Our Draft Quality Account / Report 2013/14

making a difference together

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PART 1: STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE OF THE TRUST

I am pleased to be able to present Tees, Esk and Wear Valley NHS Foundation Trust's (TEWV) Quality Account / Report for 2013/14. This is the sixth Quality Account / Report we have produced and it tells you a lot of what we have done to improve the quality of our services in 2013/14 and how we intend to make further improvements in 2014/15.

Please note: for the purposes of publication in the Trust's Annual Report, the Quality Account is termed the Quality Report, and therefore, is termed as both of these throughout this document.

Our Mission, Vision & Strategy

The purpose of the Trust is:

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

Our vision is:

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

Our commitment to delivering high quality services is supported by our second strategic goal:

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

This commitment is embedded within the TEWV approach *(see page 5).*

Our starting point in delivering this strategic goal was to understand what quality means to the Trust and all our stakeholders. In order to be able to demonstrate that we are delivering quality we believe our services must:

- **Provide the perfect experience** – this means that the people who use our services consider that the way we work with them ensures that they are listened to, engaged with and treated with compassion, respect and dignity.
- **Be appropriate** – this means that treatment and care should be safe, 'does no harm', be evidence-based and relevant to the needs of the individual.
- **Be effective** – this means that what we do, delivers the outcomes that we and our service users and carers expect, and makes a positive difference to people's lives.

In the 2013 NHS service user survey of community services, the Trust scored **7.5 out of 10** (sample size of 217) for 'overall care'. This was a similar score to other mental health Trusts in the survey.

In the Trust's own surveys in 2013/14, **91%** (sample size of 5,547) of service users reporting 'excellent' or 'good' to the question 'overall how would you rate the services you have received'

- **Reduce waste** – this means that we should remove or minimise any activity that does not add value to people who use our services, our staff and our other stakeholders.
- **Be built upon** the standards set by the Care Quality Commission and the other regulators we are accountable to.

To support the delivery of our vision, the Trust has developed a quality strategy which sets out our ambition for quality:

'To ensure safe, patient centred and effective high quality clinical care and treatment, delivered by valued individuals and teams'

In 2013/14, in the Family & Friends Test, the Trust scored **45** on a scale between -100 and +100 (sample size of 1,293).

This means that to the question 'would you recommend the Trust as a place to receive treatment', **87%** of patients reported 'extremely likely' or 'likely', and **5% (68 patients)** reported 'unlikely' or 'extremely unlikely'.

To deliver this we have identified a number of priorities to be addressed in 2014/15. Section two of the Quality Account / Report sets out four quality priorities for 2014/15 that were developed and agreed with our stakeholders. Within the Trust's business plan there are additional priorities for 2014/15 and beyond which also have a focus on improving quality.

What we have achieved in 2013/14

Section two of the Quality Account / Report also sets out our progress on our four quality priorities for 2013/14. However, these quality priorities are not the only ways we have improved the quality of our services in 2013/14. The following are other notable examples of quality improvements within our services / localities in 2013/14:

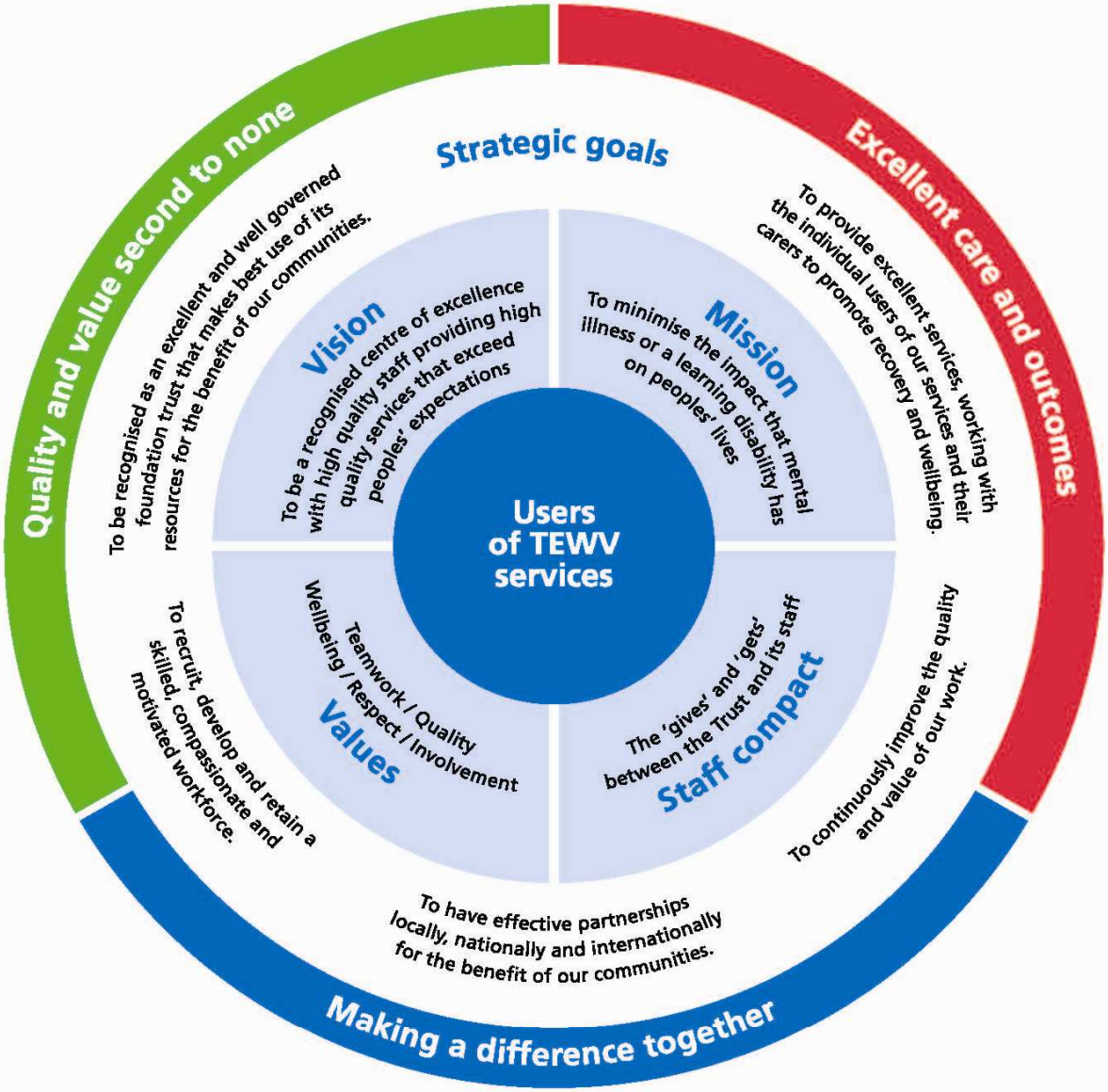
- We have continued to invest in ensuring our buildings provide appropriate and therapeutic environments. In 2013/14 we saw the completion of a brand new complex care ward at Springwood in Malton, the opening of a purpose built low secure ward for children and young people at the West Lane site in Middlesbrough, the upgrade of the lodge at Bankfields Court to support an individual package of care, and the development of a new community team base at Windsor House in Harrogate.
- We have continued to work with our commissioners to deliver new services to meet the needs of those who use our services. For example:
  - A new section 136 suite and a street triaige service in Scarborough
  - A crisis and recovery house in Shildon, County Durham.

In the 2013 NHS Staff Survey, the Trust scored **3.89 out of 5.00** (sample size of 492) for the question 'would recommend the Trust as a place to work and receive treatment'.

This was an **improvement on 2012** and within the **top 20%** of all mental health Trusts who participated in the survey.

Overall in 2013 TEWV was ranked **1st out of 57** mental health Trusts for the NHS Staff Survey

The TEWV approach



Note: The staff compact is a psychological or cultural relationship that exists between staff and the Trust. It sets out what staff should 'give' – to provide the best possible customer experience – and what staff should 'get' back from the Trust in return for this – the Trust will endeavour to be a great organisation to work for. It also describes what the Trust should 'give' and 'get' back in return.

- We have worked with our partners to improve services. For example:

  - We have worked with Dementia Forward and the Red Cross in Harrogate to develop additional activities for those with dementia outside hospital.
  - We have provided training to care home staff to promote the use of evidence-based practice.
  - We have continued to develop our liaison services to support the acute Trusts in our area to provide improved experiences for theit patients who also have mental health problems.

In the Trust's own surveys in 2013/14, **77%** (sample size of 1,109) of carers replied 'yes, always' to the question 'do you feel that you are actively involved in decisions about the person you care for'

In addition to these examples above, we have continued to drive improvements in the quality of our services through using the TEWV Quality Improvement System (QIS). This is the Trust's framework and approach to continuous quality improvement and uses tried and tested techniques to improve the way services are delivered. Some notable examples of what we achieved within our services in 2013/14 are:

- The time taken from referral to the specialist eating disorders team and acceptance for treatment by the specialist team has reduced from 43 days to **6** days.
- **100%** of service users who leave adult mental health inpatient wards in North Yorkshire now leave with a summary of their care and their discharge plan which includes their medications. This avoids the risk of duplication with multiple prescriptions.
- Harrogate dementia collaborative ran an improvement event to reduce attendance of people with dementia to the emergency department at Harrogate District Hospital. Outcomes included:

  - Creating a 'best practice' file for service users to support care homes manage their care including clear, visual representations of key support information.
  - Developing a system to support communication and action for care homes to address a deterioration of a service user's health.

- We have significantly reduced the time it takes for children to transfer to adult services when they are 18 years old.
- We have redesigned the care planning process on our low secure forensic learning disability wards which has resulted in patients experience ratings improving form 6 out of 10 to **8 out of 10**.

In the Trust's own surveys in 2013/14, **77%** (sample size of 3,000) of service users reporting 'yes always' to the question 'did you feel safe on the ward'.

The majority who felt they did not always feel safe were in wards where behaviours that challenge are more prevalent.

In 2013/14 the Trust was also recognised externally when we won or were shortlisted for a number of prestigious awards, in particular:

Eight Awards Won:	Six Awards Shortlisted:
Nursing Times Awards 2013: • Nursing in Mental Health • Nursing in Learning Disabilities National Dementia Care Awards: Best Inspiring Leader HSJ Awards 2013 Innovation in Mental Health: Learning Disability Inpatient Service in Durham NHS Leadership Awards 2013: NHS Leader of Patient Inclusivity of the Year National Service User Achievement: Service User Led Initiative for My Shared Pathway in Forensic Services Hospitality Assured Business Excellence Team of the Year Award 2013: Hotel Service Team HFMA: Finance Director of the Year	Royal College of Psychiatrists Psychiatric Team of the Year for Older Adults 2013 Nursing Times Awards 2013: • Nurse Leader • Nurse of the Year National Leadership Awards: • NHS Inspirational Leader of the Year • NHS Leadership Development Champion of the Year A carer who works with our Trust was shortlisted for the Royal College of Psychiatrists Carer Contributor of the Year Award 2013

What we have learnt in 2013/14

Of course we know we do not always get it right. The Trust is working hard to develop a culture of openness and honesty to help improve its quality. The systems of complaints, incident reporting, surveying and regulation are critical to this.

During the year we have listened to our service users and carers, staff, partner organisations and regulators. The following are some examples of the lessons we have learnt and improvements made in 2013/14:

- Improvement has been made to clinical risk assessment and management as a result of root cause analyses of serious untoward incidents.
- The Trust developed a workbook to help qualified nursing staff manage service user's physical care following concerns raised by clinical staff regarding their knowledge and skills.
- Greater effort is being made to explain the purpose of medication and assess side effects following feedback from patient surveys that this was not always done well.
- In response to feedback from carers that they were not always involved in decisions about treatment and care, in some of our services, we

In 2013/14 the Trust reported **83** serious untoward incidents. Of these **60** resulted in the death of a patient or alleged homicide.

As a result of the root cause analysis of these incidents in 2013/14, **269** action points were generated. At March 2014, **12** of these action points were outstanding beyond their originally agreed timescale.

have committed to contacting carers on a regular basis and providing drop-in sessions for carers.

- Feedback from patient surveys on an adult learning disabilities ward specifically requested a cinema room. A room was re-decorated, blinds and a projector installed and the room now operates as a cinema room.

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

- Section 2 – Information on how we have improved in the areas of quality we identified as important for 2013/14, the required statements of assurance from the Board and our priorities for improvement in 2013/14.
- Section 3 – Further information on how we have performed in 2013/14 against our key quality metrics and national targets.

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

A full statement of Directors' responsibilities in respect of the Quality Account / Report is included in **Appendix 1**. This is further supported by the signed limited assurance report provided by our external auditors on the content of the 2013/14 Quality Account / Report which is included in **Appendix 2**.

In 2013/14 the Trust received **150** complaints. Of these **83%** were resolved satisfactorily with the complainant.

As a result of these complaints **78** action plans to learn the lessons were generated. At March 2014, **17** of these action plans were outstanding beyond the originally agreed timescale.

I hope you find this report interesting and informative.

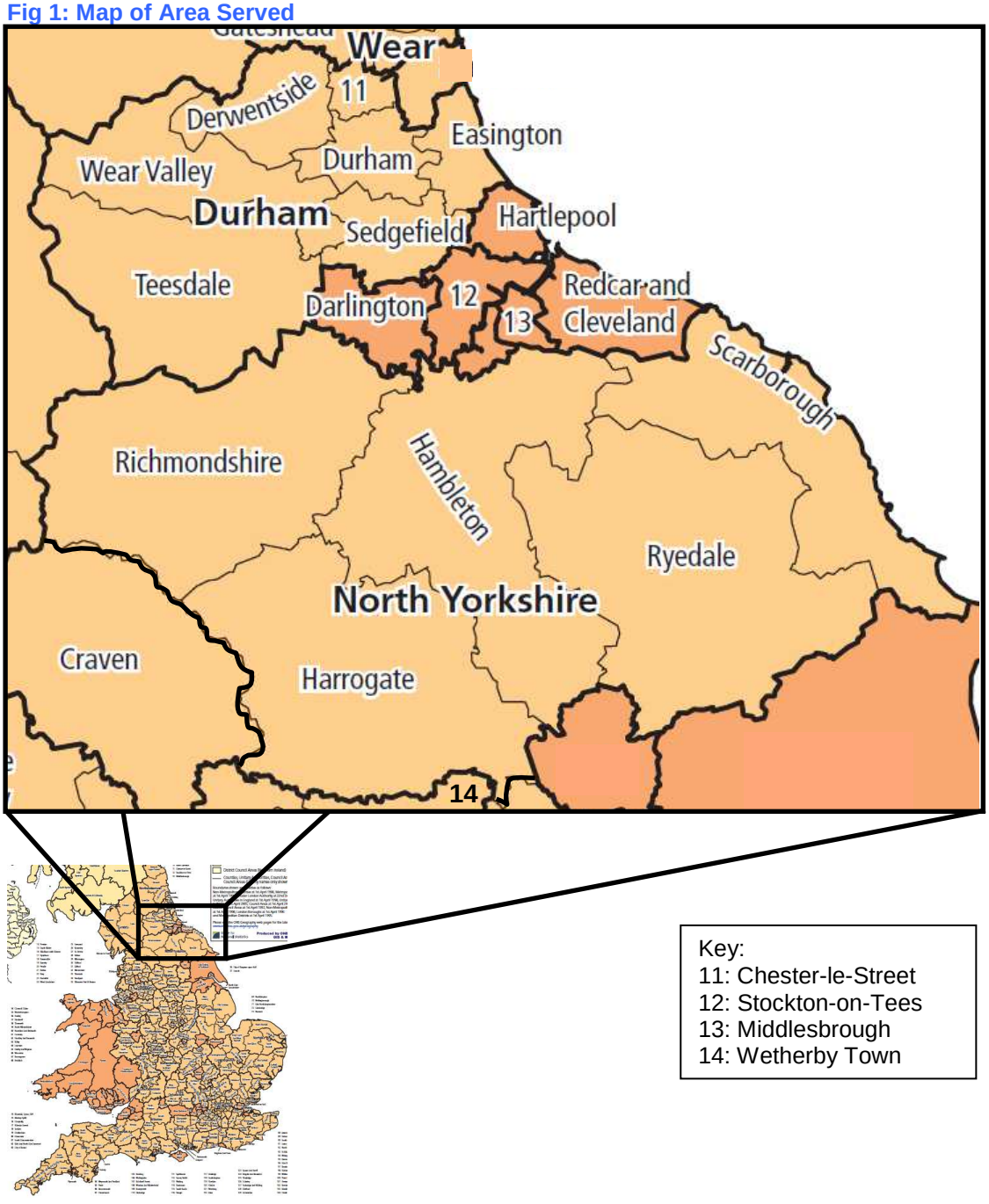
If you would like to know more about any of the examples of quality improvement we have highlighted in this report, or have any feedback or suggestions on how we could improve our Quality Account / Report please do let us know by e-mailing either myself at martinbarkley@nhs.net, Chris Stanbury (Director of Nursing & Governance at chris.stanbury@nhs.net or Sharon Pickering (Director of Planning & Performance) at sharon.pickering1@nhs.net

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

A Profile of the Trust

The Trust provides a range of mental health, learning disability and substance misuse services for 1.6 million people across a wide geographical area of approximately 3,600 square miles. The areas covered by the Trust include County Durham and Darlington, the four Teesside boroughs of Hartlepool, Stockton, Middlesbrough and Redcar & Cleveland, the Scarborough & Whitby, Ryedale, Hambleton & Richmondshire and Harrogate districts of North Yorkshire, and Wetherby Town in West Yorkshire. The Trust also provides learning disability services to the population in Craven and some regional specialist services (e.g. specialist eating disorder services) to the North East and beyond.

