Niche: Governance Report – 20 March 2023

TEWV Assurance Statement

We would like to reiterate how deeply sorry we are for the events that contributed to the deaths of Christie, Nadia and Emily.

The report makes it clear there were shortfalls in both care and leadership at the time of these tragic incidents. Both have changed significantly over the last three years.

Since 2019, we have made significant progress towards the recommendations outlined in the Niche Governance Report.

Our three big strategic goals in Our Journey to Change, which was launched in March 2021, confirm our commitment to listen to and act on the voices of our service users, their families and their carers, as well as to our staff and our partners. We use the term co-creation to describe that ambition. This helps us provide a better experience of high-quality, effective, and safe care to the people who use our services, offering clinical care that is person-centred, timely, compassionate, and kind. All of this is underpinned by our values of respect, responsibility and compassion, which are at the heart of everything we do.

We have employed two lived experience directors who bring their own knowledge, understanding and compassion to the strategic leadership of the Trust, to make sure that experienced voices are heard at all levels of the organisation, and that shared decision making is modelled from ward to Board. We now employ 28 peer support workers too.

These roles were developed as part of a wholesale organisational restructure which was put in place from April 2022, following a governance review in early 2021. Our new structure:

- simplifies the governance processes – giving nurses more time to care, supporting clinical teams to make decisions with the people they care for and making it easier for everyone to understand their role and responsibilities,
- strengthens reporting from teams through our two care groups directly to the Board,
- embeds increased line of sight from ward to Board.

This is all part of the journey the Trust is on to completely transform the services it provides, in parallel to our organisation-wide culture change programme. We are seeing positive results with the most recent NHS staff survey showing we are the most improved mental health trust in England.

We recognise that these things take time, however, patient safety is our unrelenting focus, with clear priorities including:

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

This assurance statement outlines the improvements we have made in response to the Niche Governance Report recommendations.

Recommendation 1 (TEWV): It is clear from our research that patients and their families (and some staff) were ignored and that their concerns and complaints are now found to be, on the whole, justified. The Trust must seek assurance that complaints, concerns and feedback are taken seriously and managed in line with The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 particularly in relation to recording receipt of a formal complaint. Additionally, feedback and concerns on a service must be comprehensively reported and reviewed on a frequent basis, and importantly, that feedback is acted upon.

TEWV response

The Trust takes concerns raised, feedback and complaints very seriously and has been working to improve its complaints process in line with guidance above. This includes a full and comprehensive review of our patient advice and liaison service (PALS), and how we manage complaints.

The most recent benchmarking data provided by NHS England in December 2022, showed that 93% of people would rate their experience of our services as very good or good (national average 84%). However, we know that there is still more to do, and we are embedding a more empathic and restorative approach into daily practice and improving culture to provide a better outcome for our patients, carers and their families.

An ongoing programme of external training has been delivered since 2019 to help our staff respond to concerns with compassion and empathy and to really understand the issues being raised by putting themselves in the shoes of others. PALS and complaints staff have attended this training which has helped them develop a more empathic and compassionate approach, to better understand how to deal with emotive and difficult conversations with patients, carers, and bereaved families, and support meaningful engagement to positively improve the experience of patients and their loved one. Whilst this will take time to fully embed, we are seeing a shift in culture and approach to issues raised, with staff feeling more confident in dealing with these situations.

New NHS Complaints Standards are currently being piloted, these set out how organisations providing NHS services should approach complaints handling. This new framework will support organisations in providing a quicker, simpler, and more streamlined complaint handling service, with a strong focus on early resolution by empowered and well-trained staff.

The Trust is using the development of these new standards to undertake a full end-to-end comprehensive review of its PALS and complaints function. This is being led by our lived experience directors who joined the organisation in Summer 2022. This will ensure that people with lived experience of our services and organisation are involved in any improvements and that we learn from their experiences, whether that be as a service user, carer, or partner. This review is scheduled to complete in January 2024. Interim improvements are expected to be piloted once formal scoping is complete in early Summer 2023. This new model will explore a more restorative approach to PALS and complaint resolution and embed a culture of listening and learning from complaints and issues raised, and how that translates into improvement action plans. The review currently underway involves patients, families and carers, and staff across our services, as well as range of partners including police, acute trusts, local authorities, and the voluntary and community sector. This will enable us to work together to co-create and shape what these services look like in the future and will include upskilling those who respond across the organisation.

In terms of reporting, the Trust seeks assurance that concerns, complaints, and feedback are listened to and acted on in a number of ways including:

- A monthly PALS, complaints and patient and carer experience report is reported through to the Executive Quality Improvement subgroup detailing themes from complaints.
- In addition, an integrated quality and learning report is reported into the Care Group Boards Quality Assurance and Improvement subgroups, and monthly to Quality Assurance Committee to provide assurance on key areas of quality and safety of patient care.
- NHS England and NENC ICS also received a monthly update on PALS, complaints and patient and carer experience.
- Immediate concerns and/or learning arising from complaints are actioned quickly through better recording systems and escalation.
- Feeling safe focus groups have taken place across our secure inpatient and adult inpatient services, to understand what concerns patients have and how we can improve their stay on our wards.
- Each Care Group has developed a co-created patient and carer experience service improvement action plan, involving our patients and their carers really embedding lived experience in our governance, to ensure we are held to account.

