DARLINGTON
Borough Council

Health and Housing Scrutiny Committee Agenda

9.30 am
Wednesday, 14 June 2023
Council Chamber, Town Hall, Darlington, DL1 5QT

Members of the Public are welcome to attend this Meeting.

1. Introduction/Attendance at Meeting

2. Election of Chair for the purpose of the meeting

3. Declarations of Interest

4. Quality Accounts 2022/2023 –
   Report of the Assistant Director Law and Governance
   (Pages 3 - 6)

   (a) County Durham and Darlington NHS Foundation Trust Quality Accounts 2022-2023 (Pages 7 - 124)

   (b) Tees, Esk and Wear Valley NHS Foundation Trust Quality Account 2022/23 (Pages 125 - 226)

Luke Swinhoe
Assistant Director Law and Governance

Tuesday, 6 June 2023

Town Hall
Darlington.

Membership
Councillors Baker, Crudass, Dillon, Holroyd, Johnson, Kane, Layton, Mammolotti, Pease and Walters

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
14 JUNE 2023

QUALITY ACCOUNTS 2022/2023

SUMMARY REPORT

Purpose of the Report

1. To consider information included in the local Foundation Trusts Quality Accounts 2022/2023 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 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.

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

4. The draft Quality Accounts for CDDFT and TEWV are attached at appendices a and b.

Recommendation

5. It is recommended that draft commentaries for :

   (a) County Durham and Darlington NHS Foundation Trust be formulated and forwarded for inclusion in the Quality Accounts for 2022/2023; and

   (b) Tees Esk and Wear Valleys NHS Foundation Trust be formulated and forwarded for inclusion in the Quality Accounts for 2022/2023;

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

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

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

8. 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.

9. 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.

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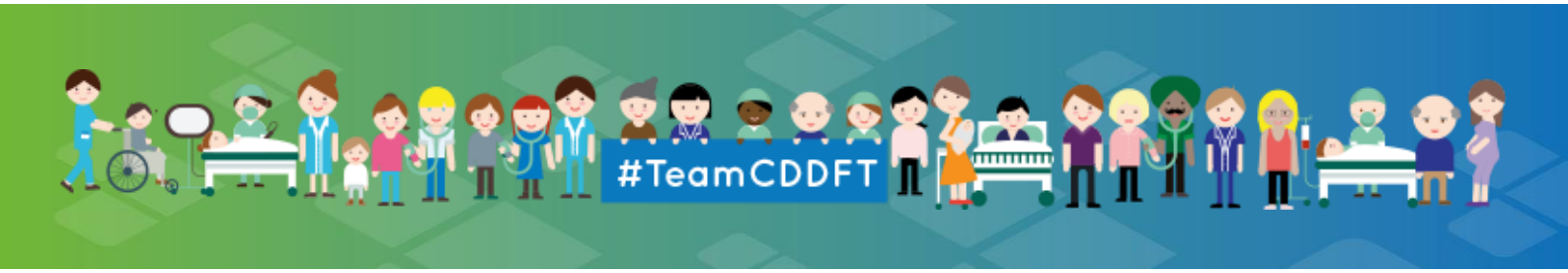


County Durham and Darlington NHS FT

QUALITY ACCOUNTS

2022 - 2023

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 2022/23. It also sets out our priorities for the coming year 2023/24. Early in 2022/23 we re-wrote and launched our quality strategy, "Quality Matters". We agreed quality priorities with our stakeholders which reflected both our emerging strategic objectives, together with those objectives from 2021/22 which had not been achieved and where further work was needed.

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 2022/23 Quality Priorities
Part 2B	2023/24 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 our 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 2023/24.

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.

I am delighted to introduce to you our Quality Account and Quality Report for County Durham and Darlington NHS Foundation Trust for 2022/23

Once again I am able to take great pride in reflecting upon the compassion and dedication shown by our staff, volunteers and partners for the way in which they come together, to care for all our patients – whether receiving acute, planned or emergency based care – to maintain cancer services and to 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 the ongoing Covid-19 pandemic for much of the year, exacerbated by high levels of influenza during the winter and the ongoing impacts of national pay disputes.

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'.

Our priorities were taken mainly from our four-year quality strategy, "Quality Matters", which we consulted on and agreed with all our stakeholders. Where we had not achieved our objectives from previous years, we also rolled these forwards.

Quality Matters 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.

2022/23 also saw the roll out of our Electronic Patient Record System, which provides a huge, and exciting, opportunity to drive quality improvement through technology and which is already supporting us in better understanding and improving our quality.

During 2022/23:

- We achieved the objectives which we had set ourselves for learning from excellence and mortality reduction;
- We implemented the substantial majority of the actions we set out to implement;
- We saw increases in the number of falls, and falls with harm, linked to patient acuity. However, the majority of the 49 rapid reviews were carried out found no lapses in care. We have reinvigorated our Falls Strategy and Falls Team under the leadership of a Patient Safety Matron.
- We had one / no Grade 3 or 4 pressure ulcers against our zero tolerance (awaiting investigation outcome);
- We have one MRSA bacteraemia against our zero tolerance and exceeded our nationally set threshold for C-Diff cases by two. However, were within the thresholds for all Gram Negative Bloodstream Infections;
- We strengthened our procedures for detecting and acting on patient deterioration, reinvigorated the use of local safety standards for invasive procedures (LocSSIPs) and rolled out new or updated sepsis screening tools in urgent care, community services and maternity services. We aim to go further, however, with respect to training in the deteriorating patient and life support; in ensuring high levels of compliance with LocSSIPs; and in minimising the time for antibiotics to be administered to patients with a suspicion of sepsis;
- We established a Maternity Quality Improvement Programme, which empowered staff in the service to drive improvements in: the use of digital systems; antenatal screening; and engaging, development and deploying our workforce. A range of projects were implemented to improve quality and safety with more in the pipeline;

- Working with partners in the local authority and voluntary sectors were able to introduce effective multi-agency arrangements to support safe, timely and effective discharge when patients are ready to leave hospital;
- We continued to develop and consult on our end of life care strategy and saw significant improvement in how we recognise when patients are reaching the end of their lives and support them, and their families with what is to come. However, estate constraints meant that we were not always able to provide side rooms for such patients.
- We refreshed and re-launched training for staff in looking after patients with dementia and with learning disabilities or autism, and consolidated the support that our LD nurses and lead dementia nurse provided to front-line services. Working with Tees, Esk and Wear Valleys NHSFT and other partners, we have implemented effective joint working arrangements to develop and implement care plans for patients with mental health needs whilst in our hospitals
- We have rolled out quality improvement projects to support the nutrition and hydration of patients but need to embed the use of the nutritional needs assessment in our new EPR system.

Over the last quarter, we have improved our A&E waiting times' performance and significantly reduced long waits in the department and the numbers of patients waiting over 12 hours for a bed. Ambulance handover times now average within 30 minutes and we are sustaining these improvements. We are taking further actions for 2023/24, such as expanding Same Day Emergency Care at Durham, to consolidate these improvements.

We have rated ourselves as amber for most quality priorities, which reflects the fact that we set ourselves ambitious and stretching targets and that 2022/23 was only the first year of our quality strategy.

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 and have added new quality goals related to the launch and roll out of our bespoke Patient Safety Strategy, Patient Safety Matters.

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 2022/23 Quality Priorities

The following section of the report sets out our performance with respect to each of the quality priorities we set for 2022/23. Wherever available, historical data is included so that our performance can be seen over time.

Summary of 2022/23 Quality Priorities

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		
Meet Maternity Standards including Ockenden recommendations		
Embed local safety standards 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: update the palliative care strategy and ensure appropriate access to private rooms for dignity	Improve access to paediatric specialist services
	Continued improvement of nutrition including assessment and provision for specific needs	Increasing excellence reporting
		Learning from Deaths (including 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	Summary Hospital Mortality Indicator (SHMI) Patient Reported Outcome Measures (PROMS)

	Ambition achieved		Some but not all elements achieved / improvement on prior year		Ambition not met

We deliberately set ourselves stretching objectives – to drive meaningful and long-term quality improvement - 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 2023/24.

Patient Safety

Reducing harm from inpatient falls

Actions planned have been implemented and the majority of falls subject to rapid review have not involved lapses in care; however, we have seen an increase in the number of falls per 1,000 bed days and in falls with harm.

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. Colleagues from therapies and pharmacy are now involved in the rapid review process to ensure a more multi-disciplinary approach.

The Falls Team has continued to provide targeted support, particularly 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.

In January 2023, a new post of Patient Safety Matron was implemented within the Patient Safety team, and the post-holder is also the Trust Falls Lead. As a result, the service is undergoing a refresh, including a review of the falls policy and ensuring a multi-disciplinary approach to the falls review process with an emphasis on quality improvement and shared learning. The Falls Team has been further supported by the appointment of an additional Charge Nurse which has enabled outreach support to clinical areas for education targeted by findings from the review of incidents.

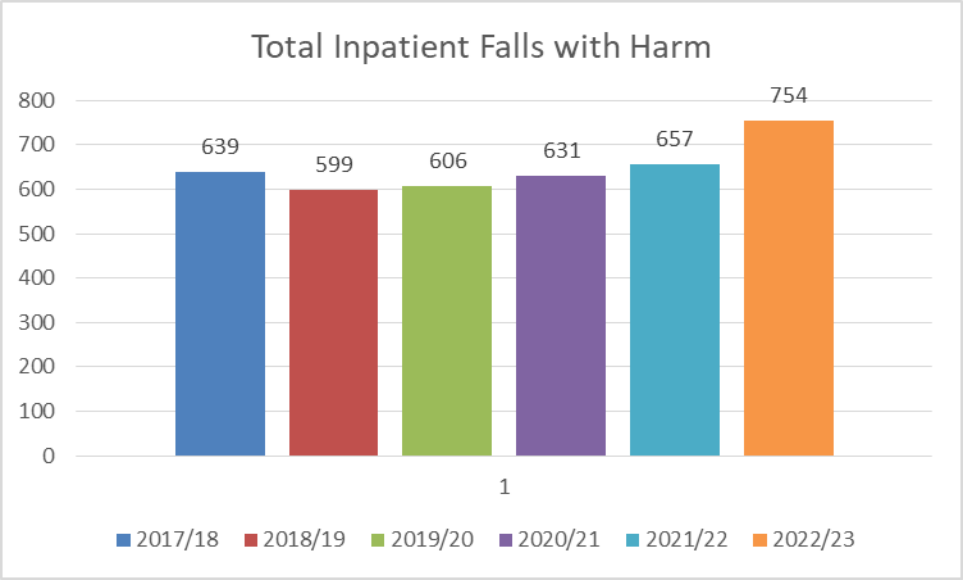
Number of Falls and Falls per 1,000 bed days

There has been an increase in the number of falls overall across the Trust, reflective of the continued system pressures and high bed occupancy. The number of falls per 1000 bed days (relating number of falls to activity) has slightly increased in acute but more significantly in community services.

	2022/23	2021/22	2020/21
Acute sites	6.5	6.4	6.8
Community sites	6.8	5.9	8.0

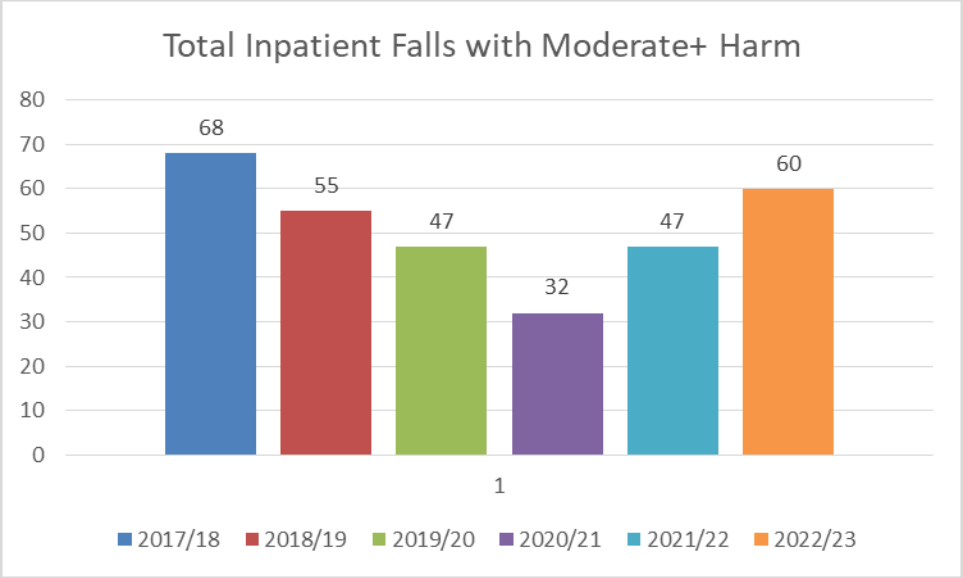
The trend in falls is influenced by patient acuity and comorbidities. Our approach therefore focuses on seeking to identify and learn from lapses in care.

Number of falls with harm



We have built questionnaires into our Incident Reporting system to allow all falls to be assessed for lapses in care and improvement targets have been set based on falls with lapses in care. Our ward based documentation has been updated to the latest falls care bundle, which is supported by ongoing, face to face, education provided by the Falls team to all wards and teams The Trust also recently appointed a Quality Improvement Senior Sister, who, along with the Patient Safety Matron, are focusing on falls as a first priority and supporting improvement projects on wards in acute and community settings.

Number of falls with moderate/severe harm



The number of falls resulting in moderate or greater harm increased from 46 reported in 2021/22 to 60 reported in 2022/23, which is in line with the overall trend for falls with harm.

We completed 49 rapid reviews of falls with moderate or greater harm between April 2022 and March 2023. All reported falls which result in a fractured neck of femur, or a subdural bleed, or are otherwise identified as being of significant concern. Where lapses in care which contributed to the fall have been identified, these are reported to our commissioners as Serious Incidents. There were nine serious incidents reported in 2022/23. However, in most cases, the outcome of the rapid review was that the fall could not be predicted /prevented and did not, therefore, involve lapses in care.

Reducing harm from health care associated infections (HCAIs)

Ambition partly met

The Trust reported one MRSA case, against its zero tolerance, in 2022/23 and exceeded its nationally mandated threshold for C-Diff. Infection rates reduced, however, for all reportable organisms except C-Diff and the Trust met its thresholds for Pseudomonas, Klebsiella and E.Coli.

In the period we have reported one MRSA bacteraemia (exceeding our zero tolerance) and 61 C-Diff cases against our full-year threshold of 59. All cases are reviewed and learning implemented. All providers in the North East, except one, have reported MRSA cases. The trend in C-Diff is replicated in the region and nationally.

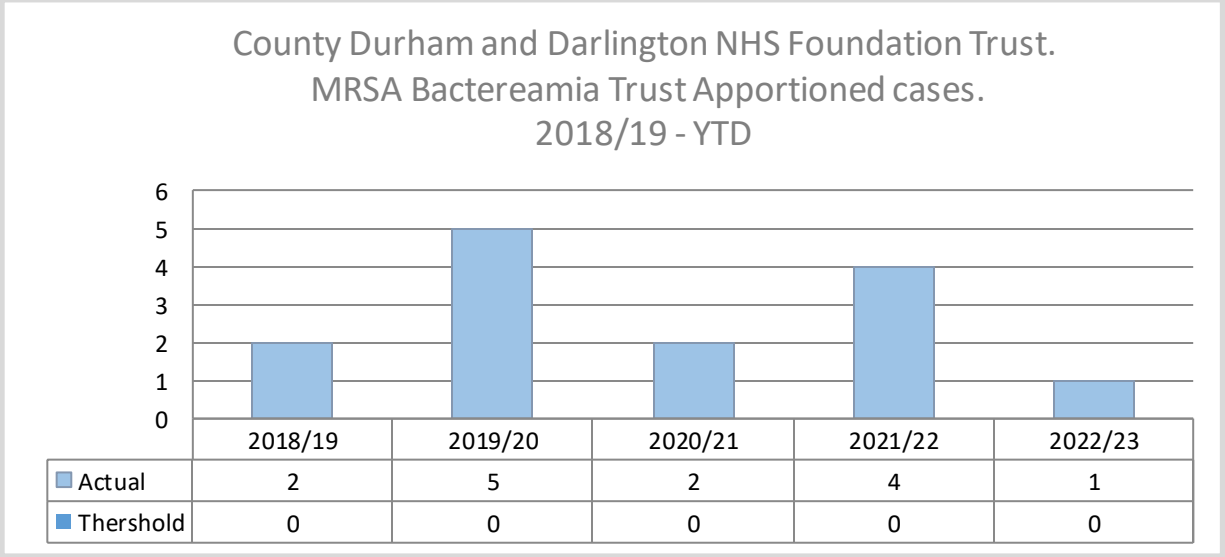
The Trust is above its internally set trajectory for MSSA infections but below national trajectories for Klebsiella, Pseudomonas and e-coli. We have implemented a programme of back to basics audits to reinforce compliance with good infection control practice in all areas. Initially the audits were undertaken every month; however, they have since been adapted to allow the Infection Prevention and Control (IPC) team to provided more intensive support to those areas with challenges, so that most areas are now audited every quarter.

All HCAIs are subject to a Post Infection Review (PIR) by the IPC team to identify any areas of non-compliance with best practice, which enables the IPC team to support the relevant clinical team, and to identify and track themes, enabling targeted support in response to lessons learned.

The charts below demonstrate the Trust's position for 2022/23 against mandatory and local thresholds.

MRSA Bacteraemia

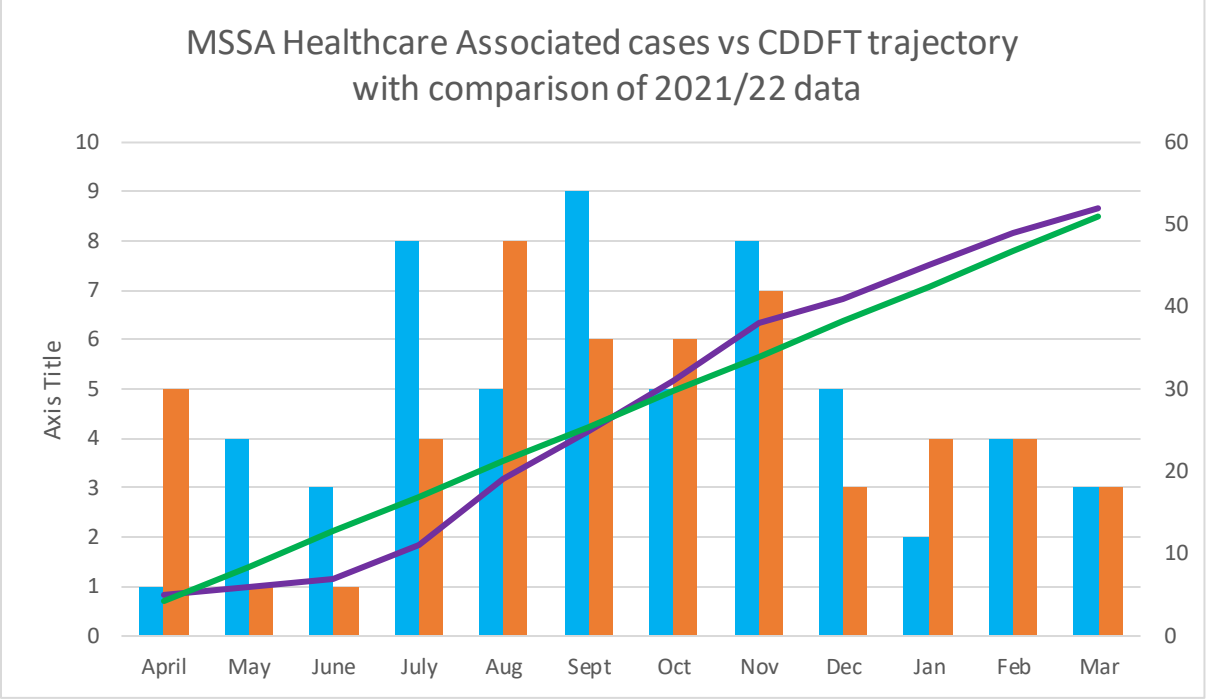
CDDFT reported one case of MRSA Bacteraemia against NHSE threshold of zero avoidable infections. This is a 75% reduction on the previous financial year.



	2018/19	2019/20	2020/21	2021/22	2022/23
Actual	2	5	2	4	1
Thershold	0	0	0	0	0

MSSA Bacteraemia

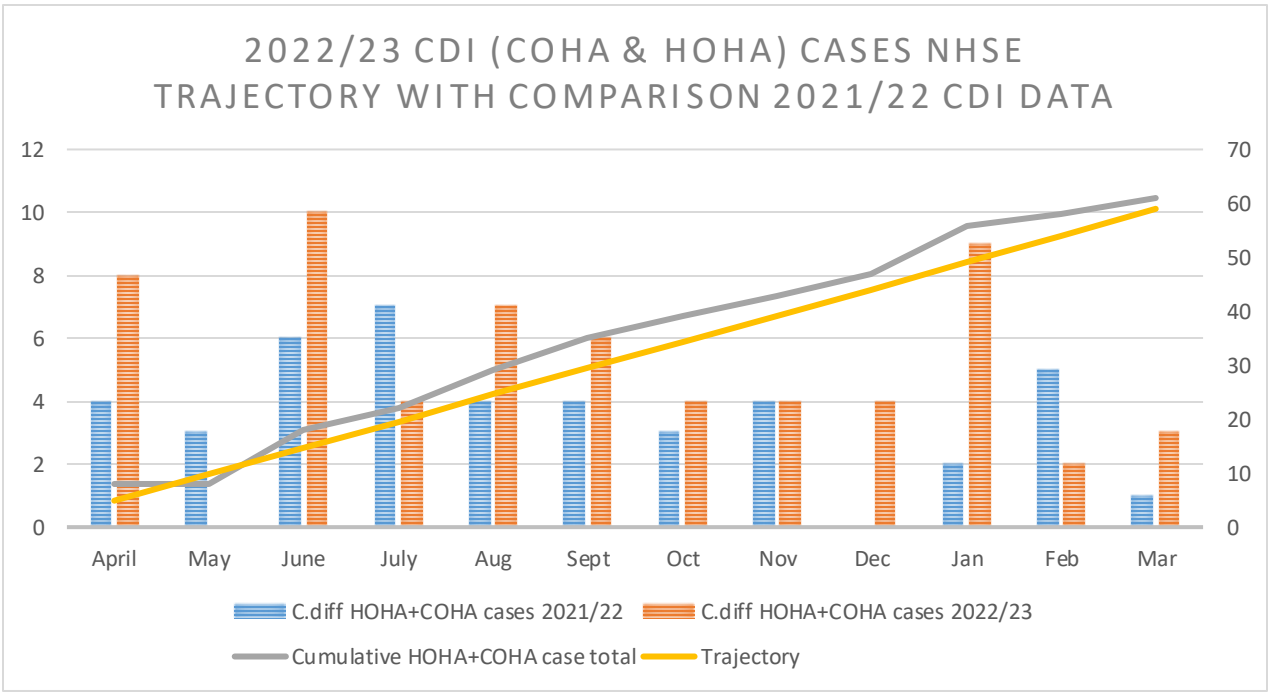
A stretching self-imposed threshold of 51 cases of MSSA was agreed through the Trust's Infection Control Committee. During 2022/23 CDDFT reported 52 Healthcare Associated MSSA cases. This was a **9%** reduction on the previous financial year.



Clostridioides difficile Infection (C-Diff)

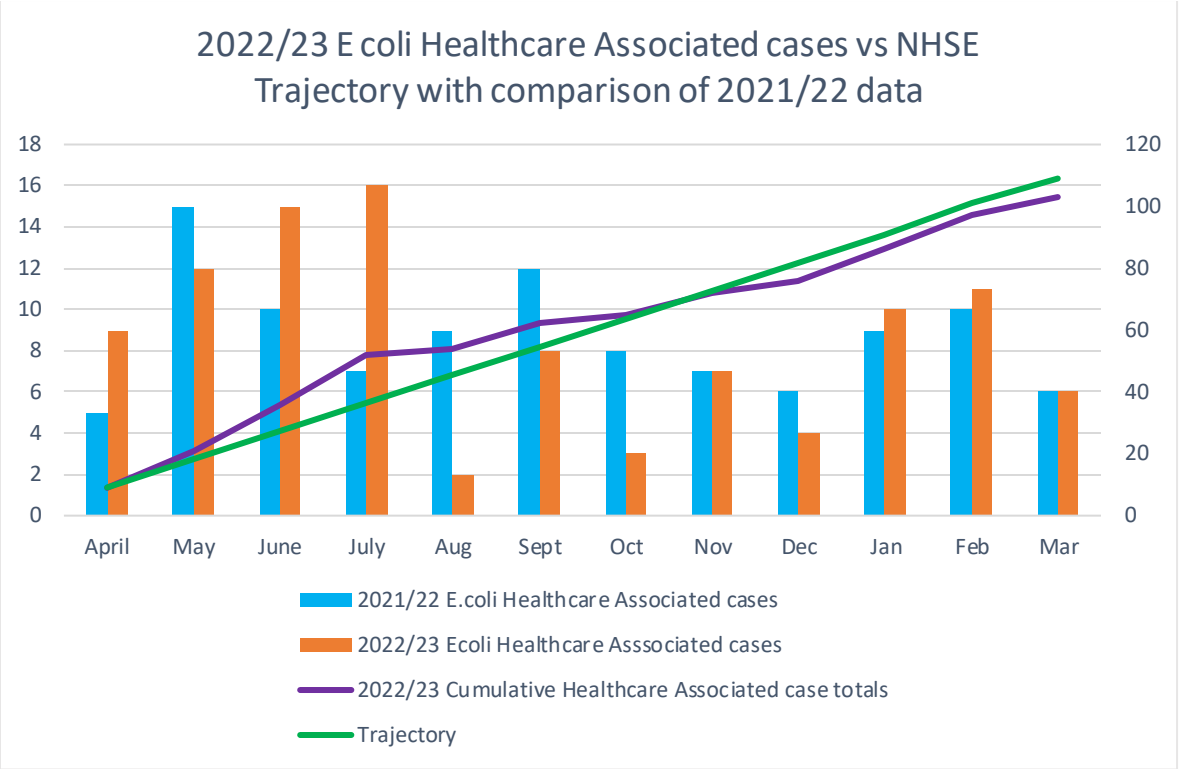
In 2022/23, the Trust reported 61 cases. Whilst this was a **42% increase** from the previous financial year, it was two more than the threshold set for the Trust by NHS England which recognised rises in C-Diff cases nationally. Of the 61 cases, 40 were hospital onset healthcare associated (HOHA) infections and 21 were community onset healthcare associated infections (COHA).

There is no definitive research to explain the increase in C-Diff cases seen nationally following the Covid-19 pandemic. However, the trend has been seen across the North East region, with most providers seeing increases.



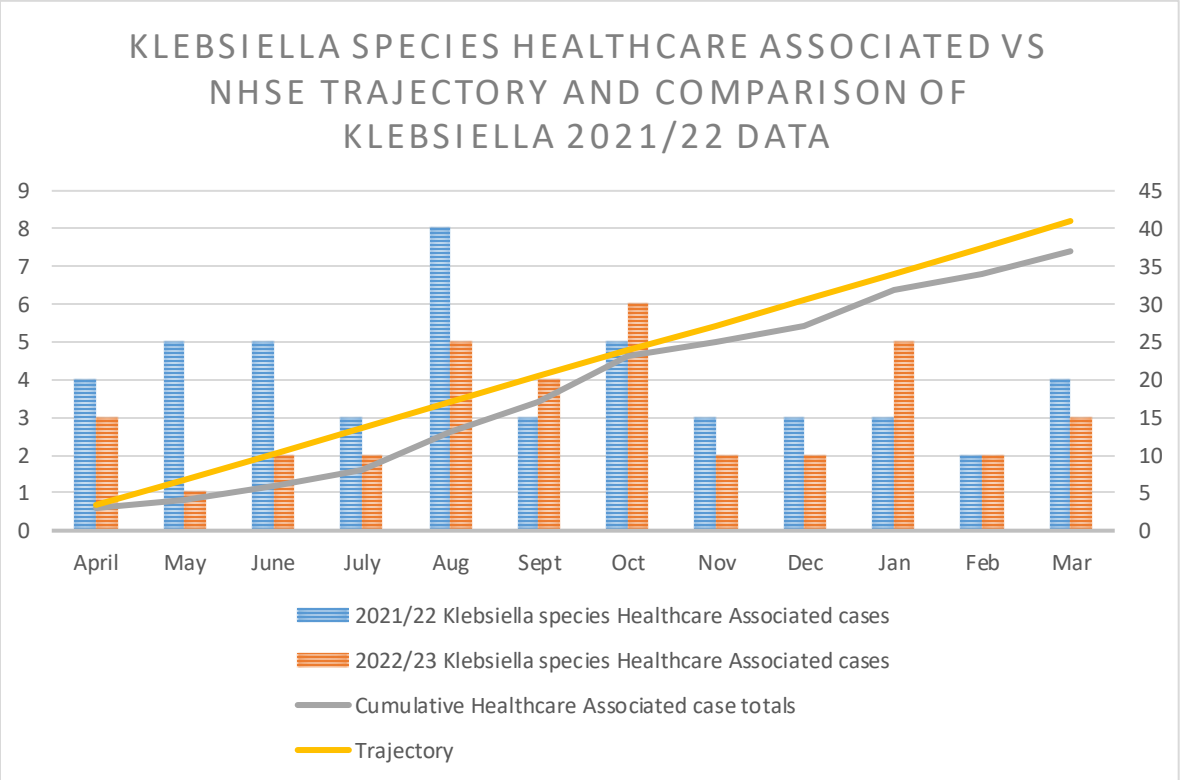
E coli

In 2022/23 CDDFT reported 104 Healthcare Associated E.coli cases against NHSE annual threshold of 109. This was a **1% reduction** on the previous financial year.



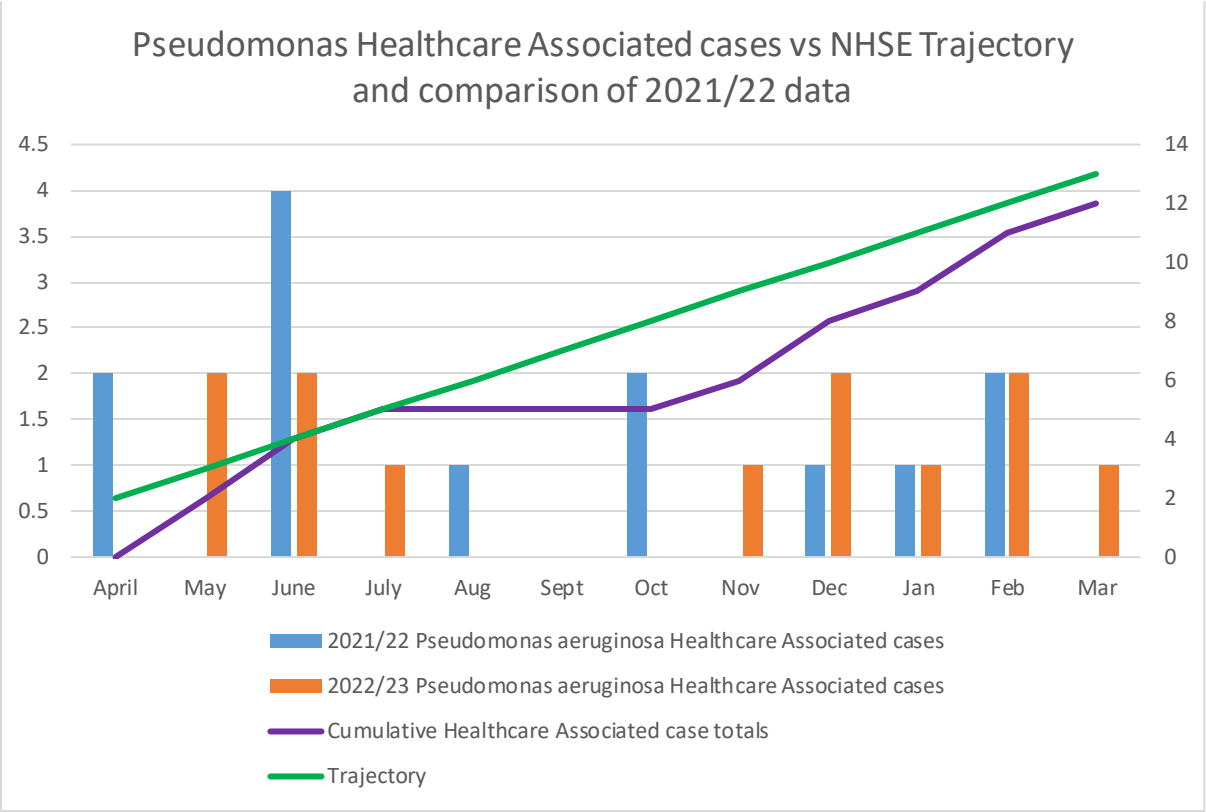
Klebsiella sp

In 2022/23, the Trust reported 38 Healthcare Associated Klebsiella against NHSE threshold of 41. This was a **22% reduction** on the previous financial year.



Pseudomonas

In 2022/23 CDDFT reported 12 healthcare associated pseudomonas cases against NHSE trajectory of **13**. This was a **14% reduction** on the previous financial year.



Reducing harm from category 3 and 4 pressure ulcers

Ambition partly met

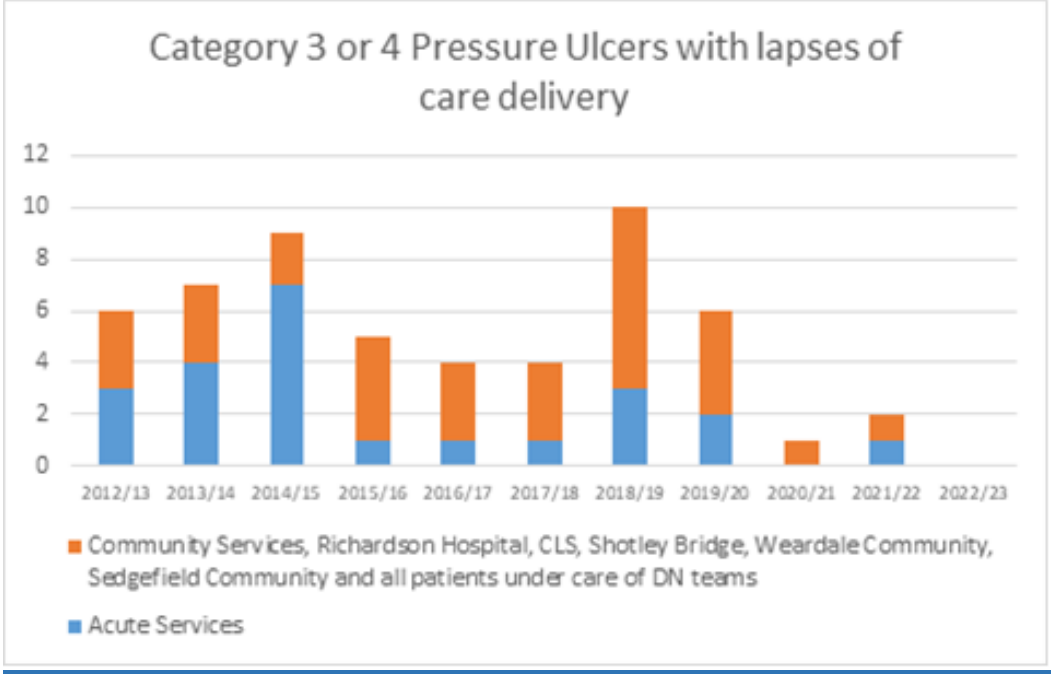
There have been no Category 3 or 4 pressure ulcers with lapses in care reported during year; however, there is one such case still under investigation.

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. At the time of writing there is one high grade pressure ulcer with a potential lapse in care that is the subject of an ongoing investigation by our Tissue Viability team. Otherwise there are no Grade 3 or 4 pressure ulcers with lapses in care reported during the year. Pending the outcome of the investigation were are reporting that we have partly met our objective [Drafting Note – if there is no confirmed lapse in care prior to the final document being issued we will report that our ambition has been met]

Our rapid reviews of all Grade 3 and 4 ulcers which occur in our care ensure that incident reviews are timely, and that learning takes place promptly for all departments and teams. The reviews are multi-disciplinary and are led by a Tissue Viability Matron. Incident reports for Grade 2 ulcers are accompanied by questionnaires designed to assess compliance with Trust policies and to identify lapses in care. The outcomes are validated – on a sample basis – by our specialist Tissue Viability teams with any thematic learning disseminated.

The Tissue Viability team has focused on providing education and support to front-line teams, with particular emphasis on pressure ulcer prevention and the correct categorisation of pressure ulcers. We have a number of Wound Resource Educational Nurses (WRENS), who work in both Community and Acute Tissue Viability services and are hoping to introduce an equivalent role for our HCA staff, which would cover basics skin care and prevention.

The below table shows the long-term trend for Category 3 and 4 pressure ulcers in the Trust, subject to the outcome of the investigation noted above.



Maternity Standards including Ockenden recommendations

Ambition partly met

We have made good progress in implementing our action plans in relation to the Ockenden report and made further quality and safety improvements to our service through a dedicated Maternity Quality Improvement Framework. There is work ongoing to recruit, engage and develop staff in line with service needs and a range of further quality improvements being implemented early in 2023-24.

The Trust implemented a Maternity Quality Improvement Framework, to empower staff within the service to deliver improvements with Executive support and hep from relevant specialists in corporate directorates. This included many of the improvement actions contained in our action plan response to the Ockenden report. MQIF had five work-streams covering: digital systems, workforce, continuity of carer, antenatal and newborn screening and quality and safety.

In line with the national directive we suspended the roll out of Continuity of Carer and implemented a model to sustain acute and community services following extensive consultation with staff. The model includes retaining a small number of teams to provide continuity of carer where there are clear benefits to women and birthing people in the local population and our staffing is sufficiently resilient.

Successes and challenges:

Our key quality improvement initiatives for the maternity service are summarised below, together with successes in the year and areas of ongoing focus and challenge.

- Our maternity service has undergone a full programme of Digital Transformation; including the introduction of a digital solution for maternity record keeping and a patient portal, Badgernet, in addition to the integration of a full system electronic organisational electronic patient record:
    - As part of this integration the service has improved the quality of core datasets and submissions, being an exemplar for data validation within the region;
    - Our digital systems have facilitated live communication and record sharing not only between professionals and families but across Trusts regionally; and
    - They also include risk assessments and decision support functionality to aid staff in providing clinical care and responding to particular presentations and conditions.

- Midwifery Continuity of Carer was introduced in a planned way following full consultation with staff. By early 2022, some 64% of women and birthing people were covered by Continuity of Carer and the approach saw improvements in public health metrics including smoking and breastfeeding, and in clinical outcomes with higher rates of vaginal deliveries and decreased intervention, and significant feedback regarding family satisfaction. In additional the safeguarding teams noted improvements to care and outcomes of vulnerable families receiving continuity of care. Unfortunately, due to a national shortage of midwives and the findings of the Ockenden Inquiry, there was a national improvement to pause the Continuity of Carer programme during the year. In keeping with most maternity services, the Trust was experiencing its staffing pressures and needed to re-evaluate the model of care. Following an extensive programme of staff engagement and consultation we implemented a new model of care proposed by staff - a 'hybrid' approach. This model allows 4 teams to increase caseloads to 1:70 and provide one planned shift a week into the acute service which enables the skills of midwives to be maintained and also for staff to retain an element of the transformational model of care.

- Public Health and Inequalities: in 2022/2023 the service worked collaboratively with the commissioners and local authorities to build on the public health and inequalities offer for Durham and Darlington. This has included the successful opening of the first family hub in Bishop Auckland integrating the continuity of carer team with teams from other services to provide multi-professional support and care for families through a central point of access. This collaborative work has led to the jointly-funded appointment of a Health Inequalities Matron for a three year period, to develop our understanding of the inequalities across our region and help reshape services to address them.

- Workforce: As is well documented, there is a national shortage of midwives, with a current national vacancy rate of around 10%. Retention is also a challenge, partly driven by the impact of national transformation programmes, some of which have far-reaching impacts on work / life balance. We continue to experience such pressures in our own service but have responded proactively through a wide range of developments to recruit, retain and support our staff including:
    - Commissioning an independent assessment of our safe staffing arrangements by the national 'Birth Rate Plus' team, which is ongoing at the time of writing.
    - Investing in a proactive and widely-marketed external recruitment programme and in international recruitment, with 10 internationally-qualified midwives joining us in the summer of 2023.
    - Further developing our successful preceptorship programme in line with national standards for newly qualified midwives.
    - Maintaining our 'Blossom' scheme to support and welcome new midwives.
    - Appointing a Recruitment and Retention Midwife to provided dedicated leadership to all of the work above.
    - Recruitment of specialist midwifery roles covering, for example: digital systems, foetal wellbeing and screening.
    - Developing a 'Maternity Matters' engagement strategy and rolling out a staff engagement programme include protected 'time out' sessions for teams to come together to work on developments and challenges.

  We measure the demands on our service, including patient acuity, six times every day, and proactively monitor rosters and adjust staffing across our maternity service to match staffing to demand.

  Our Homebirth service has been suspended during 2022-23 because of the staffing pressures in the service. We are committed to restoring the service, with an enhanced model of care, as staffing levels allow and we are actively exploring options to do so.

- Estate: Estates constraints have impacted on the maternity service during 2022-23. The Birthing Pool at Darlington has been out of use, pending works to enhance the water quality on the site. We anticipate being able to bring the pool back into use during the coming summer. In addition, necessary changes made during the Covid-19 have resulted in early pregnancy and antenatal

outpatient services being co-located in Durham. Recognising the impact on the patient experience we hope to be able to provide services from separate areas within the Maternity Service footprint at UHND in the near future. We are also looking to upgrade bathroom facilities on our wards at DMH, which are outdated.

More positively, our new bereavement facility for families with pregnancy loss will be formally opened in Durham in summer 2023 and a similar facility is planned for Darlington.

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	2022/23	2021/22
Maternity 12 week bookings	90%	88.8%	88.6%	88.7%	90.5%	89.2%	84.1%
Maternity breast feeding at delivery	60%	64.4%	67.1%	64.9%	66.3%	65.7%	62.6%
Maternity smoking at delivery	22.4%	14.8%	13.6%	12.4%	14.8%	13.9%	12.3%

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

We have established a system to monitor, and obtain assurance that, LocSSIPs are further actions necessary to embed compliance.

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 have been working to implement robust monitoring, auditing and governance procedures to provide assurance that our new LocSSIPs policy is followed.

Our goal for the year was to implement a robust system to monitor, and obtain assurance, that LocSSIPs are correctly followed in practice, that the correct versions are in use and that ownership is clear and transparent. We have; introduced a CDDFT LocSSIP policy and Standard Operating Procedure; updated the CDDFT internet and intranet sites to improve document management and ensure that correct versions are available; and completed an audit of the use of each LocSSIP document in place with results feedback to Clinical Directors, Clinical Leads, Executive and Non-Executive Directors. A Task and Finish group has been established, under the leadership of a Care Group Director to implement improvement actions identified through the audits undertaken.

Following the roll out of our Electronic Patient Record System (EPR), a development programme has begun which will eventually see all LocSSIPs migrated into the system, thereby removing paper copies form the process, enhancing audit functionality and improving compliance.

Embedding prompt recognition and action on signs of patient deterioration

We have made significant improvements in areas such as acute kidney injury and have introduced functionality in our electronic patient record system to help staff identify and act on signs of patient deterioration. We need to embed the use of this functionality and to continue to step back up training in recognising deterioration and providing life support.

One of the key ambitions in the Trust's quality strategy 'Quality Matters' 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 for cardiac arrest prevention and specialist hospital at night and Acute Kidney Injury (AKI) teams, we have continued 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 alongside our regional and national peers we have faced very high demands on our Emergency Departments, and associated long waits, which poses a potential risk to prompt and rapid response to signs of patient deterioration.

In 2022-23 we set out to reinvigorate our resuscitation and deteriorating patient training programmes (from a reduced programme during the active pandemic). Training compliance was monitored monthly and improved for all staff groups and teams. We did not, however, meet our 85% compliance target and will therefore maintain this goal for 2023-24. We have increased class sizes for face to face training with respect to recognition and treatment of deterioration and are gradually recovering after the pandemic.

Our AKI and renal in-reach services have been subject to an interim evaluation, which demonstrated clear benefits identified in terms of: length of stay; improved specialist support to nursing staff and junior doctors; patients' experience, and adherence to NICE guidance and evidence-based standards. Further evidence is needed but the service is also expected to have contributed to reductions in mortality and in preventing unnecessary admissions to critical care.

We have introduced an acute competency development pathway for registered nurses in our Acute Medical Units (AMUs) with further training in managing the deteriorating patient and to impart essential skills such as arterial blood gas interpretation, taking blood cultures and basic rhythm recognition.

The introduction of "Call for Concern", a support service which allows anyone concerned about a patient's condition to call a member of our Acute Intervention Team, has also evaluated well based on an initial review, and we are committed to publicising the service more widely. The Acute Intervention Team work with the ward-based team to review the patient's condition and there are examples where contact from relatives or friends has made a difference to the care of a patient and / or improved communication with the family.

The roll out of Cerner, our electronic patient record system, has prompted changes in some areas and departments in their response to the deteriorating patient. All in-patient areas and Emergency Departments can input vital signs in real time using a handheld electronic device, which also enables escalation to clinicians as events occur. Our focus for the coming year is on embedding the use of this functionality. Treatment Escalation Plans have been captured in our EPR system, as have pain scoring, risk assessment, care planning and staff alerts for patient deterioration. We are also embedding the completion of patient risk assessments and response to alerts.

Improving the management of patients with Sepsis

Ambition partly met

New screening tools have been implemented in paediatrics, maternity, urgent care and community services and a nurse-led sepsis pathway has been implemented to reduce reliance on medical staff and increase the timeliness of interventions including antibiotics. Despite these actions, we continue to experience challenges in providing antibiotics within one hour when our A&E Departments are under pressure.

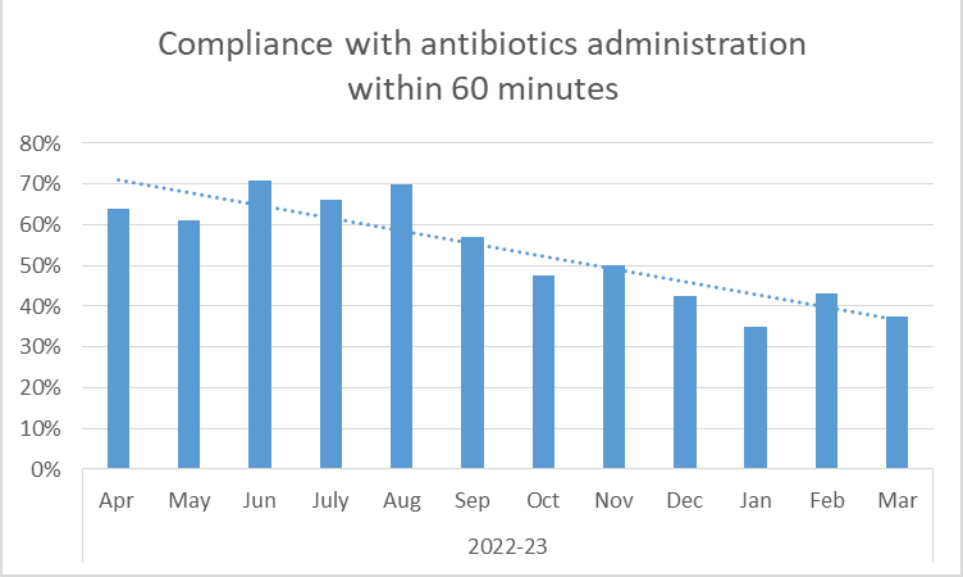
Our aim was to improve the percentage of patients receiving antibiotics within 1 hour of diagnosis in the Emergency Department and to improve both staff awareness and processes to improve the prompt recognition of, and response to sepsis. As a result of recent technological improvements and process innovations at CDDFT, 100% of patients who fit the regionally agreed criteria are screened for sepsis.

The regional sepsis screening tool is now integrated within our nursing observations system. Sepsis screening occurs every time a set of observations are recorded within this system. If a patient is confirmed as a positive sepsis screen, decision support within the system will ask staff to complete the 'Sepsis Six' treatment and inform the medical team for urgent review. All patients within CDDFT are therefore automatically screened for sepsis. A Maternity and Paediatric Sepsis Screening Tool was also recently revised and launched Trust-wide.

A Patient Group Direction (PGD) has been developed which is now available for use within the EPR system for staff who have completed the Nurse-led Sepsis training for Sepsis of Unknown Origin.

Antibiotic Compliance

We continue to monitor compliance with administering antibiotics within one hour of sepsis diagnosis. Unfortunately performance has dropped, which is considered to be associated with operational pressures restricting the availability of medical staff and suitable clinical space to administer antibiotics. We will continue to prioritise this Patient Safety objective in the year head, with further development of a nurse led sepsis pathway and, potentially, additional patient group directions.



Sepsis Education

A Sepsis Study Day is held four times a year and has recently been reinstated following the pandemic. A new programme has been designed which includes simulation training for all ward-based staff to help improve staff awareness of Sepsis and support prompt recognition and response.

Sepsis based simulation training and education for the senior nursing staff in DMH Emergency Department has been in place since July 2021 and has been delivered to 44 members of staff. Ongoing sessions are planned throughout 2023 to extend the training to encompass senior staff working in A&E at UHND and more junior staff.

Prior to implementation of the PGD referred to above, the ED team received bespoke training and were required to complete competencies allowing them to administer IV Tazocin and IV fluids using a PGD. This included high-fidelity simulation scenarios and theory based knowledge from various specialities. Staff were expected to complete e-learning training to ensure that they had basic knowledge of sepsis prior to attending simulation training. All staff involved were required to obtain a clinical skills qualification and be able to order chest x-rays, enabling them to be able to take an in-depth clinical history and give clear evidence of a possible source of infection which would assist their decision making and any request for a medical clinician to review. This pathway supports nursing staff to recognise, respond and refer patients whilst waiting for a senior clinician to review patients resulting in more timely treatment, improved patient outcomes and a decrease in patient mortality. By initiating this change it is envisaged that more antibiotics will be given within the recommend sixty minute guideline endorsed by NICE (2017).

