DARLINGTON
Borough Council

Health and Housing Scrutiny Committee Agenda

2.00 pm
Wednesday, 18 May 2022
Council Chamber, Town Hall, Darlington, DL1 5QT

Members of the Public are welcome to attend this Meeting.

1. Introduction/Attendance at Meeting

2. Declarations of Interest

3. Quality Accounts 2021/2022 –
   Report of the Assistant Director Law and Governance
   (Pages 3 - 6)

   (a) Tees, Esk and Wear Valley NHS Foundation Trust Draft Quality Account 2021/2022 (Pages 7 - 98)

   (b) County Durham and Darlington NHS Foundation Trust Draft Quality Account 2021/2022 (Pages 99 - 178)

Luke Swinhoe
Assistant Director Law and Governance

Tuesday, 10 May 2022

Town Hall
Darlington.

Membership
Councillors Bartch, Bell, Dr. Chou, Heslop, Layton, Lee, McEwan, Newall, Wright and Vacancy

If you need this information in a different language or format or you have any other queries on this agenda please contact Hannah Miller, Democratic Officer, Operations 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: hannah.miller@darlington.gov.uk or telephone 01325 405801

HEALTH AND HOUSING SCRUTINY COMMITTEE
18 MAY 2022

QUALITY ACCOUNTS 2021/2022

SUMMARY REPORT

Purpose of the Report

1. To consider information included in the local Foundation Trusts Quality Accounts 2021/2022 to enable this Committee's input into the draft commentaries.

Summary

2. Scrutiny Committee had previously 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 2021/2022.

3. Scrutiny also agreed to receive regular performance reports from Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) and County Durham and Darlington NHS Foundation Trust (CDDFT).

Recommendation

4. It is recommended that draft commentaries for :

   (a) Tees Esk and Wear Valleys NHS Foundation Trust be formulated and forwarded for inclusion in the Quality Accounts for 2021/2022; and

   (b) County Durham and Darlington NHS Foundation Trust be formulated and forwarded for inclusion in the Quality Accounts for 2021/2022.

Luke Swinhoe
Assistant Director Law and Governance

Background Papers

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

Hannah Miller : Extension 5801

S17 Crime and Disorder	This report has no implications for Crime and Disorder.
Health and Wellbeing	This report has implications to address Health and Well Being of residents of Darlington, through scrutinising the services provided by the NHS Trusts.
Carbon Impact and Climate Change	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
Council Plan	The report contributes to the Council Plan in a number of ways through the involvement of Members in contributing to the delivery of the Plan.
Efficiency	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

Information and Analysis

5. The Health Act 2009 and the National Health Service (Quality Accounts Regulations 2010) requires NHS Foundation Trusts to publish an Annual Quality Account Report.

6. 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.

7. Overview and Scrutiny Committees 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.

8. 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.

Tees, Esk and Wear Valleys NHS Foundation Trust

9. Members of this Scrutiny Committee received updates on performance information from the Trust in a timely manner.

10. As a result of these updates, Members feel informed to be able to make comments for inclusion in the draft Quality Accounts 2021/2022 (Appendix a).

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 2021/2022 (Appendix b).

This page is intentionally left blank

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

TEWV Quality Account 2021/22 and 2022/23

Darlington Health OSC
18th May 2022

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Purpose

- To look back at progress made on the Quality Account improvement metrics and priorities this year
- To outline proposed quality improvement priorities for 2022/23 (to be included in the Quality Account 2021/22 document)
- To set out the probable dates for formal consultation and discuss how this Committee can best respond
- Please note that Darlington data in this presentation also includes Durham. Trust data includes County Durham, Darlington, Teesside, North Yorkshire and York

Quality Metrics (1)

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

	Quarter 4 21/22			Trend	Comments	20/21
	Durham Actual	Target	Trust Actual			
1: Percentage of patients who report 'yes, always' to the question 'Do you feel safe on the ward?'	**72.48%**	88.00%	**65.30%**	↑	This is the best position over the last five years but we still remain a long way from target. We are committed to improving patient safety and will keep this as a Quality Account priority during 2022/23	64.66%
2: Number of incidents of falls (level 3 and above) per 1000 occupied bed days (OBDs) – for inpatients	**0.06**	0.35	**0.07**	↓		0.13
3: Number of incidents of physical intervention/ restraint per 1000 occupied bed days	**36.34**	19.25	**37.66**		Although this metric is a long way from the target, these incidents relate largely to a small number of patients in our Learning Disability Unit at Lanchester Road Hospital. These patients are acutely unwell and have very complex needs	20.90

Quality Metrics (2)

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

	Quarter 4 21/22				Comments	20/21
	Durham Actual	Target	Actual			
4: Existing percentage of patients on Care Programme Approach who were followed up within 72 hours after discharge from psychiatric inpatient care	**86.46%**	>95%	**88.51%**	**N/A**	This is a revised metric for 2021/22, where follow-up was previously within 7 days. The reasons why this target is not being achieved are largely due to difficulties in engaging with the patient after discharge or breakdown in internal processes	N/A
5: Percentage of Quality Account audits completed	**N/A**	**N/A**	**N/A**	→	No Quality Account audits were scheduled for completion during Q4 2021/22	**100%**
6: Patients occupying a bed over 90 days	**N/A**	<61	**60**	**N/A**	This is a new metric for 2021/22	N/A

Quality Metrics (3)

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

	Quarter 4 21/22				Comments	20/21
	Durham Actual	Target	Trust Actual			
7: Percentage of patients who reported their overall experience as excellent or good	**93.88%**	94.00%	**94.34%**	↑	This is the first time that the Trust has achieved this target; the Durham Locality is also very close to achieving the target. Patient Experience is one of the three goals of Our Journey to Change	93.21%
8:Percentage of patients that report that staff treated them with dignity and respect	89.53%	94.00%	**89.14%**	↑	The results against this metric have remained essentially static over the past few years. Work on this is underway throughout our service delivery linked to the Trust values of respect, compassion and responsibility	86.77%
9: Percentage of patients that would recommend our service to friends and family if they needed similar care or treatment	**93.00%**	94.00%	**91.08%**	↑	There has been a consistent improvement in performance against this metric throughout the year, the Locality is almost achieving this target and has performed better than other areas within the Trust	91.60%

Actions we've taken in Durham in response to the Quality Metrics

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

- Developed a business case for the further roll-out of body cameras on wards
- Undertaken a robust exploration of the data and intelligence influencing the Friends and Family Test; the Patient Experience Team have worked with the locality to implement more robust governance and to set up Patient Experience Groups
- Shared key successes and learning from a review of patient safety and promoted the role of the Trust Patient Safety Specialist
- Gathered views of families and involved them in improving the Serious Incident Process
- Implemented a process to capture informal concerns and complaints that enabled us to identify any key themes where patients have raised issues

Quality Metrics for 2022/23

- We are going to review the suite of metrics to align them more closely with our new quality journey
- We also want to align them more closely to our improvement priorities
- Some of the metrics will still be the same
- We will analyse our data in a more sophisticated way, so that we can see where things are really improving or getting worse

Quality Account Improvement Priorities during 2021/22

- Improve the personalisation of Care Planning
- Safer Care
- Compassionate Care

- 46 actions under these headlines
- **30** of the **46** were achieved or on track at the end of 2021/22

Reasons for delays in implementation

- Covid
  - Some public events, such as conference with bereaved families to help us learn from their experiences could not be held
  - Staff diverted to infection prevention control work
  - Staff diverted to the vaccination programme
  - Restrictions on entering wards slowed down some key “feeling safe” initiatives such as installation of sensing technology (Oxehealth)
- Non-Covid
  - National policy changes on Care Programme Approach have meant some of our proposed actions are not relevant now

Priorities during 2022/23

- The Trust has identified the following **three** priorities for the new Quality Account:
  - Care Planning
  - Implementation of the new Patient Safety Incident Reporting Framework
  - Feeling Safe

Detailed plans are currently being drafted

Care Planning

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Q1 22/23

- Establish working groups linked to outputs from the Care Planning event in March 2022, all of which link to Cito implementation
- Care planning patient and carer information: review existing patient and carer information that refers to/is about care planning
- Care planning training and guidance: develop and approve package around goal setting and solution-focused approaches
- Care planning monitoring and embedding: agree metrics around care planning – to link into caseload management work
- Care planning in Secure Inpatient Services: to agree piloting of the use of DIALOG and DIALOG+ as a replacement for 'my shared pathway'
- The CPA wind-down: review everything that refers to CPA and agree how to change language and processes in line with community transformation and iThrive
- Establish Care Planning Steering Group to report into Quality and Safe and Clinical Journey Boards
- Develop goal setting training and resources to complement move to DIALOG
- Introduce DIALOG and DIALOG+ to all inpatient services to further embed individualised goal based-plans

Care Planning (2)

Tees, Esk and Wear Valleys NHS Foundation Trust

Q2 22/23

- Develop, approve and publish new patient and carer information in line with new approaches to care planning
- Deliver training on goal setting and solution-focused approaches that will further strengthen and support Cito training and guidance
- Gather data for baseline position using agreed metrics that will be transferable to Cito
- Test use of DIALOG and DIALOG+ in agreed wards within SIS
- Develop new policies and procedures in relation to CPA winding down
- Continue with inpatient work around understanding, implementation and embedding of DIALOG and DIALOG+

Care Planning (3)

Tees, Esk and Wear Valleys NHS Foundation Trust

Q3 22/23

- Go live of Cito: it is envisaged that much of Quarter 3 will be the supporting of staff in the use of DIALOG, DIALOG+ and individualised care planning elements of Cito (including training and guidance refining and development)
- Publish new policies and procedures in relation to care planning and new ways of working (linked to Community Mental Health Framework)
- Embed processes for gathering key care planning metrics
- Review SIS testing of DIALOG and DIALOG+ and agree next steps/roll out

Q4 22/23

- Continue with Cito support
- Next steps/roll out of DIALOG and DIALOG+ in SIS
- Continue measurement of metrics

Feeling Safe

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

In 2022/2023 we will:

- Review the information we have available from patient surveys, incidents and complaints from adult inpatient services to identify any new emerging themes that may help inform our programme of improvement work in this area
- Increase the visibility of staff within adult inpatient areas
- Focus on reducing patient-on-patient violence through exploring further use of Information Technology solutions
- Continue to implement the Safe Wards initiative (an evidence-based tool to reduce violence and support a safe ward environment)

Implementation of the new Patient Safety Incident Reporting Framework

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

In 2022/2023 we will:

- Roll out the two-part incident approval process across all areas of the Trust. This involves operational staff taking responsibility for reviewing and approving incidents that have occurred within their service before submitting centrally
- A triage process for incidents that have been categorised as moderate and serious harm to determine quickly the appropriate route for review
- Develop the daily patient safety huddle to include service staff and subject matter experts to ensure we can effectively review reported incidents in a timely way and where rapid reviews can be undertaken where appropriate that lead to immediate actions and improve safety
- A Serious Incident Review process that is robust and utilises evidence-based tools and that involve families to the level of their satisfaction
- Provide updates for staff on the duty of candour to ensure all have a full understanding
- Improve the quality and oversight of action plans
- Refresh the Terms of Reference for the Director Assurance Panels

What next?

- We have circulated our draft Quality Account to you on Wednesday 11th May, with a closing date for comments of Monday 13th June
- The document will go to the TEWV Board of Directors on Thursday 16th June
- Publication of the final document on 30th June
- We will be happy to bring six-monthly update on progress during 2022/23 to this Committee

Tees, Esk and Wear Valleys
NHS Foundation Trust

Quality Account 2021/22

DRAFT

Table of Contents

Part One: Introduction & Context

What is a Quality Account?

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

What are the aims of the Quality Account?

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

Who reads the Quality Account?

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

What information can be found in the Quality Account?

In this document, you will find information about how we measure and review the quality of services that we provide. You will also find our priorities for improvements for the year ahead. Like all NHS healthcare providers, we focus on three different aspects or “domains” of quality:

- Patient **safety**
- Clinical **effectiveness**
- Patient **experience**

Structure of this Quality Account document

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

- **Part 1** Introduction and Context
- **Part 2:** Information on how we have improved in the areas of quality we identified as important for 2021/22, our priorities for improvement in 2022/23 and the required statements of assurance from the Board and
- **Part 3:** Further information on how we have performed in 2021/22 against our key quality metrics and national targets and the national quality agenda

A Profile of the Trust

Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) is a TEWV is a large and complex organisation with around 7,800 employees who provide a range of inpatient and community mental health and learning disability services for approximately 2 million people of all ages living in

- County Durham
- The five Tees Valley boroughs of Darlington; Hartlepool, Stockton, Middlesbrough and Redcar and Cleveland

- The Scarborough, Whitby, Ryedale, Hambleton, Richmondshire, Selby and Harrogate areas of North Yorkshire
- The City of York
- The Pocklington area of East Yorkshire; and
- The Wetherby area of West Yorkshire

In addition, our adult inpatient eating disorder services, and our Secure Inpatient (Forensic) wards serve the whole of the North East and North Cumbria. TEWV also provides mental health care within prisons located in North East England, Yorkshire and the Humber, and North West England.

Our Quality Account. Quality Governance and Quality Issues

TEWV has changed its governance arrangements from 1st April 2022.

This is because it has become clear that the way we were structured, and the way our governance operated, needed to change so we provide well-governed clinical care alongside partners across our systems.

Our new governance structure will help us achieve 'Our Journey to Change' (see next page) by making sure the Trust is:

- Clinically led and operationally enabled
- Better able to align around the regional changes in the form of the two Integrated Care Systems in which we provide services
- Able to deliver on individual and collective system wide accountability effectively and consistently, by making all roles clearer and manageable for post holders
- Organised in a more simple, less complex way formally incorporating patient leadership into our structures.

The changes do not save money because their aim is to provide safe, high quality, effective clinical services, and the best possible experience for people in our care, families and carers, our colleagues, and our partners.

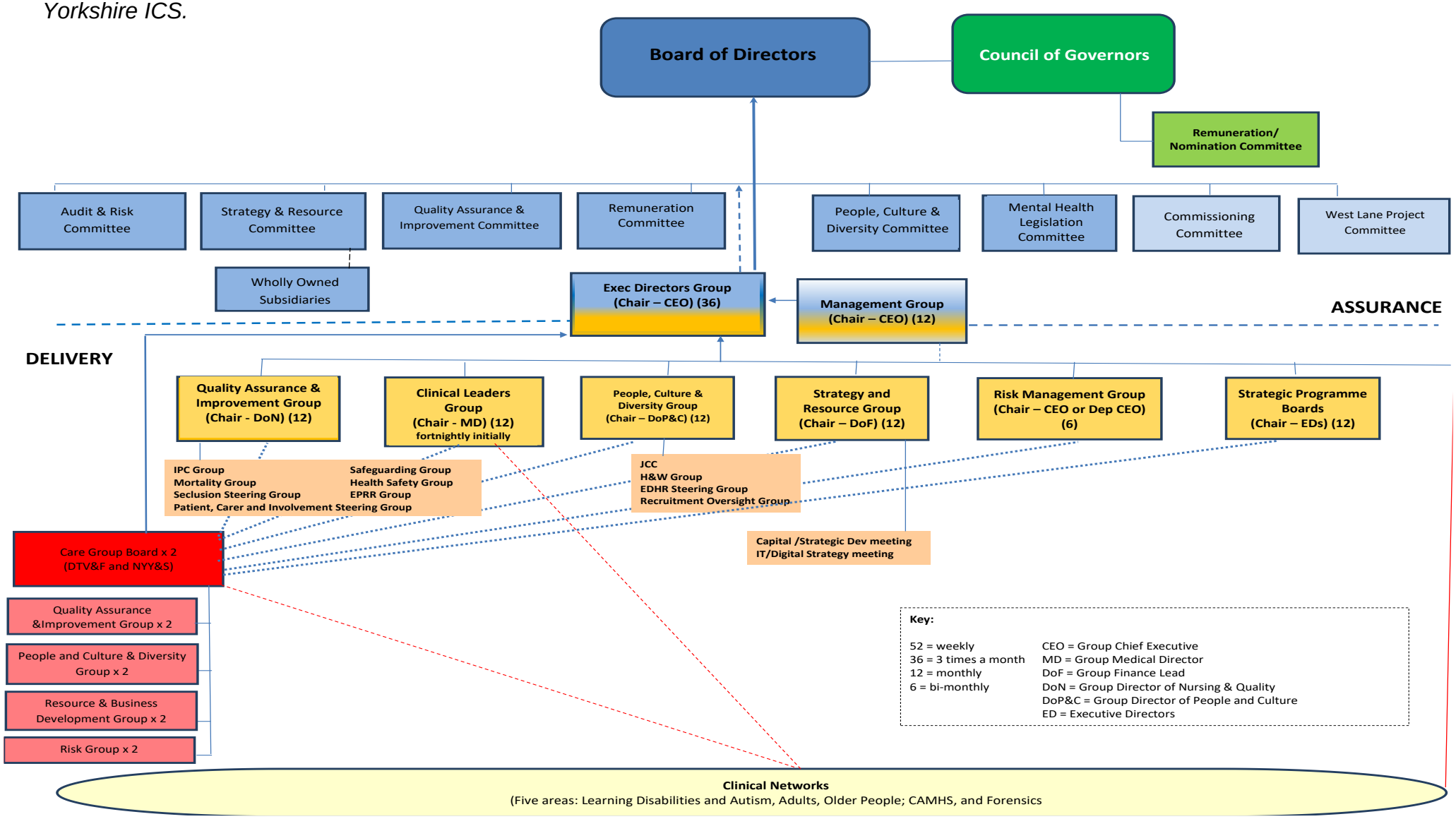
The new structure is shown in ***Figure 1*** the next page. However, the data and commentary contained in this document were produced using the governance structures and processes in place prior to April 2022. The key features of this were that In line with our previous Clinical Assurance Framework the review of data and information relating to our services was undertaken monthly by the relevant Quality Assurance Group (QuAG) for each service. A monthly report is produced for each QuAG which includes information on:

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

Figure 1: Summary of the Trust Journey to Change

Figure 2: Trust Governance from 1st April 2022

This diagram shows the new structures and governance within TEWV. An important feature is the creation of two Care Groups – one for services serving the population of the North East North Cumbria ICS and one for services serving the Humber and North Yorkshire ICS.



Following discussion at the QuAG any areas of concern were escalated to the relevant Locality Management and Governance Board (LMGB) and from there to the Trust Board's Quality Assurance Committee (QuAC). The QuAC received formal Quality and Learning reports from each of the LMGBs on a monthly basis, as well as a Trust level report.

We also implemented a Quality Assurance programme that focused on the quality of patient risk assessments, safety summary and safety plans as well as broader care standards. A range of methods were used to gather this information and involved Trust staff as well as some of our CCG colleagues. This was supported by other activities such as clinical audits and leadership walkabouts.

Some normal aspects of governance were disrupted by the restrictions related to the Covid-19 pandemic. Peer review and Board visits to wards and teams, for example, were affected with some only taking place virtually via Microsoft Teams.

However, as staff updated the electronic patient record, online incident log, complaints database and other systems we were increasingly able to triangulate different sources of data and intelligence and to report/act on a holistic (whole) picture. Our Integrated Information Centre is a key tool in enabling this.

We also regularly provide our commissioners with information on the quality of our services. This includes holding regular Clinical Quality Review meetings with commissioners where we review key information on quality that we provide, with a particular emphasis on providing assurance on the quality of our services. At these meetings, we also provide information on any thematic analyses or quality improvement activities we have undertaken and on our responses to national reports that have been published.

In last year's Quality Account, we noted that, following an unannounced inspection from the Care Quality Commission (CQC), our acute wards for Adults and Psychiatric Intensive Care Units were rated as 'inadequate' for both 'safe' and 'well-led'. During 2021/22 we have made significant achievements in implementing the resulting CQC Action Plan.

Following further CQC inspections, our CQC core service and well-led inspection report was issued on 10th December 2021. The Trust's overall rating remained at 'requires Improvement'. CQC rated the 'safe', 'responsive' and 'well-led' domains as "requires improvement", and the effective and caring domains as 'good'.

In the inspection report the CQC acknowledged that TEWV had embarked on a significant change programme to change our governance and organisational arrangements. They also acknowledged that Our Journey to Change showed we had a strategy, co-created with service users, staff and stakeholders which would help the organisation to address the changes which needed to be made.

The CQC also highlighted positive practice in the report including:

- Further workforce investment and recruitment into inpatient services
- A strategic approach to people and culture within the trust, good record

of developing staff and engagement with staff side
- Robust systems in place in relation to the effective management of medicines and controlled drugs.
- More effective systems in place to comprehensively assess and manage patient risks

Issues that the CQC found in their inspection included:

- A variable culture across some services within the Trust
- Systems to identify, understand, monitor, and reduce or eliminate risks were not always effective and required further development
- Improvements were needed to safeguarding policies and processes, particularly in Adult Mental Health Services
- Insufficient staffing levels for the Trust's Community CAMHS caseload
- Some areas of poor compliance with mandatory training
- TEWV's approach to equality and diversity could be improved
- Investigations into complaints and serious incidents were not always carried out in line with trust policies.

A further action plan has been developed. Some of the actions have already been delivered but others will be delivered during 2022/23. There is more detail about the CQC's findings, inspection rating and our action plan on page **37**

During 2020/21 we have reported to and been support by an external Quality Board chaired by the North East North Cumbria ICS Lead Officer.

Unfortunately, the Trust is not always successful in preventing patients from ending their lives. We are very grateful to those relatives who have worked with us to help us better understand the root cause of these serious incidents and what we could do to reduce risk in the future. Inquests are also a chance to reflect on what has gone wrong and what could be done better in the future.

Our newly developed Clinical Journey to Change (Clinical Strategy) describes our ambition to be an outward looking, modern Mental Health, Learning Disability and Autism service by providing a roadmap through co-created transformation. The purpose is to improve the overall health and wellbeing of people with mental health issues, a learning disability or autism in our region. Our approach is to consider the whole person, whole life, whole system to deliver personalised care sooner, safer, and more holistically.

We have also developed Our Journey to Safer Care that sets out our key safety priorities and enablers. This forms part of the new Quality Strategy that is in development and will also include our ambitions for improving the experience of our patients.

The Trust fully acknowledges that our services are not always of the quality our patients require and the public (who fund the NHS) deserve. But we are absolutely committed to improving and Our Journey to Change which we developed in 2020/21 is starting to move us in the right direction.

In addition to the quality improvement priorities included within this Quality Account, the Trust also has a Business Plan which summarises all of our change plans. You can find this on the internet at **[weblink to be added once plan finalised]**

We think it is essential to highlight the good work that Trust staff have achieved as well as highlighting the issues that we still need to tackle. Therefore, we have included a short section on the following pages which highlights the positive progress made by the Trust and the individuals who work for us.

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

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

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

- Elizabeth Moody (Director of Nursing & Governance) at: elizabeth.moody1@nhs.net
- Avril Lowery (Director of Quality Governance) at a.lowery1@nhs.net

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

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

What we have achieved in 2021/22

In his introduction on the previous pages, the Chief Executive notes the importance of highlighting the positive progress made by the Trust as a whole and by individuals who work for it. Some of these positives are presented below. By doing this we hope to give our staff and stakeholders confidence that we will overcome the ongoing quality issues that still face the Trust in the months and years ahead.

Trust achievements in 2021/22 include:

- TEWV lived experience members were successful in receiving an award for 'Leading Change' from South Tees Healthwatch as part of their role within the programme to create a new vision for how services will work in the future
- We reviewed our process for Freedom to Speak Up and Whistle Blowing and produced standard work to ensure consistency across the trust, and continued to encourage staff to speak out when they see unacceptable quality
- We implemented an improved waiting list process including an initial risk assessment for every child and a robust Keeping in Touch process.
- Over 4,000 Trust staff have been trained in how to use our new electronic patient record system (cito), which will go live in late summer/early autumn 2022
- In September 2021, Children and Young People's Mental Health Services in York moved to new premises at Orca House, on the Link Business Park is Osbaldwick, just outside York City Centre. Young people and their parents and carers were involved at every stage and level, from the naming of the premises to the look and feel of the main reception area and the clinical/therapy rooms
- The Trust has supported the creation and operations of the North East North Cumbria and Humber, Coast and Vale Resilience Hubs launched in February 2021 in response to the Covid-19 pandemic. These offer a wide range of emotional and wellbeing support to the health, care, and emergency services workforce across the area we serve. As well as providing outreach support and training, therapeutic interventions and assessments, the Hub has also implemented a range of support groups. The Humber Coast and Vale Hub's Long Covid Support Programme has been recognised as a national exemplar
- The new Care Home Liaison service in Durham recruited a variety of multi-disciplinary professionals to work closely with care home staff to prevent placement breakdown and which in turn improved outcomes for patients in these settings (e.g., removal from 'behaviours that challenge' Clinical Link Pathway (CLiP)
- In August 2021, the Trust opened a new community mental health hub at North Moor House in Northallerton. This hub houses mental health and learning disability services under one roof and provides modern outpatient facilities for local people of all ages who need to access these services. It also contains community team offices and increased consulting room space, supporting improved access to services and allowing more people to be seen as quickly as possible
- The 'Wellbeing in Mind' service, which supports young people and helps education establishments to develop a 'whole school approach' to wellbeing has received additional funding and now covers Harrogate, York and Hambleton and Richmondshire, supporting a further 27 schools and colleges to evaluate and develop their current wellbeing provision, to deliver staff training, co-facilitate student/pupil workshop and assemble and support student forums, campaigns and events to help raise awareness about the common problems young people experience and how to deal with them
- A successful partnership between Scarborough Survivors and TEWV helped Accident & Emergency workers during peak times in the winter period by providing support to people attending Scarborough General Hospital A&E department who presented with a suspected

mental health condition; helping improve communication between A&E and mental health services and strengthening the multi-agency approach to mental health care in the area

- The Trust have taken a proactive approach to national nurse recruitment issues by launching an international nurse recruitment programme overseen by a dedicated programme co-ordinator, and provides dedicated pastoral care and support with accommodation and education for those joining the Trust
- The Memory Service in Hambleton and Richmondshire has maintained its Memory Service National Accreditation Programme status for the 9th year. The team were commended for maintaining the same level of service throughout the pandemic by adapting and using virtual appointments and post-diagnostic sessions for individuals and groups, including virtual clinical environments to include families who live away from their loved ones and improving access for those who find it hard to travel
- The Care Home Wellbeing service in Durham and Darlington was set up to improve the wellbeing of care home residents and staff and to support recovery from the impacts of the Covid-19 pandemic
- We have co-created workshops to discuss our new values and how they can support new works of working together. A number of workshops have been delivered and will now be running on an ongoing basis. Evaluation data is demonstrating significant improvement in understanding of values and confidence in having conversations about them
- We have also co-created the first module of the collective leadership programme with service users and staff, which has now been piloted and rolled out
- The Trust signed the Armed Forces Covenant in March 2022; the Covenant is a pledge that together we understand that serving personnel, veterans, their families, and service leaders should be treated with fairness in respect in the communities, economy, and society they serve with their lives
- The Trust has developed two lived experience director roles for people with lived experience of mental illness, to ensure that services continue to be developed and improved by working closely with our network of patients and carers, local communities, and colleagues in other lived experience roles
- The Trust has established an Enhanced Physical Health Facilitation Team – a proactive and preventative approach to supporting physical health needs in our learning-disabled population in the Tees Valley, alongside further developments to the Specialist Health Teams enhanced capabilities in Durham
- A new role has been introduced – a STOMP (Stopping Over Medication of People with learning disabilities) lead nurse in Tees, who will work with the PCN pharmacists and GP Practices to raise knowledge and understanding and support structured medication reviews
- We introduced a new listening service in Teesside to provide a 24/7 telephone call line to support service users prior to the need to access crisis services

National Awards – Won or Shortlisted

In addition to the Trust achievements listed above, external bodies have recognised the work of individuals or teams through the award shortlisting, or award wins listed in the two tables below.

Awarding Body	Award Status	Name/Category of Award	Team/Individual
Positive Practice Mental Health Collaborative	Highly Commended	All Age Crisis and Acute Mental Health Care	Crisis & Assessment Suite: Roseberry Park
Positive Practice Mental Health Collaborative	Highly Commended	Addressing Inequalities in Mental Health	Westerdale North Inpatient Team: Sandwell Park
Patient Experience Network	Won	Transformer of Tomorrow Award	Dementia-friendly Village Project: Easington
NEPACS	Awarded	Ruth Cranfield Awards 2021	Speech & Language Therapy Team: HMP Holme House
Building Better Healthcare	Won	Best Interior Design (2020)	Foss Park Hospital
Building Better Healthcare	Highly Commended	Best Healthcare Development £10m+ (2020)	Foss Park Hospital
Healthcare Financial Management Association – Northern Branch	Won	Apprenticeship of the Year	Alex Pederson
Healthcare Financial Management Association – Northern Branch	Won	Chair's Unsung Hero Award	Andrea Reid
Bright Ideas in Mental Health	Won	Innovation Champion Award	Dr Mani Santhanakrishnan
The Dizzy's Life on the Level	Won	Best Balance Friend	Tracey Marston
Royal College of Psychiatrists (RCP)	Awarded	Enabling Environment Award	Primrose Service, HMP Low Newton

Awards where TEWV as an organisation, or one of our teams/staff members were nominated or shortlisted for an award but did not win that award during 2021/22 were:

Awarding Body	Award Status	Name/Category of Award	Team/Individual
Royal College of Psychiatrists (RCP)	Shortlisted	Care Contributor of the Year	Patient & Carer Participation Group: Tees-wide MHSOP Community Services
Royal College of Psychiatrists (RCP)	Shortlisted	Psychiatric Team of the Year: Quality Improvement	Research & Development: ECG Project
Royal College of Psychiatrists (RCP)	Shortlisted	Psychiatric Team of the Year: Older-age adults	MHSOP Inpatient Services: Lustrum Vale
Royal College of Psychiatrists (RCP)	Shortlisted	Psychiatrist of the Year	Dr Mani Santhanakrishnan
Royal College of Psychiatrists (RCP)	Shortlisted	Higher Psychiatric Trainee of the Year	Dr Sundar Gnanavel
Dynamo North East	Shortlisted	Tech for Good & People's Choice	TEWV & NENC AHSN
Health Service Journal	Shortlisted	NHS Communications Initiative of the Year	Preventing Suicide (Tees)

Awarding Body	Award Status	Name/Category of Award	Team/Individual
Bright Ideas in Mental Health	Shortlisted	Development of an Innovative Device or Technology	Anti-Psychotic Medication Monitoring
Bright Ideas in Mental Health	Shortlisted	Demonstrating an Impact upon Patient Safety and/or Quality Improvement	Remote Autism Assessments
Bright Ideas in Mental Health	Shortlisted	Helping our Workforce to recover from the Pandemic	Humber, Coast & Vale Resilience Hub
Health Technology Newspaper	Shortlisted	Health Tech Leader of the Year	Kam Sidhu

Part 2: Quality Priorities for 2021/22 and 2021/22 and required statements of assurance from the Board

2021/2022 and 2022/2023 Priorities for Improvement – How did we do and our future plans

In this first section of part 2, we look backwards at the progress we made in implementing our quality priorities during 2021/22 and the impact this had. Following this, we set out our quality improvement priorities for 2022/23.

Where we look back at 21/22, we use colours to show how much progress we made. The key for this is:

	Action completed by time of publication of this Quality Account
	Action not completed.

Our Progress on implementing our 2021/2022 Quality Improvement Priorities

Priority One: Making Care Plans more personal

Why this is important:

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

Feedback from service users shows that our current approach to Care Planning does not always promote a personalised approach, hence this being identified as a priority in 2021/22.

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

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

What we did in 2021/22:

What we said we would do	Did we achieve this?	Comment
Develop and implement a communications plan to ensure all relevant stakeholders are aware of changes to CPA processes, primarily via the introduction of DIALOG and other Cito developments		
Work with IT and other key stakeholders to ensure finalised, working version of DIALOG is embedded within CITO		Cito, the Trust's new electronic patient record interface, goes live in Autumn 2022
Develop multi-media guidance and training to support the implementation of DIALOG in a variety of clinical settings and scenarios		
Undertake a current state assessment to identify how many patients/agreed others receive a care plan, and to understand key elements of safety, quality, timeliness, and accessibility to inform a plan to address the issues identified		This wasn't needed because an existing baseline assessment gave enough information to allow the Cito plan to be developed
Produce a plan to address the issues identified in the above current state assessment		This was addressed in the design of the care planning elements into Cito
Review and revise local CPA policy in line with system changes and national guidance – especially in relation to guidance around the implementation of the Community Services Framework for Adults and Older Adults		We are still waiting for updated, clearer national guidance before reviewing and revising our CPA policy
Review and update care planning training to include a co-created and co-delivered explanation of the legal requirements set out by the Human Rights Act		This has not been progressed as we want to wait for national clarity on care planning requirements. We also need to consider the implications of the commitment given by government in December 2021 to abolish the Human Rights Act
Assess additional actions and priorities to remove barriers to care planning, including skills, clinical capacity, right staffing and mandatory training		
Work with teams and commissioners to ensure sufficient capacity is built into clinic scheduling to properly co-create and develop care plans, and that is reflected in efficiency requirements within our CCG contracts		To be completed in Quarter 1 2022/23; a one-day event will be held in May 2022 to set the principles and interim position and two workshops will then be held in June 2022 to look forward and work out how to build in sufficient capacity, and in particular look at what Cito can do to help with this

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 2021/22	Actual 2021/22	Timescale
Patients know who to contact outside of office hours in times of crisis	84%	80%	Q4 21/22
Patients were involved as much as they wanted to be in what treatments or therapies, they received	85%	85%	Q4 21/22
Patients were involved as much as they wanted to be in terms of what care they received	85%	73%	Q4 21/22

The measures for the above come from the NHS Community Mental Health Survey which is administered by the CQC. The targets we set were very aspirational targets, and the experience that our service users reported relates to their experiences in the Trust as a whole, rather than in relation to their experience of care planning alone. Evidence also suggests that service users are more likely to complete this questionnaire if they have had a negative rather than a positive experience. It is pleasing to see that we have achieved good standards of service, however involving patients as much as they want to be in the care that they received is an area that we need to improve upon.

Priority Two: Safer Care

Why this is important:

Patient Safety continues to be the key priority for the Trust, and we have already identified four Patient Safety priority areas that we will focus upon going forward:

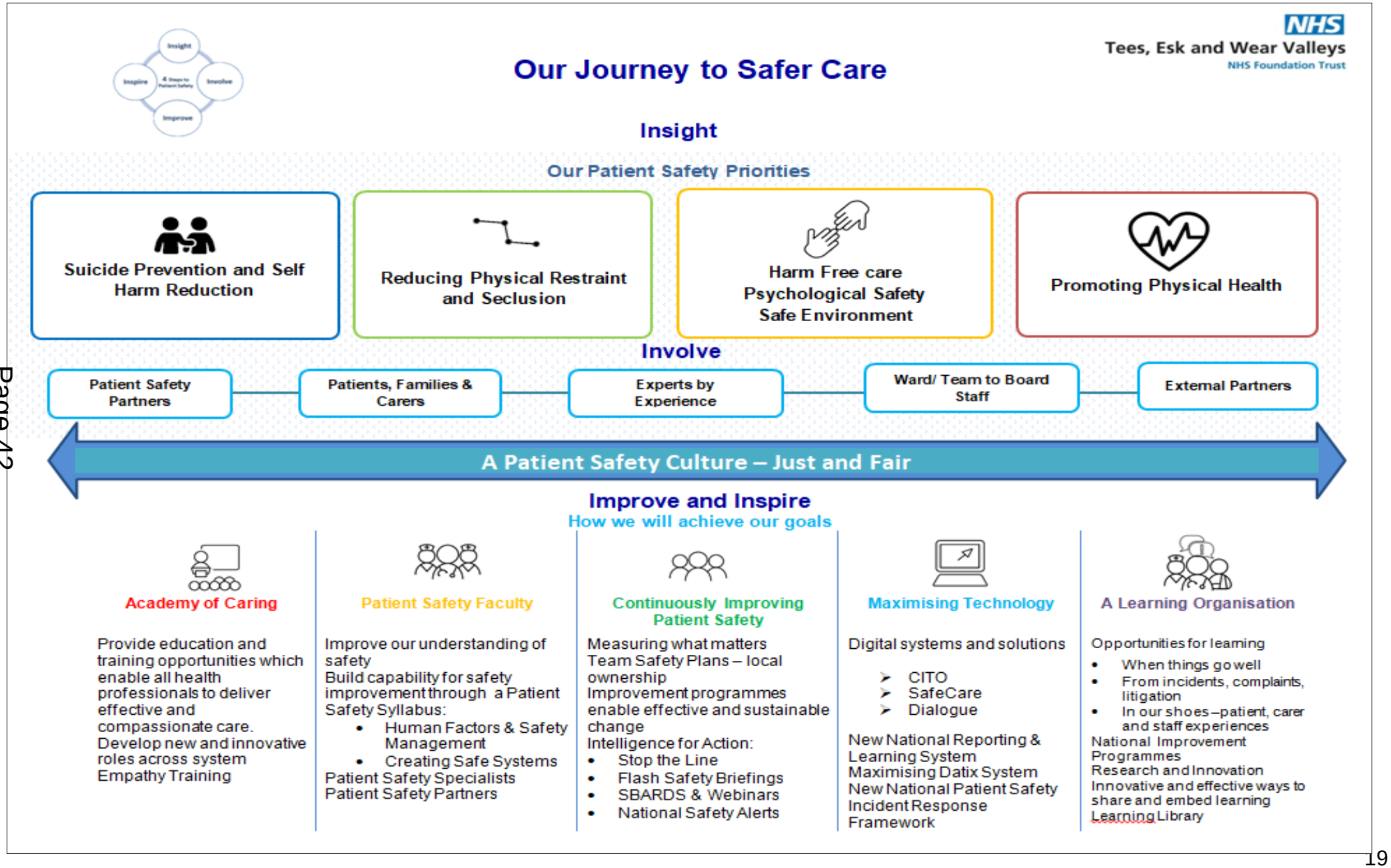
- Suicide prevention and self-harm reduction
- Reducing physical restraint and seclusion
- Promoting harm-free care, improving psychological and sexual safety (allowing staff and patients to speak out safely by fostering an open and transparent culture), providing a safe environment
- Promoting physical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

These are illustrated in ***Figure 3 - 'Our Journey to Safer Care'.*** This provides an overview of our approaches and key enablers.

