County Durham and Darlington NHS
NHS Foundation Trust

Quality Accounts
2015 – 2016

WORKING VERSION DRAFT

with you all the way

INTRODUCTION

As discussed in the quality report last year County Durham & Darlington NHS Foundation Trust had begun seven key projects which were at the heart of our plans to improve the quality of services that we offer to our patients.

The projects are aligned to our vision for services Right First Time Every Time, and they continue to underpin the priorities that we have set ourselves in this year's Quality Accounts.

The seven projects have progressed throughout last year and will continue during the coming year. These are:

- **Transforming Unscheduled Care at University Hospital of North Durham (UHND)** by developing a new 24/7 front of house clinical model including expanded and co-located Consultant-led multi-agency assessment, urgent and ambulatory care facilities. The aim is to have the new configuration in place by late 2017. This will go a long way towards addressing one of the greatest strategic challenges for the local health economy: non-elective pressures at UHND.
- **Integration and co-location of the Darlington Urgent Care Centre with Accident & Emergency at Darlington Memorial Hospital (DMH)**. The aim is to have the new configuration in place by late 2016.
- **Creating Centres of Excellence**. In this connection, work is underway to upgrade theatres at Bishop Auckland Hospital in order to move most elective Orthopaedics work to that site from Spring 2016. This will shelter it from the non-elective pressures at UHND and DMH which disrupt the elective service and cause inconvenience to patients through cancelled operations.
- **DMH theatres and support services**. The Trust has commenced demolition of the Pierremont Building in preparation for its replacement by a new building housing twelve modern theatres (to replace the existing six), new mortuary and bereavement facilities.
- **Introduction of mobile working for CDDFT community staff**. This project involves supplying staff with electronic devices, enabling them to remotely access and add to patient notes, saving repeated journeys to and from the office. The project is already in its implementation phase with roll-out taking place incrementally to all community teams.
- **Development and sustaining of the award winning DMH multi-disciplinary team** for complex and frail elderly people over 60 who are most at risk of hospital admission.

A Guide to the Structure of this Report

The following report summarises our performance and improvements against the quality priorities we set ourselves in the 2015/16 period. It also outlines those we have agreed for the coming year (2016/17).

The Quality Accounts are set out in three parts:

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

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

What are Quality Accounts?

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

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

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

PART 1: Statement from Chief Executive

County Durham & Darlington NHS Foundation Trust is pleased to present our Quality Account. I would like to thank staff and stakeholders who continue to work with us to review our progress against priorities for 2015/16 and agree our priorities for 2016/17.

Our ambition for our services

County Durham & Darlington NHS Foundation Trust (CDDFT) is one of the largest providers of community, hospital and health and wellbeing services in the NHS. Our aim is to provide:

- Services that are evidenced based, accessible, safe, sustainable and effective
- Care that delivers improvements in health outcomes and reduces inequalities
- Patient pathways that are integrated across providers

Our vision and goals

Our vision – "Right First Time, Every Time", has been agreed working with staff. It summarises how we envisage services in the future: provided by the right professional, in the right place – in hospital or close to home – at the right time, first time, every time, 24 hours a day, where necessary.

Our mission - "with you all the way" describes our commitment to put patients at the centre of everything we do in delivering the very best integrated healthcare and being the best provider of community, hospital and health and well-being services.

Key to the delivery of our Mission are our 'touchstones', as follows:

- The **best health outcomes** for patients – we need to achieve the highest possible standards of care and improved results for patients;
- The **best patient experience** – because evidence shows that better outcomes are linked to a better experience;
- The **best efficiency** – reducing our costs so we can continue to invest for the future; and,
- Being a **best employer** – because high levels of staff motivation and satisfaction are closely related to better patient care.

Central to the delivery against our Touchstones is maintaining the sustainability of high-quality, safe services. The quality strategy which was developed last year, called Quality Matters 2015/17 continues to underpin our quality goals.

The priorities identified for the coming year have been produced with engagement from our Stakeholders, Governors and our staff taking into account the overarching strategies and projects outlined above. Our priority areas for clinical quality and improvement and safety are aligned to these three essential dimensions.

Safety
Patient Falls
Healthcare associated infections
Management of pressure ulcers
Learning from incidents
Management of patients with sepsis
Duty of Candour

Experience
Care of patients with dementia
End of Life care
Nutrition & Hydration

Effectiveness
Care bundles
Unscheduled Care
Maternity and paediatric care

I believe that this Quality Account demonstrates our commitment to continued improvement in the quality of our patient care. The Board is confident that our planned target outcomes for the coming year will build on our strengths and demonstrate our commitment further.

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

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

Review of our key priorities for 2015/16

Last year we set 18 priorities. These have been set under the following headings:

- Safety
- Patient Experience
- Clinical Effectiveness

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

Performance Results at a Glance for 2014/15 Priorities in relation to 2013/14 Priorities

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

		2014/15	Upper Threshold	Position	
SAFETY					
Falls	Patient falls – reduce falls/1000 bed days community hospital Patient falls – reduce falls/1000 bed days acute hospital	5.84 ☑ 6.89 ☒	8.0 5.6	**TBC**	**TBC**
	Introduce sensory training	Over 720 ☑	720	Over 720	☑
	Follow up patients with fragility fracture	91.43% ☑	50%	**TBC**	**TBC**
	Complete root cause analysis for falls resulting in fractured neck of femur	All complete	All complete	All complete	☑
Care of patients with dementia	Development of a dementia pathway and audit of compliance	Further roll out required ⊖	December 2014	Complete	☑
Healthcare Associated Infection (HCAI)	Meticillin Resistant Staphylococcus aureus (MRSA) post 48 hour bacteraemia	6 ☒	0	3	⊖
	Clostridium *difficile* post 72 hour	18 ☑	19	21	☒
Pressure Ulcers	To have no avoidable grade 3 or above pressure ulcers within acute or community services	9 ☒	0	5	⊖
Venous thromboembolism (VTE)	Maintain venous thromboembolism assessment compliance at or above 95%	96.21% ☑	95%	95.7%	☑

Discharge	Discharge summaries	90.56% ⊖	95%	93.3%	⊖
Incidents	Rate of patient safety incidents reported via National Reporting and Learning System (NRLS)	Reporting within 25% ☒	Reporting to within 75%	Reporting to within 50%	⊖
	Rate of patient safety incidents resulting in severe injury or death from National Reporting and Learning System (NRLS)	0.2% ☑	0.4%	0.2%	☑
Sepsis	To implement sepsis care bundle and audit effectiveness	N/A	Complete	Complete	☑
Duty of Candour	To monitor implementation	N/A	System of monitoring introduced	Complete	☑
PATIENT EXPERIENCE					
Nutrition and Hydration	To review audit tool	complete	Complete	Complete	☑
	To agree new indicators	complete	Complete	Complete	☑
	To audit against new indicators	In pilot stage	Complete	Roll out continues	⊖
End of Life Care	Ensure that we recognise when a patient may benefit from palliative care both at the end of their life and earlier in their illness	Actions to continue ⊖	Complete	Progress made but work to continue	⊖
Development of a Learning Disabilities outreach service$_1$ **(Continuation)**	To follow up all patients with a learning disability upon discharge into the community setting, initially with a telephone call, followed by a visit in their own home where appropriate. Monitor admission and readmission rates so that any recurring themes can be reported on and raised with the appropriate partner agencies A biannual report will be produced and submitted to Quality & Healthcare Governance Committee to show progress and remedial action taken.	Continue ☑	Complete	Complete	☑
Patient personal needs	Responsiveness to patients personal needs	Improved result for 4 out of 5 indicators for personal needs ☑	Improved positive responses in comparison to this year's results	Improved result in all indicator questions for personal needs	☑
Percentage of staff who would recommend the provider to family or friends needing care	To achieve average national performance against staff survey	**On a scale of 1 to 5** 3.45 ☒	**On a scale of 1 to 5** 3.71	**On a scale of 1 to 5** 3.60	⊖

Friend and family test	To increase Friends and Family response rates	☑	**Over 20% in Emergency Department** **Over 30% Inpatient areas**	**TBC**	
CLINICAL EFFECTIVENESS					
Reduction in risk adjusted mortality (RAMI)	To continue RAMI and run alongside Standardised Hospital Mortality Index (SHMI) monthly measure – no more than 100 monthly	RAMI SHMI as expected ☑	As expected	As expected	☑
Reduction in readmission to hospital (within 28 days)	To reduce emergency readmissions	**0-15 years** 11.8% **16 years and over** 11.8%% **Total** 11.8%% ⊖	7%	**0-15 years** **TBC** **16 years and over** **TBC** **Total** **TBC**	
To reduce length of time to assess and treat patients in accident and emergency department	**Patient impact indicators:** - Unplanned re-attendance no more than 5%	0.5% ☑	<5%	**TBC**	
	- Left without being seen no more than 5%	1.5% ☑	<5%	**TBC**	
	Timeliness indicators: - 95% to be treated/admitted/discharged within 4 hours	94.30% ☒	95%	**TBC**	
	- Time to initial assessment no more than 15 minutes	57mins ☒	15 mins	**TBC**	
	- Time to treatment decision no more than 60 minutes	29mins ☑	60 mins	**TBC**	
To reduce length of time for ambulance services to hand over patients to emergency departments	Baseline measurement quarter one – leading to reduction throughout year (2 hours ambulance delays)	☒	Reduction	**TBC**	
Patient Reported Outcome Measure (PROM)	To gain better understanding of patient's view of their care and outcomes - Hip	0.44 0.32 0.05 ⊖	Improved rates	**TBC**	

	- Knee - Hernia				

Introduction to 2016/2017 priorities

Key priorities for 2016/2017 have been agreed through consultation with staff, governors, local involvement networks, commissioners, health scrutiny committees and other key stakeholders. Throughout the year we have updated both our staff and stakeholders on progress against our quality improvement targets. In addition an event was held earlier in the year where a series of presentations were given to a wide range of staff and stakeholders. All were in agreement that these events were very useful in informing the priorities for the coming year and identifying the areas for continued monitoring.

The table below summarises the specific priorities and objectives that have been agreed for inclusion in the 2016/2017 Quality Accounts. The table also indicates where this is a new or mandatory objective and where this is a continuation of previous objectives. While most of the priorities are not new we have introduced different methods for monitoring where the priority has changed or the service objectives have changed.

Priority	Rationale for choice	Measure
SAFETY		
Patient Falls$_1$ **(Continuation)**	Targeted work continued to reduce falls across the organisation. To ensure continuation and consolidation of effective processes to reduce the incidence of injury To continue sensory training to enhance staff perception of risk of falls To continue a follow up service for patients admitted with fragility fractures	To collect data on number of falls reported internally onto Safeguard incident management system and report to Safety Committee via the Incident Report on a monthly basis. To aim for a further reduction in falls to bring in line with national average. To aim for 5.6 per 1000 bed days in acute ward areas and 8 per 1000 bed days in community bed areas. Report monthly figures via monitoring charts to Trust Board. To continue sensory training into staff education programmes To follow up patients identified as having fragility fractures To investigate the causes of preventable falls Produce key actions from the results of the national falls audit Roll out 1:1 supervision guidelines
Care of patients with dementia$_1$ **(Continuation)**	Continued development and roll out of a dementia pathway and monitoring of	Pathway in place Development of the service following employment of dementia nurse lead

	care for patients with dementia	Dementia friendly signage to be rolled out to all inpatient wards 18 inch faced clocks to be in place in all high volume dementia areas Review and update mental health intranet site to include dementia workstreams and resources Engage in national dementia audit and act on analysis of findings when available Sensory garden to be established on DMH site Continue rollout of coloured toilet seats, coloured door frames to complete in all appropriate areas All ward areas to have a supply of coloured crockery, adapted cutlery and opaque jugs and glasses to meet the needs of patients with dementia as determined by ward manager Roll out of orientation boards to all areas that care for patients with dementia as determined by ward/department manager Develop and roll out dignity leaflet once agreed through relevant stakeholders Relevant staff to engage in "Inside out of mind" video and discussion session Review content of workbook attached to "Inside out of mind" to establish whether any aspects need to be incorporated into current training
Healthcare Associated Infection **MRSA bacteraemia**[1,2] **Clostridium *difficile***[1,2] ***(Continuation and mandatory)***	National and Board priority. Further improvement on current performance	Achieve reduction in MRSA bacteraemia against a threshold of zero. No more than 19 cases of hospital acquired Clostridium *difficile* Both of these will be reported onto the Mandatory Enhanced Surveillance System and monitored via Infection Control Committee
Venous thromboembolism risk assessment[1,2] **(Continuation and mandatory)**	Maintenance of current performance	Maintain VTE assessment compliance at or above 95% within inpatient beds in the organisation. This mandated indicator will continue during 2016/17 Assessment will be captured onto a Trust database and reported weekly to wards and senior managers.

		Performance will be reported and monitored at Trust Board using performance scorecards
Pressure ulcers$_{1}$ ***(Continuation)***	To have zero tolerance for grade 3 and 4 avoidable pressure ulcers	Full review of any identified grade 3 and 4 pressure ulcers to determine if avoidable or unavoidable Reduce incidence from last year to zero avoidable grade 3 or 4 pressure ulcers All identified pressure ulcers will be reported onto the Trust internal incident reporting system and numbers reported to Safety Committee via monthly incident report
Discharge summaries$_{1}$ **(Continuation)**	To continue to improve timeliness of discharge summaries being completed	Monitor compliance against Trust Effective Discharge Improvement Delivery Plan Enhance compliance to 95% completion within 24 hours Data will be collected via electronic discharge letter system and monitored monthly with compliance reports to Care Groups and Trust Board via performance scorecards
Rate of patient safety incidents resulting in severe injury or death $_{1,2}$ **(Continuation and mandatory)**	To increase reporting to 75th percentile against reference group	Cascade lessons learned from serious incidents Introduce specific monthly monitoring to highlight and action poor compliance with timeliness of reporting and investigating serious incidents via Incident Report to Safety Committee. Upload patient safety incidents to NRLS each month Measure compliance against NRLS data. Enhance incident reporting to 75th percentile against reference group Identify areas who are poor reporters of incidents Continue thematic analysis for inclusion in annual report
Improve management of patients identified with sepsis$_{3}$ **(Continuation)**	To implement sepsis care bundle and audit effectiveness	Continue to implement sepsis care bundle across the Trust Continue to implement post one hour pathway Continue to audit compliance and programme Hold professional study days
Duty of candour (New indicator)	To demonstrate introduction and compliance with statutory Duty of Candour	During 2016/17 we will report on further enhancements to the introduction of Duty of Candour
EXPERIENCE		

Nutrition and Hydration in Hospital[1] **(Continuation)**	To promote optimal nutrition for all patients	Re-energise protected meal times Increase the use of volunteers for mealtime assistance Continue to use nutritional bundle for weekly nutritional care planning of patients nutritionally at risk for inpatients Trust wide menu review of finger foods Report and monitor compliance monthly via Quality Metrics
End of life and palliative care[1] **(Continuation)**	We want our workforce to be equipped to provide high quality end of life care. We want patients approaching the end of life to be confident in receiving high quality care in accordance with their wishes.	Survey targeted staff groups about their confidence in delivering end of life care before and after delivery of end of life education. This was not undertaken as there are no valid & reliable methods of measurement & it would be difficult to evidence. Monitor the proportion of staff accessing end of life training and to continue in pilot areas Care of patients who are identified as approaching the end of life will be audited against the regional guidance for the care of patients ill enough to die will continue in pilot areas Carry out a survey of bereaved relatives. Proposal shared at EOL Steering Group & methodology being refined prior to launch in the coming year
Learning disabilities[1] **(Continuation)**	As a continuation from the work developed through the learning disability guarantee and outreach service we have highlighted that not all service users arrive into the acute hospital setting with enough information to support staff in delivering reasonably adjusted care. Readmission rates could be further reduced with the implementation on emergency health care plans in specific cases.	This goal is now embedded within the organisation and will move to "business as usual" from this year.
Responsiveness to patients personal needs[1,2] **(Continuation and mandatory)**	To measure an element of patient views that indicates the experience they have had	Continue to ask the 5 key questions and aim for improvement in positive responses in comparison to last years results

		Quarterly reports to Quality & Healthcare Governance Committee and any emerging themes monitored for improvement. The Trust will participate in the national inpatient survey
Percentage of staff who would recommend the trust to family or friends needing care[1,2] **(Continuation and mandatory)**	To show improvement year on year bringing CDDFT in line with the national average by 2017-18	To bring result to within national average Results will be measured by the annual staff survey. Results will be reviewed by sub committees of the Trust Board and shared with staff and leaders and themes considered as part of the staff engagement work In addition we will show results for harassment & bullying and Race Equality Standard as suggested by Monitor for this year and coming years
Friends and Family Test[1] **(Continuation)**	Percentage of staff who recommend the provider to Friends and Family	During 2016/17 we propose to increase or maintain Friends and Family response rates. All areas participating will receive monthly feedback and a quarterly report of progress will be monitored by Quality and Healthcare Governance Committee
EFFECTIVENESS		
Risk Adjusted Mortality (RAMI)[1] **Standardised Hospital Mortality Index (SHMI)[1,2]** **(Continuation and mandatory)**	To closely monitor nationally introduced Standardised Hospital Mortality Index (SHMI) and take corrective action as necessary	To monitor for improvement via Mortality Reduction Committee To maintain RAMI and SHMI at or below 100 Results will be captured using nationally recognised methods and reported via Mortality Reduction Committee. We will continue to benchmark both locally and nationally with organisations of a similar size and type. Monthly updates will be submitted to Trust Board via the performance scorecard Weekly mortality reviews led by the Medical Director will continue, and any actions highlighted monitored through Care Group Integrated Governance Reports
Reduction in 28 day readmissions to hospital[1,2] **(Continuation and mandatory)**	To improve patient experience post discharge and ensure appropriate pathways of care To support delivery of the	To aim for no more than 7% readmission within 28 days of discharge Information will be submitted to the national database so that national

	national policy to continue to ensure patients receive better planned care and are supported to receive supported self – care effectively	benchmarking can continue. Results will be monitored via Trust Board using the performance scorecard and any remedial actions measured and monitored through the performance framework.
To reduce length of time to assess and treat patients in Accident and Emergency department[1,2] **Continuation and mandatory)**	To improve patient experience To improve current performance	No more than expected rate based on locally negotiated rates. Monthly measure Information will be submitted to the national database so that national benchmarking can continue. Results will be monitored via Trust Board using the performance scorecard and any remedial actions measured and monitored through the Front of House Task Group
Patient reported outcome measures[1,2] **(Continuation and mandatory)**	To improve response rate	Response rate for all 4 indicators to be in line with the national average by 2015/16 Data submitted via national database and monitored with Care Groups using performance scorecards so that any action can be monitored To aim to be within national average for improved health gain. To monitor by care group performance meetings as data is released
Maternity standards (new indicator following stakeholder event)	To monitor compliance with key indicators	To monitor for maintenance and improvement in relation to breastfeeding, smoking in pregnancy and 12 week booking Complete gap analysis against "Saving babies lives" NHS England document
Paediatric care (new indicator following stakeholder event)	Improved paediatric pathways for urgent/emergency care	To monitor and report on changes to the pathways

1 - continuation from previous year

2 - mandatory measure

3 - new indicator following stakeholder events

In complement the above the Trust has embarked on the 'Sign up to Safety' campaign and aligned the priorities closely with the Quality Account. The priorities for 2016/17, which follow through from 2015/16, are as follows:

- **Put safety first -** Commit to reduce avoidable harm in the NHS by half and make public our goals and plans developed locally, in particular, reducing sepsis, providing safe staffing levels, introducing e-observations & reviewing the serious incident levels.
- **Continually learn –** make our organisation more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe our services are.

- **Honesty –** Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.
- **Collaborate –** Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.
- **Support –** Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress.

Review of performance against priorities 2015/2016

The following section of the report focuses on our performance and outcomes against the priorities we set for 2015/2016. These will be reported on individually under the headings of Safety, Patient Experience and Clinical Effectiveness. Wherever available, historical data is included so that our performance can be seen over time.

PATIENT SAFETY

Patient Falls

	TBC

Our aim

We are committed to and focused on continued improvement in this area. The section below summarises the targets which we set ourselves in relation to patient falls, what we did throughout the year to achieve reduction and the improvements we plan to make for 2016/2017. The number of falls within the organisation is identified from the incident reporting system and reported to the Safety Committee on a monthly basis. Data is captured in a monthly incident report and as part of the Board performance monitoring data.
Patient falls that result in fractured neck of femur are reported as a Serious Incident and an in depth analysis of the cause of the fall is carried out to establish whether there are any lessons that can be learned to prevent falls for other patients.

Progress

For monitoring purposes the Trust continues to measure the number of falls against the national mean. This remains at 5.6 per 1000 bed days for acute and 8.0 per 1000 bed days for community. Focused work remains fundamental to ensuring a continued reduction in falls.

Sensory awareness training has continued this year with on-going positive feedback from members of staff. This training focuses on the vulnerability of people with sensory impairments and their risk of falls. To assist with those patients at a higher risk of falls a supervision policy has been completed and is now being launched to become part of everyday practice.

Mandatory training for all registered nurses continues, with an overview given of multifactorial risk assessment and intervention given to all attendees.

A national audit was carried in May 2015. There were a number of good practices, however further work is required across all sites to deliver on the key areas where areas of suboptimal practice has been identified. The action plan includes further work in compliance with lying and standing blood pressure, medication review, walking aid availability, and continence care and delirium assessment.

The falls group presently meets on a monthly basis and during this meeting avoidable serious incident falls are discussed. During this discussion themes are discussed and action taken as a result.

Next steps

The Falls Bundle is presently being evaluated and changed to ensure all patients over the age of 65 years have a falls preventative care plan in place. This will ensure that more vulnerable patients have a cognitive assessment and a delirium assessment.

As part of the national audit action plan a bedrail audit will be completed and further audits will be undertaken to ensure that any areas of focus are identified and remedial action taken. Technology is proving invaluable in present day health care and early discussion is taking place on how clinical staff can identify all patients who are at risk of falls.

Care of Patients with Dementia

☑	Trust ambition achieved

Our Aim
To introduce monitoring indicators against the dementia strategy to show improvement in care of patients with dementia

Progress
This indicator was introduced last year following Stakeholder event as a key priority for the Trust. There have been some key achievements throughout the year and plans are in place to improve the service further throughout 2016/17

- Dementia pathway produced and in place
- Introduction of dementia champions. Forty three of these have completed the educational programme and regular update meetings are established
- Secured charitable funding to secure a sensory garden on DMH site – planning of this by Youth Group
- Dementia task and finish group established
- Development of a finger food menu and pilot of use in specific wards
- Completion of Carers survey. From feedback development of Dignity leaflet
- All patients aged 75 years and over are asked about their memory on admission

Next Steps

- Dementia friendly signage to be rolled out to all inpatient wards
- 18 inch faced clocks to be in place in all high volume dementia areas
- Review and update mental health intranet site to include dementia workstreams and resources
- Engage in national dementia audit and act on analysis of findings when available
- Sensory garden to be established on DMH site
- Continue rollout of coloured toilet seats, coloured door frames to complete in all appropriate areas
- All ward areas to have a supply of coloured crockery, adapted cutlery and opaque jugs and glasses to meet the needs of patients with dementia as determined by ward manager
- Roll out of orientation boards to all areas that care for patients with dementia as determined by ward/department manager
- Develop and roll out dignity leaflet once agreed through relevant stakeholders
- Relevant staff to engage in “Inside out of mind” video and discussion session

- Review content of workbook attached to “Inside out of mind” to establish whether any aspects need to be incorporated into current training

Healthcare Associated Infections

MRSA bacteraemia

⊖	Improvement demonstrated but objective not achieved.

Clostridium *difficile*

☒	Trust ambition not achieved

MRSA Bacteraemia

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

Our aim

The trust aims to deliver on the zero tolerance approach to MRSA Bloodstream infections NHS commissioning boards planning guidance “Everyone Counts; planning for patients 2014/2015 to 2018/2019”

Progress

The trust has reported three patients who were identified as having MRSA bacteraemia whilst receiving care in our organisation. A full post infection review was carried out for each case and a summary is provided below.

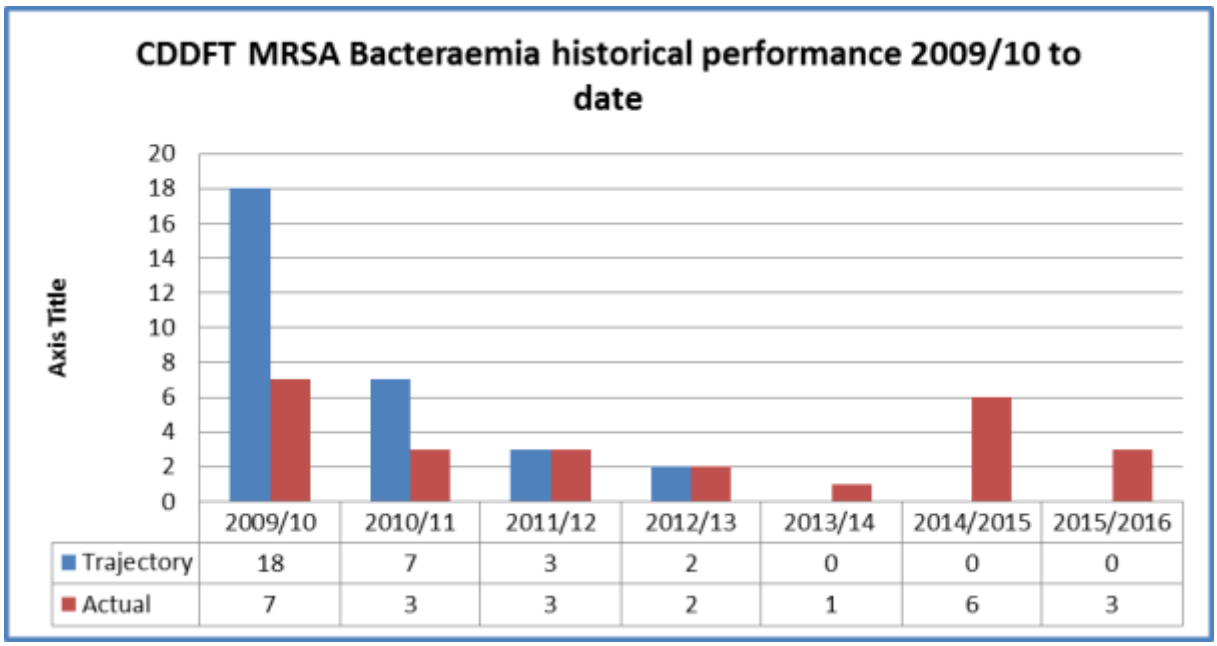
Case 1; Source of infection deemed likely to be from central line but unable to confirm this as no culture was taken peripherally as patient had extremely difficult venous access due to gross oedema of extremities.

Case 2; Source of infection deemed likely to be from respiratory tract, in a patient with known nasal MRSA carriage.

Case 3; Source of infection difficult to determine due increased risk factors but deemed likely to be a contaminant.

