panel has been established and there has been an event looking at key themes relating to physical health deaths. We have started to share these themes with external stakeholders in keeping with the Community Mental Health Framework which focuses on how we can improve the physical health of people who also experience difficulties with mental health.

In 2020/21 there was 1* patient where on review of their care it was considered that their death may have been potentially preventable. This means that it was more likely than not to have resulted from problems in healthcare. The Trust is committed to eliminating such preventable deaths and continues to work hard to achieve this through a range of improvement programmes. These programmes have been developed based on the learning identified from reviewing patient care at both a local and national level. This work ranges from a focus on clinical risk assessment, environmental risk reduction, revision of Trust policies and procedures to ensure they are informed by a contemporary evidence base. Implementation of revised practices are supported by the development of competence based training and assessment. Our work on eliminating harm and preventable deaths will continue to develop over the coming year. Following the CQC focussed inspection in January 2021, the Trust held a Quality Improvement event to ensure that robust systems were in place to comprehensively assess and mitigate patient risk. This improvement work has encompassed and enhanced ongoing actions to address the four most common root cause or contributory findings as detailed above. Work has included providing detailed guidance on clinical risk assessment and management to clinical staff to support practice in line with the Trusts Harm Minimisation policy as well as simplifying related documentation on the electronic patient record in the form of the safety summary and safety plan, leave and observation care plan.  Harm minimisation training and suicide prevention training content and delivery has also been reviewed to bring greater clarity on standards and expectations as well as more detailed focus on clinical risk assessment aligned to particular patient needs.

Unfortunately the number of serious incidents where it was identified that the Trust contributed to the incident has not reduced during 2020/21. However, each of these incidents has a robust action plan in place for service improvement with the aim of reducing similar incidents during 2021/22.

## Increasing the proportion of inpatients who feel safe on our wards

**Why this is important:**

A known theme among mental health inpatients is that they do not feel safe whilst on our wards; this is identified as a priority for Trusts in the NHS Long-Term Plan (2019). Feedback from our stakeholders in 2019/20 indicated awareness of this as an issue and we therefore agreed to include this as one of our priority areas for improvement within the Quality Account 2020/1 with the aim to increasing the proportion of inpatients who feel safe on our wards.

To enable us to measure this, the question *'during your stay, did you feel safe?'* has been included in a suite of questions within the trust wide Friends and Family Test patient experience survey for some time. The survey is offered to patients and carers at each touch point throughout their journey i.e. at a review meeting or a discharge planning meeting or as a minimum every three months, Patients also have the opportunity to expand on their answers through providing additional narrative.

The Trust is committed to improving this area of our patients' experience. Work has been ongoing for some time to continually review the patient experience survey results and to better understand the reasons why some of our patients do not feel safe on our wards.

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

- An overall improved patient and family experience
- An increase in the percentage of our service users feeling safe when they are in a Trust inpatient setting
- Increased collaboration between service users, staff and peers
- A reduction in incidents e.g. violence and aggression, absence without leave, drug misuse
- Improved understanding of ward environments and why service users feel unsafe
- Increased opportunity to use digital technology to support the delivery of care

**What we did in 2020/21:**



| **What we said we would do:** | **What we did:** |
| --- | --- |
| • Use existing data to identify priority wards and actions; collate existing Friends and Family Test and other data | • We undertook a deep dive into the patient survey narrative provided by patients to further understand the reasons why our patients might not feel safe. The key themes identified were due to the environment, due to their illness, other patients and staffing. |
| • People with lived experience to talk to people currently on the TEWV inpatient wards with the highest and lowest current FFT scores, produce a 'lessons learned' report, develop a plan for each ward identified as a priority and deliver actions from this plan | • This action has been rolled over to our Quality Improvement Business Plan for 2021/22 |
| • Undertake work to improve liaison with the Police | • We have undertaken work to improve liaison with the Police over the past year; this has now been embedded as 'business as usual'. This includes working together to address the issues of violence affecting staff and patients, including developing an action plan to introduce an improved method of recording non-urgent crimes to |

| | |
|---|---|
| | ensure that when NHS staff need police to attend they are available. This had led to a significant improvement in feedback on incidents reported. There are also regular urgent care interface meetings with the Police to address any issues between both partners. We also have an ongoing safe community work stream with Police and Substance Misuse Services to share community intelligence, think strategically about our approach to care and how we can work collaboratively to overcome criminal activity and risks associated with substance misuse |
| • Continue monitoring of Key Performance Indicators (KPIs) during the pilot phase of body cameras and develop a Business Case for further roll-out of these cameras (if supported by monitoring of benefit KPIs) | • Although the pilot phase of body cameras has continued during 2020/21, there has been no monitoring of KPIs undertaken due to the Covid-19 pandemic. It is planned to continue the pilot during 2021/22 by rolling out to a further 5 wards. Further consideration will be given to further implementation based on an evaluation/benefits realisation. |
| • Install the technology required for sensor technology in five wards and develop required governance in relation to this pilot work; a benefits realisation of the pilot will be undertaken | • We have tested the Oxehealth Digital Care Assistant in three wards across the Trust. Approval has been given to extend this to a further 12 wards including some seclusion and Section 136 areas – the approach will include three workstreams, overseen by an Implementation Steering Group chaired by the Director of Nursing & Governance that will meet every three to four weeks until three months post 'go-live' when the ongoing project and partnership working is then overseen by a Partnership Board. The Partnership Board will report key information into our Senior Leadership Group meeting. We see this initiative as being key to our plans for keeping patients safe |

**How do we know we have made a difference?**

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

| Indicator | Target | Actual |
|---|---|---|
| • Percentage of inpatients who report feeling safe on our wards | 88% | 65% |
| • Percentage of inpatients who report that they were supported by staff to feel safe | 65% | 68% |

Across all of our inpatient wards we have introduced the Safe Wards model. The model is evidenced based and provides approximately 300 ideas for interventions that could be helpful to reduce levels of conflict and containment to make the wards a safer place. A number of interventions have been introduced since its launch including, mutual help meetings between staff and patients, calm down boxes that contain items to lower the level of arousal and agitation and the implementation of bad news mitigation plans when a patient may receive unwelcoming information. Individual wards are required to take ownership of these initiatives and evaluate progress. The wards have been asked to review their local interventions by the end of March 2021 and to consider any additional interventions that could be introduced onto the ward. This will be done in collaboration with the service users where possible and each ward will provide feedback to the Quality Assurance Groups.

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## Our Quality Improvement Priorities for 2021/22

**A summary of our plans for 2021/22 can be found in *Appendix 5: Our Quality Account Plan on a Page***

### Priority One: Making Care Plans more personal

**What we will do in 2021/22:**

| We will: |
|---|
| • Establish a Steering Group to oversee the development and implementation of high quality, collaborative care planning<br>• Agree principles and format (inpatients and community) of what constitutes a personalised care plan as opposed to a treatment or intervention plan<br>• Produce a plan to inform the communication, introduction and safe transition of DIALOG into the patient record and other Cito developments and policy amendments required<br>• Co-create guidance on 'writing good care plans' |

- Co-create updated Care Planning training and agree roll-out plan
- Audit the percentage of service users within inpatient and community services with a personalised care plan and agree an improved target
- Co-create patient reported measures of personalised care plans
- Undertake patient reported evaluation of personalised care plans
- Review Cito plan and produce update on progress
- Undertake service user experience evaluation
- Evaluate embeddedness and make recommendations for sustainability

**How will we know we are making things better?**

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

| Indicator: | Target 21/22: | Timescale: |
|---|---|---|
| • Do you know who to contact out of office hours if you have a crisis? | 84% | All Q4 2020/21 |
| • Were you involved as much as you wanted to be in deciding what treatments or therapies to use? | 85% | |
| • Have you been given information by NHS Mental Health Services about getting support from people who have experience of the same mental health needs as you? | 42% | |
| • Do the people you see through NHS mental health services help you with what is important to you? | 87% | |
| • Were you involved as much as you wanted to be in agreeing what care you will receive? | 85% | |
| • Were you involved as much as you wanted to be in discussing how your care is working? | 89% | |
| • Does the agreement on what care you will receive take your personal circumstances into account? | 87% | |

## Priority Two: Safer Care

This priority builds on previous priorities related to improving patient safety, learning from patient safety events and deaths and how this drives improvement as well as increasing the percentage of patients who feel safe on our wards.