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

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

Figure 3: Our Journey to Safer Care



What we did in 2021/2022:

What we said we would do	Did we achieve this?	Comment
Implement 'Our Journey to Safer Care'		
Determine the programmes of work for each of the four patient safety priorities		
Identify process and outcome KPIs for each of the four patient safety priorities		This will be completed in 22/23; will be revisited in line with programme to ensure they are correct and fit with the programme priorities
Assess current baseline for each performance indicator identified and set incremental targets for improvement throughout 2022/23		
Promote the role of the Trust's Patient Safety Specialist		
Work in collaboration with the ISC 'Better Tomorrow programme: learning from deaths, learning from lives' to improve our processes for identifying lessons learned using information to improve future care and to develop support networks in undertaking mortality reviews within a wider community of practice		
Review and update Learning from Deaths Policy		
Increase the percentage of our inpatients who feel safe on our wards:		
Work proactively within the newly formed Regional Patient Experience Network; maximise opportunities for benchmarking patient experience data		
Use existing data to identify priority wards/teams and actions: collating existing Friends and Family Test (FFT) and other data		Robust exploration of the data and intelligence influencing the FFT scoring completed. Patient Experience Team have worked with services to implement more robust governance and setting up of Patient Experience Groups.
Develop a plan for each ward/team identified as a priority, with involvement from clinical staff, management and service users and deliver actions throughout the year		This has been rescheduled for 22/23
People with lived experience to talk to people currently on wards with highest and lowest current FFT scores		This was not possible due to Covid restrictions
Further review information from patient experience surveys and concerns raised from patients and carers through PALS contact and complaints and use this to feed into report and action plan, and deliver actions throughout the year		
Seek ideas as part of the 'mutual help' meetings that take place on the wards on what we can do to make patients feel safe - roll out across the Trust		

Review current 'ward orientation' process for patients being admitted onto our wards and incorporate into personal safety plans - roll out across the Trust (currently in Tees only)		
Continue existing pilot of body cameras to a further six wards and an additional 60 cameras		It was initially agreed to commence the body camera project in April 2020; however, delays occurred due to the pandemic. The project commenced in November 2020 with four wards. Following an initial review in April 2021, Senior Leadership Group agreed to a six-month extension of the pilot and an increase in participation to ten services across the Trust Since implementation in November 2020 staff have reported the use of cameras as a positive addition to the ward environment that improves staff safety. Patients have highlighted no concerns from the use of the cameras on wards however it is acknowledged that further co-creation and lived experience is needed to gain a greater appreciation within this sensitive area. The data currently available shows no significant impact on the use of restrictive interventions, however delays in implementation due to safety concerns or technical issues may have limited effectiveness. Further embedding and review of footage needs to be undertaken to fully evaluate the impact of the body worn cameras. Learning from other Trusts that have successfully embedded the approach has identified that it can take several years to fully embed systems and skills required to fully access the ability of this technology and achieve the benefits for patient care
Develop a business case for further roll-out of body cameras (if supported by monitoring of benefit Key Performance Indicators		See above with reference to extension of pilot project
Strengthen organisational learning, including learning from deaths:		
Implement an Organisational Learning Group (OLG)		Relatives/carers were invited to join this group to talk about their experiences and discuss how

		we could embed learning Trust-wide
Deliver the four organisational learning work programmes that aim to strengthen and embed robust systems for the identification and sharing of learning (infrastructure and governance, systems for communication of immediate patient safety concerns, development and launch of a Learning Library and share learning from West Lane Hospital	*	These workstreams were implemented and have made good progress: Infrastructure & Governance: developed the terms of reference for the OLG and developed the strategic infrastructure for 1) the identification and capture of learning from patient safety events, 2) communication of learning and actions to be taken, 3) assessing the impact of actions taken as a consequence of learning Systems for communication of immediate patient safety concerns: the work has focused on the development of Safety Briefings, and these are now well-embedded in the organisation The creation of a learning library: a learning library has been developed and is hosted on the Trust Intranet site. It contains a wide range of information for staff to access from across the organisation. This includes safety briefings, learning bulletins, medication safety information, safeguarding information, and information related to the Trust's improvement work relating to patient safety and quality *This action was placed in our Quality Account in the expectation that the independent review into West Lane would report during 2021/22 but this is now anticipated to be late summer or early autumn of 2022. The Trust will of course closely study the findings and learn from them
Have in place an Integrated Organisational Learning Report with an initial focus on learning from patient safety issues		
Have in place a mechanism assessing the impact of organisational learning		

Increase the percentage of our inpatients who feel safe on our wards:		
Work proactively within the newly formed Regional Patient Experience Network; maximise opportunities for benchmarking patient experience data		The Trust are members of the newly formed Regional Patient Experience Network, sharing ideas and best practice. Work is underway to benchmark our feeling safe data with the network. This has been slightly delayed due to capacity in services
Further review information from patient experience surveys and concerns raised from patients and carers through PALS contact and complaints and use this to feed into report and action plan, and deliver actions throughout the year		All patient experience surveys have a developed action plan and is displayed on trust notice boards in the form of 'you said, we did'. Learning from Patient Experience, PALS and Complaints is captured within a learning database. Further work is needed to ensure that these are shared more robustly across the Trust

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 2021/22	Actual 2021/22
Expand the pilot use of staff body cameras to include a further five wards	Body cameras in place in a further five wards	Roll-out extended to ten sites across the Trust
Percentage of inpatients who report feeling safe on our wards	88%	64.37%
Percentage of inpatients who report that they were supported by staff to feel safe	65%	68.04%

Priority Three: Compassionate Care

Why this is important:

'Our Journey to Change' (see page **6**) describes the kind of organisation we want to be:

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

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

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

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

What we did in 2021/22:

What we said we would do	Did we achieve this?	Comment
Serious Incident reviews		
Develop the Serious Incident review process to take account of feedback from patients and families regarding a more collaborative and informed approach		This will be further developed and embedded during 2022/23
Undertake an evaluation of the new process		As above
Refresh current improvement plan related to responses to complaints		
Embed the new Trust Values and Behaviours within the Trust:		
Hold engagement events with staff at all levels to develop our new ways of working together, with involvement of service users and carers		Engagement sessions with staff began in May 2022; there is consideration of making these sessions mandatory for new staff
Share outputs of initial engagement events so all staff, service users and carers can access tools and resources which help to describe our new ways of working		We are developing a section on the Trust intranet to share tools and resources; however, this is still work in progress. It is anticipated that this will be completed during Q1 2022/23
Further roll-out of engagement events, to be attended by all staff		These are ongoing and are being led by the Trust Organisational Development Team
Work with staff, service users and carers to identify work which has already been developed which supports the new values.		The Trust Organisational Development Team run a service user leadership course annually; 'Our Journey to Change' will play a prominent role in the content. Specific training has also been undertaken with service users who attend our Programme Boards – these were very well received
Agree how we will learn from and build on this work		As above
All teams to co-create their ways of working and development plans		This now sits under People and Culture – there is an ongoing project to roll out a new digital solution called 'Workpal' which will help align personal objectives, team, service, and organisational level goals – this will be implemented by Q2 2022/23
Roll out empathy and compassion training across locality and corporate services		
Establish a baseline of those requiring training		A programme of training has been delivered throughout 2021/22 to staff

		within the localities and corporate services
Undertake a formal evaluation of training		

How do we know we have made a difference?

Indicator:	Target 2021/22:	Actual 2021/22	Timescale:
Percentage of patients reporting that they felt treated with dignity and respect	94%	87.98%	Q4 2021/22
Percentage of patients who were involved as much as they wanted to be in the planning of their care	70%	75.53%	Q4 2021/22
Percentage of patients who report being listened to and heard by staff	76%	79.64%	Q4 2021/22
Reduction in the number of complaints that request a further local resolution	18%	9% (27 out of 293 complaints)	Q4 2021/22

Quality Improvement Priorities for 22/23

Developing the Priorities

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

TEWV did not hold our traditional quality account stakeholder workshops in 2021/22. This was partly due to the risks associated with Covid infection which meant that large public face-to-face events could not take place. However, it also reflected our belief that:

- We have improved day to day, continuous engagement with service users, carers and stakeholders and should use what we learn from this to inform our Quality Account, rather than hold special one-off events
- The extensive engagement undertaken (mostly online) during the creation of Our Journey to Change has given a strong sense of where TEWV needs to improve, and the large number of participants (e.g., over 300 service users and carers) gives this feedback and data particular weight in considering priorities

Priority One: Care Planning

Information on why this is important and the benefits/outcomes that we aim to deliver for our patients and their carers can be found earlier in this document on page 16

What we will do	When we will complete it by

• Establish working groups linked to outputs from the Care Planning event in March 2022, all of which link to Cito implementation
  • Care planning patient and carer information: review existing patient and carer information that refers to/is about care planning
  • Care planning training and guidance: develop and approve package around goal setting and solution-focused approaches
  • Care planning monitoring and embedding: agree metrics around care planning – to link into caseload management work
  • Care planning in Secure Inpatient Services: to agree piloting of the use of DIALOG and DIALOG+ as a replacement for 'my shared pathway'
  • The CPA wind-down: review everything that refers to CPA and agree how to change language and processes in line with community transformation and iThrive
• Establish Care Planning Steering Group to report into Quality and Safe and Clinical Journey Boards
• Develop goal setting training and resources to complement move to DIALOG
• Introduce DIALOG and DIALOG+ to all inpatient services to further embed individualised goal-based plans
	All Quarter 1 2022/23

• Develop, approve, and publish new patient and carer information in line with new approaches to care planning • Deliver training on goal setting and solution-focused approaches that will further strengthen and support Cito training and guidance • Gather data for baseline position using agreed metrics that will be transferable to Cito • Test use of DIALOG and DIALOG+ in agreed wards within SIS • Develop new policies and procedures in relation to CPA winding down • Continue with inpatient work around understanding, implementation and embedding of DIALOG and DIALOG+	All Quarter 2 2022/23
• Go live of Cito: it is envisaged that much of Quarter 3 will be the supporting of staff in the use of DIALOG, DIALOG+ and individualised care planning elements of Cito (including training and guidance refining and development) • Publish new policies and procedures in relation to care planning and new ways of working (linked to Community Mental Health Framework) • Embed processes for gathering key care planning metrics • Review SIS testing of DIALOG and DIALOG+ and agree next steps/roll out	/ All Quarter 3 2022/23
• Continue with Cito support • Next steps/roll out of DIALOG and DIALOG+ in SIS • Continue measurement of metrics	Quarter 4 2022/23

How will we know we are making things better?

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

Indicator	Actual 2021/22	Target for end 22/23
Patients know who to contact outside of office hours in times of crisis	80%	90%
Patients were involved as much as they wanted to be in what treatments or therapies they received	85%	95%
Patients were involved as much as they wanted to be in terms of what care they received	73%	83%

Priority Two: Feeling Safe

Information on why this is important and the benefits/outcomes that we aim to deliver for our patients and their carers can be found earlier in this document on page 18

What we will do
In 2022/23 we will: • Review the information we have available from patient surveys, incidents, and complaints from adult inpatient services to identify any new emerging themes that may help inform our programme of improvement work in this area • Increase the visibility of staff within adult inpatient areas • Focus on reducing patient-on-patient violence through exploring further use of Information Technology solutions • Continue to implement the Safe Wards initiative (an evidence-based tool to reduce violence and support a safe ward environment)

How will we know we are making things better?

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

Indicator	Actual 2021/22	Target for end 22/23
Percentage of inpatients who report feeling safe on our wards	64.37%	88%
Percentage of inpatients who report that they were supported by staff to feel safe	68.04%	75%

Priority Three: Implementation of the new Patient Safety Incident Reporting Framework

We have made excellent progress on this work over the past few months; following the event that was held in July 2021, in relation to reviewing the current reporting and learning processes from the perspective of patients, carers and families, our

staff and our external colleagues. We have used this information to design the way that we work, and this has been in collaboration with service colleagues and families. Our new processes set out how we will respond to patient safety incidents reported by staff and patients, their families, and carers as part of the work to continually improve the quality and safety of the care provided. The plan sets out the ways the Trust intends to respond to patient safety incidents to learn and improve through Patient Safety Incident Investigations and Patient Safety Reviews. The new processes are in line with the requirements of the new National Patient Safety Incident Reporting Framework that will go live in 2022.

What we will do
In 2022/23 we will implement the revised systems and processes as below: • Roll out the two-part incident approval process across all areas of the Trust. This involves operational staff taking responsibility for reviewing and approving incidents that have occurred within their service before submitting centrally • A triage process for incidents that have been categorised as moderate and serious harm to quickly determine the appropriate route for review • Develop the daily patient safety huddle to include service staff and subject matter experts to ensure we can effectively review reported incidents in a timely way and where rapid reviews can be undertaken where appropriate that lead to immediate actions and improve safety • A Serious Incident Review process that is robust and utilises evidence-based tools and that involve families to the level of their satisfaction • Provide updates for staff on the duty of candour to ensure all have a full understanding • Improve the quality and oversight of action plans • Refresh the Terms of Reference for the Director Assurance Panels

How will we know we are making things better?

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

Indicator	Actual 2021/22	Target for end 22/23
To be confirmed		

Monitoring Progress

The Trust will monitor its progress in implementing these priorities at the end of each quarter and will report to our Quality Assurance Committee, our Council of Governors and, on request to Overview and Scrutiny Committees.

Conclusion and links to the next section of this document

Pages 16 to 28 have explained:

- The progress made in implementing our 2021/22 Quality Improvement priorities and the impact this has had
- Our quality improvement plans for 2022/23

The rest of Part 2 of this Quality Account document summarises a number of data sources which together paint a picture of the quality of services in our Trust. We have followed the national Quality Account guidance in the selection of this material and have included the mandatory text where required.

TEWV's 2021 Community Mental Health Survey Results

- There were 311 completed surveys returned within the Trust, a response rate of 26%. This is the same as the national response rate, and compares with a rate of 28% in 2020

The following table shows how the Trust performed for each section of the Survey in comparison to the national average (all scores are out of 10)

Section	Trust Score	Comparison
Section 1: Health and Social Care Workers	7.3	About the same
Section 2: Organising Care	8.6	
Section 3: Planning Care	6.7	
Section 4: Reviewing Care	7.6	
Section 5: Crisis Care	7.1	
Section 6: Medicines	7.4	
Section 7: NHS Talking Therapies	7.6	
Section 8: Support and Wellbeing	4.8	
Section 9: Feedback	2.3	
Section 10: Overall views of care and services	7.1	
Section 11: Overall experience	7.1	
Section 12: Care during the Covid-19 pandemic	6.6	

The Trust did not score significantly better or worse than comparable Trusts for any of the individual questions or sections as a whole; however, the Trust did score somewhat better than expected on *Q12: Do you know how to contact this person [person in charge of their care] if you have a concern about your care?*

The Trust's top five scores against the national average were for the following questions:

- Q19: Would you know who to contact out of office hours within the NHS if you had a crisis? This should be a person or team within NHS mental health services
- Q17: In the last 12 months, have you had a specific meeting with someone from NHS mental health services to discuss how your care is working?
- Q23: Have the possible side effects of your medicines ever been discussed with you?
- Q32: In the last 12 months, did NHS mental health services support you with your physical health needs (this might be an injury, a disability, or a condition such as diabetes, epilepsy, etc?
- Q10: Have you been told who is in charge of organising your care and services? (This person can be anyone providing your care, and may be called a 'care coordinator' or 'lead professional')

The Trust's bottom five scores against the national average were for the following questions:

- Q34: In the last 12 months, did NHS mental health services give you any help or advice with finding support for finding or keeping work (paid or voluntary)?
- Q20: Thinking about the last time you tried to contact this person or team, did you get the help you needed?
- Q35: Have NHS mental health services involved a member of your family or someone else close to you as much as you would like?
- Q3: In the last 12 months, do you feel you have seen NHS mental health services often enough for your needs? (This includes contact in person, via video call and telephone)
- Q33: In the last 12 months, did NHS mental health services give you any help or advice with finding support for financial advice or benefits?

The following questions demonstrate where there was a statistically significant change in the Trust's results between 2020 and 2021:

- Q33: In the last 12 months, did NHS mental health services give you any help or advice with finding support for financial advice or benefits? ↓
- Q3: In the last 12 months, do you feel you have seen NHS mental health services often enough for your needs? ↓

The areas where service user experience is best are:

- ✓ Crisis care contact: service users knowing who to contact out of hours in the NHS if they have a crisis
- ✓ Review of care: service users meeting with NHS mental health services to discuss how their care is working
- ✓ Side effects: possible side effects of medicines being discussed with service users
- ✓ Support with physical health needs: service users being given support with their physical health needs
- ✓ Who organises care: service users being told who is in charge of organising their care and services

The areas where service user experience could improve are:

- × Support with work: service users being given help or advice with finding support for finding support for finding or keeping work
- × Crisis care help: service users getting the help needed when they last contacted the crisis team
- × Friends/Family involvement: service user's family/someone close to them is involved in their care as much as they like
- × Seen often enough: service users being seen by NHS mental health services often enough for their needs
- × Support with financial advice: service users being given help or advice with finding support for financial advice

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

https://nhssurveys.org/all-files/05-community-mental-health/05-benchmarks-reports/2021/

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

- Circulate the National Community Mental Health Survey report and findings across the Trust for discussion at local governance groups and add this report to the agendas for discussion at patient and service user involvement groups
- Develop a further action plan with particular emphasis on the availability of services, people being involved as much as they wanted to be, the help provided by crisis teams and help finding support for finding or keeping work

TEWV's 2021 National NHS Staff Survey Results

The National NHS Staff Survey is commissioned by the Picker Institute on behalf of TEWV and 24 other Mental Health and Learning Disabilities Trusts. All Trust staff were invited to participate, and returned 3,747 completed questionnaires, which is a response rate of 50%, compared to a median response rate of 52%. This is a significant increase on the response rate in 2020 (38%). TEWV were ranked 20 out of 24 compared to 11 out of 27 back in 2020

The 2021 annual NHS staff survey results for TEWV show that the Trust's overall results are around average to a little below average for mental health providers.

The questions for the 2021 survey onwards are aligned to the NHS People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements.

The following table shows how the Trust performed on each of the seven aspects of the People Promise, compared to the highest, lowest, and mean scores from similar Trusts. The domains of staff engagement and morale were also measured and have also been included here

Section	TEWV	Mean	Highest	Lowest
We are compassionate and inclusive	7.4	7.5	7.9	7.1
We are recognised and rewarded	6.2	6.3	6.8	5.9
We each have a voice that counts	6.9	7.0	7.4	6.4
We are safe and healthy	6.2	6.2	6.6	5.8
We are always learning	5.4	5.6	6.1	4.8
We work flexibly	6.3	6.7	7.1	6.1
We are a team	6.9	7.1	7.4	6.6
Staff engagement	6.8	7.0	7.4	6.5
Morale	5.9	6.0	6.5	5.5

The most improved results compared to 2020 are shown in the following table. They mostly relate to values and behaviours and suggest that work over the last couple of years to encourage positive leadership and management behaviours, and to put effective processes in place to encourage and investigate concerns raised by staff who 'speak up' is starting to have a positive impact

Question	2021	2020
Q13d: Last experience of physical violence reported	92%	87%
Q11e: Not felt pressure from manager to come to work when not feeling well enough	82%	78%
Q14c: Not experienced harassment, bullying or abuse from other colleagues	86%	84%
Q14b: Not experienced harassment, bullying or abuse from managers	92%	90%
Q14d: Last experience of harassment/bullying/abuse reported	59%	57%

The scores that declined the most between 2020 and 2021 are shown below. The impact of increased demand for mental health services and workforce availability linked to Covid can clearly be seen.

Question	2021	2020
Q3i: Enough staff at organisation to do my job properly	28%	42%
Q21c: Would recommend organisation as place to work	52%	66%
Q21d: If friend/relative needed treatment would be happy with standard of care provided by organisation	54%	65%
Q4b: Satisfied with extent organisation values my work	43%	53%
Q11d: In last three months, have not come to work when not feeling well enough to perform duties	45%	55%

Areas where the Trust scored low compared to national average:

- Support from immediate manager
- Would recommend Trust as a place to work or receive care
- Making adequate adjustments
- There is a significant piece of work to do looking at improving appraisals and linking them to feeling valued and improve how we undertake our roles

Areas where the Trust scored better than the national average:

- Career development
- Not working additional hours
- Experiencing musculoskeletal problems as a result of work

Review of Services

During 2021/22 the Trust provided and/or subcontracted **20** relevant health services. The Trust has reviewed all the data available to them on the quality of care in **20** of these relevant health services.

The income generated by the relevant health services reviewed in 2021/22 represents **100%** of the total income generated from the provision of relevant health services by the Trust for 2021/22.

Participation in clinical audits and national confidential inquiries

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

During 2021/22, **seven** national clinical audits and **three** national confidential inquiries covered the health services that TEWV provides.

During 2021/22, TEWV participated in **100% (seven out of seven)** of the national clinical audits and **100% (three out of three)** 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 2021/22 were as follows:

- Prescribing Observatory for Mental Health (POMH):
  - POMH Topic 10b: Prescribing for depression in adult mental health services
  - POMH Topic 14c: Prescribing for substance misuse: alcohol detoxification
- National Clinical Audit of Psychosis (NCAP)
  - Spotlight re-audit in EIP Services
  - AMH Community Services
- National Audit of Inpatient Falls (NAIF)
- Facilities Audit
- National Audit of Care at the End of Life (NACEL)
- National Audit of Dementia (NAD)
- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD):
- Physical Healthcare in Mental Health Hospitals
- Transition from Child to Adult Services Study

The national clinical audits and national confidential inquiries that TEWV was **participated in** during 2021/22 were as follows:

- Prescribing Observatory for Mental Health (POMH):
  - POMH Topic 10b: Prescribing for depression in adult mental health services
  - POMH Topic 14c: Prescribing for substance misuse: alcohol detoxification
- National Clinical Audit of Psychosis (NCAP)
  - Spotlight re-audit in EIP Services
  - AMH Community Services
- National Audit of Inpatient Falls (NAIF)
- Facilities Audit
- National Audit of Care at the End of Life (NACEL)
- National Audit of Dementia (NAD)
- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD):
- Physical Healthcare in Mental Health Hospitals
- Transition from Child to Adult Services Study

The national clinical audits and national confidential inquiries that TEWV participated in, **and for which data collection was completed during 2021/22** are listed below alongside the number of cases submitted to each audit or inquiry as a percentage of the number of registered cases required by the terms of the national audit or inquiry.

Audit Title	**Cases Submitted**	**% Of number of registered cases required**
POMH Topic 19b: Prescribing for depression in adult mental health services	Sample provided: 89	100%
POMH Topic 14c: Prescribing for substance misuse: alcohol detoxification	Sample provided: 11	100%
National Clinical Audit of Psychosis (NCAP): Spotlight re-audit in EIP	Sample provided: 510	100%
National Clinical Audit of Psychosis (NCAP): AMH Community	Sample provided: 100	100%
National Audit of Inpatient Falls (NAIF): Facilities Audit*	Not applicable – organisational questionnaire only	Not applicable
National Audit of Care at the End of Life (NACEL)*	Sample provided: 9	100%
National Audit of Dementia (NAD): Spotlight audit of Community-Based Memory Services*	Sample provided: 512	100%
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)	27 questionnaires sent to the Trust; 22 returned	81%
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) – Physical Healthcare in Mental Health Hospitals*	27 clinician questionnaires sent; 10 submitted questionnaires	37%
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) – Transition from Child to Adult Services Study	Not applicable – organisational questionnaire only	Not applicable

** The Trust was eligible to also participate in organisational/hospital level questionnaires for these national clinical audits/confidential inquiries. These were completed in all cases*

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

The reports of **106** local clinical audits were reviewed by the Trust in 2021/22 and TEWV intends to take actions to improve the quality of healthcare provided. **Appendix 3** includes the actions the Trust is planning to take against the **five** key themes from these local clinical audits reviewed in 2021/22

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 **72** clinical audits in 2021/22 which include clinical effectiveness projects undertaken by Trainee Doctors, Consultants, or other Directorate/Specialty Groups. These clinical audits were led by the services and individual members of staff for reasons of service improvement and professional development and were reviewed by specialities. Over the next year the Trust intends to use clinical audit applications to make clinical audits more efficient and to make it easier for teams to review their clinical quality information in a live format and to make any changes needed to improve practice and ultimately the quality of care and experience of our patients and their families.

The Trust implemented an extensive Quality Assurance Programme during 2021/22. This programme has delivered ongoing assurance for key quality and risk issues identified within the Trust. Significant improvements in practice and patient safety have been facilitated through this programme.

Participation in Clinical Research

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

The number of patients receiving relevant health service provided or sub-contracted by TEWV in 2021/2022 that were recruited during that period to participate in research approved by a Research Ethics Committee was **806**. Of the 806 participants, 768 were recruited to 27 National Institute for Health Research (NIHR) portfolio studies. This compares with 826 patients involved as participants in NIHR research studies during 2020/21.

During 2021/2022, the Trust has continued to focus on successful continuation and delivery of the BASIL+ study. The Basil C19 study examines the use of behavioural activation in older adults with low mood or loneliness and long-term health conditions during Covid-19. Sponsored by TEWV, 435 participants were recruited across 12 sites in the UK, with TEWV recruiting 60 participants to the trial.

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

- We continue to work closely with the NIHR Clinical Research Network North Est and North Cumbria to support large scale national portfolio research studies, and to measure patient research experience when taking part in studies with feedback and any actions reported to our Research Governance Group.
- We were involved in conducting **66** clinical research studies in mental health, dementias and neurodegeneration, health services research and infection, during 2021/22; 49 of these studies were supported by the NIHR through its networks

- **45** members of our clinical staff participated as researchers in studies approved by a Research Ethics Committee, with **31** of these in the role of Principal Investigator for NIHR supported studies
- **371** members of our staff were also recruited as participants to NIHR portfolio studies
- We continue to collaborate with a wide range of universities and other NHS providers to deliver large multi-site research studies for the benefit of our service users, carers, and staff, through these collaborations, we have been awarded a further two NIHR Research for Patient Benefit grants during this year.

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

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

What the Care Quality Commission (CQC) says about us

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

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

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

Between 14th June 2021 and 5th August 2021, the Trust received a series of unannounced core service inspections from the CQC. This included inspection of Secure Inpatient Services, Adult Mental Health Crisis Services and Health-Based Places of Safety, Adult Mental Health Community Services and Community Child and Adolescent Mental Health Services. Core service inspections were also followed by a well-led inspection of the Trust.

Following the inspection, the CQC raised several areas for improvement with a Section 29A notification received for Secure Inpatient and Community Child and Adolescent Mental Health Services.

Inspections of the Secure Inpatient Services observed some issues with staffing levels, safeguarding processes and governance arrangements. Inspections of the Community Child and Adolescent Mental Health Services observed some issues with staffing, the size of caseloads and systems and processes for monitoring patients

Immediate action was taken in response to these concerns and a comprehensive action plan was developed to ensure these areas of risk were being adequately addressed. Implementation has been well progressed with robust weekly reporting and oversight through the Trust's Quality Improvement Board. The deadline for implementation was 1st March 2022. It is however recognised by the CQC that fully embedding some of these actions and the impact will require longer timescales. Further plans are in place to ensure that improvements are sustained, and that service delivery continues to be safe and effective.

Section 29A issues were subsequently encompassed by the CQC with the 'Must Do' regulatory actions included within the Trust CQC inspection report issued on 10th December 2021. The Trust was rated as 'Requires Improvement'

The follow-up CQC inspection of the Adult Mental Health Inpatient Services in June 2021 noted significant improvements in risk assessment and management processes and subsequently re-rated the service as 'Requires Improvement'

In addition to clearly evidencing delivery of the required actions, the Trust continues to implement a wider programme of change and improvement. During 2021, this has included restructuring how services are delivered, strengthening governance arrangements, increasing leadership capacity and oversight, improving staffing establishments and improving mandatory training, expertise, clinical supervision, and sustainable support to our clinical teams. Work has also been achieved to enhance and embed organisational learning from a range of internal and external sources. This has included reviewing, strengthening, and developing mechanisms for capturing and communicating learning and importantly gaining assurance of the impact of our actions to improve care for service users and their families. This work continues to support the Trust in nurturing a culture of patient safety and continuous quality improvement.

Since the inspections, we have sustained a quality assurance schedule that includes a review of the quality of care documentation. This has provided ongoing assurance that patient's risks are assessed and that they have care, safety and observation plans in line with their needs.

A 'Quality Improvement Board' chaired by the Chief Executive with executive team attendance with responsibility for ward/team to board reporting on implementation has been sustained to oversee quality assurance standards including regular audit and direct observation on wards and to provide assurance to the Trust Board that appropriate actions are being taken to address improvements in patient safety.

Improvement Plan

A Regional Quality Board was established where TEWV reports on progress to other partners such as NHS England and the Integrated Care Systems as well as the CQC. The Trust is also accessing expert external support for rapid improvement and embedding actions.

In addition to the attainment of all recommendations and conditions related to the Section 29A warning notice issued by the CQC in March 2021, an umbrella improvement plan is being implemented with overarching workstreams including:

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

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

The Trust has retained an overall rating of 'Requires Improvement' with a number of actions being taken to improve the quality and safety of our services.

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

Information Governance

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

Due to the ongoing Covid-19 pandemic, NHS Digital has delayed submission of the Data Security and Protection Toolkit 2021-22 until 30th June 2022. Of the **110** mandatory evidence items and **38** assertions, we anticipate publishing the Toolkit with all except one evidence item provided and assertions met.

Similar to many other Trusts, the Trust is currently experiencing a higher than usual sickness absence rate making the mandatory requirement to ensure at least 95% of all staff have completed their annual Data Security Awareness Training problematic.

Not achieving an evidence item would require an action plan to be submitted that identifies the actions and timescales to achieve compliance.

Due to cyber security risk, NHSE/I have advised there is no appetite to reduce the mandatory 95%

In mitigation, the Trust issues monthly cyber security eLearning to all staff; all new staff complete mandatory Data Security and Protection Training for New Starters, and we have undertaken a number of phishing simulations with the findings and learning shared Trust-wide.

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

- The Trust has in place an internal group which has the responsibility for ensuring data quality within the Trust; this was put on-hold during the COVID-19 response but is set to be reinstated as part of the Trust's revised governance structure
- Data quality is included within the Corporate Risk Register which is used by the Board of Directors to monitor the risk of incomplete and inaccurate data.

The Trust has the following policies linked to data quality:

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

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

- As part of performance reporting to the Board, real-time data is used to forecast future positions, thus improving the decision-making process. Trust dashboards are available via the Integrated Information Centre (IIC) to support and enhance decision-making
- All data returns are submitted in line with agreed timescales

Freedom to Speak Up

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

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

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

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

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

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

During 2021/22, there were **78** cases referred to the Freedom to Speak Up Guardian. Of these, **25** were submitted anonymously. **34** of the concerns related to culture of bullying, and **38** related to patient safety and **15** to staff safety. The remainder related to other issues such as culture or systems/processes. We are committed to creating an open and transparent culture where every member of staff can speak out safely. Over the next year we will continue to raise the profile of the Freedom to Speak Up Guardian and triangulate the information we have with other sources to ensure the best and safest care for our service users.

Reducing Gaps in Rotas

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

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

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

The Guardian of Safe Working for Junior Doctors within the Trust produces quarterly and annual reports to the Trust Board that focus on gaps in medical rotas and safety issues.

The Trust's Board received the Guardian's annual report for 2021/22 at its meeting of 26th May 2022. During the year, the most common reasons for needing short-term/locum cover was due to vacancies on the rotas, staff sickness (short/long term) and COVID-19 related absences (sickness or self-isolation).

Exception reports received related mostly to claiming additional hours whilst on Non-Residential On-Call, having to stay later than normal working hours or shift end time or missing teaching/training due to staff shortages. Discussions on these issues have taken place where appropriate and additional staffing put in place where possible.

Bolstering staffing in adult and older adult community mental health services

One of the consequences of the additional investment into mental health services in recent years (and the Trust's decision to invest in clinical posts to address the Covid surge in demand) has been an increase in our workforce. During 2021/22 this trend has continued and our workforce in January 2022 was 206 whole time equivalent posts higher than at the start of the financial year (although workforce size peaked in November 2021). Through Commissioners, national transformation investment and Covid surge monies, the Trust has increased staffing across all clinical services, including adult and older adult community mental health services.

Examples of service improvements enabled by additional staffing include:

- Additional Healthcare Assistants appointed to combat increased demand for physical health monitoring
- Additional staff recruited into Mental Health Support Teams to allow the full target population to be able to access support, particularly in relation to issues surround Covid/Covid lockdowns
- Allied Health Professionals (Speech and Language Therapy, Physiotherapy, Occupational Therapy) plus Pharmacist recruited into the Care Home Liaison Team in Durham
- Increased staffing across Perinatal teams in Durham, Darlington, and Tees to support further delivery of the NHS Long-Term Plan
- Increased staffing within Tees AMH Community Teams to provide additional support for service users with Autism/ADHD and also into Early Intervention in Psychosis

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

Learning from Deaths

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

In Mental Health and Learning Disability Services we have a significant number of older people who are cared for in the community and their needs are such they only require minimal contact with us. Many of these people who die do so through natural

causes as happens in the wider population. This explains the difference between the total number of deaths (from all causes including natural causes) and the numbers we go on to investigate further. To support staff in their decision making regarding the investigation of deaths, staff have clear policy guidance, setting out criteria for categories and types of review. This is currently being reviewed as part of development work in preparation for the new Patient Safety Incident Response Framework which will be implemented gradually during 2022/23 in line with national guidance.

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

It is recognised that team development and skilled staff are key to the delivery of high quality, safe care, and high functioning teams to minimise the risk of incidents occurring. Community Matrons, Practice Development Practitioners and Peer Workers appointed to support co-creation, recovery and involvement are embedding their roles which has enhanced senior clinical leadership during 2021/22.

In 2019, a family conference was held with bereaved families who had experienced the serious incident process. One of the aims of the conference was to identify how we could improve the way we engage with families. May 2021, an improvement event was held to consider how we could further improve involvement with families to facilitate a more equal partnership in the Serious Incident Investigation process. (Further information can be found in relation to our new priority for 2022/23 on pages 27 to 28). The Trust was due to hold its second annual family conference in March 2020; this was put on hold due to the COVID-19 pandemic and is regularly under review.

Any death of a person open to Trust services, which is reported through our Incident Management System, is subject to an initial review by the Central Approvals Team. During 2021/22 **2,163** TEWV patients died; this comprised the following number of deaths which occurred in each quarter of that reporting period:

- **486** in the first quarter
- **556** in the second quarter
- **638** in the third quarter
- **483** in the fourth quarter

The following were Learning Disability Deaths (reported to LeDer)

- **18** in the first quarter
- **26** in the second quarter
- **23** in the third quarter
- **19** in the fourth quarter

There were 26 inpatient deaths; 22 of these deaths related to physical health, 3 deaths were potential patient safety incidents; 1 cause of death remains unknown.

In Q1, 31 serious incidents resulting in death were reported. 23 serious incidents were reviewed. Of those 23 cases, 14 had lapses in care/service delivery

In Q2, 15 deaths were reported. 18 serious incidents were reviewed. Of those 18 cases, 11 had lapses in care/service delivery

In Q3, 23 deaths were reported. 15 serious incidents were reviewed. Of those 15 cases, 12 had lapses in care/service delivery

In Q4, 31 deaths were reported. 21 serious incidents were reviewed. Of those 21 cases, 8 had lapses in care/service delivery

By 31st March 2022, in relation to unexpected and expected physical health deaths, 430 mortality reviews, including 71 structured judgement reviews had either been carried out or requested

Recurring themes relate to:

- Risk assessment/safety summaries/safety plans
- Care Programme Approach (CPA), care plans/interventions plans/formulations
- Relative/carer involvement
- Record keeping

Detailed below are some of the structures to support and embed learning in response to what we have learned from reviews of deaths during 2021/22:

Practice Development Group (PDG)

The Practice Development Teams (PDT) overseen by the PDG are addressing the areas of learning as identified by lapses of care during 2021/22, namely safety summaries/safety plans, care planning and relative/carer involvement as detailed above. Practice Development Practitioners (PDP) have been appointed and continue to develop in their posts across inpatient wards. They are also offering training in relation to risk assessment and safety summaries Trust-wide, including to community staff.

Organisational Learning Group (OLG)

The Trust continues to strengthen its arrangements for organisational learning via the Organisational Learning Group. As part of the work undertaken by this group, urgent patient safety briefings are now circulated Trust-wide. Examples of these urgent safety messages relate to new anchor points/ligature risks identified within the Trust and how these risks are to be addressed. The briefings are specific about any assurance required from services; on receipt of completed actions these are stored

in the learning database. ‘Learning from Serious Incidents Bulletins’ are also regularly distributed across the Trust. The bulletins have shared key learning and good practice highlighted in serious incident reports presented at the Director’s assurance panel. All briefings and bulletins are stored in the learning library on the Trust’s intranet for easy access. A quality improvement event is planned for August 2022 to focus on how we can further improve the communication and impact of learning in front line services.

Patient Safety Priorities

The Journey to Safer Care as part of the Trust’s ‘Journey to Change’ highlights four key patient safety priorities:

- Suicide Prevention and Self-Harm Reduction
- Reducing Physical Restraint and Seclusion
- Harm Free Care, Psychological Safety including sexual safety and a Safe Environment
- Promoting Physical Health

The Service Development Managers (SDMs) who are members of the Patient Safety Campaign steering group have been tasked to map out work that is taking place across services in relation to these priorities. This will be used to inform the work plan for the Quality and Safety Programme Board.

Suicide Prevention and Harm Minimisation

A period of engagement has been carried out with staff, service users, carers/relatives, and partners to help shape the Trust’s draft Preventing Suicide Strategy, Leadership for suicide prevention is through the Clinical Strategy Lead supported by a multi-disciplinary Preventing Suicide and Self-Harm Reduction Group which will monitor progress against the strategy’s action plan. All actions will be aligned to our ‘Our Journey to Change’

In support of the above strategy, the preventing suicide project leads continue to work closely with the Patient Safety Team and our partners by:

- Sharing information from the early alerts system in areas where this is available. This applies to suspected suicides (not just people open to the Trust) to facilitate shared learning with partners
- Attending and working with partners in all localities where there have been multiple suicides in a particular area or site (not just people open to the Trust)
- Targeted work with rail network, to work closer together with shared protocols for preventing suicides
- Providing direct support and guidance to teams on completing Rapid Reviews, reflecting on lessons learnt and how the project workers can support clinical services
- Identifying emerging themes within their locality then engaging with those services directly to share the learning and provide guidance and support on best practice

The Trust is participating in the National Collaborative Work on reducing restrictive practices

Harm-Free Care – Safe Environment

The Environmental Risk Group receives monthly incident reports involving ligatures and other risks where environmental factors may have contributed to harm as well as progression of initiatives to reduce harm. Any urgent learning from this group is disseminated Trust-wide via Patient Safety Briefings or SBARDS. As part of the ligature reduction programme, in inpatient areas, ensuite doors and main bedroom doors are currently being replaced. Main bedroom doors are being replaced with sensor doors in designated wards. The roll-out of Oxehealth continues to support patient safety through enhanced observation. An early learning report has been undertaken and will go through various governance routes over the next month to highlight progress and areas for further development. Environmental surveys with input from estates, health and safety and clinical services have been recommenced. Completion of these has been impacted by Covid.

Promoting Physical Health

Work continues in relation to improving the physical health of people with mental health problems, in keeping with ICS priorities when learning from deaths. This includes weight management, care of the deteriorating patient, reducing alcohol and drug use, reducing falls.