Fig 1: Map of Area Served



Office of National Statistics (2011)

In 2013/14:

- Our annual income was **£286** million.
- The Trust employed **6,052** staff or **5,415** whole time equivalents (WTE), of which **4,518** staff or **4,127** WTE were clinical staff.
- These staff delivered treatment and care for **47,540** people over the year.
- **5,889** service users received inpatient care from **12** locations across the Trust.
- In the community our staff provided over **1.4** million face-to-face or telephone contacts with service users.

PART 2: PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

2013/14 Priorities for Improvement – how did we do

As part of our 2012/13 Quality Account / Report the Board of Directors agreed four quality priorities to be addressed in 2013/14.

Priority 1&2: Implement the recommendations of the Care Programme Approach review relating to:
- improving care planning.
- improving communications between patients and staff.

Priority 3: To improve the delivery of crisis services through implementation of the crisis review's recommendations

Priority 4: To further improve clinical communication with GPs

Progress has been made against these four priorities and the following section provides details.

It is important to note that the achievement of priorities should not be seen as the end point. These priorities are often a key milestone in a journey of quality improvement and further work will continue to embed good practice and deliver further improvements in experience and outcomes for our service users.

Priorities 1 & 2: Implement the recommendations of the Care Programme Approach review relating to:
- **improving care planning,**
- **improving communications between patients and staff.**

Why is this important:

We are two years into a complex and significant four year programme to improve the use of the Care Programme Approach (CPA) across the Trust. CPA is the approach we use to assess patients, plan and coordinate care, and review progress with patients who require secondary mental health services and have complex needs.

In 2012/13, the Trust performed a comprehensive review of its use the Care Programme Approach (CPA). Some key findings of this review relevant to care planning and communication were:

- The quality of assessment and care planning is variable across the Trust.
- Care coordinators spend a significant amount of time on the administration of CPA and other processes related to internal and external initiatives. This reduces the time available to spend with service users and carers to listen and discuss concerns and deliver recovery focused interventions.
- Some service users and carers believe they are removed from, and not fully involved in, the care planning process or their treatment.
- Some service users and carers report that the care documentation that is shared with them is not always clear and understandable.

- There is a lack of clarity and agreed processes regarding the management of section 117 of the Mental Health Act – the statutory duty to provide health and social care to some service users following discharge from in-patient care.

In 2013/14 the focus of this priority was to develop a plan to implement the recommendations of the review and commence the implementation of this plan via the CPA project.

The Care Programme Approach and care planning is critical to the quality of care our service users receive. The full involvement and participation of service users and carers within care planning is associated with improved outcomes and the experience of care. Addressing the issues above for service users, carers, staff and all agencies with whom we work with was a clear priority for improving the quality of the services the Trust delivers.

What benefits / outcomes our service users and carers should expect:

As the recommendations of the review are fully implemented in 2014/15 and 2015/16, our service users and carers, partners in care and staff should expect to see:

- A standard of high quality care planning across the Trust.
- Service users and carers reporting that they feel listened to and understood, that they understand and are involved in the development of their care plan and subsequent care reviews, and that their care plan will help them achieve their goals.
- A reduction in staff time spent on administrative tasks associated with care planning and more face to face treatment time with service users and carers.

What we did in 2013/14:

The following is a summary of the key things we have done in 2013/14:

Developed a detailed implementation plan.	• The development of the detailed implementation plan was deferred by the Board to quarter 3 2013/14 to allow time to recruit a project manager and agree a methodology for implementation. • The CPA project commenced with appointment of a project manager on the 1st October 2013. • The detailed implementation plan was agreed in November 2013.	Achieved

Commence the delivery of the detailed implementation plan.	• We have established the project governance arrangements with representation from each locality / speciality and two service users. • We have established links with other co-dependent Trust projects e.g. recovery, model lines (a project to develop model teams and a model way of working to provide best practice care), how we communicate with GPs, payment by results (the national project to link payment for service to outcomes delivered for patients), PARIS (the electronic patient record). A significant part of the CPA project will be delivered through these projects. • We are establishing communication links with each Local Authority via existing joint meetings & partnership Boards. • We have reviewed the current CPA policy to ensure it is consistent with our plans. • We are in the process of re-issuing to every service user on CPA a copy of their care plan on yellow paper with clear instructions on how to raise concerns, a briefing note on the CPA project and an invitation to be involved in the project. At March 2014, around **2,000** service users out of a total of **10,359** people on CPA have been re-issued with a copy of their care plan. In 2014/15 all service users on CPA within all services will be re-issued with a copy of their care plan • We have further developed our service user information folder which includes: a new information leaflet about CPA and care coordination; appointment information; community team and contact information; mental health / service fact sheet; recovery diary. The Trust is considering a proposal to send a folder to all service users on CPA in 2014/15.	Achieved

What we plan to do in 2014/15:

The next steps are reflected in quality priorities 2 & 3 for 2014/15 (*see pages 44 & 45).*

Priority 3: To improve the delivery of crisis services through implementation of the crisis review's recommendations

Why this is important:

Access to and the response from the crisis teams are central to the safety and effectiveness of the care received by service users when they are experiencing a crisis. The provision of this type of intervention at a time of great need can have a significant impact on service users' recovery as well as avoiding unnecessary admissions to inpatient care. Ensuring a consistent quality of crisis care across the Trust and at any time of day is, therefore, essential.

What benefits / outcomes our service users and carers should expect:

Through the delivery of this priority, our service users and carers, our partners in care and our staff should expect to see:

- A standard of high quality crisis and home treatment services across the Trust.
- Avoidance of unnecessary admissions to inpatient care and more care closer to home.
- Service users and carers reporting an improvement in their experience of crisis services.

What we did in 2013/14:

Two projects in County Durham & Darlington and Tees were used to implement the recommendations of the crisis review in 2013/14. This priority did not include North Yorkshire as the organisational review in 2012/13 was limited to County Durham & Darlington and Tees. There has been, however, a review of community mental health teams including crisis services in North Yorkshire during 2013/14.This work has taken the recommendations of the crisis review in County Durham & Darlington and Tees and developed a model of care suited to the North Yorkshire locality. It is expected that the revised model for crisis services in North Yorkshire will be implemented alongside the recommendations for the wider community mental health services in 2014/15.

The following is a summary of the key things we have done in County Durham & Darlington and Tees in 2013/14:

Implement recommendations from the crisis review – for both County Durham & Darlington and Tees	• We have implemented a consistent operational policy. • We have developed new shift patterns to match staff numbers with peaks and troughs in demand. • We have introduced a new role of shift coordinator to release front-line staff to focus on delivering care. This has ensured a quick response to crisis intervention whilst also protecting time for intensive home treatment. During the day each team has a shift coordinator. Out of hours the teams within each locality come together with one shift coordinator covering each locality. • We have developed better joint working with inpatient wards resulting in crisis staff spending more time on wards to facilitate safe, prompt and supported discharge. • We have established a Trust crisis team collaborative / network for staff to share issues, solutions and best practice. The first formal meeting of the group will be in April 2014.	Achieved

Implement recommendations from the crisis review – specifically in County Durham & Darlington	• We have reviewed medical staffing to ensure all crisis teams have equal access to appropriate medical input. • We are implementing a standard operating protocol for handovers of patients between crisis services and other Trust inpatient and community services. • We have developed and implemented a model for a crisis / recovery house in Shildon, County Durham. • We have reviewed all staff skills and developed a training plan for '14/15.	Achieved
Implement recommendations from the crisis review – specifically in Tees	• We are piloting a centralised s136 suite at Roseberry Park – formal arrangements will be agreed based on success of pilot. • We have assessed the levels of staff stress within the crisis teams and taken action where required.	Achieved

What we plan to do in 2014/15:

The crisis services have not been chosen specifically as a priority for 2014/15. However, the quality priority for 2014/15 on managing the pressure on inpatient beds *(see pages 46 & 47)* will involve crisis services.

Priority 4: To further improve clinical communication with GPs

Why this is important:

The needs of an individual with mental ill-health and/or a learning disability are always unique and often complex. As partners in care, the Trust and its local GPs must work together to maximise our combined efforts to meet these needs. How effectively we communicate our roles, our actions and what we expect of each other is critical to this partnership, and ultimately the outcome and experience of service users and carers.

Our view of our communication with GPs was that it was variable approach across the Trust and we did not always focus on providing what GPs and service users and carers needed to know. This conclusion was borne out by the feedback we received from GPs.

What benefits / outcomes our service users and carers should expect:

Through the delivery of this priority, our service users and carers, our partners in care and our staff should expect to see:

- A standard of high quality communication with GPs across the Trust.
- GPs reporting that the Trust's communication regarding the care of service users is timely, focussed and highlights what they need to know.
- Service users and carers reporting that they are offered copies of communications between the Trust and the GP

What we did in 2013/14:

The following is a summary of the key things we have done in 2013/14:

Agree a draft standard template for clinical communications with GPs (e.g. discharge plans).	• A draft standard template was approved by the Trust in June 2013.	Achieved
Agree a business case for the implementation of the standard template.	• A business case for the implementation of the standard template was approved by the Trust in September 2013.	Achieved
Create a standard patient information / front sheet and free text template for clinical communications with GPs on PARIS.	• A key challenge was to ensure that the standard electronic template was compatible with historical and new versions of the Care Programme Approach (CPA) documentation and could be generated electronically on PARIS (the electronic patient record). • This issue created a delay and a revised project plan was agreed by the Trust in December 2013 to defer this action from quarter 2 to quarter 4 2013/14. • A final standard electronic template for clinical communications with GPs was agreed by the Trust in February 2014.	Achieved
Ensure the electronic version of the standard template on PARIS functions effectively within clinical situations.	• Given the delay in agreeing the final standard template, testing the template on PARIS did not commence until quarter 4 2013/14. • The Trust agreed in the revised project plan to defer this action to be completed by quarter 2 2014/15. • Testing is now in progress and is on track for completion by quarter 2 2014/15, however, this is outside the originally reported timeframe of 2013/14.	Not Achieved in '13/14 but on track for revised deadline of Q2 '14/15
Establish Trust wide use of the standard template for clinical communications with GPs.	• Given completing the testing of the final standard electronic template on PARIS was deferred to quarter 2 2014/15, implementing the template Trust-wide will not happen until this time. • The Trust agreed in the revised project plan to defer implementation to quarter 2 2014/15, however, this is outside the originally reported timeframe of '13/14. • In the meantime each locality is on track to develop a training and roll out plan which will support the implementation of the standard template Trust-wide by quarter 2 2014/15.	Not Achieved in '13/14 but on track for revised deadline of Q2 '14/15

Develop a standard process for telephone and email access for clinical advice.	• We have developed a standard process for giving GPs access to quick clinical advice. GPs are given a single named contact for each service. When a GP calls for clinical advice, details are logged, the best person to provide advice is identified, advice is given within 48 hours of contact, the response given is logged. • We are piloting the standard process with GPs and will roll this out across the Trust in 2014/15. • In County Durham, Darlington and Tees we have developed and distributed to all GPs a service directory outlining what GPs should expect from each of our services. These include the names and contact details of all clinical and management leads in each of the services. A similar approach is being considered for GPs in North Yorkshire.	Achieved
Establish lines of communication most effective for GP practices - e.g. emailing 'letters‘	• This action was superseded by the CQUIN target agreed with local Clinical Commissioning Groups (CCGs): to develop an improved method of delivering discharge information through electronic measures. • We scoped and identified potential options for the transfer of information based on GP requirements and respective system capabilities. • We have developed solutions for these options and discussed these with CCGs and GP practices. The outcome was that different CCGs and GP practices had different preferred options. • It is expected that a pilot with GP practices will commence in quarter 1 2014/15 with full roll out in 2014/15.	Achieved

Update on 2012/13 quality priorities

In last year's Quality Account / Report we reported on our progress with our quality priorities for 2012/13. Within this we also noted some further actions for 2013/14. In some cases, these actions were to be embodied within the quality priorities for 2013/14, and therefore, are reported within this Quality Account / Report. In other cases, these quality priorities were discontinued in the Quality Account / Report but remained a priority for the Trust. The following is a brief summary of our progress with the quality priorities that were discontinued.

To improve how we gain feedback from patients on their experience and improve our services and the feedback we receive	• In 2013/14 we extended our survey work into children & young people's services and services for adults with learning disabilities • In 2013/14 we received responses from **6,051** *(at Feb '14 – to update at end May)* service users and carers about their experience compared to **3,820** in 2012/13. This is a **58%** increase on the previous year and shows we are continuing to seek feedback on the experience of care within all our services.
To sustain an improvement in all transfers of care with standard work practices and improved communication between professionals	• A re-audit of services in 2013/14 rated the Trust **AMBER** (i.e. compliant for 50% to 79% of transfers). As a result service-level action plans have been agreed and are being implemented.
To develop broader liaison arrangements with acute Trusts around physical health needs of mental health patients.	• In 2012/13 the Trust reported that the two projects to extend acute liaison services to older people in County Durham & Darlington and Tees had been completed. It was noted that in 2013/14 a full evaluation of the projects would be performed. It was also noted that work would continue in North Yorkshire with commissioners to explore opportunities for establishing acute liaison. • In County Durham and Darlington the high visibility of the service within the hospitals has resulted in a significant increase in the number people being supported during the period of their admission, and with a reduction in urgent referrals. Over the 12 month period from October 2012 to September 2013 the service received **2,211** referrals for patients aged over 65. This is more than double the previous year, with face-to-face contacts for this period increasing by over **400%**. The average length of stay for older people in acute wards was between **0.9** and **3.2** days shorter than before the service was extended. The total number of acute hospital bed-days saved is estimated at between **1,990** and **7,075** in a full year. The economic evaluation suggested that the £2m p.a. invested in the service is more than outweighed by the cost of bed days in acute hospital care and continuing social care provision that was required prior to the service being in place. • In Tees, the service was not operational until April 2013, and therefore, the 12-month evaluation is not expected until quarter 1 2014/15.