Alongside this, we capture patient experience in a number of ways to inform our improvement actions plans. Indeed, using this qualitative and quantitative data in a more meaningful way is one of four priorities set out in our Co-creation Journey. This outlines how we plan to capture accurate patient, carer and partner experience data in a more meaningful way, including friends and family test, surveys, PALS and complaints, and triangulate this with other intelligence e.g. serious incidents, in order to continuously improve our services and the way we deal with and learn from concerns raised.

To support this, we have also been exploring better use of technology and integrated systems to improve the way that we record concerns raised at a local level, as well as our formal complaints. A full re-procurement of our existing Datix system has taken place, and we hope to be rolling out the new InPhase System by December 2023.

Recommendation 2 (TEWV): Formal corporate decision-making processes and outcomes were difficult to trace and evidence. The Trust should seek assurance that there is a ratified minute of key organisational decisions.

TEWV response

Following an independent governance review in March 2021, a full organisational restructure was undertaken, and new structures and governance has been in place since 1 April 2022. This simplified governance processes, strengthened reporting from teams through two new care groups (mirroring that of the Integrated Care Systems we report into), and the Executive Directors Group directly to the Trust's Board. It also embedded improved line of sight from ward to Board.

A comprehensive Board development plan has been in place for over 18 months and is ongoing.

As part of the restructure, the Trust's Company Secretary took on responsibility for supporting all the formal meetings of the boards, committees and groups within the governance structure, and established a professional secretariat support to support this. This approach:

- Enables the flow of reporting through the structure to be better managed.
- Provides oversight of decision-making ensuring compliance with terms of reference and delegated powers.
- Enables the creation of a central repository for all meeting documentation so that decisions are more easily traced and evidenced.

- Provides consistency of documentation (agendas, reports, minutes, action logs, etc).

Formal minutes are produced for all key management and governance meetings, and key organisational decisions are ratified. The approval of the minutes is included as a standard item on agendas for all meetings. Action logs are also maintained and reviewed.

Recommendation 3 (TEWV): Action plans relating to West Lane Hospital were not connected to improvement programmes or risk registers. The Trust should ensure that there is strategic oversight of actions through the Board, Committee or working group where multiple interventions are involved. This will ensure that actions are not duplicated with other activities or overlooked. Using a programme approach around improvement plans and risk registers increases the accountability and enforceability around actions.

TEWV response

The Trust has significantly improved and developed the way that it manages improvement programmes and priorities through a newly established programme management office (PMO). The PMO will:

- Support a dedicated programme of work through the Advancing our Quality, Safety and Clinical Programme Board (AOQSC).
- Identify dependencies between projects and ensure actions are not duplicated with other activities or overlooked.
- Develop a balanced plan which sets out the resources (money and staff), key milestones, and benefits.
- Include care group and corporate departmental members as well as clinical and quality leaders.
- Provide relevant clinical quality and programme / project management expertise.

The AOQSC Programme will include the most urgent improvements required over the next 18 months. To determine what these are we have:

- Identified the highest priority cross-cutting projects from within the clinical and quality and safety programmes specifically and extracted these into the AOQSC Programme.
- Considered other projects that are aligned to quality, safety and clinical outcomes that are currently managed within the Co-creation, People and Culture and Infrastructure Programme Boards, and took a view on their inclusion in the AOQSC Programme.

The AOQSC Programme will report into the Executive Directors Group monthly and into the Board's business planning quarterly report.

We have strengthened our governance arrangements to ensure that where key concerns or risks emerge in specific services, surveillance and oversight of the resultant improvement plans have a clear route through to our Executive Directors Group. This means that they can be effectively managed at the right level and avoid duplication. Assurance is also provided to the West Lane Project Committee (established after these tragic incidents), which reports directly into the Trust's Board.

Recommendation 4 (TEWV): There were issues with the consistent application of Duty of Candour at the Trust. The Trust should seek assurance that there are now mechanisms in place to assess that the Duty of Candour Policy is effectively implemented. Additionally, where there has been a death in a service, whether through self-harm/suicide or homicide,

that families are given appropriate, meaningful, timely and compassionate family liaison and support through personal contact with a nominated officer of the Trust.

TEWV response

We acknowledge that at the time of these incidents, there was a fundamental and consistent failure by services to inform parents about incidents involving their children under duty of candour. Since 2019 we have not provided inpatient services for children and young people, however, the concept of being open, saying sorry and developing a 'just culture' is fundamental to the way we work. To achieve this, we have undertaken significant work with our staff to embed the Trust values of respect, compassion and responsibility. We're committed to communicating outcomes and learning from incidents, and taking responsibility for our actions.