Safeguarding

Despite improvement work already undertaken to embed the principles of ‘think family’ and the use of the PAMIC tool, it continued to be a finding in serious incident investigations. It was agreed that the issue is above the qualitative aspect of how parental mental health impacts on children and that this should be considered as part of a comprehensive risk assessment under the category of risk to others. Having this as a narrative in the risk assessment has enabled fuller information to be shared/documented about what has been considered from a ‘think family’ perspective. Outcomes of this improvement work will be triangulated with evidence from the Central Approvals Team, Patient Safety Team, and the Safeguarding Team to determine the impact of changes made on patient safety. Links between the Patient Safety Team and the Safeguarding Team continue to be strengthened with joint working on serious incident cases and in the Patient Safety Team huddle.

Serious Incident Investigation Process

A quality improvement event ‘Improving the Experience of Patients, Families and Staff during Serious Untoward Incident Reviews (SIRs)’ commissioned by the Director of Quality Governance, built on existing work already being carried out to improve the SI investigation process. A further event was held in February 2022 where four additional workstreams relating to the SI process and incident reporting were identified. A Project Manager is in place to drive delivery of this improvement work as well as the wider standards in keeping with ‘Our Journey to Change’, and event has been planned for the 20th of May 2022 to facilitate full engagement with all

relevant stakeholders. Improvement work has continued to identify early learning/themes from rapid reviews ensuring that clinical services embed early actions into practice. This work has been supported by Serious Incident Reviewers and the Preventing Suicide project leads. A more proactive approach to learning from deaths has been taken by facilitating closer working relationships between clinical services and the Patient Safety Team. In some cases, clinicians, and where required subject matter advisors, are invited into the Patient Safety Team huddle to discuss early learning and immediate actions required. Reviewers are now working with clinicians in areas such as perinatal services, suicide prevention, physical health and health and safety to share Trust-wide learning at these groups. This is promoting a more 'wrap-around' approach to learning between corporate and organisational services. All newly appointed Serious Incident Reviewers are attending serious incident investigation training which is being provided by the Healthcare Safety Investigation Branch (HSIB)

Better Tomorrow Programme

The Trust is working with the Better Tomorrow Programme to review current Mortality Review Systems and processes to help identify and support with potential areas of development. This work was put on hold due to the pandemic but has recently recommenced.

Training

'Connecting for people' suicide awareness training continues with plans for further Trust staff to be trained as trainers during 2022. The Trust's mandatory harm minimisation training continues to include updated headlines from serious incidents in relation to learning from deaths. As part of the improvement work around the serious incident process and learning from deaths, several training needs for staff Trust-wide have been identified. These include incident reporting, holding difficult conversations with bereaved relatives, duty of candour/culture of candour, report writing and writing smart action plans. These have been fed into the Trust-wide training needs analysis event. The Trust will be participating in patient safety training released as part of the National Patient Safety Strategy

Clinical Strategy

Learning from deaths during 2021/22 highlighted that patients with dual diagnoses were often not followed-up proactively by mental health services. This workstream will be picked up in the clinical strategy.

Patient Safety Specialist

The Trust's Patient Safety Specialist continues to attend the Patient Safety Specialist Improvement Programme Webinars, arranged by the National Patient Safety Team. These interactive forums connect over 700 Specialists from around the country. There is also the opportunity to discuss any issues relating to patient safety including learning from deaths on the Patient Safety Specialist's workspace both from a national and regional perspective.

The definitions used by the Trust are as follows:

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

PALS and Complaints

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

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

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

During 2021/22 PALS dealt with **2,279** concerns or issues from patients and carers, an increase of **152** when compared to 2020/21. **1,123 (49%)** of the concerns raised were around AMH services across the Trust.

1,800 of the PALS concerns (**79%**) were closed within 15 working days (although no formal target is set for this). Non-compliance was largely as a result of the Covid-19 pandemic where it has not always been possible to obtain timely feedback from operational services.

301 formal complaints were received and registered during 2021/22 compared to 265 for the same period last year.

Complaints across services: **196** in AMH services, **58** in CYPS, **17** in MHSOP, **22** in Secure Inpatient Services, **0** in Health and Justice, **2** in ALD services and **6** in Corporate Services.

The most common cause for complaints across the Trust related to aspects of clinical care (216 or 71.76%) followed by communication (36) and attitude (26). Complaints have also been received relating to discharge arrangements (8), environment (6), waiting times (4), medical records (2), Hotel Service (1) and Bereavement (1).

249 responses were sent out during 2021/22, **49** (**20%**) were within timescales (60 working days). Non-compliance was in respect of the complexity of the complaints being received and the Covid-19 pandemic. The number of complaints received and closed are published on the Trust's website.

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

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

Part 3: Further information on how we have performed in 2021/22

Introduction to Part 3

Part 3 of this document contains further information which the legal guidance requires us to include. This includes statutory statements. As with Part 2, this helps to develop an overall picture of quality at the Trust.

Mandatory Quality Indicators

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

Care Programme Approach 72-hour follow-up

327 people were not followed up within 72 hours during 2021/22. Given the unprecedented times, it has not been possible to gather the level of intelligence in terms of this area of underperformance that would normally be included within the report, as all efforts have been diverted to manage the Covid-19 situation and the need to ensure that the Trust's focus remains on this clinical priority

Crisis Resolution Home Treatment team acted as gatekeeper

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

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

The figures we have included are from the CQC website

An overall Trust score is not provided, due to the nature of the survey, therefore it is not possible to compare trusts overall. For 2021, 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 2021	***National benchmarks in 2021***	***TEWV Actual 2020***	***TEWV Actual 2019***	***TEWV Actual 2018***
Overall section score: 7.3 (Sample size 282)	*Highest/Best MH Trust: 7.7* *Lowest/Worst MH Trust: 6.0*	Overall section score: 7.34 (Sample size 340)	Overall section score: 7.3 (Sample size 209)	Overall section score:7.3 (Sample size 209)

For more information, please see the section on results of the NHS Community Mental Health Survey on pages 29 to 31

Patient Safety incidents including incidents resulting in severe harm or death

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

TEWV Actual Q3 21/22	***National Benchmark in Q1 & Q2 21/22***	***TEWV Actual Q1 & Q2 21/22***	***TEWV Actual Q3 20/21***
Trust reported to NRLS: 4,297 incidents reported of which 29 (0.7%) resulted in severe harm or death* *7 Severe Harm and 22 Death	*Not available*	Trust reported to NRLS: 6,215 incidents reported of which 84 (1.35%) resulted in severe harm or death* *25 Severe Harm and 59 Death	Trust reported to NRLS: 3,105 incidents reported of which 27 (0.9%) resulted in severe harm or death

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

- Although this may seem like a large number of total incidents, this is in line with expected numbers for a Trust with a caseload the size of TEWV; the absolute numbers of incidents reported is a factor of the relative size of the Trust and the complexity of their case-mix

- The Trust is reporting 56.2 as the rate of incidents (calculated by dividing the number of incidents reported by the number of occupied bed days); the national average is 75.4 (the highest reported rate was 235.8 and the lowest 21.4)
- Amongst the most common themes reported are self-harming behaviour, patient accident, disruptive/aggressive behaviour, and medication errors which account for three-quarters of all incidents leading to harm

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

- The Trust introduced incident reporting in September 2021 as a mandatory training requirement with all staff across the Trust. This has led to an increased focus on incident reporting with an increase of incidents being reported
- To support the training, additional tools have been developed to support those reporters of incidents ensuring data quality of the incidents being reported

Our performance against our quality metrics

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

Quality Metrics 21/22

Quality Metrics		2021/22		2020/21	2019/20	2018/19	2017/18
		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%	65.30%	67.54%	62.39%	61.50%	62.30%
2	Number of incidents of falls (level 3 and above) per 1000 occupied bed days (for inpatients)	0.35	0.07	0.18	0.15	0.18	0.12
3	Number of incidents of physical intervention/restraint per 1,000 occupied bed days	19.25	37.66	26.27	30.45	33.81	30.65
Clinical Effectiveness Measures							
4	Existing Percentage of patients on Care Program Approach who were followed up within 72 hours after discharge from psychiatric inpatient care	>80%	88.51%	N/A*	N/A*	N/A*	N/A*
5	Percentage of Quality Account audits of NICE guidance completed	100%	N/A**	100%	100%	100%	100%
6	Patients occupying a bed over 90 days	<61	60	N/A*	N/A*	N/A*	N/A*
Patient Experience Measures							
7	Percentage of patients who reported their overall experience as excellent or good	94%	94.34%	90.32%	91.65%	91.41%	90.50%
8	Percentage of patients that report that staff treated them with dignity and respect	94%	86.04%	84.59%	85.80%	85.70%	85.90%
9	Percentage of patients that would recommend our service to friends and family if they needed similar care or treatment	94%	87.76%	89.94%	86.70%	86.90%	87.20%

Notes on selected Metrics

1. Data for CPA 72-hour follow-up is taken from the Trust's patient systems and is aligned to the national definition
2. The percentage of Quality Account audits of NICE Guidance completed is based on the number of audits of NICE guidelines completed against the number of audits of NICE guidelines planned. Data for this metric is taken from audits undertaken by the Clinical Directorates supported by the Clinical Audit Team
3. Data for average length of stay is taken from the Trust's patient systems

Comments on areas of under-performance

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

The end of **2021/22** position was **64.37%** which relates to **402** out of **625** surveyed. This is **23.63%** below the Trust target of **88.00%.** All localities underperformed this year. Durham & Darlington was closest to the target with 67.66% and Forensic Services was furthest away with 59.31%

When brief analysis has been undertaken of why patients do not feel safe in a ward environment, the most often cited cause has been due to the behaviour of other patients. It has also been noted that due to the acuity levels of patients who are admitted, they are likely to feel unsafe due to the fact that they are acutely unwell. As there is a persistent significant gap between our target and performance on this metric, improving safer care has been identified as a Quality Improvement priority for 2022/23 (see page **27**).

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

The end of **2021/22** position was **23.02;** which relates to **1408** interventions and **61156** OBDs; this is **4.22** worse than the Trust target of **19.25**

Durham & Darlington were the only locality achieving the target with a rate of 17.7. Of the underperforming localities, Teesside had the highest number of incidents per 1000 OBD with 34.39

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

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

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

The end of **2021/22** position was **86.04%** which relates to **2997** out of **3484** surveyed. This is **7.96%** below the Trust target of **94.00%.**

All localities underperformed in 2021/22. Teesside were closest to the target with 87.98% and Forensic Services were furthest away from the target with 75.99%.

We continue to focus on this important area of patient experience; our patients tell us that treating people with dignity and respect includes staff treating people in a caring and compassionate way which will be strengthened by the work we are doing on our Trust values and empathy training for staff. It is also about involving people in

decisions around their care which will be supported by the ongoing quality priority around personalised care planning and our goal of co-creation. Having an environment that respects privacy and dignity is important and we are proud that we have eliminated all dormitory accommodation and all patient bedrooms are now single, many with ensuite facilities.

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

The end of **2021/22** position was **87.76%** which relates to **3238** out of **3690** surveyed. This is **6.24%** below the Trust target of **94.00%.**

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

All localities underperformed in 2021/22. **Teesside** were closest to the target with **89.59%** and **Forensic Services** were furthest away from the target with **79.86%.**

Quality Metrics for 2022-23

The current set of quality metrics have been in place for several years, but changes in the national and local quality agendas now require a revised set of metrics to be monitored.

Work is underway to review the suite of metrics to align them more closely with our new quality journey and our improvement priorities.

Some of the current metrics will remain the same; however, we will analyse our data in a more sophisticated way, so that it can be identified where things are really improving or getting worse

Our Performance against the System Oversight Framework Targets and Indicators

A new System Oversight Framework (SOF) was released in June 2021, setting out NHS England and NHS Improvement's approach to the oversight of Integrated Care Systems, CCGs, and Trusts, with a focus on system-led delivery of care.

Indicators	2021/22	
	Threshold	Actual
Total access to IAPT Services: Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy	N/A	28295
IAPT: The proportion of people who are moving to recovery	50%	52.22%
3.A1: The proportion of people who wait 6 weeks or less from referral to accessing IAPT against the number of people who finish a course of treatment in the reporting period	75%	99.04%
3.A2: The proportion of people who wait 18 weeks or less from referral to accessing IAPT against the number of people who finish a course of treatment in the reporting period	95%	99.92%
3.B1: The proportion of people who wait six weeks or less from referral to their first IAPT treatment appointment against the number of people who enter treatment in the reporting period	N/A (supporting measure)	99.01%
3.B2: The proportion of people who wait 18 weeks or less from referral to their first IAPT treatment appointment against the number of people who enter treatment in the reporting period	N/A (supporting measure)	99.90%
3.C1: Number of ended referrals in the reporting period who received a course of treatment against the number of ended referrals in the reporting period who received a single treatment appointment	N/A (supporting measure)	1.80
3.C2: IAPT: Average number of treatment sessions	N/A (supporting measure)	7.94
3.C3: IAPT: The proportion of people who waited less than 28 days from their first treatment appointment to their second treatment appointment	N/A (supporting measure)	50.49%
3.C4: IAPT: The proportion of people who waited less than 90 days from their first treatment appointment to their second treatment appointment	N/A (supporting measure)	91.52%
Percentage of people who have waited more than 90 days between first and second appointments	<10%	8.48%
Implementation of IAPT – Long-Term Condition pathways	N/A (CCG ambition)	No
Number of CYP aged under 18 supported through NHS funded mental health with at least one contact	N/A (CCG ambition)	31,796
The proportion of CYP with ED (routine cases) that wait four weeks or less from referral to start of NICE-approved treatment (rolling 12 months)	95%	53.82%
The proportion of CYP with ED (urgent cases) that wait one week or less from referral to start of NICE-approved treatment (rolling 12 months)	95%	50.91%
Number of people accessing Individual Placement Support (IPS) services as a rolling total each quarter	N/A (CCG ambition)	674
Number of people who receive two or more contacts from NHS or NHS-commissioned community mental health services for adults and older adults with severe mental illnesses	N/A (CCG ambition)	269,446
13a: Number of inappropriate OAP bed days for adults by quarter that are either 'internal' or 'external' to the sending provider	0 by Q4	701
13b: Number of inappropriate OAP bed days for adults by quarter that are 'external' to the sending provider	0 by Q4	701
Percentage of people who are admitted to hospital without having had any prior contact with community mental health services	N/A (CCG ambition)	14.79%

Indicators	2021/22	
	Threshold	Actual
Percentage of adults discharged from CCG-commissioned mental health inpatient services receive a follow-up within 72 hours	80%	90.21%
Number of women accessing specialist community Perinatal Mental Health services in the reporting period (12-month rolling)	N/A (CCG ambition)	1126
Percentage of women accessing specialist community Perinatal Mental Health services in the reporting period (12-month rolling)	N/A (CCG ambition)	5.41%
Data Quality Maturity Index	90%	98.10%

Notes on the System Oversight Framework Targets and Indicators

IAPT: The Trust does not have as many people accessing IAPT Services as is our ambition. This continues to be impacted by staff sickness and vacancies within our services, and recruitment is ongoing in all areas. The Trust level IAPT recovery is a positive position with the standard being achieved consistently.

OAP: The Trust continuing to see an increase in the number of patients that are being placed in external beds. Whilst this is a national issue due to current demand levels, the Trust remains concerned and are committed to eliminating out of area placements by Quarter 3 2022/23.

Eating Disorders: The Trust is concerned that Children and Young People with an eating disorder are not being treated in a timely manner. Whilst this is a pressure in terms of demand that is being experienced nationally, this has been greatly impacted by vacancies within our services. Recruitment continues and work has been undertaken to increase the number of appointments.

IPS: Whilst the Trust has not achieved the ambitions set nationally for each individual CCG, work has been undertaken with partners to develop a set of local trajectories for these measures as part of the 2022/23 operational planning round for mental health services. These have been submitted to NHS England and NHS Improvement for approval.

Perinatal Mental Health Services: Whilst the Trust has not achieved the ambitions set nationally for each individual CCG, work has been undertaken with partners to develop a set of local trajectories for these measures as part of the 2022/23 operational planning round for mental health services. These have been submitted to NHS England and NHS Improvement for approval.

General: Our sickness levels continue to be higher than we aspire to in all localities and whilst all sickness is managed in line with Trust policy and is closely monitored within operational services, this is impacting on the delivery of some of our services.

External Audit

Due to the COVID-19 pandemic, the external audit of the 2021/22 Quality Account was stood down.

Our Stakeholders' Views

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

How we involve and listen to what our stakeholders say about us is critical to this process. Due to the Covid-19 pandemic we have been unable to hold our usual Stakeholder engagement events; however, we have sought views from our Stakeholders, service users, carers, and staff through a variety of other means throughout the year, including Our Big Conversation. We have used this feedback when formulating our priorities and actions for 2022/23.

In line with national guidance, we have circulated our draft Quality Account for 2021/22 to the following stakeholders:

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

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

The following are the general themes received from stakeholders in reviewing our Quality Account for 2021/22: [to be added upon receipt of Stakeholder Feedback]

The Trust will write to each stakeholder addressing each comment made following publication of the Quality Account 2021/22 and use the feedback as part of the annual lessons learnt exercise in preparation for the Quality Account 2022/23.

APPENDICES

Appendix 1: 2021/22 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 2021/22 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 2021 to May 2022
    - Papers relating to quality reported to the Board over the period April 2021 to May 2022
    - Feedback from the Commissioners dated
    - Feedback from local Healthwatch organisations dated
    - Feedback from Overview and Scrutiny Committees dated
    - Feedback from Health and Wellbeing Boards dated
    - The Trust's complaints information reported to its Quality Assurance Committee of the Board of Directors, which will be published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
    - The latest national patient survey published 3rd December 2021
    - The latest national staff survey published 11th March 2022
    - CQC inspection report dated 27th August 2021 and 10th December 2021

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

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

- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account/Report, and these

controls are subject to review to confirm that they are working effectively in practice

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

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

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

By order of the Board:

16th June 2021……. Paul Murphy (Interim Chairman)

16th June 2021 ……Brent Kilmurray (Chief Executive)

Appendix 2: Glossary

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

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

Autism: This describes a range of conditions typically characterised by social deficits, communication difficulties, stereotyped or repetitive behaviours and interests, and in some cases cognitive delays. People with autism are sometimes known as "neuro-diverse". Autism cannot be "cured", but the mental illnesses which are more common for people with autism can be treated.

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

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

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

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

Care Planning: See Care Programme Approach (CPA)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Department of Health: The government department responsible for Health Policy

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

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

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

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

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

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

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

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

Harm Minimisation: Our way of working to minimise the risks of sometimes multiple and conflicting harm to both service users and other people

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

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

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

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

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

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

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

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

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

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

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

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

NHS England (NHSE): leads the National Health Service in England

NHS Improvement (NHSI): The independent economic regulator for NHS Foundation Trusts – previously known as Monitor. This will be abolished if the current Health and Care Bill is passed by parliament, and its functions have already been subsumed into NHS England.

NHS Long-Term Plan (2019): A new plan for the NHS to improve the quality of patient care and health outcomes. It sets out how the £20.5 billion budget settlement

for the NHS, announced by the Prime Minister in summer 2018, will be spent over the next five years

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Statistical Process Control (SPC) charts: a graph used to show how a process changes over time and to see whether a situation is improving or deteriorating,

whether the system is likely to be capable to meet the standard and whether the process is reliable or variable

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

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

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

TEWV: Tees, Esk and Wear Valleys NHS Foundation Trust

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

The Trust: see TEWV above

Trust Board: See Board/Board of Directors above

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

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

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

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

Year (e.g., 2022/23): These are financial years, which start on the 1st of April in the first year and end on the 31st of March in the second year

Appendix 3: Key themes from action plans produced in response to 130 Local Clinical Audits in 2021/22

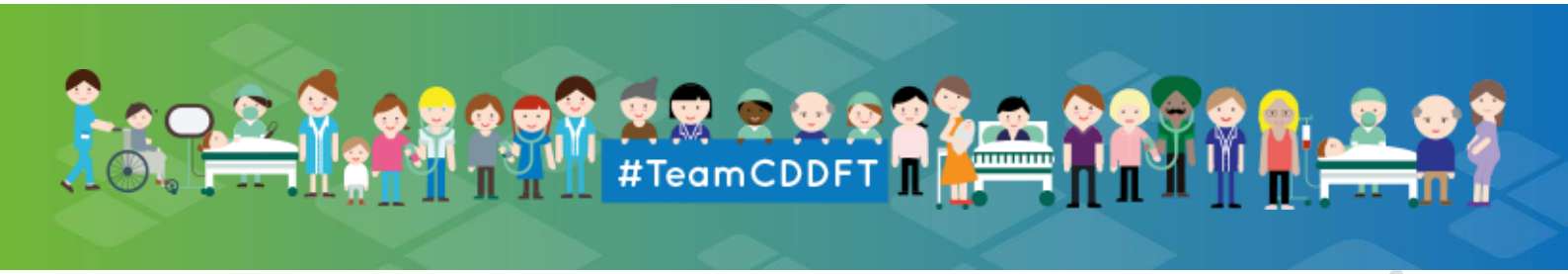
Audit Theme	Key quality improvement activities associated with clinical audit outcomes
1. Infection prevention and control	• All infection prevention and control (IPC) audits are continuously monitored by the IPC Team and any required actions are rectified collaboratively by the IPC team and ward staff. Assurance of implementation of actions is monitored using the Clinical Audit and Effectiveness Team via the clinical audit action monitoring database • A total of 76 IPC clinical audits were conducted during 2021/22 in inpatient areas, prison teams, and community teams where there is a clinic. 74% (56/76) of clinical areas achieved standards between 90-100% compliance. Local clinical audit plans were implemented in collaboration with the IPC Team and the clinical team members to mitigate any areas of non-compliance
2. Medicines Management	• The Pharmacy Team has a central mechanism to scrutinise quarterly controlled drugs (CD) audit data as it comes in. Where audits show any areas for improvement, the CD accountable officer will contact the ward manager • The Pharmacy Team will explore the feasibility of introducing electronic controlled drugs registers • A valproate initiation and monitoring chart will be developed to prompt staff to record indication/target symptoms for valproate treatment, discussions around off-label prescribing, baseline and ongoing physical health monitoring for people prescribed valproate for bipolar disorder • The Pharmacy Team will develop a valproate Pregnancy Prevention Programme (PPP) register to help teams give relevant guidance and track timely Annual Risk Acknowledgement Form (ARAF) completion • The Pharmacy Team will review all identified instances of women under 55 years of age being prescribed valproate without an ARAF in their clinical record • Following the National Clinical Audit of Psychosis (NCAP) audit, cases where patients with first episode psychosis had not been offered clozapine (after failed trials of two antipsychotics) were reviewed. This included exploration of barriers for patients commencing clozapine medication • A request will be submitted for a change to the new electronic record system to support prescribers in offering clozapine and documenting the offer to patients • A flowchart will be developed to enhance staff knowledge around offering clozapine to patients • Wards with a medicines omission rate >0.5% have implemented a ‘second checker’ process to ensure that no doses of medication are omitted unintentionally • Amendments and additions will be made to the Clozapine Initiation Checklist and Annual Review Checklist • The Pharmacy Team will develop and implement a sub-process for adding clozapine to the GP record if this is not present at the clinical check of 6-month prescriptions

Audit Theme	Key quality improvement activities associated with clinical audit outcomes
3. Safeguarding	• Safeguarding Adults Procedure audit findings were fed into the Datix task and finish group to improve reporting • Updated guidance on how to raise and complete a safeguarding concern on PARIS was shared via a Staff Briefing and also shared with staff when disseminating the audit findings • Safeguarding duty workers were reminded to follow standard processes to support safeguarding adult referrals • Safeguarding supervision details were updated within the Trust's Clinical Supervision Policy • An action briefing has been developed to be shared with staff. This reminds practitioners of their responsibility to ensure that service users' wishes, and feelings are part of the safeguarding process and are recorded • Regular reminders of the Safeguarding process will be incorporated within the Safeguarding Team's briefing • The Safeguarding Team will review a sample of records every three months to monitor compliance with the Safeguarding processes • The Safeguarding Adults Flow Chart, PARIS briefing, and eLearning package has been promoted via a Staff Briefing and the Safeguarding Link Professionals • The Safeguarding Adults intranet page will be updated to include links to PARIS briefings and eLearning packages to increase ease of access for practitioners • A briefing will be produced specifying the requirements of the Safeguarding Children Policy and this will be shared with Community Modern Matrons. A review will be undertaken with the Community Modern Matrons and learning from this will be shared focusing on the positive practice observed as well as implementing improvements to sustain high quality practice standards
4. Risk assessment and CPA	• Assessment packs will be developed for the Health and Justice service to include useful guidance in relation to the Care Programme Approach (CPA), neurodevelopmental assessments prompts, a trauma leaflet, and a leaflet about the team • Outcomes measures training will be provided to all Health and Justice Teams and a recording system will be developed for all screening tools • All Age Liaison and Diversion Teams will be developing aide memoire cards for staff and updating the visual control boards in order to improve recording of assessment and consent documentation
5. Physical Health	• The Trust-wide Physical Health Group will be reviewed and recommenced in order to provide further support to improve assessment and recording of relevant physical health activities. This will be chaired by a Clinical Director • Staff will be reminded to ensure that when physical health measures are unable to be obtained due to patients declining these, this must be recorded within the electronic patient record • The Tissue Viability and Physical Health Specialist Nurse in collaboration with Ward Managers will produce a flowchart which shows the agreed process for ensuring that all patients have a Waterlow Pressure Ulcer Risk Assessment completed and updated, along with documented evidence of interventions for those identified with a pressure ulcer (in line with the Assessment, Prevention and Management of Pressure Ulcers Procedure)

Appendix 4: Feedback from our Stakeholders

This Appendix consists of letters from our Stakeholders which will be posted into this section of the document once received at the end of the consultation period (mid-June)

This page is intentionally left blank



County Durham and Darlington NHS FT

QUALITY ACCOUNTS

2021 - 2022

Contents

WELCOME AND INTRODUCTION

County Durham & Darlington NHS Foundation Trust is one of the largest integrated care providers in England. Our 7,000 strong workforce serves a population of around 650,000 people. We provide acute hospital services from:

- Darlington Memorial Hospital; and
- University Hospital of North Durham.

In addition, we provide a range of planned and sub-acute hospital care at Bishop Auckland Hospital.

We provide services including inpatient beds, outpatients and diagnostic services in our local network of community hospitals based at:

- Shotley Bridge
- Chester le Street
- Weardale
- Sedgefield
- Barnard Castle (the Richardson Hospital)

Moreover, we provide adult community services in patients' homes, and in premises including health centres, clinics and GP practices.

Our mission "Safe, compassionate and joined up care" represents our commitment to put the patient at the centre of everything we do.

A guide to the structure of this report

The following report summarises our performance and improvements against the quality priorities we set ourselves for 2021/22. It also sets out our priorities for the coming year 2022/23. Our priorities for 2021/22 were set in the midst of the Covid-19 pandemic, at a time of uncertainty with respect to how long the NHS would need to treat patients with Covid-19 and how significant its continuing impact would be; as such, they represented interim objectives including continued work on priorities from 2020/21, pending the re-write of our quality strategy, "Quality Matters". There were no specific objectives relating to Covid-19 but there were implicit expectations with respect to patient safety, experience and clinical outcomes with respect to the virus and we have therefore included commentary in response to these in Section 3. Our Quality Strategy for 2022/23 to 2025/26 is in the final stages of consultation. Our quality priorities for 2022/23 therefore reflect our emerging strategic objectives and the residual work needed to achieve our 2021/22 objectives.

The Quality Accounts are set out in three parts:

Part 1:	Statement from the Chief Executive of County Durham & Darlington NHS Foundation Trust.
Part 2A	Review of 2021/22 Quality Priorities
Part 2B	2022/23 Quality Priorities
Part 2C	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 commissioners, 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 the priorities which we have identified with our stakeholders.

We set ourselves stretching objectives and, whilst we continue to see significant improvement and success in achieving some of our goals, it is acknowledged that, for some, we have not fulfilled our ambition. Where this is the case, we are committed to taking the further actions necessary to achieve them in 2022/23.

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

Part 1: Statement from the Chief Executive of County Durham & Darlington NHS Foundation Trust.

Draft – wording may be amended as the final version is produced.

I am delighted to introduce to you our Quality Account and Quality Report for County Durham and Darlington NHS Foundation Trust for 2021/22.

For the second year running it is with great pride that I am able to reflect upon the compassion, dedication and fortitude shown by our staff, volunteers and partners for the way in which they come together, not only to care for all our patients through further waves of Covid-19 but also to maintain cancer services and restore high levels of elective and diagnostic services which are successfully reducing long waiting lists. The performance against our quality priorities set out in this Quality Account, should be seen in the context of agile and ongoing innovation to support patients with new needs as we emerge from the pandemic: for example, through waiting well initiatives, long-Covid clinics, a widening range of virtual services and 'virtual wards' based in the community.

Our priorities for 2021/22 were set in the midst of the Covid-19 pandemic, at a time of uncertainty with respect to how long the NHS would need to treat patients with Covid-19 and how significant its continuing impact would be; as such, they represented interim objectives including continued work on priorities from 2020/21, pending the re-write of our quality strategy, "Quality Matters". There were no specific objectives relating to Covid-19 but there were implicit expectations with respect to patient safety, experience and clinical outcomes with respect to the virus and we have therefore included commentary in response to these in Section 3. Our Quality Strategy for 2022/23 to 2025/26 is in the final stages of consultation. Our quality priorities for 2022/23 therefore reflect our emerging strategic objectives and the residual work needed to achieve our 2021/22 objectives.

The Trust's strategy 'Our Patients Matter' continues to drive how we manage our business and ultimately the care and experience we are delivering to patients each and every day and night, as we aspire to our mission of providing the safest, most compassionate and joined up care.

It is underpinned by a number of key plans and knitted together by our four 'bests' – best experience, best outcomes, best efficiency and best employer - as we work to achieve our vision of delivering care which is 'right first time, every time'.

We have now refreshed and are in the final stages of consultation on our four-year quality strategy - "Quality Matters" – which includes Board-sponsored actions which aim to increase capacity and time to care; foster and sustain our safe and supportive culture for staff and build skills and capability to enable quality improvements to be made at all levels in the Trust. The roll out of our Electronic Patient Record system – during 2022/23 – provides a huge, and exciting, opportunity to drive quality improvement through technology and we have reflected just some of the specific areas where we hope to benefit in our forward priorities. You will also see further plans to invest in urgent and emergency care services to help bring about the improves that, together with our partners in the local health economy, we have been working towards.

During 2021/22:

- We achieved the objectives which we had set ourselves for improving dementia care, paediatric services and mortality reduction.
- We implemented the substantial majority of the actions we set out to implement.
- We saw reductions in falls per 1,000 bed days and falls with moderate or greater harm resulting from lapses in care
- We met national infection control thresholds for Clostridium Difficile and hospital-acquired e-coli but have more to do to meet our zero tolerance for MRSA and to meet our aspirations with respect to pseudomonas and klebsiella.
- Whilst continuing to see very low levels of serious pressure ulcers, we found one Grade 3 and one Grade 3 ulcer with lapses in care, and were unable to perform in line with our zero tolerance.
- We were unable to meet the target of 95% of electronic discharge letters being issued within 24 hours, in part due to pandemic pressures.
- We saw improvements with respect to end of life care and nutrition, but have further to go to update and roll out our local strategies.

- We strengthened our maternity services with the appointment of fetal medicine consultants and midwives, roll out of the initial stages of our continuity of carer programme and the implementation of immediate and essential actions from the Ockenden report. We continue to strengthen the resilience of midwifery staffing and look forward to a review of staffing by the national Birth Rate Plus in the coming months.
- We continue to benchmark well for excellence reporting but have seen a reduction in reporting in the year and have therefore reinvigorated the reporting arrangements.

Due to capacity constraints, the need to maintain all services and the impact of waves of Covid-19 resulting in prolonged periods with more than 100 inpatients with Covid-19, we have not made the improvements in A&E waiting times which we set out to achieve but are investing in increases in staffing, same day emergency care facilities and additional beds, as well as optimising urgent care pathways, in order to target improvements in 2022/23. With the support of our Integrated Care System, we have bid nationally for funds to significantly expand the A&E at UHND and await the outcome of that bid.

As we move into 2022/23 we will continue to focus on, and target improvements, in those areas where we have not achieved our ambitions. Our new Quality Strategy provides a cohesive framework in which we can identify and make quality improvements across a range of priorities. For 2022/23 we have identified key priorities from this strategy, alongside others where, we did not achieve our stretching ambitions in 2021/22 and aim to complete the residual work in the coming year.

I can confirm that to the best of my knowledge this Quality Account is a fair and accurate report of the quality and standards of care at County Durham & Darlington NHS Foundation Trust.

Sue Jacques
Chief Executive
30th June 2022

Part 2a: Review of 2021/22 Quality Priorities

The following section of the report sets out our performance with respect to each of the quality priorities we set for 2021/22. Wherever available, historical data is included so that our performance can be seen over time.

Summary of 2021/22 Quality Priorities

Safety	Experience	Effectiveness
Local Quality Priorities for 2021/22 (Section 2a)		
Reduce the harm from inpatient falls	Nutrition and Hydration in Hospital	Mortality Reduction
Improve the care of patients with dementia	End of life and palliative care	Maternity Standards
Reduce harm from Health Care Associated Infections		Paediatric Care
Reduce harm from category 3 & 4 pressure ulcers		Excellence Reporting
Improve the timeliness of discharge summaries		
Improve management of patients identified with Sepsis		
Mandated measures for monitoring (Section 3)		
Rate of Patient Safety Incidents resulting in severe injury or death Time spent in the Emergency Department	Percentage of staff who would recommend the provider to friends and family Responsiveness to patients personal needs	Summary Hospital Mortality Index (SHMI) Patient Reported Outcome Measures

	Ambition achieved		Some but not all elements achieved		Ambition not met

Patient Safety

Reducing harm from inpatient falls

Ambition partly met

Our aim

To reduce harm from falls in an increasingly at-risk population

Our progress

The Trust Falls Strategy was reviewed and updated with input from a wide range of stakeholders, making this a county-wide strategy and one which supports the aim of reducing admissions due to falls outside of the Trust. The strategy is aligned with, and feeds into, our new Quality Matters strategy 2022/23 – 2025/26.

In updating our strategy, we have chosen not to set a blanket target to 'reduce falls' as we need to understand the needs of each of the patient groups we care for and to target our support effectively. To make sustained, positive progress in reducing falls, and in particular falls with harm, we are focusing on establishing those falls attributable to the organisation (lapses in care) and those not attributable to care. We have developed a questionnaire to supplement the falls reporting process, the responses to which enable the Falls Team to pinpoint where support and further learning is required most.

Reviewing the actions from the 2021/22 Quality Accounts the team has continued to provide targeted support, particularly in to our international nursing recruits and those returning to practice, as well as to those wards showing an increase in incidents or are reporting concerns.

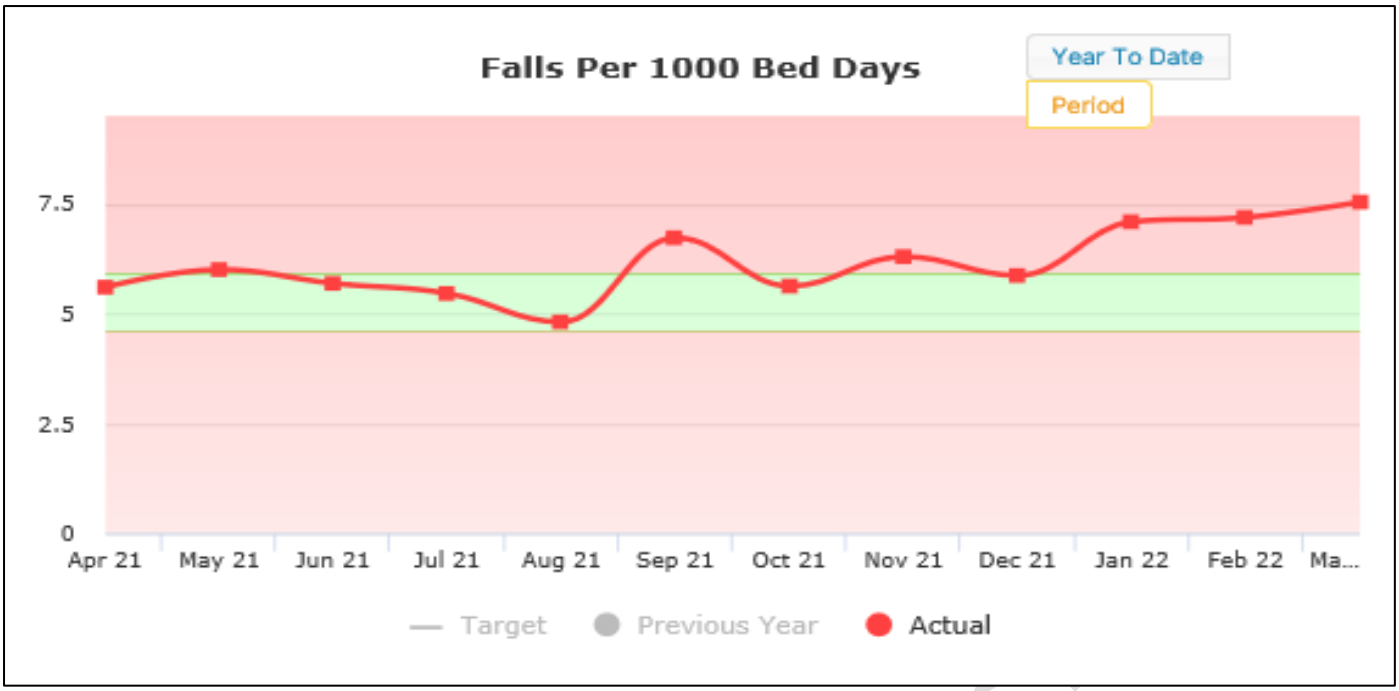
Number of Falls and Falls per 1,000 bed days

The absolute number of falls across the Trust has increased in the year 2021/22, which is reflective of the significantly increased patient flow the Trust experienced compared to 2020/21. The incidence of inpatient falls per 1000 bed days – which relates the number of falls to activity – reduced in 2021/22 compared to the prior year:

	2021/22	2020/21
Acute sites	6.4	6.8
Community sites	5.9	8.0

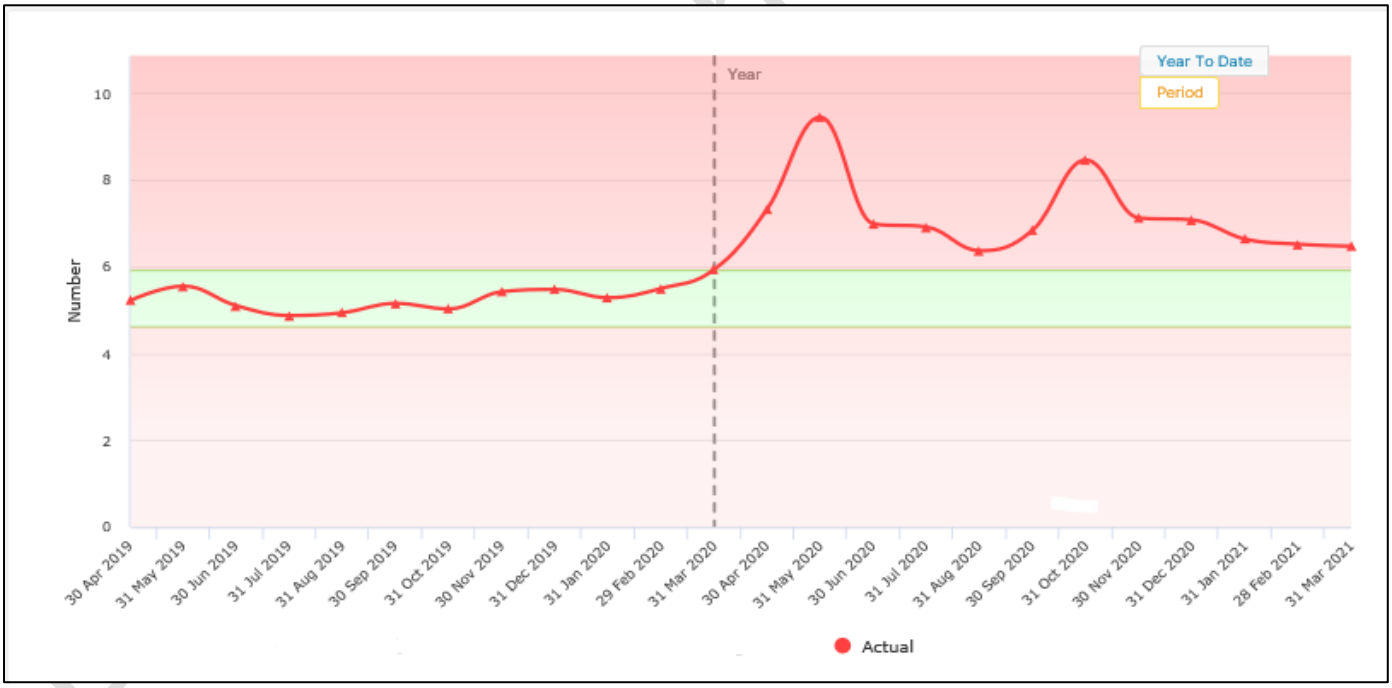
Trend graph – Falls per 1,000 bed days in 2021/22

In the graphs overleaf, the 'green' zone represents normal variation based on pre-pandemic (2019/20) levels. The Trust was able to restore the trend in line with normal variation for much of the year. However, over the last three months we have seen an increase triggered by demand-led – including Covid-19 driven – pressures, which lead to increased movement of patients and staff and a potentially greater risk of falls.