Period	No of Bacteraemia	% Rate/10,000 bed days	Trajectory
2010/2011	3	1.05	7
2011/2012	3	0.95	3
2012/2013	2	0.08	2
2013/2014	1	0.03	0

2014/2015 2015/2016	6 3	0.306 0000000	0 0

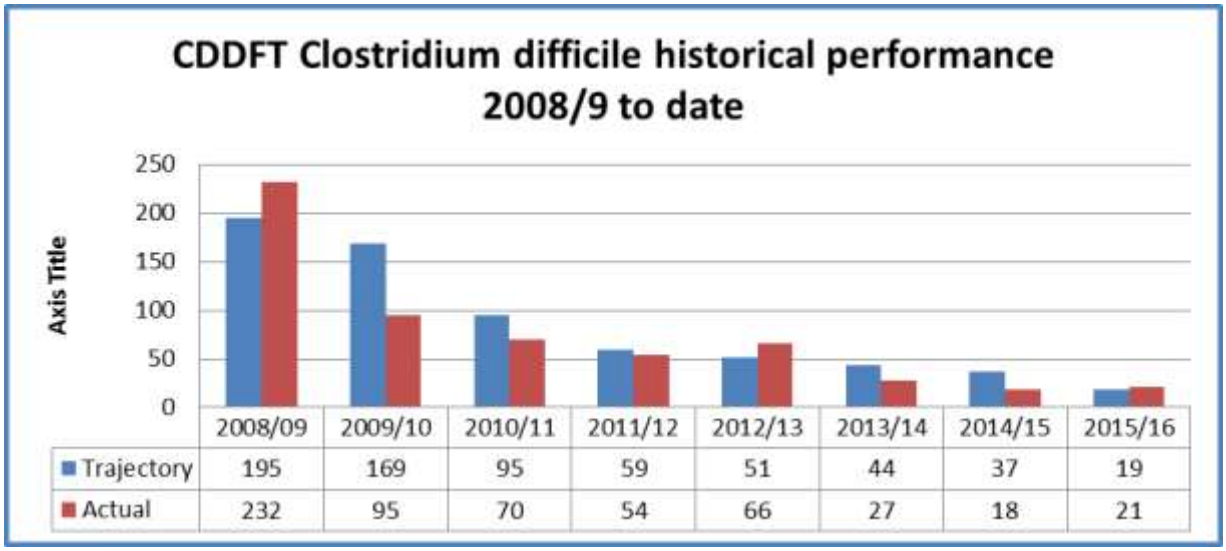


Actions for improvement

- In 2015/2016 the Saving Lives High impact Intervention self-assessment audits were reviewed and re-launched. Work is in progress to have a trust central depository so that data from all areas can be seen and monitored.
- Develop training resources on procedures for taking blood cultures and urinary catheterisation.

Clostridium *difficile*

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



CDDFT have seen performance fail against this year's trajectory in reducing the number of cases of *Clostridium difficile* infections.

Many strategies have been put into place including a number of focused interventions many implemented in the previous year and continued throughout this year.

- Executive led HCAI Reduction group
- Focus on increasing awareness around antibiotic stewardship
- Use technological advances to further improve performance in relation to antibiotic awareness and prescribing e.g. Antibiotic formulary Phone App. EPMA
- Improved pathology and stool sampling processes
- Quarterly hand hygiene Trust wide observational audits with results being feedback to individuals and care group leads
- Focus on all Trust staff carrying out a hand wash assessment
- Focus on determining the root cause and lapses in care and sharing lessons learn

Lessons learned from root cause analysis has led to a focus on managing adult patients with diarrhoea including robust assessment of the cause of diarrhoea and early identification and isolation of patients with/ suspected of diarrhoea of infectious cause

***Clostridium difficile* appeals process**

Three Clostridium difficile appeal meetings have been held with NHS England local area team colleagues. 15 cases presented for appeal have been upheld. This means that following a review of each case no lapses of care have been identified as a cause or contributory to the *Clostridium difficile* infection.

Actions for Improvements

- Focus on early identification and isolation
- Targeted work with the areas were C difficile has been identified

Next steps

A comprehensive action plan has been developed for all hospital acquired infection improvement goals,
The actions include:

- Further focus on antibiotic stewardship in particular monitoring of antibiotic prescribing across the health economy. The Trust antimicrobial team will continue their work in reviewing the Antimicrobial policy and guidelines, evaluating antimicrobial use, and providing feedback to physicians. The team are responsible for optimising antimicrobial use in the hospital by improving compliance with the guidelines, through education and regular audit of practice.
- Continuation of hand hygiene audit with a focus on publically displaying results
- The Infection Control team is working in collaboration currently other organisations within the region to ensure that all improvement techniques are applied consistently and that lessons learned can be shared with regard to reduction in Clostridium *difficile.*
- Implement new guidelines to respond to the risk of infection from emerging infectious disease, new strains and antibiotic resistance.
- We will continue to monitor and maintain progress in reducing the number of infections attributable to the Trust and these priorities are a national indicator for Quality Accounts so will continue for the 2016/2017 reporting period.

Venous thromboembolism assessment (VTE)

Assessment

☑	Trust ambition achieved

What is VTE? - Thrombosis is a condition caused by formation of a blood clot in a vessel, obstructing or stopping the flow of blood.

The Trust has continued to undertake quarterly audits on all identified deep vein thrombosis and pulmonary embolism for patients who have received care within the organisation within the previous 90 days.

Risk Assessments are undertaken on all patients admitted to the organisation with compliance monitored via the Assurance Risk and Compliance department we have been 95.7% compliant in the last year.

Learning from the root cause analyses continues and from this analysis it has been found that **TBC** have complied with national standards although we have had **TBC** reviews where there was an identified delay to administer anticoagulant.

Pressure Ulcers

⊖	Improvement demonstrated but objective not achieved

Our aim

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

Progress

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

Within the Trust hospitals data there has been a reduction in avoidable grade 2 and 3 pressure area damage. This has been a significant improvement on previous performance and is as a result of targeted education and audit on prevention and recognition of pressure ulcers. In addition the tissue viability team have been involved in research into the reduction of heel damage post operatively with some encouraging early results.

Acute Services	Avoidable Grade 2	Avoidable Grade 3/4
2012/13	34	3
2013/14	16	4
2014/15	13	7
2015/16	1	1

Community Services	Avoidable Grade 2	Avoidable Grade 3/4
2012/13	23	3
2013/14	2	3
2014/15	2	2
2015/16	0	4

This will remain a primary objective for 2016/17 as we continue with improvement measures to achieve our aspiration of zero avoidable pressure ulcers.

Next steps

We will continue to report all incidents of skin damage onto the Safeguard Incident Reporting system. A root cause analysis will be undertaken for all grade 3 and above incidents so that any remedial actions are identified and addressed.

We will ensure that training continues for healthcare assistants to embed knowledge and practice across this group of staff.

Discharge Summaries

⊖	Trust ambition not achieved but improvements made

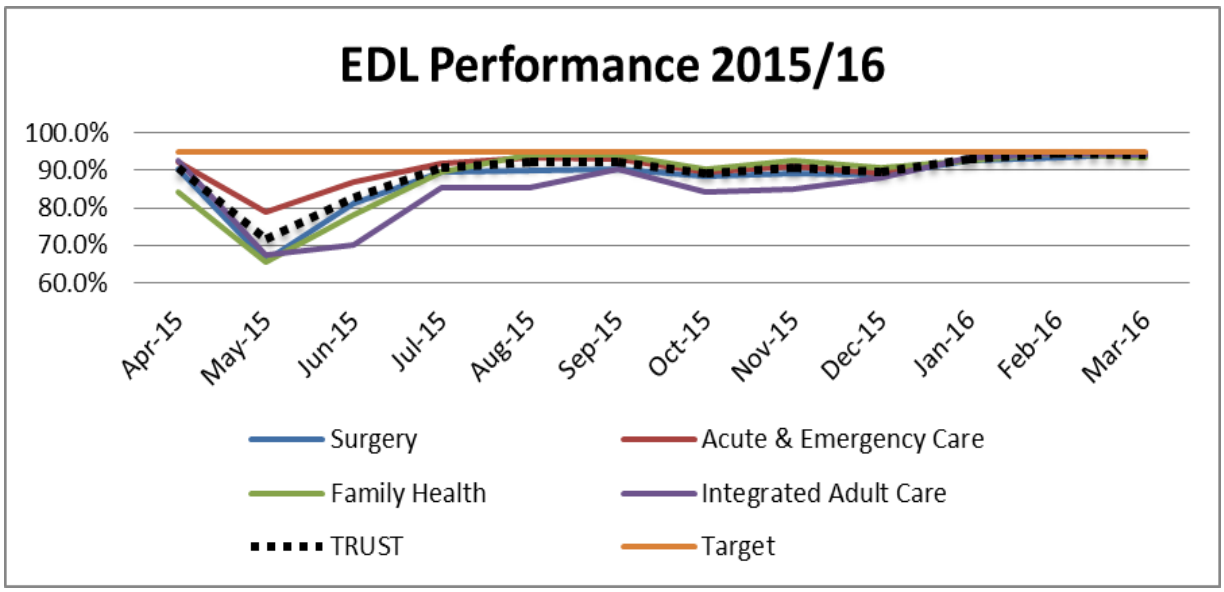
Our aim

To monitor compliance against our goal of 95% of discharge letters to be completed within 24 hours of discharge.

Progress

The care groups have taken a proactive approach to try to understand process and information technology (IT) issues that impact upon compliance. The electronic discharge letter (EDL) dashboard is utilised each day to compile reports of incomplete letters and sent to key admin staff for action. Analysis of all incomplete EDL's is undertaken on a weekly basis and education, training and reinforcement of the process with staff members when required. Training is provided to new staff and prompt cards posters and regular bulletins have been used to assist staff. Each service has a key lead to help champion the commitment to compliance. The IT department have supported system changes which include flags on the electronic system to indicate if the letter has been sent successfully. Action plans have been developed by each of the care groups which include analysis of all incomplete letters and this is monitored monthly.

The compliance for the year to date has been calculated at 93.3%, so although there have been notable improvements, the progress we hoped to achieve (sustained delivery of the 95% target) has not been reached.



Next steps

We will continue to monitor this priority throughout 2016/2017.
Analysis continues to review if there are any trends identified for under achievement with this standard. Monitoring will continue through a sub- committee of the Trust Board to identify what is required to improve performance further.
An EDL Task Force group, with representation from all care groups, health informatics and the information team is established and operational with an aim to deliver sustained improvements in performance. As an output from this forum, the informatics team have delivered a number of bespoke developments to improve notification of overdue/incomplete letters.

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

☑	Trust ambition achieved for rate of patient safety incidents resulting in severe injury or death (from NRLS)

⊖	Improvement demonstrated but objective not achieved (reporting rate)

The National Reporting and Learning Service (NRLS) was established in 2003. The system enables safety incident reports to be submitted to a national database on a voluntary basis and is designed to promote learning. It is mandatory for NHS Trusts in England to report all serious incidents to the Care Quality Commission as part of the registration process. The Trust's NRLS results for April 2015 to September 2015 show that we are in the mid 50% of reporters. This is calculated as a comparison against a national peer group, which is selected according to type or trust.

Never Event

Disappointingly, the Trust reported a never event during the period. A never event is defined as an incident that should not occur if correct procedures and policies are in place. The patient had a nasogastric tube (a tube which is inserted via the nose to the stomach) inserted. The patient received medication via this tube and it was found that it was displaced and was in the lung. The patient was closely monitored and made a full recovery. A full review of policy and procedure has been undertaken to prevent reoccurrence of this

Regulation 28
Three Regulation 28 notifications have been received from HM Coroner during the period. These are issued when the Coroner believes that further action could have been taken by the Trust in respect of a patient's care and were in relation to the following issues:

- The process for staff in a non- acute setting to gain urgent advice from an acute setting regarding deterioration of a patient's condition. Following this a full review of process and policy has been undertaken.
- The shared care of a patient with another organisation where there were unclear procedures regarding the shared management of care. The standard operating procedures have been reviewed and agreed between the organisations.
- The care of a patient who had a misdiagnosed fracture when under the care of district nursing and general practitioner leading to unnecessary pain. The patient review process has been reviewed to take into account the concerns raised.

Serious incidents
The Trust reported 88 serious incidents during 2015/16. All of these incidents have a full root cause analysis review and themes are identified from these.
Falls remain the highest reported incidents and actions taking place are reported in the falls section of the report. Other incidents have resulted in the need for more regular observations and review of the patient being undertaken and the introduction of electronic observations and the acute intervention team will facilitate improvement in these areas.

Advancements in patient safety
Electronic observations have been rolled out across the organisation. This ensures there is a process in place for:

- Consistent, regular observations for patients
- Accurate calculation of early warning score
- Automatic escalation of deteriorating patient at all times

This has been well received and provides an accurate audit trail of patient observations and review

In addition to this the Trust has approved a business case for an Acute Intervention Team. This team will provide a 24 hour service and the main focus will be in communication, support and education. Ward teams will continue patient management to prevent the risk of deskilling of clinical staff. The team will be focused on supporting the management of all patients and they will have skills in areas such as critical care, tracheostomy and end of life care.

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

The data is cleansed by a member of the patient safety team prior to upload

The data within this category is agreed through Safety Committee and at Executive level prior to upload to NRLS.

Period	Oct08 Mar09	Apr09 Sep09	Oct09 Mar10	Apr10 Sep10	Oct10 Mar11	Apr11 Sep11	Oct11 Mar12	Apr12 Sep12	Oct12 Mar13	Apr13 Sep13	Oct 13 Mar 14	Apr14 Sep14	Oct14 Mar15	Apr15 Sept15

Patient safety incidents														
CDDFT Reporting Rate (100 bed days)	4.4	4.4	4.9	5.0	5.6	4.2	5.1	4.9	6.6	6.3	5.3	26.28	35.27	40.5
CDDFT %age severe injury & death	5.08%	0.66%	0.46%	0.31%	0.14%	0.25%	0.15%	0.15%	0.16%	0.3%	0.2%	0.1%	0.2%	0.2%
National reporting rate (100 bed days)	4.7	5.4	5.4	5.4	5.6	5.9	6.2	6.5	7.1	7	7.2	35.1* Median	35.34	38.25
National %age severe injury & death	1.3%	0.6%	0.7%	0.8%	0.9%	0.7%	0.8%	0.7%	0.7%	0.6%	0.5%	0.5%	0.5%	0.4%

* From 1st April 2014 peer group changed to Acute (non-specialist) organisations and denominator data changed from per 100 admissions to 1000 bed days.

Our aim

- To continue to aim for an increase in incident reporting to within the top 75% of reporters
- To improve timeliness of reporting to and completion of reviews for moderate harm incidents
- To encourage and support staff to report all incidents and near-misses so that we are sure there is an accurate and complete picture of patient safety issues.
- To monitor and improve timeliness of reporting and completing serious incident reviews as per national guidance
- To ensure that if a patient suffers moderate or above harm from an incident whilst in our care, they are given the opportunity to discuss this in full with relevant clinical staff and are assured that a review has taken place.

Progress

Incident rate and National median

For the second successive reporting period the trust has seen an increase in the rate of incidents per 1000 bed days reported. This period shows a 14.83% increase on the last period, taking the trust above the cluster median for the first time in 18 months.

This rate increase is due to both an increase in the number of Patient Safety incidents being recorded on Safeguard and a slight reduction (5%) in the number of bed days reported. If bed days increase were to increase without a corresponding increase in the number of incidents recorded the rate would drop.

The Median for the cluster has also increased slightly for the first time in 18 months, demonstrating increased reporting rates amongst the cluster as a whole. This means that CDDFT must continually increase the number of incidents reported in order to stay above this median.

Harm rating

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

Next steps

County Durham & Darlington NHS Foundation Trust intends to take the following actions (outlined below) to improve this number and/or rate, and so the quality of its services.
Progress against the issues highlighted above will be monitored at the bi- weekly Patient Safety Forum.
Care Groups will be expected to complete reviews within the specified time period and include the position in their Integrated Governance report that is produced quarterly.

Improve management of patients identified with sepsis

☑	Trust ambition achieved

Our Aim

Implement sepsis care bundle across the Trust and develop a post one hour pathway. Development of an audit tool and programme and hold professional study days.

Progress

The Trust now has Adult, Paediatric and Maternity Sepsis Screening tools and bundles in use across the organisation. Work has also commenced piloting a community bundle in the Urgent Care Centre at Bishop Auckland Hospital, once this pilot is complete work will commence to roll this out to all Urgent Care Centres and the community hospitals. Planning work has commenced in the development of the post one hour guidance with a view to piloting this in Autumn 2016. An audit of patients coded with sepsis codes is underway and looks at the use of the sepsis bundle and how timely the 'Sepsis 6' are delivered. The Sepsis Study day is now well established and is well attended.

Next Steps

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

Update and re-launch, with appropriate education, the updated sepsis bundles in line with pending changes to national guidance. Continue to utilise audit findings and break them down to ward level to improve performance. Develop, pilot and plan for full implementation of the post 1 hour bundle in both adult and paediatrics. Begin to work on a public awareness campaign to improve the communities understanding of sepsis and the warning signs.
Measure: Trust wide audit and Sepsis Mortality.

Duty of Candour

What is duty of candour?

From the 27 November 2014 Duty of Candour placed a statutory requirement on health providers to be open and transparent with the 'relevant person' (usually the patient, but also family members and/or carers) should an incident resulting in harm occur. The Care Quality

Commission Regulation 20 prescribes health providers to inform and apologise to the 'relevant person' if the provider has caused harm. The statutory duty is activated when a 'notifiable' patient safety incident occurs which causes harm. The definitions of harm are:

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

Our Aim

To comply with the statutory duty by undertaking three steps:

- provide to the 'relevant person' a verbal apology,
- to document details of this apology in the patient's health care record, and,
- provide a written apology and explanation of the investigation process

The verbal apology has to be given 'as soon as is reasonably practicable' (Trust policy states 48 hours) and the written apology within 10 working days.

Progress

The 'Safeguard' incident reporting system has been enhanced to include a specific mandatory questionnaire section on Duty of Candour if the incident is graded moderate harm or above. This must be completed with details of the three requirements - when the apology was given and by whom, details of when the apology was documented in the medical records and the ability to upload the written apology as evidence of compliance with the third step.

Compliance with this is monitored by the Trust Patient Safety Forum on a bi-weekly basis

An information leaflet has been circulated to staff and Duty of Candour has been incorporated into educational sessions.

Next Steps

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

The Trust will continue to educate staff awareness and continue to capture data on Safeguard and advising Care Groups of their compliance rates and where improvements are needed.

PATIENT EXPERIENCE

This section reports on patient experience activity throughout 2015/2016 and the outcomes identified in the 2014/2015 Quality Accounts.

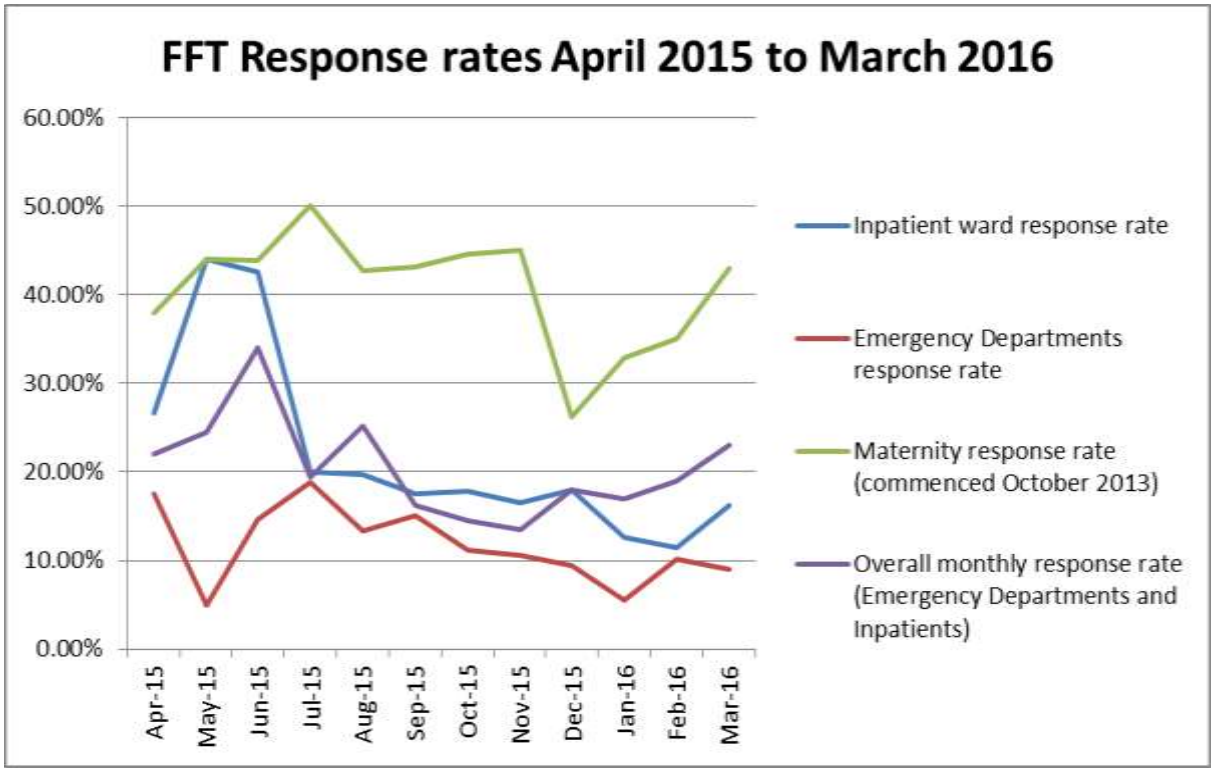
Patient involvement activity

The Trust is committed to listening to patients, carers and families. It is essential that feedback provided by patients, carers and families is acted upon in order to ensure safe, effective practice, service improvement and enhance the patient experience.

Friends and Family Test (FFT)

Throughout 2015-2016, all patients were provided with the opportunity to complete a questionnaire asking if they would recommend the service they had received to a friend or family member.
The data is collected monthly and response rates are returned to UNIFY, Department of Health. Comparative data is available via the NHS Choices website.
During 2015-16, data collected from Emergency Departments were combined with data collected from Urgent Care Centres. Similarly, Inpatient data was combined with Daycase data.

The following graph shows the response rates for Emergency Department/Urgent Care Centres, Inpatient / Daycase areas and Maternity.



In 2015 we introduced the collection of Friends and Family feedback from Outpatient departments and Community Service areas. All areas are requested to complete "you said we did" posters and display in their respective areas.

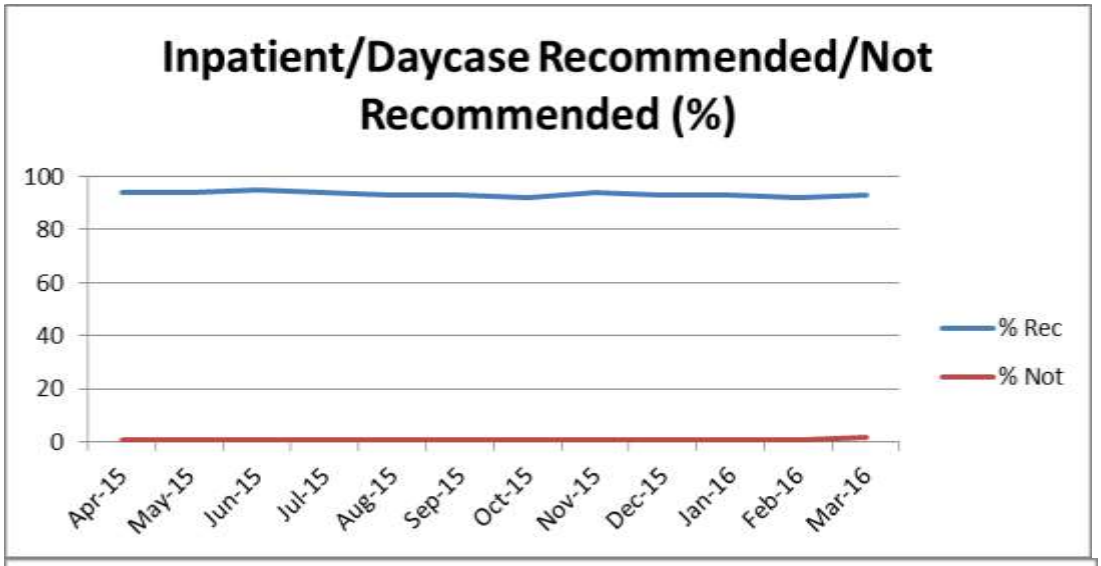
Changes to the FFT Headline Measure

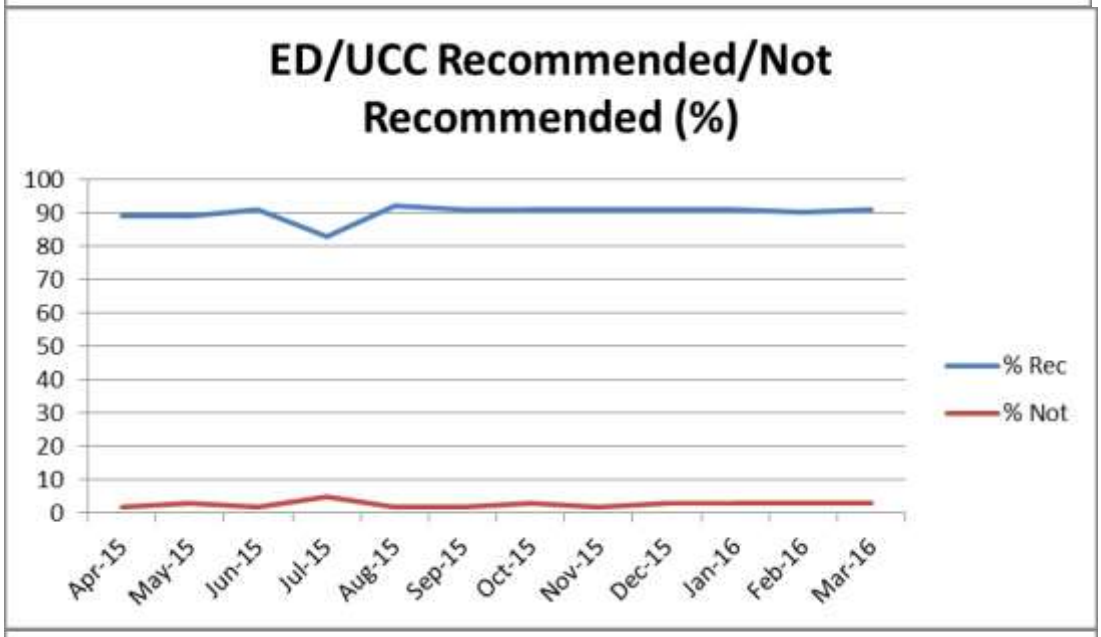
In line with the recommendation to move away from the NPS following the FFT review, NHS England statistical publication moved to using the percentage of respondents that would recommend/wouldn't recommend the service in place of the NPS from October 2014.
The percentage measures are calculated as follows:

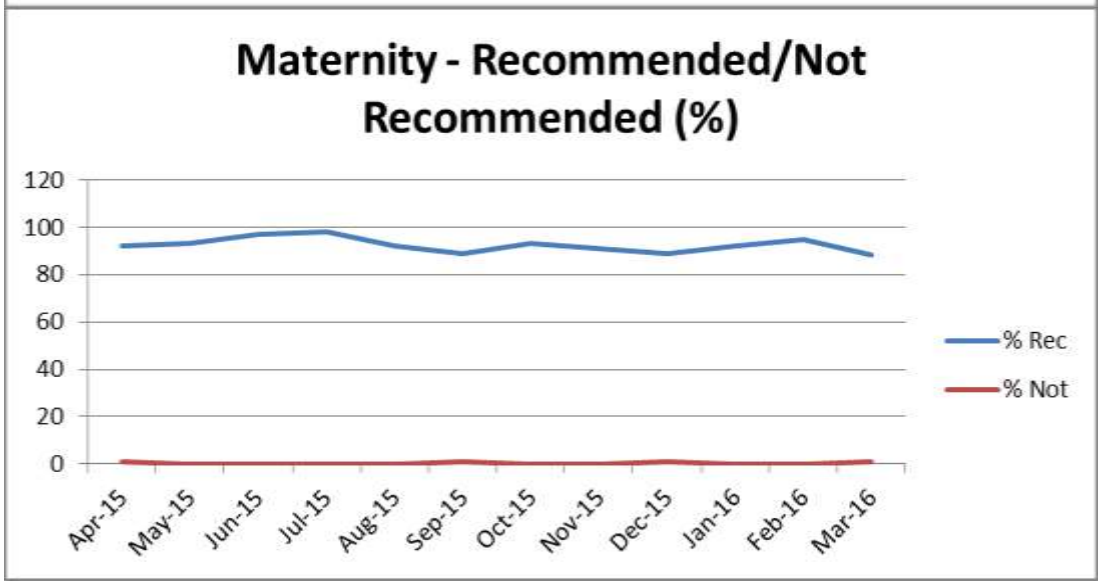
$$\textit{Recommend}\ (\%) = \frac{\textit{extremely likely} + \textit{likely}}{\textit{extremely likely} + \textit{likely} + \textit{neither} + \textit{unlikely} + \textit{extremely unlikely} + \textit{don't know}} \times 100$$

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

The following graphs show the revised headline measure from April 2015 for Emergency Department / Urgent Care Centres, Inpatient / Daycases and Maternity Services:







FFT Feedback

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

CDDFT have now rolled out the FFT to all patient areas.

