County Durham and Darlington NHS
NHS Foundation Trust

Quality Accounts
2016 - 2017

DRAFT

with you all the way

Emergency Department - To increase patient satisfaction as measured Patient Reported Outcome Measures (PROMS) - Maternity Indicators - Paediatric pathways ▪ Statement of Assurance from the Board - Review of Services - Participation in Clinical Audits and National Confidential Enquiries - Research and Development - Information on the use of CQUIN Framework - Registration with Care Quality Commission - CQC Inspection - Data Quality	
PART 3 : Additional Information ▪ Financial Review ▪ Risk Assessment Framework ▪ Priorities identified for Quality Accounts 2017/2018 data	
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INTRODUCTION

To insert

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

To insert

Safety
Patient Falls
Healthcare associated infections
Management of pressure ulcers
Learning from incidents
Management of patients with sepsis
Duty of Candour
Local Safety Standards for Invasive procedures

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

Effectiveness
Care bundles
Unscheduled Care
Maternity and paediatric care

Care Quality Commission Inspection
Following the Trust's Care Quality Commission (CQC) inspection in February 2015, the Trust was given an overall rating of 'requires improvement'. This was broadly in line with our own self-assessment which we carried out ahead of the inspection. It is useful to set this overall rating in a wider context. The Trust scored 'good' in 80% of the indicators measured and it is encouraging to note that the organisation is better positioned comparatively to similar trusts with the same rating. I am pleased to highlight that our community services were rated as 'good' overall.

The Trust is currently working on their CQC action plan in preparation for our re-inspection in 2017.

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.

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

Review of our key priorities for 2016/17
Last year we set 20 priorities. These have been set under the following headings:

- Safety
- Patient Experience
- Clinical Effectiveness

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

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

		2015/16	2016/17 Ambition	2016/17 Position	
SAFETY					
Falls	Patient falls – reduce falls/1000 bed days community hospital Patient falls – reduce falls/1000 bed days acute hospital Footnote – data April 15 to Jan 16	6.8 ☑ 5.9 ⊖	8.0 5.6		**TBC**
	Introduce sensory training	720 ☑	720	720	☑
	Follow up patients with fragility fracture	89.9% ☑	50%		**TBC**
	Complete root cause analysis for falls resulting in fractured neck of femur	All complete ☑	All complete	All complete	☑
Care of patients with dementia	Development of a dementia pathway and monitoring of care, to include enhancements to environment	Complete ☑	Complete	Complete	☑
Healthcare Associated Infection (HCAI)	Meticillin Resistant Staphylococcus aureus (MRSA) post 48 hour bacteraemia	3 ⊖	0	5	☒
	Clostridium *difficile* post 72 hour	21 ☒	19	16	☑
Pressure Ulcers	To have no avoidable grade 3 or above pressure ulcers within acute or community services	5 ⊖	0		**TBC**
Venous thromboembolism (VTE)	Maintain venous thromboembolism assessment compliance at or above 95%	95.9% ☑	95%	96.8% (provisional)	☑
Discharge	Discharge summaries	89.1%	95%	93.6%	⊖

		☒			
Incidents	Rate of patient safety incidents reported via National Reporting and Learning System (NRLS)	Reporting to within 50% ⊖	Reporting to within 75%	Reporting to within 50%	⊖
	Rate of patient safety incidents resulting in severe injury or death from National Reporting and Learning System (NRLS)	0.2% ☑	0.4%	0.3	☑
Sepsis	To implement sepsis care bundle and audit effectiveness	Complete ☑	Complete	Complete	☑
Duty of Candour	To monitor implementation	Complete ☑	System of monitoring introduced	Complete	☑
PATIENT EXPERIENCE					
Nutrition and Hydration					
	To audit against new indicators	Roll out continues ⊖	Complete	Review continues	⊖
End of Life Care	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.	Progress made but work to continue ⊖	Complete	Progress made but work to continue	⊖
Patient personal needs	Responsiveness to patients personal needs	Improved result in all indicator questions for personal needs ☑	Improved positive responses in comparison to this year's results		**TBC**
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 3.60 ⊖ **(2015)**	**On a scale of 1 to 5** 3.71	On a scale of 1 to 5 3.46 **(2016)**	☒
Friend and family test	To increase Friends and Family response rates	12.1% ☒ 18.3% ☒	**Over 20% in Emergency Department** **Over 30% Inpatient areas**		**TBC**
CLINICAL EFFECTIVENESS					
Reduction in risk mortality indices	To monitor mortality indices (HSMR and SHMI) on a monthly basis – indices should	RAMI SHMI as expected	For 2015/16 (Apr15-Mar16) HSMR: 107.21	HSMR 100 SHMI 100	YTD figures (Nov15-

	be 100 or below	☑	SHMI:103.2		Oct16) HSMR: 101.09 SHMI: 105.62 ☑
Reduction in readmission to hospital (within 28 days)	To reduce emergency readmissions	**0-15 years** 11.3% **16 years and over** 7.55% **Total** 7.98% ⊖	7%	**0-15 years** **16 years and over** **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%	0.6% ☑	<5%		**TBC**
	- Left without being seen no more than 5%	1.8% ☑	<5%		**TBC**
	Timeliness indicators: - 95% to be treated/admitted/discharged within 4 hours	93.13% ☒	95%		**TBC**
	- Time to initial assessment no more than 15 minutes	63 mins ☒	15 mins		**TBC**
	- Time to treatment decision no more than 60 minutes	34 mins ☑	60 mins		**TBC**
Patient Reported Outcome Measure (PROM)	To gain better understanding of patient's view of their care and outcomes - Hip - Knee - Hernia	⊖ 8.7 1.9 -0.9	Improved rates		**TBC**
Maternity standards (new indicator following stakeholder event)	To monitor compliance with key indicators: Breastfeeding smoking in pregnancy 12 week booking Complete gap analysis against "Saving babies lives"		60% 22.3% 90% Complete	58.5% 17.3% quarter 3 TBC Complete	⊖ ☑ TBC ☑

	NHS England document				
Paediatric care (new indicator following stakeholder event)	Improved paediatric pathways for urgent/emergency care		Improve pathways	Pathway improved	☑

Introduction to 2017/2018 priorities

Key priorities for 2017/2018 have been agreed through consultation with staff, governors, local involvement networks, commissioners, health scrutiny committees and other key stakeholders. As an integrated organisation it is important that our priorities are applicable to both acute and community services. The priorities therefore cover both of these care providers wherever appropriate. Throughout the year we have updated both our staff and stakeholders on progress against our quality improvement targets. In addition an event was held earlier in the year where a series of presentations were given to a wide range of staff and stakeholders. All were in agreement that these events were very useful in informing the priorities for the coming year and identifying the areas for continued monitoring.

The table below summarises the specific priorities and objectives that have been agreed for inclusion in the 2017/2018 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 - Produce a thematic to assist with action planning in 2017/18. - To continue to produce Trust bulletins to include the importance of key practices to improve the compliance with lying and standing blood

		pressure. - Continue to include 1:1 supervision guidelines in essential training. - Participate in National Falls audit in May 2017 - Develop a post falls management tool for use in the community. - Explore the use of a falls assessment tool for day centres.
Care of patients with dementia[1] **(Continuation)**	Continued development and roll out of a dementia pathway and monitoring of care for patients with dementia	- Continue to ensure all patients aged 75 and over are asked about their memory on admission; - Develop/implement further education in screening of dementia and on-ward referral - National dementia audit, report due July 2017, action plan to be developed and implemented as appropriate to the findings of the report. - Implement carer's access and support based on the ethos of the Johns campaign. - Carers survey, report due April 2017, action plan to be developed and implemented as appropriate to the findings of the report. - Offer nursing staff the opportunity to participate in a full study day as a group based on the inside out of mind work-book. - Participate in a 5year research project of dementia services within the Durham area. - Participate in a 1 year study in the development of a good practice audit tool for assessing patient care and services for those living with dementia.
Healthcare Associated Infection **MRSA bacteraemia[1,2]**	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*

Clostridium *difficile*[1,2] ***(Continuation and mandatory)***		- 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 2017/18 - 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 - Merge community and acute tissue viability service and undertake a full review of service offered
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 - Continue thematic analysis for inclusion in annual report
Improve management of patients identified with sepsis$_3$ **(Continuation)**	To monitor roll out of sepsis screening tool via electronic system	- 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 - Roll out electronic method of monitoring patient's for sepsis
Duty of candour (Continuation)	To monitor compliance with statutory Duty of Candour compliance	- Continue to monitor Duty of Candour compliance within fortnightly Patient Safety Forum - Implement an audit by each Care Group to ensure the Duty of Candour is being applied
Local Safety Standards for Invasive Procedures (LOCSSIPS) **(new indicator from Stakeholder event)**	To ensure full implementation of national guidance embedding Local Safety Standards into all areas conducting Invasive Procedures trust-wide.	- The Trust has formed a LocSSIP Implementation and Governance Group (LIGG) which brings together members of the Corporate Governance body with Care Group representatives in order to develop LocSSIPs. - The LIGG will work with procedural teams to support the implementation of developed LocSSIPs ensuring all individuals understand why the programme is required and how the additional steps are to be conducted. - The LIGG will co-ordinate both quantitative and qualitative audits to ensure procedural LocSSIPs are being conducted to a high standard providing reports to IQAC and the Trust Board.
- ***EXPERIENCE***		
Nutrition and	To promote optimal nutrition	- Focus on protected meal

Hydration in Hospital[1] **(Continuation)**	for all patients	times - Continue to use nutritional bundle for weekly nutritional care planning of patients nutritionally at risk for inpatients – move the nutritional assessment tool to Nerve Centre and once embedded move the care planning bundle to nerve centre also. - Trust wide menu implementation of finger foods - Report and monitor compliance monthly via Quality Metrics -
End of life and palliative care[1] **(Continuation)**	We now have an effective strategy and measures for palliative care. The measures are derived from the strategy and will support each patient to be able to say: *"I can make the last stage of my life as good as possible because everyone works together confidently, honestly and consistently to help me and the people who are important to me, including my carer(s)"*	- CQC action plan for palliative care 100% complete - Deliver at least 75% of strategic plan for end of life and palliative care - Responses to VOICES survey should be as good or better than 2012 benchmark - Continuing improvement in palliative care coding and "death in usual place of residence"
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 - The Trust will continue to participate in the national inpatient survey
Percentage of staff who would recommend the trust to family or friends needing care[1,2] **(Continuation and mandatory)**	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 continue to

		report results for harassment & bullying and Race Equality Standard
Friends and Family Test[1] **(Continuation)**	Percentage of staff who recommend the provider to Friends and Family	- 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 the Trust Board
- ***EFFECTIVENESS***		
Hospital Standardised Mortality Ratio (HSMR)[1] **Standardised Hospital Mortality Index (SHMI)**[1,2] **(Continuation and mandatory)**	To closely monitor nationally introduced Standardised Hospital Mortality Index (SHMI) and take corrective action as necessary	- To monitor for improvement via Mortality Reduction Committee - To maintain HSMR 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 national policy to continue to ensure patients receive better planned care and are supported to receive supported self – care effectively	- To aim for no more than 7% readmission within 28 days of discharge - 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 performance framework.
To reduce length of time to assess and treat patients in Accident and Emergency department[1,2]	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

Continuation and mandatory)		that national benchmarking can continue. Results will be monitored via Trust Board using the performance scorecard
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 2016/17 - To aim to be within national average for improved health gain.
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 - Monitor actions taken from gap analysis regarding "Saving Babies Lives" report
Paediatric care (new indicator following stakeholder event)	Embed paediatric pathway work stream	- Continue development of more direct and personal relationships with individuals within Primary and Secondary care by building on the work already undertaken

1 - continuation from previous year

2 - mandatory measure

3 - new indicator following stakeholder events

To complement the above the Trust has continued to commit to the pledges made in October 2014 to NHS England's "Sign Up To Safety" programme. To celebrate the work accomplished in 2015/16, the patient safety team presented at the International Nurses and Midwives conference on the 5th and 12th May 2016. This showcased the successful improvement achieved in line with the national programme and five pledges – putting safety first, be honest, collaborative and continually learn and supporting staff.

During 2017 the Patient Safety Team are leading on the Sign Up To Safety National Kitchen Table Week to further explore the art of conversation and developing different ways to enable people to talk to each other about what they know about keeping people safe.
All future improvement will continue to be monitored as a measure of the Trust's commitment to safety and quality, against the national Sign Up To Safety pledges:-

- **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.

For the June 2018 Quality Accounts, providers will be expected to report their progress in using learning from deaths to inform their quality improvement plans. This would be an annual summary of monthly/quarterly Trust Board reports on reviewing and learning from deaths. This builds on the work of the Royal College of Physicians2 in developing a methodology to support this process. Other resources to support this learning and process will be explored and implemented throughout the year.

Review of performance against priorities 2016/2017
The following section of the report focuses on our performance and outcomes against the priorities we set for 2016/2017. 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	Patient falls – reduce falls/1000 bed days community hospital. Upper threshold 8

TBC	Patient falls – reduce falls/1000 bed days acute hospital. Upper threshold 5.6

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 2017/2018. 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. The threshold target has once again been completed this year.

Mandatory training for all registered nurses continues, with an overview given of multifactorial risk assessment and intervention given to all attendees. Themes from previous Root Cuases Analysis are included in the essential training including the importance of lying and standing blood pressure, ensuring falls prevention is reassessed according to a patient's conditional change.

The National Falls Audit was carried in May 2015 and this exercise is to be repeated. A number of issues of non-compliance were highlighted as a result of this audit. Eighty staff have been trained to-date to reinforce the key requirements required of the audit.

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.

A cluster of fracture neck of femur was highlighted in one of the Care of the Elderly Wards. In response a thematic review was carried out on all falls January 2016 – July 2016. A focused action plan was devised which included a falls workbook, training and a culture reinforced that falls are preventable and not inevitable. Falls sensors were also purchased and focused training has taken place to ensure falls sensors are used appropriately.

Other high risk areas which have a high number of total falls have received further training in an attempt to reduce the total number of falls on those high risk areas.

A Standard Operating Policy is in development for the use of falls sensors.

The Falls Policy has been updated and this is being ratified presently.

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. A new Falls Bundle has been devised and this will require embedding into practice using the rapid spread methodology. This will ensure NICE compliance.

Further focussed work is required in those high risk areas to ensure falls remain at the fore of clinical decision making. Additionally, early work has been completed into the feasibility of the falls risk assessment being completed on a hand-held device.

Action planning will also take place as a result of the National Falls Audit in May 2017.

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 will continue as agreed at the 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 2017/18

- Dementia pathway has been produced and is in place
- Introduction of dementia champions. This will be continuing as new people want to participate and others step down
- The sensory garden is now in place at Darlington Memorial Hospital.
- Dementia task and finish group was established however, has become part of the wider patient experience strategy and is supported as part of the patient experience forum
- The finger food menu was implemented in January 2017 and menus continue to be reviewed as part of the wider organisational work to improve patient choice
- The Carers survey was completed and from feedback a Dignity leaflet was developed, information within the leaflet will be updated as and when information and contact details change
- All patients aged 75 years and over are asked about their memory on admission

Next Steps

- Environmental changes will be continuing as part of the life cycle programme of the hospital estate.
- Dementia friendly signage will continue to be rolled out to all inpatient wards
- The mental health intranet site to include dementia work streams and resource will be on-going as appropriate
- Produce an action plan following publication of the dementia survey

Healthcare Associated Infections

MRSA bacteraemia

☒	Trust ambition not achieved.

Clostridium *difficile*

☑	Trust ambition 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

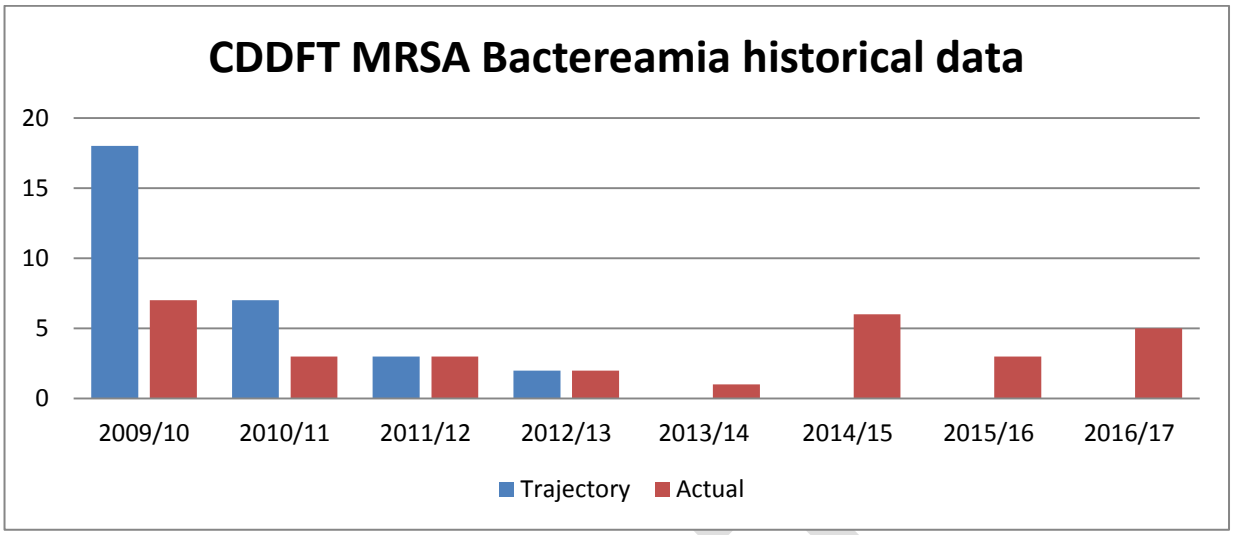
The trust aims to deliver on the zero tolerance approach to MRSA Bloodstream infections NHS commissioning boards planning guidance "Everyone Counts; planning for patients 2014/2015 to 2018/2019"

Progress

The trust has reported five 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 contaminant
- Case 2 deep seated infection
- Case 3 contaminant due to skin condition
- Case 4 urine infection leading to discitis
- Case 5 deep seated infection secondary to chest infection

Period	No of Bacteraemia	% Rate/100,000 bed days	Trajectory
2011/2012	3	0.91	3
2012/2013	2	0.61	2
2013/2014	1	0.30	0
2014/2015	6	1.86	0
2015/2016	3	0.92	0
2016/2017	5	***	0

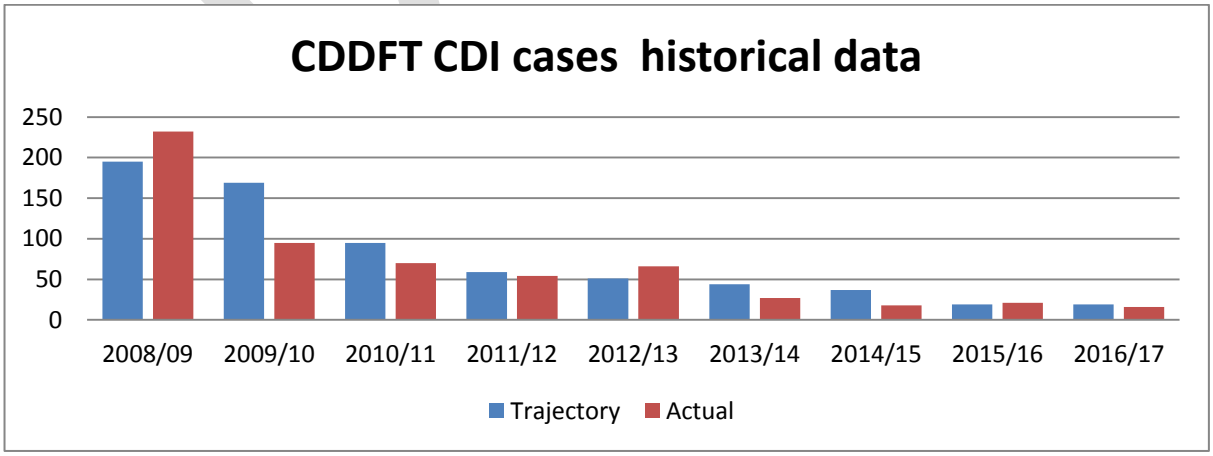


Actions for improvement

- Focus on MRSA Screening Policy
- Managing patients with HCAI alerts
- Using Trust made "Taking a blood culture" and "MRSA screening swabs" DVD's as part of wider education sessions.

