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Health and Partnerships Scrutiny Committee Agenda

DARLINGTON BOROUGH COUNCIL

9.30 am Wednesday, 1 May 2019
Committee Room No 1, Town Hall, Darlington. DL1 5QT

Members of the Public are welcome to attend this Meeting.

1. Introductions/Attendance at Meeting

2. Declarations of Interest

3. Quality Accounts 2018/19 –
   Report of the Director of Neighbourhood Services and Resources
   (Pages 1 - 4)

   (a) 9.30 to 10.30 am - County Durham and Darlington NHS Foundation Trust Draft Quality Accounts 2018/19 (Pages 5 - 126)

   (b) 10.30am to 11.30am - Tees Esk and Wear Valley NHS Foundation Trust Draft Quality Accounts 2018/19 (Pages 127 - 218)

Luke Swinhoe
Assistant Director Law and Governance

Tuesday, 23 April 2019

Town Hall
Darlington.

Membership
Councillors Newall, J Taylor, Copeland, Crichlow, Grundy, Haszeldine, Heslop, Nutt, E A Richmond, Mrs H Scott and Tostevin

If you need this information in a different language or format or you have any other queries on this agenda please contact Allison Hill, Democratic Officer, Resources Group, during normal office hours 8.30 a.m. to 4.45 p.m. Mondays to Thursdays and 8.30 a.m. to 4.15 p.m. Fridays email: Allison.hill@darlington.gov.uk or telephone 01325 405997

HEALTH AND PARTNERSHIPS SCRUTINY COMMITTEE
1 MAY 2019

ITEM NO. 3

QUALITY ACCOUNTS 2018/19

Purpose of the Report

1. To consider information included in the local Foundation Trusts Quality Accounts 2018/19 to enable this Committee's input into the draft commentaries.

Summary

2. Members will recall Scrutiny Committee agreed to be more involved with the local Foundation Trusts Quality Accounts. This has enabled Members to have a better understanding and knowledge of performance when submitting a commentary on the Quality Accounts at the end of the Municipal Year 2018/19.

3. As a result, Members committed to attending the Stakeholder events hosted by Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) and County Durham and Darlington NHS Foundation Trust CDDFT. Scrutiny also agreed to receive regular performance reports from both Trusts.

4. Scrutiny have also been requested to consider NEAS Quality Report for the Year Ending 31 March 2019 and provide comments for inclusion in a Regional response.

Recommendations

5. It is recommended that :

   (a) draft commentaries for :

      (i) Tees Esk and Wear Valleys NHS Foundation Trust be formulated and forwarded for inclusion in the Quality Accounts for 2018/19; and

      (ii) County Durham and Darlington NHS Foundation Trust be formulated and forwarded for inclusion in the Quality Accounts for 2018/19.

   (b) Comments relating to the North East Ambulance Service (NEAS) Quality Report for year ending 31 March 2019 be forwarded to the Chair, Councillor Newall, to formulate a Regional response.

Paul Wildsmith,
Director of Neighbourhood Services and Resources

Background Papers

There were no background papers used in the preparation of this report.

Allison Hill : Extension 5997

S17 Crime and Disorder	This report has no implications for Crime and Disorder.
Health and Well Being	This report has implications to the address Health and Well Being of residents of Darlington, through scrutinising the services provided by the NHS Trusts.
Carbon Impact	There are no issues which this report needs to address.
Diversity	There are no issues relating to diversity which this report needs to address.
Wards Affected	The impact of the report on any individual Ward is considered to be minimal.
Groups Affected	The impact of the report on any individual Group is considered to be minimal.
Budget and Policy Framework	This report does not represent a change to the budget and policy framework.
Key Decision	This is not a key decision.
Urgent Decision	This is not an urgent decision
One Darlington: Perfectly Placed	The report contributes to the delivery of the objectives of the Community Strategy in a number of ways through the involvement of local elected members contributing to the Healthy Darlington Theme Group.
Efficiency	The Work Programmes are integral to scrutinising and monitoring services efficiently (and effectively), however this report does not identify specific efficiency savings.
Impact on Looked After Children and Care Leavers	This report has no impact on Looked After Children or Care Leavers.

MAIN REPORT

Quality Accounts 2018/19

6. The Health Act 2009 requires Foundation Trusts to publish an Annual Quality Account Report.

7. The purpose of the Annual Report is for Trusts to assess quality across all of the healthcare services they offer by reporting information on annual performance and identifying areas for improvement during the forthcoming year and how they will be achieved and measured.

8. The priorities for improvement are divided into the three components of quality; safety, experience and effectiveness.

9. Overview and Scrutiny Committee's play an important role in development and providing assurance on Quality Accounts reports. The Health Act requires Trusts to send a copy of their report to be considered by their appropriate Overview and Scrutiny Committee.

10. In advance of the Trust's report being considered by Overview and Scrutiny Committees it is vital that the priority areas identified are considered and that discussion takes place. Comments or views from Overview and Scrutiny Committees should be reflected in the final report and involvement should be credited within the document.

County Durham and Darlington NHS Foundation Trust

11. Members of this Scrutiny Committee received updates on performance information from the Foundation Trust in a timely manner and avoided duplication.

12. As a result of these updates, Members feel informed and able to make comments for inclusion in the draft Quality Accounts 2018/19 **(Appendix 1).**

Tees, Esk and Wear Valleys NHS Foundation Trust

13. Members have attended stakeholder events and received regular performance information from the Foundation Trust throughout the Municipal Year.

14. As a result of these events and updates, Members feel informed to be able to make comments for inclusion in the draft Quality Accounts 2018/19 **(Appendix 2).**

NEAS Quality Report for Year Ending 31 March 2019

15. Regional Health Scrutiny has been requested to consider the NEAS Quality Report for Year Ending 31 March 2019. Councillor Newall is this Council's representative on Regional Health Scrutiny has regularly updated Members of this Scrutiny Committee.

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County Durham and Darlington NHS
NHS Foundation Trust

Quality Accounts
2018/2019

with you all the way

WELCOME AND INTRODUCTION

To be inserted

A Guide to the Structure of this Report

The following report summarises our performance and improvements against the quality priorities we set ourselves in the 2018/2019 period. It also outlines those we have agreed for the coming year (2019/2020).

The Quality Accounts are set out in three parts:

Part 1:	Statement from the Chief Executive of County Durham & Darlington NHS Foundation Trust.
Part 2:	Priorities for improvement and statements of assurance from the Board
Part 3:	A review of our overall quality performance against our locally agreed and national priorities.
Annex:	Statements from the NHS Commissioning Board, Local Healthwatch. organisations and Overview & Scrutiny Committees.

There is a glossary at the end of the report that lists all abbreviations included in the document.

What are Quality Accounts?

Quality Accounts are annual reports to the public from the providers of NHS healthcare about the quality of the services they deliver. This quality report incorporates all the requirements of the quality accounts regulations as well as Monitor's additional reporting requirements.

Whilst we continue to see significant improvement and success in some of our goals, it is acknowledged that for some we have not reached our Trust ambition. We will continue to aim for the standards that we have set, and are committed to ensuring that we continue the work in place to meet and move further ahead with meeting those challenges.

This report can be made available, on request, in alternative languages and format including large print and braille.

PART 1: Statement from Chief Executive

To be inserted

Sue Jacques
CHIEF EXECUTIVE

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

Review of our key priorities for 2018/2019
Last year we set 20 priorities. These have been set under the following headings:

- Safety
- Patient Experience
- Clinical Effectiveness

A summary of our progress and achievements is shown below and further detail on each priority is included in the pages that follow.

☒	Improvement not demonstrated
☑	Trust ambition achieved
⊖	Trust ambition not achieved but improvements made

		2017/2018	2018/2019 Ambition	2018/2019 Position	
Falls	Patient falls – reduce falls/1000 bed days community hospital	**6.1** ☑	8.0	To Feb 6.0	☑
	Patient falls – reduce falls/1000 bed days acute hospital	**6.2** ☒	5.6	To Feb 5.5	☑
	Follow up patients with fragility fracture	66.3% ☑	50%	TBC	
	Complete root cause analysis for falls resulting in fractured neck of femur	All complete ☑	All complete	All complete	☑
Care of patients with dementia	Development of a dementia pathway and monitoring of care, to include enhancements to environment	Complete ☑	Introduce dementia strategy and produce an action plan to monitor	Complete	☑
Healthcare Associated Infection (HCAI)	Meticillin Resistant Staphylococcus aureus (MRSA) post 48 hour bacteraemia	4 ⊖	0	2	⊖

		2017/2018	2018/2019 Ambition	2018/2019 Position	
	Clostridium *difficile* post 72 hour	21 ☒	18	19	⊖
Pressure Ulcers	To have no avoidable grade 3 or above pressure ulcers within acute or community services	4 ☒	0	9	☒
Venous thromboembolism (VTE)	Maintain venous thromboembolism assessment compliance at or above 95%	96.45% ☑	95%	**TBC (provisional 96.3%)**	☑
Discharge	Discharge summaries	91.60% ⊖	95%	91.2%	☒
Incidents	Rate of patient safety incidents reported via National Reporting and Learning System (NRLS)	Reporting to within 50% ⊖	Reporting to within 75%	Reporting to within 50%	⊖
	Rate of patient safety incidents resulting in severe injury or death from National Reporting and Learning System (NRLS)	Apr-Sep 2017 data 0.4% ☑	Within national average	Oct17-Mar18 Data 0.1% (local)	☑
Sepsis	To improve management of patients identified with sepsis	Improvement demonstrated ☑	Ensure patients are screened appropriately	Improvement demonstrated	☑
Duty of Candour	To monitor implementation	Complete ☑	Demonstrate compliance and monitoring	Embedded in practice	☑
Local Safety Standards for Invasive Procedures (LocSSIPs)	To deliver a programme of work to review LocSSIPs across the Trust	Progressing as plan	Introduce by 2019/2020	Progressing as plan	☑
PATIENT EXPERIENCE					
Nutrition and Hydration	Move nutrition assessment to Nervecentre 16/17 ambition and 17/18 to complete To audit against new indicators	Complete ☑ Monitoring and refinement introduced ⊖	Complete To continue to refine	Complete Programme continues	☑ ⊖
End of Life Care	Death in usual Place of Residence increasing Achievement of Preferred Place of Death Increasing	50% 88%	To improve and monitor care of patients at end of life as per Trust plan	52% 95 %	☑

		2017/2018	2018/2019 Ambition	2018/2019 Position	
Patient personal needs	Responsiveness to patients personal needs	**2017** 79% ☑	Within national average 68.6%	**2018** 69.3%	☑
Percentage of staff who would recommend the provider to family or friends needing care	To achieve average national performance against staff survey	On a scale of 1 to 5 3.50 ☒ **-2017**	Within national average TBC	TBC	
Percentage of staff experience harassment, bullying or abuse from staff in the last 12 months		**2017** 24% ☑	Within national average TBC	TBC	
Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion		**2017** 90% ☑	Within national average TBC	TBC	
Friend and family test	To increase Friends and Family response rates	16% (March 16 – Feb 17) ⊖	Over 20% in Emergency Department	16%	⊖
		32% ☑	Over 30% inpatient areas	30%	☒
CLINICAL EFFECTIVENESS					
Reduction in risk mortality indices	To monitor mortality indices (HSMR and SHMI) on a monthly basis – indices as expected	YTD 2017/2018 (Jan17-Dec17) SHMI: 102.32 ☑ HSMR: 96.05 ☑	To remain within expected parameters for mortality indices To introduce Learning from Deaths national policy	**TBC**	
Reduction in readmission to hospital (within 28 days)	To reduce emergency readmissions (provisional data results)	**0-15 years** 11.8% ☒	TBC	**0-15 years** 12.0%	☒
		16 years and over 12.7% ⊖		**16 years and over** 12.8%	☒
		Total 12.5% ⊖		**Total** 12.7%	☒

		2017/2018	2018/2019 Ambition	2018/2019 Position	
To reduce length of time to assess and treat patients in accident and emergency department	**Patient impact indicators:**				
	- Unplanned re-attendance no more than 5%	1.5% ☑	<5%	1.7%	☑
	- Left without being seen no more than 5%	2.4% ☑		2.3%	☑
	Timeliness indicators:				
	- 95% to be treated/ Admitted/discharged within 4 hours	91.4% ☒	95%	91.1%	☒
	- Time to initial assessment no more than 15 minutes	57mins ☒	15mins	43mins (Annual Average)	⊖
	- Time to treatment decision no more than 60 minutes	43mins ☑	60mins	41mins (Annual Average)	☑
Patient Reported Outcome Measure (PROM) *EQ-5D Index*	To gain better understanding of patient's view of their care and outcomes	2016/17 (Provisional)	National average	2017/18 (provisional)	
	- Hip	0.439 ☑	0.47	0.45	☑
	- Knee	0.324 ☑	0.34	0.336	☑
	- Hernia	0.072 ☒	-	0.090	☑
Maternity Standards (new indicator following stakeholder event)	To monitor compliance with key indicators:				
	- Breastfeeding intention	58.7% ⊖	60%	59.5%	⊖
	- Smoking in pregnancy	17.6% ☑	22.4%	16.6%	☑
	- 12 week booking	90.9% ☑	90%	90.3%	☑
	- Complete gap analysis against "Saving Babies lives" NHS England document	Gap analysis complete ☑	Implementation	Underway	☑

		2017/2018	2018/2019 Ambition	2018/2019 Position	
Paediatric care (new indicator following stakeholder event)	Improved paediatric pathways for urgent/ emergency care	Year 2 improvement demonstrated ☑	Demonstrate improved pathway	Improvement demonstrated	☑

Introduction to 2019/2020 priorities

Key priorities for 2019/2020 have been agreed through consultation with staff, governors, Healthwatch, commissioners, health scrutiny committees and other key stakeholders. As an integrated organisation it is important that our priorities are applicable to both acute and community services. The priorities therefore cover both of these care providers wherever appropriate. Throughout the year we have updated both our staff and stakeholders on progress against our quality improvement targets. In addition an event was held earlier in the year where a series of presentations were given to a wide range of staff and stakeholders. All were in agreement that these events were very useful in informing the priorities for the coming year and identifying the areas for continued monitoring.

The table below summarises the specific priorities and objectives that have been agreed for inclusion in the 2019/2020 Quality Accounts. The table also indicates where this is a new or mandatory objective and where this is a continuation of previous objectives. While most of the priorities are not new we have introduced different methods for monitoring where the priority has changed or the service objectives have changed.

Priority	Rationale for choice	Measure
SAFETY		
Patient Falls[1] **(Continuation)**	Targeted work continued to reduce falls across the organisation and the introduction of the dedicated falls team To ensure continuation and consolidation of effective processes to reduce the incidence of injury. To continue sensory training to enhance staff perception of risk of falls. To continue a follow up service for patients admitted with fragility fractures.	- To continue the introduction of the Trust Falls Strategy, covering a 3 year period. - To agree a plan of year 2 actions. - To monitor implementation of year 2 actions against the Strategy.
Care of patients with dementia[1] **(Continuation)**	Continued development and roll out of a dementia pathway and monitoring of care for patients with dementia.	- The dementia screening tool has been incorporated into the electronic nerve centre, and removes the need for paper base assessment. - The next step is to migrate the data from nerve centre to formulate the national reporting criteria. This generates the

		statistics for measuring compliance with undertaking the dementia assessment. This will be migrated the end of the year. - Action plan developed from the NAD the intention is to utilise the finding from the 2018 NAD to see if there have been any changes in practice/improvements. - Carers survey has been completed. The recommendations are to be monitored alongside the national dementia audit recommendations. The action plans have been merged and form the Strategy Action Plan 2019/2020.This will be monitored. - Participate in a 5 year research project of dementia services within the Durham area to continue during 2019/2020. Participation to continue. - Continue the study in the development of a good practice audit tool for assessing patient care and services for those living with dementia. Participation to continue.
Healthcare Associated Infection **MRSA bacteraemia**[1,2] **Clostridium *difficile***[1,2] ***(Continuation and mandatory)***	National and Board priority. Further improvement on current performance.	- Achieve reduction in MRSA bacteraemia against a threshold of zero. - No more than TBC cases of hospital acquired Clostridium *difficile.* - Both of these will be reported onto the Mandatory Enhanced Surveillance System and monitored via Infection Control Committee.
Discharge summaries[1] **(Continuation)**	To improve timeliness of discharge summary completion.	- Data collected via electronic discharge letter system and monitored via monthly performance reviews and Board reporting. - Care Groups undertake consultant level audits - Train 2019 intake of new junior doctors
Rate of patient safety incidents resulting in severe injury or death [1,2] **(Continuation and mandatory)**	To increase reporting to 75th percentile against reference group.	- Cascade lessons learned from serious incidents. - NRLS data. Enhance incident reporting to 75th percentile against reference group. - Continue to embed Trustwide

		work to embed and improve reporting of near miss and no harm incidents.
Improve management of patients identified with sepsis[3] **(Continuation)**	To maintain improvement in relation to management of sepsis	- Continue to implement sepsis care bundle across the Trust. - Continue to implement and embed post one hour pathway. - Continue to audit compliance and programme. - Hold professional study days.
EXPERIENCE		
Nutrition and Hydration in Hospital[1] **(Continuation)**	To promote optimal nutrition and hydration for all patients.	- Continue to work closely together on hospital menu development and nutritional analysis. - Continue to work closely with Speech and Language Therapy colleagues within the Trust towards achieving International Dysphagia Diet Standardisation Initiative (IDDSI) ward menus and nutritional products. - In terms of hydration we will consider how we maintain and monitor sufficient hydration status of patients requiring both artificial (intravenous or enteral) and non-artificial hydration support. - We will explore how CDDFT might require alternative ways of measuring oral fluid intake at ward level.
End of life and palliative care[1] **(Continuation)**	We now have an effective strategy and measures for palliative care. The measures are derived from the strategy and will support each patient to be able to say: *"I can make the last stage of my life as good as possible because everyone works together confidently, honestly and consistently to help me and the people who are important to me, including my carer(s)"*	- We will work with CCG and NEAS to agree a comprehensive approach to personalised care planning. - We will work with regional partners to develop electronic sharing of key palliative care information (ePaCCS). - We will support and monitor new out of hours advice service. - We will continue to deliver palliative care mandatory training for all staff. - We will implement actions from postal questionnaire of bereaved relatives (VOICES). - We will implement actions and learning from Care of Dying Audit.
Responsiveness to patients personal needs[1,2] **(Continuation and mandatory)**	To measure an element of patient views that indicates the experience they have had.	- Continue to ask the 5 key questions and aim for improvement in positive responses in comparison to last

		years results. - Quarterly Reports to Integrated Quality Assurance Committee and any emerging themes monitored for improvement through the Patient Experience Forum. - The Trust will continue to participate in the national inpatient survey.
Percentage of staff who would recommend the trust to family or friends needing care[1,2] **(Continuation and mandatory)** **Percentage of staff experience harassment, bullying or abuse from staff in the last 12 months[2]** **(Mandatory measure)** **Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion[2]** **(Mandatory measure)**	To show improvement year on year bringing CDDFT in line with the national average.	- To bring result to within national average. - Results will be measured by the annual staff survey. Results will be reviewed by sub committees of the Trust Board and shared with staff and leaders and themes considered as part of the staff engagement work. - In addition we will continue to report results for harassment & bullying and Race Equality Standard.
Friends and Family Test[1] **(Continuation)**	Percentage of staff who recommend the provider to Friends and Family.	- During 2019/2020 we will increase or maintain Friends and Family response rates. All areas participating will receive monthly feedback and a quarterly report of progress and will be monitored by the Trust Board.
EFFECTIVENESS		
Hospital Standardised Mortality Ratio (HSMR)[1] **Standardised Hospital Mortality Index (SHMI)[1,2]** **(Continuation and mandatory)**	To closely monitor nationally introduced Standardised Hospital Mortality Index (SHMI) and take corrective action as necessary. To embed "Learning From Deaths" policy	- To monitor for improvement via Mortality Reduction Committee. - To maintain HSMR and SHMI within expected levels. - Results will be captured using nationally recognised methods and reported via Mortality Reduction Committee. We will continue to benchmark both locally and nationally with organisations of a similar size and type. Updates will be submitted to Trust Board via the performance

		scorecard. - Trust mortality review process, allocation of priority reviews to central review team for completion will continue to ensure any learning, positive and negative, is embedded in patient care. - Embed "Learning from Deaths" policy. - In line with national changes the post of Lead Medical Examiner has been advertised. The successful post holder will lead the introduction of the Medical Examiner System, during the coming months.
Reduction in 28 day readmissions to hospital[1,2] **(Continuation and mandatory)**	To implement effective and safe care closer to home, improving patient experience post discharge.	- Further development of multi-disciplinary Teams Around Patients (TAPS). - Safe discharge is a key theme of the Transforming Emergency Care programme. - Monitoring through monthly performance reviews and Board reporting.
To reduce length of time to assess and treat patients in Accident and Emergency department[1,2] **Continuation and mandatory)**	To improve patient experience by providing safe and timely access to emergency care.	- Daily monitoring of performance indicators against NHSI and national 95% standards. - Monitoring through monthly performance reviews and Board reporting. - Transforming Emergency Care programme. - Review of escalation procedures.
Patient reported outcome measures[1,2] **(Continuation and mandatory)**	To improve response rate.	- To aim to be within national average for improved health gain. - NHS England have removed groin hernia and varicose vein from mandatory data collection, hip and knee will continue.
Maternity standards (new indicator following stakeholder event)	To monitor compliance with key indicators.	- Continue to monitor for maintenance and improvement in relation to breastfeeding, smoking in pregnancy and 12 week booking. - Monitor actions taken from gap analysis regarding "Saving Babies Lives" report.
Paediatric care (new indicator following stakeholder event)	Embed paediatric pathway work stream.	- Continue development of more direct and personal relationships with individuals within Primary and Secondary care by building on the work already undertaken.
Excellence	To ensure that CDDFT	- A monthly report to the Executive

Reporting (new indicator following stakeholder event)	continues to embed learning from excellence into standard culture and practice through Excellence Reporting.	and Clinical Leadership Committee (ECL) incorporating total Excellence Reports for the preceding month, a Care Group breakdown, highlights of departments with the most excellence reports and common themes. - A quarterly report to the Integrated Quality Assurance Committee (IQAC) summarising the ECL report and encompassing summary from learning from excellence group.

1 - continuation from previous year

2 - mandatory measure

3 - new indicator following stakeholder events

Review of performance against priorities 2018/2019

The following section of the report focuses on our performance and outcomes against the priorities we set for 2018/2019. These will be reported on individually under the headings of Safety, Patient Experience and Clinical Effectiveness. Wherever available, historical data is included so that our performance can be seen over time.

During 2018/2019 we will incorporate a section to include changes to services and their impact, with a particular emphasis on access to clinical services and whether their effectiveness has been diminished through service change. **To be added**

PATIENT SAFETY

Patient Falls

☑	Patient falls – reduce falls/1000 bed days community hospital.

☑	Patient falls – reduce falls/1000 bed days acute hospital.

Our Aim

Our aim is for full commitment and focus on continued improvement in all areas of the organisation to identify high risk patients and put in place falls prevention strategies. This will be realised with the work identified for year two of the multi agency falls strategy. Data is captured in the monthly incident report and as part of the Board performance monitoring data.

Progress

For monitoring purposes the Trust continues to measure the number of falls against the national mean. This remains at 5.6 per 1000 bed days for acute and 8.0 per 1,000 bed days for community and we have come in on target achieved below this for 2018/19.

Over 1,000 staff members have been trained in sensory awareness focusing on the vulnerability and risk factors which also link with falls risk and cognitive impairment problems. The actions from year one of the strategy has seen an 8% reduction in inpatient falls and we aim to have the same success during the second year.

The Royal College of Physician (RCOP) inpatient fracture neck of femur audit has commenced and the Trust is fully engaged with data collection for this..

Next Steps
The priority focus for Year 2 of the Falls Prevention Strategy is to be on collaborating with other agencies. Early prevention work will focus on health & wellbeing of the patient.

Work will continue with the regional falls group and quality improvement cycles will become utilised further and findings embedded in practice.

Care of Patients with Dementia

☑	Trust ambition achieved

Our Aim
To provide appropriate care for patients with cognitive impairment and monitor effectiveness of interventions using the Trust dementia strategy as the principle monitoring tool. To ensure patients with dementia and their families have a positive experience of the care provided by the Trust.

Progress
As stated on page 12/13 this action plan was shared with all matrons and department head, ward sisters in 2017, as NAD 4th round took place 2018, to utilise resources effectively the intension is to use the evidence from the NAD 4th round to see if there has been any improvements.

The Trust dementia strategy has been introduced and an action plan to monitor implementation of this has been developed. The areas for action and improvement are identified below and these have been shared across the Trust.

Outcome	Actions
Cognitive tests assessed on admission and again before discharge.	➢ Highlight at training sessions for medics and nurses. ➢ Promote amongst clinical leads. ➢ Promote in team meetings, handovers and in supervision.
Record factors which may cause distress and the action or actions which can help calm the patient.	

Outcome	Actions
Promote the use of *"This is me"* booklet involving patients and carers.	Ward managers and clinical teams to promote the use of the booklet in initial training, team meetings, handovers and in supervision.
Implement the use of personal patient information from "this is me/hospital passport "into care plans.	Ward managers and clinical teams to promote the use of the booklet in initial training, team meetings, handovers and in supervision.
Information regarding the episode of delirium recorded on the electronic discharge summary.	➢ Highlight at training sessions for medics and nurses. ➢ Promote amongst clinical leads. ➢ Promote in team meetings, handovers and in supervision.
Implementation of carers' passport to enable carers to be given appropriate support.	➢ Highlight at training sessions for medics and nurses. ➢ Promote amongst clinical leads. ➢ Promote in team meetings, handovers

	and in supervision.
Staff are trained in mental capacity, consent, best interest's decision making, lasting powers of attorney and supportive communication with family/carers on these topics.	➢ Safeguarding lead to ensure training is in place for medical and nursing staff. ➢ Highlight at training sessions for medics and nurses. ➢ Promote amongst clinical leads. ➢ Promote in team meetings, handovers and in supervision.

Outcome	Actions
Site nurse practitioners and bed managers to develop expertise in dementia care to ensure support for staff 24 hours per day 7 days per week.	➢ Dementia care to be built into Trust training. ➢ Clinical supervisors to promote attendance at training by relevant staff.
Ensure staff receive training in delirium and its relationship with dementia, manifestations of pain, behavioural & psychological symptoms treatment, care.	

Outcome	Actions
Further develop, implement and promote the finger food menu.	➢ Nutritional steering group to continue to lead nutritional improvements. ➢ At local level, appoint nutritional champions. ➢ Ward managers and clinical teams to promote the use of the booklet in initial training, team meetings, hand-overs and in supervision.
To promote the variety of ward based snacks available to patients in their area.	

Outcome	Actions
Patients, families/carers are involved in discharge planning. Carers are identified at first contact or as soon as possible after this.	➢ Discharge policy embodies good practice principles. ➢ Discharge management, Ward teams and discharge lounges work together with patients, carers and with other agencies to ensure discharge care packages take account of the dementia-related needs of patients.
Before a person is discharged, their physical, psychological and social needs will be assessed. The person with dementia and someone involved in their day-to-day care should be fully involved in this assessment. Plans about the date and time of discharge should be discussed with the person and their carer.	
Any organisations that will be providing services must be informed of the date and time of the person's discharge, and when they should start to provide the services.	
Documented evidence in the notes that the discharge planning and support needs have been discussed with the multi – disciplinary team , patient, family, carer, care home.	

Theme 6: Governance

Action/s agreed	By whom?
Continue to offer dementia awareness training to all staff.	➢ Dementia training to be provided for all medical and nursing staff.
Compliance with training and good practice is encouraged and supported.	➢ Feedback to Trust dementia lead. ➢ Use of national Audit data and processes.

Next Steps

- Formal monitoring against the elements of the strategy as identified above with clear escalation for support if there is any lapse in implementation

MRSA bacteraemia (also see Page 106)

☒	Trust ambition not achieved.

Clostridium *difficile*

⊖	Trust ambition achieved

What is MRSA? Meticillin resistant Staphylococcus aureus is a bacterium found on the skin and in the nostrils of many healthy people without causing problems. It can cause disease, particularly if there is an opportunity for the bacteria to enter the body, for example through broken skin or during a medical procedure. If the bacteria enter the body, illnesses which range from mild to life-threatening may then develop. Most strains are sensitive to the more commonly used antibiotics, and infections can be effectively treated. MRSA is a variety of Staphylococcus aureus that has developed resistance to meticillin (a type of penicillin) and some other antibiotics used to treat infections.

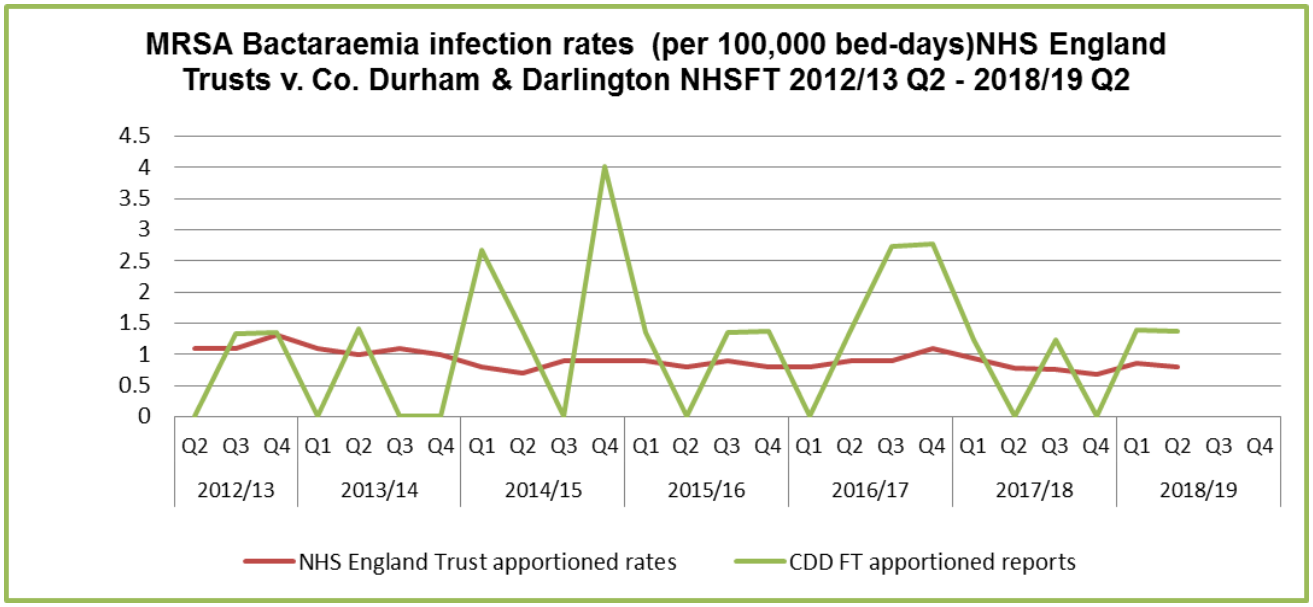
Our aim

The trust aims to deliver on the zero tolerance approach to MRSA Bloodstream infections NHS commissioning boards planning guidance “Everyone Counts; planning for patients 2014/2015 to 2018/2019”and reiterated in Guidance on the reporting and monitoring arrangements and post infection review process for MRSA bloodstream infections from April 2014 (version 2) March 2014

Progress

CDDFT has reported 2 cases of MRSA Bacteraemia since April 2018 which puts the Trust above its annual threshold of zero avoidable infections. Post infection review has been carried out for both cases. The source of infection could not be determined for case 1, and the source of bacteraemia for case 2 was thought to be cannula related. The findings of the post infection review have been shared at many forums within the organisation

Graphs below indicate the trust position at the May 2018 and Trust performance against trajectory from Q2 2012/13



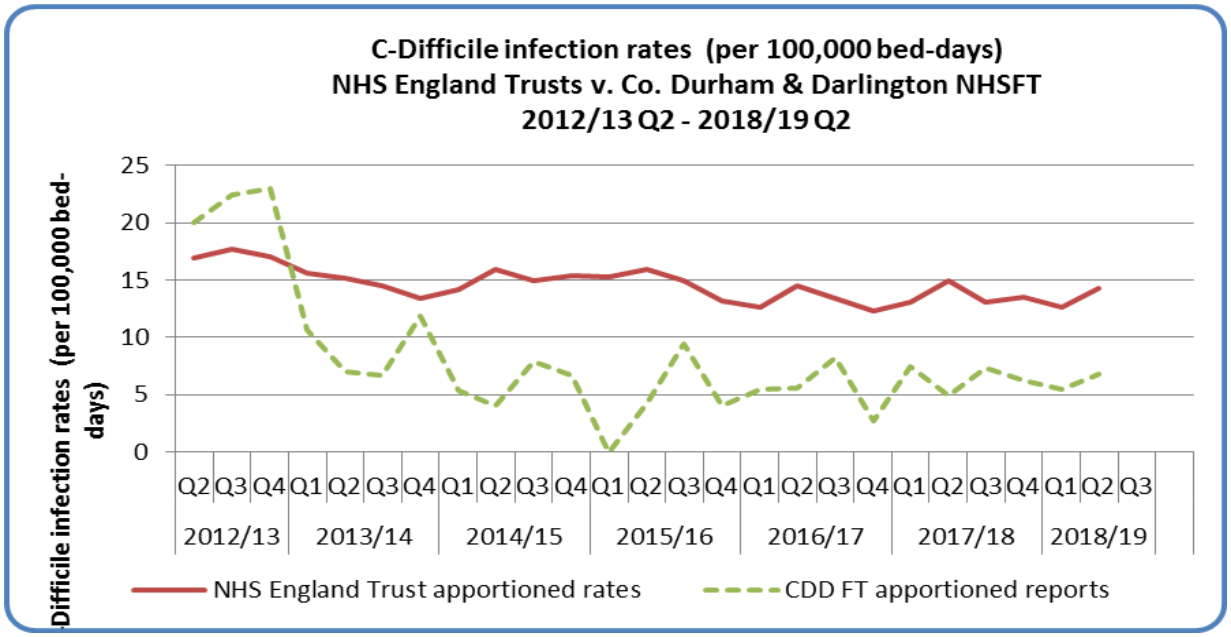
Actions for improvement

- Focus on MRSA Screening and decolonisation
- Focus on monitoring Intravenous line care

Clostridium *difficile* (also see Page 106)

What is Clostridium *difficile*? It is a bacterium that can live in the gut of a proportion of healthy people without causing any problems. The normal bacterial population of the intestine usually prevent it from causing a problem. However, some antibiotics used to treat other illnesses can interfere with the balance of bacteria in the gut which may allow Clostridium *difficile* to multiply and produce toxins. Symptoms of Clostridium *difficile* infection range from mild to severe diarrhoea and more unusually, severe bowel inflammation. Those treated with broad spectrum antibiotics, with serious underlying illnesses and the elderly are at greatest risk. The bacteria can be spread on the hands of healthcare staff and others who come into contact with patients who have the infection or with environmental surfaces contaminated with the bacteria.

CDDFT have reported 19 cases against an upper threshold of 18. Our performance in rate /100,000 bed days remains one of the best nationally. Many strategies and focused interventions have been introduced throughout this year and will be continued.



***Clostridium difficile* appeals process**

Clostridium difficile appeal meetings have been held with CCG and NHS England local area team where 2 cases have been presented for appeal and were upheld. This means that following a review of each case no lapses of care have been identified as a cause or contributory to the *Clostridium difficile* infection.