Trend graph – 2019-2021 falls per 1,000 days

The graph below shows the 2019/20 and 2020/21 trends, with the green zone again representing normal pre-pandemic levels. The improved trend in 2021/22, is apparent from a comparison of the 2020/21 trend shown below, with trend in the chart above.



Number of falls with moderate/severe harm

The number of falls resulting in moderate or greater harm increased from 31 reported in 2020/21 to 46 reported in 2021/22. However, those involving lapses in care reduced as outlined below.

All reported falls which result in a fractured neck of femur, or a subdural bleed, or are otherwise identified as being of significant concern were investigated as serious incidents (SI's). Some 26 SI' investigations were completed during the period April 2020 to July 2021, of which nine identified lapses in care against

Trust policy and 17 identified no lapses in care. The SI process took significant time to facilitate, was very time consuming for staff, and learning was only identified at the end of the process which prompted a review of our investigation process. The Trust has therefore adopted a Rapid Review process, involving visits to wards/departments where a fall has occurred within 5 working days, to complete a shorter and more focused review with immediate learning being generated and acted upon sooner. Feedback from both ward staff and the Falls Team has been positive. Since July 2021 and the introduction of the Rapid Review process, 16 rapid reviews for falls incidents have completed of which four identified lapses in care against Trust policy and 12 identified no lapses in care. As such the rate of moderate / severe falls identified due to lapses in care can be seen to be falling; 34.6% in 2020/21 to 25% in 2021/22.

Improving the care of patients with Dementia

Our aim

Building on the work already undertaken in previous years, our aim is to provide appropriate care for patients with cognitive impairment and ensure that patients with dementia and their families have a positive experience of care provided by the Trust.

Our progress

We have begun to re-establish the role of the Dementia Lead Nurse – following the pandemic - and have re-launched John's Campaign. Both initiatives were both shared with colleagues at meetings of our senior nurses and AHP leadership teams, and through our Sisters Away Days during the summer of 2021. To further improve awareness and information sharing we have re-introduced a Trust wide quarterly dementia newsletter and have begun strengthening the role of the dementia link nurse. Our original intention was to produce the Dementia Newsletter monthly however due to a reduction in the information received from different agencies it was agreed a quarterly newsletter would be more appropriate. We have a number of dementia champions are also looking to restart face to face engagement to supplement communication via the newsletter.

We have developed a Dementia-friendly Hospital and Environment Programme drawing on current research and we continue to seek out opportunities and funding to improve the hospital environment. This work is underpinned by the dementia friendly environment audit, which helps us to develop identify and share areas of good practice and is aligned to the development of frailty services. Audit findings are shared with ward managers and matrons to inform action plans.

We have re-launched the carer passport and "This is me" documentation and, during June 2021, undertook the optional case note audit within the national audit of dementia. These audit results, available in spring 2022, will inform future action plans and development schemes. CDDFT will be participating in the 5th round of the national audit of dementia in 2022-2023.

Dementia training is now available via the Trust's e-learning portal. The training target for 2021-22 was achieved, the team are looking to continue to achieve and maintain targets throughout 2022-2023. We will be re-introducing face to face training opportunities; for example, sensory training and becoming a dementia friend.

We continue to work with stakeholders, regional and national working groups to promote dementia services and understanding/awareness and to ensure the needs of those with dementia are taken into consideration, when developing services and changes in clinical practice.

Ambition partly met

Reducing harm from health care associated infections

Our aim

To reduce harm from health care associated infections, in particular by aspiring to:

- a zero tolerance of MRSA bacteraemia
- meet the following thresholds set by NHS England and Improvement:
  - No more than 45 cases of healthcare associated Clostridioides *Difficile* Infections (CDI)
  - No more than 113 healthcare associated cases E coli
  - No more than 38 cases of healthcare associated *Klebsiella sp.*
  - No more than 11 cases of healthcare associated *Pseudomonas ag*

Our progress

During 2021/22 we updated our blood culture policy in line with national guidance and provided face to face IPC training through 'topic of the month' sessions for front-line staff, both actions were identified as measures of success in our last Quality Accounts.

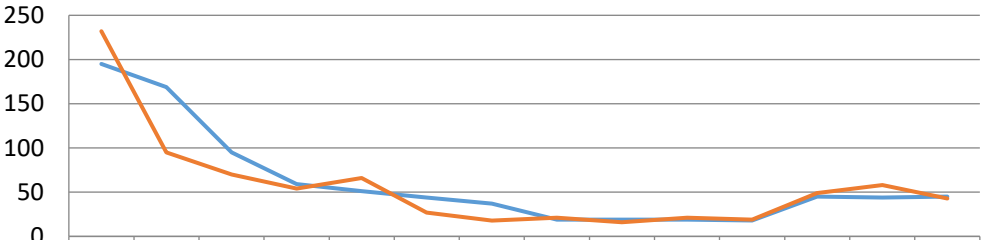
MRSA

Unfortunately there were four cases of MRSA Bacteraemia during the 2021/22 placing the Trust above its threshold of zero avoidable infections. Post infection reviews were carried out on all cases and findings shared across the organisation.

Clostridium difficile

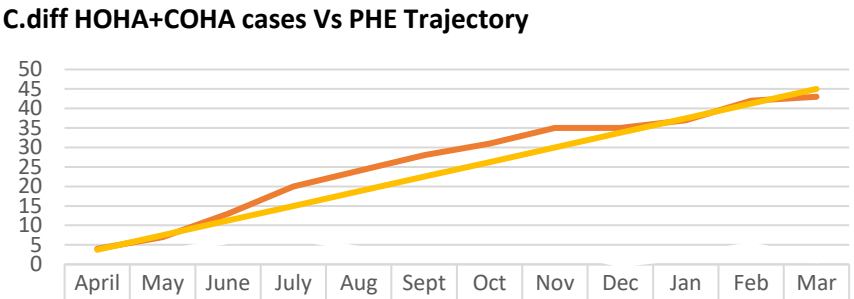
To date the Trust reported 43 trust apportioned Clostridium *Difficile* cases against NHSE/I threshold of 45. The chart below shows the Trust's performance from 2008/9 which shows significant reduction over time. The increase in both the threshold and the actual performance that can be seen from 2019/20 reflects a change to the national definition of trust apportioned cases.

Clostridium difficile Trust Apportioned cases
County Durham & Darlington NHS Foundation trust
2009/10 - 2021/22



	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Threshold	195	169	95	59	51	44	37	19	19	19	18	45	44	45
Actual	232	95	70	54	66	27	18	21	16	21	19	49	58	43

CDDFT CDI trajectory graph 2021/2022



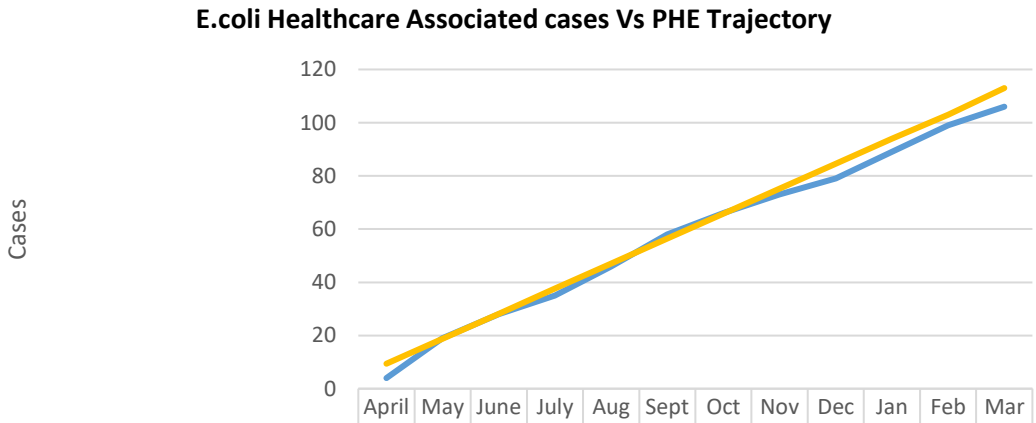
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
C.diff HOHA+COHA cases	4	3	6	7	4	4	3	4	0	2	5	1
Cumulative HOHA+COHA case total	4	7	13	20	24	28	31	35	35	37	42	43
Trajectory	3.75	7.5	11.25	15	18.75	22.5	26.25	30	33.75	37.5	41.25	45

There are still lessons to be learned within the Trust and we aim to ensure that these are embedded in practice in the coming year. Post Infection Reviews (PIR) highlighted key themes including delays in sampling, isolation, inappropriate antibiotic prescribing and inconsistent use of the diarrhoea assessment tool which will be addressed in the work planned for the coming year.

It should be noted that, relative to levels of activity and when considered in the national context, the Trust continues to have lower than average rates of Clostridioides *Difficile* per 1,000 bed days.

E coli

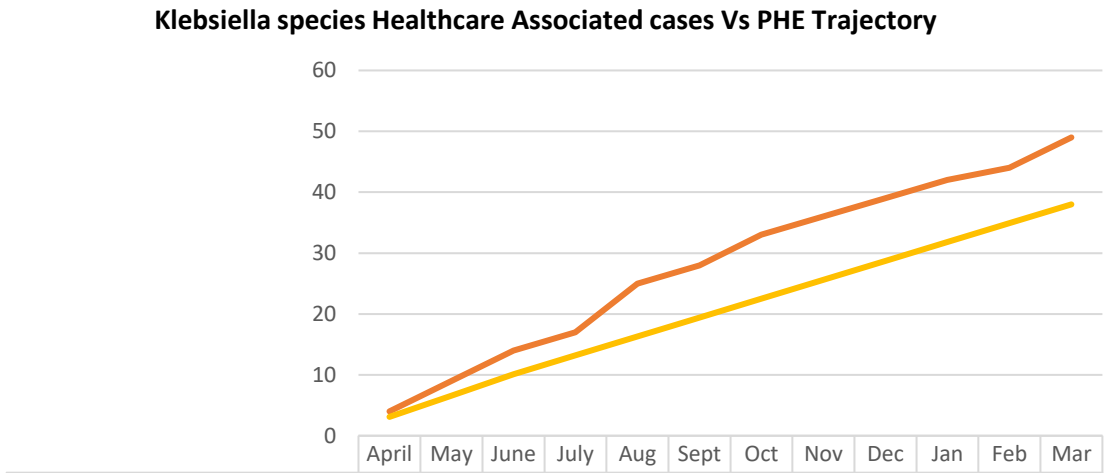
CDDFT reported 106 Trust apportioned E coli cases against the NHSE/I threshold of 113. The chart below shows the E Coli associated cases against the PHE trajectory.



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
E.coli Healthcare Associated cases	4	15	9	7	9	12	8	7	6	10	10	7
Cumulative Healthcare Associated case totals	4	19	28	35	46	58	66	73	79	89	99	106
Trajectory	9.4	18.8	28.2	37.6	47	56.4	65.8	75.2	84.6	94	103	113

Klebsiella sp

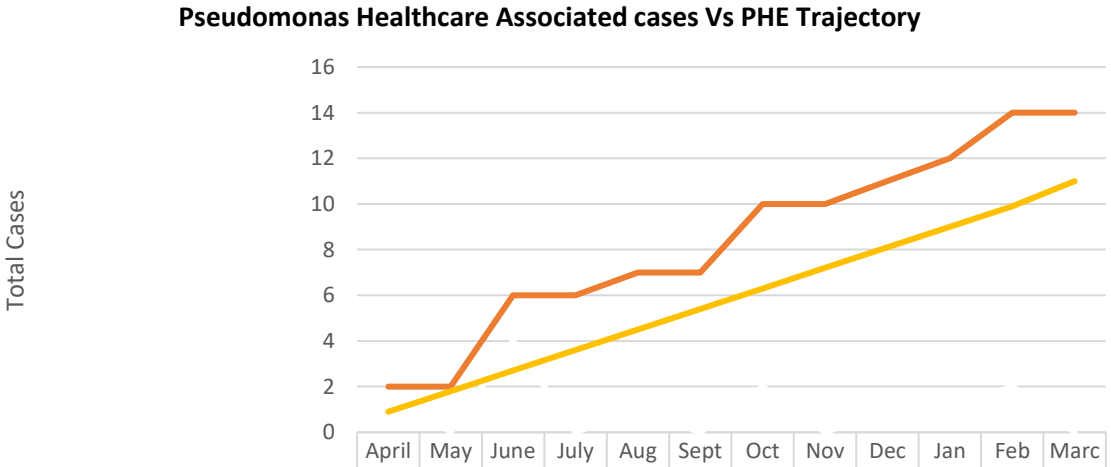
CDDFT reported 49 Trust apportioned Klebsiella cases against NHSE/I threshold of 38. The chart below shows the Klebsiella associated cases against the PHE trajectory.



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Klebsiella species Healthcare Associated cases	4	5	5	3	8	3	5	3	3	3	2	4
Cumulative Healthcare Associated case totals	4	9	14	17	25	28	33	36	39	42	44	49
Trajectory	3.1	6.6	10.1	13.2	16.3	19.4	22.5	25.6	28.7	31.8	34.9	38

Pseudomonas

To date CDDFT reported 12 Trust apportioned Pseudomonas cases against NHSE/I threshold of 11. The chart below shows the Pseudomonas associated cases against the PHE trajectory.



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Marc
Pseudomonas aeruginosa Healthcare Associated cases	2	0	4	0	1	0	2	0	1	1	2	0
Cumulative Healthcare Associated case totals	2	2	6	6	7	7	10	10	11	12	14	14
Trajectory	0.9	1.8	2.7	3.6	4.5	5.4	6.3	7.2	8.1	9	9.9	11

Reducing harm from category 3 and 4 pressure ulcers

Ambition not met

Our aim

We have a zero tolerance for pressure ulcers resulting from lapses in care and our aim is to have no Category 3 or 4 pressure ulcers involving such lapses

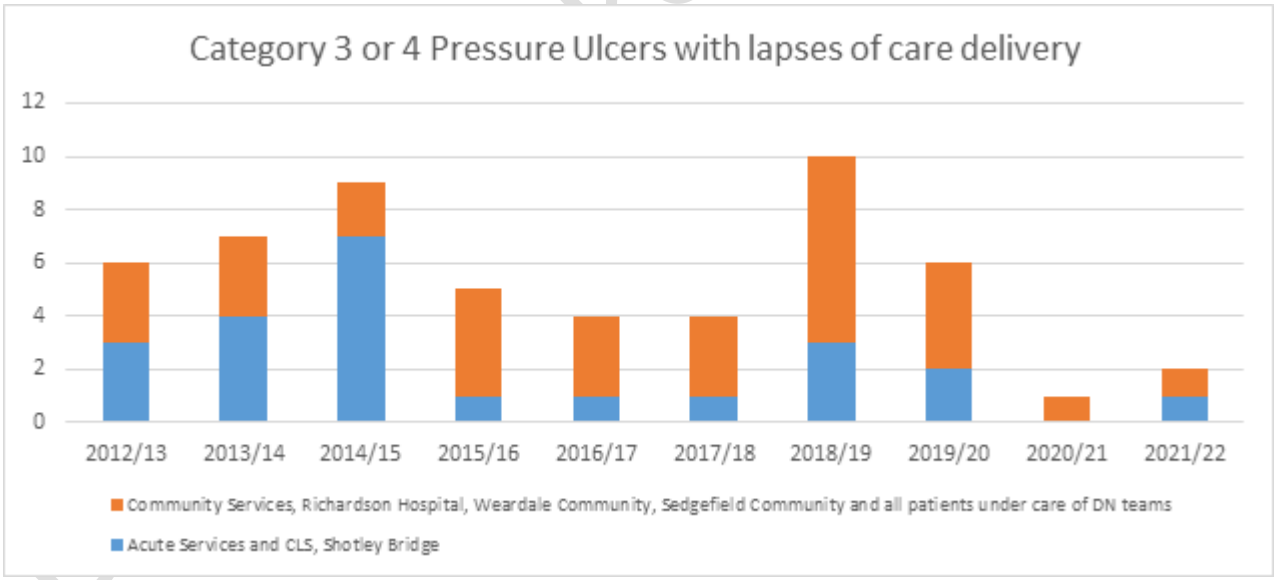
Our progress

We undertake rapid reviews of all Grade 3 and 4 ulcers occurring in our care to ensure incident reviews are timely, and that learning takes place in real time across all domains. The reviews are multi-disciplinary and are led by Tissue Viability nurses. Incident reports for Grade 2 ulcers are accompanied by questionnaires designed to assess compliance with Trust policies and identified lapses in care, which are validated – on a sample basis – by our specialist Tissue Viability teams and any thematic learning is disseminated.

We aimed to increase the number of Wound Resource Educational Nurses (WRENs) across the organisation in 2021/22 but have been unable to do so because of the pandemic. We have, however, maintained the complement of WRENs in place from 2020/21 and the team have reconfigured their work programme to include local audit involvement and more localised ownership of the WREN programme. Our aim remains to expand the number of WRENs and widen their work to encompass a multi-disciplinary team approach working with physiotherapists and Occupational Therapists in the coming year.

In 2021/22 the Trust reported one category 4 pressure ulcer and one category 3 pressure ulcer involving lapses in care.

- The Category 4 case was reviewed and an action plan put in place. Learning points were identified for both our third party wheelchair provider and our District Nurses service.
- The Category 3 case occurred within the hospital environment, and a six month action plan was put in pace. Subsequent audits show improvements, and additional pressure-ulcer specific training has been provided.



Improving the timeliness of discharge summaries sent to GP

Our aim

To send 95% of discharge summaries within 24 hours of discharge.

Our progress

During 2021/22, due to Covid-19 pressures there has been reduced focus on this specific ambition. Performance remained above 90% up until September, dropping to the lowest level of performance in December of 84.28%. The average or the year was 89.4%.

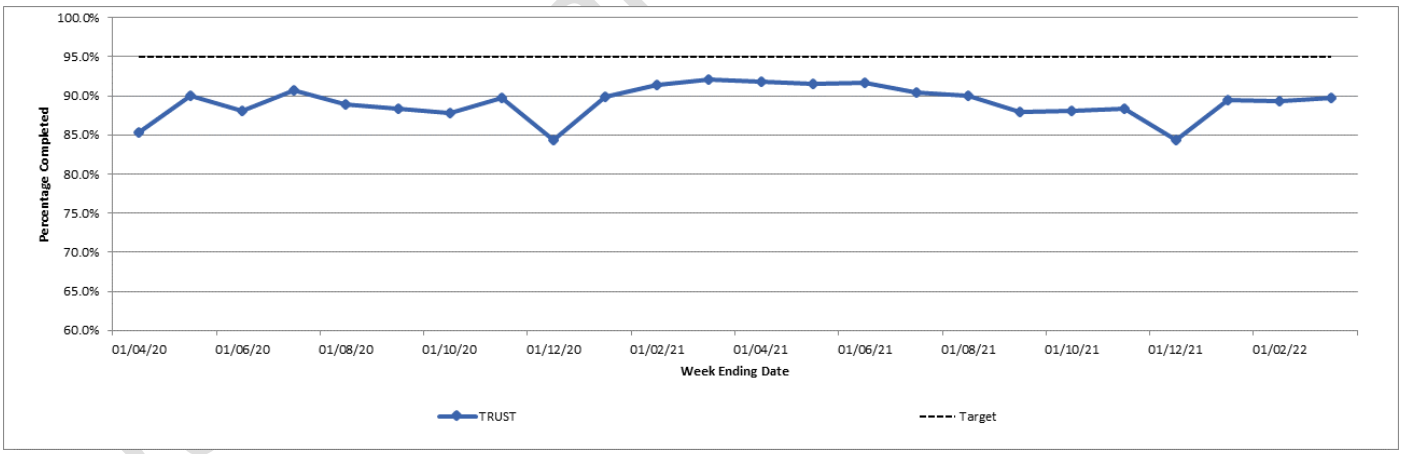
A significant amount of work has however been progressed in relation to overall discharge planning, including the development of real-time reporting of COVID and vaccination statuses and embedding the latest discharge policy guidance.

Each Care Group has a responsible lead manager to whom a weekly dataset is sent to enable them to identify variation and manage performance at specialty, consultant and ward level. Progress continues to be regularly reported to the Operational Performance and Assurance Committee and to the Trust Board.

Our current "Work As One" improvement initiative (which has run from mid-December 2021 and is ongoing) focuses closely on all aspects of discharge including timeliness of communication to GPs. The Electronic Patient Record system (EPR), which we will roll out in 2022/23 will auto-populate the discharge summary with information captured on admission and during the patient's stay, helping to improve the quality and completeness of information and to expedite the process of issuing summaries.

A renewed focus on the timeliness of discharge summaries is to be incorporated into this work in 2022/23.

Discharge Summaries dispatched within 24 hours



	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Trust	85.30%	90.00%	88.10%	90.70%	88.90%	88.40%	87.80%	89.80%	84.30%	89.90%	91.40%	92.10%	91.80%	91.50%	91.70%	90.50%	90.00%	87.90%	88.10%	88.30%	84.30%	89.50%	89.40%	89.70%
Target	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%

Improving the management of patients with Sepsis

Ambition partly met

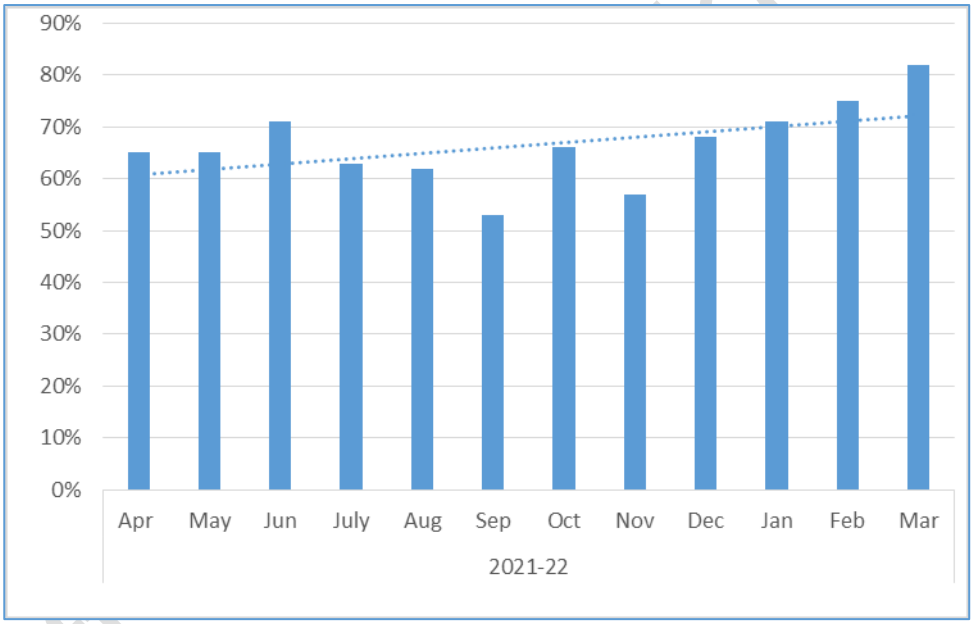
Our aim

To improve the percentage of patients receiving antibiotics within 1 hour of diagnosis in the Emergency Department and to improve both staff awareness and processes to improve the prompt recognition of, and response to sepsis.

Our progress

The regional sepsis screening tool is now integrated within our nursing observations system – Nervecentre - for inpatients and our A&E system – Symphony - for patients attending our A&E departments. All patients within CDDFT are therefore automatically screened for sepsis. The Sepsis bundle within Nervecentre enables the bundle to be completed electronically for inpatients screened as positive. The Maternity Sepsis Screening Tool was recently revised and launched Trust-wide. Three simulation study days (against our aspiration of four) were delivered in the year to help improve staff awareness of Sepsis and support prompt recognition and response. A Patient Group Direction (PGD) has also been developed, which is currently in the pilot phase, for Sepsis of Unknown Origin. A Trust Sepsis Lead Nurse has been in post since June 2021.

Audits continue in the A&E Departments; however the time to administration of antibiotics has not improved in 2021/22. We have fluctuated between 53% and 82%, with improved performance towards the year end.



The results reflect, in part, constraints with respect to the availability of staffing and physical space when the departments are experiencing high demand. Our for the year ahead is therefore to continue improvement work on the rapid delivery of antibiotics to patients within our A&E Departments, which will be supported by the roll out of the PGD to relevant nursing staff.

Patient Experience

Improving the nutritional support offered to our patients whilst in our care

Our aim
During 2021/22 we aimed to develop a strategy building on the work already undertaken to further improve the care delivered to our patients.

Our progress
Four success measures were identified last year:

- The Nutrition Steering Committee has been re-established and has good engagement;
- A business case for Nutritional Support team is in the final phase prior to submission;
- An annual calibration programme for weighing scales has been completed; and
- The development and launch of a new Nutrition Strategy.

Unfortunately the strategy was not completed or launched as planned and therefore remains a focus for the team in the coming year.

The Trust's Nutrition Steering Committee has been re-invigorated, and is chaired by the Executive Director for Nursing and Allied Health Professions with multi-disciplinary input. Clear reporting structures are in place for this committee and the two sub-groups that report into it.

Obtaining an accurate weight for a patient is an essential part of nutrition planning and is one the key elements of the screening process. As well as enabling monitoring of the patients nutritional status it also ensures that medication and other treatments can be accurately prescribed. Following on from the work undertaken in 2020/21 by Dietetics and Medical Engineering to standardise weighing scales across all areas of the organisation, the annual calibration programme has commenced. This project has ensured that all areas have access to scales that meet nationally set standards and that staff can be confident that they have been calibrated and therefore accurate.

Role-specific nurse training for nutrition has been revised and offered both face to face and via our digital platform.

End of Life and Palliative Care

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)*."

Our progress

In the most recent CQC report End of Life Care in the Trust is rated as 'Outstanding'.

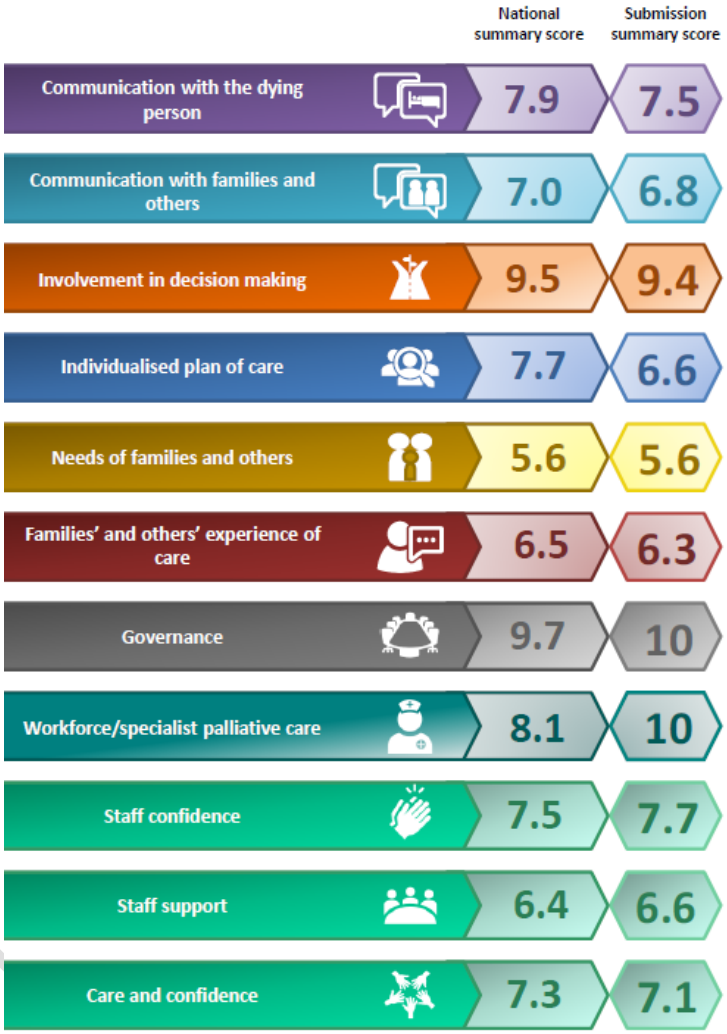
Key actions planned for 2021/22

Throughout the year we continued to engage with partners and stakeholders to refresh the palliative care strategy to 2025; however, unfortunately, delays were encountered by pandemic priorities. We have continued to promote recognition of patients who are dying in hospital – which supports compassionate, responsive and effective care planning for this group of patients – with this topic now included in Trust-wide training programmes. Local audit results shows that recognition of dying from Covid-19 was very good (90% of all deaths). Access to single rooms for patients who are dying is relatively good at DMH (88%) but remains more of a challenge at Durham due to fewer side rooms being available within the estate. A review

of the care after death documentation was undertaken, and a checklist was developed that will remain with the case notes and has rolled out across the Trust.

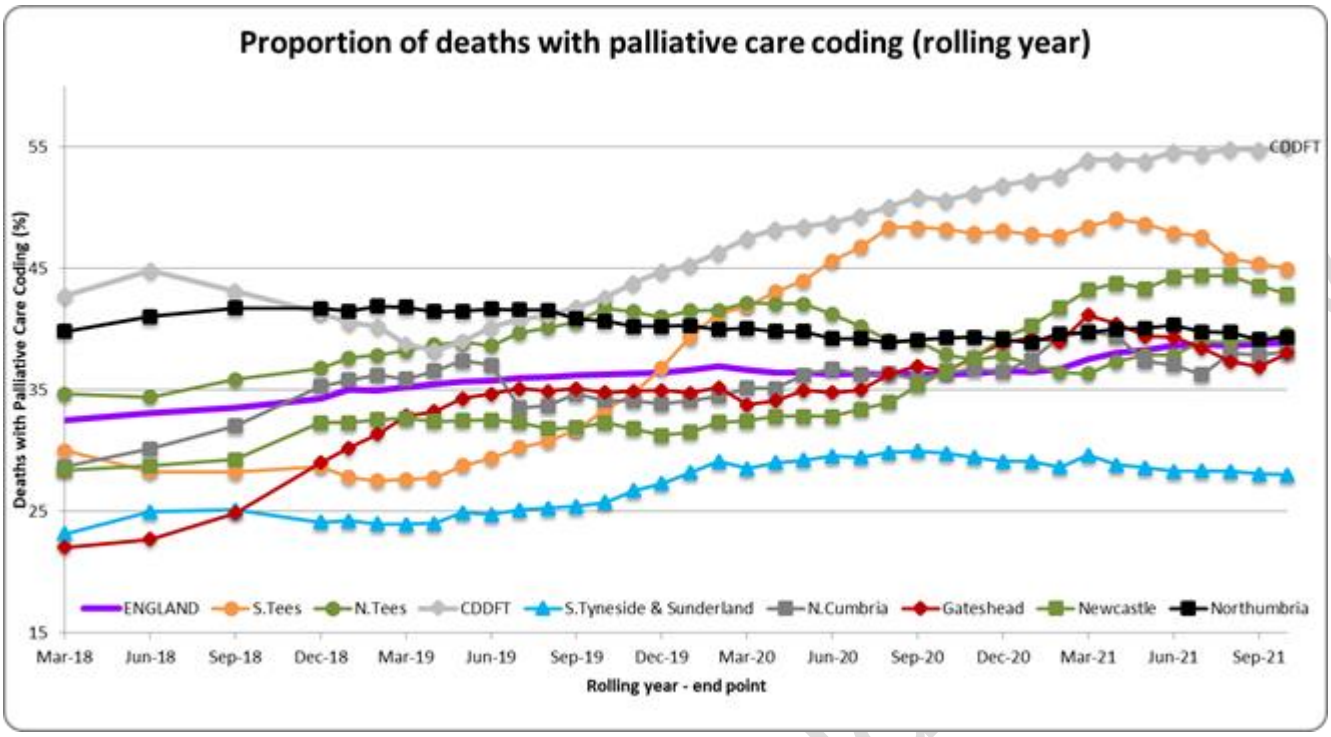
Other actions from the most recent National Audit

The results of National Audit of Care at End of Life (NACEL) 2021 and quality survey data demonstrated continuing good practice in end of life care within the Trust. These results are taken from the NACEL headline report and we await the full version being published. Until the full report is published, we are only able to undertake limited analysis and have therefore focused on a number of immediate actions looking to include key areas for improvement into our training programmes. The team are also exploring opportunities to improve documentation and compliance through the EPR system to be implemented in Autumn 2022.



The chart overleaf demonstrates that the Trust continues to have the highest proportion of deaths with palliative care coding within the region, with over 50% of patients who die in acute hospitals receiving input from the specialist palliative care team.

Palliative Care Coding (proportion of people who died who received input from specialist palliative care)



Clinical Effectiveness

Mortality

Ambition met

Our aim

To continue to strengthen our mortality review process and implement the Medical Examiner role, whilst seeking to improve our SHMI position, through education on record-keeping and coding.

Our progress

The Trust uses three main measures to understand its position in relation to mortality: the Hospital Standardised Mortality Ratio (HSMR); the Summary Hospital Mortality Index (SHMI) and Crude Mortality. CDDFT's HSMR has been below the national 100 standard throughout the 12 month period and sits within the "as expected" range when looked at nationally.

CDDFT's SHMI increased to 116.82 in April 2021, and remained above statistical limits for much of the year but decreased to 109.78 – within statistical limits - in February 2022. The original increase in SHMI was felt to be due to the fact that COVID-19 cases were being removed from the dataset, resulting in a mismatch between the observed and expected ratio. This was a theme seen nationally.

We carried out detailed investigations to understand our SHMI trend including utilising external experts and additional data from Copeland's Risk Adjusted Barometer. Other indications of mortality, and the results of the extensive programme of mortality reviews in the Trust, did not suggest the Trust was an outlier for excess deaths.

External input was provided by the North East Quality Observatory Service (NEQOS) whose Lead presented to the CDDFT Trust Board on the impact of Covid-19 on SHMI (and its reliability) in the North East. NEQOS commended CDDFT on the number and depth of learning from deaths reviews completed by the Trust and advised that more assurance should be taken from the Trust's own reviews and alternative measures which they commended as being in line with good practice.

The Mortality Committee, Clinical Effectiveness Committee and the Board continue to monitor trends closely every quarter including learning and actions.

Over the longer-term investigations have suggested a number of reasons for the Trust's reported SHMI position and were have taken steps to improve it position via the following:

- Appointment of three clinical champions, who are already contributing to the improved Trust position, by providing training and education to medical staff on wards on the depth of recording and coding required in notes and discharge letters.
- Continuing to complete mortality reviews for all deaths coded to low risk diagnosis groups.
- Making use of crude mortality, which is an unadjusted measure that reports the percentage of deaths in an organisation. Crude mortality is used together to understand the current position and identify quality improvement opportunities. The Trust's rolling 12 month crude mortality has fallen from 5.08% in April 2021 to 4.6% in September 2021. This is as expected with the number of Covid-19 related deaths.

With respect to the learning from deaths reviews completed by the Trust, for the overwhelming majority of patients the quality of care was rated as good or better with lapses in care leading to poor or very poor ratings being found in less than one per cent of cases.

	2021/22	2020/21
Mortality Reviews Completed	390	702
Total Patient Deaths recorded	2,188	2,399

In regard to the above, it must be noted that Mortality data is provided by NHS Digital, and "Priority Deaths" uploaded to the Trust's database by our Information Department the following month. These are allocated for review by the middle of that month. It can therefore take anywhere between 4-8 weeks (sometimes longer) for the central review team to complete. There are also some occasions when some deaths reviewed can be added much later than when death occurred - for example following a complaint, which may be raised many months after the patient's death. In addition, for some of the current cohort of deaths under review, such as those who have a less than 10% SHMI risk of death, this data is not available until six months after the patient has died. Therefore there is at least an 8 month wait before these reviews can be concluded. This sample made up around 40% of the deaths we reviewed last year. Taking all of these factors into account, there is therefore an inherent time lag in the completion of reviews which explains the – currently – lower number of reviews for 2021/22.

Current CDDFT Mortality RAG Rating

Measure / source of assurance	RAG
Summary Hospital Mortality Indicator (SHMI) – currently 109.8 (within expected range)	
Hospital Standardised Mortality Ratio (HSMR) – 93 and within expected range	
Copeland's Risk Adjusted Barometer (CRAB)	
Completed mortality reviews – 1,179 deaths reviewed from 2020/21, of which 10 (<1%) had evidence of lapses in care. There is a time lag in deaths being available for review. To January 2022, 182 reviews had been completed in 2021/22 with similar trends.	
North East Quality Observatory (NEQOS) Independent Review	

Despite all of the ongoing work there remain some challenges re: capturing all comorbidities necessary for an accurate assessment of the risk of mortality; however, the EPR system being rolled out in 2022/23 will better support this. EPR will enable immediate access to notes that are legible and accessible to all, in addition to optimising work flows in Sepsis and AKI. Monitoring will continue through thematic analysis of case reviews, monitoring in Mortality reduction committee and mortality indicator data.