The Trust's Duty of Candour Policy, 'being open, honest and transparent' was updated in 2020, and sets out our expectation for all staff to be honest and transparent when something goes wrong in the course of the care and treatment we provide.

The Trust's serious incident framework (SIF) has been updated and significant improvement work has been undertaken to strengthen these processes. This includes quality improvement, and a deep-dive event that took place in July 2021, led by our Director of Quality Governance, which involved feedback from patients, families and carers. One of the aims was to improve the experience of patients and families throughout the serious incident review process. A further event was held in February 2022 alongside the NHS England support team and the patient safety team. Four additional work streams, relating to the serious incident process and reporting, were identified including duty of candour.

Further to this, we have modified our rapid review response template, which is used for incidents categorised as near miss, moderate and above, to incorporate a section on duty of candour. This places the initial responsibility on clinical services to contact the patient or relevant other, to apologise for the harm caused and to share information known at the time.

The Trust invested in the creation of a Family Liaison Officer role in 2020, specifically to provide dedicated supported and improved communication to people who have lost a loved one in our care. We continue to provide externally sourced training to staff who are involved in complaints or patient safety incidents to support a response that is not just compliant with statutory duties but is meaningful and empathic to patients and their families.

We recognise the importance of working with people when things go wrong and the harm that can happen if this isn't done well. We commissioned an external review of our duty of candour processes and independent review of Trust policy, to ensure that we are taking the right actions to support our staff to work in this way. The results will support any further revisions and service improvements.

Recommendation 5 (TEWV, CNTW, North East & North Cumbria ICB, Middlesborough Council, NHSE and provider collaborative, and CQC): TEWV, CNTW and System Partners need to seek assurance that they have resolved the problems associated with the clinical transitions phase (between services and child to adult). A compound recommendation is required to address this deficit:

a) **TEWV must provide assurance that a full gap analysis between the 2018 Healthcare Safety Investigation Branch (HSIB) investigation and its own position has been completed. As the Trust still delivers Tier 3 CAMHS services they should expedite a review of processes and procedures in relation to transitions.**

b) *CNTW need to expedite a review of processes and procedures in relation to transitions.*
c) **Patient as well as stakeholder feedback associated with transitions between CAMHS and other services (such as AMHT) should be sought and incorporated into service redesign by all parties.**
d) **Effective governance surrounding transitions was not always in place. The good practice relating to transitions which is described within NICE Guidance should be translated into practice and delivered by all parties.**
e) **Where a young person is in receipt of T4 care and transferring back to T3, there must be a joint response between health and the relevant local authority children's services (in this case Middlesborough Council) so that the young person is prepared for life in the community and can be properly supported and their risks appropriately managed.**
f) *ICBs, NHSE and provider collaboratives must ensure that providers with a PICU have a written protocol that details the pathway for discharge, including timescales for involving in arrangements, the families and the young person. This will ensure that, wherever possible, a young person is not suddenly transferred without adequate preparation.*

TEWV response

Services have developed to improve care for young people who require transition from CAMHS to Adult Mental Health Services (AMHS).

Transitions between services use a 'panel' approach where AMHS and CAMHS work together with the young person to share information to make sure the transfer works smoothly where a transition is required. The processes have been formally reviewed and revised in Durham and Darlington services and a quality improvement event is planned to ensure processes and improvements are consistent across the Trust.

This work is based on NICE guidance for transitions from children to adult services for young people using health or social care services (NG43), and feedback from parents, young people, other agencies, and complaints about the current TEWV system. The ongoing work includes co-creation with children and young people and their families to improve and modify processes to ensure the transition fits with their individual needs.

For young people who have more complex presentation and needs who require multi-agency and multidisciplinary support, the following are in place:

1. Dynamic Support Registers (DSR): in line with national guidance for transforming care, the DSR's provide multiple agency support for people with a learning disability and/or who are autistic. TEWV are actively involved in these in all areas of the Trust. People who require this support are also identified through the Care (Education) and Treatment Reviews (CETR) process. In addition, the trustwide autism team identify people requiring support through the DSR and CETR processes.

2. For young people who have needs relating to attachment and/or adversity/experience of trauma but who are not autistic or do not have a learning disability, there are different approaches across the Trust as these have developed with partner agencies. In Durham and Darlington, the local authority 'rapid response' team and the TEWV intensive home treatment team work together to support young people who are in crisis, or who are transferring from inpatient care, or who may be at risk of needing inpatient care. This model is used across TEWV with local authority partners in each area.

In addition, each of the four local authorities within the Tees Valley area have separate processes set up to manage multi-agency working with vulnerable, exploited, missing or trafficked young people.