County Durham & Darlington NHS Foundation Trust.

Friends and Family Action Plan

Ward:
Site:
Care Group:
NPS and Month:
Date completed:
Completed by:

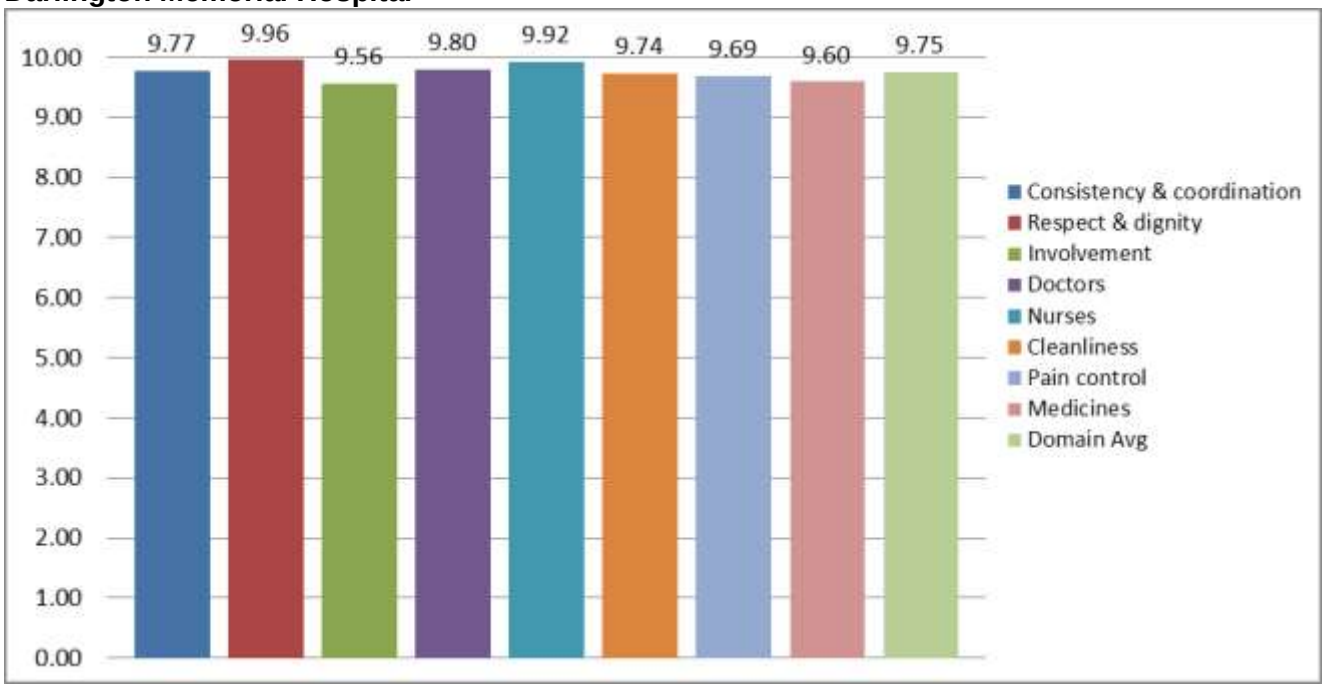
Source	Comment / issue identified	Plan of action	Timescale for completion	Review date	Lead
Friends and Family Ward Report comments					

In-Patient Interviews

During 2015/16 the Patient Experience Team have continued to undertake real time in-patient interviews at DMH, UHND and Community hospitals, interviewing approximately 614 in-

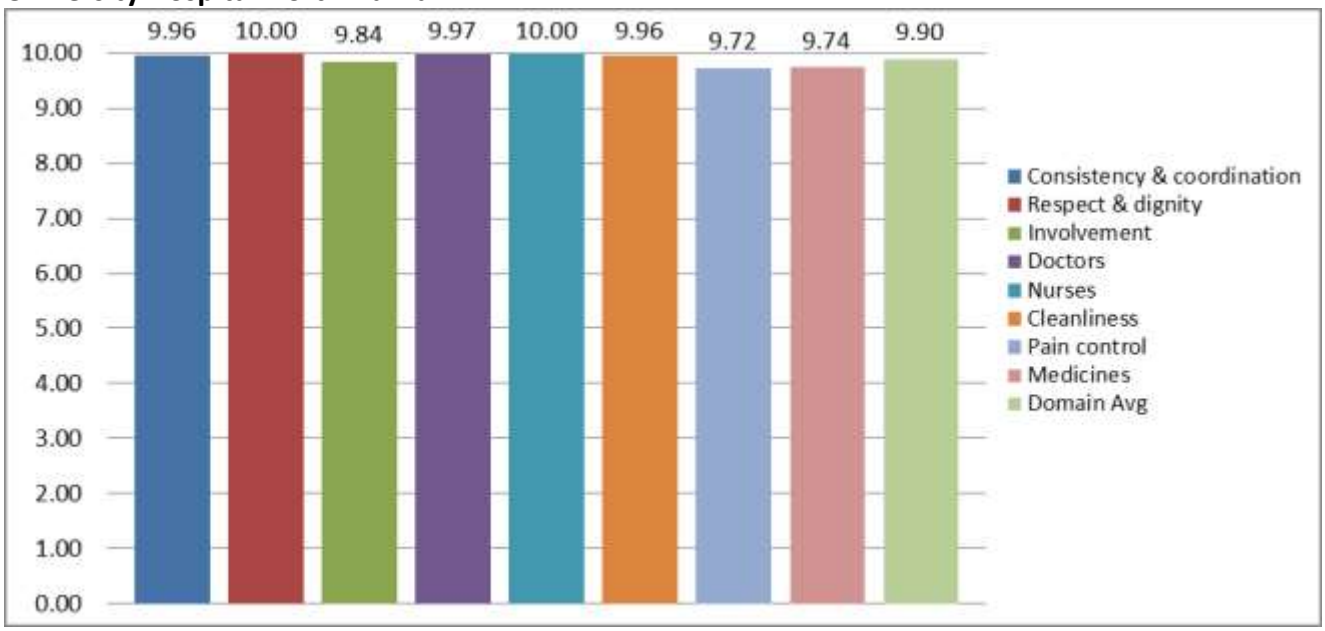
patients. Real time feedback is captured, based on the core domains of what patients want from an in-patient episode (Picker Institute, 2009).
Each ward is provided with individual feedback and encouraged to utilise patient comments to deliver improvements and to display information on ward performance boards.
The results for 2015/16 by site are illustrated below:

Darlington Memorial Hospital



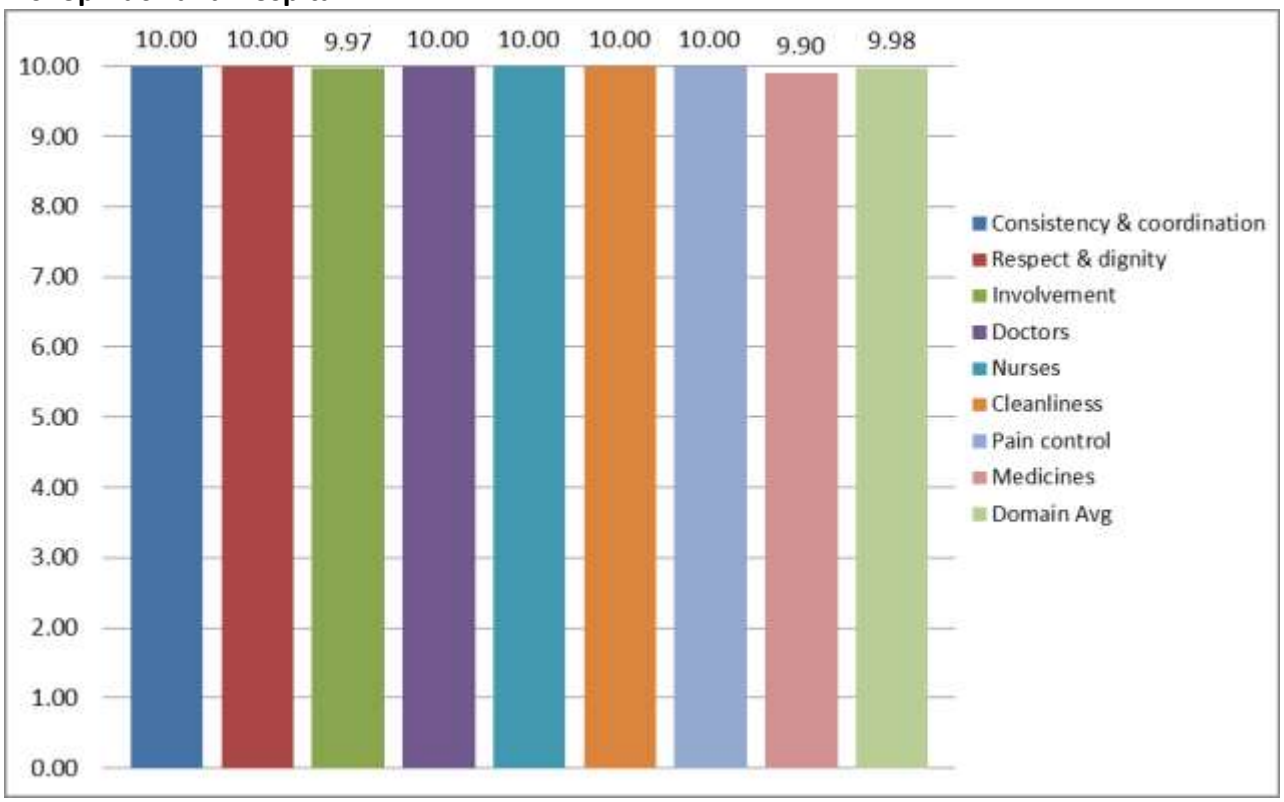
On a scale of 1-10, the likelihood of recommendation to families & friends based on the care at this hospital is **8.83**

University Hospital North Durham



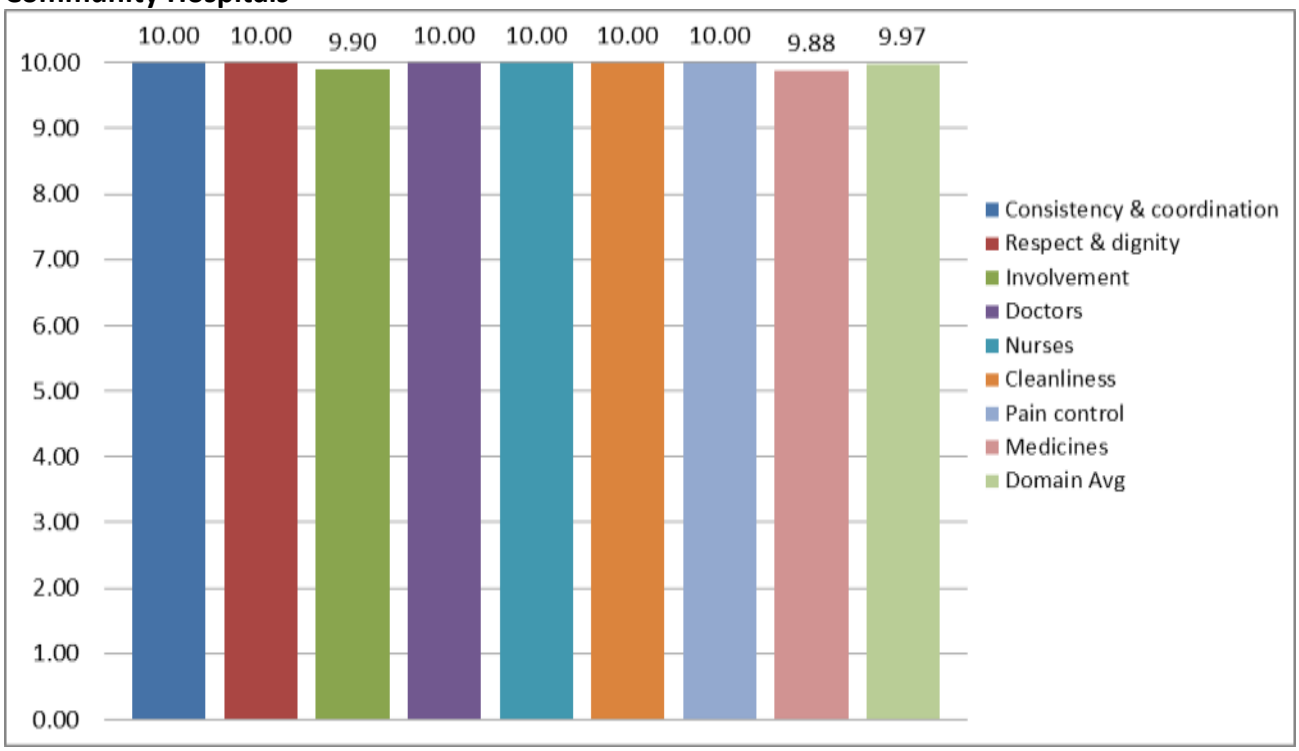
On a scale of 1-10, the likelihood of recommendation to families & friends based on the care at this hospital is **8.88**

Bishop Auckland Hospital



On a scale of 1-10, the likelihood of recommendation to families & friends based on the care at this hospital is **9:24**

Community Hospitals



On a scale of 1-10, the likelihood of recommendation to families & friends based on the care at this hospital is **9.11**

Training

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

The Patient Experience Team continues to deliver training at student nurse induction programmes. When available, service users attend these sessions and relay their experience which provides a valuable insight from a patient perspective. The sessions are evaluated and feedback has been extremely positive. Further training programmes include Trust induction as well as supporting safety workshops for junior doctors. The Customer Care e learning package is available to all staff groups. Bespoke customer care programmes have been taken forward within individual care groups.

Patient Experience Team offered Customer Care training which incorporated a section on dignity awareness and expectations of all staff in line with “Dignity for All”

The Podiatry team completed the above training in November 2015. Further sessions are currently being prepared for ED and UCC teams.

NHS Choices

Quarterly reports are collated and presented at the Quality and Healthcare Governance Committee. Themes are identified, in line with all patient experience measures in order to ensure appropriate actions are developed and monitored. Individual responses to feedback are provided on-line by the Trust and meetings to discuss issues further are offered.

National Surveys 2015/2016

National Children Inpatient and Daycase Survey

This Survey was carried out in November 2014 with the results published June 2015.
This Survey involved 137 NHS Trusts. 182 responses were received which was a 24% response rate.
Positive feedback was received from 0-7 year old patients in relation to:

- Quality of patient food.
- Felt safe whilst in hospital care.

Parents reported positively in relation to

- Adequate explanation received regarding operations or procedures in a way which was understood.

An area of improvement related to:

- Provision of adequate information on how children could use and take new medication.

Maternity Survey

The National Maternity Survey yielded a 40% response rate, capturing feedback from 154 participants. Positive comments were received across all aspe4cts of the survey particularly within staffing criteria. This included:

- Staff introduced themselves before treatment and examination.
- Concerns were taken seriously during labour and at birth
- Effective communication during labour and at birth
- Dignity and respect during labour and at birth

National Inpatient Survey

The National Inpatient Survey was undertaken in July 2015 **and is currently embargoed. Awaiting report from CQC.**

Post Discharge Survey

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

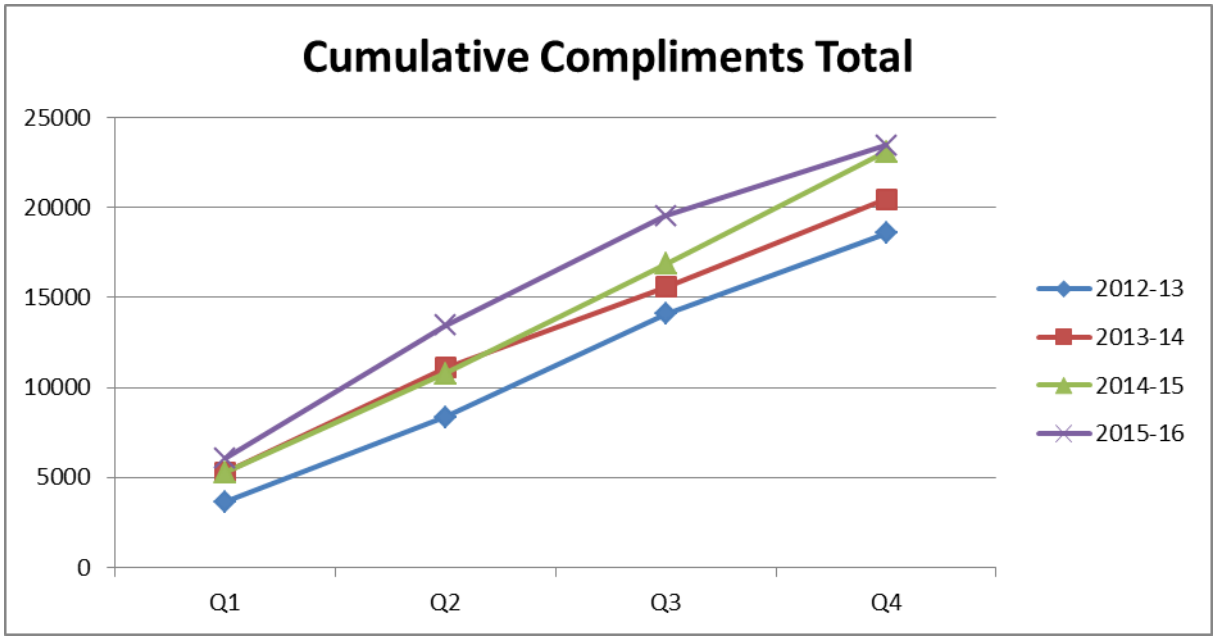
The data below shows the responses in relation to the CQUIN indicator questions comparing each quarter with the National Inpatient Survey results for 2015

Patient Experience Indicator Questions	2014 Nat In-pt	Q1 2015	Q2 2015	Q3 2015	Q4 2016	Ave	↑↓
Did you feel involved enough in decisions about your care and treatment? (Q11)	71%	76%	81%	79%	81%	79%	↑
Were you given enough privacy when discussing your condition or treatment? (Q14 was 13)	81%	88%	89%	86%	88%	88%	↑

Did you find a member of staff to discuss any worries or fears that you had? (Q16 was 15)	**50%**	**81%**	**82%**	**78%**	**83%**	**81%**	↑
Did a member of staff tell you about any medication side effects that you should watch out for after you got home in a way that you could understand? (Q22 was 19)	**49%**	**64%**	**70%**	**63%**	**62%**	**65%**	↑
Did hospital staff tell you who you should contact if you were worried about your condition or treatment after you left hospital? (Q25 was 22)	**76%**	**85%**	**81%**	**77%**	**80%**	**81%**	↑

Compliments

Quarter	2012-13	2013-14	2014-15	2015-16
1	**3662**	**5297**	**5288**	**6058**
2	**4698**	**5782**	**5473**	**7406**
3	**5730**	**4523**	**6123**	**6078**
4	**4493**	**4863**	**6228**	**3902**
Total	**18,583**	**20,465**	**23,112**	**23,444**



The table above illustrates the number of recorded compliments received by CDDFT and shows a slight increase during 2015/2016. Patients and carers are also encouraged to share their comments on the CDDFT website, as well as NHS Choices. All comments are shared with service teams and displayed in patient areas.

Working in Partnership with Healthwatch:

The Trust works in partnership with Healthwatch County Durham and Healthwatch Darlington. Healthwatch play a vital role liaising with the general public and capturing feedback about health services which is shared with the trsut in order that we can learn from general trends or specific issues. Representatives of Healthwatch County Durham and Healthwatch Darlington continue to attend the trust's Patient Experience Forum which was introduced in August 2014. Healthwatch provide constructive feedback from service users and members of the community. We will continue to meet regularly in 2016 to continue to gather feedback and improve services. Healthwatch teams have provided invaluable support and feedback to the Perfect Week initiative at University Hospital of North Durham and Darlington Memorial Hospital in 2015. Healthwatch members also support a peer review process whereby current anonymised complaint reports and responses are reviewed to ensure a fair and balanced response is provided to patients.

Patient Experience Projects

During 2015/16 members of the Patient Experience Team have worked with a number of services to undertake bespoke patient experience projects. The following services have been involved:

- **Pain Management Unit**
  This project sought feedback from patients attending the Pain Management Unit at University Hospital of North Durham. A full report was provided in 2015.

- **STEM Project:**
  As a result of the theatre and mortuary redesign at Darlington Memorial Hospital, the Patient Experience Team and Healthwatch have supported face to face interviews with service users in order to gain a full understanding of patient experiences of services during a time of disruption.

- **Carers report:**
  The 2014/15 CQUIN indicator for Dementia report, carried out for County Durham and Darlington Foundation Trust recommended a review of carer experiences of services, to be completed in 2015. This review focussed on carers who support patients with dementia to determine whether they feel supported during their hospital journey, and to gain feedback on their experience of hospital services.

- **Visitor to Patient report:**
  As part of CDDFT's Patient Experience Forum 'Quick Fix ' schemes, the Visitor to Patient Policy was reviewed and open visiting for patients (11.00 – 19.00 hours) was introduced across the Trust. To evaluate the policy and the effectiveness of revised visiting times, a questionnaire was developed for both staff and patients/visitors. This resulted in further adaptation to visiting times changing to 13.00 – 19.00 hours.

- **Perfect Week:**
  During November and December 2015, PET staff together with staff from across all disciplines, carried out the role of Perfect Week Liaison Officers (PWLO's) staff members worked on wards across the trust to observe and give feedback on how the

ward functioned on a day to day basis. PET staff also collected feedback from identified areas on a daily basis following patients who were discharged from hospital.

Dignity for All

The focus of Dignity Action Day in 2016 was in relation to carer support within the CDDFT. Supported by the Trust Dignity Lead, a Carers Pack and poster was designed and developed, to ensure that we are robust in our efforts to promote dignity in our hospitals for carers and patients. The patient experience team supported by Macmillan staff, co-ordinated promotional stands at DMH and UHND. The Macmillan team at BAH distributed the Carer Pack for comment.

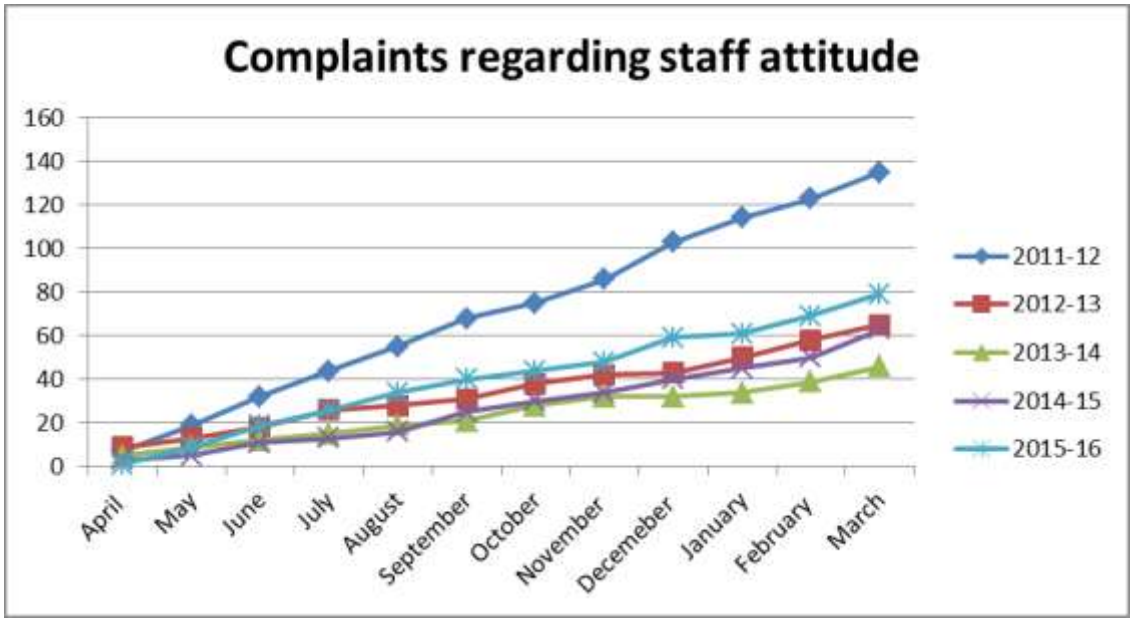
Learning from Experience

From the quarterly analysis of patient feedback themes are identified and included in thematic action plans which are presented to the Care Groups for action, these action plans are monitored at the Complaints, Litigation, Incidents and Pals (CLIP) meeting and Care Group Governance meetings. Individual action plans are developed in response to partly and founded complaints and shared with the complainant. Examples of other action plans and "You said, we did" posters are mentioned earlier in this report. To ensure learning across the organisation the Patient Experience Team continue to produce the newsletter called 'Quality Vibes' which identifies examples of lessons learned throughout the quarter, this is disseminated via the weekly bulletin and available on the intranet.

Complaints Monitoring

As well as proactive patient feedback the Trust also receive complaints 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'. Complaints form part of the quarterly CLIP analysis and themes identified are included in the Care Group thematic action plans.

The Trust continues to monitor complaints in relation to staff attitude. We aim to remain below the threshold set in the 12/13 Quality Accounts of 70 per year. During 2015/16, this number increased to 79. This will be monitored closely and proactive measures implemented to ensure this improves.



Patient Stories

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

An example of a shared story involves a young gentleman who was diagnosed with autism at three years old. He was referred for a chest x ray and attended with his carer. The carer reported a really positive experience where the nurses gave a full explanation of the procedure to be carried out and that this put the patient immediately at ease. The carer commented *"Life is so busy and rushed. You are pushed through everything like you are on a conveyor belt".* She felt that if everyone had the attitude shown to the patient on this occasion and behaved to him in this way over his lifetime, they would not have required the support that they had.

Nutrition and hydration in hospital

TBC	

Our aim

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

Progress

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

In addition the dietetic service has also continued with the agreed work throughout 2015/16. This includes:

- Implementation of a dietetic assistant handover standard operating procedure
- Change to the dietetic referral form to make it clearer with reason for referral and medical diagnosis
- Movement to 'Stop, think, refer' and reason for referral to be checked by 2 registered
- Development of a nutrition bundle which pulls all nutritional information into one place – to pilot first quarter 2015/16 and its implementation in quarter three of 2015/16.
- Nutritional discussions twice a week (huddles), within the Nutrition and Dietetic service, to discuss patients that the dietitians are concerned about and those who have been under their care for greater than one week.