To develop broader liaison arrangements with acute Trusts around physical health needs of mental health patients (cont.)	• In North Yorkshire, the Trust has worked with its commissioners to develop opportunities for mental health liaison including input into acute Trusts. Business cases for three services in Scarborough, Northallerton and Harrogate have been agreed. It is anticipated that these services will commence in 2014/15.

Statement of Assurances from the Board 2013/14

The Department of Health and Monitor 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 2013/14. These statements are contained within the blue boxes. In some cases additional information is supplied and where this is the case this is provided outside of the boxes.

Review of services

During 2012/13 TEWV provided and/or sub-contracted **7** relevant health services.

TEWV has reviewed all the data available to them on the quality of care in **7** of these relevant health services.

The income generated by the relevant health services reviewed in 2012/13 represents **100%** per cent of the total income generated from the provision of the relevant health services by TEWV for 2013/14.

Our seven services are:

- Adult Mental Health Services
- Mental Health Services for Older People
- Children & Young Peoples Mental Health and Learning Disability Services
- Adult Learning Disability Services
- Forensic Mental Health Services
- Forensic Learning Disabilities Services
- Substance Misuse Services

The review of services is undertaken by the Quality and Assurance Committee and includes a six-monthly report from each clinical division. This report includes information on:

- Patient safety – including information on incidents, serious untoward incidents, levels of violence and aggression, medication incidents, implementation of safety alerts.
- Clinical effectiveness – including information on the implementation of National Institute for Clinical Excellence (NICE) guidance and the results of clinical audits.
- Patient experience – including information on complaints, claims, contacts with the Trust's patient advice and liaison service, results from the service user surveys and visits from the service user and carer led teams.
- Care Quality Commission – compliance with the essential standards of safety and quality and any risks to compliance or the quality of services.

In addition to the formal report, the services deliver a presentation on any particular areas of work that have been undertaken to improve quality and invite service users

and carers to talk to the Trust's Quality and Assurance Committee on the experience they have had and what they think we could do to improve.

The data reviewed as described above covers the three areas of patient safety, clinical effectiveness and patient experience. However, the Quality and Assurance Committee recognises that some of the data is more available and robust than others. The data on standard clinical outcomes in mental health is still limited.

The Board also undertakes monthly visits, and the Executive Management Team bi-monthly visits, to our wards and teams across the Trust. They listen to what service users, carers and staff think and feel about the services we provide. A key part of the Board visit is the production of a report and action plan which is then presented to the Board at its next formal meeting for approval and subsequent monitoring.

On a monthly basis, all the services review their quality and clinical assurance performance. The information collated includes:

- Patient safety – a thematic analysis of serious incidents, actions taken for improvement, safety alerts, infection prevention and control audit and incident data, medicines management review, safeguarding audits and an action plan update for children and adults.
- Care Quality Commission compliance – details of monthly Quality Risk Profile reports and feedback from Care Quality Commission inspections and reviews.
- Patient experience – details of lessons learned from complaints, patient feedback / surveys and patient reported outcomes.
- Clinical audit and evidence based practice information.

On a quarterly basis we have clinical quality and risk governance meetings with commissioners.

Participation in clinical audits and national confidential inquiries

During 2013/14, **6** national clinical audits and **1** national confidential inquiry covered the relevant health services that TEWV provides.

During 2013/14, TEWV participated in **100%** of national clinical audits and **100%** of national confidential inquiries of the national clinical audits and 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, and did participate in, during 2013/14 are as follows:

- National Audit of Schizophrenia.
- Prescribing Observatory in Mental Health (POMH) UK topic 13a – prescribing for attention deficit hyperactivity disorder (ADHD).
- POMH UK topic 7d – monitoring of patients prescribed lithium.
- POMH UK topic 4b – prescribing anti-dementia drugs.
- POMH UK topic 10c – use of antipsychotic medicine in children and young

peoples mental health services (CAMHS).
- National Audit of Psychological Therapies (NAPT) in adult mental health.
- National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH).

NB: For POMH UK Topics 13a, 7d, 4b and 10c above the Trust has adopted a local audit approach.

The national clinical audits and national confidential inquiries that TEWV participated in, and for which data collection was completed during 2013/14, are listed below alongside the number of cases submitted to each audit or inquiry as a percentage of the number of registered cases required by the terms of the national audit or inquiry.

Audit Title	Cases Submitted	% of the number of registered cases required
National Audit of Schizophrenia	100	100%
POMH UK topic 13a – prescribing for ADHD	35	100%
POMH UK topic 7d – monitoring of patients prescribed lithium	868	100%
POMH UK topic 4b – prescribing anti-dementia drugs	***	100%
POMH UK topic 10c – use of antipsychotic medicine in CAMHS	***	100%
National Audit of Psychological Therapies (NAPT) in adult mental health	4,241****	100%
National Confidential Inquiry into Suicide & Homicide by People with Mental Illness	n/k*	97%**

* Cases are submitted confidentially and directly by individual consultants, and therefore, the number of cases submitted is not known.

** Extract from National Confidential Inquiry Annual Report July 2013: for the final year of the patient suicide and homicide analysis we estimated the final number of cases based on data completeness in previous years. Projected figures are based on the average annual return of inquiry questionnaires in England, i.e. for suicide 97% and for homicide 98%. Page 11 Para 2 National Confidential Inquiry.

*** POMH Topic 4b and Topic 10c are currently underway and the reports are anticipated by the end of March 2014 and July 2014 respectively. It should be noted that there has been a delay in the publication of the national report for POMH topic 4b by POMH-UK.

**** The NAPT clinical audit is a retrospective case record audit of people who completed therapy between 1st July 2012 and 31st October 2012.

The reports of **3** national clinical audits were reviewed by the provider in 2013/14 and TEWV intends to take the following actions to improve the quality of healthcare provided:

- POMH UK topic 13a – prescribing for attention deficit hyperactivity disorder (ADHD).

  Actions:

  - The physical healthcare group to consider access to percentile and

growth charts via the electronic patient record system.
  - The clinical audit report to be presented to the children's and adult mental health services development groups and distributed to all relevant teams.
  - The clinical audit report to be presented to the drug and therapeutics committee

- POMH UK topic 7d – monitoring of patients prescribed lithium.

  Actions:

  - To disseminate the clinical audit results to clinical directors, heads of service, team managers and lithium register designated links.
  - Action plans for ensuring pre-treatment checks are performed to be requested from the Chester-le-Street, Ripon and Whitby adult mental health teams.
  - Action plans for ensuring annual weight/BMI/waist circumference are recorded to be requested from all teams.
  - To share the clinical audit results with the Drug and Therapeutics Committee.
  - To set up three monthly exception reporting of pre-treatment checks.

- National Audit of Psychological Therapies (NAPT) in Adult Mental Health.

  Actions:

  - The localities to review their local reports, develop and implement action plans to improve clinical practice where identified as necessary.
  - To look at attrition rates across the speciality and identify any potential improvements to address this area which was below the national average.

The reports of **81** local clinical audits (**186** individual audits) were reviewed by the provider in 2013/14 and TEWV intends to take the following actions to improve the quality of healthcare provided. **Appendix 4** includes a selection of **9** key themes from these local clinical audits reviewed in 2013/14.

In addition to those local clinical audits reviewed (i.e. those that were reviewed by the Trust's Quality and Assurance Committee), the Trust undertook a further **65** clinical audits in 2013/14.

All the clinical audits referenced above were included in the annual internal forward audit programme for reasons of quality assurance, service improvement or professional development. The forward audit programme is agreed every year with the clinical services to include 'must do' national or Trust-wide audits and those requested by services as part of their quality assurance or quality improvement plans. The audits vary in focus – some monitor compliance against an internal policy or procedure and others measure the variance of current practice against national standards, such as NICE guidance. A number are designed to provide evidence of

the outcomes from a service initiatives or new practice, particularly the quality improvement initiatives agreed as CQUINs.

The findings from these audits are reported to the Trust Quality and Assurance Committee, with any risks from findings escalated through the management systems. Any learning and recommendations from the audit results are expressed as actions for the services to implement to achieve further improvement. Many of the actions are simply to prompt and remind staff about existing guidance and some result in change to processes and systems. Audit findings are regularly used in other quality improvement projects to plan where to focus change and development.

The delivery of actions is monitored through the Trust governance systems and delays in achievement are escalated. At the end of March 2014 there were **16** *(at Feb 2014 – to update at end May)* action points that were overdue beyond their originally agreed timescales. Topics are re-audited to monitor that improvement actions have been effective.

Participation in clinical research

The number of patients receiving NHS services provided or subcontracted by TEWV in 2013/14 that were recruited during the period to participate in research approved by a research ethics committee was **1,411**.

Of the **1,411, 1,049** were recruited to National Institute for Health Research (NIHR) portfolio studies. This compares with **536** patients involved as participants in NIHR research studies during 2012/13 and **433** in 2011/12. This is a key indicator of the Trust's rapidly increasing involvement with large scale, often complex, national research across clinical disciplines such as psychosis, attention deficit hyperactivity disorder, addictions, drug safety, forensic mental health, dementia, affective disorders and personality disorder.

The Trust's growing participation in clinical research through 2013/14 reflects our firm commitment to improving the quality of care we provide, as well as contributing to the broader goals of mental health research.

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

- We were involved in conducting **92** clinical research studies during 2013/14. This compares with **104** in 2012/13. **46** of these studies were supported by the NIHR through its networks and **22** new studies approved through its coordinated research approval process.
- **73** members of our clinical staff participated as researchers in studies approved by a research ethics committee, with **42** of these in the role of principal investigator for NIHR supported studies.
- **19** researchers from outside the organisation were granted access under the National Research Passport Scheme to perform research with us compared to **9** in 2012/13.

- We have continued to develop our collaborative partnership with Durham University across a number of areas of shared interest including primary care mental health, evaluation of psychological interventions in young people and prescribing quality and safety. This year we celebrated five years of this partnership. Of more than **20** high impact publications resulting from this collaboration, findings from a study involving people with schizophrenia who can't or won't take antipsychotic drug treatment were published in the Lancet. This ground breaking research involving Trust participants suggests that cognitive therapy without medication could be safe and effective in reducing psychotic symptoms.
- 2013/14 saw a rapid growth in Trust support of large scale dementia research. In response to the Prime Minister's Challenge on Dementia, the Trust is scoping development of a research pharmacy capability, consolidating plans for further collaboration with pharmaceutical industry in dementia research. Over **80** participants have been recruited this year to dementia studies which included recognition of the Trust as the highest performer nationally in recruiting to a study of the prevalence of visual impairment in dementia.
- The Trust is one of five NHS Trusts across the UK hosting a trial which aims to establish whether lamotrigine, a mood stabiliser, is an effective treatment for borderline personality disorder. There are currently no medicines licensed for the treatment of borderline personality disorder, which affects between 0.5% and 2% of the population. So far over **20** participants have been randomised to the trial across a spread of services including those from Harrogate and Ripon. The study delivery is overseen locally by a study steering group whose composition includes two users of services to ensure that all study governance and delivery is properly informed from patient perspective.
- An important study of an oral health intervention for people with serious mental illness has been undertaken, successfully engaging all Trust early intervention in psychosis teams.
- Commercially sponsored research remains a priority for government, our network funders and our Trust's research and development growth strategy. This year we submitted a number of expressions of interest for participation in pharmaceutical company sponsored research. Notable was a Lundbeck sponsored observational study involving patients with schizophrenia treated with anti psychotic injections. Recruitment targets have been exceeded with agreement of the sponsor.

We have also developed processes to ensure research has led to improvements in quality of care. This has been achieved by ensuring that the design, delivery and findings of research are communicated and discussed by research interest groups. We also support and nurture lead researchers within clinical specialties in order that the research and development activity is aligned with the skills and knowledge needs articulated by the services.

Goals agreed with commissioners

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

A proportion of TEWV's income in 2013/14 was conditional upon achieving quality improvement and innovation goals agreed between TEWV and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation Payment Framework (CQUIN).

As part of the development and agreement of the 2013/14 mental health contract, discussions were held between the Trust and each of its commissioners to agree a set of goals and indicators that both parties felt were appropriate and relevant to local and national strategies. Indicators linked to patient experience, patient safety and clinical effectiveness were key to both provider and commissioner. These are monitored at meetings every quarter with our commissioners.

An overall total of **£5,948,598** was available for CQUIN to TEWV in 2013/14 conditional upon achieving quality improvement and innovation goals across all of its CQUINs, and a total of **£5,884,071 (98.92%)** *(at Feb 2014 - to update figure at end May)* was received for the associated payment on 2013/14. This compares to £5,938,580 (100%) and £3,744,990 (99.9%) received in 2012/13 and 2011/12 respectively.

Some examples of CQUIN indicators which the Trust made progress with in 2013/14 were:

- To improve access to support for service users and carers from the point of diagnosis of dementia to support them in coming to terms with the impact of the condition and the losses they experience. In quarter 4 2012/13 the Trust reported that between **3%** and **15%** of service users surveyed had received the relevant information leaflets on diagnosis, medication, support of carers, etc. By quarter 4 2013/14 this had increased to between **73%** and **98%** depending on leaflet and locality and above the target set by commissioners of **20%**.
- To deliver improvement in the level of falls using data from NHS Safety Thermometer. In quarter 3 2013/14, **70%** of mental health services for older people inpatient staff and **97%** of community learning disabilities staff were trained in the falls pathway against a year-end target of **60%** and **80%** respectively. An audit has confirmed that all older people admitted to inpatient care and all people with learning disabilities open to caseload are now screened for their risk of falls with all those at high risk receiving a falls intervention plan.
- Patients with a learning disability and epilepsy who experience prolonged or serial seizures have an epilepsy rescue medication protocol in place. At quarter 3 2013/14 it was reported that across County Durham, Darlington and Tees **80%** of people identified had a rescue plan in place against a year end target of **75%**.
- **100%** of all children and adolescent mental health service patients have a transition care plan in place by the age of 17.5 years.

However, we did not always make such good progress throughout the whole year. Delays have meant that the following CQUINs were not on track in 2013/14.

- To improve the implementation of the pathway of care in A&E services by improving the implementation of the borderline personality disorder integrated care pathway. Progress with the plan has been delayed, in particular, with gaining service user involvement and joint working with the emergency departments within acute Trusts.
- To have achieved a minimum agreed response rate for uptake of the inpatient survey ensuring data is maintained of those who refuse to participate. Although progress has been made in most areas, response rates in several services and localities (for example North Yorkshire adult mental health 77%; Durham mental health services for older people 79%) are below the target of 80%.

What others say about the provider

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

TEWV is required to register with the Care Quality Commission and its current registration status is **registered to provide services with no conditions attached**.

The Care Quality Commission has **taken one** enforcement action and raised **one moderate concern** and **one minor concern** against TEWV during 2013/14.

TEWV has participated in **13** special reviews or compliance inspections by the Care Quality Commission relating to the following areas during 2013/14:

- Two inspections at **Auckland Park, Bishop Auckland** – a unit providing care and treatment for older people's mental health inpatient care, day care and outreach services. There are three wards on site which have 12 beds each.
- **Tunstall Ward, Lanchester Road Hospital, Durham** – a 20 bed acute admission ward for female patients only and accommodates patients both detained under sections of the Mental Health Act 1983 (MHA) and informal patients who are not detained under the Act.
- **West Lane, Middlesbrough** – an inpatient service with three wards for young people. One ward provides assessment and treatment, one ward is a low secure facility, and the third ward is an inpatient eating disorder service.
- **Dental Suite Ridgeway, Roseberry Park, Middlesbrough** – this service is provided within the Health Centre at Roseberry Park Hospital. It provides services to patients within the low and medium secure wards at the hospital. The provider uses the facilities of the health centre which are maintained by the Trust. The management of appointments is maintained by staff working within the health centre.
- **Trust Headquarters, West Park – two community teams** – for the Care Quality Commission (CQC) purposes, Trust Headquarters is registered as the central location for the main community services of the Trust. CQC visited a sample of two community teams. This included teams delivering support for

those with psychosis and affective disorder.