A good example of this is in Tees CAMHS, where there have been improvements in services for people who present with more complex needs including autism and experience of trauma/adversity. These include an expansion of the offer within the CAMHS intensive home treatment team. The ASD Intensive Positive Behaviour Support (ASD IPBS) Service is aimed at offering the same intensive PBS approach to young people with an ASD diagnosis. The vision is to offer an alternative to hospital admission or placement breakdown. The service has been operational since November 2022 and funding has been secured for the next financial year.

There have also been developments in the Intensive Positive Behaviour Support children with moderate to severe learning disabilities who are at risk of admission and placement breakdown. The service aims to work with families using a PBS approach to maintain young people in the home. This service is funded by CNTW and has been operational since mid-2020.

Joint work with Middlesbrough Council progresses on a case-by-case basis and responsive to need. Joint developments with the local authority would be welcomed to continue to make positive improvements.

In the North Yorkshire, York and Selby locality the psychologically informed partnership approach (PIPA) team is commissioned by the local authority and delivered by TEWV for people who are under 25 with a social worker, or who are care leavers to provide this aspect of the service.

The Trust's autism project team work with people under the care of TEWV who are autistic. They offer support to clinical teams with formulating, and support all aspects of case work (transitions, supervision, the MDT). They work across the Trust (all ages and specialities). The team brings expertise in working with complexity where this exists due to multiple interacting issues which may include trauma/adversity and long-standing difficulties.

Recommendation 6 (TEWV): There was a gap between the development and successful implementation of important care initiatives (such as least restrictive practice), plans and evidence-based changes to practice. The Trust must seek assurance that there are implementation plans for new initiatives, policies or procedures and that these are evidence-based, being implemented correctly within services and monitored appropriately.

TEWV response

We have made significant progress in the way we manage improvement programmes and priorities and have established a programme management office (PMO). The PMO will support a newly established dedicated programme of work in the form of an Advancing our Quality, Safety and Clinical Programme Board (AOQSC) - see recommendation 3.

The new structure is designed to be clinically-led with nursing, medical and therapies (psychological professions and AHPs) and lived experience staff working collectively at all levels of the Trust. This gives multiple opportunities for implementation and monitoring of initiatives.

We gain assurance that the implementation of any new initiatives or key quality and safety policies are having the desired impact through our quality assurance schedule and improvement, which is

continually monitored and reported within and up through the organisation. A good example of this is our revised Observation and Engagement Policy. The launch of this policy in January 2020 only went ahead once we had confirmation that 85% of clinical staff were trained and had successfully achieved a competency-based assessment.

Our quality assurance framework tells us that we have consistently sustained a good level of assurance in the application of this policy, which has really helped us understand any barriers to adoption, and to enhance and demonstrate clinical grip and oversight.

Recommendation 7: There was a lack of systematisation in relation to the identification, mitigation and actioning of known risks at a ward, service and corporate level. A compound recommendation is required to address this deficit:

a. **TEWV must ensure that risk assessments for young people in CAMHS are based on a psychological formulation and are developed by a multidisciplinary team in conjunction with the young person and their family.**
b. **TEWV must ensure that proper training is provided to staff around clinical risk management and how to ensure that action is taken consistently.**
c. **TEWV must provide assurance that it meets the requirements of the new Patient Safety Incident Response Framework by 2023.**
d. **The North East & North Cumbria Integrated Care Board (ICB), NHSE, and provider collaborative must seek assurance that TEWV has a robust environmental and ligature risk assessment process and the ability to respond effectively and urgently to mitigate risks identified through this process (including risks identified on Tunstall Ward).**
e. *North East & North Cumbria Integrated Care Board must assure themselves that CNTW are following the NHS Child and Adolescent Mental Health Services Tier 4 (CAMHS T4): General Adolescent Services including specialist eating disorder service specification and the QNIC standards for use of mobile phones and social media access in inpatient environments.*
f. *The application of robust risk assessment forms part of the CQC regulatory framework. The CQC should routinely examine the quality and consistent application of TEWV's clinical risk assessment, clinical risk training and the relationships to local and corporate risk registers.*

TEWV response

a. **TEWV must ensure that risk assessments for young people in CAMHS are based on a psychological formulation and are developed by a multidisciplinary team in conjunction with the young person and their family.**

   In April 2021, new safety summary and safety plan documents were introduced into CAMHS, strengthening our approach to risk assessment and management. They support a psychological formulation approach to risk assessment with children, young people, their families and carers. The documents require consideration of a young person's history about what has happened to them, and any patterns to help understand when they have been better or become more unwell. These risk assessment and management plans need to be developed alongside a thorough understanding of the young person within their context. Risks of harm to self and others are considered, incorporating family members including younger siblings present in the family. This forms an integral aspect of care planning; building on the assessment, formulation and shared decision-making process described above and includes consideration of risk to others. Safeguarding policies are followed where required.

Our quality assurance programme currently shows that 96.8% of children in treatment have a safety summary and safety plan in place across the Trust.