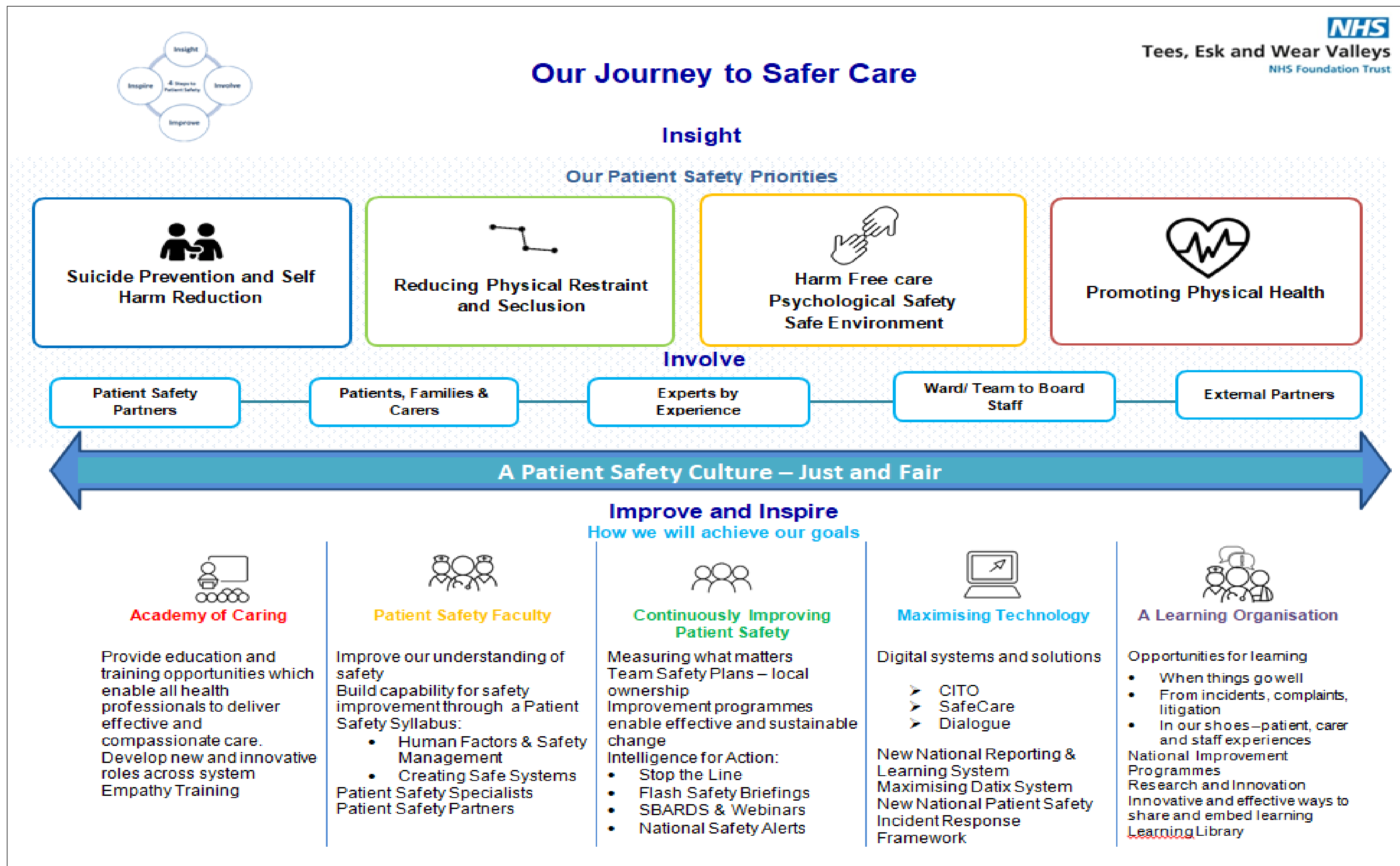
**Why this is important:**

Patient Safety continues to be a key priority for the Trust and we have already identified four Patient Safety priority areas that we will focus upon over the next three years:

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

These are illustrated in Figure 1 over the page - ‘Our Journey to Safer Care.’ This provides an overview of our approaches and key enablers.

*Figure 1: Our Journey to Safer Care*




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

- Improved patient safety and reduction of patient harm
- Increased capability for patient safety improvement

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

**What we will do in 2021/22:**

**We will:**

**We will implement 'Our Journey to Safer Care'**

- Communicate and share the agreed patient safety priorities across defined internal and external stakeholders using a range of mediums and mechanisms as part of the trust patient safety campaign
- Determine the programmes of work for each of the four patient safety priorities
- Identify process and outcome KPIs for each of the four patient safety priorities
- Assess current baseline for each performance indicator identified and set incremental targets for improvement throughout 2022/23
- Promote the role of the Trusts Patient Safety Specialist
- Work in collaboration with the ISC 'Better Tomorrow programme: learning from deaths, learning from lives' to improve our processes for identifying lessons learned using information to improve future care and to develop support networks in undertaking mortality reviews within a wider community of practice
- Review and update Learning from Deaths Policy

**We will increase the percentage of our inpatients who feel safe on our wards:**

- Work proactively within the newly formed Regional Patient Experience Network , maximise opportunities for benchmarking patient experience data
- Use existing data to identify priority wards/teams and actions: collating existing Friends and Family Test (FFT) and other data
- People with lived experience to talk to people currently on wards with highest and lowest current FFT scores
- Develop a plan for each ward/team identified as a priority, with involvement from clinical staff, management and service users and deliver actions throughout the year
- Further review information from patient experience surveys and concerns raised from patients and carers through PALS contact and complaints and use this to feed into report and action plan, and deliver actions throughout the year

- Seek ideas as part of the ‘mutual help’ meetings that take place on the wards on what we can do to make patients feel safe - roll out across the Trust
- Review current ‘ward orientation’ process for patients being admitted onto our wards and incorporate into personal safety plans - roll out across the Trust (currently in Tees only)
- Continue existing pilot of body cameras to a further six wards and an additional 60 cameras
- Develop a business case for further roll-out of body cameras (if supported by monitoring of benefit Key Performance Indicators)

**We will strengthen organisational learning, including learning from deaths:**

- Implement an Organisational Learning Group (OLG)
- Deliver the four organisational learning work programmes that aim to strengthen and embed robust systems for the identification and sharing of learning (infrastructure and governance, systems for communication of immediate patient safety concerns, development and launch of a Learning Library and share learning from West Lane Hospital
- Have in place an Integrated Organisational Learning Report with an initial focus on learning from patient safety issues
- Have in place a mechanism assessing the impact of organisational learning

**How will we know we are making things better?**



| Indicator: | Target 2021/22: | Timescale: |
|---|---|---|
| Expand the pilot use of staff body cameras to include a further five wards | Body cameras in place in a further five wards | Q1 2021/22 |
| Percentage of inpatients who report feeling safe on our wards | 88% | Q4 2021/22 |
| Percentage of inpatients who report that they were supported by staff to feel safe | 65% | Q4 2021/22 |

## Priority Three: Compassionate Care

**Why this is important:**

The Trusts new strategic framework describes the kind of organisation we want to be:

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

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

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

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

**What we will do in 2021/22:**

| **We will:** |
|---|
| • Develop the Serious Incident review process to take account of feedback from patients and families regarding a more collaborative and informed approach<br>• Undertake an evaluation of the new process<br>• Refresh current improvement plan related to responses to complaints<br><br>**We will embed the new Trust Values and Behaviours within the Trust:**<br><br>• Hold engagement events with staff at all levels to develop our new ways of working together, with involvement of service users and carers<br>• Share outputs of initial engagement events so all staff, service users and carers can access tools and resources which help to describe our new ways of working<br>• Further roll-out of engagement events, to be attended by all staff<br>• Work with staff, service users and carers to identify work which has already been developed which supports the new values. Agree how we will learn from and build on this work<br>• All teams to co-create their ways of working and development plans |

| **We will roll out empathy and compassion training across locality and corporate services:**<br><br>• Establish a baseline of those requiring training<br>• Undertake a formal evaluation of training |
|---|

**How will we know we are making things better?**

| Indicator: | Target 21/22: | Timescale: |
|---|---|---|
| • Percentage of patients reporting that they felt treated with dignity and respect | 94% | All Q4 2021/22 |
| • Percentage of patients who were involved as much as they wanted to be in the planning of their care | 70% | |
| • Percentage of patients who report being listened to and heard by staff | 76% | |
| • Reduction in the number of complaints that request a further local resolution | 18% | |

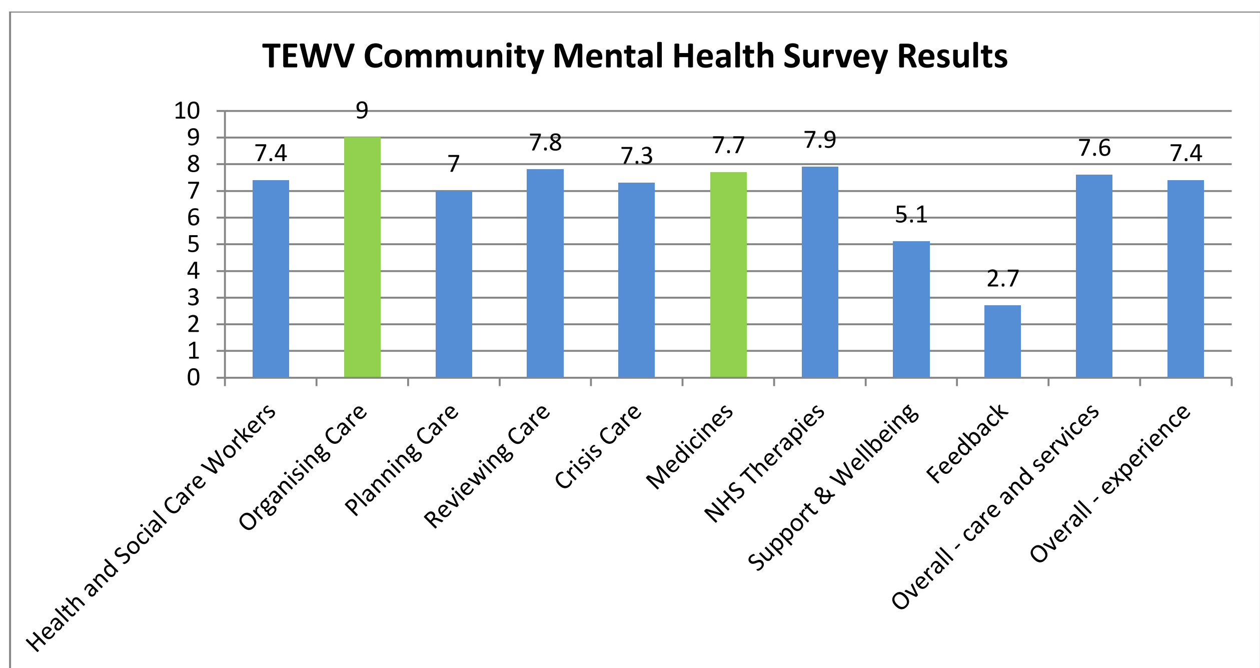


## Monitoring Progress

The Trust will monitor its progress in implementing these priorities at the end of each quarter and will report to our Quality Assurance Committee, our Council of Governors and our wider Stakeholders.