- **Trust Headquarters, West Park – clozapine and lithium clinics** – the CQC visited a sample of outpatient clinics for this inspection. At a previous inspection in 2012/13, CQC found concerns with the Trust's arrangements for medicines. CQC carried out this inspection to check whether action had been taken to address these concerns. They found that improvements had been made.
- **Bankfields Court, Middlesbrough** – Bankfields Court provides an assessment and treatment, rehabilitation and respite service for adults with learning disabilities from the Teesside area who also have associated mental health problems, challenging behaviour or severe epilepsy. There are two units with six beds each and a converted house with one bed for assessment and treatment; six rehabilitation flats and eight respite beds.
- **Thornaby Road, Middlesbrough** – a small home providing personal and nursing care for five people with learning disabilities and additional support needs.
- **Lanchester Road Hospital, Durham** – five learning disability and forensic learning disability assessment and treatment wards.
- **163 Durham Road, Stockton** – two five-bedded assessment and treatment wards providing services for adults with a learning disability and associated challenging behaviours, autism, and epilepsy, and a respite service for adults with a learning disability who can have complex needs or present with challenging behaviours.
- **Ridgeway, Roseberry Park, Middlesbrough** – forensic learning disability wards – although the CQC visited these wards in 2013/14 the report on these visits is not due until 2014/15.
- There was one review for **HMP Holme House** for which the Trust is sub-contracted to provide specialist mental health care by the lead contractor Care UK. As such, the outcome of this review is within the Quality Account / Report for Care UK.

The CQC also undertook a review of health services for looked after children and safeguarding operating in the areas of the Trust served by Stockton Borough Council. A recommendation for TEWV as a result of this inspection was to ensure that practitioners are assessing and describing the risk to children and families when making referrals to children's social care to enable social workers to make informed decision. A further recommendation was to assess the training requirements of practitioners working in a supporting role to ensure that they are accessing safeguarding training at a level commensurate with their duties

TEWV has also participated in **38** Mental Health Act inspections by the Care Quality Commission to the following ward areas during 2013/14:

Ward	Service Type	Locality
Abdale House	Adult Mental Health Rehab	Harrogate
Bankfields	Learning Disabilities Assessment & Treatment	Middlesbrough
Bedale	Adult Mental Health Psychiatric Intensive Care	Middlesbrough
Bek	Learning Disabilities Assessment & Treatment	Durham
Bilsdale	Adult Mental Health Assessment & Treatment	Middlesbrough

Ward	Service Type	Locality
Binchester	Older Peoples Mental Health Challenging Behaviour	Bishop Auckland
Birch	Adult Mental Health Assessment & Treatment	Darlington
Bransdale	Adult Mental Health Assessment & Treatment	Middlesbrough
Cedar	Adult Mental Health Assessment & Treatment	Harrogate
Ceddesfeld	Older Peoples Mental Health Challenging Behaviour	Bishop Auckland
Danby	Adult Mental Health Assessment & Treatment	Scarborough
Earlston House	Adult Mental Health 24 Hour Nursed Care	Durham
Evergreen	Children's Eating Disorders	Middlesbrough
Farnham	Adult Mental Health Assessment & Treatment	Durham
Fulmar	Non Forensic Mental Health Low Secure	Middlesbrough
Kirkdale	Non Forensic Mental Health Low Secure	Middlesbrough
Langley	Forensic Learning Disabilities	Durham
Lincoln	Adult Mental Health Assessment & Treatment	Hartlepool
Lustrum Vale	Adult Mental Health 24 Hour Nursed Care	Stockton
Mandarin	Forensic Mental Health Low Secure	Middlesbrough
Maple	Adult Mental Health Assessment & Treatment	Darlington
Merlin	Forensic Mental Health Medium Secure	Middlesbrough
Mulberry House	Adult Mental Health 24 Hour Nursed Care	Easington
Newberry	Children's Mental Health Assessment & Treatment	Middlesbrough
Oakwood	Forensic Learning Disabilities Rehab	Middlesbrough
Picktree	Older Peoples Mental Health Assessment & Treatment	Durham
Primrose Lodge	Adult Mental Health 24 Hour Nursed Care	Chester-le-Street
Ramsey	Learning Disabilities Assessment & Treatment	Durham
Roseberry	Older Peoples Mental Health Assessment & Treatment	Durham
Rowan	Older Peoples Mental Health Assessment & Treatment	Harrogate
Springwood	Older Peoples Mental Health Continuing Care	Malton
Talbot	Learning Disabilities Assessment & Treatment	Durham
The Dales	Learning Disabilities Assessment & Treatment	Stockton
Tunstall	Adult Mental Health Assessment & Treatment	Durham
Ward 14	Older Peoples Mental Health Assessment & Treatment	Northallerton
Ward 15	Adult Mental Health Assessment & Treatment	Northallerton
Westerdale (S)	Older Peoples Mental Health Assessment & Treatment	Middlesbrough
Westwood	Children's Mental Health Low Secure	Middlesbrough

The CQC Mental Health Act Commissioners also undertook an inspection to look at the arrangements for assessment and application for detention that operate in the areas of the Trust served by Durham County Council Social Services and Darlington Borough Council. The primary action was for the two local authorities to address conveyance / transport issues. However the Trust was requested to identify and progress action to reduce the time that police are waiting at Section 136 suites.

The reports following these inspections highlighted that all but two services met full compliance requirements. The following outlines the two services which required action.

Auckland Park, Bishop Auckland: during August 2012, the CQC raised one moderate concern and one minor concern impacting on compliance and requiring

improvement actions. Following a further inspection in April 2013 an enforcement action and moderate concern was raised. Whilst the CQC did not indicate that there were any issues in terms of the quality of the care provided at Auckland Park, they did find that some processes on the ward were not tailored to meet individual assessments of the needs of the patients.

TEWV took the following actions to address the conclusions or requirements reported by the Care Quality Commission. TEWV has made the following progress by 31st March 2014 in taking such actions.

Auckland Park, Bishop Auckland

Outcome 1 (Regulation 17): respecting and involving people who use services.
Enforcement Action: essential standard not met – the provider had not provided appropriate opportunities, encouragement and support to people who used the service in relation to their autonomy and independence.

Actions and Progress

- Bedroom and en-suite doors are now not locked unless there are:
  - Unmanageable risk issues identified in the individual intervention plans that describe the risk management, or
  - Documented patient / carer wishes for the doors to be locked.
- Staff ensure individual views are considered and risks assessed relating to autonomy and independence and document the assessment outcomes giving a rationale for the decisions made. Outcomes of assessments are recorded in the electronic patient record (PARIS).
- All staff have participated in retraining and a discussion on the principles of regulation 17, the related patient outcome, and positive risk taking approaches developed for Auckland Park
- Capacity to make decisions about care and treatment for every individual is assumed unless there is evidence to indicate that there is compromise to their level of capacity to make those decisions. Individual capacity assessments are carried out when patients are involved in decisions about their care.
- When patients have been assessed to have a reduced capacity to make decisions about their care, then families, carers and advocates are involved to represent the patient's view. Referral requests for an Independent Mental Capacity Advocate and notes from involvement discussions are recorded in the PARIS record.
- Staff assess individual views and risks and document the assessment outcomes to give the rationale for the risk management plan agreed and decisions made.
- On admission / transfer to the ward, patients and carers are advised that bedrooms and en-suite bathrooms are usually left unlocked. Their wishes in relation to this and the plan agreed are recorded in the case note section of the PARIS record. An information leaflet and standard process checklist has been developed for this process.

- Health records include decisions to give patients individual bedroom keys and take account of individual patients' capacity, best interests, risks and wishes. A standard process checklist has been developed for this process.
- Decisions about the need to lock bedrooms are reviewed on a weekly basis as a minimum, at the time the intervention plan is reviewed and a case note entry is made to reflect this.
- Doors leading to Ceddsfield Ward and Hamsterley Ward gardens are unlocked during daylight hours.
- Changes to signage recommended by the Stirling audit (a tool for assessing the environment within which people with dementia are cared for) have been implemented e.g.:

    - Signs have been placed at low height.
    - Black/blue font on yellow background is used.
    - Pictorial and word content are both used.

- A range of communication strategies for those who no longer are able to understand the written word have been developed. These include sharing best practice from other services.
- A standard care plan has been implemented for all patients on admission to Auckland Park that identifies the essentials required for person centred care within a positive risk framework. The care plan describes the specific individual needs and wishes of the individual patient.

Outcome 2 (Regulation 18) : consent to care and treatment
Moderate Concern: essential standard not met – the provider had not suitable arrangements in place to obtain and act in accordance with the consent of people who used the service.

Actions and Progress

- The Trust's policy for controlling access to in-patient areas (including the locking of ward doors) has been implemented. Individual intervention detailing risk assessment and risk management plans identifies the ward egress and access level for each patient.
- Where it is assessed that an informal patient should not be allowed to leave the ward unaccompanied for reasons relating to risk, the team consider whether a liberty has been deprived. It is then considered how that deprivation should be authorised, either via the Mental Health Act or Mental Capacity Act, and then follow the appropriate policy and document in the patient's notes.
- An individually meaningful picture that assists a patient in distinguishing their room is used on bedroom doors as well as the person's name.
- There are clear procedures and guidelines in place for the use of mental capacity assessments. These are being implemented appropriately.
- All staff are up to date with Mental Capacity Act and deprivation of liberty training and are competent in the application of the legislation.
- Ward managers have agreed suitable environmental improvements with advice from staff trained in implementing the recommendations of the Stirling

audit. Environmental improvements consider the needs and abilities of patients and are culturally and generationally appropriate.

- Cognitive stimulation boxes are available for all patients and stored appropriately following discussion with the patient and their carers and in accordance with their capacity, risks and wishes.
- Where patients cannot manage free access, cognitive stimulation boxes are accessible as described in the individual intervention plan to promote positive therapeutic access.
- Training in the use of the Malnutrition Universal Screening Tool (MUST) has been provided to each of the wards and the tool has been implemented for every patient on all wards at Auckland Park.

163 Durham Road, Stockton

Outcome 4: care and welfare of people who use the service.
Minor concern: people should get safe and appropriate care that meets their needs and supports their rights.

Actions and Progress

- Although the inspection was completed in March 2014, the report was received on the 15th April 2014. *Actions and progress to add in May.*

The enforcement action and moderate concern raised for Auckland Park was removed following a further re-inspection in August 2013.

During this inspection the CQC found that:

- The Trust had fully implemented the improvement plans, and had achieved compliance in both essential standards.
- The improvements meant Auckland Park Hospital had in place appropriate opportunities, encouragement and support to people who used the service in relation to their autonomy and independence.
- Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.
- Where people did not have the capacity to consent, the Trust had acted in accordance with legal requirements.

The family members that the CQC spoke with were extremely complimentary about the service and staff. They told the CQC that this was the best service their relatives had used and that all the staff were extremely skilled and competent. Comments from relatives included:

"I have absolutely no complaints about the hospital and staff. All the staff are absolutely marvellous and the care is second to none. I don't know why anyone would not consider the service to be first class.", and

"The service is excellent. It really is marvellous."

Quality of data

TEWV submitted records during 2013/14 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data: *(figures at Dec 2014 – to update at end May)*

- Which included the patient's valid NHS number was: **99.50%** for admitted patient care; **99.80%** for outpatient care.
- Which included the patient's valid General Medical Practice Code was **95.05%** for admitted patient care; **97.26%** for outpatient care.

TEWV Information Governance Assessment Report overall score for 2013/14 was **88%** and was graded **satisfactory**.

The Information Governance Toolkit measures the Information Security and Caldicott Functions of the Trust.

It is important to patients because it demonstrates that the Trust has safe and secure processes in place to protect the sensitive personal information that we process. It demonstrates that our staff have robust training in areas such as confidentiality and the Trust carries out its legal duties under the Data Protection Act 1998, Freedom of Information Act 2000 and aspects of the Human Rights Act.

88% (satisfactory) means that we achieved at least the level 2 standard on all elements of the toolkit, however, in a significant number of elements we met the level 3 (the highest score). This is an improvement on the 2012/13 score of **85%.**

TEWV was **not** subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.

Monitor, the regulator of Foundation Trusts, at the end of 2013 issued draft guidance for the coming financial year. This requires organisations to implement outcome measurement as a key requirement of developing Mental Health Payment by Results. The areas for development are:

- **Clinically Reported Outcome Measure (CROM)**: this will be the Health of the Nation Outcome Score (HoNOS) and reported via the Mental Health Minimum Data Set.
- **Patient Reported Outcome Measure (PROM)**: the Trust is currently testing as part of a scale pilot a patient reported wellbeing measure, the Warwick-Edinburgh Mental Well-being Scale (WEMWBS), as recommended in the Monitor 2014/15 currency and tariff development guidance.

- **Patient Reported Experience Measure (PREM)**: This will be the Friends and Family Test *(Mental Health Guidance for PbR: 2012/13: section 7.1).* Specifically, the percentage of service users surveyed during the reporting period who would recommend the Trust as a provider of care to their family or friends.

In response to this guidance, the Trust is developing its approach to recording and reporting these measures. The testing of these measures will form part of the payment by results contract with commissioners in 2014/15 and will be a step towards future mandated requirements.
The Trust has and continues to play a significant national role in these developments. We are undertaking national work on behalf of the Department of Health to analyse pilot data on HoNOS and in relation to the PROM and PREM developments.

At end of March 2014 *(end Feb - to update at end May):*

- **94.8%** of service users on the adult mental health and mental health services for older people caseload were assessed using the mental health clustering tool. The clustering tool is the nationally agreed approach for categorising patients' needs and is the basis for payment by result.
- **89.9%** of service users on the adult mental health and mental health services for older people caseload were reviewed within the guideline timeframe.

At the time of publication, there is limited national benchmarking data to compare against the Trust reported figures.

Further work for 2014/15 includes:

- The inclusion of key payment by results development metrics as part of routine performance management.
- Embedding the new metrics into clinical services.
- Further development of the Integrated Information Centre within the Trust to assist reporting of payment by results data.

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

- We have a data quality improvement group chaired by the Director of Finance and Information which meets on a monthly basis and addresses data quality issues in terms of patient, staff, financial and risk information.
- We have a data quality strategy and scorecard to monitor improvement. The strategy aims:
    - To maximise the accuracy, timeliness and quality of all our data wherever and however it is recorded.
    - To ensure that every member of our staff understands that data quality is the responsibility of everyone and an integral part of their role.
    - To ensure we achieve compliance with all our statutory and regulatory obligations.

- We have established regular reports on key elements of data which show how well data is being recorded on the various information systems, particularly the patient information system and the staff information system.
- In 2014/15, the Trust is continuing to implement an Integrated Information Centre. Within this there is a data quality engine that will enable services and teams to assess and improve the quality of their data in real time.
- Regular reports are available to all services so that they can target improvement work on areas where problems occur. Data quality is a key item for discussion in the monthly performance meetings that are held between the services and the Chief Operating Officer, the Director of Finance and Information and the Director of Planning and Performance.

Mandatory quality indicators

The following are the mandatory quality indicators relevant to mental health trusts, issued jointly by the Department of Health and Monitor and effective from February 2013.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127382/130129-QAs-Letter-Gateway-18690.pdf.pdf
For each quality indicator we have presented a mandatory statement and the data on the NHS Information Centre (NHSIC) for the most recent and the previous reporting period available.