Eight Medical Examiners and five Medical Examiner Officers have now been appointed and pre-screening is now in place for 100% of deaths at DMH. We are working towards pre-screening of all deaths at UHND during 2022/23.

Maternity Standards

Our aim
To continue to progress the plans developed in 2020/21 in reference to the Ockenden Report (December 2020) and implementation of the Continuity of Carer initiative.

Our progress

Key actions from 2021/22

In response to our goals for 2021/21:

- Fetal Medicine Consultants are now in place at both acute sites and a Fetal Wellbeing Lead Nurse has been appointed;
- The role of the Head of Midwifery has been upgraded in line with Ockenden recommendations and reports to the Director of Nursing (in his capacity as Executive Maternity Safety Champion).
- There are bi-monthly meetings with the Maternity Safety Champions, supplemented by site visits and channels for regular meetings with staff; staffing ratios meet “birth rate” plus standards (based on establishments); and
- We have rolled out our ‘Infinity (Continuity of Carer) programme to three teams in full, with three others completing shadowing and shortly to go live. National leads have visited the Trust and commended the approach. We are taking stock of staffing across all our acute and community midwifery services to ensure that it remains safe prior to moving to each planned stage of the programme, which has now been recommended as the right following the second report from the Ockenden Inquiry.
- Staffing ratios meet “birth rate” plus standards (based on establishments). The Trust aims to staff its acute sites in line with the recommended staffing ratios for tertiary centres given the needs of the women it looks after. In practice, staffing has needed to be kept under continual review due to sickness absence, maternity leave and the impact of the pandemic (in common with other Trusts). We have secured national funding to recruit beyond current vacancies to support resilience.

Other actions:

Our Community and Continuity of Care Teams have worked tirelessly over the pandemic to ensure that all women receive their first appointment with Maternity Services in a timely manner. Booking appointments remain in place over a virtual platform providing flexibility for booking of care quickly and in a timely manner.

Difficulties have been encountered throughout the pandemic particularly where women have sometimes been unable to present as promptly as we would prefer. In response we have introduced direct referral to Community and Continuity Teams, with booking appointments evaluating well when completed in this way. All women are given a face to face “Early Birds” appointment to receive all the key Health Promotion advice in line with the Public Health Agenda, and also completion of their booking bloods with adherence to National Screening standards.

The Infant Feeding Team have maintained our UNICEF accreditation and are currently preparing for UNICEF GOLD accreditation. The Infant Feeding Team continues to grow and develop: our Band y

Specialist Midwife will from May become a job share opportunity, allowing us to retain the skills of an experienced midwife, whilst developing a new specialist in this area. New appointments also include a Band 6 Midwife and B2 Team support officer. The Team continues to provide support with complex feeding issues, plans, Frenulotomy, and Antenatal and Postnatal bespoke feeding support.

Face to Face training for Infant Feeding has been modified due to constraints surrounding Covid-19. Whilst training was delivered via MS Teams plans are in place to return to the face to face format. The Team continues to support women with all aspects of Infant Feeding support and can point to excellent qualitative data and user feedback via the Maternity Voice Partnership.

We continue to make great improvements in reducing smoking during pregnancy among those who use our services. Our Community Midwifery teams are proactive in undertaking carbon monoxide monitoring and in making early referrals to smoking cessation services. Work is currently underway to reinvigorate Antenatal Clinic contacts with Stop Smoking Services with two dedicated roles being appointed to.

The Trust has continued to monitor the following maternity standards and has made good progress against all three, as shown below. All targets were met in the fourth quarter.

	Target	**Q1**	**Q2**	**Q3**	**Q4**	**2021/22**	2020/21	2019/20
Maternity 12 week bookings	90%	76.8%	84.5 %	88.3%	90.4%	84.1%	92.4%	90.8%
Maternity breast feeding at delivery	60%	57.9%	61.8 %	66.7%	64.8%	62.6%	58%	59.4%
Maternity smoking at delivery	22.4%	10.4%	11.9 %	14.0%	13.0%	12.3%	14.9%	16.9%

Paediatric Care

Our aim

We aimed to provide expanded access to Paediatric Assessment services and further develop partnerships with other providers

Our planned measures of success were:

- For the UHND Paediatric Assessment Area to operates a 24/7 model;
- For Multi-agency pathways of care to be in place for children and young people with mental health problems; and
- To continue to develop pathways and relationships across primary and secondary care.

Our progress

Having operated a 12/24 model, the Paediatric Assessment Area at UHND moved to a 24/7 model of operation from October 2021. Children are now able to access this age-appropriate environment 24 hours per day, which has improved streaming from ED and means that children are not accommodated in a waiting room with adults, resulting in a much better patient experience.

A dedicated paediatric emergency unit opened at Darlington Memorial Hospital in September 2021. It includes a triage room, treatment rooms that have been decorated with colourful murals, and a paediatric resuscitation room. The unit also features a sensory room that has been designed for those infants, children or young people who are particularly anxious or sensitive to noise and lights who could benefit from a very relaxing calming space. This provides a more age-appropriate, relaxing and calm environment that is separate from the adult emergency department. We have also increased our complement of

children's nurses in A&E at DMH and established training in paediatric competencies for all nursing staff working that area.

In response to the significant increase in young people requiring hospital admission due to the physical effects of an eating disorder, we have worked alongside Tees, Esk and Wear Valley NHS Foundation Trust (TEWV) to develop a care pathway, which involves a specialist Eating Disorders Nurse being present on the daily ward round on both inpatient paediatric wards to provide a seamless and holistic approach to care and timely discharge, followed by an intensive support package in the community.

We introduced an evidence based admission pathway for young people underpinned by the national Management of Really Sick Patients with Anorexia Nervosa (MARSiPAN) guidelines. A partnership Dietician post, hosted by TEWV, has been created to support the development of meal plans and provide support throughout the care pathway, both at home and in hospital. We have developed an Operational Mental Health Group with representation from CDDFT and TEWV to support the development of integrated care pathways.

Excellence Reporting

Our aim

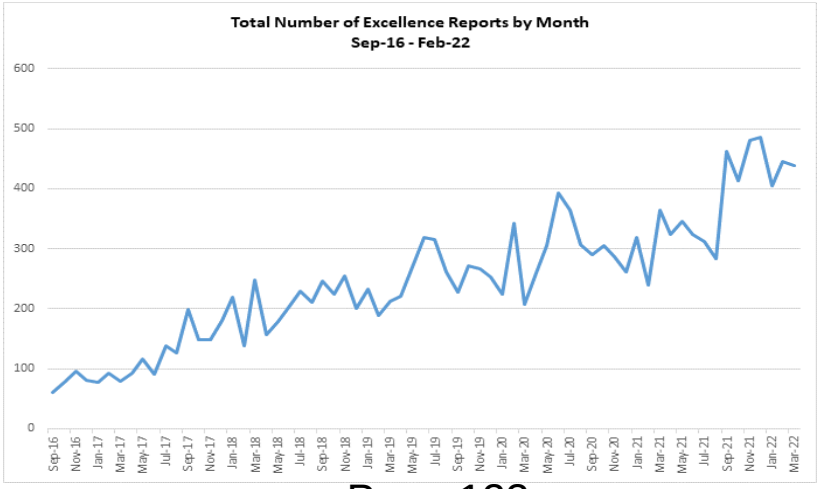
Our objective for 2021/22 was to continue to embed learning from excellence into standard culture and practice through Excellence Reporting and effective collaboration with colleagues across the organisation to triangulate activities / work streams.

Our progress

The Trust continues to promote the reporting of excellence, to both celebrate and learn from it, in the organisation via: a quarterly Trust wide bulletin; "Walls of Awesomeness" on some of our main corridors; and various other communication channels such as Facebook Live Briefings and Directors' Briefings. The number of members in the group has recently increased, and the remit of the group has evolved somewhat, incorporating some Appreciative Inquiry in line with the new Patient Safety Strategy and some patient stories from the Patient Experience Team Compliments into the bulletin.

The Trust's excellence reporting process compares favourably with Trusts nationally, is well embedded and we consistently see high numbers of excellence reports being submitted, i.e. 250-330 reports received per month.

From June 2021 staff excellence reports and a proportion of patient generated compliments were reported collectively, the improvement noted in the graph below is therefore misleading. On further investigation, the amalgamation of staff to staff excellence reports and patient compliments was identified and interrogation of the data actually showed a decrease in staff to staff excellence reports. Through the latter part of the year the team have been working on reinvigorating the staff to staff excellence reporting system. The compliments received from patients/families will soon have their own platform on the Ulysses system, therefore separating again these two strands of reporting. The group are continuing to look at ways to develop the initiative further throughout the coming year.



Part 2B - Priorities for 2022/23

The Trust has refreshed its Quality Strategy following consultation with staff and patients and a wide range of external stakeholders. Priorities for 2022/23 reflect both the priorities in this strategy and further priorities (described as “retained” priorities) where further work is required to meet 2021/22 objectives.

Safety	Experience	Effectiveness
Quality Strategy Priorities		
Reduce the harm from inpatient falls	Provide a positive experience for those in our care whose with additional needs including patients with dementia, learning disabilities, autism and mental health support needs	Reduce waiting times in A&E covering: Time to assess, Time to treat, Total time in the department
Reduce incidence of, and harm, from Health Care Associated Infections	Ensure a positive patient experience through the discharge process	
Maintain zero tolerance of Grade 3 & Grade 4 pressure ulcers		
Maternity Standards including Ockenden recommendations		
Embed safe practice for invasive procedures: LocSSIPs		
Embed prompt recognition and action on signs of patient deterioration		
Retained priorities for 2022/23: work ongoing		
Improve the timeliness of administration of antibiotics for patients with suspected sepsis	End of life care: palliative care strategy, ensuring appropriate access to private rooms for dignity	Improving access to paediatric specialist services
	Continued improvement of nutrition including assessment and provision for specific needs	Increasing excellence reporting
		Learning from Deaths (in particular the roll out of Medical Examiners reviews)
Mandated measures for monitoring		
Rate of Patient Safety Incidents resulting in severe injury or death Time spent in the Emergency Department	Percentage of staff who would recommend the provider to friends and family Responsiveness to patients personal needs	SHMI Patient Reported Outcome Measures

Patient Safety

Quality Strategy Aims:

Reducing harm from inpatient falls

Why we chose this priority

This continues to be a priority for the organisation, with falls being one of the highest reported incidents across the Trust.

Goals

To reduce harm from falls in an increasingly at-risk population

How will we do this?

We will:

- Use our electronic systems to support staff in improving lying and standing blood pressure documentation and escalation;
- Work with EPR leads to ensure all falls assessments are captured;
- Introduce a Falls Prevention Advocate role, related meetings and plan actions ;
- Work with all partner organisations to develop a falls pathway to support patients at whichever point they enter the system;
- Develop a toolkit of interventions for Ward managers to choose from to aid in falls prevention;
- Create a Falls Leaflet to support access to the Falls Team and community-based support; and
- Further development of the Rapid Review process with a view to increasing ward staff ownership.

Measures of success

We will be able to identify falls with lapses in care, and set meaningful baselines from which we will see a reduction in 2022/23 compared to 2021/22.

Reducing the incidence of, and harm from, Healthcare Associated Infections

Why we chose this priority

This remains a high priority for the organisation and continuation of this priority will support the work ongoing within the team.

Goals

Our goals are to:

1. Meet our zero tolerance for MRSA bacteraemia.
2. Achieve thresholds to be set by NHS England and Improvement for Clostridium Difficile and Gram Negative Blood Stream Infections.

How will we do this?

MRSA:

We will:

- Focus on MRSA Screening and decolonisation;
- Review and update the Trust MRSA policy; and

- Continue to investigate cases and share findings with the organisation.

Clostridium Difficile Infections (CDI)

We will:

- Focus on early identification and isolation
- Continue with our Antimicrobial stewardship programme, including engagement with the Senior Responsible Officer through Integrated Care System;
- Share learning in a timely manner to drive improvement; and
- Review and update our CDI policy in line with NICE guidelines.

Gram Negative Blood Stream Infections (GNBSI)

We will:

- Continue to monitor practices for both acute and community onset infections and ensure that joint reviews are undertaken to focus on improvement across the health economy;
- Continue to comply with UK Health Security Agency (UKHSA) guidance;
- Actively participate in the UKHSA data collection covering GNBSIs;
- Continue to audit healthcare practices which include:
    - Monitoring and improving Visual Infusion Phlebitis (VIP) Scoring, through the introduction of a trust wide WASP framework;
    - Participating and leading elements of the newly established CDDFT Asepsis group; and
- Improve the resilience and responsiveness of the IPC team and restructure to support a 7-day IPC service

Measures of success

These will comprise:

- An updated CDI policy;
- An updated MRSA policy;
- An updated policy for Principles of Infection Control and Guidance on Isolation;
- Reinstatement of formal face to face IPC training building on the 'topic of the month' approach in 2021/22 - this started from 1st April 2022;
- Joint working on Infection Prevention and Control strategies within the Antimicrobial stewardship programme;
- Continued development of an improved IPC service.

Reducing harm from category 3 and 4 pressure ulcers

Why we chose this priority

Reducing harm from pressure ulcers continues to be a patient safety priority for the organisation.

Goals

For patients within our care to have no category 3 or 4 pressure ulcers that have been identified as having lapses in care delivery.

How will we do this?

We will:

- Continue to develop our learning in real time across all domains;
- Embed, and refine, the rapid review process;

- Ensure all patients identified with category 3 and above pressure ulcers whilst in our care have a formal review.
- Undertake Quarterly thematic reviews are undertaken on all category 2 pressure ulcers, with findings reported to Care Group Governance meetings for action and learning.

Measures of success

- For patients within our care to have no category 3 or 4 pressure ulcers that have been identified as having lapses in care delivery.
- An increase in the number of Wound Resource Educational Nurses (WRENs) across the organisation.
- A revised educational programme including local audit, an increase localised ownership of the WREN programme and a multi-disciplinary team approach, working with Physiotherapists and Occupational Therapists.

Meeting Maternity Standards, including Ockenden Recommendations

Why did we choose this priority?

Maternity safety remains a high priority nationally with the publication of the second Ockenden Inquiry Report in April 2022, and the implementation of the "Continuity of Carer" initiative as part of the Maternity Transformation agenda, together with numerous work streams that remain on going around the Saving Babies Lives care bundle.

Goals

To continue to progress the plans developed in 2021/22 and implement all recommendations from the Ockenden reports applicable to the Trust.

How will we do this?

We will:

- Complete the gap analysis against the latest Ockenden recommendations now underway;
- Receive and act on an independent assessment of staffing against the Birth Rate Plus standards;
- Continue to implement our Continuity of Carer strategy, ensuring that staffing across the whole of the maternity service remains safe and that risk is balanced, in line with national position following publication of the second Ockenden Inquiry report; and
- Develop the workforce through recruitment and retention work that remains ongoing.

Measures of success

These will comprise:

- Development and implementation of an action plan following the completion of the gap analysis noted above.
- A full workforce review presented to our Board of Directors every six months, which addresses any recommendations from the external review against Birth Rate Plus standards.
- Progressing our Continuity of Carer strategy, based on risk assessment and management of safe staffing across the service as a whole.
- Continued improvement of the outcomes of those women who are in receipt of Continuity of Carer an report these at board level.
- Increasing retention rates for staff working in our Maternity Services.

Embedding safe practice for invasive procedures, inside and outside of theatres

Why did we choose this priority?

The use of local patient safety standards for invasive procedures (LocSSIPs) ensures that all necessary safety checks are undertaken before, during and after a procedure to protect the patient. Having migrated responsibility for the development, issue and adherence to LocSSIPs to local teams, we need to implement robust monitoring, auditing and governance procedures to provide assurance that our new LocSSIPs policy is followed.

Goals

To provide a system of assurance and compliance monitoring that LocSSIPs are correctly followed, that tracking processes are maintained and that ownership is clear and transparent.

How will we do this?

We will:

- Ensure that general access to LocSSIPs via the internet / intranet is controlled;
- Audit the currency of LocSSIP documentation and adherence to it practice, establishing a two year audit programme, focusing on higher risk areas in 2021/22;
- Develop LocSSIPs as electronic forms in our EPR system to assist staff in adhering to the requirements; and
- Introduce robust monitoring and governance processes.

Measures of success

- Full audit of in-use LocSSIPs completed in line with the two year plan.
- Robust monitoring and reporting processes established at Trust and Care Group level.
- Development of a suite of electronic LocSSIPs in EPR, supported by appropriate training to staff.

Embedding prompt recognition and action on signs of patient deterioration

Why did we choose this priority?

One of the key ambitions in the Trust's Quality Matters strategy is to maintain and continuously improve our safety practices, as a 'Highly Reliable' organisation. Whilst we have made some substantial improvements in how we recognise and act on deterioration through our arrangements cardiac arrest prevention, hospital at night and Acute Kidney injury, we continue to see some incidents resulting in moderate or greater harm to patients where the signs of deterioration could have been recognised and acted on sooner.

In addition, during the pandemic, the Trust necessarily agreed to a reduction in the frequency of training programmes related to patient deterioration to maintain staff on the front-line and now needs to refresh this training.

Goals

To reinvigorate compliance with training with respect to patient deterioration and resuscitation and further reduce incidents involving delayed recognition or action on patient deterioration in line with our 'highly reliable organisation' ambition.

How will we do this?

We will:

- Reinstate frequency requirements and closely monitor compliance with relevant training programmes;

- Promote wide learning and education in response to any incidents of harm or significant near misses involving delayed recognition or action on deterioration; and
- Celebrate successful interventions and improvements in early recognition and action on patient deterioration under the banner of our 'Highly Reliable Organisation' activities.

Measures of success

We will see a reduction in incidents with moderate or greater harm involving delayed recognition or action on signs of deterioration, improved compliance rates with training and substantive examples of sharing of learning and success.

Retained Priorities from 2021/22 – Work ongoing:

Improving the management of patients with sepsis

Why we chose this priority

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

Goals

- To improve the percentage of patients receiving antibiotics within 1 hour of diagnosis in the Emergency Department
- To improve staff awareness and processes to ensure prompt recognition and response.

How will we do this?

We will:

- Hold multi-professional study days which include assessments based on simulation exercises.
- Continue planned Sepsis audits and monitor sepsis mortality.
- Deliver planned education to clinical staff and improve the quality of care for patients with sepsis.
- Review the current regional screening tool for adults and how this will align to the Electronic Patient Record (EPR) in our EPR system now under development.
- Enhance our current Sepsis e-resources for staff.
- Roll out a Patient Group Direction to allow senior nurses to administer antibiotic therapy to patients with sepsis of unknown origin.

Measures of success

- Four multi professional study days held per year
- A substantive improvement in the percentage of patients triggering for sepsis who are administered antibiotics in the first hour in our A&E departments, measured through ongoing audits.

Patient Experience

Quality Strategy Aims:

Providing a positive experience in our care for those with additional needs

Improving care of patients with dementia

Why did we choose this priority?

To continue to build on our work to ensure that our patient environments are dementia-friendly and that our staff have high levels of awareness and understanding of how to support patients with dementia.

Goals

To embrace opportunities to enhance and provide appropriate care for patients with cognitive impairment such as dementia and to ensure that they, and their families, have a positive experience in our care.

How will we do this?

By focusing on opportunities to further develop, a dementia friendly hospital and evidence based care/practice

Measures of success

These will comprise:

- Wider Trust understanding supported by increased completion of Dementia related staff training programmes.
- Further development of the role of the Dementia link nurses
- Delivery of dementia audit programme and development / delivery of associated action plans.

Improving care of patients with Learning Disabilities or Autism

Why did we choose this priority?

We recognise that people with a learning disability or autism require extra support and reasonable adjustments making towards their care. We know that we can do more to ensure that all of our staff are able to fully understand and respond proactively to the needs of patients with learning disabilities or autism and to ensure that the environment in which we provide care is always the most suitable.

Goals

To embrace opportunities to enhance and provide appropriate care and support for patients with a learning disability or autism and to ensure that they and their families will have a positive experience in our care.

How will we do this?

By seeking opportunities to further develop, a learning disability and autism friendly service. We follow our learning disability guarantee, which is unique to CDDFT, to ensure that our patients with a learning disability and autism receive individualised support and care under the guidance and support of our learning disability team. We will work with service users and their families to understand and learn from their experiences to continuously improve our care.

Measures of success

- Completion of Learning Disability and Autism related staff training programmes resulting in wider and deeper understanding of how to support patients with learning disabilities or autism across the Trust.
- Further development of the role of the Learning Disabilities Liaison Nurses.
- Delivery of a Learning Disability and Autism Guarantee.
- Monitoring of A&E attendances and working with community staff to help them support patients with learning disabilities or autism to provide help at home and reduce the need for A&E attendances.
- Monitoring the effectiveness of our discharge follow up visits for people with a learning disability or autism to reduce readmissions.
- Learning from the Trust's mortality reviews and LeDeR programme.

Ensuring a positive patient experience through the discharge process

Why did we choose this priority?

Discharging a patient from our care requires often detailed planning, communication with families and carers and – often – detailed coordination between different teams and with partner agencies. Delays in discharge and issues in communication, can lead to a poor patient experience and increase anxiety for our patients and those looking after them. The vast majority of patients are discharged with no issues; however, we know that this is not always the case and, in aspiring to be a highly reliable organisation we want every discharge to be safe, timely and well-communicated to families and those responsible for onward care.

Goals

To build on arrangements for discharge established over the winter of 2021/22 as part of our "Work As One" initiative, to:

- Bring forward discharges (on average) to earlier in the day;
- Ensure that patients have a positive experience through the discharge process; and
- Minimise incidents and adverse events relating to the discharge process.

How will we do this?

We will:

- Continue to develop the roles of our Discharge Champions and Facilitators
- Monitor the timeliness of discharge and delays in discharge, targeting improvements in both
- Share and learn from patient stories – positive and negative – with respect to discharge
- Continue to work with partner agencies to review and learn from any adverse events occurring on discharge and disseminate learning to all teams

Measures of success

We will our discharge curve brought forward to earlier in the day, improved patient satisfaction through post-discharge surveys and a reduction in incidents and adverse events related to discharge.

Retained Priorities from 2021/22 – Work ongoing:

End of life and palliative care

Why did we chose this priority

The Trust continues to strive to implement the overarching aim of the national strategy: *"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)" This builds on the improvements that have already taken place.

Goals

To further deliver on the national strategy in line with a refreshed local strategy.

How will we do this?

We will:

- Work with stakeholders to develop and roll out a new palliative care strategy to 2025;
- Focus intensively on recognition of dying in hospital to enhance care; and
- Explore solutions to the relative lack of single rooms: Ensuring appropriate access to private rooms for dignity.

Measures of success

These will comprise:

- Checklist developed and implemented for care after death documentation.
- Palliative Care Strategy launched.
- Solutions proposed to the relative lack of single rooms.

Improving the nutritional support offered to our patients whilst in our care

Why did we choose this priority?

In 2015, Jane Cummins Chief Nursing Officer stated *"The link between nutrition and hydration and a person's health is a fundamental part of any stage of life, but all the more so for the sick or vulnerable. Person-focussed, quality compassionate care involves looking at what matters to a person as a whole, not only concentrating on their specific medical condition*."

Eating and drinking are essential for maintenance of nutrition and hydration but are also important for pleasure and social interactions. The ability to eat and drink hinges on a complex and coordinated system, resulting in significant potential for things to go wrong.

Goals

To develop a strategy building on the work already undertaken to further improve the nutritional care delivered to our patients. We will continue to strive to work across professional disciplines to drive good nutrition practices across the organisation

How will we do this?

- Progression of Nutrition Support Team business case to increase Trust compliance with NICE CG32 (2017) recommendations
- Development of a Catering Dietitian business case to support recommendations from Hospital Food Review (2020);
- Revising the Trust's Nutrition and Hydration Policy;
- Developing and implementing the Nutrition Strategy;
- Supporting the implementation of nutrition screening through our forthcoming EPR system; and
- Working with EPR colleagues to support achievement of the 95% target for MUST assessments to be completed for new admissions to each ward.

Measures of success

These will comprise:

- Submission of Nutrition Support Team business case
- Submission of Catering Dietitian business case
- Nutrition screening tool (MUST) compliance and usability of screening tool via EPR
- Updated Nutrition and Hydration Policy with launch of strategy
- Consistently achieving the 95% target for MUST assessments

Clinical Effectiveness

Quality Strategy Aims:

Reducing waiting times in A&E: Time to assess, Time to treat, Total time in the department

Why did we choose this priority?

Given current levels of demand on our A&E services, and capacity constraints relating to the size our department at UHND and our bed base, we can experience delays providing treatment and / or in admitting patients. There is evidence that long waits in accessing treatment can affect patient outcomes and – of themselves – long waits are a poor patient experience.

Goals

To further optimise our clinical pathways, working with partners, for urgent and emergency care and expand our same day emergency care services – to take some pressure off the A&E department at UHND during 2021/22.

With the support of the North East and North Cumbria Integrated Care System, to secure capital funding and cover to move forward with our plans for a new Emergency Care Centre at UHND.

To expand and optimise medical staffing for our A&E departments and to enhance our nursing staffing is in line national safe nursing care standards.

How will we do this?

We will:

- Recruit additional junior doctors, funding for which has already been allocated.
- Recruit additional middle grade doctors, following approval of a business case currently in process.
- Piloting the safe nursing care standards in our A&E at UHND and adapting our nursing staffing accordingly.
- Opening an expanded front of house SDEC facility at UHND from late summer 2022
- Working with commissioners and primary care to agree and implement the optimum model for urgent care at the UHND site
- Increasing our bed base at both UHND and DMH, over of the course of the year, to improve flow out of our A&E departments.
- Working to secure funding and capital approvals to commence work on a new Emergency Care Centre at UHND.

Measures of success

These will comprise:

- Substantive increases in medical staffing
- Nursing staffing aligned to the recommendations from the pilot exercise
- The new SDEC facility at UHND open and being able to treat and discharge patients, which are currently using our A&E department but do not need A&E care and / or admission.

- Agreeing and rolling out a model of urgent care at UHND that supports the A&E department.
- Improvements in waiting times with respect to assessment, treatment and the total time in the department.

Retained Priorities from 2021/22 – Work ongoing:

Paediatric Care

Why did we choose this priority?

The Trust has selected this priority to build on the work already undertaken and to strengthen partnerships across mental health, local authorities and primary care. This is particularly important as the Trust, as has been seen nationally, have seen an increase in children and young people with mental health issues which can only be addressed as a whole health economy

Goals

To provide expanded access to Paediatric Assessment services and further develop partnerships with other providers

How will we do this?

We will:

- Sustain the operating hours of Paediatric Assessment Area (PAA) at UHND to 24/7
- Review the provision of front of house paediatric assessment at Darlington Memorial Hospital
- Further develop partnership working with local authorities and mental health trusts to develop pathways of care for children and young people with mental health problems

Measures of success

- UHND Paediatric Assessment Area operates a sustainable 24/7 model; and
- Multi-agency pathways of care are in place for children and young people with mental health problems

Excellence Reporting

Why did we choose this priority?

The Trust has selected this priority to continue to embed learning from excellence within the Trust, in line with the direction of the new national Patient Safety Strategy.

Goals

To continue to embed learning from excellence into our organisational culture and practice through Excellence Reporting, Appreciative Inquiry and patient stories from compliments received.

How will we do this?

We will:

- Promote the use of the excellence reporting system;
- Share and promote stories of learning from excellence;
- Share Appreciative Inquiry cases;
- Share patient stories from compliments received;

- Continue to collaborate with group members from across the organisation, including Workforce Experience Team in order to maximise the effectiveness of the group and work stream and triangulate with other organisational activities.

Measures of success

These will comprise:

- Continued or increased levels of excellence reporting
- Examples of sharing of excellence and resulting learning across the Trust
- Examples of effective collaboration across the organisation and triangulation of activity

Learning from Deaths

Why did we chose this priority?

To progress work-streams in support of the local and national learning from deaths agenda, in order to maximise the effectiveness with which we identify and act on learning from the work of our medical examiners and mortality reviews.

Goals

We will continue to strengthen our mortality review process and implement the Medical Examiner role, whilst seeking to maintain improvements in our SHMI position, through education on record-keeping and coding.

How will we do this?

We will:

- Continue 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.
- Provide care groups with quarterly learning from deaths reports identifying themes of learning as commenced in 2019/20.
- Continue to work with Regional and Primary Care colleagues to ensure joint learning.
- Ensure triangulation between mortality review and patient safety and incident reporting established in 2021-22 continues.
- Embed Trust-wide implementation of the Medical Examiner Service, including pre-screening of all deaths.
- Utilise the EPR system which enables immediate access to notes that are legible and accessible to all, in addition to optimising work flows in Sepsis and AKI.

Measures of success

These will comprise:

- Quarterly learning reports shared.
- Full Medical examiner service in place.
- Maintaining SHMI within statistically 'normal' limits.

Part 2C Statements of Assurance from the Board

Review of Services

Review of the performance of the Trust's services is undertaken by the Trust Board and its Operational Performance and Assurance sub-committee (OPAC). Both receive a monthly Integrated Quality and Performance Report (IQPR) covering performance against the key national and local standards and measures. This process has continued throughout the year.

Additionally, in normal times, each of the Trust's five Care Groups' operational performance is reviewed monthly with the Director of Performance and any significant risks escalated to Executive Directors. During Covid-19 surges, this process was suspended when appropriate to do so, and performance has been covered every month in Senior Leadership Team meetings and any exceptional performance escalated through the Command Structure that was stood in response to the pandemic.

Externally, the Trust has continued to work closely with:

- Other regional Trusts, including participation in regional hub planning.
- The independent sector, which has provided some elective and diagnostic activity
- Partners in the CCG and Local A&E Delivery Board (LADB)

Participation in Clinical Audit

Background

Clinical Audit is embedded within the operating rhythm of the trust and is included as a substantive item on the agenda in monthly Care Group Governance meetings and quarterly reports to the Clinical Effectiveness Committee. Assurance is provided to the Board through the Integrated Quality and Assurance Committee which scrutinises quarterly reports from the Clinical Audit Team.

All National Audit reports are reviewed by the Lead Clinician and the Clinical Audit Team, and a specific action plan is developed for each audit and approved by both the Speciality and Care Group Clinical Audit Leads. Action plans are monitored by the Clinical Audit team and Care Group Governance Facilitators.

Participation in Clinical Audit

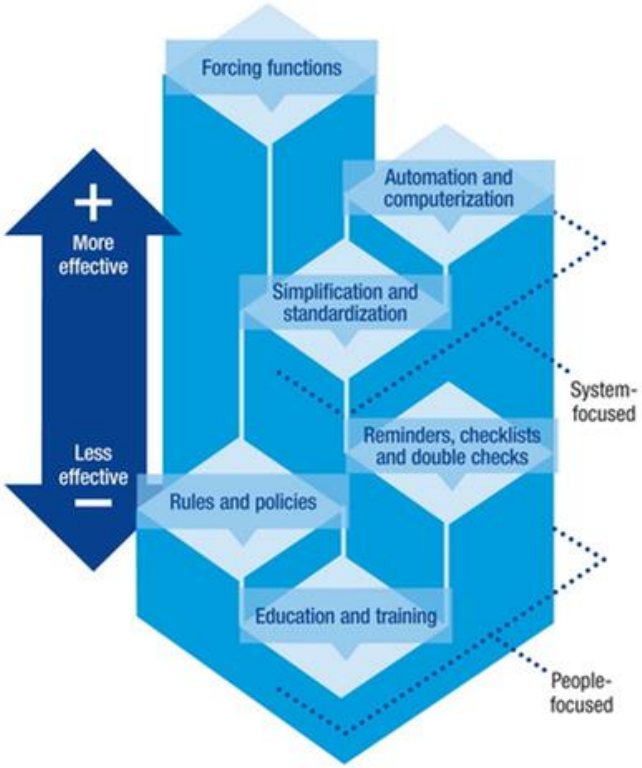
During 2021/22 there were **47** national clinical audits and **7** national confidential enquiries applicable to the NHS services that County Durham & Darlington NHS Foundation Trust provides. Of the **47** national clinical audits there was no participation due to impact of Covid-19 for **2** national clinical audits (as a result of suspension, delay, or no data collection due to re-deployment of staff related to the care of patients with Covid-19). These two audits have been excluded from the calculation of the percentage participated below.

During 2021/22 County Durham & Darlington NHS Foundation Trust participated in **96**% of the national clinical audits, and **100** % of the national confidential enquiries which it was eligible to participate in.

The reports of **37 National Clinical Audits** and **48 Local Clinical Audits** were reviewed by the provider in **2021/22** and County Durham & Darlington NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Actions typically include the education and training of staff, review of patient pathways, the alignment of local processes to national guidelines, changes to current systems and processes and the introduction of new systems and processes where necessary to support staff in delivering excellent patient care.

For Quality Improvement (QI) programs such as Clinical Audit to be effective they need to be embedded within the culture of the Trust, easily accessible and supported by senior leadership. The structures outlined above are essential to achieving this. The Clinical Audit Team is dedicated to promoting Clinical Audit as a QI tool, refining the audit process and supporting staff through engagement and access to training as follows.

Communication & Engagement	
• Promoting clinical audit through excellence reporting. • Enhancing access to clinical audit training and online resources. • Actively engaging with other QI initiatives throughout the Trust. • Supporting junior doctors with access to a library of routine audits.	
Measuring Success	
• Developing a high level overview of the performance of the clinical audit programme. • Encouraging audits that indicate the effectiveness of previous interventions. • Feedback from staff on the clinical audit process.	
Supporting Effective Change	
• Support and training with root cause analysis and the use of human factors techniques. • Investigate and remove barriers to accessing QI processes and implementing change. • Support and training on appropriate, efficient and effective interventions. • Adopting a holistic approach to QI, making use of both people and system focused changes/ interventions to ensure the delivery of high quality and effective patient care. • Emphasising the importance of smaller achievable changes where appropriate, that which can be owned by individuals or teams. Particularly for Junior Doctors on short rotations who have limited time to complete QI activities.	
	KEEP, A. B. J. CLINICAL AUDIT DOES NOT WORK, IS QUALITY IMPROVEMENT ANY BETTER? HTTPS://DOI.ORG/10.12968/HMED.2018.79.9.508 79, 508–510 (2018).

The national clinical audits and national confidential enquiries that County Durham & Darlington NHS Foundation Trust was eligible to participate in, participated in and for which data collection was completed during 2021/2022 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 Audits Applicable to County Durham & Darlington NHS Foundation Trust

National Program	Topic	Participation	% cases submitted
Case Mix Programme (CMP)	N/A	✓	100%
Child Health Clinical Outcome Review Programme	Transition from child to adult health services	✓	Ongoing
Elective Surgery (National PROMs Programme)	N/A	✓	Hip (76%) Knee (53%)
Emergency Medicine QIPs	Infection Prevention and Control	✓	Ongoing
	Pain in Children	✓	Ongoing
Falls and Fragility Fracture Audit Programme (FFFAP)	National Audit of Inpatient Falls	✓	100%
	National Hip Fracture Database	✓	100%
	Fracture Liaison Service Database (FLS-DB)	✓	55%
Gastro-intestinal Cancer Audit Programme (GICAP)	National Bowel Cancer Audit	✓	100%
	National Oesophago-Gastric Cancer Audit (NOGCA)	✓	100%
LeDeR - learning from lives and deaths of people with a learning disability and autistic people	N/A	✓	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal mortality surveillance and confidential enquiry (confidential enquiry includes morbidity data)	✓	Ongoing
	Perinatal confidential enquiries	✓	Ongoing
	Perinatal mortality surveillance	✓	Ongoing
Medical and Surgical Clinical Outcome Review Programme	Community acquired pneumonia	Data Collection Scheduled for 2022	
	Crohn's disease	Data Collection Started April 2022	
	Epilepsy Study	✓	67%
National Adult Diabetes Audit (NDA)	National Diabetes Foot Care Audit	✓	Ongoing
	National Diabetes Inpatient Safety Audit (NDISA)	✓	Ongoing
	National Core Diabetes Audit	✓	Ongoing
	National Diabetes in Pregnancy Audit	✓	Ongoing
	NDA Integrated Specialist Survey	✓	N/A

National Program	Topic	Participation	% cases submitted
National Asthma and COPD Audit Programme (NACAP)	Adult Asthma Secondary Care	✓	100%
	Chronic Obstructive Pulmonary Disease Secondary Care	✓	100%
	Paediatric Asthma Secondary Care	✓	Ongoing
	Pulmonary Rehabilitation Organisational and Clinical Audit	✓	Ongoing
National Audit of Breast Cancer in Older Patients (NABCOP)	N/A	✓	100%
National Audit of Cardiac Rehabilitation	N/A	✓	Ongoing
National Audit of Care at the End of Life (NACEL)	N/A	✓	100%
National Audit of Dementia	Spotlight Audit for Memory Assessment Services	✓	100%
National Bariatric Surgery Register	N/A	✓	94%
National Cardiac Arrest Audit (NCAA)	N/A	✓	100%
National Cardiac Audit Programme (NCAP)	Myocardial Ischaemia National Audit Project (MINAP)	✓	Ongoing
	National Audit of Cardiac Rhythm Management (CRM)	✓	100%?
	National Heart Failure Audit	✓	Ongoing
National Comparative Audit of Blood Transfusion	2021 Audit of Blood Transfusion against NICE Guidelines	✓	Postponed due to Covid-19
National Emergency Laparotomy Audit (NELA)	N/A	✓	DMH 96% UNHD 98%
National Joint Registry	10 work-streams that all report within Annual report: Primary hip, knee, shoulder, elbow and ankle replacement, Revision hip, knee, shoulder, elbow and ankle replacement.	✓	100%
National Lung Cancer Audit	N/A	✓	Utilises existing datasets

National Program	Topic	Participation	% cases submitted
National Maternity and Perinatal Audit (NMPA)	N/A	✓	100%
National Neonatal Audit Programme (NNAP)	N/A	✓	Ongoing
Respiratory Audits	Smoking Cessation Audit- Maternity and Mental Health Services	✓	100%
	National Outpatient Management of Pulmonary Embolisms Audit	✓	Ongoing
Sentinel Stroke National Audit Programme (SSNAP)	N/A	✓	100%
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	N/A	✓	Ongoing
Society for Acute Medicine Benchmarking Audit (SAMBA)	N/A	✓	Ongoing
Trauma Audit & Research Network (TARN)	N/A	✓	100%
National Ophthalmology (NOD)	Age-related Macular Degeneration Audit (AMD)	✓	100%
	Adult Cataract Surgery	✗	N/A
Epilepsy 12 - National Audit of Seizures and Epilepsies for Children and Young People	Epilepsy12 has separate work-streams / data collection for: Clinical Audit, Organisational Audit	✓	100%
Perioperative Quality Improvement Programme (PQIP)	N/A	✗	N/A
Inflammatory Bowel Disease Audit	N/A	✗	Staff re-deployed due to Covid-19
UK Parkinson's Audit	N/A	✗	Postponed due to Covid-19
National Paediatric Diabetes Audit (NPDA)	N/A	✓	100%

National Audits **Not** Applicable to County Durham & Darlington NHS Foundation Trust

National Program	Topic
Breast and Cosmetic Implant Registry	N/A
British Spinal Registry	N/A
Cleft Registry and Audit NEtwork (CRANE)	N/A
Medical and Surgical Clinical Outcome Review Programme	Physical Health in Mental Health Hospitals
National Cardiac Audit Programme (NCAP)	National Adult Cardiac Surgery Audit
Management of the Lower Ureter in Nephroureterectomy	Management of the Lower Ureter in Nephroureterectomy
Mental Health Clinical Outcome Review Programme	Real-time surveillance of patient suicide
	Suicide (and homicide) by people under mental health care
	Suicide by middle-aged men (Topic closed 2021/22)
Muscle Invasive Bladder Cancer at Transurethral REsection of Bladder Audit (MITRE)	Muscle Invasive Bladder Cancer at Transurethral REsection of Bladder Audit (MITRE)
National Audit of Pulmonary Hypertension	N/A
National Clinical Audit of Psychosis (NCAP)	N/`A
Transurethral REsection and Single instillation intra-vesical chemotherapy Evaluation in bladder Cancer Treatment (RESECT) Improving quality in TURBT surgery.	N/A
National Prostate Cancer Audit (NPCA)	N/A
National Vascular Registry	N/A
Neurosurgical National Audit Programme	N/A
Out of hospital cardiac outcomes (OHCAO)	N/A
Paediatric Intensive Care Audit Network (PICANet)	N/A
Prescribing Observatory for Mental Health	Prescribing for depression in adult mental health services
	Prescribing for substance misuse: alcohol detoxification in adult mental health inpatient services
	Prescribing of antipsychotic medication in adult mental health services, including high dose, combined and PRN
	Use of clozapine
Renal Audits	National Acute Kidney Injury Audit
	UK Renal Registry Chronic Kidney Disease Audit
UK Cystic Fibrosis Registry	N/A
National Cardiac Audit Programme (NCAP)	National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)
	National Congenital Heart Disease Audit (NCHDA)

Participation in Clinical Research

Research and Innovation continues to be a priority within CDDFT, with a ward to board ethos. We have developed a blueprint for the future, which has received excellent feedback from both internal and external stakeholders – this will sit alongside the existing strategy and will inform further developments.

