Public Document Pack

Health and Housing Scrutiny Committee Agenda

10.00 am Wednesday, 7 October 2020
Microsoft Teams

In accordance with Local Authorities and Police and Crime Panels (Coronavirus) (Flexibility of Local Authority and Police and Crime Panel Meetings) (England and Wales) Regulations 2020, this meeting will be held on a virtual basis. Members of the Public can view a live stream of the meeting at: https://www.darlington.gov.uk/livemeetings Members of the public wanting to raise issues/make representations at the meeting can do so by emailing hannah.fay@darlington.gov.uk 24 hours before the meeting begins

1. Introduction/Attendance at Meeting

2. Declarations of Interest

3. Quality Accounts –
   Report of the Managing Director.
   (Pages 1 - 4)

   (a) County Durham and Darlington NHS Foundation Trust Draft Quality Accounts 2019/20 (Pages 5 - 140)

Luke Swinhoe
Assistant Director Law and Governance

Tuesday, 29 September 2020

Town Hall
Darlington.

Membership
Councillors Bell, Donoghue, Dr. Chou, Heslop, Layton, Lee, McEwan, Newall, Tostevin and Wright

If you need this information in a different language or format or you have any other queries on this agenda please contact Hannah Fay, Democratic Officer, Resources Group, during normal office hours 8.30 a.m. to 4.45 p.m. Mondays to Thursdays and 8.30 a.m. to 4.15 p.m. Fridays email: hannah.fay@darlington.gov.uk or telephone 01325 405801

This document was classified as: OFFICIAL

HEALTH AND HOUSING SCRUTINY COMMITTEE
7 OCTOBER 2020

QUALITY ACCOUNTS 2019/20

Purpose of the Report

1. To consider information included in the County Durham and Darlington NHS Foundation Trust Quality Accounts 2019/20 to enable this Committee's input into the draft commentary.

Summary

2. Scrutiny Committee had previously agreed to be more involved with the local Foundation Trusts Quality Accounts. This has enabled Members to have a better understanding and knowledge of performance when submitting a commentary on the Quality Accounts at the end of the Municipal Year 2019/20.

3. As a result Scrutiny agreed to receive regular performance reports from the Trust; and were invited to attend Quality Account Stakeholder events.

Recommendations

4. It is recommended that a draft commentary for County Durham and Darlington NHS Foundation Trust be formulated and forwarded for inclusion in the Quality Accounts for 2019/20.

Paul Wildsmith,
Managing Director

Background Papers

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

Hannah Fay : Extension 5801

S17 Crime and Disorder	This report has no implications for Crime and Disorder.
Health and Wellbeing	This report has implications to the address Health and Wellbeing of residents of Darlington, through scrutinising the services provided by the NHS Trusts.
Carbon Impact and Climate Change	There are no issues which this report needs to address.
Diversity	There are no issues relating to diversity which this report needs to address.
Wards Affected	The impact of the report on any individual Ward is considered to be minimal.
Groups Affected	The impact of the report on any individual Group is considered to be minimal.
Budget and Policy Framework	This report does not represent a change to the budget and policy framework.
Key Decision	This is not a key decision.
Urgent Decision	This is not an urgent decision
One Darlington: Perfectly Placed	The report contributes to the delivery of the objectives of the Community Strategy.
Efficiency	The Work Programmes are integral to scrutinising and monitoring services efficiently (and effectively), however this report does not identify specific efficiency savings.
Impact on Looked After Children and Care Leavers	This report has no impact on Looked After Children or Care Leavers.

MAIN REPORT

Quality Accounts 2019/20

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

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

7. Overview and Scrutiny Committees play an important role in development and providing assurance on Quality Accounts reports. The Health Act requires Trusts to send a copy of their report to be considered by their appropriate Overview and Scrutiny Committee.