The Nutrition and Dietetic Department and Catering Service continue to work closely together on hospital menu development and nutritional analysis.

Patient Led Assessments of the Care Environment

In 2014 the Department of Health and the NHS Commissioning Board required all hospitals, hospices and independent treatment centres to undertake an annual assessment of the quality of services and condition of buildings. These assessments are referred to as Patient Led Assessments of the Care Environment (PLACE), and they replaced the Patient Experience Action Team (PEAT) assessments.

PLACE assessments were undertaken for each of the in-patient sites operated by County Durham and Darlington NHS Foundation Trust.

The aim of PLACE assessments is to provide a snapshot of how an organisation is performing against a range of non-clinical activities which impact on the patient experience of care, which include Cleanliness; the Condition, Appearance and Maintenance of healthcare premises; the extent to which the environment supports the delivery of care with Privacy and Dignity; and the quality and availability of Food and Beverages. A new question set for dementia was included for the PLACE inspection 2015/16.

Each PLACE assessment generated a score across the four domains. Preliminary results were notified to the Trust in July 2015 with an opportunity for validation. National publication was in August 2015 and the data will have been shared with the following organisations: Care Quality Commission, Department of Health, NHS England, and Clinical Commissioning Groups.

The following table illustrates the final results for the Trust's overall organisation score set against the national average:

	Food
National Average Score	**88.49%**
County Durham and Darlington NHS Foundation Trust	**92.21%** ↑

The following table illustrates the final results for the Trust's sites set against the national average:

	Food and Hydration Overall	Ward Food Score	Organisation Food Score
National Average Score	**88.48%**	**89.27%**	**87.21%**
Bishop Auckland Hospital	**90.87%** ↑	**93.19%** ↑	**88.19%** ↑
Chester Le Street Community Hospital	**91.95%** ↑	**96.55%** ↑	**86.18%** ↓
Darlington Memorial Hospital	**93.45%** ↑	**95.51%** ↑	**85.67%** ↓
Richardson Hospital	**90.33%** ↑	**96.67%** ↑	**87.44%** ↑
Sedgefield Community Hospital	**91.45%** ↑	**96.91%** ↑	**85.55%** ↓
Shotley Bridge Community Hospital	**93.43%** ↑	**98.61%** ↑	**87.44%** ↑
University Hospital North Durham	**91.75%** ↑	**94.25%** ↑	**84.41%** ↓
Weardale Community Hospital	**95.36%** ↑	**100%** ↑	**89.80%** ↑

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

Scores highlighted in **red** indicate below the national average score.

Organisational Food - Chester Le Street, University Hospital North Durham, Darlington Memorial and Sedgefield Community Hospital scored below the national average :
Darlington Memorial Hospital

- Patients choosing their meals two meals ahead
- Only 1 hot option available at breakfast time
- Lunch meal service commenced before 12.30pm
- Supper meal service commenced before 5.30pm
- Fresh fruit not available 24 hours per day

University Hospital North Durham

- Patients choosing their meals two meals ahead

- No hot option available at breakfast time
- Lunch meal service commenced before 12.30pm
- Supper meal service commenced before 5.30pm
- Fresh fruit not available 24 hours per day

Chester Le Street Community Hospital

- Only 1 hot option available at breakfast time
- Lunch meal service commenced before 12.30pm
- Supper meal service commenced before 5.30pm
- Fresh fruit not available 24 hours per day

Sedgefield Community Hospital

- Only 1 hot option available at breakfast time
- Lunch meal service commenced before 12.30pm
- Supper meal service commenced before 5.30pm
- Fresh fruit not available 24 hours per day
- Specific or unusual dietary needs are not met by the standard menu

There is also a requirement to carry out meal tasting at ward level on each site with a detailed audit Proforma to complete. The food tastings evaluated and scored very well.

Measuring Customer Satisfaction

Customer Satisfaction is also measured by the following:

- Friends and Family Test
- Patient Discharge Survey
- Compliments
- Complaints
- Reduction in Food Waste

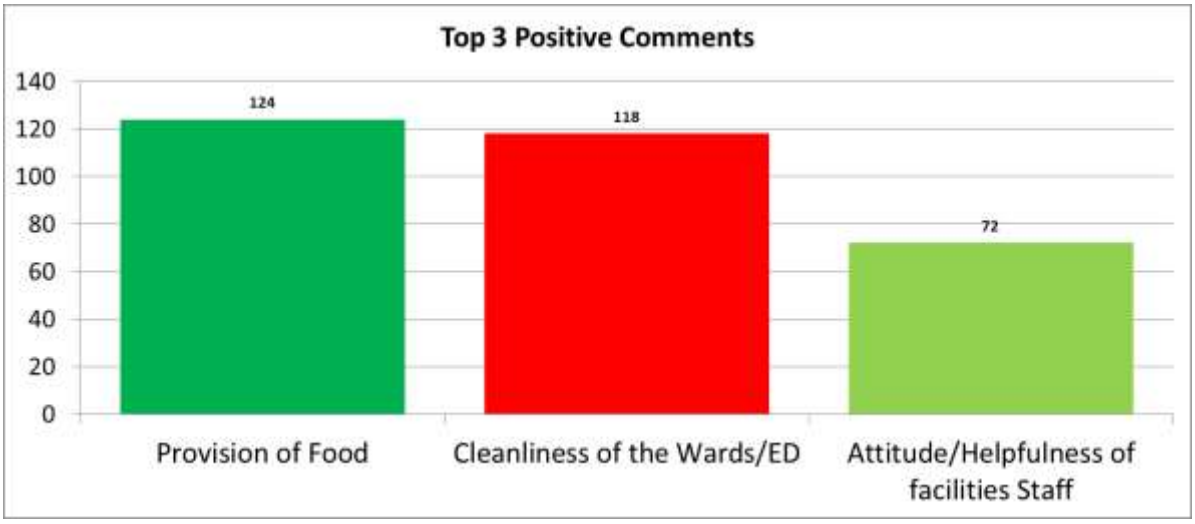
Friends and Family Test Findings

The comments are collated under the following three headings:

- Positive Comments
- Negatives Comments
- Suggestions for Improvement

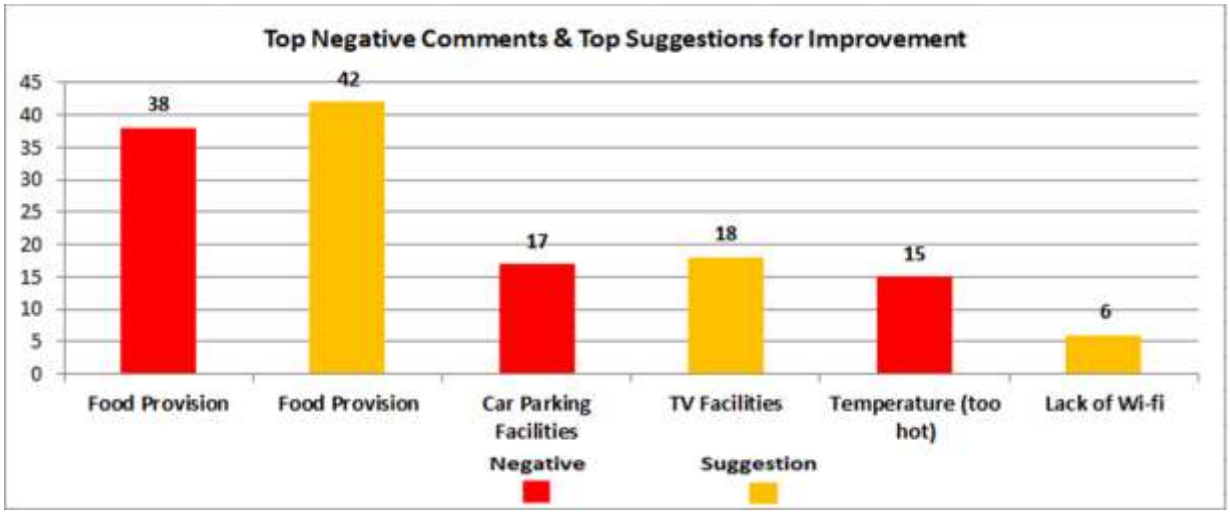
During the period 314 positive comments were received.

The following graph illustrates the top three positive comments over the reporting period (October 2015 to March 2016).



During the period 70 negative comments and 66 suggestions for improvement were received.

The following graph illustrates the negative comments and suggestions for improvement over the reporting period



The negative comments and suggestions for improvement in relation to the provision of patient food and beverages have been further analysed from which the following themes were identified:

- choice of food
- temperature of food
- presentation of food
- choice of beverages

There were also a number of negative comments and suggestions for improvement relating to availability of retail catering services.

The number of negative comments and suggestions for improvement in relation to the provision of patient food and beverages has also been compared against the number of meals served, number of positive comments received and the total number of reviews over the reporting period. The data is illustrated in the following table.

	October	November	December	January	February	March	Total

Number of Meals Served	84,712	78,232	77,834	87,274	86,742	83,587	**498,381**
Total Number of Reviews	2,465	No data recorded	3,331	3,560	3,913	2,659	**15,928**
Negative Comments	28	No data recorded	23	26	17	24	**118**
Suggestions for Improvement	18	No data recorded	26	16	11	31	**102**
Positive Comments	29	No data recorded	9	33	11	37	**119**

Of the 15,928 reviews 0.5% related to the provision of patient meals and beverages.

The number of negative comments and suggestions for improvements equated to 0.04% of the 489,381 meals served.

Key Actions in Response to Negative Comments and Suggestions for Improvement

Provision of food and beverages

A new Trust Wide menu was launched to coincide with the National Nutrition and Hydration week 16-22 March 2015. This menu was again reviewed in September 2015 by discussing with patients and staff on feedback but also to look at the uptake on the new menu, in total 23 adjustments were made to the menu which commenced October 2015.

Finger Food Menu

In collaboration with the Nutrition and Hydration sub group a full review was completed to supply a finger food menu on both elderly and dementia wards. The review concentrated on patients who require a finger food menu to be able to pick from the normal menu which ensured that all of our patients were been treated and had the same menu as other patients in the ward. The trials are continuing on ward 52 at Darlington and Ward 6 at University Hospital North Durham with the goal of rolling out Trust wide.

Menu Ordering

The Trust are currently reviewing an electronic ordering system which will both reduce waste and ensure that the patient is ordering their food closer to the time of service. Visits are taken place to Glasgow Hospital to understand the system.

Food Service at University Hospital North Durham

Ward hostess have now been deployed to focus only on the food service in the majority of wards at Durham this has released domestic staff to concentrate on the cleaning and for catering staff to ensure that a catering service mirrors the food service at Darlington.

Local Procurement
The Trust continues to source food ingredients locally where possible within the local procurement framework.

Food Production
Patient food for all eight hospital sites is produced from the catering production unit at Darlington Memorial Hospital. The Catering team follow standardised recipes to ensure consistency of the product.

Food for staff and visitors is also produced from the catering production unit at Darlington Memorial Hospital for the following hospital restaurants; Bishop Auckland Hospital, Darlington Memorial Hospital, University Hospital of North Durham.

Food Hygiene

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

Food Safety Officers, authorised by the Council, inspect food premises to assess compliance with food hygiene legislation, which includes Food Hygiene and Safety, Structure and Cleaning and Confidence in Management and Control Systems, to ensure food is being prepared in a safe and clean environment and all relevant records are being maintained. All main kitchens must be inspected at regular intervals by Environmental Health Officer's (EHO). The frequency of EHO inspections depends on the type of food business. The EHOs use a star rating system of which one is the lowest and 5 is the highest. The following table illustrates the date and star rating from the last inspection for food premises within CDDFT.

Environmental Health Officer inspections	Last Inspection	Star Rating
Darlington Memorial Hospital	July 2015	✡✡✡✡✡
University Hospital North Durham	December 2013	✡✡✡✡✡
Bishop Auckland Hospital	March 2016	✡✡✡✡✡
Chester le Street Hospital	September 2015	✡✡✡✡✡
Shotley Bridge Hospital	June 2015	✡✡✡✡✡
Sedgefield Community Hospital	September 2014	✡✡✡✡✡
Weardale Community Hospital	June 2015	✡✡✡✡✡
Richardson Community Hospital	November 2015	✡✡✡✡✡

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

In July 2015 the catering department were assessed at a higher level of accreditation which is aimed at food suppliers for the public sector. The higher level audit places more emphasis on effective environmental monitoring programmes to reduce the risk of the growth of listeria monocytogens which is a higher risk within a cook chill environment. The Catering Department were successful in achieving the higher level accreditation.

The following table illustrates the external accreditation held by Facilities

Accreditation	Service	Last Audit	Next Audit/ Inspection
STS (Support Training Solutions)	Catering DMH	July 2015	July 2016

Next Steps

Collaboration

The Catering Department have been speaking to North Tees & Hartlepool NHS Trust to work in collaboration for the provision of patient catering from the cook chill unit at Darlington this will result in additional income for the Trust but also focusing on how 2 Trusts can work in collaboration.

The Catering Department are also working with Age UK Darlington to continue the success story of the luncheon clubs which commenced in 2014 in one club and we now support 6 luncheon clubs in Darlington which has enabled the users of the clubs to receive a hot meal in the company of their friends

HENE Funding
Funding has been requested from the HENE fund to enable over 100 catering staff to gain a recognised food safety qualification which would ensure that the Trusts catering staff are aware of all the latest food hygiene regulations.

End of Life Care

⊖	Trust ambition not achieved but improvements made

Our aim

We aim to ensure that patients under our care have a dignified and peaceful end of life experience. When appropriate we aim to improve recognition and communication of the palliative nature of patients at an earlier stage. We aim for patients and their families to be involved in developing individualised care plans which address the physical, psychological and spiritual needs of patients who are known to be approaching the end of life.

Progress

Use of the Liverpool Care Pathway was discontinued in July 2014. Prior to this we were involved in developing North East region-wide guidance to support the care of patients who are ill enough to die. This was a collaborative approach and this guidance has now been rolled out throughout the Trust to support patients who are ill enough to die. This guidance focuses on recognition, effective sensitive communication, agreeing an individualised care plan with the patient or family and delivering effective, compassionate care that meets the needs of both the patient and family. The initial roll out was followed up with further education about the use of the guidance at the Deciding Right launch as well as targeted training to selected community and ward teams. Audit of compliance with the guidance commenced in March 2015 and continued throughout 2015/16.

Deciding Right, which is an integrated approach to making care decisions in line with Mental Capacity Act, was launched in the Trust in October 2014. As well as covering the Deciding Right principles and documents the launch event included seminars on fundamental palliative care skills such as recognising the dying patient and decision making. Following the launch a significant and sustainable education strategy is now needed to equip our workforce to provide high quality end of life care and to fully implement Deciding Right in practice. An end of life education strategy is being developed through the End of Life Steering Group to support this work.

In last year's report we hoped to devise a process to simplify the way that the palliative care needs of the patients known to the team are communicated to primary care. This has not progressed as hoped due to IT/Licence issues and an alternative process is being devised.

Next steps

Pilot areas are identified and support has been introduced to enhance the knowledge and skills required for staff to feel confident using the Deciding Right documents.

Education around "do not resuscitate" continues and other elements of decision making and care towards the end of life.

An audit programme for the use of the guidance for care of patients' ill enough to die and development of appropriate actions continues in pilot areas

The Specialist palliative care team will commence implementation of a palliative discharge summary utilising the newly developed SystmOne template. This has been discontinued and an alternative method is being developed

Development of a Learning Disability Guarantee

☑	Trust ambition achieved

Our aim
To ensure that all patients with a learning disability who access our services have a formalised approach to ensuring that their care needs are met
Patients with a learning disability may need to use our services and it is important the we make every effort to ensure that they have a positive experience of care and that reasonable adjustments are made where necessary, following a formalised process.

Progress
A learning disabilities guarantee and action plan has been implemented that ensures that all needs and any reasonable adjustment needs are assessed in a formalised way and that this is correctly documented.

Next Steps
Although the Learning Disability guarantee has been produced and implemented across the organisation, it is important that we remain focussed in this area and ensure that we continue to enhance the service we offer. The work and processes implemented from the guarantee continue. The follow up visits developed as part of the outreach service and implementation of emergency health care plans and individualised "coming into hospital" pack for service users are now fully embedded and this priority will now move to business as usual.

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

⊖	Trust ambition not achieved but improvements made

Our aim

To increase the weighted score of staff who would recommend the provider to friends and family within the national average for acute trusts.

Work continues to engage with staff at all levels of the organisation and an Organisation Development strategy "Staff Matter" has been produced, which complements the Quality Strategy.

As reported by the Health and Social Care Information Centre and NHS Staff Survey National Co-ordination Centre overall results are as follows:

Key Finding	2014		2015		Trust Improvement/ Deterioration
	Trust	National Average	Trust	National Average	
KF1. Staff recommendation of the trust as a place to work or receive treatment	3.45	3.67	3.60	3.71	Improvement of 0.15

The results for the key finding 24 Staff recommendation of the trust as a place to work or receive treatment has seen an improvement of 0.15 therefore although we have not met our ambition to achieve a national average score improvements have been made in staff experience. The trust score of 3.60 (on a scale of 1 to 5, where 5 is best and 1 is worst) falls short of the national average for combined acute and community trusts by 0.11. This score benchmarks the trust as *a worse than average* ranking.

Key Finding 1 is comprised of three individual questions which can be seen below:

	2014		2015		
Question	Trust	National Average	Trust	National Average	Trust Improvement/ Deterioration
Q21a Care of patients / service users is my organisation's top priority (strongly agree and agree)	62%	70%	69%	73%	Improvement of 7%
Q21c I would recommend my organisation as a place to work (strongly agree and agree)	48%	58%	55%	58%	Improvement of 7%
Q21d If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation (strongly agree and agree)	54%	65%	61%	67%	Improvement of 7%

Question 21d: If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation has improved by 7% in the 2015 survey compared to the 2014 results. However the score falls short of the national average by 6%.

KF 1 is one of three key findings that make up the staff engagement score in the national NHS staff survey. A summary of the staff survey results for 2015, actions taken from the 2014 results and future priorities (including staff engagement) can be found under the Our People and Community Involvement section of this annual report.

Progress

During 2015/16 CDDFT has focussed effort on staff engagement activity to improve the responses for staff recommending the Trust as a place to work and receive treatment. Key programmes and work streams that have been undertaken and introduced include:

TO ADD SURVEY RESULTS FOR HARASSMENT & BULLYING (KF19) AND WORKFORCE RACE EQUALITY SYADNARD (KF27)

Quality Matters & Staff Matter

In response to consultation with our staff, and particularly our clinical teams, the Trust has refreshed its clinical and quality strategies and pulled together a separate organisational development strategy. This strategy "Staff Matter" sets out all of the work required to enable us to develop a fully equipped and engaged workforce capable of delivering our quality priorities.

Staff Survey

Based on the results from the staff survey two key pieces of work have been undertaken. A short term piece of work commissioned by the Chief Executive involving 17 service areas with the lowest staff engagement scores were provided with additional bespoke support with a view to improving indicators linked to staff morale. This tailored approach included a small team that provided a range of interventions including focus groups to explore staff issues, and a whole range of workshops designed to address identified issues.

The second piece of work which is a longer term project has involved working with the Kings Fund to conduct a Trust wide culture audit. The culture audit identifies six key areas and these are: Vision and Values; Goals and Performance; Learning and Innovation; Support and Compassion; Team Working and Collective Leadership. The results of the audit will be fed back by the Kings Funds at the end of February and will inform our OD Strategy – Staff Matter into 16/17.

Senior Managers and Heads Of Departments (SMHODs)

Senior Manager and Heads of Department monthly meetings with the Chief Executive/ Board meeting are an opportunity for open, frank two way discussions on important topical issues. Every quarter an extended SMHOD's is organised to focus on development needs that have been identified for the senior leaders within the Trust. Over the last 12 months these have concentrated on issues such as Duty of Candour, Staff Engagement, Improving Quality and Patient Safety etc.

Leadership and Management Development Framework

A Leadership and Management Development Framework has been produced and launched in April 2015. This framework pulls together in one place all of the leadership and management

development available to staff within the Trust. The framework identifies the corporate offering; development available from the North East Leadership Academy and National Leadership Academy; External provision such as level 4 and 5 Vocational qualifications.

Great Line Management Programme

In 2015/16 the GLM Programme was extended to a two day programme on the back of feedback of managers. The programme was reviewed to focus on people management skills. The content for day one includes the national and local strategic operating context; leadership skills and behaviours required to manage effectively within this context; staff engagement; supporting staff through change. Day two focuses on the personal development for each delegate and looks at emotional intelligence, effective leadership, personality preferences, and coaching styles.

New Managers Induction Programme

The Trust has developed and implemented a New Managers Induction Programme as part of the core offering for staff moving into new management roles or new appointments into the Trust. Initially piloted in 14/15 this programme follows a similar format to the Great Line Management Programme with an additional module on the Trusts HR policy and processes.

Manager Mini guides to Human Resources

The human resources mini guides have continued to be a popular resource for busy line managers to manage staff more effectively. A new Agency mini guide was introduced in 2015 to complement the existing suite of guides: Recruitment, Managing absence, Disciplinary, Dignity at work and Capability.

Trust Vision, Values & Behaviours

2015 has seen the introduction of the new Trust Behaviours Framework that has been fully embedded within the recruitment, appraisal procedures, Great Line Management and New Managers Induction Programme. The Framework was launched with an attachment to staff payslips to ensure every member of staff received their own copy.

Staff Annual Awards

Staff Annual Awards February 2016 recognised staff for their outstanding contribution. Staff were nominated under eight categories: shining star (clinical and non-clinical), making a difference behind the scenes, leadership for change, research and innovation, technology enhancement, service improvement, Chief Executive award, Governors - making you feel better and Chairman's - quality award.

Breakfast with the Chief Executive

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

Personal Resilience

Staff development sessions promoting personal resilience strategies introduced in July 2014 have continued throughout 15/16 to support the workforce to develop coping strategies in a changing environment.

Health Advocates

Staff volunteers working on projects to improve staff health and wellbeing have once again achieved the Continuing Excellence standard of the Better Health at Work Award.

Appraisal

The monitoring of appraisal completion and quality audits have been a focus of work during 15/16 to ensure staff are getting the development they need to do their job and support to progress in their careers in line with the new behaviours framework for staff.

Staff Benefits & Reward

Staff benefits continue to be expanded offering staff local discounts that they can access when they produce their identification badge and a range of salary sacrifice schemes. The Total Reward Scheme was introduced in 2013 and the newly appointed Employee Assistance Programme provides a range of services for staff to access for support.

Next steps

County Durham & Darlington NHS Foundation Trust intends to take the following actions to improve this data, and so the quality of its services.

OD Strategy – Staff Matter

During 16/17 the OD Strategy Staff Matter will be reviewed and updated based on intelligence available from the Cultural Audit and recommendations from the Kings Fund, Staff Survey 2015 results, on-going quarterly feedback from the Staff Friends and Family Test alongside organisational drivers on from the Quality Matters strategy.

Leadership and Management Development Framework

The leadership and management development framework will be reviewed and refreshed for 16/17 to ensure it meets current and future leadership and management development needs.

Clinical Leadership Programme

A bespoke development programme is being designed for clinical leaders within the Trust to be implemented in 16/17.

CLINICAL EFFECTIVENESS

Reduction in Risk Adjusted Mortality (RAMI) and Standardised Hospital Mortality Indicator (SHMI)

☑	Trust ambition achieved

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

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

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

In previous years the Trust also used the Risk Adjusted Mortality Indicator (RAMI) to monitor mortality. This was an indicator produced by CHKS, the Trust's information provider partner, and considers in hospital deaths only. However, recently the Trust has re-tendered for its information provider and is in the process of moving to Healthcare Evaluation Data (HED) and will be working with staff from HED to ensure robust mortality information is available to the Trust.

HED data includes SHMI and the Hospital Standardised Mortality Ratio (HSMR) as comparators of mortality. In addition, bespoke views can be developed for specific patient groups with clinician input, and outcomes monitoring in key areas is supported. Indicators are complemented with statistical measures denoting the indicator's status to allow trusts to understand their outlier status. Using the modules it is possible to highlight patient groups within trusts requiring investigation or monitoring, and then to drill through enabling detailed investigation and root cause analysis.

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

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

Our aim

Our aim is to remain at or below the national average for mortality rates and lower than comparable regional peers.

Progress

County Durham & Darlington NHS Foundation Trust considers that this data is correct for the following reasons:

- The data is collected as prescribed nationally and reported as per national guidelines
- The data presented is as shown by the Health and Social Care Information Centre

The next series of graphs shows our comparative position when measured across hospitals in England and an indication of what that means.

HSMR

The timeline below shows that from a peak in January 2015, when we know that there was nationally the highest number of winter deaths since 1990/00, there has been a steady fall in the Trust's HSMR to a 12 month low of 82.88.

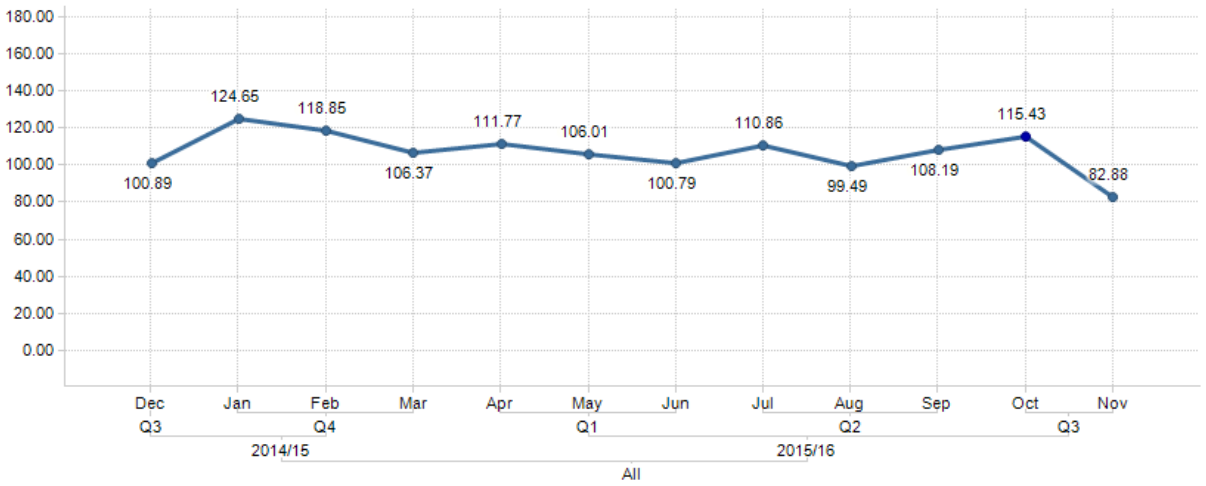


Figure 1 – HSMR timeline (Dec 2014 – Nov 2015)

Unfortunately, the funnel plot showing expected number of deaths and HSMR for the latest 12 months (Figure 2) shows that the Trust has slipped above the upper control line.

