County Durham and Darlington NHS
NHS Foundation Trust

Quality Accounts
2017 - 2018

with you all the way

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WELCOME AND INTRODUCTION

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

We provide acute hospital services from:

- Darlington Memorial Hospital
- University Hospital of North Durham
- A range of planned hospital care at Bishop Auckland Hospital

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

- Shotley Bridge
- Chester le Street
- Weardale
- Sedgefield
- The Richardson in Barnard Castle

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

Our mission "With you all the way" represents our commitment to put the patient at the centre of everything we do.

All the way - means across the care pathway for:

- Prevention
- Treatment
- Rehabilitation

And in different care settings:

- In the home
- In community facilities
- In local hospitals

Working with our partners:

- Our patients
- Our staff
- Our stakeholders

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 2017/18 period. It also outlines those we have agreed for the coming year (2018/19).

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

DRAFT

I am delighted to introduce to you our Quality Account and Quality Report for County Durham and Darlington NHS Foundation Trust for 2017/18.

Our mission 'with you all the way' places patients at the centre of all that we do. Delivering the highest quality patient care remains our top priority and this is reflected in our mission and values as well as our annual objectives. We could not do this without our dedicated workforce and we are proud to be able to present an outline of our achievements and successes against our quality priorities over the past 12 months.

2017/18 has been about further embedding good practice in line with the Trust's 'Quality Matters' strategy launched in 2017 and which takes us through to 2020. Working with colleagues and partners, we set ourselves a number of quality priorities for the three year period, to improve patient safety, clinical outcomes and the experience of those who need our care. These are the areas where we know we can make the greatest difference.

Just as importantly, however, we are working to equip and support our staff with the tools, techniques, training and support needed to deliver quality improvements in all areas, day in day out.

During 2017/18, the consistent focus on our priority areas has been rewarded with improved performance and positive movement forwards in terms of meeting our targets.

High level highlights to which I would like to draw your attention include our performance against our targets for the reduction of pressure sores and the prevalence of falls across our acute hospitals. We perform consistently well on infection control and are positively positioned nationally in terms of mortality rates. We know we also have challenges and whilst pleased to see a significant reduction in never events, we will not rest until we have none. A never event does not imply that significant harm has occurred but does identify those incidents which can occur if processes or procedures are not fully embedded. The report gives more detail on these incidents.

During 2017/18 we worked with support from NHS Improvement to advise and assist our improvement journey which is has been realised in a number of local service projects and at a Trust-wide level. In June 2018, we will hold the third in our series of 'Becoming a Highly Reliable Organisation' (BAHRO) conferences. These large scale engagement events have proved to be fantastic learning opportunities bringing together internal audiences with national experts and speakers to share experiences and support improvements.

We have also performed well in relation to the introduction and implementation of national and local safety standards (LocSSIPs) and have benefitted from the drive and

dedication brought to the project by the clinical leadership supporting the roll out across the organisation.

Sharing and embedding learning play a strong role in the culture of CDDFT and in addition to the BAHRO conferences we have now also established annual conferences for our nursing and midwifery colleagues. In 2017, we also launched our 'Nursing Travel Award' which supports applications from nursing colleagues to spend time with a different organisation either in the UK or abroad to learn and share practice which can be brought back for the benefit of our County Durham and Darlington communities.

Nationally and locally there continues to be an increasing demand for services against a challenging financial climate, however based on our track record of success I am confident that #TeamCDDFT will continue to rise to these challenges and I hope this Quality Account provides you with a clear picture of how important quality improvement and patient safety are to us at County Durham and Darlington NHS Foundation Trust.

And as we present our Quality Accounts for 2017/18, I would like to take the opportunity to thank all #TeamCDDFT colleagues, partners and stakeholders for their continued commitment and support as we continue to work together on delivering our vision; 'Right First Time, Every Time'.

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

Sue Jacques
CHIEF EXECUTIVE

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

Review of our key priorities for 2017/18

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

		2016/17	2017/18 Ambition	2017/18 Position	
Falls	Patient falls – reduce falls/1000 bed days community hospital	**6.1** ☑	8.0	6.1 (provisional)	☑
	Patient falls – reduce falls/1000 bed days acute hospital	**6.2** ☒	5.6	6.1 (provisional)	☒
	Follow up patients with fragility fracture	66.3% ☑	50%	**TBC**	
	Complete root cause analysis for falls resulting in fractured neck of femur	All complete ☑	All complete	All complete	☑
Care of patients with dementia	Development of a dementia pathway and monitoring of care, to include enhancements to environment	Complete ☑		**TBC**	
Healthcare Associated Infection (HCAI)	Meticillin Resistant Staphylococcus aureus (MRSA) post 48 hour bacteraemia	5 ☒	0	4	☒
	Clostridium *difficile* post 72 hour	16 ☑	19	21	☒
Pressure Ulcers	To have no avoidable grade 3 or above pressure ulcers within acute or community services	4 ⊖	0	2	⊖
Venous thromboembolism (VTE)	Maintain venous thromboembolism assessment compliance at or above 95%	96.9% ☑	95%	96.6% (provisional)	☑
Discharge	Discharge summaries	93.60%	95%	**TBC**	

		2016/17	2017/18 Ambition	2017/18 Position	
		⊖			
Incidents	Rate of patient safety incidents reported via National Reporting and Learning System (NRLS)	Reporting to within 50% ⊖		**TBC**	
	Rate of patient safety incidents resulting in severe injury or death from National Reporting and Learning System (NRLS)	0.30% ☑		**TBC**	
Sepsis	To improve management of patients identified with sepsis	Complete ☑		Work continues	☑
Duty of Candour	To monitor implementation	Complete ☑		**TBC**	
Local Safety Standards for Invasive Procedures (LocSSIPs)	To deliver a programme of work to review LocSSIPs across the Trust	N/A		Complete	☑
PATIENT EXPERIENCE					
Nutrition and Hydration	Move nutrition assessment to Nervecentre 16/17 ambition and 17/18 to complete To audit against new indicators	Planning continues ⊖ Review continues ⊖		**TBC**	
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 ⊖		**TBC**	
Patient personal needs	Responsiveness to patients personal needs	**2016** 68.8 ☑		TBC	
Percentage of staff who would recommend the provider to family	To achieve average national performance against staff survey	On a scale of 1 to 5 3.46	3.75	On a scale of 1 to 5 3.50	⊖

		2016/17	2017/18 Ambition	2017/18 Position	
or friends needing care		⊖ **-2016**			
Percentage of staff experience harassment, bullying or abuse from staff in the last 12 months		**2016** 20% ☑	23%	**2017** 24%	☑
Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion		**2016** 90% ☑	85%	**2017** 90%	☑
Friend and family test	To increase Friends and Family response rates	13.20% (March 16 – Feb 17) ☒		TBC	
		17.80% ☒		TBC	
CLINICAL EFFECTIVENESS					
Reduction in risk mortality indices	To monitor mortality indices (HSMR and SHMI) on a monthly basis – indices should be 100 or below	YTD 2016/17 (Feb16-Jan17) SHMI: 106.09 ⊖ HSMR: 101.57 ☑		TBC	
Reduction in readmission to hospital (within 28 days)	To reduce emergency readmissions	**0-15 years** 12.9% ☒	7%	**0-15 years** **TBC**	
		16 years and over 11.8% ⊖		**16 years and over** **TBC**	
		Total 12.0% ⊖		**Total** **12.5%**	
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% - Left without being seen no more than 5%	0.90% ☑ 1.90% ☑	<5%	**TBC**	

		2016/17	2017/18 Ambition	2017/18 Position	
	Timeliness indicators: - 95% to be treated/ Admitted/discharged within 4 hours - Time to initial assessment no more than 15 minutes - Time to treatment decision no more than 60 minutes	93.19% ☒ 60mins ☒ 36mins ☑	95% 15mins 60mins	**TBC**	
Patient Reported Outcome Measure (PROM) *EQ-5D Index*	To gain better understanding of patient's view of their care and outcomes - Hip - Knee - Hernia	2015/16 (provisional) 0.393 ☒ 0.321 ☑ 0.075 ☑		**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" NH England document	58.1% ⊖ 16.7% ☑ 90.2% ☑ Complete	60% 90%	58.2% TBC 91%	⊖ ☑
Paediatric care (new indicator following stakeholder event)	Improved paediatric pathways for urgent/ emergency care	Pathway improved		**TBC**	

Introduction to 2018/2019 priorities

Key priorities for 2018/2019 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 introduce the new Trust Falls Strategy. To agree a plan of year 1 actions To monitor implementation of year 1 actions against the Strategy
Care of patients with dementia[1] **(Continuation)**	Continued development and roll out of a dementia pathway and monitoring of care for patients with dementia	- Adherence to the national standards on assessment of patients aged 75 and over to ensure they are asked about their memory on admission; and measure ongoing referral rate. Monitoring to continue - Explore feasibility of introducing the screening tool into existing electronic assessment tool - Action plan developed from the results of the National Dementia audit to be monitored for improvement - Carers survey has been completed. The recommendations are to be monitored alongside the national dementia audit recommendations. - Participate in a 5year research project of dementia services within

		the Durham area to continue during 2018/19 - Continue the 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*** **Clostridium *difficile*$_{1,2}$** ***(Continuation and mandatory)***	National and Board priority. Further improvement on current performance	- Achieve reduction in MRSA bacteraemia against a threshold of zero. - No more than 18 cases of hospital acquired Clostridium *difficile* - Both of these will be reported onto the Mandatory Enhanced Surveillance System and monitored via Infection Control Committee
Venous thromboembolism risk assessment$_{1,2}$ **(Continuation and mandatory)**	Maintenance of current performance	- Maintain VTE assessment compliance at or above 95% within inpatient beds in the organisation. This mandated indicator will continue during 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. This indicator will move to part 3 of the report as background monitoring as process is now well developed
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
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	To increase reporting to 75th percentile against reference group	- Cascade lessons learned from serious incidents

resulting in severe injury or death [1,2] **(Continuation and mandatory)**		- NRLS data. Enhance incident reporting to 75th percentile against reference group - Carry out bespoke Trustwide work to embed and improve reporting of near miss and no harm incidents
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
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 Hydration in Hospital [1] **(Continuation)**	To promote optimal nutrition for all patients	- Focus on protected meal 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 - Quarterly Reports to Integrated Quality and Governance Committee and any emerging themes monitored for improvement through the Patient Experience Forum - The Trust will continue to participate in the national inpatient survey
Percentage of staff who would recommend the trust to family or friends needing care[1,2] **(Continuation and mandatory)** **Percentage of staff experience harassment, bullying or abuse from staff in the last 12 months[2]** **(Mandatory measure)** **Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion[2]** **(Mandatory measure)**	To show improvement year on year bringing CDDFT in line with the national average by 2018/19	- To bring result to within national average - Results will be measured by the annual staff survey. Results will be reviewed by sub committees of the Trust Board and shared with staff and leaders and themes considered as part of the staff engagement work - In addition we will continue to report results for harassment & bullying and Race Equality Standard

Friends and Family Test[1] **(Continuation)**	Percentage of staff who recommend the provider to Friends and Family	- During 2018-19 we propose to increase or maintain Friends and Family response rates. All areas participating will receive monthly feedback and a quarterly report of progress and will be monitored by the Trust Board.
EFFECTIVENESS		
Hospital Standardised Mortality Ratio (HSMR)[1] **Standardised Hospital Mortality Index (SHMI)**[1,2] **(Continuation and mandatory)**	To closely monitor nationally introduced Standardised Hospital Mortality Index (SHMI) and take corrective action as necessary	- To 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 - Embed "Learning from Deaths" policy
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] **Continuation and mandatory)**	To improve patient experience To improve current performance	- No more than expected rate based on locally negotiated rates. Monthly measure - Information will be submitted to the national database so that national benchmarking can continue. Results will be monitored via Trust Board using the performance scorecard
Patient reported outcome measures[1,2] **(Continuation and mandatory)**	To improve response rate	- 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
Excellence Reporting	To ensure that CDDFT continues to embed learning from excellence into standard culture and practice through Excellence Reporting.	A monthly report to the Executive and Clinical Leadership Committee (ECL) incorporating total Excellence Reports for the preceding month, a Care Group breakdown, highlights of departments with the most excellence reports and common themes. A quarterly report to the Integrated Quality Assurance Committee (IQAC) summarising the ECL report and encompassing summary from learning from excellence group.

1 - continuation from previous year

2 - mandatory measure

3 - new indicator following stakeholder events

7 Day Service Standards

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

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

As part of our plan continue to drive improvements, the trust participates in national audits. The last audit conducted in September 2017, reported;

- 100% patients with high dependence care needs receiving twice daily review
- 80% of patients were seen within 14 hours by the consultant.

Review of performance against priorities 2017/18
The following section of the report focuses on our performance and outcomes against the priorities we set for 2017/18. 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. We set our target in 2017/18 but have not reached all of the targets agreed. The number of falls within the organisation is identified from the incident reporting system and reporting to the Falls Group on a monthly basis so that any remedial action can be taken. 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 Incidents 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. The training focuses on the vulnerability of people with sensory impairments and their risk of falls which also links with dementia/cognitive impairment problems.

Mandatory training for all registered nurses continues, with an overview given of multifactorial risk assessments and intervention given to all attendees. Themes from previous Root Cause Analysis are included this training.

The National Falls Audit was carried out in May 2017 with positive results when measured against regional performance.

A falls strategy has been developed which all stakeholders in the region have agreed to follow so focused work will be taking place in the next year:

1. Education, awareness and training around falls prevention amongst the workforce and wider community.
2. Improved partnership working between community and acute services to streamline services
3. Increased accuracy of identifying those at risk of falls.
4. Map out and develop a clear pathway for falls and fragility services in acute and community settings.

Next Steps

- Dedicated multidisciplinary team focussed on reducing falls and falls with harm in acute hospitals and community hospital with the aim is to reduce falls by 10% every year over the next three years.
- Monitoring of safe staffing levels with identification of any areas that require remedial action following a cluster of falls.
- Risk assessments and patient roundings - continue a targeted approach based on patient outcomes with remedial work when any area identified.
- Monitor access to mental health liaison services to have consistently good and meaningful engagement by all staff.
- Patients who require 1:1 or cohorting are provided with this service.
- Explore work with Care Homes to prevent admission following a fall
- Explore work and improve falls prevention in patients own homes to prevent falls and admission to acute sector working with district nurses, and falls clinics.

Care of Patients with Dementia

☑	Trust ambition achieved

Our Aim

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

Progress

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

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

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

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

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

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

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

Theme 6: Governance

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

Next Steps

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

Healthcare Associated Infections

MRSA bacteraemia

☒	Trust ambition not achieved.

Clostridium *difficile*

☒	Trust ambition not achieved

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

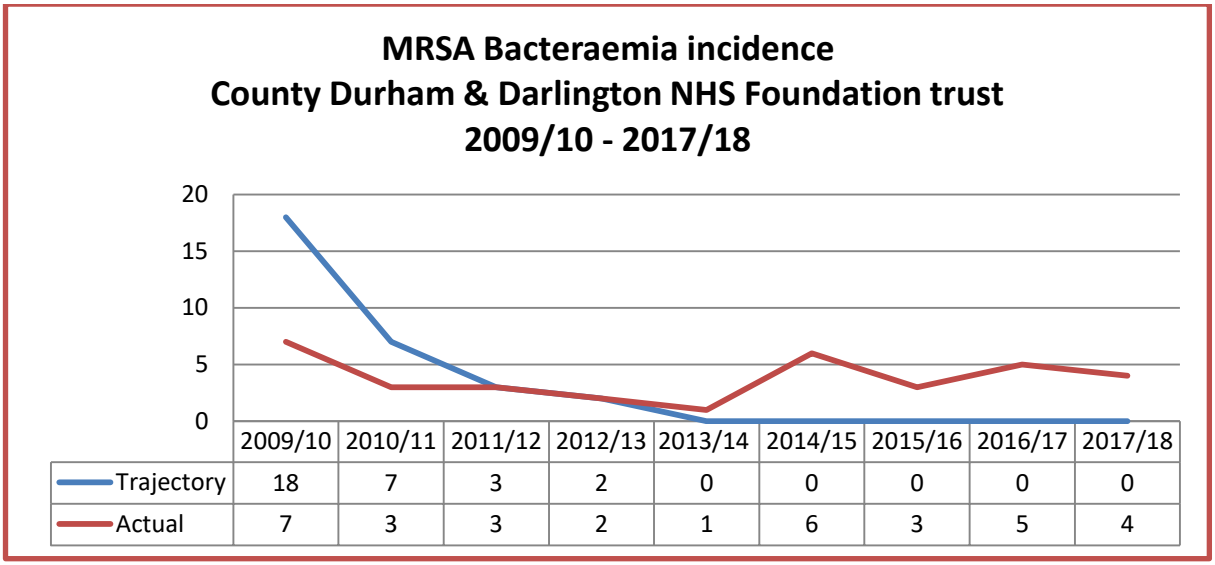
Our aim

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

Progress

CDDFT has reported 4 cases of MRSA Bacteraemia since April 2017 which puts the Trust above its annual threshold of zero avoidable infections
All 4 were very complex patients with a number of co-morbidities increasing their infection risk. Some key issues were identified and are being shared through the organisation as lessons to be learned.

Graphs below indicate the trust position at the end of March 2018 and Trust performance against trajectory from April 2009



	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Trajectory	18	7	3	2	0	0	0	0	0
Actual	7	3	3	2	1	6	3	5	4

Actions for improvement

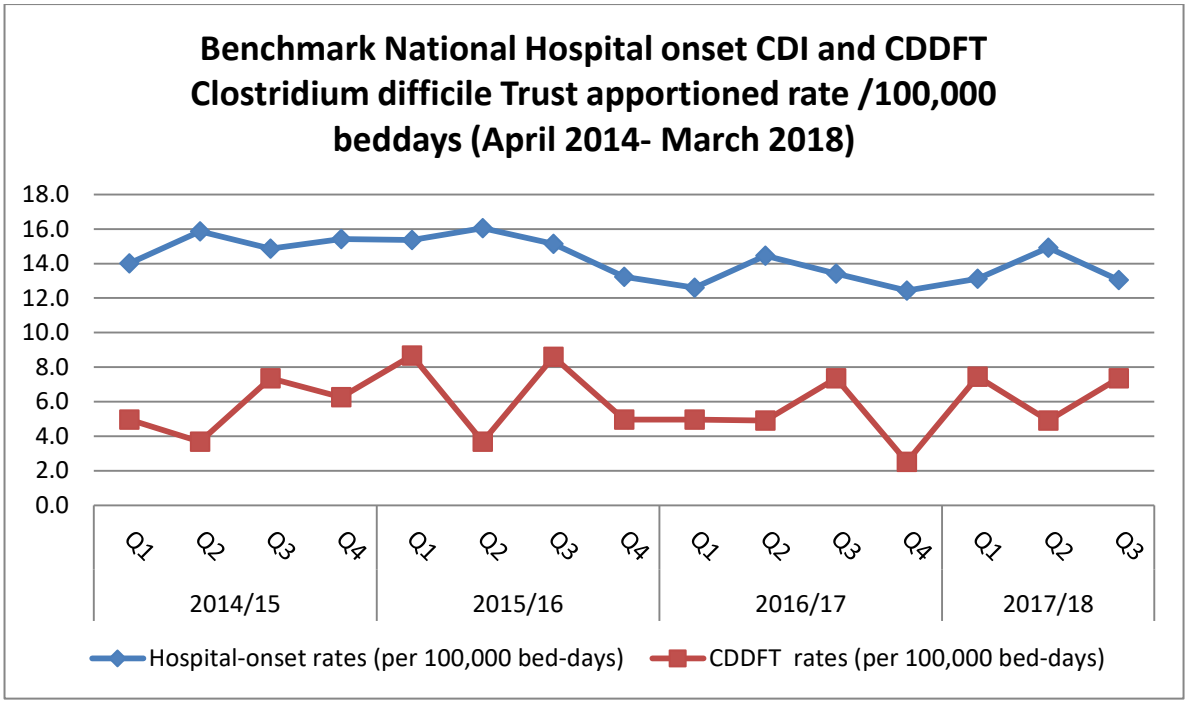
- Focus on MRSA Screening and decolonisation
- Focus on monitoring Intravenous line care

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 reported 21 cases against an upper threshold of 19. Although we have exceeded this year trajectory by 1 case, our performance in rate /100,000 bed days remains one of the best nationally. Many strategies and focused interventions have been introduced throughout this year and will be continued.

- Executive led HCAI Reduction group
- Focus on increasing awareness around antibiotic stewardship
- 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



***Clostridium difficile* appeals process**

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

Actions for Improvements

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

Next steps

A comprehensive action plan 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

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 have been reviewed.

Risk Assessments are undertaken on all patients admitted to the organisation with compliance monitored via the Assurance Risk and Compliance department we have been 96.6% compliant in the last year.