Our focus is to ensure research and innovation is core business. The next steps will be to strengthen our multi-disciplinary research agenda and to work closely with the quality improvement team and patient safety.

The number of patients receiving relevant health services provided or sub-contracted by County Durham & Darlington NHS Foundation Trust in 2021/22 to date, that were recruited during that period to participate in research approved by a Research Ethics Committee was 3,236 participants.

This recruitment number was higher than 2020/21 despite a shift from Covid-19 to non-Covid-19 studies. The Trust recruited to 53 National Institute Health Research Portfolio studies with most paused studies due to Covid-19 now re-opened. The Trust had 67 active Principal Investigators in 2021-22.

The Trust is part of the Durham Tees Valley Research Alliance (DTVRA) alongside North Tees & Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. This last year has seen our department deliver a number of Urgent Public Health Covid-19 studies as well as re-open all of our non-Covid trials that had been previously paused during the pandemic. One of the key successes was to deliver the NOVAVAX Covid vaccine trial from the hub at Hartlepool Hospital. We over recruited to this trial enrolling 532 participants against a target of 350.

In this past year we have submitted data on 1,342 patients for the CCP ISARIC Covid-19 data collection study. Overall, 1,446 participants from the Trust have contributed data to Covid-19 and infection studies.

Other highlights from some of the research trials open at CDDFT:

- The White9 Study (Orthopaedics) UHND is the top national recruiter opening in August 2021;
- The ROCKETS Study (Obstetrics and Gynaecology) UHND is consistently top national recruiter;
- The ENRICH-AF study (Cardiology) UHND – a top 10 recruiter globally;
- The GENOMICC Study (Covid-19) UHND is in the top 10 recruiters;
- For CONSCOP2 (a trial of contrast-enhanced colonoscopy), the Trust is the second highest recruiting site in UK;
- The GI Research Team at DMH recruited the first UK patient to the MESSINA trial, a commercial trial giving a new treatment to patients with Eosinophilic Oesophagitis; and
- The PERSPECTIVES Study (Gastroenterology): 1,176 patients were recruited this year into a locally-led study by one of our Clinical Nurse Specialists.

Goals agreed with commissioners

County Durham and Darlington income in 2020/21 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework because the scheme was suspended due to the Covid-19 pandemic.

CQC Registration

County Durham & Darlington NHS Foundation Trust is required to register with the Care Quality Commission; the Trust's current registration status is 'registered without conditions.

The Care Quality Commission has not taken enforcement action against County Durham and Darlington NHS Foundation Trust during 2021/22.

Care Quality Commission Ratings

The Trust was last inspected between June 2019 and September 2019, with the final report being issued in December 2019. Three key services were inspected in June 2019 at both DMH and UHND: Surgery, End of

Life Care and Urgent and Emergency Care. In addition, Trust-wide reviews of "Well-Led" arrangements and our Use of Resources were undertaken. The Trust received an overall Good rating, which was replicated for the significant majority of its services. Our current ratings are those set out in CQC's report, published in December 2019, and combine 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 and the further inspection reported in March 2018.

Overall ratings by Domain are set out below:

Are services safe?	Requires Improvement (RI)
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good
Overall rating for quality	**Good**

Use of Resources Assessment	Good

Ratings grids for each Hospital / Community Services are as follows:

Darlington Memorial Hospital (DMH)

All services are rated "Good", except End of Life care which is rated Outstanding.

Ratings for Darlington Memorial Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good ↑ Oct 2019	Good →← Oct 2019	Good →← Oct 2019	Requires improvement →← Oct 2019	Good →← Oct 2019	Good ↑ Oct 2019
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	Good ↑ Oct 2019	Good →← Oct 2019	Good →← Oct 2019	Good →← Oct 2019	Good ↑ Oct 2019	Good ↑ Oct 2019
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	Good ↑ Oct 2019	Good ↑ Oct 2019	Good →← Oct 2019	Outstanding ↑ Oct 2019	Outstanding ↑↑ Oct 2019	Outstanding ↑↑ Oct 2019
Outpatients and Diagnostic Imaging	Good Sept 2015	N/A	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015

University Hospital North Durham (UHND)

All services are rated Good overall, except for End of Life Care (Outstanding) and Urgent and Emergency Care (Requires Improvement). Actions required by CQC following the 2015 inspection for the Safe Domain for Critical Care, and following the 2018 inspection for the Effective Domain for Medicine, have been fully implemented; however, CQC do not review ratings until services are formally re-inspected.

Ratings for University Hospital of North Durham

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement →← Oct 2019	Good →← Oct 2019	Good →← Oct 2019	Requires improvement →← Oct 2019	Good →← Oct 2019	Requires improvement →← Oct 2019
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	Good ↑ Oct 2019	Good →← Oct 2019	Good →← Oct 2019	Good ↑ Oct 2019	Good ↑ Oct 2019	Good ↑ Oct 2019
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	Good ↑ Oct 2019	Good ↑ Oct 2019	Good →← Oct 2019	Outstanding ↑ Oct 2019	Outstanding ↑↑ Oct 2019	Outstanding ↑↑ Oct 2019
Outpatients and Diagnostic Imaging	Good Sept 2015	N/A	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015

Community Services

All services are rated Good overall. Actions agreed with CQC following the 2015 inspection have been fully implemented; however, ratings are not reviewed until services are formally re-inspected.

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	Good Sept 2015	Good Sept 2015	Requires improvement Sept 2015	Good Sept 2015
Community urgent care service	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

Implementation of actions from the 2019 inspection

We have implemented all of the Must Do actions agreed with CQC. Whilst we have improved our medical staffing and arrangements for children accessing our A&E departments to have access to specialist children's nurses, continue to further strengthen and improve the resilience of our arrangements in both areas. As outlined earlier in this document: we are recruiting additional medical staff to our A&E Departments; we have opened a 24 hour Paediatric Assessment Area – co-located with the A&E department at UHND; and, at DMH we have recruited more specialist nurses to staff the children's A&E area, working alongside general nurses

who are approved to work with children in A&E, following assessment by senior nurses from our A&E and Paediatrics Services based on a rigorous competency framework.

In addition to the above, we have implemented the substantial majority of improvement recommendations included in CQC's reports, subject to a minority which could not be implemented because of the way in which the Covid-19 pandemic changed our operations and management arrangements.

We are now are actively working on enhancements to services and key processes as we seek to consolidate our Good rating and embed further outstanding practices; as we strive to continuously improve services for our patients.

Data Quality

County Durham and Darlington NHS Foundation Trust submitted records during 2021/22 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 patients valid NHS number was:
  - 99.5% for Admitted Patient Care
  - 99.7% for Outpatient Care
  - 97.6% for Accident and Emergency Care

- which included the patient's valid General Medical Practice Code was:
  - 99.7% for Admitted Patient Care
  - 99.5% for Outpatient Care
  - 99.5% for Accident and Emergency Care

Data Security and Protection Toolkit Annual Return

The Trust can report that, in line with NHS Digital compliance requirements it will be aiming to publish its Data Security and Protection Toolkit annual return, and predict a publication status prior to 30th June 2022 of 'standards met' but are aiming towards 'standards exceeded' if Cyber Essentials Plus certification is achieved.

Clinical Coding Error Rate

County Durham and Darlington NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2021/22 by the Audit Commission.

Learning from Deaths

During 2021/2022, 2,188 patients died in the Trust, a quarterly breakdown is provided below:

- 429 in the first quarter;
- 569 in the second quarter;
- 607 in the third quarter; and
- 560 in the fourth quarter.

By 31 March 2022, 390 case record reviews and eight investigations had been carried out in relation to 2188 of the deaths included above.

In eight 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:

- 149 in the first quarter;
- 121 in the second quarter;
- 85 in the third quarter; and

- 35 in the fourth quarter.

Four (0.18%) of the patient deaths during the reporting period were 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:

- 1 representing 0.2% for the first quarter;
- 1 representing 0.2% for the second quarter;
- 1 representing 0.2% for the third quarter; and
- 1 representing 0.2% 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's Serious Incident Reporting Process.

The key learning themes identified from the reviews completed in 2021/2022 have been in relation to ensuring the physiological observation policy is followed, repeating blood tests and documentation. Learning identified through case record review overall has related to: escalation planning and decision making, and recognition that a patient is reaching the end of their life and communication with family. Treatment of Sepsis and Acute Kidney Injury are also an ongoing theme for quality improvement.

Actions that County Durham and Darlington NHS Foundation Trust has taken in relation to the learning identified from those deaths in 2021/22 form part of comprehensive SMART action plans monitored through the Trust governance processes. Since March 2021, the Trust has operated 'Call for Concern', which allows patients and relatives to alert clinical teams to concerns, in response to learning from mortality reviews.

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

Some 452 Case Record Reviews and 4 investigations were completed after 31st March 2021 which related to patient deaths which took place before the start of the reporting period.

Eight deaths, representing 0.3% of the deaths before the reporting period were judged to be more likely than not to have been due to the problems in the care provided to the patient. 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.

Staff who 'Speak Up' (Including Whistle-blowers)

The Trust has a number of channels through which staff can speak up, and raise concerns regarding quality of care, bullying, harassment and patient safety, in particular:

- The Trust has a 'Raising Concerns' policy which is aligned to the National Freedom to Speak Up Strategy. The policy encourages staff to raise and resolve concerns through the management chain, where appropriate and where they feel comfortable in doing so.
- Where concerns are serious and staff consider that they would be unable to use the management chain, they can raise concerns formally under the policy and / or raise matters through the Trust's Freedom to Speak Up Guardian. Any referrals made formally to the Guardian are logged and overseen by them. Cases raised through Human Resources are logged and overseen through a case management system. In either case, providing feedback to staff and ensuring that staff do not suffer any detriment are cornerstones of the Trust's approach.
- Staff can raise concerns around safety through the incident management system, Ulysses, for investigation and action in line with the defined protocols. Reports can be made anonymously where staff wish to do so. Serious reports are routed to Trust senior managers for follow up, and the Associate Director of Nursing (Patient Safety) monitors reports to identify serious matters or themes for follow up work to be agreed with the Medical and Nursing Directors.

The Trust's Freedom to Speak Up Guardian is a registered nurse who has previously worked in senior nursing management roles. Their appointment has been publicised through the Trust's intranet site,

screensavers, staff bulletins and staff meetings and also through wider staff engagement events using Facebook. In previous years, the Guardian has undertaken a wide-ranging programme of visits to wards and departments; this was not possible for much of the last two years due to the pandemic. However, such visits are now programmed in and taking place.

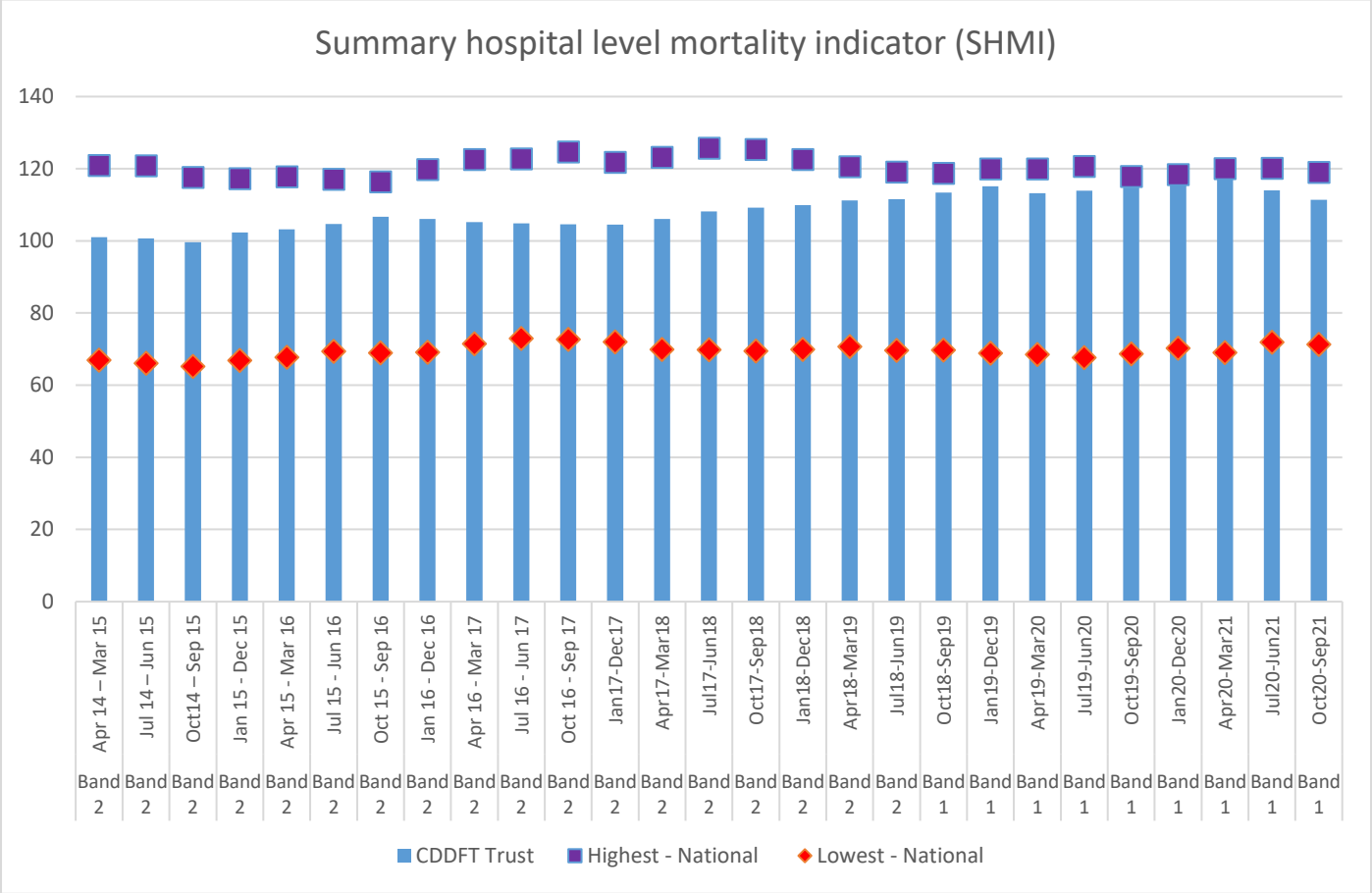
The Trust promotes the National Guardian's Office's training modules "Speak Up" and "Listen Up" to all staff and managers respectively, through its e-learning platform and monitors uptake.

The Freedom to Speak Up Guardian actively participates in national and regional networks in order to identify and implement good practice within the Trust. The Guardian is supported by two Freedom to Speak Up Champions, who provide a confidential sounding board for staff considering raising a concern, and signpost them to the Guardian. The Guardian reports to the Chief Executive and the Trust Board on her work, trends and benchmarking.

The Freedom to Speak Up Guardian is supported by the Senior Associate Director of Assurance and Compliance and by a Non-Executive Director. The Board has agreed a Freedom to Speak Up Strategy for, which aims to embed a culture in which staff feel able to speak up, and in which the Trust universally listens to, looks into and learns from concerns raised. This ran to 31st March 2022 and is being refreshed.

Reporting against core indicators

Domain 1 – Preventing people from dying prematurely
SHMI and Palliative Care Coding



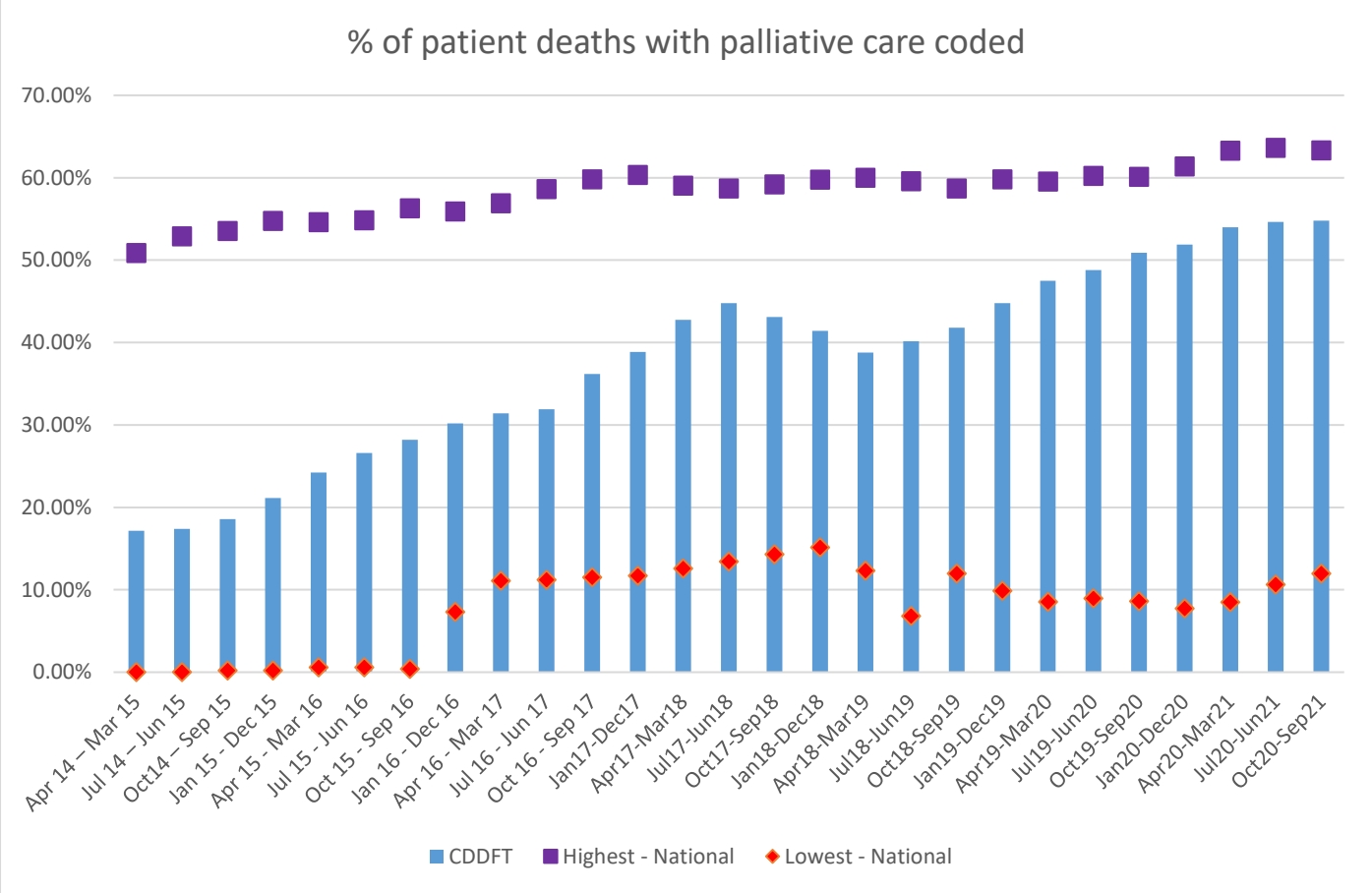
Data source: NHS Digital

The County Durham and Darlington NHS Trust considers that this data is as described for the following reasons: this data is regularly reviewed by the Trust Mortality Reduction Committee

The County Durham and Darlington NHS Trust intends to take the following actions to improve the indicator and so the quality of services by continuing to ensure that mortality remains a strong focus for the Trust. The Trust will continue to build on the mortality review process within the organisation and provide care groups with quarterly learning from deaths reports identifying themes of learning. Work will continue with Regional and Primary Care colleagues to ensure joint learning. The Trust has appointed a lead Medical Examiner and continues to recruit more Medical Examiners to enable the Trust to provide a full service. This year the Trust will also implement a new EPR system which will enable immediate access to notes that are legible and accessible to all, in addition to optimising work flows in Sepsis and AKI. Monitoring will continue through thematic analysis of case reviews, and reporting of Mortality indicators and the results of learning from deaths reviews to the Mortality Committee.

As outlined in Part 2A, the Trust has appointed three clinical champions providing education and training in recording of comorbidities in notes and discharge letters, so that patient episodes are accurately coded to the correct diagnosis group, and has also appointed AKI nurses to support our wards in recognising and acting on signs of AKI. The Trust carried out detailed investigations to understand its SHMI trend including utilising external experts and additional data from Copeland's Risk Adjusted Barometer. The external view of CDDFT's SHMI position was provided by NEQOS who commended the Trust on the number and depth of learning from deaths reviews completed and advised that more assurance should be taken from the Trust's own reviews and alternative measures which NEQOS stated was in line with good practice. As a result of this work CDDFT's SHMI is now within the expected range.

Percentage of deaths with palliative care coded



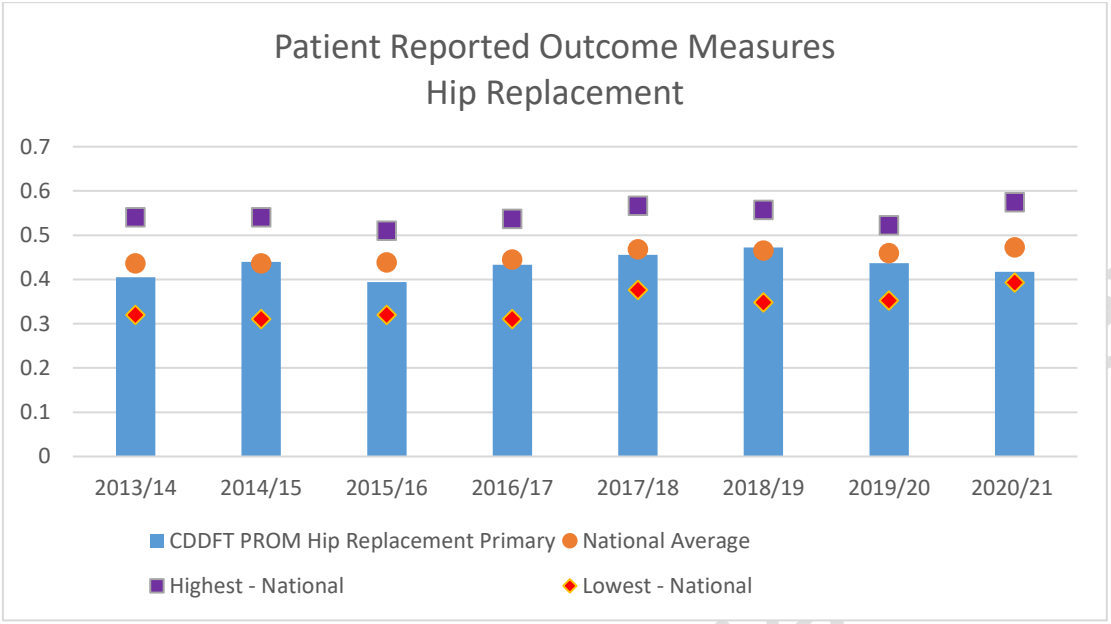
Data source: NHS Digital

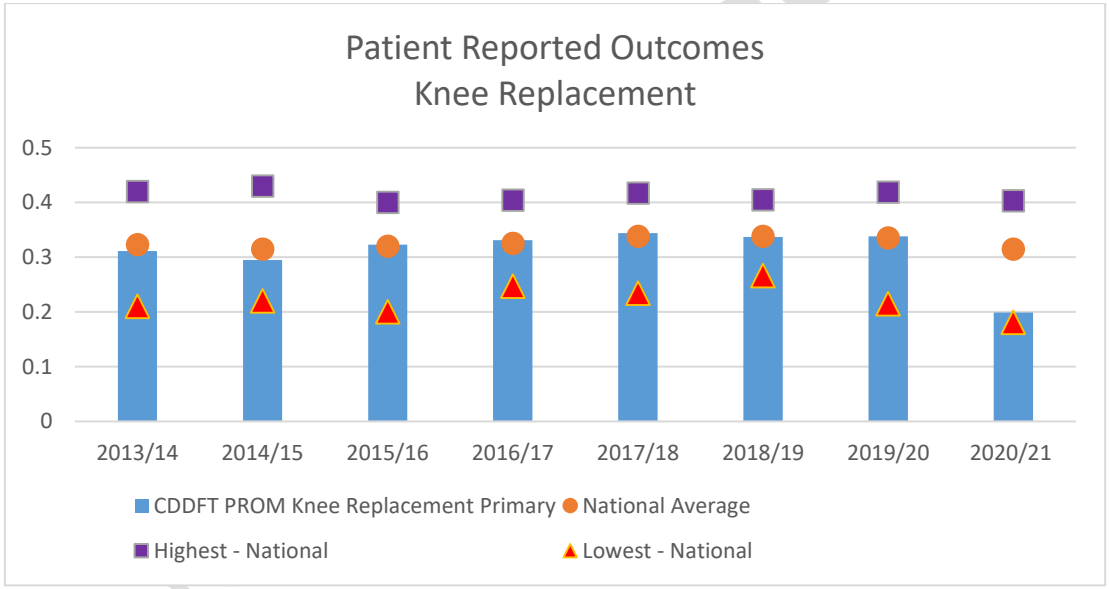
The County Durham and Darlington NHS Trust considers that this data is as described for the following reasons: this data is regularly reviewed at the Trust End of Life Steering Group

The County Durham and Darlington NHS Trust intends to take the following actions to improve the percentage and so the quality of services by: continuing to work with stakeholders to develop and implement the five year palliative care strategy which was delayed due to pandemic priorities; continuing our focus on the recognition of dying in hospital so that people can be identified at an early stage of the process and improve the care and support to them and their families; exploring solutions to the relative lack of single rooms (which is good in DMH (88%) but remains more of a challenge at Durham) and exploring changes to documentation within the new Electronic Patient Record (EPR).

Domain 3 – Helping people to recover from episodes of ill health or following injury

Patient Reported Outcome Measures (PROMS)





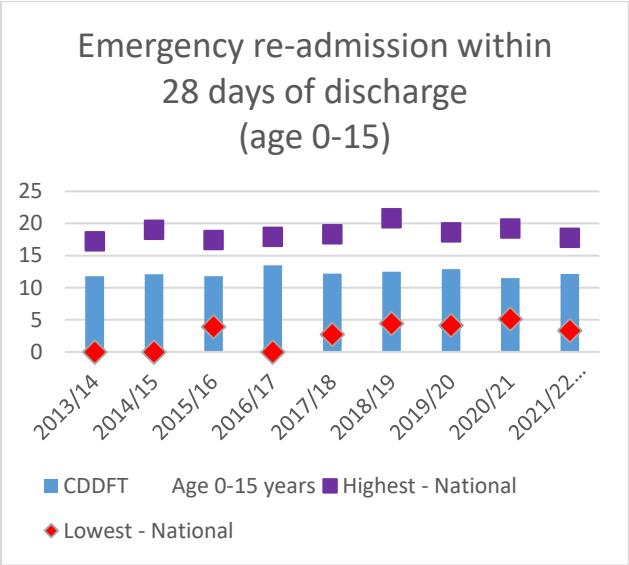
Data source: NHS Digital

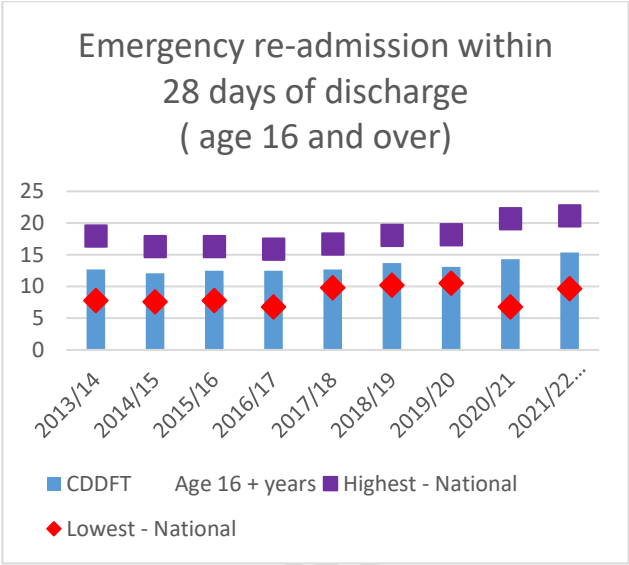
The County Durham and Darlington NHS Trust considers that this data is as described for the following reasons: the data is collected by a dedicated team and is reviewed by the Surgery Care group.

The County Durham and Darlington NHS Trust intends to take the following actions to improve the percentage and so the quality of services by: implementing recovery plans for planned, elective Orthopaedic surgery and theatre staffing to be monitored by Executive Directors. Planned Orthopaedic surgery, like all planned surgery, has been significantly hampered by the Covid-19 pandemic. Ward bed availability and infection control policies have resulted in a significant decrease in elective surgery as witnessed in the results above. The Trust has also had to contend with a reduction of trained Orthopaedic Theatre staff and therefore a reduction in available Theatre sessions, a product of retirements, Covid-19 shielding and the need to train newly qualified staff. The impact is particularly stark for knee arthroplasty.

Patients re-admitted to a hospital within 28 days of being discharged

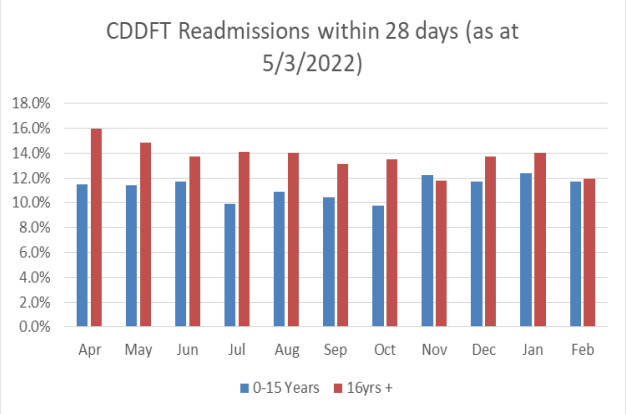
Timely and safe discharges or transfers of care remain a priority for CDDFT.





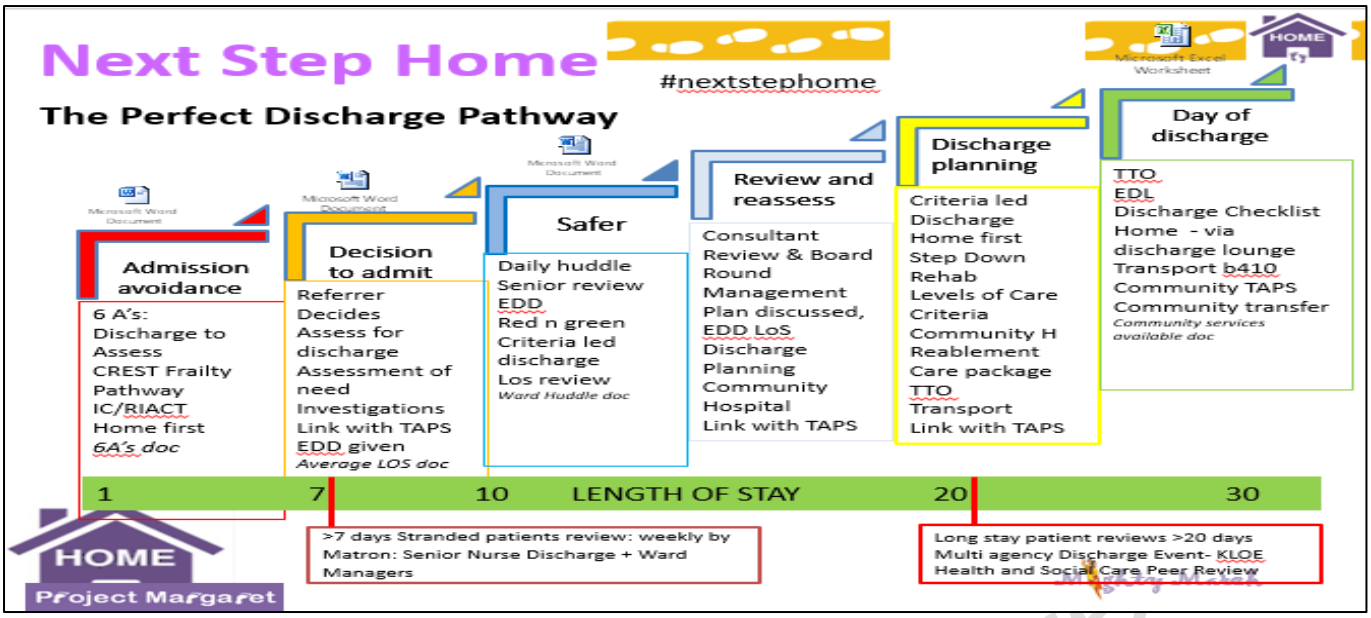
There remains a lower re-admission rate amongst 0-15 year olds.

The re-admission rate peaked at 16% in April and has reduced throughout the year.



This data is collated and submitted as per national guidelines and is regularly reviewed.

The Trust has continued to implement Discharge Guidance via an internal Discharge Working Group, reporting ultimately to the Local A&E Delivery Board, and through the Trust's Next Step Home initiative:



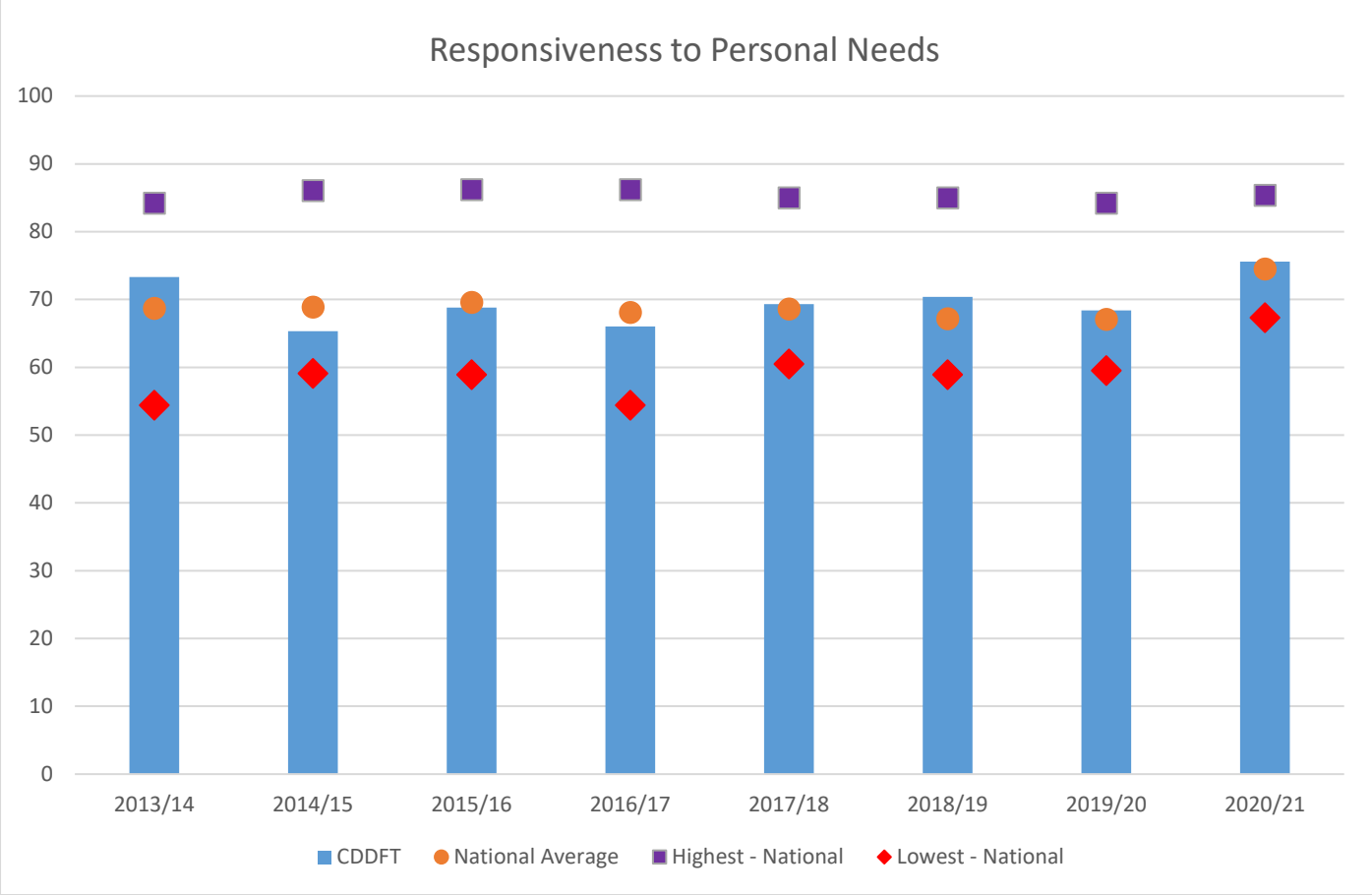
A number of actions have been taken in support of this measure:

- Introduction of community-based urgent crisis response services. Patients, over 90% of the time, receive a response with two hours to support them at home. Work is underway to develop quality markers for this service.
- Investment has been made into adult therapies who are instrumental to support discharge and timely transfers of care.
- There has been increased bed capacity in all community hospitals for those patients who are not quite ready to go home, but do not require an acute bed. They may need an additional period of rehabilitation.
- Primary Care Colleagues have access to a Clinical Advice Line, which enables them to access consultant advice without the need for a re-admission or an out-patient appointment.
- All rapid access services providing alternatives to admission have been reviewed and promoted to partners.