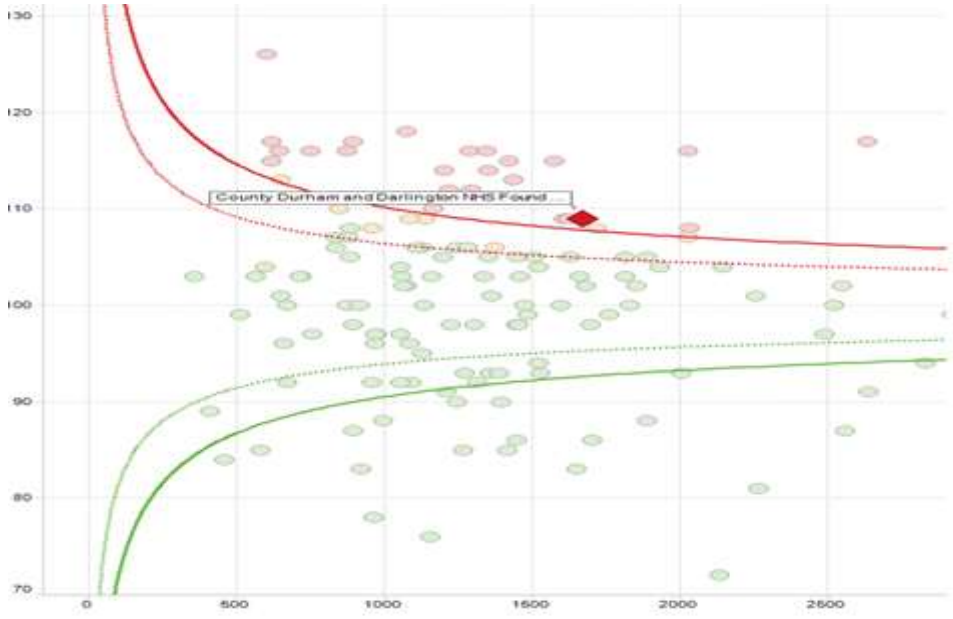


Figure 2 - Funnel plot showing expected number of deaths and HSMR for the latest 12 months

Further analysis of this data allows the production of a 'treemap' (Figure 3) that shows the number of excess deaths by Clinical Classification System (CSS) diagnosis group. It can be seen that Pneumonia is the CSS group with the most excess deaths.

The Trust was aware of this and consultants within the Trust are working as part of a regional project looking at community acquired pneumonia and the uptake of specific 'clinical focus areas' defining best clinical practice. This work is on-going but data currently available shows that CDDFT has comparable levels of uptake of these areas, compared to others in the region, and exceeded the regional average in a number of key areas including 'oxygen given within 1hr of arrival' and 'appropriate initial antibiotic regimen received'.

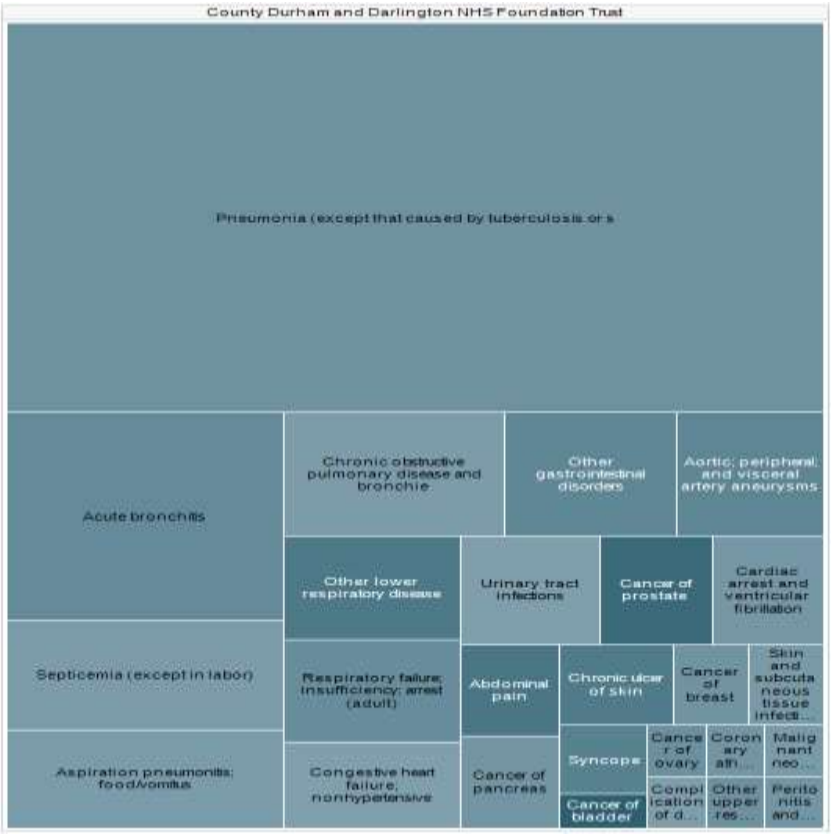
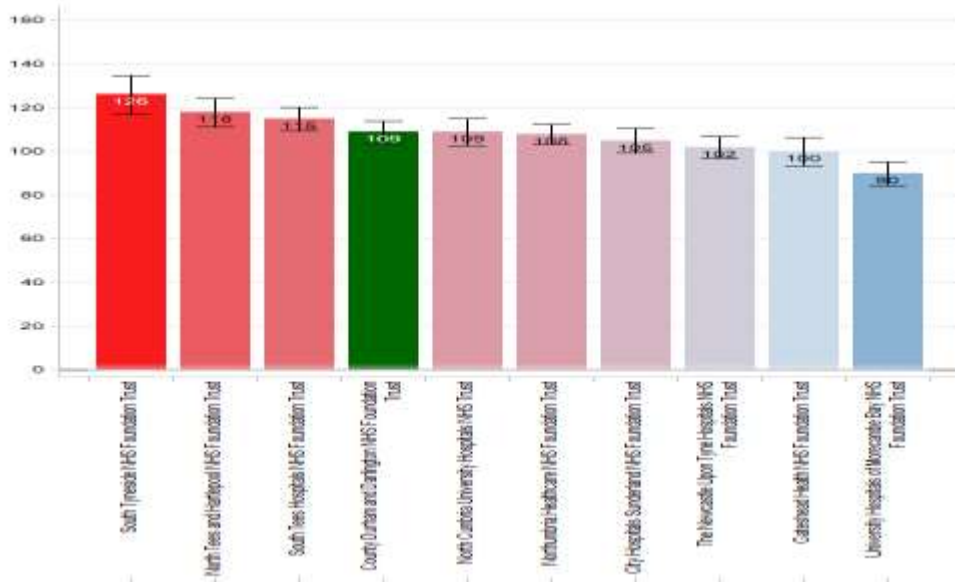


Figure 3 - Treemap shows the number of excess deaths by Clinical Classification System (CCS) diagnosis groups.

When the Trust's HSMR is compared with the Trust's peers across the North East region, the Trust sits in the middle of the comparable trusts.



Standardised Hospital Mortality Index (SHMI)

The SHMI data shows more favourable results for the Trust. The timeline below (Figure 4) shows that the Trust has been consistently at or below the recognised standard of 100. This is further reflected in the funnel plot (Figure 5) that shows the Trust sitting in the middle of plot.

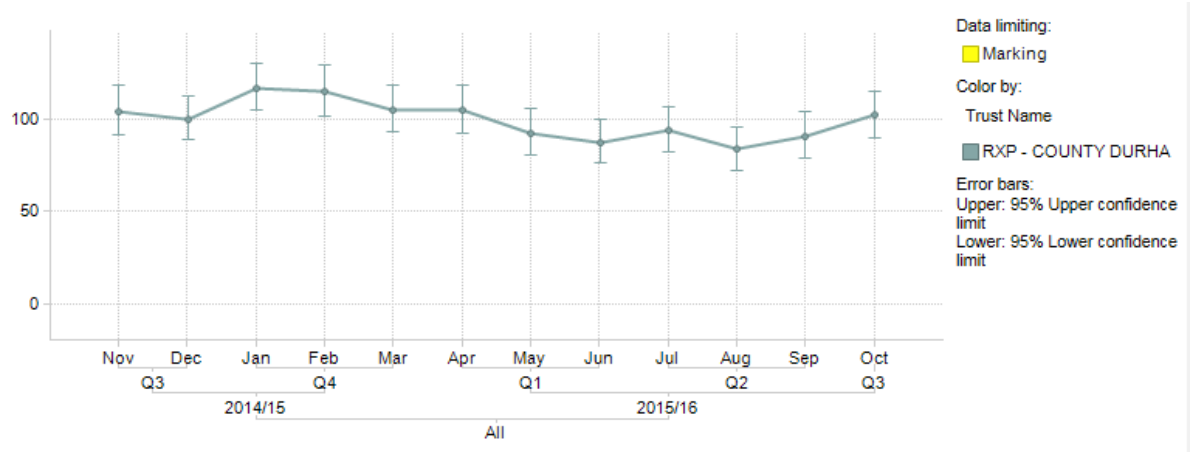


Figure 4 – SHMI timeline (Nov 14 – Oct 15)

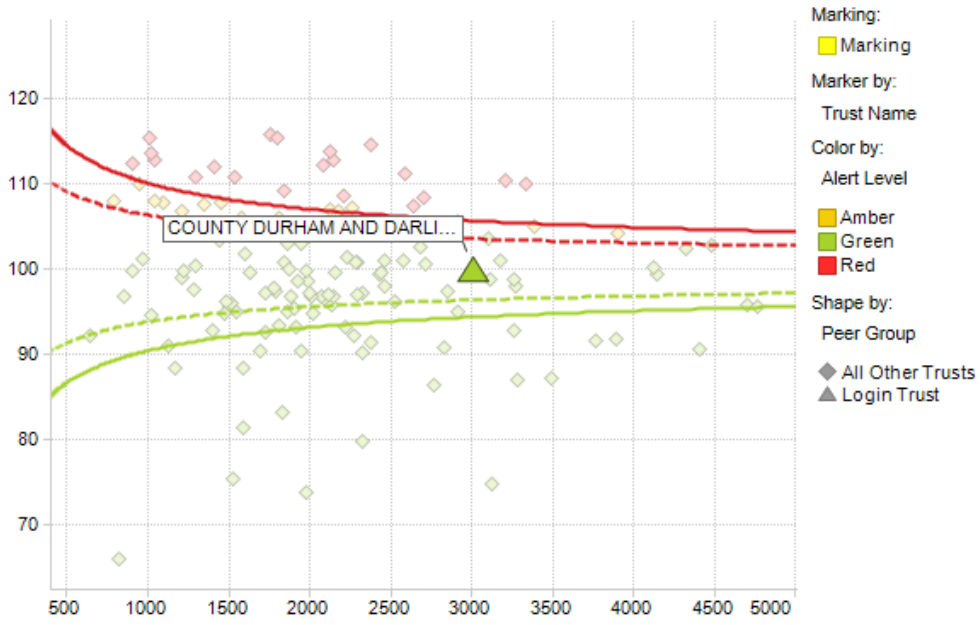
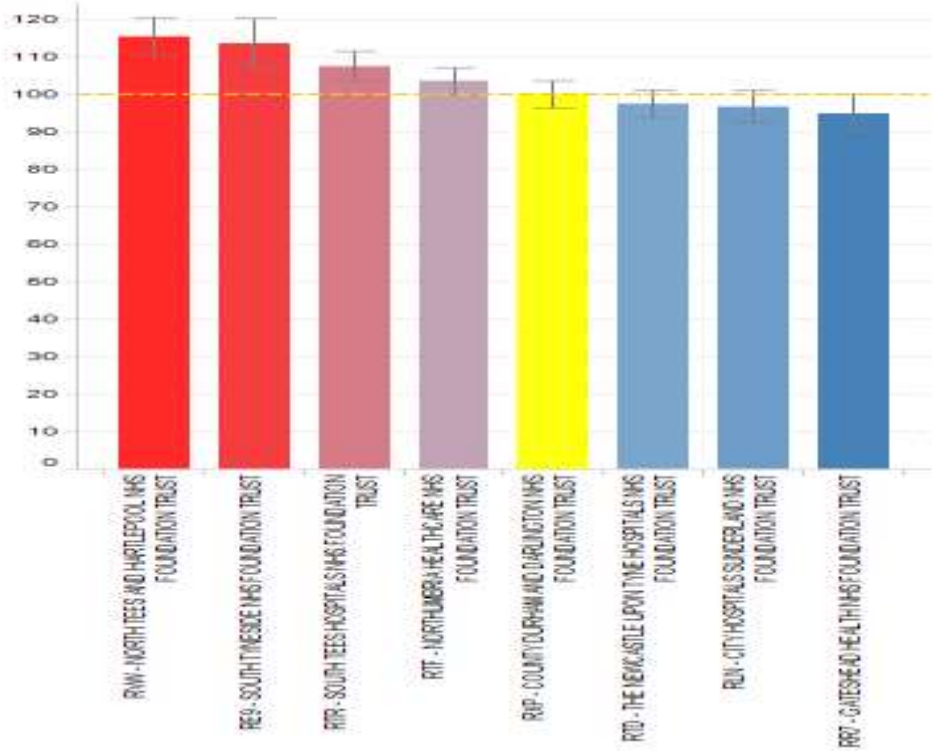


Figure 5 - Funnel plot showing expected number of deaths and SHMI for the latest 12 months

Comparison with the other Trusts in the region shows again that CDDFT sits with in the middle of the comparator group.



Crude Mortality

The Trust's crude mortality figure shows a more dramatic fall since a high in January 2015 and again stands at a 12 month low at 2.26%

Figure 6 – Crude Mortality timeline (Dec 14 – Nov 15)

Coding

Palliative Care Coding: Figure 7 shows the rolling 12 month proportion of deaths with specialist palliative care coding by North East trust per the SHMI contextual indicator. Palliative care coding within CDDFT has remained broadly stable but we are therefore worsening relative to England and other trusts in the region. This is important as the rate of palliative care coding impacts directly (negatively) on HSMR and therefore may be adversely impacting upon our HSMR ratio. The trust must prioritise this coding in order to present an accurate picture for HSMR.

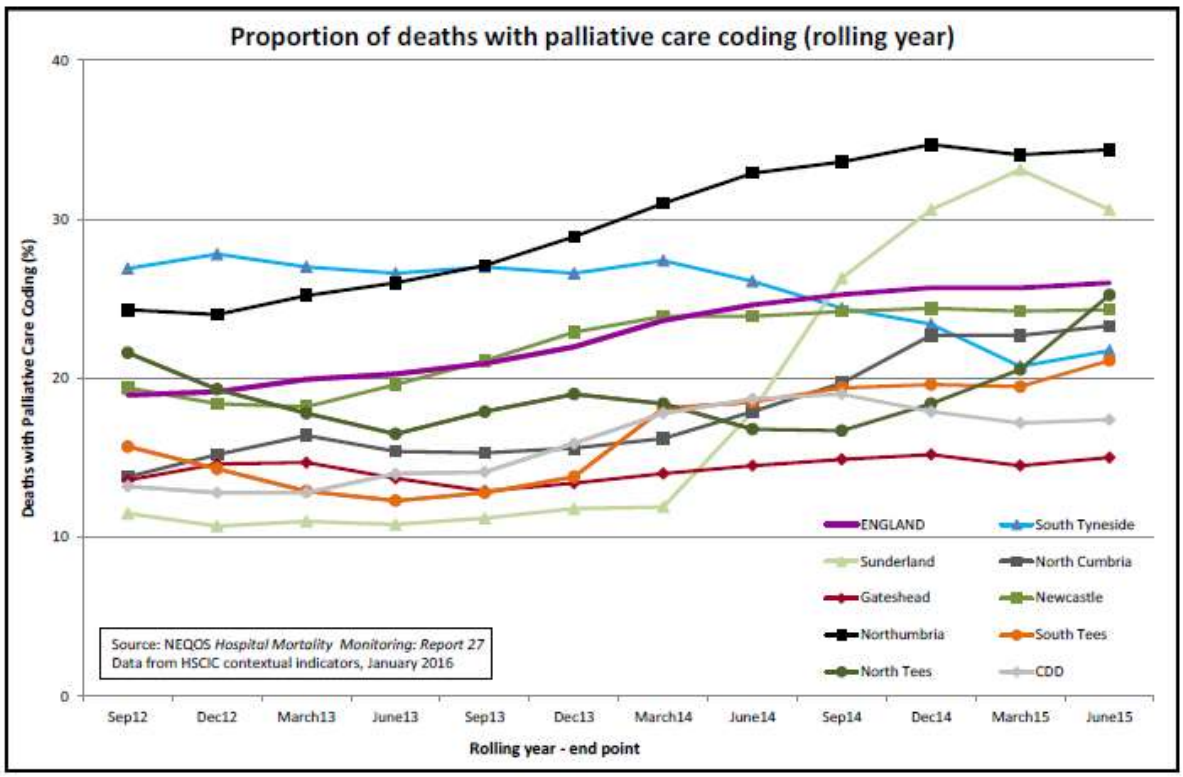


Figure 7: Proportion of deaths with palliative care coding

The level of coding for comorbidities has shown a steady rise over the last 3 years reflecting better clinical documentation , and is in line with other trusts in the region and England as a whole.

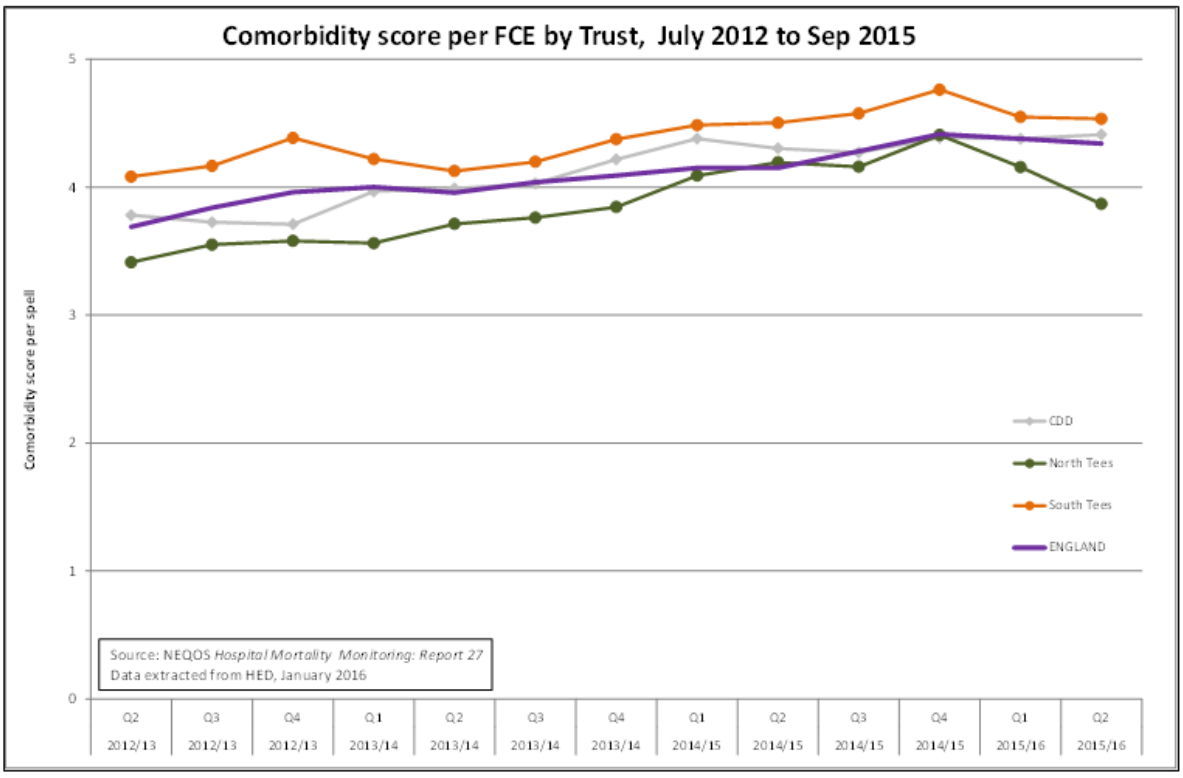


Figure 8: Comorbidity score per FCE by Trust

Next Steps

County Durham & Darlington NHS Foundation Trust has taken the following actions to improve these indicators and so the quality of its services

- Understand how the mortality review process may change over the next 12 months following the letter from Dr Mike Durkin and Professor Sir Bruce Keogh to all trusts and also the decision by NHS England to award the national retrospective case record review process to the Royal College of Physicians.
- On-going work with the local Coroner to gain access to post-mortem reports to allow information be used as part of the review process.
- Continue to develop ward specific reports
- Continue to develop links with Primary Care colleagues to ensure joint learning.
- Improve palliative care coding

It is generally accepted that the overriding purpose of mortality rates is to promote enquiry into clinical practice and in the context of mortality this necessitates critical review of deaths. The Trust has a number of different forums where mortality is reviewed and discussed. The Emergency Departments undertake a mortality review process of all deaths that occur within the ED clinical area, maternity and paediatrics have a separate mortality review process that fulfils statutory requirements in these area and the Cardiac Arrest Prevention Team undertake mortality reviews on specific groups of patients. All other deaths are brought to the Weekly Mortality Review Group (WMRG) for review. This work is coordinated by the Associate Director for Mortality and reported into the Trust's Mortality Reduction Committee.

The WMRG consists of a number of consultants and senior nursing staff from a wide range of clinical specialities including acute medicine, care of the elderly medicine, gastroenterology, anaesthetics and surgery. The group reviews patient care within a month of the patient dying and currently over 30% of deaths are reviewed in this forum. Trust will be seeking to improve this figure in 2016/17.

The Trust received a letter from Dr Mike Durkin and Professor Sir Bruce Keogh challenging all trusts to improve their governance arrangements around mortality review. Whilst CDDFT currently meets many of the recommendations in the letter, there was a challenge that 'In order to understand the standard of care being delivered to those who die there needs to be a high level assessment of all deaths. This is quite achievable if the responsibility is distributed amongst all consultants in those specialties with large numbers of deaths (e.g. acute medicine).'

The Trust will need to consider the implications of moving from a centralised, standardised, independent and replicable process, which is currently undertaken by the WMRG, to one where mortality review is undertaken within specialties. In addition, the national retrospective case record review (NRCRR) process was awarded to the Royal College of Physicians and the Trust awaits an update on how this process will be implemented.

To try and further increase the depth of information available at the time of undertaking a review the Trust has sought permission from the local Coroner to gain access to the post mortem reports that are commissioned by him. The Coroner has supported this move and the Trust is currently finalising the process so that these reports are available.

Whilst undertaking mortality reviews are essential it is equally important the information gained from the reviews are fed back to clinical teams in a timely fashion. The try and achieve this, the Trust has started to produce quarterly feedback reports to ward areas. These reports include information relating to;

- Main Diagnosis on Admission
- Comorbidities
- Appropriateness – on ward at admission / of ward at time of death
- Outcome - rate of expected deaths / proportion of deaths from cardiac arrests / NCEPOD and Hogan scores
- Number receiving further review / escalation
- Lessons Learnt

These data should then be used by the clinicians in the ward, speciality and care group governance meetings to inform staff of outcomes, generate debate and lead to change in practice.

The trust is also collaborating with peers across the region and with colleagues in primary care to share learning and to undertake joint work to improve patient care. Regional there are projects looking at the management of sepsis and acute kidney injury that have been generated form the regional mortality work.

In primary care, all cases where the reviewer identifies a potential issue with pre-hospital care are escalated to either the community nursing teams, where CDDFT are involved, or directly with primary care colleagues, to ensure that lessons can be learnt and policies and procedures changed if required. This work will continue to be developed in 2016/17.

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

TBC	

Our aim

Our aim is to reduce the number of avoidable re-admissions, which are inconvenient for patients and suggest their care might not have been optimal. Reducing avoidable re-admissions also enables more money to be spent on care closer to home and less on hospital beds, in line with Government policy.

Progress

We have achieved a small reduction in re-admissions so far in 2015 due to a fall in the numbers being re-admitted after an elective spell.

	Apr-Nov 2014	Apr-Nov 2015	Variance
Electives	1,053.00	970.00	-7.9%
Non-electives	3,917.00	3,982.00	1.7%
Total	4,970.00	4,952.00	-0.4%

Over 55% of re-admissions following an elective spell take place in General Surgery, Gastroenterology (Endoscopy) and Ophthalmology; 56% take place in short stay or

assessment areas, such as the Surgical short stay units, the endoscopy suites and assessment units.

Over 65% of re-admissions following a non-elective spell take place in General Medicine, General Surgery or Accident and Emergency, about 36% of which occur in short-stay, assessment or ambulatory care wards.

The key multi-agency approaches to reducing unnecessary re-admissions include:

- the Intermediate Care Strategy (IC+ in Durham, RIACT in Darlington) involving a range of services such as: multi-disciplinary assessment teams, a 24/7 single point of access, night-sitting services, short-stay and emergency nursing home beds, help in the home, early Consultant-led assessment of complex elderly patients. A major review of the Durham scheme has been completed and will inform investment decisions in 2015.
- A multi-agency complex elderly assessment team (CREST) operates at UHND providing rapid assessments of frail elderly patients. Consideration is being given to replicating this service at DMH.
- the Trust has access to beds in five community hospitals, which also include day hospitals, and is currently reviewing access criteria and usage.
- the Trust is participating in a quality improvement (CQUIN) scheme in 2015-16 to improve the sharing of information about and care of elderly patients with complex health needs.
- the Trust and commissioners have developed improved discharge support schemes to ensure patients are discharged into appropriate environments with the right amount of care.

Next Steps

1. The major review of Intermediate Care Services in Durham will guide investment decisions for 2016-17.
2. The Trust's Emergency Care Improvement Programme includes a number of actions agreed with multi-agency partners to improve discharge planning and services including, for example, extending discharge to assess schemes, a new Family Choice Policy and supportive services for patients needing to go into a Care Home, improved use of Community Hospitals, more rapid access to community services for patients from more distant CCGs (eg: North Yorkshire).

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

TBC	

Our Aim

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

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

Progress

CDDFT A&E Departments continue to be amongst the busiest nationally. Type 1 (main A&E) attendances grew by 1.5% (DMH: +1.5%; UHND: +1.4%) between Apr-Dec 2015 compared to the same period in the previous year.

	A&E Attendances (Type 1)			4-hour breaches (All types)		
	Volume	National Position (out of 143)	Regional Position (out of 8)	Percentage	National Position (out of 143)	North East Position (out of 8)
Q1 2015-16	32,494	33	2	94.4%	76	7
Q2 2015-16	31,548	39	3	97.5%	8	2
Oct. 2015	11,291	33	2	94.9%	32	5
Nov. 2015	10,661	37	3	95.5%	10	3

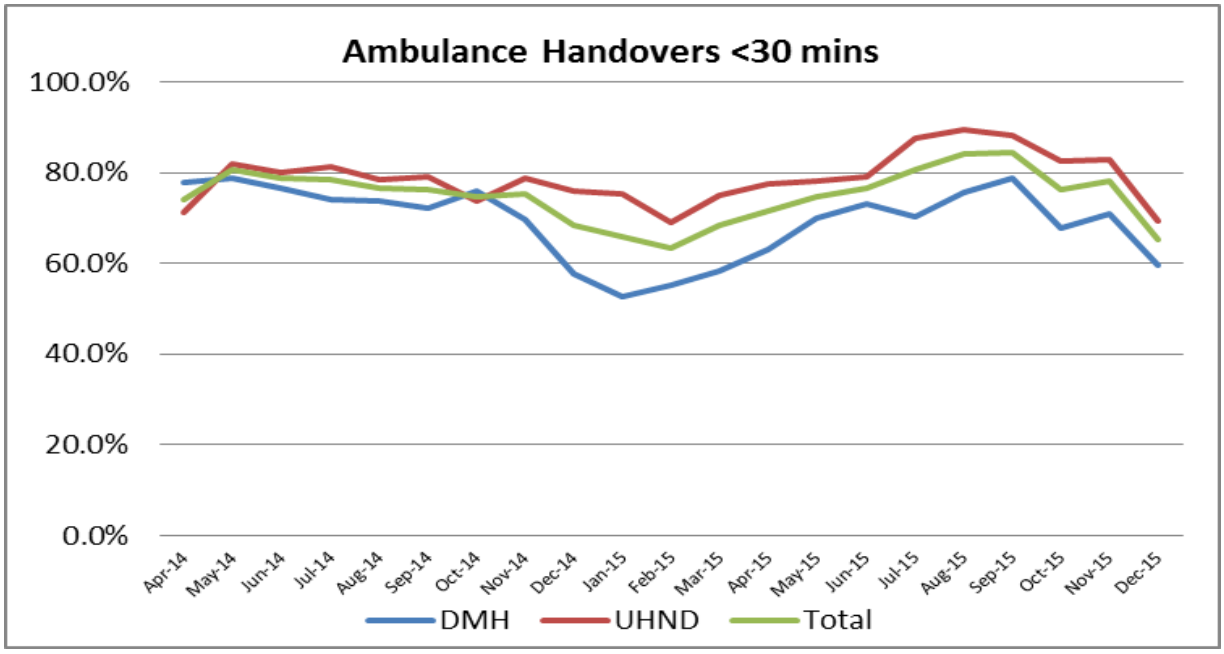
Source: NHS England – full Q3 figures not yet published

Notwithstanding the fact that in Q1 and Q3, the Trust did not achieve the 4-hour waiting time standard, performance has been better than average since Q1. Only seven Trusts nationally bettered the CDDFT performance in Q2 and only nine in November. Regionally only one Trust bettered CDDFT performance in Q2 and two in November.