In addition, planned "10@10" sessions supported by consultant microbiologists in both DMH and UHND Emergency Departments support staff education on the overuse of Tazocin and the use of frailty antibiotics along with education for the correct antibiotic prescribing for community acquired pneumonia (CAP) based on the patient's risk score.

Community based Sepsis Tool

Urgent Treatment Centres (UTC) within the Trust document care on SystmOne, which is different to the EPR system used within our hospitals. Recently it was recognised that Sepsis guidance within SystmOne was based on a different tool. Development work has therefore been undertaken to ensure that SystmOne uses the regionally recognised and approved screening tool. Staff within UTCs and community based teams were involved with this change and education was required to ensure that the system worked correctly and was user friendly to staff; this work is now fully completed.

Community teams have established a sepsis pathway called 'Is my patient unwell'. This pathway helps community staff to establish whether a patient meets the sepsis criteria and whether they require emergency treatment, taking account of their early warning score and the sepsis regional tool. In addition to the typical sepsis screening process, this tool also includes 'soft signs' which assist staff in being confident to raise concerns to clinical teams. The tool is now well embedded and enables teams to be able to make a rapid informed clinical decision in the community and gives a structured SBAR tool to escalate patients to GP's and paramedics if required.

E-Learning for Registered Nurses

Sepsis e-learning is available for all registered nurses within the trust via the e-learning for health (e-LFH) programme. Information has been made available for all staff to register via a weekly communications bulletin. The Cardiac Arrest Prevention website provides a range of information and prompts staff to access educational sessions, the sepsis regional tool, NICE guidelines and the UK sepsis trust manual.

Sepsis Poster and leaflets for Patients and Relatives

Sepsis posters, with a QR code and leaflets attached, have been designed to meet NICE quality standards. Posters are displayed in the Emergency Departments, Same Day Emergency Care Services and Urgent Care Centres. The QR code is linked to the Trust's internet site enabling patients and relatives to download relevant information supporting awareness of signs and symptoms of sepsis and signposting to help if required.

Patient Experience

Improving the care of patients with additional needs - Dementia

In summary, good progress has been made with respect to specific training and specialist nursing support for patients with Dementia. Our ongoing aim is to recruit more Dementia Champions, increase the coverage of our training and embed practice developments.

Our aim is to provide appropriate care for patients with cognitive impairment and ensure that patients with an impairment such as dementia and their families have a positive experience of throughout their care.

We continue to communicate key learning messages to staff through our quarterly Dementia Newsletter and through our network of Dementia Link Nurses, or Champions. We have recently restarted face to face briefings for the Dementia Champions from our Lead Dementia Nurse.

One of our aims for 2022-23 was to increase the level of awareness and understanding of dementia among our staff by increasing the take up of Dementia-related training, which continues to be accessed through the Trust's e-learning portal. The training targets for 2022-2023 were achieved. Over 90% of staff completed the required training in dementia awareness, with more than 95% completing Tier 1 training. September 2022 saw the re-introduction of face to face training such as sensory deprivation training, which has been completed by 142 staff, and enhanced care training has been completed by 112 staff.

Patient-led assessments of the clinical environment (PLACE) re-commenced in September 2022, which includes an assessment of how far the environment is Dementia-friendly. The assessments result in local actions, led by ward managers, and upgrades to the environment, which are built into lifecycle maintenance programmes.

The Trust has also signed up to the Dementia Friendly Hospital Charter.

The National Audit of Dementia commenced in September 2022, with the Trust participating in the fifth round of the audit. Data collection ended in March 2023 and the report is expected to be released in Summer 2023.

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

Improving care of patients with additional needs - Learning Disabilities and Autism

We have made specialist training available to all staff and continue to provide specialist nursing support and guidance to front-line teams in caring for and supporting patients with learning disabilities an autism. We are collecting feedback from patients and making changes to our information as a result. Next steps will including offering enhanced training modules and working towards a seven day specialist support service.

Our aim was to provide high quality care and support for patients with a learning disability or autism, and to ensure that they and their families and carers have a positive experience when using our services.

Throughout 2022/23 we have offered Tier 1 e-learning for all staff in CDDFT to access and we have been invited to be part of a pilot for the delivery of further, enhanced training modules, led by the North East and North Cumbria (NENC) Integrated Care Board.

We have also worked with colleagues from Tees, Esk and Wear Valleys NHS FT (TEWV), to establish how we can expand our acute liaison service to provide a seven day service, to ensure that patients'

reasonable adjustments are met and support patients with learning disabilities and autism presenting to our A&E Departments.

We have continued to follow our "Policy for care of patients with a Learning Disability and/or people with Autism" and our Learning Disability guarantee, which is unique to CDDFT, to ensure that patients receive individualised support and care under the guidance of our specialist Learning Disability nursing team, during and on discharge from acute admission.

We actively promote the role of the Acute Liaison Nurse for Learning Disabilities throughout the nursing service in the Trust, providing ongoing training and education whilst in the ward environment. In addition, we have continued to work with service users, carers, and their families to understand and learn from their experiences in order to continuously improve our care.

Our specialist LD nurses receive alerts from the patient administration system when a patient with a diagnosis of a Learning Disability is admitted onto a ward allowing them monitor acute admissions and to provide guidance and support to front-line teams. The LD nurses complete discharge reviews and work with community staff to help support patients with Learning Disabilities and/or Autism in being cared for at home, minimising unnecessary attendances at A&E.

In the last quarter of 2022/23 we launched an 'easy-read' Friends and Family test so that we can collect feedback from patients with a learning disability. We have learned that patients do not always understand the information that we give them, which has led us to consider how we present the information and what further improvements we could make.

We have a continuous audit process in place to monitor compliance with our policy in respect of Do Not Attempt Cardio-pulmonary Resuscitation orders, which provides evidence that it is being followed appropriately for patients with Learning Disabilities and Autism.

Improving the care of patients with additional needs – Mental Health Support

Following the Covid-19 pandemic we have seen an increase in patients attending our A&E departments, and requiring admission to our hospitals with both physical and mental health needs, particularly among children and young people. Accordingly we have needed to introduce new policies and procedures, based on joint working with our mental health trust and local authority colleagues so that we are able to respond to all the patient's needs and provide for their safety, and the safety of others through joint care planning.

We have established a Partnership Alliance Group with colleagues from TEWV, our local authorities and Cumbria, Northumbria, Tyne and Wear FT to jointly oversee the development of services which respond to patients with dual needs in our care, and to consolidate relationships between those leading it. There is an Operational Group sitting underneath the Alliance to deal with operational issues. Through this group we have established arrangements to agree care management plans for patients with dual needs, including any support or supervision needed on our sites from TEWV staff.

We have also:

- Developed and rolled out a policy for the care of patients with mental health needs
- Accessed training and support for staff from TEWV colleagues
- Assessed our joint arrangements against sources of good practice and published reports from the Care Quality Commission and identified and enacted related improvements.
- Review the physical environment for wards at higher risk, considering the actions required to mitigate risk including physical measures such as the removal of unnecessary ligature points and management measures such as supervision.

All of this work is ongoing.

Ambition partly met

Ensuring a positive patient experience through the discharge process

Discharge processes generally result in a positive patient experience and we have implemented effective learning processes from Section 42 Safeguarding Referrals. The Trust works well with a wide range of partners, taking a multi-agency approach to discharge planning, with a number of further improvements being planned.

Throughout the year we have been updating our approach to include learning from all previous Work As One and 'Perfect Week' exercises, building on our Next Step Home approach. We work closely with local authority partners to support early discharge using trusted assessment and time to think beds.

We have seen positive feedback (4 of the Top 5 questions for the Trust in the 2021 CQC national inpatient survey, where we were above average concerned discharge – see below) and have seen fewer Section 42 safeguarding concerns raised in recent months. The Trust's Safeguarding teams have introduced thematic working groups with Discharge Facilitators / Coordinators to embed all learning arising from sub-optimal discharge reports submitted via our Local Authority colleagues. Although only two quarters-worth of data has been reviewed thus far a number of actions were identified and implemented. We have already received positive feedback from a Care Provider who commented on the encouraging changes made by the Trust following concerns previously raised in relation to a client's discharge.

Top five scores for CDDFT:

Survey Section	Question	CDDFT Result (0-10)	Trust Average (0-10)
Leaving hospital	Q46: After leaving hospital, did you get enough support from health or social care services to you recover or manage your condition?	7.0	6.5
Leaving hospital	Q42: Before you left hospital, did you know what would happen next with your care?	7.2	6.8
Leaving hospital	Q37: Did hospital staff discuss with you whether you would need any additional equipment in your home, or any changes to your home, after leaving the hospital?	8.9	8.7
Leaving hospital	Q44: Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?	8.6	8.5

System leadership

This year, we recruited to the position of System Wide Discharge Co-coordinator, a nationally mandated post to provide system support to the discharge process, including implementing of a transfer of care hub (ToCH) which is currently in development.

The County Durham and Darlington ToCH will operated as a system-level coordination centre for local health and social care joining-up all relevant services to support safe, timely and effective discharge wherever they live within our localities. The hub will take responsible for developing timely, person-centred 'step-down' or 'step-up' plans for people based on the principle of 'no place like home'.

Discharge and Choice Policy

We are updating our Discharge & Choice Policy to align our approach to nationally-mandated pathways and best practice.

Early Discharge Planning

The Discharge Management Team provides guidance and support to help ward teams make the necessary referrals to ensure the correct agencies are involved in relation to discharge.

Multi-disciplinary Working

Multi-disciplinary working is fundamental to effective discharge planning and to improving discharge pathways. We have introduced daily interagency calls which includes all partners involved in discharge. The calls focus on finding solutions to any challenges preventing a patient from being discharged when they are ready to leave hospital. The multi-disciplinary approach to discharge planning for patients able to return home or who need temporary placements is proving effective, as we are seeing a reduction in the number of people remaining in hospital for more than seven days after they are medically-optimised, and particularly for those waiting more than 21 days.

All wards now have a directory of services available to support discharges across Durham, Darlington and North Yorkshire. 'Home group' assist this new initiative by supporting those with low level mental health needs with housing and financial problems pre and post discharge. We have already seen improvements in reducing the need for patients to re-attend because such additional needs have not been met.

Housing and Related Services

Effective referral systems are now in place, particularly in relation to hospital discharges, as a result of housing representatives being core participants in the daily interagency calls. A great deal of work has been undertaken to implement a system-wide approach to supporting the homeless with successful outcomes for some very complex cases, including collaborating with the third sector.

Home First / Discharge to Assess

Whilst the focus is on 'Home First' for patient discharges from hospital, capacity and availability within re-ablement and domiciliary care have been a challenge. The development of 'Step Down' facilities and services has enabled patients to be discharged from hospital into a more suitable care environment, once they no longer need hospital-based care but are waiting to access domiciliary care.

All social assessments are now carried out in the community rather than in hospital settings, helping patients to leave hospital sooner once they are ready to do so.

Improved Discharge to Care Homes

Care Home Select (CHS), a brokerage/trusted assessor service for care homes, has worked closely with the Trust and social services to reduce the time in hospital for those requiring more permanent placements particularly for those who are approaching end of life

The Trust has representatives on a number of care home groups/forums which focus on improving discharge pathways

In addition our community nursing service receive daily lists of admissions and discharges from care homes to facilitate communications and appropriate follow up care which continues to work well.

Monitoring and responding to system demand and capacity

Daily medically-optimised patient lists are used to track patients, enabling those involved in discharge to be able to identify and action the next steps required in the discharge process. There is further work to do to ensure that our systems are fully up to date and guidance is being produced for ward-based staff to assist with this.

Ambition partly met

End of Life and Palliative Care

In summary, our draft strategy is being consulted upon, and we are demonstrating real improvement in earlier recognition of when patients are close to the end of their lives. However, access to side rooms for privacy and dignity remains a challenge, especially given estates restraints at UHND.

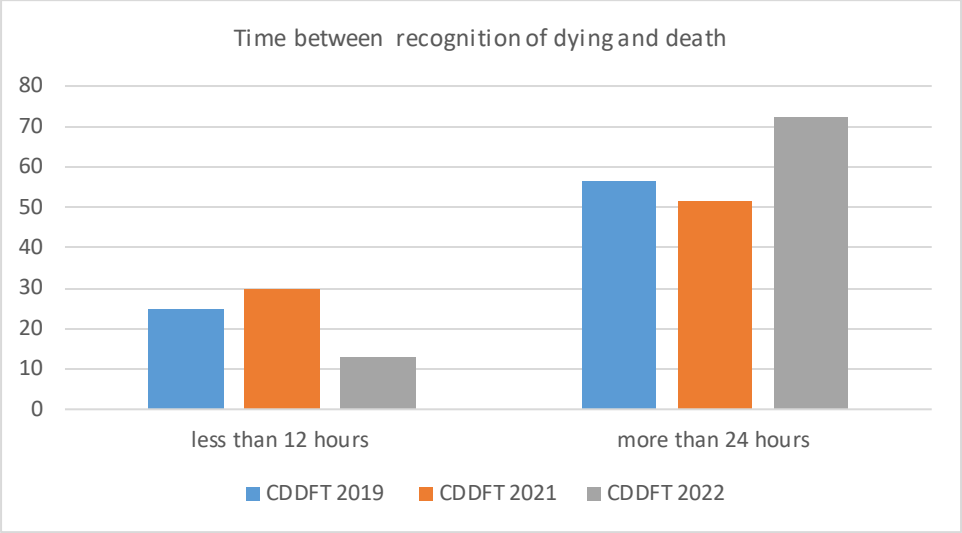
The Trust's End of Life Care was rated as 'Outstanding' in the most recent CQC report. Throughout the year we continued to engage with partners and stakeholders to refresh the palliative care strategy to 2025; however, unfortunately, delays were encountered by pandemic priorities.

Our End of Life Care Strategy has been updated and is out for consultation.

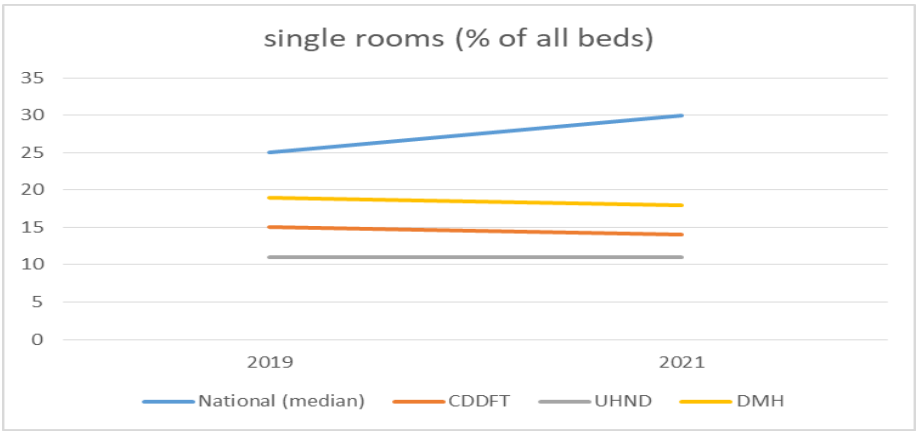
The results of National Audit of Care at End of Life (NACEL) 2022/23 and quality survey data demonstrated continuing good practice in end of life care within the Trust.

Figure notes: NC743 = UHND, NC742 = DMH, quality survey results apply to both acute hospitals

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. Results from NACEL (table 2) show a marked improvement in recognition of patients approaching the end of their lives. Early recognition allows us to discuss what is coming with patients and their loved ones, and to prepare them for it. The results that our interventions of the last few years are beginning to work.

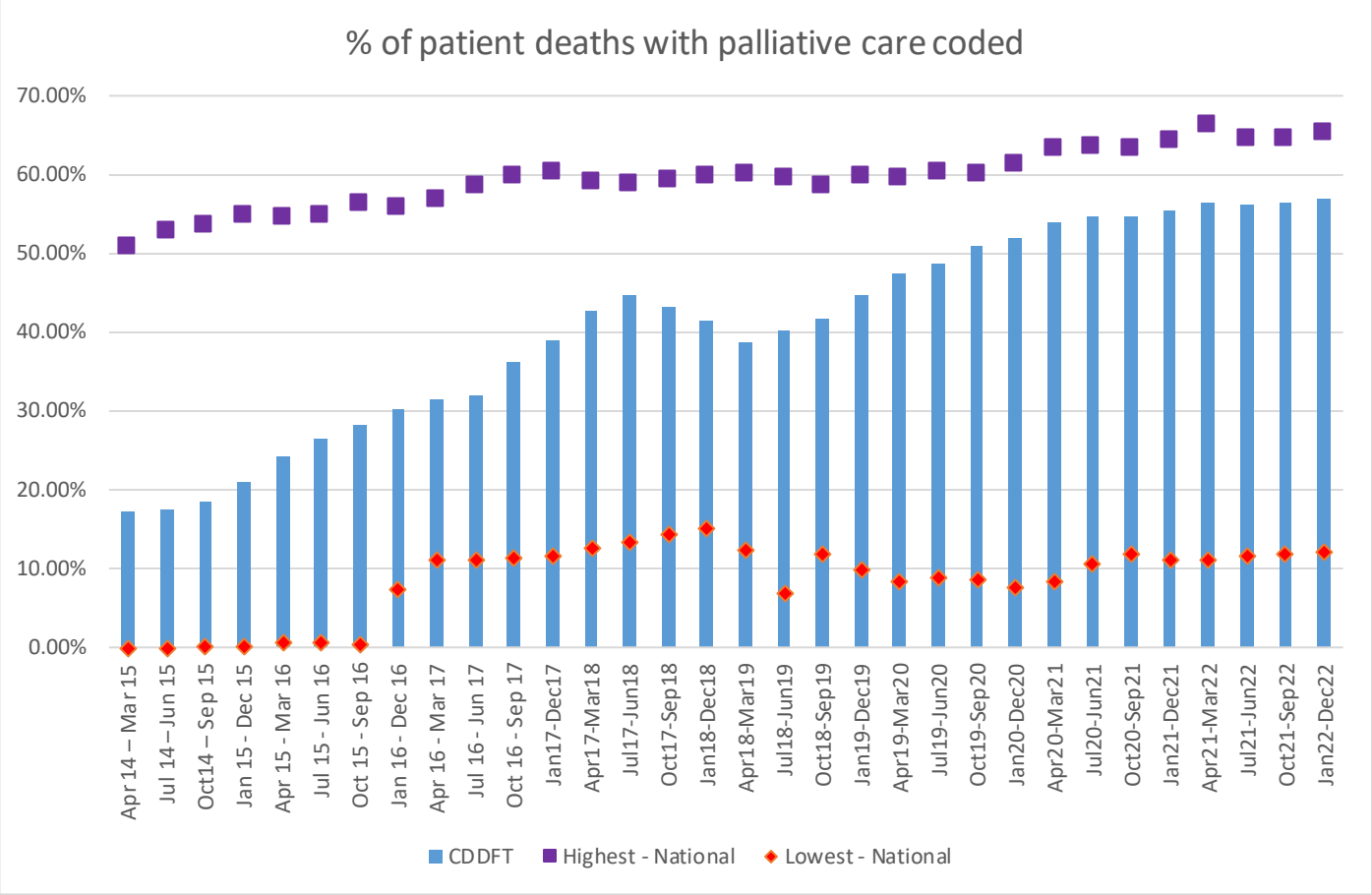


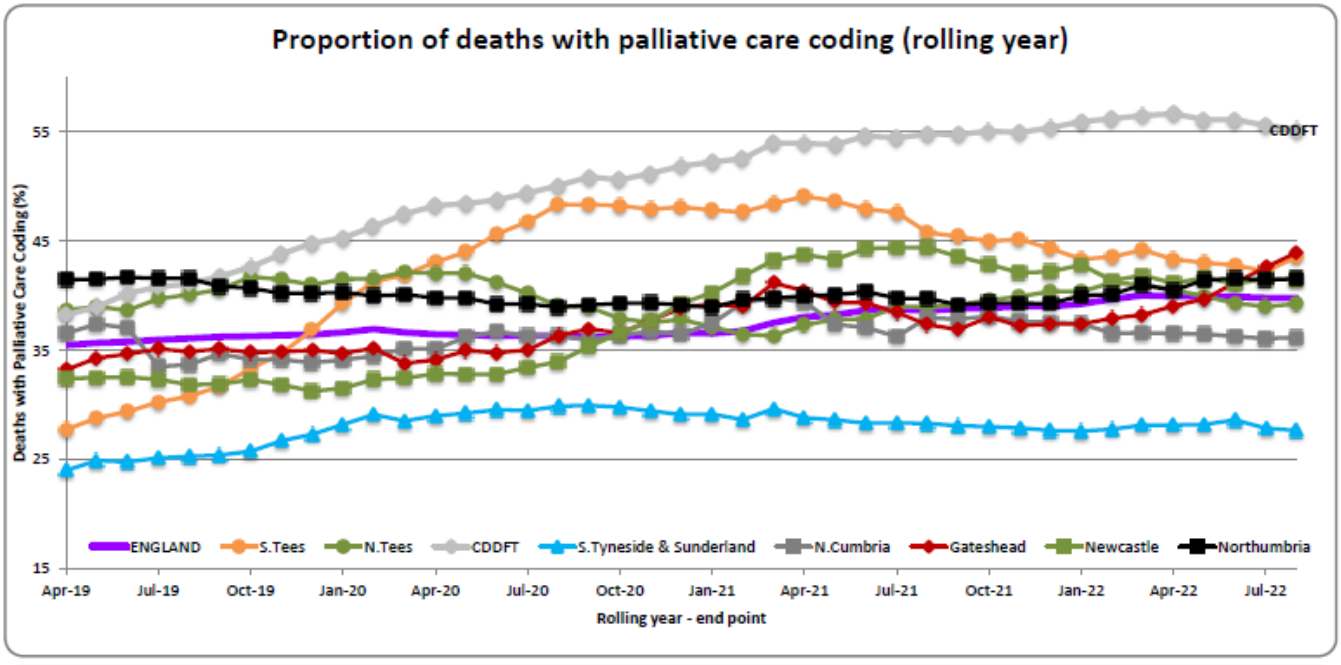
Access to single rooms for patients who are dying is relatively good at DMH (88%) but remains more of a challenge at Durham, where more than 50% of patients die in four bedded bays because of fewer side rooms being available within the estate. The proportion of single rooms continues to decline compared to the national average. Where possible and appropriate, we make use of community hospitals where and are reviewing opportunities to increase side rooms across the Trust's estate, including incremental increases as we extend existing wards, or develop new ones. Education is provided to staff on ways to maintain the privacy and dignity of end of life care patients within the wider hospital footprint where side rooms are not available.



The Trust continues to have the highest proportion of deaths with palliative care coding within the region, as a result of which more than 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)





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

The Dietetics Service has proactively supported front-line staff through a range of initiatives and we have introduced specific campaigns to monitor and maintain hydration. Nutritional needs assessments improved over the first half of the year; however, new processes in our EPR system require further time to embed.

During 2022/23 we aimed to develop a strategy, building on work previously undertaken, to further improve the care delivered to our patients, and to develop and embed nutritional needs assessment and care planning within the Trust's electronic patient record system.

Over the past 12 months we have: implemented annual calibration of weighing scales across the organisation; launched nutrition screening and care planning for adult services via the electronic patient record; and continued to meet NICE guidance through our Nutrition Steering Committee. In addition, as a result of feedback from service users, and learning from incidents and complaints, our Dietitians have extended their scope of practice to undertake enteral tube related procedures. This has resulted in admission avoidance, and more timely discharges, and has supported troubleshooting at ward level. We plan to further develop this service.

Our Dietetics teams have supported wards in maintaining and improving compliance with completion of MUST assessments within four hours of admission. On our medical wards, compliance ranged from 88% to 96% between April and September, with most wards regularly scoring over 90%. There has been a dip since the implementation of the Trust's new EPR system, as has been noted for all risk assessments, however, intensive education and training is being provided on wards to help embed understanding and use of the new system functionality.

In addition to the above:

- We are updating our Nutrition Policy to set out more explicit procedures to protect mealtimes; and
- We have continued to offer role-specific nutrition training for nursing staff.

We are also rolling out the use of "traffic light" jugs to support better hydration among patients. Patients start the day with a red jug, which is replaced with an amber and then a green jug. The traffic-lighting alerts staff to when jugs have not been replaced for some time, putting to a potential lack of hydration. We have also rolled out a 'Drip or Drink' campaign on our wards to encourage staff to consider whether patients who are taking on little hydration should be placed on a drip.

Clinical Effectiveness

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

Recent months have seen improved performance on waiting times, fewer long waits for beds and overall, and strong performance in respect of ambulance handover times. We need to sustain these improvements and to increase the percentage of patients assessed within 15 minutes of arrival.

The Trust has, for the last quarter, seen and treated / admitted around 70 to 73% of patients attending A&E within four hours. This is, generally, slightly above the national average and broadly in line with the region, albeit one or two per cent below on occasion.

At the height of winter, due to respiratory viruses and other demands, the Trust experienced pressure, and patients experienced longer waits and high numbers of 12 hour waits for a bed, following a decision to admit them. However, over the last quarter of 2022/23 we achieved significant reductions in patients waiting over 12 hours in the department and in patients waiting 12 hours or more for a bed, from a decision to admit, as well as in ambulance handover delays. The changes reflect some reduction in demand but also a range of process improvements. The next priority is to maintain and improve performance around the time to assessment and time to treatment indicators.

It is worth noting that the 2023/24 planning target is for Trusts to see and treat / admit at least 76% of patients in four hours by March 2024. We are assured that, given our starting position and with the developments planned for the coming year, such as expansion of Same Day Emergency Care at UHND, we can meet this expectation.

The Trust was asked to present, regionally, on the improvements made in respect of ambulance handover times and 12 hour waits for beds.

Around 62% of patients were assessed within 15 minutes of arrival in the department, in February and March 2023.

In order to deliver the improvements described above we have; doubled the size of the ambulance handover bay at our Darlington hospital, increased the resilience of our bed base (with further increases in capacity planned for early in 2023/24) and recruited additional paediatric specialist nurses to meet the Royal College of Paediatrics and Child Health (RCPCH) recommendations for our A&E at Darlington. We have also fully embedded our Same Day Emergency Care service (as an alternative to A&E for suitable patients) at Darlington and increased the number of patients using it. Additional staff have been assigned into our waiting rooms to monitor patients and undertake safety checklists and checklists to ensure patients receive food and drink whilst waiting and there is in-reach into the departments from acute care physicians when patients require medical review but there is a delay in a medical bed becoming available.

We continue to be well supported by our local authorities to address challenges with access to beds in the community or domiciliary care, supporting timely patient discharge.

We have agreed, and are rolling out, additional investments in middle grade and junior doctors in our A&E Departments and are working on investing in seven day services to ensure all patients receive a medical review every day. Implementation is expected to be incremental, however, given dependence on funding and the recruitment market this will take some time.

Paediatric Care

We have sustained a 24/7 front of hours Paediatric Assessment serviced at UHND and increased specialist staffing, including in the Emergency Department at Darlington. Recruitment of staff for our inpatient wards continues and continue to embed joint working with TEWV for young people with mental health needs.

Over the past 12 months we have continued to make improvements towards our stated goals including; sustaining 24/7 opening for the front of house Paediatric Assessment Area at Durham, recruiting additional specialist nursing staff in line with our aim to meet the RCPCH standards for the Paediatric A&E area at Darlington and made further investments in specialist paediatric and neonatal staff.

Ward based staffing is also increasing to ensure a 1:4 nursing ratio given the acuity and needs of our patients, having seen increased presentations of respiratory viruses and mental health needs. We have established a Partnership Alliance Group, and an operational group with Tees, Esk and Wear Valleys NHSFT (TEWV) and local authority partners to jointly plan and coordinate care for children and young people with mental health needs. The operational group looks after care planning and mitigation of risks.

As part of our commitment to care for young people, and through our work with TEWV, we have reviewed our ligature risk assessments for paediatric wards and are implementing the actions identified, as well as working with the support of the regional Paediatrics Network with respect to the changes we are making to our services.

Excellence Reporting

Excellence reporting has continued to increase year on year and exceeds levels seen at the majority of our peer organisations. The membership of the Learning from Excellence Group continues to increase.

Our objective for 2022/23 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 and work-streams.

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 through a range of communication channels such as Facebook Live Briefings and Directors’ Briefings. The number of members in the group has recently increased, which has seen the remit of the group evolve to incorporate Appreciative Inquiry in line with the new Patient Safety Strategy and patient stories provided by the Patient Experience Team.

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. 381 - 536 reports received per month.

Learning from Deaths (in particular the roll out of Medical Examiners reviews)

All national mortality indicators are in line with statistical parameters. Learning from death reviews continue to find less than 1% of cases which were potentially avoidable and the medical examiner service is fully established in our main hospitals.

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 has remained within the "as expected" range for the last twelve months.

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

During the year we have developed our mortality review approach, and supporting processes, through a range of projects including:

- A project focused on ensuring that patient care is accurately captured with coding, being led by the Quality Improvement Senior Sister.
- Reviewing a sample of deaths for patients who had a prolonged stay within the Emergency Department and died during the same admission. This work will replace the previous reviews completed on coded low risk of death groups.
- Lowering the threshold for mortality review for deaths in our vulnerable groups (such as patients with a known Learning Disability or Mental Health condition).

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.

	2022/23	2021/22	2020/21
Mortality Reviews Completed	438	696	702
Total Patient Deaths recorded	2316	2,207	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 by NHS Digital 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 Variable Life Adjusted Display alerts, this data is not available until six months after the patient has died.

Transition to SJR plus

CDDFT is transitioning to a data collection method known as Structured Judgement Review Plus (SJR+). The SJR+ method enables the Trust to have a better understanding of the quality of care provided than the current data capture approach.

After a successful pilot of SJR+ it was agreed this was the preferred method to support learning from deaths in CDDFT. Training for the central review team is underway and NHS England's Making Data Count team are supporting the trust with the Mortality Dashboard. The aim is for SJR+ to be fully implemented in 2023.

Current CDDFT Mortality RAG Rating

Measure / source of assurance	RAG
Summary Hospital Mortality Indicator (SHMI) – currently 109.69 (within expected range)	
Hospital Standardised Mortality Ratio (HSMR) – 88.52 and within expected range	
Copeland's Risk Adjusted Barometer (CRAB) Annual review data has shown improvements in Surgical Mortality but considered a prompt for further review in medicine relating to global triggers. A review has been completed but not found any cause for concern.	
Completed mortality reviews –currently on track with the mortality review process.	
North East Quality Observatory (NEQOS) Independent Review Monitoring of our VLAD's continue and a sample of VLADS with a less than 20% risk of dying are included in our priority reviews.	

Current CDDFT Mortality RAG Rating

The Medical Examiner Service is now fully operational at Bishop Auckland, Darlington Memorial Hospital and University Hospital of North Durham at CDDFT. We are working towards scrutiny of community deaths by the statutory deadline of October 2023; however, reviews of community deaths will mainly be undertaken by primary care colleagues

Part 2B - Priorities for 2023/24

The Trust refreshed its Quality Strategy during 2022 following consultation with staff and patients and a wide range of external stakeholders. Priorities for 2023/24 reflect both the priorities in this strategy and further priorities (described as "retained" priorities) where further work is required to meet 2022/23 objectives.

Safety	Experience	Effectiveness
Quality Strategy Priorities / Retained priorities for 2023/24: work ongoing		
Reduce the harm from inpatient falls, focusing on identification and learning from lapses in care	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		
Implement actions, in line with Ockenden and other recommendations to sustain safety in maternity services.		
Embed safe practice for invasive procedures: LocSSIPs		
Embed prompt recognition and action on signs of patient deterioration		
Improve the timeliness of administration of antibiotics for patients with suspected sepsis	End of life care: conclude and roll out the palliative care strategy, ensuring appropriate access to private rooms for dignity as far as possible.	Improving access to paediatric specialist services
Meet first year milestones for the roll out of the Trust's patient safety strategy.	Continued improvement of nutrition including assessment and provision for specific needs	
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 / Retained Priorities from 2022/23 – Work ongoing:

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. Minimising harm from falls remains is one of priorities within the Trust's Quality Matters Strategy.

Goals

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

How will we do this?

We will:

- Complete rapid reviews and implement learning from falls with moderate or greater harm with lapses in care, throughout the Trust.
- Increase the population of minor or no harm falls reviewed to identify lapses in care, to identify and act on themes for learning.
- Continue to focus education on key areas such as completing lying and standing blood pressures appropriately and ensuring falls assessment documentation is completed in a timely.
- Look to maximise the benefit of quality improvement initiatives such as 'Zonal Nursing'
- Review the after action review documents to move in line with the new Patient Safety Incident Response Framework.
- Work in partnership with other NHS trusts and organisations to promote safe mobilisation.

Measures of success

Reduction in incidence of falls with lapses in care that contribute to the patient's fall.

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

Why we chose this priority

Minimising harm from HCAIs remains is one of priorities within the Trust's Quality Matters Strategy.

Goals

To minimise the potential risk of patient harm from avoidable HCAI. We aim to be within the national thresholds set for mandatory and local reporting of the below organisms:

- C-Diff
- MRSA
- MSSA
- Gram-negative bloodstream infections:
    - Klebsiella
    - Pseudomonas
    - E coli

To date 2023/24 national thresholds have not been set.

To minimise the risk of transmission to patients/staff/visiting personnel from respiratory viruses inclusive of Covid-19.

How will we do this?

We will implement specific plans for each type of infection as outlined below.

Clostridioides Difficile Infections (C-Diff)

We will:

- Focus on early recognition of suspected/infective diarrhoea and appropriate patient management.
- Continue with our Antimicrobial stewardship programme.
- Hold weekly multi-disciplinary C-Diff meetings.
- Share learning in a timely manner to drive improvement.
- Work with partners to monitor cleanliness standards.

MRSA:

We will:

- Review the Trust's MRSA policy and ensure it is aligned to best practice.
- Audit compliance with the policy.
- Focus on MRSA screening and decolonisation.
- Continue to investigate cases and share findings with the organisation.

MSSA:

We will:

- Continue to investigate cases and share any learning across the organisation to support individual areas with any educational requirements.

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.
- Share information on sources of infection and themes from good practice and from lessons learned Trust-wide.
- Undertake prevalence audits for patients with a urinary catheter to ensure best practice is delivered.

Covid-19:

We will:

- Continue to monitor changes in national guidance and incorporate them into our local protocol/policy.
- Continue to monitor prevalence rates and tailor mandatory IPC precautions in line with prevalence.
- Monitor and investigate local periods of increased incidents (PII) and outbreaks.

Measures of success

To remain within nationally set thresholds for all mandatory reporting healthcare associated infections and internal reduction strategies.

Reducing harm from Category 3 and 4 pressure ulcers

Why we chose this priority

Minimising harm from pressure ulcers remains is one of priorities within the Trust's Quality Matters Strategy.

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 for all Category 2 pressure ulcers, with findings reported to Care Group Governance meetings for action and learning.
- Develop an equivalent of the WREN for our HCA staff, to cover basics skin care and prevention.
- Develop an Acute Tissue Viability referral criteria to appropriately signpost staff.
- Develop a skin care pathway to promote the most appropriate cleansing and use of products.
- Develop and introduce a Haematoma Pathway.
- Work with colleagues in Procurement to align the Acute Dressings formulary with community thus providing more consistency with dressing choice and treatment.

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.

Meeting Maternity Standards, including Ockenden Recommendations

Why did we choose this priority?

Safety in maternity services remains a high priority nationally with the publication of the second Ockenden Inquiry Report in April 2022, the Maternity Transformation agenda, and ongoing focus on the Saving Babies Lives care bundle. It remains one of the key priorities in our Quality Matters strategy.

Goals

We aim to further increase the resilience of our maternity services and to implement all of the actions required following national reviews, alongside local quality improvement initiatives, so that we continue to provide high-quality, evidenced based care. In doing so, we aim to consolidate our workforce, ensuring that care is always provided by skilled, knowledgeable, engaged, fulfilled and compassionate professionals.

How will we do this?

We will:

- Implement our 'maternity matters' staff engagement strategy, which focuses on team wellbeing, culture and ways of working in support of high quality care.

- Evaluate the effectiveness of the governance framework within the maternity service and make identified improvements.
- Continue to sustain and strengthen the workforce through recruitment and retention.
- Review models of care to ensure that we maintain safe staffing and quality across all modes of delivery, including home birth.
- Create and implement a strategy to deliver against 'The Three year delivery plan for maternity and neonatal services'.
- Engage and work collaboratively with the ICB and local maternity and neonatal system.

Measures of success

These will comprise:

- Realising the benefits of the 'maternity matters strategy'
- Delivery of the actions following the workforce review to enhance our maternity service and increasing our staff retention rates;
- Restarting our homebirth service;
- Improving our estate and facilities for women, birthing people and their families;
- Full implementation of actions national reports and our local quality improvement programmes; and
- Continued improvement of the outcomes of those women who are in receipt of Continuity of Carer an report these at board level.

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

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. Our work to embed safe practice, which commenced in 2022, continues. Our audit of the 38 LocSSIPs in place in CDDFT shows us that there is still work to do to implement robust monitoring, auditing and governance procedures to provide assurance that our new LocSSIPs policy is followed. This is one of the safety priorities within the Trust's Quality Strategy.

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.
- Continue to audit LocSSIP documentation and adherence to practice.
- Develop LocSSIPs as electronic forms in our EPR system to assist staff in adhering to the requirements.
- Introduce robust monitoring and governance processes.
- Establish a Clinical Director-led working group to build on the work already completed, working towards the stated goals.

Measures of success

- Standard audit reports produced at regular intervals for in-use LocSSIPs and reported into governance structures.
- 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.
- Data reports for any electronic LocSSIP provided by the information team and shared into the governance structures.

Embedding prompt recognition and action on signs of patient deterioration

Why we chose this priority

A key ambition in the Trust's quality strategy 'Quality Matters' 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, we have continued 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.

Goals

To improve 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.
- Audit early warning scores and escalation to ensure that Trust procedures are being followed.
- Publicise more widely our "Call for Concern" service.
- Embed completion of patient risk assessments in the Trust's new EPR system.

Measures of success

We will see improved compliance rates with training (target is 85% completion) and improvements with observation and escalation audits.

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:

- Continue multi-professional study days which include assessments based on simulation exercises.
- Continue planned Sepsis audits and monitor sepsis mortality.
- Increase uptake of the Sepsis based simulation training and education for Band 6 and band 7 sisters in CDDFT Emergency Departments
- Introduce '10@10 sessions' attended by Consultant Microbiologists and CDDFT Emergency Department staff – an educational session focusing on the overuse of Tazocin, the use of frailty antibiotics and provide education for the correct antibiotics for community acquired pneumonia (CAP) based on CURB65 scores
- Further develop the nurse-led sepsis pathway and evaluate the potential for further patient group directions to support improvement in antibiotic administration.

Measures of success

We will see improved compliance rates with the percentage of patients receiving antibiotics within 1 hour of diagnosis in the Emergency Department

Year one implementation of the patient safety strategy

Why we chose this priority

For many years the Trust has pursued a Safety II approach, endeavouring to prevent incidents from ever occurring through direction of resource, quality improvement work and pro-active projects to minimise the potential for harm. This has seen tangible improvements in patient safety over the last decade however there remains more that can be achieved. The Trust Patient Safety Strategy defines how the Trust will continue to staff to deliver safe, reliable, and effective care with the aspiration of zero avoidable physical or psychological harm to our patients.

Goals

We aim to:

- Create a detailed, shared implementation plan, detailing how we will implement and deliver identified actions from the strategy;
- Transition the Trust from serious incident report to reporting in line with the national Patient Safety Incident Response Framework (PSIRF);
- Collaborate with Care Groups to define patient safety priorities which will be identified from Care Group service clinical strategies; and
- Work with Information Services to develop a suite of quality insight and improvement measures.

How will we do this?

We will:

- Embed safety as everyone's business
- Implement governance structures to support the roll out of the strategy

Measures of success

- PSIRF will be rolled out and embedded in the Trust;
- We will see good engagement with Care Groups and those directly involved in improving patient safety;
- We will see reduced timelines for incident closure; and
- Extract richer learning from patient safety incidents.

Patient Experience

Quality Strategy Aims / Retained Priorities from 2022/23 – Work ongoing:

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

i) Patients with dementia

Why did we choose this priority?

To continue to build on our work already undertaken, 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/cognitive impairment, especially those who require extra support and reasonable adjustments making towards their care. We are aware 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 dementia/cognitive impairment to ensure that the environment in which we provide care is the most suitable.

Goals

To embrace opportunities which will 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 environment and evidence based care/practice.
- By restarting face to face meetings with Dementia Champions - four meetings planned throughout 2023, with the first one being in April 2023.
- Working with stakeholders, local, regional and national working groups to promote dementia services and ensuring the needs of those with dementia are taken into consideration when developing services and changes in clinical practice.
- Increasing the number of Dementia Champions.

Measures of success

Meeting our 85% compliance targets for dementia awareness and related training.
Improvement in PLACE assessment results for dementia-friendly environments.
The balance of feedback from service users and carers is positive and improves year on year.

ii) Patients with Learning Disabilities and / 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 can still 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.

We recognise the requirement and need to keep learning disabilities and autism high on our agenda in providing a positive experience for our patients.

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 under the supervision and support of our learning disability team.

To continue with face to face visits from the learning disability team to patients within our care for a period of more than 48 hours.

To complete a review of all patients with a learning disability or autism that have a hospital stay of more than 5 days to ensure a clear plan of care is followed.

To develop a plan on how to deliver an achievable training programme of "The Oliver McGowan Mandatory Training on Learning Disability and Autism" under the guidance of the Secretary of State' Code of Practice, due to be approved during 2023.

How will we do this?

By:

- Seeking opportunities to further develop a learning disability and autism friendly service, using valuable feedback from patients, families, and carers on their experience of a hospital stay.
- Using patients' experiences as stories for education and learning opportunities. We will work with service users and their families to understand and learn from their experiences to continuously improve our care.
- Continuing to follow our learning disability guarantee, which is unique to CDDFT, to ensure that our patients with a learning disability and / or autism receive individualised support and care under the guidance and support of our learning disability team at all stages of their patient journey.
- Designing and delivering an achievable training programme of "The Oliver McGowan Mandatory Training on Learning Disability and Autism"

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.
- Demonstrating effective discharge follow up contacts and visits for people with a learning disability or autism to reduce readmissions.
- Learning from the Trust's mortality reviews and LeDeR programme.

iii) Patients with Mental Health support needs

Why did we choose this priority?

Following the Covid-19 pandemic we have seen an increase in patients attending our A&E departments, and requiring admission to our hospitals with both physical and mental health needs, particularly among children and young people. Accordingly we have needed to introduce new policies and procedures, based on joint working with our mental health trust and local authority colleagues so that we are able to respond to all the patient's needs and provide for their safety, and the safety of others through joint care planning.

Goals

We aim to:

- Embed the understanding of our policies and procedures for looking after patients with both physical and mental health needs among staff through training and on-the-ward support.
- Ensure that robust care management plans are in place for patients with these needs.
- Ensure that our policies and procedures remain evidence-based.
- Maintain effective partnership working with TEWV and local authority colleagues focusing on the needs of the patient.
- Ensure that risks in the environment are minimised as far as possible whilst meeting the needs of patients with acute, physical health conditions.

How will we do this?

By:

- Continue to work through our Partnership and Alliance and Operational Group to strengthen provision for patients with dual needs, including as appropriate consideration of joint posts, training and adaptations to policies and procedures.
- Jointly evaluate the workings of both groups and implement any agreed improvements.
- Monitor and audit our adherence to policies and procedures.
- Evaluate the training and support provided to staff and implement any agreed improvements.
- Where possible, removing risks in the environment

Measures of success

- Staff understand and are able to implement our policies and procedures
- Policies and procedures meet evidence-based good practice
- There are effective management plans in place for all patients with dual needs
- The Partnership Alliance evaluates well
- Training provided to staff evaluates well and / or is improved
- Up to date environmental and ligature risk assessments with action taken to remove risks where possible

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 which were established during 2021/22, focusing on *the High Impact Change Model (HICM) for Managing Transfer of Care* to reflect changes in hospital discharge policy, the 10 point plan and “SAFER” guidance, recognising the importance on the ‘end to end’ pathway for patients.

- Bring forward discharges (on average) to earlier in the day, ensuring ‘home first’ wherever possible;
- 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:

- Work closely with local authority partners to support early discharge using trusted assessment and time to think beds;
- Continue to develop the roles of our Discharge Champions and Facilitators;
- Implement a transfer of care hub (ToCH);
- Review and issue a revised Discharge and Choice Policy;
- Implement a database and performance dashboard for discharge tracking;
- Monitor the timeliness of discharge and delays in discharge, and achieving improvements in both;
- Embed improvements from thematic work regarding Section 42 safeguarding concerns;
- Facilitate earlier discharges in the day i.e. to aim for all discharges by 6pm;
- Improve the times to turnaround tertiary transfers i.e. time of referral and time of transfer;
- Share and learn from patient stories – positive and negative – with respect to discharge.

Measures of success

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

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 and increase single room availability across the Trust.

How will we do this?

We will:

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

Measures of success

These will comprise:

- Palliative Care Strategy launched.
- Further improvement in recognition of the dying.
- 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?

Good nutrition is recognised as pivotal in each part of a patient journey within the Trust. This ranges from those receiving care in a community setting to acute hospital setting; those receiving artificial nutrition to those with no dietary requirements. It also encompasses those whose relatives/ carers are using CDDFT commercial food outlets and staff within the Trust.

Goals

To ensure that patients receive adequate nutrition and hydration by embedding the use of EPR functionality and ensure high levels of compliance in completing nutritional needs (MUST) assessments and associated care plans and by providing effective Dietetics support to front-line teams.

How will we do this?

- We will bring forward business cases for the following:
    - Nutrition Support Team – to increase compliance with NICE Guidelines on Adult Nutrition Support.
    - Catering Dietitian – to meet recommendations from the Hospital Food Review (2020) and NHS England National standards for healthcare food and drink
    - Children's ward Dietitians – to meet service need and demand, and to establish working group to progress nutrition screening in children and young people using inpatient services at CDDFT
- Re-launch the Trust's Nutrition Policy
- Work closely with digital nursing team and senior nursing, midwifery and AHP leadership team to embed the use of EPR in completing MUST assessments and associated care plans.
- Continue to learn from patient and family feedback including compliments, complaints and incidents relating to nutrition ensuring that all professional stakeholders are aware

Measures of success

These will comprise:

- Submission of business cases
- Updated Nutrition Policy with launch of strategy
- Established working group for children's nutrition screening tool (dependent on outcome of business case)
- Nutrition Steering Committee continues in current functionality
- A significant increase in recorded nutrition assessment compliance

Clinical Effectiveness

Quality Strategy Aims / Retained Priorities from 2022/23 – Work ongoing:

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

Why did we choose this priority?

Levels of demand on our A&E services continue to be high, and capacity constraints relating to the size of our department at UHND and our bed base, have, over the past 12 months meant that we have experienced delays providing treatment and / or in admitting patients. Significant improvements have been made, however there is still work to be done.

Goals

To further optimise our clinical pathways, move towards a 7-day clinical service, working with partners, for urgent and emergency care and expand our Same Day Emergency Care services and Same Day Urgent Care – to release pressure in the A&E department at UHND during 2023/24.

With the support of the North East and North Cumbria Integrated Care System, to continue 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, funding for which has already been allocated.
- Increase medical staffing to support discharge and patient flow, as part of the seven day services business case.
- Increase the Trust's bed base in line with the capital programme.
- Implement full front of house Same Day Emergency Care at UHND.
- Progress work on a new Emergency Care Centre at UHND.

Measures of success

These will comprise:

- Improvements in waiting times with respect to assessment, treatment and the total time in the department when measured against national performance targets:
    - Time to initial assessment – the percentage of patients within 15 minutes
    - Time to treatment – less than 60 minutes
    - The number, and percentage, of patients spending more than 12 hours in A&E
    - The average time spent in A&E for admitted and non-admitted patients
    - 12 hour waits for beds
    - Treatment and / or admission within four hours
    - Ambulance handover times under 30 minutes.

Paediatric Care

Why did we choose this priority?

The Trust has seen a continual rise in children and young people with mental health issues, which is in keeping with the national picture, following the pandemic. There is a need for a proactive multi-disciplinary response and approach, to ensure that these patients receive holistic care and support and that they, and those around them, are kept safe.

The growing demands on the service, allied to workforce shortages, make it challenging for the Trust to obtain all the staff it needs and there is a desire to develop our own staff into higher roles.

How will we do this?

We will:

- Continue to develop partnership working with local authorities and mental health trusts to build frameworks for children and young people presenting to the trust in a mental health crisis.
- Ensure our staff have the skills and support to care for the children and young people in a mental health crisis.
- Work in partnership with local Higher Education providers to support the re-introduction of the specialist practice qualifications.

Measures of success

- Maintain robust multi – agency frameworks for children and young people in mental health crisis and ensure staff are supported appropriately through education packages.
- Clinical educators being recruited into post.
- Staff able to apply to join Higher Education programmes to gain specialist practice qualifications.

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 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.

Each of the Trust's five Care Groups' operational performance is reviewed monthly with the Executive Director of Operations, the Deputy Director of Operations and the Head of Planning and Performance.

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 ICB and Local A&E Delivery Board (LADB)

Participation in Clinical Audit

Background

Clinical Audit is a quality improvement (QI) cycle (Figure 1) that seeks to improve patient care and outcomes through a systematic review of care against explicit criteria. The results are used to identify opportunities for improvement and to agree the specific actions or changes required. Further audits determine the efficacy of the changes and support continuous improvement. In short:

Clinical audit is about improving the quality, safety and delivery of patient care.