## TEWV's 2020 Community Mental Health Survey Results

- There were 340 responses from people about the Trust
- The Trust's score for 'Overall Experience' was 74% compared to 71% in 2019, 66% in 2018 and 71% in 2017, demonstrating a steady improvement over the past few years
- The Trust performed 'Better' than most other Trusts that took part in the survey in the following categories: Organising care and Medicines
- The Trust performed 'About the same' as most other Trusts that took part in the survey in the following categories: Health and social care workers, Planning care, Reviewing care, Crisis care, NHS therapies, Support and wellbeing, Feedback, Overall views of care and services and Overall experience
- The Trust did not perform 'Worse' than most other Trusts that took part in the survey in any of the categories




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

https://www.cqc.org.uk/provider/RX3/survey/6

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

- Improve communication between services, patients and GPs by focusing on the sharing of information between the Trust, Partners, Patients and Carers
- Aim to reduce waiting times for therapy and appointments through a recruitment programme of additional clinical staff
- Hold a scoping/improvement event to review and agree future Crisis Operational Models Trust-wide. This follows on from the implementation of the all-age single central crisis line in May 2020 and subsequent evaluation undertake alongside

the review of the telephony system requirements and demand and capacity predications
- Allow the patient to be included more in consultations and decision-making by recording of attendance at CPA meetings and reviews on PARIS and undertaking further Patient Experience Surveys
- Circulate the National Community Mental Health Survey report and findings across the Trust for discussion at local governance groups and add this report to the agendas for discussion at patient and service user involvement groups
- Develop a further action plan in relation to the issues raised by the survey

## TEWV's 2020 National NHS Staff Survey Results

The National NHS Staff Survey is commissioned by the Picker Institute on behalf of TEWV and 26 other Mental Health and Learning Disabilities Trusts.

- TEWV were ranked 11th out of 27 Trusts
- All TEWV Staff were invited to participate
- The response rate decreased from 45% in 2019 to 38% in 2020 – there were 2,785 participants in total which is a decrease of 186 staff from 2019
- The median response rate across all Mental Health Trusts was 45%
- Overall staff engagement remained at 7 (out of ten)

The following table shows the categories where the Trust scored 'Better', 'Worse' or 'About the Same' as other Mental Health Trusts:

| | |
|---|---|
| **Better** | • Equality, Diversity and Inclusion |
| **Worse** | • Immediate Managers<br>• Quality of Care<br>• Safe Environment – Violence<br>• Staff Engagement<br>• Team Working |
| **About the Same** | • Health and Wellbeing<br>• Morale<br>• Safe Environment – Bullying and Harassment<br>• Safe Culture |

**Benchmarking**

Below are the questions where the Trust scored above or below average when benchmarked against the other organisations, along with the percentage difference from the average score:

- Have adequate materials, supplies and equipment to do my work (+6%)
- Satisfied with level of pay (+6%)
- In last 12 months, have not experienced musculoskeletal problems as a result of work activities (+5%)
- Organisation acts fairly: career progression (+6%)

- Not experienced discrimination from patients/service users, their relatives or other members of the public (+5%)
- Organisation treats staff involved in errors/near misses/incidents fairly (-5%)

**Top Five Scores**

- Have adequate materials, supplies and equipment to do my work (69%)
- In last 12 months, have not experienced musculoskeletal problems as a result of work activities (78%)
- Organisation acts fairly: career progression (89%)
- Satisfied with level of pay (45%)
- Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public (76%)

**Bottom Five Scores**

- Organisation treats staff involved in errors/near misses/incidents fairly (54%)
- Last experience of physical violence reported (87%)
- Immediate manager values my work (76%)
- Satisfied with opportunities for flexible working patterns (63%)
- Not felt pressure from manager to come to work when not feeling well enough (76%)

An overview of these results have been shared with the Trust's Senior Leadership Groups/Committees and the locality-specific free text comments have also been shared with the leadership teams within each locality. We have identified locality representatives and an initial meeting will be scheduled to discuss the approach the Trust will take in order to take forward these results in relation to improving our staff experience and what assurance this approach will offer. Our journey to safer care goals will also help us to address our staff feeling safer to raise errors and incidents and violence reduction within our inpatient settings. We will focus on themes and 'bite-size' improvements, so as not to overwhelm staff with more actions/targets and to ensure that we implement improvements which will really make a difference to our staff.

## TEWV's Staff Friends and Family Test Results

Due to the ongoing Covid-19 pandemic, data collection for the Staff Friends and Family Test was stood down during 2020/21

## Review of Services

During 2020/21 the Trust provided and/or subcontracted **20** relevant health services. The Trust has reviewed all the data available to them on the quality of care in **20** of these relevant health services.

The income generated by the relevant health services reviewed in 2020/21 represents **100%** of the total income generated from the provision of relevant health services by the Trust for 2020/21.

## Participation in clinical audits and national confidential inquiries

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

During 2020/21, **four** national clinical audits and **two** national confidential inquiries covered the health services that TEWV provides.

During 2020/21, TEWV participated in **100% (four out of four)** of the national clinical audits and **100% (two out of two)** 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 2020/21 were as follows:

- POMH Topic 20a: Improving the Quality of Valproate Prescribing in Adult Mental Health Services
- POMH Topic 18b: Use of Clozapine
- National Clinical Audit of Psychosis (NCAP): Spotlight re-audit in EIP
- National Audit of Inpatient Falls (NAIF)
- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

The national clinical audits and national confidential inquiries that TEWV was **participated in** during 2020/21 were as follows:

- POMH Topic 20a: Improving the Quality of Valproate Prescribing in Adult Mental Health Services
- POMH Topic 18b: Use of Clozapine
- National Clinical Audit of Psychosis (NCAP): Spotlight re-audit in EIP
- National Audit of Inpatient Falls (NAIF)
- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (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 2020/21** are listed below alongside the number of cases submitted to each audit or inquiry as a percentage of the number of registered cases required by the terms of the national audit or inquiry.

| Audit Title | Cases Submitted | % of number of registered cases required |
|---|---|---|
| POMH Topic 20a: Improving the Quality of Valproate Prescribing in Adult Mental Health Services | Sample provided: 203 | 100% |
| POMH Topic 18b: Use of Clozapine | Sample provided: 120 | 100% |
| National Clinical Audit of Psychosis (NCAP): Spotlight re-audit in EIP | Sample provided: 440 | 100% |
| National Audit of Inpatient Falls (NAIF) | Sample provided: 3 | 100% |
| National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) | 22 questionnaires sent to the Trust; 12 returned | 55% |
| National Confidential Enquiry into Patient Outcome and Death (NCEPOD) | * | * |

** The Trust was eligible to participate in this confidential enquiry during 2020/21; data collection, however, continued into 2021/22 therefore figures will be reported within the 2021/22 Quality Account*

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

The reports of **130** local clinical audits were reviewed by the Trust in 2020/21 and TEWV intends to take actions to improve the quality of healthcare provided. **Appendix 3** includes the actions the Trust is planning to take against the **ten** key themes from these local clinical audits reviewed in 2020/21

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 **36** clinical audits in 2020/21 which include clinical effectiveness projects undertaken by Trainee Doctors, Consultants or other Directorate/Specialty Groups. These clinical audits were led by the services and individual members of staff for reasons of service improvement and professional development and were reviewed by the Specialty Clinical Audit Subgroups. Over the next year the Trust will explore the use of audit apps to make audits quicker and more efficient and to make it easier for teams to understand their information and make the changes needed.

## Participation in Clinical Research

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

The number of patients receiving relevant health service provided or sub-contracted by TEWV in 2020/2021 that were recruited during that period to participate in research approved by a Research Ethics Committee was **836**. Of the **836** participants, **826** were recruited to **20** National Institute for Health Research (NIHR) portfolio studies. This compares with **658** patients involved as participants in NIHR research studies during 2019/20.

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

- We were involved in conducting **52** clinical research studies during 2020/21; **43** of these studies were supported by the NIHR through its networks
- **36** members of our clinical staff participated as researchers in studies approved by a Research Ethics Committee, with **27** of these in the role of Principal Investigator for NIHR supported studies
- **2921** members of our staff were also recruited as participants to NIHR portfolio studies
- We continue to collaborate with a wide range of universities and other NHS providers to deliver large multi-site research studies for the benefit of our service users, carers and staff
- Many studies have adapted recruitment methods to accommodate over the phone and video calls to ensure participants can still consent to and have access to research opportunities. The ability to receive feedback from research participants through the Participant in Research Experience Survey has been impacted upon by Covid-19.
- **2293** TEWV staff took part in NHS CHECK which is a major study of the impact of the COVID-19 pandemic on the short and long-term health and wellbeing of all staff working within 18 partner NHS Trusts.

**Key achievements:**

The emergence of Covid-19 has seen research in the global spotlight to develop solutions swiftly. Our staff and service users have been taking part in research that is finding effective vaccines, developing treatments and informing government policy. The Department of Health gave Urgent Public Health status to a variety of studies where research is essential and deemed to have an important effect on the progress and outcome of the pandemic. TEWV is sponsor for the only interventional mental health research study badged as Urgent Public Health, the Basil C19 study, which examines the use of behavioural activation in older adults with low mood or loneliness and long term health conditions during Covid-19.