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 a year of strong against this year's trajectory in reducing the number of cases of *Clostridium difficile* infections. This is the result of many strategies and focused interventions introduced throughout this year and are continued.

- 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
- Quarterly hand hygiene Trust wide observational audits with results being feedback to individuals and care group leads
- 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 assessing and managing adult patients with diarrhoea with 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 CCG and NHS England local area team colleagues. 8 cases have been presented for appeal and 6 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 and awarding areas with 100% compliance for more than a year.
- Implement new guidelines to respond to the risk of infection from emerging infectious disease, new strains and antibiotic resistance.
- We will continue to monitor and maintain progress in reducing the number of infections attributable to the Trust and these priorities are a national indicator for Quality Accounts so will continue for the 2017/2018 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 VTE task & finish group has been re-established and the policy and information leaflets will be reviewed throughout 2017/18.

Risk Assessments are undertaken on all patients admitted to the organisation with compliance monitored via the Assurance Risk and Compliance department we have been 95.9% compliant in the last year.

Pressure Ulcers

TBC	

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	2	1
2016/17	5 (to date)	1 (to date)

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
2016/17	TBC	TBC

This will remain a primary objective for 2017/2018 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.

There will be designated education across community services areas for pressure ulcer and related skin damage.
WREN education across acute hospitals has been commenced and is progressing very well, this will be rolled out over the coming year to incorporate DN teams.

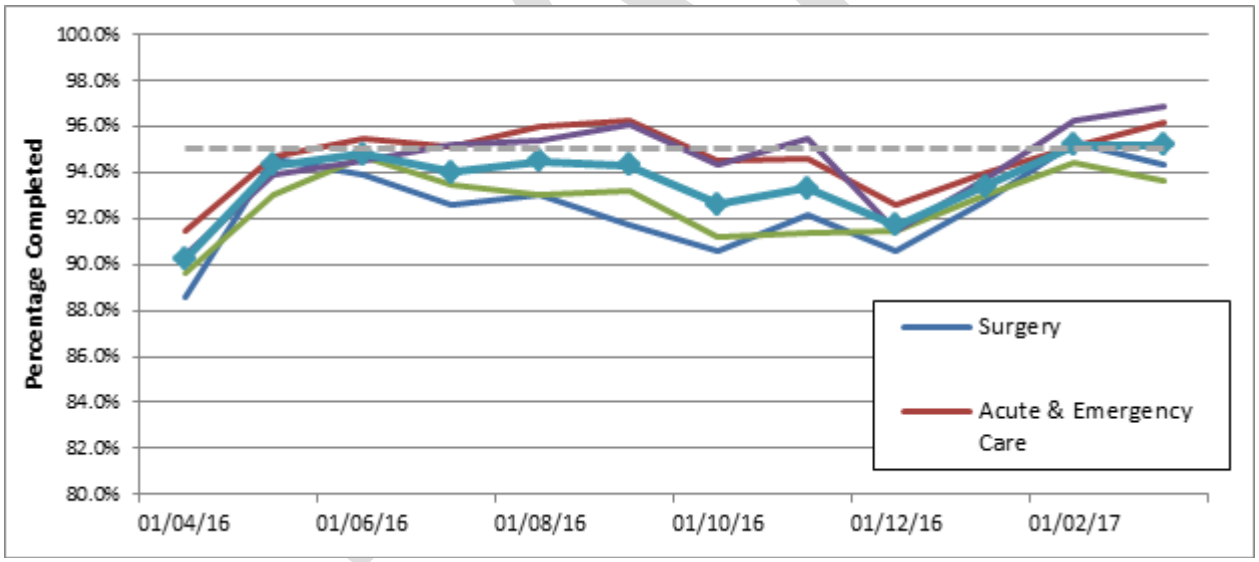
Discharge Summaries

⊖	Improvement demonstrated but objective not achieved

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 93.6%, so although there has been improvements and focus, 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 2017/18.

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 continues to be in-place, 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 demonstrated from the improvement for 2016/17 when performance was only 89%.

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

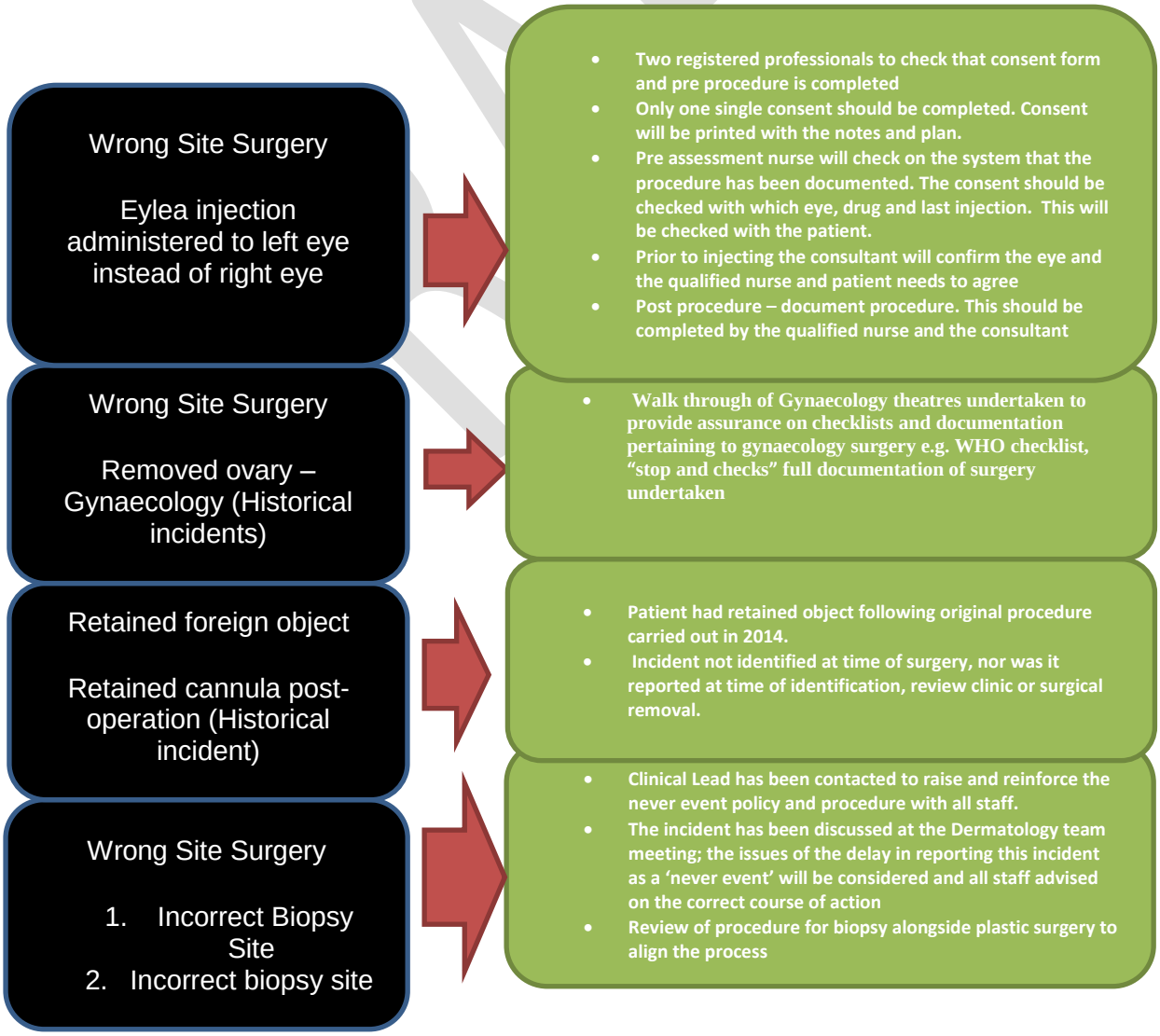
☑	Trust ambition achieved for rate of patient safety incidents resulting in severe injury or death (from NRLS)

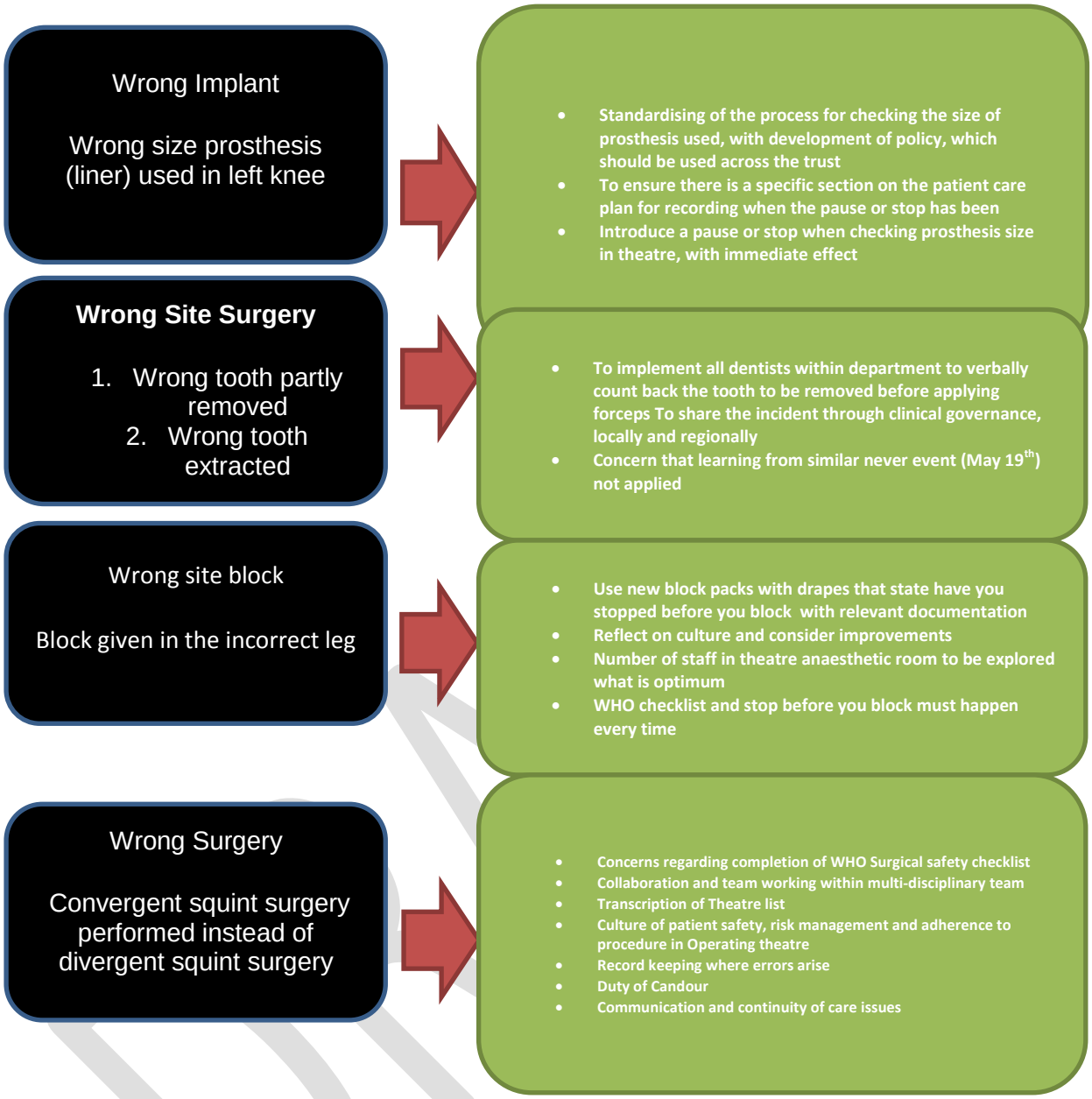
⊖	Improvement demonstrated but objective not achieved (reporting rate)

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 2016 to September 2016 show that we are in the mid 50% of reporters. This is calculated as a comparison against a national peer group, which is selected according to type or trust.

Never Events

Disappointingly, the Trust reported eight never events during the period. A never event is defined as an incident that should not occur if correct procedures and policies are in place. The Never Events are shown below alongside a brief description of actions implemented to prevent recurrence. In addition to the eight reported Never Events, a further three which occurred prior to 2016/17 were also identified. These are also described below.





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

- Human factors
- Busy theatre environment
- Staff pressure to complete cases in timely way
- Increased stress regarding site capacity and workload
- Reporting and grading of incidents
- Consent processes

The Trust recognises the importance of organisation learning from safety incidents and, as part of a wider piece of work, restructuring the Board sub-committees have introduced a new Clinical Quality and Safety Panel. Meeting fortnightly, this group engages all clinical leaders and the executive in a sharing of all adverse events, immediate learning and action plans so that a coordinated approach is taken to learning and remediation. The meeting have now commenced, the never events that have occurred and learning identified have been shared widely across the organisation and through communications and presentations.

NHS Improvement will work alongside the Trust for the first part of 2017/18, to assist with understanding of the analysis of the Never Events and to co-ordinate an improvement programme.

Regulation 28
The Trust received four Regulation 28 letters of the Coroner's Investigation Regulations from 2013 during 2016/2017. All of these have been responded to and appropriate actions have been put in place to prevent recurrence. A summary is detailed below.

There was a delay in diagnosing fractures in a patient in our care following falls at home and in hospital despite being regularly seen in the community. A more robust system of managing falls in the community has been established.

A patient with gross ascites due to alcoholic liver disease died after an ascitic drain was inserted without the use of an ultrasound scan causing damage to the bowel and resulting in the death. The national and international guidelines do not require ultrasound scans to be used for this purpose. The Trust agreed to provide patients with more information about the risks and also to carry out these procedures from 8am – 8pm so that any complications could be escalated for senior review in a more timely manner.

There was a defective oxygen flowmeter and the patient died whilst using this. The matter was reported to the MRHA and they investigated and said that the patient would still have been receiving enough oxygen despite the crack that was found. All flowmeters have now been checked and a Medical Devices Newsletter was issued about this.

A patient gave birth in hospital and was found deceased after leaving the hospital and going to another environment. It was agreed that all agencies involved needed to work together more effectively to achieve a care plan that met the needs of the mother and the baby.

Serious incidents
The Trust reported 86 serious incidents during 2016/17. 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.

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	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	Oct15 Mar16	Apr16 Sept16
Patient safety incidents														
CDDFT %age reporting Rate (1000 bed days)	4.9	5.0	5.6	4.2	5.1	4.9	6.6	6.3	5.3	26.28	35.27	40.5	38.85	35.17

CDDFT %age severe injury & death	0.46	0.31	0.14	0.25	0.15	0.15	0.16	0.3	0.2	0.1	0.2	0.2	0.4	0.3
National %age reporting rate (1000 bed days)	5.4	5.4	5.6	5.9	6.2	6.5	7.1	7	7.2	35.1* Median	35.34	38.25	39.31	40.02
National %age severe injury & death	0.7	0.8	0.9	0.7	0.8	0.7	0.7	0.6	0.5	0.5	0.5	0.4	0.4	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 revised sepsis care bundle in line with 2016 NICE guidelines across the Trust.

Progress
The Trust has signed up to utilising a regional sepsis screening tool and bundle. A collaboration between staff from Trusts in the North East developed the tool which was formally approved in January 2017. Utilising the Nervecentre system, CDDFT has opted to progress this tool one step further and integrate it within the system. From the 1st April 2017 all patients within CDDFT scoring a NEWS of 5, or one observation in the red, will be automatically screened for sepsis. This ensures every inpatient that should be screened, is screened. If a patient is identified as having sepsis staff will be told to commence the sepsis bundle which is also within Nervecentre. The Trust believe they are only the second in the country to utilise e-screening.

The Trust has held a medicine for members event which was well attended and evaluated.

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.

Closely monitor the e-screening and timeliness of bundle delivery to target education in specific areas of weakness and improve the quality of care.

Measure: Trust wide audit and Sepsis Mortality.

Duty of Candour

☑	Trust ambition achieved

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

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

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

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

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

Progress
Within the past two years since the implementation of the Duty of Candour regulation the Trust has undertaken a number of actions to ensure compliance as outlined below:

- Safeguard Incident Management system has been updated to enable recording of the Duty of Candour.
- The Being Open Policy has been amended to incorporate the requirements for Duty of Candour with a detailed flowchart, to show the key stages to record on Safeguard.
- Duty of Candour has been included within various Trust wide training programmes such as corporate staff induction, essential training, root cause analysis.
- A satnd alone training programme has been developed and rolled out for Duty of Candour, however, the uptake has been poor.
- Fortnightly Duty of Candour compliance reports are reviewed at the Patient Safety Forum.
- Care Group Leads alongside their Service Manager(s) will ensure that Duty of Candour is recorded in Safeguard Incident Management system.

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

- Continue to monitor Duty of Candour compliance fortnightly in Patient Safety Forum.
- Further education with staff groups in recording Duty of Candour via Trust wide training programmes and bespoke training days.
- Develop a programme of audit to be implemented by each division to ensure the Duty of Candour is being applied.

MATERNITY STANDARDS

Maternity Standards : Breastfeeding

	Trust ambition not achieved but improvements made

Our Aim
To improve breastfeeding initiation rates – Target 60%

Progress
Year to date performance 2016/17 – 58.5%

Next Steps:
- Implementation of Baby Buddy App.
- Roll out of Solihull Approach to parenting.
- Unicef Baby friendly Reaccreditation June 2017.
- Progress to Unicef Gold award following successful Unicef reaccreditation

Maternity Standards: Smoking in Pregnancy

☑	Trust ambition achieved

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

Progress
Quarter 3 performance 17.3%

Next Steps:
- Work with commissioners and FRESH in targeting women in DDES CCG area (high prevalence) offering an incentivised voucher scheme.
- CDDFT and NECA have secured tender for Darlington area and work is underway to engage with maternity services to re-establish stop smoking support, pharmacology and data capture.
- Continue to work with solutions 4 health in training, support and data capture to continue to improve quit rates.

Maternity Standards: 12 week booking

⊖	Trust ambition not achieved but improvements made

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

Progress

	2016-09	2016-10	2016-11	2016-12	2017-01	2017-02
Total Reviews	514	480	495	464	510	316
>12 Weeks	50	44	46	42	60	28
<12 Weeks	464	436	449	422	450	288
% Over	**9.73%**	**9.17%**	**9.29%**	**9.05%**	**11.76%**	**8.86%**
% Under	**90.27%**	**90.83%**	**90.71%**	**90.95%**	**88.24%**	**91.14%**
Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%

Next Steps
- Include information on new Maternity Web page
- Continue to monitor weekly data

- Continue to validate weekly data.
- Continue to communicate with Information on women who transfer in.
- Circulate information to wider health population including school nurses

Saving Babies Lives

☑	Trust ambition achieved

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

Gap Analysis

Element	Achieved Yes/No	Planned Actions
Element 1	Yes	• Post-delivery CO monitoring of all women • DDES funding initiative from PHE to support voucher incentive scheme
Element 2	Yes	• Presentation of specific audit of outcomes for SGA/IOL/NNU admissions etc • On-going scanning pathway & capacity work stream
Element 3	Yes	• Reduced Fetal Movement inserts & stickers ordered to identify patients attending with RFM to prompt pathway
Element 4	Yes	• Central CTG monitoring & archiving system including Dawes-Redman capacity on Trust risk register

Paediatric Care

☑	Trust ambition achieved

Our Aim

Most of the urgent/ emergency admissions to paediatric wards come directly from GP/ Primary care to the paediatric ward based assessment areas. The average, and most frequent length of stay for children is less than 1 day (0 days)

We aimed to improve the pathway for children referred to hospital through developing a number of initiatives which require sharing of knowledge and expertise and strengthening the interface between Primary care and Secondary care clinicians.