Care Programme Approach 7 day follow-up

The data made available by the Health and Social Care Information Centre (NHSIC) with regard to the percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period.

TEWV Actual Quarter 4 2013/14	***TEWV Actual Quarter 3 2013/14***	**** National Benchmarks in Quarter 3 2013/14***	***TEWV Actual Quarter 2 2013/14***	***TEWV Actual Quarter 1 2013/14***
Trust Final Reported: **97.83%** Trust Reported to Monitor: **97.83%** *(at Feb 2014 – to update at end May)*	Trust Final Reported and figure reported to Monitor: **97.95%** NHSIC Reported: **98.20%**	NHSIC Reported: National Average MH Trust = **96.70%** Highest/Best MH Trust = **100%** Lowest/Worst MH Trust = **77.20%**	Trust Final Reported: **98.62%** Trust Reported to Monitor: **98.64%**	Trust Final Reported and figure reported to Monitor: **97.68%**

* latest benchmark data available on NHSIC at quarters 3 2013/14

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

- The discrepancy between the Trust final reported figure and the figure reported to Monitor in quarter 2 2013/14 is due to the fact the Trust final figure is refreshed throughout the year to reflect a validated position as data quality issues are resolved. The figure reported to Monitor is the position at quarter end and is not refreshed after submission.
- The discrepancy between the NHSIC and the Trust / Monitor figure is due to the fact the NHSIC data is submitted at a Clinical Commissioning Group (CCG) level, and therefore, excludes data for patients from CCGs outside the Trust area or where the CCG is unspecified in the patient record.
- The few actual breaches, **37** in total in 2013/14 *(as at Feb '14 – to update at end May)*, were a result of:
    - Services users not attending the follow-up appointment despite efforts of the service to contact the patient, and
    - Failure in communication between the discharging ward and the community team.

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

- Monitoring this key performance indicator via the Trust's dashboard at service and board level on a monthly basis.
- Investigating all breaches and identifying lessons learnt at director and service level performance meetings.
- Reviewing how the services maintain contact with the patient in the days following discharge to eliminate non-attendance at the follow-up appointment.
- Proactively contacting other agencies with whom the patient is in contact where there is a greater risk of non-attendance at follow-up (e.g. homelessness).
- Implementing a standard process to ensure patients discharged to other services (e.g. 24 hour care unit) are not overlooked.
- Reminding staff regarding procedures for follow-up when patients are on leave from the ward or the care coordinator is on annual leave / holiday.
- Continuously raising awareness and reminding staff at ward / team meetings of this national requirement, the need to follow the standard procedure and the need to record data accurately.

Crisis Resolution Home Treatment Team acted as a gatekeeper

The data made available by the Health and Social Care Information Centre (NHSIC) with regard to the percentage of admissions to acute wards for which the crisis resolution home treatment team acted as a gatekeeper during the reporting period.

TEWV Actual Quarter 4 2013/14	*TEWV Actual Quarter 3 2013/14*	** National Benchmarks in Quarter 3 2013/14*	*TEWV Actual Quarter 2 2013/14*	*TEWV Actual Quarter 1 2013/14*
Trust Final Reported and figure reported to Monitor: **97.58%** *(at Feb 2014 – to update at end May)*	Trust Final Reported and figure reported to Monitor: **97.67%** NHSIC Reported: **98.3%**	NHSIC Reported: National Average MH Trust = **98.6%** Highest/Best MH Trust = **100%** Lowest/Worst MH Trust = **85.50%**	Trust Final Reported and figure reported to Monitor: **97.84%**	Trust Final Reported and figure reported to Monitor: **96.63%**

* latest benchmark data available on NHSIC at quarters 3 2013/14

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

- The discrepancy between the NHSIC and the Trust / Monitor figures is due to the fact the NHSIC data is submitted at a Clinical Commissioning Group (CCG) level, and therefore, excludes data for patients from CCGs outside the Trust area or where the CCG is unspecified in the patient record.
- The few actual breaches, **36** in total in 2013/14 *(as at Feb '14 – to update at end May)*, were a result of failure to follow the standard procedure.

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

- Monitoring this key performance indicator via the Trust's dashboard at service and board level on a monthly basis.
- Investigating all breaches and identifying lessons learnt at director and service level performance meetings.
- Reviewing crisis services in 2012/13, acknowledged the lessons from breaches and building these lessons into standard work which was implemented across all crisis services in 2013/14.
- Continuously raising awareness and reminding staff at ward / team meetings of this national requirement, the need to follow the standard procedure and the need to record data accurately.

Staff Friends and Family Test

The data made available by the Health and Social Care Information Centre (NHSIC) with regard to the percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.

TEWV Actual 2013	*National Benchmarks in 2013*	*TEWV Actual 2012*	*TEWV Actual 2011*
3.89 out of 5.00 (sample size of 492)	National Average MH Trust = **3.55 out of 5.00** Highest/Best MH Trust = **4.04 out of 5.00**	**3.83 out of 5.00** (sample size of 519)	**3.73 out of 5.00** (sample size of 536)

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

- The figure is derived from the NHS staff survey.
- The 2013 result, **3.89 out of 5.00**, is a small improvement on the 2012 and 2011 results and is in the top 20% of all mental health Trusts.
- This improvement is linked to the five areas in the 2013 survey that the Trust achieved its best scores, four of which were the best score for all mental health Trusts in England.
    - Work pressure felt by staff: **2.80 out of 5.00** compared to national average of **3.07** (NB: lower better).
    - Staff job satisfaction: **3.85 out of 5.00** compared to national average of **3.67**.
    - The percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver: **83%** compared to national average of **77%**.
    - The percentage of staff feeling they are able to contribute towards improvements at work: **79%** compared to national average of **72%**.
    - Fairness and effectiveness of incident reporting procedures: **3.68 out of 5.00** compared to national average of **3.52**.

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

- Annual Trust and directorate level action plans are developed in response to the NHS Staff Survey. Some areas for improvement work in 2013/14 were:
    - Continuation of the work to try to improve the health and wellbeing of the Trust's staff. This included trying to gain a better understanding of the causes of stress. Stress assessment tools have been considered and several staff engagement workshops have taken place in both adult mental health services at Roseberry Park and learning disability forensic services.
    - The Trust reviewed and updated its policy for positive approaches to supporting people whose behaviour is described as challenging.
    - The Trust introduced more ways of anonymously reporting concerns. Staff can now use a form on the intranet or leave a message on the concerns line.

Patient's experience of contact with a health or social care worker

The data made available by the Health and Social Care Information Centre (NHSIC) with regard to the Trust's "patient experience of community mental health services" indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period.

TEWV Actual 2013	*National Benchmarks in 2013*	*TEWV Actual 2012*	*TEWV Actual 2011*
NHSIC Reported: **89.40** (sample size of 217)	NHSIC Reported: National Average MH Trust = **85.80** Highest/Best MH Trust = **90.90** Lowest/Worst MH Trust = **80.90**	NHSIC Reported: **88.42** (sample size of 230)	NHSIC Reported: **87.35** (sample size of 223)

Notes on metric

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

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

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

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

- The figure is derived from the NHS service user survey.
- The Trust's score for 2013 was **89.4.** The Trust's score in 2013 is an improvement on 2012 and 2011 and is closer to the best mental health Trust score of **90.9** compared to 2012.
- The individual scores that this figure is based on were:
    - Did this person listen carefully to you: **9.1 out of 10**, and better than the national average.
    - Did this person take your views into account: **8.7 out of 10**, and better than the national average.
    - Did you have trust and confidence in this person: **8.5 out of 10**, similar to the national average.
    - Did this person treat you respect and dignity **8.7 out of 10**, and better than the national average.

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

- Annual Trust and directorate level action plans were developed and implemented in response to the NHS Service User Survey for community services. However, a key part of our approach to improvement was the implementation of the recommendations of the review of the Care Programme Approach outlined in the quality priorities for 2013/14 and 2014/15. A benefit expected from these priorities will be a reduction in staff time spent on administrative tasks and more face to face time to listen to, understand and gain the confidence of service users and carers.
- In addition to the feedback from the national survey, the Trust's local surveys include the questions similar to those used nationally. In 2013/14, **6,051** *(at Feb '14 – to update in May)* service users were surveyed locally on these questions. It is the act of continuously surveying the experience of service users and responding to the feedback which ensures that the Trust continuously improves on this metric.

Patient safety incidents including incidents resulting in severe harm or death

The data made available by the Health and Social Care Information Centre (NHSIC) 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 Quarters 3&4 2013/14	***TEWV Actual Quarters 1&2 2013/14***	***TEWV Actual Quarters 3&4 2012/13***	**** National Benchmarks in Quarters 3&4 2012/13***
Trust Reported to NRLS: **2,841** incidents reported of which **19** (**0.67%**) resulted in severe harm or death *(at Feb 2014 – to update at end May)* NB: NRLS reported figure not available until 2014/15	Trust Reported to NRLS: **3,285** incidents reported of which **36** (**1.10%**) resulted in severe harm or death NRLS Reported: **?** incidents reported of which **?** (**?%**) resulted in severe harm or death *(NRLS data not yet available)*	Trust Reported to NRLS: **3,027** incidents reported of which **41** (**1.4%**) resulted in severe harm or death NRLS Reported: **3,048** incidents reported of which **41** (**1.4%**) resulted in severe harm or death	NRLS Reported: National Average MH Trusts: **2,041** incidents reported of which **27** (**1.3%**) resulted in severe harm or death Lowest MH Trust: **3** incidents reported of which **1** resulted in severe harm or death Highest MH Trusts: **6,737** incidents reported of which **170** (**2.5%**) resulted in severe harm or death

* latest benchmark data available on NRLS

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

- The Trust reported and National Reporting & Learning System (NRLS) reported data for 2013/14 differ because the Trust's definition of a patient safety incident is wider than that of the NRLS.

- There is currently no nationally agreed or regulated approach to reporting, categorising and validating patient safety incidents. Different Trusts may choose to apply different approaches. For example, the approach taken to determine a classification such as those 'resulting in severe harm' will often rely on clinical judgement which may, acceptably, differ between professionals. The classification of an incident may also be subject to a potentially lengthy investigation which may result in the classification being changed. The change may not be reported externally and the data held by a Trust may not be the same as that held by the NRLS.
- The number of incidents reported by TEWV to the NRLS for quarters 3 and 4 2012/13 is above the national average. The percentage resulting in severe harm or death is similar to the national average. However, it is not possible to use this data to comment of the 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 Trusts and the complexity of their case-mix. Similarly, the percentage of incidents reported as severe harm or death is a factor of the different methodologies used by Trusts to identify incidents and categorise their severity and therefore comparisons between Trusts are inconclusive. We can say, however:

    - The reporting of patient safety incidents in the Trust is increasing year on year.
    - Amongst the most common themes are disruptive / aggressive behaviour, accidents (including falls) and self harming behaviours which account for three-quarters of all incidents leading to harm.

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

- Analysing all patient safety incidents. These are reported and reviewed by the Trust's Quality and Assurance Committee via the quarterly Patient Safety Report and the six-monthly review of services, and with commissioners via the Clinical Quality Review Process.
- Introducing a web-based reporting system that enables timely and service-specific analysis and a transparent corporate overview.
- Analysing areas of low reporting and trends in high risk incident categories. These are reviewed monthly by the responsible service with action plans developed and monitored as appropriate to address warning signs.
- Subjecting all serious untoward incidents (i.e. those resulting in sever harm or death) to a 'root cause analysis'. This is a robust and rigorous approach to understanding how and why each incident has happened, to identify any causal factors and to implement any lessons for the future.
- Raising awareness of staff, through clinical team leads, of the importance and value of reporting and reviewing 'near misses'.

2014/15 Priorities for Improvement

The Trust's Quality and Assurance Committee is responsible, on behalf of the Board of Directors, for ensuring that appropriate structures, systems and processes are in place to deliver safe, high quality effective care, which is continuously improving. In doing so it also takes responsibility for recommending to the Board the key quality priorities for any given year to ensure that we continue to improve the quality of services we deliver.

The process of identifying the key priorities for 2014/15 involved a number of our stakeholders. The process was as follows:

- An internal review was undertaken on the findings of serious untoward incidents, other incidents / 'near misses', complaints, patient advice and liaison service contacts and audit findings to identify common themes for improving quality.
- These were discussed with the Trust's Quality and Assurance Committee, and together with the views of the other locality and specialty-specific quality groups across the Trust, a set of key themes for improving quality were developed.
- An event was held in July 2013 where these findings and key themes were shared with our stakeholders to get feedback on where they think the quality of our services needs to be improved.
- Representatives from the following stakeholders agencies were invited to attend:

    - Clinical Commissioning Groups (x9)
    - Local Authority Overview & Scrutiny Committees and Directors of Social Services (x7)
    - Healthwatch (x7)
    - Trust Governors – Public (x33)
    - Trust Governors – Elected (x14)

- From this workshop **13** key quality themes were selected and these were presented to the Board of Directors in October 2013.
- At its formal meeting in November, the Board of Directors agreed the **four** quality priorities for 2014/15 from the **13** key quality themes identified by our stakeholders. The remaining themes identified by the stakeholders were fed into the business planning process and are included within the Trust's Business Plan for 2014/17.
- For each quality priority a lead Director was identified who developed the key actions that would be taken to address the priority in 2014/15.
- A second stakeholder workshop, with the same invitees as shown above, was held in February 2014 where our four quality priorities and proposed plans to deliver these were shared.
- The stakeholders gave comments on our plans and were asked to consider what benefits / outcomes they would expect for our service users and carers from these priorities. Their ideas were captured and taken into account in our final action plans for each priority as described below.

Our four priorities for 2014/15 are:

Priority 1: To have more staff trained in specialist suicide prevention and intervention.
Priority 2: Implement recommendations of Care Programme Approach (CPA) review, including,
- Improving communication between staff, patients and other professionals.
- Treating people as individuals.

Priority 3: Embed the recovery approach (in conjunction with CPA).
Priority 4: Managing pressure on acute inpatient beds.

Priority 1: To have more staff trained in specialist suicide prevention and intervention

Why this is important:

From 1981 to 2007, age-standardised suicide rates in the North East of England reduced year on year to a low in 2007 of 10.5 per 100,000 of the population. This was significantly higher than the rate for England in 2007 of 9.5. Since 2007 the rate in the North East of England has increased and was 12.0 per 100,000 of the population in 2012 and similar to levels seen in the first few years of the decade. Again the rate in the North East of England in 2012 remained significantly higher than the rate for England of 10.4. It is therefore a priority that the recent upward trend is reversed and the gap between the North East of England and the rest of England is reduced. However, it is recognised that the suicide rate is influenced by many social and economic factors which are beyond the control of the Trust. The Trust, therefore, aims to play its part by improving how staff recognise the warning signs and intervene early to prevent avoidable suicides.

What benefits / outcomes our service users and carers should expect:

- The number of staff trained in specialist suicide prevention and intervention will have increased.
- Staff who have received specialist training will be confident in suicide prevention and intervention.
- Care will be provided in a way that manages risk whilst promoting recovery and keeping our service users safe.

What we will do in 2014/15:

We will:
• Approve the project scope by quarter 1 2014/15.
• Recruit the project team and establish the project group to take this forward by quarter 1 2014/15.
• Review current practice within the Trust by quarter 1 2014/15.