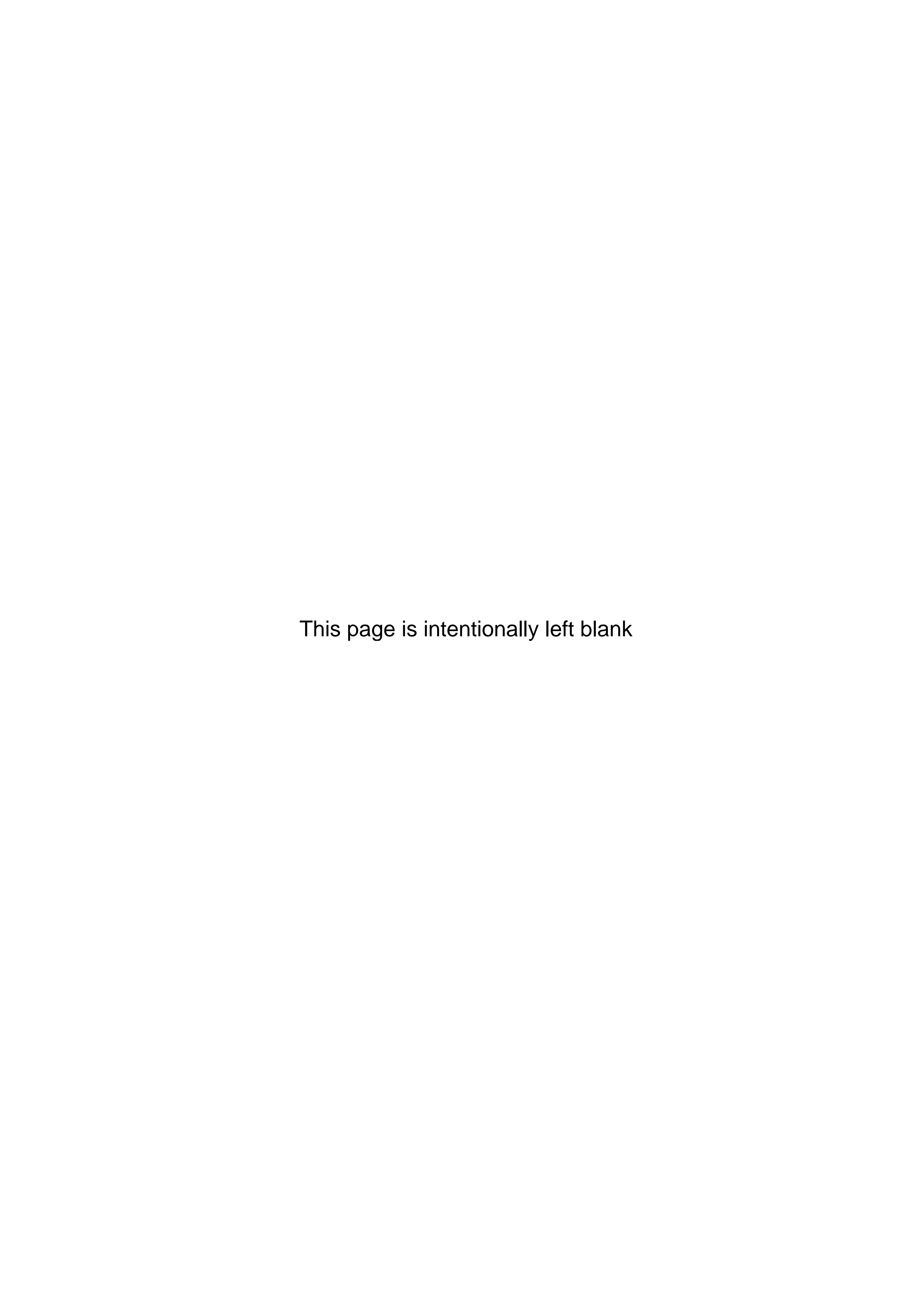
8. In advance of the Trust's report being considered by Overview and Scrutiny Committees it is vital that the priority areas identified are considered and that discussion takes place. Comments or views from Overview and Scrutiny Committees should be reflected in the final report and involvement should be credited within the document.

9. The Department for Health and Social Care requires providers to publish Quality Accounts by 30 June each year following the end of the reporting period. An amendment to the National Health Service (Quality Accounts) (Amendment) (Coronavirus) Regulations 2020 means there is no fixed deadline by which providers must publish their 2019/20 quality account; NHS England and NHS Improvement recommends for NHS providers that a revised deadline of 15 December 2020 would be appropriate, in light of pressures caused by COVID-19.

County Durham and Darlington NHS Foundation Trust

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

11. As a result of these updates, Members feel informed to be able to make comments for inclusion in the draft Quality Accounts 2019/20 (Appendix).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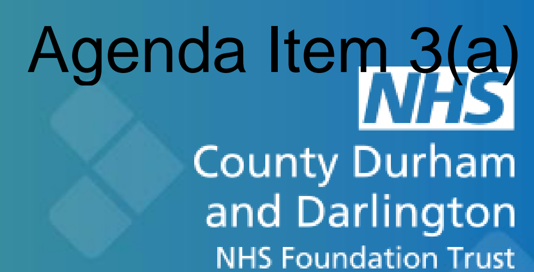

Darlington Health and Housing Scrutiny Committee

Quality Accounts 2019/2020

Joanne Todd
Associate Director of Nursing
7th October 2020

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PURPOSE OF THE REPORT

To update the Scrutiny Committee on progress of County Durham & Darlington NHS Foundation Trust with regards to the agreed priorities for improvements for the 2019/2020 period. This report provides and update from April 2019 to March 2020.