We are looking forward to welcoming our first research participant to Foss Park Clinical Research Facility with the opening of a new commercial research study to

compare two medications as add-on treatment to anti-depressant therapy for adults with depression and sleep problems.

The ComBAT study (Community Based Behavioural Activation Training for depression in adolescents) has now opened. It is a 5-year programme grant that commenced in January 2021 and aims to develop and deliver a standardised community based behavioural activation training programme in consultation with adolescents, their parents and professionals from the NHS, schools and charities. The partnership with the University of York continues to thrive with new emerging grant applications in progress.

The Trust is proud to have a Consultant Nurse who is funded by the NIHR through the '70@70 Senior Nurse and Midwife Research Leader Programme'. We are committed to increasing the visibility of nursing research and nurses' contribution to research delivery. Our Consultant Nurse has worked collaboratively to overcome challenges and drive changes in this area.

The programme is now in its final year and key objectives for 2020/21 are:

- Complete Care Covid Study – data collection, analysis, write-up, presentation and feedback to relevant groups
- Complete dissemination and agreed actions on recommendations from Nurse Consultant research activity audit
- Complete job planning work for TEWV Nurse Consultants
- Continue supporting preceptor programme in TEWV
- Complete the podcasts we are currently making with the Local Clinical Research Network: North East & North Cumbria
- Undertake a three-year survey in TEWV of what nurses want in terms of required support etc. to become more involved in research
- Work with the TEWV Research & Development Team and Nursing & Governance Directorate to ensure actions from the research strategy and nursing strategy are met as planned
- Prepare abstract and poster for end of year three as per '70@70' three-year plan
- Final Year three report as per '70@70' three-year plan
- Continue supporting individual nurses for NIHR Clinical Academic Pathways and PhD preparation
- Agree arrangements for follow up to the role in the Trust with the Director of Nursing & Governance for TEWV

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

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

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

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

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

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

In January 2021, the CQC carried out an unannounced, focussed inspection of five of our Acute Wards of Adults of Working Age and Psychiatric Intensive Care Units (PICU) and observed that some risk assessment and management processes were not fully effective to support the delivery of safe patient care. A number of urgent and immediate actions were taken across the core service and a quality improvement event was held to address standards around risk assessment and organisational learning across all services.

In March 2021, due to enforcement action taken in the safe and well-led dimensions, the CQC inspection report rated the Acute Wards for Adults of Working Age and PICUs as inadequate in these areas. The Trust was required to complete an improvement plan addressing all the requirements in the inspection report and the Section 29A Warning Notice with actions to be completed by 3rd May 2021.

In addition to clearly evidencing delivery of the required actions, the Trust acknowledges that a wider programme of change and improvement is required beyond this date. It is recognised that increasing multidisciplinary involvement and oversight, improving staffing establishments, building in appropriate training, expertise, sustainable support, clinical supervision and leadership to our clinical teams is critical to prioritising a culture of patient safety and continuous quality improvement. In addition, work is underway to enhance and embed organisational learning from a range of internal and external sources. This includes reviewing, strengthening and developing mechanisms for capturing and communicating learning and importantly gaining assurance of the impact of our actions to improve care for services users and their families.

Since the inspection, we have invested £5.4 m in staffing, with a focus on inpatient services, seven-day capacity and quality governance. An improved assurance schedule that includes a review of care documentation has been put in place to provide assurance that patients risks are assessed and that they have a safety plan in line with their needs.

A ‘Quality Improvement Board’, chaired by the Chief Executive with executive team attendance with responsibility for ward/team to board reporting on implementation has been put in place to oversee quality assurance standards including regular audit and direct observation on wards and to provide assurance to the Trust Board that actions being taken to address patient safety are improving. Community assurance processes have included the development of a dashboard to support community caseload reporting and improved clinical supervision.

**Improvement Plan**

A Regional Quality Board has been set up where TEWV is reporting on progress to other partners such as NHSE and ICSs as well as the CQC. We are also accessing expert support from outside the Trust to support with rapid improvement and embedding actions.

In addition to the attainment of all CQC recommendations and conditions related to the Section 29a warning notice issued by CQC in March 2021, an umbrella improvement plan has been developed with overarching work-streams which include:

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

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

Although we have retained a ‘Good’ rating for the well-led domain, we now have an overall rating of ‘Requires Improvement’ with a number of actions having been taken to improve the quality and safety of our services.

The CQC’s current rating for the Trust for each key domain overall is:

| Overall Requires improvement | | |
|---|---|---|
| Read overall summary | | |
| | Safe | Requires improvement |
| | Effective | Good |
| | Caring | Good |
| | Responsive | Requires improvement |
| | Well-led | Good |

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

## Quality of Data

It is important that data used by NHS services is of a high quality so that it can be best used to inform decisions on the management of patients. In addition, data must be of a high quality to help inform organisational decision-making and planning. For example, it is also important that the General Medical Practice Code is recorded so information about the patient's health and any hospital treatment received is sent back to their GP, who should be able to treat the patient appropriately.

The Trust did not submit records during 2020/21 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics; these were stopped by the 'reducing the burden team at NHS Digital, as the Trust submits to the Mental Health Services Data Set it is no longer required to make these submissions.

## Information Governance

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

Due to the ongoing Covid-19 pandemic, NHS Digital have delayed submission of the Data Security and Protection Toolkit 2020-21 until 30th June 2021. Of the **110** mandatory evidence items and **42** assertions, we anticipate publishing the Toolkit with all evidence provided and assertions met.

In the most recent NHS Digital published results (January 2021) TEWV gained a score of 98.1% for the Data Quality Maturity Index which is a measurement of data quality in the NHS

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

- The Trust has in place an internal group which has the responsibility for ensuring data quality within the Trust; this was put on-hold during the COVID-19 response but is set to be reinstated as part of the Trust's revised governance structure

- Data quality is included within the Corporate Risk Register which is used by the Board of Directors to monitor the risk of incomplete and inaccurate data. The Trust has a Data Quality Strategy which provides a framework for improvements in this important area

- The Trust has the following policies linked to data quality:

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

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

- A significant amount of training is provided to support staff using PARIS and to ensure compliance with CPA. Training is provided where issues around data quality have been identified

- As part of performance reporting to the Board, real-time data is used to forecast future positions thus improving the decision-making process. The Trust has introduced the use of Statistical Process Control (SPC) charts this year to enhance decision making

- All data returns are submitted in line with agreed timescales

## Freedom to Speak Up

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

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

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

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

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

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

During 2020/21, there were **51** cases referred to the Freedom to Speak Up Guardian. Of these, **20** were submitted anonymously. **21** of the concerns related to culture of bullying, and **9** related to patient safety and **11** to staff safety. The remainder related to other issues such as culture or systems/processes. We are committed to creating an open and transparent culture where every member of staff can speak out safely. Over the next year we will continue to raise the profile of the Freedom to Speak Up Guardian and triangulate the information we have with other sources to ensure the best and safest care for our service users.

## Reducing Gaps in Rotas

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

Commission and by the continued scrutiny of the quality of training by Health Education England.

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

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

The Guardian of Safe Working for Junior Doctors within the Trust produces quarterly and annual reports to the Trust Board that focus on gaps in medical rotas and safety issues. The Trust's Board received the Guardian's annual report for 2020/21 at its meeting of 29th April 2021. During the year, the most common reasons for needing short-term/locum cover was due to vacancies on the rotas, staff sickness (short/long term) and COVID 19 related absences (sickness or self-isolation).

Exception reports received related mostly to not having five hours continuous rest while working between 10pm and 7am on a Non-Residential On-Call rota, having to stay later than normal working hours or shift end time or missing teaching/training due to staff shortages. Discussions on these issues have taken place where appropriate and additional staffing put in place where possible.

## Bolstering staffing in adult and older adult community mental health services

The Trust through its Commissioners, national transformation investment and Covid Surge monies has increased its staffing across all clinical services to include CYP and Learning Disability Services. The table below shows the additional staffing in post in March 2021.These staff were recruited across a range of clinical services, in particular to respond to demand with in urgent care services, enhancing community and inpatient teams in particular to improve skills in responding to complex presentations

Examples include Structured Clinical Management Practitioners in County Durham, which is a nationally recognised model to support patients with a Personality Disorder.

We have also enhanced our GP-aligned Mental Health services to provide additional capacity to support practice-based nurses and the Access Service – their focus will be on people with lower level needs who require a level of intervention that does not need to be provided in secondary care.

Within North Yorkshire and York MHSOP Services have increased capacity with dedicated roles to improve Physical Health Monitoring, which is a recognised area of need. A Social Worker as also been introduced to this team, who will be facilitating a virtual ‘Steps to Recovery’ group in addition to working with individuals and families in the community and providing discharge liaison support where inpatient treatment is appropriate

The North Yorkshire and York AMH integrated teams will also begin working six days a week (two members of the team to work on Saturday) and will be joined by support workers from the Crisis Team. Due to the recent changes in the Urgent Care Service at the Friarage Hospital, overnight crisis services in this area have been reviewed. There has been additional funding for additional Senior Crisis Practitioners to enable provision of the All Age Crisis Helpline.

In North Yorkshire and York MHSOP Services staff have been trained in non-governed psychological therapies to increase skills within the Community Teams, and physiotherapy, pharmacy and dietetics have also all been incorporated into the community model. Physiotherapy staff have also developed a virtual group around physical health interventions.