Specific aims were focused on enabling more children and young people to receive more of their care in Primary Care by making Secondary Care expertise more available locally by:

- Providing additional education for GPs.
- Being more accessible to GPs for clinical advice
- Providing Consultant-led sessions in Primary Care

To begin to reshape local children's services in line with local priorities, the CDDFT Clinical Strategy and remain consistent with the direction of travel within the Sustainability and Transformation Programme

Progress
All of the individual elements of the plan have been implemented resulting in changes to the pathway. Some of the most successful changes have been those made in building relationships with Primary care colleagues, and developing shared ownership of the pathway. This year has been about developing and testing the various elements and developing a blueprint for what has worked well, what may require further work, and a better understanding of how to adapt and apply what has been learned and developed across the entire referral pathway.

Next Steps
Clinical engagement has progressed and the broader strategic aims are now coming into sharper focus. What is required now is the development of more direct and personal relationships with individuals within Primary and Secondary care, and whilst this can be nurtured and facilitated, it requires time to flourish and bear fruit. However the foundations are now in place.

PATIENT EXPERIENCE
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.

In 2016-2017, we refined our Patient Experience Strategy. Our purpose is to be PROUD by ensuring as a team we are:
Patient centred
Responsive
Outcome focussed
Working in **U**nity
Delivering quality feedback.

The below chart highlights the Patient Experience Team objectives ensuring the patient / carer is central to all CDDFT activity.

Friends and Family Test (FFT) for patient feedback.

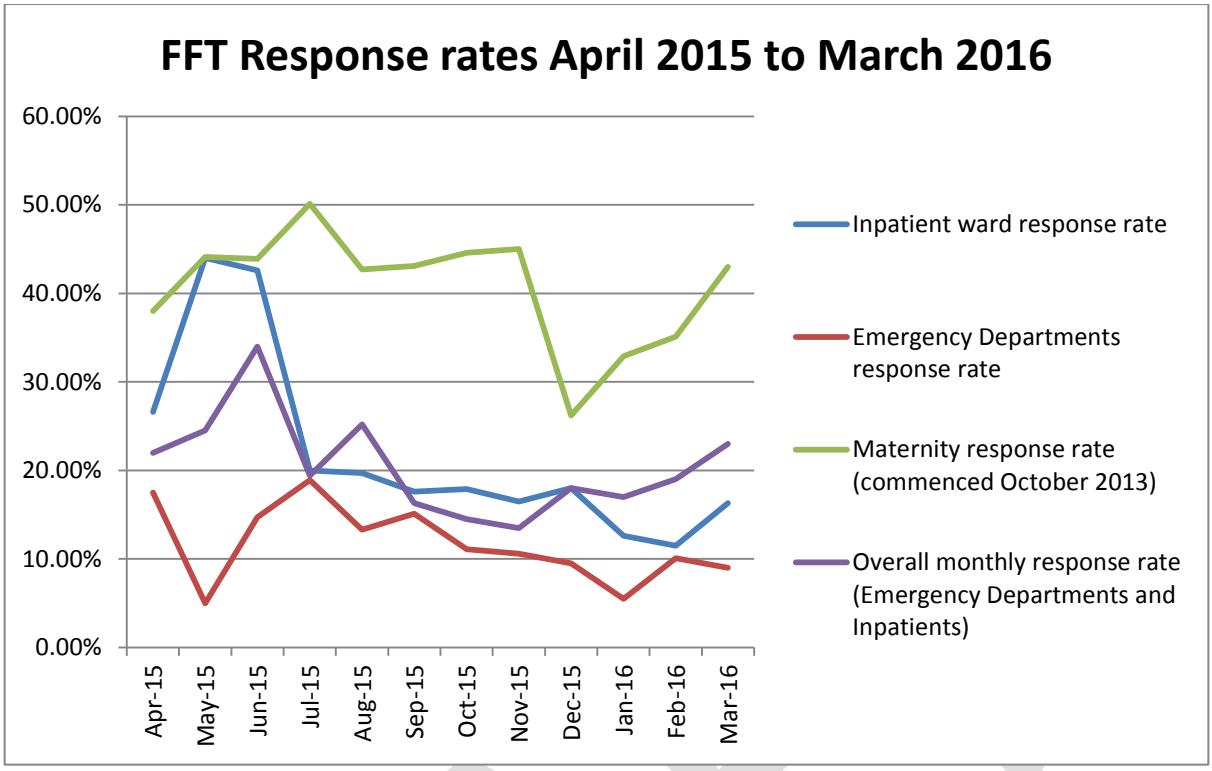
Throughout 2016-2017, all patients were provided with the opportunity to complete a questionnaire asking if they would recommend the service they had received to a friend or family member.

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

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

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

To update



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

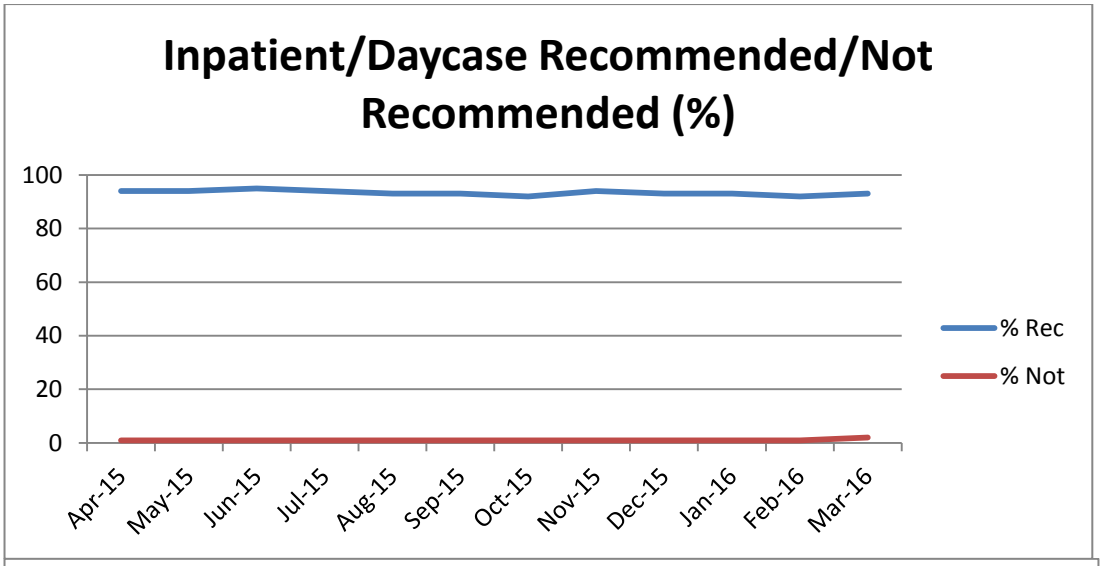
FFT Headline Measure

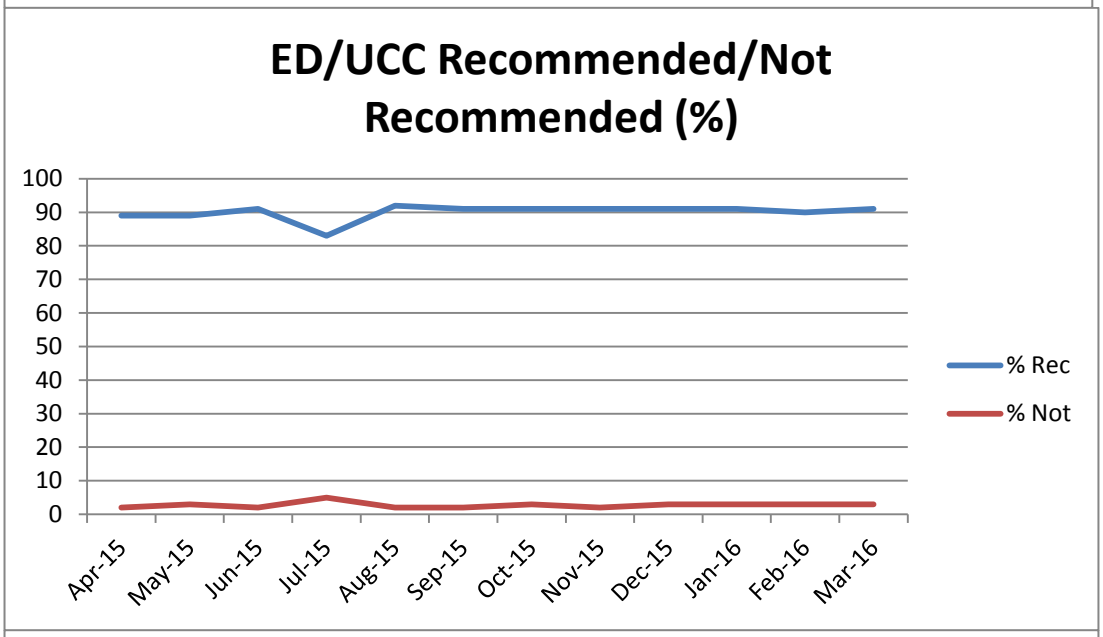
The percentage measures are calculated as follows:

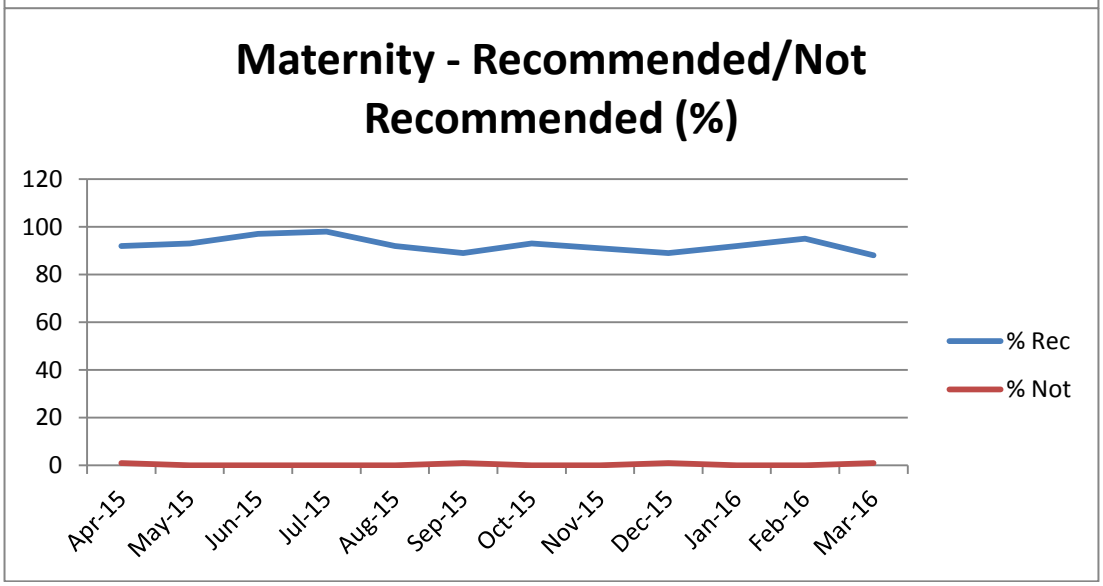
$$\textit{Recommend}\ (\%) = \frac{\textit{extremely likely} + \textit{likely}}{\textit{extremely likely} + \textit{likely} + \textit{neither} + \textit{unlikely} + \textit{extremely unlikely} + \textit{don't know}} \times 100$$

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

The following graphs show the revised headline measure from April 2016 for Emergency Department / Urgent Care Centres, Inpatient / Day cases and Maternity Services:
To update


Inpatient/Daycase Recommended/Not Recommended (%)
100
80
60
40
20
0
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16
% Rec
% Not


ED/UCC Recommended/Not Recommended (%)
100
90
80
70
60
50
40
30
20
10
0
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16
% Rec
% Not


Maternity - Recommended/Not Recommended (%)
120
100
80
60
40
20
0
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16
% Rec
% Not

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:
To update poster

In-Patient Interviews
In 2016-17, the Quality Matters process was introduced which incorporated patient experience feedback of all wards on a monthly basis. The real time patient interviews were stopped in order to avoid duplication. The questions captured based on the core domains of what patients want from an inpatient episode (Picker Institute 2009) were incorporated into the Quality Matters process.

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 and awareness sessions have been delivered to Trust induction sessions as well as supporting safety workshops for junior doctors, Governor induction sessions, Cardiac rehabilitation programmes, cancer support groups and ???. The Customer Care e learning package is available to all staff groups. Bespoke customer care programmes have been taken forward within individual care groups, and a newly devised Great Expectations customer care course commenced in 2016.

Dignity for All
In February 2017, we celebrated Dignity Action Day, taking this opportunity to consult with attendees on the CDDFT dignity campaign, with the intention of aligning "Hello My Name Is" project to our "Dignity For All – Our Promise to You" project. Feedback from staff, visitors, volunteers, carers and governors, was very positive and work is on-going to take this campaign forward.

NHS Choices
Quarterly reports are collated and presented at the Integrated Quality and Assurance 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 to update survey info
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.**

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.

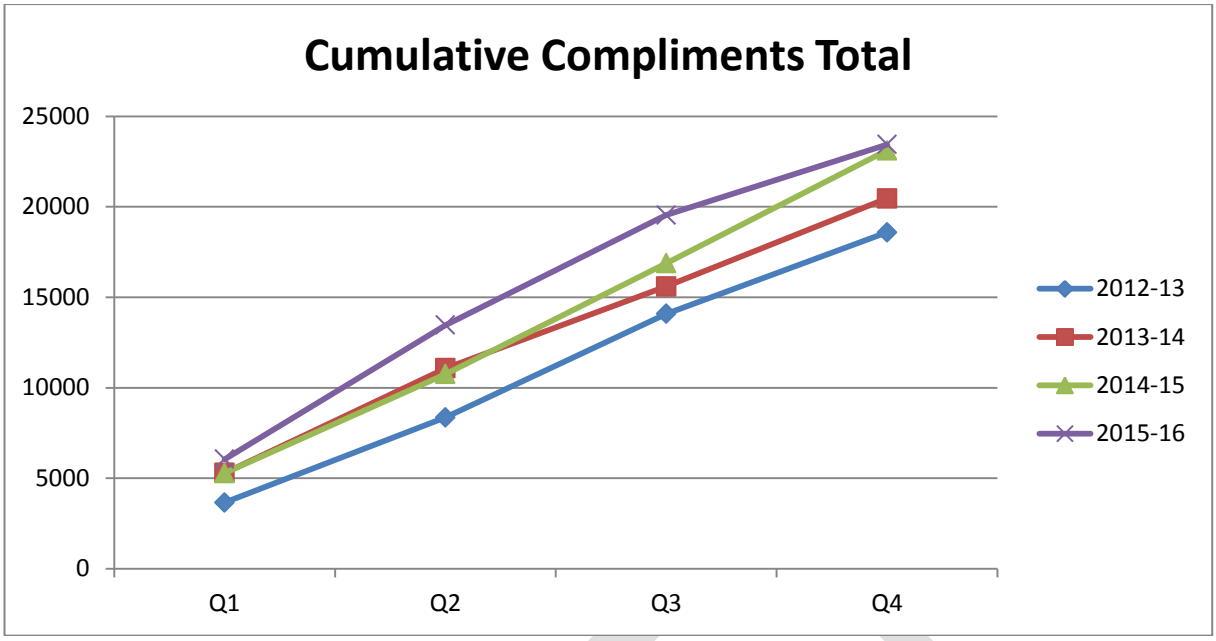
The data below shows the responses in relation to the CQUIN indicator questions comparing each quarter with the National Inpatient Survey results for 2015

To add Q4 info

Patient Experience Indicator Questions	2015 Nat In-pt	Q1 2016	Q2 2016	Q3 2016	Q4 2017	Ave	↑↓
Did you feel involved enough in decisions about your care and treatment? (Q11)	74%	80%	80%	79%	81%	79%	↑
Were you given enough privacy when discussing your condition or treatment? (Q14 was 13)	84%	90%	86%	85%	88%	88%	↑
Did you find a member of staff to discuss any worries or fears that you had? (Q16 was 15)	58%	85%	84%	77%	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)	50%	72%	67%	60%	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)	79%	82%	81%	76%	80%	81%	↑

Compliments

Quarter	2012-13	2013-14	2014-15	2015-16	2016-17
1	**3662**	**5297**	**5288**	**6058**	**4761**
2	**4698**	**5782**	**5473**	**7406**	**4953**
3	**5730**	**4523**	**6123**	**6078**	**5355**
4	**4493**	**4863**	**6228**	**3902**	**xx**
Total	**18,583**	**20,465**	**23,112**	**23,444**	



To update chart above plus text below when results known
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 trust in order that we can learn from general trends or specific issues. Representatives of Healthwatch County Durham and Healthwatch Darlington 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. Healthwatch teams have provided invaluable support and feedback to the STEM project at Darlington Memorial Hospital in 2016. any others? Healthwatch members continue to support a peer review process whereby current anonymised complaint reports and responses are reviewed to ensure a fair and balanced response is provided to patients.

Patient Experience Projects
During 2016/17 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:

- **LAC Project**
  - This project commenced in January 2017
- **Carers report:**
  - The 2015/16 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 2016. 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. This is now an annual report.
- **Volunteer Report**
  - During December 2016 and January 2017, all Trust volunteers were asked for their views of their experiences of volunteering at CDDFT. A full report will be shared later in 2017. A Volunteer Steering Group meets three times per year to

ensure the recruitment process and support mechanisms are in place to create a positive environment for all volunteers. An action plan will be developed and co-ordinated as a result of volunteer feedback.

In February 2017, we were fortunate to receive the Volunteer Kitemark award for our commitment and support offered to volunteers who give their time and energy to support patients and staff across CDDFT. All volunteer managers have access to volunteer manager guidance documents and volunteers have access to a volunteer information pack.

Kitemark Award 2017

The recruitment and management processes have been reviewed to ensure volunteers are well supported and receive appropriate training for the role they play within the organisation.

Learning from Experience

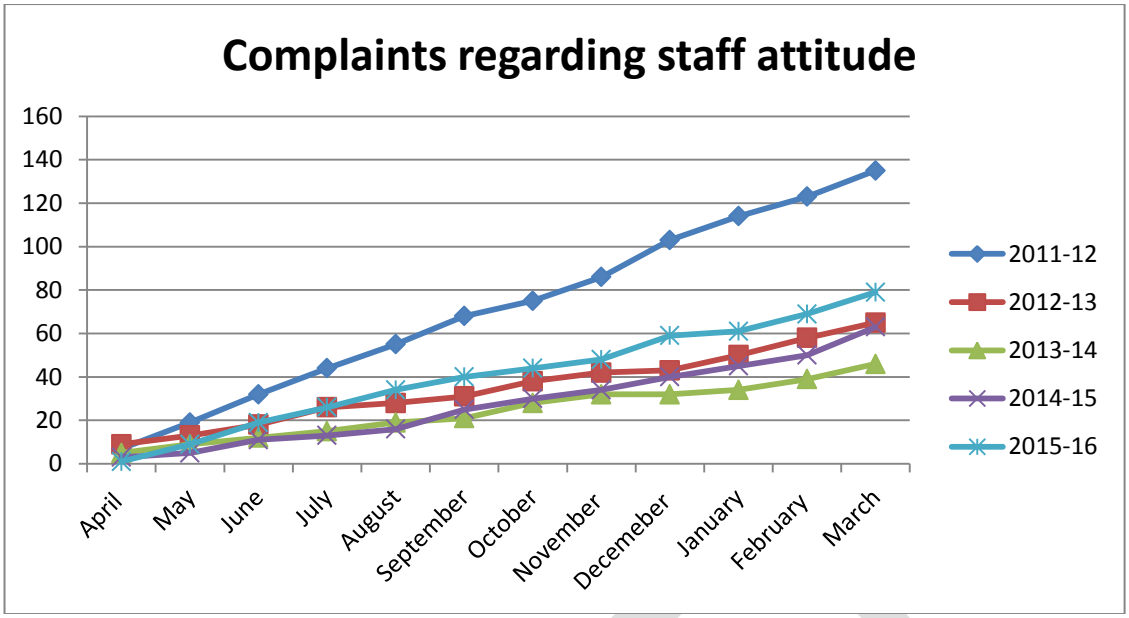
From the quarterly analysis of patient feedback themes are identified and included in thematic action plans which are presented to the Care Groups for action, these action plans are monitored at the Complaints, Litigation, Incidents and Pals (CLIP) meeting and Care Group Governance meetings. Individual 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 formal complaints and informal concerns via the patient experience team. The Trust follows the NHS complaints procedure and accepts complaints either verbally or in writing. If complaints are founded or partially founded the complainant receives an action plan to address the issues identified as well as a response. Complainants are offered a meeting and or a written response and are encouraged to participate in action planning to turn 'complaints into contributions'. Complaints and concerns 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 and in 2016 – 17 this increased further to XX. This is monitored closely and shared at Integrated Quality and Assurance Committees. Proactive measures are implemented to ensure this improves.