Pressure Ulcers

⊖	Improvement demonstrated but objective not achieved

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

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

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

Acute Services Hospitals – DMH, UHND, CLS, Shotley Bridge	**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	4	1
2017/18	0	0

Community Services Richardson Hospital, Weardale Community, Sedgefield Community and all patients under care of DN teams	**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	2	3
2017/18	TBC	2

This will remain a primary objective for 2018/2019 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 grades 3 and above incidents so that any remedial actions are identified and addressed.

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

There is current an ongoing revision of policy following the implementation of new higher specification mattresses as standard. New chairs with pressure reduction cushions as standard, 700 installed in 2017 across all areas of the trust.

New innovative projects for the prevention of heel blisters in orthopaedic patients now in protocol and implemented as a NICE guideline.

New innovative prevention work commencing in April 2018 within paediatric areas for prevention of pressure ulcers.

Discharge Summaries

TBC	

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

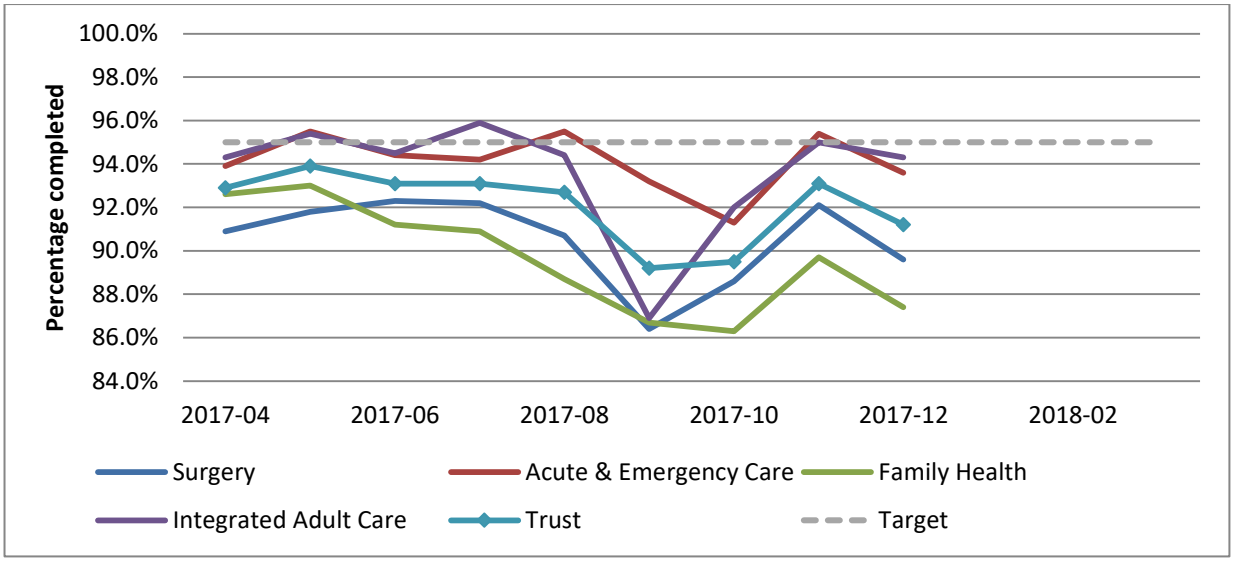
Progress

This remains a high priority for GPs who maintain that without timely discharge information they are unable to provide effective and safe follow-up care for their patients after a hospital stay.

Since January 2017, the Acute and Emergency Care and Integrated Adult Care Groups have averaged over 94%, just short of the national target, whilst Family Health and Surgery have both averaged just over 90%. A dip in September performance is thought to be due to the inexperience of the new intake of junior doctors.

Training is provided to new staff and regular reminders are sent emphasising the importance of this target. Each Care Group has a responsible lead manager.

The performance of each Care Group is monitored in monthly Performance Reviews and Executive-led quarterly reviews. Progress is also reported monthly to the Executive and Clinical Leaders Group, the Integrated Quality and Assurance Committee and to the Trust Board.



Next steps

The Trust will continue to monitor this priority and re-emphasise to all front-line staff its clinical importance. Current reporting arrangements will continue.

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

TBC	Most recent results below but expect a further output prior to publication

TBC	As above

The National Reporting and Learning Service (NRLS) system enables safety incident reports to be submitted to a national database on a voluntary basis and is designed to promote learning. It is mandatory for NHS Trusts in England to report all serious incidents to the Care Quality Commission as part of the registration process. The Trust's NRLS results for April 2017 to September 2017 show that we are in the mid 50% of reporters. This is calculated as a comparison against a national peer group, which is selected according to type or trust.

Never Events

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

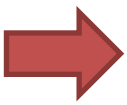
Retained foreign object

Retained Foreign Object Post-Operation and injury to bowel

- Internal process to be agreed on how staff raise risks identified with equipment/devices to be highlighted to manufacturers and Trust Governance Meeting
- Consideration of including an area in WHO checklists to identify theatre staff roles and responsibilities, in line with Trust LocSIPPs and guidelines.
- Development of LocSIPP for procedure in conjunction with manufacturers guidelines
- Inclusion of guidance on the checks required for single use equipment/device to be in the Trust Medical Device policy
- Immediate withdrawal of device whilst undertaking of the RCA and MHRA investigation
- All committees approving use of medical devices/equipment to be quorate in line with Trust guidelines
- All theatre staff to have an understanding of equipment and devices used within the theatres environment, to troubleshoot where applicable.
- Medical Device Training for MiniTouch device to be recorded for all staff members learning records who have attended
- Liaison with MHRA and manufactures regarding the fitness for purpose of this device and whether consideration should be given to withdrawal of the device from market.

Wrong site block

Wrong side femoral nerve block



- Stop before you block procedure not undertaken despite being aware of it.
- Complex intubation involved with this patient, which reinforces further the need for stop before you block process to double-check site and side of the block.

Retained foreign object

Tampon retained post-delivery following a forceps delivery, episiotomy and 2nd degree tear

- Continuity of swab counts - same people, stay in room
- Any change of operator requires swab count and a new swab count to be started
- White board must include tampon
- Perineum's should be inspected daily whether in hospital or community
- Avoid interruption intra procedures
- If registrar hands over procedure trainee should still be supervised, i.e. he / she should not leave room
- Only the midwife can hand items to obstetrician
- Apply clip to tape of tampon at time of insertion so anything internal is indicated with a visible marker outside
- After doing a repair always do a PV then a PR
- If patient attends with unusual discomfort - patient should be examined with a speculum – at least one finger pv - to look for a foreign body

Wrong Route Administration of Medication

Oral oramorph given intravenously

- IV syringes **MUST NOT** be used to measure or administer oral liquid medicines by mouth or enteral feeding tube.
  A medicine cup or 5ml spoon should be used to measure and administer oral liquid medication except in the following situations where :-
  PURPLE oral/enteral syringe MUST be used: The dose cannot be accurately measured using a medicine cup or 5ml spoon e.g. less than 5ml or not a multiple of 5ml, or where dose measurement is critical e.g. digoxin, phenytoin
- Case discussed with all staff on duty it is a rare event that oral medication is used in resus but the trust policy should have been followed.

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

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

NHS Improvement worked 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.

The never events that have occurred and learning identified have been shared widely across the organisation and through communications and presentations. Organisational learning events took in April and September 2017, where over 600 staff attended, in addition to external speakers and delegates from neighbouring Trusts. Feedback obtained from these events is being analysed to capture and inform further actions required to improve safety across the Trust.

Regulation 28
The Trust received no Regulation 28 letters of the Coroner's Investigation Regulations from 2013 during 2017/18.

Serious incidents
The Trust reported **57** serious incidents during 2017/18. All of these incidents have a full root cause analysis review and themes are identified from these.

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

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

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

Period	Apr13Sep13	Oct 13 Mar 14	Apr14 Sep14	Oct14 Mar15	Apr15 Sept15	Oct15 Mar16	Apr16 Sept16	Oct 16 Mar17	Apr 17 Sept 17 TBC
Patient safety incidents			4300	5631	6100	5998	5238	5527	
CDDFT %age reporting Rate (1000 bed days)	Apr11Sep11	Oct11Mar12	Apr12Sep12	Oct12Mar13	40.5	38.85	35.17	37.66	
CDDFT %age severe injury & death	0.3	0.2	0.1	0.2	0.2	0.4	0.3	0.2	
National %age reporting rate (1000 bed days)	7	7.2	35.1* Median	35.34	38.25	39.31	40.02	40.12	
National %age severe injury & death	0.6	0.5	0.5	0.5	0.4	0.4	0.4	0.3	

* 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 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

Information not yet available

Harm rating

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

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

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

Next steps

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

- Progress against the themes highlighted above will be monitored at the bi- weekly Patient Safety Forum and Safety Committee dashboards
- Care Groups will be expected to complete reviews within the specified time period and include the position in their Integrated Governance report that is produced quarterly
- To undertake audit of current reporting of incidents to establish innovations to improve reporting of near miss/ no harm incidents within 2018/19
- To explore the standardisation of lessons learnt documentation
- To consider the sharing of incident themes by speciality to involve staff in learning form incidents and mitigate the potential risk

Improve management of patients identified with sepsis

☑	Trust ambition achieved

Our Aim
To build on the foundations of the work we have done in relation to Sepsis over the last 3 years, and continue to improve the identification and treatment of patients with sepsis in our care.

Progress
The regional sepsis screening tool is now integrated within Nervecentre for inpatients and Symphony for ED patients, meaning that all patients within CDDFT are automatically screened for sepsis. For those inpatients screening positive for sepsis the Sepsis bundle is also within Nervecentre allowing the staff to complete it electronically.

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.

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

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, using the agreed Duty of Candour template.
- A written apology must be sent or given to the patient and/or relatives/carers within 10 working days of event being identified. A copy of the letter of apology should be attached to the 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

The Trust current compliance with Duty of Candour is TBC

Since the implementation of the Duty of Candour regulation the Trust has undertaken a number of actions to ensure compliance as outlined below:

- Ulysses Incident Management system enables staff to record the elements of Duty of Candour to allow monitoring of Trust compliance
- The development of an agreed patient record template for staff to document that Duty of Candour has been completed e.g. verbal apology, that is to be scanned into the patients record. This has been incorporated into the Trust Being Open/Duty of Candour Policy.
- Internal and external audits have been undertaken with 2017/18 and recommendations have been implemented to strengthen the Duty of Candour process within the Trust.
- Duty of Candour continues to be included in various Trust wide training programmes such as corporate staff induction, essential training, and root cause analysis.
- A standalone training programme is available for Duty of Candour; however, the uptake continues to be poor.
- Fortnightly Duty of Candour compliance reports are reviewed at the Patient Safety Forum.
- Care Group Leads alongside their Service Manager(s) will ensure that Duty of Candour is recorded in Ulysses Incident Management system.

Next Steps

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

- Continue to monitor Duty of Candour compliance fortnightly in Patient Safety Forum.
- Further education with staff groups in recording Duty of Candour via Trust wide training programmes and bespoke training days.
- To embed the use of the patient record template to document that Duty of Candour has been completed and evaluation of the implementation within 2018/19

Local Safety Standards for Invasive Procedures (LocSSIPs)

☑	Trust ambition achieved

Our Aim

To deliver a programme of work to review local standards for invasive procedures across the Trust and ensure that current practice is harmonised with the National Safety Standards for Invasive Procedures (NatSSIPs). The programme will implement Local Safety Standards for all Invasive Procedures that have the potential to be associated with a Never Event, in order to standardise the safety processes underpinning these procedures, to improve consistency of practice in all clinical settings, thereby delivering the safest care possible and reducing the number of associated patient safety incidents including Never Events.

Progress

The LocSSIP Implementation and Governance Group (LIGG) continues to meet regularly; co-ordinating and supporting LocSSIP development within the Care Groups. A LocSSIP programme plan details and monitors associated stages of work and the programme's project

portfolio; progress is now reported to the Trust Board via the Clinical Effectiveness Meeting, with delivery currently on schedule.

The LIGG has designed a strategy to engage junior medical staff and has developed LocSSIP pages on the intranet so that all staff can access LocSSIP related resources. A successful application to CDDFT's Dragons Den has secured funding for additional education and marketing.

A LocSSIP audit strategy continues to be developed:

- A quantitative audit tool has been tested in one procedural area and will be utilised to support further audit within the Care Groups;
- Options for an observational audit tool and staff survey are being explored.

The LocSSIP programme scope was extended in August 2017 to review the existing World Health Organisation Surgical Safety Checklist which required revision following a Never Event. This work is now complete with the new checklist due to be implemented in February pending completion of a 'how to conduct' video by the Care Group.

All of phase one's 25 procedural LocSSIPs (checklists) will be fully approved and externally printed ready to commence deployment within Care Groups by 31-3-18. 6 out of 7 Safety Notices are in place and work relating to extending the Team Brief concept to procedural areas outside theatre is progressing alongside the introduction of the procedural checklists.

Next Steps

The priority for quarter 4 2017/18 is to ensure all procedural checklists are received from the external printers and available to commence deployment before 31-3-2018. During this time, the LIGG will support the Care Groups to ensure checklists and additional materials are in place and individuals responsible for monitoring and stocking the procedural areas are identified.

Work will be undertaken to complete the Safety Notices, consolidate Team Brief development and further progress will be made on the 'Area LocSSIPs' which describe in detail what each Care Group expects from its staff with respect to the conduct of Invasive Procedures. Further communications with substantive staff will take place through governance groups and supported by posters, bulletins, direct email to Care Group governance and management leads and potentially pull-up banners located in key areas.

The audit programme will continue to be developed through the LIGG who will work with Care Group Governance Teams and advise how the tool should be implemented to measure metrics such as LocSSIP completion. The observational tool will continue to be developed with the LIGG working with specific teams where appropriate to ensure appropriate qualitative analysis is undertaken. Audit results will provide assurance of successful implementation and adoption and will guide future intervention if required.

The LIGG will remain in place throughout 2018 to ensure the programme is implemented fully. During this time it will be flexible to the ongoing needs of the Trust responding when required to ensure newly identified requirements are accommodated within the programme.

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 2017/18 – 58.2%

Next Steps:
- Implementation of Baby Buddy App.
- Monitor the usage of the Bump Buddy App through the data provided by Best Beginnings.
- Roll out of Solihull approach to parenting.
- UNICEF UK Baby Friendly Reaccreditation June 2017.
- Progress to UNICEF Gold Award following successful UNICEF reaccreditation.
- Work with Durham County Council Director of Public Health in making County Durham a Breastfeeding Friendly County.
- Maintain staff skills and knowledge through UNICEF accreditation with regular staff skills audits and revised training programme.

Other considerations:
- Review of the Maternity Care Assistant role in the Community and across the Acute Sites.
- Establish Specialist Clinics run by the Infant Feeding Co-ordinator for those mothers with complex pregnancies.
- Review of the frenulotomy (tongue tie) service.
- Setting up of Maternity Care Assistant clinics in the Community to make access easier for pregnant women.

Maternity Standards: Smoking in Pregnancy

☑	Trust ambition achieved

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

Progress
2017/18 performance – 18%

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:

- 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.
- Review training provided to Community Midwives and MCA's, to develop the brief intervention offered to women at the Booking appointment and throughout pregnancy.
- Review of the risk perception clinics (BabyClear) to ensure that these are being utilised for those women most in need.

Maternity Standards: 12 week booking

☑	Trust ambition achieved

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

Progress
2017/18 Performance 91%

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

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

Other considerations:

- Currently in discussion with Public Health regarding a late booking campaign.

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	• GROW implemented and subject to continuous audit.

		• Presentation of specific audit of outcomes for SGA/IOL/NNU admissions etc. • On-going scanning pathway & capacity work stream.
Element 3	Yes	• Exploring barriers to women accessing services promptly in presence of reduced fetal movements.
Element 4	Yes	• Central CTG monitoring & archiving system including Dawes-Redman capacity.

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

Continue to monitor against the standards identified in "Saving Babies Lives" to ensure that the elements remain embedded in practice

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

Element 2 – Identification & surveillance of pregnancies with fetal growth restriction
All Community Midwives to have GROW training redelivered including assessments of measuring SFH and completion of online learning.

SABINE task and finish group set up to monitor achievements towards the above measures. SABINE champions in all Maternity areas.

Continuous audit in place to monitor the success of the GROW initiative which is linked to the Perinatal Institute.

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

Further work being undertaken with commissioners to look at barriers to women attending as there have been delays in women accessing services when they have had episodes of reduced fetal movements.

Trust has been involved in the Tommy's Sleep on your Side campaign aimed at reducing stillbirths in the third trimester.

Element 4 – Effective fetal monitoring in labour
All Obstetric and Midwifery staff to complete K2 training package.
Fresh eyes has become hourly review, fresh ears to be implemented hourly for all low risk labours including home births.

As part of electronic patient record project, implement Central CTG monitoring & archiving system including Dawes-Redman capacity.

Within the Maternity Service there has been a tremendous amount of work targeted at improving communications and information for women and their families in line with 'Better Births' and this has resulted in the update and development of the service website which now includes up to

date information on all aspects of care and provides details on local, regional and national contacts available for further information.

Paediatric Care

☑	Trust ambition achieved

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
There are assessment teams in place on both sites:

Consultant Paediatrician available from 10 – 10 weekdays and 10 – 6 at weekends

In addition -

- UHND assessment area offers focused assessment 24 hours per day 7 days per week with nursing and medical staff (1st and 2nd tier)
- DMH offers focused assessment at weekends

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.

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.

Establish Consultant Paediatric Clinics in GP Surgeries working alongside the GP Federations. Not only will this bring care closer to home for children and families but it will support the GP's by offering advice regarding individual cases and contribute towards their continuing professional development.

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.

Excellence Reporting

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

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

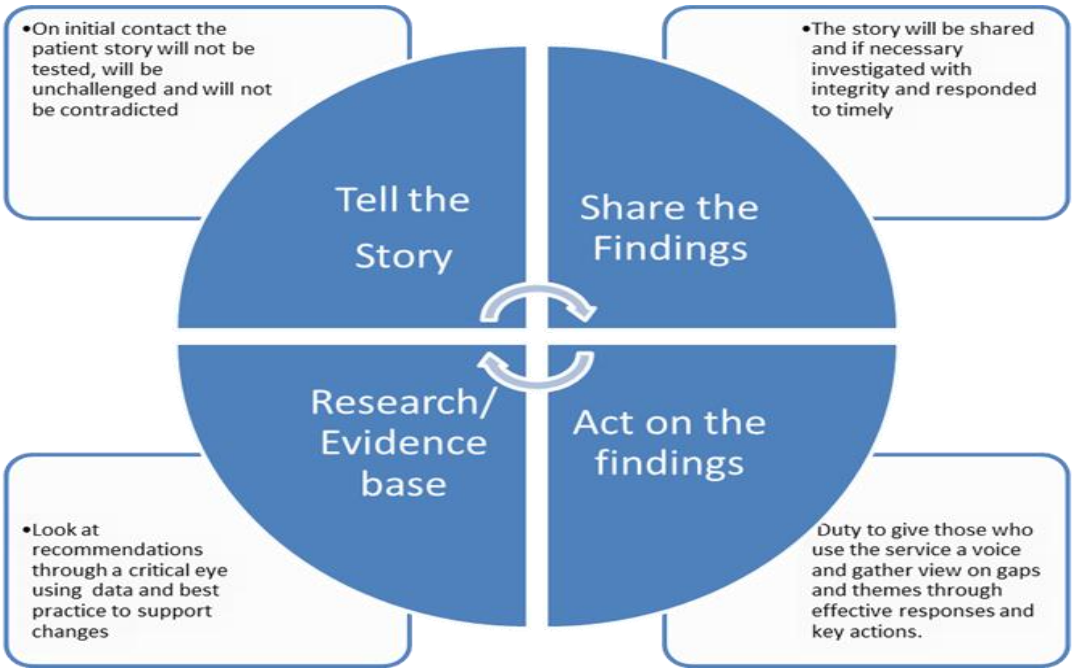
Actions
- The Trust has developed an Excellence Reporting Policy and Learning from Excellence Group, which brings together representatives from all Care Groups.
- Learning from Excellence outputs will include celebration of excellence as well as learning outcomes.
- The Learning from Excellence Group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

Measuring
- Care Groups receive monthly reports into governance meetings.
- ECL will receive a monthly summary of reports and breakdown by Care Group.
- IQAC will receive a quarterly summary incorporating a summary of ECL data and learning from excellence.