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 bi-monthly reports to the Clinical Effectiveness Committee. Assurance is provided to the Board through the Integrated Quality and Assurance Committee which reviews quarterly reports from the Clinical Audit Team.

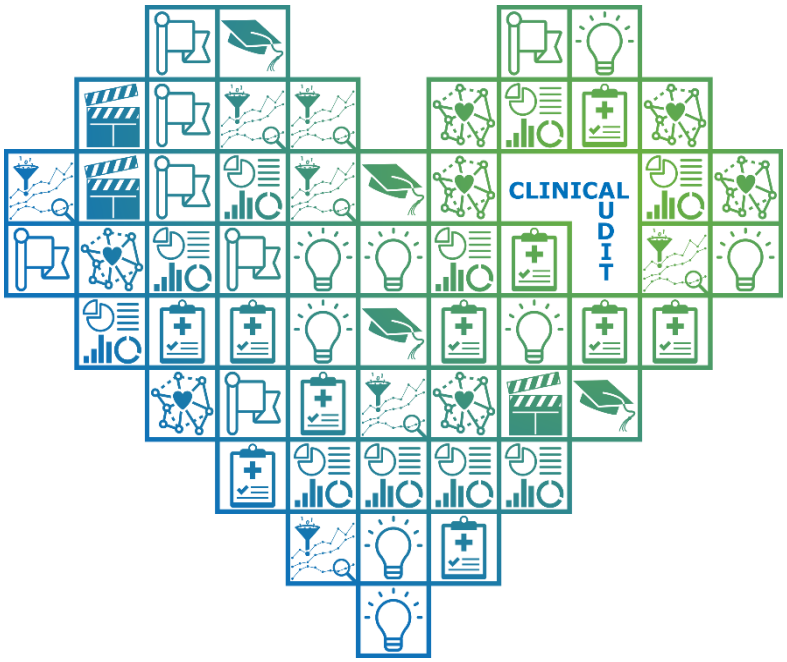
All National Audit reports are reviewed by the Lead Clinician and the Clinical Audit Team, a specific action plan is developed for each audit and approved by both the Speciality and Care Group Clinical Audit Leads. Action plans are monitored by the Clinical Audit team and the Care Group Governance Facilitators.

Participation in Clinical Audit

During 2022/2023 **51** national clinical audits and **7** national confidential enquiry covered NHS services that County Durham & Darlington NHS Foundation Trust provides.

During 2022/2023 County Durham & Darlington NHS Foundation Trust participated in **94** % of national clinical audits and **100** % of national confidential enquiries of which it was eligible to participate in.

The reports of **16 National Clinical Audits** and **18 Local Clinical Audits** were reviewed by the provider in **2022/23** and County Durham & Darlington NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:



Actions typically include: 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.

An excellent example of the effectiveness of local audits can be seen in the Local Safety Standards for Invasive Procedures (LocSSIP) audit programme. LocSSIPs are designed to ensure patient safety and eliminate never events by providing a structured set of checks before, during and after a procedure. The comprehensive audit programme covered all LocSSIPs in use across their respective areas and looked at over 1,500 records in total. The audit identified both areas of good practice and opportunities for improvement which will be investigated in early 2023/24. Each LocSSIP will continue to be audited on a two yearly cycle, to monitor their use and the effectiveness of the improvements made.

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 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. Through 2022/23 the Trust has developed a new clinical audit strategy that is due to be published in the first half of 2023/24 and covers clinical audit activity until the end of 2025/26.

The strategy focuses on 7 domains that build on one another to create an effective and efficient clinical audit programme and develop an open and honest culture throughout the Trust. The domains are.

Education/Training

- Providing resources and training to give staff the knowledge, skills and confidence to use clinical audit to benchmark performance and improve clinical quality.

Reporting Accurate and Actionable Information

- Improving access to audit data for staff, including ongoing and past audits.
- Increasing visibility of audit reports, outcomes and improvements.
- Reporting on what really matters.

Action Plans

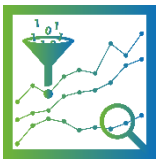
- Development of smarter and sharper action plans.
- Focusing on fewer higher quality actions that address what really matters.
- Identifying and minimise risk, waste and inefficiencies.

Assurance

- Provide robust assurance to internal and external stakeholders on standards of clinical practice
- Supporting the development and delivery of the Trust's clinical and quality strategies by fostering an open and honest culture, based on reliable, evidence-based assessment of our effectiveness.

Communication & Engagement

- Providing communications to staff updating them on clinical audit activity
- Promoting clinical audit as an essential QI tool
- Seeking staff feedback on the clinical audit process and refine



Data Collection & Insights

- Reducing the burden of data collection on staff using standard processes and digital technology
- Developing tools to analyse clinical audit data to provide further insight into the Trusts performance

New Ways of Working & Process Improvements

- Refining the clinical audit process and systems, to remove blockers and reduce friction within the process
- Driving continuous improvement and innovation in clinical practice and to both staff and patient experience

This strategy represents a step change in the way the Trust approaches clinical audit and will lead to continuous improvement of clinical services in line with the Trusts quality strategy and the strategies developed by individual services. The strategy champions the idea of clinical audit as a quality improvement process that provides valuable insight into the standard of care our patients receive, acting as a catalyst for change and encouraging us to consider how the Trust can do better for our patients and colleagues.

The national clinical audits and national confidential enquiries that County Durham & Darlington NHS Foundation Trust was eligible to participate, participated in and for which data collection was completed during 2022/2023 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	✓	27%
Elective Surgery (National PROMs Programme)	N/A	✓	Ongoing
Emergency Medicine QIPs	Pain in Children	✓	100%
	Assessing for cognitive impairment in older people	Audit Starts May 2023	
	Mental health self-harm	✓	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)	✓	100%
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 (MBRRACE-UK)	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	✓	25%
	Crohn's disease	✓	22%
	Endometriosis	✓	Ongoing
	Testicular Torsion	✓	Ongoing
National Adult Diabetes Audit (NDA)	National Diabetes Foot Care Audit	✓	Ongoing
	National Diabetes Inpatient Safety Audit (NDISA)	✓	100%
	National Core Diabetes Audit	✓	100%
	National Diabetes in Pregnancy Audit	✓	Ongoing

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	✓	91%
	Pulmonary Rehabilitation Organisational and Clinical Audit	✓	100%
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	✓	100%
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)	✓	Ongoing
	National Heart Failure Audit	✓	Ongoing
National Child Mortality Database	N/A	✓	100%
National Early Inflammatory Arthritis Audit (NEIAA)	N/A	✓	Ongoing
National Emergency Laparotomy Audit (NELA)	N/A	✓	Ongoing
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
National Obesity Audit	N/A	✓	Utilises existing datasets
Respiratory Audits	Smoking Cessation Audit- Maternity and Mental Health Services	✓	100%
	National Outpatient Management of Pulmonary Embolisms Audit	✓	Ongoing
	Adult Respiratory Support Audit	✗	N/A
Sentinel Stroke National Audit Programme (SSNAP)	N/A	✓	100%
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	N/A	✓	100%
Society for Acute Medicine Benchmarking Audit (SAMBA)	N/A	✓	100%
Trauma Audit & Research Network (TARN)	N/A	✓	100%
National Ophthalmology (NOD)	Age-related Macular Degeneration Audit (AMD)	✓	100%
	Adult Cataract Surgery	✓	100%
Epilepsy12 - 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	✓	100%
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
National Audit of Cardiovascular Disease Prevention (Primary Care)	N/A
Cleft Registry and Audit NEtwork (CRANE)	N/A
Medical and Surgical Clinical Outcome Review Programme	Prison Healthcare Study
National Cardiac Audit Programme (NCAP)	National Adult Cardiac Surgery Audit
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 2022/22)
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
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

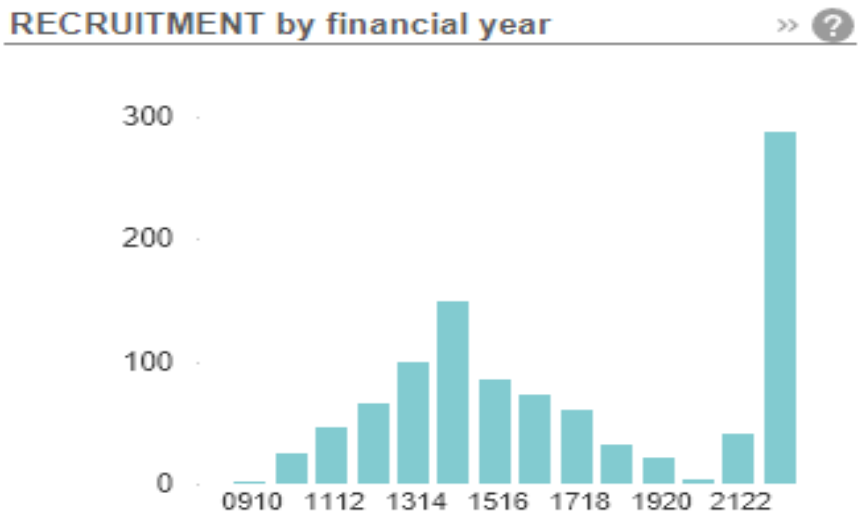
Research and Innovation continues to be a priority within CDDFT, with a ward to board ethos. We have developed a blueprint strategy for the future, which has received excellent feedback from both internal and external stakeholders, and will inform further developments.

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 increase engagement in clinical research across the Trust.

The number of patients receiving relevant health services provided or sub-contracted by County Durham & Darlington NHS Foundation Trust in 2022/23 to date, that were recruited during that period to participate in research approved by a Research Ethics Committee, was 3,259 participants.

The Trust recruited to 85 National Institute Health Research Portfolio studies, and had 67 active Principal Investigators in 2022-23.

One of the key successes in 2022-23 was to hugely increase our Commercial trial recruitment, as shown in the graph below which shows Commercial trial recruitment from 2009/10 to 2022/23



CDDFT have played an integral part in helping local innovators attract prime funding and progress innovations locally and within the trust. CDDFT has also been successful in attracting over £1m of funding to help researchers and Innovators take projects forward.

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

- We are the second highest recruiters nationally to the RESULT HIP study (Anaesthetics)
- The iGBS3 study (Children's): CDDFT is the third highest recruiter in the region
- The HARMONIE commercial trial in RSV infection (Children's): we are the highest recruiting site in the region
- CDDFT have recruited 1,399 babies to the INGRID-2 heel prick study (Reproductive Health)

Goals agreed with commissioners

County Durham and Darlington income in 2022/23 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework because the scheme was suspended. We are aware that the suspension will come to an end for 2023/2024.

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 2022/23.

Care Quality Commission Ratings

The last full inspection of the Trust took place 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, we 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 – or 'should do' actions - included in CQC's reports. 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.

CQC Maternity Services Inspection

The Trust's Maternity services were inspected by the CQC, as part of their maternity services inspection programme during the year. Site visits were undertaken on 28th and 29th March and the draft report is understood to be in preparation (drafting note – this wording will be updated should the final report be published before the issue of the Quality Accounts).

Data Quality

County Durham and Darlington NHS Foundation Trust submitted records during 2022/23 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

- which included the patient's valid NHS number was:
  99.4% for Admitted Patient Care;
  99.4% for Outpatient Care; and
  98.4% for Accident and Emergency Care.

- which included the patient's valid General Medical Practice Code was:
  99.8% for Admitted Patient Care;
  99.8% for Outpatient Care; and
  99.7% 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 version 5, 2022/23, Data Security and Protection Toolkit annual return, on the 30th June 2023 aiming to achieve 'standards met'.

For the year 2021/22 the Trust submitted 'standards met'.

Clinical Coding Error Rate

County Durham and Darlington NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2022/23 by the Audit Commission.

Learning from Deaths

During 2022/2023, 2,316 patients died in the Trust, a quarterly breakdown is provided below:

- 521 in the first quarter;
- 520 in the second quarter;
- 662 in the third quarter; and
- 615 in the fourth quarter.

By 31 March 2023, 390 case record reviews and eight investigations had been carried out in relation to 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:

- 125 in the first quarter;
- 116 in the second quarter;
- 105 in the third quarter; and
- 71 in the fourth quarter.

Three (0.1%) 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
- 0 representing 0 % for the fourth quarter.

These numbers have been generated 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 2022/23 were recognition of dying, patient hydration, long waits in the emergency departments and timely recognition of Sepsis. Use of antivirals in patients with Covid-19 was also highlighted which resulted in a quality improvement project. Recognition of the deteriorating patient has been identified largely through unexpected death reviews. This needs to be a focused area for improvement into 2023-24. A national CQUIN requirement will support this work.

Actions that County Durham and Darlington NHS Foundation Trust has taken in relation to the learning identified from those deaths in 2022/23 form part of comprehensive SMART action plans monitored through the Trust governance processes.

Some 452 Case Record Reviews and 4 investigations were completed after 31st March 2021 which related to patient deaths that 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 and Freedom to Speak Up Champions, of which there are currently five. Any referrals made formally to the Guardian / Champions 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. Her appointment has been publicised through the Trust's intranet site, screensavers, staff bulletins, posters and staff meetings and also through wider staff engagement events using Facebook. The Guardian has undertaken a wide-ranging programme of visits to wards and departments.

The Trust promotes the National Guardian's Office's training modules "Speak Up", "Listen Up" and "Follow 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. She is a member of the Peer Support North East & Cumbria Regional Network of Guardians. The six champions are expected to role model the values and behaviours associated with speaking up as well being able to provide information on options available. The Champion role can also be utilised to reduce detrimental responses to speaking up through promotion and role modelling.

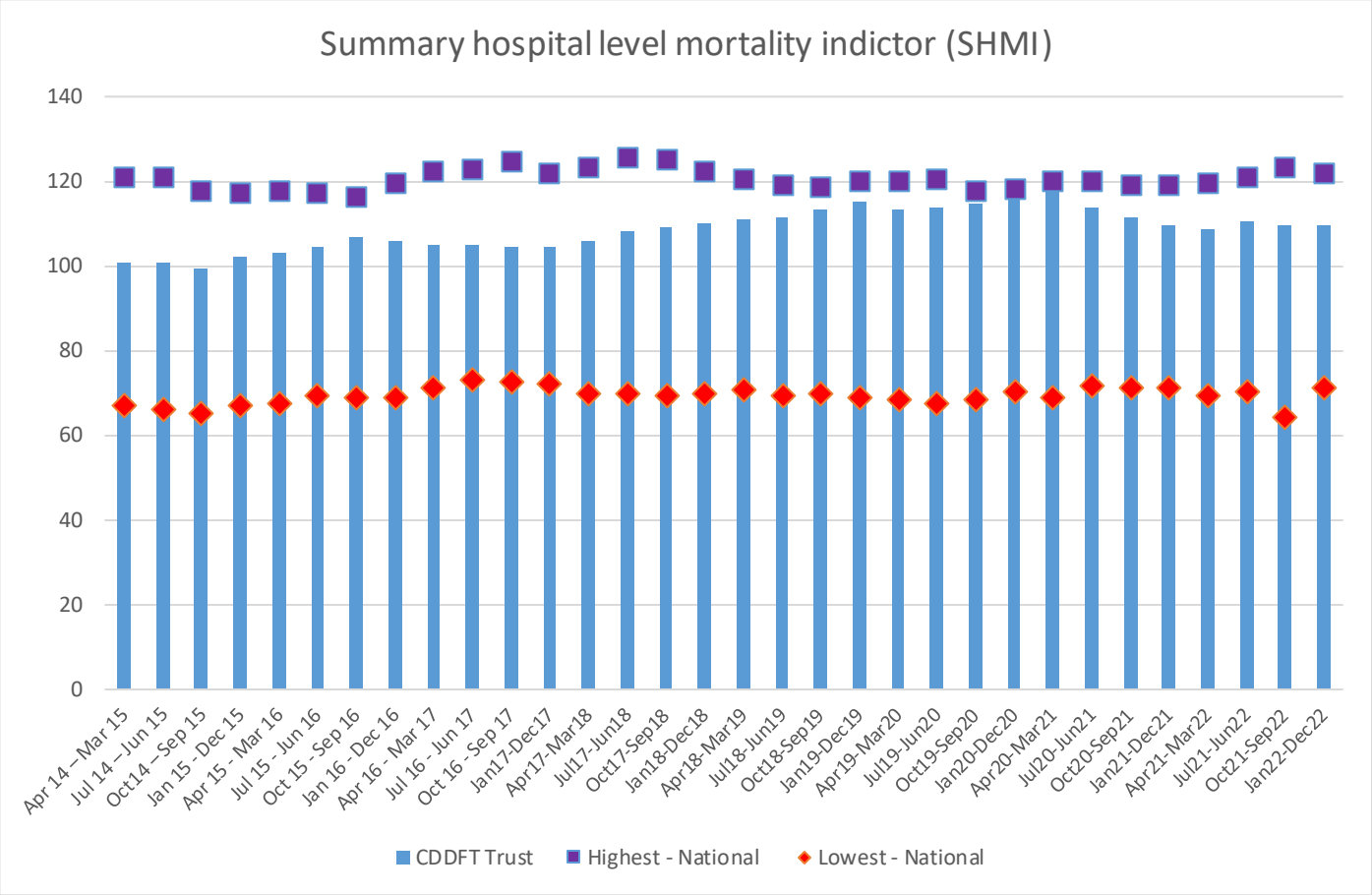
All Champions have been provided with the National Guardian's Office guidance to provide clarity on their remit including: requiring a detailed knowledge of the Speaking Up Policy, escalation routes and useful contacts. Champions are not expected to handle any cases. The outcome of having a champion network is that workers are reminded of the importance of speaking up, they can be signposted to the FTSUG or feel more empowered to take action themselves. The champion role can also be utilised to collate themes for wider learning opportunities.

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 is being refreshed for 2023-24.

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

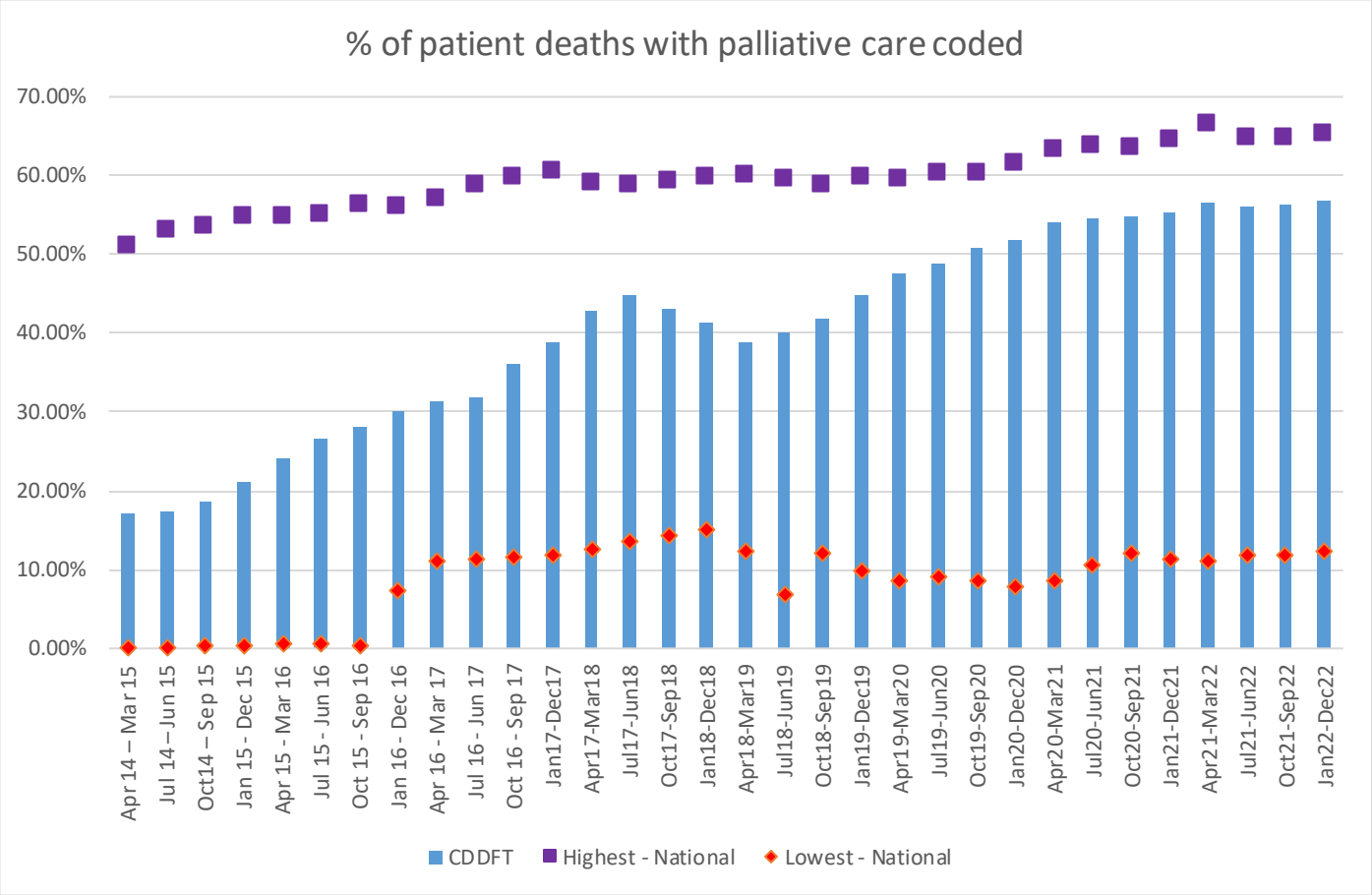
The County Durham and Darlington NHS Trust intends to take the following actions to improve the indicator and so the quality of services by continuing to ensure that mortality remains a strong focus for the Trust. Over the past twelve months our SHMI position has remained within the expected range. We will continue to improve our position via the following:

- A project focused on ensuring that patient care is accurately captured with coding, being led by the Quality Improvement Senior Sister.
- Reviewing a sample of deaths for patients that had a prolonged stay within the Emergency Department and died during the same admission. This work will replace the previous reviews completed on coded low risk of death groups.

We will also 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.

We will continue to focus on sharing learning and hope to achieve this through the adoption of "SJRplus" and the reporting dashboard which enables floor to board reporting focused on the narrative and context of care as well standard mortality indicators.

Percentage of deaths with palliative care coded



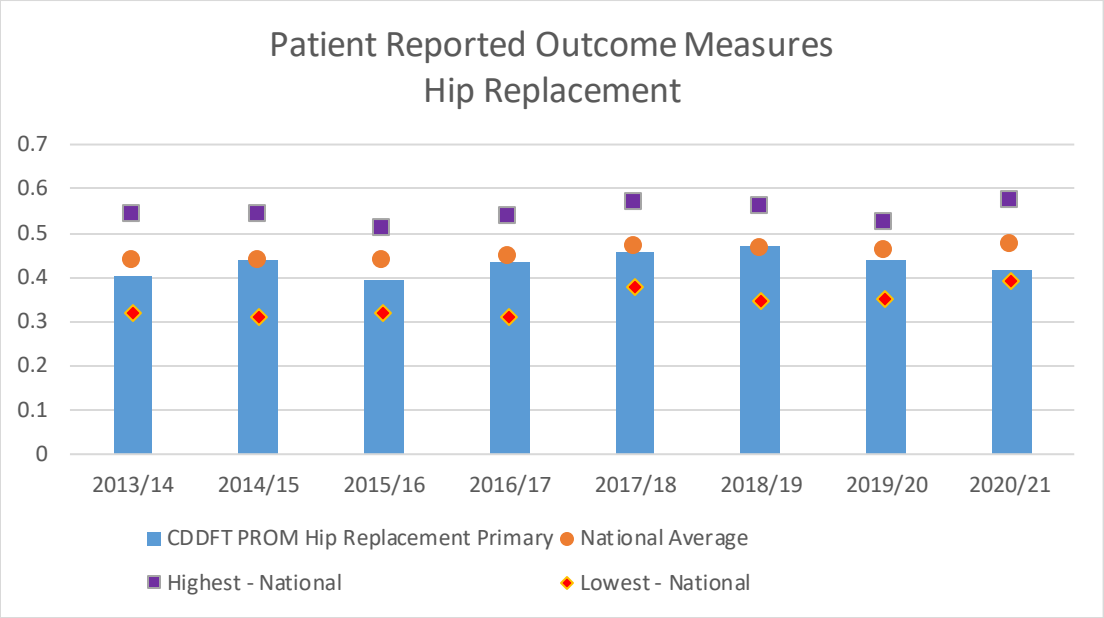
Data source: NHS Digital

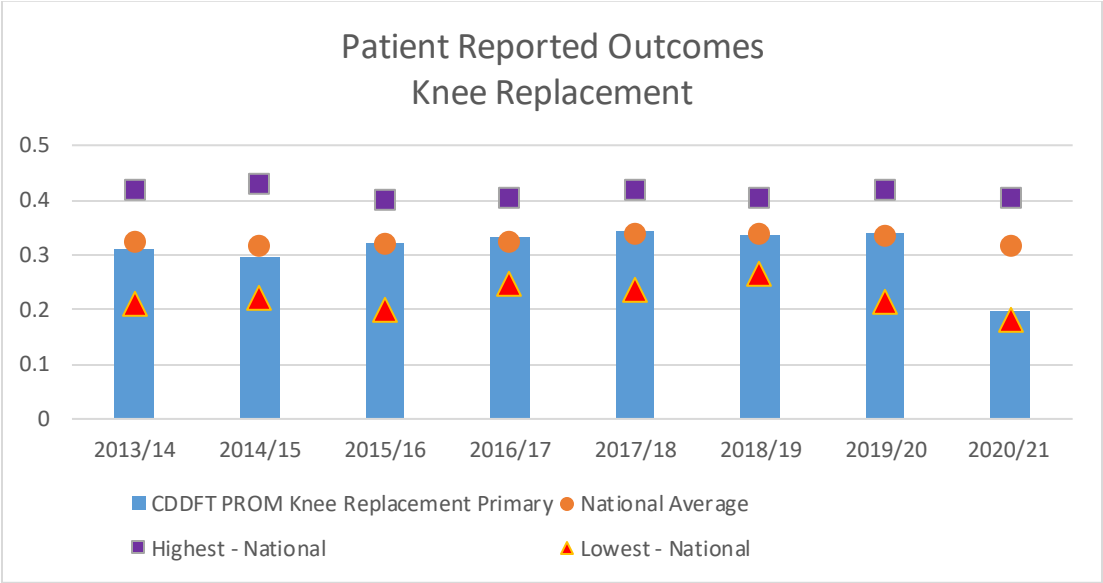
The County Durham and Darlington NHS Trust considers that this data is as described for the following reasons: this data is regularly reviewed at the Trust End of Life Steering Group

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 charts above are those submitted in our last Quality Accounts, NHS Digital PROMS advise that; '*in 2021 significant changes were made to the processing of Hospital Episode Statistics (HES) data and its associated data fields which are used to link the PROMs-HES data. Redevelopment of an update linkage process between these data are still outstanding with no definitive date for completion this present time. This has unfortunately resulted in a pause in the current publication reporting series for PROMS at this time. We will endeavour to update this linkage process and resume publication of this series as soon as we are able but unfortunately are unable to provide a timeframe for this. We will provide further updates as soon as this is known.*'

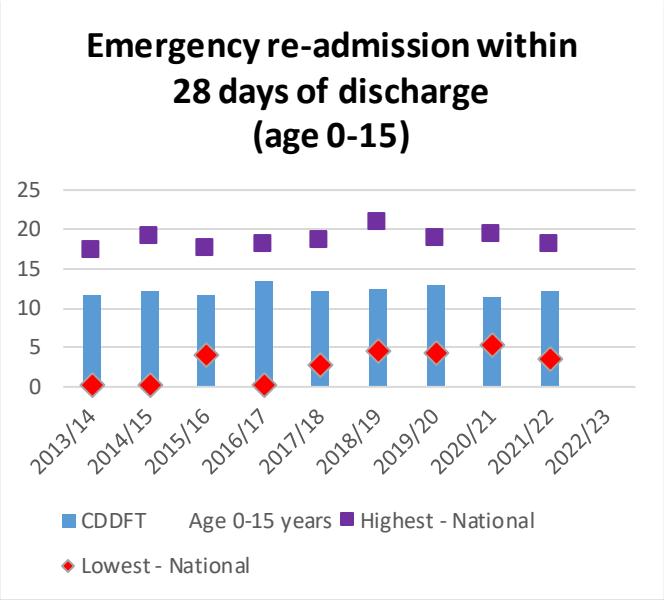
The Orthopaedics team have, in addition to the national picture shown above, been working on an internal process for PROMS compliance. Ward teams are engaged in the process, which it is hoped, will result in an increase in our data moving forward. Contact has been made with the PROMS team to ensure all the collection and delivery names and points are up to date

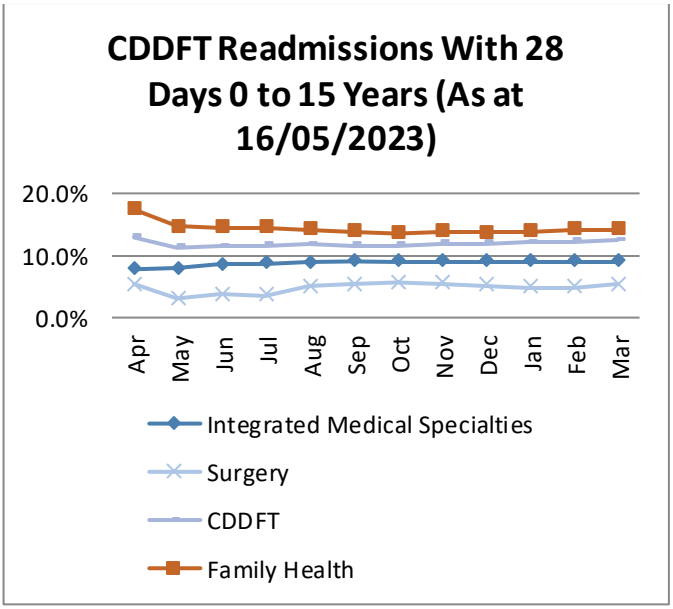
In addition, County Durham and Darlington NHS Trust have now implemented a scheme to support our elective recovery programme which has helped increase the number of theatre lists which can be run for

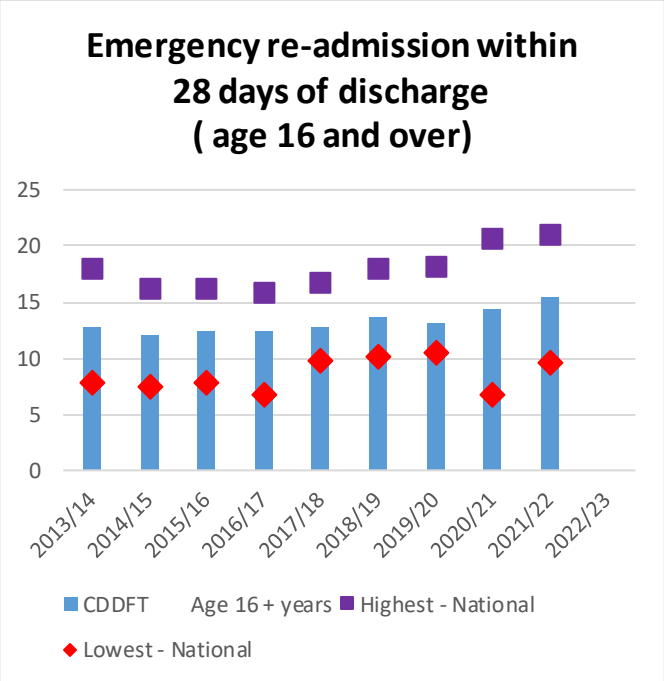
elective orthopaedic surgery. An obvious benefit of this will be an expected increase in PROMS questionnaires completion. Orthopaedics elective beds are now available at Darlington and Durham as well as the full elective ward at Bishop Auckland. We continue to have a slightly reduced theatre programme for elective orthopaedic surgery due to the reduction in trained Orthopaedics theatre staff as well as the need to prioritise Trauma activity but the number of elective sessions has increased over the last 6 months. The Orthopaedic and Day Surgery teams in conjunction with the pre assessment team have implemented a weekly meeting whereby elective surgery is discussed and PROMS questionnaire compliance is monitored.

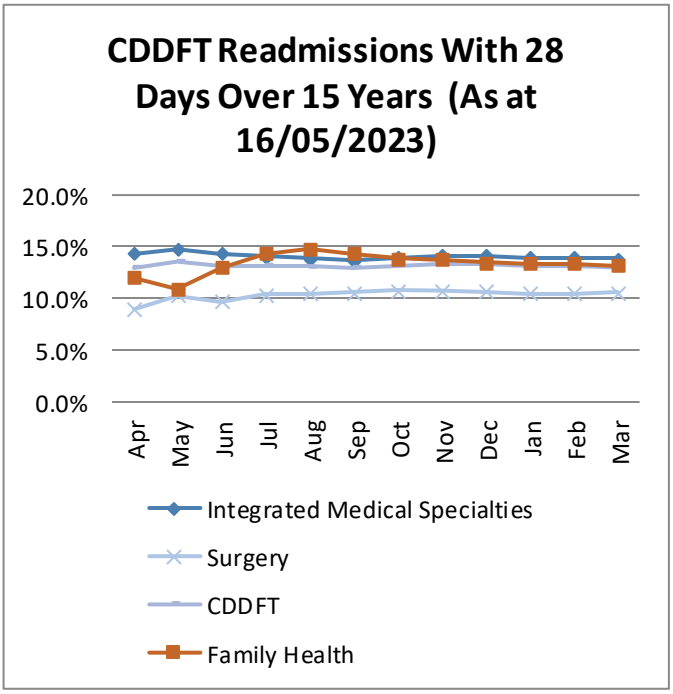
Patients re-admitted to a hospital within 28 days of being discharged

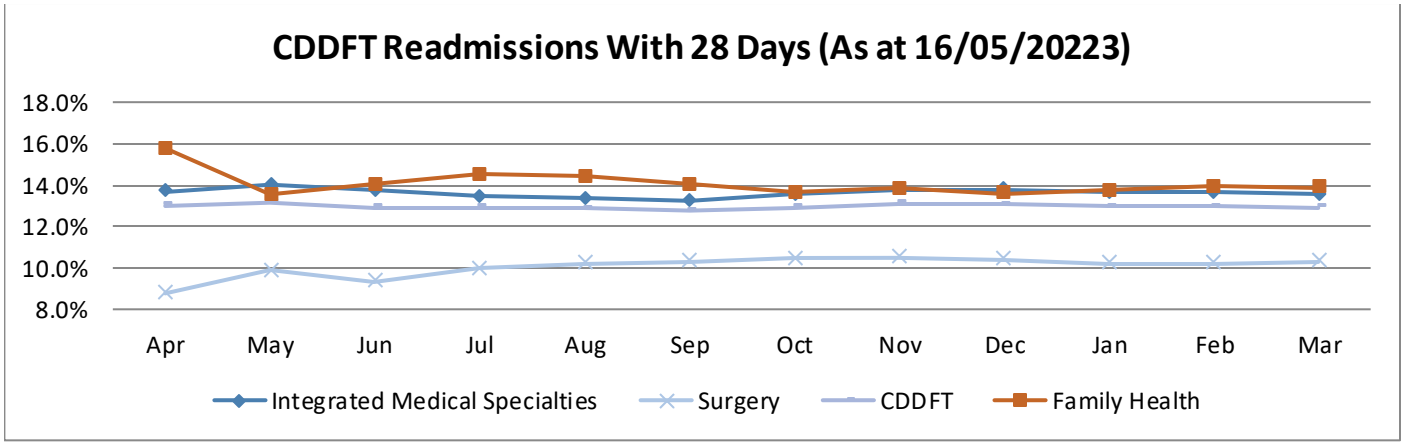
Timely and safe discharges or transfers of care remain a priority for CDDFT.











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

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:

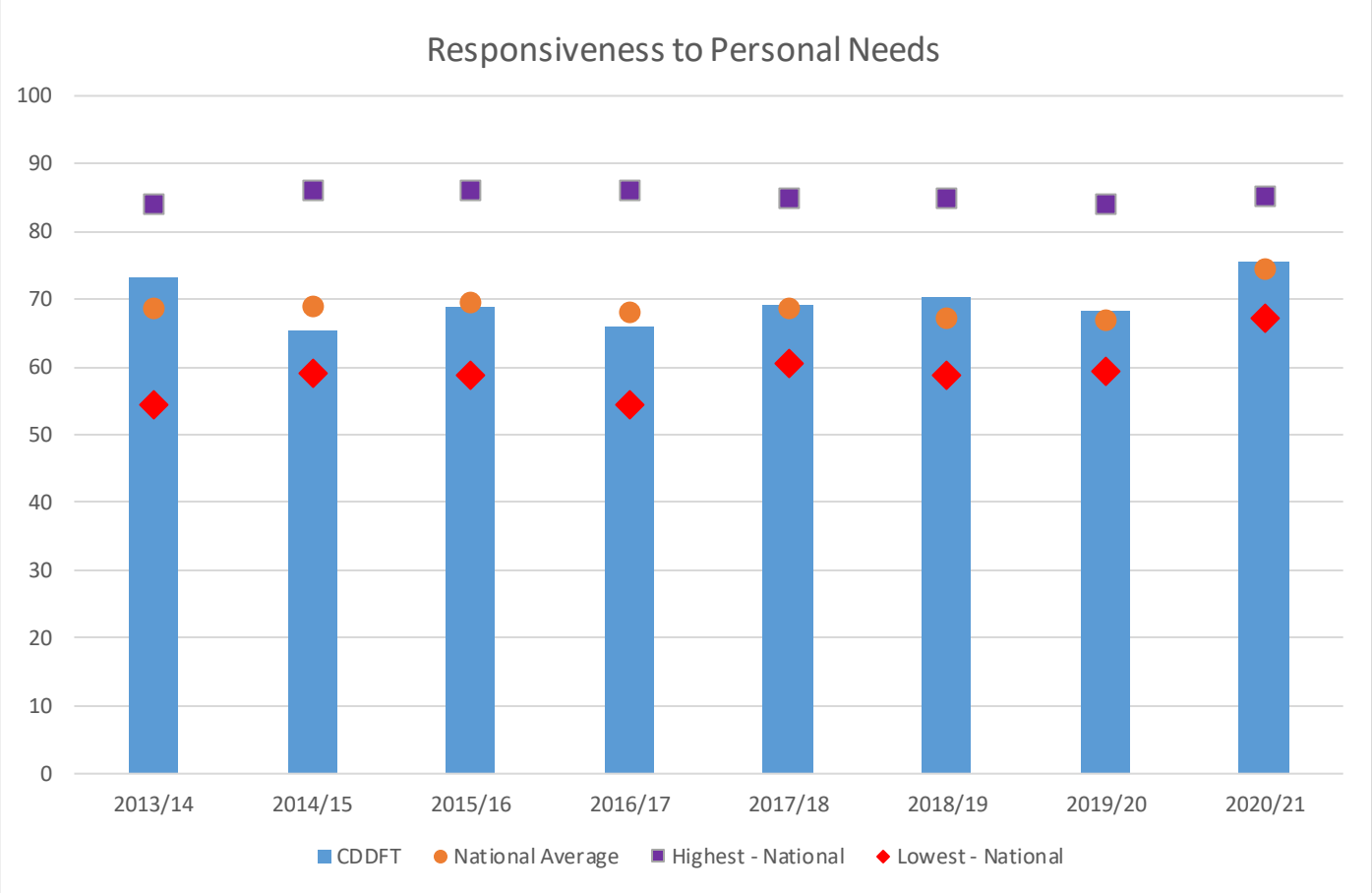
A number of actions have been taken in support of this measure:

- Introduction of community-based urgent crisis response service. 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.
- There has been increased bed capacity in all community hospitals and in 'time to think' beds for those patients who are not quite ready to go home, but do not require an acute bed. Some may need an additional period of rehabilitation.
- Primary Care Colleagues have access to clinical Advice and Guidance, 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

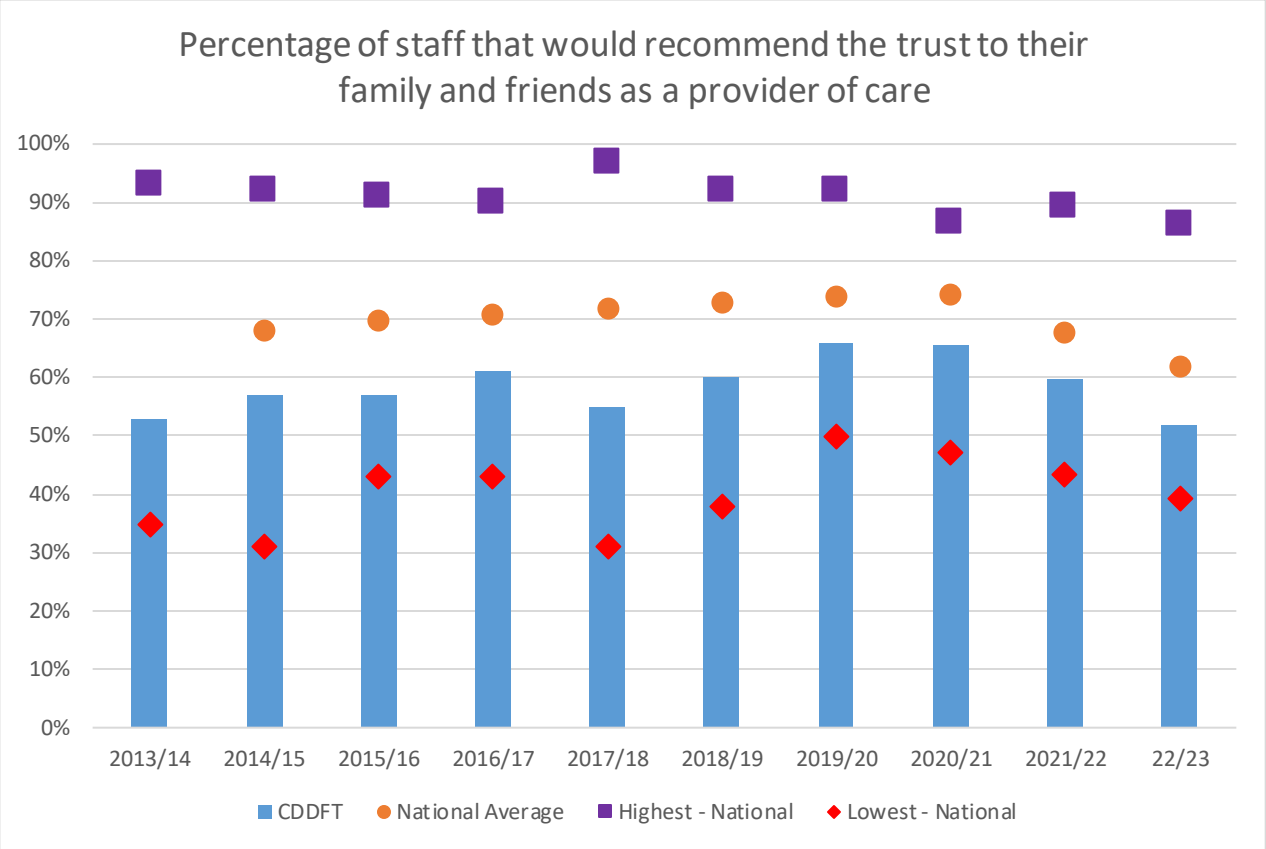


Data source: NHS Digital

The charts above are those submitted in our last Quality Accounts, NHS outcomes Framework (for the responiveness of patietns needs) advises us; '*following the merger of NHS Digital and NHS England on 1st February 2023 we are revieing the future presentation of the NHS Outcomes Framework indicators. As part of this review, the annual publication which was due to be released in March 2023 has been delayed. Further announcemnents about this dataset will be made (on this page) in due course.'*

The County Durham and Darlington NHS Trust continues to take the following actions to improve the indicator and so the quality of services by: analysing patient feedback, particularly from our own surveys, 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.

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



Data source: NHS Staff Survey 2022

The County Durham and Darlington NHS Trust considers that this data is as described for the following reasons: this data taken directly from the NHS Staff Survey.

The Trust's weighted score for the percentage of staff who would recommend it to friends and family as a place receive treatment, from NHS Staff Survey for the last two years is shown below. The national average score is also shown.

Questions	2022		2021		Trust improvement/ deterioration
	Trust	**National Average**	**Trust**	**National Average**	
Q21d. Staff recommending the organisation as a place for family and friends to receive treatment	51.7%	61.9%	59.6%	66.9%	The trust score has seen a significant deterioration compared to 2021. The score for this question has, however, also deteriorated nationally

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

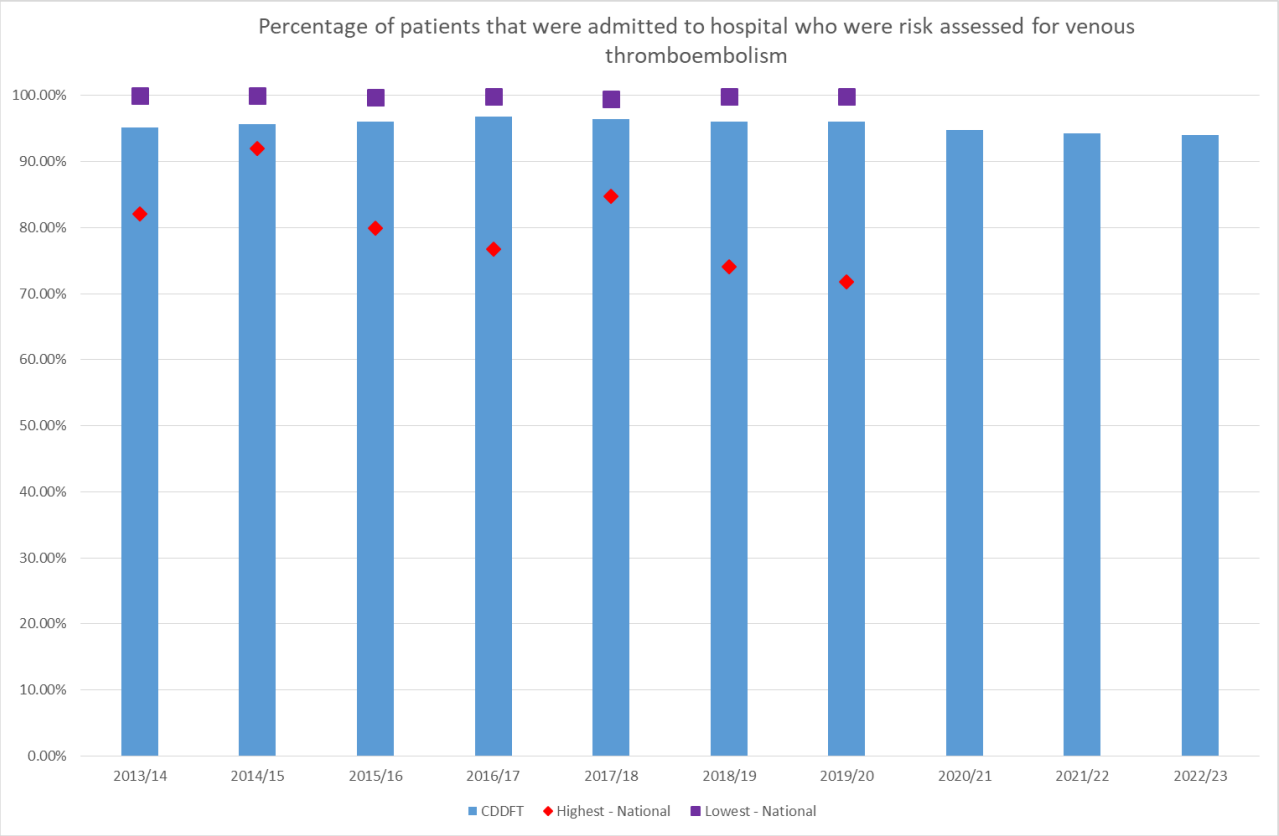
- Piloting a new approach to staff engagement which links both the workforce and the patient experience. There is good evidence that staff morale and engagement is enhanced by positive patient feedback and by implementing improvements in patient care in response to feedback. Learning from others in the region, we will collect patient feedback for a number of wards and share it with ward-based teams to support engagement and empowering them to make change.

The approach will be evaluated and, if successful, will be rolled out across the rest of the Trust. We have already refreshed our Friends and Family Test results posters and we are displaying them prominently in staff areas on our wards.

- Developing a ward quality dashboard, so that teams can celebrate success and improvement. We know from the staff survey undertaken in developing the quality strategy that staff felt they needed more information on how they are doing.
- Equipping local managers with support from both Workforce Experience and Patient Experience, and through skills development courses, such as our Engaging Managers course, to elicit feedback from staff on local issues and areas for improvement.
- Sharing work taking place as part of our Quality Matters strategy, resulting improvements in care and celebrating individual and Trust success.

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.