We continue to work with clinicians to enhance the quality of these documents and have established processes to support this via caseload supervision, clinical supervision and daily discussions (huddles). We have assurance processes including fundamental standards and peer reviews to ensure clinicians have access to a variety of sources of support.

b. TEWV must ensure that proper training is provided to staff around clinical risk management and how to ensure that action is taken consistently.

Further to the development of the new approach to risk assessment and management described above, the Trust's clinical risk management (harm minimisation) training was reviewed and enhanced with additional guidance supported by training videos and webinars, including suicide risk assessment training. The compliance for this mandatory training is currently 92% as of 13 March 2023.

To ensure that good practice around risk management is used consistently, the Trust introduced a new quality assurance programme. This focuses on the quality of clinical record keeping in relation to key clinical records, including care plans, observation records, risk assessment and management plans. It recognises that high-quality documentation is an enabler to good patient care. This is in line with national clinical record keeping policy and professional guidance for record keeping.

Audits are completed monthly and verified through a peer review process. Results from June 2021 to June 2022 activities demonstrate consistent practice standards are being achieved across the organisation in terms of: implementation of minimum standards, in line with the good practice guidance for safety summary/safety plans, observation and engagement plans, and leave documentation within the patient electronic care record system. Practice development practitioners continue to monitor compliance and to support areas where focused improvement work is required in collaboration with clinical teams.

In addition, clinical risk assessment and management guidance is provided to clinical staff to support their practice in line with the Trust's revised Harm Minimisation Policy (clinical risk assessment and management). Multi-disciplinary team (MDT) huddles were introduced in inpatient areas and outcomes are now recorded in clinical records. The quality assurance programme that was introduced in June 2021 includes the following:

- **Assurance self-declaration:** a fortnightly assurance tool reviewing all patients on inpatient wards. The tool monitors compliance with completion and updating of safety summaries, safety plans, incident reporting, leave and observation plans as well as associated documentation. The tool was updated on 23 October 2021 to provide a more focused and detailed review of the quality of patient records and clinical record keeping.
- **Modern matron quality review:** a monthly review of quality indicators and information in inpatient areas. It includes 33 standards relating to safety summaries, safety plans, patient carer involvement, leave plans, and observations plans. Each ward or team has developed continuous improvement plans based on intelligence gathering from reviews and case note reviews.
- **Practice development review:** a monthly assurance tool led by the practice development team. The practice development practitioners (PDPs) observe MDT discussions in relation to risk, leave, level of observations, mental state, medication compliance and effectiveness of medication regime. They also check whether everyone

in the MDT feels comfortable to speak up. PDPs now work with staff across inpatient and community services focusing on the completion of robust risk assessments and ensuring the quality of mental state examinations and record keeping, including observation levels.

c. TEWV must provide assurance that it meets the requirements of the new Patient Safety Incident Response Framework by 2023.

The Trust is on track to be compliant with the new requirements of the patient safety incident response framework (PSIRF) by September 2023. Our current serious incident framework (SIF) has been updated, and there has been significant improvement work to strengthen the serious incident processes since 2019. This has included quality improvement and a deep dive event involving feedback from patients, families and carers.

In preparation for the implementation of PSIRF, we carried out an in-depth review of key themes from incidents dating back several years. This has enabled us to make measurable improvements and identify areas where further work is needed to embed learning. To build on this work, the Director of Quality Governance commissioned a quality improvement event called 'improving the experience of patients, families, and staff during serious incident reviews'. The event took place in July 2021. The aim was to share, with internal and external stakeholders, the work that had been undertaken in the patient safety team in collaboration with families, patients and operational services, to:

- Improve the quality and safety of the care we provide.
- Improve the experience of patients and families throughout the serious incident review process.
- Improve the efficacy of our patient safety incident investigations by moving towards a systems-based approach identifying interconnected causal factors and systems.
- Address causal factors to prevent or minimise repeat patient safety risks and incidents.
- Measure the impact of actions taken to reduce repeat patient safety risks and incidents.
- To increase stakeholders (notably patients, families, carers, and staff) confidence in the improvement of patient safety through demonstrating the impact of learning from incidents.

A project manager was appointed to drive the continued delivery of this improvement work.

A further event was held in February 2022 with the NHS England support team and the patient safety team. Four additional work streams relating to the serious incident process and incident reporting were identified, including:

- The incident report process.
- Triaging patient safety incidents.
- Revisiting the duty of candour.
- The Trust's final assurance panel for signing off serious incident reports.

On 20 May 2022, following completion of these workstreams with the relevant stakeholders, and in line with our improvement plan in Our Journey to Change, a further event called 'co-creating for patient safety' took place. Seventy people attended including bereaved families, carers, clinical services, members of the executive management team and commissioners. It focused on sharing details of the improvement work and facilitated full engagement with all relevant stakeholders.

The Incident Reporting and Serious Incident Review Policy is being reviewed and updated to incorporate all outcomes of the improvement work.