PATIENT EXPERIENCE

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

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



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

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

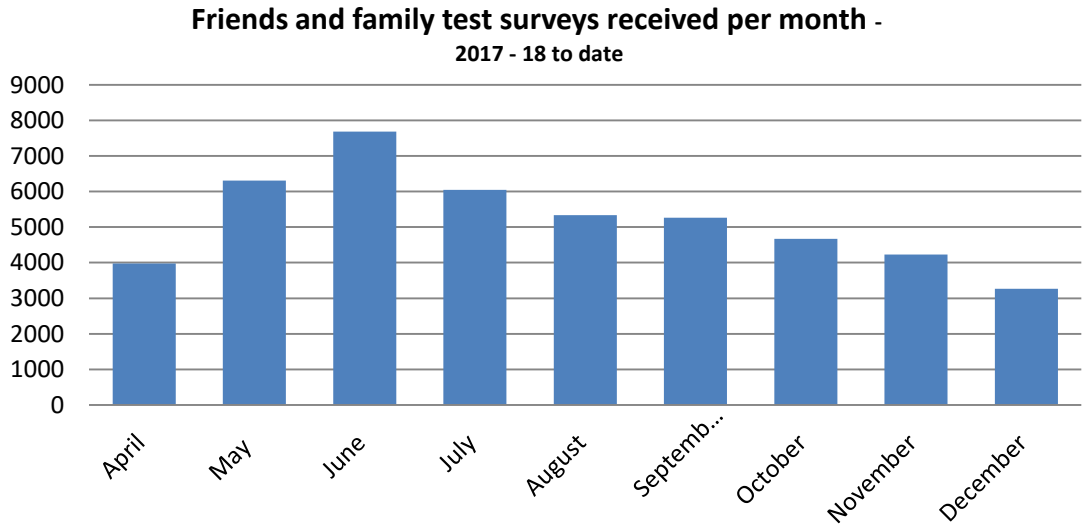
The Trust will continue to raise staff awareness and continue to capture data advising Care Groups of their compliance rates and of areas where actions are required for improvement.

Friends and Family Test (FFT) for patient feedback

Throughout 2017-2018, 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.

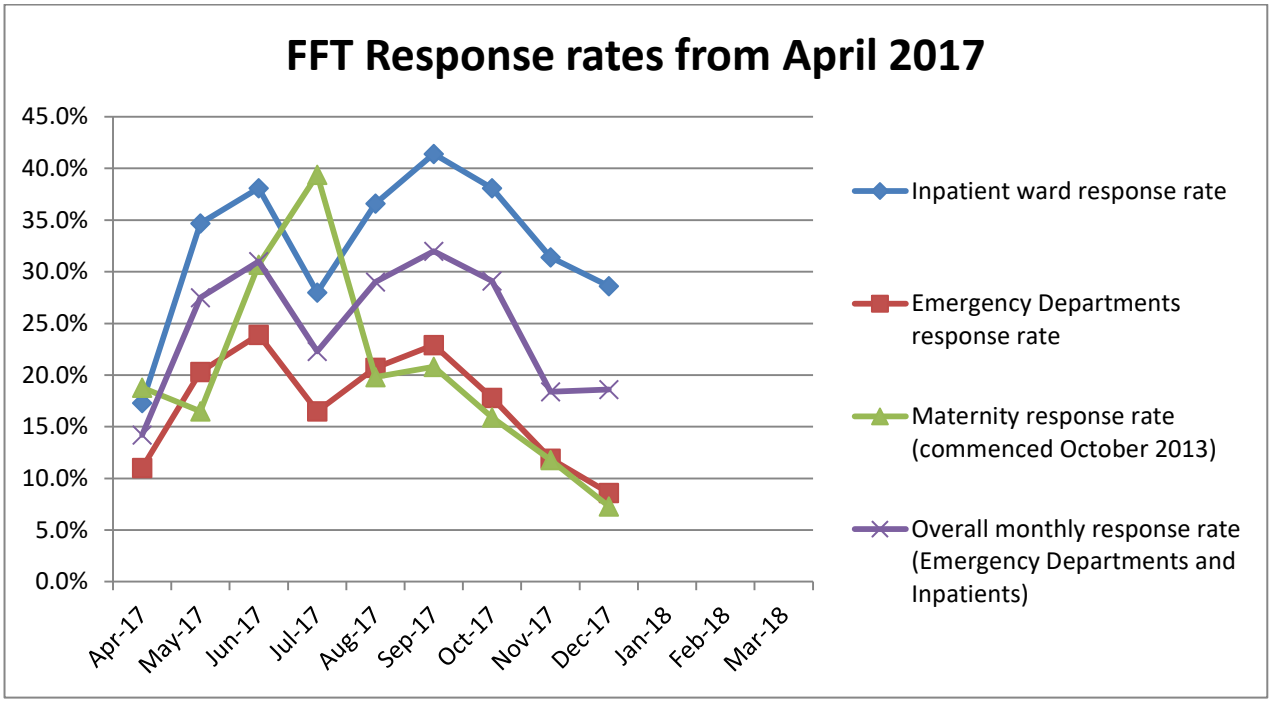
Data collected from Emergency Departments are combined with Urgent Care Centres. Similarly, Inpatient data is combined with Day case data.



The above table shows the Trust's response rates from April 2017 and demonstrates the improvement in response rates since adopting new internal process. In September response targets were met for In-patient and Emergency Departments. The drop in maternity has been identified as a direct result from changing how women receive information as the F&F questionnaire was missed from the pack. This was addressed, however it is noted following

receipt of December data that we are experiencing a gradual reduction in responses across all areas. This issue is being escalated to senior managers.

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



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

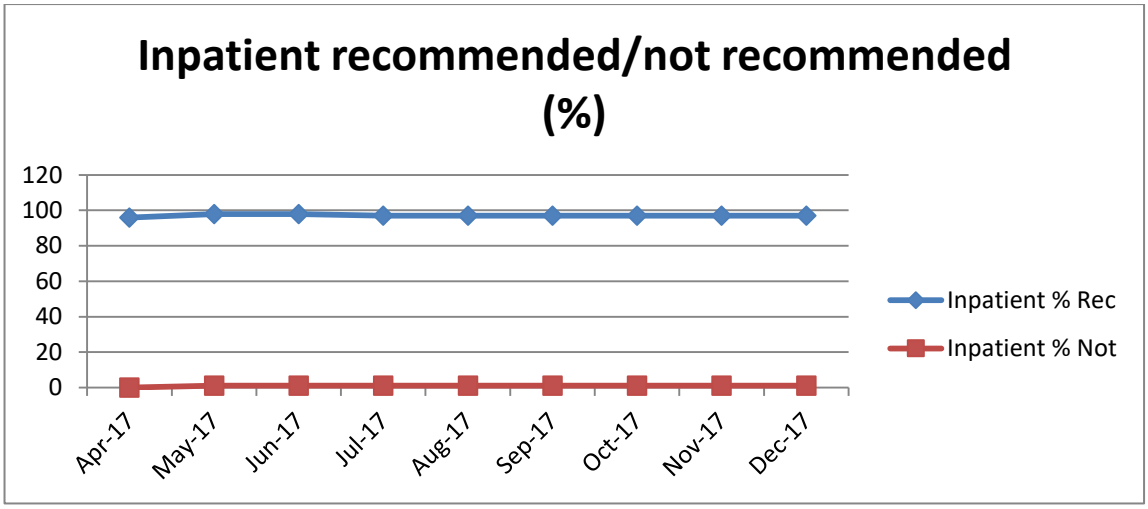
FFT Headline Measure

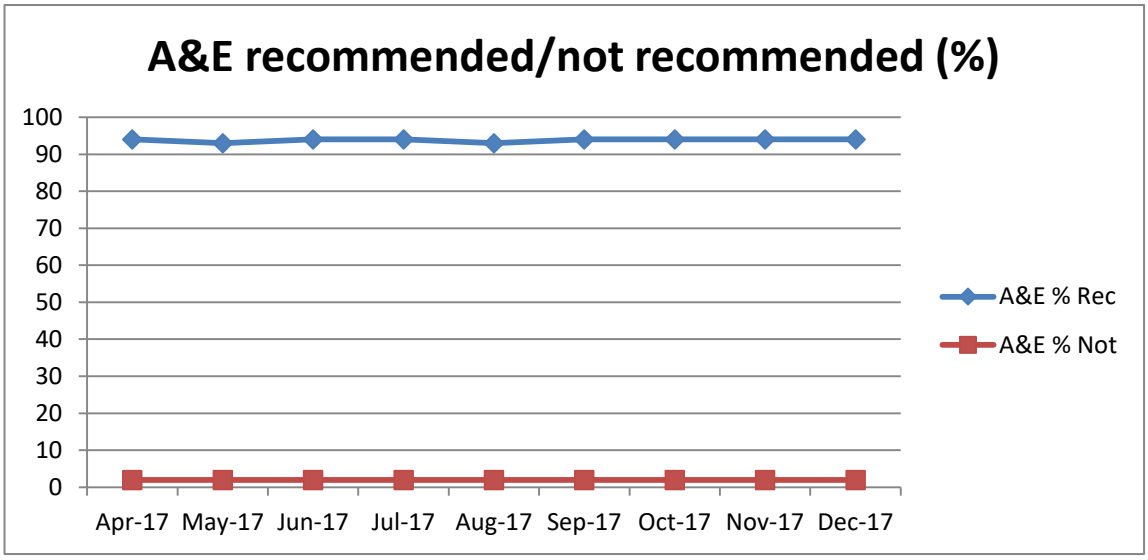
The percentage measures are calculated as follows:

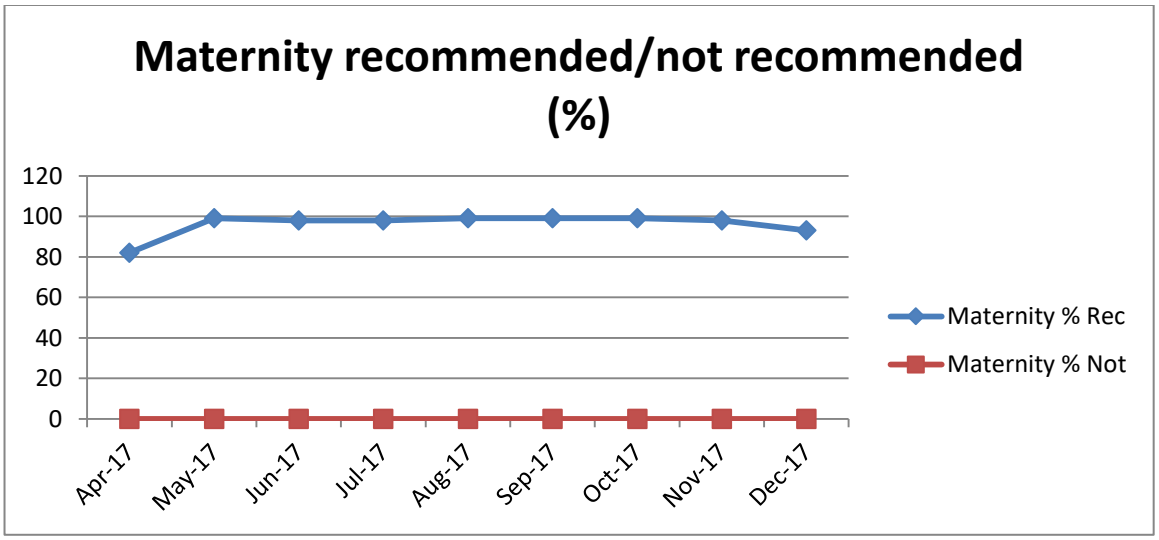
$$\textbf{\textit{Recommend}}\ (\%) = \frac{\textbf{\textit{extremely likely} + \textit{likely}}}{\textbf{\textit{extremely likely} + \textit{likely} + \textit{neither} + \textit{unlikely} + \textit{extremely unlikely} + \textit{don't know}}} \times \mathbf{100}$$

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

The following graphs show the revised headline measure from April 2017 for Emergency Department / Urgent Care Centres, Inpatient / Day cases and Maternity Services:

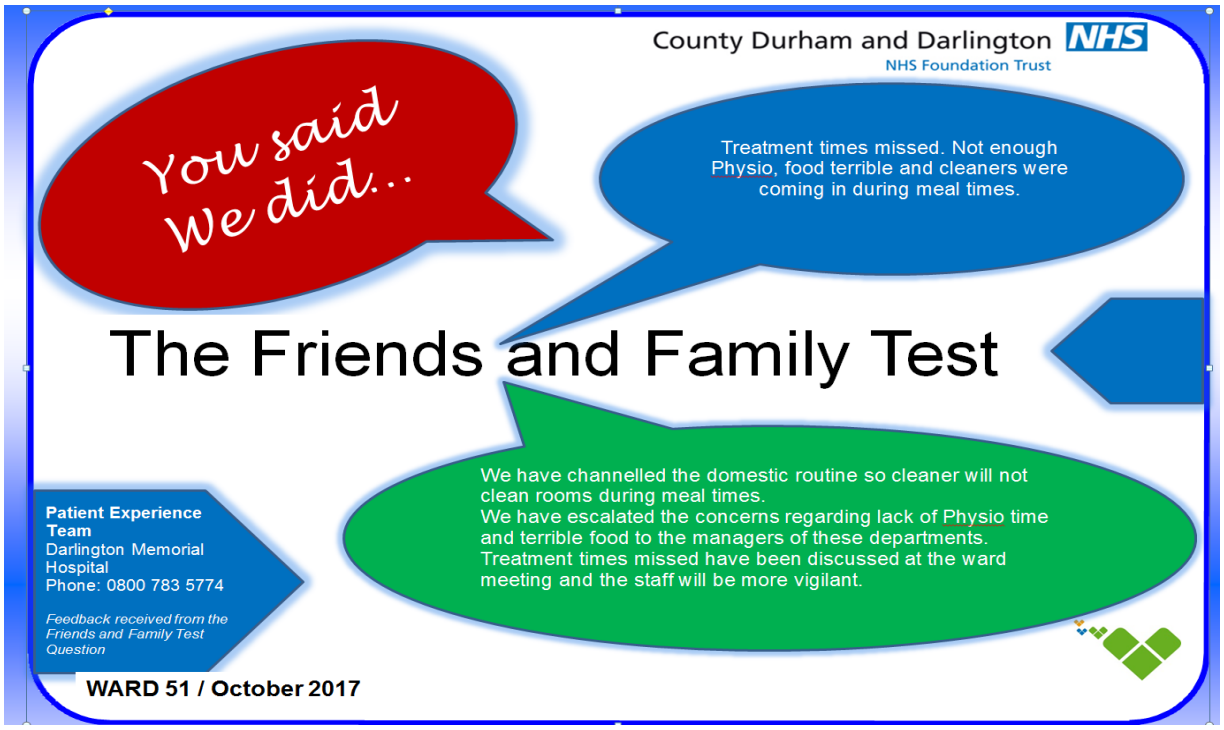






FFT Feedback

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



Training

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

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

Dignity for All

In 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.

National Survey Reports

<u>National Children Inpatient and Day Case Survey</u> - Reported November 2017
The National Children and Young People Inpatient and Day Case Survey was reported in November 2017. Results show that CDDFT compared "the same as most trusts" for all except two questions.
The two remaining questions, CDDFT scored better than most Trusts, in the top 20%.

Provision of information for parents & carers before an operation or procedure	99%
Provision of answers to questions before an operation or procedure	98%

The below areas will be monitored and actioned via Patient Experience Forum throughout 2018

- Did staff play with your child at all while they were in hospital?
- Did members of staff treating your child communicate with them in a way that your child could understand?
- Did you have access to hot drinks facilities?
- Were you given enough information about how your child should use medicine?

<u>Emergency Department Survey – Reported October 2017</u>

The National Emergency Department Survey was reported in October 2017. The results show that CDDFT scored about the same as most other trusts for 33 of the 35 questions.
One scored better than most Trusts, in the top 20% and one scored lower than most trusts in the bottom 20%

Did a member of staff tell you when you could resume your usual activities such as when to go back to work or drive a car?	42%
Did a member of staff explain the purpose of medications you were to take at home in a way that you could understand	98%

National Inpatient Survey – Reported June 2017

The National Inpatient survey was reported in June 2017.
CDDFT rated about the same as other trusts for all questions asked with an overall experience rate of 79% which was also about the same as most trusts.

There were 5 questions where CDDFT performed statistically worse than our 2015 survey results

- Did you feel that you had to wait a long time to get to a bed on a ward?
- Did you feel threatened during your stay in hospital by other patients or visitors?
- In your opinion, did the members of staff caring for you work well together?
- Did you have confidence in the decisions made about your condition or treatment?
- Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?

There were no questions with a 'significant' increase in performance (4% or greater) in 2016 compared with the 2015 Survey. Although the Trust did score well on the following areas:-

- Provision of information and explanation from anaesthetists
- Confidence of doctors and nurses

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

Maternity Survey is due for publication February 2018 and will be added if available prior to publication of this document

Post Discharge Survey

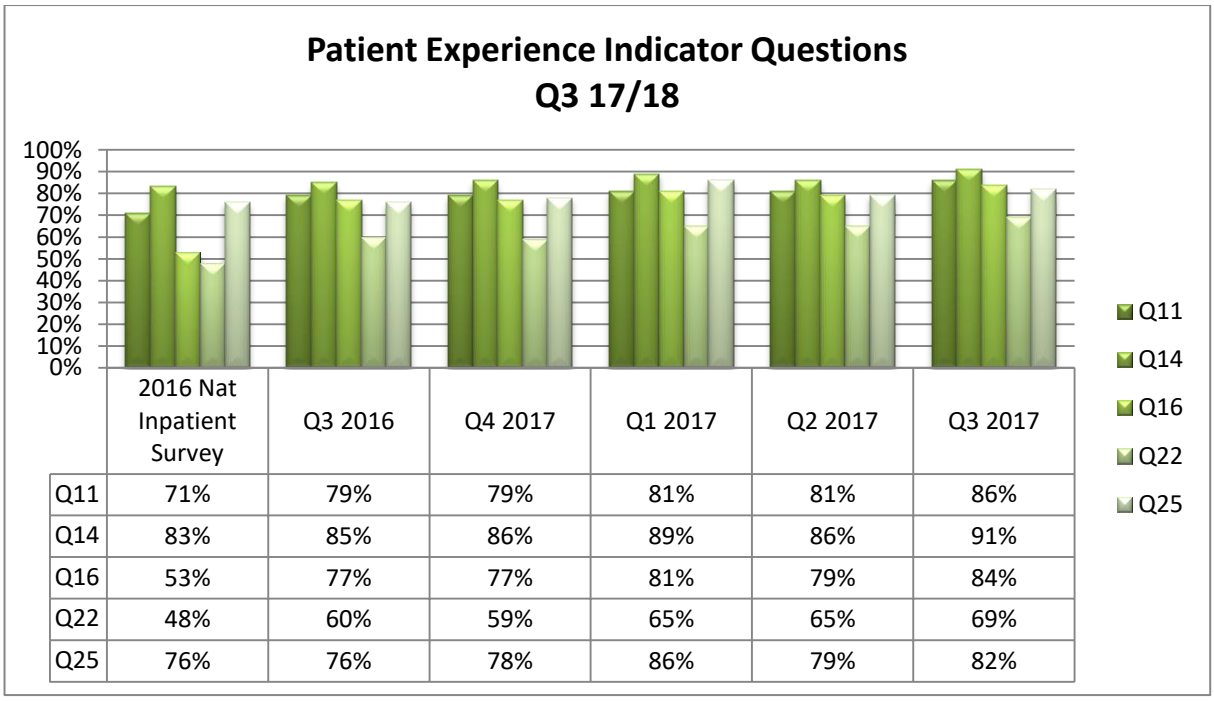
The Post Discharge Survey is posted to a sample of 400 patients on a quarterly basis; this represents 1600 patients a year which is twice the sample used in the national survey. The questions mirror that of the National Inpatient survey in order that we capture issues in real time and develop actions 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 2016 (reported 2017).