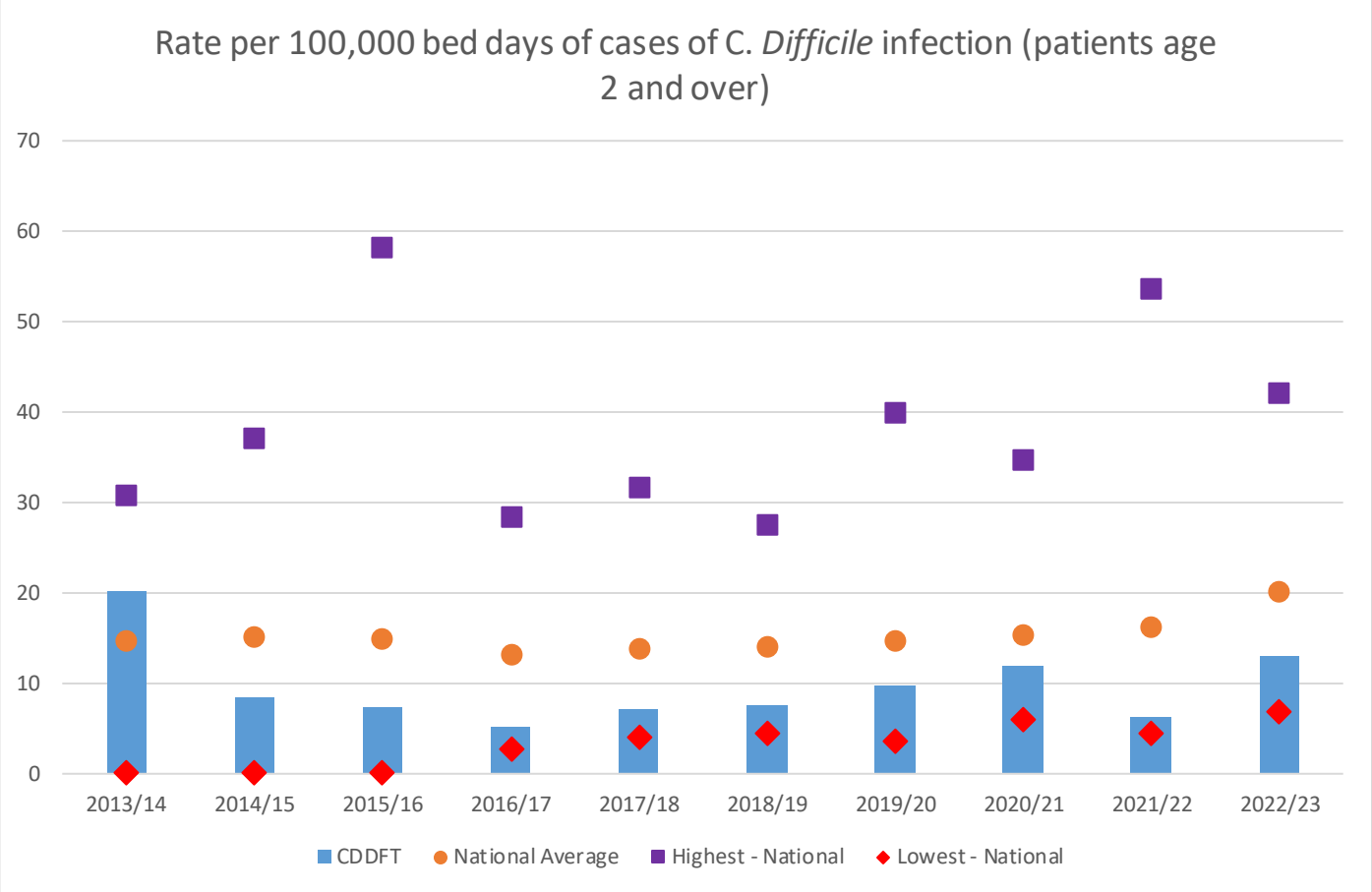


Data source: NHS Digital.

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.

Since October 2022 VTE assessment is documented within the electronic patient record. Our priority for this year and next is to ensure that clinical teams at County Durham and Darlington NHS Trust are completing this assessment correctly and to establish formal reporting metrics. Continuation of compliance monitoring to ensure that current performance is maintained, and NICE guidelines are met, and to improve the quality of service will be managed through the usual governance framework.

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

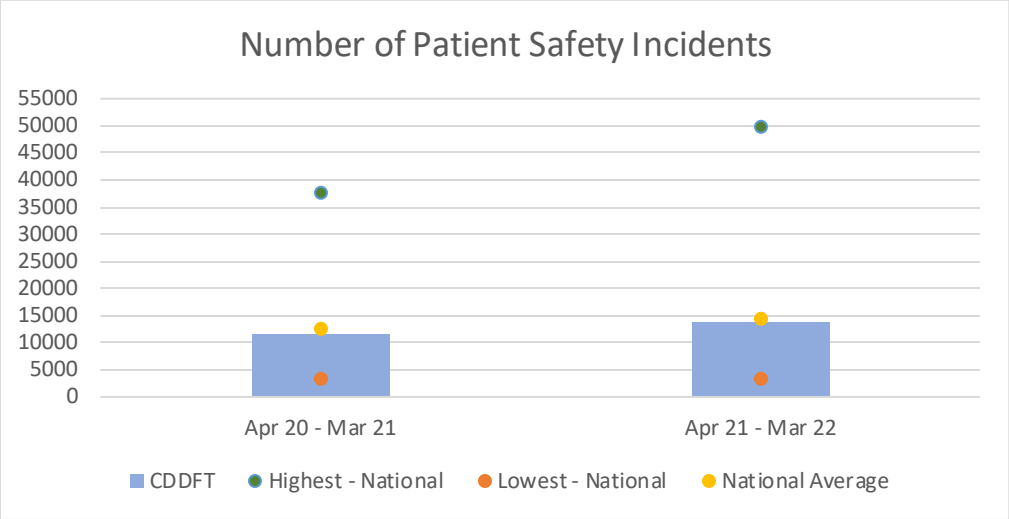


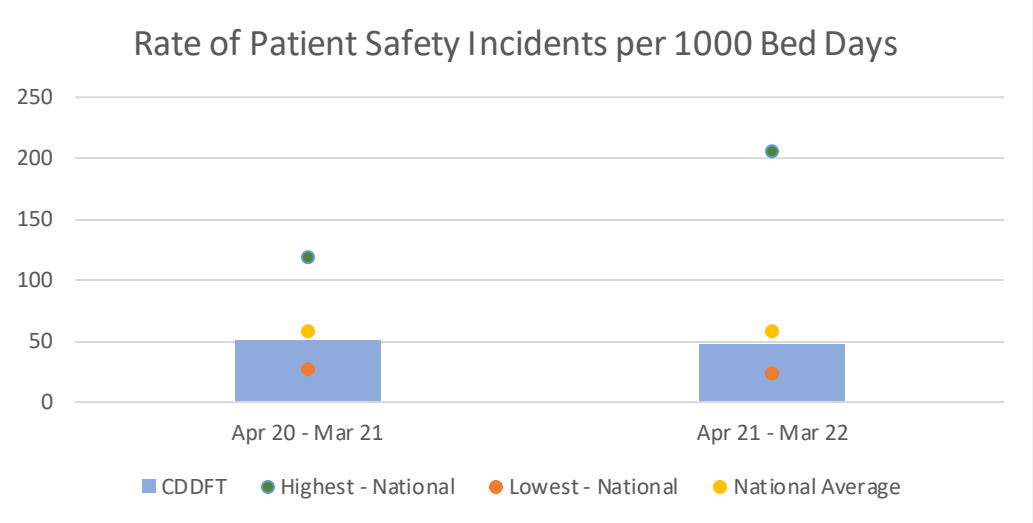
Data source: NHS Digital

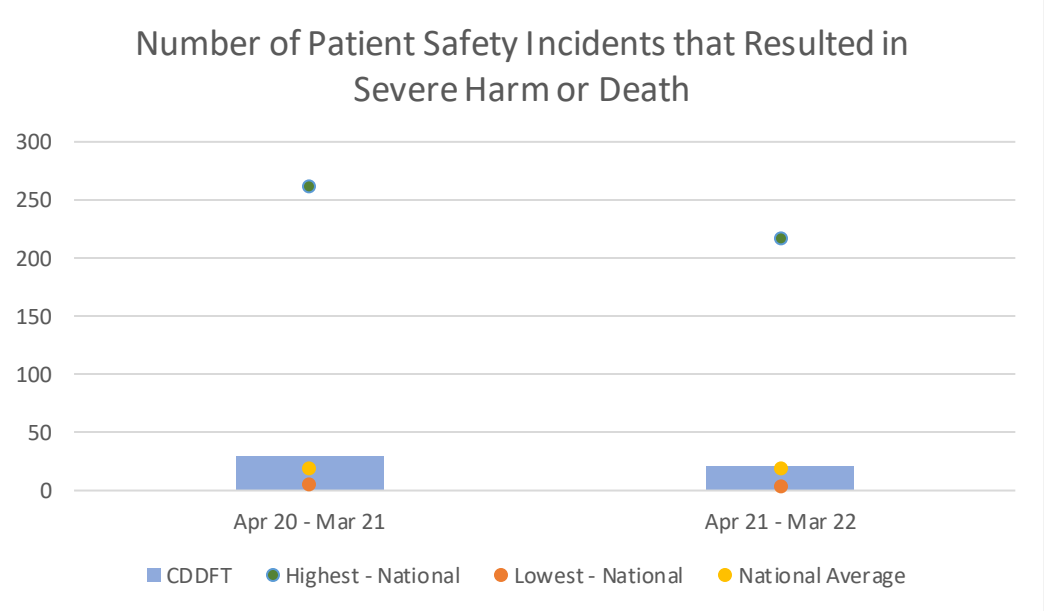
The County Durham and Darlington NHS Trust considers that this data is as described for the following reasons: the Trust monitors this data regularly via its Infection Control and Executive Patient Safety and Experience Committees. Despite a significant increase in the number of C-Diff cases from 2021/22, the national trend has been similar and the Trust remains below the national average. The Trust exceeded its nationally set threshold by two cases.

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 as well as learning from individual case reviews and back to basics audits undertaken every quarter.

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







Data source: National Reporting and Learning System (NRLS).

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.

Since April 2020, NRLS has moved to annual rather than six monthly reporting. As a result, unlike previous years, only the previous two years has been presented in the charts above to ensure appropriate data comparison. In addition, due to the national move from NRLS to Learn from Patient Safety Event Service (LFPSE) in mid-2023, some trusts that have migrated to the new system may not be included in the dataset which may impact the national figures.

The County Durham and Darlington NHS Foundation Trust intends to take the following actions to improve the indicator:

- Encouraging reporting of no harm and low harm incidents and near misses among staff during 2022/23, which resulted in an increase in reporting that will not yet be fully reflected in the NRLS data.
- Implementing a bespoke Patient Safety Strategy – Patient Safety Matters - which builds on the principles in Patient Safety Incident Reporting Framework.

Family and Friends Test and other forms of patient feedback and engagement

Throughout the pandemic responses for the Family and Friends Test were low due to posters being removed from the wall with QR codes and paper forms removed for infection prevention and control reasons. During 2022 we have reintroduced paper cards, refreshed/replaced posters and worked with wards and departments to increase the number of responses we receive to not only drive service improvement but celebrate our successes.

In response to our priorities identified in the 2022-2023 Accounts; our FFT posters were redesigned and displayed at the entrances of all ward and patient areas, ward and departments now have personalised paper cards to be given to patients on discharge or when leaving the department which include an option to scan a QR code, visit the website or manually fill in the paper cards. These initiatives have resulted in an increase in the amount of responses received and we hope this will continue to gain momentum in the coming year.

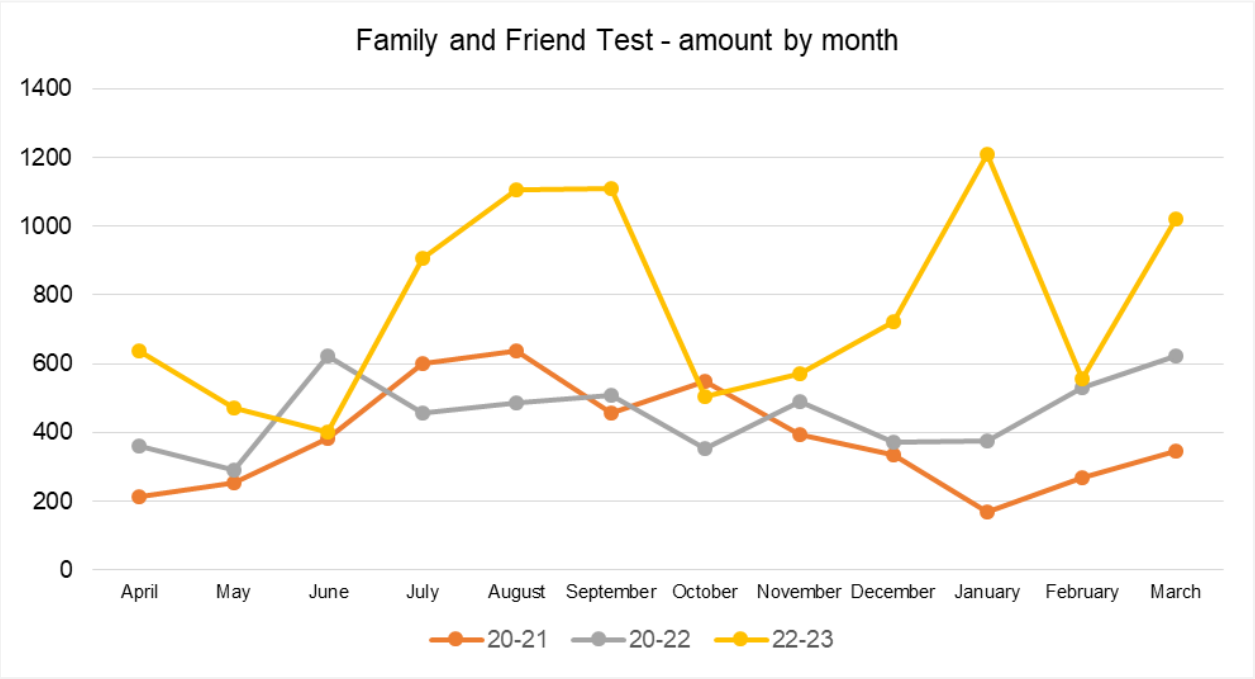
We also the Rehabilitation after Critical Illness Team (RaCI) and Rehabilitation Teams, in evaluating service improvement. The evaluation results were very positive, responders were very happy with the services and were unable to identify any areas in which they thought the services could be improved, at this stage. The evaluation was a ringing endorsement of these services with teams able to celebrate their successes.

Our 'you said, we did' campaign has identified a number of service improvements during 2022/23. Improvements have been made to our Wig Service and through the introduction of volunteers to Ward 33 which allows ward staff more time to care. Volunteers provide wide ranging support to patients including support with eating and drinking.

There has been positive work carried out with parents who remember their lost babies in the Little Angels garden at UHND. Parents have been a key part of our consultation group and supported the project to relocate the baby memorial garden on that site. Parents have had significant input into the look and style of the garden and helped the Trust consider a project plan for the relocation to be carried out empathetically. As a result of this work we have now introduced a Trustees of the Garden Group for future management of the area.

We had hoped to introduce a text messaging service in the year, however an evaluation identified that set-up and ongoing costs were too prohibitive at this time. Following the introduction of EPR, the new electronic paper record, we are now exploring ways that this initiative could be delivered through the EPR system functionality.

The graphs below show local and national comparisons to the responses received.



Part 3 Other Information

This section of the Quality Account includes an overview of the quality of care provided during 2022/23 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 recently launched 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

Quality Improvement

In October 2022, the Trust appointed a Quality Improvement Senior Sister. This new role facilitates and provides support to clinical teams looking to develop QI initiatives. The QI Senior Sister is working towards building a culture of continuous care quality improvement in the Trust giving everyone, at every level, the opportunity to participate in positive change.

Incident Reporting and Investigation

The reporting and investigation of incidents and 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 2022/23 reported 50 such incidents; this is a decrease compared to 57 reported in 2021/22. All of these incidents have had an investigation completed 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 2023-24. In previous Quality Accounts we have described how the Trust piloted a rapid review process for falls resulting in fracture neck of femurs and how the pilot had enabled 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. Having been deemed a success, the pilot, and learning outcomes, were included within the Trust's three years Falls strategy and rapid reviews are now embedded practice.

The original pilot completed 16 falls rapid reviews. For 2022/23 that number has increased to 49 falls rapid reviews completed.

This year has also seen the development of the Trust's Patient Safety Strategy for 2023-2026 which underpins the core objective in our "Quality Matters" strategy of "Keeping You Safe" when you use our services. Having pursued a Safety II approach of endeavouring to prevent incidents from ever occurring through direction of resource, quality improvement work and pro-active projects to minimise the potential for harm, the approach delivered tangible improvements in patient safety; however, there remains more that can be achieved.

Our Patient Safety Strategy outlines how we will continue to maximise the safety of our patients; involve staff, and provide meaningful and full engagement of patients and their families; use data to direct our efforts; and ensure we learn from any patient safety incidents.

Patient safety is everyone's business. By providing a safe and just culture, in which our staff are empowered to learn from incidents and act on safety risks, and by working in partnership with our patients and their families we can, together, deliver safe and reliable care which aims for zero avoidable physical or psychological harm to our patients.

Key priorities we set out in the Patient Safety Strategy include:

- Early Detection - Since 2013 the Trust has seen a 56% reduction in cardiac arrests per thousand admissions. This has been achieved through consistently reviewing, and learning from, both cardiac arrest and medical emergency calls. The strategy sets out our aim to; continue to review all Cardiac Arrests and MET Calls to maximise the potential for learning, work with the AI team to monitor for any areas of 'soft intelligence' relating to the deteriorating patient where patient safety gains could be made and remain vigilant for emerging themes to ensure swift intervention is taken to prevent patient harm occurring
- Learning from Deaths - Since 2017, CDDFT has had a robust Learning from Deaths Process and the process and policy has continuously evolved to ensure that the selection of patients reviewed maximises the potential for learning. The implementation of the ME Service further consolidates the learning from deaths processes to ensure that no stone is left unturned in the quest for learning. The strategy sets out our aim to; maintain flexibility in relation to the deaths reviewed to ensure that all areas for potential learning are explored, continue to expand the ME Service to ensure robust surveillance of patients who die whilst in the care of CDDFT and maximise the opportunities for learning and ensure that action is taken against any themes identified through the learning from deaths process.
- Learning from Excellence - We established Learning from Excellence (LfE) in 2016 and since then over 22,500 excellence reports have been made, the numbers increasing year on year. The new Learning from Patient Safety Events (LFPSE) reporting system, which replaces the current National Reporting and Learning System (NRLS) in autumn 2023, takes learning from excellence one step further. The system will integrate these events, capturing them alongside the adverse incidents, and also enabling patients and their families to report instances of excellence as well as adverse patient safety incidents. The strategy sets out our aim to; continue to promote the reporting of excellence, reinvigorate the Learning from Excellence working group, which faltered during the

Covid-19 pandemic, and focus on exploring how the learning from good practice can be disseminated into the clinical areas to ensure that it supports the delivery of high quality, safe care.

- Learning form Patient Safety incidents - The Trust's annual patient safety incident response plan (PSIRP) sets out how the Trust learns from patient safety incidents reported by staff and patients, their families and carers as part of our work to continually improve the quality and safety of the care we provide. The strategy sets out our aim to; ensure our annual PSIRP supports the robust investigation of adverse incidents and provides a clear structure to staff as to what level of investigation is required and ensure the learning from PSII's and other incident examinations is disseminated in the most effective manner into the clinical areas to minimise the risk of future incidents of a similar nature occurring.

National Patient Safety Developments

As noted above our local patient safety strategy and priorities are informed by the National Patient Safety Strategy. We continue to progress with the transition to the National Patient Safety Strategy through the following:

- The Falls rapid review process is now standardised practice.
- Patient safety incident investigations are now using the new PSIRF templates.
- We have begun to use learning teams to identify and undertake quality improvement work organisationally following a theme identified from incident reporting;
- We have made greater use 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 September 2023.

Never Events

The Trust have reported zero never events in 2022/23. A never event is defined as an incident that should not occur if correct procedures and policies are in place.

Local Patient Safety Initiatives

In 2022/23, a regional patient safety group was formed to share key priorities and ideas on matters relating to patient safety. Throughout 2022-23 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.

Associate Directors of Nursing Patient Safety Forum

The Associate Directors of Nursing Patient Safety Forum is a recently introduced forum which is responsible for monitoring any emerging patient safety issues, as well as providing senior leadership direction to manage outstanding issues in relation to incident management, Duty of Candour and Patient safety incident investigation safety actions. The forum will also ensure that investigations spanning safety, experience and / or legal are managed in the most appropriate manner to provide the best experience, in a timely manner, for the patient or their family.

Maternity Quality Improvement Forum (MQIF)

Senior leadership in maternity services and patient safety recognised the need to ensure long term, embedded changes in practice following reviews of incident action plans. Whilst short term improvements were being made, consistently translating short term actions into long term, embedded changes was less successful.

The Maternity Quality Improvement Framework (MQIF) was established with initial work streams were built on the themes observed within national learning and recommendations from high profile reports, alongside themes from local maternity patient safety incidents and safety related risks on the services risk register. The drive of each work stream was to utilise the themes to inform quality improvement

work, with ongoing monitoring, to really embed learning across the service. The initial work streams agreed upon, and approved by the executive led oversight meeting were:

- Continuity of Carer
- Workforce
- Digital
- Screening
- Quality and Safety (to incorporate other areas for learning not covered in the previous four work streams)

There have been a number of key successes within MQIF, and the framework enabled the service to drive change forwards at an increased pace, improving safety for women and babies in our care. The incidents overall in maternity services, whilst continuing to show a good reporting culture, are beginning to reduce to a level previously associated with being 'normal' within maternity services.

Patient Experience

Patient Experience

The Patient Experience and Engagement Strategy is being revised for 2023 to 2025. The objectives and work-streams have been defined and are underway 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.

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 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

The Patient Experience Team have worked with a number of complainants to capture their stories in detail, using the video testimony of the families involved, which are then shared with nursing and clinical teams, to promulgate learning and with our Integrated Quality and Assurance Committee (IQAC), for assurance and reflection. IQAC has, on several occasions, recommended that the stories – which can be particularly powerful – are shared with, and videos watched by – all Board members and has sought update on actions taken.

Learning objectives and actions are developed with the families concerned. We are now starting to invite complainants into the Trust to under-take walk-arounds to allow them to see the changes made as a result of their feedback.

One particularly powerful example of this approach is 'Andrew's Story' as noted below, with the patient involvement aspects led by the Patient Experience and Learning and Disabilities Teams. The Trust was acknowledged in NHS England's Action from Learning Report 2021/22 for this piece of work:

When Andrew was admitted to hospital with a urinary tract infection (UTI), he did not recover as expected and staff were not asking why. Andrew's family did not feel they were listened to and their concerns were ignored. Changes in Andrew's behaviour were attributed to him having dementia, and further questions were not asked. Unfortunately, this meant two pathological hip breaks went undiagnosed for several weeks.

Andrew had Down's syndrome and sadly died in early 2020 at the age of 51. County Durham Clinical Commissioning Group (CCG) and County Durham and Darlington NHS Foundation Trust (CDDFT) approached Mixit, a local drama group in the North East, who were asked to produce a film to portray Andrew's experiences. The film has been shared widely as a learning tool. Its purpose is to emphasise that reasonable adjustments should be made for people with a learning disability and that nothing should be assumed as a result of someone having a learning disability. The film was made with the consent and support of Andrew's family, who want to share his story in the hope of changing attitudes towards people with a learning disability in health and care settings. Andrew was non-verbal, but the film gives him a voice. The viewer is urged to see the person, not their learning disability, and to adapt their behaviour, ask the right questions, look the right way and, ultimately, 'See Me'.

Stories such as Andrew's encourage everyone working in health and social care, as well as the public, to challenge preconceived ideas they may have around what is best for a person with a learning disability, and instead listen to that person.

There is an ongoing plan to share Andrews's story at CDDFT from ward to board via social media, patient experience forum and also in the care groups.

Major Service Re-Design

We have undertaken extensive public engagement activity, with commissioners, with respect to the plans to replace Shotley Bridge Community Hospital with a new facility in the same locality. This has included:

- Seven formal public engagement events
- An ongoing reference group, working with local councillors
- Use of existing partnerships, to elicit the views of younger service users
- Ongoing engagement, with a dedicated Communications Lead in place for the project.

The services to be provided from the facility have been extensively discussed and finalised through the engagement process – including accounting to the public for the absence of endoscopy and theatres in the new facility. The full equality impact assessment for the facility was shared with the Board, as well as the details of the public engagement activity and outcomes, as part of the outline business case for the site, in December 2022.

Developing opportunities for feedback – harder to reach groups

The patient experience team has developed an 'easy read' version of the Friends and Family Test, to help those with learning disabilities and other relevant conditions provide feedback on their experience in our care. This augments existing patient experience feedback measures, including the main Friends and Family Test, compliments, local (post-discharge) and national surveys.

Involving patients in service evaluation

Both the implementation of the Trust's Acute Kidney Injury Service and the 'Call for Concern' initiative - which allows patients' carers, relatives or friends to contact the Acute Intervention Team should they be concerned about the deterioration of a loved one - have been subject to interim evaluations reported to the Board, and to the Clinical Effectiveness Committee respectively. Both have collected and used patient feedback as part of these initial evaluations and will do so more extensively in the final evaluation stage.

Cancer services

There is a rolling programme of cancer patient experience feedback surveys (the "5 for 5" survey) running throughout 2022/23. The survey looks at different elements of the patient's experience, including access to the service, each time it is undertaken and was used post pandemic to take patient views on access to chemotherapy services which supported the decision to reinstate services at UHND.

Service Level activity

Examples of service-led engagement, involvement and related improvement activity are summarised in the table below, this is not be an exhaustive list.

Integrated Medical Specialties	A key service change introduced in the last two years has been the development of the acute frailty model. The service has undertaken a patient survey to support the evaluation of the change covering: • Awareness of the service • How far patients and families considered their concerns were listened to • How well-informed they were with respect to the survey and their condition • How far patients, carers and families felt involved in their care and treatment • The value placed on the service. The feedback was strongly positive.
Community Services	The service is organised into Teams Around Patients working closely with the GP practices responsible for patients. This approach enables primary care services to represent the views of their patients and, at macro-level, service users' experience is considered as part of the Co Durham Integrated Care Partnership. The service works with many service users in care homes and there is a joint forum held with care home leads. As part of these discussions, feedback on the Trust's services is considered. One of the most recent service developments is the establishment of community-based Long Covid clinics. We has recently set up a Friends & Family Test to allow it to receive feedback from patients about the service. There is also regular attendance at a Countywide Patient Reference Group which is a patient and carer group meeting hosted by the ICB to provide updates on the service.
Surgery	The Care Group has considered patient feedback, obtained through complaints, and local surveys and made a number of changes, examples of which include the following: • The Ophthalmology pathway was revised following feedback from a patient and their family to ensure that patient journey is streamlined and a holistic approach is taken. The out of hours' service was also reinstated following a temporary suspension in response to patient and Governor feedback.

	• Clinical Decisions Unit UHND- patient feedback always referred to the long wait for senior review, hence the on call rota was changed to introduce 1st & 2nd on call consultant in 2020. • Clinical Decisions Unit UHND - The patient feedback has highlighted that location of the waiting room is not ideal and there is a lack of confidentiality. Work is taking place to adapt the current space to address these issues. In the meantime the service has turned one of the examination bays into a comfortable seating area with a T.V. so the patient feels more included in their care/ journey. • Families provided feedback that they felt "shut off" when doors were closed on the side room when their family member was approaching the end of their life. The service now asks the family if they would like the doors open or closed. Previously there was the assumption that families preferred the privacy; families are now always asked and assumptions are not made. • Clinical Decisions Unit DMH - patients raised concern regarding the waiting time to be seen by ENT, leading to a review of the pathway which is ongoing, with proposals expected to be taken through specialty and care group governance in the near future. • The recently, and significantly, expanded Rehabilitation after Critical Illness used patient feedback as part of an interim service evaluation.
Family Health	The Maternity Service works closely with the Maternity Voices Partnership, with the Chair of the MVP attending the Family Health Quality Governance Meetings. The Service has developed its response to the national maternity survey results, for 2021/22 in partnership with the MVP and agreed additional actions as part of their feedback. There is ongoing work between the MVP, Infinity Teams and Healthwatch on health inequalities and the MVP has been used to engage with service users with respect to the temporary suspension of the both the home birth service and birthing pool at DMH. CDDFT is working with Children's North East (CNE) to help poverty proof paediatric services recognising that our services must be accessible to citizens from all socio-economic backgrounds. The process of Poverty Proofing© Health Settings is delivered in partnership with CNE and will provide us with insights into the challenges that individuals face in accessing, attending or engaging with our services. The focus is on engaging with families (particularly those experiencing poverty) to identify barriers to engagement in health services and working together to overcome these barriers, eliminate inequalities and improve accessibility.

National Patient Survey Reports

There were three National Surveys carried out 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.

NHS Adult Inpatient Survey

The survey was administered by the Coordination Centre for Mixed Methods (CCMM) at Ipsos. A total of 166,318 patients were invited to participate in the survey across 134 acute and specialist NHS trusts. Completed responses were received from 62,235 patients, an adjusted response rate of 39%. Patients were eligible to participate in the survey if they were aged 16 years or over, had spent at least one night in hospital, and were not admitted to maternity or psychiatric units.

The Trust scored better than average for 17 of the 23 questions and, for the 10 sections, the Trust appeared in the Top 5 on six occasions.

Actions agreed

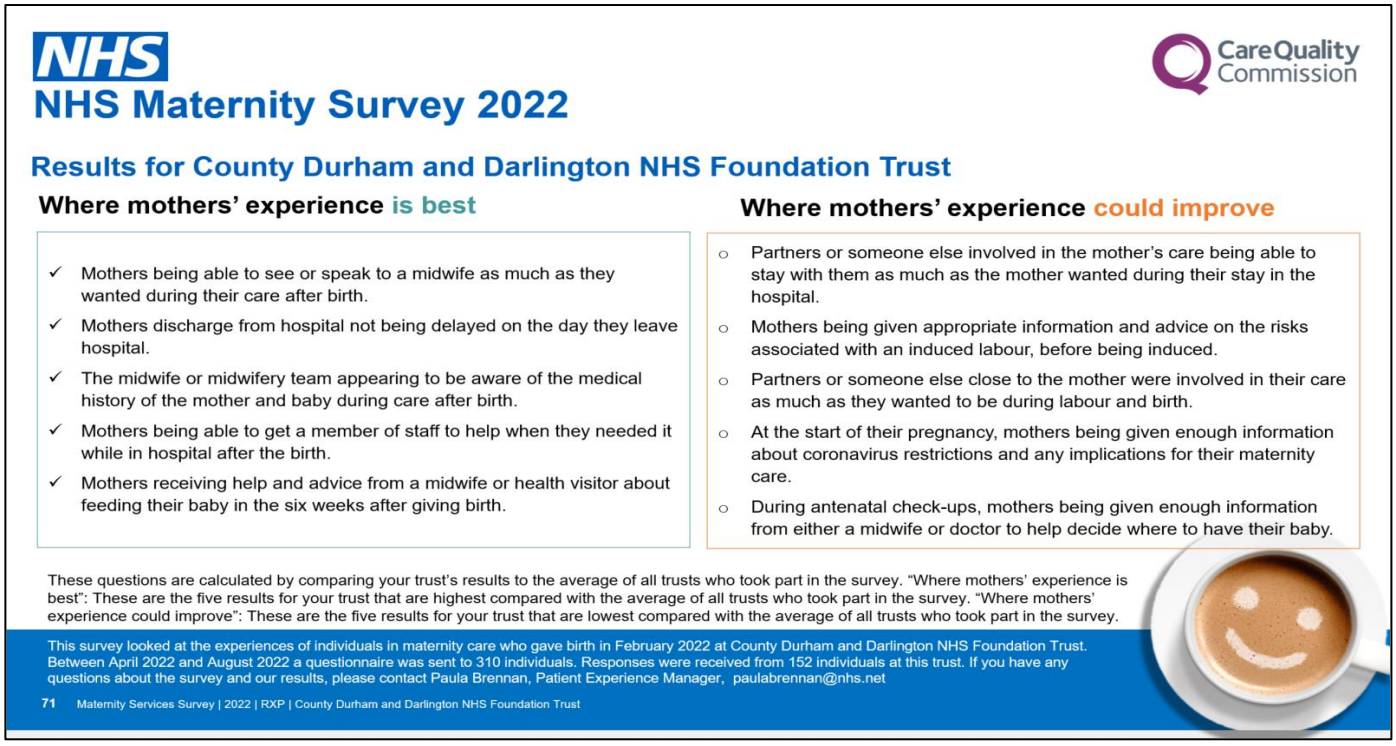
After analysis of the report there are a number of actions for consideration. We developed, and have been rolling out, an action plan covering:

- Identify those providers consistently in the 'Best 20%' from patient surveys and engage them to elicit learning
- Celebrate the successes internally from the report.
- Share the results externally, supported by the Communications Team.
- Work with wards/departments to understand obstacles with providing food outside of set meal times to understand if this can be improved.
- Work with wards/departments to raise awareness around privacy and conversations at the bedside.
- Prioritise improvements to the platforms available for patients to engage and provide feedback on the service and their experience.
- Monitor the progress quarterly through the Post Discharge Survey

CQC National Maternity Survey 2022 - Headline Summary Report

All NHS Trusts providing maternity services are required by CQC to participate in the survey. All women receiving maternity services in February 2022 were selected for the survey. There were 310 women were included in the survey and 152 responded (49%). The Patient Perspective average response rate for all 31 Trusts it surveyed was 48%. The response rate comprised three per cent of the women who delivered in our care in 2022. The average Mean Rating Score was 76.1%, slightly lower than in 2021.

We scored in the top 20% of Trusts on 7 questions and in the bottom 20% of Trusts on 14 questions out of a total of 59 questions. No questions showed at least 10% improvement on the 2021 score, and for 1 question the score was worse by 10% or more.



Action Plan co-produced with the Maternity Voices Partnership

One of the key themes from the feedback related to Induction of Labour. We are therefore undertaking a specific Induction of Labour Quality Improvement Project under the direction of the MQIF Quality and Safety Group

Challenges identified

- Lack of consistent counselling
- Variation in preferred methods cross site
- Anticipated delays
- Suitability of outpatient Induction of Labour.
- Unacceptable delays with Induction of Labour process, especially with high risk cases.
- Poor patient experience.

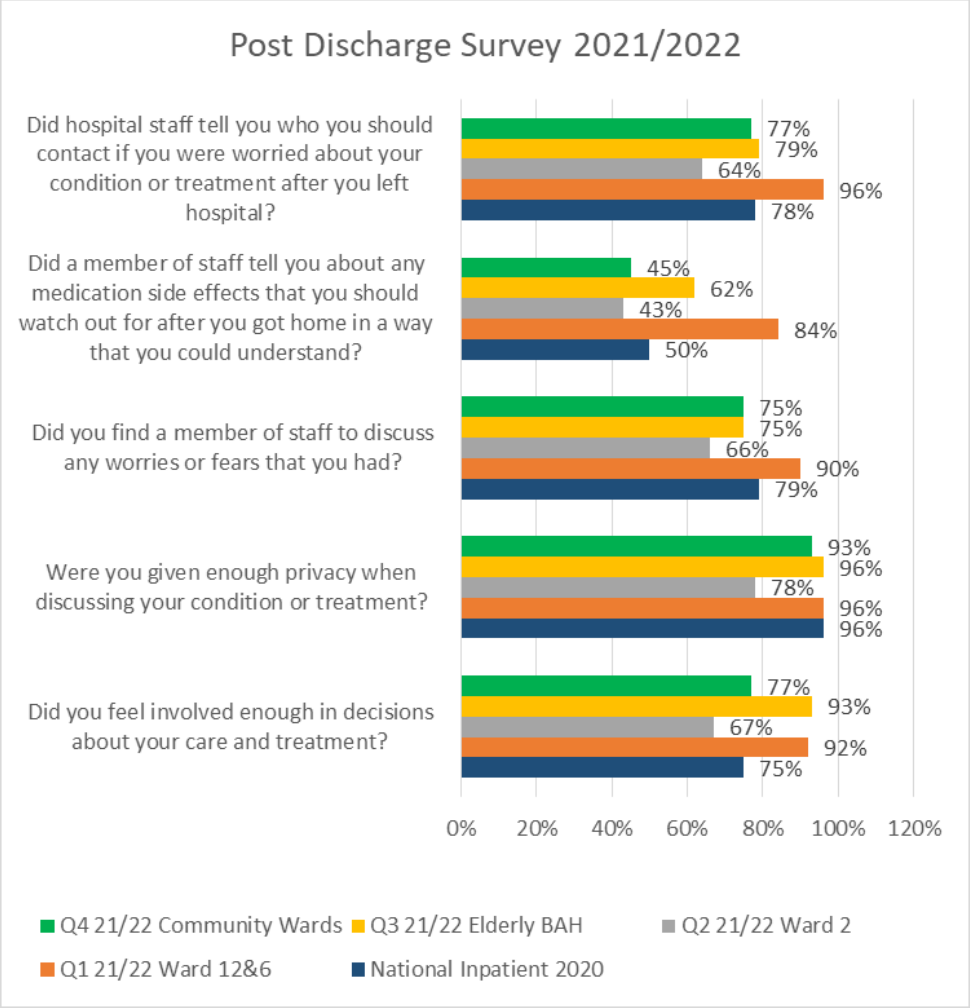
Solutions Agreed

- We have co-produced an audit tool, with the Maternity Voices Partnership, which we will use to understand more about specific women experiences.
- Separate pathway from main acute work by Induction of Labour Midwives (core team of MW who will work cross site)
- Use the IOL pro forma on BadgerNet to document IOL: reason, timeframe. Timeframe will guide the on call team if workload demands are high.
- Use the same form to document Bishop Score and Counselling provided including any anticipated delays.
- Induction of Labour leaflet on BadgerNet to be used consistently by all teams
- The service and the Communications team are to develop a video regarding Induction of Labour. This can also be signposted to the patients at the time of discussion.

Post Discharge Survey

The Trust's Post Discharge Survey was refreshed during 2021 and now runs over a quarterly cycle and 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.

The data shown is full year 2021/22. To date only Q1 and Q2 data are available for 2022/23, hence we are not able to show the full year 2022/23 data at this stage.



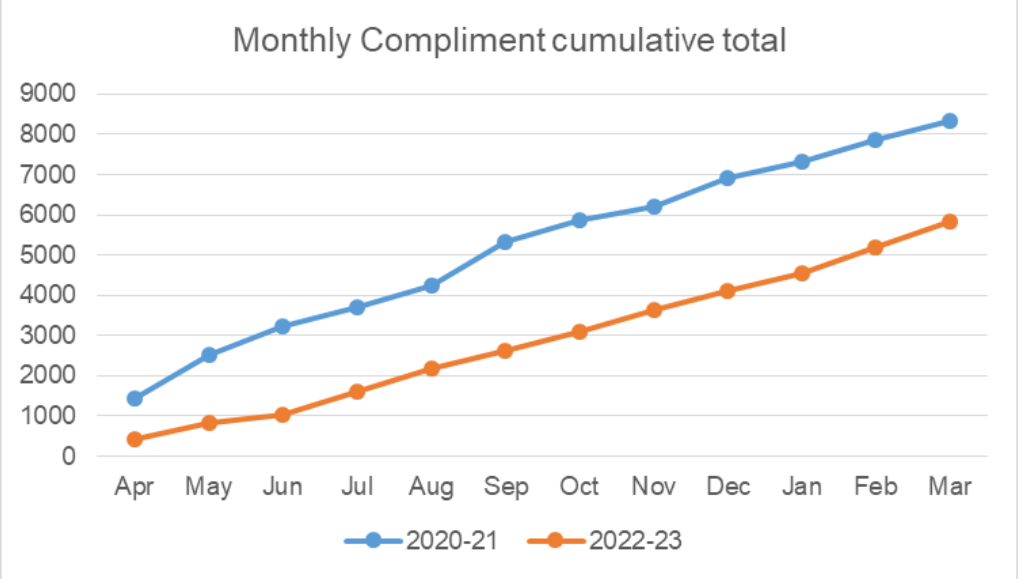
Survey results are shared with the relevant wards and local improvement plans are developed and implemented.

Carried over from the previous Quality Account 2021-2022 is ensuring a positive patient experience throughout the discharge process. The Patient Experience Team have continued to work collaboratively with Discharge Leads in the Trust to understand, agree and support the implementation of actions to drive service improvement.

Compliments

We continue to improve the way in which compliments are collated for CDDFT staff. The chart below shows that the cumulative total for compliments received for 2022-2023 remains quite low in comparison to the total for 2020/21.

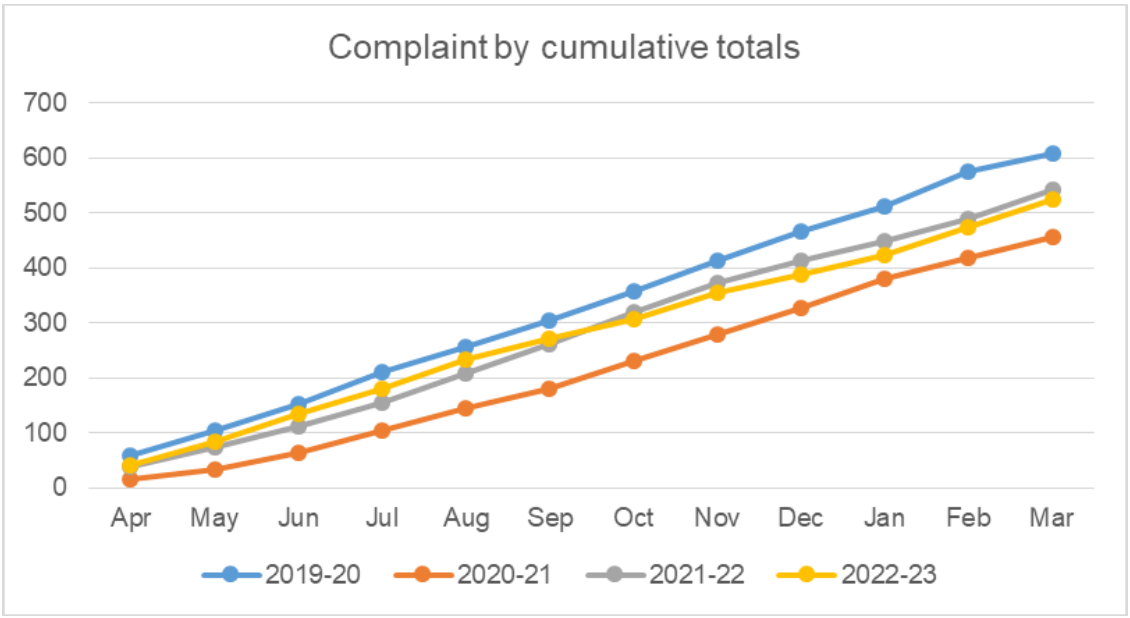
A new module for Ulysses will be implemented in the new financial year and the compliments process will be relaunched and reinvigorated.

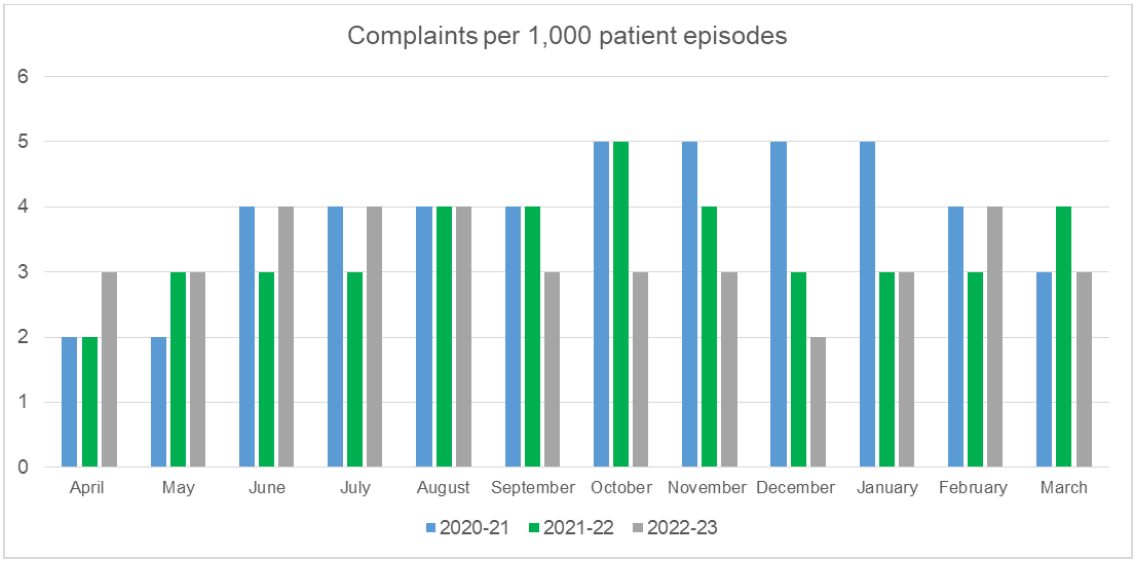


Complaints

As well as seeking to collect and learn from proactive patient feedback the Trust fully investigates, and implements learning from 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'.

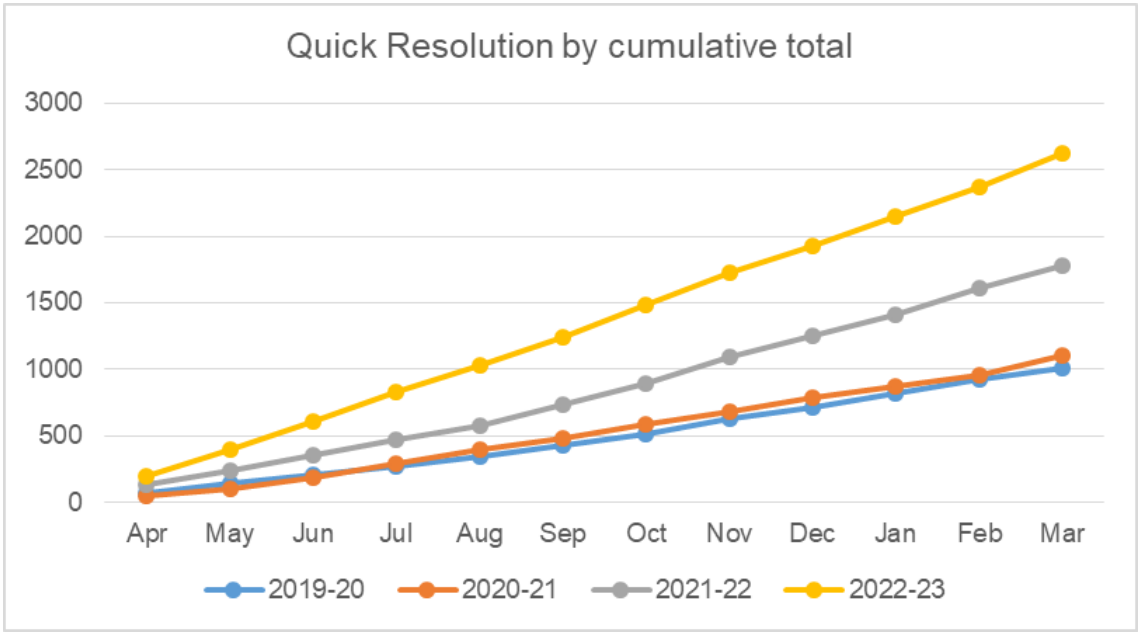
The charts below show the number of formal complaints received Trust-wide throughout 2022-23 as a cumulative total and in comparison to previous years back to 2019-20. It also shows complaints per 1,000 patient bed days so that the link between the number of complaints and activity is clear.





Quick Resolution Complaints

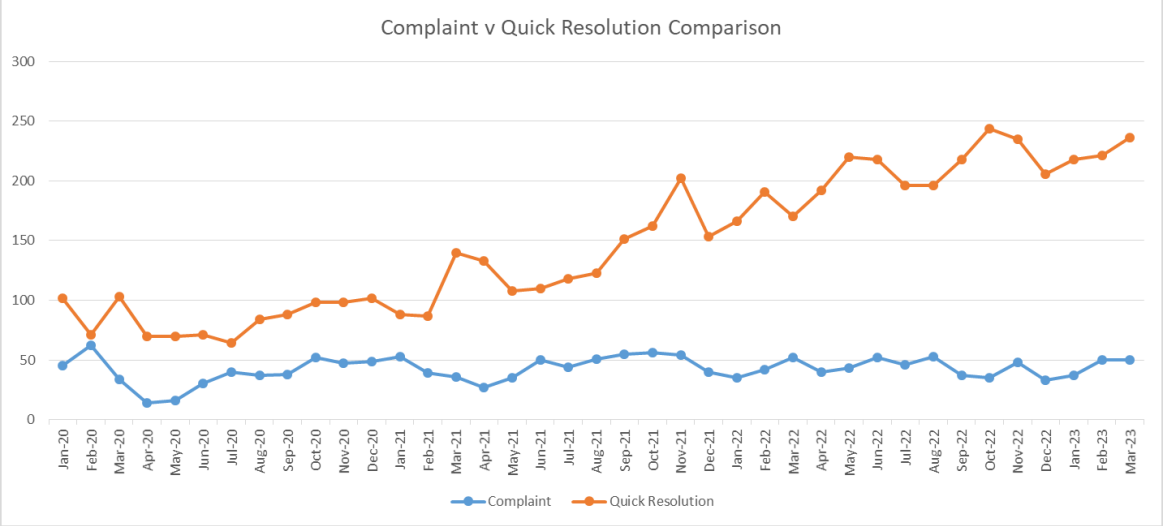
The below charts show the number of quick complaints received trust-wide throughout 2022-23 as a cumulative total and in comparison to previous years back to 2019-20, together with the number of quick resolution complaints per 1,000 patient bed days.



Complaint v quick resolution cases

The Trust participated in a national pilot exercise in 2021 which aimed to standardise the application of the national complaint framework during 2021. One of the changes made as a result of this pilot was the triage of complaints effectively to allow cases, where possible, be handled as a quick resolution case. The approach has been successful as shown in the chart overleaf.

Handling of complaints as quick resolution cases where possible has resulted in an upturn of quick resolution cases. The benefit for the complainant is that the matter is typically resolved in less than 10 days, often with a conversation where possible, whereas a formal complaint can take up to 6 months for a resolution dependent on complexity.



Learning from Experience

We have continued to use feedback from patients, in particular patient stories, to share valuable lessons to the experience of patients in our care. One recent example has resulted in the production of a video which will be used educate staff in handling the most challenging aspects of conversations around ceilings of care, and Do Not Resuscitate Orders with patients and their loved ones. The video draws on the story of a spouse who suffered from a lack of clear communication in connection.