We will:

- Develop a suicide prevention framework and training and implementation plan that describes what training is required, who will provide it and what other support is necessary for staff to provide effective suicide prevention and intervention by quarter 2 2014/15.
- Develop a training needs assessment and training plan which will describe who will receive training and how this will be rolled out across the Trust by quarter 3 2014/15.
- Commence training for priority staff (e.g. crisis teams) by Q4 2014/15 (to be completed for all relevant staff in 2015/16)

Priority 2: Implement recommendations of the Care Programme Approach (CPA), including:

- **Improving communication between staff, patients and other professionals**
- **Treating people as individuals**

Why this is important:

The Care Programme Approach (CPA) and care planning is critical to the quality of care our service users receive. The full involvement and participation of service users and carers within care planning is associated with improved outcomes and the experience of care. Addressing these issues for service users, carers, staff and all agencies with whom we work with is a clear priority for improving quality within the Trust.

What benefits / outcomes our service users and carers should expect:

- Improved service user experience, choice and involvement in their personal recovery.
- Services that are personal and meaningful to service users.
- Carers will feel recognised, valued and supported.

What we will do in 2014/15:

We will:

- Implement actions relating to CPA from model lines pilot team by quarter 2 2014/15.
- By quarter 4 2014/15, redesign CPA processes and documentation to ensure they fulfil the following:
  - meeting mandatory requirements whilst reducing unnecessary burden on staff.
  - ensuring the requirements of the Mental Health Act are met whilst reducing unnecessary burden on staff.
  - development of standard work regarding section 117 of the Mental Health Act – the statutory duty to provide health and social care to some service users following discharge from in-patient care.
- Implement regular audit and case management / supervision systems to include monitoring of transfer processes within PARIS (the electronic patient record) by quarter 4 2014/15.

It is anticipated that further work to fully implement the recommendation of the CPA review will continue into 2015/16. In 2015/16 the following actions will be delivered:

- Implement core competency frameworks to identify the competencies needed by staff to implement the revised CPA processes and documentation.
- Implement a work based competency tool to assess competency and appraises' / supervisors' performance of assessment and care planning skills.
- Implement systems and standards for training, supervision and case management of care co-ordinators and lead professionals.
- Start the development of a revised Trust / multi-agency CPA policy.

Priority 3: Embed the recovery approach (in conjunction with CPA).

Why this is important:

Many people who have experienced mental health related problems have shown us that it is possible to maintain or re-establish their wellbeing, meaning, value and purpose in life. But, despite advances in mental health care, too often people are still left feeling disconnected from themselves, from friends and family, from the communities in which they live, and from meaning and purpose in life. Clearly this can have a devastating and long-term life changing effect. It is, therefore, important that the services we provide do not just focus on alleviating the symptoms of mental ill-health, but also are provided within a culture that in every way promotes recovery where recovery is defined as:

'A deeply personal, unique process of changing one's attitudes, values, feelings and goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life within the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness. Recovery from mental illness involves much more than recovery from the illness itself'.

Recovery from mental illness: the guiding vision of the mental health system in the 1990s (Anthony), Psychosocial Rehabilitation Journal, 16(4), April 1993, 11-23.

What benefits / outcomes our service users and carers should expect:

- Recovery focussed practice across all Trust services.
- Increased opportunities for people with 'lived experience' of mental illness to co-produce services across the Trust.
- The Trust promoting a culture of harm minimisation, actively working to help service users develop resilience, control, choice, hope and empowerment.

What we will do in 2013/14:

We will:

- Develop a programme of work to ensure the principles of recovery are embedded within all key programmes e.g. CPA, model lines, risk assessment & management (ongoing).
- Establish the current position on recovery action planning and devise an implementation plan by quarter 2 2014/15.
- Increase the opportunities for volunteering by quarter 4 2014/15.
- Establish a cohort of service user / carer trainers to co-design and co-deliver recovery training by quarter 4 2014/15.
- Investigate the role of peer support workers (staff with 'lived experience' providing care and support) by quarter 4 2014/15.
- Establish recovery leads in all localities, specialities and pilot teams by quarter 4 2014/15.
- Establish a recovery college and courses by quarter 2 2014/15.

Priority 4: Managing pressure on acute inpatient beds

Why this is important:

Wherever possible we try to help people to receive care close to home so they do not need to be admitted into a hospital bed. However, sometimes, people do need to spend time in hospital. When this is necessary it is important that they are admitted to the ward that has been identified as serving that community, unless they choose to go to a different unit, or there are clinical reasons to support this. This is important as it means that service users receive their inpatient care close to home and their families and carers and also it helps ensure better engagement from the community team that will support them when they leave the ward. Currently 22% of patients do not receive care at their 'local' inpatient unit.

What benefits / outcomes our service users and carers should expect:

- In 2014/15 we are aiming for 85% of patients being treated close to home increasing to 90% in 2015/16 and beyond.

What we will do in 2013/14:

We will:

- Reduce the percentage of people on community team caseloads that are admitted to inpatient care by quarter 4 2014/15.
- Reduce the readmission rates to inpatient care following discharge by quarter 4 2014/15.
- Continue to improve the skills and effectiveness of the crisis teams as gatekeepers to inpatient care by quarter 4 2014/15.

In addition to these key actions, there are a number of other projects aimed at improving services that will impact indirectly on the Trust's ability to manage pressure of beds. For example:

- Work with community mental health teams to improve the quality of home treatment, crisis and care planning.
- Building on the work of rapid process improvement workshops in 2013/14 to improve the quality and efficiency of discharge planning.
- Evaluating the opportunity for using rehabilitation as a step-up facility from home treatment as well as a step-down facility from acute inpatient care.
- Working with commissioners to develop new services that prevent admissions and shorten lengths of stay when inpatient care is necessary e.g. street triage, crisis beds, GP liaison services.

Monitoring Progress

We will monitor formally our progress against all of the above priorities on a quarterly basis. A quarterly Quality Account / Report Performance Report, outlining performance against the overall aims, progress with the delivery of our planned actions and any corrective action required, will be shared with the Trust's Quality and Assurance Committee and Council of Governors.

In November 2014, we will also share the quarter 2 2014/15 update report with all our stakeholders as a mid-year report to facilitate our stakeholder's review of our Quality Account / Report at year end.

A key way for delivering the priorities for 2014/15 will be the use of the various tools within the Trust's Quality Improvement System. As outlined earlier, the Trust's Quality Improvement System is the Trust's framework and approach to continuous quality improvement and has within it standardised processes for monitoring progress and improvement.

PART 3: OTHER INFORMATION ON QUALITY PERFORMANCE 2013/14

Our performance against our quality metrics

The following table provides details of our performance against our set of agreed quality metrics for 2013/14.

These metrics are the same as those we reported against in our Quality Account / Report, 2012/13 which allow us to monitor progress. However, in some cases, the exact definitions in 2012/13 and 2013/14 have changed from 2009/10 and 2010/11 as we have learned lessons on what is more meaningful to quality. These are:

- The 'number of unexpected deaths' reported in 2009/11 (metric 1) was changed in 2012/13 to the 'number of unexpected deaths classed as a serious incident per 10,000 open cases'. This is because using a rate is a valid approach for making comparisons across the years even if activity within the Trust increases.
- The 'number of patient falls per 100,000 occupied bed days' reported in 2009/11 (metric 3) has been changed to the 'number of patient falls per 1,000 admissions' as experience has shown this indicator is more closely linked to new admissions rather than occupied bed days.
- The 'number of complaints per 100,000 patients' reported in 2009/11 (metric 8) has been changed to the 'percentage of complaints satisfactorily resolved' as experience has shown that it is more important to measure the satisfaction of our response to complaints as opposed to the absolute number of complaints. The latter we encourage as important feedback to the Trust on the quality of our services.

Table 2: Quality Metrics

	Quality Metrics	2013/14 Target	2013/14 Actual *(at Feb '13)*	2012/13 Actual	2011/12 Actual	2010/11 Actual	2009/10 Actual
Patient Safety Measures							
1	Number of unexpected deaths classed as a serious incident per 10,000 open cases	< 12.00*	**11.88**	15.91	12.00		
2	Number of outbreaks of Healthcare Associated Infections	0	**0**	0	0	0	0
3	Patient Falls per 1,000 admissions	< 31.04	**36.46**	34.09	37.44		
Clinical Effectiveness Measures							
4	Percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care (validated)	> 95.00%	**97.86%**	97.14%	98.08%	98.50%	97.50%
5	Percentage of clinical audits of NICE Guidance completed	100%	**97%**	89.47%	95.20%	66.70%	75.00%
6	Average length of stay for patients in Adult Mental Health and Mental Health Services for Older People Assessment & Treatment Wards	AMH <33 MHSOP <52	**AMH: 31.72** **MHSOP: 54.08**	35	37	39	47
Patient Experience Measures							
7	Delayed Transfers of Care	< 7.50%	**1.89%**	2.07%	1.60%	1.60%	2.90%
8	Percentage of complaints satisfactorily resolved	> 90.00%	**83.33%**	76.36%			
National Patient Survey							
9	Number of questions where our score was within 5% of the highest scored Mental Health Trusts	Improvement on 2012/3 survey	**12 (32%)**	11 (29%)	12 (32%)	18 (47%)	16 (42%)
	Number of questions where our score was within the middle 90% of scored Mental Health Trusts		**26 (68%)**	27 (71%)	23 (61%)	14 (37%)	22 (58%)
	Number of questions where our score was within 5% of the lowest scored Mental Health Trusts		**0 (0%)**	0 (0%)	3 (8%)	6 (16%)	0 (0%)

* The number shown here is the maximum level of unexpected deaths that we would expect to see rather than a target number we are trying to achieve

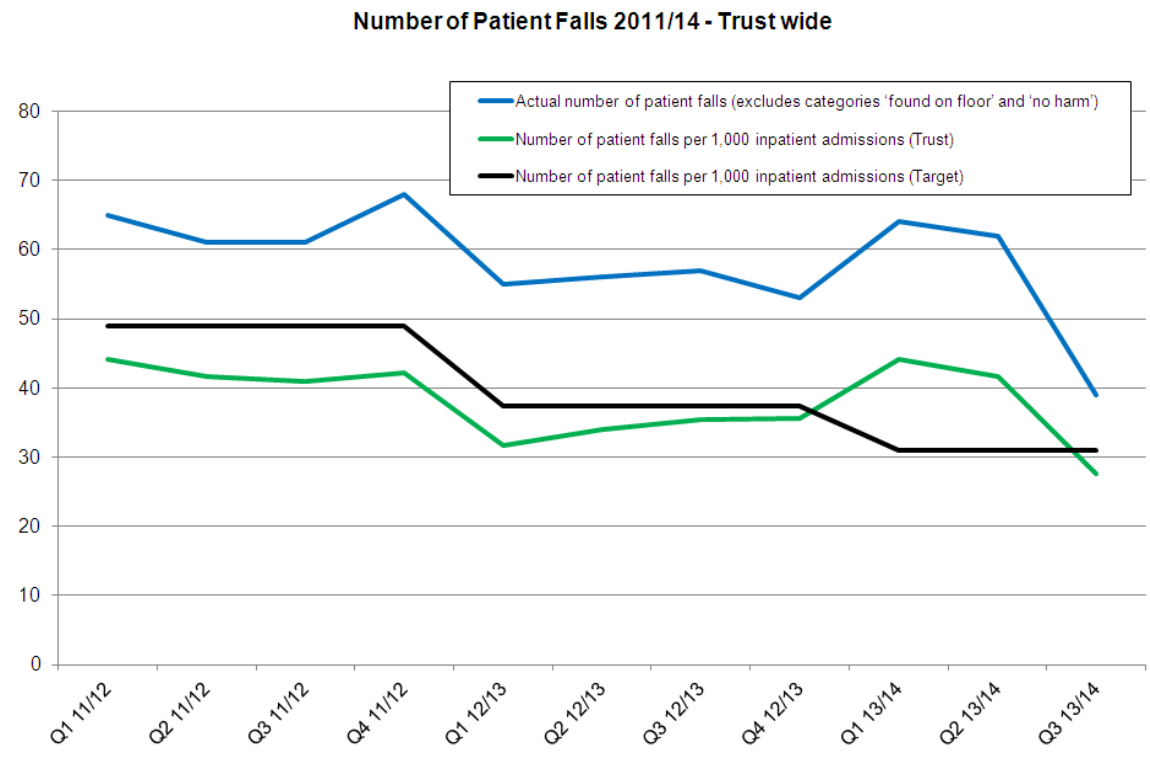
Notes on selected metrics

1. Data for this metric is taken from Incident Reports which are then reported via the National Strategic Executive Information System (STEIS).
2. Outbreaks of healthcare associated infections relates to those of MRSA bacteraemia and C Difficile. The Infection Prevention and Control Team would be notified of any outbreaks direct by the ward and that would then be recorded on an 'outbreak' form before being reported externally.
3. Patient falls excludes the categories 'found on floor' and 'no harm'. Data for this metric is taken from Incident Reports which are then reported via the Trust's Risk Management System, DATIX.
4. Data for CPA 7 day follow up is taken from the Trust's patient systems and is aligned to the national definition.
5. The percentage of clinical audits of NICE Guidance completed is based on the number of audits of NICE guidelines completed against the number of audits of NICE guidelines planned. Data for this metric is taken from audits undertaken by the Clinical Directorates supported by the Clinical Audit Team.
6. Data for average length of stay is taken from the Trust's patient systems.
7. Delayed transfers of care are based on Monitor's definition and therefore exclude children and adolescent mental health services. Data for this metric is taken from the Trust's patient systems.
8. The percentage of complaints satisfactorily resolved is based on the number of complaints where the complainant did not report dissatisfaction with the Trust's response expressed as a percentage of the total number of resolution letters sent out. Please note, if the complainant did not respond to the resolution letter it was assumed that the complainant was satisfied with the Trust's response.
9. The National Patient Survey for 2012/13 is not directly comparable to previous Community Surveys. Also the National Patient Survey for 2009/10 is an inpatient survey which is not directly comparable to the community surveys. The metrics previously reported previously were categorised as follows:
    a. Number of questions where our score was within the top 20% of Mental Health Trusts
    b. Number of questions where our score was within the middle 60% of Mental Health Trusts
    c. Number of questions where our score was within the lowest 20% of Mental Health Trusts

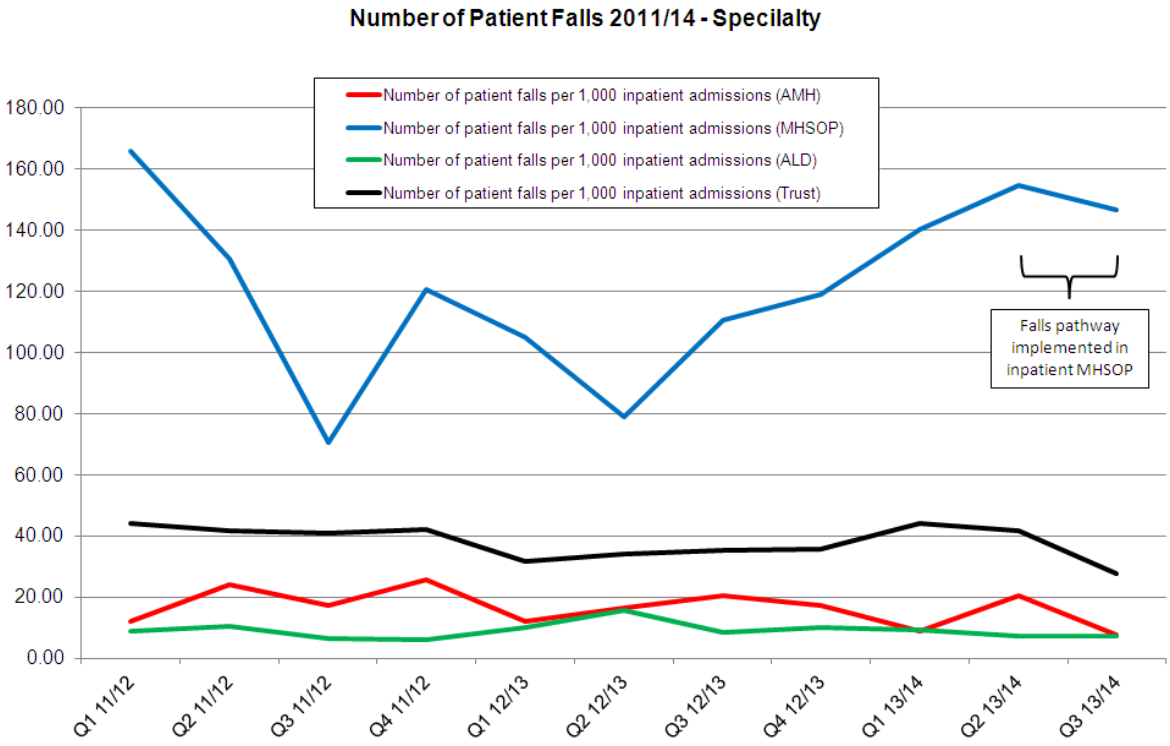
Comments on Areas of Under-Performance

Metric 3: Patient falls per 1,000 admissions

The number of falls reduced significantly in quarter 3 2013/14. The rate was **27.6** per 1,000 admissions against a target of **< 31.04** and was the lowest quarterly rate in two years. However, overall for 2013/14 the rate was **36.46** and above target due to higher falls rates in quarters 1 and 2 2013/14. The following graph shows the rate by quarter over the last two years:



Further analysis shows that the increase in 2013/14 was influenced mostly by an increase in falls in mental health services for older people services. The reduction in quarter 3 2013/14 reflects the implementation of the revised falls pathway in older people's inpatient services. It is expected, therefore, the rate will continue to fall in 2014/15 as the falls pathway is further implemented within older people's community services.