To update chart



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

A Patient Story report is published annually sharing the stories shared throughout the year. Appropriate actions where required are also highlighted.

Nutrition and hydration in hospital

⊖	Trust ambition not achieved but improvements made

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 2016/17. This includes:

- Move Nutritional assessment into nerve centre
- Development of end of life nutritional care pathway
- Development of nutrition policy
- Development of Parenteral Nutrition Policy
- Registered Nurse Nutrition Training offered monthly by Nutrition Nurse Specialist
- Further roll out of metrics capture via Quality Matters audit

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

2016 PLACE Assessments - The Department of Health and the NHS Commissioning Board requires all hospitals, hospices and independent treatment centres to undertake an annual Patient Led Assessment of the Care Environment (PLACE).

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 PLACE domain 'Disability' has been introduced. This will consider how well organisations cater for the needs of patients/visitors with disabilities. Most questions used to create this score are already included in PLACE. The only disability-specific questions are those relating to audio/visual appointment alert systems which were included in the 2015 assessment as un-scored question. As with dementia, this does not represent a comprehensive assessment against disability-related criteria, rather it is a selection of issues chosen from within the existing assessment judged to have a disability-related aspect.

Trusts are advised by the Health and Social Care Information Centre (HSCIC) six weeks in advance when they are authorised to conduct the PLACE assessment on a named site. Once this notification is received the assessments are arranged and teams must be made up of at least 50% patient assessors whilst including representatives from Infection Control, Dementia Lead, Estates, Catering, Facilities and Nursing respectively. The timeframe for assessments was from 7th March until 10th June 2016.

On completion of the assessments the data is uploaded onto a dedicated HSCIC site with formal results being notified to the Trust in July 2016 with an opportunity for validation. National publication has been provisionally programmed for release in August 2016 and the data will be shared with the 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	**88.20%**
County Durham and Darlington NHS Foundation Trust	**96.59%** ↑

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

	Food	Ward Food Score	Organisation Food Score
National Average Score	**88.20%**	**89.00%**	**87.00%**
Bishop Auckland Hospital	**97.44%** ↑	**98.91%** ↑	**95.68%** ↑

Chester Le Street Community Hospital	**96.47%** ↑	**97.21%** ↑	**95.78%** ↑
Darlington Memorial Hospital	**95.59%** ↑	**95.56%** ↑	**95.68%** ↑
Richardson Hospital	**96.49%** ↑	**96.43%** ↑	**96.56%** ↑
Sedgefield Community Hospital	**96.02%** ↑	**95.52%** ↑	**96.56%** ↑
Shotley Bridge Community Hospital	**97.44%** ↑	**98.18%** ↑	**96.56%** ↑
University Hospital North Durham	**97.57%** ↑	**98.40%** ↑	**94.85%** ↑
Weardale Community Hospital	**95.13%** ↑	**94.07%** ↑	**96.56%** ↑

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

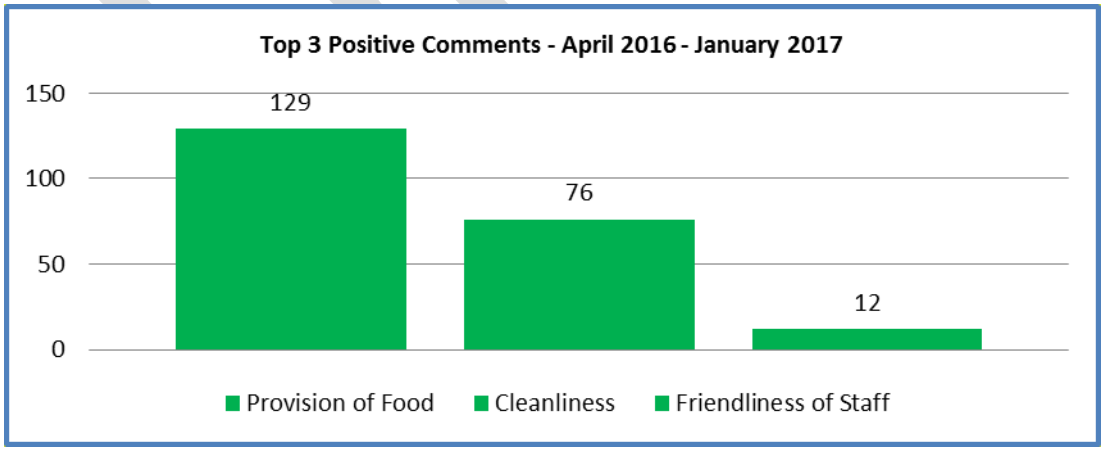
Scores highlighted in **red** indicate below the national average score.

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

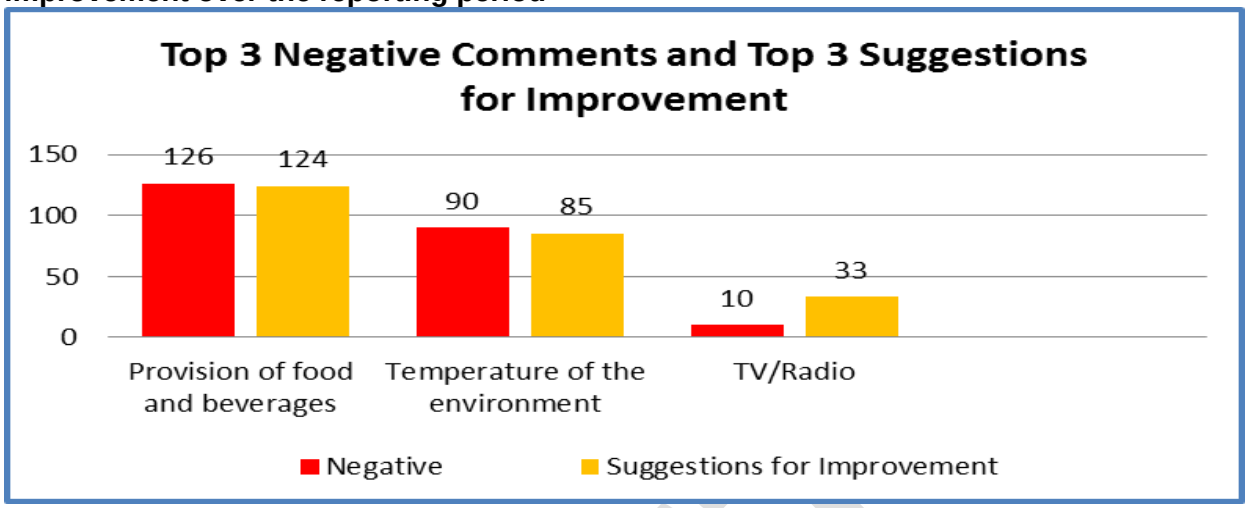
During the period April 2016 – January 2017 217 positive comments were received.

The following graph illustrates the top three positive comments over the reporting period (April 2016 to January 2017).



During the period April 2016 – January 2017 226 negative comments and 242 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
- Availability of Tea/Coffee
- Presentation of food
- Portion sizes

	Quarter 1	Quarter 2	Quarter 3	Total
Number of Meals Served	246,375	250,375	248,375	**745,125**
Total Number of Reviews	**226**	**205**	**208**	
Negative Comments	**63**	**72**	**68**	
Suggestions for Improvement	**78**	**73**	**64**	
Positive Comments	**85**	**60**	**76**	

Of the 639 reviews 2.5% related to the provision of patient meals and beverages.

The number of negative comments and suggestions for improvements equated to 1.7% of the 745,125 meals served.

Key Actions in Response to Negative Comments and Suggestions for Improvement

Provision of food and beverages
Regular audits are carried out at ward level to ensure full compliance with the regeneration of food and most importantly food is been served in an attractive manner. Feedback is now reviewed on a monthly basis

Finger Food Menu
A menu is now available Trust wide for both dementia patients and the children's ward as it was agreed that this menu can be adapted to many different users of the catering facilities

Menu Ordering
The Trust have now purchased an electronic ordering system which will go live across DMH and UHND from April 2017. Discussions are taking place to understand if this electronic system could be linked in with the nerve centre to highlight nil by mouth and allergen information.

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.

Funding was secured 2016/2017 which has enabled all catering staff across all CDDFT sites to gain there level 2 in food Safety.

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	February 2016	✡✡✡✡✡
University Hospital North Durham	July 2016	✡✡✡✡✡
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 2016	✡✡✡✡✡

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

In August 2016 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	August 2016	August 2017

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. Following trial and robust review of the first menu the menu has been re-launched Trustwide.

End of Life Care

⊖	Trust ambition not achieved but improvements made

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

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

We now have an effective strategy for palliative care with strong clinical leadership and commitment from executive and board. . There are substantial improvements in information streams, both quantitative measures and feedback from incidents and surveys.

Many of the CQC recommendations and improvements identified by national audit have been implemented. There remains much to do with key issues remain unresolved requiring collaboration with commissioners and other service providers. The trust and service are well positioned to make substantial further improvements in the coming year.

Next steps
Key next steps for the coming year are:

- Further improvement to personalised care planning through education, incident monitoring and cultural change
- Develop triangulation of quantitative data with patient led measures

- Work with regional partners to develop ePaCCS
- Support and monitor new out of hours advice service
- Establish palliative care mandatory training for all staff
- Deliver local repeat of postal questionnaire of bereaved relatives (VOICES)
- Explore regular integrated governance meeting with other local palliative care organisations

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

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

Work continues to engage with staff at all levels of the organisation and the Organisation Development Strategy "Staff Matter" complements the Quality strategy.

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

Key Finding	2015		2016		Trust Improvement/Deterioration
	Trust	National Average	Trust	National Average	
KF1. Staff recommendation of the Trust as a place to work or receive treatment	3.6	3.71	3.46	3.71	Deterioration of 0.14

The results for key finding 1 staff recommendation of the Trust as a place to work or receive treatment has seen a deterioration of 0.14 which means that we have not met our ambition to achieve the national average score. The Trust score of 3.46 (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 0.25. This score benchmarks the Trust as a worse than average ranking.

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

Question	2015		2016		Trust Improvement/Deterioration
	Trust	National Average	Trust	National Average	
Q21a Care of patients/service users is my organisation's top priority (strongly agree and agree)	69%	73%	62%	75%	Deterioration of 7%
Q21c I would recommend my organisation as a place to work (strongly agree and agree)	55%	58%	49%	59%	Deterioration of 6%
Q21d If a friend or relative needed treatment, I would be happy with the standard of care provided by this	61%	67%	59%	68%	Deterioration of 2%

organisation (strongly agree and agree)					

Progress
During 2016/17 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:

Staff Survey
Work continues to engage staff at all levels of the organisation. The results of the Culture Audit and Staff Survey were shared at Senior Managers and Heads of Department (SMHoD's) meetings. An extended SMHoD's session was used to identify the key priorities for the Trust and a Staff Matter action plan was produced as a result. This was also shared with ECL in order to obtain their input into the plan.

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

Staff Matter
For 2016/2017 the Staff Matter Strategy and resulting action plan has guided the work around staff engagement. This action plan is monitored on a quarterly basis and reported to the Board.

The OD strategy Staff Matter has been reviewed and re-written and will be ready for launch 1 April 2017. This document sets out the strategic workforce priorities CDDFT have agreed for the next three years (reviewed annually) and builds on the foundations that were developed through our outgoing 'Staff Matter' strategy.

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 staff engagement, improving quality and patient safety, change within the NHS to include the Better Health Programme and STP's.

Leadership and Management Development Framework
Based on the priorities falling out of the culture audit and staff survey CDDFT's Leadership and Management Framework has been further developed to provide a comprehensive programme of development activities, aimed at the key stages of strategic and operational management. The various options available for leadership development are brought together within the framework, which will enable Managers to access the most appropriate development activity for them. The framework will also facilitate talent management and succession planning. It identifies the corporate offering; development activities available from the North East Leadership Academy and National Leadership Academy and external provision such as level 4 and 5 vocational qualifications.

The leadership and management development programmes are divided into three routes and cover a mix of both transformational and transactional skills and behaviours:

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

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

The programme has been piloted with the Care Group Triumvirate members in order to validate the content of the programme and ensure that the content is relevant for future cohorts. The programme is being rolled out across the Trust, with priority being given to the new senior care group management teams. Cohort two is half way through the programme and cohort three will commence in April 2017.

As part of the Strategic Leadership development programme there will also be a series of development sessions offered to a wider audience which will focus on a range of challenges facing leaders within the Trust. This will be offered via an annual leadership conference and will have invited guest speakers from the world of leadership, staff and patient engagement and healthcare. The aim of this session will be to challenge our thinking around how we operate as leaders at a Trust, as well as individual level.

Developing Managers as Leaders

In 2016/17 the Great Line Management and New Manager Induction Programmes were replaced by the Great Line Management Fundamentals Programme. This programme consists of a portfolio of activities designed to develop managers as leaders and prepare them for the strategic leadership programme. Great Line Management Fundamentals focuses on developing an individual's understanding of their role as a manager and the skills needed to influence and work effectively through others e.g. people management skills which is the area most managers find difficult to master. The programme offers a comprehensive range of workshops beginning with an introductory day, followed by a series of free-standing modules covering key areas such as staff engagement, personal resilience, effective communication, HR policy and processes. In addition to a wide range of workshops, HR for Managers mini guides are available and include information on topics such as recruitment and selection and disciplinary and grievance procedures.

Talent Management
The Trust has taken an inclusive approach to talent management which consists of a "grow your own" approach and a new graduate trainee programme designed to attract talent from outside of the organisation.

Under the umbrella of "grow your own" further work has been undertaken during 2016/2017 to develop career pathways for all key roles across the Trust, linked to apprenticeship frameworks and professional standards. Current pathways include Nursing, Leadership and Management and Procurement.

In order to attract talent from outside the organisation work has been done in conjunction with the Care Groups to develop a graduate trainee scheme. The first two graduates were recruited in January and have taken up posts in Surgery and Acute and Emergency Care. The newly recruited graduate management trainees have been provided with a high level of support in the form of a Leadership Mentor, clinical Mentor, Coach and Programme Manager.

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

Personal Resilience
Given the unprecedented change facing the NHS, staff development sessions promoting personal resilience strategies have continued throughout 16/17 to support the workforce to develop coping strategies in a changing environment.

Staff Annual Awards
Staff Annual Awards 2016/17 recognise staff across CDDFT for their outstanding contribution to patient care and over 500 staff were nominated this year under seven main categories of; Chief Executive Award; Enhanced Patient Care; Making a Difference Award; Making You Feel Better Award; Research and Innovation Award; Shining Star Award; Supporting Change Award. Ultimately an overall winner has been selected to receive the 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.

Appraisal
The monitoring of appraisal completion and quality audits have been a focus of work during 16/17 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. HR Business Partners have been working closely with Care Groups to ensure appraisals are taking place. The Learning and OD Team have implemented a system to monitor the quality of appraisal on a quarterly basis. Appraisers training for managers and Appraisee training workshops have been delivered throughout the financial year.

Next steps
County Durham & Darlington NHS Foundation Trust intends to take the following actions to improve results and therefore the quality of its services and staff experience.

Leadership and Management Development Framework
The leadership and management development framework will be reviewed and refreshed for 17/18 to ensure it meets current and future leadership and management development needs. Work is underway on the design of additional workshops on Performance Management and Patient Experience. These will be incorporated into the Great Line Management Fundamentals Framework.

Strategic Leadership Programme
The SLP will continue to be rolled out across the organisation throughout 2017/2018, prioritising the new senior management teams within the Care Group restructure.

The first Leadership Conference will take place on 10 May 2017. The keynote speakers for this conference are Professor Michael West Head of thought Leadership with the Kings Fund and Nigel Risner CEO of Turning Limited People Limitless.

Talent Management Framework
A range of activities have been identified in support of talent management within the Trust and these are:

- Work will be undertaken with appropriate stakeholders to develop a Talent Management Framework ready for roll-out in April 2018.
- Further develop apprenticeship opportunities across a range of career pathways (to include traineeships).
- Work undertaken with Care Groups and Services to further develop talent/career pathways for all staff roles.
- Continued roll-out of the in-house Graduate Management Training Programme

Replace Appraisal process
Throughout the next financial year work will be undertaken to replace the current appraisal process with a new approach. This will be done via consultation with mangers and staff and development of a new process which focuses on the quality of the appraisal conversation. It will form an important part of the talent management framework and will also support senior managers in identifying the leadership strength and profile of their team(s) and in doing so identify the spread of talent and potential talent within them.

CLINICAL EFFECTIVENESS

Reduction in Hospital Standardised Mortality Ratio (HSMR) 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.

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

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

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

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

Our aim

Our aim is to 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 2016 there was a downward trend in HSMR to May 2016, a slight rise in July and then a continued downward trend. The graph also shows weekend HSMR figures which show that from February 2016 the figure has remained fairly consistent around the 100 figure.

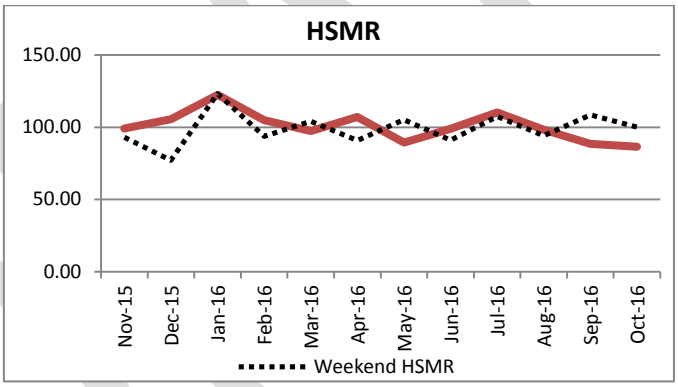


Figure 1 – HSMR timeline (Nov 2015 – Oct 2016)

The funnel plot for this time period displays expected number of deaths versus HSMR (Figure 2) and shows that the Trust sits comfortably in the 'green' zone.

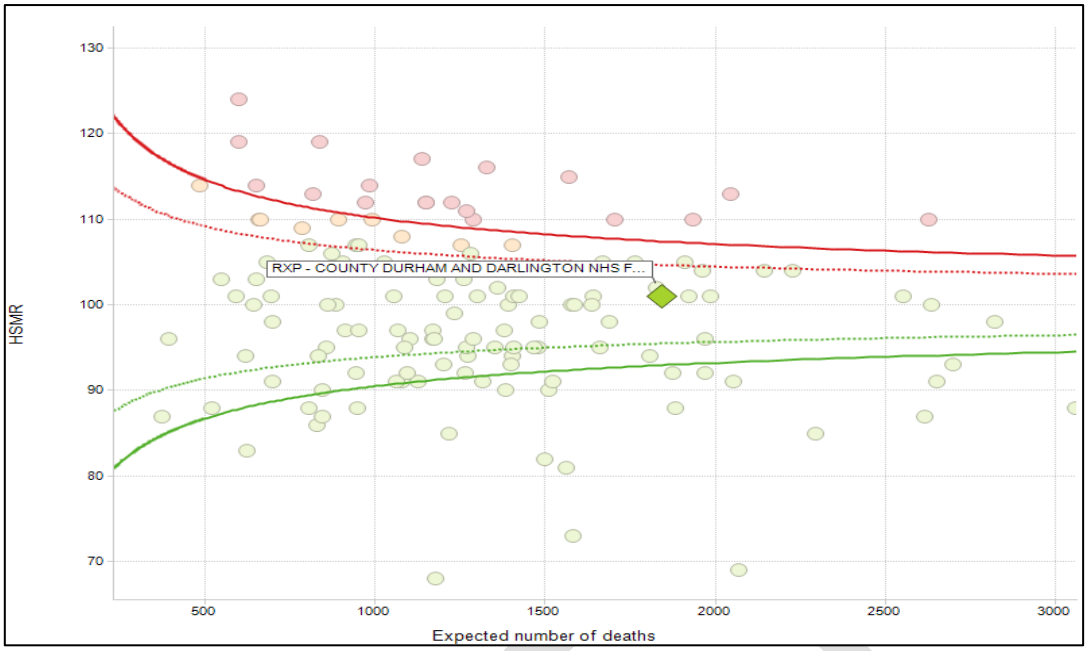


Figure 2 - Funnel plot showing expected number of deaths and HSMR (Dec15-Nov16)

SHMI

The SHMI data (Figure 3) shows a similar profile to HSMR although without the same peak in July 2016. October 2016 did see a rise above the standard of 100. Unfortunately this performance is not reflected in the funnel plot for this period with CDDFT just in the amber range but on the upper control limit.