Actions for Improvements

- Focus on early identification and isolation
- Targeted work with the areas where *Clostridium difficile* has been identified
- Continue with Antimicrobial stewardship programme

Next steps

A comprehensive action plan is being developed for 2019/20 for all hospital acquired infection improvement goals,

The actions will include but not be limited to:

- Further focus on antibiotic stewardship in particular monitoring of antibiotic prescribing across the health economy. The Trust antimicrobial team will continue their work in reviewing the Antimicrobial policy and guidelines, evaluating antimicrobial use, and providing feedback to physicians. The team are responsible for optimising antimicrobial use in the hospital by improving compliance with the guidelines, through education and regular audit of practice.
- Continuation of hand hygiene audit with a focus on publically displaying results and awarding areas with 100% compliance for more than a year.
- Implement new guidelines to respond to the risk of infection from emerging infectious disease, new strains and antibiotic resistance.
- We will continue to monitor and maintain progress in reducing the number of infections attributable to the Trust.
- Sentence on new metrics to be added

E-Coli Bacteraemia

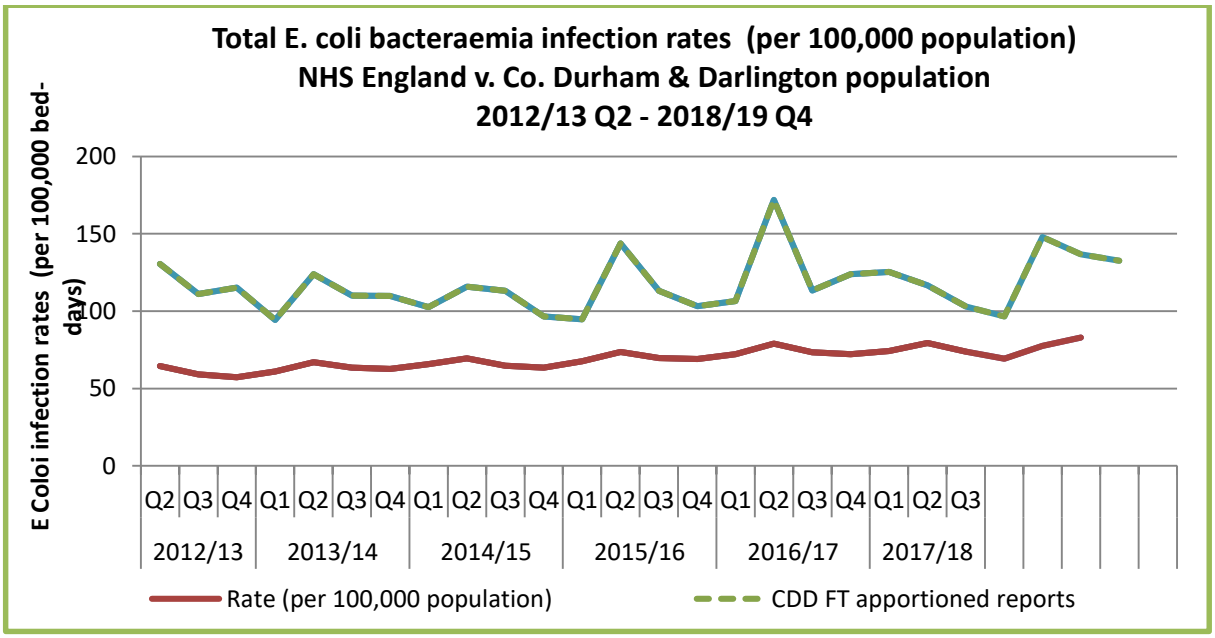
What is Escherichia coli? *Escherichia coli* (abbreviated as *E. coli*) is a Gram-Negative bacteria found in the environment, foods, and intestines of people and animals. Although most strains of *E. coli* are harmless, others can make you sick. Some kinds of *E. coli* can cause diarrhoea, while others may cause urinary tract infections, respiratory illness pneumonia, blood stream infections and other illnesses. In May 2017 the Secretary of State for Health launched an ambition to reduce healthcare associated Gram-negative bloodstream infections by 50% by 2021 and reduce inappropriate antimicrobial prescribing by 50% by 2021.The initial focus is on reducing E.coli Blood stream infections by 10%

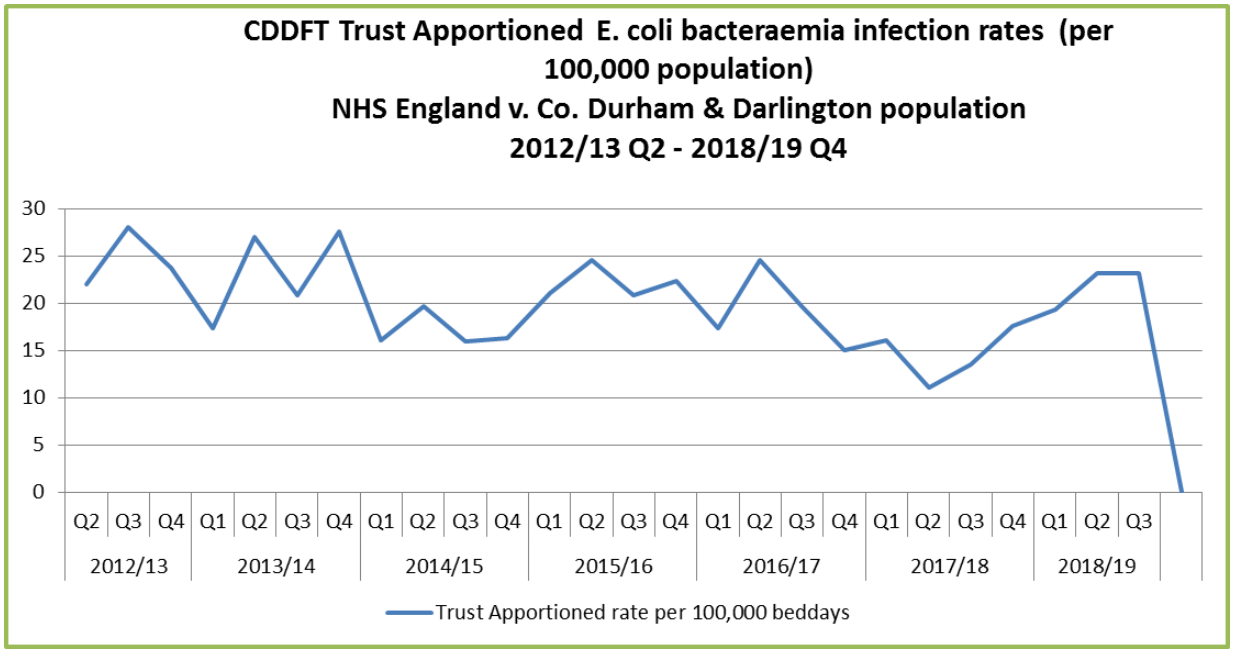
It is known that 75% of E coli bacteraemia are community onset so we are working closely with CCG colleagues on a whole health economy action plan.

The Trust reported a total of 339 cases for year 2018-2019 with 55 of these being "hospital onset" we have been working in collaboration with CCG's and implemented a local action plan to reduce total number of EColi Bacteraemia particularly those related to urinary catheters.

Actions for Improvement

- Sepsis recognising when something is not normal and escalating adhering to best practice for recognising and treating sepsis
- Preventing CAUTI; Management of patients with Urinary catheter, understanding need for catheter and planning TWOC, using alternatives such as ISC, ensuring patient has been given completed hand held passport. Adhering to trust policy and best practice.
- Preventing UTI: keeping patients hydrated. Ensure patient able to wash hands after using the toilet and before meals.
- Don't use urine dipsticks to diagnose UTI
- Good antimicrobial stewardship
- Education and Training. Ward/department Link Champions
- IV access, monitoring and management of lines





Pressure Ulcers

☒	Trust ambition not achieved

Our aim
For patients within our care to have no avoidable grade 3 or above pressure ulcers.

Progress
We have continued to carry out a full review of all patients identified with grade 3 and above pressure ulcers whilst in our care. Whilst we have seen increased focus and improvement in this area, we still have further to go and are disappointed that there have still been incidences of these throughout the year as identified below.

Although there has been an increase within community of Category 3/4, review of these cases has found that the patient is sometimes non-concordant with the advice given.

Acute Services Hospitals – DMH, UHND, CLS, Shotley Bridge	**Avoidable Category 2**	**Avoidable Category 3/4**
2012/13	34	3
2013/14	16	4
2014/15	13	7
2015/16	2	1
2016/17	4	1
2017/2018	0	1
2018/2019	5	2

Community Services Richardson Hospital, Weardale Community, Sedgefield Community and all patients under care of DN teams	**Avoidable Category 2**	**Avoidable Category 3/4**

2012/13	23	3
2013/14	2	3
2014/15	2	2
2015/16	0	4
2016/17	2	3
2017/2018	0	3
2018/2019	0	7

This will remain a primary objective for 2019/2020 as we continue with improvement measures to achieve our aspiration of zero avoidable pressure ulcers.

Next steps
We are implementing the NHSi recommendations and will be reporting Moisture Associated Skin Damage (MASD) and the following classification of Pressure ulcers, Category 2,3 and 4's, this will also now include Medical Device related pressure damage, unstageable ulcers and Deep Tissue Injuries. A short root cause analysis will be undertaken for all newly acquired grades 3 and above incidents so that any remedial actions are identified, addressed and if necessary a full review meeting will be undertaken. Newly acquired Category 2 ulcers will have a questionnaire completed by manager and any necessary actions put in place.

Tissue viability education across acute hospitals has been rolled out across all areas and will be commencing in April for all community areas with a dedicated module and competency assessments.

There is current an ongoing implementation of new higher specification mattresses as standard across the Trust. New bedframes were installed in 2018 27 across all areas of the trust.

New innovative work ongoing within Project team for Tissue Viability.

Discharge Summaries

☒	Trust ambition not achieved

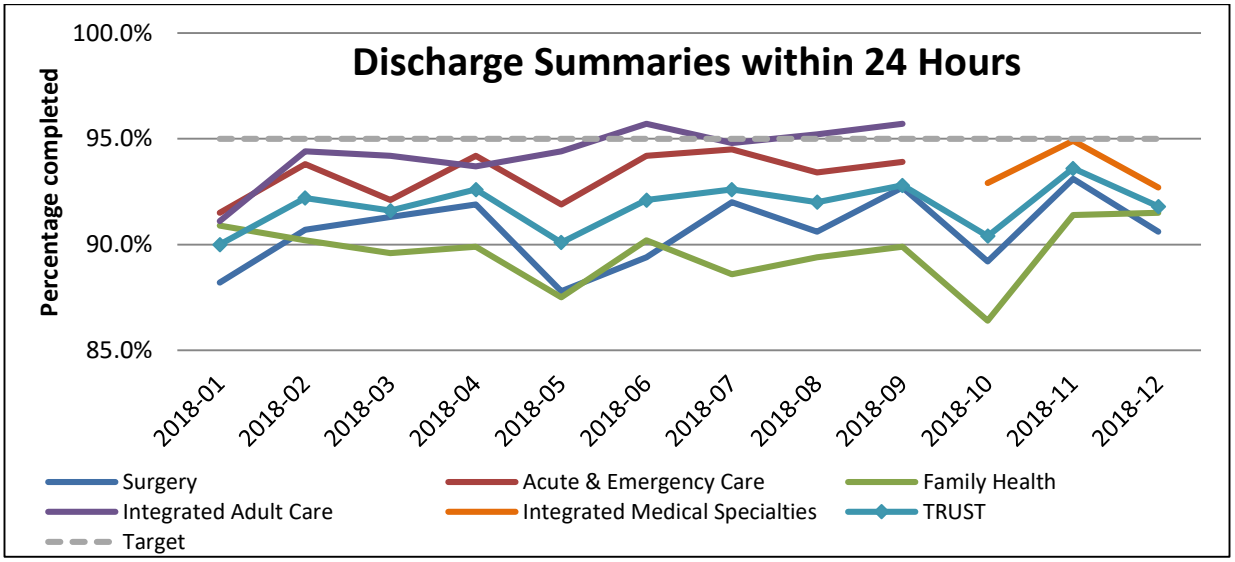
Our aim
To send 95% of discharge letters within 24 hours of discharge.

Progress
This remains a high priority for GPs. Without timely discharge information it is difficult for them to provide effective and safe follow-up care for their patients after a hospital stay.

At Trust-level, performance regularly continues to exceed 90% but falls short of the 95% target. As at the end of Q3, the Trust-wide average is 91.8%. The Surgery (93.5%) and Integrated Medical Specialties (90.7%) Care Groups averaged in excess of 90%; Family Health achieved 88.7%. A significant dip in performance in the Autumn usually coincides with the latest intake of junior doctors who have a crucial role in writing discharge letters. A further dip in December is due to holidays.

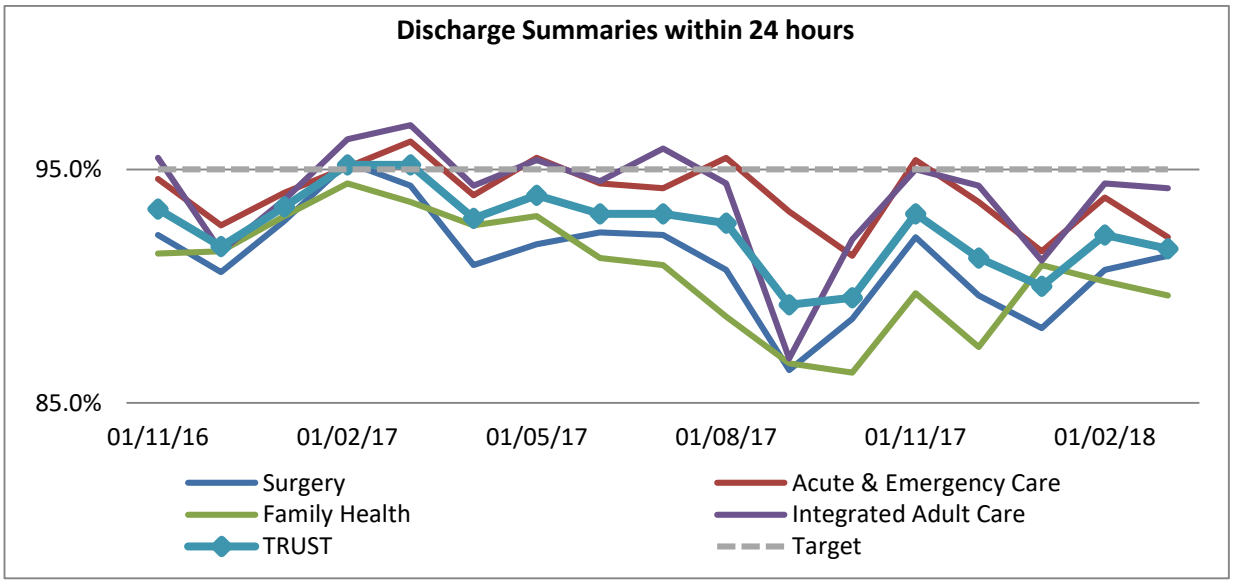
Each Care Group has a responsible lead manager and a comprehensive weekly dataset is sent to Care Groups to enable them to identify variation and manage performance at specialty, consultant and ward level. Care Groups provide training for new junior doctors and regular reminders are sent emphasising the importance of this target. The performance of each Care Group is monitored in Performance Reviews and Executive-led reviews. Progress

is also reported monthly to the Executive and Clinical Leaders Group, the Integrated Quality and Assurance Committee and to the Trust Board.



Next steps

Current reporting arrangements will continue and the Trust will continue to re-emphasise to all front-line staff its clinical importance.



Rate of patient safety incidents resulting in severe injury or death (from NRLS)

⊖	Improvement demonstrated but ambition not achieved

The National Reporting and Learning Service (NRLS) system enables safety incident reports to be submitted to a national database on a voluntary basis and is designed to promote learning. It is mandatory for NHS Trusts in England to report all serious incidents to the Care Quality Commission as part of the registration process. The Trust's NRLS results for April

2017 to September 2017 show that we are in the mid 50% of reporters. This is calculated as a comparison against a national peer group, which is selected according to type or trust.

Never Events

Disappointingly, the Trust reported four never events during the period. A never event is defined as an incident that should not occur if correct procedures and policies are in place. The Never Events are shown below alongside a brief description of actions implemented to prevent recurrence. These are also described below.

Overdose of insulin due to abbreviations or incorrect device

Insulin drawn up into a U100 Insulin syringe from a U300 Insulin pen

- Patient was administrated a dose that was 3 fold of what the dose should have been.
- This is a reminder to all staff that insulin **must not** be withdrawn from an insulin pen or pen refill and then administered using a syringe and needle.
- Please ensure you are familiar and comply with the Trust Medicine Policy (POL/MM/0001) which stipulates that:
- **Insulin doses must only be measured and prepared for administration using an insulin syringe or commercial insulin pen device.**

Wrong Implant

Wrong Ureteric stent

- During bilateral replacement of failed stents for Ureteric obstruction a previously removed stent was re-inserted into the patient.
- Policy to be reinforced at every handover for two weeks in terms of:
  - All items removed from patient to be immediately placed in waste sack.
  - Before opening pack onto theatre trolley all new implants to be checked for size, expiry and integrity of packaging with product labels to be inserted into theatre log and care plan.
  - Identification of side to be written on product liability label.
- Implant pause to be introduced.

Transfusion/ transplantation of ABO-incompatible blood components or organs

ABO mismatched blood transfusion

- Patient with A negative blood type was administered a small volume of B positive blood transfusion, which was prescribed for a different patient.
- The patient was not wearing an identification wrist band and positive identity was not confirmed.
- This is a reminder to all staff of the importance of pre-transfusion checks and positive patient identification as per the Administration of Blood and Components policy (POL/Transfusion/0001):
  - Two Qualified nurses/Midwives or the doctor & Qualified nurse/Midwife must check **at the patient's bedside** the Blood Transfusion pathway, compatibility label on blood pack, and patient's identity band and ensure the following details are identical on all of them prior to administration:-
    a) Full name
    b) Date of Birth.
    c) Hospital Number
    N.B. Where possible, ask the patient to state his/her full name and date of birth.
    Ensure the patient is wearing a correctly completed identity band, NO WRISTBAND NO TRANSFUSION

- Please ensure you are familiar and comply with the policy for correct identification of patients (POL/N&Q/0004) which stipulates the procedures for patient identification wristbands, and the positive identification of patients (including for patients that are unable to identify themselves).

Wrong Site Surgery

Wrong side of toenail removed

- Patient due to have partial nail avulsion of medial section of nail, inadvertently had lateral section of nail also removed.
- Staff to ensure that they check marked sites and proposed procedures both with the patient and against the consent form.
- Standard Operating Procedures and LocSSIP checklists must be used effectively to ensure safety.

In considering the never events the following key themes have been identified:

- Human factors.
- Failure to comply with policy/procedures.
- Increased stress regarding site capacity and workload.

The never events that have occurred and learning identified have been shared widely across the organisation and through communications and presentations. The identified learning has been shared with local NHS organisations where staff involved in the incident has been employed with an external organisation, this is to ensure the learning is greater.

Regulation 28
The Trust received no Regulation 28 letters of the Coroner's Investigation Regulation during 2018/19.

Serious incidents
The Trust reported **90** serious incidents during 2018/19. All of these incidents have a full root cause analysis review and themes are identified from these.

Falls remain the highest reported incidents and actions taking place are reported in the falls section of the report.

County Durham & Darlington NHS Foundation Trust considers that this rate is as described for the following reasons:

- The data is cleansed by a member of the patient safety team prior to upload.
- The data within this category is agreed through Safety Committee and at Executive level prior to upload to NRLS.

Period	Apr15 Sept15	Oct15 Mar16	Apr16 Sept16	Oct 16 Mar17	Apr 17 Sept 17	Oct 17 Mar 18	Apr 18 Sep 18
Patient safety incidents	6100	5998	5238	5527	5334	5324	* Not available
CDDFT %age reporting Rate (1000 bed days)	40.5	38.85	35.17	37.66	36.75	35.64	* Not available
CDDFT %age severe injury & death	0.2	0.4	0.3	0.2	0.4	0.1	* Not available
National %age reporting rate (1000 bed days)	38.25	39.31	40.02	40.12	* Not available	* Not available	* Not available
National %age severe injury & death	0.4	0.4	0.4	0.3	* Not available	* Not available	* Not available

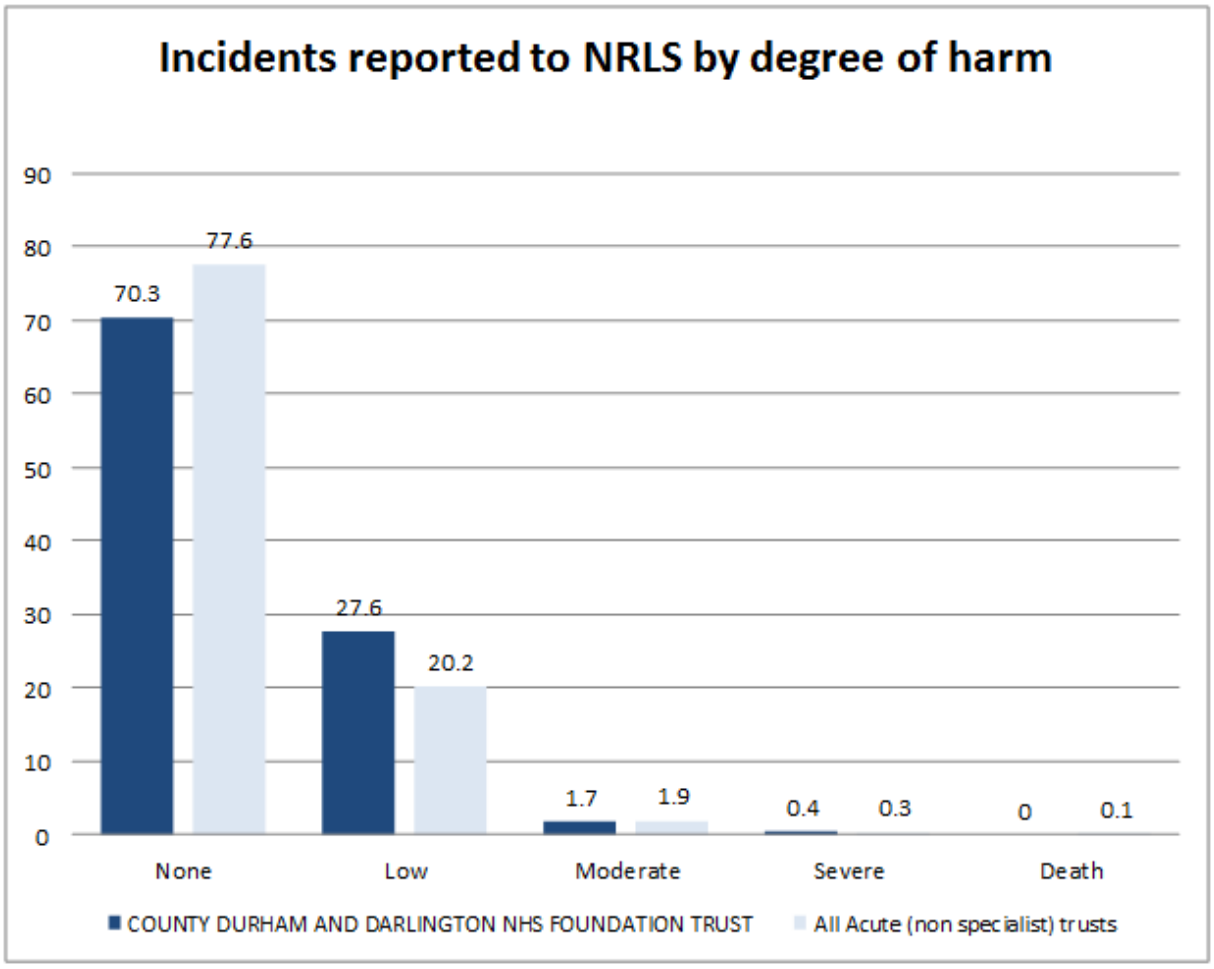
*From April 2018 the release of the organisation patient safety incident data workbook (official statistics) the NRLS organisation level summary report no longer include national average statistics.

Our aim
- To continue to aim for an increase in incident reporting to within the top 75% of reporters.
- To improve timeliness of reporting to and completion of reviews for moderate harm incidents.
- To encourage and support staff to report all incidents and near-misses so that we are sure there is an accurate and complete picture of patient safety issues.
- To monitor timeliness of reporting and completing serious incident reviews as per national guidance.

- To ensure that if a patient suffers moderate or above harm from an incident whilst in our care, they are given the opportunity to discuss this in full with relevant clinical staff and are assured that a review has taken place.

Progress

Incident Rate and National Median *(Apr – Sep17 NRLS Data)* *– Data not available yet to update graph*



Harm rating

The Trust remains an under reporter of no harm incidents (no harm and near miss on Safeguard) compared to the cluster average, whilst the percentage of low harm incidents reported is higher than average but further improvements have been seen in this period with both figures moving in the right direction.

Further work has been undertaken by the Patient Safety team to identify why we are under reporting no harm incidents and through analysis of the no harm and low harm incidents reported it seems that the incidents aren't always graded appropriately during the management process. In relation to the incidents reported and the percentages as outlined below by grading, CDDFT would be in line with other Acute (Non-specialist) organisations if the grading of some of the low harm incidents were correctly graded as no harm.

Therefore work is underway to encourage the managers to review the grading of harms when reviewing incidents, whilst encouraging staff to increase reporting of no harm and near miss incidents across the trust.

Next steps
County Durham & Darlington NHS Foundation Trust intends to take the following actions (outlined below) to improve this number and/or rate, and so the quality of its services.

- Progress against the themes highlighted above will be monitored at the bi- weekly Patient Safety Forum and Safety Committee dashboards.
- Care Groups will be expected to complete reviews within the specified time period and include the position in their Integrated Governance report that is produced quarterly.
- To undertake audit of current reporting of incidents to establish innovations to improve reporting of near miss/ no harm incidents within 2018/2019.
- To explore the standardisation of lessons learnt documentation.
- To consider the sharing of incident themes by speciality to involve staff in learning from incidents and mitigate the potential risk.

Improve management of patients identified with sepsis

☑	Trust ambition achieved

Our Aim
To continue to ensure that patients within our care with sepsis are rapidly identified and receive timely treatment.

Progress
The regional sepsis screening tool is integrated within Nervecentre for inpatients and Symphony for ED patients, meaning that all patients within CDDFT are automatically screened for sepsis. For those inpatients screening positive for sepsis the Sepsis bundle is also within Nervecentre allowing the staff to complete it electronically. A post one hour sepsis bundle has been piloted in the clinical areas in 2018/19.

Next Steps
County Durham & Darlington NHS Foundation Trust intends to take the following actions (outlined below) to improve this number and/or rate, and so the quality of its services. The further actions identified to ensure compliance is maintained are to:

Continue to closely monitor the e-screening and timeliness of bundle delivery to target education in specific areas of weakness and improve the quality of care for patients with Sepsis.

Evaluate the pilot of the post 1 hour bundle and implement it across the Organisation.

Complete Trust wide audit and monitor sepsis mortality.

Duty of Candour

☑	Trust ambition achieved

What is duty of candour?
From the 27 November 2014 Duty of Candour placed a statutory requirement on health providers to be open and transparent with the 'relevant person' (usually the patient, but also family members and/or carers) should an incident resulting in harm occur. The Care Quality Commission Regulation 20 prescribes health providers to inform and apologise to the 'relevant person' if the provider has caused harm. The statutory duty is activated when a 'notifiable' patient safety incident occurs which causes harm. The definitions of harm are:

- The **death** of a patient occurs when due to treatment received or not received (not just the patient's underlying condition).
- **Severe** harm is caused – in essence permanent serious injury as a result of care provided.
- **Moderate** harm is caused – in essence, non-permanent serious injury or prolonged psychological harm (a minimum of 28 days).

Our Aim

The regulation outlines that where the harm threshold has been breached; specific reporting requirements need to be followed. Therefore the Trust has implemented the process below for *moderate harm and above events*, to ensure they meet statutory requirements:

- An apology must be given as soon as possible following identification of a patient safety event that is considered moderate or above harm.
- All information must be documented in the patient notes, which includes that a verbal apology has been given and letter of apology is being prepared to be sent within the 10 day framework, using the agreed Duty of Candour template.
- A written apology must be sent or given to the patient and/or relatives/carers within 10 working days of event being identified. A copy of the letter of apology should be attached to the Ulysses Incident Management system.

This information is recorded by staff completing the manager's actions on the electronic Ulysses Incident Management system, which is extracted fortnightly to illustrate compliance with the duty of candour process.

Progress

The Trust current compliance with Duty of Candour is 94%.
Since the implementation of the Duty of Candour regulation the Trust has undertaken a number of actions to ensure compliance as outlined below:

- Ulysses Incident Management system enables staff to record the elements of Duty of Candour to allow monitoring of Trust compliance.
- The development of an agreed sticker for staff to place in the patients notes to record that Duty of Candour has been completed e.g. verbal apology that is to be scanned into the patient's record. This has been incorporated into the Trust Being Open/Duty of Candour Policy.
- Internal and external audits have been undertaken with 2018/19 and recommendations have been implemented to strengthen the Duty of Candour process within the Trust.
- Duty of Candour continues to be included in various Trust wide training programmes such as corporate staff induction, essential training, and root cause analysis.
- A standalone training programme is available for Duty of Candour; however, the uptake continues to be poor.
- Fortnightly Duty of Candour compliance reports are reviewed at the Patient Safety Forum.
- Care Group Leads alongside their Service Manager(s) will ensure that Duty of Candour is recorded in Ulysses Incident Management system.

Next Steps

County Durham & Darlington NHS Foundation Trust intends to take the following actions (outlined below) to improve this number and/or rate, and so the quality of its services. The further actions identified to ensure compliance is maintained are to:

- Continue to monitor Duty of Candour compliance fortnightly in Patient Safety Forum and to highlight incidents that have not met the agreed timescales for further learning.
- Further education with staff groups in recording Duty of Candour via Trust wide training programmes and bespoke training days.

- To embed the use of the patient record sticker to document that Duty of Candour has been completed and evaluation of the implementation within 2019/2018.

MATERNITY STANDARDS

Maternity Standards: Breastfeeding

⊖	Trust ambition not achieved but improvements made

Our Aim
To improve breastfeeding initiation rates – Target 60%.
This data collected is CSC breastfeeding intention in relation to this indicator.

Progress
Year to date performance 2018/2019 – 59.5%.

Next Steps
County Durham & Darlington NHS Foundation Trust is taking the following actions (outlined below) to improve this number and/or rate, and so the quality of its services:

- The Infant Feeding Team is currently under reconfiguration and all options are being considered to ensure optimum benefits for the service.

- Preparation for UNICEF UK Baby Friendly Accreditation re-assessment is progressing; this will take place in 2020.

- Alongside the UNICEF UK re-assessment we are working towards achieving the UNICEF UK Gold Award which recognises sustainment of standards, within this award all senior manager and managers expected to support proportionate responsibility and accountability and help to foster an organisation that protects and promotes the Baby Friendly Standards.

- The Infant Feeding Team are involved in the Maternity Neonatal Collaborative project in supporting high risk mothers to obtain breast milk for their babies. This includes Colostrum harvesting from 36 weeks of pregnancy.

- Many other mothers who have previously formula fed are Colostrum harvesting by choice. This also reduces the need for formula supplementation for high risk babies.

- The Infant Feeding Training Curriculum has been revised to recognise further developments in infant feeding and all staff are expected to attend an annual 4 hour update followed by practical assessments.

- The development of a Specialist Infant Feeding Clinic to provide information and support to mothers with complex needs is under discussion with a priority to promote the value of breastfeeding.

Maternity Standards: Smoking in Pregnancy

☑	Trust ambition achieved

Our Aim
To reduce the number of women smoking at delivery – Target 22.4%.

Progress
2018/2019 performance – 16.6%.

Next Steps
County Durham & Darlington NHS Foundation Trust intends to take the following actions (outlined below) to improve this number and/or rate, and so the quality of its services. The further actions identified to ensure compliance is maintained are to:

- There has been a change to Carbon Monoxide (CO) monitoring in antenatal women, all women have CO monitoring done on every contact and the policy is being updated to reflect that.

- Introduction of CO monitors on the Maternity Wards to enabling monitoring of women on Antenatal or Postnatal Wards.

- The Trust is involved with the Local Maternity Systems Reducing Smoking in Pregnancy Project. This includes additional Very Brief Awareness training for staff and development of a Regional Tobacco Dependency in Pregnancy Pathway.

Maternity Standards: 12 week booking

☑	Trust ambition achieved

Our Aim
To increase the number of women booked for maternity care by 12 weeks + 6 days – Target 90.0%.

Progress
2018/2019 Performance 90.3%.

Next Steps
County Durham & Darlington NHS Foundation Trust intends to take the following actions to improve this number and/or rate, and so the quality of its services. The further actions identified to ensure compliance is maintained are to:

- Include information about early booking on maternity web page.
- Continue to monitor weekly data.
- Continue to validate weekly data.
- Continue to communicate with Information Department on women who transfer into Trust during pregnancy.
- Circulate information to wider health population including Health Visitors.
- Work with GP surgeries to ensure enough capacity for Midwives to carry out Booking Clinics, providing a service which ensures women have access to early booking appointments.
- The development of Early Bird classes is being explored.

Saving Babies Lives

☑	Trust ambition achieved

- **Element 1 –** Reducing smoking in pregnancy by carrying out a Carbon Monoxide (CO) test at booking to identify smokers (or those exposed to tobacco smoke) & referring to stop smoking services as appropriate.
- **Element 2 –** Identification and surveillance of pregnancies with fetal growth restriction.
- **Element 3 –** Raising awareness amongst pregnant women of the importance of detecting & reporting reduced fetal movement (RFM) & ensuring providers have protocols in place, based on best available evidence to manage care for women who report RFM.
- **Element 4 –** Effective fetal monitoring in labour.

Gap Analysis

Element	Achieved Yes/No	Planned Actions
Element 1	Yes	Post-delivery CO monitoring of all women.
Element 2	Yes	GROW implemented and subject to continuous audit. Presentation of specific audit of outcomes for SGA/IOL/NNU admissions etc. On-going scanning pathway & capacity work stream.
Element 3	Yes	Exploring barriers to women accessing services promptly in presence of reduced fetal movements.
Element 4	Yes	Central CTG monitoring & archiving system including Dawes-Redman capacity.

Next Steps

County Durham & Darlington NHS Foundation Trust intends to take the following actions (outlined below) to improve this number and/or rate, and so the quality of its services. The further actions identified to ensure compliance is maintained are to:
Continue to monitor against the standards identified in “Saving Babies Lives” to ensure that the elements remain embedded in practice

Element 1 – Reducing smoking in pregnancy by carrying out a Carbon Monoxide (CO) test at booking to identify smokers (or those exposed to tobacco smoke) & referring to stop smoking services as appropriate - see above for update.

Element 2 – Identification & surveillance of pregnancies with fetal growth restriction.

All Community Midwives have received GROW training including assessments of measuring Symphysis Fundal Height and completion of online learning. There are also regular updates provided.

SABINE task and finish group set up to monitor achievements towards the above measures.
SABINE champions in all Maternity areas.
Continuous audit in place to monitor the success of the GROW initiative which is linked to the Perinatal Institute.

Element 3 – Raising awareness amongst pregnant women of the importance of detecting & reporting reduced fetal movement (RFM) & ensuring providers have protocols in place, based on best available evidence to manage care for women who report RFM.