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

| | **Additional Staff 2021/22** |
|---|---|
| **AMH** | |
| Durham & Darlington | 168 |
| North Yorkshire & York | 239 |
| Teesside | 153 |
| **Total** | **560** |
| **CYPS** | |
| Durham & Darlington | 97 |
| North Yorkshire & York | 88 |
| Teesside | 48 |
| **Total** | **233** |
| **Forensic Services** | **176** |
| **Learning Disabilities** | |
| Durham & Darlington | 64 |
| North Yorkshire & York | 9 |
| Teesside | 43 |
| **Total** | **116** |
| **MHSOP** | |
| Durham & Darlington | 29 |
| North Yorkshire & York | 143 |
| Teesside | 22 |
| **Total** | **194** |
| **TOTAL** | **1278** |

## Learning from Deaths

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

In Mental Health and Learning Disability Services we have a number of older people who are cared for in the community and their needs are such they only require minimal contact with us. We have undertaken some analysis of the average age of service users who died during 2020/21, which was found to be **79** years old. Many of these people, who die, do so through natural causes as happens in the wider population. This explains the difference between the total number of deaths (from all causes including natural causes) and the numbers we go on to investigate further. To support staff in their decision making regarding the investigation of deaths, staff have clear policy guidance, setting out criteria for categories and types of review.

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

It is recognised that team development and skilled staff are key to the delivery of high quality, safe care and high functioning teams to minimise the risk of incidents occurring. Progress is being made to enhance senior clinical leadership with recruitment to new Community Matron Roles, Practice Development Practitioners and Peer Workers to support co-creation, recovery and involvement.

In 2019, a family conference was held with bereaved families who had experienced the serious incident process. One of the aims of the conference was to identify how we could improve the way we engage with families. An action from this event was to appoint a Family Liaison Officer. This role is now well established and has received positive feedback from both families and staff. In May 2021, an improvement event is planned to consider how we can further improve involvement with families to facilitate a more equal partnership in the Serious Incident Investigation process. The Trust was due to hold its second annual family conference in March 2020; this has been put on hold due to COVID-19 and is regularly under review.

Any death of a person open to Trust services, which is reported through our Incident Management System, is subject to an initial review by the Central Approvals Team. During 2020/21 **2,315** TEWV patients died; this comprised the following number of deaths which occurred in each quarter of that reporting period:

- **926** in the first quarter
- **375** in the second quarter
- **481** in the third quarter
- **533** in the fourth quarter

From the **2,315** deaths, **2,033** were expected/physical health deaths in the community; many of these patients, as alluded to above, had minimal contact with services.

There were **249** unexpected deaths (this figure includes community and inpatients). Of these **249** deaths, **four** were deaths in inpatient services. Two of the four were unexpected physical health deaths. All four cases were reviewed as a serious incident.

There were also **32** expected, physical health deaths in inpatient services

By 31st March 2021, in relation to unexpected and expected physical health deaths **286** mortality reviews and **40** structured judgement reviews had either been carried out or requested.

The number of deaths in each quarter that were identified as requiring a serious incident investigation are as follows:

- **24** in the first quarter
- **23** in the second quarter
- **17** in the third quarter
- **27** in the fourth quarter

Out of cases that have been completed during 2020/2021 (126), 44 cases had either a root cause or contributory finding. 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. This means that Mental Health and Learning Disability organisations are using different ways of assessing this.

The definitions used by the Trust are as follows:

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

Root and/or contributory findings from serious incident reviews undertaken in 2020/21 have highlighted the following areas for learning and improvement:

- Record keeping
- Communication
- Patient risk assessments

- Non-compliance with some elements of Trust policy

The Trust has seen a decrease of over 30% in the number of serious incidents resulting in deaths in 2020/21 (133 in 2019/20)

**Detailed below are some of the actions we have already taken, or will take during 2021/22 in response to what we have learned from reviews of deaths:**

The Trust is undertaking an extensive programme of estates works to reduce potential ligature points within inpatient services to address learning from inpatient deaths and an increase in fixed ligature incidents. Phase one of the programme has focused on the replacement of sinks, taps, toilets, shower controls and soap dispensers to standardise these with anti-ligature fittings in ensuite bathrooms and agreed standards for assisted bathrooms which are recognised as high risk areas for patients. Phase two of this work will be completed during 2021/22 and will enhance the safety of bedroom doors and replace windows.

In addition, 11 wards have now been prioritised for installation of Oxehealth Digital Care Assistant, which is assistive technology that has been proven to reduce harm within in-patient services. The Environmental Risk Group, chaired by the Director of Nursing and Governance, has oversight of these safety measures and receives monthly incident reports involving ligatures and other risks where environmental factors may have contributed to harm as well as progression of initiatives to reduce harm.

A Rapid Patient Safety Review Meeting has been introduced for unexpected inpatient deaths, usually to be held within 48 hours of the incident occurring. This is to ensure that all immediate identified actions have been put in place to maintain patient safety and to share any early learning identified.

The Suicide Prevention and Self Harm Reduction Group, chaired by the Medical Director continues to develop a framework to ensure that the Trust is supported in coordinating activities designed to reduce the risk of suicide and frequency of suicide attempts. The group is also focusing on dissemination of learning and good practice around suicide prevention and self-harm. Trust Suicide Prevention Leads continue to build up and maintain effective partnership working with the suicide prevention taskforces/alliances and other agencies

In line with the North Cumbria and North East Integrated Care System (ICS) priorities around physical health and learning from deaths, the Trust has identified 'Making Every Contact Count' leads within services and is incorporating the principles of this. These include making healthy changes such as, stopping smoking, improving diet, increasing physical activity, losing weight and reducing alcohol consumption into daily practice. These can help people to reduce their risk of poor health significantly.

The Trust is strengthening its arrangements for organisational learning with the establishment of the Organisational Learning Group, chaired by the Director of Quality Governance. Workstreams include the development of effective systems for

rapid dissemination of urgent safety messages, sharing early learning and establishing and maintaining a Learning Library.

In January 2021, following the CQC focused inspection, the Trust held a Quality Improvement Event to ensure that robust systems were in place to comprehensively assess and mitigate patient risk. This improvement work has encompassed and enhanced ongoing actions to address the four most common root cause or contributory findings from serious incident investigations. Work has included providing detailed guidance on clinical risk assessment and management to clinical staff to support practice in line with the Trust's Harm Minimisation policy (clinical risk assessment and management) as well as simplifying related documentation on the electronic patient record in the form of the safety summary and safety plan, leave and observation care plan.

Harm minimisation training (clinical risk assessment and management) and suicide prevention training content and delivery has also been reviewed to bring greater clarity on standards and expectations as well as more detailed focus on clinical risk assessment aligned to particular patient needs.

As an organisation, the decision was made to provide Suicide Prevention training to staff. To progress this, 26 staff members have been trained to date by Connecting with People (4 Mental Health). These staff will then deliver the training to all TEWV registered staff – as at 28th May 2021 there had been 139 staff trained, with another 316 places already booked on future training. The training provides a whole organisational approach to embed best practice and governance, with training designed for real impact and improvement of individual and organisational working practices. The training reflects the latest evidence-based principles and best practice, and provides individuals the opportunity to reflect on their own practice and how they can utilise the skills they have refreshed or learnt in their practice. We have also recently introduced Suicide Awareness training for all non-registered staff; as at 28th May 2021 there have been 113 placed booked on this training.

## PALS and Complaints

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

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

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

During 2020/21 PALS dealt with **2,127** concerns or issues from patients and carers, a decrease of **244** when compared to 2019/20. **1,102 (52%)** of the concerns raised were around AMH services across the Trust.

**1,972** of the PALS concerns (**85%**) were closed within 15 working days (although no formal target is set for this). Non-compliance was largely as a result of the Covid-19 pandemic where it has not always been possible to obtain timely feedback from operational services.

**265** formal complaints were received and registered during 2020/21 compared to 296 for the same period last year.

Complaints across services: **172** in AMH services, **41** in CYPS, **23** in MHSOP, **11** in Secure Inpatient Services, **2** in Health and Justice, **6** in ALD services and **10** in Corporate Services.

The most common cause for complaints across the Trust related to aspects of clinical care (154), followed by communication (61) and attitude (28). Complaints have also been received relating to discharge arrangements (11), environment (5),medical records (3), waiting Times (1), General Advice (1) and Bereavement (1).

**175** responses were sent out during 2020/21, **134** (**78%**) were within timescales (60 working days).The number of complaints received and closed are published on the Trust's website.

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

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

# Part Three: Other Information on Quality Performance 2019/20

## Mandatory Quality Indicators

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

### Care Programme Approach Seven-Day follow-up

In March 2020, the national collection of this measure by NHS Digital was suspended due to the Covid-19 pandemic and the need to release capacity across the NHS to support the pandemic response. Subsequently, a consultation on the Quarterly Mental Health Community Teams Activity return opened and the outcome was published on 15th April 2021 announcing the decision to retire this collection as the measure has effectively been replaced by the new 72-hour follow-up standard.

**109** people were not followed up within seven days during 2020/21. Given the unprecedented times, it has not been possible to gather the level of intelligence in terms of this area of underperformance that would normally be included within the report, as all efforts have been diverted to manage the Covid-19 situation and the need to ensure that the Trust's focus remains on this clinical priority. However this figure should be considered within the context that **95.91% were followed up within seven days.**

The Trust intends to take/has taken the following actions to improve this percentage and so the quality of its services, by:

- Adding a dedicated item on this measure to the agendas for Service Business Meetings/Huddles and Quality Assurance and Improvement Boards
- Ensuring that all relevant teams regularly review their performance against this metric

### Crisis Resolution Home Treatment team acted as gatekeeper

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

**220** people during 2020/21 were not assessed by the Crisis Team prior to admission. Given the unprecedented times, it has not been possible to gather the level of intelligence in terms of this area of underperformance that would normally be included within the report, as all efforts have been diverted to manage the COVID-19 situation and the need to ensure that the Trust's focus remain on this clinical priority. This number needs to be considered within the context that **86.50% of individuals were assessed by a Crisis Team prior to admission**.