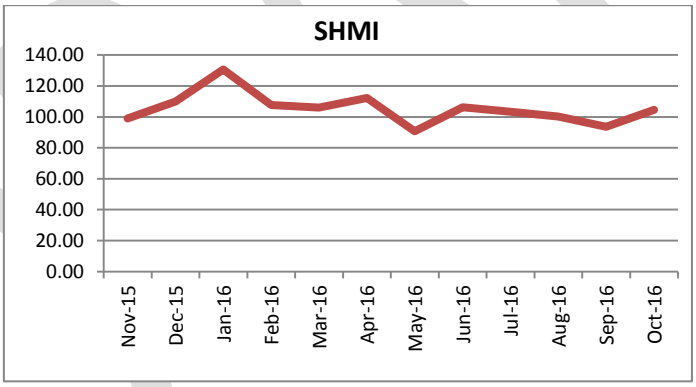


Figure 3 – SHMI timeline (Nov 2015 – Oct 2016)

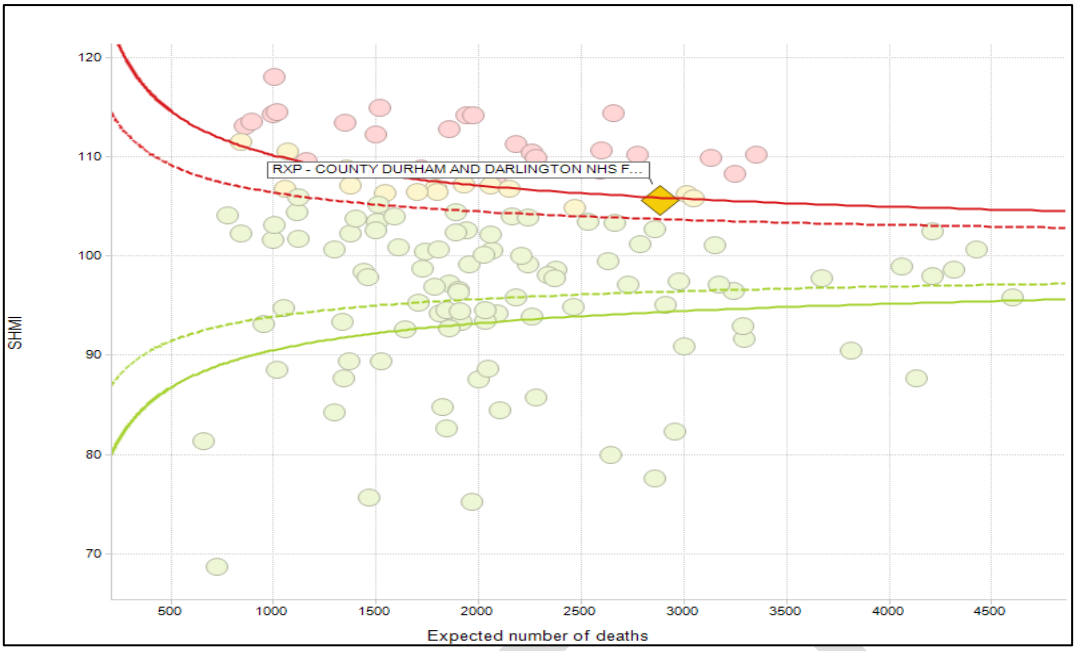


Figure 4 - Funnel plot showing expected number of deaths and SHMI for period Nov 15 – Oct 2016

Crude Mortality

The Trust's crude mortality figure showed a significant and sustained fall since a high in January 2015 and reached a 11 month low of 3.33 in September 2016.

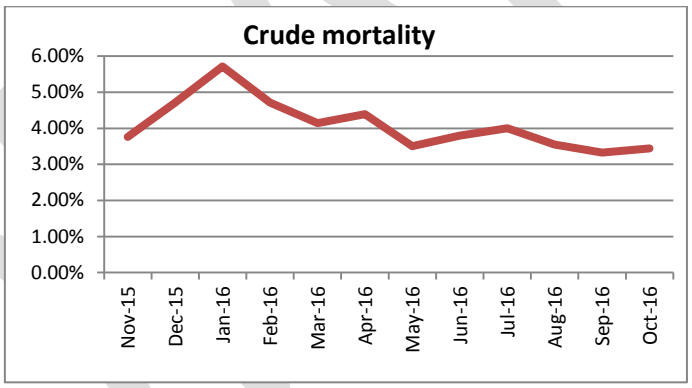


Figure 5 – Crude Mortality timeline (Nov 15 – Oct 16)

Next Steps

- Ensure that mortality remains a strong focus for the Trust
- Implement the recommendations of the CQC's report 'Learning, candour and accountability'.
- Review the current mortality review process within the organisation in light of the new, national retrospective case record review process.
- Continue to develop ward/speciality mortality reports to ensure learning from the mortality review process results in a reduction in harm
- Continue to develop links with Primary Care colleagues to ensure joint learning.

The current Associate Director (Mortality) leaves this post at the end of February 2017 and the Trust needs to ensure that continuity is maintained to ensure engagement with the mortality agenda remains strong and proactive.

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 current 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 their clinical areas, maternity and paediatrics have a separate mortality review process that fulfils statutory requirements in these area, the Cardiac Arrest Prevention Team undertake mortality reviews on specific groups of patients and individual specialities are beginning to review mortality as part of a specialty mortality and morbidity meeting. 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.

However, this process will need to be reviewed when the NHS National Quality Board issues guidance on reviewing and learning from the care provided to people who die, due before the end of March 2017, and in light of the new 'structured judgement review' process that the Royal College of Physicians has been commissioned to deliver to ensure a standardised approach across England and Scotland.

In addition, the CQC's report 'Learning, candour and accountability' places significant emphasis on engaging with families and carers as part of the review process and also looks to address the particular challenges for the investigation of deaths of people with learning disabilities. Whilst the Trust has a well-defined process for investigating deaths of people with learning disabilities, involving the Lead Nurse for Learning Disabilities, this process will also be reviewed in light of the new guidance.

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. To try and achieve this, the Trust had started to produce quarterly feedback reports to ward areas. These reports included 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. Unfortunately the production of these reports fell away in 2016 due to staff vacancies however it is imperative that they are resurrected in 2017/18.

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. Regionally there are projects looking at the management of sepsis and acute kidney injury that have been generated from the regional mortality work. Locally the Trust has begun to engage with primary care colleagues to ensure that learning is shared with community matron and GP colleagues. This work will continue to be developed in 2017/18.

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

⊖	Trust ambition not achieved but improvements made

Our aim
The Trust aims to minimise avoidable re-admissions, which are an indication of potential opportunities to improve patient care which are not being taken.

Progress
Re-admissions between April-November 2016 fell by 1.8%, compared to the same period in 2015, as a result of a 2.4% fall in re-admissions following a non-elective in-patient spell. Re-admissions following an elective spell increased by 0.7%. The largest contribution to re-admissions following an elective spell continues to come from the Endoscopy and Short-stay surgical areas. From April 2017, Endoscopy activity will be recorded as an out-patient procedure rather than as a day case. This will reduce the number of re-admissions from this source, and more accurately reflect the Trust position.

The most significant source of re-admissions following a non-elective spell are the short-stay areas; the single most significant area being the A&E short-stay unit at UHND.

The Trust last audited how many re-admissions were avoidable in July 2015. It proposes to undertake an updated Audit later this financial year or early in the next. This will be done by a multi-agency group including strong clinical input from CDDFT Consultants and nurses from acute and community settings, together with external partners such as GPs and Social Care staff. The outcome will inform decisions about where investments in community services will be most effective and will also affect Trust income from re-admissions.

Next Steps
The Trust and its partners are working to minimise non-elective admissions and re-admissions through:

- The Transforming Emergency Care Programme has continued to be the main vehicle for change. Important developments have included revised escalation procedures, co-location of the Urgent Care Centre at Darlington with the A&E Department at DMH, improved multi-disciplinary teams for the elderly at DMH and UHND, and winter investments enabling improved assessment prior to admission, such as GP and specialist nurse navigators to see, triage and treat patients attending A&E.
- The Trust welcomed a further review of its emergency services by the NHS Emergency Care Intensive Support Team (ECIST) and is beginning to implement its key recommendations, which included further steps to improve “assess to admit” services and alternatives to hospital admission and A&E, and improved deployment of medical teams to A&E to ensure timely assessment.
- Continued investment in Intermediate Care services (Intermediate Care Plus in Durham and RIACT in Darlington).
- As part of the Contract agreement for 2017-18, the Trust plans to reconfigure its community services into Community Hubs, aligning them more closely to groups of GP Practices.

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

⊖	Trust ambition not achieved but improvements made

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

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

Progress

In order to access Sustainability Transformation Fund monies the Trust agreed performance trajectories with the NHS Improvement Agency (NHSI – formerly Monitor) at the beginning of the year. The aim was to recognise that at some points in the year it would be more difficult to achieve the national standard than at others. At times of least pressure, the NHSI trajectory is more challenging than the national standard to balance times of greater pressure when Trust performance is more likely fall below the national standard.

A&E 4-hour wait performance, April – December 2016

A&E 4hr Wait Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
National Standard	95%	95%	95%	95%	95%	95%	95%	95%	95%
Monitor Trajectory	91.62%	93.19%	95.46%	96.78%	96.62%	96.55%	95.73%	93.75%	90.91%
Performance	91.62%	93.19%	95.48%	95.16%	95.70%	95.37%	94.32%	91.82%	89.52%

Until October, the Trust achieved either (or both) the national standard and the NHSI trajectory but since then the greater pressures associated with winter have caused it to fall below both.

Trust performance on the 30 minute ambulance handover standard has improved.

A&E Ambulance handovers within 30 minutes (2015-16 figures in brackets)

	Qtr 1 2016-17	Qtr 2 2016-17	Qtr 3 2016-17
DMH	77.5% (68.6%)	80.7% (74.9%)	81.5% (65.9%)
UHND	87.1% (78.2%)	90.4% (83.0%	77.8% (78.1%)
Trust	83.3% (74.3%)	86.5% (83.0%)	79.3% (73.1%)

However, the number of patients waiting more than two hours for handover has increased. This performance should be seen in the following context:

- Modest growth in A&E attendances continues. Between April-December 2016, total attendances rose 2.1% compared to the same period in 2015 (UHND by 3.3%; DMH by 0.8%). During the same period, ambulance arrivals fell by 0.9% (UHND rose by 0.5%; DMH fell by 2.9%). Most ambulance patients are brought by NEAS but DMH also attracts some ambulance patients from North Yorkshire, brought by the Yorkshire Ambulance Service.
- Between April-December 2016, 1% more patients were admitted via A&E than during the same period in 2015 (0.4% at DMH and 1.6% at UHND).
- As part of an in-year regional agreement to minimise ambulance handover delays, and as recommended by North East Vanguard, CDDFT supported the in-year adoption of a “no tolerance” approach to non-clinical diverts. Although this has undoubtedly brought benefits to patients and the ambulance service, it has restricted the ability of the two CDDFT acute sites to help each other when under pressure. The number of patients diverted between sites for non-clinical reasons has declined significantly as a result.
- Commissioners have recognised that CDDFT have a lower bed base than any other North East Trust. This base has contracted further than anticipated this year because of the closure of 16 beds at Shotley Bridge Community Hospital as a result of safety concerns raised by NHS Property Services. Closures due to staffing issues have also affected Weardale and Chester-le-Street Community Hospitals.
- Although non-elective activity has been relatively stable, pressures have been distributed unevenly between the two acute sites.

Trust-wide Admissions	Apr-Dec 2015-16	Apr-Dec 2016-17	% variance
All non-electives	**50779**	51245	0.9%
Paediatrics / neonates	6800	7620	12.1%
Gynaecology	1940	1883	-2.9%
Surgery (excluding Trauma)	6476	6989	7.9%
Trauma (excluding Paediatrics)	1941	1956	0.8%
Medicine	26412	25886	-2.0%

Commissioners have acknowledged that bed capacity is particularly tight at UHND but this site has been disproportionately affected by non-elective pressures in Q3 when the strain on the Emergency Department has been greatest. For example:

- *All Specialty* non-elective admissions rose by 1.3%, including increases of 24.4% in Surgery and 26.6% in Trauma.
- Admissions via A&E rose by 5.7%.

Next Steps

During the course of the year the Trust welcomed the offer by the NHS Emergency Care Intensive Support Team (ECIST) to conduct a review of Trust plans to improve Emergency Department performance. ECIST recommended the Trust focus onto a small number of key issues: system-wide leadership and escalation procedures; assess to admit; alternatives to hospital admission and A&E attends; today's work today, including reviewing the use of SAFER, red to green bed days and discharge meetings; discharge to assess, including trusted assessors and a single dataset showing waits across the system. This represents a comprehensive work programme for the coming year.

Encouragingly, most of these recommendations were already incorporated in the Trust's Transforming Emergency Care Programme, but the ECIST recommendations will give them added impetus. Several major strategic or operational measures had already been taken, including most significantly:

- At the beginning of the year, front-of-house assessment services at UHND were re-organised to co-locate the ambulatory care and medical assessment units; the aim being to provide more effective support to the Emergency Department and to maximise the opportunities to assess and treat patients without the need to admit them to an in-patient bed.
- The Trust's escalation framework, the vehicle through which it manages surges in non-elective demand, has been completely revised. The on call rota has been modelled on the national Gold, Silver and Bronze format and is populated exclusively by the most senior managers in the Trust. In addition, the escalation framework itself is being strengthened with the inclusion of specifically "clinical" escalation processes and aligned with new national guidance.
- In December 2016, the Urgent Care Centre in Darlington was co-located with A&E at DMH. This will provide a GP-led alternative to A&E on the same site 24/7. Commissioners have postponed the tender exercise in respect of the other Urgent Care and Out-of-Hours services, which will continue to be provided by CDDFT for the next year.
- The Trust has agreed a set of actions with commissioners to achieve the original year-end trajectory. These are: undertake a *Perfect Month* in March; nurse navigators now in place at DMH A&E to stream and treat patients; GP treatment/streaming in UHND A&E to commence in February; medical teams deployed to A&E to ensure timely assessment; twice daily board rounds in place Mon-Fri in all Specialties, whilst at weekends the on-call teams review all new admissions and patients identified by the ward teams; discharge to assess pilots began at both UHND and DMH in December with an evaluation workshop planned for February 2017 with ECIST.

- The Trust received planning permission to extend the Emergency Department at UHND. Future steps will be considered by the Board.
- The Trust has opened its new Centre of Orthopaedic Excellence at Bishop Auckland Hospital (BAH). This aims to move as much elective Orthopaedic work from DMH and UHND as is practicable, sheltering it from non-elective pressures in order to reduce the number of cancelled operations and creating a high quality elective service at BAH.

For the longer term, draft Sustainability Transformation Plan (STP) proposals for strategic changes to A&E services across the region, including Durham, Darlington and Teesside, have been published by commissioners prior to a formal consultation which is planned during 2017-18. CDDFT is a member of two STPs; the North STP taking in UHND and the South STP including DMH.

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

⊖	Trust ambition not achieved but improvements made

What are they? PROMs measure quality from the patient perspective by using questionnaires. 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. They comprise of the patient being provided with two questionnaires (one before surgery - given at pre-assessment and one after surgery – usually after a minimum of 3 months)

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

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

Our aim
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. During 2016-17, the care group and provider have worked collaboratively to work to improve participation with the completion and compliance with questionnaire 1, that which is provided during the pre-operative assessment. Since the commencement of this work, which involved training and education in respect to the benefits and realisation of the significance of collecting PROMs data our monthly compliance has significantly improved. Due to the increased uptake in the participation rates for questionnaire 1 and having an identified clinical lead to review the specific outcome data at patient level it is anticipated that we will have greater understanding of our PROMs outcomes in summer 2017 as this is presented via NHS digital 18 months in arrears.

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 2015/16 County Durham & Darlington NHS Foundation Trust provided and/or sub-contracted 121 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 2016/17 is shown in Part 3 of this report.

The Trust Board receives an Integrated Board report at each Board meeting covering the four key Touchstones: best experience, best outcomes, best efficiency and best workforce and incorporating an integrated performance scorecard.

The Trust has also refined its Performance Management Framework to incorporate a monthly review of each Care Group's Risk Register. The framework involves a monthly review of each Care Group's objectives and performance on all the key metrics affecting the four Trust Touchstones; and a quarterly Executive-led Review.

The key performance risks facing the Trust and the outcomes of the Performance Reviews are reported monthly to the Executive team and to the Integrated Quality and Assurance sub-committee of the Board.

Participation in Clinical Audits and National Confidential Enquiries

During 2016/17 38 national clinical audits and 5 national confidential enquiries covered NHS services that County Durham & Darlington NHS Foundation Trust provides.

During 2016/17 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 2016/17 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 16 – Mar 17	% cases submitted
Women's and Children's Health				
Maternal, infant and newborn programme (MBRRACE-UK)* (Also known as Maternal, Newborn and Infant Clinical Outcome review Programme)	✓	✓	On-going	100%

Neonatal intensive and special care(NNAP) -	✓	✓	✓	100%
Paediatric Pneumonia (British Thoracic Society	✓	✓	Data collection completion date 30/04/2017	N/A
Paediatric intensive care (PICANet)	X			

*.