Patient Experience Indicator Questions	National Inpatient 2016	Q3 2016	Q4 2016	Q1 2017/18	Q2 2017	Q3 2017
Did you feel involved enough in decisions about your care and treatment? (Q11)	71%	79%	79%	81%	81%	86%

Were you given enough privacy when discussing your condition or treatment? (Q14)	83%	85%	86%	89%	86%	91%
Did you find a member of staff to discuss any worries or fears that you had? (Q16)	53%	77%	77%	81%	79%	84%
Did a member of staff tell you about any medication side effects that you should watch out for after you got home in a way that you could understand? (Q22)	48%	60%	59%	65%	65%	69%
Did hospital staff tell you who you should contact if you were worried about your condition or treatment after you left hospital? (Q25)	76%	76%	78%	86%	79%	82%

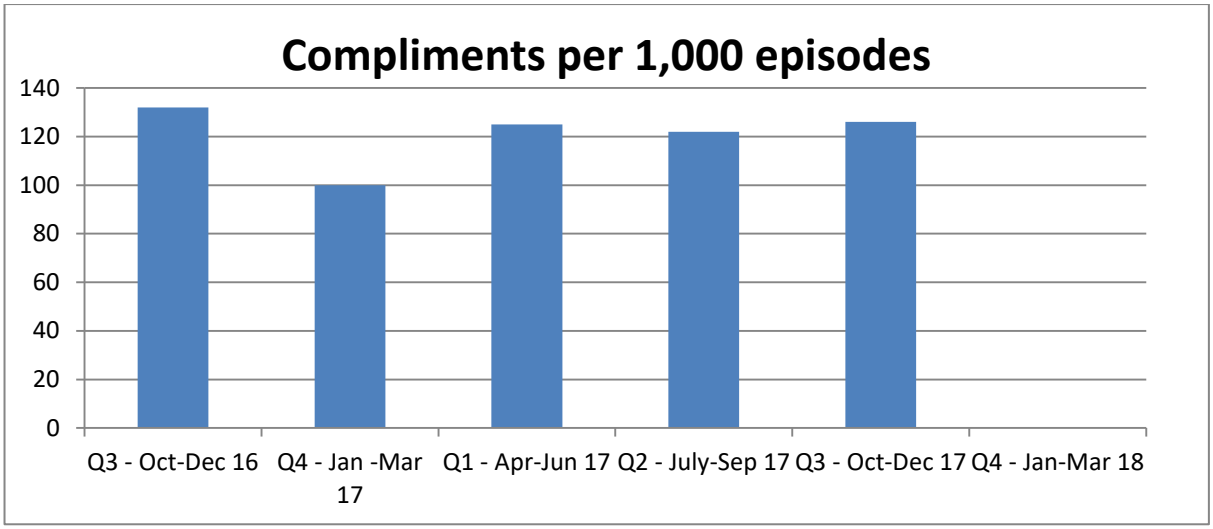
Improvements can be seen in Quarter 3 2017-18 when compared to the same quarter in the previous year as well as the national benchmarking data.

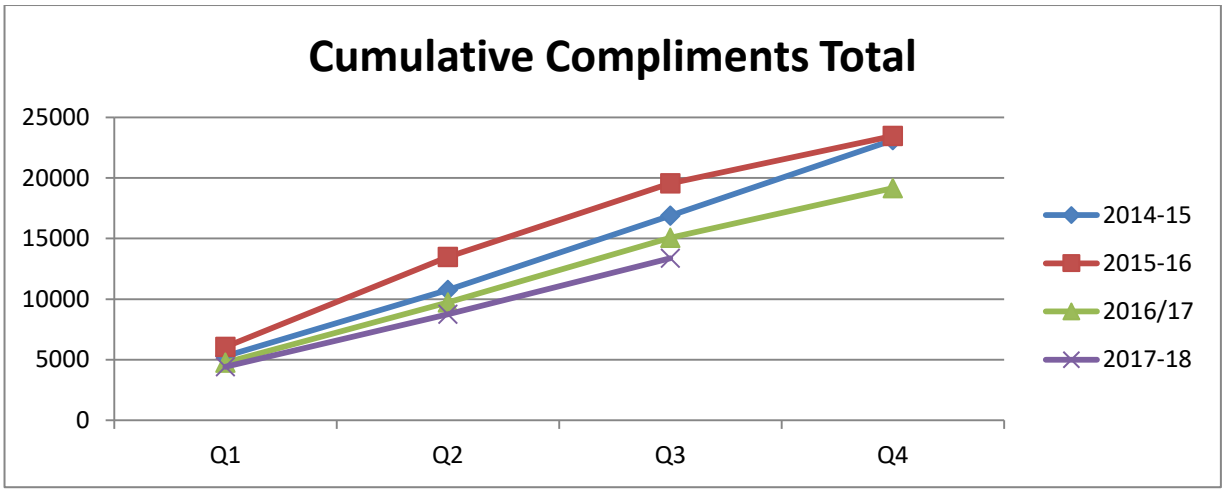


	2016 Nat Inpatient Survey	Q3 2016	Q4 2017	Q1 2017	Q2 2017	Q3 2017
Q11	71%	79%	79%	81%	81%	86%
Q14	83%	85%	86%	89%	86%	91%
Q16	53%	77%	77%	81%	79%	84%
Q22	48%	60%	59%	65%	65%	69%
Q25	76%	76%	78%	86%	79%	82%

Compliments

Quarter	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
1	3662	5297	5288	6058	4761	4409
2	4698	5782	5473	7406	4953	4339
3	5730	4523	6123	6078	5355	4628
4	4493	4863	6228	3902	4093	
Total	**18,583**	**20,465**	**23,112**	**23,444**	**19,162**	





The tables above illustrate the number of recorded compliments received by CDDFT. 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 are members of the trust's Patient Experience Forum which is held 6 times per year. Healthwatch provide constructive feedback from service users and members of the community. Healthwatch teams have provided invaluable support and feedback to xxxxx.

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.

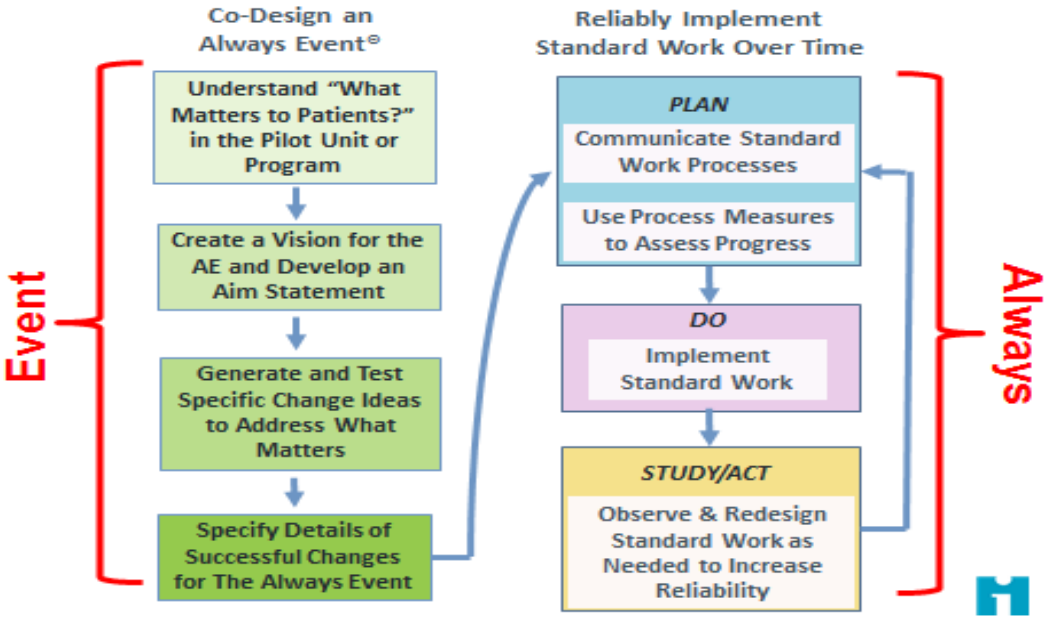
Learning from Experience

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

Always Events Initiative

This is a national project lead by NHS England with 10 pilot sites nominated. CDDFT is to become one of the pilot sites from February 2018 to look at co-designing / co-production delivery supported by front line teams. Always Events are aspects of care that should always occur when patients, carers, service users interact with healthcare professionals and the healthcare delivery system



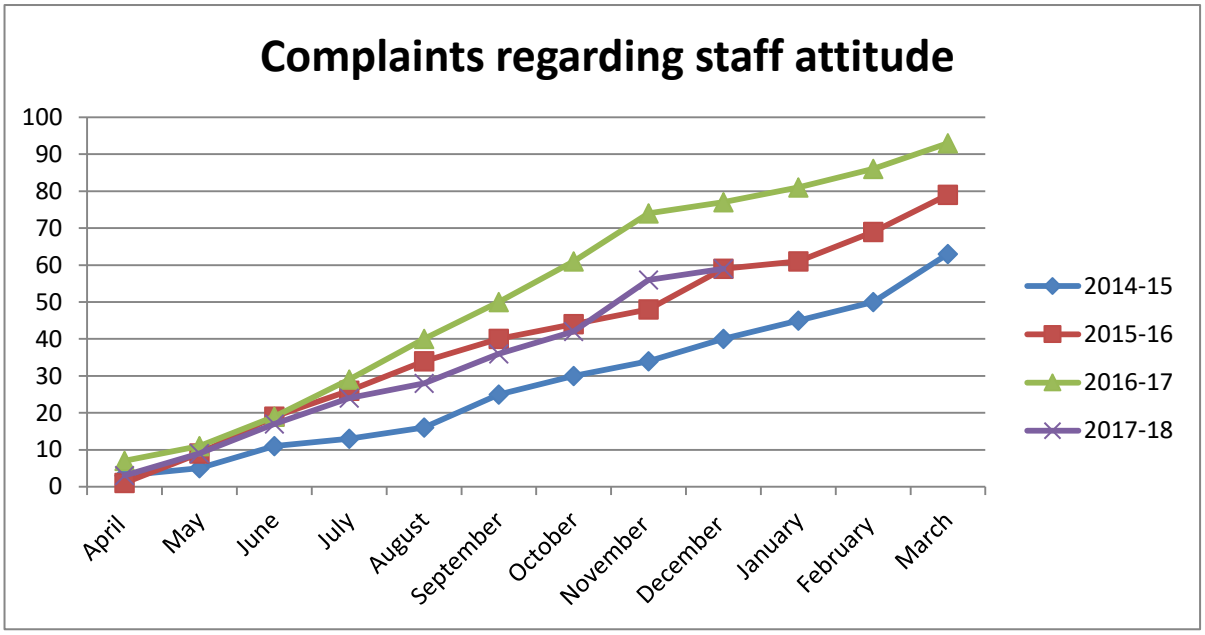
The first project taken forward as an Always Event is the "Invest in Rest" project, in response to feedback from a variety of patient experience measures highlighting noise at night as a concern for patients. This will be monitored via the Patient Experience Forum with the Director of Nursing as the Executive Sponsor.

This project is in its early stages. Front line staff are currently liaising with patients at ward level asking what they feel we can do to improve noise at night in order to promote recovery and wellbeing.

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. Our aim is to remain below the threshold set in the 12/13 Quality Accounts of 70 per year. However, during 2015/16, this number increased to 79 and in 2016/17 this increased further to 93. This is monitored closely and shared at Integrated Quality and Assurance Committees. However, this will be a priority moving into next year for the team to ensure that we understand and address the issues emerging. To date (end of December 2017) we have received 59 complaints regarding attitude of staff compared to 77 at the same time the previous year.



Patient Stories

Patient stories continue and have been instrumental formulating lessons learned and actions for staff to improve patient experience. We listen to both positive and negative stories from our patients and share these with commissioners, staff and governance committees within the Trust. A Patient Story is shared monthly at Integrated Quality and Assurance Committee. Appropriate actions where required are highlighted and monitored. We are exploring various ways of sharing stories and are hoping to develop experiences captured on video to be shared at all levels in the organisation. Where possible we encourage service users to attend strategic meetings and share their experiences, which has been very powerful and constructive.

Nutrition and hydration in hospital

⊖	Trust ambition not achieved but improvements made

Nutrition

Our aim

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

Progress

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

In addition the dietetic service has also consolidated the Nutrition Trustwide role and in 2017/18 the following areas have become business as usual.

- Nutritional Assessment (Must) in Nerve Centre
- End of life nutritional care pathway
- Nutrition policy
- Parenteral Nutrition Policy
- Nutrition Subgroups to review parenteral and enteral nutrition, nutritional screening, nutrition and hydration
- Registered Nurse Nutrition Training offered monthly by Nutrition Nurse Specialist
- WASP framework for nasogastric training in RN
- Further roll out of metrics capture via Quality Matters audit

Next steps
The service will in 2018/19 work to review the Nutrition Bundle documentation in line with Quality Matters audit.

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

Hydration

Aim
In 18/19 to understand how we maintain and monitor sufficient hydration status of patients requiring both artificial (intravenous or enteral) and non-artificial hydration support.

Objective
To explore how CDDFT might require alternative ways of measuring oral fluid intake at ward level. This may include evaluation of a trust wide initiative linked to Hydration – similar to the campaign from 2012-13 'Hydrate, Estimate, Escalate' or further innovative measures such as water drop stickers or simple measure mugs.

Patient Led Assessments of the Care Environment

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

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

The assessments involve local people (known as Patient Assessors) going into hospitals as part of teams to assess how the environment supports the provision of clinical care, assessing such things as privacy and dignity, food, cleanliness and general building maintenance and, more recently, the extent to which the environment is able to support the care of those with dementia. From 2016 the assessment will also look as aspects of the environment in relation to those with disabilities

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 27th March until 10th June 2017.

On completion of the assessments the data is uploaded onto a dedicated HSCIC site with formal results being notified to the Trust in August 2017 with an opportunity for validation. National publication has been provisionally programmed for release in August 2017 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 sites set against the national average:

	Food	Ward Food Score	Organisation Food Score
National Average Score	**89.70%**	**90.20%**	**88.80%**
Bishop Auckland Hospital	**96.09%** ↑	**97.07%** ↑	**95.08%** ↑
Chester Le Street Community Hospital	**99.16%** ↑	**99.12%** ↑	**99.19%** ↑
Darlington Memorial Hospital	**97.02%** ↑	**96.57%** ↑	**98.38%** ↑
Richardson Hospital	**96.99%** ↑	**97.47%** ↑	**96.46%** ↑
Sedgefield Community Hospital	**97.04%** ↑	**95.07%** ↑	**99.19%** ↑
Shotley Bridge Community Hospital	**95.00%** ↑	**94.10%** ↑	**95.95%** ↑
University Hospital North Durham	**96.84%** ↑	**97.26%** ↑	**96.05%** ↑
Weardale Community Hospital	**98.06%** ↑	**98.50%** ↑	**97.57%** ↑

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

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

Food Hygiene

The NHS has had a legal obligation to comply with the provisions and requirements of food hygiene regulations since 1987 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	October 2017	✡✡✡✡✡
University Hospital North Durham	March 2017	✡✡✡✡✡
Bishop Auckland Hospital	March 2016	✡✡✡✡✡
Chester le Street Hospital	September 2015	✡✡✡✡✡
Shotley Bridge Hospital	January 2017	✡✡✡✡✡
Sedgefield Community Hospital	September 2014	✡✡✡✡✡
Weardale Community Hospital	June 2015	✡✡✡✡✡
Richardson Community Hospital	November 2016	✡✡✡✡✡

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

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

The following table illustrates the external accreditation held by Facilities

Accreditation	Service	Last Audit	Next Audit/ Inspection
STS (Support Training Solutions)	Catering DMH	August 2017	August 2018

End of Life Care

☑	Trust ambition achieved

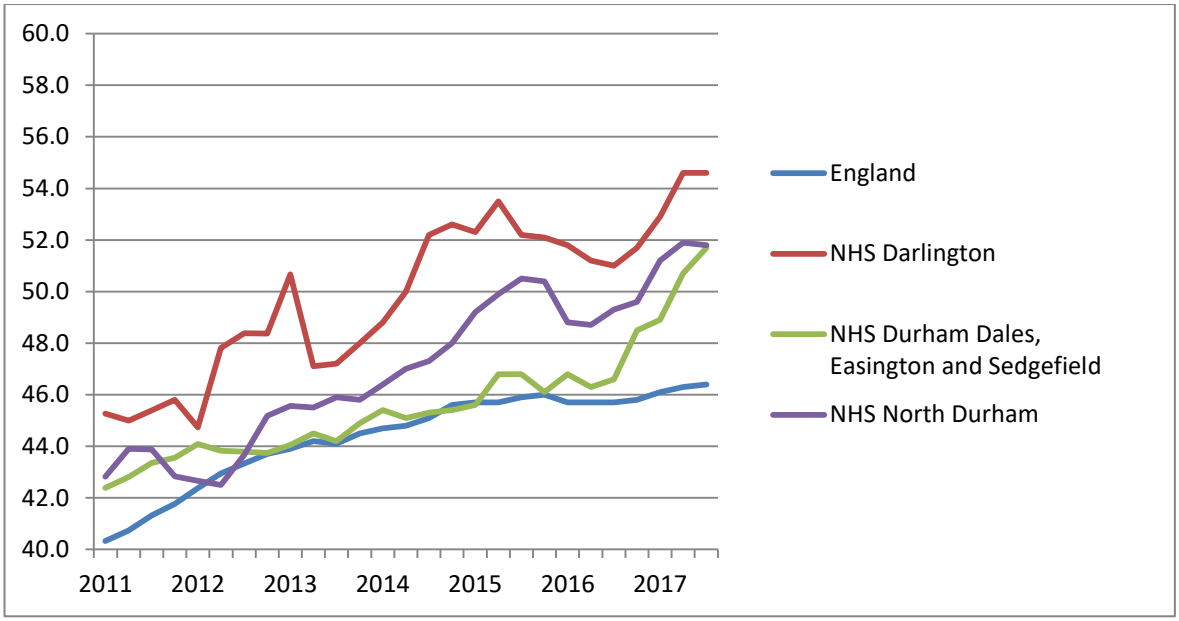
Our aim

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

Progress

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

This is a complex area which is difficult to measure. The national proxy measure for improvements in palliative care is 'death in usual place of residence' County Durham and Darlington continues to improve on this measure and is above the English National Average.



Death in Usual Place of Residence

Our local measure is achievement of preferred place of death. Over the last year this has increased from 57% to 88%.

In addition to this we have conducted an audit of care of the dying and are in the process of a survey of bereaved relatives (VOICES) to establish how effective we are in delivering care to dying patients.

Our End of Life Strategy was agreed by the board on March 2017 and we have made good progress. We have completed all the key recommendations from the 2015 CQC inspection including Out of hours advice for professionals and a new 7 day specialist service. We have established mandatory palliative care education for all staff. We are able to identify issues far better with the integration and analysis of incident reports and other sources of feedback.

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

Next steps

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

- Further improvement to personalised care planning through education, incident monitoring and cultural change
- Work with regional partners to develop ePaCCS
- Support and monitor new out of hours advice service
- Deliver palliative care mandatory training for all staff
- Deliver local repeat of postal questionnaire of bereaved relatives (VOICES)
- Continue the successful training fellow programme to develop palliative care consultants for the future

Percentage of Staff who would recommend the provider to friends and family (also see Page 108)

⊖	Trust ambition not achieved but improvements made

Our aim

To increase the weighted score of staff who would recommend the provider to friends and family as a place to work or receive treatment within the national average for acute trusts.

Work continues to engage with staff at all levels of the organisation and the Organisation Development Strategy "Staff Matter" complements the Quality strategy. As reported by the Health and Social Care Information Centre and NHS Staff Survey National Co-ordination Centre overall results are as follows:

Key Finding	**2016**		**2017**		**Trust Improvement/Deterioration**
	Trust	National Average	Trust	National Average	
KF1. Staff recommendation of the Trust as a place to work or receive treatment	3.46	3.71	3.50	3.75	Improvement of 0.4 on last year

The results for key finding 1 staff recommendation of the Trust as a place to work or receive treatment has seen an improvement of 0.4% on the Trust score for last year however the national average has increased to 3.75 which means that we have not met our ambition to achieve the national average score. The Trust score of 3.5 (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.

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

Question	**2016**		**2017**		**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)	62%	75%	64%	75%	Improvement of 2% whereas the national average has remained static
Q21c I would recommend my organisation as a place to work (strongly agree and agree)	49%	59%	49%	59%	The Trust score remains the same as last year which follows the national trend
Q21d If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation (strongly agree and agree)	59%	68%	58%	69%	Deterioration of 1% whereas the national average has increased by 1%

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

☑	Trust ambition achieved

NHS Staff Survey results for indicator KF26 (percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months). The overall score for 2017 has increased slightly (the lower the score the better) from 16% in 2016 to 18% in 2017. However this score is still in line with the national average. Further analysis of the results reveals that the % of white staff that reported experiencing harassment, bullying or abuse from staff in the last 12 months has gone up from 20% in 2016 to 24% in 2017 (the lower the score the better). This score is higher than the national average for this group which is 23%. However for BME staff reporting the figure has gone down from 35% in 2016 to 32% in 2017. The national average for this group is 29%. The Trust's performance on this level has improved in contrast to the national average which has deteriorated since 2016.

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

☑	Trust ambition achieved

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

Progress
During 2017/18 CDDFT has continued to focus 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 Staff Survey are widely shared with all managers and staff and used to identify the key priorities for the Trust. Staff Matter Action Plans identify the actions necessary to address the issues arising from the staff survey.

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

Staff Matter
The new people strategy Staff Matter was launched on 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.

Following the launch of the new strategy each Care Group and Corporate area produced a staff matter action plan For 2017/2018 and these plans have guided the work around staff engagement. The action plans are monitored on a quarterly basis via Strategic Change Board and Integrated Quality Assurance Committee. The plans will be reviewed to reflect current priorities and monitored in the same way throughout 2018/19.

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, ongoing changes within the NHS.

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

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

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

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

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

The programme has been rolled out across the Trust, with priority originally being given to the new senior care group management teams. The programme has since been extended to include Corporate areas and by the end of March 2018 100 Senior Leaders have attended the programme.