Further work being undertaken with commissioners to look at barriers to women attending as there have been delays in women accessing services when they have had episodes of reduced fetal movements.
Trust has been involved in the Tommy's Sleep on your Side campaign aimed at reducing stillbirths in the third trimester.
Trust embarked on a media campaign in June 2018, to highlight and educate on the importance of fetal movements. This was shared on all social media platforms and local intranet. A single telephone number for triage and assessment was put in place to ease access to advice for all women. A local radio station supported the campaign and also supported a roadshow across the region in which maternity staff and user representatives were involved. Posters are in place on Lifts in both acute hospitals as visual aids and a branded theme was used. This was partly funded by SANDS and our own charitable funds.

Element 4 – Effective fetal monitoring in labour.
All Obstetric and Midwifery staff to complete K2 training package. A mandatory test has been added to this package that all midwives must complete on an annual basis as part of their essential training moving into our new training year 2019/20.
Fresh eyes has become hourly review, fresh ears now implemented hourly for all low risk labours including home births.
As part of the electronic patient record (EPR) project, implement a Central CTG monitoring & archiving system including Dawes-Redman capacity. The Business Case was on hold until the procurement exercise for the Trust EPR was complete. Our local Business Case has now been updated and sits with procurement prior to Care Group approval.
Version two of the Saving Babies' Lives Care Bundle (SBLCBv2), has been produced to build on the achievements of version one and was launched in March 2019. It aims to provide detailed information for providers and commissioners of maternity care on how to reduce perinatal mortality across England. A fifth element has been introduced within the bundle which is focused on the reduction of preterm birth. The maternity service will develop a strategy to address this element.
Within the Maternity Service there has been a tremendous amount of work targeted at improving communications and information for women and their families in line with 'Better Births' and this has resulted in the update and development of the service website which now includes up to date information on all aspects of care and provides details on local, regional and national contacts available for further information.

Paediatric Care

☑	Trust ambition achieved

During 2018/19 specialist paediatric assessment has been further developed on the Darlington site, with the delivery of a dedicated Paediatric assessment area on the inpatient ward , operating 24 hours per day , 7 days per week.

The area has a separate assessment nursing team, where an ambulatory care focus is evident. Children and young people referred by either Primary care or through other non elective pathways (Emergency Departments and Urgent Care Centres) receive a targeted assessment from the assessment team of paediatric nurses, advanced paediatric nurse practitioner, and medical staff.

We aim to assess children and discharge home as soon as is safe, with support from children's community nursing team if appropriate.

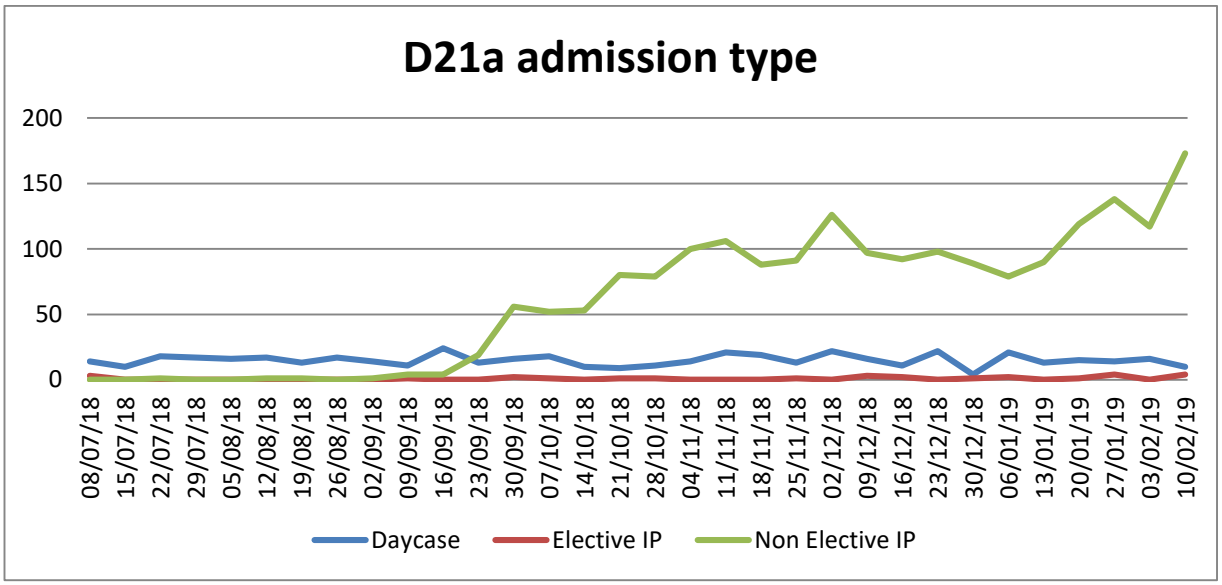
This assessment model of care supports early discharge, admission avoidance and preserves in- patient beds for those children who are unstable, critically ill or have complex disease.

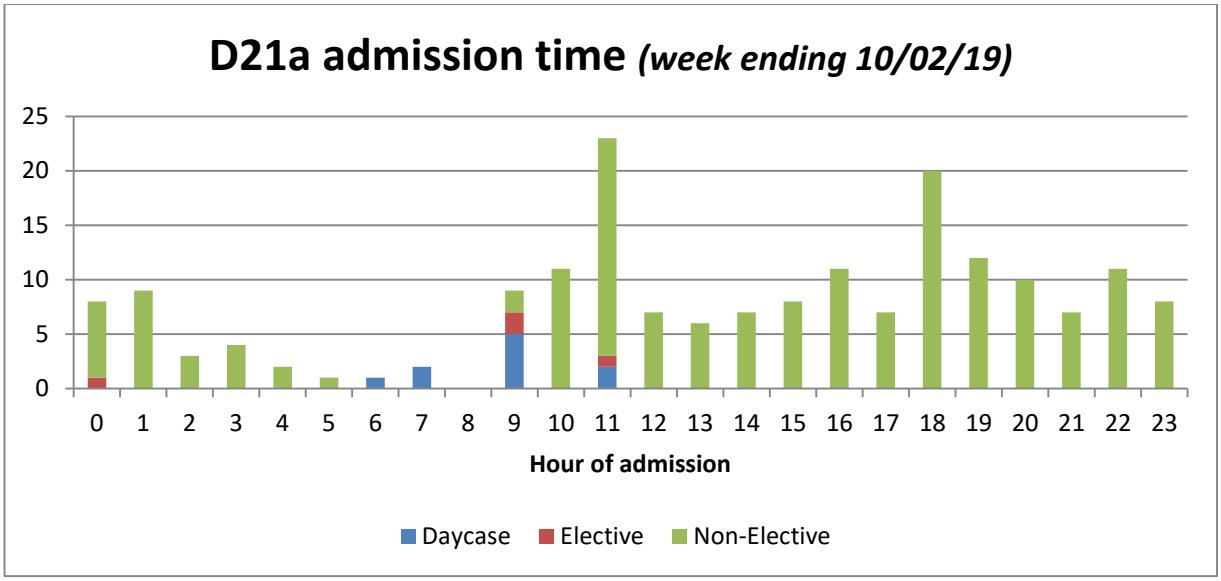
Treetops ward offer a similar assessment model, with children and young people receiving their assessment in a front of house area of the ward, and again only transfer to inpatient beds if options for care at home are unsuitable.

The role of the children's community nursing team in supporting children at home is integral to an ambulatory model of care. It is recognised that there may be some scope to further impact on admission avoidance through the development of new referral pathways to this team directly from GPs and Emergency Departments..

Admission Ward D21a: Weekly Admissions (Mon-Sun)

	Week ending																														
	08/07/2018	15/07/2018	22/07/2018	29/07/2018	05/08/2018	12/08/2018	19/08/2018	26/08/2018	02/09/2018	09/09/2018	16/09/2018	23/09/2018	30/09/2018	07/10/2018	14/10/2018	21/10/2018	28/10/2018	04/11/2018	11/11/2018	18/11/2018	25/11/2018	02/12/2018	09/12/2018	16/12/2018	23/12/2018	30/12/2018	06/01/2019	13/01/2019	20/01/2019	27/01/2019	03/02/2019	10/02/2019
Daycase	14	10	18	17	16	17	13	17	14	11	24	13	16	18	10	9	11	14	21	19	13	22	16	11	22	4	21	13	15	14	16	10
Elective IP	3	0	0	0	0	0	0	0	0	1	0	0	2	1	0	1	1	0	0	0	1	0	3	2	0	1	2	0	1	4	0	4
Non Elective IP	0	0	1	0	0	1	1	0	1	4	4	19	56	52	53	80	79	100	106	88	91	126	97	92	98	89	79	90	119	138	117	173
Total	**17**	**10**	**19**	**17**	**16**	**18**	**14**	**17**	**15**	**16**	**28**	**32**	**32**	**71**	**63**	**90**	**91**	**114**	**127**	**107**	**105**	**148**	**116**	**105**	**120**	**94**	**102**	**103**	**135**	**156**	**133**	**187**





During 2019/20 the role of the children's community nursing team is being jointly explored with CDDFT Paediatric team and commissioning colleagues, and is expected to progress this year, with the aim of supporting direct referrals to the team and avoiding admission to hospital.

Excellence Reporting

☑	Trust ambition achieved

Why is this a priority?

Excellence in healthcare is prevalent but has not previously been formally captured. CDDFT have developed and implemented a trust-wide system for reporting excellence of our staff, by our staff. Our peer reported excellence system provides us with qualitative and quantitative data and the Trust's Learning from Excellence Group will provide outputs to inform quality improvement and celebrate excellence within the Trust.

Our aim

To ensure that Excellence Reporting is embedded within CDDFT and that learning from excellence provides both qualitative and quantitative data for the Trust to ensure we can learn from the everyday excellence that is peer reported.

Next steps

County Durham & Darlington NHS Foundation Trust intends to take the following actions (outlined below) to improve this number and/or rate, and so the quality of its services. The following actions will continue to be embedded

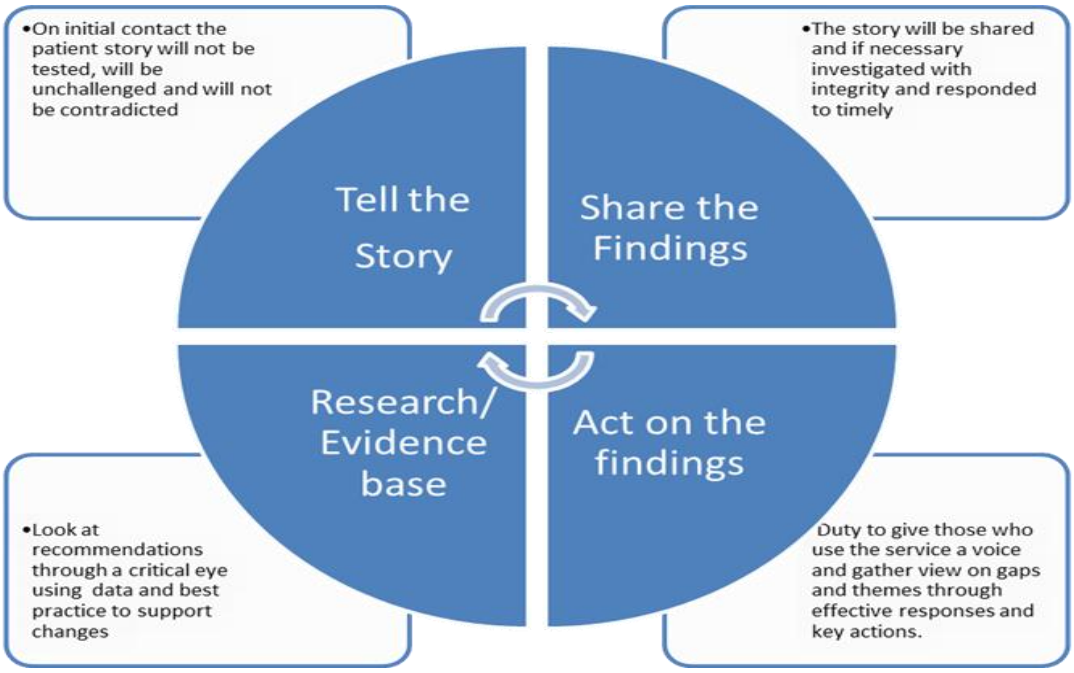
- The Trust has developed an Excellence Reporting Policy and Learning from Excellence Group, which brings together representatives from all Care Groups.
- Learning from Excellence outputs will include celebration of excellence as well as learning outcomes.
- The Learning from Excellence Group will ensure that both qualitative and quantitative data outputs are produced.

- Care Groups receive monthly reports into governance meetings.
- The learning from excellence group has developed a trust wide bulletin.
- This is shared at ECL prior to full Trust circulation.

PATIENT EXPERIENCE

The Patient Experience and Community Engagement Strategy was developed in 2017/2018 to provide an overarching strategy underpinned by the principles of Dignity for All, “Think Like a Patient”.

We aimed to create an environment within which “delivering excellence” in patient experience is seen as essential to the management and delivery of health services and the strategy outlines our engagement principles.



Our vision for services is ‘right first time, every time’ and our mission is with you all the way which means that we put our patients at the centre of all we do. The engagement of our patients, members, staff and public is key in understanding how we are performing against our vision and mission and how we develop and evaluate our services to ensure that the care we are providing is meeting the needs of our patients. The strategy sets out how we will increase engagement and involvement within our local communities which will promote trust in our services, support reputational management and help position us as the provider of choice.

The Patient Experience agenda encompasses a wide variety of objectives at CDDFT. The below chart highlights the Patient Experience Team objectives ensuring the patient / carer is central to all Trust activity.

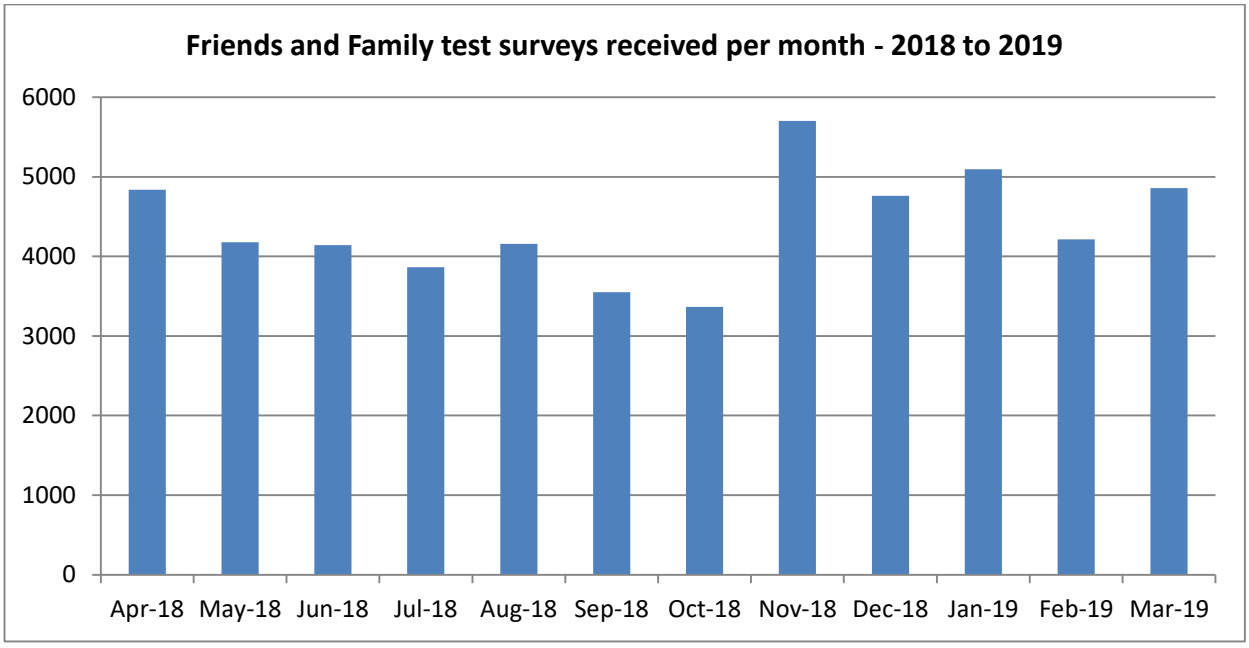
The Trust will continue to raise staff awareness and continue to capture data advising Care Groups of their compliance rates and of areas where actions are required for improvement.

Friends and Family Test (FFT) for patient feedback

Throughout 2018-19, all patients were provided with the opportunity to complete a questionnaire asking if they would recommend the service they had received to a friend or family member.

The data is collected monthly and response rates are returned to UNIFY, Department of Health. Data is available via the NHS Choices website.

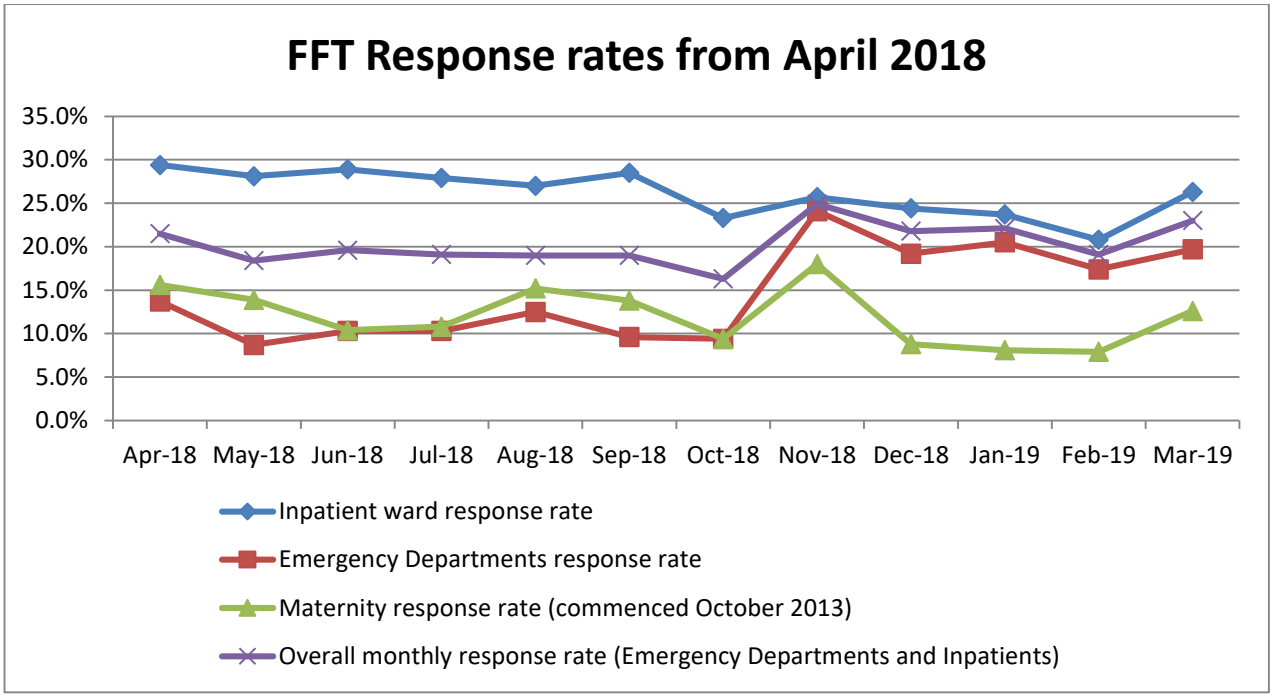
Data collected from Emergency Departments are combined with Urgent Care Centres. Similarly, Inpatient data is combined with Day case data.



The table below demonstrates the Trust's response rates for 2018/19 for Emergency Department/Urgent Care Centres, Inpatient / Day case areas and Maternity, showing the response rates since adopting a new internal process.

In November 18 the 20% response rate was achieved for the Emergency Departments and whilst subsequent months have not achieved the 20%, the threshold has only been missed by a narrow margin. The response rates for Maternity have continued to fluctuate across the year, especially since December 18, with response rates slowly dropping despite increasing efforts within the speciality to improve return rates.

April, May and June 18 saw our best response rates for Inpatients. Whilst we have not achieved the 40% threshold for returns we believe that we have sustained the improvements made. The significance of positive engagement with this process has been encouraged via meetings with senior nurse and midwifery teams as well as sisters, charge nurses and ward managers. Where negative comments emerged these are shared back to the individual wards and departments when the forms are collated. Most importantly the outcome of the returns indicates high satisfaction rates with the services.



All areas are requested to complete "you said we did" posters and display in their respective areas.

FFT Headline Measure

The percentage measures are calculated as follows:

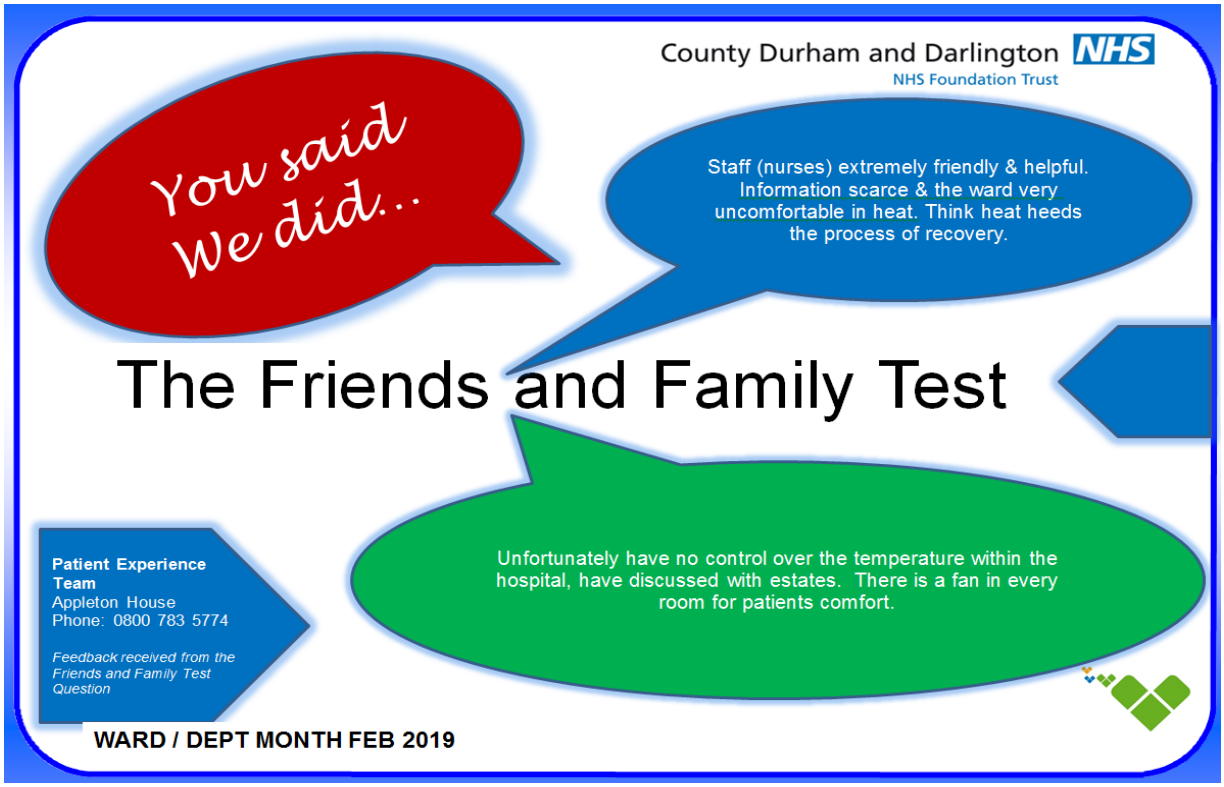
$$\boldsymbol{Recommend}\ (\%) = \frac{\boldsymbol{extremely\ likely + likely}}{\boldsymbol{extremely\ likely + likely + neither + unlikely + extremely\ unlikely + don't\ know}} \times \mathbf{100}$$

$$\boldsymbol{Not\ recommend}\ (\%) = \frac{\boldsymbol{extremely\ unlikely + unlikely}}{\boldsymbol{extremely\ likely + likely + neither + unlikely + extremely\ unlikely + don't\ know}} \times \mathbf{100}$$

The following chart shows the Trust-wide recommendation score from April 2018 for Emergency Department / Urgent Care Centres, Inpatient / Day cases and Maternity Services:

Month	Inpatient		A&E		Maternity	
	% Rec	% Not	% Rec	% Not	% Rec	% Not
April 2018	96	1	94	2	98	1
May 2018	97	1	94	1	98	0
June 2018	97	1	95	1	97	0
July 2018	97	1	95	1	97	0
August 2018	98	1	94	2	98	1
September 2018	98	1	95	1	100	0
October 2018	98	0	95	1	99	0
November 2018	97	1	92	1	98	1
December 2018	97	0	92	1	99	0
January 2019	97	0	93	1	97	1
February 2019	98	0	92	2	96	1
March 2019	97	1	94	1	98	1

FFT Feedback
The Patient Experience Team provides all wards and departments with individual ward reports and trust wide reports on a monthly basis. This provides wards and departments with the opportunity to develop improvements in service based on patient feedback, an example of a "you said, we did" poster is demonstrated below:



Training
Training sessions and presentations are provided by the Patient Experience Team on a regular basis to internal and external stakeholders in order to promote the importance of patient/carer feedback within CDDFT.

The Patient Experience Team continues to deliver training at student nurses and medical students programmes upon invitation. When available, service users attend these sessions and relay their experience which provides valuable insight from a patient perspective. The sessions are evaluated and feedback has been extremely positive. Awareness sessions and updates have been delivered to Trust governors. The Customer Care e learning package is available to all staff groups. Bespoke customer care programmes have been taken forward within individual care groups, and the Great Expectations customer care course is available to all CDDFT staff and volunteers.

National Patient Survey (NPS) Reports

<u>National Inpatient Survey – Reported June (2018)</u>

The National Inpatient Survey was reported in June 2018.

CDDFT received the rating from the CQC as "about the same"

There were 5 questions where CDDFT performed statistically better than the 2016 survey results

- For feeling they did not have to wait a long time to get to a bed on a ward
- Enough nurses for feeling that there were enough nurses on duty to care for them
- For staff caring for them working well together
- Confidence in decisions for having confidence in decisions made about their condition or treatment
- Were you told how to expect to feel after your operation or procedure

There were no questions with a 'significant' decrease in performance in 2017 compared with the 2016 CQC report.

Whilst the Inpatient Survey suggests that we are "about the same" we are able to analyse the data further. We can also use this data to benchmark against other Trusts by patient perspectives.

There are two scores that place the Trust in the top 20% of Trusts:

- Was discharge delayed due to a wait for medicines / to see a doctor / for an ambulance
- How long was the delay

There are no questions that place the Trust in the bottom 20% of Trusts

This is a significant improvement from 2016, where CDDFT were in the bottom 20% for 14 questions (23%).

Recommendations

Based on this overall, quality account, patient perspective peer groups and overall CQC survey results (quantitative and qualitative), it suggested that the areas for improvement relate to:

From quantitative data

- Changes to admission dates
- Enough help from staff to wash or keep clean
- Information about your condition or treatment
- Enough privacy when discussing condition and treatment

From qualitative data

- The discharge process and / or information
- Communication / information given by staff
- Facilities (this includes things like equipment)
- Food and drink
- Noise and disruption

Care Group thematic action plans included the issues identified within this survey where further action was required at local level. An organisational level action plan was developed to augment the organisational issues.

National Maternity Survey – Reported January (2018)

The results of the National Maternity Survey were published in January 2019.

For CDDFT, 123 maternity service users responded to the survey. The response rate for the Trust was 35.67%.

The Trust's results were better than most Trust's for three questions:

- Were you (and / or your partner or a companion) left alone by midwives or doctors at a time when it worried you?
- If you needed attention during labour and birth, were you able to get a member of staff to help you within a reasonable time?
- When you were at home after the birth of your baby, did you have a telephone number for a midwife or midwifery team that you could contact?

The Trust's results were worse than most Trust's for two questions:

- During your antenatal check-ups, did a midwife ask you how you were feeling emotionally?
- Did a midwife tell you that you would need to arrange a postnatal check-up of your own health with your GP? (around 6-8 weeks after the birth).

Comparative data shows the Trust's results were significantly higher this year for one question:

- Thinking about your care during labour and birth, were you spoken to in a way you could understand?

The Trust's results were significantly lower this year for one question:

- Thinking about your antenatal care, were you spoken to in a way you could understand?

The Trust's results were about the same as other Trusts for 46 questions. There were no statistically significant differences between last year's and this year's results for 47 questions. These results have been shared with the care group to share the areas of good practice and support the development of the areas for improvement.

The above issues form part of the National Survey action plan which is monitored and reviewed at the Patient Experience Forum.

Post Discharge Survey

The Post Discharge Survey is posted to a sample of 400 patients on a quarterly basis; this represents 1600 patients a year which is twice the sample used in the national survey. The questions mirror that of the National Inpatient Survey in order that we capture issues in real time and develop actions to address identified issues in a timely manner.

The data below shows the responses to 5 key questions and compares our survey results against the National Inpatient Survey results for 2017 (reported 2018).

Patient Experience Indicator Questions	National In-patient 2017	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19
Did you feel involved enough in decisions about your care and treatment?	75%	86%	82%	85%	81%	87%	79%
Were you given enough privacy when discussing your condition or treatment?	83%	91%	93%	88%	83%	87%	88%

Did you find a member of staff to discuss any worries or fears that you had?	58%	84%	84%	79%	81%	83%	84%
Did a member of staff tell you about any medication side effects that you should watch out for after you got home in a way that you could understand?	51%	69%	67%	68%	61%	66%	66%
Did hospital staff tell you who you should contact if you were worried about your condition or treatment after you left hospital?	80%	82%	81%	88%	75%	75%	81%

Post Discharge Survey Reports are presented quarterly at Patient Experience Forum and qualitative and quantitative data and themes are shared with senior staff to disseminate and action where appropriate.

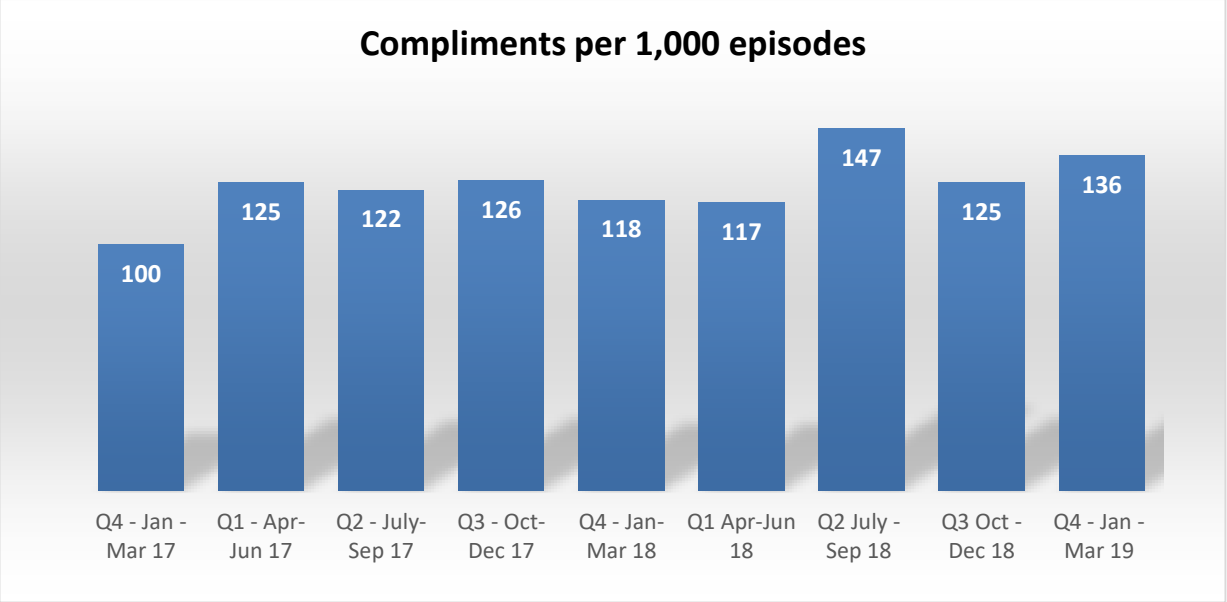
Themes for 2018-19 are identified below:

Theme	**Q2 17-18**	**Q3 17-18**	**Q4 17-18**	**Q1 18-19**	**Q2 18-19**	**Q3 18-19**	**Q4 18-19**
Food	7	1	1	4	4	4	2
Medication	2		3	2			
Treatment and care			8	9	8	7	5
Response to buzzers / for help		3					1
Communication	3	13	12	5	6	6	3
Feeling safe	1	3			1		1
Attitude	1	5	3	3	3	2	2
Personal care	1		2	1	1		
Discharge	2	2	2	2	2	2	3
Noise at night / disturbance	1	1	1	3	2	2	1
Transfer between wards	1	2	3		2	3	
Cleanliness	2				3	3	1
More information / choice	1	1					
Environment/TV/entertainment	1	3	2		3		3
Confidentiality	1	1	1			2	
Privacy & Dignity		1	4			1	1
Staffing		5	5	3	5	2	1
Parking		1		2			

Compliments

The below table and chart highlight the number of compliments received for 2018/19 in comparison to previous years. A quarterly report is available to all staff via the Trust intranet. Patients and carers are also encouraged to share their comments on the Trust's website, as well as NHS Choices.

Quarter	**2013-14**	**2014- 15**	**2015-16**	**2016-17**	**2017/2018**	**2018/19**
1	5297	5288	6058	4761	4409	4226
2	5782	5473	7406	4953	4339	5260
3	4523	6123	6078	5355	4628	4733
4	4863	6228	3902	4093	4195	5181
Total	20,465	23,112	23,444	19,162	17,571	19,400



Working in Partnership with Healthwatch

CDDFT work in partnership with Healthwatch, County Durham and Darlington. Healthwatch play a vital role liaising with the general public and capturing feedback about health services which is shared with the trust in order that we can learn from general trends or specific issues.

Representatives of Healthwatch County Durham and Healthwatch Darlington are members of the trust's Patient Experience Forum which is held 6 times per year. Healthwatch provide constructive feedback from service users and members of the community. Healthwatch teams have provided invaluable support and feedback and are currently supporting the Invest in Rest project.

Healthwatch members continue to support a peer review process whereby current anonymised complaint reports and responses are reviewed to ensure a fair and balanced response is provided to patients. Feedback is shared at Integrated Quality and Assurance Committee.

Learning from Experience

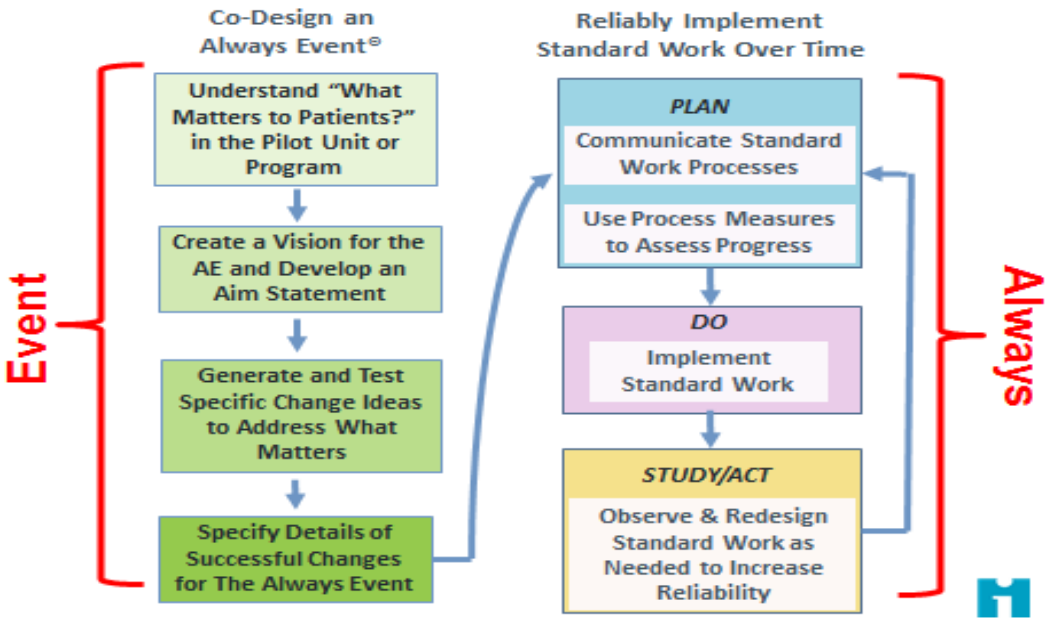
From the quarterly analysis of patient feedback, themes are identified and included in thematic action plans which are presented to the Care Groups for action, these action plans are monitored through the Complaints, Litigation, Incidents and Pals (CLIP) reports and discussed at Safety Committee.