National Audit/ National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 16 – Mar 17	% cases submitted
Acute Care				
Adult Asthma (British Thoracic Society)	✓	✓	✓	100%
	✓	X		
Adult critical care (Case Mix Programme) –	✓	✓	On-going data collection. Final quarter to be submitted May 17	100% April – Dec 16
National emergency laparotomy audit (NELA)	✓	✓	On-going Data for Year 3 locked 27/1/17	*DMH 85% UHND 104.86%
Hip, knee ankle, shoulder elbow replacements (National Joint Registry)	✓	✓	On-going	??%
Major Trauma Audit (Trauma and Audit Research Network TARN)	✓	✓	On-going. Data still being collected	6th Dec 2016 UHND -53 61% DMH 92-100+%
Asthma (paediatric and adult) care in emergency departments) (Royal College of Emergency Medicine)	✓	✓	✓	**100.0%
Severe Sepsis and Septic Shock (care in emergency departments) (Royal College of Emergency Medicine)	✓	✓	✓	**100.0%

* Case ascertainment required is >80% of expected cases between 1/12/15 and 30/11/2016

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

National Audit/ National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 16 – Mar 17	% cases submitted
Long Term Conditions				
Chronic Obstructive Pulmonary Disease (COPD) Audit Programme Chronic Obstructive Pulmonary Disease Pulmonary Rehabilitation audit . Chronic Obstructive Pulmonary Disease Secondary Care Audit	✓ ✓	✓ ✓	Data submission 31/7/17 On-going data collection starts 1/2/17	N/A N/A
Diabetes (National Adult Diabetes Audit)	✓	✓	✓	100% of cases on System One and databases
Diabetes (RCPH National Paediatric Diabetes Audit)	✓	✓	✓	100% cases on database sent
National Pregnancy in	✓	✓	✓	100%

Diabetes (NPID)				
National Diabetes Footcare Audit (NDFA)	✓	✓	✓	*100%
Inflammatory Bowl Disease (IBD) Programme (IBD Registry) National Clinical Audit of Biological Therapies	✓	✓	✓	100%
Rheumatoid and early inflammatory arthritis	✓	✓	On-going	N/A
Renal replacement therapy (Renal Registry)	X			
Chronic Kidney Disease in Primary Care	X			
UK Cystic Fibrosis Registry	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 16 – Mar 17	% 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 16 – Mar 17	% cases submitted
Older People				
Falls and Fragility Fractures Audit Programme (FFFAP): Fracture Liaison Service Database (FLS-DB) Hip fracture (National Hip Fracture Database)	✓ ✓	✓ ✓	On-going ✓	N/A???? 100%
Sentinel Stroke National Audit Programme (SSNAP)	✓	✓	On-going	70-79% (C) case ascertainment reported for Apr-Jul 16/17
National Audit of Dementia Royal College of Psychiatrists	✓	✓	✓	**100%

National Audit/ National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 16 – Mar 17	% cases submitted
Heart				
Acute Coronary Syndrome or Acute Myocardial Infarction & other ACS (MINAP)	✓	✓	On-going	Data to be submitted 31/05/2017
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 0-01/06/2017
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	Limb amputation Submission deadline July 16 ?????
Pulmonary Hypertension Audit	X			

National Audit/ National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 16 – Mar 17	% cases submitted
Cancer				
Lung cancer (National Lung Cancer Audit)	✓	✓	*Now via COSD✓	100%
Bowel cancer (National Bowel Cancer Audit Programme)	✓	✓	**✓	100%
Oesophago-gastric cancer (National O-G Cancer Audit)	✓	✓	***✓	100%
Head and Neck Cancer (HANA)	✓	✓	Upload patients between 1/11/14-31/10/16	100%
Prostate cancer (National Prostate Cancer Audit)	✓	✓	On-going monthly data submissions	100%

* Data collection deadline in 2016/17 for patients covering period Jan – Dec 2015
** Data collection deadline in 2016/17 for patients covering period 1st Apr 2015 – 31st Mar 2016
*** Data collection deadline in 2016/17 for patients covering period 1st Apr 2015 – 31st Mar 2016

National Audit/ National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 16 – Mar 17	% cases submitted
Other				
Elective surgery (National PROMs Programme)	✓	✓	N/A	N/A
Learning Disability Mortality Review Programme (LeDeR Programme)	✓	✓	???	????
National Ophthalmology Audit (NOD)	✓	X	X	None
Endocrine and Thyroid National Audit BAETS	✓	✓	???	????
National Neurosurgery Audit Programme	X			
Nephrectomy Audit	X			
Percutaneous Nephrolithotomy	X			
Radical Prostatectomy Audit	X			

National Audit/ National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 16 – Mar 17	% cases submitted
Blood transfusion and Transplant				
Re-Audit of 2015 Patient Blood Management in adults undergoing elective, scheduled surgery (National Comparative Audit of Blood Transfusion)	✓	✓	✓	??% Data collection closes 23/1/2017
2016 Audit of Red Cell and Platelet Transfusion in Adult Haematology Patients (National Comparative Audit of Blood Transfusion)	✓	✓	✓	100%
National Confidential Enquiries – Medical and Surgical Clinical Outcome Review Programme				
Non Invasive Ventilation	✓	✓	✓	Report awaited from NCEPOD
Mental Health in General Hospitals Study	✓	✓	✓	Report awaited from NCEPOD
National Confidential Enquiries – Child Health Clinical Outcome Review Programme				
Chronic Neurodisability Study	✓	✓	On-going	N/A
Young Persons Mental Health Study	✓	✓	On-going	N/A
Cancer in Children, Teens and Young Adults	✓ Only the Organisational Audit	Only the Organisational Audit	N/A	N/A

- The reports of *?? national clinical audits were reviewed by the provider in 2016 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) 15/16, Adult Critical Care (Case Mix Programme - ICNARC CMP 15/16, National Heart Rhythm Management Audit 14/15 – Ablation, there was compliance with standards.

National Clinical Audits reviewed in 2016/17	Action
National Neonatal Audit Programme (NNAP) 2015	2016 Annual Report (2015 data gone to Dec SAGE meeting action plan to be drafted and signed off by FH Care Group.
National Paediatric Diabetes Audit 14/15	**High HBA1c patients on the increase:** 1 – Plan for the regional network guidance to be introduced after approval at CG safety committee 2 – Business case for extra staff (PA's, dietician and physiologist) being submitted 3 – TWINKLE training to improve data collection 4 – Extra clinics to see increased High HBA1c cases (after new guidance implemented) 5 – staff education programme to include information about findings 6 – Extra local audits (Blood Pressure, Albuminuria etc.) **Albuminuria Measurement:** A local audit will be done to understand the issue better. A discussion within the MDT as to whether the sample should be routinely taken in clinic instead. **Foot examination:** A list of current patients waiting will be sent to podiatrist and asked for all to be seen within six months.
Royal College of Emergency Medicine – Procedural Sedation 2015 (Darlington Memorial Hospital)	Implement Procedural Sedation Proforma for the Emergency Department Darlington Memorial Hospital.
Royal College of Emergency Medicine – Procedural Sedation 2015 (University Hospital of North Durham)	Refresh existing proforma for procedural sedation and publicise its existence. Ensure the proforma is easily accessible to staff.
Royal College of Emergency Medicine – Vital Signs in Children 2015 (Darlington Memorial Hospital).	Matron to inform nurses and junior doctors to improve the percentage of sets of vital signs recorded in the notes within 15 minutes of arrival or triage, whichever is earliest. Re-enforce with doctors to ensure that there is explicit evidence in the ED records that the abnormal vital signs have been recognised. Re-enforce with doctors to ensure that there is explicit evidence in the ED records that the abnormal vital signs (if present) were acted upon in all cases. Re-enforce with doctors to ensure that any children with any recorded abnormal vital signs should have a further set of vital signs recorded in the notes within 60 minutes of the first set (including CRT).
Royal College of Emergency Medicine – Vital Signs in Children 2015 (University Hospital of North Durham)	To explore with nursing staff ways to speed up the nursing triage. Memo to include in formal education of Junior Doctors the documentation of explicit evidence in the ED record that the clinician recognised the abnormal vital signs. Memo to include in formal education of Junior Doctors the documentation of evidence that the abnormal signs (if present) were acted upon in all cases. Memo to include in formal education of Junior Doctors

	(sick childrens session) that children with any recorded abnormal vital signs have a further complete set of vital signs recorded in the notes within 60 minutes of the first set (including CRT).
Royal College of Emergency Medicine – VTE risk in lower limb immobilisation 2015. (Darlington Memorial Hospital)	Make Trauma & Orthopaedics aware of the results Protocol is now in place to risk assess patients from outside the area with long bone fractures. .
Royal College of Emergency Medicine – VTE risk in lower limb immobilisation 2015. (University Hospital of Durham)	Communication of results to Orthopaedics Team.
National Diabetes Audit (Adult) 13/14 and 14/15 Combined Report	Structured education for Type 2 patients incorporated into the new diabetes model of care to be implemented. Diabetes Lead to meet with data entry clerks to agree a pathway to input the data from Isoft onto Systm 1
National Diabetes Inpatient Day Audit 2015 Bishop Auckland Hospital.	To raise the matter of average Dietitian/hrs/week at BAH with the Head of the Dietetics Service. To implement awareness ward training
National Diabetes Inpatient Day Audit 2015 Darlington Memorial Hospital.	To continue inpatient diabetes care education on a regular basis. To improve diabetes inpatient care among Junior Doctors and Nurses via education. To improve staff awareness through education.
National Diabetes Inpatient Day Audit 2015 University Hospital of North Durham.	Junior Doctors training delivered. Foot assessment in routine clinical care. On-going learning to be given to Junior Doctors re documentation of diabetic medication. E Training to be given to nurses with increased support from DSN's. DSN's to identify severe hypoglycaemic episodes via ePMA on a daily basis to prioritise.
National Pregnancy in Diabetes Audit 2015	
National Hip Fracture Database Audit 15/16	Maintain improvement in time to surgery through regular feedback to Consultant teams and bi-monthly reporting of outcomes. Add pain scores to 'eObs' and make it mandatory to complete and make ePMa available in Emergency Department. Audit compliance with administration of nerve blocks in Emergency Department and Pre-op. Continue to emphasise the importance to anaesthetic teams of considering intra-operative nerve blocks for all patients undergoing surgery and monitor compliance. Clearly record level of supervision provided for trainees and junior staff on the operation notes and audit compliance. Audit the number of hip fractures performed on non-trauma list. Audit current practice for the indication for Intramedullary

	(IM) femoral nails to ensure that best practice is being followed. Investigate a two person Orthogeriatic service on both sites with a job plan and flexibility to cover 5 days a week Re-introduce a weekly MDT meeting NB These actions still need to be signed off at a speciality and care group level
UK IBD Biologics Audit-2015 (Darlington Memorial Hospital)	All new patients who are being planned for Infliximab treatment will be started on Biosimilar treatment with Remsima. Existing patients on Remicade Inflixmab are not planned to be switched to Biosimilar until the Trust gets the IBD Registry tool. (Decision made at IBD Away Day by concurrence of all clinicians and Specialist Nurses). Reinforcement of the pre-screening guidelines at IBD MDT. Reinforcement of the guidelines to all clinicians and specialist nurses through IBD MDT. A mandatory review through the Virtual Biologics clinic at 3 months and 12 months will be implemented. The Trust to purchase an IBD Registry compliant system in asap to enable the IBD Biologics audit to continue following the transfer to the IBD Registry
UK IBD Biologics Audit-2015 (University Hospital of North Durham)	All new patients who are being planned for Infliximab treatment will be started on Biosimilar treatment with Remsima. Existing patients on Remicade Inflixmab are not planned to be switched to Biosimilar until the Trust gets the IBD Registry tool. (Decision made at IBD Away Day by concurrence of all clinicians and Specialist Nurses). Re-enforcement of the pre-screening guidelines at IBD MDT. Biologics clinic set up (Dec 2016) to reinforce the importance of appropriate indication screening and follow up of patients on biologics. The Trust to purchase an IBD Registry compliant system in asap to enable the IBD Biologics audit to continue following the transfer to the IBD Registry
National Emergency Laparotomy Audit (NELA) Dec 14-Nov 15 (Trustwide)	Develop elderly care model based on Orthopaedics Surgery. Increase recovery Nursing staffing to facilitate operating between 17.00 – 21.00pm. Increase the number of Level 1 Nursing beds in the wards. Governance Facilitators and/or Research Nurse to support data collection Governance Facilitators to keep prospective diary of all Laparotomies undertaken. NB. These actions still need to be signed off at a speciality (April) and care group level.

British Thoracic Society (BTS) National Paedaitric Asthma Audit 2015	Large information and display drive (posters, one to one information and ward meetings) to be discussed with ward managers. Improved documentation of WMP (written management plans) and use of our asthma care bundle to be audited real time during ward visits.
British Thoracic Society (BTS) National Emergency Oxygen Audit 2015	ePMA to be used for all oxygen prescribing across Trust. Paper prescribing already being phased out. Hyperlink to guidance on oxygen prescribing and saturation targets to be set up on ePMA. Guidance to be used and location to be determined in line with Medicines Policy. Report to be developed on oxygen prescribing rates for each ward to enable feedback on oxygen prescribing practice To investigate the changes to be made on ePMA re :additional fields for recording if he patient is already on Long Term Oxygen Therapy (LTOT)and so on. Meeting to be arranged to determine the feasibility of Nerve centre being used to flag up patients requiring an oxygen prescription on ePMA and adherence to the target saturation set from nursing e obs. Develop e training session for posting on the intranet. Training to be delivered to individual nurses in medicine and AMU. Training to be provided to ED nurses at ED educational sessions. Training now given to junior doctor intakes each year. NB. These actions still need to be signed off at care group level

Confidential Enquiries
County Durham and Darlington NHS Foundation Trust has participated/is still participating in 4 enquiries during the course of 2016/17. The Trust has submitted/is submitting either patient or organisational data for all studies which were deemed relevant

The reports of 20 local clinical audits were audits reviewed by provider in 2016/17 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 2016/17	Action
Post Caesarean Section analgesia audit.	Encourage all anaesthetists to follow the protocol and prescribe adequate pain relief. Adequate update at induction for trainees and locum. Obstetric anaesthetists at both Darlington Memorial Hospital and University Hospital of North Durham to discuss and agree a standardised post op pain relief through specific leads and in discussion with pharmacy. Regular post spinal observations as defined in the protocol and review of the current protocol to be discussed in the obstetrics risk forum meeting – with

	midwives.
Do theatre staff use facemasks in accordance with the manufacturers guidelines for use.	Dissemination of National and Regional results to increase awareness. Signs up around theatre. Introduction of theatre discipline document to be disseminated to staff
To assess the inclusion of bowel perforation as a complication/risk in Surgical Consent Form for Laparoscopic Procedures.	Revisit the importance of informed consent/presentation at MDT. Promote general awareness in team about legal consequences.
Yay or NAI? Getting it Right First Time: A Retrospective Audit of Skeletal Surveys for Non-Accidental Injury	Presentation to radiographers in department so they can try and minimise artefact as much as possible. Also looking into the introduction of lead protection to cover any hands required to hold body part of interest in place. Presentation to radiographers in department to educate/refresh knowledge on current guidelines and why it is so important to have separate exposures for each view. The development of a local network to aid double reporting of skeletal surveys by radiologists with paediatric speciality or specialist-interest.
The Outcome of "High Risk" Patients admitted to the ward following Emergency Laparotomy	Introduction of an emergency laparotomy proforma to include a section for documentation of treatment escalation plans.
Improving inhalation technique in patients with COPD.	E portfolio – The introduction of inhaler technique demonstration and patient education as *Directly Observed Procedural Skill (DOPS)* and a practical procedure (To improve the percentage of junior doctors demonstrating correct inhalation technique). FY1 teaching – Inhaler technique to be included in the clinical skills training for Junior Doctors joining the Trust. Discharge checklist - TTOs including inhalers prescribed on iSOFT will include a prompt reminding the discharging clinician to assess inhaler technique also to prompt the patients GP to arrange an annual review after discharge.
Audit of effectiveness of Medical Ward Round Sheet in improving patient documentation	Implement Ward Round proformas on all medical wards across the Trust.
Outcome of Nidex Scan Biometry in Cataract Surgery.	Doctors and nurses to emphasize to patients to get post op refraction done.
Record Keeping Audit – Plastic Surgery.	Encourage all medical staff to routinely record GMC number. Encourage all medical staff to routinely record grade an name of person documenting.
Re-audit of urgent Dermatology surgical list	If second non urgent procedure is required on a patient then to relist the patient for an alternative day. All doctors to preferably arrange excision of the lesion or refer straight to plastic surgeons rather than arrange diagnostic biopsy. Alternatively arrange diagnostic biopsy and refer to

	plastics the same day.
Audit of new neck of femur clerking proforma	Moving sections of Osteoporosis assessment, FRAX score and NOGG recommendation under Ortho-geriatric review. Junior Doctors to be trained to calculate Nottingham Hip Score for identifying 30 day mortality. As part of the falls assessment the Pharmacist should review each patient's medication.
Unplanned admissions for foot and ankle day case surgery	Liaise with physiotherapist to discuss arrangements when discharging patients with block. Patient information leaflet on discharge instructions when going home with block. Ankle block tutorial at the Departmental meeting Day case anaesthesia protocol for foot surgery.
An audit of delay in surgical treatment of hip fracture patients due to inadequate treatment of high INR	Education of emergency department and surgical staff on current guidelines for dose and route of vitamin K
Assessment Of adequate exposure And Gonadal Protection in paediatric hip X-ray performed in County Durham and Darlington Foundation Trust.	Implement new guidelines for paediatric hip X-ray.
Swallowed or inhaled? A retrospective audit of inhaled or ingested foreign bodies in County Durham and Darlington Foundation Trust	Introduce a new unifying protocol.
The assessment and management of Acute Peri-Anal Abscess	Introduce an abscess pathway.
Audit of the use of a Pilot Clerking Pro Forma Incorporating The Comprehensive Geriatric Assessment (CGA) at a District General Hospital (UHND)	New document to be formulated in conjunction with the MDT (particularly AHPs). New document to be formulated in conjunction with the elderly care teams. CGA document to be trialled as a referral pathway on non-elderly care wards.
Medical Admissions: The Weigh In	Poster designed to raise the awareness of the need to weigh patients within 24 hours of admission to hospital.
Audit into the quality Of Acute Surgical Clerking's at UHND	Education of new F1 doctors at departmental induction; emphasise the need to ensure clerking's complete. Ensure middle grade doctors support and facilitate this.
Audit of the basic standards and additional recommendations for contact dermatitis as per The British Contact Dermatitis Society.	A vulval battery to be created for suspected vulval dermatitis. To inform staff referring patients for patch test to tell patients to bring the personal products which could have caused the reaction.

Research & Development
The number of patients receiving NHS services provided or sub-contracted by County Durham & Darlington NHS Foundation Trust in 2016/17 that were recruited to participate in research approved by a Research Ethics Committee was 5,593 this is the complexity adjusted figure as at 31/03/2017. Actual recruitment of 959 patients is marginally down on previous years not only locally but regionally and nationally reflecting a shift to the delivery of more complex studies reflecting the increase in the complexity adjusted figure. 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 2016/17 include:

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

During 2017 -2018 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 have increased the number of Principal Investigators across all specialties and disciplines in 2016/17 to 90, 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. In 2017/18 we hope to increase the number of Chief Investigators increasing the number of Investigator led studies within CDDFT developing further integration between primary and secondary care using Innovation.

Information on the use of CQUIN framework

A portion (2.5%) of the Trust's income in 2016/17 is conditional upon achieving quality improvement and innovation goals in areas specified by national guidance but with opportunities for locally agreed variations.

In view of the need to transform local health services by moving care closer to home, commissioners and the Trust used the opportunity to negotiate local variations by focussing some of the CQUIN monies on three transformation projects: in diabetes, paediatrics and financial recovery.

The agreed goals for 2016/17 are:

National CQUIN	
Theme	Aim
Staff Well-being: Healthy activities	Introduce staff health and wellbeing initiatives covering physical activity, mental health and improving access to physiotherapy for people with musculo-skeletal issues.
Healthy food for patients, staff and visitors	Ban price promotions, advertisements and check-out displays for sugary drinks and foods high in fat, sugar and salt; and ensure healthy eating options are available at any point including for those staff working night shifts.
Staff 'Flu vaccinations	Increase the proportion of staff having a 'flu vaccination.
Sepsis	Improve the identification and treatment of patients with sepsis.
Antimicrobial resistance	Improve the review of antibiotic usage and reduce antibiotic consumption
CQUINs agreed with local Clinical Commissioning Groups	
Diabetes Transformation	Joint CDDFT-Commissioner project to move diabetes care from Secondary into Primary Care.
Paediatric Transformation	Joint CDDFT-Commissioner project to move paediatric care from Secondary into Primary Care.
Financial Recovery	Joint CDDFT-Commissioner project to transform services and to maximise service quality within the existing funding envelope.
Dementia Strategy	Improve the care provided to patients with dementia including a dementia-friendly hospital environment
CQUINs agreed with Specialist Commissioner	
Delayed Discharges from Intensive Care	Reduce the number of patients whose transfer out of ITU is delayed for non-clinical reasons.
Chemotherapy Dose Banding standardisation.	Increase the use of standard doses of chemotherapy
Public Health and Youth Justice CQUINs	
Diabetic eye screening:	Increase uptake of diabetic eye screening for young people aged 18 – 45 years
Dental Dashboard	Provide robust information
Dental Managed Clinical	Develop a Managed Clinical Network for dental services

Network	
Improved care for residents at Aycliffe Young People's Centre:	Ensure robust health screening and care planning.

CDDFT has achieved all the CQUIN standards in Quarters 1 and 2. Evidence for the achievement of Quarter 3 standards has been submitted to commissioners and although it has not been evaluated the Trust does not anticipate any difficulties. However, some of the Quarter 4 targets are extremely challenging.

CQUIN funding:
2014/15 £10,036,221
2015/16 £9,623,218 (Month 12 flex)
To update

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 – The Trust made an application to the Care Quality Commission to remove this regulated activity from Dr Piper House. This is due to the relocation of the Urgent Care Centre to Darlington Memorial Hospital. All other regulated activity at Dr Piper House remains the same.

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.

Care Quality Commission Ratings
The Trust is rated 'Requires Improvement' following the CQC's last full inspection of the Trust, carried out in February 2015 and reported in September 2015. This was a comprehensive inspection, covering Darlington Memorial Hospital and University Hospital North Durham and the Trust's Community Services. Some 110 judgments were made, with 88 of these being rated as good.