NEAS Ambulance arrivals continue to run at marginally lower levels than in 2014-15: down 2.2%, including 3.3% at DMH and 1.4% at UHND. Although Yorkshire Ambulance attendances at DMH have risen by 5.5% over the same comparative periods, this has only partially counter-balanced the fall in NEAS arrivals.

Ambulance handovers <30 mins

	Q1	Q2	Q3
2014-15	77.8%	77.1%	72.6%
2015-16	74.3%	83.0%	73.1%



This fall in activity has probably contributed to the increased number of ambulances being able to handover the care of the patient to A& E staff within 30 minutes in Q2 and Q3.

It is recognised nationally and by local commissioners that difficulties in achieving the 4-hour A&E standard are a symptom of strains affecting the wider health and social care system. A study by local commissioners showed that increased number of 4-hour breaches correlate with pressures on acute beds. In their turn, pressures in A&E affect other organisations, most notably the Ambulance Service. When crews have to wait for longer periods of time to hand

over care of patients to A&E staff, they cannot attend to other calls from patients in the community.

Although CDDFT non-elective activity in Apr-Dec 2015 declined by 3% compared to the same period in 2014, the Trust's main pressure point, Medicine at UHND, saw activity increase by 0.9%. This is offset by the growth in activity in ambulatory and short stay units designed to take pressure off the acute beds.

Trust-wide Admissions	Apr - Dec 2014	Apr - Dec 2015	% variance
All non-electives	52376	50778	-3.1%
Paeds/neonates	7367	7271	-1.3%
Surgery (ex T&O)	6762	6479	-4.2%
T&O (ex Paeds)	2018	1940	-3.9%
Medicine	26903	26435	-1.7%
UHND (Medicine)	16103	16244	0.9%
DMH (Medicine)	10650	10079	-5.4%
Total Ambulatory/Short-stay Medicine	10974	11381	3.7%

Next Steps

The Trust has received close scrutiny by Monitor in respect of its non-elective performance. In response it has developed an Emergency Care Improvement Programme with the support of local commissioners and partner agencies. This programme contains actions which aim to:

- manage demand for acute beds more effectively through improved Primary Care and community services
- provide robust assessments of patients by senior clinicians at the hospital front door to prevent unnecessary admissions.
- ensure there are no unnecessary delays in discharging patients, including providing good discharge support.

One of the key early actions for CDDFT was to run *"Perfect Weeks"* at UHND and DMH. This involved cancelling routine work for a week to focus on delivering the ideal mix of timely and high quality non-elective care. Some of the main lessons learned, which the Trust aims to incorporate into normal practice, include:

- Deliver care to best practice standards (using guidelines) focussing on increasing the number of patients reviewed and discharged by senior clinicians in the mornings
- Improved command and control arrangements and escalation processes
- Roll-out of electronic patient flow/bed management system
- Improved matching of capacity and demand in radiology.
- Extended pharmacy and therapies cover
- Improved and extended discharge support services
- Improved access for A&E patients to rapid assessment by Specialty doctors.
- Ensure end of life patients are cared for in their preferred place, avoiding unnecessary transfer to hospital.

In the medium to longer term, several key discussions with a bearing on non-elective performance continue:

- the type and location of Urgent Care services local CCGs wish to commission. Plans are well advanced to co-locate the Darlington Urgent Care Centre with A&E at DMH, whilst co-location of the Out of Hours service and A&E at UHND has already been achieved. Plans for the remaining Centres in DDES CCG are currently being consulted upon.
- Ways in which CDDFT can shelter more elective work from the impact of non-elective pressures. In this regard, the upgrade of the theatres at BAH to clean air, will enable most elective orthopaedics work to be moved to that site where it will protected from late cancellations arising from non-elective pressures.
- Strategic changes to improve the sustainability of the health economy across Durham, Darlington and Teesside via the commissioner-led SeQiHS process.

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

	TBC

What are they? PROMs measure quality from the patient perspective by using questionnaires. They cover four clinical procedures – hip replacements, knee replacements, hernia and varicose veins. PROMs calculate the health gain after treatment using surveys carried out before and after the operation. PROMs are a measure of the patient's health status or health related quality of life at a single point in time. They provide an indication of the outcome or quality of care.

Our aim
We want to increase participation so that we can gain a good understanding of patient's view of their care and outcomes. We want to see an improvement in participation rates for all PROMs.

Patient Reported Outcome Measures (PROMs) have now been collected from all providers of NHS-funded care since April 2009 for the following procedures: Groin Hernia Repair Hip replacement Knee replacement Varicose Vein Surgery
The importance of embedding the collection of PROMs data into routine clinical practice and achieving greater coverage of these procedures has been recognised nationally. The support for this is shown by the inclusion of these measures in the NHS Outcomes Framework and locally by the development of CQUIN targets.

In addition to increasing participation rates we want to see an increase in health gain as a result of the interventions carried out.

Participation Rates (against HES data)

WAIT YEAR END DATA TO BE INSERTED
County Durham & Darlington NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services.

The data is collected prior to the surgery and post operatively to provide an indicator of the outcome of the surgery for the patient and with the change in data management provider the data is now available at patient level.

WAIT YEAR END DATA TO BE INSERTED

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

The data is collected by a dedicated team within the organisation.
The data collected is made available by the Health and Social Care Information Centre as stated above.

STATEMENTS OFASSURANCE FROM THE BOARD

During 2014/15 County Durham & Darlington NHS Foundation Trust provided and/or sub-contracted **TBC** relevant services.

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

The income generated by the relevant health services reviewed in 2015/16 represents 100 per cent of the total income generated from the provision of relevant health services by the County Durham & Darlington NHS Foundation Trust for 2015/16.

Review of Services

The Trust's performance against national priorities for 2015/16 is shown in Part 3 of this report.

The Trust has developed an Integrated Board report covering quality, performance and workforce indicators, and incorporating a comprehensive performance scorecard. The Board received monthly reports relating to all relevant indicators.

The Trust has also developed a new integrated Performance Management Framework which incorporates:

- Executive-led quarterly performance reviews of each Care Group
- Monthly performance reviews of each Care Group led by the Director of Performance
- An escalation and earned autonomy framework with degrees of support ranging from low, medium and high intensity to "special measures".

Participation in Clinical Audits and National Confidential Enquiries

During 2015/16 39 national clinical audits and 4 national confidential enquiries covered NHS services that County Durham & Darlington NHS Foundation Trust provides.

During 2015/16 County Durham & Darlington NHS Foundation Trust participated in 97% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that County Durham & Darlington NHS Foundation Trust was eligible to participate, participated in, participated in and for which data collection was completed during 2015/16 are contained within the table below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry:

National Audit/National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 15 – Mar 16	% cases submitted
Women's and Children's Health				
Maternal, infant and newborn programme (MBRRACE-UK)* (Also known as Maternal, Newborn and Infant Clinical	✓	✓	On-going	100%

Outcome review Programme)				
Neonatal intensive and special care(NNAP) -	✓	✓	✓	100%
Paediatric Asthma (British Thoracic Society	✓	✓	✓	*100%
Paediatric intensive care (PICANet)	X			

* More than BTS requirement of a minimum of 20 consecutive children's data entered. .

National Audit/ National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 15 – Mar 16	% cases submitted
Acute Care				
Emergency Oxygen Audit (British Thoracic Society)	✓	✓	✓	N/A
National Complicated Diverticulitis (CAD) *	✓	X		
Adult critical care (Case Mix Programme) –	✓	✓	On-going data collection. Final quarter to be submitted May 16	100% April – Dec 15
National emergency laparotomy audit (NELA)	✓	✓	On-going Data for Year 2 locked 15/1/16	N/A
Hip, knee ankle, shoulder elbow replacements (National Joint Registry)	✓	✓	On-going	87%
Severe trauma (Trauma and Audit Research Network TARN)	✓	✓	On-going. Data still being collected	100.0%
Procedural Sedation in Adults (care in emergency departments)) (Royal College of Emergency Medicine)	✓	✓	✓	**100.0%
Vital signs in Children (care in emergency departments) (Royal College of Emergency Medicine)	✓	✓	✓	**100.0%
VTE risk in lower limb immobilisation (care in emergency departments) (Royal College of Emergency Medicine)	✓	✓	✓	**100.0%

* The Trust could not participate in Phase 2 of this audit as it had not participated in Phase 1 of the audit, which was before it was added to the list of audits for inclusion in Quality Accounts.

** Sample required by the Royal College of Emergency Medicine has been submitted.

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National Audit/ National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 15 – Mar 16	% cases submitted
Long Term Conditions				
Chronic Obstructive Pulmonary Disease (COPD) Audit Programme Chronic Obstructive Pulmonary Disease Pulmonary Rehabilitation audit .	✓	✓	✓	N/A
Diabetes (National Adult Diabetes Audit)	✓	✓	✓	100% of cases on System One and databases

				sent 27/5/15
Diabetes (RCPH National Paediatric Diabetes Audit)	✓	✓	✓	100% cases on database sent
National Pregnancy in Diabetes (NPID)	✓	✓	On-going Data already collected for the Northern Diabetes in Pregnancy Audit and data will be transferred by RMSO	100% of cases submitted via NorDIP when transferred to NPID.
National Diabetes Footcare Audit (NDFA)	✓	✓	✓	*100%
UK IBD Audit (National IBD Audit)	✓	✓	✓	100%
Rheumatoid and early inflammatory arthritis	✓	✓	On-going	N/A
Renal replacement therapy (Renal Registry)	X			
Chronic Kidney Disease in Primary Care	X			

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

National Audit/ National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 15 – Mar 16	% cases submitted
Mental Health Conditions				
Prescribing in mental health services (POMH)	X			
Mental Health programme: National Confidential Inquiry into Suicide and Homicide for people with mental illness(NCISH)	X			

National Audit/ National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 15 – Mar 16	% cases submitted
Older People				
Falls and Fragility Fractures Audit Programme (FFFAP):				
Fracture Liaison Service Database (FLS-DB)	✓	✓	Ongoing (patient data collection began 1/1/2016	N/A
Falls workstream (National Audit of Inpatient Falls)	✓	✓	✓	*100%
Hip fracture (National Hip Fracture Database)	✓	✓	✓	100%
Sentinel Stroke National Audit Programme (SSNAP)	✓	✓	On-going	90%+ (A) case ascertainment reported for the first three quarters of 15/16
UK Parkinson's Audit (previously known as National	✓	✓	✓	**100%

Parkinson's Audit)				

* Snap shot audit of 30 consecutive patients for both main acute sites.
** Required samples collected for the Patient Management, OT, Physiotherapy and Speech and Language Therapy Audits

National Audit/ National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 15 – Mar 16	% cases submitted
Heart				
Acute Coronary Syndrome or Acute Myocardial Infarction & other ACS (MINAP)	✓	✓	On-going	Data to be submitted 31/05/2016
National Adult Cardiac Surgery Audit (Adult Cardiac Surgery)	X			
Cardiac Arrhythmia (HRM)	✓	✓	On-going	100%
Congenital Heart Disease (Paediatric Cardiac Surgery) (CHD)	X			
Coronary angioplasty (NICOR Adult cardiac interventions audit)	X			
Heart failure (Heart Failure Audit)	✓	✓	On-going	Data to be submitted 0-01/06/2016
Cardiac arrest (National Cardiac Arrest Audit)	✓	✓	✓	100%
National Vascular Registry (elements will included CIA Carotid Interventions Audit, National Vascular Database, AAA, peripheral vascular surgery/VSGBI Vascular Surgery Database.	✓	✓	On-going	100% for first 3 quarter's. Final quarter's data still being entered.
Pulmonary Hypertension Audit	X			

National Audit/ National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 15 – Mar 16	% cases submitted
Cancer				
Lung cancer (National Lung Cancer Audit)	✓	✓	*✓	100%
Bowel cancer (National Bowel Cancer Audit Programme)	✓	✓	**✓	100%
Oesophago-gastric cancer (National O-G Cancer Audit)	✓	✓	***✓	100%
Prostate cancer (National Prostate Cancer Audit)	✓	✓	On-going monthly data submissions	100%

* Data collection deadline in 2015/16 for patients covering period Jan – Dec 2014
** Data collection deadline in 2015/16 for patients covering period 1st Apr 2014 – 31st Mar 2015
*** Data collection deadline in 2015/16 for patients covering period 1st Apr 2014 – 31st Mar 2015

National Audit/ National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 15 – Mar 16	% cases submitted
Other				
Elective surgery (National PROMs Programme)	✓	✓	N/A	N/A
National Audit of Intermediate Care. (NAIC)	✓	*X		
National Ophthalmology Audit (NOD)	✓	✓	On-going Data collection scheduled to	N/A

			begin Feb/Mar 16	

* The Trust did not participate in the NAIC 2015 as the whole local health economy decided not to participate.

National Audit/ National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 15 – Mar 16	% cases submitted
Blood transfusion and Transplant				
Audit of Patient Blood Management in adults undergoing elective, scheduled surgery (National Comparative Audit of Blood Transfusion)	✓	✓	✓	100%
Audit of lower gastrointestinal bleeding and the use of blood (National Comparative Audit of Blood Transfusion)	✓	✓	✓	*100%
Audit of Red Cell and Platelet Transfusion in Adult Haematology Patients (National Comparative Audit of Blood Transfusion)	✓	✓	✓	100%
National Confidential Enquiries				
Acute Pancreatitis Study	✓	✓	✓	55%
Mental Health in General Hospitals Study	✓	✓	On-going	N/A
Chronic Neurodisability Study	✓	✓	On-going	N/A
Young Persons Mental Health Study	✓	✓	On-going	N/A

* Data for all patients admitted over a 2 month period was submitted.

- The reports of *29 national clinical audits were reviewed by the provider in 2015 and County Durham & Darlington NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

  * For the National Cardiac Arrest Audit (NCAA) 14/15, National Comparative Blood Transfusion – Patient Information and Consent Audit –, ICNARC Case Mix Programme 14/15, Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE) - Perinatal Congenital Diaphragmatic Hernia Report there was compliance with standards.

National Clinical Audits reviewed in 2015/16	Action
National Neonatal Audit Programme (NNAP) 2014	At joint meetings with Obstetrics will raise awareness of the need to improve the percentage of mothers who deliver babies between 24-34 weeks gestation and are given a dose of antenatal steroids. Although in line with network peers and national average will work to improve the percentage of documented consultation with parents by a senior member of the neonatal team within 24hrs of admission.
National Paediatric Diabetes Audit 13/14	NPDA database (Twinkle) training updates undertaken. Designated trained admin staff is needed (To be incorporated within the Trusts Admin Review). All caseload to be assigned to one Trust Code. To Pilot new Structured education delivery method in clinic To liaise with the national service regarding the retinopathy screening results.
Royal College of Emergency Medicine – Paracetamol Overdose 2014 (Darlington Memorial Hospital)	Training to be emphasized for SHO's and at induction to reiterate the importance of all patients receiving N-acetylcysteine within 8 hours of ingestion. Recording of data to show compliance with MRHA guidance to be improved.
Royal College of Emergency Medicine – Paracetamol Overdose 2014 (University Hops Memorial Hospital)	Information on management of overdose/ poisoning to be added to the handbook 'common presentations to the Emergency Department', with specific information with regards paracetamol overdose and reference to toxbase guidelines. Teaching session on overdose /poisoning management to be included in recurring Foundation 2 Doctors departmental teaching.
Royal College of Emergency Medicine – Asthma in Children 2014.	Consultation with Paediatric colleagues to improve the measuring and recording of vital signs; in particular peak flow measurements, can be very difficult. Cooperative working with the Paediatrics department to assess improve working in the following areas: • Beta 2 agonist (+/- ipratropium) given by spacer or nebuliser in the Emergency Department. • IV hydrocortisone or oral prednisone given in the Emergency Department. • Discharge prescription for oral prednisolone given. University Hospital of North Durham Memo to medical and nursing staff that vital signs should be reliably measured within 15 minutes of arrival. (Systems to be established to improve flow within the department) To discuss with IT lead as to whether a check box for peak flow can be added to the paediatric triage observations. Education/ memo re guideline of management of asthma in children. Paeds asthma pathway is available on the intranet in the Emergency Department homepage. Improved scanning of drug charts into symphony after

	discharge.
Royal College of Emergency Medicine – Asthma in Children 2014. Darlington Memorial Hospital)	Consultation with Paediatric colleagues to improve the measuring and recording of vital signs; in particular peak flow measurements, can be very difficult. Cooperative working with the Paediatrics department to assess improve working in the following areas: • Beta 2 agonist (+/- ipratropium) given by spacer or nebuliser in the Emergency Department. • IV hydrocortisone or oral prednisone given in the Emergency Department. • Discharge prescription for oral prednisolone given.
Royal College of Emergency Medicine – Initial Management of the Fitting Child 2015. (Darlington Memorial Hospital)	All staff made aware that all patients who present following a seizure require a BM to be checked and documented. Advice cards to be made available on discharge following a seizure.
Royal College of Emergency Medicine – Initial Management of the Fitting Child 2015. (University Hospital of Durham)	All staff made aware that all patients' blood glucose should be documented after seizure. Advice cards to be made available on discharge following a seizure. Discuss need for paediatric seizure proforma with senior staff, which would include a witness statement.
Royal College of Emergency Medicine – Mental Health In the Emergency Department 2015. (Darlington Memorial Hospital)	To ensure the assessment room meets all standards set by Psychiatry Liaison Accreditation Network (PLAN) To discuss at Emergency Department meeting and with psychiatry liaison team to determine whether need exists for duplication of documentation, and if so then to follow up with psychiatry liaison lead. Emergency Department staff/ and psychiatry liaison staff made aware of the need to improve documentation.
Royal College of Emergency Medicine – Mental Health In the Emergency Department 2015. (University Hospital of Durham)	To ensure the assessment room meets all standards set by Psychiatry Liaison Accreditation Network (PLAN) by: • Discuss at Senior Staff Meeting potential need to change door openings (one opens in the second out, the recommendation is that a door opens in both directions). • Furniture previously did meet requirements but had to be destroyed –appropriate furniture ordered. To discuss at Senior Staff Meeting and with psychiatry liaison team to determine whether need exists for duplication of documentation of Mental State Examination in Psychiatry notes/Emergency Department Notes, and if so then to follow up with psychiatry liaison lead. Memo to ED staff/ discussion with psychiatry liaison staff with regard to improved documentation of referral and follow up arrangements.
Royal College of Emergency Medicine – Assessing for cognitive impairment in older	University Hospital of North Durham and Darlington Memorial Hospital. To discuss with senior staff the appropriateness of doing a

people 2015	cognitive assessment in all patients over the age of 75’
National Pregnancy in Diabetes Audit 2014	• Letter to be sent to the Commissioners re encourage the use folic acid in the pre-conception care of women with diabetes, encourage women to control HbA_{1c} <48 mmol/mol in first trimester. . • Discuss pre-conception care at CAG meeting. • Better education • GP education to refer women with diabetes to the next antenatal clinic. • Letter to be sent to the GPs to refer women with diabetes to the next antenatal clinic once pregnant.. • Information leaflet to be devised to encourage women with diabetes once pregnant to contact GP immediately in order they are referred to the antenatal specialist team as quickly as possible On-going pre-conception clinic but uptake/referrals to be increasing in pre-conception care.
National Hip Fracture Database Audit 14/15	Clinical Director to work with medical colleagues to secure appointment into current vacancy. Monitor compliance at monthly steering group meeting using compliance report. Establish baseline against patient mortality at key stages post-surgery. Undertake randomised compliance audit of hip fracture admissions focussing on 36 hour wait to surgery. Undertake an audit of nerve block compliance rates. Change focus of Hip Fracture Steering Group to review morbidity and mortality. Trust to be represented at Regional Hip Fracture Collaboration. Development of electronic monitoring systems to display key deliverables i.e. theatre waits.
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme – Secondary Care Audit 2014	Look at standardising working practice across organisation and identify why we scored so differently on the 2 sites on access to specialist service (Specialist v generalist review, look at patient data to identify any specific issues). Follow action plan already in existence to address Non Invasive Ventilation issues. Customising e-alerts on e-obs to prompt nurses to review oxygen at every set of observations Emergency oxygen guidelines yearly update Including in Non Invasive Ventilation teaching. Identify lead for oxygen. Yearly oxygen training. Improve links and information though the County Durham and Darlington respiratory network meeting to inform commissioning of issues and offer guidance on service improvement and integration. Work on appropriate scheme as per NICE recommendations for Early Supported Discharge (ESD) at Darlington.

	To improve ceiling of care documentation, daily review has identified box for this on Nerve centre.
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme – Pulmonary Rehabilitation Audit 2015	Muscle strength testing to be introduced by both Pulmonary Rehabilitation Programmes. Additional pulmonary rehabilitation classes to be provided in Bishop Auckland. Provide a written discharge exercise plan to all patients completing South Durham Pulmonary Rehabilitation Programme.
UK IBD Biologics Audit-2014	Following the appointment of 1.8 WTE Gastroenterology Nurse Specialists; we intend to set up a dedicated IBD Biologics Clinic. This would help ensure that audit data is collected from a dedicated clinic. A business case for a patient management system is in the pipeline wherefrom the data could be directly fed to national biologics audit. Disease activity will be routinely assessed and monitored in the dedicated IBD Biologics Clinic. Dissemination of PROMs forms will be improved at the dedicated IBD Biologics Clinic, as will the completion of PROMs at follow up. Patients to be assessed at 12 months at Biologics Clinic. To re-enforce the need to monitor safety and efficacy over the long term and to stop biological therapies in patients that fail to respond to the treatment.
Sentinel Stroke National Audit Programme SSNAP 14/15	Stroke Services Manager to meet with Head of Speech and Language Therapy to look at improving integration of teams. Stroke Services Manager to meet with the Head of Occupational Therapy (OT) to explore the possibility of 7 day working within the OT service as regards stroke. Service Manager to work alongside commissioners on a broader scope of commissioning Psychology into the Trust. Service Manager working alongside commissioners on a broader scope of commissioning ESD(Early Supported Discharge) into the Trust. Stroke Services Manager to meet with Clinical Director for Radiology to determine if all stroke patients could be scanned within 1 hour.
National Emergency Laparotomy Audit (NELA) Dec 13-Nov 14 (Darlington Memorial Hospital)	Job plan consultant surgeons to ensure twice daily ward rounds on weekends. All patients should be reviewed within 24 hrs. To improve the percentage of patients which have a risk assessment documented pre-operatively; Consultant Anaesthetists to document risk assessment on an anaesthetic chart preoperatively. Continued education of consultant anaesthetists to improve the proportion of patients for whom goal therapy was used in theatre. To look into improving to 90+% of patients being admitted directly to critical care unit that have an emergency laparotomy. Work with the Geriatricians to ensure more patients>70yrs are assessed after surgery. Encourage referral to

	Geriatrician.
Laparotomy Audit (NELA) Dec 13-Nov 14 (University Hospital of North Durham)	Review of consultant surgeons job plans, discuss with Care Group and Medical Director. Encourage better data entry and the use of admission booklet. Review of NELA data, as not all patients need a CT scan. All emergency laparotomy patients to have their risk documented prior to booking. Ideally on patient consent form and to ensure it is documented in the patient's notes. Discussion around use and evidence for GDFT in emergency surgery at Governance meeting with consultant anaesthetists Introduce formal referral mechanism to Geriatrician. Look into increasing ICU nurse staffing to aim for 90+% of patients with pPOSSUM >5% to be admitted directly to critical care unit.
National Lung Cancer Audit 2015 (reporting on 2014 data)	Produce a business case for increased admin support to free up Lung Cancer Nurse Specialists time. Respiratory Speciality Registrar at Darlington Memorial Hospital and University Hospital to undertake an audit of 20 patients to confirm that the 95% standard achieved.
British Thoracic Society (BTS) Community Acquired Pneumonia (Adults 14/15)	Discussion with Radiology to ensure the implementation of the standard that patients with community acquired pneumonia are to have a chest X-Ray within 4 hours of admission. Compare the results from BTS with those from Clarity to determine the percentage of patients that receive their first dose of antibiotics within 4 hrs of admission.
National Oesophago-Gastric Cancer Audit 2015	A business case for HGD treatment as per recommended guidelines submitted.
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE) – Saving Lives, Improving Mothers Care 2014	To review the model of critical care for women with sepsis to ensure it remains appropriate in light of national guidance.
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE) – Perinatal Mortality Surveillance Report 2015 (2013 data)	Review the accuracy of the stabilised & adjusted stillbirth, neonatal or extended perinatal mortality rate for the Trust.
Falls and Fragility Fractures Audit Programme (FFFAP) National Inpatient Falls Audit 2015	Highlighted to all ward managers the importance of lying and standing blood pressure. Ward managers to ensure compliance across their areas of responsibility. Falls Preventative Care Plan reviewed as a delirium assessment included within the main body of the Falls Preventative Care Plan. Undertake a bed rail use audit to discover current situation within the Trust. Discuss with Pharmacy and Falls Group to undertake a specific medication review for all patient over the age of 65 in relation to falls. Visual impairment test has been included in the Falls Preventative Care Plan and will be signed by the relevant member of staff to confirm they have done it.

	Include 'Walking Aids' into a section of the Falls Preventative Policy. A Continence Care Plan requires developing for all patients with continence issues over the age of 65. Develop an audit to determine call bell use within the Trust.