Leadership Conference
The Trust has a programme of bi-annual Leadership conferences featuring guest speakers from the world of leadership, staff and patient engagement and healthcare. The aims of the sessions are to challenge our thinking around how we operate as leaders at both Trust and individual level. Two conferences took place in 2016/17, with 130 delegates attending and a further two are planned for 2017/18.

Developing Managers as Leaders

The Great Line Management Fundamentals Programme was rolled out in 2017/18. 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. The programme has been reviewed and refreshed to meet the changing needs of the organisation.

As part of a bridging programme for Band 7 staff two additional modules, Patient Safety and Operational Performance have been piloted during 2017. Further sessions have been planned for 2018/19.

Talent Management

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

Under the umbrella of "grow your own" further work has been undertaken during 2017/2018 particularly with the introduction of the apprenticeship levy which is now being used to develop career pathways for all key roles across the Trust. The apprenticeship levy is a Government initiative where large employers must pay 0.5% of their payroll bill into the levy which can only be used to fund apprenticeship training and CDDFT have in the region of £1.1million in their levy pot.

Current pathways include Nursing, Leadership and Management, Procurement and Pathology and we have staff enrolled on 20 different apprenticeships at present with more to be introduced during 2018/19. Our apprenticeship programmes currently offer Health Care at level 2, 3 and 5; Business Administration at levels 2, 3, and 4; Management level 3 4,5,6,7; IT level 2 and Cyber Crime and HR at levels 3 and 5, Customer service 2 and 3; Accountancy 4 and 7.

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

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

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

Personal Resilience
Given the unprecedented change facing the NHS, staff development sessions promoting personal resilience strategies have continued throughout 2017/18. The 2016 staff survey scores for the percentage of staff feeling unwell due to workplace stress has increased since 2015 and in order to address this issue a "Managing Stress in Others" workshop has been designed and delivered to support managers in recognising and dealing with stress in others.

Staff Annual Awards
Staff Annual Awards 2017/18 recognise staff across CDDFT for their outstanding contribution to patient care and over 1,200 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. These sessions continue to be popular and are planned for 2018/19.

Appraisal
For the past two years the Trust has had 95% rate of appraisal completion; however staff survey feedback has shown that the quality of appraisal needs to be improved. In response to this feedback, The *Appraisal Framework; Role Review and Aspiration Discussion* has been developed and indicates a new approach for the Trust. Following on from the development of team objectives, the focus of the appraisal is on the value of the conversation with individuals. The appraisal will take a collaborative approach, and consider not just performance, but also future aspirations and possible career progression. This will then inform meaningful and tailored personal development plans for individuals. Guidance has been developed and the Appraiser and Appraisee training has been refreshed to reflect the new approach, with the first training sessions taking place in March 2018 and the new process will be fully rolled out from April 2018.

Equalities, Diversity and Inclusion
Prior to this financial year the Trust's focus for ED&I has been on building secure foundations by ensuring robust policies and practices have been developed for staff and patients, together with activities to promote excellence in this field. The next phase was to produce an Equalities, Diversity and Inclusion Strategy and this work was undertaken during 2017/18. The strategy focuses on developing new and innovative ways of progressing this important agenda in order to achieve an organisational culture that fosters inclusion and leads to exceptional standards of patient care. The ED&I strategy has been approved by the Board and will be launched in April 2018.

Other work around this agenda includes taking part in Project Choice which is a supported internship hosted by CDDFT and managed by HEENE. The project is designed to give young people with learning difficulties, disabilities or autism, the chance to gain work experience, undertake an employability qualification and complete a work-based internship. The project tailors a programme to the needs of the young people which enables them to meet and develop their individual skills. Our first induction onto this programme was held on 25th September 2017. In 2017 we continued to work with a local organisation Amacus on the Leapfrog project. This focussed on recruiting people with a background of long term unemployment and from socially excluded backgrounds to gain employment as Health Care Assistants. To date we have interviewed 104 people through this project and 72 have been offered employment with the Trust.

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

Leadership and Management Development Framework
The leadership and management development framework will be reviewed and refreshed for 18/19 to ensure it meets current and future leadership and management development needs.

Board Development
A bespoke programme of Board Development has been designed and will be rolled out across 2018/19. The first of the four days will take place in June 2018.

Strategic Leadership Programme
The SLP will continue to be rolled out across the organisation throughout 2018/2019 and extra places allocated in order to ensure all Senior Leaders are afforded the opportunity to attend. A further five cohorts have been planned for this financial year.

Leadership Conference
The third Leadership Conference will take place on 24 April 2018. The keynote speakers for this conference are Andy Hope on the Art of being Brilliant and Chris Andreou sharing his views on Emotional Intelligence. The second conference will take place on 16 October 2018.

Talent Management

- CDDFT has been chosen to pilot the Shadow Board Programme for the North East Region. This is a development programme aimed at aspiring leaders who wish to become the Directors of the future. The programme will be rolled out during the first half of the new financial year

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

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

Appraisal
The new Appraisal Framework will be rolled out from April 2018. The appraisal will take a collaborative approach, and consider not just performance, but also future aspirations and possible career progression. 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 aid in succession planning.

The monitoring of appraisal completion and quality audits will continue throughout 2018/19 to in order to evaluate the new appraisal process.

Equalities, Diversity and Inclusion
The next phase of this work involves:

- The establishment of the Strategic ED&I Group in order to drive the ED&I agenda and establish priorities for the coming year. The Group will be jointly chaired by the Medical Director and the Director of Nursing and Transformation

- An ED&I working group will also be established and will consist of representatives from Care Groups and Corporate areas. This group will be responsible for actively driving the ED&I agenda across the wider organisation into all ward, service areas and departments.

- CDDFT have been one of six organisations successful in bidding for a place on the national pilot Building Leadership for Inclusion. The pilot will commence in April 2018 and the outcomes from this will inform both our ED&I agenda and our wider strategy around staff engagement.

Staff Engagement Activities
In addition to the activities outlined above other staff engagement activities include:

- The staff annual awards process will be reviewed and refreshed in readiness for 2018/19 awards

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

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

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

- Work will continue to communicate interactive channels available for staff to feedback comments, share views and suggestions including promoting the role of the Freedom to Speak Up Guardian and when appropriate feeding back on actions undertaken as a result of staff comments, and the speakinconfidence

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

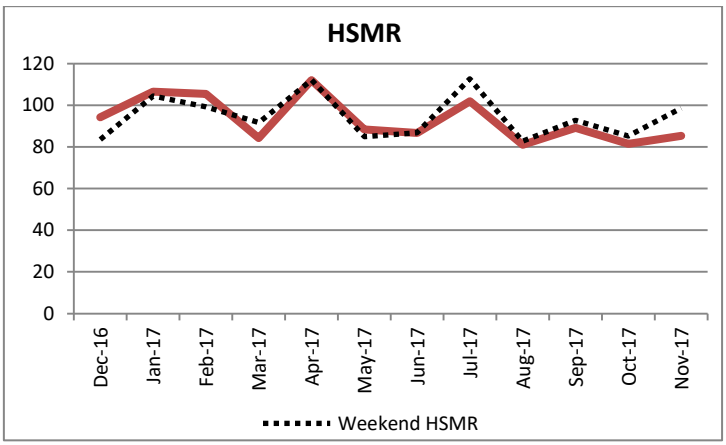


Figure 1 – HSMR timeline (Dec 16 – Nov17)

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

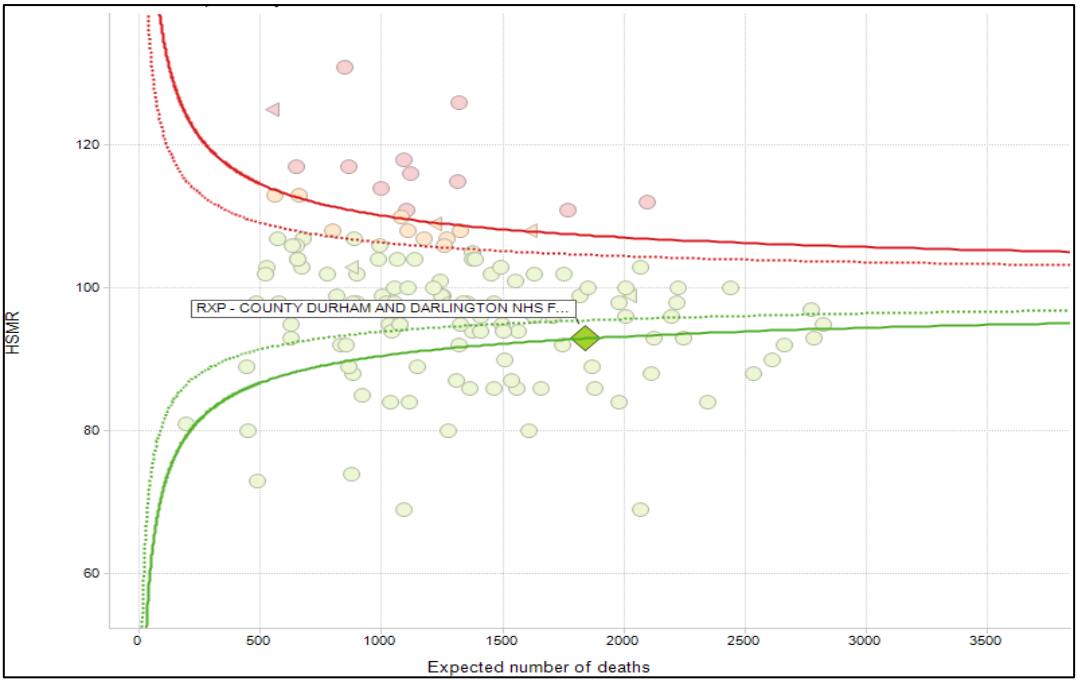


Figure 2 - Funnel plot showing expected number of deaths and HSMR (Dec 16 – Nov 17)

SHMI

The SHMI data (Figure 3) shows a peak in January 17, then fall to below the standard of 100 for the rest of the year with the exception of April. April 17 showed a slight rise to 103, mirrored by HSMR which showed a more pronounced rise that month. For the 12 months up to Nov17, the Trust sits comfortably in the middle of the funnel plot (Figure 4).

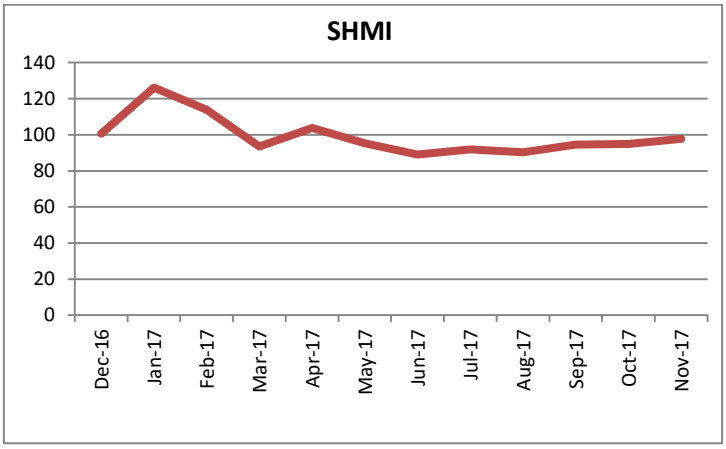


Figure 3 – SHMI timeline (Dec16 – Nov17)

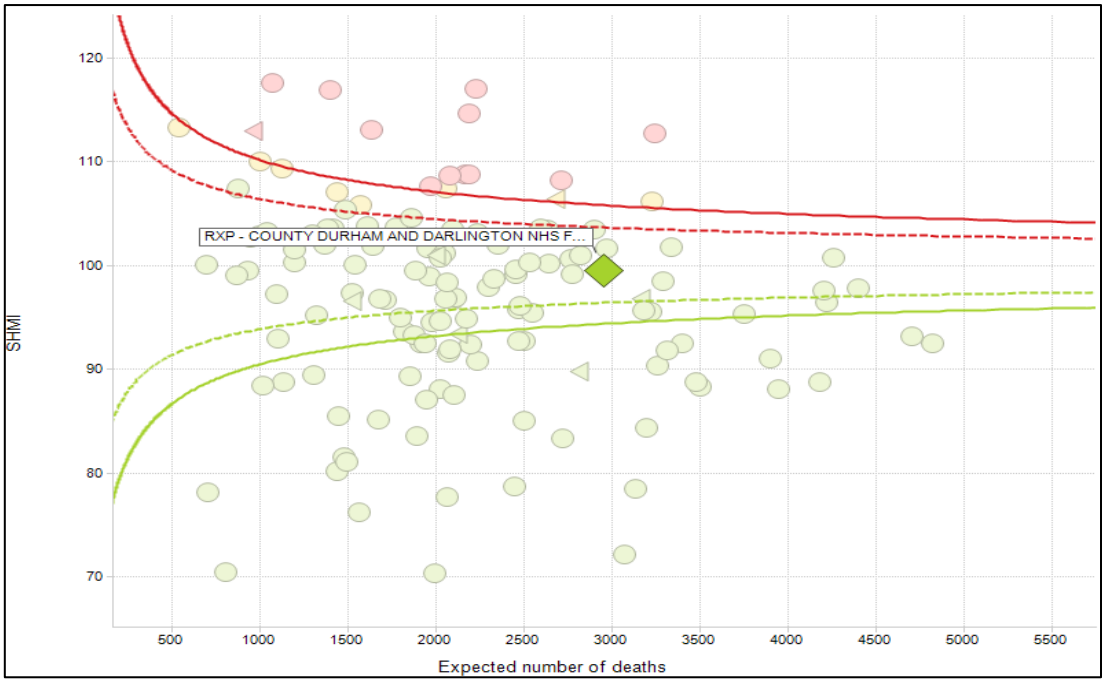


Figure 4 - Funnel plot showing expected number of deaths and SHMI for period Dec 16 – Nov 17.

Crude Mortality

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

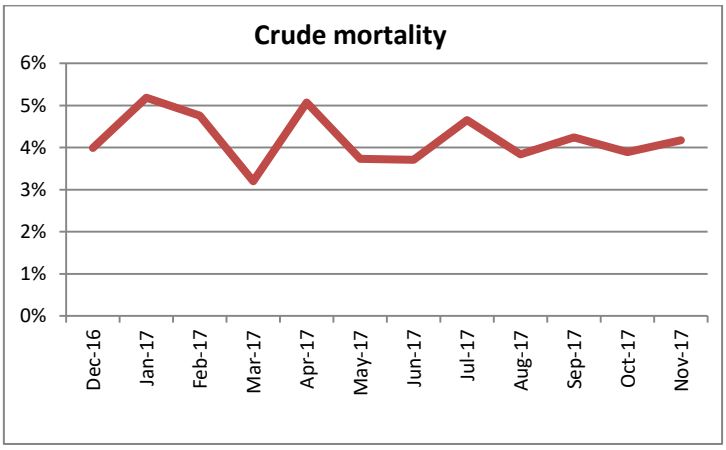


Figure 5 – Crude Mortality timeline (Dec16 – Nov17)

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:

- Ensure that mortality remains a strong focus for the Trust, by;
- Continuing to embed the recommendations of the CQC's report 'Learning, candour and accountability', and the National Quality Board's National Guidance on Learning from Deaths for Trusts March 2017.
- Build on the redesigned mortality review process within the organisation.
- Continue to develop ward/speciality mortality reports and dashboards to ensure learning from the mortality review process is relevant to individual areas and results in a reduction in harm

- Continue to develop links with Regional and Primary Care colleagues to ensure joint learning.

In support of the above, the Trust is in the process of appointing a substantive Mortality Lead who will embed the processes and progress made by the mortality project lead - anticipated start date May 2018.
It is generally accepted that the overriding purpose of mortality rates is to promote enquiry into clinical practice and in the context of mortality this necessitates critical review of deaths.

The Trust has defined which deaths are mandated for a case note mortality review, and this criteria is detailed within the Trusts Learning from Deaths policy which is published on the Trust website. A central mortality review team will review these deaths, along with a sample of 30% of all other deaths. The central review team is fully recruited to, and training of it's members is either complete or planned. The outcome of these reviews is presented on the Trust Mortality review Dashboard at the Trust board quarterly. Work is underway to ensure information from all other review forums outside the central team is also captured and presented on the dashboard. Maternity and paediatrics have a separate mortality review process that fulfils statutory requirements in these areas. This work is currently co-ordinated by the Project Lead, and moving forward the Associate Director for Mortality. All data is reported into the Trust's Mortality Reduction Committee.

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 will 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. In 2018/19 these reports will be developed further in line with the Trust level dashboard.

The trust continues to collaborate with peers across the region and with colleagues in primary care to share learning and to undertake joint work to improve patient care. Regionally there are projects looking at the management of sepsis, acute kidney injury and community acquired pneumonia that have been generated from the regional mortality work.

The Trust have appointed a Deputy Medical Director for Primary Care and work will progress 2018/19 to engage with primary care colleagues to ensure that learning is shared with community matron and Primary care colleagues. The collaborative effort with primary care colleagues will be developed in accordance to the leaning from deaths national agenda

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 and to understand the reason for them. This may shed light on opportunities to improve patient care which are not being taken.

Progress
Re-admissions between April – Nov 2017 rose by 0.9%. Re-admissions following an elective spell fell by 30% but those following a non-elective admission grew by 9%. The majority of re-admissions come from short-stay or assessment areas of the hospitals.

The Trust is still in discussion with commissioners regarding a further audit of re-admissions. Based on the previous audit, 42% of CDDFT re-admissions are currently deemed avoidable, and consequently attract a reduced tariff payment. This figure is much higher than that achieved by other Trusts in the region. Advice has been sought from NHS Improvement and revised Terms of Reference, which should reflect the real position more accurately, have been drafted in preparation for a further review.

In addition, the Trust and commissioners are seeking to review and understand the impact of the investments in re-admission avoidance services made by commissioners with the savings they have accrued from the reduced tariff payments. Superficially, very little difference is discernible. Re-admission rates remain more or less unaltered.

Next Steps
Investments have continued in the Trust's intermediate care services, in CCG schemes focussed on improved community nursing and in schemes to support care homes. In addition, a major re-configuration of community services into Community Hubs and multi-disciplinary teams around patients (TAPS) has taken place during 2017. Some instability has been caused by the commissioners' decision to tender for all the community services currently provided by CDDFT, but a decision on future provision is expected by the end of the financial year, 2017-18.

A wide range of actions, which bear on admission and re-admission rates, are also in train under the Transforming Emergency Care Programme. The key themes are *assess to admit, today's work today* and *discharge to assess*. Actions include:

- Primary care streaming at the A&E front door.
- More robust command and control mechanisms
- Revised emergency pressures policy
- Joint CCG-Council appointment of a County Durham Director of Integration
- Moving towards "discharge to assess" and "trusted assessor" models to reduce duplication of effort.
- Roll-out of SAFER care bundles across all wards (setting minimum standards for Ward and Board rounds and activities to minimise unnecessary delays.
- Extended hours discharge lounges.
- Nurse-led first responder pilot when ambulance delays are being experienced.

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) 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. This balances times of greater pressure when Trust performance is more likely fall below the national standard.

A&E 4hr Wait Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
NHSI Trajectory	**89.91%**	**92.37%**	**92.83%**	**95.16%**	**95.70%**	**95.37%**	**94.32%**	**91.82%**	**89.53%**
Performance	**94.76%**	**90.82%**	**93.16%**	**93.67%**	**95.07%**	**96.83%**	**95.56%**	**93.64%**	**85.19%**

Key: Green = achieved both NHSI trajectory and 95% national standard; Amber = failed either NHSI or 95% national standard; Red = failed both NHSI and the 95% national standard

In Quarters 1 (Q1) and Q2, Trust performance exceeded the NHSI trajectory whilst falling short of the 95% national standard. However, in Q3, Trust performance of 91.29% fell short of the STF trajectory of 91.94% in spite of the *Perfect Month* initiative in December, and a range of other actions. These included opening up to 70 extra escalation beds (including temporary conversion of day case and ambulatory care units for overnight in-patient use), introducing Primary Care Screening at both A&E Departments, and being the only Trust in the N.E. to open up Advice and Guidance services to GPs in all Specialties as an alternative to out-patient referral or admission. A&E activity continues at high levels at the beginning of Q4.

The shortfall against trajectory exposes the Trust to potentially significant financial penalties but an appeal has been submitted on the basis that the shortfall was caused by unanticipated high levels of activity, in that:

- If Urgent Care activity had been the same in Q3 this year as last year the Trust would have achieved the STF trajectory target with a performance of 93.4%. In fact, Urgent Care (type 3) attendances fell by 46.2% due to commissioning changes by DDES CCG.
- A&E activity in Q3 2017-18 was 8.5% ahead of plan and 5.1% higher than in Q3 2016-17. In December 2017 it peaked at 12.3% ahead of Plan and 11.23% higher than in December 2016.
- Non-elective admissions in Q3 were 14.8% ahead of plan and 4.7% higher than in Q3 2016, including a growth in medical admissions of 11.4%. In December 2017, total non-elective activity rose to 16% ahead of plan and 4.1% higher than in December 2016, including 10.9% more medical admissions at UHND.