Individual action plans are developed in response to partly and founded complaints and shared with the complainant. Examples of action plans and "You said, we did" posters are mentioned earlier in this report. To ensure learning across the organisation the Patient Experience Team continue to produce the newsletter called 'Quality Vibes' which identifies examples of lessons learned throughout the quarter, this is disseminated via the weekly bulletin and available on the intranet.

Always Events Initiative

This is a national project lead by NHS England with 10 pilot sites nominated. In February 2018, CDDFT became an Always Event pilot site to look at co-designing / co-production delivery , supported by front line teams. Always Events are aspects of care that should always

occur when patients, carers, service users interact with healthcare professionals and the healthcare delivery system.



The first project taken forward as an Always Event is the "Invest in Rest" project, in response to feedback from a variety of patient experience measures highlighting noise and discomfort at night as a concern for patients.

The project has been a great success and has seen the development of the Invest in rest Charter which aims indicates that we will our best to

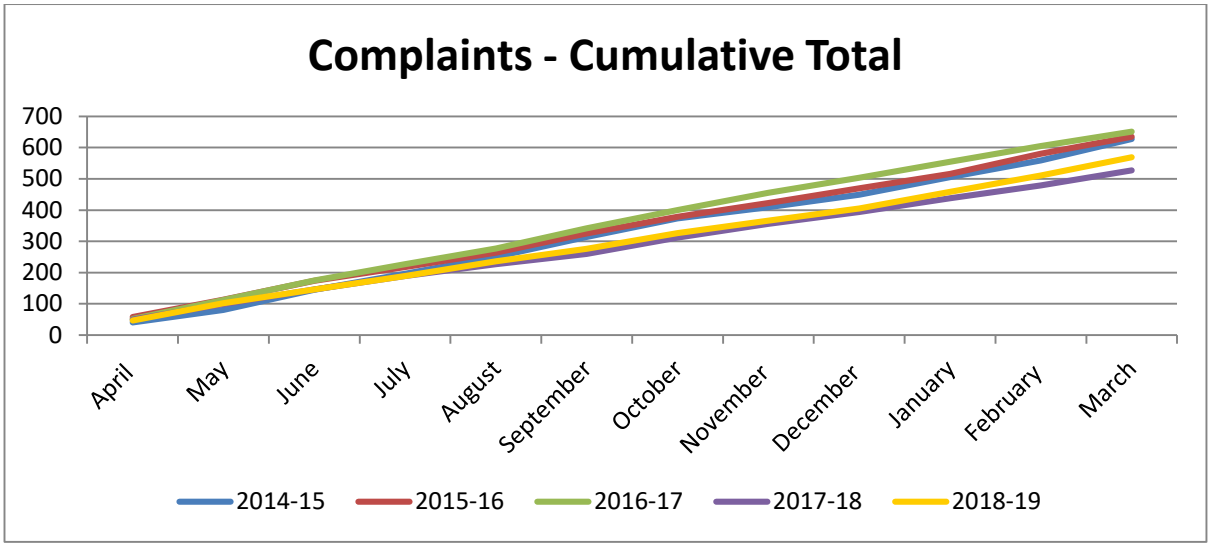
- Create a calm and restful environment for our patients to help recovery
- Provide a night pack of eye and ear plugs for patients requesting them
- Have a specified time for turning off the main overhead lights and using bedside lights
- Always keeping conversations low and appropriate
- Reduce the volume of the telephones and two way communication radios
- Answer nurse call bells and alarms promptly
- Do our best to complete medication rounds before 11pm
- Keep bed movements to a minimum

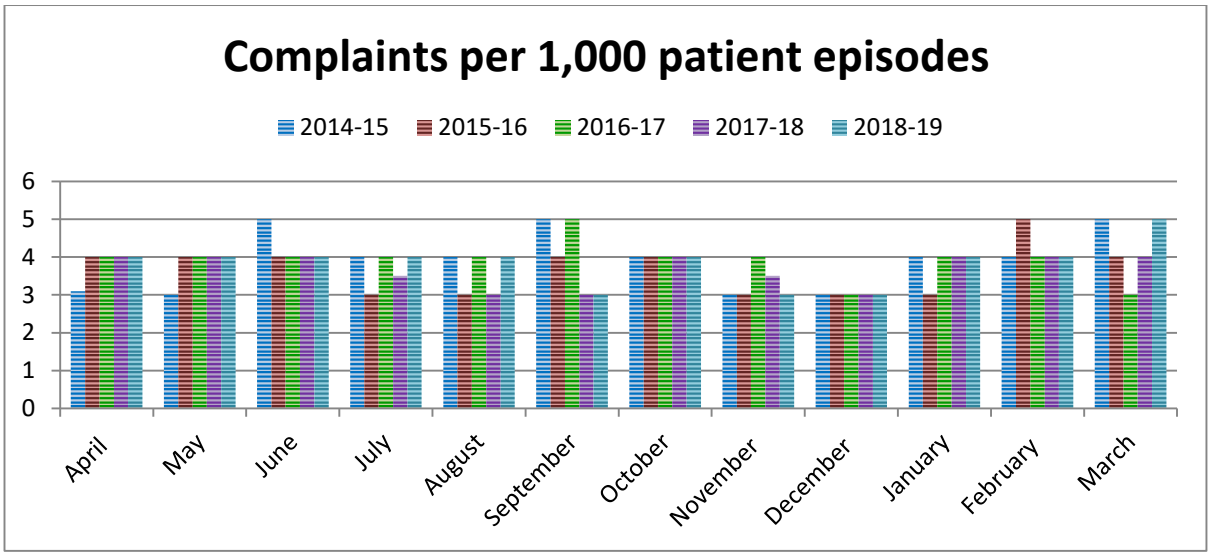
This will be monitored via the Patient Experience Forum with the Director of Nursing as the Executive Sponsor

Complaints

As well as proactive patient feedback the Trust also receive formal complaints and informal concerns via the patient experience team. The Trust follows the NHS complaints procedure and accepts complaints either verbally or in writing. If complaints are founded or partially founded the complainant receives an action plan to address the issues identified as well as a response. Complainants are offered a meeting and or a written response and are encouraged to participate in action planning to turn 'complaints into contributions'.

The below charts show the number of formal complaints received Trust-wide throughout 2018/19 as well as number of complaints per 1000 patient episodes in comparison to previous years.

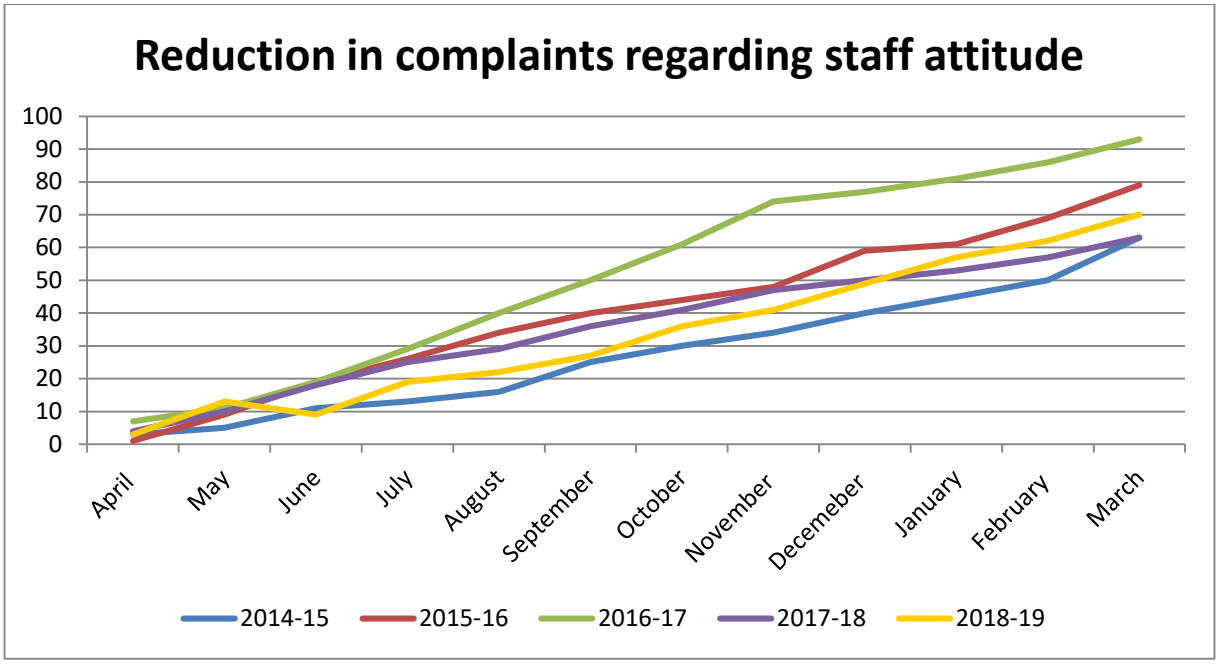




Complaints Monitoring

The Trust continues to monitor complaints in relation to staff attitude. Our aim is to remain below the threshold set in the 2012-13 Quality Accounts of 70 per year.

This has been monitored closely at Integrated Quality and Assurance Committees and Executives.. Throughout 2018-19 we have received 70 complaints regarding attitude of staff as a primary cause of concern, which is an increase on 2017-18, this represents a slight increase from the previous year but remains within the threshold of the tolerance that we set ourselves. Due to the nature of these concerns this is something that we continue to monitor.



Patient Stories

Patient stories continue and have been instrumental formulating lessons learned and actions for staff to improve patient experience. We listen to both positive and negative stories from our patients and share these with commissioners, staff and governance committees within the Trust.

However during 18-19 we have adapted our methodology to provide a more systematic review of the themes of concerns in order to Provide thematic review of high level concerns over a quarter to look at bigger issues of concerns.

- Less focus on single patient story and look at wider strategic impact.
- Use patient voice to highlight patient concerns as part of the review by using audio or video but more than one voice.
- Present overview in standardised template demonstrating key issues for the organisation.
- Analysis of the complaint themes rather than singular issue. Therefore providing wider organisational context and learning.

However, if story is powerful enough we won't dismiss the impact of sharing.

A Patient Story is shared quarterly at Integrated Quality and Assurance Committee. Appropriate actions where required are highlighted and monitored. Where possible we encourage service users to attend strategic meetings and share their experiences, which has been very powerful and constructive.

Nutrition and hydration in hospital

⊖	Trust ambition not achieved but improvements made

Nutrition

Our aim
To ensure that inpatients are adequately screened for under nutrition and dehydration and that they have onward referral as appropriate. To ensure that inpatients are regularly monitored for their risk of under nutrition and hydration and that remedial action is taken in a timely fashion. To ensure that where therapeutic dietetic intervention is identified, these inpatients are referred as appropriate.

Progress
The Quality Metrics have now been introduced and these provide a monitoring tool to audit compliance with nutritional standards.

In addition the dietetic service has also consolidated the Nutrition Trustwide role and in 2018/2019 the following areas have become business as usual.

- Nutritional Assessment (Must) in Nerve Centre.
- End of life nutritional care pathway.
- Nutrition policy
- Parenteral Nutrition policy
- Nutrition Subgroups (Parenteral and Enteral Nutrition Group and Nutrition, Hydration Improvement Team) to review parenteral and enteral nutrition, nutritional screening, nutrition and hydration.
- Registered Nurse Nutrition Training offered monthly by Nutrition Nurse Specialist.
- WASP framework for nasogastric training in Registered Nurses
- Nasal retention device policy
- Radiologically inserted gastrostomy pathway
- Further roll out of metrics capture via Quality Matters audit
- Extended scope WASP frameworks for Dietitians in the areas of gastrostomy care

Next Steps
County Durham & Darlington NHS Foundation Trust intends to take the following actions (outlined below) to improve this number and/or rate, and so the quality of its services.

The service will in 2019/2020 continue to work to review the Nutrition Bundle documentation in line with Quality Matters audit and Nerve Centre work. We will provide greater focus on effective nutrition care planning.

The Nutrition and Dietetic Department and Catering Service continue to work closely together on hospital menu development and nutritional analysis. We continue to work closely with Speech and Language Therapy colleagues within the Trust towards achieving International Dysphagia Diet Standardisation Initiative (IDDSI) ward menus and nutritional products.

In terms of hydration we will consider how we maintain and monitor sufficient hydration status of patients requiring both artificial (intravenous or enteral) and non-artificial hydration support.

In addition, we will explore how CDDFT might require alternative ways of measuring oral fluid intake at ward level. This may include evaluation of a trust wide initiative linked to hydration –

similar to the campaign from 2012-13 ‘Hydrate, Estimate, Escalate’ or further innovative measures such as water drop stickers or simple measure mugs.

Patient Led Assessments of the Care Environment

2018 PLACE Assessments

The Department of Health and the NHS Commissioning Board requires all hospitals, hospices and independent treatment centres to undertake an annual Patient Led Assessment of the Care Environment (PLACE).

April 2013 saw the introduction of PLACE, which is the system for assessing the quality of the patient environment, replacing the old Patient Environment Action Team (PEAT) inspections. The assessments primarily apply to hospitals and hospices providing NHS-funded care in both the NHS and private/independent sectors but others are also encouraged and helped to participate in the programme.

The aim of PLACE assessments is to provide a snapshot of how an organisation is performing against a range of non-clinical activities which impact on the patient experience of care, which include Cleanliness; the Condition, Appearance and Maintenance of healthcare premises; the extent to which the environment supports the delivery of care with Privacy and Dignity; how well the needs of patients with dementia are met; how well the needs of patients with a disability are met and the quality and availability of Food and Beverages.

The table below details the dates on which the PLACE assessments were undertaken.

Site	Assessment Date
Weardale	5th April
Chester-Le-Street	6th April
Shotley Bridge	10th April
Richardson	18th April
Sedgefield	25th April
Bishop Auckland	26th April
DMH	3rd May
DMH	9th May
DMH – Food – (evening meal)	17th May
UHND	15th May
UHND	18th May
UHND – Food – (evening meal)	22nd May

The teams consisted of Facilities and Clinical staff and Patient assessors who made up the 50% requirement within each team.

Following completion of the site assessments, the information was inputted onto the central website hosted by the NHS Digital for analysis and publication by the required deadline date June 4th 2018

Action plans were produced by ward/department. These will be tracked by CDDS Facilities Management to ensure actions are progressed.

Organisation Name	Cleanliness	Condition Appearance and Maintenance	Privacy, Dignity and Wellbeing	Food & Hydration Overall Score	Dementia	Disability
National Average 2018	**98.5%**	**94.3%**	**84.2%**	**90.2%**	**78.9%**	**84.2%**
County Durham & Darlington NHS Foundation Trust – 2018	99.52%	96.48%	91.44%	96.19%	81.94%	89.02%

Site	Cleanliness	Condition Appearance and Maintenance	Privacy, Dignity and Wellbeing	Food & Hydration Overall Score	Ward Food Score	Organisation Food Score	Dementia	Disability
Bishop Auckland Hospital	99.9%	95.71%	93.42%	95.57%	96.36%	94.92%	85.36%	90.81%
Chester Le Street Community Hospital	100%	99.02%	97.86%	98.09%	98.89%	97.47%	93.57%	97.89%
Darlington Memorial Hospital	98.97%	95.13%	92.88%	96.9%	96.57%	98.25%	81.65%	87.31%
Richardson Hospital	100%	100%	95.24%	98.15%	98.96%	97.47%	90.51%	95.19%
Sedgefield Community Hospital	100%	95.1%	88.0%	97.85%	98.34%	97.47%	76.84%	81.1%
Shotley Bridge Community Hospital	99.81%	95.29%	89.73%	90.38%	82.09%	96.66%	71.73%	85.77%
University Hospital North Durham	99.92%	97.95%	88.86%	95.59%	94.90%	98.41%	80.5%	90.16%
Weardale Community Hospital	100%	99.6%	95.45%	95.25%	92.8%	96.66%	92.22%	94.32%

Scores highlighted in **green** indicate above the national average score.
Scores highlighted in **orange** indicate below the national average score.

Food Hygiene

The NHS has had a legal obligation to comply with the provisions and requirements of food hygiene regulations since 1987, there are now several pieces of legislation governing food safety, including the requirement to have a food safety management system based on Hazard Analysis Critical Control Point (HACCP) principles.

Food Safety Officers (authorised by the Council) inspect food premises to assess compliance with food hygiene legislation which includes, Food Hygiene and Safety, Structure, Cleaning and Confidence in Management and Control Systems to ensure food is being prepared in a safe, clean environment and all relevant records are being maintained.

All main kitchens must be inspected at regular intervals by Environmental Health Officers (EHO). The frequency of these inspections depends on the type of business. A star rating system is used of which 1 is the lowest and 5 is the highest. Table 1 illustrates dates of the last inspection for food premises within CDDFT along with the star rating.

Environmental Health Officer inspections	Last Inspection	Star Rating
Darlington Memorial Hospital	February 2019	✡✡✡✡✡
University Hospital North Durham	October 2018	✡✡✡✡✡
Bishop Auckland Hospital	March 2016	✡✡✡✡✡
Chester le Street Hospital	September 2018	✡✡✡✡✡
Shotley Bridge Hospital	July 2018	✡✡✡✡✡
Sedgefield Community Hospital	September 2014	✡✡✡✡✡
Weardale Community Hospital	June 2015	✡✡✡✡✡
Richardson Community Hospital	November 2016	✡✡✡✡✡

As a result of the Trust providing food to external companies and to provide additional safeguards, we also commission an annual independent food safety inspection by a company known as Support Training Services (STS). STS are UKAS accredited and undertake audits for food suppliers, including manufacturers and distributors. The Catering Department has held STS accreditation since the year 2000. Previously the external Support Training Services (STS) accreditation has been based on the Code of Practice and technical standard for food processors and supplies.

In August 2017 the catering department were assessed at a higher level of accreditation which is aimed at food suppliers for the public sector. The higher level audit places more emphasis on effective environmental monitoring programmes to reduce the risk of the growth of listeria monocytogens which is a higher risk within a cook chill environment. The Catering Department were successful in achieving the higher level accreditation.

The following table illustrates the external accreditation held by Facilities:

Accreditation	Service	Last Audit	Next Audit/ Inspection
STS (Support Training Solutions)	Catering DMH	6th February 2019	August 2019

End of Life Care

☑	Trust ambition achieved

Our aim

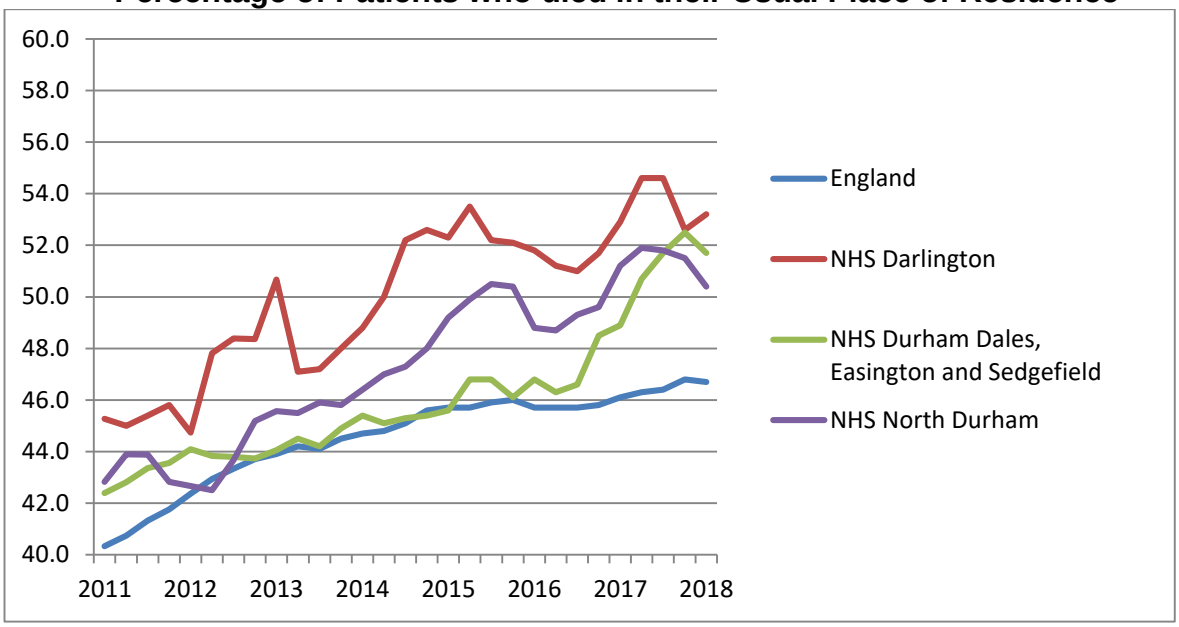
We want each patient approaching the end of their life to be able to say "I can make the last stage of my life as good as possible because everyone works together confidently, honestly and consistently to help me and the people who are important to me, including my carer(s)."

Progress

CDDFT is the largest provider of palliative care services in County Durham and provides care to most of the people who die in our area and specific palliative care to at least a third of those. The specialist service continues to improve and deliver more care. It also plays a key role in supporting other specialties and services with training and service improvement.

Death in Usual Place of Residence
The national proxy measure for improvements in palliative care is 'death in usual place of residence'. County Durham and Darlington continues to improve on this measure and is above the English National Average. (see graph below)

Percentage of Patients who died in their Usual Place of Residence



Source: Public Health England

Our local measure is achievement of preferred place of death. Over the last year this has increased from 88% to 95%.

Our care of the dying audit shows that our care has improved and has identified areas for education and action.
The survey of bereaved relatives (VOICES) project has shown improvements in many domains of care compared to the 2015 national baseline and identified several important areas for education and further exploration.

Our End of Life Strategy was agreed by the board on March 2017 and we have made good progress. We now have a robust 24/7 specialist advice service and a seven day (9 to 5) community specialist palliative care nurse service. We have two new consultants in post providing a more robust medical service in all localities. Our mandatory palliative care education is in place and on track. We continue to work with other services and organisations to improve personalised care planning.

The trust and service are well positioned to make substantial further improvements in the coming year.

Next Steps
County Durham & Darlington NHS Foundation Trust intends to take the following actions (outlined below) to improve this number and/or rate, and so the quality of its services. The further actions identified to ensure compliance is maintained are:

- Work with CCG and NEAS to agree a comprehensive approach to personalised care planning.
- Work with regional partners to develop electronic sharing of key palliative care information (ePaCCS).

- Support and monitor new out of hours advice service.
- Continue to deliver palliative care mandatory training for all staff.
- Implement actions from postal questionnaire of bereaved relatives (VOICES).
- Implement actions and learning from Care of Dying Audit.

Percentage of Staff who would recommend the provider to friends and family

Our aim
To increase the weighted score of staff who would recommend the provider to friends and family as a place to work or receive treatment within the national average for acute trusts.
Work continues to engage with staff at all levels of the organisation and the Organisation Development Strategy "Staff Matter" complements the Quality strategy. As reported by the Health and Social Care Information Centre and NHS Staff Survey National Co-ordination Centre overall results are as follows:

Key Finding	2017		2018		Trust Improvement/Deterioration
	Trust	National Average	Trust	National Average	
KF1. Staff recommendation of the Trust as a place to work or receive treatment	3.50	3.75	**TBC**	**TBC**	

The results for key finding 1 staff recommendation of the Trust as a place to work or receive treatment has seen an improvement TBC on the Trust score for last year however the national average has increased to TBC which means that we have not met our ambition to achieve the national average score. The Trust score of TBC (on a scale of 1 to 5 where 5 is best and 1 is worst) falls short of the national average for combined acute and community Trusts by TBC **To be confirmed**

The results for the key finding are comprised of three individual questions which are outlined in the table below:

Question	2017		2018		Trust Improvement/Deterioration
	Trust	National Average	Trust	National Average	
Q21a Care of patients/service users is my organisation's top priority (strongly agree and agree)	64%	75%	**TBC**	**TBC**	
Q21c I would recommend my organisation as a place to work (strongly agree and agree)	49%	59%	**TBC**	**TBC**	
Q21d If a friend or relative needed treatment, I would be happy with the standard of care provided by this	58%	69%	**TBC**	**TBC**	

organisation (strongly agree and agree)					

Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months

All results to be updated for 2018 survey
NHS Staff Survey results for indicator KF26 (percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months). The overall score for 2017 has increased slightly (the lower the score the better) from 20% in 2016 to 24% in 2017 (latest to be inserted). However this score is still in line with the national average which stands at 24% for 2017. (2018 to be inserted) Further analysis of the results reveals that the % of white staff that reported experiencing harassment, bullying or abuse from staff in the last 12 months has gone up from 20% in 2016 to 24% in 2017 (the lower the score the better). This score is higher than the national average for this group which is 23%. However for BME staff reporting the figure has gone down from 35% in 2016 to 32% in 2017. The national average for this group is 29%. The Trust's performance on this level has improved in contrast to the national average which has deteriorated since 2016.

Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion

All results to be updated for 2018
Staff survey results identified above
NHS Staff Survey results for indicator KF21 (percentage believing that Trust provides equal opportunities for career progression or promotion) for the Workforce Race Equality Standard. The overall score for the Trust has remained at 90% in 2017. This is better than the national average which stands at 85% for 2017. The % of white staff believing that the trust provides equal opportunities for progression has gone down slightly from 91% in 2016 to 90% in 2017. The Trust score for this group is better than the national average for Combined Acute and Community Trusts which is 88%. The % of black and minority ethnic staff believing there is equal opportunity for career progression has significantly increased from 67% in 2016 to 85% in 2017. This response is significantly better than the national average for this group, which is 67% for 2017.

Progress
During 2018/2019 CDDFT has continued to focus efforts into staff engagement activity in order to improve the responses of staff who would recommend the Trust as a place to work and receive treatment. Key programmes and work streams that have been undertaken and introduced include:

Staff Survey
Work continues to engage staff at all levels of the organisation. The results of the Staff Survey are widely shared with all managers and staff and used to identify the key priorities for the Trust. Focus groups have been undertaken within some areas of the Trust in order to explore the staff survey results in more detail and Staff Matter Action Plans identify the actions necessary to address the issues arising from the staff survey.

In addition to the Trust wide actions we have supported teams/services where issues or concerns have been raised. This has been done by designing and delivering bespoke interventions designed to address the needs of the service.

Staff Matter
The people strategy document Staff Matter sets out the strategic workforce priorities CDDFT have agreed for the period 2017- 2020 (reviewed annually). Each Care Group and Corporate area produced a staff matter action plan For 2018/2019 and these plans have guided the work around staff engagement. The action plans are monitored on a quarterly basis via Strategic Change Board and Integrated Quality Assurance Committee. The plans will be reviewed to reflect current priorities and monitored in the same way throughout 2019/2020.

Senior Managers and Heads of Departments (SMHODs)
Senior Manager and Heads of Department monthly meetings with the Chief Executive and Directors are an opportunity for open, frank two way discussions on important topical issues. Every quarter an extended SMHOD's is organised to focus on development needs that have been identified for the senior leaders within the Trust. Over the last 12 months these have concentrated on issues such as staff engagement, improving quality and patient safety, ongoing changes within the NHS. Further sessions are planned for 2019.

Leadership and Management Development Framework
Based on the priorities falling out of the staff survey and discussions with managers and staff CDDFT's Leadership and Management Framework has been further developed to provide a comprehensive programme of development activities, aimed at the key stages of strategic and operational management. The various options available for leadership development are brought together within the framework, which will enable Managers to access the most appropriate development activity for them. The framework will also facilitate talent management and succession planning. It identifies the corporate offering; development activities available from the North East Leadership Academy and National Leadership Academy and external provision such as level 3, 5 and 6 vocational qualifications.
The leadership and management development programmes are divided into three routes and cover a mix of both transformational and transactional skills and behaviours:

- Strategic and Clinical Leadership – to develop key skills appropriate for a senior leader whether in a Clinical or non-clinical role
- Operational Management – to develop managers as leaders
- Entry Level Management – to develop some people management skills appropriate to an aspiring manager's first management role.

The Framework continues to be reviewed and refreshed on a regular basis to ensure it is fit for purpose.

Strategic Leadership Programme
The Strategic Leadership Programme (SLP) is a broad framework covering a range of strategic leadership topics and is designed as a foundation programme for leaders, both clinical and non-clinical. The programme focuses on developing effective leadership skills using internationally recognised psychometric tools; evidence based research on leadership; and Trust specific data analysis and feedback metrics; to ensure both theory and practice are considered within the context of CDDFT and the future needs of the Trust.

The programme has been rolled out across the Trust throughout 2018/19 and feedback from delegates has been extremely positive providing a rating of eight out of ten in terms of impact on their leadership style. At the end of March 2019 166 Senior Leaders have attended the programme.

Shadow Board Programme
During 2018 CDDFT piloted the Shadow Board Programme on behalf the Northern Region. This was a development programme aimed at aspiring leaders who wish to become the Directors of the future. The programme ran from May to October 2018 with 10 senior leaders attending. The programme was evaluated by the North East Leadership Academy and results of the evaluation were shared across the region.

Leadership Conference
The Trust has a programme of bi-annual Leadership conferences featuring guest speakers from the world of leadership, staff and patient engagement and healthcare. The aims of the sessions are to challenge our thinking around how we operate as leaders at both Trust and individual level. A further two leadership conferences have been rolled out during this financial year, with the second one being combined with the Becoming a Highly Reliable Organisation conference. A total of 481 leaders attended the conferences this year.

Developing Managers as Leaders
The Great Line Management Fundamentals Programme consists of a portfolio of activities designed to develop managers as leaders and prepare them for the strategic leadership programme. Great Line Management Fundamentals focuses on developing an individual's understanding of their role as a manager and the skills needed to influence and work effectively through others e.g. people management skills which is the area most managers find difficult to master. The programme offers a comprehensive range of workshops beginning with an introductory day, followed by a series of free-standing modules covering key areas such as staff engagement, personal resilience, effective communication, managing staff absence and interview skills. In addition to a wide range of workshops, HR for Managers mini guides are available and include information on topics such as recruitment and selection and disciplinary and grievance procedures. The programme has been reviewed and refreshed to meet the changing needs of the organisation. This programme has been fully refreshed during 2018/19.

As part of a bridging programme for Band 7 staff two additional modules, Patient Safety and Operational Performance took place during 2018/19.

Personal Resilience
Given the unprecedented change facing the NHS, staff development sessions promoting personal resilience strategies have continued throughout 2018/19. The percentage of staff feeling unwell due to workplace stress has increased since 2015 and in order to address this issue a personal resilience module for staff members to consider implementing suitable coping mechanisms during times of stress has been successfully delivered and a "Managing Stress in Others" workshop for managers has been delivered to support managers in recognising and dealing with stress in others to support their teams.

Talent Management
The Trust has taken an inclusive approach to talent management which consists of a "grow your own" approach

Under the umbrella of "grow your own" further work has been undertaken during 2018/19 particularly with the introduction of the apprenticeship levy which is now being used to develop career pathways for all key roles across the Trust. The apprenticeship levy is a Government initiative where large employers must pay 0.5% of their payroll bill into the levy which can only be used to fund apprenticeship training and CDDFT have in the region of £1.1million in their levy pot.

The apprenticeship offer currently includes 20 apprenticeships including Health Care at level 2, 3 and 5; Nursing Associate, Business Administration at levels 2, 3, and 4; Management

level 3 4,5,6,7; IT level 2 and HR at levels 3 and 5, Customer service 2 and 3; Accountancy 4 and 7.

Operating Department Practitioner is a much awaited addition to the apprenticeship offer in 2019 allowing a career pathway for many staff in surgery and with Advanced Clinical Practice coming early in the New Year this really allows funded career pathways for staff within clinical areas. More and more apprenticeships are being introduced so it is anticipated these numbers will only grow in the coming years.

Prior to the levy the Trust had 439 apprentices, 341 were existing staff and 98 young people. Post levy we have 200 apprentices as at January 2019 with 170 converters or existing staff and 30 young apprentices. Public sector bodies with 250 or more staff have a target to employ an average of at least 2.3% of their staff as new apprentice starts over the period of 1 April 2017 to 31 March 2021. CDDFT currently stands at 2.42% which is very pleasing indeed.

The Trust were fortunate in 2018 to take on an NHS Graduate Management programme as an HR specialist and it is hoped that many more graduates will be welcomed into the Trust to support their career aspirations.

2018 saw the implementation of the talent matters strategy recognising that Talent Management is the systematic attraction, identification, development, engagement, retention and deployment of those individuals who are of particular value to an organisation, either in view of their 'high potential' for the future or because they are fulfilling business/operational-critical roles.

Within CDDFT, we have aligned talent management to our annual appraisal and role review framework, which acts as an umbrella framework for all staff groups both clinical and non-clinical. This process includes a 'talent conversation' for all staff and ensures both staff and managers discuss the performance, potential, ambition and readiness for progression of all staff across the Trust. These four elements form the basis of a structured approach to the development of staff for personal and career development at an individual basis, and to ensure the Trust is able to meet its workforce planning needs for future critical roles by having robust and managed succession planning.

Talent Management within CDDFT, is an inclusive process which focuses on the identification of individuals' strengths in order to further develop the capability of teams across the Trust. It also recognises that not everyone is seeking career progression, but that should not preclude them from development opportunities.

A corporate pilot was agreed to inform the strategy and 2 cohorts of corporate managers were trained to deliver talent review boards. Further training will be rolled out in the rest of the Trust in early 2019 to support the process being linked to the appraisal process commencing April 2019.

Both the Strategic Leadership Programme and the Great Line Management Fundamentals programme will provide leadership and management skills for graduates and those staff who have demonstrated potential and an interest in moving into a management or leadership role, thereby developing our leaders and managers of the future.

The Trust has taken an inclusive approach to talent management which consists of a "grow your own" approach coupled with a new graduate trainee programme designed to attract talent from outside of the organisation. The first two graduates were recruited in January 2017 and have taken up posts in Surgery and Acute and Emergency Care. The newly recruited graduate management trainees have been provided with a high level of support in the form of

a Leadership Mentor, Clinical Mentor, Coach and Programme Manager. Both have had a very successful year.

Under the umbrella of “grow your own” further work has been undertaken during 2018/2019 particularly with the introduction of the apprenticeship levy which is now being used to develop career pathways for all key roles across the Trust. The apprenticeship levy is a Government initiative where large employers must pay 0.5% of their payroll bill into the levy which can only be used to fund apprenticeship training and CDDFT have in the region of £1.1million in their levy pot.

Current pathways include Nursing, Leadership and Management, Procurement and Pathology and we have staff enrolled on 20 different apprenticeships at present with more to be introduced during 2018/2019. Our apprenticeship programmes currently offer Health Care at level 2, 3 and 5; Business Administration at levels 2, 3, and 4; Management level 3 4,5,6,7; IT level 2 and Cyber Crime and HR at levels 3 and 5, Customer service 2 and 3; Accountancy 4 and 7.