Domain 4 – Ensuring people have a positive experience of care

Responsiveness to the personal needs of patients

This is based on the average score of five domains from the National Inpatient Survey, which measures the experiences of people admitted to NHS Hospitals

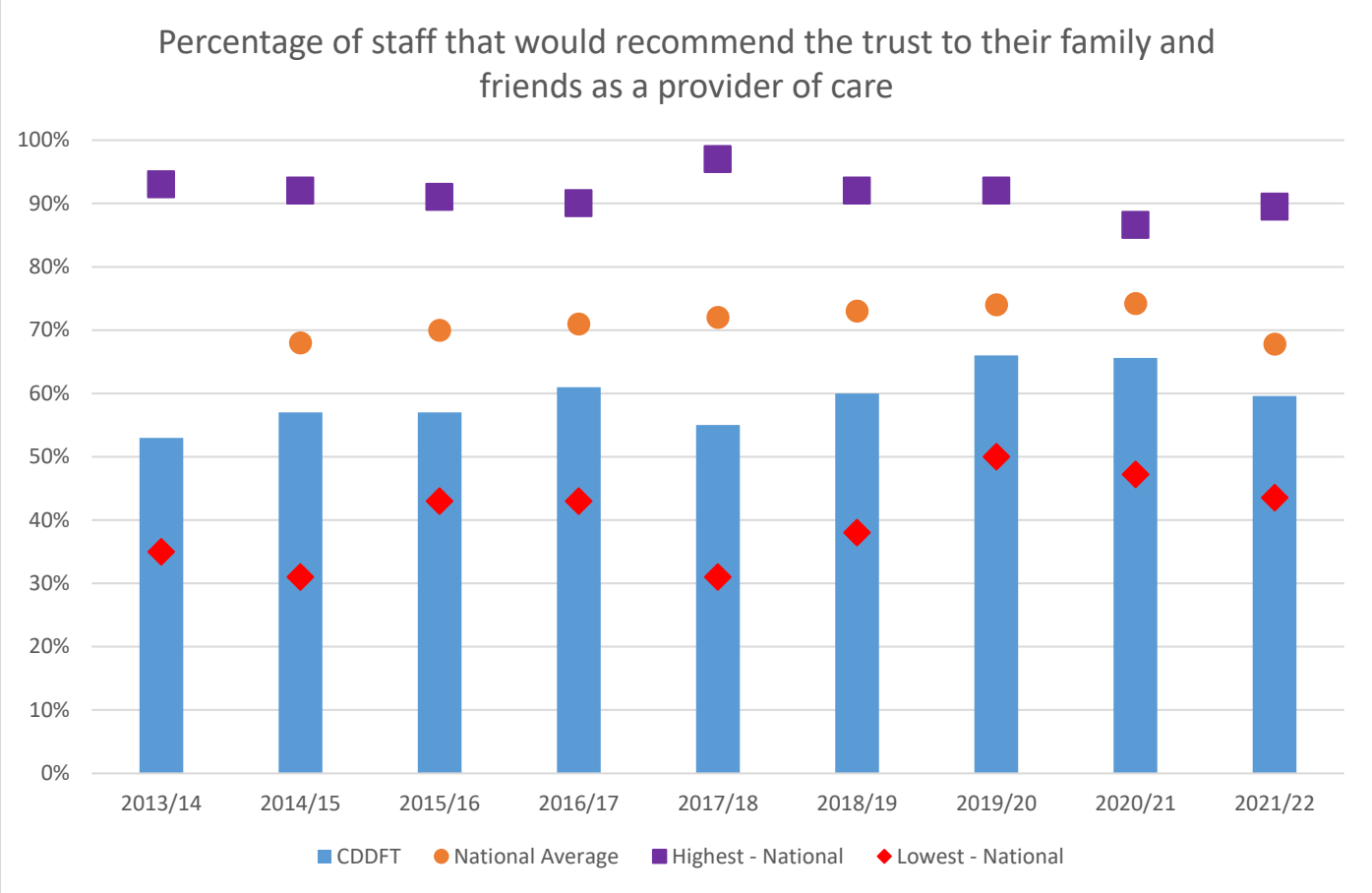


Data source: NHS Digital

The County Durham and Darlington NHS Trust considers that this data is as described for the following reasons: the data is submitted as per national guidelines. This data is reviewed and is line with local and national survey results.

The County Durham and Darlington NHS Trust has taken the following actions to improve the indicator and so the quality of services by: analysing patient feedback, particularly from our own post-discharge survey, for the five key questions underpinning this indicator, triangulating it with other sources of patient experience feedback and sharing it with wards and teams to support local improvement work.

Staff who would recommend the Trust to their family and friends as a provider of care



Data source: NHS Digital

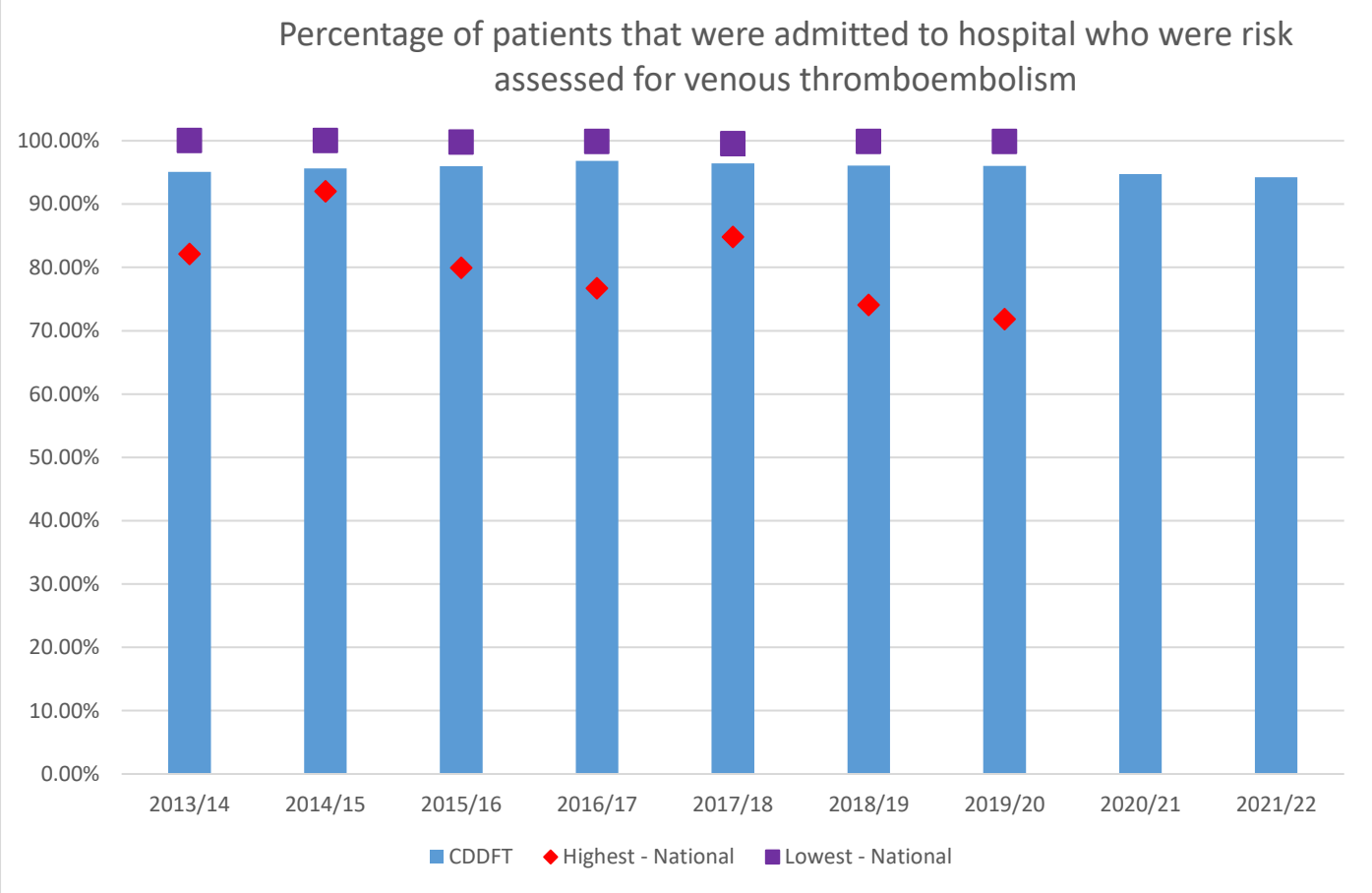
The County Durham and Darlington NHS Trust considers that this data is as described for the following reasons: the data shown is drawn from staff survey results and is reviewed by the Trust as part of the review of National Staff Survey results.

The County Durham and Darlington NHS Trust intends to take the following actions to improve the percentage and so the quality of services by:

- Continuing to promote the excellent care that the organisation provides through mechanisms such as staff bulletins and FaceBook live, hosted by Executive Directors, that highlight new innovations and accolades the organisation has achieved as well as recognising staff contributions to excellent care through Excellence awards and #TeamCDDFT Star Awards amongst other initiatives.
- The promotion of excellence reporting and celebrating successful quality and safety improvements as outlined in Section 2A.
- The roll out of a refreshed Quality Matters Strategy which – at its heart – is designed to provide staff with more capacity and time to care and build skills and capability to continuously improve the quality of care.

Domain 5 – Treating and caring for people in a safe environment and protecting them from avoidable harm.

Percentage of patients that were admitted to hospital who were risk assessed for venous thromboembolism.

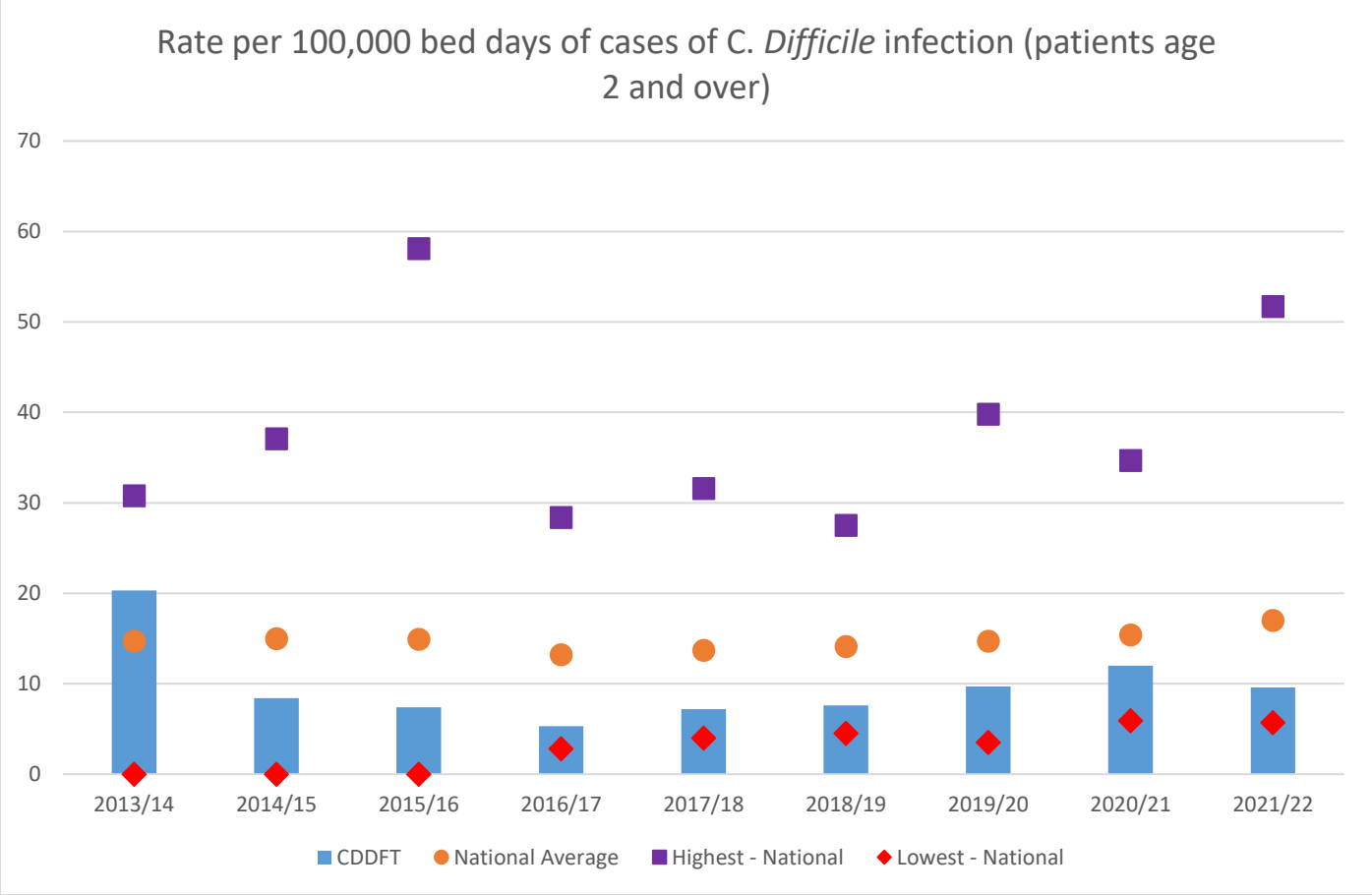


Data source: NHS Digital.

The County Durham and Darlington NHS Trust considers that this data is as described for the following reasons: the Trust has continued to monitor this data internally and performance was in line with previous years. Nationally data collection was suspended from 2020/21 therefore there is no benchmarking (lowest and highest) in the chart above.

The County Durham and Darlington NHS Trust intends to take the following actions to improve the percentage and so the quality of services by: establishing a VTE working group, led by the Deputy Medical Director for Governance, which will develop actions and support the continuation of compliance monitoring to ensure that current performance is maintained, NICE guidelines are met and improve the quality of service.

Rate per 100,000 bed days of trust apportioned C. Difficile infection that have occurred within the Trust amongst patients aged 2 or over

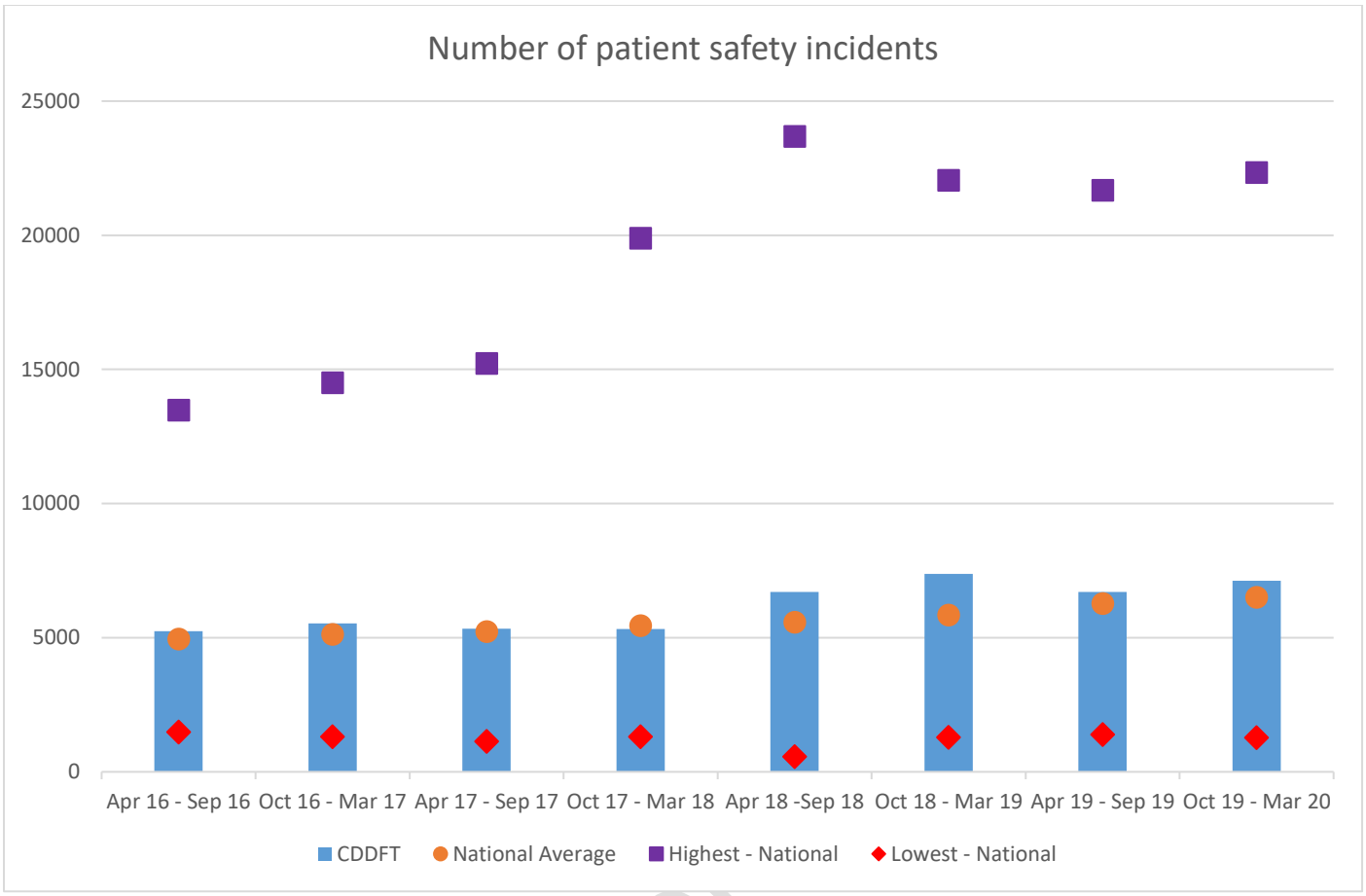


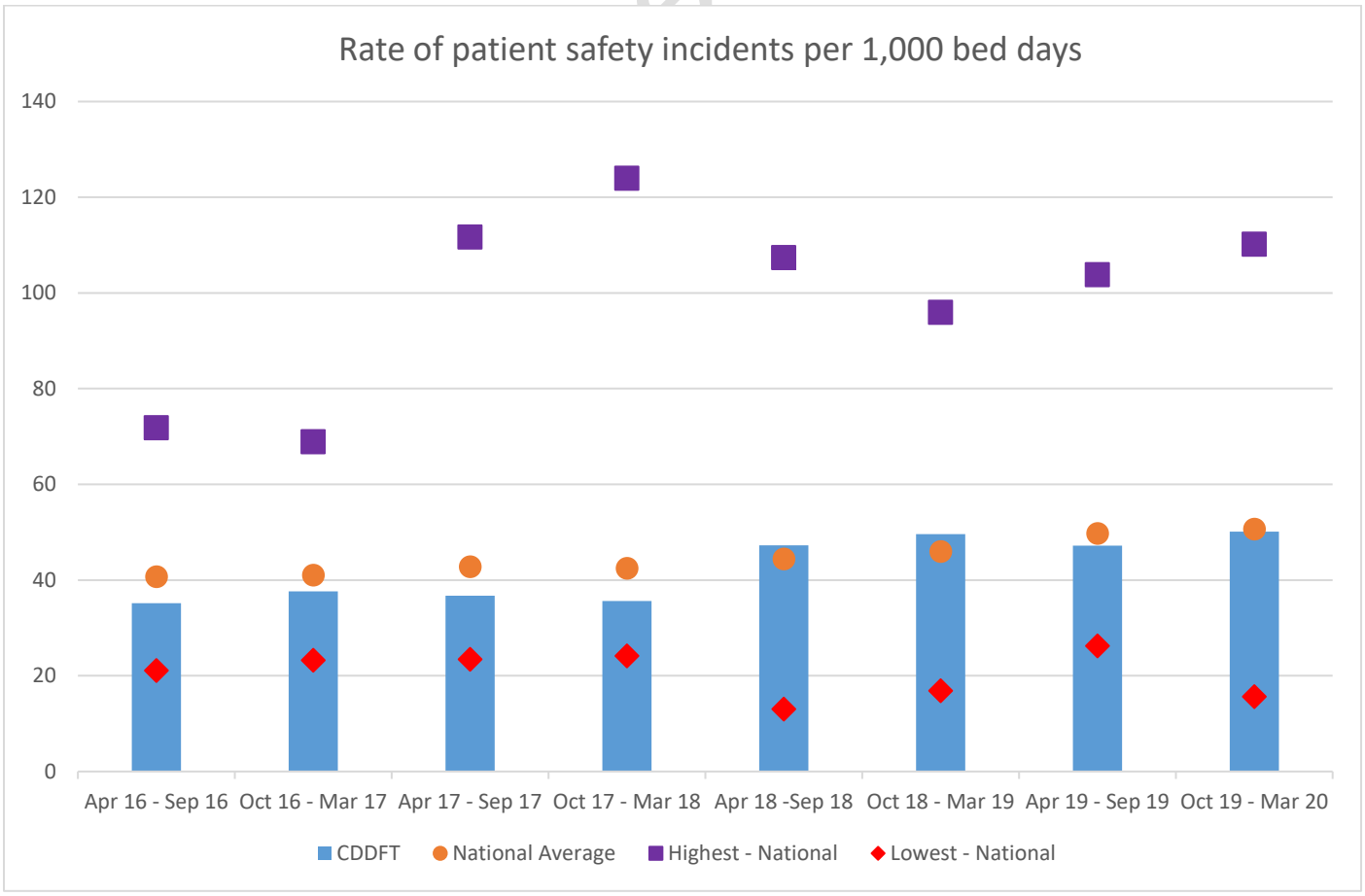
Data source: NHS Digital

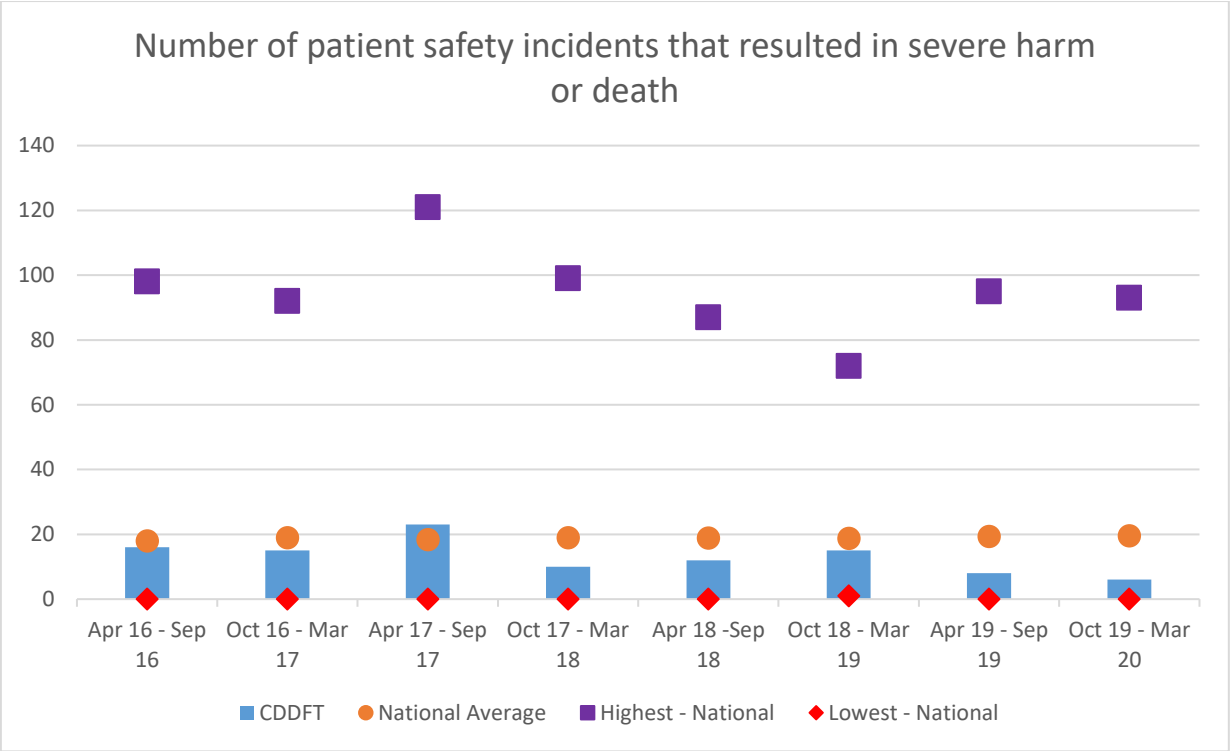
The County Durham and Darlington NHS Trust considers that this data is as described for the following reasons: the Trust monitors this data regularly via its Infection Control and Executive Patient Safety and Experience Committees. It is noted that, whilst the rate increased in 202/21, the rate dropped to pre 2019/20 levels for 2021/22, remaining well below the National Average. The Trust performed better than its full-year threshold for 2021/22 as set by NHSE/I.

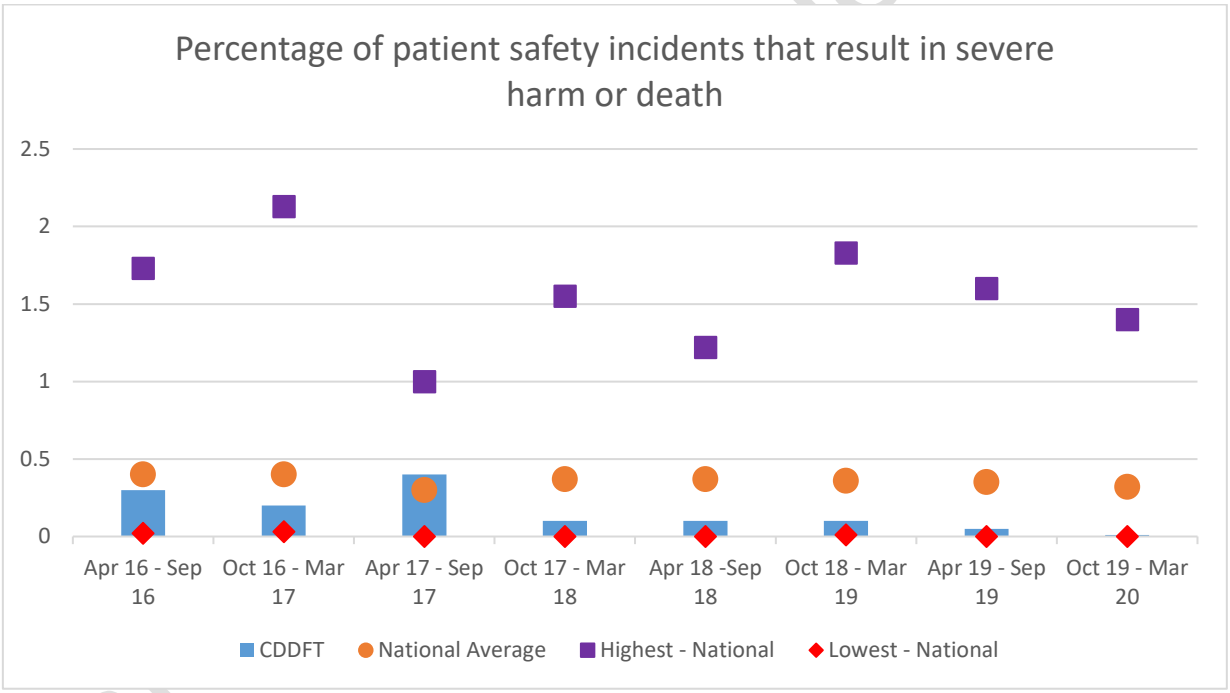
The County Durham and Darlington NHS Trust intends to take the following actions to improve the indicator and so the quality of services by: focusing on early identification and isolation; continuing to build on its antimicrobial stewardship programme; and through wider engagement via the Integrated Care System. The individual case review process is carried out in collaboration with infection control representatives from both acute care and CCGs, antimicrobial pharmacy colleagues and consultant microbiologists/ infection control doctors. These joint reviews will continue and will focus on improvement across the health economy.

Patient Safety Incidents and the percentage that resulted in severe harm or death.









Data source: National Reporting and Learning System

The County Durham and Darlington NHS Trust considers that this data is as described for the following reasons: the data is validated by the Patient Safety Team and agreed at Safety Committee and at Executive level before it is uploaded to NRLS.

The County Durham and Darlington NHS Trust intends to take the following actions to improve the indicator and so the quality of services by undertaking a full review of the National Patient Safety Strategy objectives as well as implementing the key principles identified in the Patient Safety Incident Reporting Framework.

Friends and Family Test

The Friends and Family Test data submission has now been reintroduced after it was suspended in 2020, however there has been a noted dramatic reduction in the amount of responses we capture at CDDFT. Pre pandemic, we recorded in the region of 5,000 responses monthly; however we have struggled some months to capture 500 since the electronic form was introduced. Whilst it is not known for certain, this could have been impacted by the removal of posters due to infection control reasons throughout the pandemic, or lack of footfall due to visiting restrictions.

The focus for 2022 is to improve our electronic responses for the Friend and Family Test. Some work has already been carried out as detailed below:

- Improved posters have been printed and placed in heavy footfall areas and in wards and departments, with a QR code which takes you direct to the short survey.
- We have reintroduced paper cards to compliment the electronic form, allowing all patients to have a voice.
- We have introduced patient surveys to evaluate the patient experience in areas where service improvement has been undertaken.

Work currently being considered for the future is:

- Enhancing the evaluation process for service improvements, involving patients with the planning stages rather than post evaluation only; and
- Using text messages and/or email to offer people to complete the family and friends tests when it is convenient for them.

Part 3 Other Information

This section of the Quality Account includes an overview of the quality of care provided during 2021/22 that has not already been reviewed in this report. This will include elements from Patient Safety, Patient Experience and Clinical Effectiveness. There is also a review of performance against indicators included in the NHS Oversight Framework

The Trust has recently revised its Quality Strategy, a four year forward view. A number of Trust priorities can be seen to overlap with National planning guidance. In this section of the Quality Accounts we will also be reporting on those priorities not specifically detailed in the Trust Quality Strategy but which are included here as we would expect to complete the necessary actions within the next 12 months.

Patient Safety

Health Care Associated Infections: Minimising the risk of Covid-19 transmission in our hospitals

The Trust has followed infection prevention and control guidance from the UK Health Security Agency, to mitigate the risk of transmission of Covid-19 throughout 2021/22 with key controls including:

- Provision of Personal Protective Equipment (PPE) to all staff, including fit testing for respirator masks and provision of training and advice on how to use the equipment correctly. The IPC team carried out monthly audits of compliance with PPE and other infection control measures.
- Implementing requirements for social distancing in all clinical and non-clinical areas and mandating the use of face masks for non-clinical staff accessing hospital walkways and common areas.
- Increased cleaning in clinical areas.
- Signage at our entrances, to designate walkways, in common areas and at lifts, to reinforce the need for social distancing.
- Mask and sanitiser stations at all our entrances.
- Deploying staff in our Outpatient clinics to greet staff and reinforce Covid-19 safety procedures.

- Implementing social distancing in our waiting rooms.
- Regular walk-arounds to all clinical areas from the Medical and Nursing Directors and their deputies, and by the Infection Control Team.
- Segregated pathways for patients with, and with suspicion of, Covid-19.
- Strict protocols for cohorting of patients in contact with others developing the virus.
- Daily meetings chaired by the Director of Nursing or a deputy to investigate any case of nosocomial transmission and all outbreaks.
- Rapid review of Covid-19 safety arrangements and compliance by the infection control team (patient areas) or health and safety teams (general or staff areas) in response to any outbreaks.
- Containment measures for any outbreak, ensuring that areas affected were safe to reopen.
- Involvement of Infection Control professionals in daily command and control calls including any decisions impacting on segregation of pathways and the management of any demand pressures needing re-designation of beds or changes to the management of contacts.
- Rigorous testing and screening of patients prior to admission and at intervals specified by Public Health England thereafter, monitored weekly and reported to Gold Command.
- Implementation of a Covid-19 Workplace Safety Policy, following Government, HSE and Public Health England guidance through a network of Covid-19 local safety champions supported by frequent walk-arounds by the Health and Safety Team and underpinned by a Trust-wide risk assessment and local risk assessments.

The Board, and Gold Command, sought assurance on the implementation and effectiveness of the above arrangements through:

- Audits of compliance with Covid-19 safety practices at ward level, as part of monthly Perfect Ward areas, with high levels of compliance observed throughout the year.
- Safety monitoring officer checks, on PPE compliance and other procedures on wards. The officers revisit wards and carry out further audits in response to any issues found.
- Collating evidence of compliance against NHS England and Improvement's Infection Prevention and Control Assurance Framework, and reporting to the Integrated Quality and Assurance Committee and the Board.
- Review of reports on testing compliance by Gold Command.

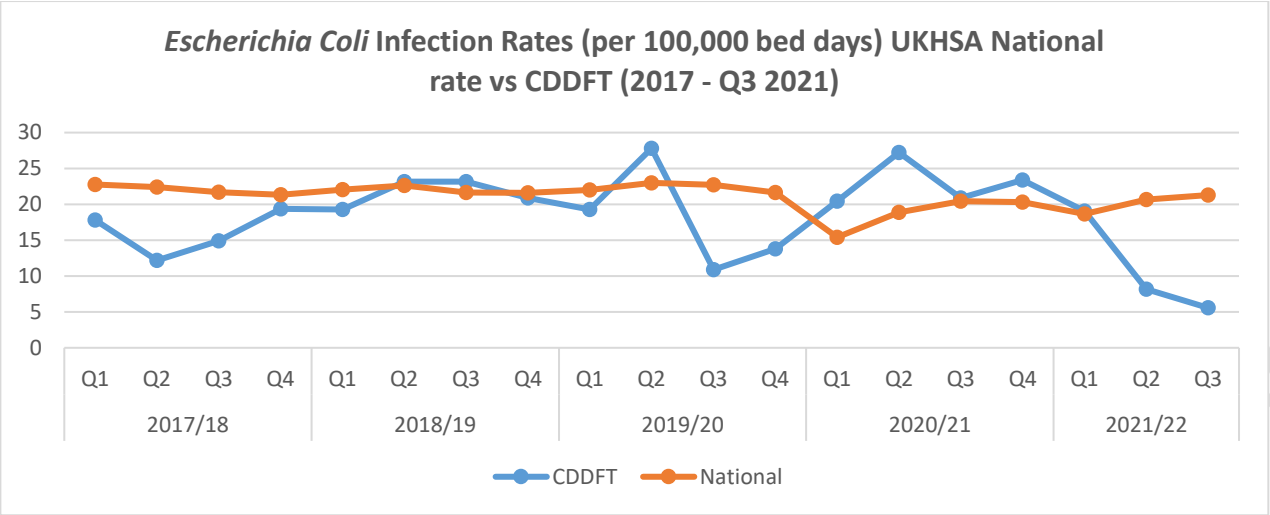
The Trust invited NHSE/I's Lead Infection Control officer to visit all three of its main sites. Observations and suggestions were acted upon and further enhancements to controls implemented.

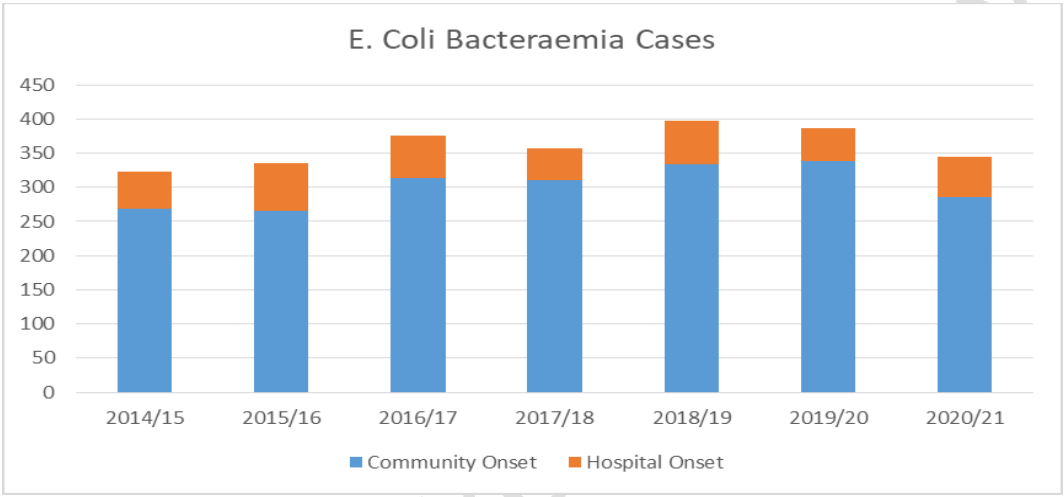
E-Coli Bacteraemia

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. 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. Meetings are planned with CCG colleagues.

From 1st June 2011 the Trust has reported all E coli bacteraemia cases. For the 2021/22 period the Trust reported a total of 324 cases of E coli bacteraemia of which 105 were hospital onset cases.





Incident Reporting and Investigation

The reporting and investigation of incidents and the subsequent learning is integral to maintaining patient safety and improving the quality of care that the Trust provides. The latest NRLS benchmarking report show that the Trust has a reporting rate of 50.7 incidents per 1000 bed days against a national average of 57.0 per 1000 bed days. In addition to this, 1% of incidents reported were moderate harm or above compared to 2% nationally.

The Trust is required to report Serious Incidents as defined with the National Patient Safety Framework and in 2021/22 reported 57 such incidents; this is a reduction on the 62 reported in 2020/21. All of these incidents have had a full root cause analysis review and themes for learning have been identified and shared.

Falls resulting in harm remain the highest reported incidents and reducing harm from falls continues to be quality priority for 2022/23. In 2021/22, CDDFT piloted a rapid review process for falls resulting in fracture neck of femurs. This pilot has allowed the Falls Lead to carry out a rapid review of a fall within five days to identify any immediate learning and to assess whether the fall required ongoing serious investigation. This pilot has been successful and the learning outcomes have been included within the Trust's three years Falls strategy.

The pilot has undertaken 16 falls rapid reviews that have been excluded from the Serious Incident investigation figures for 2021/22 and will continue to exclude alongside the new national patient safety investigation threshold from 2022/23.

Never Events

Disappointingly, the Trust reported two 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 that have occurred and learning identified have been shared Trust wide via bulletins, posters and at educational sessions and through communications and presentations. The identified learning has been shared with local NHS organisations when staff involved in the incident have been employed with an external organisation, to ensure multi agency learning.

Never Event 1: wrong site surgery. Key learning included updating the Plastics and Dermatological LocSSIP to set out a standard process for marking site and a requirement to pause immediately before injection to check that the correct site is to be injected. We have also strengthened the booking procedures for the Plastics Dressing Clinic theatre list.

Never Event 2: retained foreign object post-operation. The Trust had a similar incident during 2017, and the patient safety investigation established that mitigations put in place following the previous incident had not been in operation and, had they been, they may well have prevented the object from being retained. The investigation concluded that there had been a failure to embed learning from a previous never event and the immediate actions identified were re-established and will continue to be monitored to ensure they are embedded. The Board's Integrated Quality and Assurance Committee has scrutinised the learning from this never event in detail, and was advised that actions required following the previous never event had been taken but had – due to disruption during the pandemic – lapsed and would be reinstated with additional, on-going monitoring put in place to prevent any future lapse.