All our current serious incident reviewers have received specialised training in serious incident investigation via the patient safety incident response framework (PSIRF) approved trainers or the healthcare safety investigation branch (HSIB).

We are using our quality assurance schedule to inform this work, to help develop and transform our organisational response to incidents. This work demonstrates how the Trust is working towards the implementation of the new PSIRF by September 2023.

d. The North East & North Cumbria Integrated Care Board (ICB), NHSE, and provider collaborative must seek assurance that TEWV has a robust environmental and ligature risk assessment process and the ability to respond effectively and urgently to mitigate risks identified through this process (including risks identified on Tunstall Ward).

The Trust has undertaken a comprehensive ligature reduction programme across inpatient services since 2019. This programme continues to date in both a planned way and in response to emerging risks or themes from incidents and national alerts. By the end of March 2023, we will have invested £7.8m in this programme.

In January 2020, a trustwide environmental risk group was established with executive level oversight to agree service standards, oversee the estates works delivery programme and report on progress.

The role of the group is to assist the Trust in its management of patient safety through the oversight and management of environmental risks. The group has specifically strengthened systems and processes for identifying and reporting environmental risks and deficiencies, including emerging risks identified from themes and trends from incidents. A report from the group, outlining work completed as well as planned work, went to the Trust's Quality and Assurance Committee (a Board subcommittee) in May 2022, providing assurance on the work undertaken to date.

We have also invested in assistive technology called Oxevision, which has been installed in a number of wards. This system supports clinical teams and enhances patient safety by using contact-free, vision-based monitoring technology to monitor a patient's vital signs and high-risk activity. This offers safe and unobtrusive care, which is respectful of people's privacy. We are developing and evaluating our services to ensure we embrace the benefits of this assistive technology.

The group meet monthly to review the work programme. Incident data is examined monthly to inform risk mitigation.

The group membership includes representatives from the estates and facilities department, infection, prevention and control team, compliance team, as well as clinicians and managers representing the two care groups. Advice and agreement are sought from the service development groups on replacements and standards across specialties as required.

Following the publication of a national alert to review all policies in relation to low-level ligature risks, the Trust's Suicide Prevention Environmental Survey and Risk Assessment Procedure (our ligature risk assessment process), was reviewed and updated in October 2020. This procedure strengthens our ability to respond effectively and urgently mitigate

identified risks. The survey is conducted annually to identify any fixtures and fittings, materials and equipment which may pose a risk of self-harm. The procedure covers the Trust's formal approach to ligature reduction and has minimum standards in place to reduce harm within inpatient settings. Timeliness of completion of surveys and actions taken are monitored through the environmental risk group alongside incident data to ensure risks are effectively mitigated in a timely way.

In line with The Samaritan's media guidelines for reporting on suicide, the Trust will not publish any further information on the specific nature of this work.

Recommendation 8 (TEWV): The function of Executive team meetings in terms of operational involvement lacked clarity. The Executive team meetings must clearly define and record actions which they are directly responsible for, or, where actions have been delegated. The ET should recognise that it has the mandate to form task and finish groups.

TEWV response

The Trust appointed a new Chief Executive in 2020, who reviewed the function of executive team meetings. These changes strengthened the executive team's ability to oversee the day-to-day management of an effective system of integrated governance, risk management and internal control across the whole Trusts' activities (both clinical and non-clinical), to support the achievement of the Trust's goals.

The current executive team meetings were established in April 2022 as part of our new governance structure implemented following an independent review undertaken by the Good Governance Institute. The executive team meetings form part of a wider structure that oversees the quality, safety and effectiveness of the Trust's clinical and operational services through two care groups and corporate services. This includes oversight on statutory, legal and regulatory duties whilst delivering high-quality, patient-centred care to support the overall delivery of Our Journey to Change.

New terms of reference were agreed which clearly set out the role, functions and membership of the Executive Directors Group, and the range of groups it relates to where actions can be delegated and monitored.

To support the group to fulfil its role, standard agendas focused on key themes were developed for each of its meetings on a monthly cycle. Formal minutes of its meetings are prepared by the Trust's secretariat for ratification and action logs are maintained and reviewed.

An accountability framework has also been put in place. This provides for a devolved, high-trust and more empowered way of working, and governs the relationships between our Board, Executive Directors Group, care groups and corporate structures. It frames how individual teams and the various levels of our structures operate and provides clarity around roles, responsibilities and the expectations of each part of the leadership and governance arrangements supporting improved grip, transparency and accountability.