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

- Implemented additional capacity to Mental Health Support Teams to respond to calls from people who are in distress but do not require a crisis assessment
- Added a review of this metric to daily huddles
- Implemented Business Continuity Plans during the Covid-19 pandemic to ensure liaison psychiatry teams and CRHTs worked jointly to address gatekeeping
- Amended and updated the Crisis Operational Policy for AMH Services to clarify roles and responsibility of professionals acting on behalf of the CRHT services (out of hours) in a gatekeeping capacity
- Reviewed the Quality Standards Work for AMH Crisis Teams
- Reviewed and introduced a Safety Summary and Safety Plan for all urgent care services to improve risk recording/documentation and collaborative working with patients, improving quality of information, care and safety

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

- Undertake a scoping event to review urgent care/crisis services during 2021/22, considering the Trust-wide central crisis line, and explore potential opportunities for future development and operational models for the delivery of services, working with patients, staff, partners and stakeholders
- Use NHS England Transformation Funding to continue to support options for alternatives to crisis, working with the voluntary sector and ensuring services meet core fidelity. Work is continuing to implement innovative approaches within the localities

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

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 2020, 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 2020*** | ***National benchmarks in 2020*** | ***TEWV Actual 2019*** | ***TEWV Actual 2018*** | ***TEWV Actual 2017*** |
|---|---|---|---|---|
| **Overall section score: 7.4**<br><br>**(sample size 340)** | Highest/Best MH Trust: **7.8**<br><br>Lowest/Worst MH Trust: **6.4** | Overall section score: **7.3**<br><br>(sample size 209) | Overall section score: **7.3**<br><br>(sample size 209) | Overall section score:**7.7**<br><br>(sample size 232) |

## Patient Safety incidents including incidents resulting in severe harm or death

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

| ***TEWV Actual Q3 20/21*** | ***National Benchmark in Q1 & Q2 20/21*** | ***TEWV Actual Q1 & Q2 20/21*** | ***TEWV Actual Q3 19/20*** |
|---|---|---|---|
| Trust reported to NRLS:<br><br>**3,105** incidents reported of which **27 (0.9%)** resulted in severe harm or death*<br><br>* **10** Severe Harm and **17** Death | Not available | Trust reported to NRLS:<br><br>**6,207** incidents reported of which **80 (1.3%)** resulted in severe harm or death*<br><br>* **22** Severe Harm and **58** Death | Trust reported to NRLS:<br><br>**3,312** incidents reported of which **40 (1.2%)** resulted in severe harm or death |

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

- The number of incidents reported by TEWV to the NRLS for Quarter three 2020/21 was slightly less than the same period in 2019/20. 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

- 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 2020/21 TEWV reported **141** incidents as Serious Incidents, of which **94** were deaths due to unexpected causes. This compares with **119** (from a total of **159** in 2019/20) and **126** (from a total of **142**) in 2018/19**.**

- 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:

- Analysing all patient safety incidents; these are reported and reviewed by the Quality Assurance and Improvement Group which is a sub-group of the Trust's Senior Leadership Group. A monthly report is circulated to the Trust's Quality Assurance Committee and are reported to commissioners via the Clinical Quality Review Process

- Implementing a consistent approach to the grading of incidents and to improve the overall quality of reporting via the Trust's Central Approval Team who review all reported incidents

- 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

- Undertaking mortality reviews on those deaths that are classed as physical health expected/unexpected deaths. Mortality reviews are completed in line with guidance from the Royal College of Psychiatrist and peer organisations across the region. The mortality review tool used consists of a Part One and Part One review. Part One is a review of the care records, if any concerns are noted a Part Two (more in-depth Structured Judgement Review) will be carried out

- The identification of learning themes from incidents helps the Trust to identify key areas for improvement and this is built into our quality improvement work plans. Many examples are given within this report including the development of the suicide and self-harm reduction strategy, environmental ligature reduction, harm from falls reduction, and reducing restrictive practices

- We now have an Organisational Learning Group, chaired by the Director of Quality Governance. The group is responsible for developing robust and effective systems for sharing learning and ensuring the actions identified have the desired impact

- The official statistics publishing schedule is changing; NRLS are now publishing the Organisation and National level patient safety incident reports once a year rather than every six months, with the next publication due in September 2021. This has resulted in the Trust not being able to benchmark their data with other Mental Health Trusts

## Our performance against our quality metrics

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

### Quality Metrics

| Quality Metrics | | 2020/21 | | 2019/20 | 2018/19 | 2017/18 | 2016/17 |
|---|---|---|---|---|---|---|---|
| | | 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% | 67.54% | 62.39% | 61.50% | 62.30% | N/A |
| 2 | Number of incidents of falls (level 3 and above) per 1000 occupied bed days (for inpatients) | 0.35 | 0.18 | 0.15 | 0.18 | 0.12 | 0.37 |
| 3 | Number of incidents of physical intervention/restraint per 1,000 occupied bed days | 19.25 | 26.27 | 30.45 | 33.81 | 30.65 | 20.26 |
| **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% | 96.14% | 97.13% | 96.49% | 94.78% | 98.35% |
| 5 | Percentage of Quality Account audits of NICE guidance completed | 100% | 100% | 100% | 100% | 100% | 100% |
| 6a | Average length of stay for patients in Adult Mental Health (days) | <30.2 | 23.25 | 25.55 | 24.70 | 27.64 | 30.08 |
| 6b | Average length of stay for patients in Mental Health Services for Older People (days) | <52 | 59.80 | 66.84 | 66.53 | 67.42 | 78.06 |

| Patient Experience Measures | | | | | | | |
|---|---|---|---|---|---|---|---|
| 7 | Percentage of patients who reported their overall experience as excellent or good | **94%** | **90.32%** | **91.65%** | **91.41%** | **90.50%** | **90.53%** |
| 8 | Percentage of patients that report that staff treated them with dignity and respect | **94%** | **84.59%** | **85.80%** | **85.70%** | **85.90%** | **N/A** |
| 9 | Percentage of patients that would recommend our service to friends and family if they needed similar care or treatment | **94%** | **89.94%** | **86.70%** | **86.90%** | **87.20%** | **86.58%** |

## Notes on selected Metrics

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

## Comments on areas of under-performance

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

The end of **2020/21** position was **67.54%** which relates to **1864** out of **2760** surveyed. This is **20.46%** below the Trust target of **88.00%.** All localities underperformed this year. **Forensic Services** was closest to the target with 72.5**%** and **North Yorkshire and York** was furthest away with **62.43%**

When brief analysis has been undertaken of why patients do not feel safe in a ward environment, the most often cited cause has been due to the behaviour of other patients. It has also been noted that due to the acuity levels of patients who are admitted, they are likely to feel unsafe due to the fact that they are acutely unwell. As there is a persistent significant gap between our target and performance on this metric, improving the percentage of patients who feel safe on wards has been identified as a Quality Improvement priority for 2020/21 (see page 25).

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

The end of **2020/21** position was **26.27;** which relates to **5727** interventions and **217,975** OBDs; this is **7.02** above the Trust target of **0.35**

**Durham and Darlington** were the only locality achieving the target with a rate of **16.74**. Of the underperforming localities, **Tees** had the highest number of incidents per 1000 OBD with **43.64**

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

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

- Feasibility testing of the use of Body-worn cameras in a number of our inpatient wards to help reduce the use of restrictive interventions
- Our mandatory training for all clinical staff in the prevention and management of violence and aggression is now accredited via the national standards for reducing restrictive interventions
- We have developed new procedures for the safe use of segregation and are currently working to train staff across the Trust
- We have increased the availability of training for Advanced Practitioners in Positive Behaviour Support in collaboration with Northumbria University
- In conjunction with Cumbria, Northumberland Tyne and Wear NHS Foundation Trust and Cumbria University we have developed graduate training for staff in reducing the use of restrictive interventions, which is now available nationally

### 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 3 2013/14 reporting **59.80** days as at end of **2020/21**. This is **7.8** worse than target but is an improvement on the position reported in 2019/20. The pie chart below shows the breakdown for the various lengths of stay during 2020/21.

The median length of stay was **46** days, which is 4 days better than the target of 52 days and demonstrates that the small number of patients who had very long lengths of stay have a significant impact on the mean figures reported.