Over the course of Q1-Q3, the percentage of handovers taking >30 minutes was 86% (better than the 82.5% figure for 2016-17. As a result, NEAS lost 1388 hours awaiting handovers compared to 1716 in Q1-Q3 2016-17. In December, however, winter pressures reduced handover performance to 71.5%.

Next Steps

In line with NHSE guidance, the Trust continues to review daily whether to cancel non-urgent electives in order to create space for non-elective patients. It also plans to keep open most of the escalation beds throughout Q4 and has extended command and control arrangements by the introduction of 24/7 bronze command. A further *Perfect Month* initiative will take place in March 2018 and estates work associated with the introduction of Primary Care screening at the A&E front door will be completed.

In addition, the Trust's Transforming Emergency Care Programme, overseen by the Local A&E Delivery Board, will continue.

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 2017-18, 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. Care Group representatives from the Trust have presented improvement in compliance at National PROMs Summit in London in December 2017. 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 2018 as this is presented via NHS digital 18 months in arrears. NHS England have indicated that PROMs data will not be required to collect data for reporting for Varicose Veins and Groin Hernia moving forward.

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 2017/18 County Durham & Darlington NHS Foundation Trust provided and/or sub-contracted 125 relevant services.

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

The income generated by the relevant health services reviewed in 2017/18 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 2017/18.

Review of Services

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

At each of its meetings, the Trust Board receives an Integrated Board report covering the four key Touchstones: best experience, best outcomes, best efficiency and best workforce. The report includes an integrated performance scorecard.

The Trust has reviewed its Performance Management Framework which continues to involve a monthly review of each Care Group's objectives and performance on all the key metrics affecting the four Trust Touchstones. It also includes a quarterly Executive-led Review and an annual opportunity for Care Groups to review the performance of corporate Departments.

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

Participation in Clinical Audits and National Confidential Enquiries

During 2017/18 47 national clinical audits and 6 national confidential enquiries covered NHS services that County Durham & Darlington NHS Foundation Trust provides.

During 2017/18 County Durham & Darlington NHS Foundation Trust participated in 100% 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 2017/18 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 17– Mar 18	% 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) -	✓	✓	✓	✓

National Maternity and Perinatal Audit (	✓	✓	✓	N/A Organisational Audit
Paediatric intensive care (PICANet)	X			

National Audit/ National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 17 – Mar 18	% cases submitted
Acute Care				
Adult critical care (Case Mix Programme) –	✓	✓	On-going data collection. Final quarter to be submitted May 18	100% April – Sep 17
National emergency laparotomy audit (NELA)	✓	✓	✓	*DMH 81% UHND 82%
Hip, knee ankle, shoulder elbow replacements (National Joint Registry)	✓	✓	On-going	88%
Major Trauma Audit (Trauma and Audit Research Network TARN)	✓	✓	On-going. Data still being collected	27th Jan 2018 UHND 72 - 83% DMH 100+%
Fractured Neck of Femur (Royal College of Emergency Medicine)	✓	✓	✓	**100.0%
Procedural Sedation in Adults (care in emergency departments) (Royal College of Emergency Medicine)	✓	✓	✓	**100.0%
Pain in Children (Royal College of Emergency Medicine)	✓	✓	✓	**100.0%
National Clinical Audit of Specialist Rehabilitation for patients with complex needs following Major Injury (NCASRI)	X			

* Case ascertainment required is >80% of expected cases between 1/12/16 and 30/11/2017

** 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 17– Mar 18	% cases submitted
Long Term Conditions				
Chronic Obstructive Pulmonary Disease (COPD) Audit Programme Chronic Obstructive Pulmonary Disease Rehabilitation audit . Chronic Obstructive Pulmonary Disease Secondary Care Audit	✓ ✓	✓ ✓	✓ On-going data collection	*100% N/A
Diabetes (National Adult Diabetes Audit)	✓	✓	✓	100% of cases on System One and databases
Diabetes (RCPH National Paediatric Diabetes Audit)	✓	✓	✓	100% cases on database sent
National Pregnancy in Diabetes (NPID)	✓	✓	✓	100%

National Diabetes Footcare Audit (NDFA)	✓	✓	✓	*100%
Inflammatory Bowl Disease (IBD) Programme (IBD Registry)				
National Clinical Audit of Biological Therapies	✓	✓	✓	?????

* 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 17 – Mar 18	% 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 17– Mar 18	% cases submitted
Older People				
Falls and Fragility Fractures Audit Programme (FFFAP):				
Fracture Liaison Service Database (FLS-DB)	✓	✓	On-going Data to be extracted May/June 18	N/A
Hip fracture (National Hip Fracture Database)	✓	✓	✓	100%
Inpatient falls (RCoP)	✓	✓	✓	*100%
Sentinel Stroke National Audit Programme (SSNAP)	✓	✓	On-going 17/18 final 4 months data to be submitted by 2/5/17	70-80% (B) case ascertainment 6/4/17
National Audit of Dementia Royal College of Psychiatrists	✓	✓	✓	**100%
UK Parkinson's Audit:				
Speech and Language Therapy Audit	✓	✓	✓	***100%
Physiotherapy	✓	✓	✓	***100%
Occupational Therapy	✓	✓	✓	***100%
Elderly Care	✓	✓	✓	Iv 100%

* Snapshot audit of the care provided to a sample of up to 30 patients per acute site was achieved.
** A minimum of 50 patients for each hospital site was required (UHND = 59 and DMH= 52)
*** The minimum of 10 patients for each service was achieved.
Iv The minimum of 20 patients for each service was achieved

National Audit/ National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 17 – Mar 18	% cases submitted
Heart				
Acute Coronary Syndrome or Acute Myocardial Infarction & other ACS (MINAP)	✓	✓	On-going	Data to be submitted 30/06/2018
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 0-30/06/2018
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	?????

National Audit/ National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 17 – Mar 18	% 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)	✓	N/A	Audit ceased to be part of NCAPOP from May17	N/A
Prostate cancer (National Prostate Cancer Audit)	✓	✓	On-going monthly data submissions	100%
National Audit of Breast Cancer in Older Patients (NABCOP)	✓	✓	On-going monthly data submissions	100%

* Data collection deadline in 2017/18 for patients covering period Jan – Dec 2016
** Data collection deadline in 2017/18 for patients covering period 1st Apr 2016 – 31st Mar 2017
*** Data collection deadline in 2017/18 for patients covering period 1st Apr 2016 – 31st Mar 2017

National Audit/ National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 17 – Mar 18	% cases submitted
Other				
Elective surgery (National PROMs Programme)	✓	✓	N/A	N/A

Learning Disability Mortality Review Programme (LeDeR Programme)	✓	✓	✓	LeDeR as yet are unable to provide deaths by specific Trusts/Hospitals
National Ophthalmology Audit (NOD)	✓	✓	✓	100%
National Bariatric Surgery Registry (NBSR)	✓	✓	Prospective Ongoing data collection	100%
National Audit of Intermediate Care	✓	✓	✓	*N/A
Endocrine and Thyroid National Audit BAETS	✓	✓	Ongoing data collection by surgeons that joined BAETS in 2016 to participate	N/A
Serious Hazards of Transfusion (SHOT) :UK national haemovigilance scheme	✓	✓	No incidents for CDDFT	N/A
National Neurosurgery Audit Programme	X			
BAUS Urology Audits: Nephrectomy Audit	X			
BAUS Urology Audits: Percutaneous Nephrolithotomy	X			
BAUS Urology Audits: Radical Prostatectomy Audit	X			
BAUS Urology Audits: Cystectomy	X			
BAUS Urology Audits: Urethroplasty	X			
BAUS Urology Audits: Female stress urinary incontinence	X			

* Trust only submitted In the Organisational Audit.

National Clinical Audits reviewed in 2017/18	Action
National Neonatal Audit Programme (NNAP) 2016	Draft action plan to be drafted
National Paediatric Diabetes Audit 15/16	Draft action plan to be signed off at a speciality/care group level.
National Audit of Dementia 16/17 care in hospital UHND/DMH	Cognitive tests assessed on admission and again before discharge. (to be incorporated into the F1 training) and embedded into practice. Ward managers to promote the recording of factors which may cause distress and the action or actions which can help calm the patient. Clinical teams complete the “This is me” booklet and involves the patient and carer in this (if not already done in primary care). Ward managers to implement the use of personal patient information from “this is me/hospital passport “in to care plans. Results and sufficient information regarding the episode of delirium recorded on the electronic discharge summary. (to be incorporated into the F1 training) and embedded into practice. Implementation of carers passport to enable carers to be given the opportunity and support to spend as much time as necessary whenever they need to. Staff are trained in mental capacity, consent, best interest’s decision making, lasting powers of attorney and supportive communication with family/carers on these topics. Site nurse practitioners and bed managers to develop expertise in dementia care to ensure support for staff 24 hours per day 7 days per week. Ensure staff receive training in delirium and its relationship with dementia, manifestations of pain, behavioural & psychological symptoms treatment, care. Further develop, implement and promote the finger food menu. Patients, families/carers are involved in discharge planning. Carers are identified at first contact or as soon as possible after this. Before a person is discharged, their physical, psychological and social needs must be assessed. The person with dementia and someone involved in their day-to-day care should be fully involved in this assessment. Plans about the date and time of discharge should be discussed with the person and their carer. Any organisations that will be providing services must be informed of the date and time of the person's discharge, and when they should start to provide the services.
Royal College of Emergency Medicine – Asthma paediatrics	To include in August Educational Programme for Nursing and Medical Staff to improve both treatment and documentation.

and adults 2016 (Darlington Memorial Hospital)	A dedicated doctor will be allocated to paediatrics to ensure prompt assessment and treatment is initiated for children with asthma. Advanced Paediatric Nurse Practitioner (APNP) will deliver bespoke training to ED nurses and junior doctors on the assessment and management of paediatric asthma, including the administration of oxygen, assessment of inhaler technique. Also ensuring discharge advice is given and documented. All paediatric patients will have initial observations undertaken within 15 minutes of attendance, including oxygen saturation measurement, .. .Vital signs will be repeated and recorded on a paper observation chart and PEWS calculated so that observations and trends can easily be observed, within 60 minutes of first set. Key messages will be developed to communicate to staff.
Royal College of Emergency Medicine – Asthma paediatrics and adults 2016 (University Hospital of North Durham)	Remainder of asthma management to be placed prominently in the Emergency Department . To discuss at senior staff meeting whether oxygen should be formally prescribed on a chart. Ensure sufficient Peak Flow meters are available in all clinical areas, and publicise need for use in prominent place, Key messages. Reminder of asthma protocols to be placed in high traffic areas. As regards ensuring safe discharge planning liaise with respiratory paediatrician, with regard to action plans and discharge leaflets, and respiratory physician re: adult plans, and educate staff in key messages. When available, liaise with ward clerk to ensure discharge advice is readily accessible to clinical staff.
Royal College of Emergency Medicine – Severe Sepsis and Septic Shock 2016 (Darlington Memorial Hospital).	To include in August Educational Programme for Nursing and Medical Staff to improve both treatment and documentation. Communicated to staff as a key message and included in nursing huddles at shift handover. All patients should have an initial assessment within 15 mins of attendance, GP primary care streaming will be initiated by 1st October 2017 which will improve time to initial assessment. Medical and Nursing sepsis leads have been nominated to promote sepsis training at departmental level. On-going training on sepsis recognition carried out in Emergency Department by Cardiac Arrest Prevention Team. Emergency Department Registered Nurses trained in taking blood cultures using a WASP framework assessment.
Royal College of Emergency Medicine – Severe Sepsis	Reminder to perform BM – laminated card placed in high traffic areas.

and Septic Shock 2016 (University Hospital of North Durham)	In University Hospital of North Durham an ST3 is acceptable senior review. Encourage senior review and for this to be documented. Include in Key messages. Reminder of sepsis 6 – placed in high traffic areas. Sepsis form to be scanned into Emergency Department system - liaise with ward clerk. Ensure staff have access to Arterial Blood Gas machine login. Liaise with ward clerk re: scanning printouts Discuss with IT – is a computer link to the gas machine possible. Contact IV team- to enable nursing staff to be trained in taking blood cultures.
National Oesophago-Gastric Audit 2016	Importance of accurate description will be re-enforced to all endoscopists. A nurse led Barretts Clinic has already been set up to standardise and improve complete data.
National Diabetes Audit (Adult) 15/16	To re-emphasise to data clerk to document serum creatinine. To re-emphasise to data clerk to document urine albumin Hba1c targets: These are worse than the England averages because we see poorly controlled diabetes in secondary care and by that nature to compare would be unfair. The number of patients with Hba1c less than 58 should decrease as the service have a drive to discharge more of the patients who have good control. The service would, however prefer to see the number of patients with Hba1c more than 86mmol/mol decrease and be closer to the national average.
National Diabetes in Pregnancy Audit 2015 Darlington Memorial Hospital	Letter to be sent by Diabetic lead at DMH. To continue to education of Primary Care Trust on the use folic acid 5mg supplement prior to pregnancy. Continue to work on first trimester control and provide robust antenatal/diabetic care.
National Diabetes in Pregnancy Audit 2015 University Hospital of North Durham	Letter to be sent by Diabetic lead at UHND. To continue to education of Primary Care Trust on the use folic acid 5mg supplement prior to pregnancy. Continue to work on first trimester control and provide robust antenatal/diabetic care.
National Diabetes Inpatient Day Audit 2016 Darlington Memorial Hospital.	To continue education of Primary Care about early referral to the Diabetes Foot Clinic. To continue to educate Junior Doctors and health care professionals to ensure that prescriptions are accurate

	To continue to educate Junior Doctors and health care professionals to ensure that insulin is administered accurately.
National Diabetes Inpatient Day Audit 2016 University Hospital of North Durham.	New model of Diabetes Service to start in Oct 17. Seven day extended Diabetes Specialist Service reduce insulin infusion use. Plans to increase consultant recruitment and foot clinics in the next 24 mths. Aim to reduce severe hypoglycaemic episodes with the : New diabetes model service. Buddy ward education mode.l Diabetes Specialist Nurse Education model.
National Hip Fracture Database Audit 16/17	Draft action plan to be signed off at speciality and care group level.
MINAP 14/15	On-going review of admission criteria to acute cardiac wards (units).
MINAP 15/16	On-going review of admission criteria to acute cardiac wards (units). Re-enforce use of MINAP data collection form to ensure accurate recording of secondary prevention.
National Heart Failure Audit 2015/16	Draft action plan to be signed off at speciality and care group level.
National Diabetes Footcare Audit 14/16	To continue to educate of primary care re the pathway and the need to refer immediately there is a footcare problem.
National Emergency Laparotomy Audit (NELA) Dec 15-Nov 16 (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.
BTS Adult Asthma 16/17	Introduce an Asthma Care Bundle stamp across all wards to help ensure comprehensive data collection. Increase awareness of objective testing within Emergency Department and Acute Medical Unit at Darlington Memorial Hospital.
Falls and Fragility Fractures Audit Programme : National Inpatient Falls Audit 2017	
MBRRACE Surveillance of maternal deaths in the UK 2012-14 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-14	Care Pathway. Areas of assessment in the event of emergency at point of assessment. Guideline / pathway to be developed to ensure early referral to ECMO.
National Bowel Cancer Audit 14/15 (2016 Annual Report)	Encourage patient's in the clinic who are eligible for bowel screening.

	If no resection is offered these patients should have an alternate pathway plan. Starting enhanced recovery audit, approved by CSTC pending minor alterations. ERAS programme will identify any potential delays to discharge.
SSNAP Organisational Audit 2016	Although physiotherapy is available at weekends, staffing issues and service configuration prevents the others. On-going business case development. Continue with business case to support ESD.
SSNAP Audit 15/16	Prioritisation process in place for patients CT scans. Band 6 or above to be trained with second stage SALT assessment has been highlighted to service manager. There is current a business case in the process of being approved that would enable ESD and meet this standard.

Confidential Enquiries

County Durham and Darlington NHS Foundation Trust has participated/is still participating in 6 enquiries during the course of 2017/18. The Trust has submitted/is submitting either patient or organisational data for all studies which were deemed relevant.

Confidential Enquiries reviewed in 2017/18	**Action**
NCEPOD – Inspiring Change Acute Non Invasive Ventilation	A structured plan for future treatment should be discussed with the patient and/or carer either at the point of discharge from hospital or at subsequent follow-up.

The reports of 24 local clinical audits were audits reviewed by provider in 2017/18 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 2017/18	**Action**
A Quality Improvement Project To Improve Prescribing At The End Of Life At University Hospital North Durham	Introduce training to Foundation doctors on end of life prescribing into their Foundation Programme teaching Introduce an 'end of life' anticipatory prescribing order set into ePMA through discussion with the ePMA and Palliative Care teams.
An audit of the investigation and management of rectal cancer within the CDDFT trust March 2014 - March 2015	Liaise with radiology to decrease length of wait for staging examinations particularly with MRI. Earlier referral to specialists for downstaging chemo/radiotherapy when results of imaging available.
Neck Ultrasounds – are requests complaint with BMUS Guidelines	BMUS Guidelines to be shared with referrers. Disseminate results of audit among referrers
Neuromuscular Block Monitoring Before Extubation: Are We Following National Guidance?	To consider buying more nerve stimulators. To consider buying more quantitative monitors
Clinical Audit Inpatient Scales	Clinical areas to record any weighing equipment they hold, when it was purchased, what calibration and or

	servicing is needed, when this is required and by whom and the frequency is this to be done. Consider a tender for on-going maintenance and calibration of patient weighing equipment. To explore equipment options and costs, to make available equipment fit for purpose and that staff are trained in using any new equipment acquired Care pathway embedded into practice. Role essential training for all ward based nurses.
Reversal of treatment for Glaucoma or Occular Hypertension	All newly diagnosed patients to be seen by a senior doctor at least once to confirm the validity of the first diagnosis. Ideally, all glaucoma patients to be followed up by a team with special experience and expertise i.e. Glaucoma specialists Review all patients with Glaucoma or OH and assess the accuracy of the original diagnosis. Stop treatment in selected patients. This would help the patients with unnecessary hospital visits, thus saving expenses for all.
Impact of Papilloedema referrals on the Ophthalmology Department.	Pathway to be made available to all in Casualty. Prompt and correct referral when found to have papilloedema.
Audit to compare the use of temperature monitoring and warming methods in adults undergoing surgery at UHND with recommended national guidelines.	Disseminate an email and discuss with theatre staff regarding changing the starting fluid volumes from 1000ml to 500ml. Any further fluid needed after this should be warmed. Discuss results at departmental meeting and explain NICE guidelines into temperature monitoring and warming methods.
Outcome of Cataract Surgery in Diabetic and Non Diabetic and compare with HbA1c level.	To ensure all the patients get their post-operative BCVA on each and every visit. To update contact details on each and every visit.
Audit of Anti-Vegf treatment in Age Related Macular Degeneration.	Create a new referral form with better placement. Contact Royal College of Ophthalmology to explain the issue with audit of their standards of care when using the urgent care referral form produced by them.
Audit into the management of perioperative hypothermia.	Commence a PDSA cycle. Consider question on the pre-induction checklist asking “Is this patient at risk of hypothermia?” This may prompt staff to think about using warming systems. Increased education and awareness for staff of the importance of avoiding POH and measures that can be done to do so. Revisit the PDSA cycle re: all IV fluids >500ml should be warmed.
Outcome of Scaphoid fracture non-union fixation	Increase in the number of patients undergoing percutaneous fixation with bone grafting can potentially improve healing rate.
Ambulatory Emergency Care – Maintaining Quality and Safety.	Train nursing and medical staff to accurately record AMB scores and to complete the referral proforma.
An Audit of Appropriate Diagnosis and Management of UTI in Adults (non-pregnant).	Increasing awareness among medical staff about the importance of following the Hospital protocol through verbal communication to colleagues. Hanging a copy of the Protocol on the ward board for easy reference and a constant reminder.