Volunteer Service

The volunteer service at CDDFT was stood down throughout the pandemic. Prior to the pandemic we had over 200 volunteers in post. We currently have 80 volunteers in post. Through a series of recruitment events we are now increasing our volunteer pool towards previous levels focusing on roles which can maximise support to front-line services. We have also enrolled in the 'Volunteer to Career' programme sponsored by Health Education England and Helpforce, receiving £24,000 funding to secure a Band 3 additional member of the team to roll out scheme for the Trust.

The scheme aims to positively impact NHS workforce recruitment needs at a local level through the design of Volunteer to Career initiatives. NHS Organisations are supported with funding to support senior clinicians to work with volunteer service teams to design and develop specific roles to be undertaken by volunteers according to the local workforce recruitment needs.

A key measure of the success of the programme an increase in the number of volunteers who have an interest in pursuing a career in health and care after their volunteering experience. Learning from the programme will be scaled and spread through the development of resources, tools, learning, case studies and evidence-based models/initiatives developed within the projects and shared with other organisations.

During the recent volunteer recruitment sessions held in January 2023 the patient experience team have secured 46 successful applications of which 22 are potential volunteer to career candidates.

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).

Performance against the 4hour standard has remained pressured through the year. For the last quarter, the Trust has seen and treated / admitted around 70 to 73% of patients attending A&E within four hours.

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 its bed base, 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 and the national requirement to recover the long waiter position, we were, rightly, unable to do so in 2022/23.

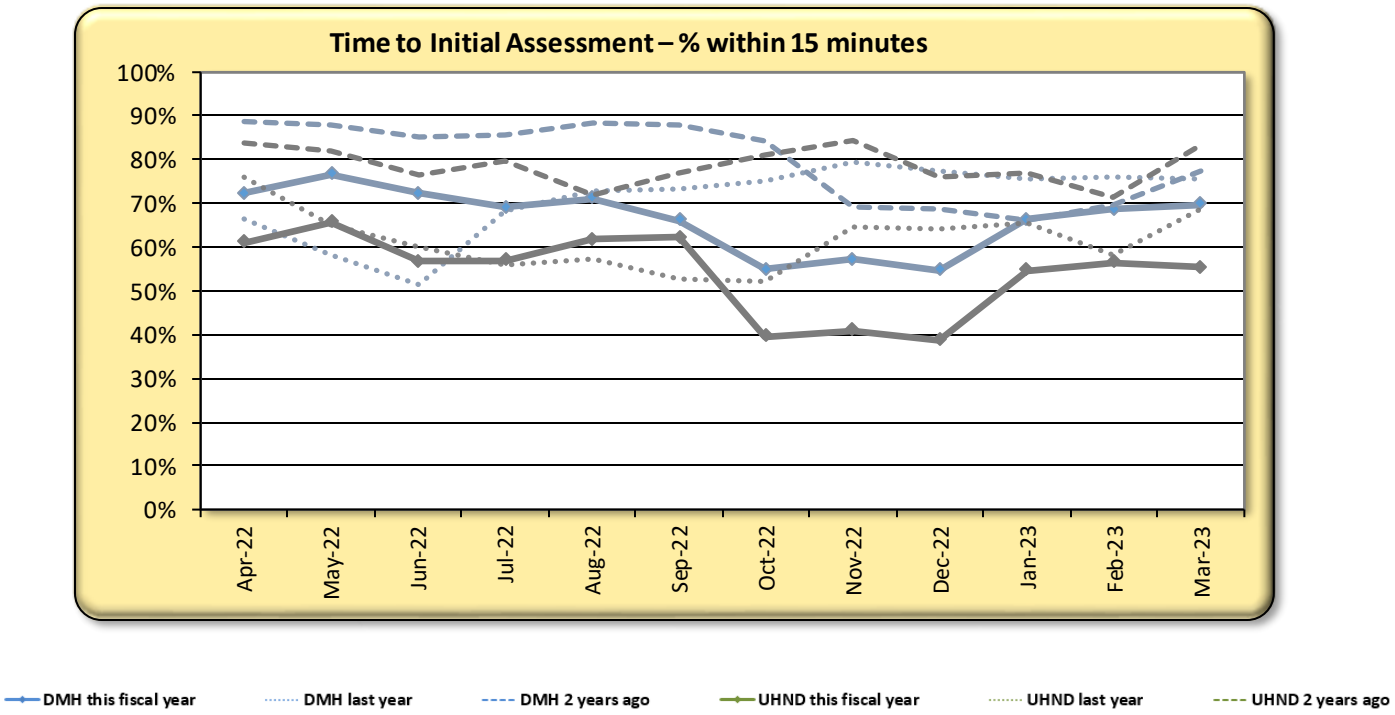
The pressures noted above were seen across the country and the Trust was not a national outlier. The North East region performed comparatively well; however, greater patient demand was a reality in County Durham which, together with the capacity limitations noted above, limited our ability to perform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

Month/Quarter	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Qtr 1 2022/23	Qtr 2 2022/23	Qtr 3 2022/23	Qtr 4 2022/23	Fiscal Year 2022/23
DMH ED attends	5,454	5,841	5,675	5,686	5,264	5,187	5,260	5,423	5,554	5,062	4,911	5,476	16,970	16,137	16,237	15,449	64,793
DMH ED 4 Hour Waits	2,432	2,100	2,564	2,733	2,686	2,564	2,975	3,090	3,250	2,853	2,607	2,921	7,096	7,983	9,315	8,381	32,775
DMH % Seen in 4 Hrs	55.41%	64.05%	54.82%	51.93%	48.97%	50.57%	43.44%	43.02%	41.48%	43.64%	46.92%	46.66%	58.19%	50.53%	42.63%	45.75%	49.42%
UHND ED attends	6,481	6,958	6,802	6,459	6,171	6,255	6,516	6,742	6,643	5,860	6,082	6,805	20,241	18,885	19,901	18,747	77,774
UHND ED 4 Hours wait	3,658	3,528	3,785	3,813	3,347	3,105	4,207	3,747	3,701	2,996	2,994	3,534	10,971	10,265	11,655	9,524	42,415
UHND % Seen in 4 Hrs	43.56%	49.30%	44.35%	40.97%	45.76%	50.36%	35.44%	44.42%	44.29%	48.87%	50.77%	48.07%	45.80%	45.64%	41.44%	49.20%	45.46%
Total ED attends - Type 1	11,935	12,799	12,477	12,145	11,435	11,442	11,776	12,165	12,197	10,922	10,993	12,281	37,211	35,022	36,138	34,196	142,567
Urgent Care Centre - Type 3 (Walk-Ins)	4,365	4,876	5,080	4,921	4,381	3,975	4,473	4,499	5,859	3,841	3,692	3,955	14,321	13,277	14,831	11,488	53,917
Urgent Care Centre - Type 3 (Booked Appointments)	3,683	4,257	4,385	4,424	3,924	3,756	4,128	5,256	6,096	5,262	6,432	6,695	12,325	12,104	15,480	18,389	58,298
Trust Over 4 hour waits	6,090	5,628	6,349	6,546	6,033	5,669	7,182	6,837	6,951	5,849	5,601	6,455	18,067	18,248	20,970	17,905	75,190
ED Only Activity % under 4 hour waits	48.97%	56.03%	49.11%	46.10%	47.24%	50.45%	39.01%	43.80%	43.01%	46.45%	49.05%	47.44%	51.45%	47.90%	41.97%	47.64%	47.26%
Reportable % under 4 hour waits (including UCC Booked from Jan '2020)	69.52%	74.34%	71.06%	69.54%	69.44%	70.43%	64.75%	68.81%	71.22%	70.79%	73.48%	71.85%	71.71%	69.79%	68.44%	72.06%	70.49%

New A&E clinical standards have been reported in shadow form since 2021/22, with focus placed on the time patients spend in the Department. The volume of patients waiting over 12 hours has fluctuated 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 and when the burden of Covid-19 and flu was significant.

Standard Month:	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Trust ED Patients spending more than 12 hours in A&E	1,435	1,042	1,376	1,349	1,297	1,140	1,905	1,878	2,614	1,543	1,056	1,244
% Trust ED Patients spending more than 12 hours in A&E	12.0%	8.1%	11.0%	11.1%	11.3%	10.0%	16.2%	15.4%	21.4%	14.1%	9.6%	10.1%

We have achieved significant reductions in patients waiting over 12 hours in the department and in patients waiting 12 hours or more for a bed, from a decision to admit, as well as in ambulance handover delays. The changes reflect some reduction in demand but also a range of process improvements. Going forward our priority is to maintain and improve performance around the time to assessment and time to treatment indicators.

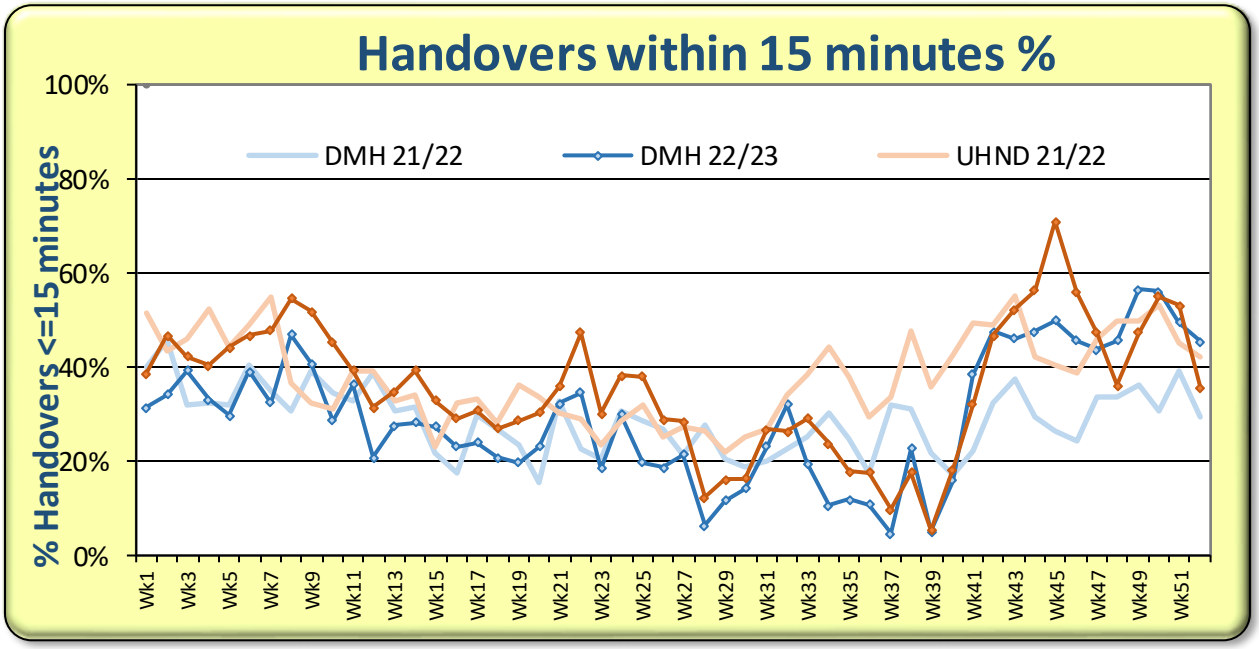


As outlined in Section 2B, reducing waiting times in our A&E Departments is a high quality improvement priority for the Trust with a number of actions planned to increase our physical and staffing capacity and to optimise our clinical pathways.

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 proportion of handovers completed within 15 minutes has varied throughout the year with lower levels experienced in October just ahead of the winter pressures period. Lower levels of performance are congruent with Covid-19 and Flu 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 December onwards, aiming to achieve arrival to clear times within 30 minutes. This improvement results directly from actions taken by the Trust, including an expansion of capacity for handover, particularly at DMH, rather than demand-led factors. It has been sustained in the first two months of 2023/24.

	Average Arrive to Clear Time (Mins)											
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Darlington Memorial A&e	39.5	39.0	44.7	50.9	54.1	57.2	83.6	64.5	143.2	45.0	28.6	27.5
Uni Hsp Of North Durham A&e	38.7	35.9	41.9	47.6	48.8	46.2	75.3	62.3	118.4	49.2	27.8	31.3

The Trust was asked to present, regionally, on the improvements made in respect of ambulance handover times and 12 hour waits for beds. Around 62% of patients were assessed within 15 minutes of arrival in the department, in February and March 2023.

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 2023/24.

Performance Summary

Recovery and restoration

During this third 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:

- Increase activity to over 104% of 2019/20 activity levels: 93.9% was achieved for April 2022 to March 2023;
- Reduce follow up activity to no more than 85% of 2019/20 activity levels: 85.3% was achieved for April 2022 to March 2023;
- Eliminate waits of over 78 weeks by March 2023: this was delivered
- Validate all patients who will be waiting 52 weeks by the end of March 2023 by 20th January 2023: this was delivered
- Hold or reduce the number of patients waiting over 52 weeks, with a plan to eliminate by March 2025: work is underway to achieve the long-term ambition, and 52 week wait volumes have been falling in the latter part of the year
- Increase the use of Advice and Guidance to 16 per 100 referrals: These requests continue to significantly exceed pre Covid-19 levels and meet the stated target
- Increase the use of Patient Initiated Follow-Up (PIFU) pathways to 5%: Plans for safe and appropriate PIFU have been rolled out in several specialties, although only around 2% of patients are moving to a PIFU pathway
- To reduce the 62 day Cancer backlog to the February 2020 level: A local target of a reduction to fewer than 132 patients was set and this has been met at times throughout the year, including at year-end. Performance against the NHS Constitution cancer standards has been strong compared to the regional position throughout the year
- To achieved the interim Faster Diagnosis Standard target of 75%.This is being routinely met
- Increase access to Diagnostics: Monthly performance has been consistently high and improving towards the temporarily relaxed national standard of 95% to seen within 6 weeks
- To increase diagnostic activity to 120% of pre-pandemic levels: Performance of approximately 110% has been achieved
- To reduce 12 hour waits to no more than 2%: this target has not been met and remains pressured
- To eliminate ambulance handovers of 60 minutes or greater: this target has not been met and, although much improved, remains pressured
- To ensure 95% of ambulance handovers take place within 30 minutes: this target has not been met and, although improved, remains pressured
- To ensure 65% of ambulance handovers take place within 15 minutes: this target has not been met and, although improved, remains pressured.

Annex 1 – Statements from Commissioners, local Healthwatch organisations and overview and scrutiny committees

On receipt of the statements from Commissioners, local Healthwatch organisations and overview and scrutiny committees, a number of points for clarification and further questions were asked. We can confirm that we have provide further clarification and additional information in response to the requests received.

Annex 2: Statement of directors' responsibilities for the Quality Report

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.

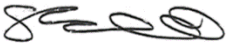
In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS foundation trust annual reporting manual 2022/23 and supporting guidance from NHSE/I on Quality Accounts 2022/23
- 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 2022 to June 2023
    - papers relating to quality reported to the board over the period April 2022 to June 2023
    - feedback from commissioners dated [TBC]
    - feedback from governors dated [TBC], [TBC]and [TBC]
    - feedback from local Healthwatch organisations dated [TBC]
    - feedback from overview and scrutiny committees dated [TBC]and [TBC]
    - the Trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated XXX Please note, the annual report for 2022-2023 is currently in development.
    - the national patient survey 2022
    - the NHS national staff survey 2022
    - the Head of Internal Audit's annual opinion of the Trust's control environment dated [TBC]
    - CQC inspection report dated 3rd December 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

[TBC] 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.

AHP – Allied Healthcare Professional

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.

Booking Bloods – Routine antenatal tests offered to all women

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.

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.

COHA – Community-Onset Healthcare Associated infection

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.

Continuity of Carer - A way of delivering maternity care so that women receive dedicated support from the same midwifery team throughout their pregnancy

Copeland's Risk Adjusted Barometer - A system which uses coded data from the Secondary Users Service (SUS) to measure the occurrence of medical triggers in inpatients as an indicator of morbidity

CQC – Care Quality Commission

Crude Mortality - Mortality from all causes in a given time interval for a given population

DMH – Darlington Memorial Hospital

ED – Emergency Department

e-Coli – Escherichia Coli, a Gram-negative bacterium

EPR – Electronic Patient Record

Fetal – From '*fetus*' - a young human being

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.

HOHA - Hospital-Onset Healthcare Associated infection

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.

Healthwatch – Independent consumer champion for health and social care

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

IPC – Infection Prevention and Control

John's Campaign (Dementia) – The offer of a unique form of support in delivering compassionate and effective patient care, for the right of people with dementia to be supported by their carers in hospital

Klebsiella sp – a Gram-negative bacteria

LADB – County Durham & Darlington Local A&E Delivery Board

LeDeR Programme – Learning Disability Mortality Review commissioned to improve standards of care for people with learning disabilities

LocSSIPs – Local Safety Standards for Invasive Procedures

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

Mortality – Death rate, the ratio of actual deaths to expected deaths

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

Nervecentre – Electronic nursing observation system

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

NHS Digital - An executive non-departmental public body, sponsored by the Department of Health and Social Care which uses information and technology to improve health and care.

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.

Nosocomial Transmission – Infections that develop as a result of a stay in hospital

NRLS - National Reporting and Learning System

Ockenden Report – by Donna Ockenden, chair of the Independent Maternity Review

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

Perfect Ward / Tendable – A quality inspection platform for healthcare settings

PGD – Patient Group Directive, used in prescribing, administration and supply of medication

PHE – Public Health England, now replaced by UKHSA (UK Health Security Agency)

PHSO – Parliamentary and Health Service Ombudsman

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

Pseudomonas ag – a Gram-negative bacteria

RAG Rating – Red, Amber Green rating system used to summarise indicator values e.g. alert, caution, on-track

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

SDEC – Same Day Emergency Care

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.

Tertiary Centre – Provider of specialist healthcare

TEWV – Tees, Esk & Wear Valley NHS Foundation Trust

This is Me Documentation - Intended to provide healthcare professionals with information about the person with dementia as an individual, to enhance the care and support given while the person is in an unfamiliar surrounding

Trust Board – another name used for the Board of Directors.

UHND - University Hospital of North Durham

UKHSA – UK Health Security Agency, replacement of PHE (Public Health England)

Ulysses system – Incident reporting and management system

UNICEF (UNICEF Gold) – United Nations International Children's Emergency Fund, Gold is awarded to services that achieve full baby friendly accreditation (Gold Baby Friendly Service)

Virtual Ward – A service for treating NHS patients at home

VTE - Venous Thromboembolism

WASP Programme - Competency assessment; witnessed, assimilated, supervised and proficient

NHS
County Durham and Darlington
NHS Foundation Trust

Darlington Borough Council - Special Health and Housing Scrutiny Committee Meeting – 14th June 2023

Quality Accounts Update

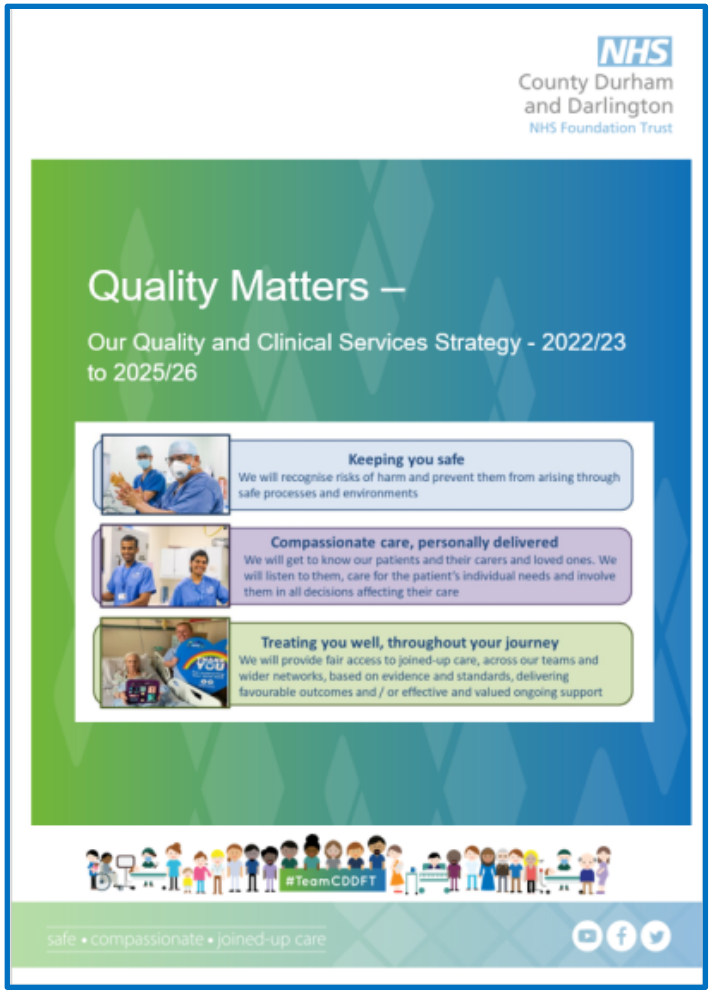
Warren Edge

Introduction

- Quality Matters – is our strategy to 2025/26 to support the achievement of our vision, **Right First Time, Every Time**, and is underpinned by our core values.

- Our priorities for 2022/23 reflected the priorities in the refreshed strategy and priorities brought forward from 2021/22 where there was further work required

- We have recruited and appointed a Quality Improvement Senior Sister to lead on sharing quality improvement work across teams and specific projects and aim to build on this approach



Summary - Safe

NHS
County Durham and Darlington

Domain	Quality Priority	2022/23 rating	Headlines	Retain for 2023/24?
Safety	Falls	Amber	Falls in our acute hospitals reduced slightly on the prior year and are slightly below the benchmark from the last national audit five years ago, set against increasing patient acuity and comorbidities. The Falls Team has been reinvigorated and are providing updated education and training and supporting a range of quality improvement projects. Falls in community hospitals have, however, increased, linked to demand and acuity pressures.	✓
	Pressure ulcers (PU)	Amber	There was one Grade 4 PU with a lapse in care in the year compared to our zero tolerance.	✓
	Healthcare Acquired Infections	Amber	We have reported one MRSA bacteraemia (exceeding our zero tolerance) and 61 C-Diff cases against our full-year threshold of 59. All cases are reviewed and learning implemented. All providers in the North East, except Gateshead have reported MRSA cases and the C-Diff trend is replicated in the region and nationally. Thresholds for other reportable infections have been met.	✓
	Maternity Services	Amber	The Trust implemented a Maternity Quality Improvement Framework, through which we have implemented many of the improvement actions contained in our action plan to respond to the Ockenden report. In line with the national direction we suspended the roll out of Continuity of Carer and have implemented a model to sustain acute and community services, with some continuity teams, following extensive consultation with staff. In line with regional and national picture, we continue to have vacancies and are actively recruiting to them and monitoring our staffing in the meantime.	✓
	Invasive procedures	Amber	All of the actions set out for 2022-23 have been taken. Compliance with all Local Safety Standards for Invasive Procedures has been audited, and improvement actions are being worked on.	✓
	Sepsis	Amber	New screening tools have been introduced for maternity, community and urgent care. However, provision of antibiotics in one hour in A&E remains a challenge.	✓

Summary – Experience/ Effectiveness

NHS
County Durham and Darlington
NHS Foundation Trust

Domain	Quality Priority	2022/23 rating	Headlines	Retain for 2023/24?
Experience	Care of patients with additional needs	Amber	Good progress has been made with respect to specific training and specialist nursing support for patients with dementia, learning disabilities (LD) and – working with partners – for those with mental as well as physical health needs. A specific FFT has been introduced for patients with LD. We aim to recruit more dementia champions, increase the coverage of our training and embed practice developments.	✓
	Discharge	Amber	We have positive (above average) results from national inpatient surveys but continue to learn from Section 42 referrals and to work on optimising our discharge pathways to avoid delay.	✓
	End of life care	Amber	Our draft strategy is being consulted upon. Access to side rooms for privacy and dignity remains a challenge, especially given estates constraints at UHND. We are increasing capacity incrementally and educating teams to make best use of alternative accommodation (community hospitals) and to maintain privacy and dignity in bays.	✓
	Nutrition and Hydration	Amber	Audit results remain positive and we have introduced specific campaigns to monitor and maintain hydration. MUST assessments improved towards target but the new processes in our Electronic Patient Record system (Cerner) require further time to embed.	✓
Effectiveness	Mortality / Medical Examiners	Green	All national mortality indicators are in line with statistical parameters. Learning from death reviews continue to find less than 1% of cases which were potentially avoidable. Additional reviews covering deaths in low risk categories have found no issues and we are now starting to undertaker reviews of deaths where patients have waited for long periods in A&E and increasing our reviews of deaths involving patient with Learning Disabilities.	No
	Paediatrics	Amber	We have strengthened paediatric specialist nursing in the Children's A&E area at DMH and sustained 24/7 Paediatrics Assessment co-located with A&E at UHND. We are increasing our ward-based staffing to sustain 1:4 nursing to patient ratios and working closely with mental health and local authority partners to provide effective, evidence-based care to children and young adults needing mental health care as well as care for their physical health.	✓
	Excellence Reporting	Green	We continue to see increasing levels of excellence reporting year on year and have forums to share learning from excellence.	No

Summary – other points

NHS
County Durham and Darlington
NHS Foundation Trust

- The continuation of the priorities into 2023/23 is to be expected as these are priorities in our quality strategy and were agreed in consultation with stakeholders, patients and staff.
- We now have a companion Patient Safety Strategy (presently in draft), focusing on Insight, Involvement and Improvement.
- We would propose to add one further quality priority for 2023/24, to the continuation of those overleaf being the year one implementation of the patient safety strategy
- Although not a local priority, A&E performance is required to be reported on in our Quality Account as a national target. The Trust has, for the last quarter, seen and treated / admitted around 70 to 73% of patients attending A&E within four hours. This is, generally, slightly above the national average and broadly in line with the region, albeit one or two per cent below on occasion. We have achieved significant reductions in patients waiting over 12 hours in the department and in patients waiting 12 hours or more for a bed, from a decision to admit, as well as in ambulance handover delays. The changes reflect some reduction in demand but also a range of process improvements. The next priority is to maintain and improve performance around the time to assessment and time to treatment indicators.

Falls

- The Falls Strategy has been revised.
- Falls per 1,000 bed days for 2022/23, compared to 2021/22 were:

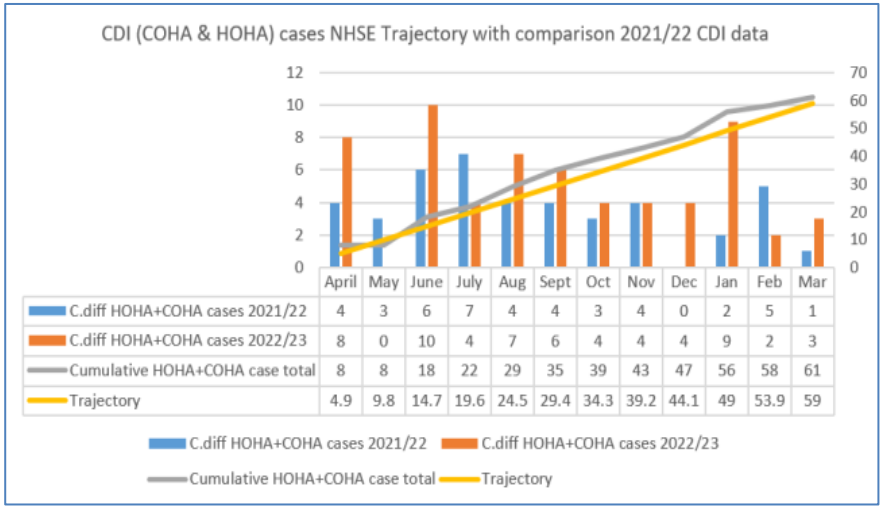
	2021/22	2022/23
Acute/ General	6.4	6.3
Community	5.9	6.8

- The national benchmark for General Hospitals from the last falls audit (five years ago) was 6.6 to 6.8 with a lower rate for community hospitals.
- Patient acuity and comorbidities are increasing. This is a factor in the trend in community hospitals along with demand pressures.
- The Falls Team completes Rapid Reviews of falls within five days
- Questionnaires have been built into the Incident Reporting system to allow all falls to be assessed for lapses in care and improvement targets set based on falls with lapses in care. Most falls reviewed could not be predicted /prevented
- Documentation on wards has been updated to the latest falls care bundle
- There is ongoing education from the Falls team to all wards and teams, face to face.
- The recently appointed Quality Improvement Senior Sister and Patient Safety Matron are focusing on falls as a first priority and supporting improvement projects on wards in acute and community settings.
- We would be happy to share examples of the QI projects with the Committee during questions.

Healthcare Acquired Infections / Pressure Ulcers

County Durham and Darlington NHS Foundation Trust

- There has been one MRSA bacteraemia infections reported in the year breaching our zero tolerance, albeit an ongoing year on year improvement. Investigation has found it to be potentially avoidable and learning is being promulgated.
- The Trust was had 61 C-Diff cases against our full year threshold of 59. This is a trend being seen nationally. All cases have been investigated and learning has been promulgated.
- All providers in the region, except Gateshead have reported MRSA cases and many have seen similar or greater increases in C-Diff cases in year.
- The Trust is above its internally set trajectory for MSSA infections but below national trajectories for Klebsiella, Pseudomonas and e-coli
- Monthly back to basics audits have been taking place to reinforce compliance with good infection control practice in all areas. These are being adapted to allow the IPC team to focus on supporting areas with challenges with most areas now covered every quarter.
- There has been only one Grade 4 pressure ulcer in the year to date (zero Grade 3 ulcers) where a lapse in care was identified. This occurred in the community, and the trust was not able to evidence from records that PU prevention measures were properly agreed and advised to the patient's carer.



Maternity Services

NHS
County Durham and Darlington
NHS Foundation Trust

Aims	Progress
Birth Rate + staffing review	This independent review is underway and expected to conclude by 30th June 2023.
To progress in rolling out Continuity of Carer	This objective has been superseded by the last Ockenden report and national 'pause' to ensure that developments recognise the overriding need for safe staffing. We have engaged extensively with our teams and evaluated safe staffing and agreed a 'hybrid' model under which well-established "Infinity" teams have been retained in some locations but traditional acute and community teams have been maintained in most others. Due to staffing constraints, we continue to monitor these arrangements.
Ockenden Action Plans	The Trust has evaluated the safety of its maternity staffing in line with the national requirement (see below) and has continued to implement the required actions, taking account of feedback from a review by the Local Maternity and Neonatal System. All aspects of the maternity service are reviewed at bi-monthly safety champions meetings and the Integrated Quality and Assurance Committee. There has been an Executive-supported Maternity Quality Improvement Framework in place which has seen real improvements in quality, safety, screening and use of IT systems.
Staffing – recruitment and retention	There is a branded recruitment programme underway, which is seeing some success ("Work with a Team that Delivers More") and we have also been successful in trialling international recruitment. In keeping with maternity services regionally and nationally, there remain staffing pressures, with some impact on morale and retention. These are kept under review with the Executive. Our Workforce Experience Team is supporting the service with wide and meaningful staff engagement and in providing wellbeing support. Daily action planning meetings are held to agree actions to maintain safe staffing for our maternity services taking account of demand and acuity.

Preventing harm from invasive procedures

NHS
County Durham and Darlington
NHS Foundation Trust

- No never events have occurred in the year.
- All Local Safety Standards for Invasive Procedures (LocSSIPs) have been reviewed and a single library of approved versions is in place on our intranet
- There is an overall policy in place for LocSSIPs and a monitoring process through our Clinical Standards and Therapeutics Committee and Integrated Quality and Assurance Committee.
- Audits of compliance have been undertaken, covering all LocSSIPs by 31st March 2023. Issues identified have been shared with the Medical Director and Care Group Directors to oversee improvement actions in the relevant clinical service teams. Most relate to ensuring full completion of certain fields and version control.
- One of our Digital Matrons is working with Clinical Leads to prioritise LocSSIPs to be built in our EPR system, with compliance to be driven by workflow functionality and mandatory fields.

Patient Deterioration

- We have increased class sizes for face to face training with respect to recognition and treatment of deterioration and gradually catching up after the pandemic.
- Our AKI and renal in-reach services have been subject to an interim evaluation, with clear benefits identified in terms of length of stay, improved specialist support to nursing staff and junior doctors, the patient experience, and adherence to NICE guidance and evidence-based standards. Further evidence is needed but the service is also expected to have contributed to improvements in mortality ratios and preventing unnecessary admissions to critical care.
- We have introduced an acute competency development pathway for registered nurses on our AMUs with further training in managing the deteriorating patient and to impart essential skills such as arterial blood gas interpretation, taking blood cultures and basic rhythm recognition.
- “Call for Concern” (see the poster) has also evaluated well, based on an initial review and we are committed to publicising the service more widely. There are examples where contact from relatives or friends has made a difference to the care of a patient and / or improved communication with the family
- Treatment Escalation Plans have been captured in our EPR system, as have pain scoring, risk assessment, care planning and staff alerts for patient deterioration. We are embedding the completion of patient risk assessments and response to alerts.

Care of Patients with Sepsis

Area	Progress
Accident and Emergency Services	Patient Group Directions (PGD) have been rolled out alongside a Nurse-led Pathway. These cover the 'Sepsis Six' and enable a senior nurse to give a first dose of antibiotics (IV Tazocin) whilst the patient is awaiting clinical review. Use of the PGD has, however, been limited because in most cases there appears to be an underlying origin known, which discounts using the PGD. Work is on-going with the Sepsis Lead Nurse/Clinical Teams to consider the options available to optimise antibiotic delivery in the Emergency Departments.
Maternity Services	The Early Detection Lead Nurse has been working closely with Maternity Services to review the current Sepsis tool which is now in line with NICE and UK Sepsis Trust recommendations.
Urgent Care and Community Services	The Sepsis Tool for Community Patients and Urgent Care Centres has been implemented across Urgent Care and Community teams at CDDFT. The tool is now live in Systmone, with an overall aim to prompt early identification and response to Sepsis. In addition to this the tool prompts the team to consider whether hospital admission could be avoided for those patients where escalation of care may not be appropriate.

Additional needs

Aims	Progress
Dementia	• Over 90% of staff have completed the required training in dementia awareness (over 95% for Tier 1) • Sensory training has been reintroduced since September 2022 and completed by 142 staff. • Enhanced care training has been completed by 112 staff. • We are reinvigorating recruitment of Dementia Champions on each ward, post pandemic and have signed up the Dementia Friendly Hospital Charter • Dementia assessments have been built into EPR.
Learning Disabilities (LD)	• There is a well-embedded pathway involving flagging of any patient (who consents to flagging) with a learning disability to the specialist LD nurses who then support risk assessment and agreement of reasonable adjustments. • Staff are encouraged to use the Hospital Passport and 'Coming Into Hospital' packs and contact details for the LD team are shared with carers. • Each patient staying more than five days is reassessed at Day 5 by an MDT team including the LD nurses • Patients are followed up after discharge, by telephone and in person if considered appropriate through our LD outreach service. • Further training in LD and Autism is being introduced for all our staff. Packages have been developed and are ready to deploy. • We have a specific friends and family test for LD patients and their families / carers in an easy read format
Patients with mental health needs as well as physical ill-health	• A Partnership Alliance and Operational Group are in place with TEWV and local authorities to plan services and agree joint are plans where appropriate • On site Psychiatric Liaison Teams are in place, in close proximity to our A&E Departments. • Joint work on good practice guides is taking place, with TEWV, to ensure relevant elements relating to an acute environment area are enacted.

Discharge

County Durham and Darlington NHS Foundation Trust

- We are updating our approach to include learning from all previous Work As One and 'Perfect Week' exercises, building on our Next Step Home approach.
- We work closely with local authority partners to support early discharge using trusted assessment and time to think beds
- We have seen positive feedback (4 of the Top 5 questions for the Trust in the 2021 CQC national inpatient survey, where we were above average concerned discharge)
- We have seen fewer Section 42 safeguarding concerns in recent months raised and there is thematic work undertaken between the Safeguarding teams and Discharge Facilitators / Coordinators to embed any learning arising
- We continue to work on facilitating discharge earlier in the day for patients

Top five scores for CDDFT:

Survey Section	Question	CDDFT Result (0-10)	Trust Average (0-10)
Leaving hospital	Q46: After leaving hospital, did you get enough support from health or social care services to you recover or manage your condition?	7.0	6.5
Leaving hospital	Q42: Before you left hospital, did you know what would happen next with your care?	7.2	6.8
Leaving hospital	Q37: Did hospital staff discuss with you whether you would need any additional equipment in your home, or any changes to your home, after leaving the hospital?	8.9	8.7
Leaving hospital	Q44: Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?	8.6	8.5

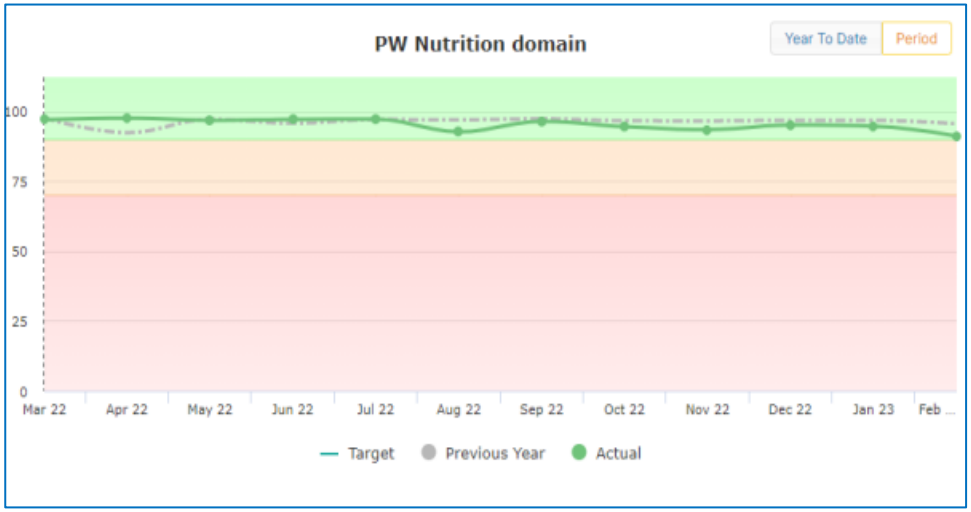
End of Life / Palliative Care

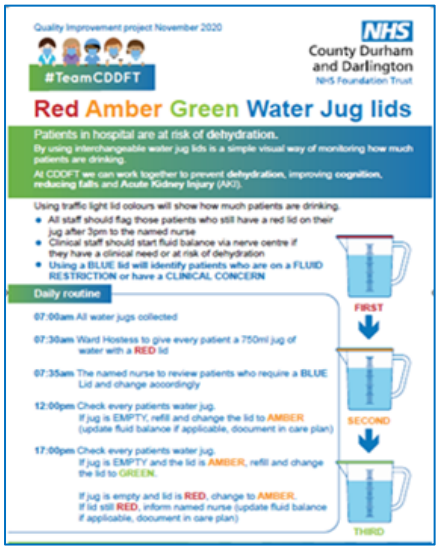
NHS
County Durham and Darlington
NHS Foundation Trust

Aims	Progress
Development of an end of life care strategy	There is a Draft End of Life Care Strategy in circulation for comment from a wide range of stakeholders. It sets out ambitions to: • Treat all patients as individuals • Provide each patient with fair access to care • Ensure maximum wellbeing and comfort • Ensure that care is coordinated • Ensure that all our staff are prepared and equipped to provide care those in their last stages of life
Access to side rooms	The constraints of the estate at UHND continue to result – at a time of high demand from respiratory and other infections – in some patients not being able to have the privacy and dignity of a side room at the end of their life. We make use of community hospitals where appropriate and are reviewing opportunities to increase side rooms across the Trust's estate, including incremental increases as we extend, or develop new, wards. Audits have shown that access to side rooms is more of a challenge at UHND. Education is provided to staff on ways to maintain the privacy and dignity of end of life care patients within the wider hospital footprint where side rooms are not available.

Nutrition and Hydration

- Compliance with nutrition measures covered by wards audits (the “PW Nutrition Domain”) remains high at over 90% and rated green
- Dietetics have supported the wards in maintaining and improving compliance with completion of MUST assessments within four hours of admission. The graph to the right covers all care groups. On our medical wards, compliance ranged from 88% to 96% between April and September, with most wards regularly scoring over 90%. There has been a dip since the implementation of Cerner as for all risk assessments with intensive education and training now being provided on wards to embed their use.





A range of quality improvement projects have been undertaken to support awareness of, and compliance with good hydration. Examples are noted to the left.

Mortality / Learning from Deaths

County Durham and Darlington NHS Foundation Trust

Measure / source of assurance	RAG
Summary Hospital Mortality Indicator (SHMI)	
Hospital Standardised Mortality Ratio (HSMR)	
Copeland's Risk Adjusted Barometer (CRAB)	
Completed mortality reviews	

HSMR measures, effectively in-hospital deaths

SHMI also includes deaths out of hospital within 30 days.

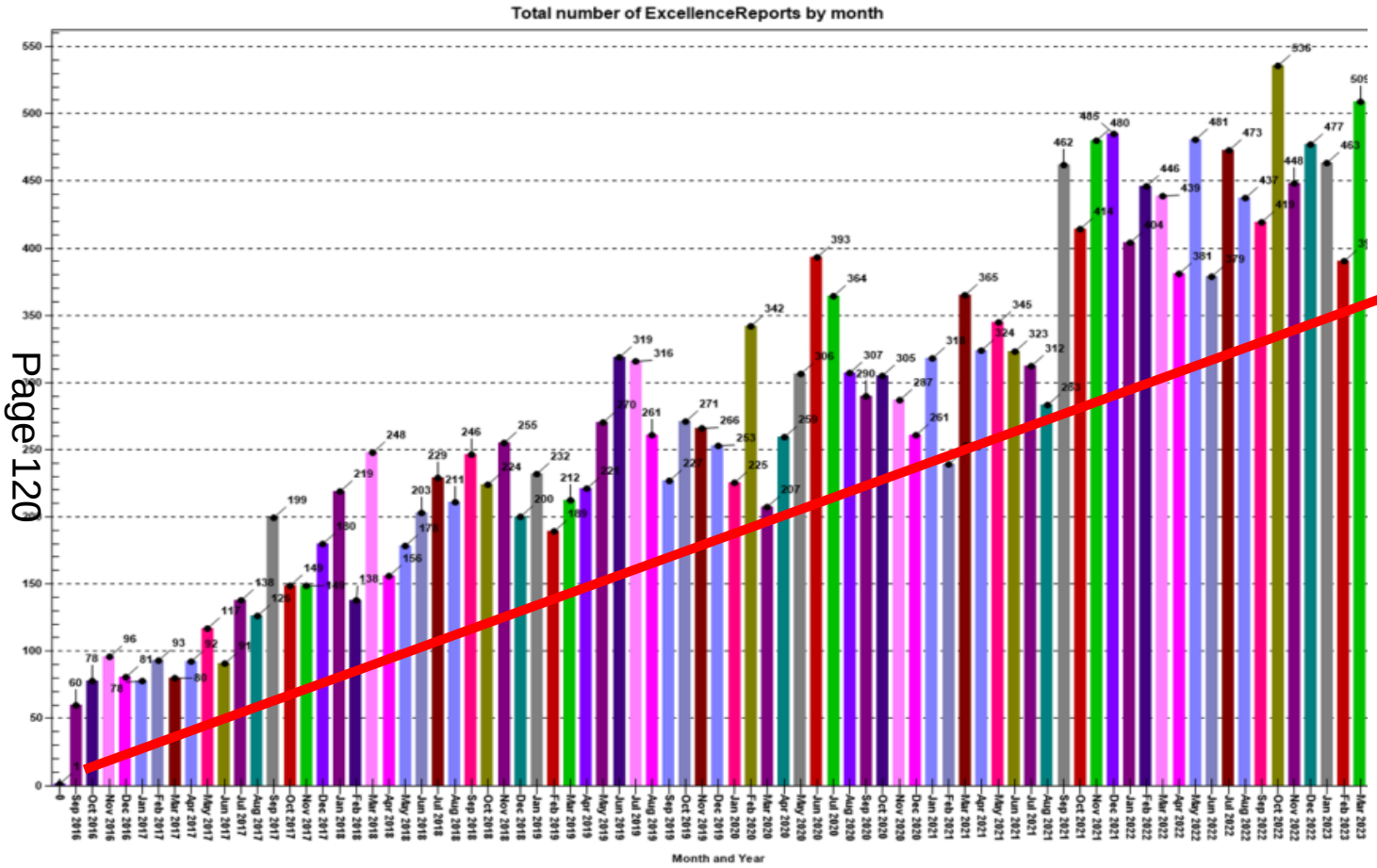
Comments

- All indicators are in line with expectations with less than one per cent of reviews completed for 2021/22 and 2022/23 pointing to any evidence that a death may have been preventable.
- SHMI remains within statistical parameters helped by our AKI service and Cerner includes functionality to increase the depth of coding resulting in more accurate data going forwards
- The Medical Examiner service is now fully staffed and fully embedded at DMH with UHND close to that stage. There is a good relationship with the Coroner already in place. Pilots are underway with respect to the community based medical examiner service and a business case will be brought forward to request further investment. The community element is dependent on the sign up of GPs to ME roles.

Paediatrics

- We have sustained 24/7 opening for the front of house Paediatric Assessment Area at Durham
- We have recruited additional specialist nursing staff in line with our aim to meet the RCPCH standards for the Paediatric A&E area at DMH.
- Further investments in specialist paediatric and neonatal staff have been agreed and are being recruited to
- We are also increasing our ward based staff to ensure a 1:4 nursing ratio given the acuity and needs of our patients e.g. respiratory viruses and mental health needs
- We have established a Partnership Alliance Group, and an operational group with TEWV and local authority partners to jointly plan and coordinate care for children and young people with mental health needs. The operational group looks after care planning and mitigation of risks
- We have reviewed our ligature risk assessments for paediatric wards with support from TEWV and are implementing actions arising.
- We are working with the support of the regional Paediatrics Network with respect to the changes we are making to our services

Excellence Reporting



The red line shows the positive year on year trend

The increasing numbers of reports are shared with staff through a bulletin and a number of “walls of awesomeness” in key locations around the Trust.

A&E waiting times

County Durham and Darlington NHS Foundation Trust

A&E performance is required to be reported on in our Quality Account as a national target. The Trust has, for the last quarter, seen and treated around 70 to 73% of patients attending A&E within four hours. This is, generally, slightly above the national average and broadly in line with the region, albeit one or two per cent below on occasion.

It is worth noting that the 2023/24 planning target is for Trusts to see and treat / admit at least 76% of patients in four hours by March 2024. We are assured that, given our starting position and with the developments planned for the coming year, such as expansion of Same Day Emergency Care at UHND, we can meet this expectation.

We have also achieved significant reductions in patients waiting over 12 hours in the department and in patients waiting 12 hours or more for a bed, from a decision to admit, as well as in ambulance handover delays. The changes reflect some reduction in demand but also a range of process improvements. The next priority is to maintain and improve performance around the time to assessment and time to treatment indicators.

The Trust was asked to present, regionally, on the improvements made in respect of ambulance handover times and 12 hour waits for beds.

Around 62% of patients were assessed within 15 minutes of arrival in the department, in February and March 2023.

A&E waiting times – actions and developments

County Durham and Darlington NHS Foundation Trust

- We have doubled the size of the ambulance handover bay at DMH, which now takes 8 patients compared to 4.
- We have fully established Ward 33 as an operational ward, increasing the resilience of our bed base, with further increases in capacity planned for early in 2023/24
- We have recruited paediatric specialist nurses to meet the Royal College of Paediatrics and Child Health recommendations for our A&E at DMH and staff will commence in post over this quarter
- We have fully embedded our Same Day Emergency Care service (as an alternative to A&E for suitable patients) at DMH and increased the number of patients using it.
- We have put additional staff (one Registered Nurse and one HCA) into the waiting rooms to monitor patients and have safety checklists and checklists to ensure patients get food and drink whilst waiting
- We have extended in-reach into the department from acute care physicians given patients can be waiting longer
- We continue to work proactively with, and are supported by, our local authorities to address challenges with access to beds in the community or domiciliary care.
- We have agreed, and are rolling out, additional investments in middle grade and junior doctors in our A&E Departments.
- We are working on investing in seven day services to ensure all patients receive a medical review every day. Implementation is expected to be incremental, however, given dependence on funding and the recruitment market this will take some time.

Any questions?

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Quality Account 2022/23

Part one

1.1 Welcome to the Quality Account and its purpose

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 achieving our quality goals.

It also looks forward to the year ahead and defines what our priorities for quality improvement will be and how we expect to achieve and monitor them.

The aims of the Quality Account

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

Who reads the Quality Account?

Lots of different people read the Quality Account. Some are people who we support through our services, their loved ones, colleagues, 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 improvement 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 the Quality Account

The structure of this Quality Account is in line with guidance 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 2022/23, our priorities for improvement in 2023/24 and the required statements of assurance from the Board
- **Part 3:** Further information on how we have performed in 2022/23 against our key quality metrics and national targets and the national quality agenda

1.2 Chief Executive's statement on quality

Welcome to our Quality Account 2022/23. It sets out the quality of our services highlighting our achievements and where we must continue to make progress.

High quality patient care is the core of what we do every day and goes hand in hand with our unrelenting focus on patient safety and clinical excellence.

Our priorities are clear:

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

You will read more about Our Quality Journey in this report and our commitment to a great experience for patients in our care and for patients and carers who want to work with us for better mental health in our region. Indeed, much of our focus now is working within communities, alongside our partners, to support people to get help early on and close to home – all part of the community mental health framework.

Nationally and regionally, organisational changes to the NHS mean we are closely linked with the two Integrated Care Boards that cover our patch. We'll continue to build these partnerships to benefit the health and wellbeing of people living in our areas.

While we are making progress, we continue to see unprecedented demand for services and recognise the impact that the pandemic continued to have last year on patients, carers and colleagues – a picture reflected nationally.

I must also acknowledge the publication of the independent reports into the tragic deaths of three young women in our care and the safety and quality of children and adolescent mental health inpatient provision at West Lane Hospital in Middlesbrough in 2019/20. They remind us we must remain fully committed to being a listening organisation and putting patient and carer experience at the heart of everything we do.