Confidential Enquiries

County Durham and Darlington NHS Foundation Trust has participated/is still participating in 4 enquiries during the course of 2015/16. The Trust has submitted/is submitting either patient or organisational data for all studies which were deemed relevant

The reports of 24 local clinical audits were audits reviewed by provider in 2015/16 and County Durham & Darlington NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Local Clinical Audits reviewed in 2015/16	Action
Re-audit on Pre-operative Fasting In Adult Elective Procedures	Slight changes to the fasting instructions for afternoon lists to enable patients to be able to drink clear fluids at least 2 hours before the anaesthetic unless contraindicated. Based on the order of the patient in the list, patients coming later on the list could be given a drink as feasible. Targeting 'team brief' at the beginning of the session
Audit of paracetamol overdose in paediatrics	Revised concise guidance to be produced on blood tests required. Education of staff to improve the standard of history taken.
An Audit Of Parent Specialty Involvement In ICU	Update ITU admission paperwork to include a prompt to document consultant involvement in decision to admit Update admission policy to make it clear what is expected of parent teams. Add to daily briefing checklist to request parent team review on day 1. Update admission policy to make it clear what is expected of parent teams. Add parent team review page to ITU admission booklet with prompt to document who the parent team consultant is. Update ITU admission paperwork to include a prompt to document ICU consultant involvement.
Audit of Fleischner Society Guidelines for the Follow-up of Indeterminate Nodules	Radiologists to recommend a clear follow-up with a specific timeframe in report conclusions- to be re-audited in a year..
Audit of Intubation Recording In Level 3 Respiratory Support Patient.	Preformed stickler label to be put in the notes after intubation with documentation to improve recording.
Audit of Cutaneous Squamous Cell Carcinoma Tumours treated by Plastic Surgery Department.	Waiting list clerks should document patients who refuse slots in their waiting time. Booking clerks should document patients who refuse slots in their waiting time.

Access to accurate prescriptions for patients presenting to an emergency department	Addition to discharge summaries as a prompt to encourage more patients to bring prescriptions on admission. Look into practicality of gaining access to NHS care records system for all prescribers
Audit of the NICE Quality Standard for Paediatric Asthma	Change Asthma Care Pathway to advise seeing GP within 2 working days of discharge. Encourage use of Asthma Care Pathway on admission and ensure it is properly filled in.
Recognition Of Neurological Complications Of Alcohol Withdrawal On Admission To Medicine	Flow chart for assessment/treatment to be posted in the MAU (Medical Admissions Unit) Office.
Audit of the Management of Acute Pancreatitis	Attempt to ensure that all acute gallbladders causing pancreatitis are operated on during admission. System to be implemented so any patient with gallstone pancreatitis is being discharged without operation is added to 2 week waiting list.
Is the follow up of patients with pulmonary embolism compliant with national guidelines?	Business case to be submitted for the development of a dedicated pulmonary embolism clinic.
Audit of prescribing errors and medication	Contact Anaesthetics re. prescribing on 'stat' side of drug chart. Discussions with those prescribers who are not happy to use the Trust protocol to identify the problems and their concerns. To continue with junior doctor induction by pharmacist and to continue with regular ward based prescribing sessions.
Audit of MAU Discharge	Speed up process of speciality review, by, electronic referral by use of Nerve Centre. Note tablets in overlabel. Anticipate TTO to reduce delays.
Medical Management (New Regimen) Of Missed Miscarriage	Need to document a reason when NICE Guidance has not been followed. Need to collect evidence to show patient dissatisfaction.
Reassessment Of VTE And Risk Of Bleeding Within 24 Hrs Of Admission	Raise awareness amongst doctors and nurses on ward 33 and 34 about: • Re-assessment of VTE risk at 24hrs -Have meeting with sister/nurses and tell them about the reassessment box at 24hrs on kardex and for them to start filling this out. • Make a poster and stick on nurses station and doctors office about reassessment of VTE risk at 24hrs • Email presentation of audit to all orthopaedic consultants so they • Inform junior doctors about issue at hand Re-audit in Feb when all above is implemented.
A retrospective audit of the medication reviews undertaken by the CREST team at UHND	CREST team to discuss whether a medication review profroma would be helpful in increasing the proportion of patients that have a medication review. Audit results to be shared with CREST team, education highlighting the STOPP/START criteria, BGS Fit for Frailty Guidelines.

Re-audit: Mood Screening of patients admitted to stroke rehabilitation at Bishop Auckland Hospital	Implement a formal mood screening tool for all stroke patients with communication difficulties. Produce combined notes for all clinical staff on the ward.
Re-audit of IV fluids prescribing in General Surgical Ward in comparison to GIFTASUP	Further education for all staff regarding fluid balance and importance of correctly documenting fluid balance charts. Reinforce low levels of potassium in Hartmann's solutions bags and education for staff on risk of hypokalaemia. Further integration into medical school and Foundation curriculum of fluid prescribing
Occupational Health Records Audit.	Education and training during clinical supervision sessions (monthly) Development of an improvement tool for all workers to follow for acceptable abbreviations to be used in the records
An Audit Into The Implementation Of The DOLs Framework On A Care Of The Elderly Ward & Healthcare Professionals' Understanding Of The DOLs Framework	Inclusion of DOLs consideration on daily 'ward huddles'
Delirium Screening On ICU (Inc NICE Guidance CG103)	RASS documented by both medical and nursing staff. Add to medical and nursing education programmes. CAM ICU performed daily by medical staff. Add to medical and nursing education programmes. Add prompt to admissions document that all patients screened for delirium on admission
UTI In Children (Audit NICE QS 36 UTI)	Aide memoire to made and put in all clinic rooms to improve the documentation of urine flow, evidence of spinal lesion and dysfunctional voiding, previous pyrexia of unknown origin and family history of vesicourteric reflux.
Analgesia In Hip Fracture: Re-Audit. (Inc NICE Clinical Guidleine 124)	Accident and emergency staff increasing frequency of fascia iliaca blocks and have documentation. Fascia iliaca blocks followed up by acute pain team. To discuss with A&E staff who are piloting the blocks and new documentation.
Audit Of NICE Recall Guidelines (Inc NICE Clinical Guidelines 19 Dental Recall)	All clinicians within the CDS need to allocate a recall to patients and identify their disease risk, placing both of these in the notes. A proforma (either stamp/sticker) is to be produced to be placed in the notes at the end of each patient exam. This proforma will require the clinician to state caries, periodontal and oral cancer disease risk on a scale of high, medium or low. The proforma will also require a recall interval in months.

Research & Development

The number of patients receiving relevant health services provided or sub-contracted by County Durham & Darlington NHS Foundation Trust in 2015/16 that were recruited to participate in research approved by a Research Ethics Committee was (1084 as at 02/03/2016). Recruitment is marginally down on previous years not only locally but regionally and nationally reflecting a shift to the delivery of more complex studies. However, we have increased the breadth and intricacy of our portfolio of research activity, expanding in areas

such as, Anaesthetics / Critical Care, Children, ENT, Genitourinary Medicine, Obstetrics, Pain Management and Surgery.

County Durham & Darlington NHS Foundation Trust is committed to participation in clinical research and continued successful recruitment to research studies demonstrates our desire to improving the quality of care we offer and to making our contribution to wider health improvement. Through research our clinical staff remain informed of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

During the period County Durham & Darlington NHS Foundation Trust was involved in conducting National Institute for Health Research (NIHR) Portfolio clinical research studies in the following areas –

- Accident and Emergency
- Anaesthetics and Critical Care
- Cancer (inc. Breast, Head & Neck, Lung, Bowel, Prostate and Haematology)
- Cardiovascular
- Child Health
- Dementias and Neurodegenerative
- Dermatology
- Diabetes
- Dietetics
- ENT
- Gastrointestinal (inc. Endoscopy and Colorectal)
- Generic Health Relevance
- Genitourinary Medicine
- Hepatology
- Infection
- Musculoskeletal (inc. Orthopaedic and Rheumatology)
- Obstetrics
- Opthalmology
- Pain Management
- Radiology
- Respiratory
- Reproductive Health and Childbirth
- Stroke
- Surgery

Areas in which non-NIHR clinical research studies were conducted by County Durham & Darlington NHS Foundation Trust in 2015/16 include:

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

During 2016 -2017 our aim is to continue to work towards a culture that values and promotes research and to continue to provide opportunities for patients to be recruited to new studies. We also aim to increase the number of Principal Investigators across all specialties and disciplines and to increase integration between primary and secondary care, there are currently 85 demonstrating a good platform from which to build ensuring research is firmly embedded as core Trust business, with the majority of specialties participating in the research agenda.

Information on the use of CQUIN framework

A proportion (2.5%) of County Durham & Darlington NHS Foundation Trust's income in 2015/16 was conditional upon achieving quality improvement and innovation goals agreed between the County Durham & Darlington NHS Foundation Trust and commissioners.

Further details of the agreed goals for 2015/16 and for the following 12 month period are available electronically at **TBC** (web link)

The agreed goals for 2015/16 were:

National pick list CQUINs	
Theme	Aim
Acute Kidney Injury	Improving AKI diagnosis and treatment and the plan of care to monitor kidney function after discharge
Sepsis	For patients arriving in the hospital improve screening for sepsis and the rapid initiation of intravenous antibiotics for appropriate patients.
Dementia	Improved identification, assessment and care of dementia patients; improved support for carers and training of staff
Mental Health attenders at A&E	Reduce the number of frequent attenders with mental health problems at A&E through the use of Care Plans.
Mental Health recording of A&E attenders	Improve the diagnosis and recording of mental health issues in A&E.
Improve care of complex elderly patients	Implement the use of multi-agency Care Plans for complex elderly patients.
CQUINs agreed with local Clinical Commissioning Groups	
Learning Disability Information and Health Plans	Improve information available to patients coming into hospital who have learning disabilities and implement the use of Health Care Plans.
Paediatric Admission Avoidance	Implement a pilot paediatric outreach service to prevent acute paediatric admissions
Criteria-led discharge	Improve the use of criteria-led discharge in Community Hospitals
Maternity – Safe Care	Implementation of new guidance for Intrapartum Care
End of Life	Improve end of life care
CQUINs agreed with Specialist Commissioner	
Oncotype DX	Implement a new diagnostic test allowing for greater accuracy in determining which patients will benefit from surgery.
QUIPP	Savings on drug costs
Delayed Discharges from Intensive Care	Reduce the number of patients whose transfer out of ITU is delayed for non-clinical reasons.
2 Year outcomes for infants <30 weeks gestation	Improve outcomes for pre-term births
Outcomes of major lower limb amputation	Improve outcomes in respect of lower limb amputations
Area Team CQUINs	
Health Visitor and Midwife joint working	Improve joint working and handover arrangements

Dental Dashboard	Provide robust information
Diabetic Eye Screening	Improve “did not attend” rates.

Registration with Care Quality Commission

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

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

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

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

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

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

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

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

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

Dr Piper House, Darlington
Treatment of disease, disorder or injury
Diagnostic and screening procedures
Transport services, triage and advice provided remotely

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

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

County Durham and Darlington NHS Foundation Trust has no conditions on registration. The Care Quality Commission has not taken enforcement action against County Durham and Darlington NHS Foundation Trust during 2015/16.

CQC Inspections

The CQC carried out an inspection of County Durham & Darlington NHS Foundation Trust from 3 to 6 February 2015 under their new inspection process. The Trust was rated overall as 'requires improvement'. In total, 88 of the 110 individual indicators (80%) were "good" and 22 indicators were "requiring improvement". Our community services were rated as "good" overall.

The Trust has developed an action plan in response to the findings from our inspection which is monitored closely by the Executive Clinical Leadership Group.

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

The Trust was inspected by Care Quality Commission in February 2015. The inspection covered services at University Hospital North Durham, Darlington Memorial Hospital and the Trust's Community Services. Overall, the Trust was assessed as 'Requires Improvement'. Ratings grids for the Trust, for its hospitals and community services are set out below:

Overall

Are services safe?	Requires Improvement
Are services effective?	Requires Improvement
Are services caring?	Good

Are services responsive?	Good
Are services well-led?	Requires Improvement

The above assessment was similar to the Trust Board's own self-assessment, which rated the Trust as 'Requires Improvement' overall, and for the safe, responsive and well-led domains. Effectiveness and caring were rated as good in this self-assessment. As shown in the individual ratings tables below, 88 out of 108 individual judgments were rated as good.

Darlington Memorial Hospital (DMH)

	Safe	Effective	Caring	Responsive	Well-led		Overall
Urgent & emergency services	RI	Good	Good	RI	RI		RI
Medical care	RI	Good	Good	Good	Good		Good
Surgery	Good	Good	Good	Good	Good		Good
Critical care	Good	Good	Good	Good	Good		Good
Maternity & Gynaecology	Good	Good	Good	Good	RI		Good
Children & young people	Good	Good	Good	Good	Good		Good
End of life care	RI	RI	Good	Good	RI		RI
Outpatients &Diagnostic Imaging	Good	Inspected but not rated[1]	Good	Good	Good		Good
Overall	RI	Good	Good	Good	RI		RI

University Hospital North Durham (UNHD)

	Safe	Effective	Caring	Responsive	Well-led		Overall
Urgent & emergency services	RI	Good	Good	RI	RI		RI
Medical care	RI	RI	Good	Good	Good		RI
Surgery	Good	Good	Good	Good	Good		Good
Critical care	RI	Good	Good	Good	Good		Good
Maternity & Gynaecology	Good	Good	Good	Good	RI		Good
Children & young people	Good	Good	Good	Good	Good		Good
End of life care	RI	RI	Good	Good	RI		RI
Outpatients &Diagnostic Imaging	Good	Inspected but not rated[1]	**Good**	Good	Good		Good
Overall	RI	RI	Good	Good	RI		RI

Community Services

	Safe	Effective	Caring	Responsive	Well-led		Overall
Community health services for adults	Good	Good	Good	Good	Good		Good
Community health services for children, younger people and families	Good	Good	Good	Good	Good		Good
Community health inpatient services	Good	Good	Good	Good	Good		Good
End of life care	Good	Good	Good	Good	Requires improvement		Good
Community dental services	Good	Good	Good	Good	Good		Good
Urgent Care centres	Requires improvement	Good	Good	Good	Good		Good
Overall	Good	Good	Good	Good	Good		Good

Improvement plans

The Trust agreed a 77 point action plan with the Care Quality Commission, and with stakeholders at the Quality Summit meeting held on 25th September 2015. Progress in completing actions is monitored fortnightly by the Executive and Clinical Leadership Committee, and reported through the Board's Quality and Healthcare Governance Committee, with summaries provided to each Board meeting. Updates are also provided to our commissioners at each meeting of the Clinical Quality Review Group.

Some 58 of the 77 actions were complete by 31st March 2016, with most remaining actions due to deliver in May or June 2016. Whilst action has been taken, as agreed, to increase consultant staffing in our Emergency Departments and for our Palliative Care services, this remains challenging and work to strengthen rota cover will continue beyond this date.

Services rated as requiring improvement overall were: A&E services, end of life care and medicine at UHND. Actions taken to date, and those which are on-going, are summarised below:

- Medicine at UHND: A key theme was the need to strengthen arrangements for the care of patients receiving non-invasive ventilation (NIV), ensuring that sufficient numbers of competent staff and robust procedures and documentation were in place. Since the inspection, protocols have been introduced to increase and maintain staffing levels, all staff involved in providing NIV have been re-trained using documented competency assessments, and procedures in line with the British Thoracic Society Guidelines are now in place. Clinical audits of outcomes for NIV patients have been performed. Equipment used for NIV has been harmonised between DMH and UHND, facilitating greater cross cover and resilience. As agreed with CQC, the Trust is exploring further options to strengthen care for patients requiring high dependency medical care including introducing a dedicated Acute Care Intervention Team to

provide 'track and trigger' cover for patients at risk of deterioration. Further audits of NIV outcomes are planned and staffing ratios are reviewed for compliance with protocols on a day to day basis.

- Accident and Emergency Departments: Since the inspection we have introduced improvements in staffing, cleanliness, infection and stock control practices in our A&E departments; 24x7 cleaning is now in place in both our A&Es, staffing has been reviewed resulting in plans to increase specialist nursing staff and infection and stock control practices have been reinforced. This is an on-going process. Consultant staffing ratios remain challenging and the Trust has obtained external support to review rotas within its Emergency Departments.
- End of Life Care: The Trust is implementing actions in response to the National Care of the Dying Audit of Hospitals and other identified actions to develop End of Life Care. A dedicated steering group is in place, overseeing the action plan resulting from the audit. Management and governance arrangements for the service have been strengthened. Discussions have been held with our commissioners to jointly develop plans to strengthen palliative care staffing and secure out of hours support for palliative care services. Attempts have been made to recruit additional consultants; however the recruitment market is challenging, hence alternative staffing models including nurse consultants are now being explored. Our commissioners are very supportive of our efforts to develop a holistic approach to Palliative Care across the whole health economy, including working with hospices and community-based services.

Data Quality

Indicator	Target	2015-16 Quarters 1-3
Data completeness community services - RTT*	50%	100.0%
Data completeness community services - Referrals*	50%	99.6%
Data completeness community services - Treatment activity*	50%	99.7%
% of SUS data altered*	10%	27.5%
Discharge summaries within 24 hours	95%	90.5%
Valid NHS number field submitted via SUS - Acute	99%	99.6%
Valid NHS number field submitted via SUS - A&E	95%	98.6%

County Durham & Darlington NHS Foundation Trust submitted records during 2015/16 to the Secondary Uses services for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- which included the patients valid NHS number was:
  99.4% for Admitted Patient Care
  99.6% for Outpatient Care
  98.6% for Accident and Emergency Care
  All of which have increased compared to the same period last year.

- which included the patient's valid General Medical Practice Code was:
  100% for Admitted Patient Care
  100% for Outpatient Care
  100% for Accident and Emergency Care
  (Note: 100% shown from SUS DQ, but may still include negligible invalid numbers or pseudo practice codes allowed under SUS rules).

Overall CDDFT provider SUS data quality score is 95.9% as at February SUS inclusion point.

The last external clinical coding audit which was carried out in 2015/16, but based on 2014/15 yielded the following results. We are not due to have a PBR external coding audit on 2015/16 data.

- 95.5% Correct for Primary Diagnosis
- 96.6% Correct for Secondary Diagnosis
- 98.2% Correct for Primary Procedure
- 85.1% Correct for Secondary Procedure

The results are based on a 200 episode sample across selected HRG chapters and were carried out by CHKS Capita auditors. Target is 90%; therefore only secondary procedure has fallen below this.

The audit did not pick up on any systematic bad practices resulted in any targeted training needed, however, document quality (misfiled notes) and ECDM speed issues were annotated in the audit report.

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

- Regular Data Quality meetings to be augmented with a re-established Information Quality Assurance group.
- Dementia daily validation prompts to ensure accuracy of ISOFT dementia recording.
- Readmission Within 30 Days daily validation to ensure accuracy of recording and allow for Care Group level internal audit to be carried out as and when required.
- Junior doctor training in relation to discharge summary completion and accuracy.
- Specialty specific Consultant/coding joint working to ensure correct documentation and wording is used in the correct locations to be picked up by Clinical Coding.
- Continued audits of individual coder accuracy with attention given to depth and relevance and targeted training programmes.
- Regular reporting output from the PBR Benchmarking tool to explore potential opportunities for improved data quality targeted to those specialties where CDDFT is an outlier in coding depth and complexity.
- Progress awareness around correct RTT Outcome coding and use of Admin Events in clock stopping RTT periods out-with clinic so as to ensure that an accurate representation of the Trust's Incomplete pathways can be maintained and improved on where possible.
- Establish a kite mark data quality scoring to be used in conjunction with the board report initially in demonstrated the reliability of the data source from a quality assurance perspective.

PART 3 ADDITIONAL INFORMATION

Financial Review

TO BE INSERTED

Risk Assessment Framework

Performance against the relevant indicators and thresholds set out in the Risk Assessment Framework are included in the table below.

EXPERIENCE INDICATORS	Target	2015-16 Quarters 1-3
RTT - % Incompletes waiting <18wks	92%	94.31%
RTT waits over 52 weeks*	0	6
A&E % seen in 4hrs - Trust Total	95%	95.2%
A&E % seen in 4hrs - All UCC 'Walk-ins' Type 3	95%	100.0%
Ambulance handovers >15-30mins	0	3888
Ambulance handovers >30-60mins	0	1374
Ambulance handovers >60mins	0	494
12 Hour Trolley Waits	0	2
% Diagnostic Tests >=6wks	99%	97.68%
Cancer 2WW*	93%	94.2%
Cancer 2WW Breast Symptoms*	93%	92.3%
Cancer 31 Days Diagnosis to Treatment*	96%	99.8%
Cancer 31 Days Subsequent Treatment - Surgery*	94%	99.2%
Cancer 31 Days Subsequent Treatment - Anti Cancer Drug*	98%	100.0%
Cancer 62 Days to First Treatment*	85%	86.8%
Cancer 62 Days Screening*	90%	89.4%
Cancer 62 Days Consultant Upgrade*	85%	100.0%
Patient Satisfaction (National Survey)		
A&E % Seen in 4hrs - DMH	95%	91.5%
A&E % Seen in 4hrs - UHND	95%	87.2%
A&E CI - Unplanned Re-attendance rate	<=5%	0.6%
A&E CI - Time to treatment (median)	<=01:00	00:31
Ambulance Handovers - no. >120 minutes	0	42
Choose and Book - Availability of appointment slots	4%	19.1%
Maternity 12 week bookings	90%	91.2%
Stroke - 90% of time on a stroke unit*	90%	91.2%
Stroke - CT scan within 24 hours*	90%	94.2%
Sleeping accommodation - failure to agree EMSA plan	0	0
Sleeping accommodation - breach of an EMSA milestone	0	0
Sleeping Accommodation Breach	0	0
Cancelled Operations - Breaches of 28 Days	0	1
Urgent Operations cancelled for 2nd time	0	0

Community nursing - urgent and OOH referral waiting times		93.1%
Community nursing - non-urgent referral waiting times		61.9%
OUTCOME INDICATORS		
Clostridium difficile cases (cumulative)	12	17
MRSA Bacteraemia	0	2
MSSA		20
Ecoli		250
VTE*	95%	95.7%
Failure to publish formulary	Compliance	
Duty of candor	Compliance	
Never events*	0	1
Certification against compliance with requirements regarding access to health care for people with a learning disability (Q)	Compliance	
Serious Incidents reported within 2 working days of identification*		100%
Total number of incidents reported (Monitoring trends)*		12325
Serious Incidents Interim reports within 72 hours *		100%
SUIs reported via STEIS as a proportion of all incidents involving severe injury or death within a Trust *		20
Serious Incident RCAs submitted within 60 working days** +		
Ambulance Handovers - Trust Use of Screens %	>=95%	83.31%
Delayed transfers of care	3.5%	0.17%
6 hour wait in Urgent Care Centres	95%	99.9%
WORKFORCE INDICATOR		
High executive team turnover		18.5%
Sickness/Absence Rate*		4.4%
Proportion of temporary staff		7.7%
Staff turnover		12.8%
Number of health visitors		159.1

Year end data to be added when available

Once again, we achieved compliance with level 2 for all essential Information Governance Toolkit standards.

What our Regulator says

Monitor, the independent regulator of Foundation Trusts (FT), requires each Foundation Trust to submit an Annual Plan and quarterly performance reports during the year. Monitor assigns each FT an annual and quarterly risk rating which reflects the level of compliance with these plans and the Trust's terms of authorisation. There are three possible ratings: Green (no concerns or need for review), Under Review (requiring more information or review), Red (need for regulatory action. Ratings are based upon performance against selected national access and outcomes standards, outcomes of CQC inspections and assessments, financial governance and any other relevant information.

In 2014-15 to date, CDDFT has reported performance risks in relation to:

- the 4-hour A&E waiting time (in common with the majority of Trusts in England),
- 62-day Cancer Screening, which is always a risk because of the very low number of patients using this pathway
- 62-day Cancer Treatment, in which performance has been better than the national and regional average but where rising referrals and complex pathways of care involving more than one provider mean the standard is becoming increasingly challenging.
- 2 week Cancer breast symptomatic.
- C.Diff, because the CDDFT target is extremely tough due to the excellent Trust performance in 2014/15.

Performance Risks

Non-elective pressures

In line with national trends, the Trust's main operational challenge comes from continuing growth in Accident and Emergency (A&E) attendances, patient flow pressures arising from the number of emergency admissions of very poorly patients, and difficulties in discharging patients in a timely manner, particularly those with complex needs.

It is not yet clear how effective the multi-agency investments in Primary, community and social care services will be in moving care closer to home, or stemming the growth in Acute emergency activity. However, the first positive signs may be the small decline taking place in non-elective admissions across a number of Specialties. Activity during Apr-Dec 2015 in the major non-elective Specialties is down by a net 3%. However, activity in the most pressured area - Medicine at UHND - rose by 0.9%. Ambulatory and short-stay activity grew by 3.7%. The vast majority of patients attending the ambulatory care units at UHND and DMH are discharged without the need for admission to an in-patient bed. In December, 97% of ambulatory care patients in Darlington and 92% in UHND were discharged direct; whilst 70% of patients admitted to the UHND ED short-stay unit were also discharged direct into the community.

Elective pressures

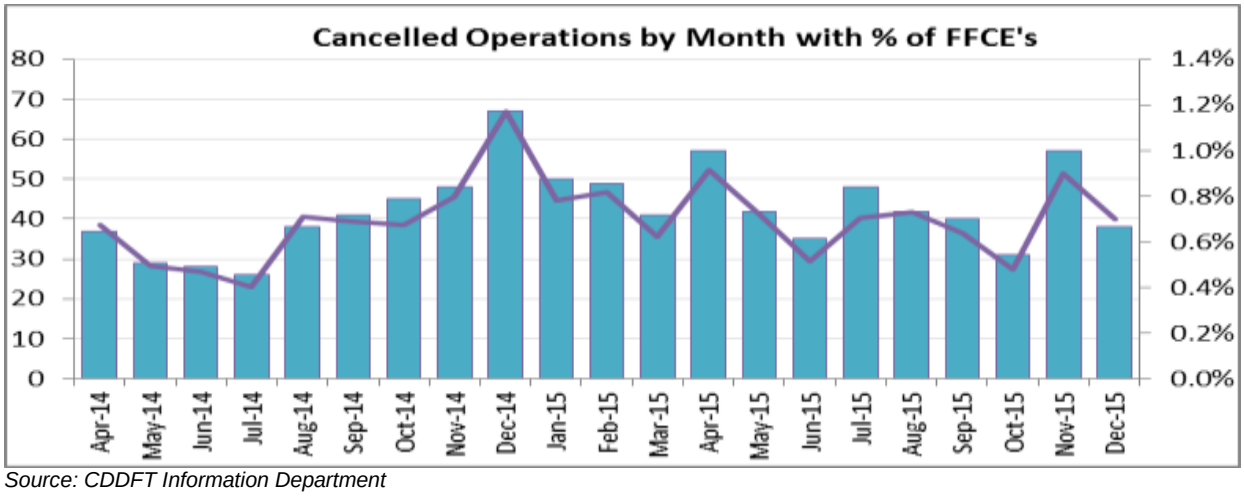
Whilst not reported to Monitor as a formal performance risk elective pressures continue to be a feature. In spite of elective referral growth the Trust has achieved the 18 week Referral to Treatment standard throughout 2015-16 to date. Referrals in the period Apr-Dec 2015 rose by 0.6% as a result of a 2.4% growth in GP referrals. Non-GP referrals fell by 2.3%. The number of admitted patients waiting longer than 18 weeks for treatment has been rising gradually to 991 at 3rd January 2016, a level not seen since April 2015. However, overall the Trust remains above the 92% standard. The main pressure points continue to be Orthopaedics and General Surgery. At the end of December the Trust recorded four patients who had waited longer than 52 weeks for treatment.

The Trust has treated an increasing number of patients on a day case basis instead of as in-patients. During Quarters 1–3, of 2015-16, in-patient activity fell by 4% whilst day case activity grew by 6%. 88% of elective activity now takes place as day cases.

Specialty-level Action Plans are closely monitored by Executives. We have also been participating with commissioners in a rolling programme of Specialty-level out-patient reviews to move patient care closer to home.