Prior to the levy the Trust had 439 apprentices, 341 were existing staff and 98 young people. Of the young people, 65 were healthcare apprentices and 33 Business and administration and 55 of them still work for the Trust

Public sector bodies with 250 or more staff have a target to employ an average of at least 2.3% of their staff as new apprentice starts over the period of 1 April 2017 to 31 March 2021. CDDFT currently stands at 2.03% which is very pleasing indeed. In the past 5 years we have had 559 apprentices within the Trust, 439 Existing staff and 120 young people and we hope to build on this success in the coming year.

Both the Strategic Leadership Programme and the Great Line Management Fundamentals programme will provide leadership and management skills for graduates and those staff who have demonstrated potential and an interest in moving into a management or leadership role, thereby developing our leaders and managers of the future.

Staff Annual Awards
2018 saw a review of the Staff Annual Awards. New categories have been drafted linked more closely with the Trust’s Vales and Behaviours and proposals have been prepared to change the format of the event, how it is funded and a new nomination process are currently under discussion with the Chairman.

Building leadership for Inclusion Pilot
As part of our approach to staff engagement CDDFT was successful in bidding for one of six places on the national Building Leadership for Inclusion (BLFI) pilot. BLFI is an NHS system wide programme of work that seeks to raise the level of ambition on inclusion, quicken the pace of change and ensure that leadership is equipped to achieve and leave an ever increasing and sustainable legacy of inclusion.

This work has involved the establishment of an internal team drawn from all levels across the Trust and representative of its broad geographical and functional areas. The Team also reflects the diversity dimensions, cutting across age, gender, race, disability, religion and sexual orientation.

The first phase of the project was to conduct an in-depth diagnosis of CDDFT’s approach to equality, diversity & inclusion. A report was produced and presented to Executive Directors in October 2018.

Following on from this work key priorities have been agreed and work on these has taken place over the last quarter of this financial year.

Breakfast with the Chief Executive
'Breakfast with Sue' gives a random selection of staff a genuine opportunity to meet the Chief Executive and talk to her about working life at the Trust. These events held each month are small and personal rather than a large group event which gives every attendee the chance to speak. These sessions continue to be popular and are planned for 2019/2020.

Appraisal
For the past three years the Trust has had 95% rate of appraisal completion. In response to staff feedback about the quality of appraisal a new process and associated paperwork was rolled out from the 1 April 2018. Following on from the development of team objectives, the focus of the appraisal is on the value of the conversation with individuals. The appraisal takes a collaborative approach, and considers not just performance, but also future aspirations and possible career progression. Guidance has been developed and the Appraiser and Appraisee training was refreshed to reflect the new approach, with training sessions taking place from March 2018 onwards. Evaluation of the new appraisal process highlighted that over 80% of staff who responded thought that the new process was better than the previous one and was a more positive experience. Staff responding to the survey also felt that the appraisal made them feel their work is valued by CDDFT and that the new paperwork was easy to use.

Equalities, Diversity and Inclusion (ED&I)
Prior to this financial year the Trust's focus for ED&I has been on building secure foundations by ensuring robust policies and practices have been developed for staff and patients, together with activities to promote excellence in this field. In April 2018 the Trust's Equalities, Diversity and Inclusion Strategy was officially launched and this focuses on developing new and innovative ways of progressing this important agenda in order to achieve an organisational culture that fosters inclusion and leads to exceptional standards of patient care.

As a Trust we continue in our aim to support and employ more staff with a learning disability through our continued commitment of signing up to the NHS Learning Disability Employment Pledge which we have been have been awarded at Level 2.

Other work around this agenda includes our continued involvement with the NHS Project Choice which is a supported internship hosted by CDDFT and managed by HEENE. The project is designed to give young people with learning difficulties, disabilities or autism, the chance to gain work experience, undertake an employability qualification and complete a work-based internship. The project is tailored to the needs of the young people which enable them to meet and develop their individual skills.

The first cohort of 22 was recruited in October 2017 and finished June 2018. Of these one secured an apprenticeship with the Trust and two secured apprenticeships with Durham County Council. Another student has gone on to volunteer within the Trust and one student has secured a further placement with Mediquip. In October 2018 a second cohort of 15 commenced with the Trust and all students are encouraged to apply for apprenticeships and jobs. One student has already secured employment with another organisation.

In addition the Trust has been successful in being selected to take part in the pilot Apprenticeships for All which is a fully interactive programme for managers focusing on the sharing of understanding, good practice and experiences to date of employing staff with a learning disability. The pilot also offers individual focused coaching around new approaches to accessible recruitment. *So far the Trust has trained 64 staff members as part of this programme.*

To improve and raise awareness of equality & diversity we have reviewed the number of equality & diversity policies we have and replaced these, where appropriate, with a framework document outlining a process, giving supporting information and/or guidance for managers and staff. We will be continuing to develop additional framework documents around more of the nine protected characteristics.

Development of a new Transgender framework will provide guidance to support colleagues who are proposing to undergo, are currently undergoing or have undergone a process (or part of a process) of gender reassignment – "transgender colleagues". It supports line managers to operate within the law and in line with the Trust's Behaviour's Framework.

We launched three closed Facebook groups (Disability Staff Network Group, The Ethnic Minority Network Group and the LGBT Staff Network Group) in November 2018.

A draft Staff Network Groups Framework has been developed which outlines the code of conduct, TOR for membership and an outline of who would be encouraged to join these groups.

In addition we are continuing to update and add more information to the equality & diversity Intranet site to support the information contained in the framework documents as well as providing staff and managers with additional relevant information around equality, diversity and inclusion.

We continue to work with external partners – Police, City Councils, Healthwatch and Pride to raise the profile of CDDFT as an employer of choice. Over the next year we plan to continue to develop links with other public sector organisations and community networks.

The promotion of NELA leadership courses Stepping Up programme (targeting Black, Asian and Minority Ethnics staff grades 5 to 7) and the Ready Now programme for Black, Asian and Minority Ethnics staff in bands 8a and above) continues across the Trust.

Following the completion of the 2018 Workforce Race Equality Standard report a robust action plans has been developed and is currently being worked on to improve the workplace experiences, promotion opportunities and inclusion for staff from a BAME background

Work is currently underway with Workforce Services in preparation for the new national report Workforce Disability Equality Standard to ensure we are ready for its launch in April 2019.

In November 2018 we launched our Health Passport - which is completed as an undertaking entered into between a line manager, on behalf of the organisation, and an employee, who has declared they have a disabled or have a long term health condition.

Next Steps

County Durham & Darlington NHS Foundation Trust intends to take the following actions to improve staff experience and the quality of its services, thereby improving results:

Moving to Good

A key Workforce and OD objective for this coming year is planned to focus on staff engagement, which during times of change is more important than ever. Plans are in place for the development of a staff engagement strategy as part of our organisational culture journey. This will be directed initially by the Moving to Good Programme which the organisation has committed to with an aim of providing a much longer term strategic direction for the workforce experience.

Leadership and Management Development Framework
The leadership and management development framework will be reviewed and refreshed for 2019/2019 to ensure it meets current and future leadership and management development needs.

Strategic Leadership Programme (SLP)
Following a review of the SLP programme the final cohorts will be rolled out throughout 2019/20.

Leadership Conference
The fifth Leadership Conference will take place in June 2019 and will once again be combined with the Becoming a Highly Reliable Organisation conference. The keynote speaker for this conference is Paul Redmond who will be sharing his thoughts and expertise on generational diversity.

Talent Management

- The Trust will continue to utilise the apprenticeship levy to further develop apprenticeship opportunities across a range of career pathways (including traineeships).

- Both the Strategic Leadership Programme and the Great Line Management Fundamentals programme will continue to be used to provide leadership and management skills for graduates and those staff who have demonstrated potential and an interest in moving into a management or leadership role, thereby developing our leaders and managers of the future.

- The Talent Matters Strategy will be revisited and priorities identified.

Appraisal
The monitoring of appraisal completion and quality audits will continue throughout 2019/2020 to in order to evaluate the new appraisal process.

Equalities, Diversity and Inclusion

The next phase of this work over 2019/20 involves:

- The establishment of the Strategic ED&I Group in order to drive the ED&I agenda and establish priorities for the coming year. The Group will be jointly chaired by the Director of Nursing and Transformation, Noel Scanlon and the Family Health Care Group Clinical Director Ria Willoughby

- An ED&I working group will also be established this group will be responsible for actively driving the ED&I agenda across the wider organisation into all ward, service areas and departments

- Workshops have been organised with representation from across all the Care Groups. From a national reporting point of view using these groups will ensure we have Trust wide input into all the final NHS national reports we produce and enable the Trust to set more effective and relevant action plans

- The continued update of additional information to the equality & diversity Intranet site to support the framework documents as well as providing staff and managers with additional relevant information around equality, diversity and inclusion

- Staff engagement will continue to be measured via the quarterly Staff Friends and Family Test. Results will be used to further inform staff matter action plans.

- Continued use of quarterly survey monkey questionnaires to look at key themes from staff survey, well-led, CQC and which link to Health and Wellbeing CQUIN targets.

- The Trust has put in place a programme of structured cross-site visits by Executive and Non- Executive Directors to support the work being done to understand culture within the organisation and collect feedback to inform action plans.

CLINICAL EFFECTIVENESS

Reduction in Hospital Standardised Mortality Ratio (HSMR) and Standardised Hospital Mortality Indicator (SHMI)

NEED YEAR END GRAPHS IN THIS SECTION

☑	Trust ambition achieved

There are a number of different published mortality indices that seek to provide a means to compare hospital deaths between trusts. Mortality measurement is a complex issue and much has been written about the usefulness of mortality ratios with academics and trusts getting involved in wide debate regarding their accuracy and validity.

NHS England use the Summary Hospital-level Mortality Indicator (SHMI) as their standard indicator. SHMI reports on mortality at trust level across the NHS in England using a standard and transparent methodology. It is produced and published quarterly as an official statistic by the Health and Social Care Information Centre (HSCIC).

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. The indicator includes deaths in hospital and within 30 days of discharge.

The Trust's information providers, Healthcare Evaluation Data (HED) and the North East Quality Observatory Service (NEQOS), supply the SHMI data as well as the Hospital Standardised Mortality Ratio (HSMR) as comparators of mortality.

The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths (multiplied by 100) for 56 diagnosis groups in a specified patient group. The expected deaths are calculated from logistic regression models with a case-mix of: age band, sex, deprivation, interaction between age band and co-morbidities, month of admission, admission method, source of admission, the presence of palliative care, number of previous emergency admissions and financial year of discharge.

The Trust also uses 'Crude Mortality' as a measure of mortality rates. This is simply the number of deaths as a percentage of the total number of discharges. It does not, unlike other indices, take into account any other factors.

In keeping with our commitment to openness and transparency we continue to review and analyse our mortality data in a continuing attempt to understand what the data is telling us.

Our aim

Our aim is to not only remain be comparable to the national average and regional peers for mortality rates, but lower than comparable regional peers.

Progress

County Durham & Darlington NHS Foundation Trust considers that this data is correct for the following reasons:
The data is collected as prescribed nationally and reported as per national guidelines.
The data presented is as shown by the Health and Social Care Information Centre.
The next series of graphs shows our comparative position when measured across hospitals in England and an indication of what that means.

HSMR

The timelines below shows that HSMR has generally been below the 100 standard with the exception of seasonal rises in January and February, before peaking at 112 in April. Weekend HSMR follows a similar trend, but peaks in July 17 at 112.

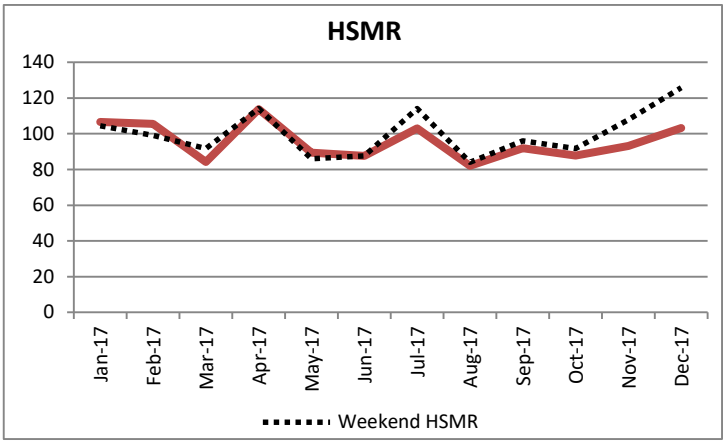


Figure 1 – HSMR timeline (Jan17-Dec17)

The funnel plot for this time period displays expected number of deaths versus HSMR (Figure 2) and shows that the Trust sits at the lower 'green' control limit.

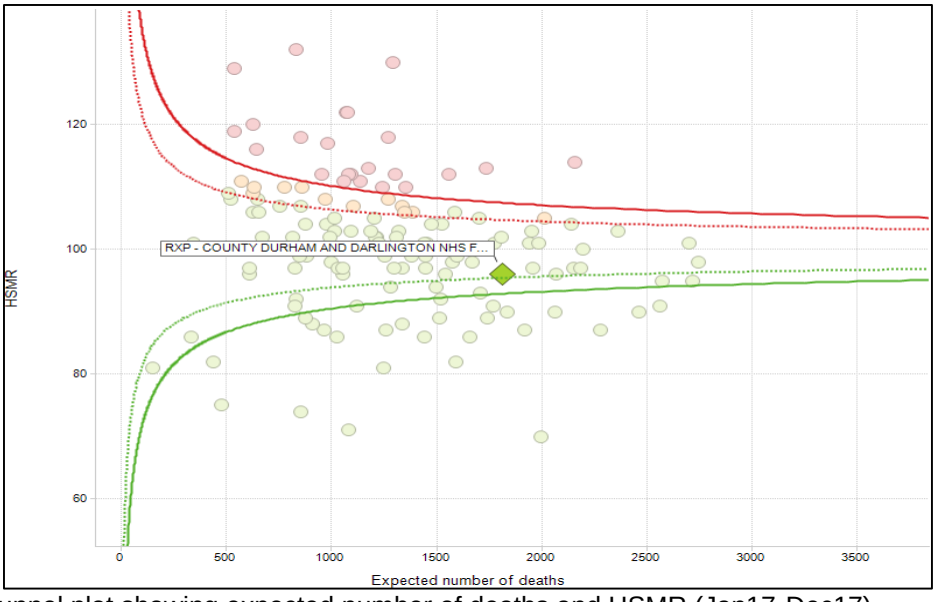


Figure 2 - Funnel plot showing expected number of deaths and HSMR (Jan17-Dec17)

SHMI

The SHMI data (Figure 3) shows a peak in January 17, then fall to below the standard of 100 for the rest of the year with the exception of April. April 17 showed a slight rise to 103, mirrored by HSMR which showed a more pronounced rise that month. For the 12 months up to Dec 17, the Trust sits comfortably in the middle of the funnel plot (Figure 4).

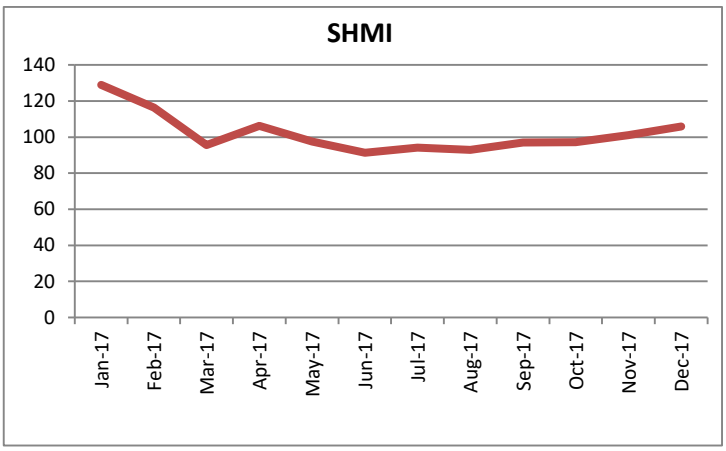


Figure 3 – SHMI timeline (Jan17-Dec17)

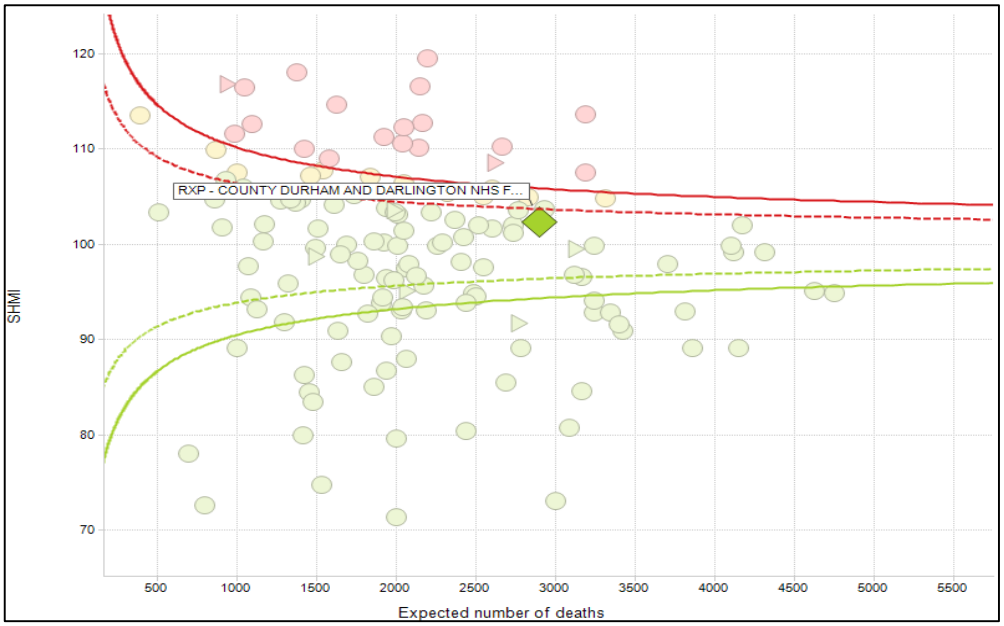


Figure 4 - Funnel plot showing expected number of deaths and SHMI for period Jan17-Dec17.

Crude Mortality

The Trust's crude mortality reached a peak of 5.18% in January 17, and showed a similar trend to HSMR, with subsequent peaks in April (5.07%) and July (4.65%).

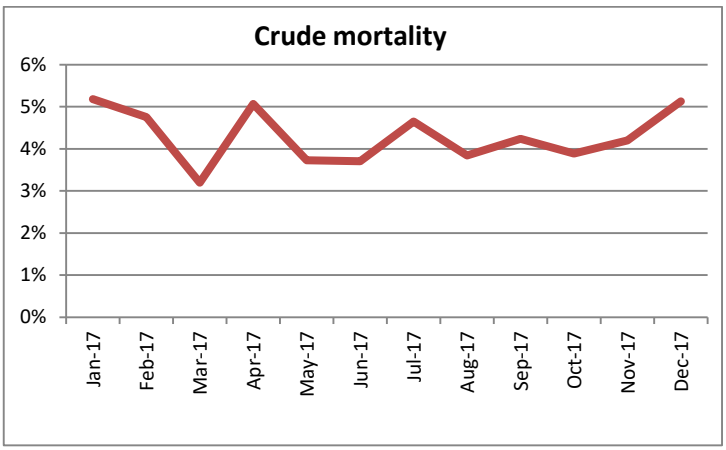


Figure 5 – Crude Mortality timeline (Jan17 – Dec17)

Next Steps

County Durham & Darlington NHS Foundation Trust intends to take the following actions (outlined below) to improve this number and/or rate, and so the quality of its services:

- Ensure that mortality remains a strong focus for the Trust, by;
- Continuing to adhere to the recommendations of the CQC's report 'Learning, candour and accountability', and the National Quality Board's National Guidance on Learning from Deaths for Trusts March 2017.
- Having embedded the Learning from Deaths policy in 2018/19 the Trust will continue to build on the mortality review process within the organisation.
- Ensure care group review dashboards and associated learning are provided for review and any necessary action within care group governance meetings.
- Continue to work with Regional and Primary Care colleagues to ensure joint learning.

The Trust have appointed a Mortality Lead who is continuing to embed Learning from Deaths policy and has improved the triangulation between mortality review and patient safety and incident reporting.
The Trust has defined which deaths are mandated for a case note mortality review, and this criteria is detailed within the Trusts Learning from Deaths policy which is published on the Trust website. A central mortality review team will review these deaths, along with a sample of other deaths. The outcome of these reviews is presented on the Trust Mortality review Dashboard at the Trust board quarterly. Mortality reviews completed outside the central review team, for example from surgical M&M meetings, are now captured and reflected within the Trust Dashboard. Maternity and paediatrics have a separate mortality review process that fulfils statutory requirements in these areas. This work is co-ordinated the Associate Director for Mortality and Deputy Medical Director for Safety and Governance. All data is reported into the Trust's Mortality Reduction Committee.

Whilst undertaking mortality reviews are essential it is equally important the information and learning gained from the reviews is translated into the care delivered in CDDFT.

Learning from mortality reviews is discussed at the central team monthly meetings and also disseminated within the relevant committees to which the learning relates for example escalation planning discussed within Resuscitation and Deteriorating Patient Committee.

In 2019/20 the Trust will explore how the foundations of sharing learning can be built upon and that both the positive and negative learning is incorporated into future care delivery. In the first instance this will include regular updates within the Trust wide Medical Directors podcasts, it is proposed to include updates in leading a highly reliable organisation. From a medical workforce perspective, this will be disseminated via the Medical Directors bulletin.
The trust continues to collaborate with peers across the region and with colleagues in primary care to share learning and to undertake joint work to improve patient care, facilitated by discussion of learning at the Trusts Clinical Effectiveness Committee. The new Care Group Director within Community services will support and enable us to further work with primary care colleagues to share learning. Regionally there are projects looking at the management of sepsis, acute kidney injury and the deteriorating patient that have been generated from the regional mortality work.

Medical Examiner
There is a multi-disciplinary Task and Finish group ongoing to implement the Medical Examiner System, with the post of lead Medical Examiner currently out to advert. This will be a phased implementation, pending further guidance centrally.

To reduce the number of emergency readmissions to hospital within 28 days of discharge

⊖	Trust ambition not achieved but improvements made

Our aim
The Trust aims to minimise avoidable re-admissions.

Progress
The Trust-wide re-admission rate for 2017/2018,

Re-admission numbers are up by 5.6%year as at the end of November 2018 compared with the same period last year. Most of the increase took place during the end of Q1 and the start of Q2. November is also up against November last year, but the figures are not yet fully coded. When they are, the Trust would expect this year's figure to come down slightly. Respiratory conditions were responsible for the largest number of re-admissions (where the discharge and readmission were the same HRG chapter), followed by Gastroenterology and Cardiology respectively.

	Apr-Nov 2017	Apr-Nov 2018	Variance	% variance
Elective	757	726	-31	-4.1%
Non-elective	4,651	4,985	334	7.2%
Total	5,408	5,711	303	5.6%

General Surgery and Gynaecology account for 42% of re-admissions following an elective spell.

Short-stay in-patient units continue to the most significant source of re-admissions following a non-elective admission, with the UHND A&E short stay unit accounting for 14.5% of re-admissions. By contrast, the two RAMACs account for a total of 8%. Altogether, 59% of such re-admissions originated in General Medicine, General Surgery or A&E.

Next Steps
Building on existing Intermediate Care provision, developments in the Community Care Group, such as the locality-based Teams Around Patients (TAPS), have as one of their chief goals a reduction in the incidence of both admissions and re-admissions.

Other actions to reduce admissions and re-admissions include:

- Improved discharge processes including Home to Assess (assessing people in their own home rather than whilst in hospital), Levels of Care criteria, Criteria-led discharge.
- Introduction of *Consultant Connect*, providing GPs with an opportunity to seek immediate advice from a medical consultant as an alternative to sending a patient to A&E or for direct admission.

To reduce the length of time to assess and treat patients in Emergency Department

⊖	Trust ambition not achieved but improvements made

Our Aim
We aim to assess and treat all patients in A&E in a timely and safe manner. Key standards are:

- 95% patients are assessed and treated within 4 hours of arrival at A&E.
- Ambulance crews can hand over the care of patients to CDDFT staff within 30 minutes of arrival.

Progress
In the period Apr-Dec 2018, A&E attendances fell by 1% although non-elective medical admissions were up 1.3%. The Trust has not achieved the national 95% standard to treat A&E patients within 4-hours.

A&E 4hr Wait Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
National Standard	**95%**	**95%**	**95%**	**95%**	**95%**	**95%**	**95%**	**95%**	**95%**
NHSI Trajectory	**94.81%**	**90.79%**	**93.13%**	**93.70%**	**95.16%**	**96.76%**	**95.62%**	**93.71%**	**84.81%**
Performance	**89.74%**	**93.61%**	**89.97%**	**90.00%**	**91.08%**	**88.59%**	**92.76%**	**90.01%**	**88.59%**

Green = achieved 95% national standard and monthly NHSI trajectory; Amber = achieved one of the above; Red = achieved neither of the above

This performance mirrors national trends. For example, in Quarter 3, CDDFT saw more patients in A&E than any other N.E. Trust but was placed just outside the top quartile nationally for 4-hour A&E wait performance:

Quarter 3	Type 1 attends	4-hour wait performance	National position
North Tees And Hartlepool	11,594	97.1%	3rd
South Tees	32,441	95.2%	8th
QE Gateshead	23,696	93.2%	19th
Newcastle	31,162	95.9%	7th
Northumbria	27,033	95.0%	10th
South Tyneside	15,944	94.8%	12th
CDDFT	33,359	90.6%	36th
City Hospitals Sunderland	25,770	91.3%	32nd
England	3,930,120	87.7%	

Out of 134 Trusts nationally

Although overall activity has not increased, ambulance pressures have grown. The latest data available, for example, over the winter holiday period (22nd Dec – 2nd Jan) 37 more NEAS ambulances (4%) arrived at CDDFT sites than during the same period in 2017-18. In spite of this, fewer ambulance diverts took place. During the holiday period in 2017-18, of the 36 NEAS diverts in the NE Region, 31 took place from UHND and 3 from DMH. During the same period this year, 27 diverts were recorded, of which 14 were from UHND and 0 from DMH. Most of these transfers were patients being moved from one CDDFT site to another.

In addition, there were fewer ambulance handover delays this year compared to last: only 8 CDDFT patients waited >120 minutes during this holiday season compared to 30 in 2017. A significantly higher proportion of patients were transferred in <30 minutes. The ambulance handover nurses have played a key role in this improvement.

Table 3: Ambulance handover delays

	Dec-17				Dec-18		
	<30 mins	30-120 mins	120+ mins		<30 mins	30-120 mins	120+ mins
DMH	72.53%	255	10		87.50%	78	1
UHND	70.81%	336	20		82.60%	238	7

Consequently, NEAS suffered far fewer waiting time delays during this Bank Holiday period and Q3 than last year. The average handover time lost per ambulance patient in October at CDDFT was 2 minutes 32 seconds compared to a regional average of 3 minutes 8 seconds. In December the comparative figures were 4 minutes 44 seconds compared to a regional average of 4 minutes 57 seconds (Table 4).

Table 4: NEAS average time lost per handover (minutes:seconds)

	Oct 18	Dec-18
DMH	3:09	2:36
UHND	2:06	6:11
CDDFT Total	2:32	4:44
James Cook	3:33	4:43
NSEC	5:34	9:00
QE Gateshead	0:30	1:08
RVI	2:29	2:45
South Tyneside	3:50	6:53
Sunderland Royal	2:49	5:51
North Tees	3:05	1:41
Regional average	3:08	4:57

Next Steps

A wide range of actions are in train under the Transforming Emergency Care Programme. Since last year's report, a great deal has been done to improve patient flow across health and social care pathways. The Programme covers all aspects of the emergency care pathway including developing alternatives to admission, streamlining acute care processes, improving and creating more timely discharge processes, and creating more robust community services into which patients can be discharged.

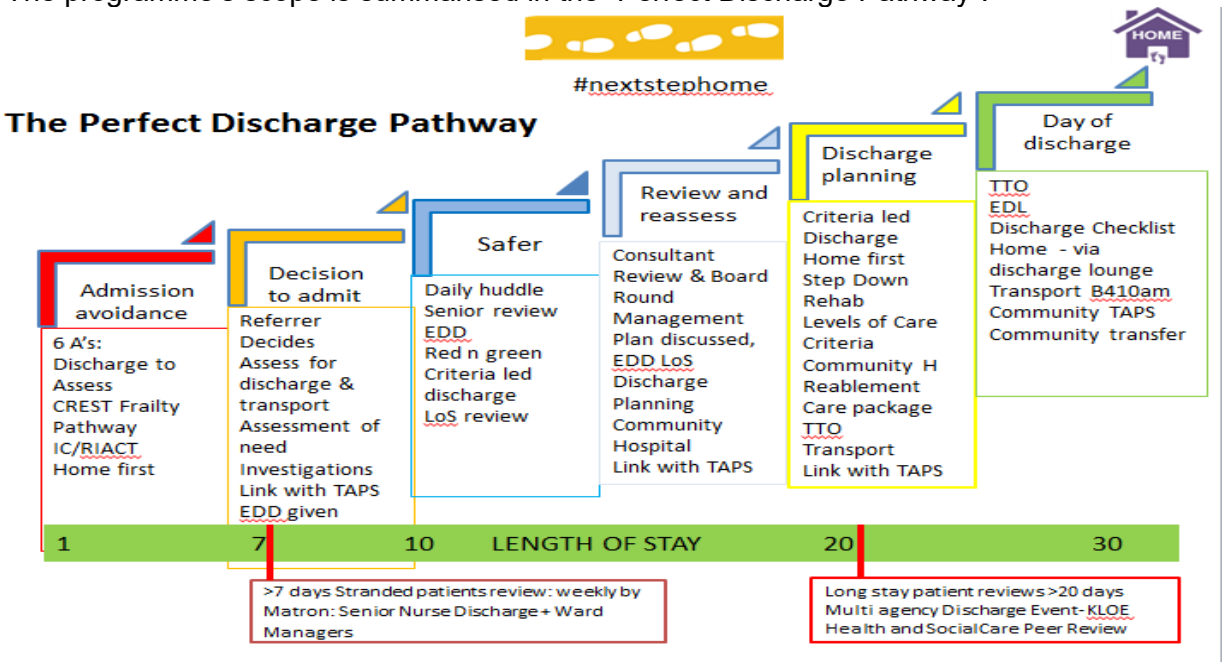
Key changes include:

- Over the winter, the Surgery Care Group loaned 20 beds on each acute site to Medicine to accommodate the usual surge in medical admissions and enable medical patients to be

cared for by specialist medical staff rather than being boarded out onto non-medical wards.

- GP screening has been successfully introduced in both Emergency Departments, enabling GPs to triage and treat many patients who would otherwise have had to wait for an A&E doctor.
- Specialist ambulance handover nurses at both acute sites have been instrumental in reducing handover delays, freeing ambulance staff to attend other emergencies in the community more rapidly.
- Revision of on-call rotas, command and control and escalation frameworks
- Extended hours for discharge lounges
- Roll-out of SAFER care bundles across all wards (setting minimum standards for Ward and Board rounds and activities to minimise unnecessary delays.

The programme's scope is summarised in the "Perfect Discharge Pathway":



7 Day Service Standards

CDDFT are committed to delivering high quality care for patients. The Transforming Emergency Care (TEC) programme has been established to drive service improvements in emergency care, ensure timely assessment and treatment for patients. This programme of work is a key to the delivery of the 4 national priority standards; ensuring patients;

- don't wait longer than 14 hours to initial consultant review.
- get access to diagnostic tests.
- get access to specialist, consultant-directed interventions.
- with high-dependency care needs receive twice-daily specialist consultant review, and those patients admitted to hospital in an emergency will experience daily consultant-directed ward rounds.

As part of the plan to continue to drive improvements, the trust participated in national audits. The last audit was conducted in May 2018 and the results were reported in September 2018. The findings were:

- 100% patients with high dependence care needs receiving twice daily review.

- 92% of patients were seen within 14 hours of admission to hospital by a consultant a significant improvement from 2017 when it was 80%.
- The Trust has appropriate access to diagnostic tests
- The Trust has access to specialist, consultant directed interventions.

From 2019 onwards the priority 7 Day Standards will be assessed as part of the Trust's Board Assurance Framework and work is currently ongoing to establish the appropriate mechanism to do this.

To increase patient satisfaction as measured Patient Reported Outcome Measures (PROMs)

⊖	Trust ambition not achieved but improvements made

What are they? PROMs measure quality from the patient perspective by using questionnaires. In 2018 the national requirement for collection of PROMs changed in NHS Trusts. Previous to this, the outcomes of four clinical procedures were collected – hip replacements, knee replacements, hernia and varicose veins. This requirement from NHS England has now changed in that NHS Trusts are measured against outcomes following Total Knee and Total Hip replacement surgeries only. PROMs calculate the health gain after treatment using surveys carried out before and after the operation. PROMs are a measure of the patient's health status or health related quality of life at a single point in time. They provide an indication of the outcome or quality of care and comprise of the patient being provided with two questionnaires (one before surgery - given at pre-assessment and one after surgery – usually after a minimum of 3 months).

All patients irrespective of their symptoms are asked to participate by completing a common set of questions about their health status.

The post-operative questionnaires also contain additional questions about the surgery, such as patient perception in respect of the outcome of surgery and whether they experienced any post-operative complications.

Our aim

During 2017/2018, the Surgery Care Group and third party provider worked collaboratively to improve participation with the completion and compliance with questionnaire 1, which is provided during the pre-operative assessment. Since the commencement of this work, which involved training and education in respect to the benefits and realisation of the significance of collecting PROMs data our monthly compliance has significantly and sustainably improved. During 2018/2019 and due to this increased uptake in the participation rates for questionnaire 1 and having a defined Clinical Lead to review the specific outcome data, the Care Group has commenced greater analysis of our outcome data utilising the complete data from both questionnaires. In doing this it is anticipated that we will have greater understanding of our PROMs outcomes. Due to the time lag for data validation this is not expected to be fully realised for up to 2 years, as questionnaire 2 is sent approximately 6 months following surgery.

The Surgery Care Group has discussed ceasing to collect PROMs data for groin hernia and varicose vein surgery with our commissioners and this has been agreed.

County Durham & Darlington NHS Foundation Trust considers that the outcome scores are as described for the following reasons:

The data is collected by a dedicated team within the organisation.

The data collected is made available by the Health and Social Care Information Centre as stated above.

STATEMENTS OFASSURANCE FROM THE BOARD

During 2018/2019 County Durham & Darlington NHS Foundation Trust provided and/or sub-contracted 125 relevant services.

The County Durham & Darlington NHS Foundation Trust has reviewed all of the data available to them on the quality of care in all of these relevant health services.

The income generated by the relevant health services reviewed in 2018/2019 represents 100 per cent of the total income generated from the provision of relevant health services by the County Durham & Darlington NHS Foundation Trust for 2018/2019.

Review of Services

The Trust's performance against national priorities is shown in Part 3 of this report.

The Trust Board receives a regular Integrated Board report covering the Trust's four key Touchstones: best experience, best outcomes, best efficiency and best employer. The report includes an integrated performance scorecard.

The Trust has once again reviewed its Performance Management Framework. Each Care Group is reviewed monthly using key metrics relating to the four Trust Touchstones. Matters requiring senior discussion are escalated for executive review.

In addition to reports to the Board, the key performance risks and the outcomes of the Performance Reviews are reported monthly to the Executive team and to the Integrated Quality and Assurance sub-committee of the Board.