Overall ratings by Domain are set out below:

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

Ratings grids for each Hospital / Community Services are:

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 and Progress

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. Delivery of the plan has been overseen by the Executive and Clinical Leadership Committee, scrutinised by the Board's Integrated Quality and Assurance Committee and reported to public meetings of the Trust Board.

All of the actions have been implemented, although further monitoring continues with respect to a small number of actions, to ensure that changes are embedded and the actions lead to the desired improvements.

The three services rated as 'Requires Improvement' were:

- Urgent and Emergency Care (DMH and UHND);
- End of Life Care (DMH and UHND); and
- Medicine (UHND).

Key improvements implemented are noted below. There remain some challenges, associated with national and regional staff shortages; these are also noted in the commentary below.

Urgent and Emergency Care	A new, strengthened leadership team is place, and the Trust has been able to increase specialist Paediatric nursing cover on both sites, and consultant staffing numbers at UHND. The Trust has worked with NHS Improvement's Emergency Care Improvement Team, and with partners in the local health economy, to bring about improvements in the responsiveness of its Emergency Care services and has put in place the infrastructure to sustain these for the long-term. Twenty-four hour, seven day cleaning services were introduced in both departments shortly after the inspection and infection control and stock control have been repeatedly reinforced through the nursing walk-rounds and mock inspections noted above. Challenges remain because of regional and national shortages of A&E consultants and specialist nurses, as well as the limitations of the physical size and layout of both departments. ECL has reviewed, in detail, the arrangements in place to safely staff and manage medical staffing and Paediatric Nursing rotas for both departments and plans are in place to extend and improve both Departments in future years.
End of Life Care	Clinical and service leadership for End of Life Care has been reviewed and strengthened. A regional strategy and steering group are now in place. The steering group now regularly receives information on the quality and effectiveness of End of Life care and commissioners have put in place arrangements for out of hours support. Medical staffing for End of Life Care has also been increased and now allows all teams to be supported by a consultant. We have not, however, been able to increase consultant numbers in line with recommended standards because of the national shortage of such consultants. Several recruitment campaigns have been run, with the support of our commissioners, but these have struggled to secure appointments.
Medicine	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. The Trust has overhauled its policies and procedures, which are now in line with the British Thoracic Society Guidelines, and harmonised equipment and practice across both sites. All staff involved in initiating or administrating NIV are subject to competency assessments, which have been completed and updated since the last inspection and protocols are in place to ring-fence beds, cohort patients, and maintain safe staffing levels. The newly implemented Acute Intervention Team provides further support for patients at risk of deterioration. Audits of the outcomes of NIV care have been completed showing the Trust to be in line with national comparators. A second theme was care planning and patient records. Records are now audited every month on every ward and care planning has been the subject to extensive training and coaching with staff. This work continues.

Additional visits during 2016/17

The safety and leadership of the Trust's Maternity Services were the subject of a specific CQC inspection carried out in September 2017. The report on this inspection concluded that, overall, services were safe and well led. However, actions were required to embed improvements in clinical governance, embed initiatives in place to strengthen teamwork within

clinical teams and comply with the WHO checklist. These actions have, alongside actions from other external reviews, formed part of a comprehensive action plan monitored both within the Maternity Service and through the Board's Integrated Quality and Assurance Committee.

During April 2017, CQC published the report of safeguarding children and services for looked after children following the review of health services in the geographical area of Durham in November 2016.This review was carried out under section 48 of the Health & Social Care Act 2008, following an agreed methodology which is set out on their website here.

There are no specific judgements on performance within this methodology, but the report provides a narrative account of the quality of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children. It is important to note that there were no special notices applied to the organisation. However, they have made recommendations to support improvements to the service. There are also some recommendations that sit jointly with other organisations however, these have been reflected in the overall action plan but where there is specific local level aspects these have been highlighted in the action plan.

Recommendations

- Put in place facilities and arrangements at the emergency department to ensure effective observation of children waiting for treatment and the prompt identification of the deteriorating child
- Ensure the provision of at least one paediatric trained nurse on duty at all times in the emergency department in line with RCPCH and CQC requirements
- Ensure that children and young people's safeguarding risk assessment is well informed, comprehensive and rigorous, prompts professional curiosity, captures the voice of the child and is subject to robust quality assurance and governance arrangements at an operational level
- Ensure that risk assessment documentation in use in the urgent care centres and emergency department promotes the consideration of risks to children as a result of hidden harm
- Ensure that paediatric ward staff complete discharge documentation fully to facilitate effective discharge
- Ensure information set out in notifications of attendances at the ED to primary care and the public health 0-19 service is sufficient to support optimum decision making about clinical and safeguarding follow-up
- Include an overall risk evaluation of information gathered on the home environment assessment with guidance to practitioners on the appropriate next steps resulting from the analysis
- Ensure that case recording in midwifery includes routine analysis of casework and evaluation of risk to facilitate effective progress tracking and monitoring of cases where children are known to have vulnerabilities
- Ensure that practitioners' use of the body mapping template at the urgent care centre is well supported by comprehensive guidance to promote consistency of practice
- Ensure a robust approach to identifying and responding to young people at risk of sexual exploitation is in place in the urgent care centres
- Ensure that where children and young people have been admitted to the paediatric ward through serious self-harm, individual risk assessment and risk management plans are put in place in order that environmental and personal safety/peer safety risks are fully considered and addressed
- Put effective operational governance arrangements in place to ensure that practitioners are systematic in their assessments, recordings, articulation of risks and in stating expected outcomes when making referrals into children's social care
- Make effective use of child sexual exploitation risk assessment tools to identify children and young people who may be at risk of exploitation
- Ensure that practitioners in the emergency department and the urgent care centre

have a good understanding of the raised vulnerability of looked-after children, that appropriate consent to treatment is obtained and appropriate notification of the child's attendance is made to facilitate robust follow-up
- Ensure community midwifery caseloads are brought within the guidelines of the Nursing and Midwifery Council
- Ensure robust frontline safeguarding governance arrangements are in place in services providing emergency treatment in order that safeguarding concerns are appropriately identified and acted upon
- Ensure that mechanisms for evaluating improvements in practice arising from formal briefings, specific training or procedural developments as a result of serious case reviews are embedded
- Ensure that clinical and non-clinical staff in services providing emergency treatment are well supported through robust safeguarding supervision arrangements in line with trust policy
- Include consideration of the young people' presentation and demeanour as part of the standard assessment in the sexual health service.
- Ensure that practitioners hear and record the Voice of The Child when undertaking initial and review health assessments, quoting the child whenever possible in order that the child's voice fully informs the assessment and health plan
- Ensure that practitioners undertaking initial and review health assessments of unaccompanied asylum seeking young people have received training on the asylum seeking experience
- Work with Durham County Council to further develop the use of strengths and difficulties questionnaires and sharing of information to best inform the health assessments and health planning for looked-after children and young people
- Ensure that quality assurance for health assessments and the resultant health plans for looked-after children is undertaken in the relevant frontline services and that arrangements are effective in driving up quality and consistency
- Ensure that young people who are looked after are engaged in co-producing the provision of health passports for care leavers; that the final health reviews of care leavers are comprehensive, aligned with the statutory review and subject to effective quality assurance

Next steps
An action plan has been developed to address the key issues from the report and will be monitored through the Safeguarding Group and Executive Clinical Leadership.

CQC Re-inspection
Given the time lapse since the comprehensive inspection undertaken in February 2015, the Trust expects to be re-inspected early in 2017/18. The Trust continues to work to implement the outstanding actions from the most recent reviews, and to address the challenges noted in the commentary above, in order to maximise the potential for a "Good" rating when it is re-inspected.

Data Quality

Indicator	Target	2016-17 Quarters 1-4
Data completeness community services - RTT*	50%	100.0%
Data completeness community services - Referrals*	50%	99.7%
Data completeness community services - Treatment activity*	50%	99.7%
% of SUS data altered*	10%	39.4%

Valid NHS number field submitted via SUS - Acute	99%	99.7%
Valid NHS number field submitted via SUS - A&E	95%	98.7%

County Durham & Darlington NHS Foundation Trust submitted records during 2016/17 to the Secondary Uses services for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

** Please note the latest available report for the following is M5 **

- which included the patients valid NHS number was:
  - 99.5% for Admitted Patient Care
  - 99.7% for Outpatient Care
  - 98.6% for Accident and Emergency Care
- which included the patient's valid General Medical Practice Code was:
  - 100% for Admitted Patient Care
  - 100% for Outpatient Care
  - 99.9% for Accident and Emergency Care
  - (Note: 100% shown from SUS DQ, but will still include negligible invalid numbers)

County Durham & Darlington NHS Foundation Trust Information Governance Assessment Report overall score for 2016/17 was 93% green and Satisfactory

County Durham & Darlington NHS Foundation Trust was not subject to the Payment By Results clinical coding audit during 2016/17 by the Audit Commission, however, internal audit carried out by our accredited audit yielded the following accuracy scores:-

- 99.0% Correct for Primary Diagnosis
- 97.4% Correct for Secondary Diagnosis
- 98.4% Correct for Primary Procedure
- 98.2% Correct for Secondary Procedure

The results should not be extrapolated further than the actual sample audited. The specified areas do not constitute a representative sample of overall Trust performance but are an indication of sound controls and processes. The programme included data testing of a random sample of episodes as there were no specific areas to be addressed or highlighted by commissioner input. These are well above national expectations.

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

- Communications and feedback process with the A&E department in relation to the accuracy of data recording on the Symphony system.
- 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 of coding.

PART 3 ADDITIONAL INFORMATION

Financial Review

The period 2015/16 was a challenging year. The trust is reporting an overall outturn deficit of £56.481m for 2015/16 which compromises of £14.472m operational deficit (Which is £234k ahead of the 2015/16 monitor plan expectation) and £42.009m with regard to Impairment resulting from revaluation of Land and Buildings**. TO UPDATE**

Performance Framework

The Trust's operational scorecard is built upon the Four Touchstones. Detailed information for most indicators is available till the end of December.

Patient Experience	Target	Quarters 1-3
RTT - % Incompletes waiting <18wks	92%	93.27%
RTT waits over 52 weeks	0	0
A&E % seen in 4hrs - Trust Total	95.0%	93.6%
A&E % seen in 4hrs - All UCC 'Walk-ins' Type 3	95%	100.0%
Ambulance handovers >15-30mins	0	4531
Ambulance handovers >30-60mins	0	1213
Ambulance handovers >60mins	0	551
12 Hour Trolley Waits	0	5
% Diagnostic Tests >=6wks	99%	99.85%
Cancer 2WW*	93%	93.1%
Cancer 2WW Breast Symptoms*	93%	91.6%
Cancer 31 Days Diagnosis to Treatment*	96%	99.6%
Cancer 31 Days Subsequent Treatment - Surgery*	94%	98.9%
Cancer 31 Days Subsequent Treatment - Anti Cancer Drug*	98%	100.0%
Cancer 62 Days to First Treatment*	85%	85.1%
Cancer 62 Days Screening*	90%	75.3%
Cancer 62 Days Consultant Upgrade*	85%	100.0%
Patient Satisfaction (National Survey)		
A&E % Seen in 4hrs - DMH	95%	87.7%
A&E % Seen in 4hrs - UHND	95%	84.9%
A&E CI - Unplanned Re-attendance rate	<=5%	0.8%
A&E CI - Time to treatment (median)	<=01:00	00:36
Ambulance Handovers - no. >120 minutes	0	67
Maternity 12 week bookings	90%	90.3%
Stroke - 90% of time on a stroke unit*	90%	87.2%
Stroke - CT scan within 24 hours*	90%	96.3%
Sleeping accommodation - failure to agree EMSA (mixed sex accommodation) plan	0	0
Sleeping accommodation - breach of an EMSA (mixed sex accommodation) milestone	0	0
Sleeping Accommodation Breach	0	2
Choose and Book ASI % of DBS Bookings **	4%	19.5%
Cancelled Operations - Breaches of 28 Days	0	4
Urgent Operations cancelled for 2nd time	0	0
Community nursing - urgent and OOH referral waiting times* (72 hr target)	93%	91.5%
Community nursing - non-urgent referral waiting times* (72 hr target)	62%	60.1%
Outcome	Target	Quarters 1-3

Clostridium difficile cases	19	14
MRSA Bacteraemia	0	3
MSSA		19
E-coli		282
VTE*	95%	96.8%
Failure to publish formulary	Compliance	
Duty of candour	Compliance	
Never events*	0	7
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)**		11496
Serious Incidents Interim reports within 72 hours *		99%
SUIs reported via STEIS as a proportion of all incidents involving severe injury or death within a Trust*		68
Serious Incident RCAs submitted within 60 working days** +		
Ambulance Handovers - Trust Use of Screens %	>=95%	89.32%
Delayed transfers of care*	3.5%	0.11%
6 hour wait in Urgent Care Centres	95%	99.8%
Efficiency	Target	Quarters 1-3
Data completeness community services - RTT*	50%	100.0%
Data completeness community services - Referrals*	50%	99.7%
Data completeness community services - Treatment activity*	50%	99.7%
% of SUS data altered*	10%	34.70%
Discharge summaries within 24 hours	95%	93.30%
Valid NHS number field submitted via SUS - Acute	99%	99.7%
Valid NHS number field submitted via SUS - A&E	95%	98.6%
Workforce	Target	Quarters 1-3
Trust Effective Shortfall	<5%	7.0%
Consultant Shortfall	<5%	9.5%
Voluntary Turnover	<7.5%	9.4%
Essential Training	80.0%	79.7%
Overall Appraisal Rate	80.0%	42.8%
Total Agency Spend	Reduce	£12,131,181.0
Sickness	<3.5%	5.0%
Bank Spend	Increase	£6,304,749.0
Bank Spend as % of Total Pay		3.3%

*Month: December 2016 * One month in arrears ** Two months in arrears*

What our Regulator says

The NHS Improvement Agency (NHSI – formerly Monitor), the independent regulator of Foundation Trusts (FT), requires each Foundation Trust to submit an Annual Plan and quarterly performance reports during the year.

During 2016-17, the main reported performance risks are:

- the 4-hour waiting time and associated A&E targets
- 62-day Cancer Screening, which is always a risk because of the very low number of patients using this pathway

- 62-day Cancer Treatment, where rising referrals, new guidance and complex pathways of care involving more than one provider mean the standard has proved increasingly challenging.
- 2 week Cancer breast symptomatic where the Trust has continued to experience high levels of demand because of the absence of a comprehensive service in Sunderland.
- C.Diff, because the CDDFT target is extremely challenging due to excellent Trust performance in 2014/15.

Performance Risks

Non-elective pressures

The Trust's main operational and performance risk remains high levels of 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. Although CDDFT has not experienced the dramatic growth in emergency admissions and A&E attendances reported for some Trusts in the national media, modest but consistent growth, particularly at the Trust's busiest site, UHND, continues to put pressure on all services.

Multi-agency investments in Primary, community and social care services may take some credit for helping to arrest the rise of medical admissions which have fallen 2% year-on-year (Apr-Dec). However, this is entirely due to a 4.4% fall in admissions at UHND. DMH has seen growth of 2%.

This performance should be seen in the following context:

- Modest growth in A&E attendances continues. Between April-December 2016, total attendances rose 2.1% compared to the same period in 2015. UHND attendances grew by 3.3%; those at DMH by 0.8%. During the same period, ambulance arrivals fell by 0.9%, due to a fall of 2.9% at DMH; although UHND arrivals increased by 0.5%. Most ambulance arrivals are brought by NEAS but DMH also attracts some ambulance patients from North Yorkshire, brought by the Yorkshire Ambulance Service.
- Between Apr – Dec 2016, 1% more patients were admitted via A&E than during the same period in 2015 (0.4% at DMH and 1.6% at UHND).
- As part of an in-year regional agreement to minimise ambulance handover delays, and as recommended by North East Vanguard as beneficial to patients and the Ambulance service, CDDFT supported the in-year adoption of a "no tolerance" approach to non-clinical diverts. Although this has undoubtedly brought benefits to patients and the ambulance service, and has reduced the number of non-clinical diverts between sites it has restricted the ability of the two CDDFT acute sites to help each other when under pressure.
- Commissioners have recognised that CDDFT have a lower bed base than any other North East Trust. This base has contracted further than anticipated this year because of the closure of 16 beds at Shotley Bridge Community Hospital as a result of safety concerns raised by NHS Property Services. Closures due to staffing issues have also affected Weardale and Cheter-le-Street Community Hospitals.
- Although non-elective activity has been relatively stable, pressures have been distributed unevenly between the two acute sites.

Trust-wide Admissions	Apr-Dec 2015-16	Apr-Dec 2016-17	% variance
All non-electives	**50779**	51245	0.9%
Paediatrics / neonates	6800	7620	12.1%
Gynaecology	1940	1883	-2.9%
Surgery (excluding Trauma)	6476	6989	7.9%
Trauma (excluding Paediatrics)	1941	1956	0.8%
Medicine	26412	25886	-2.0%

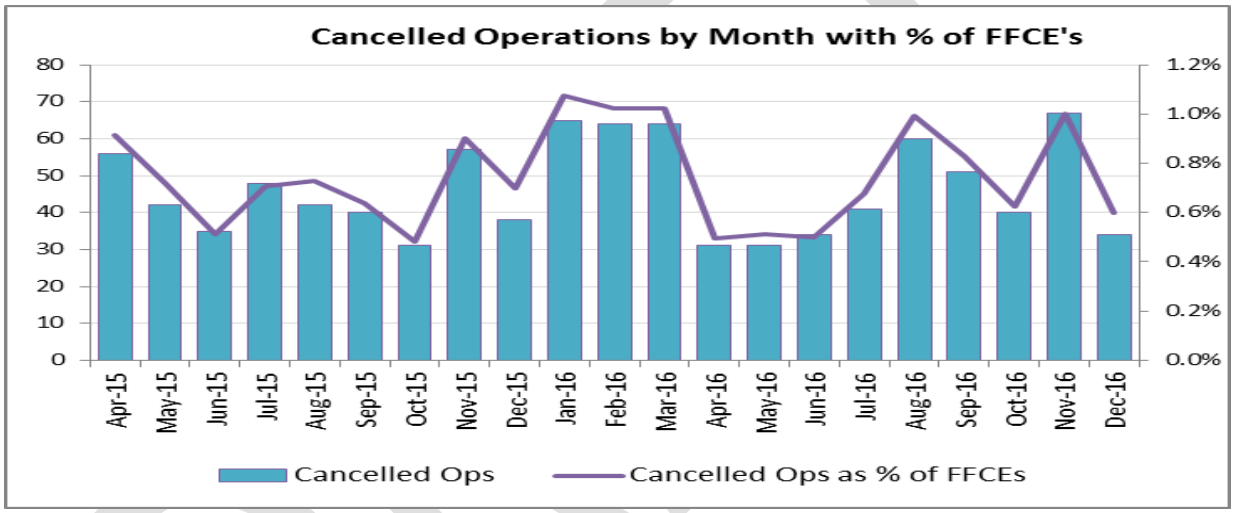
Commissioners have acknowledged that bed capacity is particularly tight at UHND but this site has been disproportionately affected by non-elective pressures in Q3 when the strain on the Emergency Department has been greatest. For example:

- *All Specialty* non-elective admissions rose by 1.3%, including increases of 24.4% in Surgery and 26.6% in Trauma.
- Admissions via A&E rose by 5.7%.

Elective pressures

Whilst not reported to NHSI as a formal performance risk elective referral growth continued in the early part of the year, but new CCG referral management arrangements in Q3 have contributed to a net fall of 0.5% in year-to-date GP referrals. Nevertheless, for the moment the elective waiting list backlog remains at historically high levels, and this year the trend towards more day case activity and fewer elective in-patient admissions has stalled. Elective in-patient activity during Apr-Dec grew by 2.1% whilst day case activity fell by 0.5%. These trends, coming in addition to non-elective pressures, exert a strain on acute in-patient bed capacity.

In spite of this, the Trust continues to achieve the 18 week Referral to Treatment standard and cancelled operations are running at similar levels to the previous year.