Recommendation 9: Safeguarding between mental health providers and system partnerships was insufficient to protect young people in West Lane Hospital. Despite the availability of Working Together Guidance, responsibilities and obligations internally and externally between agencies (providers and system colleagues) were confused, interpreted differently by individuals and consequently gaps developed. A compound recommendation is required to address this deficit:

a. *NHS England Specialised Commissioning, the North East & North Cumbria ICB and provider collaborative and the South Tees Safeguarding Children Partnership Board and LADO should now all reflect upon matters raised within this report and determine whether further internal review is required to ensure proper learning occurs within each respective agency. All relevant Safeguarding Children's partnerships Need to ensure that there are sufficient mechanisms in place to prevent a recurrence of the same*
b. *The North East & North Cumbria ICB and provider collaboratives should obtain assurance that provider organisations have sound systems and processes to safeguard young people in mental health facilities, and these provide regular robust assurance to NHS England Specialised Commissioning of effective working.*
c. *Middlesbrough Council and Health providers/ key partners must ensure that there is clarity about the roles and responsibilities of each agency in the planning and delivery of care to young people in Tier 4 CAMHS provision to ensure that support is holistic and meets the educational; social; physical health and emotional needs of children and young people as well as their mental health needs.*
d. **Local Authorities and Health providers must provide appropriate challenge where there are concerns about unsafe discharge arrangements from Tier 4 inpatient care, including appropriate escalation up to chief officers where concerns for children's safety are high.**
e. *Durham County Council must ensure that responses to referrals are completed within expected time frames, and subsequent assessments always incorporate the views of the family and young person.*
f. *North East and North Cumbria Integrated Care Board and the Provider Collaborative must consider the impact and risks on Tier 4 CAMHS if a local Safeguarding Board is found to be weak or inadequate, or a local provider is found to have a major staffing issue.*
g. **Where Safeguarding concerns are raised about a child, these must include a formal consideration of other vulnerable family members for the lifespan of care.**
h. *Middlesbrough Council must respond formally to serious concerns raised about the care and treatment of a young person under their care and explore concerns with the family and the young person.*

TEWV response

d. **Local Authorities and Health providers must provide appropriate challenge where there are concerns about unsafe discharge arrangements from Tier 4 inpatient care, including appropriate escalation up to chief officers where concerns for children's safety are high.**

As providers of community care for children and young people, we work with our partners and the young person to ensure there is a safe discharge.

Where known to the Trust, our community clinicians remain involved with a young person throughout their inpatient stay in another hospital and attend discharge planning meetings. We are therefore aware of the importance of multi-agency and multi-disciplinary working. We appropriately and robustly challenge where our staff are concerned about patient safety.

Where a professional agreement is not reached, and the Trust has concerns about unsafe discharge arrangements, we escalate this through our operational and safeguarding processes. We fully endorse this approach and can provide recent examples where this has been actioned.

g. **Where Safeguarding concerns are raised about a child, these must include a formal consideration of other vulnerable family members for the lifespan of care.**

As providers of community care for children and young people we work with our partners and the young person to ensure that safeguarding risks are appropriately shared so that they can be effectively managed, taking a multi-agency approach with partner agencies.

All levels of our safeguarding training have a 'think family' approach. Our safeguarding level 3 training is now delivered face to face (via MS Teams) over a full day to support compliance with training (currently at 84% trustwide) and to facilitate effective learning. Level 3 training is for all clinical staff on AFC band 5 and above.

The Trust has developed new safety summary and safety plan documents to improve the assessment and management of clinical risks. These support a psychological formulation approach to risk assessment with children, young people, their families and carers. Risks of harm to self and others are considered including where there are other vulnerable family members present in the family.

Recommendation 10 (TEWV): Reporting structures were disconnected between various tiers of governance, and this prevented the 'drill-down' required for effective oversight and effective learning. The Trust must ensure rounded reporting arrangements to support proper Board assurance consisting of both hard evidence and soft intelligence. This should include a 'trigger tool' when a ward or department is experiencing 'stress', such as failing to complete training, debriefs, high sickness absence, low staff morale and this should be viewed alongside patterns of incidents, harms and complaints.

TEWV response

We have improved connectivity between our tiers of governance through the new arrangements implemented in April 2022. There is now a natural flow of oversight, assurance and learning from ward to Board through the Care Group Boards, the Executive Directors Group, the Board's committees and the Board.

To support our governance structure, we have developed a more integrated approach to quality and performance assurance and improvement through our integrated performance report (IPR). This enables us to have oversight, monitor and report key measures that demonstrate the delivery of the quality of services we provide and provide assurance to the Board through our new governance structure.

Within our Board integrated performance dashboard, we use Statistical Process Control (SPC) charts to determine whether we have any underlying causes for concern. SPC is an analytical tool that plots data over time. It helps understand variation in data, and in doing so, guides when and where it is appropriate to take action.

We have developed a suite of committee performance indicators.

The IPR is aligned to our Board Assurance Framework. Through this we examine the relationship between performance and controls assurance enabling us to determine where action should be focussed.

Alongside the IPR we have developed our quality and learning report and our positive and safe dashboard. This allows us to drill down to the appropriate ward and team level to further understand what the data is telling us and drive the actions that need to be taken.