The reports make it clear that at the time of the tragedies there were shortfalls in care and leadership – both of which have changed significantly during the last three years. This includes our new governance structure, embracing patient and carer experience and using their insights to continually improve, as well as our unrelenting focus on patient safety – all underpinned by Our Journey to Change.

We welcomed the Care Quality Commission into our services with inspectors acknowledging that improvements are being made following inspections of our children and adolescent mental health community service and our secure inpatient services.

In October 2022 we acted quickly on concerns raised about our adult learning disability and autism wards to make the positive changes that were needed.

You will see in this report the awards that colleagues have won and been shortlisted for – it is testament to the hard work and commitment of individuals and teams who I am proud to work alongside. I witness people living our values of compassion, respect and responsibility every single day to deliver safe and kind care to those we support.

As we move into the new financial year, we will continue to put quality and safety above all else, working with patients and carers and our partners to support people in our region to live their best possible lives.

Brent Kilmurray
Chief Executive
30 June 2023

1.3 About our Trust

We are the mental health and learning disability NHS foundation trust for more than 2 million people living across County Durham and Darlington, Teesside, North Yorkshire, York and Selby. We provide a range of inpatient and community mental health, learning disability and eating disorders services.

We are also a catchment area for the largest concentration of armed forces personnel in the UK – Catterick Garrison – and our adult inpatient eating disorder services and adult secure (forensic) wards serve the whole of the North East and North Cumbria.

From education and prevention, to crisis and specialist care – our talented and compassionate teams work in partnership with patients, communities and partners to help the people of our region feel safe, understood, believed in and cared for.

We nurture the recovery journey of people in our care. Patients and carers have a say in how they are supported and treated because we know how important it is to listen and treat people as individuals. Our patients, their families and carers work together with us towards better mental health.

We also provide mental health care within prisons, and an immigration removal centre, located in the North East, Cumbria and parts of Lancashire.

Around 7,800 staff work across more than 90 sites, including Foss Park, a state of the art 72-bed hospital and research space in York which opened in 2020.

On 1 April 2022 our new leadership and governance structure came into effect with the creation of two Care Group Boards – one covering Durham, Tees Valley and Forensic services and one for North Yorkshire, York and Selby.

Our new organisational and governance structure:

- Simplifies governance processes – this gives nurses and other healthcare professionals more time to care, supports clinical teams to make decisions with the people they care for and makes it easier for everyone to understand their role and responsibilities.
- Strengthens reporting from teams through our two new care groups directly to our Trust Board.
- Embeds increased line of sight and oversight from ward to Board

We deliver care under six clinical directorates across our Care Group Boards:

- Adult mental health services
- Mental health services for older people
- Children and young people's mental health services
- Learning disabilities
- Health and justice
- Secure inpatient services

1.4 Our Journey to Change

Everything we do is guided by Our Journey to Change and our values. Our Journey to Change sets out where we want to be and how we'll get there. It includes our goals that we co-created with patients, carers, colleagues and partners:

- To co-create a great experience for our patients, carers and families.
- To co-create a great experience for our colleagues
- To be a great partner

"I've found that the staff members who I've worked with have been keen to hear our views and include us in decision making.

"I'm optimistic that TEWV's new way of co-creating services, which relies on developing trust, relationships and equalising power, can and will improve lives.

"It will take time and require much reflection but is an exciting journey to be on. Everyone needs to feel that their experiences are important and that they are valued."
Ros, carer

1.5 Co-creation

We're embracing patient and carer experience and using their insights to continually improve; working in close partnership with patients, families and carers to provide the best possible experience and outcomes. We also work in partnership with our partners and regulators to ensure we understand what good looks likes so we bring meaningful change to the care we provide.

We refer to this partnership-style of working as co-creation.

It is at the heart of Our Journey to Change and is fundamental to how we improve the care we provide to the communities we serve.

We want this to run through everything we do, so that it becomes the normal way of doing things from:

- Care plans written in partnership, where patients and families have choice about their care and make shared decisions with their clinician.
- A thriving and diverse involvement community that supports co-creation across all areas of our Trust from policy to research, recruitment to quality improvement.
- A growing and diverse peer workforce across all services, underpinned by peer values and driven by peer leadership.
- Innovative and diverse methods to really hear the experience of all patients and families and understand the relationship between patient experience, complaints and serious incidents.
- Lived experience leadership roles supporting transformation and culture change. By lived experience we mean people who have experience of mental illness as a patient or carer and who are using their experiences and insights to help others.

We are making progress. We recruited two lived experience directors into our leadership team in 2022 to make sure the patient voice is heard at the very highest level in the organisation.

A number of our trainers have experience of mental illness and are supporting staff to put themselves in the shoes of both patients and their families so that we show true empathy in the care we deliver.

We also employ peer support workers, who have lived experience of mental illness either themselves or as a carer.

"To me, being a peer is about being your authentic self; and that is enough. Having lived experience and using that experience to build meaningful relationships is making a difference to people's lives, to my own life too. The validation you stir up when someone knows you really get it is so rewarding and really helps to form mutual relationships with people which is the key to people feeling empowered. When someone is empowered – look out world!"
Rachel, peer worker

Examples of co-creation and lived experience in action

- CAMHS team in Northallerton are working on a newspaper with young people about mental wellbeing.
- The crisis team have co-produced information for young people who are accessing intensive home treatment.
- A Mental Health Older Peoples Service User and Carer Participation Group have been involved in many projects and service developments.
- Our Tees Valley Community Mental Health Transformation lived experience board members have guided the programme that is now working with partners to develop community hubs.
- We have worked with carers to develop a carers' hub – a one stop shop for people who have a loved one in our services, providing a range of support and information.
- The learning disability shadow quality assurance group in North Yorkshire continue to enhance governance in this area.
- Stockton Occupational Therapy Community Team have worked with patients and colleagues to design and grow the Ideal House allotment, transforming it into a calming green space.

1.6 Involvement member story

A veteran and one of our involvement members is using his skills to help develop our services and has also created paintings for patients and staff to enjoy.

Veteran Bob Etherton signed up to the army in 1959 and became a special operator in the Royal Corps of Signals as well as joining the regiment's band as a piper. Serving in Germany, Singapore, Borneo, Cyprus, Australia and the Falkland Islands, to name a few, he had many adventures and a rewarding and progressive career until his retirement in 1992.

When Bob spent time in our care, he was approached to become a Trust involvement member, and now works with us to help develop our services.

"I thought I'd give it a try," said Bob, "I knew it would be challenging, but I was able to draw on my army experience. I take part in workshops, focus groups, meetings, interview boards and much more that has all been positive experiences. My contributions are valued as are those of other service users and carers and working with the Trust has very much helped my recovery and personal development.

"I also found a talent for art, painting and drawing and it's something I find most therapeutic. I wanted to pay tribute to the wonderful life and 70 years of service of Queen Elizabeth II and create something that the patients and staff can enjoy."

Bob's paintings are on display at our mental health services for older people at Cross Lane Hospital in Scarborough and Foss Park Hospital in York.

1.7 The services we provide

We deliver care under six clinical directorates across our Care Group Boards:

- Adult mental health services
- Mental health services for older people
- Children and young people's mental health services
- Learning disabilities
- Health and justice
- Secure inpatient services

There is further detail about our Trust and the services we deliver in section 1.3.

1.8 Our CQC ratings

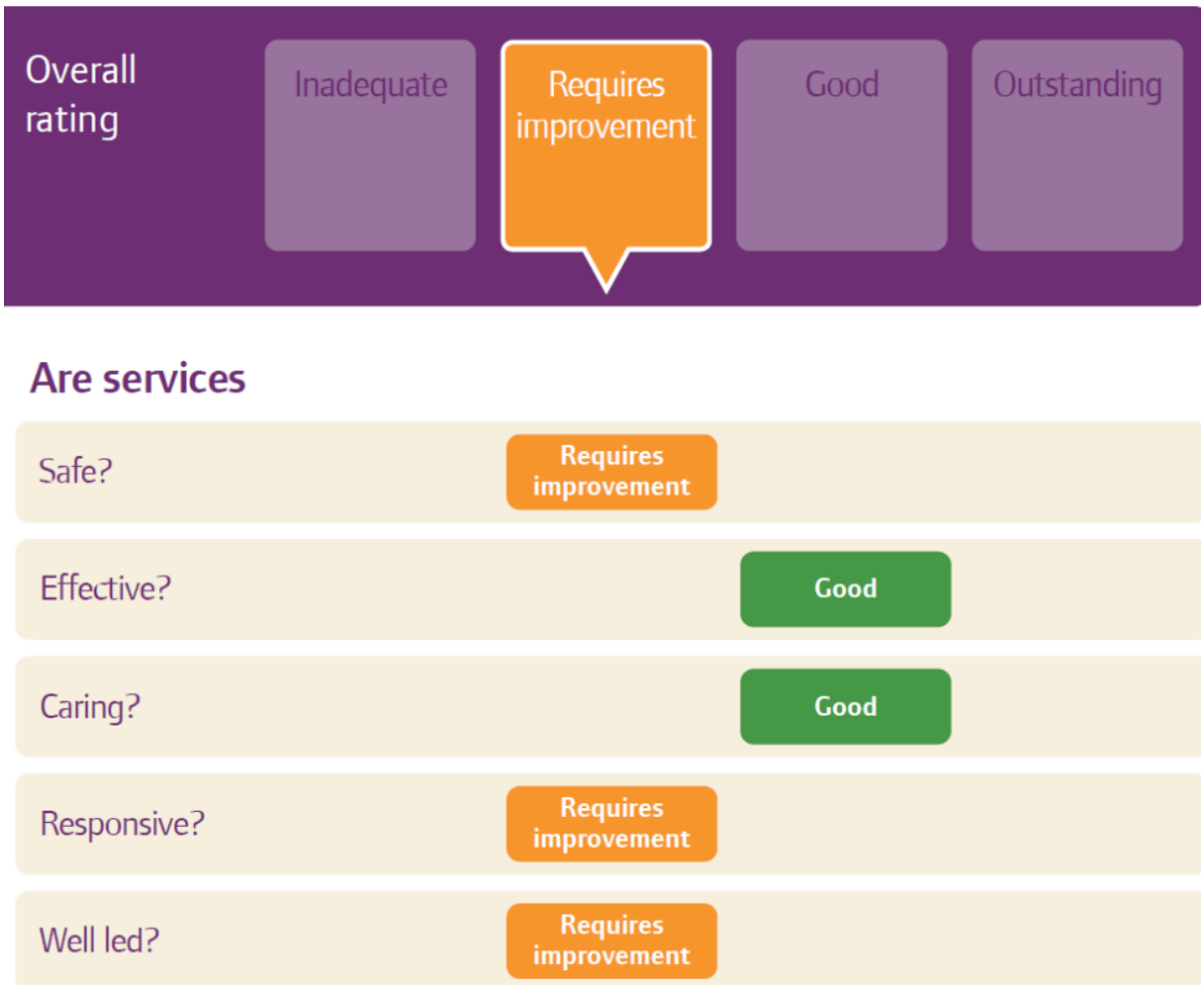
The CQC's current ratings for our Trust overall and for each key domain is as follows:

Overall rating: Requires improvement

For each key domain our Trust is rated:

- Safe: Requires improvement
- Effective: Good

- Caring: Good
- Responsive: Requires improvement
- Well-led: Requires improvement



Further information can be viewed within section 2.13, What the Care Quality Commission (CQC) says about us.

1.9 What we have achieved in 2022/23

We're making progress on our goals and working together to deliver a great experience for patients, carers and families, for colleagues and to be a great partner.

How we're co-creating a great experience for patients, carers and families

- £5m spent on making our wards safer since 2019, and almost £3m more planned in 2023.
- Waiting lists down by nearly 50% for children accessing mental health support.
- Carers Charter launched and being embedded in the Trust. It sets out our commitment to working with and supporting carers.

- Investing in our estates by opening a new community mental health hub in Northallerton and a new centre for young people in York.

- Installing innovative patient safety technology on some of our wards.

- Supporting members of the Armed Forces and showing our commitment to them by signing the Armed Forces Covenant.

- 46% more people helped to find work by our Individual Placement Service

- Putting patient experience at the heart of what we do.

- Peer support workers on our wards who are trained to use the knowledge and expertise that comes from their own lived experience of mental health services to support patients.

- Two lived experience directors bringing their own knowledge, understanding and compassion to the strategic leadership of our Trust.

"The team tried lots of different approaches and medications, and really listened to me."

"They were so helpful, so supportive, which helped me come out of myself a lot more."
James, patient, North Yorkshire

How we're co-creating a great experience for colleagues

- Recruiting 700 more staff since start of COVID in 2020.

- Introducing large scale recruitment events for healthcare assistants and nurses.

- We're on an international recruitment drive too.

- Streamlining our process making it quicker to recruit new people.

- Giving people a voice in our Trust by strengthening our staff networks.

- Investing in the health and wellbeing of our people.

- Introducing a staff awards and recognition scheme.

- Supporting teams to put patient experience at the heart of decision making.

"We have a really nice team. There is always somebody that you can check things with, that you can talk through issues with. It does feel like a big family really, where people look after each other and look out for each other."
Adele, Manager

How we're working with our partners

- More mental health nurses are working in GP surgeries across our region – supporting people to get the right help early on and close to home.

- 27 more schools are part of our mental health support programme helping young people and training teachers.

- Our innovative and world-class research team is part of a vital COVID-19 vaccine trial along with NHS partners and the University of York.

- Together with Hartlepool Borough Council we supported rough sleepers with their mental health.

- Our apprenticeship team has developed a strong partnership with Derwentside College to deliver a range of apprenticeship training to colleagues.

"They didn't need to take the partnership working approach they did but have chosen to. It's delivered a new and effective way of working."
Martin, Stockton Council

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

1.10 National awards – won and 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 table below.

Award body	Awarding status	Name / category of award	Team / individual
Health Watch Middlesbrough	Won	Leading Change Award	Tees Valley community mental health transformation lived experience members - Sophie Richardson, Michael Moorhouse and Sandra Bell
British Psychological Society's Division of Forensic Psychology	Won	Excellence in Forensic Psychology Practice Award	Alison Hodgson
Hull York Medical School Teaching Excellence	Shortlisted	Medicine Phase II and III Tutor of Excellence Award	Dr Meena Inasu, Dr Ioana Varvari and Dr Dan Whitney
Healthcare Financial Management Association (HFMA) - Northern Branch	Shortlisted	Accounting Technician of the Year	Emma Cruttenden and Laura Gittins
We Are NHS People	Won	NHS international HR Day	Michelle Lockwood

Hospitality Assured	Awarded	Covid Resilience Award - Premier Accreditation	Hotel services
British Institute of Learning disabilities (BILD)	Won	Positive Behavioural Support Coach of the Year	Steven Wilson
Nepacs' Ruth Cranfield Awards 2022	Won	Certificate of Excellence	Integrated Support Unit and PiPE team, HMP YOI Low Newton and TEWV
North of England Reserve Forces and Cadets Association	Awarded	Employer Recognition Scheme Silver Award 2022	Tees, Esk and Wear Valleys NHS Foundation Trust
Healthcare People Management Association	Shortlisted		Michelle Lockwood
LGBT Alliance	Awarded	Positive impact on LGBT Health	Roseberry Park
BBC Tees Making a Difference	Shortlisted	Together	Stephanie Addison
Northumbria in Bloom	Won	Best Grounds of a Hospital - Gold Award	Lanchester Road Hospital
Royal College of Nursing	Shortlisted	Commitment to Carers Award	Laura Blake
Positive Practise in Mental Health Awards	Won	Non-Clinical Team of the Year Mental health rehab and/or recovery Outstanding Leadership Forensic Mental Health Services (including Criminal Justice and Prisons)	Voluntary services team Recovery and outcomes support team Tom Hurst Cook healthy, eat, repeat ‘A recipe for a healthier lifestyle’
Positive Practise in Mental Health Awards	Highly commended	Complex Needs Mental Well-being of Workforce	Primrose Service - HMP & YOI Low Newton Employee support service

Royal Society for Public Health's prestigious Health and Wellbeing	Shortlisted	Arts and Health	York St John University - Converge
Nursing Times	Won	Nurse Leader of the Year	Judith-Marie Rose
Nursing Times	Shortlisted	Clinical Research Nursing	Nurses leading research
RC Psyche	Shortlisted	Psychiatric Team of the Year: Older-age adults	Mental health services for older people, inpatient organic service
Perinatal Quality Network (RC Psyche)	Awarded	Accreditation	Tees perinatal mental health team
Cavell Star	Won	Award	Suzanne Spence
Bright Ideas in Health Awards	Shortlisted	Cross-organisation Working to Deliver Research	Food Insecurity in Adults with Severe Mental Illness
Better Health at Work Awards	Awarded Awarded	Silver and Gold standard Bronze standard	Talking Changes IAPT service in Durham and Darlington Wellbeing team

Part 2: Quality priorities for 2022/23 and required statements of assurance from the Board

2.1 Introduction – purpose of this section

In part two of our Quality Account, we outline our planned quality improvement priorities for 2023/24 and provide a series of statements of assurance from the Board on mandated items, as outlined in the Detailed requirements for quality reports 2019/20 from NHSI.

In this section, we will also review the progress we have made in relation to the quality priorities we set ourselves in the 2022/23 Quality Account.

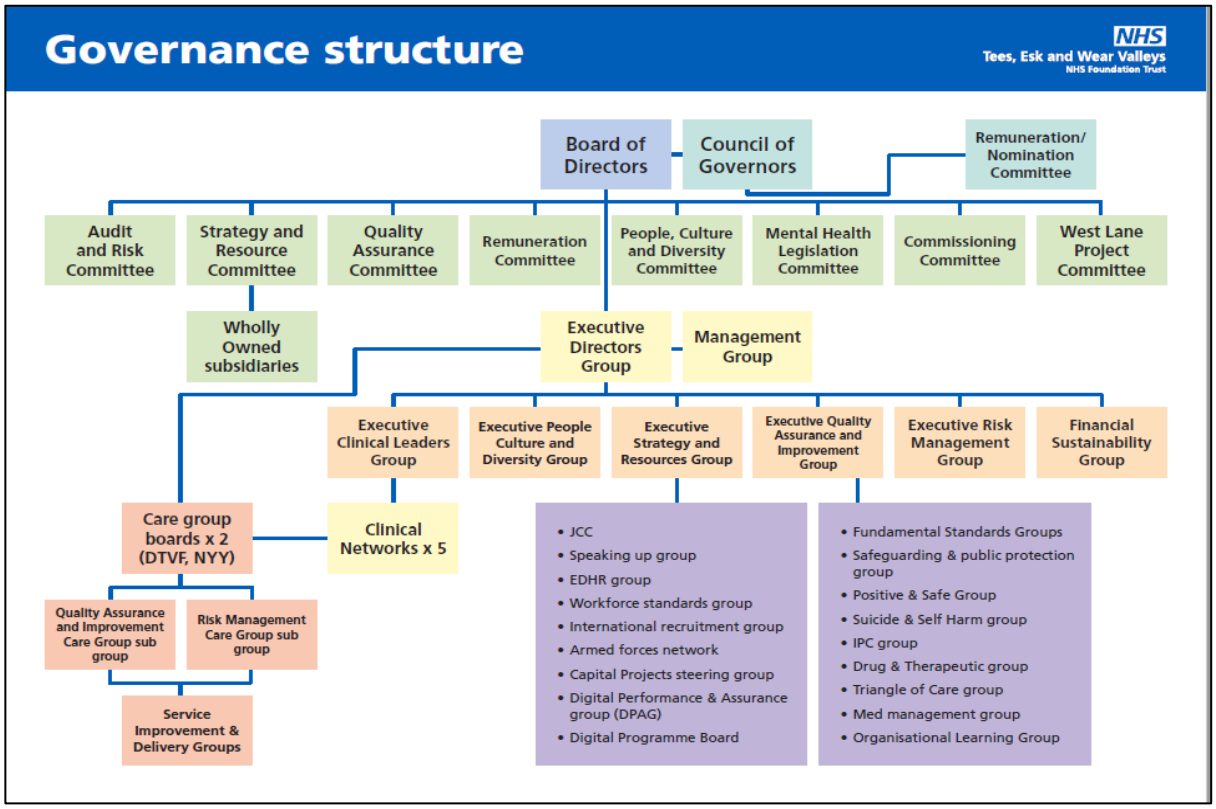
2.2 Our approach to quality governance and improvement

Our Trust has a robust governance infrastructure, with new arrangements put in place as part of the organisational restructure from 1 April 2022. The new governance structure is focused on enhanced oversight and accountability and is supported by the Trust's Accountability Framework.

Our new governance structure supports the delivery of Our Journey to Change by making sure we are:

- 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.

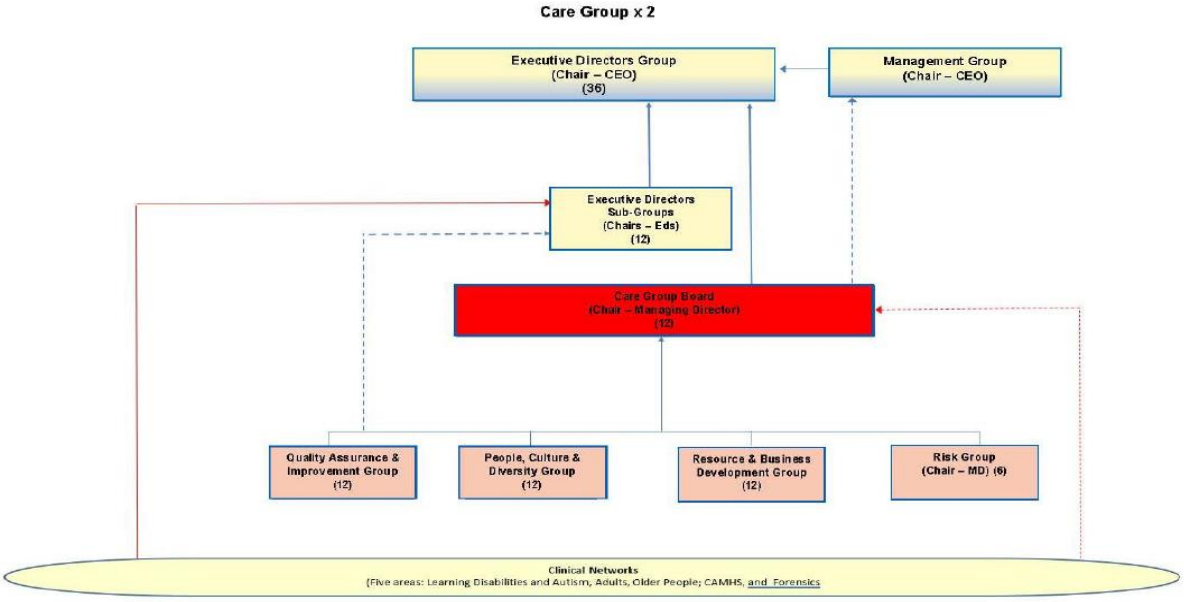
The new structures have been under review and evaluation to support us to provide safe, high quality, effective clinical services, and the best possible experience for people in our care, families and carers, our colleagues, and our partners. We continue to adapt and develop our governance process to achieve this aim. The structure in place during 2022/23 is shown in the figure below*.*



Our Trust Board ensures robust quality governance through the Quality Assurance Committee, a committee of the Board.

The Quality Assurance Committee is chaired by a non-executive director. Its strategic purpose is to provide assurance to the Board on the quality, safety and effectiveness of clinical and operational services through effective systems, structures and processes.

Each Care Group has quality governance arrangements to address the key elements of quality and safety. These are outlined in the figure below. Each Care Group reports directly to the Executive Quality Assurance and Improvement Group monthly, and to the Executive Directors Group weekly on quality performance issues that require executive oversight and/or escalation. Each Care Group is required to provide assurance to the Quality Committee against its quality improvement plans.



Quality Assurance and Improvement

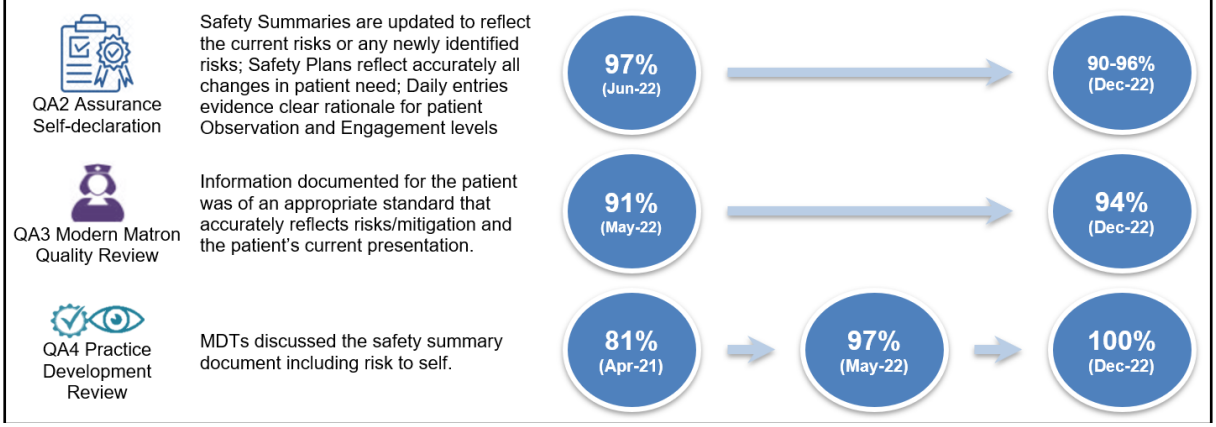
We have a well-established Quality Assurance and Improvement Programme which was first initiated in April 2021. This is focused partly on patient care documentation, recognising that high quality documentation is an enabler of high-quality patient care, as well as observation of practice and talking to teams in clinical areas.

The Programme comprises of a range of quality assurance tools that are used to gain a holistic assessment of the quality of patient care. These tools are subject to review to ensure they are informed by current areas of risks where further assurance is required.

- QA2: Assurance MDT self-declaration
- QA3: Modern matron quality review
- QA4: Practice development reviews
- QA5: Community Quality review
- QA6: Peer review
- QA7: MDT walkabout
- QA12: Directors visits

The Quality Assurance and Improvement Programme is an effective method of monitoring compliance against key standards of care related to patient safety, clinical effectiveness and patient experience. It has facilitated significant sustained practice improvements and provides the organisation with both quantitative and qualitative assurance evidence. Our Practice Development Practitioners continue to facilitate required practice improvements through supporting clinical staff via coaching, mentoring, education, and training.

Examples of Safety summary aspects indicating practice improvements from the QA programme – Quality Account



Key learning from incidents, patient surveys, complaints and other forms of intelligence helps to shape our Trust's quality improvement priorities and continues to be monitored using the Quality Assurance and Improvement Programme.

We have embedded an infrastructure and a range of approaches that support the delivery of high quality care and effective quality governance. Some examples are set out below:

- We have been using Quality Improvement (QI) since 2007 and, as a core element of Our Journey to Change, we will continue to use it in the future. Our QI approach gives people who access our services, who deliver our services and who partner with us to have a voice and to participate in QI activity to help make our Trust a great place to work and a great partner to work with, enabling people to live their best possible lives. Our dedicated Quality Improvement Team provides expertise and support across the Trust. To continue to build our capacity and capability QI training is provided at four different levels: foundation, intermediate, leader and expert.
- A wide range of staff training and development opportunities. We have implemented the National Patient Safety Syllabus at levels 1 and 2 as mandatory for all our staff.
- We have developed our training provision in relation to risk management and will be implementing a newly procured risk management system from July 2023 onwards. The system has a number of modules that provide digital solutions to incident reporting, risk registers, policies and procedures, complaints ad concerns, clinical audit and assurance and the CQC fundamental standards of care.
- Systems and structures that support organisation wide learning including rapid patient safety reviews, safety alerts, learning from serious incident bulletins and share and learn webinars.
- Working collaboratively with organisations on specific areas of practice and patient care e.g. sexual safety, implementing the HOPES model in adult learning disability services, suicide prevention and harm minimisation.

Co-creation is central to our overall approach. We work closely with patients, families and carers to identify and deliver our priorities. We are one of the first trusts nationally to create lived experience director roles for people with lived experience of mental illness and currently have two lived experience directors in post. These roles 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.

2.3 Our Progress on implementing our 2022/2023 quality improvement priorities

In this first section of Part 2, we look backwards at the progress we made in implementing our quality priorities during 2022/23 and the impact this had for patients and their families/carers. Following this, we set out our quality improvement priorities for 2023/24.

Priority 1 – Improving Care Planning

Why it is important:

In any health and social care organisation, care planning is a vital component of safe and effective patient care and treatment. In July 2021, NHS England published a formal statement advising all mental health trusts to move away from the Care Programme Approach (CPA) in favour of a community mental health framework. DIALOG+ as part of a wider piece of work, is the tool to enable the move away from CPA while providing a clear co-created, care plan for patients.

The DIALOG+ process approach allows healthcare professionals to have supportive and meaningful conversations with patients about the aspects of their lives that are most important to them such as family, relationships, leisure activities and accommodation, in addition to their mental and physical health. It uses a person centred and patient rated scale that measures patient reported outcomes as well as a measure of patient experience. The output of the DIALOG+ assessment will be a care plan that the patient and health professional create together that is specific, co-created and clear. The care plan will be digital easy to change and updated regularly as agreed with the service user.

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

- Personal circumstances, and what is most important to the person and those closest to them, are viewed as a priority when planning care and treatment.
- 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.
- Discussions that lead to shared decision-making and co-creation of meaningful care plans.
- Agreed plans recorded in a way that can be understood by the patients and everybody else that needs to have this information.
- Information about support from people who have experience of the same mental health needs.

What we said we would do and what we did:

Record all care plans on our new Cito electronic patient record (EPR) system
Due to unforeseen circumstances, we have not been able to go live with the Cito system as anticipated and this has prevented us from achieving this action. However, we are pleased to report that Cito will go live on 1 July 2023 which will enable us to meet our ambition of recording all patient care plans in this system from this point onwards.

Ensure all clinical staff are trained in our new DIALOG+ care planning system
This action was aimed at adequately preparing and training our staff in the use of the digital care planning tool DIALOG+. However, due to the delays in launching Cito, we have had to adapt our approach to preparation. We have introduced a paper-based version of DIALOG+ and have taken an incremental approach to its introduction. We have successfully

implemented this in adult mental health services and mental health services for older people supported by staff education and training. Roll out of the paper-based version is continuing and this will converge toward the one plan approach embedded within Cito. However, now that Cito online training has commenced, DIALOG+ training will start at the end of May 2023.

Publish new policies and procedures in relation to care planning and new ways of working (linked to Community Mental Health Framework)
This action is linked to system wide changes and is dependent on working with system wide partners to agree on the future approach. There have been several meetings with our senior leaders about how best to move away from the Care Planning Approach (for most services) and how this links to the wider community transformation of mental health services. Following an initial scoping meeting, a series of multiagency engagement events workshops are being held, the first took place in March 2023.

Introduce improvements to care planning in Secure Inpatient Services
Work started in October 2022 to move away from My Shared Pathway to goal based plans, in line with DIALOG+. A three-phase work programme was developed. Phase one focused on decluttering and organisation of current intervention plans, with a view of removing any duplication and also to assess if information would sit more suitably elsewhere such as within Safety Summary/Safety Plans.

A range of staff workshops have been held, led by the CPA lead and Practice Development Practitioners to facilitate this work. Good progress has been made. Currently approximately 75% of plans have transitioned to the new goal-based approach, with work continuing to complete the remainder. An assessment of the quality of care plans is being undertaken by the Practice Development Practitioner. Work will continue over the coming year to transition to the Cito based DIALOG+.

Update all patient and carer information resources about care planning
This has not yet been done but will be part of the work to move toward personalising care/advancing the CPA in our Trust that has started as this information should be co-created. Ideally this will be completed in conjunction with the autism project - at an event in 2022 it was agreed that if we made all information autism/neuro-divergent friendly then it would prevent the need to produce separate resources. It is worth noting that during 2022 getting inpatient services up and running with DIALOG+ and changing the approach to care planning in Secure Inpatient Services were the priority issues. In addition, the information available now is not wrong it just needs to be updated to be in line with system and culture changes.

Have data collection and monitoring systems in place to assess the impact of our clinical interventions on the goals set out in patient care plans
This work is directly linked to the Cito development, outcomes, and caseload management work that is ongoing. Cito has much improved data collection capabilities and has been designed so that care plan goals are at the front and centre of the system. DIALOG+ (badged as shared decisions in Cito) ensures that the process used to agree these goals is a personalised experience and that the goals are realistic and achievable. The measurement of the impact of the interventions against the goals will be via the DIALOG+ rating system, in conjunction with other outcome measures such as ReQoL-10 and GBO (or others for non adult mental health or mental health for older people services). All of this is against the backdrop of increasing communication and emphasis on the move toward a more interventionist approach that is expected as part of the wider community transformation and CPA position statement.

What was the outcome/impact:

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

Indicator	Target 2021/22	Actual 2021/22	Actual 2022/23
Patients know who to contact outside of office hours in times of crisis	84%	80%	78%
Patients were involved as much as they wanted to be in what treatments or therapies, they received	85%	85%	75%
Patients were involved as much as they wanted to be in terms of what care they received	85%	73%	73%
Percentage of patients who were involved as much as they wanted to be in the planning of their care	70%	75.53%	83%

Question	May 2022	March 2023
Inpatient		
Were you involved as much as you wanted in the planning of your care?	78%	74%
Were your family/carers involved in your care as much as you wanted?	81%	72%
Community		
Were you involved as much as you wanted in the planning of your care?	91%	92%
Were your family/carers involved in your care as much as you wanted?	84%	80%
Carer Survey		
Have you been asked to provide your experiences and history of the person you care for?	83%	84%
Do you feel that you are actively involved in decisions about the person you care for?	90%	88%

Priority 2 – feeling safe

Why it was important:
Patient safety continues to be our key priority. Our Quality Journey (the quality strategy) identifies a number of patient safety priorities that we will continue to focus on going forward.

Patients feeling safe on our inpatient wards is a key area for improvement for us. It is acknowledged nationally that some patients report not feeling safe while in the care of mental health services. A survey, undertaken in 2020 by the Parliamentary and Health Ombudsman, examined people's experiences of NHS mental health care in England, reporting that one in five patients reported feeling unsafe.

On a monthly basis patients on our wards are asked: do you feel safe on the ward?

The data from our survey is telling us that on average 56% of patients feel safe within our inpatient areas against a target of 75% which is frequently not met, however there is a lack of data nationally to allow any benchmarking comparisons to be made.

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

- Improved patient safety and reduction of patient harm.
- An increase in the percentage of our patients feeling safe when they are in an impatient setting.
- Increased collaboration between patients, staff, and peers.
- A reduction in incidents e.g. violence and aggression, absence without leave, drug misuse.
- Improved understanding of ward environments and why patients feel unsafe
- Increased opportunity to use digital technology to support the delivery of care

What we said we would do and what we did:

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

From the review undertaken we were able to identify the following themes:

- Environmental – missing bedroom keys, uncertainty around ward routine, doors banging, ward generally noisy, should feel homely.
- Staffing – patients value their relationships with staff, not enough staff around, staff are not always visible, lack of engagement from agency staff, staff don't feel safe due to low staffing, turnover of staff resulting in lack of consistent support, training of staff, lack of empathy, poor communication, staff sleeping whilst on duty, staff attitude.
- Ward based activities – should continue to be enhanced and there should be more productive use of courtyard areas.
- Patient safety – inadequate searches taking place on the ward, care planning, assessments not taking place in a timely manner, out of area admissions, medication reviews not being timely, sexual safety, assaults and patients being violent, dual diagnosis, timeliness of intervention and support, leave arrangements.
- Waiting times – for neurodevelopmental pathways, ADHD, ASD and autism assessments.
- Unsafe discharge – no care package in place, too early.
- Communication – patients not being able to get through to the team, calls not being returned, patients not being listened to, meeting the needs of the patient.
- Concerns being raised by MPs or via CQC rather than being reported directly to the Trust, repeated contacts from patients.

These themes have informed Our Quality Journey and further development of our Quality Assurance and Improvement Programme. In addition, the Patient and Carer Experience team (PaCE Team) have undertaken a series of focus groups between July 2022 and March 2023 across all inpatient wards. This was to understand what feeling safe means to our patients and staff and ask them what they feel would improve safety.

What did we ask patients and staff?

Patient questions

- What does feeling safe mean to you?
- During your stay on the ward have you felt safe?
- When you don't feel safe, what has caused this?
- What things help you when you don't feel safe?
- What does a safe day on the ward look like to you?
- When was the last time you felt safe?
- What was happening to make you feel like that?

Staff questions

- What does feeling safe mean to patients?
- During their stay on the ward have patients felt safe?
- When they don't feel safe what has caused this?
- What things help them when they don't feel safe?
- What does a safe day on the ward look like to you?

What patients said

- Peer support – talking to other patients on the ward.
- Staff support – getting reassurance from staff who listen and are adequately trained with the right skills and experience.
- Being able to easily identify staff members from patients.
- Being able to go to my bedroom when there are incidents on the ward.
- Accessing a place on the ward that is quiet.
- Listening to music, arts and crafts and access to the gym.
- Doing something productive, planting things looking after an allotment.
- PAT therapy animals on the ward.
- Doing activities, keeping myself occupied during the day.
- Being able to access leave, if I can't get out on my own having enough staff to escort me.

What staff said

- Access to patient alarms on the ward.
- Accessing one to one support and time with staff to offer them reassurance.
- Familiar faces and consistent staff on shift.
- Coping mechanisms and distraction techniques.
- Knowing the patients care plan, risks and offering debriefs when incidents happen.

Some of the things we have done in response to what our patients and staff have said:

Safe and visible staffing

- Introduced health care assistant and registered nurse councils to ensure that staff have a voice in our secure inpatient services.
- Introduced the SafeCare system (a nurse rostering system). This enables efficient allocation of staff and has inbuilt patient safety triggers to support patient safety.
- Improved the skill mix of staff on duty by investing in band 6 staff and recruiting advanced nurse practitioners and a positive and safe lead - this role focuses on adherence to best practice regarding restrictive interventions. There is also improved

clinical leadership through the introduction of practice development practitioners (PDPs) to support service improvement.
- Improved the continuity of care and safety on the wards by improving recruitment and retention within the service to provide consistent staffing.
- Invested in staff break areas to support wellbeing in the workplace.
- We are introducing an Agency Passport to improve competencies, training and induction of agency staff prior to them working on the wards.
- Supported block booking agency staff to ensure consistent staffing on the wards.
- Practice development practitioners are supporting improvements to the induction process for agency staff.

Patient leave
- Introduced a dedicated leave team to support patients to access leave.
- Patient access to leave is consistently discussed in the daily ward huddles

Patient activities
- An annual timetable of activities and health promotion activities has been produced and is offered across our secure impatient services.
- Recruited to a number of activity coordinators who work on our wards across a seven day week.
- Introduced pet therapy animals within some wards.
- Recruited gym instructors for both PICUs.
- Support from the arts at Foss Park Hospital and Cross Lane Hospital with projects, co-created with patients, that are creating a better environment.

Patient environment
- Improvements to Roseberry Park Hospital courtyard areas including decorating feature walls and installing new planters which are managed by activity coordinators on the wards.
- Allocated lifecycle funds to replace outside furniture.
- Improved the safety of the internal space by introducing heavy duty furniture onto wards. On some wards there is ongoing estates work to improve the ward environment with daily (ward managers) and weekly (matron) walkabouts to ensure issues are addressed.
- Installed anti-ligature doors within Tunstall ward.
- Continue to review the use of carpets in collaboration with the IPC team and acoustics have been considered as part of the Roseberry Park Hospital rectification works.
- A number of actions in place as part of the environmental ligature reduction work with regular reporting through estates and facilities management.

Each care group has developed a patient experience improvement plan that incorporates actions related to a range of patient feedback and includes those actions related to patients feeling safe on our wards. The plans are reported and monitored through the care group quality assurance meetings and reported for assurance to the Executive Quality Assurance and Improvement Group. This area of patient safety will continue as a priority over the coming year.

Increase the visibility of staff within adult inpatient areas

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Review of the ward clerk and administrative roles: The introduction of seven day a week administrative support to wards is supporting the provision of an increase in the clinical time available to clinical staff. The impact of these developments has increased the quality of care and patient safety within our Trust and also aims to improve staff wellbeing and retention.

Introduction of new roles: The introduction of peer support and activity workers on our wards increase engagement and improve meaningful and diversional activity on the wards.

Focus on reducing patient-on-patient violence through exploring further use of information technology solutions

A pilot of body worn cameras: Ten wards are testing the use of body worn cameras. The aim is to prevent violence on acute mental health wards by recording audio and video footage of interactions between staff and patients. This is based on evidence around the impact of their use on police and public behaviour. The aim of the initiative is to assess the impact on patient aggression.

As the pilot has progressed there has been a range of emerging challenges. These include IT issues and the need for additional training to further progress the pilot.

Wards and teams can then explore ways in which they can develop sustained local processes focused upon maintenance and reviewing footage. Although the prime expected benefit of this technology is a reduction in restraint, national studies have also suggested that incidents (which include patient-patient violence) should be reduced.

Oxevision: Oxevision is a tool that helps colleagues care for patients more safely and was developed in collaboration with patients. The system has been designed specifically for mental health care and includes a regulated medical device which operates with an infrared-sensitive camera. It helps staff visually confirm a patient is safe through measuring their pulse and breathing rate - without disturbing their sleep.

The evaluation of the Oxevision pilot has reported some positive outcome for patients to date as shown below. Our Trust has also supported a national review of the use of vision-based patient monitoring systems (VBPMS) in mental health wards and is disseminating the resulting guidance to relevant wards. Oxevision is being rolled out to further wards across our Trust following the success observed to date. This includes:

Improved safety on the wards

- Over 90% of staff reported Oxevision improves safety on the ward and helps them identify falls they may otherwise not have known about. 90% of staff reported the system enabled them to prevent potential incidents and 86% reported the system made it easier to monitor the physical health of patients.
- 83% of patients felt the system kept them safer and 88% felt that it allowed staff to respond to them more quickly.

Older adults (Rowan Lea ward)

- 16% relative reduction in falls in bedrooms when compared to the control ward
- 25 - 40% relative reduction in assaults across the bedroom and ward respectively when compared to the control ward.

Acute (Elm ward)

- 7% relative reduction in self-harm in bedrooms when compared to the control ward.
- Harmful self-harm in the bedroom had a relative reduction of 85% when compared to the control ward.
- Ligatures also had a relative decrease when compared to the control ward.

Psychiatric Intensive Care Units (Cedar ward)

- 25% reduction in self-harm in bedrooms compared to its baseline.

- 17% and 10% increase in assaults bedrooms and across the ward, respectively, compared to its baseline.

Improved patient experience

- 100% of patients felt the system reduced disturbance at night-time.
- 89% of patients felt that the system improved their wellbeing and 92% felt it enabled staff to care for them better.
- Patients felt the system helps them get better sleep (80%), gives them a greater sense of privacy (83%) and dignity (90%) and improved their relationship with staff (88%).

Positive impact on risk management and restrictive practice levels

- 90% staff reported that the system enables them to better manage patient risk.

Improved care quality

- 79% of staff reported that the system enables them to provide better care for patients.
- 72% of staff reported that the system provides them with more information to help make better care or clinical decisions.

Continue to implement the Safewards initiative (an evidence-based tool to reduce violence and support a safe ward environment)

Use of the Safewards model and its 10 core interventions remains a key part of our overall strategy for reducing restrictive interventions. Its implementation is documented within our policy for supporting behaviours that challenge and the annual Positive and Safe Report 22/23.

Each ward has identified champions for implementing the approach in their wards. Training on the Safewards model is included in our Restrain Reduction Network accredited courses and must be completed by all staff working across inpatient services.

All inpatient wards complete a Safewards self-assessment checklist each month. Compliance is shared and discussed via local Positive and Safe Groups each month.

Additional workshops for staff in champion or ward leadership roles are available each month for staff to focus upon specific ward implementation issues. We hold a Trustwide Safewards Sharing Practice Group every three months for ward staff to network and share good practice.

Wards can seek specific support regarding the Safewards model anytime through our Positive and Safe team.

What was the outcome / impact?

Indicator	Target	Actual 2021/22	Actual 2022/23
Percentage of inpatients who report feeling safe on our wards	75%	64.37%	56%
Percentage of inpatients who report that they were supported by staff to feel safe	66%	68.04	85%

Priority 3 - implementation of the new Patient Safety Incident Reporting Framework

Why it was important
The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

The PSIRF is a contractual requirement under the NHS Standard Contract and as such is mandatory for services provided under that contract, including acute, ambulance, mental health, and community healthcare providers. This includes maternity and all specialised services.

What we said we would do and what we did

- **Roll out the two-part incident approval process across all areas of our Trust. This involves operational staff taking responsibility for reviewing and approving incidents that have occurred within their service before submitting centrally.** Roll-out of this programme continues and 150 clinical areas have adopted the two-part approval of incidents. Significant training and staff support have been required to reach this point and we are closely monitoring progress with the approval of incidents. To facilitate this, daily reports are provided to services to enable them to have oversight of incident occurrence, stage of review and approval. Twice weekly sit rep meetings take place to enable strategic oversight and performance and weekly reports are provided to the Executive Directors Group.

- **Introduce a triage process for incidents that have been categorised as moderate and serious harm to quickly determine the appropriate route for review.** We have successfully implemented the incident triage process implemented

- **Develop the daily patient safety huddle to include service staff and subject matter experts so 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.** The Patient Safety Huddle is now embedded as routine practice and is operating effectively.

- **Improve our Serious Incident Review process so it is robust and uses evidence-based tools and involves families to the level of their satisfaction.** We have a continued focus on improving the quality of incident reporting, investigation, and identification of key learning. A strategic project manager, with additional support from the NHSE/I's System Improvement Team initially provided support for this workstream. Key improvements across the incident reporting and investigation pathway have been implemented incrementally and we continue to develop and embed these changes ensuring that they are compliant with the requirements of the National NHS Patient Safety Strategy and the PSIRF. This improvement workstream forms part of our key quality priorities within the Quality Journey and our Quality Strategy, with formal governance reporting routes in place. The Incident Reporting and Serious Incident Policy has also been fully reviewed and consulted upon. Further review of the policy is planned as PSIRF implementation progresses. PSIRF is to be fully implemented by 30 September 2023

- **Provide updates for staff on the duty of candour to ensure all have a full understanding.** As part of the improvement work related to learning from deaths, several training needs for staff Trustwide 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 Trustwide training needs analysis event.

An internal audit of the Duty of Candour Policy identified some areas for improvement. We have since reviewed the policy and updated it in line with current best practice to support staff understanding of the standards to be met. We have also held listening events to gain a better insight of staff understanding and application of the duty of candour. We will be using this to make improvement over 2023/24.

- **Improve the quality and oversight of action plans.** We continue to work on this improvement action. We have developed a standard action plan template for use across our Trust. However, the quality of some actions plans continue to be less than expected. We will continue to focus on this over the coming months.

- **Refresh the terms of reference for the Director Assurance Panels.** The Directors Assurance Panel terms of reference have now been revised and implemented. The function and performance of the review panel is under continual review to ensure continuous improvement.

2.4 Our Quality Journey

We focused on five areas to support Our Journey to Change. During 2022 we worked with patients, carers, partners and colleagues to create strategies – that we're calling journeys – to show what we will do and how each area will enable us to achieve Our Journey to Change.

The five journeys are:

- Clinical – how we will provide high quality, safe, kind, effective and personalised clinical care to the people we support
- Quality – how we will make our services safer and improve patient experience through evidence-based care
- Co-creation – how we will seek out and act upon the voices of the people we work with to improve care
- Infrastructure – how the places we work, such as our hospitals and offices, the equipment we use, the information we gather and the systems and processes we put in place will support excellent patient care
- People – how we will ensure everyone who works and volunteers with us has a great experience, whether they're permanent employees, people working as bank staff or through an agency, students or volunteers

The journeys set out specific ambitions and principles that support the mission, values and goals of Our Journey to Change and will drive both incremental and large-scale improvement initiatives. The journeys will be delivered through a series of programmes and workplans that make up our 2023/24 delivery plan.

The journeys create a strong framework and strategic vision that allow our Trust to prioritise key work. They will introduce rigour and support through a programme management approach and allow the Trust Board to receive assurance that we are making sufficient progress and achieving the outcomes and impact required.

Our Quality Journey sets out our quality ambitions for the next three to five years showing where we want our journey to take us. It sets out key principles and explains how our

objectives connect to the national NHS Patient Safety Strategy. It also outlines our key strategic quality objectives.

Our ambition is that by 2028, we will achieve the specific aims and measurable improvements set out in Our Quality Journey, through continuous learning and improvement using a range of tools and enablers. This Journey has been shaped by our other journeys; Clinical, Co-creation, People and Infrastructure.