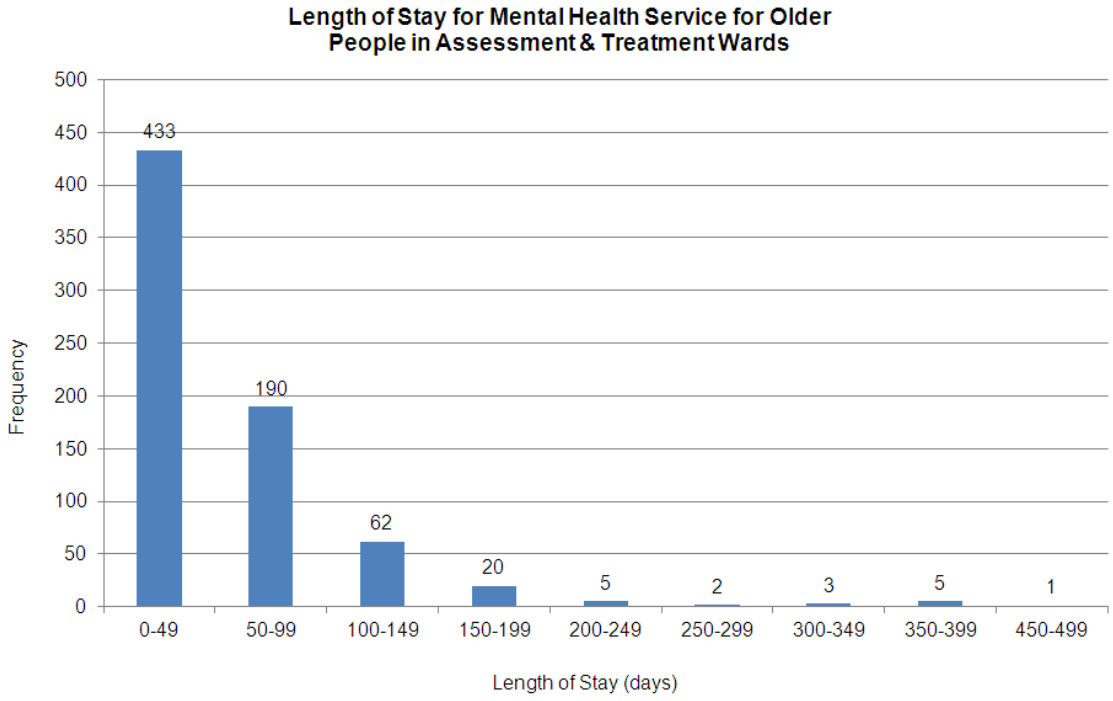
Metric 5: Percentage of clinical audits of NICE Guidance completed

In 2013/14, **97%** (35 out of 36) of NICE clinical audits planned for completion in 2013/14 were completed. The remaining one NICE clinical audit that was planned for completion but not completed in 2013/14 was undertaken and the action plan is awaiting final sign-off in quarter 1 2014/15.

Metric 6: Average length of stay for patients in adult mental health and mental health services for older people assessment & treatment wards

The average length of stay for adults has remained steady and below the target for 2013/14 and is, therefore GREEN. The average length of stay for older people was within target for quarters 1 and 2 but increased from 50/51 days to **56** days in quarter 3 2013/14 which is above the target of < 52 days, and therefore RED.

The following table shows the actual lengths of stay for **722** older people discharged in 2013/14. Whilst the average length of stay for patients on mental health services for older people assessment and treatment wards was **54** days, the average was skewed by a few long stay patients. In fact **16** patients in 2013/14 had stays over 200 days. If the stays of these **16** patients were capped at 200 days, the average length of stay would be **51.9** days and within the target of < 52 days.



Metric 8: Percentage of complaints satisfactorily resolved

Complaints are monitored by the Quality Assurance Committee and are thoroughly investigated. Both the Patient Experience Department and Patient Advice and Liaison Services (PALS) strive to resolve as many concerns/complaints as possible informally.

Table 3 below shows the resolution rate of complaints by service. This indicates that those 10 complaints not satisfactorily resolved were all in adult mental health.

Table 3: Complaints Resolution

Service	Locality	Total number of complaints resolution letters sent	Percentage (numbers) satisfactorily resolved*
Adult Mental Health	Durham & Darlington	21	76% (16)
	Tees	13	77% (10)
	North Yorkshire	3	33% (1)
Mental Health Services for Older People	Durham & Darlington	3	100% (3)
	Tees	4	100% (4)
	North Yorkshire	1	100% (1)
Children's & Young Peoples Services Mental Health & Learning Disabilities	Durham & Darlington	1	100% (1)
	Tees	3	100% (3)
	North Yorkshire	0	n/a
Adult Learning Disabilities	Durham & Darlington	1	100% (1)
	Tees	1	100% (1)
	North Yorkshire	1	100% (1)
Forensic Services	Trust-wide	7	100% (7)
Other	Trust-wide	1	100% (1)
Total		**60**	**83.33% (50)**

* The percentage of complaints satisfactorily resolved is based on the number of complaints where the complainant did not report dissatisfaction with the Trust's response expressed as a percentage of the total number of resolution letters sent out. Please note, if the complainant did not respond to the resolution letter it was assumed that the complainant was satisfied with the Trust's response.

Our performance against national targets and regulatory requirements

The following table demonstrates how we have performed against a wide range of targets set for us by the Department of Health, our regulator Monitor and our commissioners.

Table 4: National Targets & Regulatory Requirements

Indicators		2013/14		2012/13	2011/12	2010/11	2009/10
		Target	Actual (at Feb '13)	Actual	Actual	Actual	Actual
a	The Trust has registered with CQC with no conditions	Fully met	**Fully met**	Fully met	Fully met	Fully met	Fully met
b	Number of occupied bed days of under 18s admitted to adult wards	0	**48**	64	83	70	173
c	Retention rate substance misuse (rolling 12 months and reported 3 months behind)	=/> 92.90%	**92.45%**	89.91%	89.90%	84.40%	89.70%
d	Number of early intervention in psychosis new cases (cumulative position)	> 259	**619**	599	479	455	407
e	Number of crisis resolution home treatment episodes (cumulative position)	> 3,338	**3,725**	6,152	5,965	5,751	5,191
f	Percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper (validated)	> 95.00%	**97.52%**	97.35%	96.00%	97.00%	97.20%
g	Percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care (validated)	> 95.00%	**97.86%**	97.14%	98.08%	98.50%	97.50%
h	Maintain level of crisis resolution teams set out in 2003/06 planning round	Maintain	**Maintained**	Maintained	Maintained	Maintained	Maintained

Notes on national targets and regulatory requirements

b) Retention rate is the percentage of people who misuse substances who stay within treatment for the duration of the course of treatment. The information is subject to a 3-month delay in reporting, therefore, the figure shown is the position reported in the January 2013 report which covers November 2012 to October 2013.

e) The number of crisis home treatment episodes in 2013/14 is significantly less than previous years. This is due to a change in the definition of the indicator where multiple linked contacts are now counted as a single episode rather than individual episodes.

Comments on Areas of Under-Performance

Indicator b: Number of occupied bed days of under 18s admitted to adult wards

There were **48** occupied bed days for the 'under 18s admitted to adult wards' in 2012/13. This relates to **10** patients.

It is important to note that all of these admissions were clinically appropriate. For example, an admission of an adolescent aged 17 years and 10 months for an episode that is likely to last more than two months avoids an unnecessary transition to adult mental health later. Or, where the clinical need of the service user would be best met on an adult ward.

Indicator c: Retention rate substance misuse (rolling 12 months and reported 3 months behind)

The percentage of people who misuse substances and stay within treatment for the duration of the course of treatment is **92.49%** at Oct 2013 and below the target of **92.90%.** *To update at in May*.

External Audit

For 2013/14, our external auditors have to provide a limited assurance report on whether two mandated indicators included in the Quality Account / Report have been reasonably stated in all material respects. In addition the Council of Governors have the option to choose one further local indicator for external assurance. The three indicators which have been included in the external assurance of the Quality Account / Report 2013/14 are:

- The percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care.
- The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper.
- Percentage of complaints satisfactorily resolved.

The full definitions for these indicators are contained in **appendix 5.**

Our stakeholders' views

The Trust recognises the importance of the views of our stakeholders as part of our assessment of the quality of the services we provide and to help us drive change and improvement. How we involve and listen to what our stakeholders say about us is critical to this process. In producing the Quality Account / Report 2013/14, we have tried to improve how we involved our stakeholders in assessing our quality in 2013/14.

The following are some positive comments we received from our stakeholders following the two events we held in July 2013 and February 2014:

- *Honest and open with data presented – as always.*
- *Good to have an opportunity to discuss the issues.*
- *Group work was useful and wide ranging.*
- *No facilitation and leading on issues – good listening.*
- *Good quality discussion.*
- *Very positive attitude to create progress.*
- *Good pre-event reading / informative material (i.e. Information Pack).*
- *Mix of ideas and participants.*
- *Good to be part of the development of the Quality Account / Report and see where our work fits in.*

The following are the comments from our stakeholders on things we could do better in our Quality Account / Report:

- *Try to increase attendance and encourage wider participation e.g. GPs, people with direct patient contact.*
- *Try running two events to avoid peak holiday time.*
- *No chance to network as work groups stayed the same.*
- *A long afternoon – could have been done in less time if presentations shorter.*
- *Get views from people not in the room – websites, twitter, facebook.*

In response the Trust will continue to make the production of the Quality Account / Report an open and transparent process and encourage participation through its stakeholder events and systems for reporting quality and assurance to its stakeholders.

In line with national guidance, we have circulated our draft Quality Account / Report for 2013/14 to the following stakeholders:

- NHS England – Area Teams (x2)
- Clinical Commissioning Groups (x9)
- Health & Wellbeing Boards (x7)
- Local Authority Overview & Scrutiny Committees (x7)
- Local HealthWatch (x7)

All the comments we have received from our stakeholders are included verbatim in **Appendix 3**.

The following are the general themes received from stakeholders in reviewing our Quality Account / Report for 2013/14:

- *To add end May.*

Our stakeholders did raise a number of points of clarity and, where possible, these have been addressed in the document before publication. However, the Trust will write to each stakeholder addressing each comment made following publication of the Quality Account / Report 2013/14 and as part of an annual lessons learnt exercise in preparation for the Quality Account / Report 2014/15.

In response to many stakeholders' requests, the Trust has agreed to continue providing all stakeholders with a half-year update in November 2014 on the Trust's progress with delivering its quality priorities and metrics for 2014/15.

Appendix 1

2013/14 STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE QUALITY ACCOUNT / REPORT

The Directors are required under the Health Act 2009 and the National Health Service (Quality Account) Regulations 2010 to prepare Quality Accounts / Report for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Account / Report (which incorporate the above legal requirements) and on the arrangements that 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 2013/14;

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

    - Board minutes and papers for the period April 2013 to June 2014;
    - Papers relating to Quality reported to the Board over the period April 2013 to June 2014;
    - Feedback from the commissioners dated May 2014;
    - Feedback from Governors dated 19th March & 7th April 2014;
    - Feedback from Local Healthwatch organisations dated May 2014;
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated ?nd May 2014
    - The latest national patient survey published on 17th September 2013;
    - The latest national staff survey published on 25th February 2014;
    - The Head of Internal Audit's annual opinion over the Trust's control environment received by the Audit Committee on ?th May 2014;
    - Care Quality Commission quality and risk profiles dated 8th April 2014.

- 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 / Report is robust and reliable, conforms to specified data quality

standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Account / Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Account / Report regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Account / Report (available at: www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275)

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

Date: Chairman

Date: Chief Executive

Appendix 2

2013/14 LIMITED ASSURANCE REPORT ON THE CONTENT OF THE QUALITY ACCOUNTS / REPORT AND MANDATED PERFORMANCE INDICATORS

To add end May

Appendix 3

FEEDBACK FROM OUR STAKEHOLDERS

The following responses to our stakeholders were received from our stakeholders (in alphabetical order):

To add end May

The following stakeholders were given the opportunity to comment on our draft Quality Account / Report for 2013/14 and made a short comment by email:

- *To add end May*

The following stakeholders were given the opportunity to comment on our draft Quality Account / Report for 2013/14 but chose to offer no comments:

- *To add end May*

Appendix 4

KEY THEMES FROM 81 LOCAL CLINICAL AUDITS (186 INDIVIDUAL AUDITS) REVIEWED IN 2013/14

Audit Theme	Summary of Actions
Infection Prevention and Control (IPC) audits (77 individual audits of ward / team areas)	• All infection prevention and control audits are continuously monitored by the IPC team and required actions are rectified collaboratively with the IPC team and ward staff.
Clinical audit of NICE guidance on autism (2 local clinical audits)	• The findings of the audit are to be used to inform an adult autism rapid process improvement workshop (RPIW) and rapid pathway development workshop (RPDW) scheduled in 2014/15. • The audit results are to be cascaded across adult mental health services to encourage participation in autism training in 2014/15.

Clinical audit of NICE guidance on bipolar disorder (2 local clinical audits)	• The findings will be highlighted in the audit bulletin to improve awareness of the specific requirements to:
	  ◦ Consider alternative options if there has been no response to a combination of preventative medications.
	  ◦ Further encourage patient involvement in relapse prevention and self help support groups.
	  ◦ Further encourage family/carer involvement in support groups.
	• The results to be discussed in all consultant groups, specifically to:
	  ◦ Increase awareness to ensure physical health checks are completed fully, routinely and recorded on PARIS (the electronic patient record).
	  ◦ Further ensure that when medication is changed, a clear statement should be entered on PARIS of the factors considered including psychiatric factors, physical health and patient preference.
	  ◦ Further ensure that a statement is entered on PARIS (at least annually) about the patient's views of their treatment.
	  ◦ Further ensure the most appropriate referral route for obtaining a second opinion for people with treatment resistant bipolar disorder.
	  ◦ Further ensure that the risk of suicide/self harm is documented regularly (at least at each review for stable low risk patients).
	• To be re-audited with new audit tool in 2014/15.