We have recently developed a team/ward risk assessment trigger tool. This tool allows us to look across a range of indicators that may highlight stress factors in a service or team through poor performance against training, high incident rates, high restraint/restrictive interventions etc. Initially this was to undertake a cultural risk assessment into closed cultures. The tool, however, can be expanded to provide a heat map view across our services and teams, allowing us to see, at a glance, where it may be necessary to undertake further deep dive reviews and provide support.

Risk groups have been established at each tier of our governance structure. These are supported by risk management processes and reporting to ensure that there is visibility, based on significance, and risks are managed and overseen at the most appropriate level. Training on risk management is progressing.

Our reporting template has been amended. We now seek to avoid reports merely to provide information and now focus on controls assurance.

These changes have significantly strengthened the cohesion of our governance arrangements and have made a significant improvement to our approach to learning and our understanding and oversight of risk and the effectiveness of controls.

We recently reviewed our new organisational and governance restructure. The purpose of the review was to ensure our governance structure supports the provision of evidence-based assurance, to enable the organisation to have meaningful interrogation of themes and trends, and thereby help identify and respond to emergent risks and ensure safe and high-quality care for patients. We have also worked with members of the NHS England and Integrated Care Board commissioned intensive support team to provide an independent view on our quality assurance and improvement flow. A series of recommendations have been made to further refine the structure to ensure we are talking about the right things in the right places.

Recommendation 11: There were gaps in relation to both the commissioning of effective services and in relation to the regulatory oversight in relation to West Lane Hospital. Assurance seeking activity was weak with a lack of sufficient scrutiny of both hard and soft intelligence. A compound recommendation is required to address this deficit:

a. *NHS England Specialised Commissioning and the Care Quality Commission (CQC) must ensure that when there is enhanced surveillance of services following quality concerns, the themes and patterns of all incidents are rigorously scrutinised and analysed.*
b. *NHS England Specialised Commissioning, the provider collaborative and the North East & North Cumbria ICB, should work together with the Directors of Children's Services in the North East region. This is to ensure that services are commissioned which will meet the needs of the growing number of young people with complex needs and challenging behaviours that require integrated health and social care responses.*
c. *A demand and capacity review (under the provider collaboratives programme and in association with each local authority) should be undertaken to ensure services have the appropriate capacity locally to minimise placing children out of area and to ensure the availability of suitable specialist care.*
d. **TEWV/NHS England, the provider collaborative and Middlesbrough Council must provide assurance that all looked after children specifically with a diagnosis of autism have care provided that is in line with the NICE guidance on autism spectrum disorder in under 19s: support and management, recognising the challenges in the system.**

TEWV response

The North East North Cumbria Children and Young People (CYP) Provider Collaborative was launched on 1 April 2021. This is led by CNTW with close partnership working with TEWV. The provider collaborative oversees CYP mental health services in the region, with a specific focus on specialised commissioning which includes the CYP mental health units. Feedback from young people who are inpatients in the mental health wards and their families is embedded into the governance framework to provide assurance and oversight. These include family ambassadors, peer support on the wards, the CNTW involvement team and NHS England/Provider Collaborative case managers. There are established, close working relationships between TEWV and CNTW with oversight at every point of contact between services, and a significant change in culture including improvements around patient/carer lived experience voice which is central.

Within TEWV, the trustwide autism project works with people (all ages, any speciality, inpatient and community) who are autistic. They offer direct work with autistic people, and consultation support for teams including formulating, supervision, advice regarding transitions, and complex case discussion. TEWV participate in the Dynamic Support Register and CETR multi-agency work, to offer and coordinate care across agencies to support autistic young people who may also have other co-occurring difficulties.

The autism team works with clinical teams, multi-disciplinary and multi-agency teams, and with the Trust's senior leadership to promote system-wide understanding of the adjustments required for autistic people to be best cared for within our services. Adjustments can include sensory considerations, social and environmental considerations, and adjustments regarding ways of communicating. Underpinning all adjustments is the requirement that care is flexible and responsive to someone's individual needs whilst also following policy and best practice guidance.

Since 2019, the team have been providing full-day training to clinical and corporate staff across all specialties, including adult inpatient services, and with senior operational leads and with the complaints team, and well as continued training within clinical services. Health Education England has developed the core capabilities framework standards and our training is aligned with this. It includes consideration of the impact of autism and consequent reasonable adjustments that staff may need to make when caring for and supporting an autistic child, young person or adult. This includes sensory considerations, social and environmental considerations and communication needs, ensuring that care is individual to the response and responsive to their needs.

We have undertaken environmental checklists (recommended in NICE guidance) and this programme is underway for all wards. This creates a baseline of understanding of the sensory environment which then enables personalisation when autistic people are present on the ward. We have also provided training for the estates department, so they are aware of the needs of autistic people.

A programme of this training is also being developed for our team for our 28 peer support workers.

From September 2020, the autism project has offered consultation and supervision for clinical staff working with an autistic child, young person or adult accessing our services in the community and as an inpatient. Reasonable adjustment workshops have been delivered (co-facilitated) in all adult mental health community teams across the Trust.