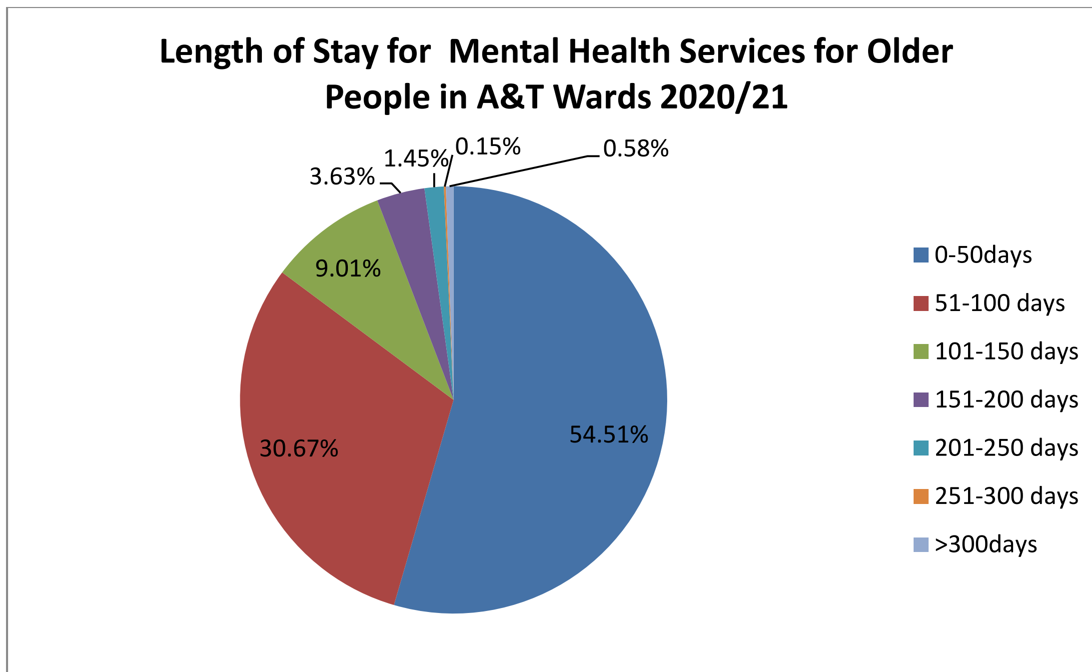



***Figure 2: Average length of stay for MHSOP during 2020/21***

The length of stay of patients (for both adults and older people) is closely monitored by all services within the Trust. The reasons for the increase in average length of stay for patients are due to a small number of patients who were discharged after a very long length of stay, which has skewed the overall average. In total (Adults and MHSOP) **82.63%** of lengths of stay were between 0-50 days, with **12.52%** between 51-100 days. There were 26 patients who had a length of stay greater than 200 days. Given the unprecedented times, it has not been possible to gather the level of intelligence in terms of this area of underperformance that would normally be included within this report.

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

The end of **2020/21** position was **90.32%** which relates to **10,109** out of **11,192** surveyed. Whilst we have not reached our target of 94% we are very pleased to see that over 90% of our patients reported their overall experience as excellent or good

All localities underperformed against the target in 2019/20. **Teesside** were closest to the target with **93.42%** and **Forensic Services** was performing furthest away from the target at **86.21%.**

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

The end of **2020/21** position was **84.59%** which relates to **9363** out of **11,069** surveyed. This is **9.41%** below the Trust target of **94.00%.**

All localities underperformed in 2020/21. **Teesside** were closest to the target with **88.62%** and **Forensic Services** were furthest away from the target with **81.23%.**

We continue to focus on this important area of patient experience; our patients tell us that treating people with dignity and respect includes staff treating people in a caring and compassionate way which will be strengthened by the work we are doing on our Trust values and empathy training for staff. It is also about involving people in decisions around their care which will be supported by the ongoing quality priority around personalised care planning and our goal of co-creation. Having an environment that respects privacy and dignity is important and we are proud that we have eliminated all dormitory accommodation and all patient bedrooms are now single, many with ensuite facilities.

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

The end of **2020/21** position was **89.94%** which relates to **9521** out of **10,586** surveyed. This is **4.06%** below the Trust target of **94.00%.**

Whilst the Trust has not met its own target, we are pleased that almost 90% of our patients would recommend our services and we continue to focus on a range of improvement work focused on providing high quality and responsive services that provide a good patient experience. Examples are given throughout this report.

All localities underperformed in 2020/21. **Teesside** were closest to the target with **93.55%** and **Forensic Services** were furthest away from the target with **85.43%.**

## Our Performance against the Single Oversight Framework Targets and Indicators

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

## Single Oversight Framework

| Indicators | | 2020/21 | | 2019/20 | 2018/19 | 2017/18 | 2016/17 | 2015/16 |
|---|---|---|---|---|---|---|---|---|
| | | Threshold | Actual | Actual | Actual | Actual | Actual | Actual |
| A | Percentage of people experiencing a first episode of psychosis that were treated with a NICE approved care package within two weeks of referral | 56% | **77.58%** | **77.53%** | **64.89%** | **73.32%** | **70.04%** | **55.91%** |
| B | IAPT/Talking Therapies – proportion of people completing treatment who move to recovery (from IAPT minimum dataset) | 50% | **50.89%** | **48.83%** | **51.29%** | **50.44%** | **48.32%** | **N/A** |
| C | Percentage of people | 75% | **98.70%** | **96.49%** | **97.91%** | **95.49%** | **95.44%** | **84.01%** |

| | referred to the IAPT programme that were treated within six weeks of referral | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| D | Percentage of people referred to the IAPT programme that were treated within 18 weeks of referral | 95% | **99.93%** | **99.84%** | **99.73%** | **99.89%** | **99.14%** | **95.93%** |
| E | Percentage of patients on Care Programme Approach who were followed up within seven days after discharge from psychiatric inpatient care | >95.00% | **96.14%** | **97.56%** | **97.31%** | **96.52%** | **98.35%** | **97.75%** |
| F | Admissions to adult facilities of patients who are under 16 years old | N/A | **1** | **0** | **0** | **1** | **N/A** | **N/A** |
| G | Inappropriate out of area placements (OAPs) for adult mental health services | N/A | **2061** | **2367** | **874** | **1913** | **N/A** | **N/A** |
| H | Data Quality Maturity Index (DQMI) – Mental Health Services Data Set Data Score | N/A | **98.20** | **98.2** | **N/A** | **N/A** | **N/A** | **N/A** |

## Notes on the Single Oversight Framework Targets and Indicators

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

### Metric F: Admissions to adult facilities of patients who are under 16 years old

There was one Tees Valley CCG patient under the age of 16 admitted to an adult ward in February 2021. The patient was admitted under section because no CAMHS PICU beds were available nationally; they spent one night in a Trust AMH unit but in a specific area separated from the main adult ward under 2:1 observations. The child did not therefore come into contact with any of the AMH service users on the main part of the ward.

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

The national standard we agreed with NHS England has been largely impacted by an ongoing concern in Durham & Darlington Locality. Adult Mental Health Services have reported an increase in acuity that has particularly affected female wards, resulting in increased lengths of stay and higher bed occupancy, which has led to more female patients requiring placement out of area. This has been further

impacted by Covid-19 outbreaks on wards, which necessitated temporary closures to new admissions and beds having to be sourced within other areas of the Trust. The Service does not have the facility to utilise swing beds, so are not able to flex AMH female and male bed capacity to respond to demand. Pressure remains on AMH female beds and admissions continue to be coordinated proactively across the locality and repatriated where possible.

Within Mental Health Services for Older People the increase has been primarily attributable to a Covid-19 outbreak on a ward, which prevented new patients from being admitted to the ward and beds having to be sourced within other areas of the Trust.

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

The latest available published data is at December 2020.

## External Audit

Due to the COVID-19 pandemic, the external audit of the 2020/21 Quality Account was stood down.

## Our Stakeholders' Views

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

How we involve and listen to what our stakeholders say about us is critical to this process. Due to the Covid-19 pandemic we have been unable to hold our usual Stakeholder engagement events; however we have sought views from our Stakeholders, service users, carers and staff through a variety of other means throughout the year, including Our Big Conversation (see Page 12). We have used this feedback when formulating our priorities and actions for 2021/22.

In line with national guidance, we have circulated our draft Quality Account for 2020/21 to the following stakeholders:

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

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

The following are the general themes received from stakeholders in reviewing our Quality Account for 2020/21:

The Trust will write to each stakeholder addressing each comment made following publication of the Quality Account 2020/21 and use the feedback as part of the annual lessons learnt exercise in preparation for the Quality Account 2021/22.

# APPENDICES

## Appendix 1: 2020/21 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 20120/21 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 2020 to May 2021
    - Papers relating to quality reported to the Board over the period April 2020 to May 2021
    - Feedback from the Commissioners dated…
    - Feedback from Governors dated…
    - Feedback from local Healthwatch organisations dated…
    - Feedback from Overview and Scrutiny Committees dated…
    - Feedback from Health and Wellbeing Boards…
    - The Trust's complaints information reported to its Quality Assurance Committee of the Board of Directors, which will be published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
    - The latest national patient survey published 24th November 2020
    - The latest national staff survey published 11th March 2021
    - The Head of Internal Audit's annual opinion over the Trust's control environment dated….
    - CQC inspection report dated 3rd March 2020 and 26th March 2021

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

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

- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account/Report, and these controls are subject to review to confirm that they are working effectively in practice

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

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

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

By order of the Board:

25th June 2021……………………………………………………………Chairman

25th June 2021………………………………………………………Chief Executive

## Appendix 2: Glossary

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

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

**Autism Services/Autistic Spectrum:** This describes a range of conditions typically characterised by social deficits, communication difficulties, stereotyped or repetitive behaviours and interests, and in some cases cognitive delays

**BAME:** Black and Minority Ethnic; is defined as all ethnic groups except White ethnic groups. It does not relate to country of origin or affiliation

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

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

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

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

**Care Planning:** See Care Programme Approach (CPA)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Department of Health:** The government department responsible for Health Policy

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

**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

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

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

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

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

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

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

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

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

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

**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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**NHS England:** leads the National Health Service in England

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**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

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

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

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

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

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

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

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

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

**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

**Statistical Process Control (SPC) charts:** a graph used to show how a process changes over time and to see whether a situation is improving or deteriorating, whether the system is likely to be capable to meet the standard and whether the process is reliable or variable