We will continue to have an unrelenting focus on patient safety and are committed to:

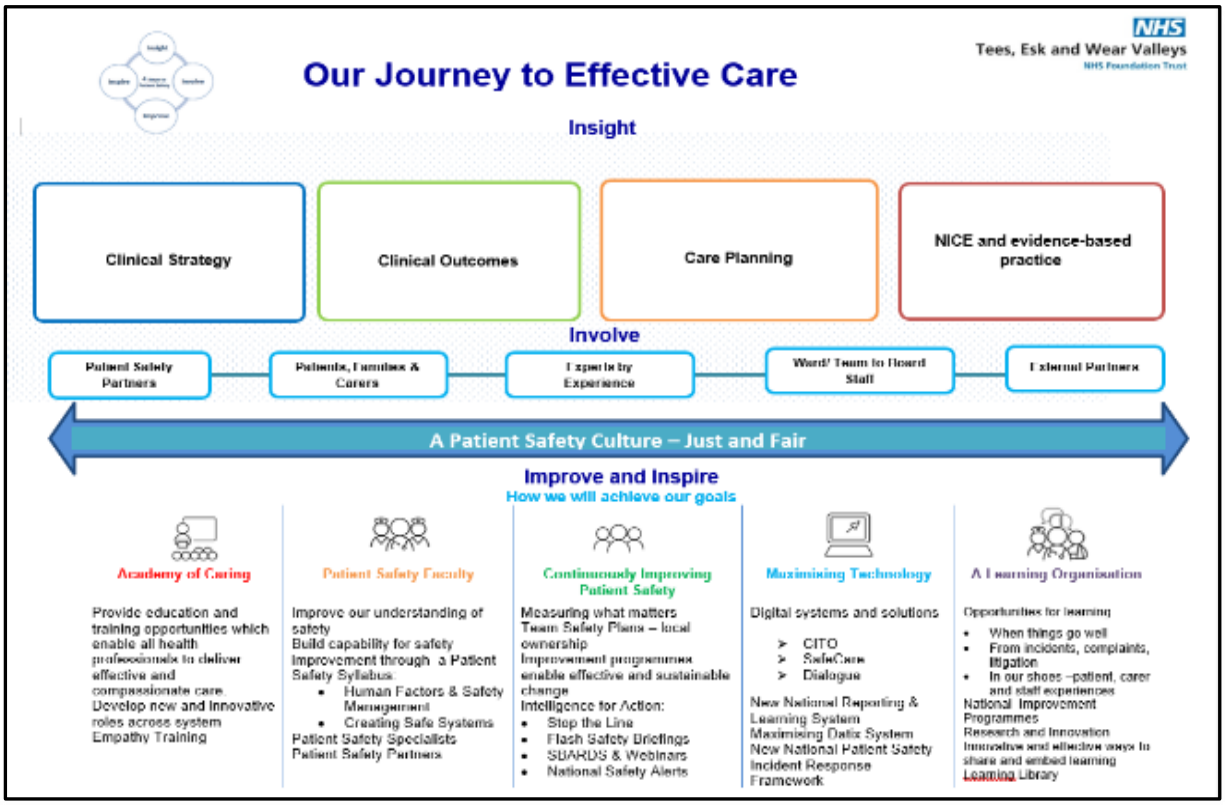
- Driving improvements in patient safety across our Trust, together with patients, carers and families, colleagues, and partners, and supported by a positive culture.
- Providing a great experience for patients in our care and for patients, carers and families who want to work with us for better mental health in our region.
- Providing safe and kind care that's based on evidence and has outcomes that matter to people

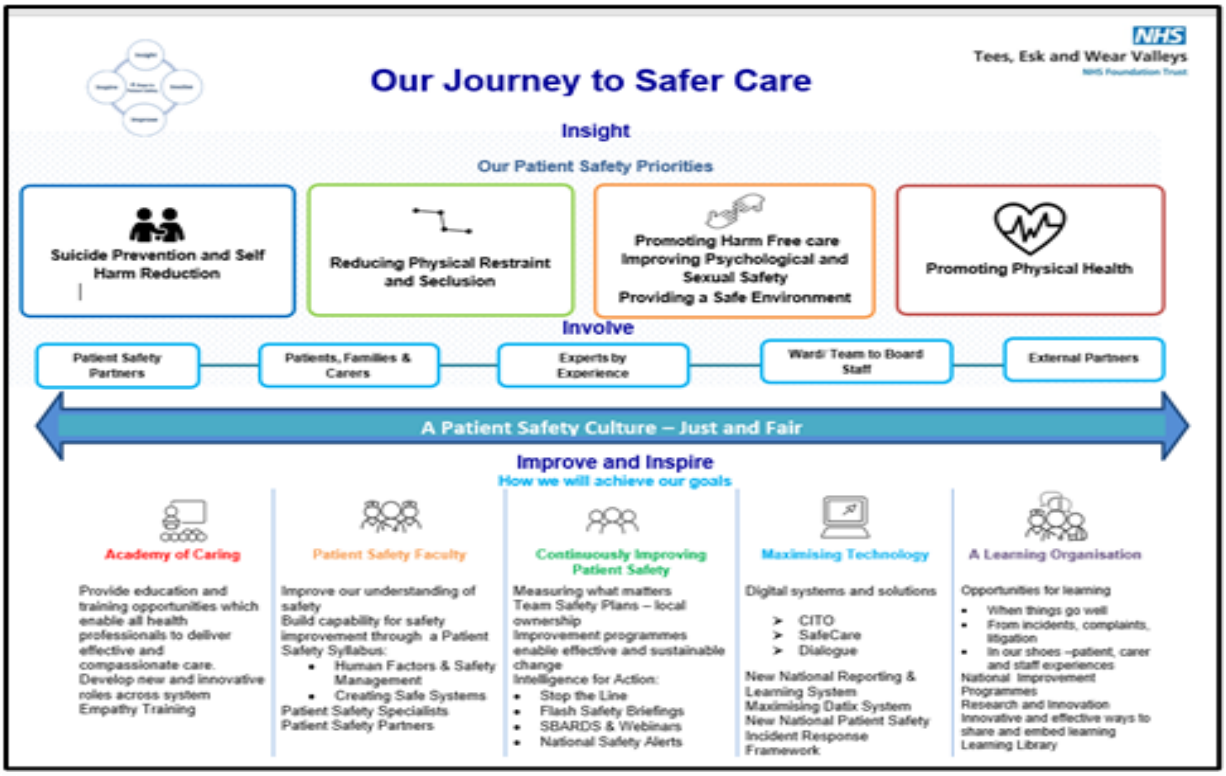
It is often important to make quick changes to tackle quality issues, and our governance system will promote a culture and processes where data is analysed holistically, and changes implemented swiftly. This means that not everything we need to improve will have a detailed, long-term plan around it.

However, there will be some potential changes which will require lengthy development and implementation periods. These will be governed as projects, grouped into programmes, and be backed by clear business cases which set out the benefits (improvements) that should be seen and when they should be expected to occur.

During 2023/24 the initial set of quality related programs will be:

- Personalised care planning, including implementing the DIALOG+ model. This is a shared ambition with the Co-creation Journey.
- Harm free care, including psychological safety, feeling safe on our wards, sexual safety, self-harm / suicide / misadventure reduction, safeguarding, environmental risk minimisation.
- Patient safety, including electronic risk management system procurement, patient safety incident reporting framework (PSIRF), rapid learning from serious incident investigations and sharing learning at every level.


Our Journey to Effective Care
NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust
Insight
Clinical Strategy
Clinical Outcomes
Care Planning
NICE and evidence-based practice
Involve
Patient Safety Partners
Patients, Families & Carers
Experts by Experience
Ward/ Team to Board Staff
External Partners
A Patient Safety Culture – Just and Fair
Improve and Inspire
How we will achieve our goals
Academy of Caring
Provide education and training opportunities which enable all health professionals to deliver effective and compassionate care
Develop new and innovative roles across system
Empathy Training
Patient Safety Faculty
Improve our understanding of safety
Build capability for safety Improvement through a Patient Safety Syllabus
Human Factors & Safety Management
Creating Safe Systems
Patient Safety Specialists
Patient Safety Partners
Continuously Improving Patient Safety
Measuring what matters
Team Safety Plans – local ownership
Improvement programmes enable effective and sustainable change
Intelligence for Action:
Stop the Line
Flash Safety Briefings
SBARDS & Webinars
National Safety Alerts
Maximising Technology
Digital systems and solutions
CITO
SafeCare
Dialogue
New National Reporting & Learning System
Maximising Datix System
New National Patient Safety Incident Response Framework
A Learning Organisation
Opportunities for learning
When things go well
From incidents, complaints, litigation
In our shoes –patient, carer and staff experiences
National Improvement Programmes
Research and Innovation
Innovative and effective ways to share and embed learning
Learning Library


Tees, Esk and Wear Valleys
Our Journey to Safer Care
Insight
Our Patient Safety Priorities
Suicide Prevention and Self Harm Reduction
Reducing Physical Restraint and Seclusion
Promoting Harm Free care
Improving Psychological and Sexual Safety
Providing a Safe Environment
Promoting Physical Health
Involve
Patient Safety Partners
Patients, Families & Carers
Experts by Experience
Ward/ Team to Board Staff
External Partners
A Patient Safety Culture – Just and Fair
Improve and Inspire
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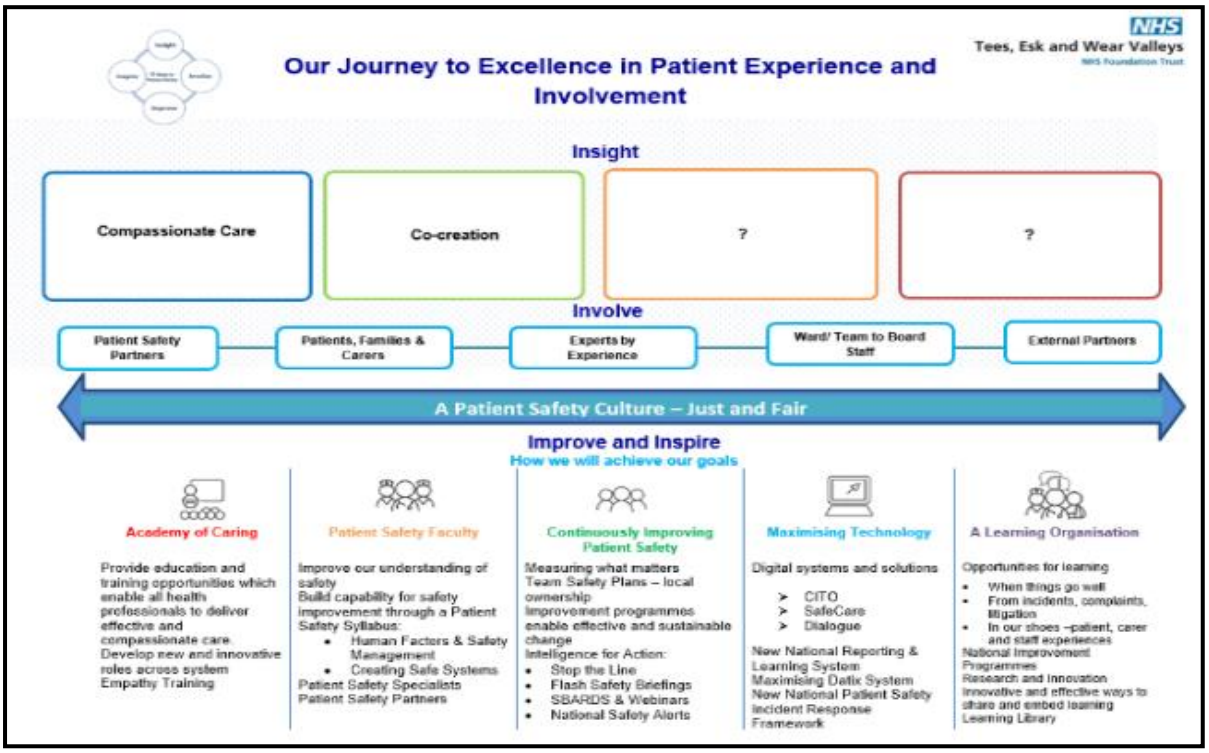
Tees, Esk and Wear Valleys
Our Journey to Excellence in Patient Experience and Involvement
Insight
Compassionate Care
Co-creation
?
?
Involve
Patient Safety Partners
Patients, Families & Carers
Experts by Experience
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2.5 Our priorities for 2023/24

Developing our priorities

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

We did not hold our traditional quality account stakeholder workshops in 2022/23, however considerable engagement has been undertaken during the creation of our journeys and particularly Our Quality Journey. This together with consideration of a range of patient safety and experience data and information, and the level of progress made against priorities in 2022/23, has given a strong sense of where we need to improve.

Priority 1 – 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.

By 31 March 2024 we will:

a) Ensure all clinical staff are trained in our new DIALOG+ care planning system.
b) Record all care plans on our new Cito patient record system using DIALOG+.
c) Have measurable goals in all patient care plans.
c) Publish new policies and procedures in relation to care planning and new ways of working (linked to Community Mental Health Framework).
e) Have data collection and monitoring systems in place to assess the impact of our clinical interventions on the goals set out in patient care plans.

How will we know we have made a difference / made an impact

Indicator	Target 2021/22	Actual 2021/22	Actual 2022/23
Patients know who to contact outside of office hours in times of crisis	84%	80%	78%
Patients were involved as much as they wanted to be in what treatments or therapies, they received	85%	85%	75%
Patients were involved as much as they wanted to be in terms of what care they received	85%	73%	73%
Percentage of patients who were involved as much as they wanted to be in the planning of their care	70%	75.53%	83%

Priority 2 – 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 xx

By 2023/24 Q4 we will:

a) Implement the range of actions identified from the Feeling Safe focus groups with patients and staff.
b) Continue to progress our body worn camera pilot work and evaluate its impact.
c) Continue to implement the Safewards initiative.

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	Actual 2022/23	Target for end 2023/24
Percentage of inpatients who report feeling safe on our wards	64.37%	56%	75%
Percentage of inpatients who report that they were supported by staff to feel safe	69.04%	85%	75%

Priority 3 – embed the new Patient Safety Incident Reporting Framework (PSIRF)
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 xx.

By 2023/24 Q4 we will:
a) Be compliant with the national requirements regarding PSIRF.
c) Increase the number of staff completing level 1 and 2 training within the national Patient Safety Syllabus training.
d) Introduce an annual patient safety summit.
e) Introduce the role of patent safety partners.
f) Complete the focused work we have initiated on the Duty of Candour through the delivery of an improvement plan

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 indicators:

- Full implementation of PSIRF.
- Compliance with level 1 and 2 national patient safety training.
- Delivered our Duty of Candour Improvement Plan.

2.6 Statement of assurances from the Trust

In this section of the Quality Account, the Trust is required to provide statements of assurance in relation to a number of key performance indicators which are as follows:

- Review of services provided by or contracted our Trust
- Our 2023 Community Mental Health Survey results
- Our 2023 National NHS Staff Survey results
- Clinical Audit: Participation in clinical audits and national confidential inquiries
- Clinical Research
- Use of the Commissioning for Quality and Innovation (CQUIN) Payment Framework
- What the Care Quality Commission (CQC) says about us
- Information governance
- Freedom to Speak Up
- Reducing gaps in rotas
- Learning from deaths
- PALS and complaints

- Data quality
- Mandatory quality indicators

2.7 Review of services provided by or contracted by our Trust

During 2022/23 our Trust provided and/or subcontracted 20 relevant health services. Our Trust reviewed all the data available to us on the quality of care in 20 of these relevant health services.

The income generated by the relevant health services reviewed in 2022/23 represents 100% of the total income generated from the provision of relevant health services by our Trust for 2022/23.

2.8 Our 2022 Community Mental Health Survey Results

There were 253 completed surveys returned within our Trust for the 2022 Community Mental Health Survey, a response rate of 20.69%. This is the same as the national response rate and compares with a rate of 20.9% in 2021.

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

Section	2022 score	Band
1: Health and Social Care workers	7.4	
2: Organising Care	8.2	
3: Planning care	7.0	
4: Reviewing care	7.5	
5: Crisis care	7.1	Somewhat better
6: Medicines	7.5	
7: NHS Talking Therapies	7.2	
8: Support and Wellbeing	5.2	
9: Feedback	2.2	
10: Overall view of care and services	7.2	
11: Overall experience	6.9	
12: Responsive care	7.9	

Our Trust did not score significantly better or worse than comparable Trusts for any of the individual questions or sections as a whole, however, we did score better and somewhat better than expected as set out below:

Better

- Has the purpose of your medicines ever been discussed with you?
- Have the possible side effects of your medicines ever been discussed with you?

Somewhat better

- Were you given enough time to discuss your needs and treatment?
- Would you know who to contact out of office hours within the NHS if you had a crisis? This should be a person or a team within NHS mental health services.

Our top five scores against the national average were for the following questions:

Top five questions	Score
Q13. Do you know how to contact this person if you have a concern about your care?	96.0%
Q6. Have you received your care and treatment in the way you agreed?	85.8%
Q38. Overall, in the last 12 months, did you feel that you were treated with respect and dignity by NHS mental health services?	83.6%
Q19. Did you feel that decisions were made together by you and the person you saw during this discussion?	83.2%
Q24. Has the purpose of your medicines ever been discussed with you?	82.7%

Our bottom five scores against the national average were for the following questions:

Bottom five questions	Score
Q39. Aside from in this questionnaire, in the last 12 months, have you been asked by NHS mental health services to give your views on the quality of your care?	21.9%
Q34. In the last 12 months, did NHS mental health services give you any help or advice with finding support for financial advice or benefits?	41.4%
Q35. In the last 12 months, did NHS mental health services give you any help or advice with finding support for finding or keeping work?	46.3%
Q33. In the last 12 months, did NHS mental health services support you with your physical health needs?	50.3%
Q3. In the last 12 months, do you feel you have seen NHS mental health services often enough for your needs?	60.1%

There are 13 areas where we are in the top 20% nationally and these are:

- Have you received your care and treatment in the way you agreed?
- Were you given enough time to discuss your needs and treatment?
- Did the person or people you saw understand how your mental health needs affect other areas of your life?
- Have you been told who is in charge of organising your care and services?
- Have you agreed with someone from NHS Mental Health Services what care you will receive?
- Did you feel that decisions were made together by you and the person you saw during this discussion?
- Do you know who to contact out of office hours if you have a crisis?
- Thinking about the last time you tried to contact this person or team, did you get the help needed?
- How do you feel about the length of time it took you to get through to this person or team?
- Has the purpose of your medicines ever been discussed with you
- Have the possible side effects of your medicines ever been discussed with you?

- In the last 12 months, did NHS Mental Health Services give you any help or advice with finding support for finding or keeping work?
- Have NHS Mental Health Services involved a member of your family or someone else close to you as much as you would like?

The areas where service user experience could improve are:

- Organising the care and services that individuals need
- Knowing who to contact when you have a concern about your care
- Receiving the help that they need
- NHS Talking Therapies explained in a way that is easily understood
- People are involved as much as you wanted to be in deciding what therapies to use

Full results of the survey for our Trust can be found at: https://nhssurveys.org/all-files/05-community-mental-health/05-benchmarks-reports/2022/

To take forward these results so we continue to improve our patient experience, we are:

Organising the care and services that individuals need.

- Included within the Service Improvement Plan for each Care Board

Ensuring patients know who to contact when they have a concern about their care.

- PALs and Complaints service is currently going through a whole service review. The team has introduced pop up clinics in hospital reception areas and are visiting wards to raise their profile and be more accessible.

Supporting people to receive the help that they need.

- An improvement event was held in June 2022 where the current Crisis line system and infrastructure were reviewed. This identified improvements that can be made.

Explaining NHS Talking Therapies in a way that is easily understood.

- Leaflets are available including easy read versions and translated into other languages.

Involving patients, as much as they want to be, in deciding what therapies to use.

- The IAPT team provide support in the way that feels best for the individual. For example, some people find guided self-help really suits them, others find counselling can help.

2.9 Our 2022 National NHS Staff Survey Results

All colleagues were invited to participate in the 2022 national NHS Staff Survey.

Guidance now states that colleagues have to be absent from work for at least 365 days before being considered as long term sick and not eligible for the survey. Previously this was 90 days. This meant that 304 people (3.5%) were unable to complete the survey.

The final response rate was 44% compared to 50% in 2021, 3330 participants in total.

We ranked 15th against the other 25 mental health trusts who commission Picker for the survey and first in overall positive score change.

Our overall staff engagement score remained seven out of 10.

The most improved results compared to 2021 are shown in the following table.

	2022	**2021**	**Increase**
Received appraisal in the past 12 months	84%	79%	5%
Feel organisation respects individual differences	74%	69%	5%
Organisation is committed to helping balance work and home life	51%	47%	4%
Feel supported to develop my potential	62%	57%	5%
Team members often meet to discuss the team's effectiveness	69%	65%	4%

The scores that declined the most between 2021 and 2022 are shown below.

	2022	**2021**	**Decrease**
Satisfied with level of pay	31%	38%	7%
Have adequate materials, supplies and equipment to do my work	62%	65%	3%
If friend/relative needed treatment would be happy with standard of care provided by organisation	51%	54%	3%
Don't work any additional unpaid hours per week for this organisation, over above contracted hours	40%	42%	2%
Organisation acts on concerns raised by patients/service users	74%	76%	2%

Areas where the Trust scored low compared to national average:

- If friend or relative needed treatment would be happy with standard of care
- Staff involved in a near miss or incident feel treated fairly
- Would recommend Trust as a place to work

Areas where the Trust scored better than the national average:

- Career progression

- Not experiencing musculoskeletal problems as a result of work
- Not experiencing discrimination from patients, carers and families

2.10 Clinical Audit: 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. For local audits, the Trust evaluates 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 2022/23, four national clinical audits and one national confidential enquiry covered NHS services that Tees, Esk and Wear Valleys NHS Foundation Trust provides.

- During that period, Tees, Esk and Wear Valleys NHS Foundation Trust participated in 100% of national clinical audits and 100% of the national confidential enquiries which it was eligible to participate in.

- The national clinical audits and national confidential enquiries that Tees, Esk and Wear Valleys NHS Foundation Trust was eligible to participate in during 2022/23 are as follows:

    - National Audit of Inpatient Falls (NAIF) – continuous audit
    - National Clinical Audit of Psychosis (NCAP) EIP Re-audit
    - POMH Topic 21a: The use of Melatonin
    - POMH Topic 20b: Valproate Prescribing in Adult Mental Health Services
    - National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)

- The national clinical audits and national confidential enquires that Tees, Esk and Wear Valleys NHS Foundation Trust participated in, and for which data collection was completed during 2022/23, are listed 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.

Audit Title	Cases Submitted	% of number of registered cases required
National Audit of Inpatient Falls (NAIF) – Continuous audit	3	100%
National Clinical Audit of Psychosis (NCAP) EIP re-audit	507 (and a further 7 contextual team level questionnaires)	100%
POMH Topic 21a: The use of Melatonin	Sample provided: 242	100%
POMH Topic 20b: Valproate Prescribing in Adult Mental Health Services	Sample provided: 197	100%
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)	69 questionnaires sent to the Trust with 46 returned	67%

- The reports of six national clinical audits were reviewed by the provider in 2022/23 and Tees, Esk and Wear Valleys NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

  - Existing procedures in relation to alcohol detoxification were re-circulated to all staff with a copy of the clinical audit report and the findings shared.
  - Our Deputy Chief Pharmacist and Cito Clinical Locality Lead collaborated to develop effective guidance and prompts which will be included as part of the Cito developments before this is launched.
  - As part of the depression medication pathway review, a checklist was added for annual reviews which cover assessment of medication adherence, side-effects (with example rating scales), alcohol and substance use and co-morbidities.
  - Barriers to performance in relation to the NCAP standards were explored and actioned within our EIP Steering Group. This included an identified plan and timeline for delivery of At Risk Mental State (ARMS) provision within the North Yorkshire, York and Selby Care Group.
  - A review was undertaken of the shared pathway between EIP and CAMHS.
  - The process and recording flowchart were disseminated to all teams via the adult mental health clinical network.
  - Key physical health Key Performance Indicators (KPIs) have been developed, led by our Physical Health Group, which facilitates the recommendations highlighted from the NCEPOD Physical Healthcare in Mental Health inpatient settings audit.

- The reports of 129 local clinical audits were reviewed by the provider in 2022/23 and Tees, Esk and Wear Valleys NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

  - Indication was added as a necessary field for antibiotics on the Electronic Prescribing and Medicines Administration (EPMA) system which is being piloted during 2023. Options were explored including using protocols for antibiotic regimens, mandating stop/review dates and having links to guidelines within the new prescribing system.
  - Training was provided for delivering Performance Development Reviews (PDR) to mental health team managers and assistant team managers and facilitated sessions included the appraisal process and how to identify measurable outcomes included throughout supervision sessions with staff.

- Briefings were shared (developed with the Practice Development Practitioner Group) including key areas requiring improvement highlighted from the NEWS2 clinical audit report.
- Amendments were made to the Quality Assurance and Improvement Programme QA tools following recommendations highlighted from clinical audit findings to facilitate regular monitoring and oversight.
- Educational videos were shared in relation to diabetes management.
- Assurance was gathered that mattress checklists were in place across the Trust and following the clinical audit, the Trust Infection Prevention and Control (IPC) Team developed and shared an educational video to demonstrate the correct full mattress checking process required.
- A clinical audit summary briefing was developed by the Safeguarding and Public Protection Team illustrating key findings from the Safeguarding Children's Policy audit. This was shared with teams and the Care Group Fundamental Standards Groups as well as being published within our Trust's weekly bulletin.
- Amendments were identified following clinical audit results in relation to our Trust's emergency equipment annual audit. This included the requirement that locations have clear signage to the emergency response bag/AED and oxygen, updates made in relation to items within three month of expiry requiring replacement, updates made to the checklists used for teams and explicit guidance as to which spare oxygen should be available for areas.
- The reporting of staff allegations, Making Safeguarding Personal (MSP), record keeping, and safeguarding supervision have been incorporated into the Safeguarding Level 3 Training for staff following the clinical audit results.
- All Infection Prevention and Control audits are continuously monitored by the IPC Team and any required actions are rectified collaboratively by the IPC Team and ward staff. Assurance of implementation of actions is monitored by the Clinical Audit and Effectiveness Team via the clinical audit action monitoring database. A total of 110 IPC clinical audits were conducted during 2022/23 across inpatient areas, prison teams, and applicable community teams where there are clinic facilities. 71% (78/110) of clinical areas achieved standards between 90-100% compliance. Local clinical audit action plans were implemented in collaboration with the IPC Team and the clinical team members to mitigate any areas of non-compliance.

In addition to those local clinical audits reviewed (i.e., those that were reviewed by our Quality Assurance Committee and Quality Assurance and Improvement Group), we undertook a further 52 clinical audits in 2022/23 including clinical effectiveness projects by trainee doctors, consultants and other professionals, in addition to those by directorates/specialty groups. These clinical audits were led by the services and individual members of staff to support service improvement and professional development and were reviewed by specialties.

Over the next year, our Trust intends to use an electronic clinical audit application to make clinical audits more efficient and 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 the experience of our patients and their families.

We continued to implement an extensive Quality Assurance and Improvement Programme during 2022/23. This provides ongoing assurance that key quality and risk issues identified are addressed. Significant improvements in practice and patient safety have been facilitated through this programme.

2.11 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 our Trust in 2022/2023 that were recruited during that period to participate in research approved by a Research Ethics Committee was 975. Of the 975 participants, 827 were recruited to 36 National Institute for Health Research (NIHR) portfolio studies. This compares with 806 patients involved as participants in 27 NIHR research studies during 2021/22.

As well as acting as a research site and participant identification centre, our Trust sponsors research including three major NIHR grant-funded multi-centre studies (COMBAT, MODS WP3&4 and CASCADE). As part of this role our research and development team are actively engaged in governance activities such as site set-up and performance tracking. As sponsor, during 2022/2023, our Trust oversaw the completion of the BASIL pilot study which showed the acceptability of behavioural activation intervention amongst older adults (https://bmjopen.bmj.com/content/13/3/e064694).

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 East 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.
- 23 different staff members took on the role of Principal Investigator for NIHR supported 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 grants this year.

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

A proportion of our Trust's income in 2022/23 was conditional on achieving quality improvement and innovation goals agreed between Tees, Esk and Wear Valleys NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2022/23 and for the following 12 month period are available on request from Ashleigh Lyons, Head of Performance, email Ashleigh.lyons@nhs.net.

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

The 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 Valleys 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 took enforcement action against Tees, Esk and Wear Valleys NHS Foundation Trust during 2022/23. We have not participated in a special review/investigation by the CQC during the reporting period.

We are subject to periodic reviews by the CQC and a number of reviews have taken place this year. A comprehensive inspection of adult inpatient learning disability wards took place between 29 May to June 22.

A further focused inspection of community child and adolescent mental health services and secure inpatient services took place in July 2022. This considered review of the actions and improvements taken by these services in response to the Section 29a notification issued in August 2021.

The CQC's assessment of our Trust following these reviews remained requires Improvement. Changes to the core service areas inspected did however change, and the overall rating for adult inpatient learning disability wards moved from good to inadequate.

The outcome of the community child and adolescent mental health services inspection remained as requires improvement, with the safe domain improving from inadequate to requires improvement.

The outcome of the secure inpatient service inspection improved overall ratings, increasing from inadequate to requires improvement.

Inspections of the adult inpatient learning disability wards demonstrated that people's care and support was provided in a clean, well-equipped, well-furnished and well-maintained environment which mostly met people's sensory and physical needs. Some people made choices and took part in activities which were part of their planned care and staff supported them to achieve their goals.

However, some issues with care delivery were noted. The service did not meet all of the principles of Right Support, Right Care, Right Culture. Inspections of the service observed some issues with staffing levels, training, restrictive practices and safeguarding processes. Some people experienced delayed discharges due to there not being sufficient appropriate community provision.

Inspections of community child and adolescent mental health services were undertaken by the CQC to see if improvements had been made following the section 29a notification issued in June 2021. The CQC found that the senior management team had responded promptly to address issues identified at the previous inspection. Inspections demonstrated that the service was achieving its targets of maintaining contact with children and young people on waiting lists. It also observed that premises were clean, well maintained and well furnished.

Some issues were noted regarding a high number of vacancies and high caseloads in some teams. Improvements were also required in completion of mandatory training for some staff.

Inspections of the secure inpatient service were undertaken by the CQC to see if improvements had been made following the CQC section 29a notification issued in June 2021. The CQC found that the culture within the service had improved since the previous inspection, staff felt more supported by managers and there were mechanisms in place to

allow staff to escalate any staffing concerns. Staff actively involved patients, families and carers in care decisions and staff supported patients well to live healthier lives. The ward teams had access to a range of specialists required to meet the needs of patients and staff worked well together as a multi-disciplinary team.

Some issues were noted regarding staffing, safeguarding and restrictive practices and improvements were required in facilitating holistic activities for patients.

Tees, Esk and Wear Valleys NHS Foundation Trust intends to take the following action to address the points made in the CQC's assessment: Immediate action was taken in response to the inspection findings and a comprehensive action plan was developed to ensure that areas of risk were being adequately addressed. Implementation of the action plan has been well progressed with routine reporting and oversight through the Trust's Quality Improvement Board.

Tees, Esk and Wear Valleys NHS Foundation Trust has made the following progress by 31 March 2023 in taking such action: 68 of 74 actions (92%) must do actions within the action plan have now been completed. The remaining six actions were on track with little risk to delivery.

Actions have included:

- Implemented a programme that will increase the knowledge and skills of staff in relation to patient safety, improve incident reporting and enable learning from patient safety incidents.
- Undertaken a caseload deep dive in community child and adolescent mental health services to improve caseload management and reduce team's overall caseload size and to allow for more timely appointments.
- Developed Keeping In Touch processes for patients waiting for community child and adolescent mental health services.
- Improved recruitment to vacant posts.
- Implemented recruitment and retention programmes to attract new staff.
- Undertaken a staffing establishment review.
- Undertaken a review of the clinical model in adult learning disability services.
- Improving the staffing skill mix in adult learning disability wards.
- Increased leadership capacity and visibility.
- Improved staffing escalation processes in secure inpatient services and adult learning disability services.
- Developed and implemented adult learning disability specific post incident rapid review guidance to support rapid reflection and learning.
- Implemented Reducing Restrictive Practice Assurance Panels.
- Improving mandatory and statutory training compliance.
- Embedding the new governance structure.
- Implemented the revised Board Assurance Framework.
- Developed systems for learning from incidents and complaints.
- Developed and enhanced the Trust's corporate risk register.
- Review of the Safeguarding Policy.
- Reviewing the Speak Up and Whistle Blowing Policy.

In addition to clearly evidencing delivery of the required actions, we continue to implement a wider programme of change and improvement. During 2022/23 this has included, strengthening governance arrangements, increasing leadership visibility and oversight, improving staffing establishments and improving mandatory training and the quality of clinical supervision. Work has also been achieved to enhance organisational learning from a

range of internal and external sources. This has included strengthening and further developing mechanisms for capturing and communicating learning. In addition, significant progress has been made in implementing learning from the Quality Assurance and Improvement Programme to improve practice and gain assurance of the impact of our actions to improve care for patients, their families and carers.

This work continues to nurture a positive culture of patient safety and continuous quality improvement.

During 2022/23 we reported to and have been supported by an external Quality Board jointly chaired by the North East North Cumbria Integrated Care Board Lead Officer and the Regional Chief Nurse.

Tees, Esk and Wear Valleys NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

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

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

2.14 Information governance

The reporting deadline for the toolkit is now 30 June, so our position is as for our 2021/22 position which is 'approaching standards'.

We are currently at 91% completion of our information governance mandatory and statutory training.

Our Trust currently has a sickness rate of higher than 5% so our ability to achieve the 95% target has been impacted. Many other healthcare organisations are in the same situation, and NHS E have taken this on board for future iterations of the toolkit.

2.15 Freedom to Speak Up

There are a number of routes through which staff can raise concerns:

- Through their own management or professional structures.

- Through the Freedom to Speak Up team. This is as confidential as the person asks for it to be. Concerns are shared with the Director of People and Culture where possible to provide oversight of any ongoing or widespread themes, but where the person does not want this to happen, the Freedom to Speak Up team will support any investigation independently. Depending on the concern this may lead to a review commissioned by someone independent of the service or support given to the individual eg. through the Employee Support Service. Feedback is given to the person on a regular basis, in line with our revised process. As much feedback is given as appropriate although, by the nature of some concerns and investigations, full feedback is not always possible.

- Through the online raising concerns form which people can complete anonymously. Where the person leaves their name we respond directly to them. Where it is anonymous, the relevant director provides a written response to go on the staff intranet.

- Through our safeguarding team or directly to the CQC.

- Through our formal HR processes, the timescales of which vary and are laid out in the relevant policy.

- Through the Employee Support Service who will signpost and provide guidance on how to make best use of the options available.

- Through any trade union of which they are a member.

Any concerns of detriment are, in line with national guidance, dealt with through our normal HR processes. We have recently agreed that concerns will be passed to our Associate Director for Operations and Resourcing, with indication of who should not be involved in any review. They will provide the names of three people who could potentially look into it, so the person raising the concern has the opportunity to identify any conflicts of interest.

The Non-Executive Director Freedom to Speak Up lead has agreed that they will receive quarterly reports on these concerns and raise any issues with the Director of People and Culture and include their feedback in the Freedom to Speak Up reports to our Board.

2.16 Reducing gaps in rotas

Please note we are awaiting information on progress in bolstering staffing in adult and older adult community mental health services, following additional investment from local CCGs' baseline funding.

The role of Guardian of Safe Working for Postgraduate Doctors within our Trust 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 postgraduate 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 10pm and 7am
- 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 Postgraduate Doctors within our Trust produces quarterly and annual reports to the Board that focus on gaps in medical rotas and safety issues.

The Board received the Guardian's annual report for 2022/23 at its meeting of 27 April 2023. During the year, the most common reasons for needing short-term/locum cover was due to vacancies on the rotas and staff sickness (short/long term).

Exception reports received related mostly to claiming additional hours whilst on NROC, 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 at the relevant forums and additional staffing put in place where possible.

2.17 Learning from deaths

Please note we are still awaiting information to complete this section of the Quality Account – you will see the gaps below.

1. During 2022/23 2339 of patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 577 in the first quarter, 552 in the second quarter, 669 in the third quarter and 541 in the fourth quarter.

2. By the end of 2022/23 xx case record reviews and xx investigations were carried out in relation to 2339 of the deaths included in item 1.

In xx 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: xx in the first quarter; xx in the second quarter; xx in the third quarter; xx in the fourth quarter.

3. [xx] representing XX% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of: [Number] representing [number as percentage of the number of deaths which occurred in the quarter given in item 1]% for the first quarter; [Number] representing [number as percentage of the number of deaths which occurred in the quarter given in item 1]% for the second quarter; [Number] representing [number as percentage of the number of deaths which occurred in the quarter given in item 1]% for the third quarter; [Number] representing [number as percentage of the number of deaths which occurred in the quarter given in item 1]% for the fourth quarter.

These numbers have been estimated using the [name, and brief explanation of the methods used in the case record review or investigation].

4. Significant work was undertaken during 2022/2023 to identify learning and themes from both case record reviews and serious incidents investigations.

The top seven themes from serious incidents were identified as:

- Risk assessment and management (Safety Summary/Plan/contingency planning)
- Care planning
- Safeguarding (including use of PAMIC tool)
- Family involvement
- Record keeping
- Multi-agency working
- Records management

Themes from case record reviews were identified as:

- Risk assessment/risk management
- Communication between Trust teams
- Poor multi-agency working

- Poor consideration and management of risks related to medication and obesity
- Need to have a greater focus on review of service users mental state at depot clinics
- Poor physical health monitoring
- Poor record keeping

All learning in our Trust is now referred to as actionable learning which replaces previous categories of learning including root and contributory causes. This language supports our approach towards a just and learning culture in line with Our Journey to Change and a systems-based approach to learning.

Learning from all types of reviews is triangulated to identify emerging themes.

5. Learning from serious incidents, once reviewed, continues to be monitored against the themes identified in item 4 above. Our Quality Assurance Programme is regularly updated to reflect learning from patient safety incidents. It provides assurance that improvements are being made in relation to risk assessment, risk management, and contingency planning, care plans and carer involvement and that these improvements are being sustained in both inpatient and community settings.

Work around care planning and safeguarding forms part of our quality strategy in keeping with Our Journey to Change.

Practice Development Practitioners (PDPs) are addressing areas of learning within their teams through compliance audits, coaching and supervision of staff. PDPs are integrated into the Fundamental Standards group where wider learning is shared to inform improvements in other areas.

Findings from case record reviews are discussed within the clinical networks, where appropriate, to ensure that learning feeds into existing improvement work. Outcomes are captured in minutes at the following mortality review panel. Where the learning identified is related to the work of a specific professional group, for example pharmacy, the relevant mortality review panel member ensures this is actioned and shared Trustwide. Good examples of assurance can be evidenced from the workstreams related to Clozapine, Lithium and Depot Injections. Learning for individuals is also shared with operational teams where appropriate and addressed via supervision and local governance processes.

Previous learning from case record reviews and early learning reviews has suggested that a community frailty pathway to help staff in recognising the deteriorating patient in community settings should be actioned. Training has commenced in recognition of the physically deteriorating patient in community settings. Work is underway with key stakeholders including the primary care networks to create a pathway and guidance document.

Our Trust continues to strengthen arrangements for organisational learning via the Organisational Learning Group. The groups role is to gain assurance that:

a) we identify areas of learning
b) we are implementing change to address areas of learning, and
c) the actions we are taking are having the desired impact.

Agenda items have included analysis of the Quality Assurance and Improvement report to determine the effectiveness of the assurance tools used, identification of emerging themes, effectiveness of associated actions and the learning from deaths improvement work with the Better Tomorrow Programme.

Forty patient safety briefings have been circulated trust wide during 2022/23 as a result of learning.

Examples of these briefings include:

- Accurate documentation of observations and general observations/care rounds for all inpatient, respite, and residential settings.
- Ensuring all staff are aware of how to access anti-barricade doors especially if there may be pressure behind the door.
- The importance of bowel monitoring when patients are on high dose anti-psychotic therapy (HDAT), or any medications where constipation could cause significant issues such as Clozapine.
- Delivering compassionate care and the importance of raising concerns.
- Raising awareness of the importance of seamless transfers of care and service delivery when patients move between services/trusts.
- Door handles - potential ligature risks.
- Shower drain – potential ligature risk.
- Emergency rescue of a collapsed person.
- Observation and engagement/care rounds.
- Guidance to support the identification and management of safeguarding (adult/child) cases.
- Patient leave - sharing of relevant information and keeping in touch plans.

The briefings circulated are specific about any assurance required from services. On receipt of completed actions these are documented in the local safety alert and learning database.

Learning from Serious Incidents Bulletins are also regularly distributed across our Trust. The bulletins have shared key learning and good practice highlighted in serious incident reviews considered at the Directors Assurance Panels. All briefings and bulletins are stored in the learning library on our staff intranet and are accessible to all employees.

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. Environmental surveys with a multi professional input from estates, health and safety and clinical services were recommenced.

In relation to safeguarding, the Quality Assurance tool for practice development reviews has demonstrated improvements in relation to identification of risk to others and from others within the safety summaries being discussed within Multi-disciplinary Team. Peer reviews (Quality Assurance tool 6) have evidenced good examples of safeguarding procedures and staff knowledge. Training figures indicated that over 90% of staff are compliant with mandatory safeguarding training in both Care Groups.

Connecting for people, suicide awareness training, continues, and our mandatory harm minimisation training was revised. The harm minimisation training continues to include updated headlines from serious incidents in relation to learning from deaths. Training dates are available up to 2024. Training has been adapted for relevant specialties, for example CAMHS. The training considers completion of documentation/record keeping, patient/carer involvement and the importance of multi-agency working. Bespoke training sessions in hot spot areas are available on request. For example, in front line teams such as Crisis.

As part of the improvement work around the serious incident process and learning from deaths, several training needs for staff Trustwide were 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 were fed into the Trustwide training needs analysis event.

The Incident Reporting and Serious Incident Review policy was reviewed to incorporate improvement work which was co-produced with clinical services and bereaved families/carers. It also includes the Patient Safety Incident Response standards. A designated programme manager continues to work with the project team to implement the Patient Safety Incident Response Framework (PSIRF) which will gradually be introduced in line with national requirements during Autumn 2023.

The Learning from Deaths policy was also reviewed. Both policies are aligned to Our Journey to Change in that we will ensure carers and families receive compassionate care following the loss of a loved one. We will continue to work closely with families and carers of patients who have died to ensure meaningful support and engagement with them at all stages, from the notification of death through to actions taken following an investigation/review.

We continue to work collaboratively as part of the Better Tomorrow Programme to facilitate shared learning/good practice and valid comparisons with other trusts.

A replacement risk management system has been procured that will bring additional benefits in terms of triangulation of learning and oversight of serious incident action plans.

Deaths of people with a dual diagnosis are increasing. Community transformation work has facilitated collaborative pathways across the system it operates within. It aims to create a core mental health service which is aligned with primary care networks and voluntary sector organisations to ensure that services are accessible to the community it serves and inclusive of population need.

6. Our Quality Assurance Programme uses a range of tools to measure compliance with key areas of practice that relate to the seven key learning themes. This has provided quantitative evidence of sustained improvement Results show that improvements have been made across all seven learning themes.

MDT walkabouts have also identified that staff are aware of learning issued by patient safety briefings that are circulated across the Trust.

Good examples of assurance can be evidenced from the workstreams related to critical medications such as Clozapine and Lithium.

The national lead from the Better Tomorrow Programme indicated that improvement work carried out by our Trust will be used as a case study and have shared work completed as good practice.

7. [Number] case record reviews and [number] investigations completed after [date] which related to deaths which took place before the start of the reporting period.

8. [Number] representing [number as percentage of number in item 27.1 of the relevant document for the previous reporting period] % of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the [name, and brief explanation of the methods used in the case record review or investigation].

9. [Number] representing [number as percentage of number in item 27.1 of the relevant document for the previous reporting period] % of the patient deaths during [the previous reporting period] are judged to be more likely than not to have been due to problems in the care provided to the patient.

2.18 PALS and complaints

Complaints are managed following national guidance and we endeavour to respond to all our formal complaints within 60 days. We have a complaints manager aligned to each Care Group of our Trust who works with operational colleagues, patients and/or carers to resolve the issue that has been raised.

Our policy and procedure for the Management of Compliments, Comments, Concerns and Complaints outlines our approach to receiving valuable feedback and information from patients and their carers about the services we provide.

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 2022/23 PALS dealt with 2,438 concerns or issues from patients and carers, an increase of 157 when compared to 2021/22.

1,008 (41%) of the concerns raised were around adult mental health services.

1,950 of the PALS concerns (80%) were closed within 15 working days (although no formal target is set for this). Non-compliance was largely in relation to obtaining timely feedback from operational services.

338 formal complaints were received and registered during 2022/23 compared to 300 for the same period last year.

Complaints across services:

- 230 in adult mental health services
- 69 in children and young people services
- 1 in crisis
- 13 in mental health services for older people
- 8 in secure inpatient services
- 0 in Health and Justice
- 1 in adult learning disability services and
- 16 in corporate services

2.19 Data quality

The latest published Data Quality Maturity Index (DQMI) score is 97.4. This is for December 2022.

Our Trust did not submit records during 2022/23 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

Our Trust was not subject to the Payment by Results clinical coding audit during 2022/23 by the Audit Commission.

We did have a clinical coding audit for the Information Governance Toolkit. The results were 99% correct for primary diagnosis and 90.8% correct for secondary diagnosis.

We stopped making Commissioning Data Sets submissions that go to Secondary Uses Service and Hospital Episode Statistics about four years ago as the data was duplicated with the Mental Health Services Data Set. The Mental Health Services Data Set data quality for NHS Number and GP practice from the Data Quality Maturity Index publication for December 2022 were both 100%

2.20 Mandatory quality indicators

Please note we are awaiting information for this section on the following indicators:

- *The percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care during the reporting period*

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

- *The percentage of patients aged:*
  (i) 0 to 15 and
  (ii) 16 or over readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.

- *Our patient experience of community mental health services indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period.*

- *The number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.*

The indicators below were removed from national reporting and we are therefore not including these figures in this year's Quality Account:

- Care Programme Approach 72-hour follow-up
- Crisis Resolution Home Treatment team acted as gatekeeper

PART 3 – Further Information on how we have performed in 2022/23

3.1 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 our Trust.

3.2 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.

Please note we are awaiting information to complete the table below.

Quality metrics	Target	Whole Trust 22/23	Whole Trust 21/22	Whole Trust 20/21	National benchmark (where available)	
Patient safety indicators						
Percentage of patients who report 'yes, always' to the question 'do you feel safe on the ward?'	75.00%	55.57%	65.30%	64.66%	Not measured nationally	Please refer to section on Feeling safe. We are unable to benchmark with other mental health trusts as this is not universally collected. Intelligence gathered via the focus groups has informed the patient experience improvement plan and the work is being implemented. Delivery against the actions is being closely monitored via the care group and strategic governance routes. We also recognise that the feeling of safety is affected by some of an inherent aspect of some of our patient's mental health conditions. We will continue to focus on this important area of patient safety in 2023/24.
Number of incidents of falls (level 3 and above) per 1000 occupied bed days (OBDs) – for inpatients	0.35	0.28	0.17	0.13	The Royal College of Physicians discourage any benchmarking or comparisons due to the high number variables that exist that makes comparison unreliable.	Analysis of information suggests the slight increase in the rate of falls is associated with the increase in the acuity of patients accessing our services.

The number of incidents of physical intervention/ restraint per 1000 occupied bed days	19.25	33.27	28.84	20.9	Please refer to Further benchmarking data in section below.
The number of medication errors with a severity of moderate harm and above	2.5	13	12	7	TBC
The number of serious incidents reported on STEIS	-	144	141	142	TBC
Clinical Effectiveness Indicators	**Target**	**Whole Trust 22/23**	**Whole Trust 21/22**	**Whole Trust 20/21**	**National Benchmark**
Percentage of adults discharged from CCG-commissioned mental health inpatient services receive a follow-up within 72 hours	85%	88%	Previously reported indicator: (Existing percentage of patients on Care Programme Approach who were followed up within 72 hours after discharge from psychiatric inpatient care)		
Adults with a long length of stay over 60 for adult admissions	TBC	TBC			*Awaiting information*
Older adults with a long length of stay over 90 days for older adult admissions	TBC	TBC			

Patient experience indicators	Target	Whole Trust 22/23	Whole Trust 21/22	Whole Trust 20/21	National benchmark
Percentage of patients who reported their overall experience as very good or good	92.00%*	92.16%	94.34%	93.21%	87%
Percentage of patients that report that staff treated them with dignity and respect	94.00%	86.69%	84.72%	86.77%	TBC
Number of complaints raised	-	338	257	533	TBC

* *Previous target was 94% changed Dec 2023 to 92%*

Comments on areas for improvement

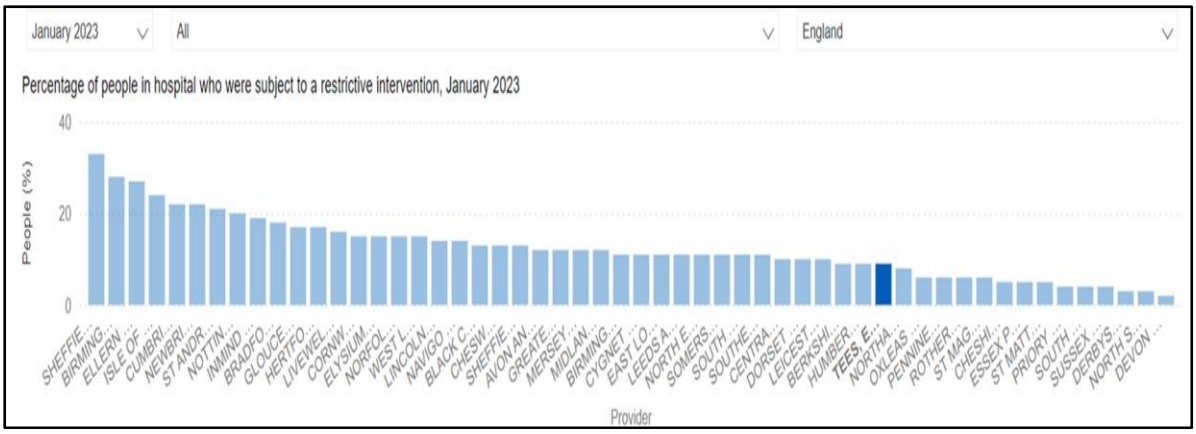
Percentage of patients reported 'yes always' to the question 'do you feel safe on the ward'?
The end of 2022/23 position was 55.57% which relates to 962 out of 1731 surveyed. This is 19.43% below our target of 75.00%. Both Care Groups have underperformed this year. Durham, Tees Valley and Forensics with 54.72% and North Yorkshire, York and Selby with 58.94%. This area continues to be a priority for 2023/24.