MRSA Decolonisation in neck of femur fracture patients.	Guidance booklet re: prescribing MRSA prophylaxis being written for new foundation doctors starting surgical placements.
Audit of TARN quality indicators for trauma CT	Agreement with administrator on which data to be taken from Radiology systems. Detailed analysis of the cases which missed the targets to identify root cause. Agree a target time for CT to be sent to Medics for reporting e.g. 10 mins. Introduce a provisional trauma report template to aid swift reporting.
Hypopack Audit	Paediatricians agreed to ensure urine samples are sent. Raising awareness amongst staff in A&E regarding the indications for and importance of sending Hypopacks when identifying hypoglycaemia in children.
VTE Risk Assessment and Prophylaxis	Renew push to re-educate junior doctors about the importance of VTE risk assessment & prophylaxis. Encourage the T&O department to think about a move away from paper VTE assessment tools to electronic tools by incorporating VTE risk assessment as part of the EPMA electronic prescribing system on iSOFT such as that already practiced by the medical department.
Audit of consent forms in Trauma Orthopaedic Surgery in Darlington Memorial Hospital.	To discuss blood transfusions with all patients if this is applicable and to offer information leaflet. Write box of 'not applicable for this section' (special requirements). Consenting doctors should fill this in for all patients. All doctors should offer patients copy of consent forms and record this information. Designing patient friendly info leaflet for trauma patients.
An audit of awareness of tools for diagnosing delirium	Increase awareness of CAM as screening tool for delirium by: • Posters in ward offices. • Liaise with IT to have delirium screensavers and make the CAM proforma available on the intranet.. • Liaise with mental health to suggest a delirium awareness day. • Consider mandatory delirium screening on iSoft within 24 hrs of admission of any patient over the age of 65.
Are we complying with the Trust's Guidelines: Management of Venepuncture (Adults) and Management of Cannulation (Adult), In the specific steps to reduce the risk of haemolysis.	Clear standards/instruction will be developed to identify best practice in relation to skin preparation. Clear standards/instruction will be developed to identify best practice in relation to tourniquet time. Five venesection trays will be ordered Disseminate venesection tray instruction. During first week of introduction, venesection will only take place using a 'fresh stab' vacutainer system. Prior to introduction full instructions must be given to all staff relating to the above action. During introduction utilise every shift handover to reinforce details regarding the intervention.
Three year block dissection	Add indication to proforma.

	Undertake a literature review re: Antibiotic protocol for groin dissection and discuss with Microbiology.
An Audit of AMU performance against Society of Acute Medicine (SAM) clinical quality indicators regarding the time of initial clerking and senior review.	Reminding doctors of the importance of documentation on admission clerking documents. Sharing the information at the Junior Doctors Forum. Reminding the on-call team about the target of 100% od patients seen within 4hrs of admission. Discuss on ways to improve junior doctors cover especially during winter.
Compliance of AMTS documentation at admission of patient's >70 yrs	To improve compliance with documentation of AMTS in >70 yrs present findings of audit an implement changes (presentations and education session and visual reminders. Constant reminder to juniors \nursing staff to document AMTS at admission for patients aged >70 yrs with Consultant support.
Audit of Acute Kidney Injury (AKI) Management	Education on AKI aimed at junior and senior medical staff. AKI bundle to be trailed on AMU.

Research & Development

The number of patients receiving NHS services provided or sub-contracted by County Durham & Darlington NHS Foundation Trust in 2017/18 that were recruited to participate in research approved by a Research Ethics Committee was 1874 participants. The table below shows the areas research has taken place within CDDFT. The complexity adjusted recruitment figures for 2017/18 were 12259 showing a 63% increase in the complexity of the studies delivered as compared to 31% average for the Clinical Research Network North East & North Cumbria (CRN: NE&NC).

Managing Specialty	Total
Anaesthesia, Perioperative Medicine and Pain Management	**2**
Cancer	**189**
Cardiovascular Disease	**58**
Children	**54**
Critical Care	**178**
Dementias and Neurodegeneration	**2**
Dermatology	**89**
Diabetes	**33**
Ear, Nose and Throat	**4**
Gastroenterology	**507**
Genetics	**1**
Haematology	**5**
Health Services Research	**53**
Hepatology	**16**
Infection	**95**
Injuries and Emergencies	**12**
Mental Health	**12**
Metabolic and Endocrine Disorders	**6**
Musculoskeletal Disorders	**31**
Neurological Disorders	**2**
Primary Care	**12**
Renal Disorders	**3**
Reproductive Health	**327**
Respiratory Disorders	**8**
Stroke	**76**
Surgery	**99**
Total	**1874**

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

During 2017/18 County Durham & Darlington NHS Foundation Trust was involved in conducting National Institute for Health Research (NIHR) Portfolio clinical research studies in the following new areas of sexual health and ENT

Areas in which non-NIHR clinical research studies were conducted by County Durham & Darlington NHS Foundation Trust in 2017/18 include:

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

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

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

We have 90 Principal Investigators (PI's) across all specialties and disciplines with 38 currently leading multiple clinical research studies across the organisation demonstrating a good platform from which to build ensuring research is firmly embedded as core Trust business and have successfully increased the number of NMAHP PI's with two of the top five recruiting PI's for 2017/18 being nurses. In 2018/19 we aim to continue to develop more Chief Investigators within CDDFT therefore the number of Investigator Initiated studies in line with national priorities.

2017/18 also saw the formal coming together of the Clinical Research Department and the Innovation team further embedding a fully integrated Research & Innovation Department within the Trust.

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

The main CQUIN scheme covers two years (2017-19) and carries financial incentives to the value of 2.5% of the total Trust contract; of which 1% is contingent upon CDDFT participation in the regional Sustainability and Transformation Plans (STP) and achieving financial targets agreed with NHS Improvement (NHSI).

A further 1.5% is contingent upon quality improvements in several nationally defined indicators. In addition to its main CCG contract, CDDFT has small contracts with NHS Specialist Commissioners and with NHS Public Health, both of which include small CQUINs.

The CQUINs are:

CCG CQUINS – nationally mandated

CQUIN	Year 1 targets
1a. Staff Survey Improvements (Acute and Community)	5% improvement on two of three questions from Staff Survey: 1. Does your organisation take positive action on health and well-being? 2. In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities? 3. During the last 12 months have you felt unwell as a result of work related stress?
1b. Healthy Food (Acute and Community)	70% of drinks lines stocked must be sugar free; 60% of confectionery and sweets do not exceed 250 kcal; at least 60% of pre-packed sandwiches and other savoury pre-packed meals available contain 400kcal (1680 kJ) or less and do not exceed 5.0 g saturated fat per 100g. CQUIN applies to UHND, DMH, BAH, CLS, Shotley.
1c. Staff - Flu Vaccinations (Acute and Community)	Flu Vaccinations. Achieve an uptake of flu vaccinations by frontline clinical staff of 70%
2a. Sepsis screening in ED	90% target
2a. Sepsis screening in In-patients	90% target
2b. Sepsis treatment within one hour in ED	90% target
2b. Sepsis treatment within one hour in IPs	90% target
2c. Antibiotic review within 72 hours (Acute)	90% target by Q4
2d. Reducing antibiotic usage	Reducing antibiotic consumption.: all antibiotics, carbapenem and piperacillin-tazobactam
4. Improving services for MH patients in A&E	Identify cohort, Audit coding, establish governance process and Care Plans, reduce by 20% A&E attendances by a defined group of frequent attenders with mental health problems.
6. Offering Advice & Guidance (A&G)	Agree Specialties and quality standard, mobilise first tranche, plan for 75% of Specialties to provide A&G, 35% of GP referrals to be made into Specialties which have an Advice and Guidance service.
7. E-Referrals	100% Consultant OP clinics on C&B and slot issues reducing to 4%.
8. Proactive & Safe Discharge (Acute and Community)	47.5% of >65 non-elective patients discharged to normal place of residence.
9. Wound care	Number of wounds which have failed to heal after 4 weeks that receive a full wound assessment.
10. Personalised Care / Support Planning	Submission of a plan to ensure care & support planning, Identify patient cohort, staff training, identify patients with Long-term conditions and a low activation level
11. Preventing ill health alcohol & tobacco	Tobacco and alcohol screening, brief advice & tobacco treatment offer for all non-elective admissions to community hospitals
SpecComm CQUINs	

Chemotherapy Dose Banding	Standardisation of chemotherapy doses
Medicines Optimisation	Adoption of best value drugs
Public Health & Youth Justice CQUINs	
Dental - Dashboard and Managed Clinical Network	Populate a quarterly Dashboard and contribute to development of a Managed Clinical Network
Bowel Screening - Patient feedback	Develop patient feedback mechanisms
Aycliffe Nursing - Patient feedback	Develop patient feedback mechanisms

Total CQUIN monies for 2017-18 amount to approximately £8.6m. A local agreement has been reached that CCGs will re-invest half of any monies CDDFT lose as a result of failure to achieve CQUIN targets. In Q1 all quality targets were achieved. In Q2, small losses occurred in relation to two CQUINs. Q3 evidence is in the process of being compiled for submission.

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 2017/18.

Care Quality Commission Ratings

The Trust is rated 'Requires Improvement' following the CQC's last inspection of the Trust, carried out in September and October 2017 and reported in March 2018. This inspection covered the following services at both Darlington Memorial Hospital (DMH) and University

Hospital North Durham (UHND): Urgent and Emergency Care; Medicine; Surgery and Maternity. Services were selected according to a risk assessment. CQC's report, published in March 2018, set out ratings tables which combined the outcomes of the latest inspection with ratings for those services not inspected, which were brought forward from the comprehensive inspection reported in September 2015.

Overall ratings by Domain are set out below:

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

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

Ratings grids for each Hospital / Community Services are:

Darlington Memorial Hospital (DMH)

Ratings for Darlington Memorial Hospital

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

University Hospital North Durham (UNHD)

Ratings for University Hospital of North Durham

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

Community Services

Ratings for community health services

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

Context and key issues

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

CQC have acknowledged that actions from the 2015 inspection were, in the main, fully implemented and noted a number of improvements in their report, in particular:

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

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

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

Improvement Plans and Progress

The Trust submitted a 51 point action plan to CQC on 23rd March 2018. This captured both initial actions, which had been taken in response to verbal feedback and CQC's draft reports, and the further actions required to address 'Must Do' requirements and 'Should Do' recommendations included in the final reports. The majority of the actions identified are already being implemented. Governance arrangements are in place to drive and assure delivery of the specific actions as follows:

- Actions are owned by Matrons and Heads of Service, or by relevant Heads of corporate departments in the case of Trust-wide policy and training issues concerning Mental Health conditions and the Mental Capacity Act.
- Accountability for service specific actions is included in annual operating plans agreed between the Executive Directors and the relevant Care Groups and these actions are to be monitored through the Care Group's Quality Governance forums and reported on, every month, to the Executive Patient Safety and Experience Committee. The Executive Director of Nursing will hold Executive accountability, through this meeting, for actions relating to nursing practice and staffing and the Executive Medical Director, or his delegate, will attend and be accountable for actions with respect to medical staffing and practice.
- Semi-independent monitoring checks will be undertaken by the Trust's Assurance and Compliance Team, and by Senior Nurses undertaking 'Back to Practice' visits to wards and Emergency Departments, to assess whether changes made are effective.
- The Board's Integrated Quality and Assurance Committee, chaired by a Non-Executive Director, will receive monthly reports to provide assurance of progress with respect to implementation of actions.

The Trust is seeking to enrol in NHS Improvement's 'Moving to Good' programme, which is designed to support Trusts with an overall 'Requires Improvement' rating in moving to a Good rating. Through this programme, alongside monthly meetings with NHS Improvement and bi-

monthly meetings with the CQC team, the Trust will avail itself of a wide range of support both to implement the specific actions but also to ensure that our culture, management and oversight arrangements are sufficiently robust to sustain improvements and maintain good performance across all services. The Trust will seek to obtain insight from Trusts rated 'Outstanding' and will seek independent support to strengthen mock inspections and other monitoring checks as part of this process.

The tables below summarise the actions underway to address the requirements and recommendations from CQC:

Urgent and Emergency Care	• Rooms used to assess patients with Mental Health conditions are to be modified to comply with best practice guidance on minimising opportunities for patients to harm themselves and others. A wider piece of work is being undertaken with Tees, Esk and Wear Valleys NHS Foundation Trust to implement the good practice with respect to patients with Mental Health conditions, set out in the National Confidential Enquiry "Treat As One" in our acute hospitals. • A risk assessment has been completed with respect to other potential ligature risks within our Emergency Departments. Where appropriate, work will be undertaken to mitigate risks identified. • Record-keeping and reconciliation procedures for controlled drugs have been standardised and made subject to frequent spot checks and audits to confirm compliance. • Arrangements have been put in place to secure intravenous infusions for potassium separately from other drugs, and to provide lockable cupboards in short stay rooms to secure patients own medications. • Guidance on recording of blood sugar levels has been reiterated and will be subject to regular spot checks and audits. • The policy for prescribing of oxygen therapy is to be reviewed and reiterated Trust-wide.
	• Medical and nursing staffing rotas are to be reviewed with expert support and nursing staffing aligned to demand. Recruitment of consultants and Associate Specialists will continue with the aim of enabling the Trust to meet Royal College of Emergency Medicine staffing guidelines. • A review of pathways is underway to strengthen our capacity to take ambulance handovers, to provide access to Children's Nurses for Paediatrics patients, and to assess patients within 15 minutes of arrival within our Emergency Departments. The Trust already has a range of actions in place, working with NHS Improvement's Emergency Care Intensive Support Team and our Local Accident and Emergency Delivery Board to seek to meet the 95% target for patients attending our Emergency Department to be seen and treated in four hours. These will continue.

Medicine	• A Task and Finish Group has been established to update the Trust's policies for compliance with the Mental Capacity Act in line with best practice. The policy has been rewritten and is undergoing review with external specialists prior to approval. The Group is also reviewing the training needs of all staff and will develop training programmes to meet those needs. • Weekly monitoring is now in place with respect to the application of Deprivation of Liberty Standards (DOLS), where appropriate, for patients subject to supervision or cohorting due to the risk of falls. • Required changes to the nursing assessment documentation have been identified, to prompt due consideration of capacity and DOLS issues. These are to be made to the templates in our electronic observations system, Nervecentre and trialled over the next quarter, with a view to full implementation in the second quarter of the year. • Our Safeguarding Adults Lead is working closely with ward staff to raise their awareness and understanding of the above requirements and we will create and appoint a lead for the Mental Capacity Act. • Further actions are planned to address additional, specific recommendations.
Surgery	• We will continue the roll out of arrangements to reinforce patient safety in theatres and to mitigate the risk of never events. These include Local Safety Standards for Invasive Procedures and associated training and audit procedures, so that we are assured that these standards are followed in practice. Independent audits will also be undertaken to assure ourselves that teams are complying with protocols introduced in response to never events in 2016/17 and 2017/18. • The Trust has an on-going programme of work in place to strengthen the culture within operating theatres, with some success. However, this has further to go and additional Organisation Development support will be provided to consolidate the positive changes experienced to date. • Theatre staffing has been reviewed against good practice guidance and recommendations. Further granularity is being sought prior to recommendations being made to the Board. Six monthly safe staffing reports to the Board will then be introduced as for other services. • Additional monitoring arrangements are to be put in place to ensure that time is protected for training for Theatre staff and that targets for training of staff in Safeguarding are met. • Spot checks are being put in place, reinforced by independent observational audits, to ensure that the difficult intubation trolley is checked in line with policy. • Further actions are planned to address additional, specific recommendations.

Conclusion

The Trust is committed to working with CQC, and with support from NHS Improvement, to address all requirements and recommendations and to sustain improvements in quality to achieve a "Good" rating at the next inspection.

Data Quality

Indicator	Target	2017-18 Months 1 -11
Data completeness community services - RTT*	50%	100.0%
Data completeness community services - Referrals*	50%	99.8%
Data completeness community services - Treatment activity*	50%	99.7%
% of SUS data altered*	10%	27.2%
Valid NHS number field submitted via SUS - Acute	99%	99.7%
Valid NHS number field submitted via SUS - A&E	95%	98.5%

County Durham & Darlington NHS Foundation Trust submitted records during 2017/18 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 M11 **
- which included the patients valid NHS number was:
  - 99.6% for Admitted Patient Care
  - 99.7% for Outpatient Care
  - 98.3% for Accident and Emergency Care
- which included the patient's valid General Medical Practice Code was:
  - 99.9% for Admitted Patient Care
  - 99.8% for Outpatient Care
  - 99.9% for Accident and Emergency Care

County Durham & Darlington NHS Foundation Trust Information Governance Assessment Report overall score for 2017/18 was 93% Green and Satisfactory.

County Durham & Darlington NHS Foundation Trust was not subject to the Payment By Results clinical coding audit during 2017/18
by the Audit Commission, however, internal audit carried out by our accredited audit yielded the following accuracy scores:-

- 98% Correct for Primary Diagnosis
- 94% Correct for Secondary Diagnosis
- 97% Correct for Primary Procedure
- 94% 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. The sample size had a combined denominator of 1,411 clinical codes.

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 and completion of the new Emergency Care Dataset
- 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.
- Co-morbidity validation reporting at record level, exception based.
- Improved clinical coding turnaround has resulted in a final quarter position that is under the 10% threshold.

Learning from Deaths

During 2017/18 1850 of Co Durham and Darlington NHS Foundation Trust's patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

439 in the first quarter;
433 in the second quarter;
524 in the third quarter;
454 in the fourth quarter.

By 31/3/18 191 case record reviews and 9 investigations have been carried out in relation to 1850 of the deaths included above.

In 9 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

79 in the first quarter;
60 in the second quarter;
37 in the third quarter;
15 in the fourth quarter.

Four, representing 0.11% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.
In relation to each quarter, this consisted of:

1 representing 0.23% for the first quarter;
1 representing 0.23% for the second quarter;
1 representing 0.19% for the third quarter;
1 representing 0.22% for the fourth quarter.

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

The key learning themes identified through both those deaths identified 2017/18 have been in relation to adherence to policy, documentation, escalation of care and sepsis. Learning identified through case record review overall has included caring for patients with an acute kidney injury, advanced care planning and initiation of DNACPR forms.

Actions that Co Durham and Darlington NHS Foundation Trust has taken in relation to the learning identified from those deaths in 2017/18 form part of comprehensive SMART action plans monitored through the Trust governance processes. The key actions are in relation to ensuring robust application of policy and procedure and taking steps to improve communication pathways and documentation.

A detailed action plan is in development in relation to improving advance care planning. The Trust has also recently appointed to a falls lead post.

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

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

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

Seven, representing 0.35% of the patient deaths during 2016/17, are judged to be more likely than not to have been due to problems in the care provided to the patient.

PART 3 ADDITIONAL INFORMATION

Financial Review

Despite a very challenging economic environment, the trust delivered an overall deficit of £tbc in 2017/18, which comprised an operational surplus of £tbcm (which was £tbcm ahead of plan) and an impairment of £tbcm resulting from a reduction in the value of the trust's land and buildings following a review by the trust's valuers, together with the trust's charity spending £tbcm in excess of the income it received in year.

Performance Framework

The Trust's operational scorecard is built upon the Four Touchstones. The latest figures available are for December 2017.