Local Patient Safety Initiatives

In 2021/22 the Patient Safety Champion role was relaunched in the organisation to support the communication of learning from incidents to front line staff at all levels working in collaboration with Patient Safety Team and Care Group Facilitators. Throughout 2021/22 the Patient Safety Champions continued to meet and share learning and experiences from a wide range of specialties and staff groups within both community and acute sites.

National Patient Safety Developments

The Patient Safety team undertook a full review of the National Patient Safety Strategy within 2021/22 and identified key actions to be taken to ensure relevant process and systems are in place in CDDFT to meet these principles and standards. The Patient Safety Team have led a number of pilots and initiatives, examples of which are outlined below:

- Pilot of Rapid Review process for thematic incidents – specifically falls/pressure ulcers;
- Pilot of the New Patient Safety Investigation Process for two incidents that would have currently meet the Serious Incident criteria within the Patient Safety Incident Review Framework;
- The use of learning teams to identify and undertake quality improvement work organisationally following a theme identified from incident reporting;
- Pilot of immediate debriefs following an incident to determine the ongoing patient safety investigation required.

The Patient Safety Team will continue to align the Patient Safety priorities for the Trust to the National Patient Safety Strategy for full implementation by April 2023.

Patient Experience

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”.

Our vision for services is “Right First Time, Every Time” and our mission - ‘safe compassionate joined up care’ - puts patients at the centre of all we do. The engagement of our patients, members, staff and public is key to understanding how we are performing against our vision and mission and how we need to 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 strategy has been reviewed and revised for 2022/23 and, whilst continuing to be underpinned by the principles of Dignity for All, “Think Like a Patient”, sets out our aims and aspirations to raise the agenda of patient and public involvement and engagement and also embed the new PHSO NHS Complaints Framework.

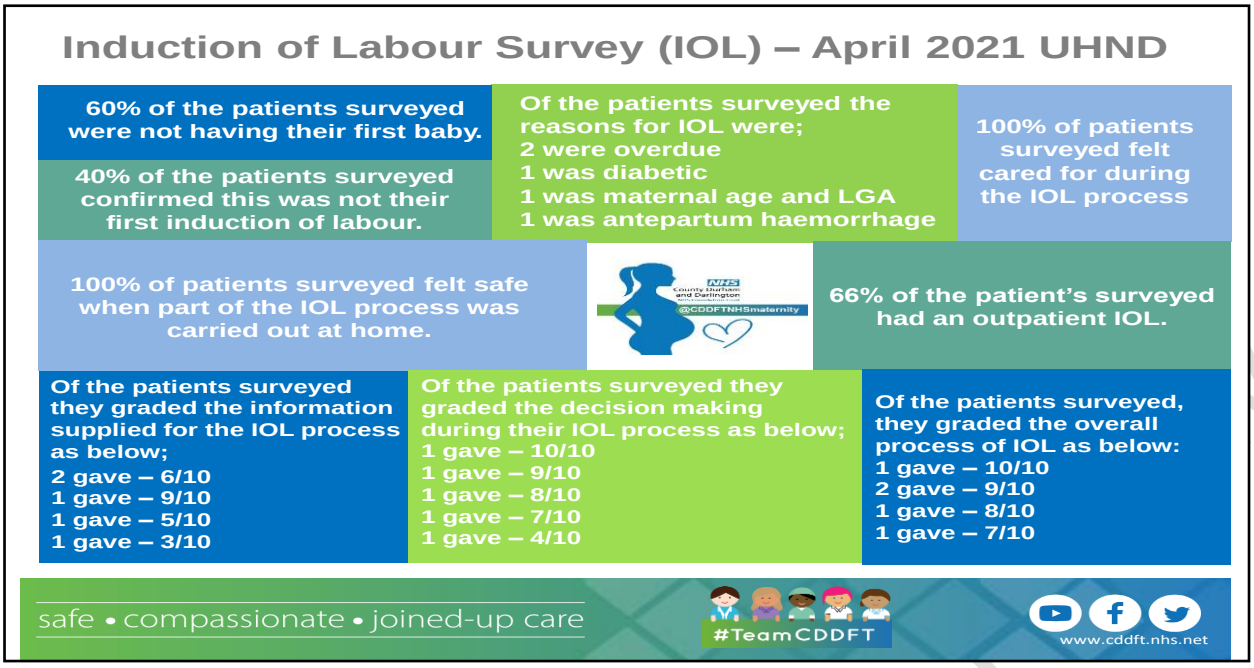
The Trust will continue to raise staff awareness and continue to capture data advising Care Groups of their compliance rates and of areas of complaints learning where actions are required for improvement.

Patient and Public Involvement

During 2021 the Patient Experience Team have worked on numerous patient and public involvement projects with various departments throughout the Trust, focusing on post service improvement evaluations for the services noted below:

- Obstetrics joint epilepsy nurse led clinic
- Wellbeing for 4 the time being – SALT and Occupational Therapy/Physiotherapy
- Rehabilitation after Critical Illness Team
- Home Enteral Feeding
- Respiratory – Cognitive Behavioural Therapy
- Acute Frailty Team
- Pathology
- Induction of Labour

The findings are presented in a poster format and an example is shown below.



The introduction of pre service improvement evaluation will be the focus of our 2022/23 work to allow our patients, public and carers to assist in shaping our services at CDDFT.

National Patient Survey Reports

There were three National Surveys carried out during 2021 by our service provider Patient Perspective and these results are benchmarked to their clients rather than nationally. A summary of the results is set out below.

CQC National Maternity Survey 2021 - Headline Summary report

- Some 307 mothers were included in the survey.
- A total of 173 responses were received, a response rate of 56.9%
- The average score was 77.4, about the same as the Patient Perspective (PP) average of 77.5.
- The Trust was better by 10% or more than the PP average on 2 questions.
- The Trust was worse by 10% or more than the PP average on 1 question.
- The Trust was about the same as the PP average on the remaining 55 questions.

Children and Young Peoples Patient Experience Survey 2020

- Overall 990 questionnaires were emailed, with 265 responses, a response rate of 28%.
- The Trust scored in the top 20% of Trusts on 6 questions and the bottom 20% of Trusts on 7 questions.
- There was an improvement of 10% or more on 2 questions. Results were worse by 10% or more for 4 questions.

NHS Children and Young People's Patient Experience Survey Benchmark Headline Report 2020

The survey was administered by the Survey Coordination Centre for Existing Methods (SCCEM) at Picker Institute. The average result is based on Trusts who use Patient Perspective to carry out the surveys for them.

A total of 113,943 patients were invited to participate in the survey across 125 acute and specialist NHS trusts. Completed responses were received from 27,374 parents and children and young people, an adjusted response rate of 24.2%.

Patients were eligible to participate in the survey if they had been admitted to hospital, were aged between 15 days and 15 years old and had been discharged between 1 November 2020 and 31 January 2021.

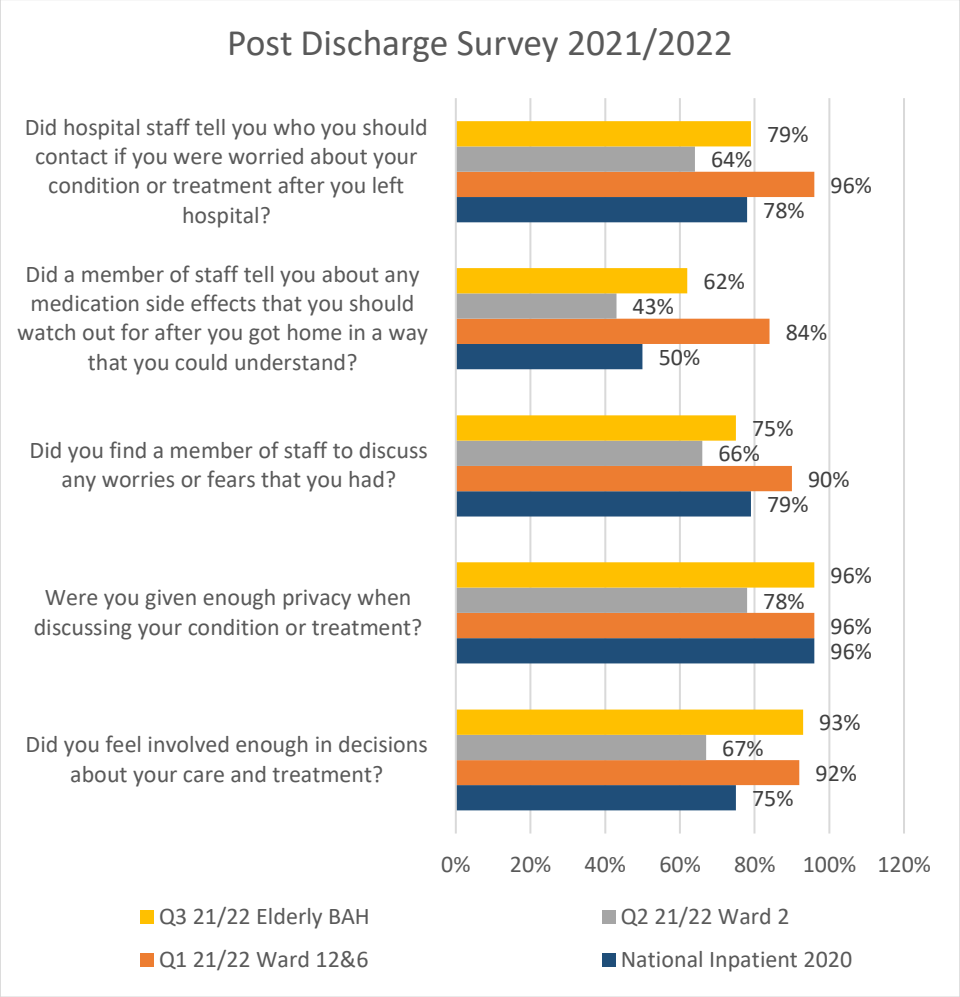
For CDDFT there was a sample of 1,137 people invited to take part and 265 completed the response, this was made up of 177 urgent/emergency admissions and 88 planned admissions. This was a response rate of 24% in comparison with 25% for the previous survey.

In comparison to other trusts CDDFT was somewhat better in 1 question, about the same in in 28, somewhat worse in 6 and worse than expected in 2.

In comparison with CDDFT's previous report in 2018 we were significantly better in 4 questions no different in 50 and significantly worse in 3.

Post Discharge Survey

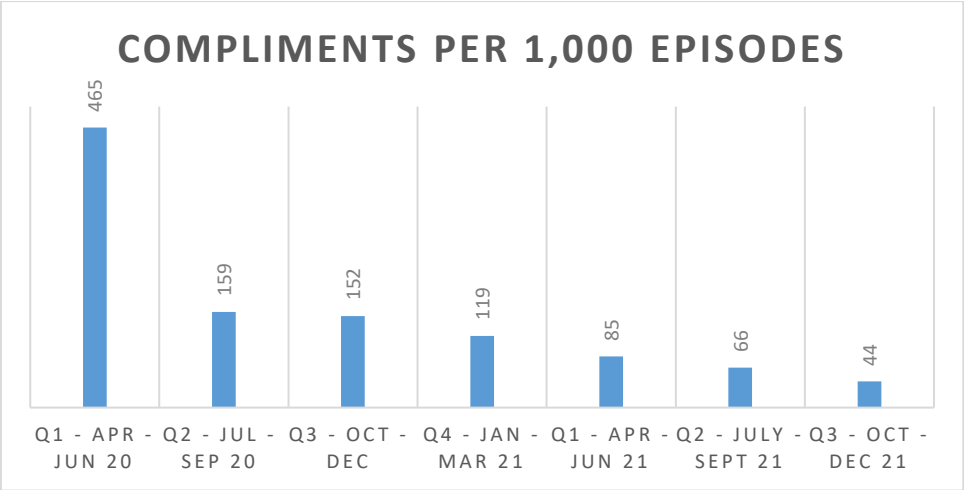
The Post Discharge Survey was redeveloped during 2021 and now runs as a quarterly cycle. This survey is aligned to the national survey. The table below shows the Trust quarterly results for 2021-2022 in comparison to the National Survey results from 2020.



Survey results are shared with the relevant wards and local improvement plans developed and implemented.

Compliments

The chart and table below show the quarterly trend of compliments received per 1,000 patient episodes. As it clearly shows there has been a reduction of compliments made throughout the pandemic.



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'.

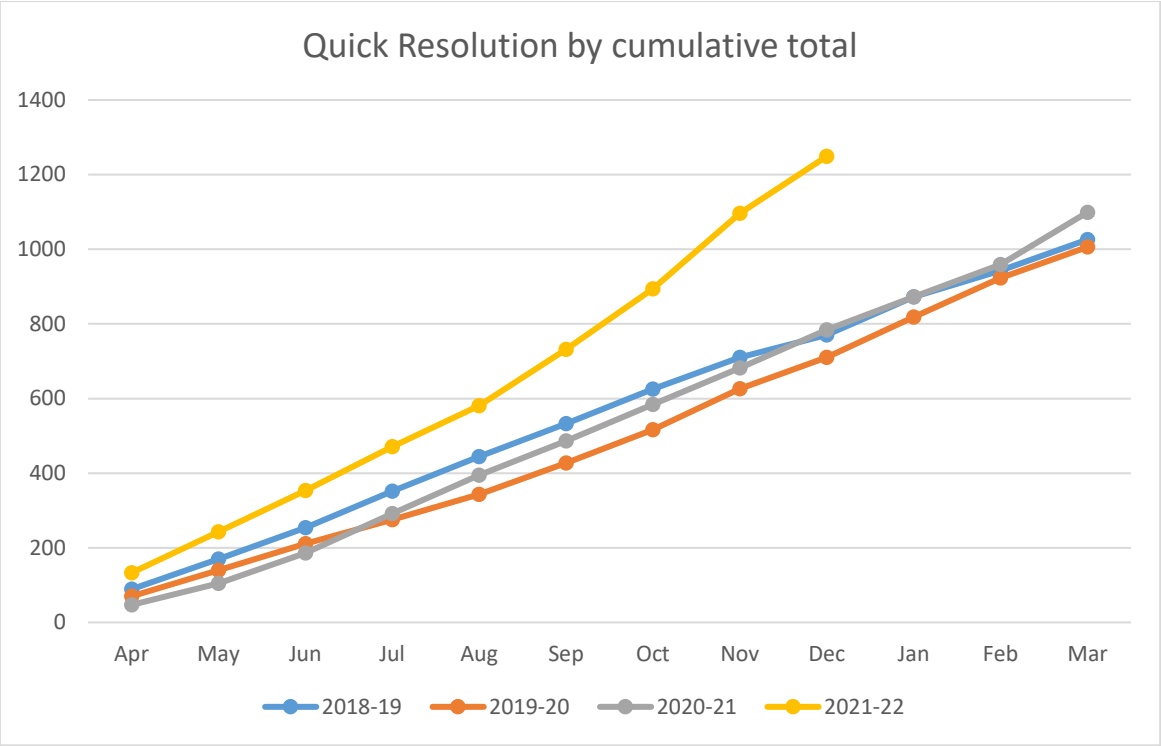
The charts below show the number of formal complaints received trust-wide throughout 2021-22 as a cumulative total and in comparison to previous years back to 2018-19. And also complaints in comparison to 1000 patient bed days.

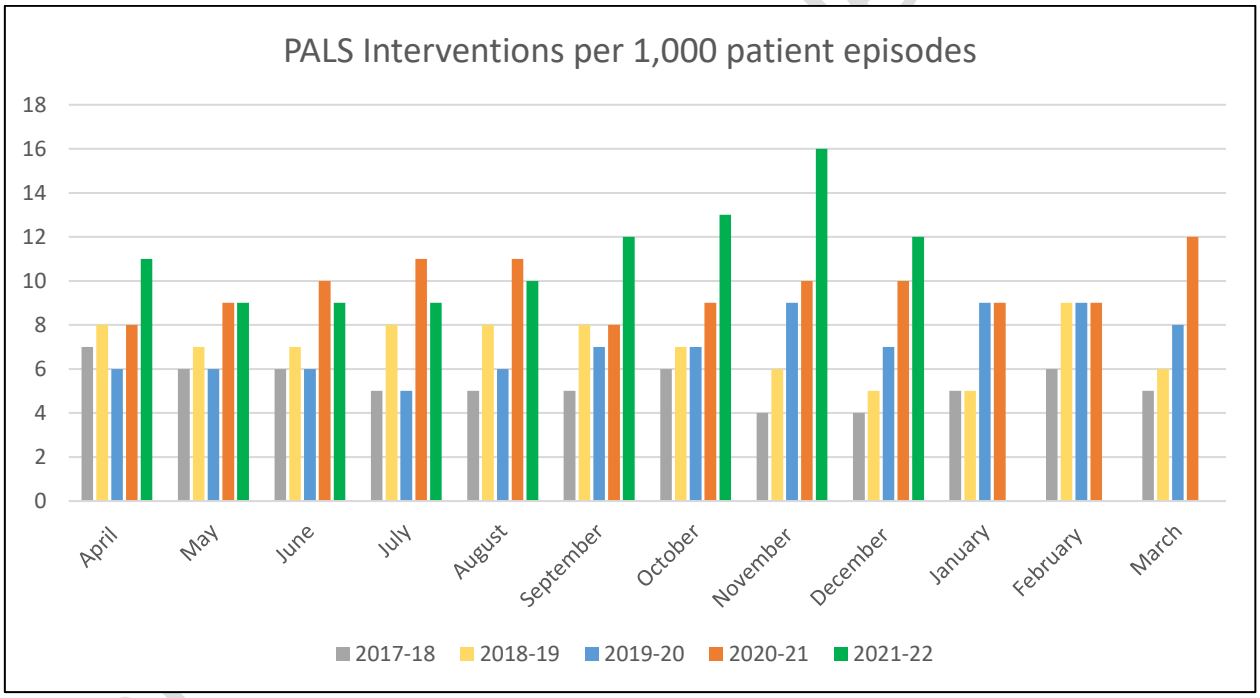
[Drafting Note: Charts are being validated and will be included in the final published document]

Quick Resolution Complaints (Formally PALS)

As part of the PHSO National Standard pilot going forward PALS will be reported as "quick resolution complaints" rather than PALS. Whilst these are categorised as a complaint they will be processed in the same timeframes for patients.

The below charts show the number of quick complaints received trust-wide throughout 2021-22 as a cumulative total and in comparison to previous years back to 2018-19. And also complaints in comparison to 1000 patient bed days. The trend is under investigation but is considered to relate to the promotion of local resolution of complaints by our Integrated Medical Services care group and pandemic-related impacts including lack of visiting (and therefore informal channels for communication) and increased waiting times for appointments.





Working in Partnership with Healthwatch

With the recent implementation of the Trust's Patient Experience Network Group, working partnerships with our Healthwatch colleagues have been reinstated and now active once again.

Working in collaboration will be a priority during 2022 and will included asking Healthwatch to resume their reviews of a sample of anonymised complaint letters and responses on our behalf, which provides a valuable, independent and patient-centred perspective on the quality of our complaints responses. We also review the yearly agenda for Healthwatch County Durham and Healthwatch Darlington and plan how we can align the patient experience agenda to produce reports written in collaboration with robust actions plans for areas of improvement. Any action plans will be presented for assurance at the Patient Experience Network Group on a quarterly basis once these have been approved through internal governance processes.

Learning from Experience

The Patient Experience Team produced their first interactive patient story in 2020 and this was well received. A second patient story video was produced in November 2021 and presented across the Trust in December 2021. We will look to share patient stories evidencing excellent practice in the same format throughout 2022.

The Patient Experience Team continues to work in partnership with the Trust's Care Groups to learn from the issues identified in all formal and quick resolution complaints, and to obtain assurance from actions and to celebrate the excellence identified through Patient Experience.

Looking after the experience of patients and families during Covid-19

During 2021/22 the Trust gradually eased visiting restrictions in line with national guidance, allowing a level controlled visiting to general wards and the support of partners to be provided during pregnancy, and parents to remain with children. We continued to use iPads to facilitate virtual visiting in line with the guidance.

Relatives were also able to leave non-valuable belongings, such as a change of clothes, with our hospital receptions for rapid delivery to the patient by a member of the portering team.

We have complied with national duty of candour requirements, and appointed an advocate to contact the families of anyone who died following infection with Covid-19 acquired in hospital. This service has been well received with families expressing gratitude for the fact that we had remembered their loved one and for our openness.

Clinical Effectiveness

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

We aim to assess and treat all patients in A&E in a timely and safe manner. The national standard requires 95% of patients to be treated and transferred or discharged within 4 hours of arrival in the Emergency Department (ED).

During the early part of the year, when Covid-19 inpatient numbers subsided and lockdowns led to reduced overall ED activity, performance against the four hour standard improved and was closer to 90%. As activity started to return, performance dropped off resulting in average performance, over the year, of 74.25%. The Each wave of Covid-19 had a high impact on our performance, not only because Covid-19 patients require additional beds but because of the inherent issues in managing patients with the virus: the need to await test results and then isolate patients appropriately, closure of bays due to patient contacts or outbreaks and the need to flex the number of Covid-19 beds up or down (which sometimes results in some ring-fenced beds necessarily remaining empty as they cannot be used for non-Covid-19 patients). Pre pandemic, the Trust had plans to increase its capacity for same day emergency care – taking some patients out of the A&E queue who could be treated and discharged on the same day, to increase the footprint of the A&E department and to increase the number of beds, in response to capacity limitations. A number of these changes were delayed, magnifying the impact of Covid-19 pressures. It is also important to note that, pre-pandemic, we reduced the amount of elective activity undertaken in winter to free up more beds to cope with non-elective pressures; however, given the growth in waiting lists during the pandemic, we were – rightly – unable to do so in 2021/22.

The pressures noted above were seen across the country and the Trust was not a national outlier. The North East region performed well overall; however, comparatively greater patient demand was a reality in County Durham and in South Tyneside and Sunderland which – together with the capacity limitations noted above – limited our ability to perform as well as some others in our region.

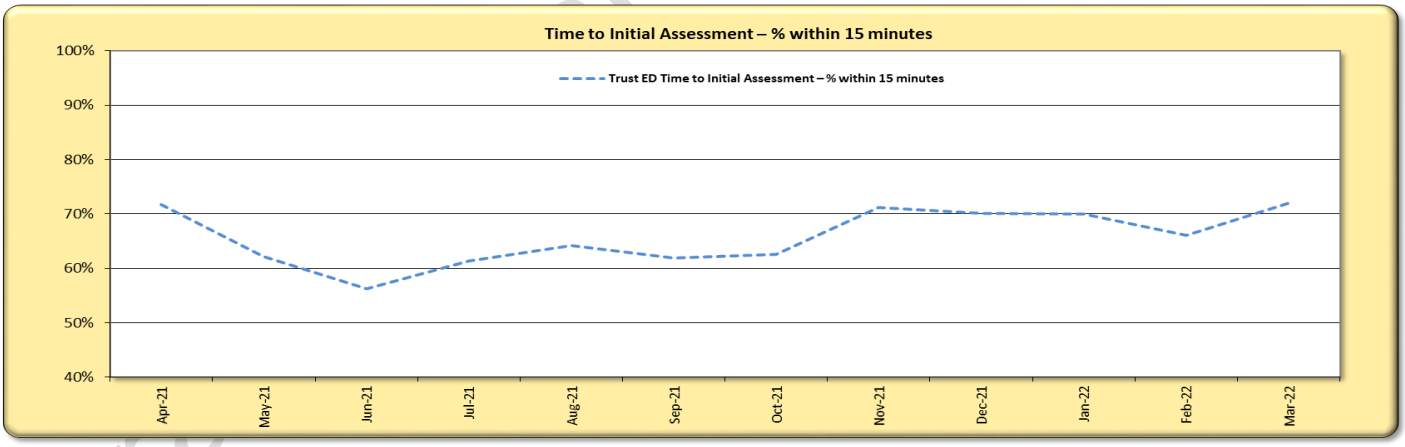
Month/Quarter	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
DMH ED attends	5,514	5,617	5,871	5,624	5,571	5,569	5,588	5,217	5,148	5,257	4,883	6,056
DMH ED 4 Hour Waits	729	1,073	1,363	1,796	1,947	2,344	2,520	2,277	2,396	2,311	2,224	2,089
DMH % Seen in 4 Hrs	86.78%	80.90%	76.78%	68.07%	65.05%	57.91%	54.90%	56.35%	53.46%	56.04%	54.45%	65.51%
UHND ED attends	6,728	7,280	7,420	7,040	6,773	6,704	6,901	6,618	6,218	6,406	6,047	7,041
UHND ED 4 Hours wait	1,372	2,035	2,420	3,087	3,104	3,449	3,894	3,867	3,359	3,381	3,484	2,871
UHND % Seen in 4 Hrs	79.61%	72.05%	67.39%	56.15%	54.17%	48.55%	43.57%	41.57%	45.98%	47.22%	42.38%	59.22%
Total ED attends - Type 1	12,242	12,897	13,291	12,664	12,344	12,273	12,489	11,835	11,366	11,663	10,930	13,097
Urgent Care Centre - Type 3 (Walk-Ins)	3,080	3,868	4,187	4,469	4,250	4,965	4,982	4,513	4,133	3,604	3,482	4,437
Urgent Care Centre - Type 3 (Booked Appointments)	2,225	2,544	2,271	2,013	2,790	3,093	3,081	2,927	3,101	3,073	3,178	3,330
Trust Over 4 hour waits	2,101	3,108	3,783	4,883	5,051	5,793	6,414	6,144	5,755	5,692	5,708	4,960
ED Only Activity % under 4 hour waits	82.84%	75.90%	71.54%	61.44%	59.08%	52.80%	48.64%	48.09%	49.37%	51.20%	47.78%	62.13%
Reportable % under 4 hour waits (including UCC Booked from Jan '2020)	88.03%	83.90%	80.84%	74.50%	73.94%	71.51%	68.79%	68.12%	69.06%	68.96%	67.55%	76.23%

New A&E clinical standards have been reported in shadow form in 2021/22, with focus placed on the time patients spend in the Department. The volume of patients waiting over 12 hours has gradually increased throughout the year, with higher volumes of patients spending more than 12 hours in the department during the winter period, as a result of the factors outlined above.

Standard Month:	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Trust ED Patients spending more than 12 hours in ED	78	151	248	404	666	938	1,211	1,097	991	1,000	1,081	727
% Trust ED Patients spending more than 12 hours in ED	0.6%	1.2%	1.9%	3.2%	5.4%	7.6%	9.7%	9.3%	8.7%	8.6%	9.9%	5.6%

A further indication of the pressures we have experienced is the number of patients who have breached the 12 hour 'trolley' wait for a base ward bed following a decision to admit. Breaches started to occur in September and have done throughout the winter period, only starting to reside in the last two months of the year.

The time to initial assessment has also varied, aligned to operational pressures and the impact of Covid-19 surges.



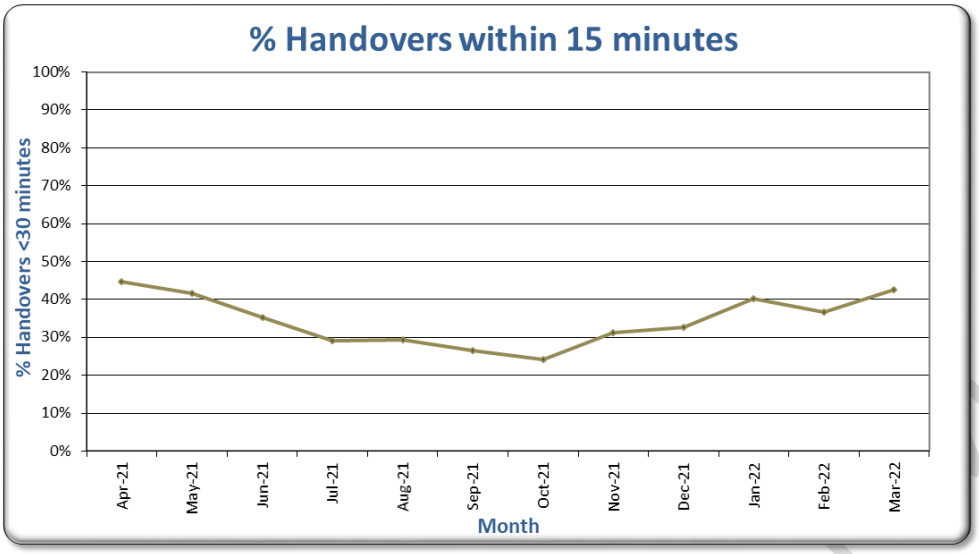
As outlined in Section 2B, reducing waiting times in our A&E Departments is a high quality improvement priority for the Trust with a number of actions planned to increase our physical and staffing capacity and to optimise our clinical pathways.

Ambulance handovers

With respect to ambulance handovers, we aim for crews to handover the care of patients to CDDFT staff within 15 minutes of arrival. The Trust actively captures all ambulance arrivals, pro-actively utilising the handover screens in the Emergency Departments to record the timing of handovers, over 90% of the time.

The number of handovers completed within 15 minutes has varied throughout the year with lower levels experienced in September and October just ahead of the winter pressures period. Lower levels of

performance is congruent with Covid-19 surges and increased activity. The Trust's performance is not significantly out of line with the region.



The Trust also monitors the total arrival to clear times and improvement can be seen from November onwards, aiming to achieve arrival to clear times within 30 minutes.

	Average Arrival to Clear Times (Minutes)											
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Darlington Memorial A&E	35.1	37.5	38.1	49.0	50.9	54.2	55.3	50.0	43.3	45.1	40.1	37.8
UHND A&E	33.9	36.5	40.0	43.1	44.8	54.0	54.3	45.6	43.3	35.2	37.9	33.1

The improvements reflect a number of actions taken to improve handover performance.

- Securing temporary additional workforce from CIPHER Medical to staff ambulance handover bays until such as time to reach full recruitment.
- Escalation processes strengthened
- Embedding of a new ambulance handover SOP produced by the North East Ambulance Service

There is a long term plan for a new ED build at UHND and in the interim, a number of estate works are now underway to impact in 2022/23.

Optimising treatments for Covid-19

Throughout the pandemic, we sought to deploy up to date treatments based on research and emerging evidence regionally, nationally and internationally.

We have contributed actively to research into Covid-19 as outlined in "Participating in Clinical Research" earlier in this section and supported colleagues in the region in setting up and operating a limited Covid-19 Medicines Delivery Unit to ensure that prescribed anti-viral treatments could be dispensed and transported to vulnerable patients in the community.

We also supported public vaccination programmes through our own vaccination sites, and working in primary care sites. We vaccinated over 25,000 members of the public in addition to vaccinating our own staff and staff from partner organisations.

Performance Summary

Recovery and restoration

During this second year of Covid-19, several pieces of guidance were issued aiming to restore and recover elective activity.

In relation to the requirements, we performed as follows:

- Restore Cancer referrals: Patients have been encouraged to come forward with their concerns. Referrals now exceed pre Covid-19 levels.
- Increase activity to over 89% of 2019/20 activity levels: 99% was achieved for October 2021 to March 2022.
- Eliminate waits of over 104 weeks by March 2022: There were three patients waiting over 104 weeks at 31st March 2022 two of which were due to patient choice.
- Hold or reduce the number of patients waiting over 52 weeks: The number has continued to reduce month on month.
- Stabilise waiting lists around the level seen at the end of September 2021: Waiting lists have grown incrementally throughout the year.
- Increase the use of Advice and Guidance: These requests continue to significantly exceed pre Covid-19 levels.
- Increase the use of Patient Initiated Follow-Up (PIFU) pathways, instead of providing automatic follow-up out-patient appointments: Plans for safe and appropriate PIFU have been developed for a number of specialties and this will widen to all specialties in 2022/23.
- To reduce the 62 day Cancer backlog: A local target of a reduction to less than 132 patients was set and this was exceeded. Performance against the NHS Constitution cancer standards has improved month on month through the year.
- Increase access to Diagnostics: Monthly performance has been consistently high to the national standard of 99% to seen within 6 weeks all year, achieving the standard in February 2022.

Annex 1 – Statements from Commissioners, local Healthwatch organisations and overview and scrutiny committees

To be added when received.

Annex 2: Statement of directors' responsibilities for the Quality Report

REQUIRES UPDATING PRIOR TO PUBLICATION

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 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 report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS foundation trust annual reporting manual 2019/20 and supporting guidance Detailed requirements for quality reports 2019/20
- the content of the quality report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2020 to June 2021
    - papers relating to quality reported to the board over the period April 2020 to June 2021
    - feedback from commissioners dated 25/06/2021
    - feedback from governors dated 02/06/2021, 09/06/2021, 11/06/2021
    - feedback from local Healthwatch organisations dated 18/06/2021
    - feedback from overview and scrutiny committees dated 24/06/2021 and 25/06/2021
    - the Trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 21/05/2021
    - the national patient survey 02/07/2020
    - the national staff survey 05/2020
    - the Head of Internal Audit's annual opinion of the Trust's control environment dated 01/06/2021
    - CQC inspection report dated 03/12/2019
- the quality report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the quality report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality 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 report 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 accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the board

Chairman

Chief Executive

GLOSSARY OF TERMS

Accident and Emergency (A&E) - hospital department that assesses and treats people with serious injuries and those in need of emergency treatment (also known as Emergency Departments).

Acute – describes a disease or injury of rapid onset, severe symptoms and brief duration. In the context of a hospital, 'acute' describes a facility for the treatment of such diseases and injuries.

AKI – Acute Kidney Injury

Benchmarking – process that helps professionals to take a structured approach to the development of best practice.

BAH – Bishop Auckland Hospital

BAME – Black, Asian and minority ethnic

Board of Directors – the powers of a Trust are exercised by the Board of Directors (also known as the Trust Board). In a foundation Trust, the Board of Directors is accountable to governors for the performance of the Trust.

Clinical Care Group / Care Group – one of the Trust's five operating divisions, which include Integrated Medical Specialties, Surgery, Clinical Specialist Services, Community Services and Family Health.

Cavendish Review – An independent review, held in the wake of the Francis enquiry into Mid-Staffordshire Hospitals NHS Trust, which made recommendations with respect to the recruitment development and support of unregistered staff working in health and social care.

CDDFT –County Durham and Darlington NHS Foundation Trust

CCG - Clinical Commissioning Groups – Entities which are responsible for commissioning many NHS funded services under the new Health and Social Care Act 2012, established 1 April 2013.

Clostridium *Difficile* (C.Difficile or C. Diff) – a health care associated intestinal infection that mostly affects elderly patients with underlying diseases.

CoG - Council of Governors.

Commissioning for Quality and Innovation (CQUIN) – a payment framework developed to ensure that a proportion of a providers' income is determined by their work towards quality and innovation.

Community based health services – services provided outside of a hospital setting, usually in clinics, surgeries or in the patient's own home.

Community hospitals - local hospitals providing a range of clinical services.

DMH – Darlington Memorial Hospital

ED – Emergency Department

FFT – Friends and Family Test

Foundation Trust (FT) – NHS hospitals that are run as independent public benefit corporations and are controlled and run locally.

Freedom to Speak Up Guardian – a role created following the national 'Freedom to Speak Up' review which examined arrangements in the NHS to support staff raising concerns about care. The role is independent of management and reports to the Chief Executive and the Board. The Guardian's role is to support the development of an environment in which staff are supported in raising concerns, to encourage them to do so, and to monitor the effectiveness with which concerns are looked into and acted upon.

Frenulotomy Service – This is a service providing treatment for babies with tongue tie

GP –General Practitioner

Healthcare Associated Infection (HCAI) – infections such as MRSA or *Clostridium difficile* that patients or health workers may acquire from a healthcare environment such as a hospital or care home.

Hospital Standardised Mortality Ratio (HSMR) – the number of deaths in a given year as a percentage of those expected.

Health and Wellbeing Boards (HWB) – Boards comprised of health and social care commissioners and the consumer watchdog (Healthwatch), in place to oversee the development and delivery of a joint health and well-being strategy and plans for the geographical areas which they cover.

Infection Control – the practices used to prevent the spread of communicable diseases.

Integrated Care System - new partnerships between the organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups

MDT – Multi Disciplinary Team A multidisciplinary team (MDT) is a group of health and care staff who are members of different organisations and professions (e.g. GPs, social workers, nurses), that work together to make decisions regarding the treatment of individual patients and service users

MRSA - Methicillin-Resistant Staphylococcus Aureus - bacterium responsible for several difficult to treat infections.

MUST - Malnutrition Universal Screening Tool

National tariff (tariff) – centrally agreed list of prices for particular procedures; linked to the Payment by Results policy.

NCEPOD - National Confidential Enquiry into Patient Outcome and Death

NEQOS - North East Quality Observatory System

Never Events - Serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.

NEWS – National Early Warning Score - tool which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes.

NHS – Abbreviation used to refer to National Health Service

NHSI/E NHS Improvement/England– the national body which awards the Trust its provider licence and regulates the Trust against it.

NHSFT –NHS Foundation Trust

NHS Constitution – establishes the principles and values of the NHS. It sets out the rights and responsibilities of public, patients and staff to ensure that the NHS operates fairly and effectively.

NHS Providers – a national association representing Trusts and Foundation Trusts

NICE - Abbreviation used to refer to National Institute for Health and Care Excellence

Non-Executive Directors (NEDs) of foundation Trusts – independent directors appointed by the Governors to sit on the Board of Directors, with no responsibility for the management of the business on a day to day basis. The Chair of the foundation Trust will be a Non-Executive Director.

NRLS - National Reporting and Learning System

Operated Healthcare Facility – The provision of a fully operating healthcare facility, including estate, facilities, consumables and equipment, in this case provided under contract by the Trust's subsidiary, SCL.

OSC - Overview and Scrutiny Committee

Patient Advice and Liaison Services (PALS) – services that provide information, advice and support to help patients, families and their carers

PPI - Patient and Public Involvement

PPE – Personal and Protective Equipment. This is term that is used to describe equipment that staff are provided with to keep themselves and others safe in the work place including masks, aprons, gloves etc.

Primary care – the collective term for family health services that are usually the patient's first point of contact with the NHS; includes general medical and dental practices, community pharmacy and optometry.

PRISM2 – This is methodology used for mortality review

PROM - Patient Recorded Outcome Measure, which is a measure of health improvement reported by a patient following an operation.

Provider Sector – Trusts and Foundation Trusts

Referral to Treatment (RTT) Time – the description for the performance measure relating to how long a patient has to wait for an elective operation following a referral. The performance measure is that 92% of patients must be seen within 18 weeks.

SALT – Speech and Language Therapy

Secondary care – care provided in hospitals.

Summary Hospital-level Mortality Indicator (SHMI) – Indicator which uses standard and transparent methodology for reporting mortality at hospital level.

SystmOne – electronic patient record used in primary care and community services

Trust Board – another name used for the Board of Directors.

UHND - University Hospital of North Durham

UTI - Urinary Tract Infection

VTE - Venous Thromboembolism

This page is intentionally left blank