Number of incidents of physical intervention/ restraint per 1000 occupied bed days (OBDs) – for inpatients
The end of 2022/23 position was 33.27 which relates to 7873 incidents and 236,605 OBDs. This is 14.02 above our target of 19.25

North Yorkshire, York and Selby were the only Care Group achieving the target with a rate of **12.78**. Within Durham, Tees Valley and Forensics Care Group the actual rate was **38.23.** This higher rate is due to a large proportion of the restrictive intervention usage in a small number of wards in adult learning disabilities where this is more likely to occur in a small group of patients with complex needs.

We have been working with Mersey Care NHS Foundation Trust implementing the HOPES model, a care approach that reduces the use of long-term segregation sometimes experienced by autistic adults, adults with a learning disability and children and young people. We now have a dedicated HOPE(S) practitioner, to work in partnership with the national team and Mersey Care NHS Foundation Trust.

The graph below illustrates the Trusts positive position against other mental health trusts nationally. We continue to work towards the long-term reduction of all forms of restrictive intervention. A range of actions are in progress via our Restrictive Intervention Reduction Plan.



	Total mean 22/23	Total mean 22/23 (ALD inpatient services excluded)
Incidents involving restrictive interventions	578.56	321.20
Total number of restrictive interventions used	897.73	504.82
Use of prone restraint	10.08	8.04
Use of supine restraint	208.68	88.64
Use of rapid tranquilisation	107.32	91.12
Use of seclusion	82.82	14.64
Use of tearproof clothing	7.64	7.64
Use of mechanical restraint	2.48	2.48

Percentage of patients that report that staff treated them with dignity and respect
The end of **2022/23** position was **86.69%** which relates to **8718** out of **10057** surveyed. This is **7.31%** below our target of **94.00%.**

Broken down by Care Groups, we are pleased that the majority of our patients are treated with dignity and respect. North Yorkshire, York and Selby are closest to the target with **91.03%** with Durham, Tees Valley and Forensics **85.06%**.

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.

The number of medication errors with a severity of moderate harm and above
The end of **2022/23** position was **13** which is **10.5** above our target of **2.5.**

These 13 were split across the Care Groups. North Yorkshire, York and Selby had five and Durham, Tees Valley and Forensics had eight medication errors with a severity of moderate harm and above.

A review of incidents (moderate harm and above) identified medication errors occurring mainly in relation to medications such as Clozapine, Lithium and Depot Medication. In response to this, the Pharmacy Team has led workstreams focused on making practice improvements to reduce the number of incidents reported. The Safe Medication Practice Group has co-created action plans to address key issues. Actions delivered during 2022/23 have included changes to procedures, development of e-learning training packages for staff and the production of posters focused on patients to raise their awareness of the key side effects of medication.

These incidents occur in low numbers and are routinely reported to the Trust's Board through the Integrated Performance report to ensure robust monitoring and oversight.

3.3 Our Performance against the System Oversight Framework Targets and Indicators

The NHS Oversight Framework is built around five national themes:

- Quality of care, access and outcomes
- Leadership and capability
- People
- Preventing ill health and reducing inequalities
- Finance and use of resources

A sixth theme focusses on local strategic priorities.

The five themes are underpinned by 23 key performance measures and sub-measures and Trust and Integrated Care Board (ICB) performance is monitored via an allocation to a top, inter or bottom quartile. Typically, those within the top quartile indicate the higher performing Trusts.

To provide an overview of the level and nature of support and the oversight arrangements required across systems, Integrated Care Boards and Trusts are allocated to one of four segments, determined by the scale and nature of their support needs, ranging from no specific support needs (segment 1) to intensive support needs (segment 4).

Our Trust is currently placed within segment 3; bespoke mandated support, potentially through a regional improvement hub, drawing on system and national expertise as required.

There are a number of measures where we are placed in the lowest performing quartile which indicates a position of concern or where we are not achieving the Oversight Standard.

These are:

- Access rate for IAPT services (North East and North Cumbria)*
- Overall CQC rating
- NHS Staff Survey compassionate culture people promise element sub score
- NHS Staff Survey compassionate leadership people promise element sub score
- CQC well led rating
- Staff survey engagement theme score
- Proportion of staff in a senior leadership role who are from a BME background

*Please see the relevant sections within the Integrated Performance Report, Long Term Plan and Performance Improvement Plans

Further details on our performance are below:

1) Quality, access and outcomes: Mental health
There are four mental Health measures monitored as part of the 2022/23 Framework; 1 is monitored at Trust level and 3 are monitored at ICB level. Our achievement against these has been provided in the tables below.

TEWV	Oversight standard	Q1	Q2	Q3	Q4	Latest national position
Number of inappropriate OAP bed days for adults by quarter that are either internal or external to the sending provider	0	1094	1031	431	951	Interquartile ranges as at December 2022 (500) 23 out of 56 Trusts.

North East and North Cumbria ICB	Oversight standard	Q1	Q2	Q3	Q4	Latest national position
Access rate for IAPT services	100%	93.23 %	71.93%	81.23%	88.50%	Lowest performing quartile (a position of concern) as at December 2022 32 out of 42 ICBs
Number of children and young people accessing mental health services as a % of population	100%	114.52 %	113.38 %	113.65 %	112.47 %	
Access rates to community mental health services for adult and older adults with severe mental illness	100%	211.2 %	211.49 %	214.24 %	217.97 %	

Humber and North Yorkshire ICB	Oversight standard	Q1	Q2	Q3	Q4	Latest national position

Access rate for IAPT services	100%	85.67 %	85.53%	97.43%	96.39%	Interquartile ranges as at December 2022 21 out of 42 ICBs
Number of children and young people accessing mental health services as a % of population	100%	148.9 %	153.31 %	153.10 %	154.21 %	
Access rates to community mental health services for adult and older adults with severe mental illness	100%	239.47 %	231.06 %	227.55 %	218.56 %	

Quality of care, access and outcomes: safe, high-quality care

Quality of care, access and outcomes: safe, high-quality care	**Oversight standard**	**Q1**	**Q2**	**Q3**	**Q4**	**Latest national position**
National Patient Safety Alerts not completed by deadline	0	0	0	0	0	Data as at January 2022
Consistency of reporting patient safety incidents	100.00%	100.00%	100.00%	100.00%	100.00%	Data as at January 2022 Highest performing quartile (a positive position) as at September 2022 (100%) 1 out of 71 Trusts
Overall CQC rating	N/A	Requires improvement				Lowest performing quartile (a position of concern) as at

						February 2023 53 out of 69 Trusts
NHS Staff Survey compassionate culture people promise element sub-score		6.9	6.9	6.9	6.8	Lowest performing quartile (a position of concern) as at 2021 survey 63 out of 70 Trusts
NHS Staff Survey raising concerns people promise element sub-score		6.7	6.7	6.7	6.7	Interquartile range as at 2021 survey 49 out of 70 Trusts
Adult acute length of stay over 60 days	0%	10.87%	13.43%	11.07%	12.93%	Highest performing quartile (a positive position) as at December 2022 (12.1%) 6 out of 50 Trusts
Older adult acute length of stay over 60 days	0%	33.59%	33.81%	40.15%	28.28%	Interquartile range as at December 2022 (32.4%) 15 out of 50 Trusts

Leadership and capability: leadership

Leadership and capability: leadership	**Oversight standard**	**Q1**	**Q2**	**Q3**	**Q4**	**Latest national position**
NHS Staff Survey compassionate leadership people promise element sub-score	As per staff survey benchmarking group results	7.17	7.17	7.17	7.3	Lowest performing quartile (a position of concern) as at 2021 survey 65 out of 70 Trusts
CQC well-led rating	N/A	Requires improvement				Lowest performing quartile (a position of concern) as at February 2023

			55 out of 69 Trusts

People: Looking after our people

People: Looking after our people	Oversight Standard	Q1	Q2	Q3	Q4	Latest national position
Staff survey engagement theme score	As per staff survey benchmarking group results	7.00	7.00	7.00	6.80	Lowest performing quartile (a position of concern) as at 2021 survey (6.79) 64 out of 70 Trusts
Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from managers	As per staff survey benchmarking group results	8.00%	8.00%	8.00%	7.00%	Interquartile range as at 2021 survey (8.33%) 32 out of 70 Trusts
Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from other colleagues	As per staff survey benchmarking group results	14.00%	14.00%	14.00%	14.00%	Interquartile range as at 2021 survey (13.80%) 28 out of 70 Trusts
Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from patients/service users, their relatives or other members of the public	As per staff survey benchmarking group results	25.00%	25.00%	25.00%	23.00%	Interquartile range as at 2021 survey (24%) 20 out of 70 Trusts
NHS staff leaver rate	None	13.87%	13.39%	12.91%	12.31%	Highest performing quartile (a positive position) as at December

						2022 (7.34%) 7 out of 71 Trusts
Sickness absence rate (working days lost to sickness)	None	6.44%	6.11%	6.16%	6.71%	Interquartile range as at October 2022 (6.33%) 51 out of 71 Trusts

People: Belonging in the NHS

People: Belonging in the NHS	**Oversight Standard**	**Q1**	**Q2**	**Q3**	**Q4**	**Latest national position**
Proportion of staff in senior leadership roles who a) are from a BME background b) are women c) disabled staff						
BME background	12%	1%	1%	1%	1%	Lowest performing quartile (a position of concern) as at 2021 calendar year (1.99%) 64 out of 69 Trusts
Women	62%	66%	67%	64%	65%	Interquartile range as at December 2022 (62.3%) 29 out of 47 Trusts
Disabled staff	3.20%	4%	4%	6%	6%	
Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual	As per staff survey benchmarking	56.00 %	56.00 %	56.00 %	63.00 %	Interquartile range as at 2021 calendar year (60.50%) 28 out of 70 Trusts

orientation, disability or age						

Finance and use of resources

There are 4 measures and sub measures monitored as part of finance and use of resources; of these, a Trust assessment has not been possible at this stage. Work is currently underway to develop the agency measures.

Finance and use of resources	Oversight Standard	Q1	Q2	Q3	Q4	Latest national position
Financial efficiency - variance from efficiency plan - Recurrent	N/A	£1,208,577	£3,871,945	£6,482,000	£9,963,681	Financial values with brackets indicate a (Surplus) or (Favourable) position, financial values without brackets indicate a deficit or adverse position.
Financial efficiency - variance from efficiency plan - non-recurrent	N/A	£361,173	£722,346	£1,044,000	£3,754,319	
Financial stability - variance from break-even	N/A	£1,296,930	£4,290,781	£4,718,089	-£1,207,855	
Agency spending: Agency spend compared to the agency ceiling	100%	Not currently available	208.23%	224.76%	221.14%	
Agency spending: Price cap compliance	100%	Not currently available	64%	64%	63%	

3.4 Learning from West Lane Hospital

On 2 November 2022, three NHS England independent investigation reports were published following the deaths of three young people in our care between 2019 and 2020.

The reports looked at the care and treatment of Christie Harnett, Nadia Sharif and Emily Moore at West Lane Hospital in Middlesbrough, and in addition for Emily, at Lanchester Road Hospital in Durham, as well as the actions for partner organisations. The investigation was commissioned by NHS England and carried out by Niche Health and Social Care Consulting.

In response to the findings of the three reports our Chief executive said:

“On behalf of the trust, I would like to apologise unreservedly for the unacceptable failings in the care of Christie, Nadia and Emily which these reports have clearly identified.

“The girls and their families deserved better while under our care. I know everyone at the trust offers their heartfelt sympathies and condolences to the girls’ family and friends for their tragic loss.

“We must do everything in our power to ensure these failings can never be repeated.

“However, we know that our actions must match our words. We accept in full the recommendations made in the reports – in fact the overwhelming majority of them have already been addressed by us where applicable to our services.

“It is clear from the reports that no single individual or group of individuals were solely to blame – it was a failure of our systems with tragic consequences.

“We have since undergone a thorough change in our senior leadership team and our structure and, as importantly, changed the way we care and treat our patients. However, the transformation needed is not complete. We need to get better and ensure that respect, compassion, and responsibility is at the centre of everything we do.”

The reports and our response to the identified recommendations is available as follows:

Report and our response to the recommendations: Christie Harnett
Report and our response to the recommendations: Nadia Sharif
Report and our response to the recommendations: Emily Moore

In addition to the three reports published, a further system-wide independent investigation report was published on 21 March 2023 looking into the concerns and issues raised relating to the safety and quality of CAMHS provision at West Lane Hospital.

The report included recommendations for our Trust as well as other organisations. The assurance statement is our response to the recommendations, and this was published at the same time.

The report and our response is available as follows:

Report and response to the recommendations: System-wide independent investigation

We stopped delivering inpatient CAMHS provision in September 2019 at West Lane Hospital.

Our Trust accepted in full the recommendations made in the reports and we reiterated how deeply sorry we are for the events that contributed to the deaths of Christie, Nadia and Emily.

In the three years since these tragedies, we've made significant improvements in our environments, how we organise staff and services and most importantly how we more closely involve families and loved ones themselves.

These improvements are being delivered through our five year change programme, Our Journey to Change, in line with our three big goals to co-create a great experience for our patients, carers and their families, for our staff and our partners. This includes an unrelenting focus on patient safety, supported by a robust quality assurance schedule.

3.5 Learning from Okenden- the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust

The consideration of learning from organisations across the health and social care system is essential to continuous improvement and the provision of high quality care. All trust boards have a duty to prevent failings found in the wider NHS from happening within their organisations and the local system. Our Trust is committed to applying such learning and to take action to mitigate any risks identified.

The independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust commenced in the summer of 2017. It was originally requested by the Rt Hon Jeremy Hunt MP when he was Secretary of State for Health and Social Care, and commissioned by NHS Improvement, to examine 23 cases of concern collated by the tireless efforts of the parents of Kate Stanton-Davies and Pippa Griffiths, who both died after birth at the Trust in 2009 and 2016 respectively.

The independent review examined the maternity care of 1,486 families, the majority of which were patients at the Trust between the years 2000 and 2019. The review found that consistently lessons were not learned, mistakes in care were repeated, and the safety of mothers and babies was unnecessarily compromised as a result.

There were a number of reviews carried out by external bodies, including local clinical commissioning groups and the Care Quality Commission, during the last decade. The review team was concerned that some of the findings from these reviews gave false reassurance about maternity services at the Trust, despite repeated concerns being raised by families, and therefore opportunities for improvement were lost.

The Ockenden report from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust was published on 30 March 2022 and is available as follows:

Ockenden review: summary of findings, conclusions and essential actions

NHSE/I wrote to all trusts to ask that the Ockenden report and its recommendations be considered at public board meetings and shared with all relevant staff. Trusts were expected to take action to mitigate any risks identified and develop robust plans against areas where services need to make changes, paying particular attention to the report's four key pillars:

1. Safe staffing levels
2. A well-trained workforce
3. Learning from incidents
4. Listening to families

In April 2022 a paper presenting the key learning from the Ockenden review was presented to our Trust Board. It recognised the wider implications for learning and improvement across our organisation in relation to the four key pillars.

Key learning from the four pillars has helped inform continuous improvement workstreams in our Trust, for example the ongoing work on safer staffing, implementation of the national Patient Safety Incident Review Framework, developing mechanisms for recognising and sharing learning from incidents, patient safety events, complaints and patient, family and carer feedback and involving families in the serious incident review process.

The Trust's Organisational Learning Group has reviewed the report further and agreed additional actions to mitigate any risks identified with specific reference to the four key pillars

3.6 Identifying closed cultures

Following findings of patient abuse at the Edenfield Centre at Greater Manchester Mental Health Foundation Trust, the National Director for Mental Health wrote to all NHS trusts to request specific areas of care were reviewed by trust boards. In addition to this, the Humber and North Yorkshire Integrated Care Board requested that providers within the Mental Health, Learning Disability and Autism Provider Collaborative review the mitigations in place to prevent closed cultures like that at the Edenfield Centre from developing.

The CQC has undertaken some significant work on defining and identifying closed cultures. They describe a closed culture as, "a poor culture in a health or care service that increases the risk of harm. This includes abuse and human rights breaches. The development of closed cultures can be deliberate or unintentional – either way it can cause unacceptable harm to a person and their loved ones."

Our Trust recognises that many of our services are at inherent risk of developing a closed culture because of the services provided, where some people are not free to leave and have multiple vulnerabilities. This includes all our inpatient services where people may be treated under the Mental Health Act.

In response to learning from the Edenfield Centre and the need to provide assurance both internally and to the ICB, the Nursing and Governance Directorate developed a cultural assessment tool or 'trigger tool'. This tool was informed by the characteristics of a closed culture identified through the project work of the CQC.

The first stage of our review involved a tabletop review of all inpatient wards using the cultural assessment tool. This allowed us to identify wards with the highest risk of developing a closed culture. Following this the 48 inpatient wards were independently visited.

We used the 'see, hear and feel' approach to test out, at patient care level, the factors that impact on patient and staff safety and experience and therefore impact on culture. Findings were reviewed for positive and negative themes. Any immediate concerns identified were escalated and remedial action was taken.

The exercise gave us improved visibility and there was positive feedback received from the Trust's Care Groups and visiting teams about this approach.

It should be acknowledged that quantitative, qualitative data and ward reviews alone will not inform the Trust of closed cultures, however they support the identification of early warning signs of poor cultures and therefore are effective at mitigating risks in conjunction with a wider quality assurance approach.

The majority of feedback from both staff and patients and from observations of practice suggested many aspects of good practice from compassionate and caring staff.

While teams and reviewers found this work to be worthwhile, no closed cultures were identified. We recognise that closed cultures are very difficult to spot, therefore this exercise has been seen as part of a need for wider and ongoing surveillance to identify risks and address poor cultures emerging at an early stage.

3.7 Reading the Signals - Maternity and Neonatal Services in East Kent

Following concerns raised about the quality and outcomes of maternity and neonatal care, NHS England and NHS Improvement (NHS E/I) commissioned Dr Bill Kirkup CBE to undertake an independent review into maternity and neonatal services at East Kent Hospitals University NHS Foundation Trust.

The final report Reading the Signals - Maternity and Neonatal Services in East Kent was published in October 2022.

It reviewed 202 cases of families who received care in East Kent between 2009 to 2020.

The review found a clear pattern. Over that period, those responsible for the services too often provided clinical care that was suboptimal and led to significant harm, failed to listen to the families involved, and acted in ways which made the experience of families unacceptably and distressingly poor.

The individual and collective behaviours of people providing the services were visible to senior managers and the Trust Board in a series of reports right through the period from 2009 to 2020 and lay at the root of the pattern of recurring harm. The report identified eight clear separate missed opportunities, both internally and externally, when these problems could and should have been acknowledged and tackled effectively.

It found that the Trust treated problems as limited one-off issues, rather than acknowledging the systemic nature of the challenges and confronting the issues head on. When issues were brought into public focus, it found the Trust focussed on reputation management, reducing liability through litigation and a ‘them and us approach’. This got in the way of patient safety and learning.

A copy of the full report is available as follows:

Reading the signals: Maternity and neonatal services in East Kent – the Report of the Independent Investigation

There were four key areas for action identified within the report as follows:

1. Monitoring safe performance and identifying poorly performing units – finding signals among noise.
2. Standards of clinical behaviour – giving care with compassion and kindness, technical care is not enough.
3. Team working with a common purpose – rather than flawed teamworking, pulling in different directions,
4. Organisational behaviour – looking good while doing badly. Responding to challenge with honesty rather than focussing on reputation management.

A paper was presented to our Trust Board in February 2023 that set out the key issues and learning from the national report, recognising that they are not unique to East Kent Trust or only trusts delivering maternity services. The paper provided details on how learning from

the report has been taken forward to mitigate risks to quality and safety and included an overview of assurance against the recommendations and potential delivery risks.

Our response reinforced the importance of culture and the need for patient safety to be a priority for the Board. The paper detailed the assurance mechanisms in place across our Trust including the recent use of team cultural assessments across all inpatient wards, the development of quality and safety dashboards to highlight hot-spots and track changes in quality and safety including safe staffing over time and improved systems for organisational learning.

In relation to culture and behaviours, the establishment of two lived experience directors as core members of the Care Group Boards as well as the continued recruitment of peer workers into our Trust seeks to positively influence culture and achieve our goals of co-creation in everything we do.

Work also includes improvements to risk management systems and the more effective use of the risk register to support enhanced oversight, assurance and management of risks. In addition, our dedicated Quality Assurance and Improvement Programme focuses on key quality and safety issues and is informed and regularly refreshed to take account of new learning.

We have also set out actions we will take to further triangulate workforce and quality information and to continuously improve teamwork with a common purpose. Due to the importance of the learning, an interactive discussion and presentation on the Kirkup review has continued to be delivered at multiple clinical and managerial leadership sessions across our Trust.

3.8 External audit

Under guidance from NHS England, the Quality Account 2022/23 is not subject to review by external audit.

3.9 Our stakeholders' views

Summary of stakeholders' views to be included

Appendix 1: 2023/24 Statement of directors' responsibilities in respect of the Quality Account

Please note we are awaiting some dates in this section.

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 2022/23 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 2022 to May 2023
  - Papers relating to quality reported to the Board over the period April 2022 to May 2023
  - Feedback from the integrated Care Boards *dated xx* and *dated xx*
  - Feedback from Healthwatch *dated xx*
  - Feedback from Overview and Scrutiny Committees *dated xx*
  - Feedback from Health and Wellbeing Boards *dated xx*
  - 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 xx*
  - The latest national staff survey *published xx*
  - CQC inspection report *dated xx*
  - The Quality Account/Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered
  - The performance information reported in the Quality Account/Report is reliable and accurate
  - There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account/Report, and these controls are subject to review to confirm that they are working effectively in practice
  - The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
  - The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Account regulations) as well as the standards to support data quality for the preparation of the Quality Report

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

By order of the Board.

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: Our 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 England. It also:

- Ensure effective dialogue between our Trust and the communities we serve
- Monitors and ensures high quality services
- Is responsible for our financial viability
- Appoints and appraises our executive management team

Business plan: A document produced once a year 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 our staff and patients, 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 our 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 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): Our 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 our 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. We have an Adult Learning Disability (ALD) service in each Care Group and also specific wards for Forensic LD patients. We provide 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 (OSC): 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 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 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: Our 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 our Trust that offers confidential advice, support, and information on health-related matters. The team provides 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 our Trust, 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 (1 April to 31 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.

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 us 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 Trustwide.

The Trust: Tees, Esk and Wear Valleys NHS Foundation Trust.

Trust Board: See Board/Board of Directors above

Trustwide: The whole geographical area served by our Trust.

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 our 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 1 April in the first year and end on the 31 March in the second year.

Appendix 3: Stakeholders' views

Feedback to be included

Tees, Esk and Wear Valleys
NHS Foundation Trust

TEWV Quality Account 2022/23

Look back at 2022/23 quality achievements and look forward to 2023/24 quality improvement priorities

Avril Lowery
Director of Quality Governance
June 2023

Purpose

- To look back at progress made on the Quality Account improvement priorities and quality indicators in the past year.
- To outline proposed quality improvement priorities for 2023/24 (which will be included within the 2022/23 Quality Account).

Tees, Esk and Wear Valleys
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Looking Back – Quality Priorities 2022/23

Personalising Care planning

NHS
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NHS Foundation Trust

- Improving care planning is now part of the Advancing Our Clinical , Quality and Safety Journey programme which is prioritising and escalating the areas of highest risk
- DIALOG is a care planning system and is based on and facilitates a co-creation approach to care planning
- Significant work has already been undertaken introducing the principles of DIALOG in preparation for the electronic version which launches 01 July 2023
- Work targeting AMH and MHSOP inpatient care planning, via the introduction of a paper-based version of DIALOG and DIALOG+ continues to progress well.
- There continues to be a key focus on improving carer involvement through the introduction of a designated carers tab on CITO, a new Carers Hub and launch of the Trust Carers Charter
- There has been a big focus on developing high quality actions plans with regard to improving the patient experience across clinical services.
- Following a scoping meeting there are plans to hold a multi-agency engagement event in relation to moving away from the Care Planning Approach

Measuring Progress

NHS
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NHS Foundation Trust

Question	May 2022	March 2023
Inpatient		
Were you involved as much as you wanted in the planning of your care?	78%	74%
Were your family/carers involved in your care as much as you wanted?	81%	72%
Community		
Were you involved as much as you wanted in the planning of your care?	91%	92%
Were your family/carers involved in your care as much as you wanted?	84%	80%
Carer Survey		
Have you been asked to provide your experiences and history of the person you care for?	83%	84%
Do you feel that you are actively involved in decisions about the person you care for?	90%	88%

Improving Safety on our Wards

Tees, Esk and Wear Valleys NHS Foundation Trust

Feeling Safe

- Our data is telling us that on average 59% (September) of patients feel safe within our inpatient areas against a target of 88% which is frequently not met.
- Feeling safe is not a mandated measure nationally – no comparisons possible
- A survey published in 2020 by the Parliamentary and Health Service Ombudsman found that one in five people did not feel safe while in the care of the NHS mental health service that treated them.
- Not feeling safe may be a an inherent feature of an individual mental health condition however there are many other elements that can impact upon how safe patients feel on our inpatient wards.
- We aim to create a positive relationship in which patients feel safe.
- There is a need to create an open and rehabilitative environment that promotes patient recovery, patient safety and a good working environment for staff. Therefore, it is important to create a safe environment through preventative interventions so that both staff and patients can feel safe.
- To better understand this issue we held Focus Groups in October 2022 across Adult Mental Health Services in DTVF

Improving Safety on our Wards

Tees, Esk and Wear Valleys NHS Foundation Trust

Feeling Safe

These are some of the key things patients said to us when we asked them what feeling safe meant to them:

Feeling secure

Being able to trust staff

Feeling both Psychologically and physically safe

Being in a safe environment

What did we ask patients and staff?

Tees, Esk and Wear Valleys NHS Foundation Trust

Patients

- What does feeling safe mean to you?
- During your stay on the ward have you felt safe?
- When you don't feel safe, what has caused this?
- What things help you when you don't feel safe?
- What does a safe day on the ward look like to you?
- When was the last time you felt safe? what was happening to make you feel like that?

Staff

- What does feeling safe mean to patients?
- During their stay on the ward have patients felt safe?
- When they don't feel safe what has caused this?
- What things help them when they don't feel safe?
- What does a safe day on the ward look like to you?

Some of our findings

Tees, Esk and Wear Valleys NHS Foundation Trust

- **78%** of patients said that they felt safe on the ward they were currently staying on, patients said that sometimes other patients can cause them to feel unsafe.
- In comparison, **75%** of staff said that they thought patients felt safe on the ward. However, they identified the following reasons why some patients may not always feel safe: **when there are new patients admitted to a ward, not enough staff and lack of skills for some staff to effectively manage patient risk and engage with patients to keep them safe.**

  Some of the **reasons patients gave** for not feeling safe included: **other patients being violent, drugs and drink on the ward, their own illness, lack of engagement from some agency staff, staff not being visible in communal areas, noise and doors banging.**
- This was reiterated by staff that told us that patient presentation, violence and the ward environment can make patients feel unsafe. Staff told us that they didn't always feel safe on shift due to low staffing numbers and presentation of complex patients.
- **Reassurance from staff and staff support** is a key protective factor in ensuring that patients feel safe on the ward, patients value their relationships with staff.

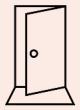
What helps patients to feel safe:

Tees, Esk and Wear Valleys NHS Foundation Trust

Peer support – talking to other patients on the ward

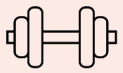
Staff support – getting reassurance from staff who listen to them and are adequately trained with the right skills and experience.

Being able to easily identify staff members from patients



Being able to go to my bedroom when there are incidents on the ward.

Accessing a place on the ward that is quiet.



Listening to music, arts and crafts and access to the gym.

Doing something productive, planting things looking after an allotment.

PAT therapy animals on the ward.

Doing activities, keeping myself occupied during the day.

Being able to access leave, if I can't get out on my own having enough staff to escort me.

This is now informing the development and delivery of our Patient Experience Improvement plans.

Some of the things we have done in response to what our patients and staff have said:

Tees, Esk and Wear Valleys NHS Foundation Trust

Safe and visible staffing

- ✓ Releasing clinical staff time to care through 7 day a week administrative support to wards
- ✓ Introduced the SafeCare system (a nurse rostering system). This enables efficient allocation of staff and has inbuilt patient safety triggers to support patient safety.
- ✓ Improved the skill mix of staff on duty by investing in band 6 staff and recruiting advanced nurse practitioners and a positive and safe lead - this role focuses on adherence to best practice regarding restrictive interventions.
- ✓ Introduction of Practice Development Practitioners (PDPs) to support service improvement.
- ✓ We are introducing an Agency Passport to improve competencies, training and induction of agency staff prior to them working on the wards.
- ✓ Practice development practitioners are supporting improvements to the induction process for agency staff.
- ✓ Introduced Health Care Assistant and Registered Nurse Councils to ensure that staff have a voice in our secure inpatient services.

Patient leave

- ✓ Introduced a dedicated leave team to support patients to access leave.
- ✓ Patient access to leave is consistently discussed in the daily ward huddles

Some of the things we have done in response to what our patients and staff have said:

Tees, Esk and Wear Valleys NHS Foundation Trust

Patient activities

- ✓ An annual timetable of activities and health promotion activities has been produced and is offered across our secure impatient services.
- ✓ Recruited to a number of activity coordinators who work on our wards across a seven day week.
- ✓ Introduced pet therapy animals within some wards.
- ✓ Recruited gym instructors for both PICUs.
- ✓ Support from the arts at Foss Park Hospital and Cross Lane Hospital with projects, co-created with patients, that are creating a better environment.

Patient environment

- ✓ Improvements to Roseberry Park Hospital courtyard areas including decorating feature walls and installing new planters which are managed by activity coordinators on the wards.
- ✓ Allocated lifecycle funds to replace outside furniture.
- ✓ Improved the safety of the internal space by introducing heavy duty furniture onto wards. On some wards there is ongoing estates work to improve the ward environment with daily (ward managers) and weekly (matron) walkabouts to ensure issues are addressed.
- ✓ Installed anti-ligature doors within Tunstall ward.
- ✓ Continue to review the use of carpets in collaboration with the IPC team and acoustics have been considered as part of the Roseberry Park Hospital rectification works.
- ✓ A number of actions in place as part of the environmental ligature reduction work with regular reporting through estates and facilities management.

Improving Safety on our wards

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Oxevision

- Oxevision is a tool that helps us care for patients more safely and was developed in collaboration with patients. The system has been designed specifically for mental health care and includes a regulated medical device which operates with an infrared-sensitive camera. It helps staff visually confirm a patient is safe through measuring their pulse and breathing rate - without disturbing their sleep.
- We have implemented it an a number of areas in the Trust and undertaken an evaluation of its impact
- The Trust has supported a national review in mental health wards and is disseminating the resulting guidance to relevant wards.
- Oxevision is also being rolled out to further wards across the Trust following the success observed to date.

oxevision®

Evaluation of Oxevision pilot

Tees, Esk and Wear Valleys NHS Foundation Trust

Improved safety on the wards

- Over 90% of staff reported Oxevision improves safety on the ward and helps them identify falls they may otherwise not have known about.
- 90% of staff reported the system enabled them to prevent potential incidents and 86% reported the system made it easier to monitor the physical health of patients.
- 83% of patients felt the system kept them safer and 88% felt that it allowed staff to respond to them more quickly.

Older adults (Rowan Lea ward)

- 16% relative reduction in falls in bedrooms when compared to the control ward
- 25 - 40% relative reduction in assaults across the bedroom and ward respectively when compared to the control ward.

Acute Care (Elm ward)

- 7% relative reduction in self-harm in bedrooms when compared to the control ward.
- Harmful self-harm in the bedroom had a relative reduction of 85% when compared to the control ward.
- Ligatures also had a relative decrease when compared to the control ward.

Psychiatric Intensive Care Units (Cedar ward)

- 25% reduction in self-harm in bedrooms compared to its baseline. .

Evaluation of Oxevision pilot (2)

Tees, Esk and Wear Valleys NHS Foundation Trust

Improved patient experience

- 100% of patients felt the system reduced disturbance at night-time.
- 89% of patients felt that the system improved their wellbeing and 92% felt it enabled staff to care for them better.
- Patients felt the system helps them get better sleep (80%), gives them a greater sense of privacy (83%) and dignity (90%) and improved their relationship with staff (88%).

Positive impact on risk management and restrictive practice levels

- 90% staff reported that the system enables them to better manage patient risk.

Improved care quality

- 79% of staff reported that the system enables them to provide better care for patients.
- 72% of staff reported that the system provides them with more information to help make better care or clinical decisions.

Improving Safety on our wards

Tees, Esk and Wear Valleys NHS Foundation Trust

Body worn cameras

- The other technological innovation being trialled are staff bodycams. 10 wards are piloting this initiative. As the pilot has progressed there has been a range of emerging challenges. These include TEWV and supplier IT issues and additional training required to further progress the pilot.
- Wards and teams can explore ways in which they can develop sustained local processes focused upon maintenance and reviewing footage. Although the prime expected benefit of this technology is a reduction in restraint, national studies have also suggested that incidents (which include patient-patient violence) should be reduced.

Environmental work to reduce potential ligature points

- Programme for the installation of sensor doors
- Continued to embed the Safe Wards initiative (an evidence-based tool to reduce violence and support a safe ward environment)

Implementing the Patient Safety Incident Response Framework (PSIRF)

Tees, Esk and Wear Valleys NHS Foundation Trust

- We have continued to review and improve our Serious Incident Review processes and reports to utilise evidence-based tools, with a focus on learning and identification of emerging themes.
- Staff have undertaken national training from Healthcare Safety Investigation Branch (HSIB).
- Involving families and carers throughout the process.
- Introduced a triage process for incidents that have been categorised as moderate and serious harm to determine quickly the appropriate route for review and to identify early learning.
- Introduced daily patient safety huddles to include clinical staff and subject matter experts.
- Reviewed and refreshed Directors Serious Incident Assurance Panels.

Implementing the Patient Safety Incident Response Framework (PSIRF)

Tees, Esk and Wear Valleys NHS Foundation Trust

- Procured a new risk management/ incident reporting system
- Undertaken some listening exercises to ensure our staff have a full understanding of the Duty of Candour, undertaken an audit against Trust standards and identified some areas for improvement
- Work continues to improve the quality and oversight of patient safety action plans
- Introduction of Patient Safety Partners

Learnings about patient safety from West Lane Hospital

Our Trust stopped delivering inpatient children and adolescent mental health services (CAMHS) in September 2019 following a series of incidents at West Lane Hospital. Following this, NHS England commissioned an independent review looking at the care and treatment of three young woman who sadly died in our care in 2019 and 2020.

The review was clear that we needed to improve some of the ways that we work:

Improving the ward environment:

To reduce ligature risks we have made changes to some ward environments. We have:

- Removed shower curtains
- Replaced old taps with anti-ligature ones
- Installed anti-ligature doors in some areas
- Ligature risk is assessed monthly by your matron during walk-arounds
- We are also piloting a system called Oxehealth in some areas. Oxehealth is an alert system designed to improve safety for the people we care for.

Improving patient safety

We have changed the way we talk about risk; we now use safety summaries and safety plans. Patients, families and carers are much more involved in this.

- We used to record information about risk in multiple places. This led to mistakes. The primary place of recording risk is in the safety summary and safety plan.
- The quality of our records and content are regularly checked. We use a quality assurance schedule and peer visits to do this.
- Learning from these audits and visits is shared in team meetings and huddles so everybody knows how to keep patients safe.
- As part of our daily ward safety review, we now share important information which helps keep our patients safe.
- We have improved our response to incidents and how we learn from these.

Improving Our governance

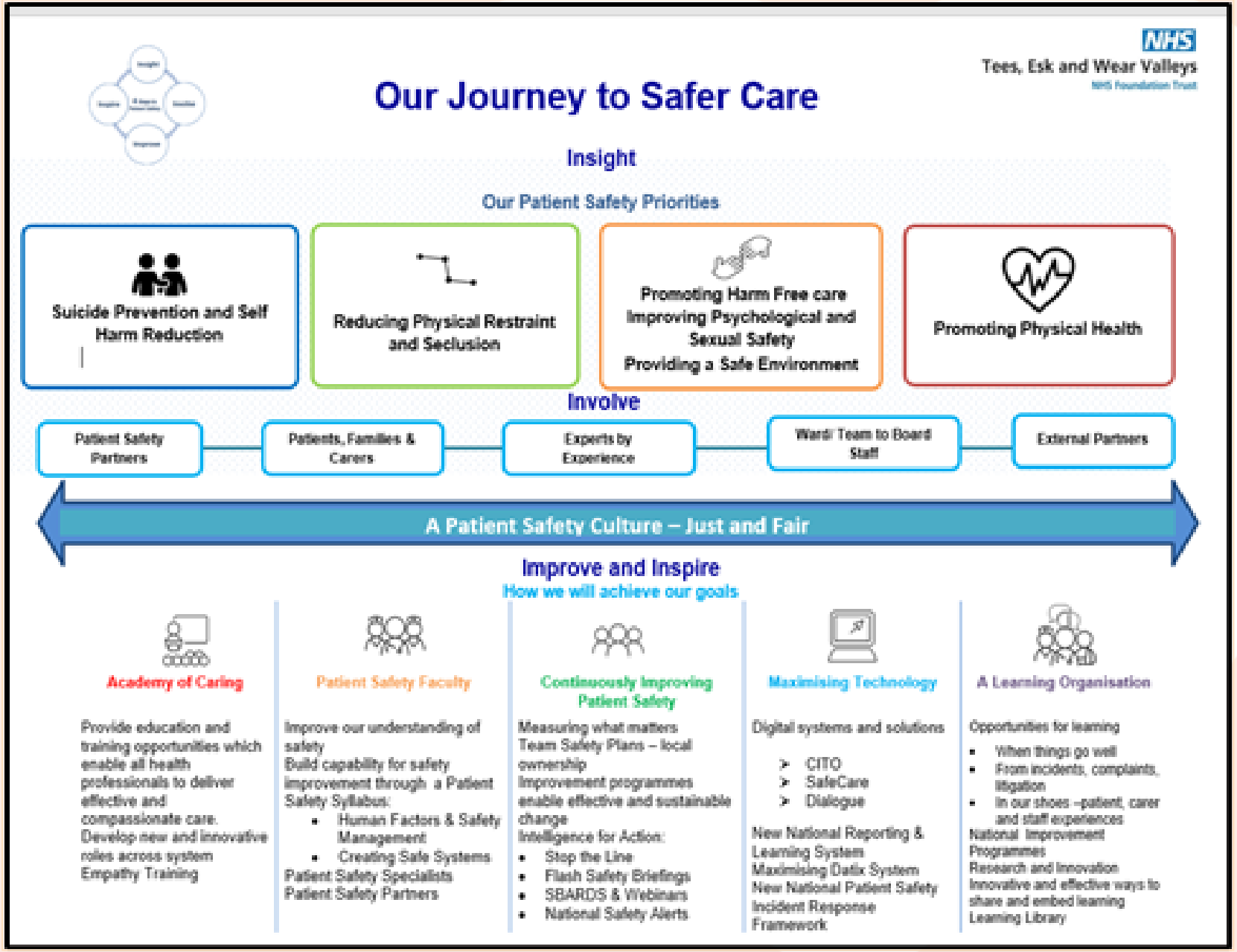
Good governance is about having the right people in the right place with the right skills. This supports services to continuously improve and helps us to provide safe and effective care. We know we weren't getting this right and needed to make some changes:

- We have changed the way we share information from ward to board.
- New meeting structures have been developed.
- We are improving the way we are using data and information to better understand how to improve our services.
- We have introduced several new roles, so you may have noticed new faces. We have increased the clinical leadership and focus to help us inform our care.
- To enhance the patient voice, we have recruited lived experience directors and increased the number of peer support workers.

Quality Priorities for 2023/24

Our Quality Journey (our Quality Strategy)

- Developed during 2022, with service user and carer input
- Links back to Our Journey to Change which was developed in 2020. This was based on over 2,000 inputs from service users, carers, stakeholders and staff and sets out our vision, mission, goals and values.
- Is supported by our clinical, cocreation, people and infrastructure journeys.
- Is being implemented through TEWV's OJTC Delivery Plan which was agreed at our April 2023 Board of Directors' meeting



National Patient Safety Strategy

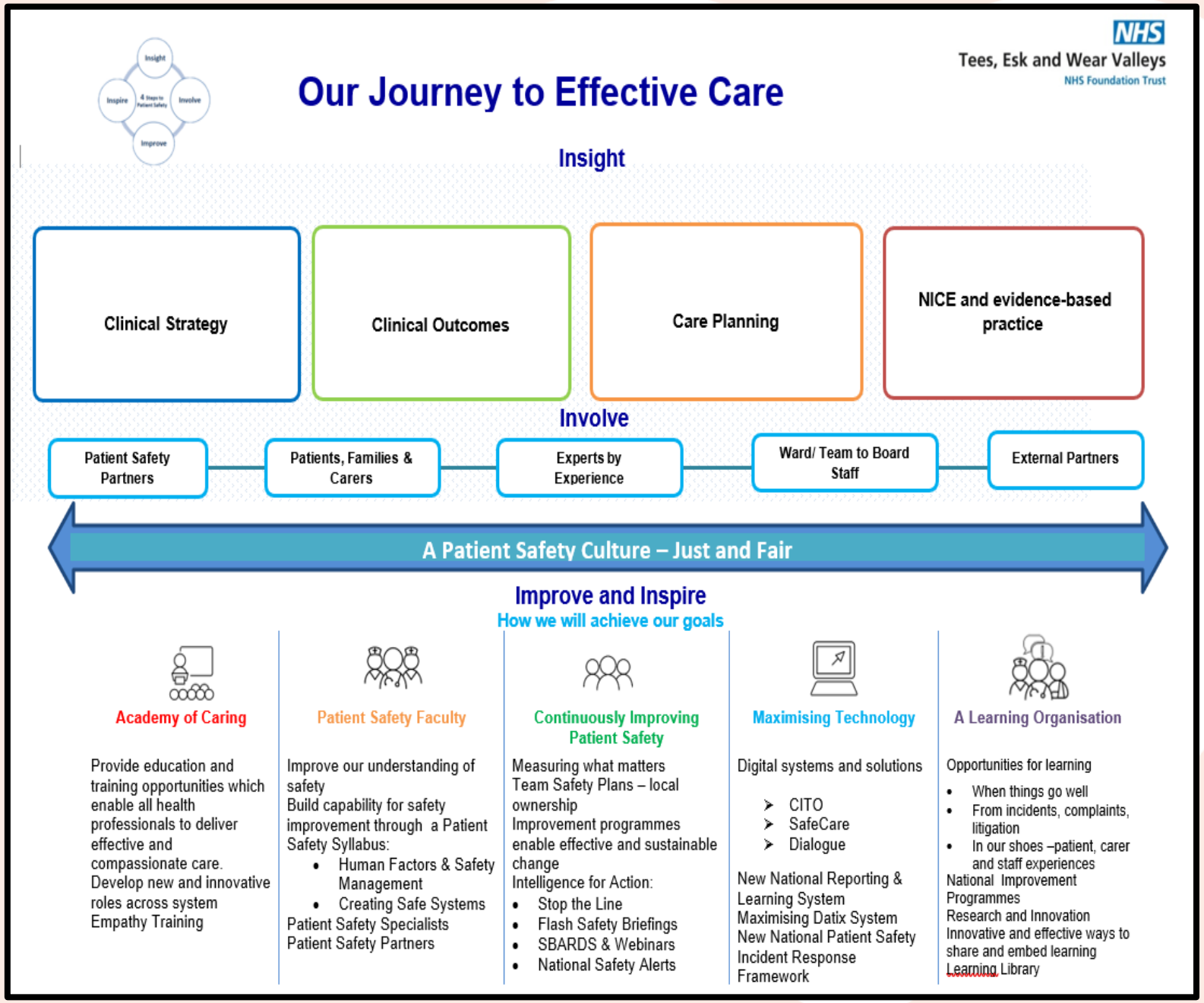
Reporting incidents directly via the new Learning From Patient Safety Events (LFPSE)

Improving Patient Safety through the transformation of the Patient Safety Incident Reporting Framework (PSIRF)

✓Patient Safety Syllabus

✓Patient Safety Specialists

✓Patient Safety Partners

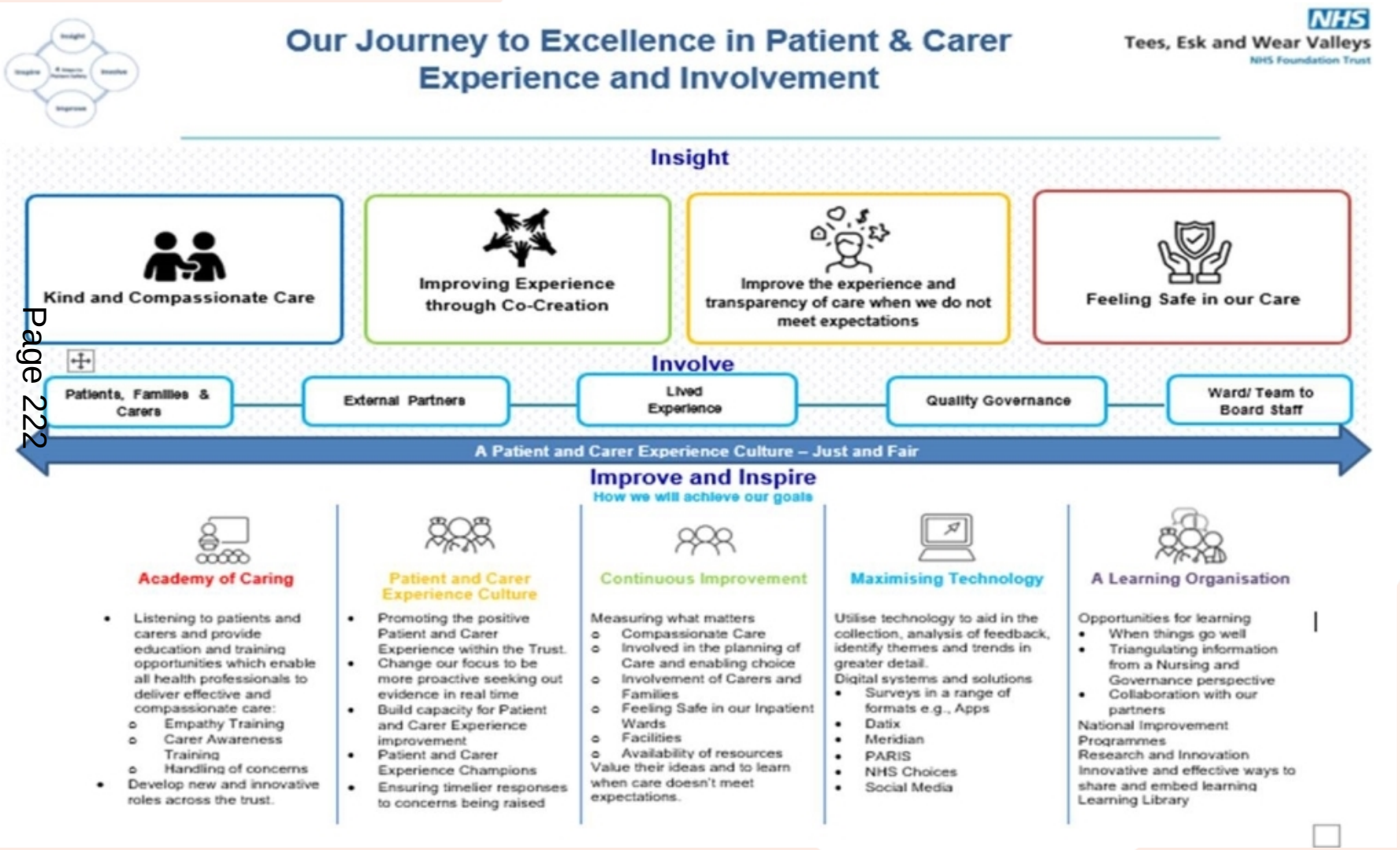


✓For each service, we will have in place a suite of clinical outcome measures and patient reported outcomes (effectiveness of care measures)

✓We will have improved data quality with regard to the 'effectiveness of care' measures that will be utilised by clinicians to better understand the impact of different approaches to patient care and treatments

✓Using this data, we will see an increase in the number of patients reporting an improvement in their symptoms after receiving care and treatment from the Trust

✓There will be an increase in patients telling us they have been able to influence their care and all care plans will be co-created with patients and their families



- We will demonstrate significant improvements in the experiences of the people using our services through using an increased range of methods and range of quantitative and qualitative information
- Service users, carers and staff will see that their voice makes a difference – by speaking out about poor care and making suggestions for improvements they are continuously improving the experience people have of our services.
- Patients will talk positively about the impact of restrictions on their recovery
- Patients on our wards will feel safe

Draft Quality Improvement Priorities for 2023/24

Tees, Esk and Wear Valleys NHS Foundation Trust

Patient Safety

- To fully implement the new National Patient Safety Incident Reporting Framework by September 2023. To include:
  - The introduction of Patient Safety partners
  - Increase the number of staff undertaking the Level 1 and 2 Patient Safety Syllabus
  - Introduce an annual Patient Safety Summit

Patient Experience

- Continue to focus on patients feeling safe on our wards
- Increase the opportunities to involve carers in planning of care and decision making, in shaping and developing Trust initiatives
- Increasing responses for patient and carer feedback
- Utilise technology to aid in the collection and analysis of feedback, identifying themes and trends in greater detail

Clinical Effectiveness

- Embed DIALOG, our new digital care planning tool, and increase the percentage of carers/families involved in the planning of care

What next?

Tees, Esk and Wear Valleys NHS Foundation Trust

- We welcome your comments for inclusion in our Quality Account.
- The Quality Account will be presented to the Trust Board of Directors in June 2023.
- Publication of the final document by 30th June 2023 on our website.
- We will be happy to bring six-monthly update on progress during 2023/24 to this Committee.

Questions and Comments

Tees, Esk and Wear Valleys NHS Foundation Trust

We hope you can see:

- The huge amount of improvement work undertaken during 2022/23 and the key improvements achieved
- Why we have chosen the quality priorities we have for 2023/24

We are happy to take any questions or for you to share your comments.

Thank You