Audit Theme	Summary of Actions

Clinical audits of supervision (local clinical audits across 4 service areas)	• Team / ward managers / clinical leads to ensure a high standard of supervision in line with the Trust's supervision policy, including:
	  ◦ All staff to have identified their own clinical supervisor within one month of start date or change of supervisor
	  ◦ A copy of all clinical supervision contracts to be retained in staff personal files
	  ◦ Increasing the number of staff encouraged to participate in a minimum of eight one- hour clinical supervision sessions and four one-hour managerial supervision sessions per year
	  ◦ Ensuring supervision logs are kept up-to-date.
	  ◦ Ensuring supervision to address work pressures e.g. sickness absence, stress management, caseload management
	  ◦ Where appropriate establish monthly peer group supervision sessions.

Clinical risk assessment and management audits (local clinical audits across 7 service areas)	• Audit results to be disseminated to teams and individuals highlighting key themes where further improvement can be made. • A key facts bulletin to be developed and published to all staff to encourage further improvement on risk assessment and management. • Feedback sessions to be held with the Team managers for the individual cases where data was not recorded sufficiently. • Refresher training to be provided to staff on specific areas including: the responsibilities of the 'lead professional' role; the use of SAMURAI risk assessment tool; recording risk assessments on PARIS; ensuring risk assessment information is linked to the care plan. • A re-audit of cases highlighted as not meeting the standard to be performed following refresher training. • Deputy medical directors to have discussion with clinical directors regarding sign off of risk assessments by consultants. • Ensure that risk assessment and management is routinely discussed as part of clinical supervision.

Clinical audit of safer lithium monitoring audits (3 local clinical audits)	• Audit results to be shared with the safe medication practice group and fed back to prescribers in teams.
	• Key areas for further improvement to highlight:
	  ◦ Ensuring lead professionals / care co-ordinators continue to document efforts made for monitoring and record outcome of discussion with patient on PARIS.
	  ◦ Ensuring prescribers continue to discuss monitoring with patient, and if patient is not aware of this then letter to GP should reflect this.
	  ◦ Ensure all patients are given/offered a lithium alert card and this is documented on PARIS.
	  ◦ Ensuring staff continue to document PARIS what monitoring has been done / offered.
	• To explore possibility of reviewing lithium visual display boards to include key headings (e.g. BMI etc).

Audit Theme	Summary of Actions
Suicide prevention audits (3 local clinical audits across 5 service areas)	• Individual inpatient ward and community team action plans were produced at the time of auditing. Action plans will be monitored via the appropriate locality governance routes. • The findings from the audit shall be used as evidence within the quality priority for 2014/15: to have more staff trained in specialist suicide prevention and intervention *(see page 47 & 48).*

Transfers of care audits (local clinical audits across 5 service areas)	• The audit report will be shared with the relevant service governance groups and with care pathway work streams to build findings into standard operating procedures.
	• The audit report to be discussed with the Trust's CPA project lead to further embed standards of best practice into care coordination practice.
	• Key areas for services to further improve transfers include:
	  ◦ Ensuring the staff record a narrative on forensic history including stating where no forensic history exists.
	  ◦ Further ensuring that staff review care plans within one month of discharge and provide patients/carers with a written copy of their care plan.
	  ◦ Ensuring that for patients who have transferred from mental health inpatients services, the receiving care coordinator documents the outcome of the 7 day follow-up, including FACE risk assessment.
	• Ward and team managers will randomly spot check at least two discharges per month and report findings to the relevant service governance groups.

Safeguarding children audits (3 local clinical audits)	• Audit lead to produce lessons learned briefing for all the safeguarding team and link professionals which includes a summary of the audit and identified areas for improvement. • Link professionals and safeguarding team to use the lessons learned bulletin to further support the training provided to staff with a focus on the improvement areas identified. • The senior nurse to remind safeguarding children supervisors of the importance of ensuring records identify the date and findings of when the child was last seen and, if appropriate, spoken to. • Clear explanations of consent for child protection, child in need and common assessment framework referrals to be included on Trust's webpage on safeguarding children and in safeguarding children training. • Perform a mapping exercise to look at who the current link professionals are, what areas they cover and where the gaps are. • Following identification of gaps, senior managers to be informed and asked to address this by identifying link professionals. • E-bulletin notice to inform staff of who their named nurse and doctor are for safeguarding children, and also the role of the safeguarding team and link professionals.

Appendix 5

QUALITY PERFORMANCE INDICATOR DEFINITIONS

Percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care

Data definition:

All patients discharged to their place of residence, care home, residential accommodation, or to non psychiatric care must be followed up within 7 days of discharge. All avenues need to be exploited to ensure patients are followed up within 7 days of discharge*. Where a patient has been discharged to prison, contact should be made via the prison in-reach team.

Exemptions:

- Patients who die within 7 days of discharge may be excluded.
- Where legal precedence has forced the removal of the patient from the country.
- Patients transferred to NHS psychiatric inpatient ward.
- CAMHS (children and adolescent mental health services) are not included.

The 7 day period should be measured in days not hours and should start on the day after discharge.

Accountability:

Achieving at least 95% rate of patients followed up after discharge each quarter.

* Follow up may be face-to-face or telephone contact, this excludes text or phone messages

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

Data definition:

Gate-keeping: in order to prevent hospital admission and give support to informal carers, crisis resolution home treatment teams are required to gate-keep all admission to psychiatric inpatient wards and facilitate early discharge of service users. An admission has been gate-kept by a crisis resolution team if they have assessed** the service user before admission and if the crisis resolution team was involved in the decision making-process, which resulted in an admission.

Total exemption from crisis resolution home treatment teams gate-keeping:

- Patients recalled on a Community Treatment Order.
- Patients transferred from another NHS hospital for psychiatric treatment.
- Internal transfers of service users between wards in the Trust for psychiatry treatment.
- Patients on leave under Section 17 of the Mental Health Act.

- Planned admission for psychiatric care from specialist units such as eating disorder unit.

Partial exemption:

Admissions from out of the Trust area where the patient was seen by the local crisis team (out of area) and only admitted to this trust because they had no available beds in the local areas. Crisis resolution home treatment teams should assure themselves that gate-keeping was carried out. This can be recorded as gate-kept by crisis resolution home treatment teams.

* This indicator applies to patients in the age bracket 16-65 years and only applies to CAMHS patients where they have been admitted to an adult ward.

** An assessment should be recorded if there is direct contact between a member of the team and the referred patient, irrespective of the setting, and an assessment made. The assessment should be face-to-face and only by telephone where face-to-face is not appropriate or possible

Percentage of complaints satisfactorily resolved

Numerator:

From the number of resolution letters sent during the month the number where there is no indication that the complainant indicates they are not happy with the response and wants further action following receipt of the resolution letter.

Denominator:

Number of resolution letters sent within the month.

Indicator format:

Standard percentage.

Appendix 6

GLOSSARY

Affective Disorders: are mental disorders reflected in disturbances of mood. They may be regarded as lying along the affective spectrum a grouping of related psychiatric and medical disorders which may accompany bipolar, unipolar, and schizoaffective disorders at statistically higher rates than would normally be expected.

Antipsychotic Medication: an antipsychotic (or neuroleptic) is a psychiatric medication primarily used to manage psychosis (including delusions, hallucinations, or disordered thought), particularly in schizophrenia and bipolar disorder, and is increasingly being used in the management of non-psychotic disorders.

Attention Deficit Hyperactivity Disorder (ADHD): one of the most common childhood disorders and can continue through adolescence and adulthood. Symptoms include difficulty staying focused and paying attention, difficulty controlling behavior, and hyperactivity (over-activity).

Autistic Spectrum Disorders: describes a range of conditions including autism, Asperger syndrome, pervasive developmental disorder not otherwise specified (PDD-NOS), childhood disintegrative disorder, and Rett syndrome, although usually only the first three conditions are considered part of the autism spectrum. These disorders are typically characterized by social deficits, communication difficulties, stereotyped or repetitive behaviors and interests, and in some cases, cognitive delays.

Bipolar disorder: is a mental illness typically classified as a mood disorder. It is characterized by episodes of an elevated or agitated mood known as mania, usually alternating with episodes of depression.

Body Mass Index (BMI): is a measure for human body shape based on an individual's mass and height

C Difficile: a species of bacteria of the genus Clostridium that causes severe diarrhea and other intestinal disease when competing bacteria in the gut flora have been wiped out by antibiotics.

Care Programme Approach (CPA): describes the approach used in specialist mental health care to assess, plan, review and co-ordinate the range of treatment care and support needs for people in contact with secondary mental health services who have complex characteristics. It is a called “an approach” rather than just a system because the way that these elements are carried out is as important as the actual tasks themselves. The approach is routinely audited.

Care Quality Commission (CQC): the independent regulator of health and social care in England who 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.

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 of the GP groups 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.

Clozapine: is an atypical antipsychotic medication used in the treatment of schizophrenia.

Commissioning for Quality and Innovation (CQUIN): is a payment framework such that a proportion of NHS providers' income is conditional on quality and innovation. Its aim is to support the vision set out in *High Quality Care for All* of an NHS where quality is the organising principle.

Council of Governors: the Council of Governors is made up of elected public and staff members, and also includes non elected members, such as the Prison Service, Voluntary Sector, Acute Trusts, Universities, Primary Care Trusts 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.

Divisions: services in TEWV are organised around six Divisions: Adult Metal Health Services, Substance Misuse Services, Mental Health Services for Older People, Adult Learning Disability Services, Children & Young Peoples Services, Forensic Services – see also Localities

FACE Risk Assessment: a portfolio of assessment tools designed for adult and older people's mental health settings. Risk is assessed using the FACE Risk Profile based on four factors: violence; self-harm / suicide; and self neglect / vulnerability.

Forensic Services: forensic 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 secure hospital from prison or court, where their needs can be assessed and treated. These services are intended to see that people with severe mental illness or learning disability who enter the criminal justice system get the care they need.

Health Care Associated Infections (HCAIs): treatment-resistant infection contracted as a consequence of being in contact with healthcare services, predominantly MRSA and c-difficile.

Healthwatch: local bodies made up of individuals and community groups, such as faith groups and residents' 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.

Hospital Episode Statistics (HES): is 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.

Information Governance Toolkit & Assessment Report: is 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.

Lithium: lithium carbonate is a medicine which is used in depression, mania, bipolar disorder, self-harming behaviour and treating aggressive behaviour.

Localities: services in TEWV are organised around three Localities (i.e. County Durham & Darlington, Tees, North Yorkshire) and one Directorate (i.e. Forensic Services) – see also Divisions.

Mental Capacity Act: is a framework to provide protection for people who cannot make decisions for themselves. It contains provision for assessing whether people have the mental capacity to make decisions, procedures for making decisions on behalf of people who lack mental capacity and safeguards. The underlying philosophy of the MCA is that any decision made, or action taken, on behalf of someone who lacks the capacity to make the decision or act for themselves must be made in their best interests.

Mental Health Research Network (MHRN): is part of and funded by the National Institute for Health Research and provides the NHS infrastructure to support commercial and non-commercial large scale research in mental health including clinical trials.

Monitor: the independent economic regulator for NHS Foundation Trusts.

MRSA: is a bacterium responsible for several difficult-to-treat infections in humans. MRSA is especially troublesome in hospitals, prisons and nursing homes, where patients with open wounds, invasive devices, and weakened immune systems are at greater risk of infection than the general public.

National Audit of Psychological Therapies (NAPT): funded by the Healthcare Quality Improvement Partnership (HQIP) and is an initiative of the College Centre for Quality Improvement (CCQI). Aims to promote access, appropriateness, acceptability and positive outcomes of treatment for those suffering from depression and anxiety.

National Confidential Inquiries (NCI) and National Clinical Audit: research projects funded largely by the National Patient Safety Agency (NPSA) that examine all incidents of, for example suicide and homicide by People with Mental Illness, with the aim is to improve mental health services and to help reduce the risk of these tragedies happening again in the future. Supported by a national programme of audit.

NHS Service User Survey: the annual survey of service users' experience of care and treatment received by NHS Trusts. In different years has focussed both on inpatient and community service users.

NHS Staff Survey: an annual survey of staffs' experience of working within NHS Trusts.

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 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 patients and the public.

National Reporting and Learning System (NRLS): an NHS led central database of information on patient safety incidents used to identify and tackle important patient safety issues at their root cause.

National Research Passport Scheme: a scheme to streamline procedures associated with issuing honorary research contracts or letters of access to researchers who have no contractual arrangements with NHS organisations who host research, and who carry out research in the NHS that affects patient care, or requires access to NHS facilities.

National Strategic Executive Information System (STEIS): a new Department of Health system for collecting weekly management information from the NHS.

Near Misses: an event or circumstance that could have resulted in unnecessary damage, loss or harm such as physical or mental injury to a patient, staff, visitors or members of the public which was averted through intended or unintended action.

Overview & Scrutiny Committees (OSCs): statutory committees of the Local Authority provided to scrutinise the development and progress of strategic and operational plans of multiple agencies within the Local Authority area. One such OSC is for Health & Wellbeing.

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

Patient Advice & Liaison Team (PALs): the team working with the Trust that provides advice and information about Trust services or signposting people to other agencies, and manages service users' and carers' comments, concerns or complaints.

Payment by Results (PBR): a new system being implemented across the NHS, and piloted in mental health Trusts, to provide a transparent, rules-based system for paying NHS Trusts. The system aims to reward efficiency, support patient choice and diversity and encourage activity for sustainable waiting time reductions. Payment will be linked to activity, adjusted for case-mix, and outcomes. Importantly, this system aims to ensure a fair and consistent basis for hospital funding rather than being reliant principally on historic budgets and the negotiating skills of individual managers.

Personality Disorder: class of personality types and enduring behaviours associated with significant distress or disability, which appear to deviate from social expectations particularly in relating to other humans.
Prescribing Observatory in Mental Health (POMH): a national agency, led by the Royal College of Psychiatrists, that aims to help specialist mental health services improve prescribing practice via clinical audit and quality improvement interventions.

Psychosis: is the term used to describe a type of mental health issue that seriously affects the way that a person thinks or feels and where the person can lose contact with reality.

Quality and Assurance Committee (QuAC): sub-committee of the Trust Board responsible for quality and assurance.

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

Quality Risk Profile Reports: The Care Quality Commission's (CQC) tool for providers, commissioners and CQC staff to monitor provider's compliance with the essential standards of quality and safety.

Rapid Process Improvement Workshop (RPIW): a technique for improving quality within the overall TEWV Quality Improvement System (QIS)

Root Cause Analysis (RCA): a technique employed during an investigation that systematically considers the factors that may have contributed to the incident and seeks to understand the underlying causal factors.

Schizophrenia: is a mental disorder characterized by a breakdown in thinking and poor emotional responses. Common symptoms include delusions, such as paranoia; hearing voices or noises that are not there; disorganized thinking; a lack of emotion and a lack of motivation.

Section 136 of the Mental Health Act: is the law which can be used to admit a person to hospital for assessment and/or treatment for a mental illness. The police can use section 136 of the Mental Health Act to take a person to a place of safety when they are in a public place. They can do this if they think the person has a mental illness and are in need of care. A place of safety can be a hospital or a police station. The police can keep the person under this section for up to 72 hours. During this time, mental health professionals can arrange for a Mental Health Act assessment.

Serious Untoward Incidents (SUIs): defined as an incident that occurred in relation to NHS-funded services and care, to ether 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 the deliver of services, absconding from secure care.

TEWV Quality Improvement System (QIS): the Trust's framework and approach to continuous quality improvement based on Kaizen / Toyota principles.

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

Visual Control Boards: a technique for improving quality within the overall TEWV Quality Improvement System (QIS).