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

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

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

**TEWV:** Tees, Esk and Wear Valleys NHS Foundation Trust

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

**The Trust:** see TEWV above

**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

**Trust Board:** See Board/Board of Directors above

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

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

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

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

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

## Appendix 3: Key themes from action plans produced in response to 130 Local Clinical Audits in 2020/21

| Audit Theme | Key quality improvement activities associated with clinical audit outcomes |
|---|---|
| **1.** Infection Prevention and Control (IPC) | • All Infection Prevention and Control (IPC) audits are continuously monitored by the IPC Team and any required actions are rectified collaboratively by the IPC Team and ward staff. Assurance of implementation of actions is monitored by the Clinical Audit and Effectiveness Team via the clinical audit action monitoring database.<br>• A total of **96** IPC clinical audits were conducted during 2020/21 in inpatient areas, prison teams, and community teams where there is a clinic. **73% (70/96)** of clinical areas achieved standards between 90-100% compliance. Local clinical audit action plans were implemented in collaboration with the IPC Team and the clinical team members to mitigate all areas of non-compliance. |
| **2.** Medicines Management | • The Trust Pharmacy Team continues developments to ensure that documentation is robust for leave/discharge controlled drugs medication. Pharmacy have re-introduced the controlled drugs newsletter within the Trust to encourage improvement in the management of controlled drugs and to share good practice.<br>• The admissions checklist was updated to provide a prompt to staff to document evidence that patients are given information about their medication.<br>• The Pharmacy Team issued a bulletin including key areas of note from the National Prescribing Observatory for Mental Health (POMH) clinical audit in relation to antipsychotic prescribing for people with a learning disability. Key areas highlighted included awareness of the Mental Capacity Act principles at the time of prescribing and associated documentation and use of the Trust's Psychotropic Medication Monitoring Guide.<br>• The High Dose Antipsychotic Treatment (HDAT) monitoring chart was made available as a Word document to support recording of monitoring on the electronic patient record.<br>• A presentation was given to the Trainee Doctor induction which included results from the Clinical Audit of Prescription and Administration Chart Standards. This highlighted the importance of completing all information on the new and re-written charts. The information was also adapted within the Nurse Medicines Management training to remind staff of the importance of not giving medication after the stop date and to ensure that there are two signatures obtained for depot medication. |

| Audit Theme | Key quality improvement activities associated with clinical audit outcomes |
|---|---|
| **3.** Physical Healthcare | • A number of community mental health teams in MHSOP services have established health and wellbeing exercise programmes using existing facilities following clinical audit results.<br>• The use of the Measure Yourself Medical Outcome Profile (MYMOP) was promoted to be conducted as part of the Physiotherapy Functional Clinical Link Pathway (CLiP).<br>• All inpatient wards have the New Early Warnings Score (NEWS) as an agenda item within the MDT meeting or on their report out board<br>• Clinical audit has evidenced key quality improvements for compliance with the Emergency Response Bag equipment and associated daily monitoring.<br>• The requirement to conduct an e-cigarette risk assessment on admission of patients was highlighted to all teams. Teams were advised to undertake weekly reviews looking at suitability of product choice, strength, and quantity of nicotine for patients identified as smokers and admitted for more than one week.<br>• Additional dedicated support was provided to specific wards by the Smoke Free Trust Lead following the clinical audit findings.<br>• The assessment documentation has been adapted to include the requirements of history taking for medical or genetic problems/disorders for Autism Spectrum Disorder. An information pack on genetics and family risk of Autism is in development.<br>• The Trust continues to use information from the monthly NHS Patient Safety Thermometer to compare and review this data against wider incident data to inform the Trust position in relation to measurable patient harms. |
| **4.** Service Provision | • Clinical audit results have been used to successfully establish a resource increase within the Autism Spectrum Disorder (ASD) Team. |
| **5.** Policy and Pathway Developments | • The Trust Did Not Attend (DNA) / Was Not Brought policy was amended following clinical audit findings to highlight the requirements relating to attempting same day contact with all patients irrespective of whether the patient has previously not attended or is unknown to services. The policy also includes a standard protocol for Crisis Teams and this was shared with all Crisis Team Managers.<br>• A review of policies/procedures was undertaken and established that there was clear guidance in the Trust which includes a recording template to be for services to use.<br>• The Autism Pathway will be amended to include a flowchart to ensure that there is a clear process for staff to follow all appropriate steps.<br>• The Venous Thromboembolism (VTE) e-Learning training will be linked within the VTE Trust Policy.<br>• The Trust Care Programme Approach (CPA) policy will be revised following clinical audit findings in line with system changes and national guidance, particularly in relation to the implementation of the Community Services Framework for Adults and Older Adults. |
| **6.** Supervision | • Specialist services monitor and routinely report the duration of clinical supervision received by staff. Local actions have been progressed within Locality Performance Improvement Groups in collaboration with Team Managers and Modern Matrons to make improvements in practice.<br>• Clinical Audit has facilitated improvements in the documentation of supervision requirements within Health and Justice, Prison and Liaison & Diversion Teams. This is being further enhanced Trust wide through the recording of all supervision sessions on the electronic system (Foundry). |
| **7.** Transition from CAMHs to AMHs | • A review of the administration capacity available to support transition panels (for young people moving into adult services) in each locality is in progress. A standard process description has been implemented for meetings between professional to ensure consistent documentation of panel meetings. An agreed panel meeting format will also be standardised across the Trust led by the Service Development Manager. |

| Audit Theme | Key quality improvement activities associated with clinical audit outcomes |
|---|---|
| **8.** Systems Development | • Findings from the Prescribing Observatory for Mental Health (POMH) audit cycle regarding Prescribing for Depression in Adult Mental Health Services have been used to support the development of the new electronic care records system (CITO).<br>• Findings of the National Clinical Audit of Psychosis in EIP services have been used to support the development of the physical health monitoring for psychosis module within the new electronic care record.<br>• Clinical audit findings identified areas which required improvement related to documenting functional problems/disorders. This is being actioned by adaptations to the differential diagnosis and screening document within the electronic care record.<br>• The VTE risk assessment document will be built into the electronic care records system. This will facilitate generation of an automatic alert if the risk assessment has not been completed for the patient by the clinical staff. |
| **9.** Care Programme Approach | • A communication plan is in development to ensure staff are aware of changes in the CPA processes, primarily to support the introduction of DIALOG and other system developments.<br>• A range of multi-media guidance is in development following learning from clinical audit findings to support the implementation of DIALOG. |
| **10.** Training | • Training in Autism Diagnostic Observation Schedule (ADOS-2) assessments was provided to clinical staff following clinical audit findings.<br>• The Level 3 Safeguarding training was updated to include areas of good practice and areas for improvement identified by the safeguarding clinical audit. |

## Appendix 4: Feedback from our Stakeholders

## Appendix 5: Our Quality Account – Plan on a Page

**Priority One: Making Care Plans more personal**

- Ensure finalised, working version of DIALOG is embedded within CITO
- Ensure all relevant stakeholders are aware of changes to CPA processes
- Develop guidance and training to support the implementation of DIALOG
- Identify how many patients/agreed others receive a care plan and understand key elements of safety, quality, timeliness and accessibility and address the issues identified
- Establish Steering Group with identified governance structures to oversee the development and implementation of high quality, collaborative care planning that is fit for purpose
- Agree how to align with but not duplicate the care plan and safety plan to ensure a simple, consistent and comprehensive plan
- Review and revise local CPA policy in line with system changes and national guidance
- Review and update care planning training
- Assess additional actions and priorities to remove barriers to care planning
- Work with teams and commissioners to ensure sufficient capacity is built into clinic scheduling to properly co-create and develop care plans

**Priority Two: Safer Care**

- Communicate and share the agreed patient safety priorities
- Determine the programmes of work for each of the four patient safety priorities, assess current baseline and identify process and outcome KPIs
- Promote the role of the Trusts Patient Safety Specialist
- Work in collaboration with the 'Better Tomorrow programme: learning from deaths, learning from lives' to improve our processes and develop support networks
- Review and update Learning from Deaths Policy
- Work proactively within the newly formed Regional Patient Experience Network
- Identify priority wards, talk to people currently on these wards, develop and implement an action plan
- Further review information from patient experience surveys and concerns raised from patients and carers
- Seek ideas as part of the 'mutual help' meetings that take place on the wards on what we can do to make patients feel safe
- Review current 'ward orientation' process for patients being admitted onto our wards and incorporate into personal safety plans
- Continue existing pilot of body cameras and develop a business case for further roll-out
- Deliver the four organisational learning work programmes
- Develop an integrated organisational learning report with an initial focus on patient safety
- Develop our systems for ensuring the impact of improvement actions from learning



**Priority Three: Compassionate Care**

- Hold engagement events with staff to develop our new ways of working together, with involvement of service users and carers and share outputs from these events
- Commission and deliver a range of educational approaches with a focus on Empathy and Compassion
- Design, develop and deliver a Trust leadership programme with service users and carers and all staff in formal leadership positions to complete
- Seek views of staff about organisational processes and systems which do not live the values, or which get in the way of them living the values
- Review People & Culture processes and policies in relation to Trust values
- Review our people management processes and policies in relation to Trust values
- Ensure people have access to meaningful breaks and thinking time
- Model the values in how we communicate, how we hold meetings
- Promote the values through our interactions with service users and carers
- Identify additional involvement opportunities e.g. HealthWatch, survivor groups, support groups
- Produce a prioritised plan for the future in conjunction with other partners
- Present findings and discuss possible changes with lead Directors around organisational processes and systems which do not live the values
- Implement a process to capture informal concerns and complaints that enables us to identify any key themes where patients have raised issues with us
- Director of Quality Governance and Patient Safety Team to work with patients and families to develop the Serious Incident review process

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