*Month: December 2017 * One month in arrears ** Two months in arrears ***Three months in arrears*

BEST EXPERIENCE		
Indicator	Target	Year to December
RTT - % Incompletes waiting <18wks*	92%	92.8%
RTT waits over 52 weeks*	0	0
A&E % seen in 4hrs - Trust Total	95%	93.1%
A&E % seen in 4hrs - All UCC 'Walk-ins' Type 3	95%	100.0%
Ambulance handovers >15-30mins	0	4401
Ambulance handovers >30-60mins	0	1151
Ambulance handovers >60mins	0	350
Ambulance Handovers - no. >120 minutes	0	32
12 Hour Trolley Waits	0	0
% Diagnostic Tests <6wks	99%	99.81%
Cancer 2WW*	93%	94.0%
Cancer 2WW Breast Symptoms*	93%	95.3%
Cancer 31 Days Diagnosis to Treatment*	96%	99.8%

Cancer 31 Days Subsequent Treatment - Surgery*	94%	98.8%
Cancer 31 Days Subsequent Treatment - Anti Cancer Drug*	98%	100.0%
Cancer 62 Days to First Treatment*	85%	87.5%
Cancer 62 Days Screening*	90%	92.8%
Cancer 62 Days Consultant Upgrade*	85%	100.0%
A&E % Seen in 4hrs - DMH	95%	91.7%
A&E % Seen in 4hrs - UHND	95%	86.2%
A&E CI - Unplanned Re-attendance rate	<=5%	1.5%
A&E CI - Time to treatment (median)	<=01:00	00:42
6 hour wait in Urgent Care Centres	95%	99.3%
Maternity 12 week bookings	90%	91.4%
Maternity Breast Feeding at Delivery	60%	57.9%
Maternity Smoking at Delivery	22.4%	18.2%
Stroke - 90% of time on a stroke unit***	90%	94.4%
Stroke - CT scan within 24 hours***	90%	93.2%
Stroke - Scan within 1 hour***	50%	77.8%
Sleeping Accommodation Breach	0	3
ERS - ASI % of DBS Bookings *	4%	22.1%
Cancelled Operations - Breaches of 28 Days	0	9
Urgent Operations cancelled for 2nd time	0	0
Delayed transfers of care	3.5%	0.05%
Community nursing - urgent and OOH referral waiting times* (72 hr target)	93%	92.59%

BEST OUTCOME

Indicator	Target	Year to December
Clostridium difficile cases	19	16
MRSA Bacteraemia	0	4
MSSA		18
Ecoli		281
VTE*	95%	96.6%
Sepsis Screening AE (Quarterly)*		
Sepsis Screening IP (Quarterly)*		
Duty of candour	Compliance	
Never events	0	3
Serious Incidents reported within 2 working days of identification		100%
Total number of incidents reported (Monitoring trends)*		13679
Serious Incidents Interim reports within 72 hours		100%
SUIs reported via STEIS as a proportion of all incidents involving severe injury or death within a Trust		57
Serious Incident RCAs submitted within 60 working days***		95%
Readmissions within 30 days of previous discharge following elective*		759
Readmissions within 30 days of previous discharge following emergency*		4662
Crude Mortality***		4.13%
HSMR***		94.96
SHMI***		102.44

Dementia - eligible admissions screened*	90%	90.7%
Dementia - AMTS compliance*	90%	84.7%
Dementia - onward referrals*	90%	28.9%

Quality Account Indicators (not covered elsewhere)

Indicator	Target	Year to December
Falls - Acute (Incident Report)		1273
Falls - Community (Incident Report)		153
Reduction in Falls - Acute (per 1000 bed days) (Cumulative)	5.6	6.1
Reduction in Falls - Community (per 1000 bed days) (Cumulative)	8	6.0
Continuation of Sensory Training into staff education programmes	180 per Q	
Falls & Fragility fractures - patients screened****		
Falls & Fragility fractures - % eligible patient receiving follow up assessment for osteoporosis****	50%	
Falls & Fragility fractures - % patients with appropriate referral for axial scan (as a proportion of eligible patients)****		
Falls & Fragility fractures - % patients commenced on bone sparing drugs (as a proportion of eligible patients)*****		
Grade 3 & 4 newly acquired avoidable pressure ulcers - Acute	0	0
Grade 3 & 4 newly acquired avoidable pressure ulcers - Community	0	3
Grade 2 newly acquired avoidable pressure ulcers - Acute	Monitor	0
Grade 2 newly acquired avoidable pressure ulcers - Community	Monitor	0
% adult patients that are correctly screened for undernutrition within 4 hours ***	85%	TBC
% adult patients rescreeened weekly for undernutrition ***	89%	TBC
% adult patient identified at moderate or high risk of undernutrition have evidence that a nutrition care plan has been implemented, which fulfils recommendation on the 'MUST' nutritional tool***	79%	TBC
% adult patients identified at moderate or high risk of undernutrition have evidence of well completed food and fluid record charts***	89%	TBC
Rate of patient safety incidents resulting in severe injury or death	Within national average	
Rate of patient safety incident reporting	75th %ile	
Did you feel involved enough in decisions about your care and treatment?	76%	86.0%
Were you given enough privacy when discussing your condition or treatment?	80%	91.0%
Did you find a member of staff to discuss any worries or fears you had?	85%	84.0%
Did a member of staff tell you about any medication side effects that you should watch out for after you got home in a way that you could understand?	65%	69.0%
Did hospital staff tell you who you should contact if you were worried about your condition or treatment after you left hospital?	75%	82.0%
% of staff who would recommend the trust to family and friends needing care (Staff Survey) Annual		

Friends and Family Test - increased response rate in In patients		32.9%
Friends and Family Test - increased response rate in A&E		16.9%
Summary Hospital Mortality Indicator (SHMI) ***		102.44
Hospital Standardised Mortality Ratio (HSMR) ***		94.96
Crude Mortality***		4.13%
Deaths with a palliative care code (Z515)***		30.0%
Readmissions within 28 days**	7%	11.9%

BEST EFFICIENCY		
Indicator	Target	Year to December
Data completeness community services - RTT*	50%	100.0%
Data completeness community services - Referrals*	50%	99.8%
Data completeness community services - Treatment activity*	50%	99.7%
% of SUS data altered*	10%	34.6%
Discharge summaries within 24 hours	95%	92.1%
Valid NHS number field submitted via SUS - Acute*	99%	99.7%
Valid NHS number field submitted via SUS - A&E*	95%	98.5%
GP referrals		70,925
Non GP referrals		53,140
Outpatient attendances		419,783
Elective day case admissions		33,162
Elective inpatient admissions		5,645
Theatres (utilisation)	85%	80%
Non-elective admissions		51,827
Digital Dictation - upload to approve		6.78
Summary Income and Expenditure (£000s) (cumulative)*		-7,401
Agency cap (£000s) (cumulative)*		-6,402
Cost Reduction (£000s) (cumulative)*0		-4,919

BEST EMPLOYER		
Indicator	Target	Year to December
Trust Sickness*	<4%	4.81%
Agency Spend*	Decrease	£9,443,936
Bank Spend*	Increase	£8,632,651
Appraisal Figures - All staff*	90.0%	66.58%
Essential Training - All staff*	90.0%	86.00%
Voluntary Turnover*	9.0%	7.22%
Total Turnover*	Information	14.37%
Vacancy Rates -Effective shortfall*	<5%	5.15%

Performance Risks

Non-elective pressures

The Trust's main operational and performance risk remains the non-elective pathway. Growth in A&E attendances and non-elective admissions, particularly at the Trust's busiest site, UHND, continues to put pressure on all services. Length of stay for non-elective patients remains broadly constant.

Although non-elective admissions are only up by 1.2% during Apr-Oct 2017 (compared to the same period in 2016) admissions accelerated in Q3 by 4.7%. Medical admissions, the main type of non-elective activity grew 5.1% during Apr-Dec, accelerating to 11.4% in Q3.

Elective pressures

The Trust is achieving the NHSI trajectory by a small margin each month.

18 weeks RTT	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
NHSI Trajectory	**92.5%**	**92.5%**	**92.5%**	**92.5%**	**92.5%**	**92.5%**	**92.5%**	**92.5%**	**92.5%**
Performance	92.83%	93.44%	93.50%	92.93%	92.61%	92.11%	92.52%	92.84%	92.12%

Key: Green = achieved both NHSI trajectory and 92% national standard; Amber = failed either NHSI or 92% national standard; Red = failed both NHSI and the 92% national standard

The risk of undershooting the trajectory is significantly higher in January due to the number of cancellations of electives that have taken place to accommodate non-elective demand. Transfer of work to the independent sector has taken place in breast, surveillance endoscopy, and orthopaedics patients scheduled for treatment at BAH who cannot be treated within 18 weeks.

This performance has taken place in the context of:

- a significant fall in referrals. During Apr-Dec 2017 (compared to the same period in 2016 and taking account of the endoscopy counting change in April 2017), referrals fell by 7.8% (GP referrals by 10.2% and non-GP referrals by 3.9%) across all major Specialties with the exception of breast surgery, plastics and obstetrics. The largest falls in GP referrals into the major specialties are orthopaedics (22%), urology (42.6%) and rheumatology (29%), but many other Specialties have seen falls of more than 10%, including general surgery, ophthalmology, diabetes, gastroenterology, dermatology, and respiratory medicine. The Surgery Care Group, which is the one principally affected, is developing a recovery plan with the support and supervision of the Director of Operations.
- a 7.2% fall in Consultant-led new out-patient appointments across many major specialties, particularly in Surgery. Day case activity has fallen by 8.8% and elective in-patient activity by 13.7%. As a result, in spite of the fall in referrals, several specialties have not reduced their out-patient and in-patient waiting list sizes to target levels, and have undershot their financial targets.

Demand and capacity plans are considered every week in the Referral to Treatment (RTT) Assurance Group. Operational Plans incorporating demand and capacity analyses for 2018-19 are being finalised.

In response to workforce and financial pressures, CDDFT and their main CCG commissioners have worked to re-configure services and reduce costs in several Specialties, the main ones being: ophthalmology (particularly the glaucoma pathway), A&E out-patient clinics; rheumatology, gastroenterology, occupational therapy, podiatry, dietetics, MSK physio and gynaecology. Most of these work-streams will continue into 2018-19.

Cancer

The main cancer targets are for two week waits (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. The 62-days to first treatment target is the subject of an NHSI trajectory, although no financial incentives/penalties are involved.

During Apr-Nov 2017, the number of two week wait cancer referrals fell by 4%.

Cancer performance against national standards

	Target	Oct
Cancer 2WW	93%	94.1%
Cancer 2WW Breast Symptoms	93%	94.6%
Cancer 31 Days Diagnosis to Treatment	96%	99.5%
Cancer 31 Days Subsequent Treatment - Surgery	94%	100%
Cancer 31 Days Subsequent Treatment - Anti Cancer Drug	98%	100%
Cancer 62 Days to First Treatment	85%	86.3%
Cancer 62 Days Screening	90%	100%

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

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. Some successful recruitments has taken place but some services remain fragile, notably ophthalmology and rheumatology. The region-wide STP process will have a crucial role in creating sustainable services region-wide.

Health Care Infections. the Trust has had four cases of MRSA in 2017/18 against a target of 0; and 21 cases of *Clostridium difficile* compared to an end-of-year target of 19.

Never Events: the Trust has had four never events during 2017-18. All such events are subject to a rigorous root cause analysis and the lessons learned are publicised throughout the Trust.

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	2017/18 (provisional)
Readmission within 28 days of discharge[1]								
CDDFT Age 0-15 years	10.4	10.3		11.2	11.8	11.3	12.6	11.8
National high	14.1	14.9				17.1	14.5	18.2
National low	0.0	0.0				0.0	0.0	0.0
CDDFT Age 16 + years	12.0	12.1		11.2	11.8	10.8	10.8	12.7

National high	14.1	13.8				18.3	20.3	18.5
National low	0.0	0.0				0.0	0.0	0.0
CDDFT MRSA per 100,000 bed days[3]	1.4	1.1	0.9	0.6	1.8	0.7	1.7	
North East	2	2	1	1	1.0	0.8	1.1	
England	3	2	1	1	0.8	0.9	0.9	
National high	9	9	10	11	3.2	6.5	2.7	
National low	0	0	0	0	0	0	0	
CDDFT - Post 72 hour cases of Clostridium difficile per 100,000 bed days (aged 2 years and over)[3]		24.5	16.5	20.3	8.4	7.4	5.3	
England	29.7	222.3	17.4	14.7	15	14.9	13.2	
National high		71.2	58.2	30.8	37.1	58.11	28.4	
National low		0	0	0	0	0	2.8	
Patient Reported Outcome measures (PROM) – case mix adjusted health gain[1]	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17 (provisional)	2017/18 (provisional)
CDDFT PROM Groin Hernia	0.10	0.12	0.10	0.10	0.06	0.08	0.07	0.09
England	0.08	0.09	0.09	0.09	0.08	0.09	0.09	0.09
National high	0.14	0.12	0.14	0.15	0.14	0.16	0.14	0.14
National low	0.01	0.03	0.03	0.01	0.01	0.02	0.01	0.06
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	0.39	0.44	
England				0.44	0.44	0.44	0.44	
National high				0.54	0.54	0.51	0.53	
National low				0.32	0.31	0.32	0.33	
CDDFT PROM Hip Revision				NA	NA	NA	NA	
England				0.27	0.28	0.28	0.29	
National high				0.35	0.37	0.37	0.36	
National low				0.17	0.16	0.22	0.24	
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	0.32	0.32	
England				0.32	0.32	0.32	0.32	
National high				0.42	0.43	0.40	0.40	
National low				0.21	0.22	0.20	0.24	
CDDFT PROM Knee Revision				NA	NA	NA	NA	

England				0.25	0.26	0.26	0.27	
National high				0.37	0.32	0.34	0.30	
National low				0.20	0.12	0.19	0.16	

	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
CDDFT VTE assessment Trust				**95.10%**	**95.65%**	**95.99%**	**96.83%**	**96.54%**
National Low				**82.10%**	**92.00%**	**79.93%**	**76.68%**	**87.02%**
National High				**100.00%**	**100.00%**	**99.76%**	**99.88%**	**99.45%**

YEAR	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
CDDFT Responsiveness to personal needs of the patient[1]	71.5	67.9	68.5	73.3	65.3	68.8	66	
England	67.3	67.4	68.1	68.7	68.9	69.6	68.1	
National high	82.6	85	84.4	84.2	86.1	86.2	86.2	
National low	56.7	56.5	57.4	54.4	59.1	58.9	54.4	

YEAR	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18 (Provisional)
CDDFT Percentage of staff who would recommend the trust to their family or friends[1]	49%	50%	57%	53%	57%	57%	61%	54%
England					68%	70%	71%	72%
National high		94%	94%	93%	92%	91%	90%	97%
National low		35%	40%	35%	31%	43%	43%	40%

	Reporting Period	Highest	Lowest	CDDFT Trust	Peer	Comments
SHMI	Jan 12 - Dec 12	119.2	70.3	104.1	102.2	
	Apr 12 - Mar 13	117.0	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	
	Jan 16 - Dec 16	119.8	69.2	106.1	104.2	
	Apr 16 - Mar 17	122.6	71.5	105.2	103.8	

	Jul 16 - Jun 17	122.8	73.0	104.9	105.3	
	Oct 16 - Sep 17	124.7	72.7	104.6	101.9	
	Jan17-Dec17 *(provisional HED data)*	119.5	71.4	102.3	100.6	
The banding of the summary hospital-level indicator	Apr 12 - Mar 13			2 (As Expected)		7 Trusts higher than expected
	Jul 12 - Jun 13			2 (As Expected)		9 Trusts higher than expected
	Octr 12 - Sep13			2 (As Expected)		8 Trusts higher than expected
	Jan - Dec 13			2 (As Expected)		7 Trusts higher than expected
	Ap 13 - Mar 14			2 (As Expected)		9 Trusts higher than expected
	Jul 13 - Jun 14			2 (As Expected)		9 Trusts higher than expected
	Oct 13 - Sep 14			2 (As Expected)		9 Trusts higher than expected
	Jan – Dec 14			2 (As Expected)		11 Trusts higher than expected
	Apr 14 – Mar 15			2 (As Expected)		16 Trusts higher than expected
	Jul 14 – Jun 15			2 (As Expected)		14 Trusts higher than expected
	Oct14 – Sep 15			2 (As Expected)		18 Trusts higher than expected
	Jan 15 - Dec 15			2 (As Expected)		14 Trusts higher than expected
	Apr 15 - Mar 16			2 (As Expected)		16 Trusts higher than expected
	Jul 15 - Jun 16			2 (As Expected)		11 Trusts higher than expected
	Oct 15 - Sep 16			2 (As Expected)		10 Trusts higher than expected
	Jan 16 - Dec 16			2 (As Expected)		10 Trusts higher than expected
	Apr 16 - Mar 17			2 (As Expected)		10 Trusts higher than expected
	Jul 16 - Jun 17			2 (As Expected)		12 Trusts higher than expected
	Oct 16 - Sep 17			2 (As Expected)		12 Trusts higher than expected
	Jan17-Dec17 *(provisional HED data)*			2 (As Expected)		
The percentage of patient deaths with palliative care coded	Apr 12 - Mar 13	44.00%	0.10%	12.80%		
	Jul 12 - Jun 13	44.10%	0.00%	14.00%		
	Octr 12 - Sep13	44.90%	0.00%	14.10%		
	Jan - Dec 13	46.90%	1.30%	15.90%		
	Ap 13 - Mar 14	48.50%	0.00%	17.80%		
	Jul 13 - Jun 14	49.00%	0.00%	18.70%		
	Oct 13 - Sep 14	49.40%	0.00%	19.00%		
	Jan – Dec 14	48.30%	0.00%	17.70%		
	Apr 14 – Mar 15	50.85%	0.00%	17.18%		
	Jul 14 – Jun 15	52.90%	0.00%	17.39%		
	Oct14 – Sep 15	53.53%	0.20%	18.59%		
	Jan 15 - Dec 15	54.75%	0.19%	21.12%	26.14%	
	Apr 15 - Mar 16	54.60%	0.58%	24.22%	27.55%	
	Jul 15 - Jun 16	54.83%	0.57%	26.58%	27.84%	
	Oct 15 - Sep 16	56.27%	0.39%	28.19%	28.06%	
	Jan 16 - Dec 16	55.90%	7.30%	30.20%	28.30%	
	Apr 16 - Mar 17	56.90%	11.10%	31.40%	28.17%	
	Jul 16 - Jun 17	58.60%	11.20%	31.90%	28.84%	

	Oct 16 - Sep 17	59.80%	11.50%	36.20%	29.14%	
	Jan17-Dec17 *(provisional HED data)*			38.66%		

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)
4http://www.nrls.npsa.nhs.uk/patient-safety-data/organisation-patient-safety-incident-reports/
5 Data from NHS Digital quarterly SHMI publications

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

SAFETY

Falls and falls resulting in injury
Why is this a priority?
Nationally falls are the most frequently reported patient safety incidents
Our aim
We have seen a reduction in falls resulting in injury but 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 implement actions from the published National Falls Audit
We will formulate an action plan and begin embedding the priorities identified from the Falls Strategy
We will introduce improvement cycles in relation to falls reduction
Measuring and monitoring
We will continue to collect information on all patient falls and review this with our clinical teams at Falls Group.
This information is collected internally using data retrieved from the Safeguard incident reporting system and contained within the monthly trust Incident Report. This data is not governed by standard national definition.

Care of patients with dementia
Why is this a priority?
Hospitals have seen an increase in patients requiring care in their services for patients who have a background of dementia. These patients are particularly vulnerable and we want to ensure that they are receiving a high standard of care.
Our aim
We want to ensure that patients who have dementia have a positive experience when under our care and that all needs are considered.
Our actions
We will continue to roll out key elements of the dementia strategy and introduce monitoring tools to measure compliance against this
Measuring and monitoring

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

MRSA Bacteraemia

Why is this a priority?

MRSA 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 18 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 discharged back to the care of their own GP. If not, the GP does not know what prescription or other changes have taken place or are recommended by the discharging Consultant. In addition, if a patient has died in hospital, it is important for the GP to be advised quickly in case the Practice tries to contact the patient or relatives for some reason, unaware of the patient's death.

Over a three year horizon progress has been excellent, but in 2017 the national 95% target has only been achieved in two months. For the reminder of the time performance has fluctuated within a narrow range of 89% - 94%.

Our aim

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

Our actions

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

Measuring and monitoring

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

Rate of patient safety incidents resulting in severe injury or death

Why is this a priority?

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

Our aim

To ensure that accurate and timely data is uploaded to the national reporting system and 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.

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 2016/1718. 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.

Whilst this indicator is not governed by national standard definitions, the production of LocSSIP is decided using national definitions.

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
- Work with regional partners to develop ePaCCS
- Support and monitor new out of hours advice service
- Deliver palliative care mandatory training for all staff
- Deliver local repeat of postal questionnaire of bereaved relatives (VOICES)
- Continue the successful training fellow programme to develop palliative care consultants for the future

Measuring and monitoring

- Audit action plans for palliative care 100% complete
- Deliver all key milestones in 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''

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

Responding to patients personal needs

Why is this a priority?

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

Our aim

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. We will measure compliance against "Learning from Deaths" policy. These data are governed by standard national definition.

Reduction in readmissions to hospital

Why is this a priority?

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

Our aim

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

Our actions

Together with partners in Primary and Social Care, the 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

The Trust is advocating the need to hold a further joint CCG-CDDFT audit of re-admissions in order to establish the penalty threshold beyond which CDDFT will only receive a reduced tariff payment for re-admissions. It is also seeking to understand the effectiveness of the re-admissions avoidance schemes in which commissioners have invested with the monies saved from reduced tariff payments. This data is governed by standard national definition

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

Why is this a priority?

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

Our aim

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

Our actions

Pressures in A&E rise are an indicator of pressures in the wider health system. The Trust's Transforming Emergency Care Programme is the main improvement vehicle with progress monitored through the multi-agency Local A&E Delivery Board (see section in Review of Performance against priorities 2017-18).

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, chaired by the Trust's Chief Executive and, where performance falls short of the agreed NHSI trajectory, to NHSI. This data is governed by standard national definition.

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 dangerous and 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 the Transforming Emergency Care Programme and *Perfect Month* initiatives as described earlier.

Measuring and monitoring

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

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

NHS Darlington Clinical Commissioning Group

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

NHS North Durham Clinical Commissioning Group

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

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

TO BE ADDED WHEN RECEIVED

Feedback from Darlington Borough Council Health and Partnerships Scrutiny Committee

County Durham and Darlington NHS Foundation Trust – Draft Quality Account 2017/18

TO BE ADDED WHEN RECEIVED

Feedback from Healthwatch Darlington

TO BE ADDED WHEN RECEIVED

Feedback from Healthwatch Durham

TO BE ADDED WHEN RECEIVED

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

DURHAM COUNTY COUNCIL ADULTS WELLBEING AND HEALTH OVERVIEW AND SCRUTINY COMMITTEE

COMMENTS ON COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST QUALITY ACCOUNT FOR 2017/18

TO BE ADDED WHEN RECEIVED

Feedback from Health and Wellbeing Board

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

TO BE ADDED WHEN RECEIVED

Statement of Directors' Responsibility in Respect of the Quality Report

TO BE ADDED

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
Quayside House
110 Quayside
NE1 3DX

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