Participation in Clinical Audits and National Confidential Enquiries

During 2018/2019 43 national clinical audits and 4 national confidential enquiries covered NHS services that County Durham & Darlington NHS Foundation Trust provides.

During 2018/2019 County Durham & Darlington NHS Foundation Trust participated in *98% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in. (* the Trust as part of the North East Region instead of participating in the National Mortality Case Record Review Programme uses PRISM(2) method and is compliant with the recommendation from NHS Improvement document 'Learning from Deaths'. The National Mortality Case Record Review Programme is aware of this.

The national clinical audits and national confidential enquiries that County Durham & Darlington NHS Foundation Trust was eligible to participate, participated in, participated in and for which data collection was completed during 2018/2019 are contained within the table below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry:

National Audit/National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 18– Mar 19	% cases submitted
Women's and Children's Health				
Maternal, infant and newborn programme (MBRRACE-UK)* (Also known as Maternal, Newborn and Infant Clinical Outcome review Programme)	✓	✓	On-going	100%
Neonatal intensive and special care(NNAP) -	✓	✓	✓	100%
National Maternity and Perinatal Audit (	✓	✓	✓	N/A Organisational Audit
National Audit of Seizures and Epilepsies in Children and Young People (RCPCH)	✓	✓	✓	N/A Organisational Audit only 2018
Paediatric intensive care (PICANet)	X			

National Audit/ National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 18 – Mar 19	% cases submitted
Acute Care				
Adult critical care (Case Mix Programme) –	✓	✓	On-going data collection. Final quarter to be submitted May 19	100% Oct – Dec 18
British Thoracic Society (BTS) – Adult Community Acquired Pneumonia	✓	✓	Data submission deadline 31/5/2019	N/A
National emergency laparotomy audit (NELA)	✓	✓	✓	*DMH 78% UHND 100%
Hip, knee ankle, shoulder elbow replacements (National Joint Registry)	✓	✓	On-going	31/1/2019 87%
Major Trauma Audit (Trauma and Audit Research Network TARN)	✓	✓	On-going. Data still being collected	Jan-Jul 2018 UHND 100+% DMH 100+%
VTE risk in lower limb immobilisation (Royal College of Emergency Medicine)	✓	✓	✓	**100.0%
Vital Signs in Adults (care in emergency departments) (Royal College of Emergency Medicine)	✓	✓	✓	**100.0%
Feverish Children (care in emergency departments) (Royal College of Emergency Medicine)	✓	✓	✓	**100.0%
National Clinical Audit of Specialist Rehabilitation for patients with complex needs following Major Injury (NCASRI)	X			

* Case ascertainment required is >85% of expected cases between 1/12/17and 30/11/2018

** Sample required by the Royal College of Emergency Medicine has been submitted unless there were not enough patients that met the inclusion criteria over the audit period 1/8/18- 31/1/19.

National Audit/ National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 18– Mar 19	% cases submitted
Long Term Conditions				
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) Adult Asthma - Secondary Care Audit . Chronic Obstructive Pulmonary Disease (COPD) - Secondary Care Audit	✓ ✓	✓ ✓	Ongoing data collection began in Nov 2018 ✓	N/A N/A
National Audit of Pulmonary Hypertension (NHS Digital)	X			
UK Cystic Fibrosis Registry (Cystic Fibrosis Registry)	X			
British Thoracic Society (BTS) – Non Invasive Ventilation Adults	✓	✓	Data collection completion date 30/06/2019	N/A
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	✓	✓	Ongoing data collection first data extraction for reporting 8/5/2019	N/A
Diabetes (National Adult Diabetes Audit)	✓	✓	✓	100% of cases on System One and databases
Diabetes (RCPH National Paediatric Diabetes Audit)	✓	✓	✓	100% cases on database sent
National Pregnancy in Diabetes (NPID)	✓	✓	✓	100%
National Diabetes Inpatient Audit. (NaDIA)	✓	✓	✓	N/A Organisational Audit only 2018
NaDIA Harms	✓	✓	To December 2018 only nil submissions	N/A
National Diabetes Footcare Audit (NDFA)	✓	✓	✓	*100%
Inflammatory Bowl Disease (IBD) Programme (IBD Registry) National Clinical Audit of Biological Therapies	✓	✓	✓	N/A

* Data entered for all patients that consented to participate in the audit.

National Audit/ National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 18 – Mar 19	% cases submitted
Mental Health Conditions				
Prescribing in mental health services (POMH)	X			
National Clinical Audit of Psychosis (NCAP)	X			

Mental Health programme: National Confidential Inquiry into Suicide and Homicide for people with mental illness(NCISH)	X			

National Audit/ National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 18– Mar 19	% cases submitted
Older People				
Falls and Fragility Fractures Audit Programme (FFFAP):				
Fracture Liaison Service Database (FLS-DB)	✓	✓	✓	43% of expected fragility fractures
Hip fracture (National Hip Fracture Database)	✓	✓	✓	100% Validated up to Dec 18
Inpatient falls (RCoP)	✓	✓	Data collection started 1/1/2019.Still ongoing.	N/A
Sentinel Stroke National Audit Programme (SSNAP)	✓	✓	On-going 18/19 final 4 months data to be submitted by 6/5/2019	>80% (A) case ascertainment Jul-Sep 18
National Audit of Dementia Royal College of Psychiatrists	✓	✓	✓	*100%

* A minimum of 50 patients for each hospital site was required

National Audit/ National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 18 – Mar 19	% cases submitted
Heart				
Acute Coronary Syndrome or Acute Myocardial Infarction & other ACS (MINAP)	✓	✓	On-going	Data to be submitted 30/06/2019
National Adult Cardiac Surgery Audit (Adult Cardiac Surgery)	X			
Cardiac Arrhythmia (HRM)	✓	✓	On-going	100%
Heart failure (Heart Failure Audit)	✓	✓	On-going	Data to be submitted 30/06/2019
Cardiac arrest (National Cardiac Arrest Audit)	✓	✓	✓	100%
National Vascular Registry (elements will included CIA Carotid Interventions Audit, National Vascular Database, AAA, peripheral vascular surgery/VSGBI Vascular Surgery Database.	✓	✓	On-going	As of the 31/12/2018 Carotids = % AAA = % Amputations %
National Audit of Cardiac Rehabilitation (University of York)	✓	✓		
National Audit of Percutaneous Coronary	X			

Interventions(PCI)				
National Congenital Heart Disease (CHD)	X			

National Audit/ National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 18 – Mar 19	% cases submitted
Cancer				
Lung cancer (National Lung Cancer Audit)	✓	✓	✓	100%
Bowel cancer (National Bowel Cancer Audit Programme)	✓	✓	**✓	100%
Oesophago-gastric cancer (National O-G Cancer Audit)	✓	✓	***✓	100%
National Prostate Cancer Audit.	X	X		
National Audit of Breast Cancer in Older Patients (NABCOP)	✓	✓	On-going monthly data submissions	100%

* Data collection deadline in 2018/2019 for patients covering period Jan – Dec 2017
** Data collection deadline in 2018/2019 for patients covering period 1st Apr 2017 – 31st Mar 2018
*** Data collection deadline in 2018/2019 for patients covering period 1st Apr 2017 – 31st Mar 2018

National Audit/ National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 18 – Mar 19	% cases submitted
Other				
Elective surgery (National PROMs Programme)	✓	✓	N/A	N/A
Learning Disability Mortality Review Programme (LeDeR Programme)	✓	✓	✓	100%
National Mortality Case Record Review Programme	✓	*X		
National Ophthalmology Audit (NOD)	✓	✓	✓	100%
National Bariatric Surgery Registry (NBSR)	✓	✓	Prospective Ongoing data collection	100%
National Audit of Intermediate Care	✓	**X	X	*N/A
Serious Hazards of Transfusion (SHOT) :UK national haemovigilance scheme	✓	✓	No incidents for CDDFT	N/A
National Audit of Care at the End of Life (NACEL)	✓	✓	✓	Acute 39.6% Community 100% of deaths in audit period
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	✓	✓		
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) Antibiotic Consumption -Public Health England	✓	✓		
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) Antibiotic Consumption - Public Health England	✓	✓		

Surgical Site Infection Surveillance Service (SSISS) - Public Health England	✓	✓	Data for Oct - Dec 18 will be submitted April 2019	100%
Seven Day Hospital Services (NHS England)	✓	✓		
National Audit of Anxiety and Depression	X			
National Neurosurgery Audit Programme	X			
BAUS Urology Audits: Nephrectomy Audit	X			
BAUS Urology Audits: Percutaneous Nephrolithotomy	X			
BAUS Urology Audits: Radical Prostatectomy Audit	X			
BAUS Urology Audits: Cystectomy	X			
BAUS Urology Audits: Female stress urinary incontinence	X			

* The Trust in common with the rest of the Northern East Region will be not be adopting the SJR method but PRISM 2 instead. NMCRR already aware of this.
** As the rest of the local health economy were not participating there was no benefit in Trust submitting the Organisational Audit only again.

National Audit/ National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 18 – Mar 19	% cases submitted
Other				
Blood transfusion and Transplant				
2018 Audit of the use of O neg red cells (National Comparative Audit of Blood Transfusion)	✓	✓	✓	100%
2018 Audit of Massive Haemorrhage (National Comparative Audit of Blood Transfusion)	✓	✓	✓	100%
2018/19 Audit of Maternal Anaemia (National Comparative Audit of Blood Transfusion)	✓	✓	Still On-going	N/A
2018 Audit of the use of Fresh Frozen Plasma, Cryoprecipitate and other blood components In Neonates and Children (National Comparative Audit of Blood Transfusion	X			
National Confidential Enquiries – Medical and Surgical Clinical Outcome Review Programme				
Peri-operative management of surgical patients with diabetes	✓	✓	✓	
Pulmonary Embolism	✓	✓	✓	
Acute Bowel Obstruction	✓	✓	On-going	N/A
Long Term Ventilation	✓	✓	On-going	N/A

- The reports of *23 national clinical audits were reviewed by the provider in 2018 and County Durham & Darlington NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

* For the National Cardiac Arrest Audit (NCAA) 17/18, National Bariatric Surgery 17/18 there was compliance with standards.

National Clinical Audits reviewed in 2018/2019	Action
National Audit of Dementia Assessment of Delirium 2017/18	Education and Training of Staff. Identify Trust clinical lead for Delirium.
Royal College of Emergency Medicine – Fractured neck of Femur Audit 2017 (Darlington Memorial Hospital).	To improve the documentation of pain assessment /relief given pre-hospital. Reinforce at induction for doctors and nurses to undertake pain assessment score within the RCEM national standard. Reinforce at induction for doctors and nurses to ensure that patients in severe pain should receive appropriate analgesia within the RCEM national standards. Reinforce at induction for doctors and nurses to ensure that patients in moderate pain should receive appropriate analgesia within the RCEM national standards. Improve documentation when check undertaken and patient comfortable.
Royal College of Emergency Medicine – Fractured neck of Femur Audit 2017 (University Hospital of North Durham).	To embed pain scoring within the triage process Ensure clinicians are aware of appropriate drugs for different levels of pain. Embedding pain score in ED after first dose of analgesic.
Royal College of Emergency Medicine – Pain in Children 2017 (Darlington Memorial Hospital).	Reinforce RCEM standard that pain is assessed within 15 minutes of arrival at doctor and nursing induction training. Matron not reinforce that patients in severe pain should receive appropriate analgesia according to local guidelines within 60 minutes of arrival or triage whichever is earlier at the Emergency Department Governance Meeting. To reinforce that all patients in moderate pain should receive appropriate analgesia according to local guidelines within 60 minutes arrival or triage whichever is the earliest at doctors and nurses induction training. To reinforce that patients in severe or moderate pain should have documented evidence of re-evaluation and action within 60 minutes of receiving the first dose of analgesic at doctors and nurses induction training. To reinforce that If analgesia is not prescribed and the patient has moderate or severe pain the reason should be documented in the notes at doctors and nurses induction training.
Royal College of Emergency Medicine – Pain in Children 2017 (University Hospital of North Durham).	Implementation of Emergency Department Paediatrics Analgesia Pathway.
Royal College of Emergency Medicine – Procedural sedation 2017 (Darlington Memorial Hospital).	Reinforce that all patients undergoing procedural sedation in the ED should have documented evidence of pre-procedural assessment, including a) ASA grading, b) Prediction of difficulty in airway management and c) pre-procedural fasting status. Include the requirement for documented evidence of the

	patient's informed consent unless lack of mental capacity has been recorded in both: Junior Doctor Induction training Nursing Induction Training. Include the requirement that all procedural sedation should be undertaken in a resuscitation room or one with dedicated resuscitation facilities in both : Junior Doctor Induction training Nursing Induction Training. All doctors and nurses to fully complete the procedural sedation proforma, Include the requirement that appropriate oxygen therapy should be given from the start of sedative administration until the patient's condition is returned to baseline in both : Junior Doctor Induction training Nursing Induction Training. Implement LocSSIP. Refresher Training to be given on the use of LocSSIP to doctors and nurses. To design a patient information leaflet giving post-procedural sedation advice.
Royal College of Emergency Medicine – Procedural sedation 2017 (University Hospital of North Durham).	Revise Procedural Sedation Pathway and Documentation. Implement appropriate LocSSIP's.
National Oesophago-Gastric Audit 2017.	
National Diabetes Audit (Adult) 16/17.	New Model of Diabetes implemented across all 3 CCG's in 2017/18. Live Dashboards for all 8 care processes are monitored monthly at the Diabetes Governance Board. New Model of Diabetes meant majority of Type 2 patients being cared for in primary care thereby stream lining secondary care specialist clinics. This will enable improvements in all the care process to meet the national benchmarks.
National Diabetes in Pregnancy Audit 2016 Darlington Memorial Hospital.	Letter to be sent by Diabetic lead from Darlington Memorial Hospital. To continue the education of Primary Care Trust on the use folic acid 5mg supplement prior to pregnancy. Continue to work on first trimester/ongoing control and provide robust antenatal/diabetic care.
National Diabetes in Pregnancy Audit 2016 University Hospital of North Durham.	Letter to be sent by Diabetic lead at University Hospital of North Durham. To continue the education of Primary Care Trust on the use folic acid 5mg supplement prior to pregnancy. Continue to work on first trimester/ongoing control and provide robust antenatal/diabetic care.
National Diabetes Inpatient Day Audit 2017 Darlington Memorial Hospital.	Continue to educate primary care colleagues for screening for active foot disease in primary care Continue education of inpatient teams re: appropriate use of insulin infusions
National Diabetes Inpatient Day Audit 2017 University	Plans to increase consultant recruitment and foot clinics in the next 24 months.

Hospital of North Durham.	Recruitment to Diabetes Specialist Nurse posts. Seven day extended Diabetes Specialist Nurse service will reduce insulin infusion use. New Consultant recruited will improve care provision of active foot disease patients. Online e-learning module (an introduction to insulin safety) is now mandated for all nursing staff. Develop self-administration of insulin policy. Ongoing plans to provide education to nursing and medical staff. Plans to enhance pharmacy support Development of an Insulin/hypo card for Junior Doctors. Online e-learning module (safe management of hypoglycaemia) is now mandated for all nursing staff. POCT testing. Accu-check inform II glucose meter training is held monthly with the support of the POCT testing co-ordinator. A 6 monthly audit of the system is fed back to ward managers to action.
MINAP 16/17	Identify professionals and elements of patient flow responsible for patients allocation and discuss poor allocation of patients to specialty ward - diagnosis (Acute Physician), consultation (Cardiologist of the Day), appropriate ward assignment (Bed Manager), transfer (Ward Manager) Improve communication between the team identifying patients with a myocardial injury early after admission and Ward managers (Heart Nurses team and Ward managers) Encourage active transfer of care to Cardiology Ward in justified cases (ward managers to be aware of misallocated patients and contact relevant teams for transfer of responsibility) A Cardiologist of the Day to be mindful of the transfer and to confirm its suitability.
National Heart Failure Audit 16/17	At the University Hospital of North Durham site support the use of Discharge Management Plans At University Hospital of North Durham /Darlington Memorial Hospital audit a sample of patients from each site to determine the reasons why patients may have not receive discharge planning. To review the contents of a discharge plan and compare both sites.
National Diabetes Footcare Audit 16/17.	To continue education of Primary Care Physicians about pathway and early referral to the MDT.
National Hip Fracture Database Audit 17/18.	Investigate increasing the availability of the Ortho-geriatrician. Look at increasing staff levels University Hospital of North Durham to provide comparable mobilisation of patients levels with Darlington Memorial Hospital. Use the screening tool to identify patients at risk of delirium earlier. Investigate what proportion of delays in surgical

	operations are the result of avoidable inefficiencies in pre-operative planning. Also in the organisation of theatre lists. Investigate 1) Low rates of THR in eligible cases. 2) Low rates of SHS for A1/A2 fractures. Acute Hip Fracture teams must examine their approach to 120 day follow-up. Reflect on elements of care which have influence on aspect of the outcome, even after the patient leaves the acute trust.
National Emergency Laparotomy Audit (NELA) Dec 17-Nov 18 (Trustwide).	Look into funding of more critical care beds. Cancel elective admissions over emergency cases.
Maternal, Newborn and Infant Clinical Review Programme - Saving Lives and Improving Care - Confidential Enquiry Maternal Deaths and Morbidity 2013-15	Guideline to be reviewed in relation to pre-conceptual counselling of women with epilepsy. Guideline for women presenting with a stroke being developed. Guidelines being developed for women presenting with medical and general surgical disorders.
Maternal, Newborn and Infant Clinical Review Programme - Saving Lives and Improving Care - Perinatal Confidential Enquiry - Term, singleton, intrapartum stillbirth and intrapartum-related neonatal deaths	Review of the content of the Trusts fetal monitoring training underway. Current guideline available - Newborn Resuscitation will be reviewed in 12 months' time.
Maternal, Newborn and Infant Clinical Review Programme - Saving Lives and Improving Care - Perinatal Mortality Survey Jan -Dec 16.	Guidelines have been changed and all placentas are sent with foetus to the perinatal pathologist. Placenta is stored for any baby unexpected admitted to the neonatal unit.
Sentinel Stroke Audit Programme (SSNAP) 17/18	Re-iterations with staff to get patients admitted directly to stroke ward / Review CT scan request procedure. Review current processes and service development opportunities. Applicable patient to be screened for nutrition and seen by a dietician by discharge. All patients to receive mood and cognition screening. Continue with business case to support Early Supported Discharge (ESD) in 2018/19. Continue with escalation to CCG / business case development for access to psychologist.

Confidential Enquiries

County Durham and Darlington NHS Foundation Trust has participated/is still participating in 4 enquiries during the course of 2018/2019. The Trust has submitted/is submitting either patient or organisational data for all studies which were deemed relevant.

Confidential Enquiries reviewed in 2018/2019	Action
NCEPOD – ' Each and Every Need "-Chronic Neurodisability	Agree coding and standards for data collection. All children with suspected cerebral palsy should be referred to Community paediatricians from outset. Education to ensure all paediatricians document learning disability. Include oral health and dental care as a routine requirement. Improve liaison between acute and community services. Consider improving facilities and resources at all sites where disabled children are seen. Improvement of website presentation.

The reports of 19 local clinical audits were reviewed by provider in 2018/2019 and County Durham & Darlington NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Local Clinical Audits reviewed in 2018/2019	Action
Serious Disease Notification (SDN), copy letter to the patient and Clinical Specialist Nurse (CSN) compliance audit	Nurses remind doctor to fill in SDN. Mark the patients with cancer diagnosis on list, in order to the doctor an SDN form prior to seeing the patient.
Pre-septal and Orbital Cellulitis in Paediatrics.	Maintain excellence compliance to treatment protocol for Pre-septal Cellulitis. Educate stakeholders regarding protocol for Orbital Cellulitis e.g. posters, education sessions
Ophthalmology Consent Audit	All new staff to be given detailed training at induction. Staff to complete the Be-Informed E-learning module.
Completion of Level 1 Medicines Reconciliation in Orthopaedic Clerking Documentation	Education of all those clerking orthopaedic admission regarding need to document "no regular medications" if appropriate to demonstrate that this has been checked, and use of MiG via iSoft. Re-education of all those clerking orthopaedic admission regarding the importance of documenting allergy status in the designated field in the clerking document.
Medical Clerking Documentation.	Produce a laminated poster for Ward 16, Ward 4 and ANP office Bishop Auckland Hospital to raise awareness of standards.
Lens touch cataract following intravitreal injections.	To stop the injections being done by locum doctors and only substantive trained staff to take over.
HIV clinical indicator testing in Intensive Care	Production of Trust wide HIV testing guideline for intensive care.

Quality referrals to ENT Emergency Clinic	Revised guideline to be shared for ease of access. Including F1 and F2 doctors form general surgery in ENT Induction teaching. Use tabulated format/ register for booking patients.
CIN 2 Audit	Safeguarding where notes are lost from digital records. Safeguarding where patients are lost to follow up. Improved colposcopic examination documentation with regard to reason for referral, documentation of colposcopic findings, site of biopsies. Improved consistency in treatment depths with respect to TZJ type.
Audit on compliance of Dermatology with BAD standards for PUVA treatment. (PUVA guidelines)	Staff training on MPD calculation. All clinicians to ensure PIL on consultation is documented in clinic letters. More clinicians to consider oral PUVA treatment to reduce topical treatment.
Pulmonary Embolism, Ventilation/Perfusion scan and the practicalities.	Poster on the correct completion of V/Q scan request forms. Liaising with iSoft team to include Well's score and D-dimer results in text fields in requests. Training, particularly to junior doctors on the importance of accurate and complete referral information and about the legal duties of the referrer tests that include ionising radiation.
Physiotherapy Hip Sprint Audit.	If medically suitable make sure staff prioritise early mobilisation of patients including walking, standing, transferring to chair on day 1 regardless of their cognitive impairment. If medically suitable assess by day 3 if patients are suitable for rehab or return to care home/home with support. Put rehab guidelines in place to intensify rehabilitation to include strength, mobility, endurance and where possible balance. Investigate with Nursing and other MDT staff options for continuing re-hab when Therapy staff are unavailable. Refer patients from the acute trust to the correct on-going re-hab session, ie MSK outpatients, Community Physio, Day Hospital. Collaboration between Acute and Community teams to improve current pathway(Trusted Assessor).
Tobacco and alcohol CQUIN Audit.	The Nurse assessment is to be included in the Nervecentre System which will improve compliance re: • Tobacco screening • Tabacco brief advice • Tobacco referral and medication offer • Alcohol screening • Alcohol brief advice or referral.

Family Heath Consent Audit	Educate staff to complete proforma. To review the proforma to see if changes are needed.
Re-audit of Obstetrics and Gynaecology Handover	To separate the audit process for Obstetrics and Gynaecology. Amend handover sheet – Clarify Obs 1st & 2nd. Condensing key information. Consideration to protect handover time – Engage with staff & educational intervention.
DVT and thromboprophylaxis in Pregnancy	Agreement with the anaesthetics department if advanced gestation, patient to be referred to the on-call anaesthetist. To raise awareness among consultants and trainees of the importance of timely referral to the obstetrics medicine antenatal clinic and MDT (via email and risk management meeting)
DHS Leg Screw Audit	Ensure screw is in the correct and desirable position at all times. Ensure adequate X-ray's are available at all times.
Hyperemesis Gravidarum.	Consideration & educational intervention Formal teaching with staff on how to devise and complete a Pregnancy -Unique Quantification of Emesis questionnaire that is adequate enough to guide a patients journey.
Upper GI Bleed Audit	Consultants reminded to enter all endoscopy procedures including out of hours on the endosoft system. Re-designed upper GI bleed form containing both Rockall and Blatchford scores with space to enter completed scores.

Research & Innovation

The number of patients receiving relevant health services provided or sub-contracted by County Durham & Darlington NHS Foundation Trust in 2018/2019 that were recruited during that period to participate in research approved by a Research Ethics Committee was 1957 participants. The table below shows the areas research has taken place within CDDFT.

Managing Specialty	CDD	Total
Anaesthesia, Perioperative Medicine and Pain Management	217	**217**
Cancer	147	**147**
Cardiovascular Disease	41	**41**
Children	37	**37**
Critical Care	214	**214**
Dementias and Neurodegeneration	4	**4**
Dermatology	100	**100**
Diabetes	16	**16**
Ear, Nose and Throat	11	**11**
Gastroenterology	637	**637**
Genetics	1	**1**
Haematology	3	**3**
Health Services Research	207	**207**
Hepatology	4	**4**
Infection	61	**61**
Injuries and Emergencies	16	**16**
Metabolic and Endocrine Disorders	6	**6**
Musculoskeletal Disorders	27	**27**
Neurological Disorders	1	**1**
Primary Care	23	**23**
Renal Disorders	8	**8**
Reproductive Health and Childbirth	107	**107**
Respiratory Disorders	1	**1**
Stroke	53	**53**
Surgery	15	**15**
Total	**1957**	**1957**

County Durham & Darlington NHS Foundation Trust is committed to participation in clinical research and innovation and our continued successful recruitment to clinical research studies demonstrates our desire to improving the quality of care we offer and to making our contribution to wider health improvement locally, regionally and nationally. Through research our clinical staff remains informed of the latest possible treatment possibilities and it has been shown research-active institutions provide better care and have better patient outcomes than those NHS Trusts that conduct less clinical research.

During 2018/19 County Durham & Darlington NHS Foundation Trust was involved in conducting National Institute for Health Research (NIHR) Portfolio clinical research studies in the following new areas of sexual health and ENT.

Areas in which non-NIHR clinical research studies were conducted by County Durham & Darlington NHS Foundation Trust in 2017/2018 include:

- Cardiovascular.
- Colorectal Disease.
- Dermatology.
- Gynaecology.
- Health Service & Delivery Research.

Building on national strategy, Research & Innovation have developed a Research & Innovation Strategy 2018-2021 with the aim of continuing to work towards developing:

- A culture that values and promotes research and to continue to provide opportunities for patients to be recruited to new studies.
- Increase the opportunities for all people across the region to participate in health research
- Provide researchers with the practical support they need to make clinical research studies happen in the NHS
- Improve the efficient delivery of high quality clinical research.
- Increase commercial clinical research investment and activity to support the Trust's growth
- Provide a coordinated and innovative approach to local and national research priorities.
- Assist CDDFT in retaining a high quality workforce through education and training, targeted strategic investment of both medical and nursing, midwifery and allied health professionals and creating opportunities for professional and leadership development and strategic contribution.

We have 90 Principal Investigators (PI's) across all specialties and disciplines with 38 currently leading multiple clinical research studies across the organisation demonstrating a good platform from which to build ensuring research is firmly embedded as core Trust business and have successfully increased the number of NMAHP PI's with two of the top five recruiting PI's for 2018/2019 being nurses. In 2019/2020 we aim to continue to develop more Chief Investigators within CDDFT therefore the number of Investigator Initiated studies in line with national priorities.

2018/2019 also saw further embedding of the Clinical Research Department and the Innovation team facilitating a fully integrated Research & Innovation Department within the Trust.

Information on the use of the Commissioning for Quality and Innovation (CQUIN) framework

CQUIN schemes are in place covering services which CDDFT provides for its main NHS commissioners: the Clinical Commissioning Groups, Specialist Commissioners and Public Health.

In previous years CQUIN income has been contingent upon achieving the required targets. This year, with the Trust being on a block contract with its main three commissioning CCGs this does not apply. It still applies, however, to the other associate CCGs (mainly Sunderland, Hambleton Richmond and Whitby, Gateshead and South Tyneside) and to Specialist and Public Health Commissioners. Nevertheless, CQUINs are important drivers for change and quality improvement so it is important for the Trust to strive to achieve all targets.

The 2018-19 CQUINs follow on from those in 2017-18.

CQUIN
Staff Survey: 5% Improvement on responses to two questions from Staff Survey about the Trust's approach to staff health and well-being:
Healthy Food: improve availability of healthy food at UHND, DMH, BAH, CLS, Shotley.

Staff - Flu Vaccinations – 70% uptake
Sepsis screening in ED – 90% screened
Sepsis screening in In-patients – 90% screened
Sepsis treatment within one hour in ED – 90% treated
Sepsis treatment within one hour in IPs – 90% treated
Antibiotic review within 72 hours (Acute) – 90%
Reducing antibiotic usage (IP and OP): (Acute): 1. Total 2. Carbapenem 3. Piperacillin-tazobactam
Improving services for MH patients in A&E (Acute) and reduce by 20% A&E attendances by a defined group of frequent attenders with mental health problems
Offering Advice & Guidance (Acute)
E-Referrals (Acute) 100% Consultant OP clinics on C&B and slot issues reducing to 4%.
Wound care (Community) - Number of wounds which have failed to heal after 4 weeks that receive a full wound assessment
Personalised Care / Support Planning (Community)
Preventing ill health: alcohol & tobacco (Community Hospitals)
SpecComm and Public Health CQUINs
Chemotherapy Dose Banding
Medicines Optimisation. Adoption of best value drugs
Dental - Populate a quarterly Dashboard and contribute to development of a Managed Clinical Network
Bowel Screening - Patient feedback
Aycliffe Nursing - Patient feedback

In Quarters 1 and 2, the only targets not fully achieved were sepsis treatment in A&E; alcohol and tobacco screening in community hospitals and medicines optimisation. All these were partially achieved.

Registration with Care Quality Commission
County Durham & Darlington NHS Foundation Trust is required to register with the Care Quality Commission, the Trust's current registration status is described below under each specified location:

University Hospital of North Durham, Durham City
Assessment or medical treatment for persons detained under the Mental Health Act 1983.
Diagnostic and screening procedures.
Family planning.
Maternity and midwifery services.
Surgical procedures.
Termination of pregnancies.
Treatment of disease, disorder or injury.
Transport services, triage and advice provided remotely.

Chester-le-Street Community Hospital, Chester-le-Street
Assessment or medical treatment for persons detained under the Mental Health Act 1983
Diagnostic and screening procedures.
Family planning.
Treatment of disease, disorder or injury.

Shotley Bridge Community Hospital, Shotley Bridge
Assessment or medical treatment for persons detained under the Mental Health Act 1983
Diagnostic and screening procedures.
Family planning.
Maternity and midwifery services.
Surgical procedures.
Treatment of disease, disorder or injury.
Transport services, triage and advice provided remotely.

Richardson Community Hospital, Barnard Castle
Diagnostic and screening procedures.
Treatment of disease, disorder or injury.

Weardale Community Hospital, Stanhope
Diagnostic and screening procedures.
Treatment of disease, disorder or injury.

Sedgefield Community Hospital, Sedgefield
Diagnostic and screening procedures.
Treatment of disease, disorder or injury.

Bishop Auckland Hospital, Bishop Auckland
Assessment or medical treatment for persons detained under the Mental Health Act 1983
Diagnostic and screening procedures.
Family planning.
Maternity and midwifery services – service currently suspended due to workforce capacity
Surgical procedures.
Termination of pregnancies.
Treatment of disease, disorder or injury.
Transport services, triage and advice provided remotely

Darlington Memorial Hospital, Darlington
Assessment or medical treatment for persons detained under the Mental Health Act 1983
Diagnostic and screening procedures.
Family planning.
Maternity and midwifery services.
Personal Care – registered as HQ for delivery in the community.
Surgical procedures.
Termination of pregnancies.
Treatment of disease, disorder or injury.
Transport services, triage and advice provided remotely.

Dr Piper House, Darlington
Treatment of disease, disorder or injury.
Diagnostic and screening procedures.

Peterlee Community Hospital, Peterlee
Treatment of disease, disorder or injury.
Diagnostic and screening procedures.
Transport services, triage and advice provided remotely.

Seaham Primary Care Centre, Seaham
Treatment of disease, disorder or injury.
Diagnostic and screening procedures.
Transport services, triage and advice provided remotely.

County Durham and Darlington NHS Foundation Trust has no conditions on registration. The Care Quality Commission has not taken enforcement action against County Durham and Darlington NHS Foundation Trust during 2018/2019.

County Durham & Darlington NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Care Quality Commission Ratings

The Trust is rated 'Requires Improvement' following the CQC's last inspection of the Trust, carried out in September and October 2017 and reported in March 2018. This inspection covered the following services at both Darlington Memorial Hospital (DMH) and University Hospital North Durham (UHND): Urgent and Emergency Care; Medicine; Surgery and Maternity. Services were selected according to a risk assessment. CQC's report, published in March 2018, set out ratings tables which combined the outcomes of the latest inspection with ratings for those services not inspected, which were brought forward from the comprehensive inspection reported in September 2015.

Overall ratings by Domain are set out below:

Are services safe?	Requires Improvement (RI)
Are services effective?	Requires Improvement (RI)
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

CQC's inspection methodology includes a three-day detailed assessment of Trust leadership arrangements against Key Lines of Enquiry for the Well-Led Domain. The rating for 'Well-Led' at the Trust level reflects the outcome of this detailed assessment. The rating for 'Well-Led' for services at each of the Trust's hospitals reflects the leadership of services and aggregates the ratings for the services provided at those locations. The aggregation methodology results in 'Requires Improvement' ratings for Well-Led for services at both DMH and UHND.

Ratings grids for each Hospital / Community Services are:

Darlington Memorial Hospital (DMH)

Ratings for Darlington Memorial Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement ↔ Mar 2018	Good ↔ Mar 2018	Good ↔ Mar 2018	Requires improvement ↔ Mar 2018	Good ↑ Mar 2018	Requires improvement ↔ Mar 2018
Medical care (including older people's care)	Good ↑ Mar 2018	Good ↔ Mar 2018	Good ↔ Mar 2018	Good ↔ Mar 2018	Good ↔ Mar 2018	Good ↔ Mar 2018
Surgery	Requires improvement ↓ Mar 2018	Good ↔ Mar 2018	Good ↔ Mar 2018	Good ↔ Mar 2018	Requires improvement ↓ Mar 2018	Requires improvement ↓ Mar 2018
Critical care	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Maternity	Good ↔ Mar 2018	Good ↔ Mar 2018	Good ↔ Mar 2018	Good ↔ Mar 2018	Good ↑ Mar 2018	Good ↔ Mar 2018
Services for children and young people	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
End of life care	Requires improvement Sept 2015	Requires improvement Sept 2015	Good Sept 2015	Good Sept 2015	Requires improvement Sept 2015	Requires improvement Sept 2015
Outpatients and Diagnostic imaging	Good Sept 2015	N/A	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Overall*	Requires improvement ↔ Mar 2018	Good ↔ Mar 2018	Good ↔ Mar 2018	Good ↔ Mar 2018	Requires improvement ↔ Mar 2018	Requires improvement ↔ Mar 2018

University Hospital North Durham (UNHD)

Ratings for University Hospital of North Durham

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement ↔ Mar 2018	Good ↔ Mar 2018	Good ↔ Mar 2018	Requires improvement ↔ Mar 2018	Good ↑ Mar 2018	Requires improvement ↔ Mar 2018
Medical care (including older people's care)	Good ↑ Mar 2018	Requires improvement ↔ Mar 2018	Good ↔ Mar 2018	Good ↔ Mar 2018	Good ↔ Mar 2018	Good ↑ Mar 2018
Surgery	Requires improvement ↓ Mar 2018	Good ↔ Mar 2018	Good ↔ Mar 2018	Good ↔ Mar 2018	Requires improvement ↓ Mar 2018	Requires improvement ↓ Mar 2018
Critical care	Requires improvement Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Maternity	Good ↔ Mar 2018	Good ↔ Mar 2018	Good ↔ Mar 2018	Good ↔ Mar 2018	Good ↑ Mar 2018	Good ↔ Mar 2018
Services for children and young people	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
End of life care	Requires improvement Sept 2015	Requires improvement Sept 2015	Good Sept 2015	Good Sept 2015	Requires improvement Sept 2015	Requires improvement Sept 2015
Outpatients and Diagnostic imaging	Good Sept 2015	N/A	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Overall*	Requires improvement ↔ Mar 2018	Requires improvement ↔ Mar 2018	Good ↔ Mar 2018	Good ↔ Mar 2018	Requires improvement ↔ Mar 2018	Requires improvement ↔ Mar 2018

Community Services

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Community health services for children and young people	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Community health inpatient services	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Community end of life care	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Requires improvement Sept 2015	Good Sept 2015
Urgent care	Requires improvement Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Overall*	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015

Context and key issues

It is important to note that End of Life Care was not included in the inspection taking place in September 2017, at each hospital site. The Trust believes that it has made significant improvements in the safety, effectiveness and leadership of End of Life Care, based upon national audit data, surveys of those relying on the service and a review by NHS Improvement. The Trust looks forward to further inspection by CQC in due course.