The number of medical patients using surgical beds also continues to have an adverse impact on elective surgery as operations have to be cancelled because post-operative beds are not available. Cancelled operations between Apr - Dec 2015 are running 8.6% ahead of 2014-15

figures (390 compared to 356) although there was an improvement in Q3. The main reasons remain list overruns, which are often associated with bed pressures, and Ward bed availability. General Surgery, Orthopaedics, Plastics and Gynaecology were the most affected Specialties; and UHND the most affected site.



Source: CDDFT Information Department

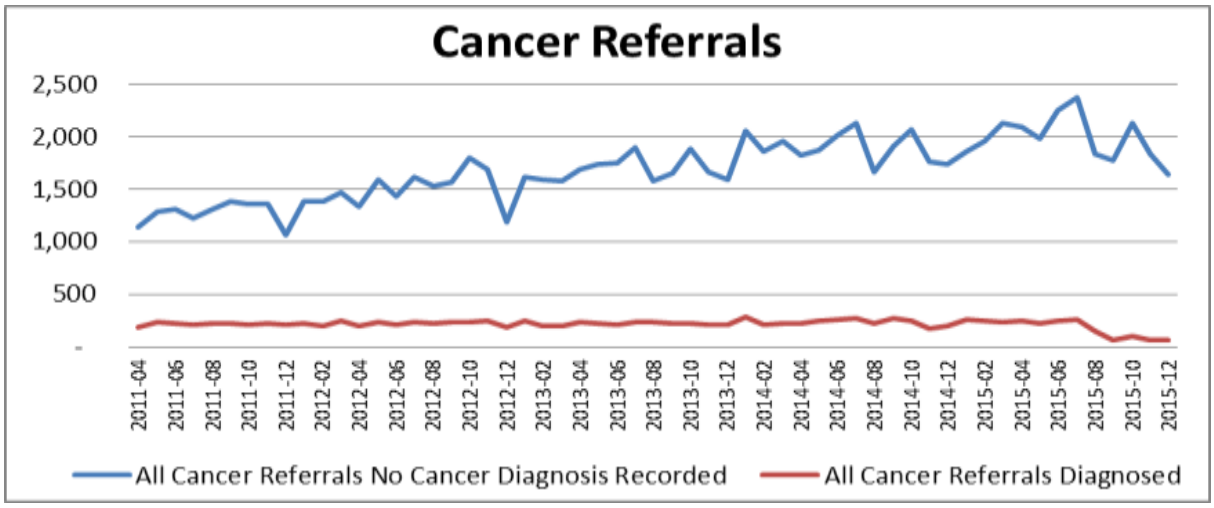
An important aspect of the Trust's Clinical Strategy remains increasing the separation between elective and emergency work. Work is underway to convert all four theatres at Bishop Auckland to clean air in order to enable the Trust to move most elective Orthopaedic activity onto that site. This will create a Centre of excellence protected from acute pressures.

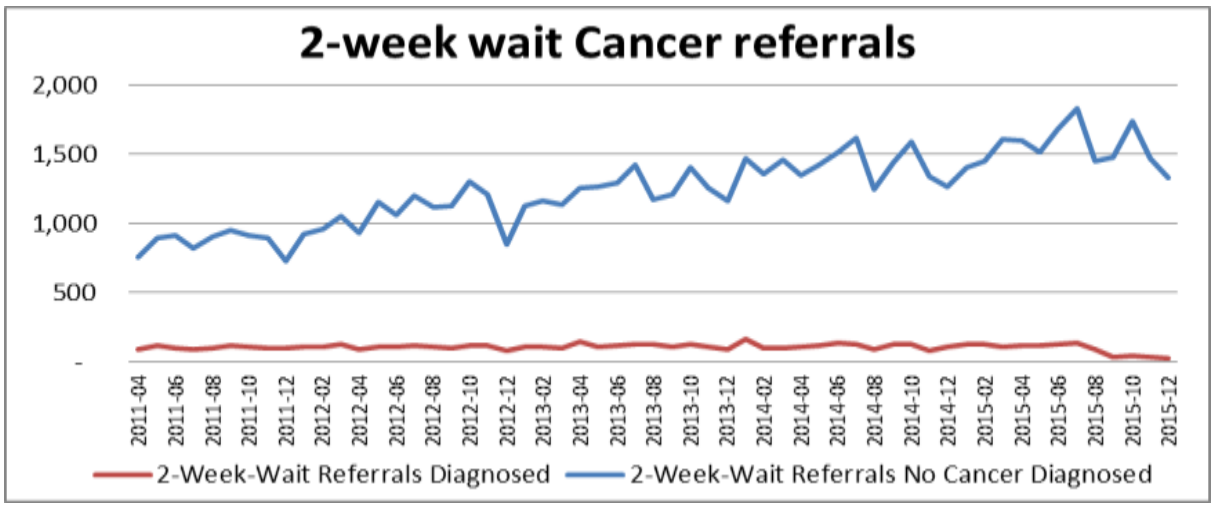
For much of 2014-15, many Trust patients waited longer than the national standard of six weeks for an endoscopy. This situation has been brought back in line with the national standard so that, with the odd exception, all patients now receive diagnostics within six weeks. In common with other Trusts, CDDFT expected the new 2-week wait cancer guidance might result in increased pressure on endoscopy but this has not so far proved to be the case.

Nevertheless, use of the independent sector continues to be a vital means of meeting access targets, particularly for General Surgery, Orthopaedics and endoscopy. The aim is to eliminate routine dependence on the independent sector by the Autumn of 2016. In order to assist this the Trust has appointed new upper GI and vascular surgeons.

Cancer

CDDFT's good performance has continued in spite of growth in referrals. Although referrals have grown 6.8% during Apr-Dec 2015 compared to the same period in 2014 cancer diagnoses resulting from them have fallen by 12%. 2-week wait referrals have also grown by 11% whilst cancer diagnoses resulting from them have fallen by 13.7%.





In relation to the 62-day treatment standard, the Trust is participating in a Cancer Network review of complex pathways and is reviewing with Multi-disciplinary team Clinical Leads the key 'high risk' pathways. Root cause analysis of each breach is undertaken; and all patients who have reached day 48 in their pathway are highlighted for attention.

Breast symptomatic 2-week referrals pose a particular challenge. GP referrals have risen by nearly 30% year on year, largely as a result of the temporary closure of the City Hospitals Sunderland service. In Apr-Dec 2015, GP referrals from Sunderland CCG averaged 38 per month compared to 3 per month in 2014. DDES GPs (mainly Easington) are also referring in 33% more; whilst even Darlington GP referrals have begun to increase their referral rates; perhaps because, more recently, James Cook Hospital has experienced similar problems. Nevertheless, all breaches on this pathway are due to patient choice as all are offered at least one appointment within the 2WW target and significant numbers do not take up the first, or even second, offer. The main risks going forward are the continuing difficulties in Sunderland and Middlesbrough, radiology capacity and a potential price cap which may make the service unviable to provide.

In the meantime, commissioners have suspended penalties in relation to the breast symptomatic target because of the significant impact of the Sunderland (and now also the Teesside) difficulties; CDDFT continues to make extensive use of independent sector capacity, and a service is expected to resume early in the new financial year in Sunderland.

Other key performance risks:

- **Staffing**: in common with many Trusts across the country, the Trust continues to rely heavily on locum and Agency staff in some Specialties to fulfil both nursing and medical roles. The recent national cap on Agency spend has helped the Trust to drive down agency costs, but more needs to be done to determine which services we need to re-shape to maximise our chances of recruiting and retaining key staff.

- **Health Care Infections**. Although the Trust has had three cases of MRSA in the period 2015/16 against a target of 0, it remains within the de-minimis level beneath which it is not classed by Monitor as a performance breach. During the same period it has had 21 cases of *Clostridium difficile* compared to a target of 19. This challenging target was set due to the Trust's good performance in 2014-15.

Priorities for 2016/2017

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

YEAR	08/09	09/10	10/11	11/12	12/13	13/14
Readmission within 28 days of discharge[1]					Not available	
Age 0-15 years	10.92	9.17	10.44	10.32		
National high		15.35	14.11	14.94		
National low		0	0	0		
Age 16 plus years	11.37	11.03	11.97	12.1		
National high		13.3	14.06	13.8		
National low		0	0	0		
MRSA per 100,000 bed days[3]	6.2	1.4	1.1	0.9	0.6	Not available
North East	5	2	2	1	1	
England	4	3	2	1	1	
National high	12	9	9	10	11	
National low	0	0	0	0	0	
Post 72 hour cases of Clostridium difficile per 100,000 bed days (aged 2 years and over)[3]			24.5	16.5	20.3	8.4
England			29.7	22.2	17.3	14.7
National high			71.2	58.2	30.8	37.1
National low			0	0	0	0
						Provisional

Patient Reported Outcome measures (PROM) – case mix adjusted health gain[1]						
PROM hernia		0.1	0.12	0.1	0.10	0.08
England		0.08	0.09	0.09	0.09	0.09
National high		0.14	0.12	0.14	0.15	0.14
National low		0.01	0.03	0.03	0.01	0.01
PROM Hip		0.43	0.38	0.38		
England		0.41	0.41	0.41		
National high		0.48	0.47	0.47		
National low		0.29	0.26	0.32		
PROM Hip - Primary					0.45	0.41
England					0.44	0.44
National high					0.54	0.54
National low					0.32	0.31
PROM Hip - Revision					NA	NA
England					0.27	0.26
National high					0.35	0.37
National low					0.17	0.16
PROM Knee		0.32	0.29	0.3		
England		0.3	0.3	0.3		
National high		0.37	0.38	0.37		
National low		0.17	0.2	0.18		
PROM Knee - Primary					0.31	0.31
England					0.32	0.32
National high					0.42	0.43
National low					0.21	0.22
PROM Knee - Revision					NA	NA
England					0.25	0.25
National high					0.37	0.32
National low					0.20	0.12

	2011/12	2012/13	2013/14
VTE assessment Trust	**93%**	**93.60%**	**95.10%**
National Low	**55.30%**	**86.90%**	**82.10%**
National High	**98.10%**	**100%**	**100%**

YEAR	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14

Responsiveness to personal needs of the patient[1]	72.7	71.8	71.5	67.9	68.5	73.3
England	67.1	66.7	67.3	67.4	68.1	68.7
National high	83.4	81.9	82.6	85.0	84.4	84.2
National low	56.9	58.3	56.7	56.5	57.4	54.4
	2009	**2010**	**2011**	**2012**	**2013**	**2014**
Percentage of staff who would recommend the trust to their family or friends[1]	63%	56%	49%	50%	57%	53%
England						
National high				94%	94%	93%
National low				35%	40%	35%

Period	Oct08-Mar09	Apr09-Sep09	Oct09-Mar10	Apr10-Sep10	Oct10-Mar11	Apr11-Sep11	Oct11-Mar12	Apr12-Sep12	Oct12-Mar13	Apr13-Sep13	Oct 13-Mar 14	Apr14-Sep14
Patient safety incidents												
CDDFT Reporting Rate (100 bed days)	4.4	4.4	4.9	5.0	5.6	4.2	5.1	4.9	6.6	6.3	5.3	26.28
CDDFT %age severe injury & death	5.08%	0.66%	0.46%	0.31%	0.14%	0.25%	0.15%	0.15%	0.16%	0.3%	0.2%	0.1%
National reporting rate (100 bed days)	4.7	5.4	5.4	5.4	5.6	5.9	6.2	6.5	7.1	7	7.2	35.1* Median
National %age severe injury & death	1.3%	0.6%	0.7%	0.8%	0.9%	0.7%	0.8%	0.7%	0.7%	0.6%	0.5%	0.5%

* From 1st April 2014 peer group changed to Acute (non-specialist) organisations and denominator data changed from per 100 admissions to 1000 bed days.

	Reporting Period	Highest	Lowest	Trust	Peer	Comments
SHMI	July 2011 - June 2012	125.59	71.08	101.3	101.92	
	October 2011 - September 2012	121.07	68.49	103.1	101.76	
	January 12 - December 12	119.19	70.31	104.1	102.2	
	April 12 - March 13	116.97	65.23	104.5	101.9	
	July 12 - June 13	115.63	62.59	104.3	101.9	
	October 12 - September 13	118.59	63.01	103.8	101.1	
	January - December 13	117.6	62.4	102.4	100.8	
	April 13 - March 14	119.7	53.9	101.9	100.9	
	July 13 - June 14	119.8	54.1	102.5	101	

	October 13 - September 14	119.8	59.7	103.1	101.3	
The banding of the summary hospital-level indicator	October 2011 - September 2012			2 (As Expected)		
	January 12 - December 12			2 (As Expected)		11 Trusts higher than expected
	April 12 - March 13			2 (As Expected)		7 Trusts higher than expected
	July 12 - June 13			2 (As Expected)		9 Trusts higher than expected
	October 12 - September 13			2 (As Expected)		8 Trusts higher than expected
	January - December 13			2 (As Expected)		7 Trusts higher than expected
	April 13 - March 14			2 (As Expected)		9 Trusts higher than expected
	July 13 - June 14			2 (As Expected)		9 Trusts higher than expected
	October 13 - September 14			2 (As Expected)		9 Trusts higher than expected
The percentage of patient deaths with palliative care coded	July 2010 - June 2011	40.10%	0.10%	12.40%		
	April 2011 - March 2012	44.20%	0.00%	14.70%		
	July 2011 - June 2012	46.30%	0.30%	13.60%		
	October 2011 - September 2012	43.30%	0.20%	13.20%		
	January 12 - December 12	42.70%	0.10%	12.28%		
	April 12 - March 13	44.00%	0.10%	12.80%		
	July 12 - June 13	44.10%	0.00%	14.00%		
	October 12 - September 13	44.90%	0.00%	14.10%		
	January - December 13	46.90%	1.30%	15.90%		
	April 13 - March 14	48.50%	0.00%	17.80%		
	July 13 - June 14	49.00%	0.00%	18.70%		
	October 13 - September 14	49.40%	0.00%	19.00%		

Data source for the above table of information
1 National Statistics http:// Indicators.ic.nhs.uk/webview
2 NHS England
3 www.hpa.org.uk (Hospital Episode Statistics for age 2 and above)
4
http://www.nrls.npsa.nhs.uk/patient-safety-data/organisation-patient-safety-incident-reports/

Local Priorities for the Trust

The information below indicates the progression of these priorities, where appropriate.

SAFETY

Falls and falls resulting in injury
Why is this a priority?
Nationally falls are the most frequently reported patient safety incidents
Our aim
We have seen a reduction in falls resulting in injury but need to work harder to reduce this further. We want to see a reduction in falls to within or below the national average, and a continued reduction in falls resulting in fractured neck of femur. We aim to reduce falls to 5.6 per 1000 bed days for acute wards and 8 per 1000 bed days for community based wards.
Our actions
We will continue to monitor against the actions identified earlier in the report.
We will continue sensory training for staff to increase their perception of patients who have risk of falls.
We will continue to identify a cohort of patients who are identified as having fragility fractures and ensure appropriate follow up.
We will measure the rate of falls per 1000 bed days for both community and acute hospital in patient ward areas.
We will roll out the supervision guidance
We produce an action plan from the results of the national falls audit
Measuring and monitoring
We will continue to collect information on all patient falls and review this with our clinical teams at Safety Committee.
This information is collected internally using data retrieved from the Safeguard incident reporting system and contained within the monthly trust Incident Report. This data is not governed by standard national definition.

Care of patients with dementia
Why is this a priority?
Hospitals have seen an increase in patients requiring care in their services for patients who have a background of dementia. These patients are particularly vulnerable and we want to ensure that they are receiving a high standard of care.
Our aim
We want to ensure that patients who have dementia have a positive experience when under our care and that all needs are considered.
Our actions
We will continue to roll out key elements of the dementia strategy and introduce monitoring tools to measure compliance against this
Measuring and monitoring
Key metrics will be introduced to monitor implementation of the strategy
This data is not governed by standard national definition.
MRSA Bacteraemia

Why is this a priority?
MRSA can cause serious illness and this is a mandatory indicator.
Our aim
We aim to have zero patients with hospital acquired MRSA bacteraemia as set by as set by NHS England guidance.
Our actions
We will continue to regular meetings with senior staff to ensure that any actions identified are monitored and implemented. The action plan can be accessed via the infection prevention and control team.
Measuring and monitoring
All hospital acquired bacteraemia cases identified within the trust will be reported onto the Mandatory Enhanced Surveillance System. This data is governed by standard national definitions. Any reported cases will be discussed at Infection Control Committee and reported to Trust Board. Reported cases will be subject to full root cause analysis to ensure that any remedial actions are addressed.

Clostridium difficile
Why is this a priority?
Clostridium difficile can be a serious illness that mainly affects the elderly and vulnerable population and this is a mandatory indicator.
Our aim
To have no more than 19 patients identified with *Clostridium difficile* infection that are attributed to the trust, as set by NHS England guidance.
Our actions
We will continue with regular meetings with senior staff to ensure that any actions identified are monitored and implemented. The action plan can be accessed via the infection prevention and control team.
Measuring and monitoring
Reports of *Clostridium difficile* will be reviewed at HCAI reduction group meeting, the Infection Control Committee and reported to Trust Board.
This data is governed by standard national definitions.

Pressure ulcers
Why is this a priority?
Pressure ulcers are distressing for patients and can be a source of further illness and infection. This can prolong the treatment that patients need and increase the need for antibiotic therapy.
Our aim
To continue with the programme of monitoring of patients with pressure ulcers and carry out a full review of all pressure ulcers graded 3 or above to ascertain whether avoidable or unavoidable, and take remedial action where necessary to ensure learning within the Trust. We aim to have zero avoidable grade 3 and 4 pressure ulcers and see a decrease in grade 2 avoidable pressure ulcers.
Our actions
We will ensure that all of our hospital inpatients continue to be risk assessed for their risk of pressure ulcers and that this is regularly reviewed during the admission period. We will ensure timely provision of pressure relieving mattresses if required, and access to specialist tissue viability advice as indicated.
Measuring and monitoring
We will continue to monitor that all patients are assessed for their risk of developing pressure ulcers and report this through the ward performance framework. All grades of pressure ulcers will continue to be reported and reported to Trust Board via the performance scorecard.
Whilst this indicator is not governed by national standard definitions, the assessment of grade of pressure ulcer is used using national definitions.

Venous thromboembolism

Why is this a priority?

Each year 25,000 people in the United Kingdom die from venous thromboembolism (VTE). The National Institute of Clinical Excellence have set guidelines and this is a mandatory indicator as set by the Department of Health.

Our aim

To maintain compliance with VTE assessment within 24 hours for hospital inpatients at or above 95%.

Our actions

We want to maintain and improve on this standard to ensure optimum prevention measure can be implemented as required for patients under our care.

Measuring and monitoring

Weekly reports on compliance will be submitted to wards and senior managers. Performance will be reported to Trust Board.

This data is governed by standard national definitions.

Discharge summaries

Why is this a priority?

It is important that communication is of a high standard when patients are moving between care settings. One way to monitor this is with the timeliness of discharge summaries. We introduced this indicator in 2012/13 and we can demonstrate significant improvement from 81% in 2012/2013 to 86.1% in 2013/2014, however we did not reach the national target of 95%. Data 2014/15 90.56%. Data for 2015/16 93.3%

Our aim

To reach 95% compliance with discharge summaries being completed within 24 hours of a patient discharge.

Our actions

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

Measuring and monitoring

We will continue to measure this on a monthly basis and feed back to Care Groups via the performance scorecard. We will continue to educate medical staff on the importance of timeliness for this.

This data is governed by standard national definition.

Rate of patient safety incidents resulting in severe injury or death

Why is this a priority?

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

Our aim

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

Our actions

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

Measuring and monitoring

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

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

Duty of Candour
Why is this a priority?
Compliance with duty of candour is a statutory obligation under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and a requirement of the NHS Contract. Non-compliance is a criminal offence, and individuals and corporate bodies have a legal duty to comply with the law and a moral duty to inform patients when things go wrong.

Our aim
To meet our legal and professional duties as individuals and the corporate body to comply with the law. We aim to be fully compliant with the timescales laid down in statute and the NHS Contract.

Our actions
In addition to promoting it at mandatory and essential training sessions for all staff, we will continue to provide specific training sessions on duty of candour.
We will continue to monitor compliance with duty of candour by using 'Safeguard' as a performance tool.
The 'Being Open' Policy has been updated to reflect the legislative changes.

Measuring and monitoring
We will continue to measure compliance by extracting data from the Duty of Candour questionnaire section in 'Safeguard'. The extract is included on a performance dashboard which is monitored fortnightly at the Trust's Patient Safety Forum meeting attended by Trust executives, senior managers and clinical leads.

EXPERIENCE

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

End of life and palliative care
Why is this a priority?

Our workforce can only deliver high quality individualised care to patients and their families if they are adequately trained to do so. Delivering high quality palliative and end of life care requires additional skills, in particular communication skills, so additional training for many staff groups is required.

Our aim

We want our workforce to be equipped to provide high quality end of life care.
We want patients approaching the end of life to be confident in receiving high quality care in accordance with their wishes.

Our actions

We will continue to work with pilot areas and support them to enhance the knowledge and skills required for staff to feel confident using the Deciding Right documents.

We will continue to educate around "do not resuscitate" continues and other elements of decision making and care towards the end of life.

We will continue to audit in pilot area for the use of the guidance for care of patients' ill enough to die and development of appropriate actions continues in pilot areas

We will continue to develop a palliative care discharge summary.

Measuring and monitoring

We will continue an audit programme in pilot areas for the use of the guidance for care of patients ill enough to die. The results will be presented to the End of Life Steering Group.

We will carry out a survey of bereaved relatives. The results will be presented to the End of Life Steering Group. Proposal shared at EOL Steering Group & methodology being refined prior to launch.

Whilst this data is not governed by standard national definition, the trust uses the regional "Deciding Right" principles.

Responding to patients personal needs

Why is this a priority?

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

Our aim

This priority contains 5 question areas related to patient experience, and the results of these show improvement in all of the questions asked. Once we have the results we will reach agreement on the percentage improvement to ensure that we aim to be at or above national average.

Our actions

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

Measuring and monitoring

Quarterly results will be reported to Quality & Healthcare Governance Committee and emerging themes discussed so that actions can be taken. Results of the national survey will be published to allow benchmarking against other organisations.
This data is governed by standard national definition as outlined in the national inpatient survey questions.

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

Why is this a priority?

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

Our aim

To achieve average national performance against the staff survey.

Our actions

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

Measuring and monitoring

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

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

EFFECTIVENESS

Mortality monitoring

Why is this a priority?

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

Our aim

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

Our actions

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

Measuring and monitoring

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

These data are governed by standard national definition.

2 Reduction in readmissions to hospital

Why is this a priority?

It is not possible to prevent re-admissions but they can be inconvenient and distressing for patients and carers, and can be an indicator of where care has been sub-optimal. This is a mandated indicator by the Department of Health.

Our aim

We want to ensure optimal care in the right place for our patients, and to eliminate unnecessary re-admissions to hospital.

Our actions

Together with partners in Primary and Social Care, the voluntary sector and others we have developed a range of intensive short-term intervention services to prevent avoidable

admissions and re-admissions, and to improve the support available to patients being discharged from hospital.

Measuring and monitoring

In 2015/16 (Apr-Nov), our rate of emergency re-admissions within 28 days has been **TBC** compared to the 7% target. This data is governed by national standard definitions. We will continue to explore all possible means of achieving the national standard.

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

Why is this a priority?

Patients want to be treated in a timely manner. Staff morale can be adversely affected if they feel the service they are able to offer is not provided to a high standard.

Our aim

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

Our actions

Pressures in A&E rise when the wider health system is under strain. In addition to the two *Perfect Weeks* run in quarter 3 at UHND and DMH we continue to work with partners in the local Strategic Resilience Group to implement the Emergency Care Improvement Programme drawn up under the oversight of Monitor.

Measuring and monitoring

This issue is governed by standard national definitions and reporting arrangements. In addition to internal monitoring, monthly reports are provided to the Durham/Darlington System Resilience Group chaired by a local GP-commissioner.

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

Why is this a priority?

Ambulances waiting at A&E to hand over patients to our care are not available to respond to emergencies in the community. Delays are also distressing for patients and carers.

Our aim

We aim to take over the care of ambulance patients within 30 minutes of their arrival at A&E.

Our actions

We continue to work with partners in the local Strategic Resilience Group to implement the Emergency Care Improvement Programme drawn up under the oversight of Monitor.

Measuring and monitoring

We review all instances in which an ambulance cannot hand over care within 2 hours. Ambulance handover performance is governed by national and local quality requirements.

To add when data available

5 Patient Reported Outcome Measures

Why is this a priority?

PROMs measure the quality of care received from their perspective so providing rich data and this is a mandated priority as set by the Department of Health.

Our aim

Last year we monitored ourselves for improvement in participation rates but for the coming year we will focus on the rates for health gain and hope to see that this is within national average.

Our actions

We will continue to drive the agenda for encouraging participation through identified staff. We will continue to educate staff on the importance of this priority and the benefits of using this alternative care as an indicator of the care we provide. We will continue to monitor ourselves against national benchmarking data to assess the impact for the patient in terms of health gain.

Measuring and monitoring

Results of the PROMs health gain data will be monitored on the Care Group performance scorecard and reviewed at performance meetings. Results will be included in scorecards presented to Trust Board.
This data is governed by standard national definitions.

ANNEX 1

Feedback from Durham and Darlington Clinical Commissioning Groups

NHS
Durham Dales, Easington and Sedgefield
Clinical Commissioning Group

Statement from North Durham, Durham Dales, Easington, Sedgefield and Darlington Clinical Commissioning Groups, for County Durham and Darlington NHS Foundation Trust (CDDFT) Quality Account 2014/15.

For and behalf of North Durham Clinical Commissioning Group, Darlington Commissioning Group and Durham Dales Easington and Sedgefield Commissioning Group.

Feedback from Healthwatch County Durham

healthwatch
County Durham

Healthwatch County Durham
The Work Place, Heighington Lane,
Aycliffe Business Park, Newton Aycliffe,
County Durham, DL5 6AH
Tel: 01325 375960
Freephone: 0808 8010384
Email: info@healthwatchcountydurham.co.uk
www.healthwatchcountydurham.co.uk

Feedback from Healthwatch Darlington

healthwatch
Darlington

Feedback from Darlington Borough Council Health and Partnership Scrutiny Committee

DARLINGTON
BOROUGH COUNCIL

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Feedback from Durham County Council Adults Wellbeing and Health Overview and Scrutiny Committee

Feedback from County Durham Health and Wellbeing Board

Statement of Directors' Responsibility in Respect of the Quality Report

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

Glossary

A&E	Accident & Emergency
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CDDFT	County Durham & Darlington NHS Foundation Trust
DMH	Darlington Memorial Hospital
ED	Emergency Department
FFT	Friends and Family Test
GP	General Practitioner
HCAI	Healthcare Associated Infections
HES	Hospital Episode Statistics
MRSA	Meticillin resistant Staphylococcus aureus
MUST	Malnutrition Universal Screening Tool
NHS	National Health Service
NHSFT	NHS Foundation Trust
NICE	National Institute of Health and Care Excellence
NEQUS	North East Quality Observatory System
NPSA	National Patient Safety Agency
NRLS	National Reporting and Learning System
NEAS	North East Ambulance Service
PALS	Patient Advice and Liaison Service
PE	Pulmonary Embolism
PROM	Patient Recorded Outcome Measure
RAMI	Risk Adjusted Mortality Index
SHMI	Summary Hospital-level Mortality Indicator
UHND	University Hospital of North Durham
VTE	Venous Thromboembolism