Demand and capacity plans are considered every week in the Referral to Treatment (RTT) Assurance Group. Operational Plans incorporating demand and capacity analyses are being finalised. The use of the independent sector (IS) has continued to be vital to achieving access targets, particularly for General Surgery, Orthopaedics, Dermatology and endoscopy, but it is hoped that as the Bishop Auckland Orthopaedic Centre becomes fully operational the need to outsource orthopaedics to the independent sector will decline; whilst dependence on the IS for endoscopy has already declined.

Historically, CDDFT has contracted with an independent provider, Alliance, for MRI scanning at DMH. From 1st April 2017, the Trust will provide an in-house service. This will allow for greater control and for a more flexible service.

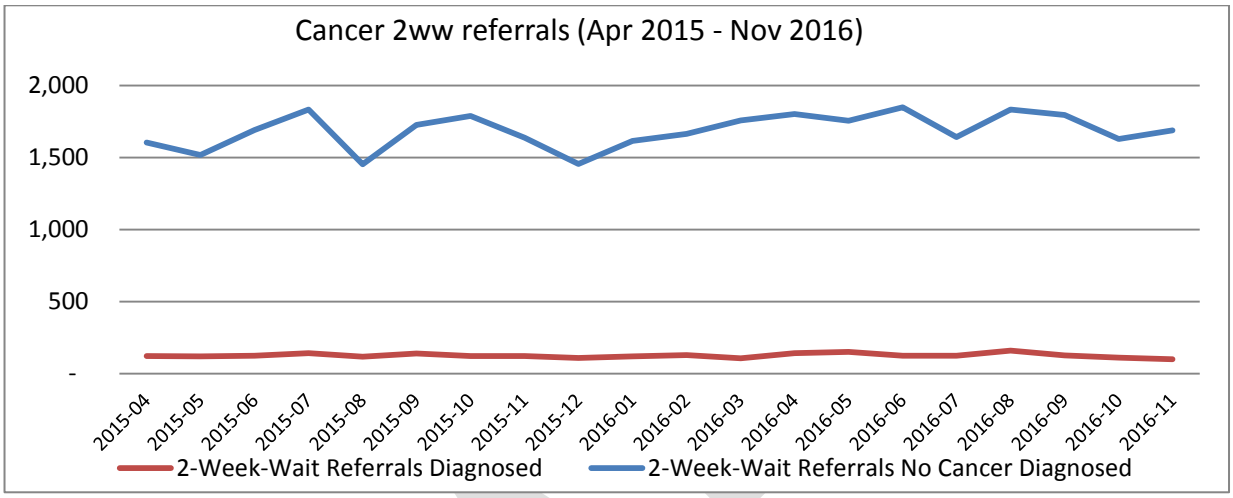
Cancer

The main cancer targets are for 2ww, 31 days and 62 days. The targets at risk are the 2ww breast symptomatic, and the two 62-day targets. The 31-day target is not normally problematic because the entire pathway is under the control of the Trust.

	Target	Year to date
Cancer 2WW	93%	93.1%
Cancer 2WW Breast Symptoms	93%	91.6%
Cancer 31 Days Diagnosis to Treatment	96%	99.6%

Cancer 31 Days Subsequent Treatment - Surgery	94%	98.9%
Cancer 31 Days Subsequent Treatment - Anti Cancer Drug	98%	100%
Cancer 62 Days to First Treatment	85%	85.1%
Cancer 62 Days Screening	90%	75.3%

The number of 2-week wait (2ww) referrals continued to grow. Between April-November 2016, 5.6% more were received than during the same period in 2015, of which 3.1% more resulted in a cancer diagnosis.



Breast symptomatic 2ww referrals pose a particular challenge. GP referrals continue at historically high levels due to the continuing absence of a comprehensive service in Sunderland. The Trust is in discussion with the regional Screening Centres, Gateshead and North Tees, regarding possible hub and spoke arrangements but the situation may only be resolved as part of the eventual STP agreement. In the year to the end of November, performance is 91.6% against a standard of 93%.

In relation to the 62-day standards, the screening standard is always a risk because of the very limited number of patients using the pathway. The more significant standard is the 62-day treatment standard, in relation to which the Trust has agreed an NHSI trajectory as part of STF funding arrangements.

Monitor Trajectory	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
National Standard	85%	85%	85%	85%	85%	85%	85%	85%
Monitor Trajectory	83.4%	83.9%	85.2%	85.7%	83.8%	85.3%	85.6%	85.7%
Performance	85.63%	84.51%	86.21%	86.21%	88.46%	86.18%	83.25%	80.77%

Until October, the Trust had achieved either national standard or the NHSI trajectory, or both. In October and November the Trust fell short of both, with the result that performance for Q3 as a whole is at risk. The Trust will be required to submit an explanation to NHSI together with assurance that it has put in place measures to bring performance back on track by the year-end. A range of actions are in place, including:

- Daily report on all patients with 21 days or less before breach date.
- Daily report to diagnostics on all patients at potential risk of a breach
- Redesigned pathways in some Specialties
- Increased theatre capacity devoted to pressurised Specialties.

Other key performance risks:

- **Staffing**: in common with many Trusts, CDDFT continues to rely heavily on locum and Agency staff in some Specialties to fulfil both nursing and medical roles. Efforts to secure key staff from abroad are being made. The region-wide STP process will have a crucial role in creating sustainable services region-wide.
- **Health Care Infections**. the Trust has had three cases of MRSA to the end of Q3 against a target of 0, but it remains within the de-minimis level beneath which it is not classed by NHSI as a performance breach. During the same period it has had 14 cases of *Clostridium difficile* compared to a year-to-date target of 15 and an end-of-year target target of 19. This is an improvement on 2015-16.

Priorities for 2017/2018

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

YEAR	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17 (provisional)
Readmission within 28 days of discharge[1]							
CDDFT Age 0-15 years	10.44	10.32		11.2	11.8	11.3	12.49
National high	14.11	14.94				17.13	16.28
National low	0	0				0	0
CDDFT Age 16 + years	11.97	12.1		11.2	11.8	7.55	7.45
National high	14.06	13.8				18.32	22.58
National low	0	0				0	0
CDDFT MRSA per 100,000 bed days[3]	1.4	1.1	0.9	0.6	1.8	0.7	
North East	2	2	1	1	0.95	0.8	
England	3	2	1	1			
National high	9	9	10	11	3.16	6.45	
National low	0	0	0	0	0	0	
CDDFT - Post 72 hour cases of Clostridium difficile per 100,000 bed days (aged 2 years and over)[3]		24.5	16.5	20.3	8.4	7.4	
England		29.7	22.2	17.3	14.7		
National high		71.2	58.2	30.8	37.1	58.11	
National low		0	0	0	0	0	
Patient Reported Outcome measures (PROM) – case mix adjusted health gain[1]	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16 (provisional)	2016/17
CDDFT PROM Groin Hernia	0.10	0.12	0.10	0.10	0.06	0.08	
England	0.08	0.09	0.09	0.09	0.08	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		
CDDFT 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				
CDDFT PROM Hip Replacement				0.45	0.44		
England				0.44	0.44	0.45	
National high				0.54	0.54		
National low				0.32	0.31		
CDDFT PROM Hip Revision				NA	NA		
England				0.27	0.28	0.29	
National high				0.35	0.37		
National low				0.17	0.16		
CDDFT PROM Knee	0.32	0.29	0.30				
England	0.30	0.30	0.30				
National high	0.37	0.38	0.37				
National low	0.17	0.20	0.18				
CDDFT PROM Knee Replacement				0.31	0.30	0.37	
England				0.32	0.32	0.34	
National high				0.42	0.43		
National low				0.21	0.22		
CDDFT PROM Knee Revision				NA	NA		
England				0.25	0.26	0.29	
National high				0.37	0.32		
National low				0.20	0.12		

	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17 (Provisional)
CDDFT VTE assessment Trust				**95.10%**	**95.65%**	**95.99%**	**96.83%**
National Low				**82.10%**	**92.00%**	**79.93%**	**76.68%**
National High				**100.00%**	**100.00%**	**99.76%**	**99.88%**

YEAR	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
CDDFT Responsiveness to personal needs of the patient[1]	71.8	71.5	67.9	68.5	73.3	65.3	68.8
England	66.7	67.3	67.4	68.1	68.7	68.9	69.6
National high	81.9	82.6	85	84.4	84.2	86.1	86.2
National low	58.3	56.7	56.5	57.4	54.4	59.1	58.9

YEAR	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
CDDFT Percentage of staff who would recommend the trust to their family or friends[1]	56%	49%	50%	57%	53%	57%	57%
England						68%	70%

National high			94%	94%	93%	92%	91%
National low			35%	40%	35%	31%	43%

	Reporting Period	Highest	Lowest	CDDFT Trust	Peer	Comments
SHMI[5]	Jan 12 - Dec 12	119.2	70.3	104.1	102.2	
	Apr 12 - Mar 13	117.0	65.2	104.5	101.9	
	Jul 12 - Jun 13	115.6	62.6	104.3	101.9	
	Octr 12 - Sep13	118.6	63.0	103.8	101.1	
	Jan - Dec 13	117.6	62.4	102.4	100.8	
	Ap 13 - Mar 14	119.7	53.9	101.9	100.9	
	Jul 13 - Jun 14	119.8	54.1	102.5	101.0	
	Oct 13 - Sep 14	119.8	59.7	103.1	101.3	
	Jan – Dec 14	124.3	65.5	100.9		Peer was via CHKS
	Apr 14 – Mar 15	121.0	67.0	101.0		Peer was via CHKS
	Jul 14 – Jun 15	120.9	66.1	100.7		Peer was via CHKS
	Oct14 – Sep 15	117.7	65.2	99.6		Peer was via CHKS
	Jan 15 - Dec 15	117.3	66.9	102.3	102.1	
	Apr 15 - Mar 16	117.8	67.8	103.2	103.7	
	Jul 15 - Jun 16	117.1	69.4	104.7	103.2	
	Oct 15 - Sep 16	116.4	69.0	106.7	103.1	
The banding of the summary hospital-level indicator	Apr 12 - Mar 13			2 (As Expected)		7 Trusts higher than expected
	Jul 12 - Jun 13			2 (As Expected)		9 Trusts higher than expected
	Octr 12 - Sep13			2 (As Expected)		8 Trusts higher than expected
	Jan - Dec 13			2 (As Expected)		7 Trusts higher than expected
	Ap 13 - Mar 14			2 (As Expected)		9 Trusts higher than expected
	Jul 13 - Jun 14			2 (As Expected)		9 Trusts higher than expected
	Oct 13 - Sep 14			2 (As Expected)		9 Trusts higher than expected
	Jan – Dec 14			2 (As Expected)		11 Trusts higher than expected
	Apr 14 – Mar 15			2 (As Expected)		16 Trusts higher than expected
	Jul 14 – Jun 15			2 (As Expected)		14 Trusts higher than expected
	Oct14 – Sep 15			2 (As Expected)		18 Trusts higher than expected
	Jan 15 - Dec 15			2 (As Expected)		14 Trusts higher than expected
	Apr 15 - Mar 16			2 (As Expected)		16 Trusts higher than expected
	Jul 15 - Jun 16			2 (As Expected)		11 Trusts higher than expected
	Oct 15 - Sep 16			2 (As Expected)		10 Trusts higher than expected
The percentage of patient deaths with palliative care coded	Apr 12 - Mar 13	44.00%	0.10%	12.80%		
	Jul 12 - Jun 13	44.10%	0.00%	14.00%		
	Octr 12 - Sep13	44.90%	0.00%	14.10%		
	Jan - Dec 13	46.90%	1.30%	15.90%		
	Ap 13 - Mar 14	48.50%	0.00%	17.80%		
	Jul 13 - Jun 14	49.00%	0.00%	18.70%		
	Oct 13 - Sep 14	49.40%	0.00%	19.00%		

	Jan – Dec 14	48.30%	0.00%	17.70%		
	Apr 14 – Mar 15	50.85%	0.00%	17.18%		
	Jul 14 – Jun 15	52.90%	0.00%	17.39%		
	Oct14 – Sep 15	53.53%	0.20%	18.59%		
	Jan 15 - Dec 15	54.75%	0.19%	21.12%	26.14%	
	Apr 15 - Mar 16	54.60%	0.58%	24.22%	27.55%	
	Jul 15 - Jun 16	54.83%	0.57%	26.58%	27.84%	
	Oct 15 - Sep 16	56.27%	0.39%	28.19%	28.06%	

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/
5 NHS Digital quarterly SHMI publications

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

SAFETY
Falls and falls resulting in injury
Why is this a priority?
Nationally falls are the most frequently reported patient safety incidents
Our aim
We have seen a reduction in falls resulting in injury but 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.

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 89.1%

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.

Local safety standards for invasive procedures (LOCSSIPS)
Why is this a priority?
Never Events persist on a national level with CDDFT reporting an unprecedented number during 2016-17. Existing processes built upon the Surgical Safety Checklist only capture invasive procedures undertaken in theatres whereas procedures that may be associated with Never Events are conducted in multiple procedural areas. Without reviewing, updating and embedding Local Safety Standards in all relevant clinical areas, risk of further never events will persist.
Our aim
We wish to ensure full implementation of national guidance embedding Local Safety Standards into all areas conducting Invasive Procedures trust-wide.

Our actions
- The Trust has formed a LocSSIP Implementation and Governance Group (LIGG) which brings together members of the Corporate Governance body with Care Group representatives in order to develop LocSSIPs.
- The LIGG will work with procedural teams to support the implementation of developed LocSSIPs ensuring all individuals understand why the programme is required and how the additional steps are to be conducted.
- The LIGG will co-ordinate both quantitative and qualitative audits to ensure procedural LocSSIPs are being conducted to a high standard providing reports to IQAC and the Trust Board.

Measuring and monitoring
- Quantitative and qualitative (observational) audit evidence of successful implementation.
- An elimination of Never Events and a reduction in patient safety incidents related to the Invasive Procedures covered by the LocSSIP programme.
- Continued Care Group engagement with further development to capture areas not associated with 'never events' but where the LocSSIP approach would be of clinical benefit.

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; there was a mid-year decrease in the nutritional indicators, as a result of this the nutrition and dietetic department have worked closely with all ward sisters to ensure that the rational for nutritional screening, re-screening and care planning is understood. The indicators were revised at ward level, after discussion between senior nurses and dietetics as a result of trends seen within the metrics.

This data is not governed by standard national definition but is based on the nationally recognised MUST score.

End of life and palliative care

Why is this a priority?

Palliative Care has been recognised as an area for improvement by the trust, the CQC inspection and the Health and Wellbeing Board.

Our aim

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

Our actions

- Further improvement to personalised care planning through education, incident monitoring and cultural change
- Develop triangulation of quantitative data with patient led measures
- Work with regional partners to develop ePaCCS
- Support and monitor new out of hours advice service
- Establish palliative care mandatory training for all staff
- Deliver local repeat of postal questionnaire of bereaved relatives (VOICES)
- Explore regular integrated governance meeting with other local palliative care organisations

Measuring and monitoring

- CQC action plan for palliative care 100% complete
- Deliver at least 75% of strategic plan for end of life and palliative care
- Responses to VOICES survey should be as good or better than 2012 benchmark
- Continuing improvement in palliative care coding and ''death in usual place of residence''

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.

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.

Reduction in readmissions to hospital

Why is this a priority?

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

Our aim

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

Our actions

Together with partners in Primary and Social Care, the voluntary sector and others the Trust has developed a range of intensive short-term intervention services to prevent avoidable admissions and re-admissions, and to improve the support available to patients being discharged from hospital.

Measuring and monitoring

We will continue to explore all possible means of achieving the national standard and will re-audit re-admissions in search of further improvement opportunities.

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. The Trust's Transforming Emergency Care Programme has been led by the Acute and Emergency Care Group but involves all Care Groups and external partners. The main immediate future focus will be the recommendations arising from the recent ECIST visit, reported earlier in this Report.

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 Local A&E Delivery Board for Durham/Darlington, chaired by the Trust's Chief Executive.

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

Why is this a priority?

Ambulances waiting at A&E to hand over patients to the care of the Trust are not available to respond to emergencies in the community. Delays are also potentially 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 A&E Delivery Board to implement ECIST recommendations and the Transforming Emergency Care Programme as described earlier in this Report.

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.

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.

Maternity Care

Why is this a priority?

Nationally the five year forward plan and the national maternity review place maternity care as a priority. NHS England have also produced a report “Saving Babies Lives” and this reports on standards required to ensure safe, effective care in this area.

Our aim

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

Our actions

We will complete a gap analysis against the report and agree any actions that result from this.

Measuring and monitoring

Key metrics will be introduced to monitor implementation of any identified actions

This data is not governed by standard national definition.

Care of patients requiring paediatric care

Why is this a priority?

The care of children in emergency/ urgent care settings will be delivered using bespoke pathways for that care and it is important that pathways are enhanced to ensure that practice continues to be evidence based and triangulates all areas of speciality.

Our aim

We want to ensure that children continue to receive care which is evidence based using pathways to inform decision making. This will also have the aim of enhancing the child’s experience.

Our actions

We will continue to introduce pathways of care for paediatric patients.

Measuring and monitoring

With the introduction of paediatric pathways.

This data is not governed by standard national definition.

ANNEX 1

Feedback from Durham and Darlington Clinical Commissioning Groups

NHS Darlington Clinical Commissioning Group

NHS Durham Dales, Easington and Sedgefield Clinical Commissioning Group

NHS North Durham Clinical Commissioning Group

TO BE ADDED WHEN RECEIVED

Feedback from Darlington Borough Council Health and Partnerships Scrutiny Committee

DARLINGTON
BOROUGH COUNCIL

County Durham and Darlington NHS Foundation Trust – Draft Quality Account 2015/16

TO BE ADDED WHEN RECEIVED

Feedback from Healthwatch Darlington

TO BE ADDED WHEN RECEIVED

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

Contact: Cllr John Robinson
Direct Tel: 03000 268140
e-mail:
Your ref:
Our ref:

TO BE ADDED WHEN RECEIVED

Members
Durham County Council, County Hall, Durham DH1 5UQ
Main Telephone (03000) 260000 Minicom (0191) 383 3802 Text 07786 02 69 56

Website: www.durham.gov.uk

DURHAM COUNTY COUNCIL ADULTS WELLBEING AND HEALTH OVERVIEW AND SCRUTINY COMMITTEE

COMMENTS ON COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST QUALITY ACCOUNT FOR 2015/16

Feedback from County Durham Health and Wellbeing Board

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

TO BE ADDED WHEN RECEIVED

Cabinet Office
Durham County Council, County Hall, Durham DH1 5UL
Main Telephone 03000 260 0000

www.durham.gov.uk

Feedback from Healthwatch County Durham

TO BE ADDED WHEN RECEIVED

Healthwatch County Durham
The Work Place, Heighington Lane
Aycliffe Business Park, Newton Aycliffe
County Durham DL5 6AH

Tel: 01325 375 967
Fax: 01325 375 901
Email: info@healthwatchcountydurham.co.uk
www.healthwatchcountydurham.co.uk

Statement of Directors' Responsibility in Respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

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

- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2016 to May 2017;
    - papers relating to quality reported to the board over the period April 2016 to May 2017;
    - feedback from commissioners dated XXXX;
    - feedback from governors dated XXXX;
    - feedback from local Healthwatch organisations dated XXXX;
    - feedback from Durham County Council Adults Wellbeing and Health Overview and Scrutiny Committee dated XXXX;
    - feedback from Darlington Borough Council Health and Partnership Scrutiny Committee dated XXXXX;
    - feedback from County Durham Health and Wellbeing Board dated XXXXX
    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
    - the 2014 **?** national patient survey;
    - the 2015 **?** national staff survey;
    - the 2015/16 **?** Head of Internal Audit's annual opinion over the trust's control environment; and
    - the May 2015 **?** CQC Intelligent Monitoring Report.
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, confirms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as

well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual).

The directors confirm to the best of their knowledge and belief they have complied with the requirements in preparing the Quality Report.

By Order of the Board:

NB: Sign and date in any colour ink except black

……Date ……Chairman

……Date ……Chief Executive

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

TO BE ADDED WHEN RECEIVED

KPMG LLP
Chartered Accountants
Newcastle upon Tyne

May 2017

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