In their inspection report, CQC acknowledged that actions from the 2015 inspection were, in the main, fully implemented and noted a number of positive developments, including:

- In most areas nurse staffing had improved.
- Staff investigated incidents quickly, and shared lessons learned.
- Wards and department areas were clean and equipment was well maintained. Staff followed infection control policies that managers monitored to improve practice.
- Staff provided care and treatment based on national guidance and evidence and used this to develop new policies and procedures.
- Staff cared for patients with compassion, treating them with dignity and respect.
- Patients, families and carers gave positive feedback about their care.
- The hospital escalation policy and procedural guidance was followed during busy times.

Requirements and recommendations included in CQC's final reports can be summarised by theme as follows:

- The need to further embed learning from never events, including further strengthening of the culture and staffing within operating theatres. CQC acknowledged the work undertaken by the Trust in response to a high number of never events reported in 2016/17, together with an active programme to improve staffing and culture in theatres but concluded that both work-streams needed to go further.
- The need to strengthen policies, training and education and systems with respect to the application of the Mental Capacity Act and Deprivation of Liberty Standards and related matters such as the administration of covert medications.
- The need to review and improve the safety of facilities within the Trust's Emergency Departments used to assess and treat patients with Mental Health conditions, in line with national best practice.

- Actions and recommendations in respect of specific findings concerning administration and security of medications and oxygen; nursing assessments and record-keeping.

Improvement Plans and Progress
The Trust submitted a 51 point action plan to CQC in March 2018. This captured both initial actions, which had been taken in response to verbal feedback and CQC's draft reports, and the further actions required to address 'Must Do' requirements and 'Should Do' recommendations included in the final reports.

All 'Must Do' actions have now been implemented, together with 25 out of 29 'Should Do' actions. Monitoring processes remain in place to seek assurance that changes implemented are being embedded. A rigorous governance process has been in place, throughout 2018/19, to monitor the implementation, and authorise the closure, of actions. The Executive Patient Safety and Experience Committee, chaired by the Director of Nursing, has reviewed all open actions at each of its monthly meetings and provided approval for closure of actions, once satisfied that sufficient evidence of implementation has been provided. The Board's Integrated Quality and Assurance Committee, chaired by a Non-Executive Director, has sought assurance on both the process to monitor the implementation of actions and the sufficiency of the actions being taken. To ensure that there was collective ownership of actions and full oversight of progress, the Trust Board has also received monthly progress reports.

The four actions which remain open concern: the ongoing need for recruitment of medical staff to work in our Emergency Departments; improvements in pathways for children attending our Emergency Departments overnight; and actions embedded within a system-wide programme of work to improve Urgent and Emergency Care Pathways.

The tables overleaf summarise the improvements which we have made since the last inspection.

Urgent and Emergency Care	• Rooms used to assess patients with Mental Health conditions and adjacent wash rooms have been modified to comply with best practice guidance on minimising opportunities for patients to harm themselves and others. • A comprehensive risk assessment has been completed with respect to other potential ligature risks within our Emergency Departments. Action plans are being worked through to mitigate risks as far practicable. • Record-keeping and reconciliation procedures for controlled drugs have been standardised and subjected to frequent spot checks and audits to confirm compliance. • Intravenous infusions for potassium are now stored separately from other drugs, and lockable cupboards used in short stay rooms to secure patients own medications. • A formal protocol for oxygen prescribing in our Emergency Departments has been implemented. • Nursing staffing rotas have been revised to ensure that resource is matched to the daily demand profile and there is a programme of ongoing recruitment for medical staffing posts. • Ambulance handover bays have been introduced, together with changes to procedures for booking in, triage and streaming of patients resulting in substantive reductions in ambulance handover delays and time to initial assessment. There is a comprehensive system-wide programme of work in place, drawing on best practice and expert advice from NHS Improvement, which is overseen by the Local Accident and Emergency Delivery Board to optimise pathways for Urgent and Emergency Care, including patient flow and discharge. There remains further to go; however, Friends and Family Test results highlight that the Trusts' patients have a generally positive experience of our Urgent and Emergency Care compared to the national average and our peer group. In addition, the Trust has introduced monthly audits of compliance with the patient safety checks recommended nationally by CQC, to ensure that patient safety is not compromised at times of high demand. • The Trust is developing plans, taking account of good practice elsewhere in the region, to strengthen pathways for the care of children requiring emergency care out of hours, recognising the challenge of recruiting sufficient specialist paediatric emergency care nurses to provide 24 hour cover, seven days per week.
Medicine	• The Trust's policies for compliance with the Mental Capacity Act have been overhauled with support from external specialists. Training programmes have also been reviewed and strengthened and prompts and tools for assessment have been built into our 'Nervecentre' application, which is used for patient assessments and observations. • Weekly monitoring has been established with respect to the application of Deprivation of Liberty Standards (DOLS), where appropriate, for patients subject to supervision or cohorting due to the risk of falls. • The Trust has substantially increased resources for Mental Capacity and Safeguarding Adults, to facilitate increased auditing and monitoring of compliance, and to enable ward-based staff to access advice, coaching and support with much greater frequency. • The Trust's policy on administration of covert medications has been revised in line with good practice, and rolled out to all wards with

	training provided by the Safeguarding Adults team.
Surgery	• Local Safety Standards for Invasive Procedures and safety protocols introduced in response to the high number of never events reported in 2016/17 are now embedded and a programme of observational auditing is in place to monitor adherence to them. The Trust reported four never events in 2018/19, a substantial reduction on 2016/17 and only one of these involved a Surgery specialty. • The Trust has an on-going programme of work in place to strengthen staffing, management process and culture within operating theatres. Progress is reported to the Trust Board every six months. Staffing rotas now fully comply with national best practice recommendations; improved staffing structures, which better support education and training of staff, have been filled and a recent peer review completed by Newcastle Hospitals – whilst confirming the need to follow through a number of on-going actions – validated improvements in morale and culture. • Spot checks are in place, reinforced by independent observational audits, to ensure that the difficult intubation trolley is checked in line with policy. • Further actions have been taken to address specific recommendations.

Broader developments

The Trust enrolled in NHS Improvement's 'Moving to Good' programme, which is designed to support Trusts with an overall 'Requires Improvement' rating in moving to a Good rating. The Trust Board has participated in four seminars with the Moving to Good team, covering organising, governing and measuring for quality improvement and cultural factors, as a result of which the Board has agreed on its key quality priorities for the coming year and is now working on the measures and reporting processed to monitor them. The Trust is also rolling out a Trust-wide Quality Improvement Approach, known as "IMPS", with sponsorship from the Trust Board. Over 100 staff have been trained to the initial 'bronze' level of competence to date, and training to the practitioner or 'silver' level has commenced. Through the Moving to Good programme the Trust has secured further resource for peer reviews and training for a wide range of staff in the use of improved quality measurement tools, in particular Statistical Process Control Charts which are now being deployed more widely.

A wider piece of work is also being undertaken with Tees, Esk and Wear Valleys NHS Foundation Trust to implement the good practice with respect to patients with Mental Health conditions, set out in the National Confidential Enquiry "Treat As One" in our acute hospitals.

Conclusion

The Trust has continued to work with CQC, and with support from NHS Improvement, to address all requirements and recommendations and is now focusing on embedding and sustaining improvements in quality with the aim of achieving a "Good" rating at the next inspection.

Data Quality

Indicator	Target	2018/19 Months 1 - 12
Data completeness community services - RTT*	50%	100.0%
Data completeness community services - Referrals*	50%	99.8%
Data completeness community services - Treatment activity*	50%	99.4%
% of SUS data altered*	10%	18.0%
Valid NHS number field submitted via SUS - Acute	99%	99.7%
Valid NHS number field submitted via SUS - A&E	95%	98.5%

County Durham & Darlington NHS Foundation Trust submitted records during 2018/2019 to the Secondary Uses services for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

Please note the latest available report for the following is M12

- which included the patients valid NHS number was:
  - 99.5% for Admitted Patient Care
  - 99.8% for Outpatient Care
  - 95.7% for Accident and Emergency Care
- which included the patient's valid General Medical Practice Code was:
  - 100.0% for Admitted Patient Care
  - 99.9% for Outpatient Care
  - 99.8% for Accident and Emergency Care

County Durham & Darlington NHS Foundation Trust was not subject to the Payment By Results clinical coding audit during 2018/2019 by the Audit Commission, however, internal audit carried out by our accredited audit yielded the following accuracy scores:-

- 94.5% Correct for Primary Diagnosis (Mandatory)
- 90.8% Correct for Secondary Diagnosis (Advisory)
- 96.1% Correct for Primary Procedure (Advisory)
- 95.3% Correct for Secondary Procedure (Advisory)

The results should not be extrapolated further than the actual sample audited. The specified areas do not constitute a representative sample of overall Trust performance but are an indication of sound controls and processes. The programme included data testing of a random sample of episodes as there were no specific areas to be addressed or highlighted by commissioner input. The sample size had a combined denominator of 1,622 clinical codes.

County Durham & Darlington NHS Foundation Trust is taking the following actions to improve data quality:-

- Monthly spot samples of discharges, comparing transfer and discharge times within the notes to the system recorded times.
- Monthly data quality group with corporate and care group representation feeding up to the Information Quality Assurance agenda with SIAO meeting.

- Junior doctor training in relation to discharge summary completion and accuracy.

- Specialty specific Consultant/coding joint working to ensure correct documentation and wording is used in the correct locations to be picked up by Clinical Coding.

- Continued audits of individual coder accuracy with attention given to depth and relevance of coding.

- Coding team to be aligned with Care Group specific specialty structured to aid better team working, coverage and skill mix and experience. Specialty specific workshops will be carried to facilitate this new way of working.

- Co-morbidity validation reporting at record level shared within clinical teams for validation and recode if documented Co-morbidity clinically signed off. Approximately 300-350 validation records created and distributed every month.

- In depth NHS Number status review process being carried out as mobilisation preparation for EPR implementation. This will move into contact and activity records during the mobilisation phase.

- Review of Community services data quality following initiation of Community Dataset transmissions to the National portal.

Cyber-security

The Trust remain committed to achieving and maintaining the highest standards of data security and continue to invest in world class technical controls and counter measures in order to protect the availability, integrity and confidentiality of all of its data assets.

The Trusts board approved cyber-security strategy continues to develop in line with changing business needs and an ever increasing threat landscape, but the principle of good governance, process management, user education and awareness coupled with highly focussed reporting and vigilance remain at its core. This strategy and its delivery continues to remain a highly effective means of maintaining protection and mitigation against threats whilst still providing effective and usable systems to our staff and partners. CDDFT are actively engaged with NHS Digital and its partner organisations in a continuous program of Cyber-Security improvement and have now been chosen as a contributor and pilot adopter of a new developing Unified Cyber Risk Framework which is intended to help all NHS organisation achieve an effective level of protection.

Learning from Deaths (data 4/2/19 so may change by year end)

During 2018/2019 1620 of County Durham and Darlington NHS Foundation Trust's patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

514 in the first quarter;
445 in the second quarter;
465 in the third quarter;
196 in the fourth quarter.

By 04/02/19 383 case record reviews and 8 investigations have been carried out in relation to 1620 of the deaths included above.

In 8 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

199 in the first quarter;
142 in the second quarter;
39 in the third quarter;
3 in the fourth quarter.

Four, representing 0.25% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.
In relation to each quarter, this consisted of:

2 representing 0.39% for the first quarter;
2 representing 0.45% for the second quarter;
- X representing X.XX% for the third quarter;
Xrepresenting X.XX% for the fourth quarter.

These numbers have been estimated using the PRISM 2 mortality review methodology or through County Durham and Darlington NHS Foundation Trust Serious Incident Reporting Process.

The key learning themes identified through those deaths identified in 2018/2019 have been in relation to adherence to policy, ensuring all observations are documented within Nervecentre and documentation. Learning identified through case record review overall has included escalation planning, recognition that a patient is reaching the end of their life , documentation
Actions that County Durham and Darlington NHS Foundation Trust has taken in relation to the learning identified from those deaths in 2017/2018 form part of comprehensive SMART action plans monitored through the Trust governance processes. The key actions are in relation to ensuring robust application of policy and procedure and taking steps to improve communication pathways and documentation.

A quality improvement project to support clinicians with escalation planning and recognition of patients nearing the end of their lives has commenced at the end of 2018/19 and will continue for twelve months.

The impact of the learning is carefully monitored through audit, ongoing surveillance of deteriorating and acutely unwell patients and through mortality reviews.

No case record reviews and no investigations were completed after 1st April 2017 which related to deaths which took place before the start of the reporting period.

No cases, representing 0% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the PRISM 2 mortality review methodology or the Co Durham and Darlington NHS Foundation Trust Serious Incident Investigation Process.

Three, representing 0.15% of the patient deaths during 2017/18, were judged to be more likely than not to have been due to problems in the care provided to the patient.

PART 3 ADDITIONAL INFORMATION

Financial Review

Despite a very challenging economic environment, the trust delivered an overall deficit of **TBC** in 2018/2019, which comprised an operational surplus of **TBC** (which was **TBC** ahead of plan) and an impairment of **TBC** resulting from a reduction in the value of the trust's land and buildings following a review by the trust's valuers, together with the trust's charity spending **TBC** in excess of the income it received in year.

Performance Framework

The Trust's operational scorecard is built upon the four Touchstones. The latest figures available are for December 2018.

*Month: December 2018 * One month in arrears ** Two months in arrears ***Three months in arrears, etc.*

Experience		
Indicator	Target	YTD
RTT - % Incompletes waiting <18wks	92%	92.0%
RTT waits over 52 weeks	0	1
A&E % seen in 4hrs - Trust Total	95%	90.5%
A&E % seen in 4hrs - All UCC 'Walk-ins' Type 3	95%	100.0%
Ambulance handovers >15-30mins	0	7177
Ambulance handovers >30-60mins	0	1885
Ambulance handovers >60mins	0	523
Ambulance Handovers - no. >120 minutes	0	24
12 Hour Trolley Waits	0	0
% Diagnostic Tests <6wks	99%	99.90%
Cancer 2WW*	93%	93.26%
Cancer 2WW Breast Symptoms*	93%	93.18%
Cancer 31 Days Diagnosis to Treatment*	96%	99.06%
Cancer 31 Days Subsequent Treatment - Surgery*	94%	97.91%
Cancer 31 Days Subsequent Treatment - Anti Cancer Drug*	98%	100.00%
Cancer 62 Days to First Treatment*	85%	87.72%
Cancer 62 Days Consultant Upgrade*	85%	100.00%
A&E % Seen in 4hrs - DMH	95%	87.3%
A&E % Seen in 4hrs - UHND	95%	82.4%
A&E CI - Unplanned Re-attendance rate	<=5%	1.7%
A&E CI - Time to treatment (median)	<=01:00	00:41
6 hour wait in Urgent Care Centres	95%	99.6%
Maternity 12 week bookings	90%	90.1%
Maternity Breast Feeding at Delivery	60%	60.0%
Maternity Smoking at Delivery	22.4%	15.9%
% Emergency C-Section births (grade 1-3)		13.2%
Stroke - 90% of time on a stroke unit	90%	93.3%
Stroke - Scan within 1 hour	50%	45.4%
Sleeping Accommodation Breach	0	29
ERS - ASI % of DBS Bookings**	4%	24.9%

Cancelled Operations - Breaches of 28 Days	0	8
Urgent Operations cancelled for 2nd time	0	0
Delayed transfers of care (% of all admissions)*	3.5%	0.02%

Outcome

Indicator	Target	
Clostridium difficile cases	18	14
MRSA Bacteraemia	0	2
MSSA		18
Ecoli		304
VTE	95%	96.3%
Sepsis Screening AE (Quarterly)*		
Sepsis Screening IP (Quarterly)*		
Duty of candour	Compliance	
Never events	0	4
Serious Incidents reported within 2 working days of identification		100%
Total number of incidents reported (Monitoring trends)		14675
Serious Incidents Interim reports within 72 hours		100%
SUIs reported via STEIS as a proportion of all incidents involving severe injury or death within a Trust		80
Serious Incident RCAs submitted within 60 working days***		98%
Readmissions within 30 days of previous discharge following elective*		726
Readmissions within 30 days of previous discharge following emergency*		4985
Crude Mortality***		4.71%
HSMR***		102.05
SHMI****		107.74
Dementia - eligible admissions screened*	90%	90.6%
Dementia - AMTS compliance*	90%	79.8%
Dementia - onward referrals*	90%	100.0%

Quality Account Indicators not elsewhere reported	Target	YTD
Falls - Acute (Incident Report)		1149
Falls - Community (Incident Report)		150
Reduction in Falls - Acute (per 1000 beddays) (Cumulative)	5.6	5.6
Reduction in Falls - Community (per 1000 beddays) (Cumulative)	8	6.2
Continuation of Sensory Training into staff education programmes*	180 per Q	
Falls & Fragility fractures - patients screened**		
Falls & Fragility fractures - % eligible patient receiving follow up assessment for osteoporosis**	50%	
Falls & Fragility fractures - % patients with appropriate referral for axial scan (as a proportion of eligible patients)***		
Falls & Fragility fractures - % patients commenced on bone sparing drugs (as a proportion of eligible patients)***		
Grade 3 & 4 newly acquired avoidable pressure ulcers - Acute	0	2
Grade 3 & 4 newly acquired avoidable pressure ulcers - Community	0	4
Grade 2 newly acquired avoidable pressure ulcers - Acute	Monitor	4

Grade 2 newly acquired avoidable pressure ulcers - Community	Monitor	0
% adult patients that are correctly screened for undernutrition within 6 hours*	85%	96.55%
% adult patients re-screened weekly for undernutrition *	89%	97.06%
% adult patient identified at moderate or high risk of undernutrition have evidence that a nutrition care plan has been implemented, which fulfils recommendation on the 'MUST' nutritional tool*	79%	96.30%
% adult patients identified at moderate or high risk of undernutrition have evidence of well completed food and fluid record charts*	89%	94.25%
Rate of patient safety incidents resulting in severe injury or death	Within national average	
Rate of patient safety incident reporting	75th %ile	
Did you feel involved enough in decisions about your care and treatment?*		87.0%
Were you given enough privacy when discussing your condition or treatment? *		87.0%
Did you find a member of staff to discuss any worries or fears you had?		83.0%
Did a member of staff tell you about any medication side effects that you should watch out for after you got home in a way that you could understand? *		66.0%
Did hospital staff tell you who you should contact if you were worried about your condition or treatment after you left hospital? *		75.0%
% of staff who would recommend the trust to family and friends needing care (Staff Survey) Annual*		
Friends and Family Test - increased response rate in Inpatients		27.0%
Friends and Family Test - increased response rate in A&E		12.9%
Friends and Family Test - increased response rate in Maternity		12.9%
Friends and Family Test - increased response rate in Community*		3.4%
Summary Hospital Mortality Indicator (SHMI) ****		107.74
Hospital Standardised Mortality Ratio (HSMR) ***		102.06
Crude Mortality (HSMR) ***		4.71%
Deaths with a palliative care code (Z515)****		43.8%
Readmissions within 28 days*	7%	12.7%

Efficiency

Indicator	Target	YTD
Data completeness community services - RTT	50%	99.9%
Data completeness community services - Referrals	50%	99.8%
Data completeness community services - Treatment activity	50%	99.4%
% of SUS data altered*	10%	14.7%
Discharge summaries within 24 hours	95%	91.9%
Valid NHS number field submitted via SUS - Acute*	99%	99.7%
Valid NHS number field submitted via SUS - A&E*	95%	98.4%
GP referrals		72,813
Non GP referrals		55,949
Outpatient attendances		409,942
Elective day-case admissions		32,735
Elective inpatient admissions		5,107

Theatres (utilisation)	85%	79.2%
Non-elective admissions		52,471
Digital Dictation - upload to approve		6.82
Summary Income and Expenditure (£000s) (cumulative)*		-306,422
Agency cap (£000s) (cumulative)**		-5547
Cost Reduction (£000s) (cumulative)*		-10,442

Workforce

Indicator	Target	YTD
Trust Sickness*	<4%	4.56%
Appraisal Figures - All staff*	85.0%	62.00%
Essential Training - All staff*	85.0%	86.00%
Voluntary Turnover*	9.0%	6.63%
Total Turnover*	Information	12.51%
Vacancy Rates -Effective shortfall*	<5%	4.31%

Performance Risks

Non-elective pressures

The Trust's main operational and performance risk remains the non-elective pathway. Although growth in A&E attendances appears to have eased, non-elective admissions continue to put pressure on all services. During Apr-Dec, emergency admissions for all specialties grew by 1.3% across the Trust, with the main pressure once again at UHND which has experienced 2.8% growth. Length of stay has remained relatively static.

Elective pressures

18 weeks RTT	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
NHSI Trajectory	**92.5%**	**92.5%**	**92.5%**	**92.5%**	**92.5%**	**92.5%**	**92.5%**	**92.5%**	**92.5%**
Performance	92.41%	93.00%	92.50%	93.00%	92.11%	91.30%	91.90%	91.38%	90.00%

Green = achieved 92% national standard and monthly NHSI trajectory; Amber = achieved one of the above; Red = achieved neither of the above

Commissioners continue to be largely successful in restricting referral growth to CDDFT (Table 6). GP referrals to CDDFT fell by 0.1% although if non-GP referrals are counted, total referrals grew by 2.1%. All three main local CCGs have referral management systems in place.

CDDFT and their main CCG commissioners have a continuing programme to re-configure services closer to home and reduce costs. In addition, N.E. regional Integrated Care Partnerships have been established to review services at a regional level. By virtue of its geography, CDDFT is a member of the Central and South partnerships.

	Apr-Dec 2017	Apr-Dec 2018	% variation
GP Referrals	72913	72813	-0.1%
Non-GP Referrals	53140	55949	5.3%
Total	126053	128762	2.1%

Several high volume Specialties have experienced a >10% decline in GP referrals (during Apr-Dec 2018): ophthalmology (16.3% - offset by growth of 13% in non-GP referrals);

Oral Surgery (11.1%); Pain management (56% - probably due to the introduction of the Tier 2 service); diabetic medicine (26.9%); thoracic medicine (18.0%).

Several high volume Specialties have also experienced considerable referral growth, for example: breast surgery (11.8% - due to the continuing regional under-provision); paediatric sub-specialties (10.2%). General Surgery (6.7%), dermatology (7.2%) and gynaecology (7.8%). Orthopaedics GP referrals are down 0.6% but non-GP referrals are up 8.5% (probably due to new MSK pathways) making for a net rise in referrals of 6.1%.

The high volume Specialties with the largest backlogs are: Orthopaedics (477 patients - 20.26%), Ophthalmology (414 patients - 20.9%), Plastics (180 patients - 18.33%), Dermatology (323 patients - 13.42%), Rheumatology (129 patients - 18.19%).

Patient access is reviewed every week in the Referral to Treatment (RTT) Assurance Group. Operational Plans incorporating demand and capacity analyses for 2019/2020 are being finalised by all Care Groups.

In order to bring RTT performance back on track Care Groups are taking the following actions:

Dermatology: a finance and activity plan has been agreed with Executives to manage the backlog. In addition, the Service is working hard with commissioners in Durham, Darlington, Sunderland and South Tyneside to bring forward for implementation in April a tele-dermatology scheme. Dermatology being a sub-regional service, it is important that all CCGs adopt the same new pathway at the same time. The scheme aims to ensure that GPs making 2-week wait skin cancer referrals accompany the referral with an image taken with a dermatoscope. This will be triaged by a Consultant. It is anticipated that this will ease 2-week wait pressures as many patients will be triaged into a routine appointment or for management in Primary or community services.

Orthopaedics: work continues to move as much elective work as possible to Bishop Auckland (BAH). Pathways making use of skilled MSK teams to divert what work they can are in place.

Ophthalmology: additional independent agency cataract lists at week-ends should reduce the backlog. In addition, ophthalmology lists are being given priority for theatre staffing; and ophthalmology theatre staffing at BAH is to be better aligned with ophthalmology out-patient work from January 2019.

Plastics: The process for filling plastics lists has been reviewed to ensure the patients who have waited the longest are removed from the list weekly.

Rheumatology: The Care Group continues to focus on building up the physio and pharmacy-led service alternatives in the absence of being able to recruit a full consultant complement.

Cancer
The main cancer targets are for two week waits (2ww), 31 days and 62 days. The 31-day target is not problematic because the entire pathway is under the control of the Trust.

The more challenging targets are the 2-week wait and 62-days to first treatment targets. Nevertheless, the Trust has achieved these targets consistently throughout the year.

Cancer performance against national standards: year to end of November

	Target	Nov 2018
Cancer 2WW	93%	93.26%
Cancer 2WW Breast Symptomatic	93%	93.18%
Cancer 62 Days to First Treatment	85%	87.72%
Cancer 62 Days Screening	90%	86.15%

Breast symptomatic 2ww referrals continue at historically high levels due to the continuing absence of a comprehensive service in Sunderland and the lack of progress on a regional solution. The Trust continues to play a valuable role in supporting the regional position albeit it has to send considerable amounts of activity to the independent sector to achieve the targets.

The 62-day screening target is always at risk due to the very small numbers of patients using this pathway, so a single patient can make a significant difference to the % performance.

Other key performance risks:

Staffing: in common with many Trusts, CDDFT continues to rely heavily on locum and Agency nursing and medical staff in some Specialties. Some successful recruitments have taken place (for example, several ophthalmology consultants have been recruited. In other specialties, the Trust is taking the opportunity to introduce different service models. For example, rheumatology is creating new pharmacy and physio-led roles and clinics. In other cases, such as paediatrics, specialties have adapted pathways to take account of consultant vacancies.

Finance: four of the five Care Groups, Community being the exception, have been in financial escalation throughout the year mainly due to the difficulties they face in achieving the cost improvement targets. The situation is regularly reviewed by executives.

Health Care Infections: the Trust faces challenging targets, but so far is performing better than last year. As at the end of Q3, it has had two cases of MRSA against a target of 0; and 19 cases of *Clostridium difficile* compared to an end-of-year target of 18. All cases are subject to root cause analysis.

Never Events: the Trust has had four never events during 2018-19. All such events are subject to a rigorous root cause analysis and the lessons learned are publicised throughout the Trust.

Priorities for 2018/2019

The table below illustrates the results for the organisation against the national mandated indicators. The national average, national high and national low results are stated as available. Where gaps are shown this is because data is not available but updates for some will be available prior to publication. The source of the data is stated below the table.

YEAR	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/2018	2018/2019 (provisional)
Readmission within 28 days of discharge[1]								12.6	12.7
CDDFT Age 0-15 years	10.4	10.3		11.2	11.8	11.3	12.6	11.8	11.7
National high	14.1	14.9				17.1	14.5	16.4	16.2

National low	0	0				0	0	0.0	0.0
CDDFT Age 16 + years	12	12.1		11.2	11.8	10.8	10.8	12.7	13.0
National high	14.1	13.8				18.3	20.3	18.5	18.0
National low	0	0				0	0	3.8	4.0
CDDFT MRSA per 100,000 bed days[3]	1.4	1.1	0.9	0.6	1.8	0.7	1.7	0.7	1.0
North East	2	2	1	1	1	0.8	1.1	0.7	0.6
England	3	2	1	1	0.8	0.9	0.9	0.8	0.8
National high	9	9	10	11	3.2	6.5	2.7	5.8	5.3
National low	0	0	0	0	0	0	0	0.0	0.0
CDDFT - Post 72 hour cases of Clostridium difficile per 100,000 bed days (aged 2 years and over)[3]		24.5	16.5	20.3	8.4	7.4	5.3	7.23	9.29
England	29.7	222.3	17.4	14.7	15	14.9	13.2	12.6	14.99
National high		71.2	58.2	30.8	37.1	58.11	28.4	31.56	35.26
National low		0	0	0	0	0	2.8	3.98	2.57
Patient Reported Outcome measures (PROM) – case mix adjusted health gain[1]	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/2018 (provisional)	
CDDFT PROM Groin Hernia	0.100	0.120	0.098	0.081	0.064	0.075	0.072	0.090	
England	0.080	0.090	0.085	0.085	0.084	0.088	0.086	0.089	
National high	0.140	0.120	0.140	0.150	0.140	0.160	0.135	0.137	
National low	0.010	0.030	0.030	0.010	0.010	0.020	0.006	0.292	
CDDFT PROM Hip	0.430	0.380	0.380						
England	0.410	0.410	0.410						
National high	0.480	0.470	0.470						
National low	0.290	0.260	0.320						
CDDFT PROM Hip Replacement Primary				0.405	0.440	0.394	0.433	0.450	
England				0.436	0.436	0.438	0.445	0.470	
National high				0.540	0.540	0.510	0.537	0.581	
National low				0.320	0.310	0.320	0.310	0.398	
CDDFT PROM Hip Replacement Revision				NA	NA	NA	NA	NA	
England				0.260	0.277	0.283	0.290	0.293	
National high				0.350	0.370	0.370	0.362	0.354	
National low				0.170	0.160	0.220	0.239	0.191	
CDDFT PROM Knee	0.320	0.290	0.300						
England	0.300	0.300	0.300						
National high	0.370	0.380	0.370						
National low	0.170	0.200	0.180						

CDDFT PROM Knee Replacement Primary				0.311	0.295	0.323	0.331	0.336	
England				0.323	0.315	0.320	0.325	0.340	
National high				0.420	0.430	0.400	0.404	0.425	
National low				0.210	0.220	0.200	0.247	0.217	
CDDFT PROM Knee Replacement Revision				NA	NA	NA	NA	NA	
England				0.248	0.261	0.258	0.273	0.291	
National high				0.370	0.320	0.340	0.296	0.338	
National low				0.200	0.120	0.190	0.156	0.304	

	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/2018	2018/19 YTD
CDDFT VTE assessment Trust				**95.10%**	**95.65%**	**95.99%**	**96.83%**	**96.45%**	**96.28%**
National Low				**82.10%**	**92.00%**	**79.93%**	**76.68%**	**84.77%**	**83.93%**
National High				**100.00%**	**100.00%**	**99.76%**	**99.88%**	**99.53%**	**99.46%**

YEAR	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/2018	
CDDFT Responsiveness to personal needs of the patient[1]	71.5	67.9	68.5	73.3	65.3	68.8	66.0	69.3	
England	67.3	67.4	68.1	68.7	68.9	69.6	68.1	68.6	
National high	82.6	85	84.4	84.2	86.1	86.2	86.2	85.0	
National low	56.7	56.5	57.4	54.4	59.1	58.9	54.4	60.5	

YEAR	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/2018	2018/19 provisional
CDDFT Percentage of staff who would recommend the trust to their family or friends[1]	49%	50%	57%	53%	57%	57%	61%	55%	57%
England					68%	70%	71%	72%	73%
National high		94%	94%	93%	92%	91%	90%	97%	92%
National low		35%	40%	35%	31%	43%	43%	31%	23%

	Reporting Period	Highest	Lowest	CDDFT Trust	Peer	Comments
SHMI	Jan 12 - Dec 12	119.2	70.3	104.1	102.2	
	Apr 12 - Mar 13	117	65.2	104.5	101.9	
	Jul 12 - Jun 13	115.6	62.6	104.3	101.9	
	Octr 12 - Sep13	118.6	63	103.8	101.1	
	Jan - Dec 13	117.6	62.4	102.4	100.8	
	Ap 13 - Mar 14	119.7	53.9	101.9	100.9	
	Jul 13 - Jun 14	119.8	54.1	102.5	101.0	
	Oct 13 - Sep 14	119.8	59.7	103.1	101.3	
	Jan – Dec 14	124.3	65.5	100.9		Peer was via CHKS
	Apr 14 – Mar 15	121	67	101		Peer was via CHKS
	Jul 14 – Jun 15	120.9	66.1	100.7		Peer was via CHKS

	Oct14 – Sep 15	117.7	65.2	99.6		Peer was via CHKS
	Jan 15 - Dec 15	117.3	66.9	102.3	102.1	
	Apr 15 - Mar 16	117.8	67.8	103.2	103.7	
	Jul 15 - Jun 16	117.1	69.4	104.7	103.2	
	Oct 15 - Sep 16	116.4	69	106.7	103.1	
	Jan 16 - Dec 16	119.8	69.2	106.1	104.2	
	Apr 16 - Mar 17	122.6	71.5	105.2	103.8	
	Jul 16 - Jun 17	122.8	73	104.9	105.3	
	Oct 16 - Sep 17	124.7	72.7	104.6	101.9	
	Jan17-Dec17	121.81	72.04	104.48	102.4	
	Apr17-Mar18	123.21	69.94	106.11	103.3	
	Jul17-Jun18	125.72	69.82	108.21	103.4	
	Oct17-Sep18 (provisional)	125.41	69.53	109.22	102.0	
The banding of the summary hospital-level indicator	Apr 12 - Mar 13			2 (As Expected)		7 Trusts higher than expected
	Jul 12 - Jun 13			2 (As Expected)		9 Trusts higher than expected
	Octr 12 - Sep13			2 (As Expected)		8 Trusts higher than expected
	Jan - Dec 13			2 (As Expected)		7 Trusts higher than expected
	Ap 13 - Mar 14			2 (As Expected)		9 Trusts higher than expected
	Jul 13 - Jun 14			2 (As Expected)		9 Trusts higher than expected
	Oct 13 - Sep 14			2 (As Expected)		9 Trusts higher than expected
	Jan – Dec 14			2 (As Expected)		11 Trusts higher than expected
	Apr 14 – Mar 15			2 (As Expected)		16 Trusts higher than expected
	Jul 14 – Jun 15			2 (As Expected)		14 Trusts higher than expected
	Oct14 – Sep 15			2 (As Expected)		18 Trusts higher than expected
	Jan 15 - Dec 15			2 (As Expected)		14 Trusts higher than expected
	Apr 15 - Mar 16			2 (As Expected)		16 Trusts higher than expected
	Jul 15 - Jun 16			2 (As Expected)		11 Trusts higher than expected
	Oct 15 - Sep 16			2 (As Expected)		10 Trusts higher than expected
	Jan 16 - Dec 16			2 (As Expected)		10 Trusts higher than expected
	Apr 16 - Mar 17			2 (As Expected)		10 Trusts higher than expected
	Jul 16 - Jun 17			2 (As Expected)		12 Trusts higher than expected
	Oct 16 - Sep 17			2 (As Expected)		12 Trusts higher than expected
	Jan17-Dec17			2 (As Expected)		13 Trusts higher than expected
	Apr17-Mar18			2 (As Expected)		13 Trusts higher than expected
	Jul17-Jun18			2 (As Expected)		15 Trusts higher than expected
	Oct17-Sep18 (provisional)			2 (As Expected)		
The percentage of patient deaths with palliative care coded	Apr 12 - Mar 13	44.00%	0.10%	12.80%		
	Jul 12 - Jun 13	44.10%	0.00%	14.00%		
	Octr 12 - Sep13	44.90%	0.00%	14.10%		
	Jan - Dec 13	46.90%	1.30%	15.90%		
	Ap 13 - Mar 14	48.50%	0.00%	17.80%		

	Jul 13 - Jun 14	49.00%	0.00%	18.70%		
	Oct 13 - Sep 14	49.40%	0.00%	19.00%		
	Jan – Dec 14	48.30%	0.00%	17.70%		
	Apr 14 – Mar 15	50.85%	0.00%	17.18%		
	Jul 14 – Jun 15	52.90%	0.00%	17.39%		
	Oct14 – Sep 15	53.53%	0.20%	18.59%		
	Jan 15 - Dec 15	54.75%	0.19%	21.12%	26.14%	
	Apr 15 - Mar 16	54.60%	0.58%	24.22%	27.55%	
	Jul 15 - Jun 16	54.83%	0.57%	26.58%	27.84%	
	Oct 15 - Sep 16	56.27%	0.39%	28.19%	28.06%	
	Jan 16 - Dec 16	55.90%	7.30%	30.20%	28.30%	
	Apr 16 - Mar 17	56.90%	11.10%	31.40%	28.17%	
	Jul 16 - Jun 17	58.60%	11.20%	31.90%	28.84%	
	Oct 16 - Sep 17	59.80%	11.50%	36.20%	29.14%	
	Jan17-Dec17	60.34%	11.70%	38.86%	29.48%	
	Apr17-Mar18	59.02%	12.58%	42.76%	30.10%	
	Jul17-Jun18	58.70%	13.40%	44.80%	30.53%	
	Oct17-Sep18 (provisional)			43.12%		

Data from NHS Digital quarterly SHMI publications

Local Priorities for the Trust
The information below indicates the progression of these priorities, where appropriate.

SAFETY

Falls and falls resulting in injury
Why is this a priority?
Nationally falls are the most frequently reported patient safety incidents
Our aim
We have seen a reduction in falls resulting in injury but further work is required. We want to see a reduction in falls to within or below the national average, and a continued reduction in falls resulting in fractured neck of femur. We aim to reduce falls to 5.6 per 1000 bed days for acute wards and 8 per 1000 bed days for community based wards.
Our actions
We will implement actions from the published National Falls Audit
We will formulate an action plan and begin embedding the priorities identified from year one of the Falls Strategy and agree priorities for year two.
We will introduce improvement cycles in relation to falls reduction
Measuring and monitoring
We will continue to collect information on all patient falls and review this with our clinical teams at Falls Group.
This information is collected internally using data retrieved from the Safeguard incident reporting system and contained within the monthly trust Incident Report. This data is not governed by standard national definition.

Care of patients with dementia

Why is this a priority?

Hospitals have seen an increase in patients requiring care in their services for patients who have a background of dementia. These patients are particularly vulnerable and we want to ensure that they are receiving a high standard of care.

Our aim

We want to ensure that patients who have dementia have a positive experience when under our care and that all needs are considered.

Our actions

We will continue to roll out key elements of the dementia strategy and introduce monitoring tools to measure compliance against this

Measuring and monitoring

Key metrics will be introduced to monitor implementation of the strategy
This data is not governed by standard national definition.

MRSA Bacteraemia

Why is this a priority?

MRSA blood stream infections can cause serious illness and this is a mandatory indicator.

Our aim

We aim to have zero patients with avoidable hospital acquired MRSA bacteraemia as set by as set by NHS England guidance.

Our actions

We will continue to hold regular meetings with senior staff to ensure that any actions identified are monitored and implemented. The action plan can be accessed via the infection prevention and control team.

Measuring and monitoring

All hospital acquired bacteraemia cases identified within the trust will be reported onto the Mandatory Enhanced Surveillance System. This data is governed by standard national definitions. Any reported cases will be discussed at Infection Control Committee and reported to Trust Board. Reported cases will be subject to post infection review to ensure that any remedial actions are addressed.

Clostridium difficile

Why is this a priority?

Clostridium difficile can be a serious illness that mainly affects the elderly and vulnerable population and this is a mandatory indicator.

Our aim

To have no more than **TBC** identified with *Clostridium difficile* infection that are attributed to the trust, as set by NHS England guidance.

Our actions

We will continue with regular meetings with senior staff to ensure that any actions identified are monitored and implemented. The action plan can be accessed via the infection prevention and control team.

Measuring and monitoring

All cases identified within the trust will be reported onto the Mandatory Enhanced Surveillance System. This data is governed by standard national definitions. Any reported cases will be discussed at HCAI reduction group Infection Control Committee and reported to Trust Board. Reported cases will be subject to a comprehensive review to ensure that any remedial actions are addressed.

Pressure ulcers

Why is this a priority?

Pressure ulcers are distressing for patients and can be a source of further illness and infection. This can prolong the treatment that patients need and increase the need for antibiotic therapy.

Our aim

To continue with the programme of monitoring of patients with pressure ulcers and carry out a full review of all pressure ulcers graded 3 or above to advise any change in practice, and take remedial action where necessary to ensure learning within the Trust. We aim to have zero avoidable grade 3 and 4 pressure ulcers and see a decrease in grade 2 avoidable pressure ulcers.

Our actions

We will ensure that all of our patients both within hospital or community settings continue to be assessed for their risk of pressure ulcers and that this is regularly reviewed during the admission period. We will ensure timely provision of pressure relieving equipment if required, and access to specialist tissue viability advice as indicated.

Measuring and monitoring

We will continue to monitor that all patients are assessed for their risk of developing pressure ulcers and report this through the ward performance framework. Pressure ulcers will continue to be reported and reported to Trust Board via the performance scorecard.

Whilst this indicator is not governed by national standard definitions, the assessment of grade of pressure ulcer is used using national definitions.

Discharge summaries

Why is this a priority?

Communication should be of a high standard when patients are discharged back to the care of their own GP. If not, the GP does not know what prescription or other changes have taken place or are recommended by the discharging Consultant. In addition, if a patient has died in hospital, it is important for the GP to be advised quickly in case the Practice tries to contact the patient or relatives for some reason, unaware of the patient's death.

Over a three year horizon progress has been excellent, but in 2018/2019 performance has fluctuated within a fairly narrow range just short of target but with the Integrated Medical Specialties Care Group, in particular, occasionally achieving the target.

Our aim

To complete and send 95% of discharge summaries within 24 hours of a patient discharge.

Our actions

The Care Groups will continue to review, develop and implement improvement plans.

Measuring and monitoring

This will continue to be monitored by directors in the monthly Performance Review meetings and thence to the Board and its IQAC sub-committee. This standard is governed by a national definition.

Rate of patient safety incidents resulting in severe injury or death

Why is this a priority?

We want to improve our incident reporting to ensure that we capture all incidents and near misses that occur. This will allow us to understand how safe our care is and take remedial action to reduce incidents resulting in harm.

Our aim

To ensure that accurate and timely data is uploaded to the national reporting system and those incidents are reviewed in a timely fashion so that lessons can be identified for learning. To remain within the national average for both incident reporting and the rate of incidents results in severe injury of death.

Our actions

To ensure that our staff are fully educated in the importance of reporting incidents and near misses. We will do this by continuing with an educational programme. We will ensure that serious incidents are fully reviewed so that lessons can be learned and cascaded across the trust.

Measuring and monitoring

We will continue to monitor compliance with timeliness of report completion via Safety Committee. A monthly report will give detail on incidents reported and reviews undertaken and

will be submitted to Safety Committee and Care Groups. We will monitor our relative position against the national reporting system.
Whilst this data is not governed by standard national definition, the trust uses the reporting grade as recommended by Department of Health.

EXPERIENCE

Nutrition and hydration in hospital
Why is this a priority?
Many of our patients are elderly and frail and require assistance to ensure that their nutritional needs are met to aid recovery and prevent further illness. Therapeutic dietetic advice can aid their treatment and recovery for specific conditions and we ensure that these patients dietetic requirements are assessed.
Our aim
To ensure that nutritional and hydration needs are met for patients who use our services.
Our actions
We will continue to use already established systems and documentation to record that patients who have been assessed as being at risk are continually monitored and corrective actions taken as required.
Measuring and monitoring
We will continue to monitor compliance using the newly produced ward quality metrics. We did not reach full compliance against our goals last year but there were improvements in all outcome measures. The indicator relating to nutrition care planning remains an area for improvement. Nutrition care planning has been incorporated into the Registered Nurses mandatory training. This is an area we will continue to monitor closely, providing support to ward areas where required.
This data is not governed by standard national definition but is based on the nationally recognised MUST score.

End of life and palliative care
Why is this a priority?
Palliative Care has been recognised as an area for improvement by the trust, the CQC inspection and the Health and Wellbeing Board.
Our aim
Each patient to be able to say "I can make the last stage of my life as good as possible because everyone works together confidently, honestly and consistently to help me and the people who are important to me, including my carer(s)."
Our actions
- Further improvement to personalised care planning through education, incident monitoring and cultural change
- Work with regional partners to develop ePaCCS
- Continue to deliver palliative care mandatory training for all staff.
- Support and monitor new out of hours advice service
- Develop and deliver actions from VOICES survey

Measuring and monitoring
- Achieve interim targets for mandatory three year education programme (33% at end of year 1)
- Continuing improvement in palliative care coding
- Continuing improvement in ''death in usual place of residence'' (DIUPR)
- Maintain Achievement of Preferred Place of Death (specialist Palliative Care Service) at over 90%

This data is not governed by standard national definition but is based on the nationally recognised end of life national documents.

Responding to patients personal needs
Why is this a priority?

Responding to patients needs is essential to provide a better patient experience. Ensuring that we are aware of patients views using 5 key questions allows us to target and monitor for improvement. This is a mandated priority as set by the Department of Health.

Our aim

To maintain improvement in results from inpatient surveys and remain within or better than national average for the indicators

Our actions

Quarterly in house measurement of the 5 questions will continue to ensure that we are aware of any emerging themes for action.

Measuring and monitoring

Quarterly results will be reported to Integrated Quality Assurance Committee and emerging themes discussed so that actions can be taken. Results of the national survey will be published to allow benchmarking against other organisations.

This data is governed by standard national definition as outlined in the national inpatient survey questions.

Percentage of staff who would recommend the provider to family or friends needing care

Why is this a priority?

The annual national survey of NHS staff provides the most comprehensive source of national and local data on how staff feel about working in the NHS. All NHS trusts take part in the survey and this is a mandated priority as set by the Department of Health.

Our aim

To achieve average national performance against the staff survey.

Our actions

To continue with a programme of staff engagement and development to build on current successes and improve areas where our performance is below average.

Measuring and monitoring

Results will be measured by the annual staff survey. Results are reviewed by sub committees of the Board and Trust Board and shared with staff and leaders so that actions and emerging themes can be considered as part of staff engagement work.

This data is governed by standard national definition as outlined in the national staff survey.

EFFECTIVENESS

Mortality monitoring

Why is this a priority?

We want to measure a range of clinical outcomes to provide assurance on the effectiveness of healthcare that we provide and this is a mandatory indicator as set by the Department of Health.

Our aim

To remain at or below the national average for the mandated indicator.

Our actions

We will continue to monitor the Trust's mortality indices to understand how we compare regionally and nationally. We will continue to undertake patient specific mortality reviews in line with any agreed national process that is mandated and to share the themes from these reviews with clinicians and colleagues in primary care. In addition, we will continue to use multiple sources of information to ensure we understand where any failings in care may have occurred and to use this information to inform the process of pathway review to improve patient care. This process will continue to be reviewed by the Mortality Reduction Committee, to ensure that mortality is fully reviewed and any actions highlighted implemented and monitored.

Measuring and monitoring

We will continue to benchmark ourselves against the North East hospitals and other organisations of a similar size and type. We will publicise our results through the Quality Accounts. We will provide a monthly update of crude and risk adjusted mortality to Trust Board

via the performance scorecard. We will measure compliance against “Learning from Deaths” policy. These data are governed by standard national definition.

Reduction in readmissions to hospital

Why is this a priority?

It is not possible to prevent all re-admissions but they can be distressing for patients and carers, and can be an indicator of a lack of care and ineffective use of resources. This is a mandated indicator by the Department of Health.

Our aim

The Trust aims to deliver the best and most effective care to patients by eliminating unnecessary re-admissions to hospital.

Our actions

Together with partners in Primary and Social Care, the Trust has developed a range of intensive short-term intervention services to prevent avoidable admissions and re-admissions, and to improve the support available to patients being discharged from hospital. The development of Teams Around Patients (TAPs) will also improve the delivery of robust multi-disciplinary care.

Measuring and monitoring

The Trust and local partners recently held an audit in March 2018 to review the reasons for a sample of recent re-admissions. The majority of re-admissions took place because of limited front-of-house services (including particularly surgery services. The newly re-organised Community Care Group is responsible not only to the Trust but also to the Director of Integration, employed the Durham CCGs and County Council.

To reduce the length of time to assess and treat patients in the Emergency Department (ED)

Why is this a priority?

Patients want to be treated in a timely manner. If this does not happen, cubicles in A&E become blocked slowing the process of care for everyone, creating additional risk and inconvenience for all patients, and leading to ambulance handover delays.

Our aim

We aim to assess and treat 95% of patients within four hours in line with national standards.

Our actions

Pressures in A&E rise are an indicator of pressures in the wider health system. The Trust’s Transforming Emergency Care Programme is the main improvement vehicle with progress monitored through the multi-agency Local A&E Delivery Board (see section in Patient Experience above).

Measuring and monitoring

This issue is governed by national definitions and reporting arrangements. In addition to internal monitoring, monthly reports are provided to the Local A&E Delivery Board, chaired by the Trust’s Chief Executive and, where performance falls short of the agreed NHSI trajectory, to NHSI. Financial benefits are linked to the attainment of targets agreed with NHSI.

To reduce the length of time that ambulance services have to wait to hand over the care of the patient in the Emergency Department (ED)

Why is this a priority?

Ambulances waiting at A&E to hand over patients to the care of the Trust are not available to respond to emergencies in the community. Such delays are potentially dangerous and distressing for patients and carers.

Our aim

We aim to take over the care of ambulance patients as soon as possible following their arrival at A&E.

Our actions

We continue to work with partners in the local A&E Delivery Board to implement the Transforming Emergency Care Programme and associated initiatives as described earlier.

Measuring and monitoring
We review all instances in which an ambulance cannot hand over care within 2 hours. Ambulance handover performance is governed by standard national definition, national and local quality requirements. Regular reports are provided for LADB and for internal monitoring bodies, including Trust Board and its Integrated Quality and Assurance sub-committee.

Patient Reported Outcome Measures
Why is this a priority?
PROMs measure the quality of care received from their perspective so providing rich data and this is a mandated priority as set by the Department of Health.
Our aim
We will continue to focus on the rates for health gain and hope to see that this is within national average.
Our actions
We will continue to drive the agenda for encouraging participation through identified staff. We will continue to educate staff on the importance of this priority and the benefits of using this alternative care as an indicator of the care we provide. We will continue to monitor ourselves against national benchmarking data to assess the impact for the patient in terms of health gain.
Measuring and monitoring
Results of the PROMs health gain data will be monitored on the Care Group performance scorecard and reviewed at performance meetings. Results will be included in scorecards presented to Trust Board.
This data is governed by standard national definitions.

Maternity Care
Why is this a priority?
Nationally the five year forward plan and the national maternity review place maternity care as a priority. NHS England have also produced a report “Saving Babies Lives” and this reports on standards required to ensure safe, effective care in this area.
Our aim
We want to ensure that patients who receive care have a positive experience when under our care and that all needs are considered.
Our actions
We will continue to embed learning from the gap analysis around compliance with this standard and agree any actions that result from this.
Measuring and monitoring
Key metrics will be introduced to monitor implementation of any identified actions
This data is not governed by standard national definition.

Care of patients requiring paediatric care
Why is this a priority?
The care of children in emergency/ urgent care settings will be delivered using bespoke pathways for that care and it is important that pathways are enhanced to ensure that practice continues to be evidence based and triangulates all areas of speciality.
Our aim
We want to ensure that children continue to receive care which is evidence based using pathways to inform decision making. This will also have the aim of enhancing the child’s experience and ensuring that care between primary and secondary settings is streamlined by the provision of increased education and improved accessibility to GPs.
Our actions
We will continue to introduce pathways of care for paediatric patients.

Measuring and monitoring
With the introduction of paediatric pathways.
This data is not governed by standard national definition.

ANNEX 1

Feedback from Darlington, Durham Dales, Easington and Sedgefield and North Durham Clinical Commissioning Groups

NHS Darlington Clinical Commissioning Group

NHS Darlington CCG
Dr Piper House
King Street
Darlington
DL3 6JL

NHS Durham Dales, Easington and Sedgefield Clinical Commissioning Group

NHS Durham Dales Easington and Sedgefield CCG
Sedgefield Community Hospital
Salters Lane
Sedgefield
Stockton-on-Tees
TS21 3EE

NHS North Durham Clinical Commissioning Group

NHS North Durham CCG
The Rivergreen Centre
Aykley Heads
Durham
DH1 5TS

Feedback from Darlington Borough Council Health and Partnerships Scrutiny Committee

County Durham and Darlington NHS Foundation Trust – Draft Quality Account 2017/2018

Feedback from Healthwatch Darlington

County Durham and Darlington Foundation Trust (CDDFT) Quality Accounts 2017-2018.

DURHAM COUNTY COUNCIL ADULTS WELLBEING AND HEALTH OVERVIEW AND SCRUTINY COMMITTEE

COMMENTS ON COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST QUALITY ACCOUNT FOR 2017/2018

Feedback from Health and Wellbeing Board

Contact: Cllr Lucy Hovvels
Direct Tel: 03000 268 801
email: lucy.hovvels@durham.gov.uk
Your ref:
Our ref:

Statement of Directors' Responsibility in Respect of the Quality Report

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST ON THE QUALITY REPORT

Glossary

A&E	Accident & Emergency
BAHRO	Becoming A Highly Reliable Organisation
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CDDFT	County Durham & Darlington NHS Foundation Trust
CEO	Chief Executive Officer
CLS	Chester le Street
DDES	Durham, Dales, Easington & Sedgefield
DMH	Darlington Memorial Hospital
ECL	Executive Clinical Leadership
ED	Emergency Department
FFT	Friends and Family Test
GP	General Practitioner
HCAI	Healthcare Associated Infections
HMSR	Hospital Standardised Mortality Index
HES	Hospital Episode Statistics
IQAC	Integrated Quality Assurance Committee
LIGG	LocSSIP Implementation and Governance Group
MCA	Maternity Care Assistant
MRSA	Meticillin resistant Staphylococcus aureus
MUST	Malnutrition Universal Screening Tool
NED	Non Executive Director
NHS	National Health Service
NHSFT	NHS Foundation Trust
NICE	National Institute of Health and Care Excellence
NEQOS	North East Quality Observatory System

NPSA	National Patient Safety Agency
NRLS	National Reporting and Learning System
NEAS	North East Ambulance Service
PALS	Patient Advice and Liaison Service
PE	Pulmonary Embolism
PROM	Patient Recorded Outcome Measure
RCA	Root Cause Analysis
SHMI	Summary Hospital-level Mortality Indicator
UHND	University Hospital of North Durham
VTE	Venous Thromboembolism
WHO	World Health Organisation

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NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

making a difference together

Table of Contents

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

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

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

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

Our Mission, Vision and Strategy

The Mission of the Trust is:

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

The Trust's Vision is:

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

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

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

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

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

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

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

The Quality Strategy contains three goals, which are:

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

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

A Profile of the Trust

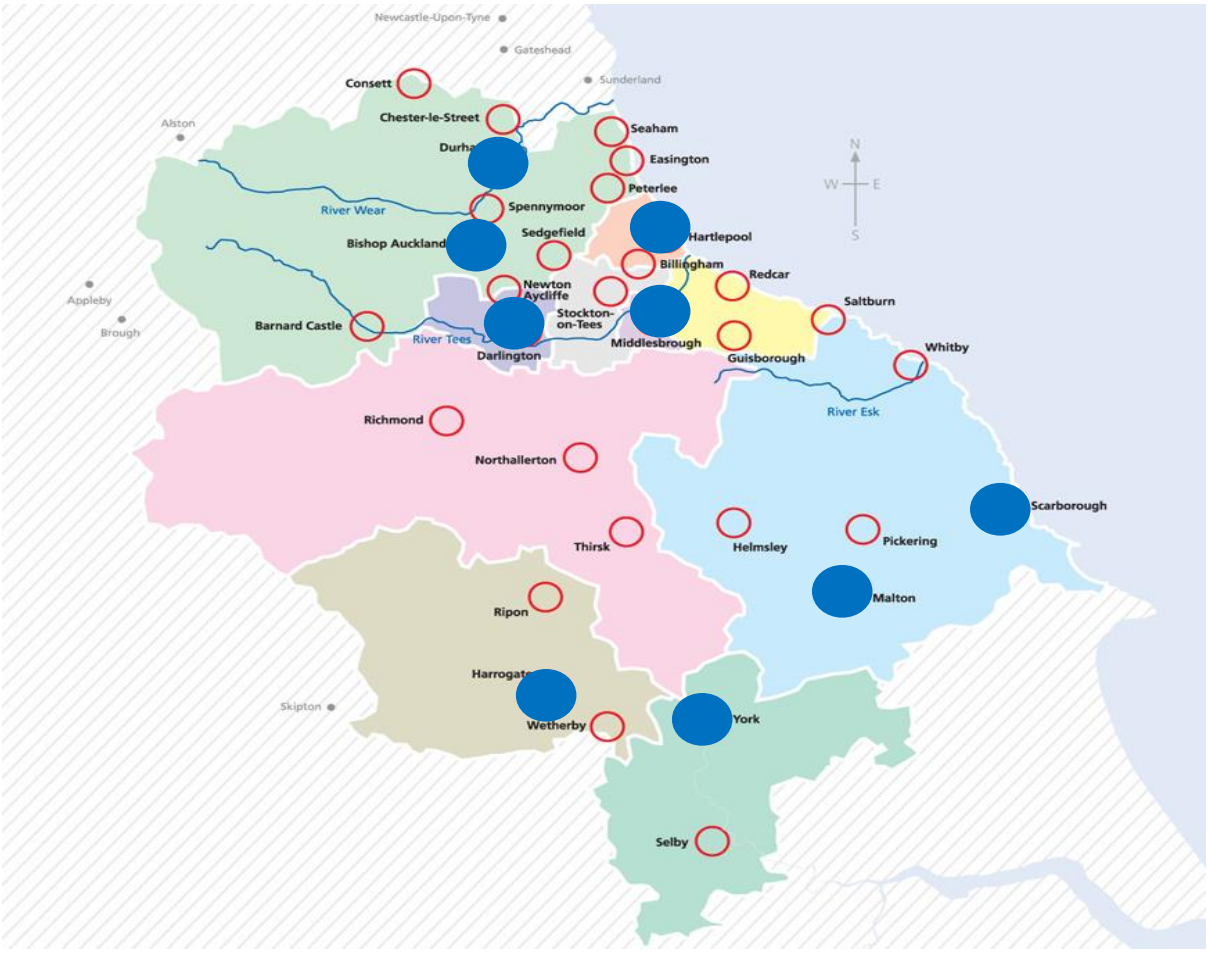
The Trust provides a range of Mental Health, Learning Disability and autism services for around two million people living in County Durham, Darlington, Teesside, North Yorkshire (with the exception of Craven District) and York.

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

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

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

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



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

What we have achieved in 2018/19:

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

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

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

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

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

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

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

TEWV's 2018 Community Mental Health Survey Results

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

TEWV's National NHS Staff Survey Results 2018*

*This data covers the calendar year 2018

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

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

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

TEWV's Staff Friends and Family Test Results

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

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

National Awards – Won or Shortlisted

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

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

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

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

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

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

Structure of this Quality Account Document

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

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

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

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

I hope you find this report interesting and informative.

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

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

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

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

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

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

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

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

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

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

Why this is important:

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

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

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

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

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

What we did in 2018/19:

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

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

How do we know we have made a difference?

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

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

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

What we will do in 2019/20:

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

- Set improvement trajectories for the remainder of 2019/20 based on outcomes of the analysis above during Q1 2019/20 and report on these trajectories during Q2, Q3 and Q4 2019/20
- Review the Healthcare Safety Investigation Branch report 'Transition from child and adolescent mental health services to adult mental health services' and identify any action or learning for the Trust during Q1 2019/20 and report on progress during Q3 and Q4 2019/20
- Hold a joint CYPS & Adult Services Engagement Event during Q2 2019/20 and report on the actions from this event during Q3 and Q4 2019/20
- Establish any potential barriers to successful transitions and consider how these could be overcome
    - Establish agreed models for transition panels
    - Include Experts by Experience sharing their experiences of transitions
    - Include presenting case studies of difficult to manage transitions and the learning regarding how to overcome difficult to manage transitions
    - Include partners from other organisations
- Evaluate the effectiveness of transition panels across the Trust during Q4 2019/20

How will we know we are making a difference?

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

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

Priority 2: Reduce the number of Preventable Deaths

Why this is important:

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

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

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

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

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

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

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

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

What we did in 2018/19:

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

How do we know we have made a difference?

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

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

What we will do in 2019/20:

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

We will:

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

How will we know we are making a difference?

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

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

Priority 3: Making Care Plans more personal

Why this is important:

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

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

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

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

What we did in 2018/19:

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

How do we know we have made a difference?

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

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

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

What we will do in 2019/20:

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

We will:

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

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

How will we know we are making a difference?

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

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

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

Why this is important:

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

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

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

What we did in 2018/19:

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

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

How do we know we have made a difference?

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

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

*AMH, CYPS, MHSOP, Learning Disabilities and Forensics

What we will do in 2019/20:

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

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

How will we know we are making a difference?

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

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

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

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

Why this is important:

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

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

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

The benefits/outcomes our patients and carers should expect:

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

What we will do in 2019/20:

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

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

How will we know we are making a difference?

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

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

Monitoring Progress

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

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

Statement of Assurances from the Board 2018/19

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

Review of Services

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

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

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

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

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

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

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

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

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

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

Participation in clinical audits and national confidential inquiries

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

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

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

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

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

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

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

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

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

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

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

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

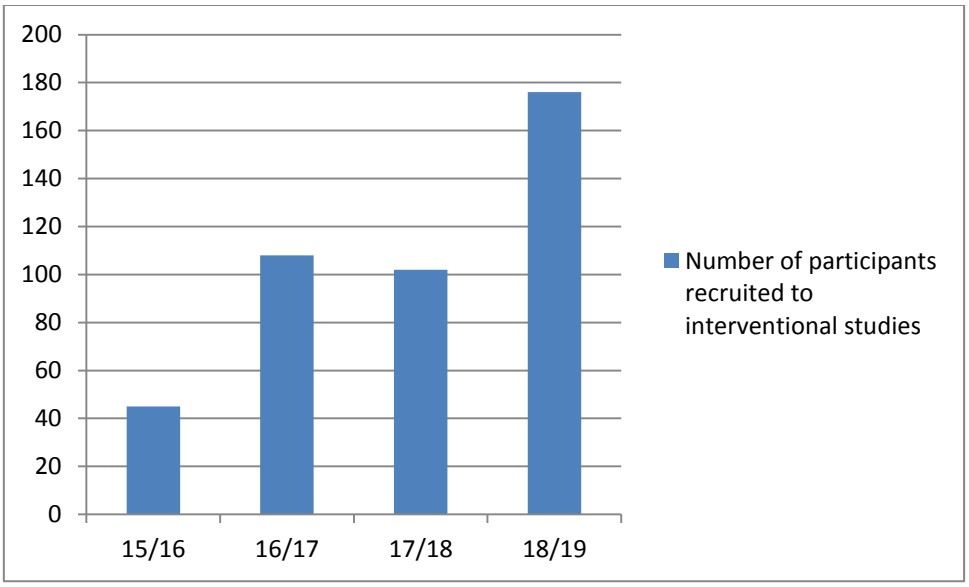
Participation in Clinical Research

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

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

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

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



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

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

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

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

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

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

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

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

Goals agreed with Commissioners

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

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

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

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

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

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

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

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

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

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

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

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

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

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

What others say about the provider

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

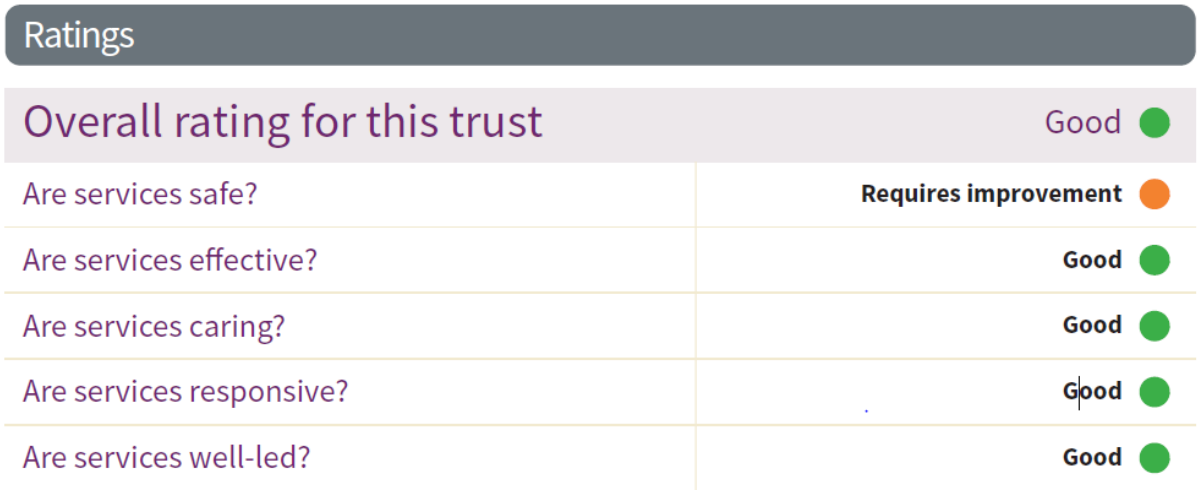
TEWV is required to register with the Care Quality Commission and its current registration status is **registered to provide services with no conditions attached.** The CQC **has not** taken enforcement action against TEWV during 2018/19

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

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

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

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



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

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

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

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

Mental Health Act Inspections

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

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

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

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

Quality of Data

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

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

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

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

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

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

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

The Trust has no unmet assertions.

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

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

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

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

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

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

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

Further work for 2019/20 includes:

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

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

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

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

Learning from Deaths

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

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

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

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

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

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

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

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

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

In relation to each quarter, this consisted of:

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

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

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

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

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

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

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

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

Two representing **2.3%** of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using findings from Serious Incident investigations. Where there has been a root cause found from incident review then this has been used as a way to determine if the patient death may have been attributable to problems with care provided.

Freedom to Speak Up

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

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

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

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

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

Reducing Gaps in Rotas

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

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

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

Mandatory Quality Indicators

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

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

Care Programme Approach Seven-Day follow-up

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

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

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

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

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

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

Crisis Resolution Home Treatment team acted as gatekeeper

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

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

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

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

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

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

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

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

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

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

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

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

Notes on Metric

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

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

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

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

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

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

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

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

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

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

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

Patient Safety incidents including incidents resulting in severe harm or death

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

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

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

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

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

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

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

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

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

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

Part 3: Other Information on Quality Performance 2018/19

Our performance against our quality metrics

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

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

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

Quality Metrics

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

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

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

Notes on selected Metrics

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

Comments on areas of under-performance

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

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

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

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

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

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

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

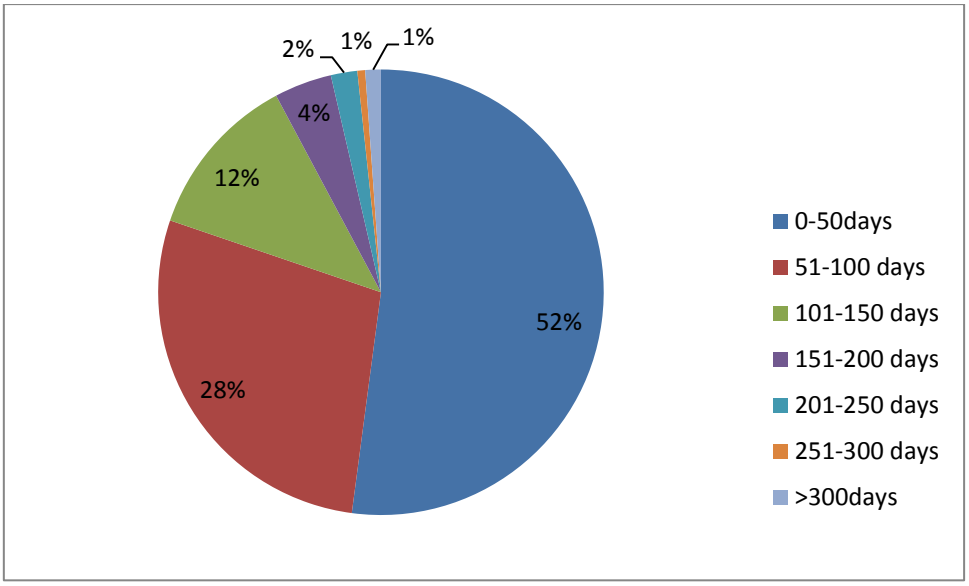
The high amount of physical restraints on Teesside reflects the high use of restraint within West Lane Hospital (CAMHS inpatient services) which is managed by the Trust's Teesside Locality, which however serves the whole Cumbria and North East England region and beyond due to the specialist services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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

Our Performance against the Single Oversight Framework Targets and Indicators

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

Single Oversight Framework

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

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

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

Notes on the Single Oversight Framework Targets and Indicators

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

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

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

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

External Audit

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

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

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

Our Stakeholders' Views

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

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

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

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

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

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

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

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

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

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

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

[To be inserted once feedback in received]

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

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

APPENDICES

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

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

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

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

- The content of the Quality Account/Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2018/19 and supporting guidance

- The content of the Quality Account is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2018 to May 2019
    - Papers relating to quality reported to the Board over the period April 2018 to May 2019
    - Feedback from the Commissioners dated **xx**
    - Feedback from Governors dated **xx**
    - Feedback from local Healthwatch organisations dated **xx**
    - Feedback from Overview and Scrutiny Committees dated **xx**
    - Feedback from Health and Wellbeing Board dated **xx**
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, received **xx**
    - The latest national patient survey published **xx**
    - The latest national staff survey published **xx**
    - The Head of Internal Audit's annual opinion over the Trust's control environment dated **xx**
    - CQC inspection reports dated **xx**

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

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

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

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

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

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

By order of the Board:

-- May 2019……Chairman

-- May 2019……Chief Executive

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

[To be inserted once received]

Appendix 3: Glossary

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

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

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

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

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

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

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

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

Care Planning: See Care Programme Approach (CPA)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Department of Health: The government department responsible for Health Policy

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TEWV: Tees, Esk and Wear Valleys NHS Foundation Trust

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

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

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

The Trust: see TEWV above

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

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

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

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

Trust Board: See Board/Board of Directors above

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

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

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

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

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

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

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

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

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

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

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

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

Appendix 5: Trust Business Plan additional Priorities

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

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

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

Appendix 6: Quality Performance Indicator Definitions

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

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

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

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

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

Exemptions:

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

Accountability:

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

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

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

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

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

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

Data definition:

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

Exemptions:

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

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

Data definition:

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

Exemptions:

There are no exemptions for this indicator

Accountability:

QuAC and Patient Safety Group

Numerator:

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

Denominator:

The total number of responses to this question

Appendix 7: Feedback from our Stakeholders

[To be added once received]