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. The primary purpose is to encourage leaders of healthcare organisations to assess the quality of care they deliver. The Quality Accounts for County Durham & Darlington NHS Foundation Trusts includes indicators set by the Department of Health and those we have identified as local priorities.

PRIORITIES FOR 2019/2020

The table below sets out the priorities and position (where data is available). The priorities were agreed through consultation with staff, governors, local improvement networks, commissioners, health scrutiny committees and other key stakeholders.

Where progress can be reported at this point this has been colour coded as follows;

RED – not on track
AMBER – improvement seen but not to level expected
GREEN – on track

Priority	Goal	Position/Improvement
SAFETY		
Patient Falls[1] **(Continuation)**	Targeted work continued to reduce falls across the organisation and the introduction of the dedicated falls team 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 continue the introduction of the Trust Falls Strategy, covering a 3 year period. - To agree a plan of year 2 actions. - To monitor implementation of year 2 actions against the Strategy. **Acute falls = 5.8 per 1000 bed days** **Community falls = 5.8 per 1000 bed days** **Quality Improvement work continues and red zimmer frames have been introduced into key areas. Lying/standing blood pressure has been built into the electronic observations tool to improve compliance.**

Care of patients with dementia[1] **(Continuation)**	Continued development and roll out of a dementia pathway and monitoring of care for patients with dementia.	- The dementia screening tool has been incorporated into the electronic nerve centre, and removes the need for paper base assessment. - The next step is to migrate the data from nerve centre to formulate the national reporting criteria. This generates the statistics for measuring compliance with undertaking the dementia assessment. This will be migrated the end of the year. - Action plan developed from the NAD the intention is to utilise the finding from the 2018 NAD to see if there have been any changes in practice/improvements. - Carers survey has been completed. The recommendations are to be monitored alongside the national dementia audit recommendations. The action plans have been merged and form the Strategy Action Plan 2019/2020.This will be monitored. - Participate in a 5 year research project of dementia services within the Durham area to continue during 2019/2020. Participation to continue. - Continue the study in the development of a good practice audit tool for assessing patient care and services for those living with dementia. Participation to continue.
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. **Six cases reported during 2019/20** - No more than 45 (new reporting mechanism) cases of hospital acquired Clostridium *difficile.* **49 cases reported during 2019/20** Both of these will be reported onto the Mandatory Enhanced Surveillance System and monitored via Infection Control Committee.
Pressure ulcers[1] ***(Continuation)***	To have zero tolerance for grade 3 and 4 pressure ulcers	- Implement new national reporting metrics - Review of all identified grade 3 or 4 pressure ulcers - Continued education programme **Four identified in community setting and two identified in acute setting for 2019/20 where lapses in care**

		were identified
Discharge summaries[1] **(Continuation)**	To improve timeliness of discharge summary completion.	- Data collected via electronic discharge letter system and monitored via monthly performance reviews and Board reporting. - Care Groups undertake consultant level audits - Train 2020 intake of new junior doctors **Compliance is around 90% during the period. Work programme continues.**
Rate of patient safety incidents resulting in severe injury or death [1,2] **(Continuation and mandatory)**	To increase reporting to 75th percentile against reference group.	- Cascade lessons learned from serious incidents. - NRLS data. Enhance incident reporting to 75th percentile against reference group. **Rate no longer reported** **Remain within national average for incidents resulting in serious harm or death** - Continue to embed Trustwide work to embed and improve reporting of near miss and no harm incidents.
Improve management of patients identified with sepsis[3] **(Continuation)**	To maintain improvement in relation to management of sepsis	- Continue to implement sepsis care bundle across the Trust. - Continue to implement and embed post one hour pathway. - Continue to audit compliance and programme. - Hold professional study days. **Regional screening tool integrated into electronic systems, meaning that all patients within CDDFT are automatically screened for sepsis.**
EXPERIENCE		
Nutrition and Hydration in Hospital[1] **(Continuation)**	To promote optimal nutrition and hydration for all patients.	- Continue to work closely together on hospital menu development and nutritional analysis. - Continue to work closely with Speech and Language Therapy colleagues within the Trust towards achieving International Dysphagia Diet Standardisation Initiative (IDDSI) ward menus and nutritional products. - In terms of hydration we will consider how we maintain and monitor sufficient hydration status of patients requiring both artificial (intravenous or enteral) and non-artificial hydration support. - We will explore how CDDFT might require alternative ways of measuring oral fluid intake at ward level. **Quality metrics have been**

		introduced that provide a monitoring tool to audit compliance with nutritional standards.
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)"*	- We will work with CCG and NEAS to agree a comprehensive approach to personalised care planning. - We will work with regional partners to develop electronic sharing of key palliative care information (ePaCCS). - We will support and monitor new out of hours advice service. - We will continue to deliver palliative care mandatory training for all staff. - We will implement actions from postal questionnaire of bereaved relatives (VOICES). - We will implement actions and learning from Care of Dying Audit. **Preferred place of death audit demonstrates continuous improvement**
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 Assurance Committee and any emerging themes monitored for improvement through the Patient Experience Forum. - The Trust will continue to participate in the national inpatient survey. **Remains within national average**
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)**	To show improvement year on year bringing CDDFT in line with the national average.	- 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. **Significant improvement in Trust score but still below the national average.** - In addition we will continue to report results for harassment & bullying and Race Equality Standard. **Significant improvement in the Trust score and better than the national average.**

Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion[2] **(Mandatory measure)**		**Trust score improved and higher than national average.**
Friends and Family Test[1] **(Continuation)**	To increase Friends and family response rates	- During 2019/2020 we will 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. **Improvement seen in response rates - sustained increase seen in Emergency department but no improvement seen in maternity department rates**
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 embed "Learning From Deaths" policy	- To monitor for improvement via Mortality Reduction Committee. - To maintain HSMR and SHMI within expected levels. - 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. Updates will be submitted to Trust Board via the performance scorecard. - Trust mortality review process, allocation of priority reviews to central review team for completion will continue to ensure any learning, positive and negative, is embedded in patient care. - Embed "Learning from Deaths" policy. - In line with national changes the post of Lead Medical Examiner has been advertised. The successful post holder will lead the introduction of the Medical Examiner System, during the coming months. **SHMI is increased and review shows this is due to depth of coding and acute kidney injury. A task & finish group is established to review depth of coding and two acute kidney injury nurses are now**

		employed. HSMR within expected range
Reduction in 28 day readmissions to hospital[1,2] **(Continuation and mandatory)**	To implement effective and safe care closer to home, improving patient experience post discharge.	- Further development of multi-disciplinary Teams Around Patients (TAPS). - Safe discharge is a key theme of the Transforming Emergency Care programme. - Monitoring through monthly performance reviews and Board reporting. - Agreement with Stakeholders to set this threshold at a higher level and aim for year on year improvement on this. Set at 12% for 2019/2020 **Current performance 12.9%. work continues to improve on this**
To reduce length of time to assess and treat patients in Accident and Emergency department[1,2] **Continuation and mandatory)**	To improve patient experience by providing safe and timely access to emergency care.	- Daily monitoring of performance indicators against NHSI and national 95% standards. - Monitoring through monthly performance reviews and Board reporting. - Transforming Emergency Care programme. - Review of escalation procedures. **4 hour wait indicator remains below 95%.**
Patient reported outcome measures[1,2] **(Continuation and mandatory)**	To improve response rate.	- To aim to be within national average for improved health gain. - NHS England have removed groin hernia and varicose vein from mandatory data collection, hip and knee will continue. **Knee responses within national average. Hip response rates outside of national average**
Maternity standards (new indicator following stakeholder event)	To monitor compliance with key indicators.	- Continue 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. **12 week booking 90.8%** **Breastfeeding 57.3%** **Smoking in pregnancy 16.6%**
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. **Dedicated paediatric unit now opened adjacent to Emergency**

		Department
Excellence Reporting (new indicator following stakeholder event)	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. **Embedded within Care Groups monthly reports produced and shared.**

1 - continuation from previous year
2 - mandatory measure
3 - new indicator following stakeholder events

Three Never Events have been reported since April 2019. Action plans are developed and monitoring is in place for completion. The report also identifies that the Trust received a Regulation 28 during the year. Action plans have been developed and completed to address this.

Post setting this year's Accounts the Trust received correspondence from the Chief Nursing Officer to ask that the newly formed Learning Disability standards were included in the Quality Accounts. It was noted that Trusts are expected to publish their performance against these standards in their annual accounts: to demonstrate to the population they serve how they measure quality of services and whether quality is improving. This is included in the report this year and progress will be monitored

Clostridium *difficile* (CDI) objectives for 2019/2020

Acute provider objectives for 2019/20 will be set using these two categories:

- **Hospital onset healthcare associated**: cases that are detected in the hospital three or more days after admission
- **Community onset healthcare associated**: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks.

CDI Objectives for CDDFT have been set at **45** cases or rate of **16.4** per 1000 bed days

Timeframes

As you are aware Quality Accounts this year have been delayed due to COVID-19 pandemic. Providers have a revised deadline of 15th December 2020 for submission and are no longer expected to obtain assurance from external auditor.

We would however be very grateful if you would still sent us your overarching comment on the Quality Accounts as in previous years so that these can be inserted into the back of the report to be received 12th October 2020 for inclusion in the report.

Governor Responsibilities

The local indicator for audit from the Governors was stood down due to Covid-19 pandemic and the report will not be the subject of external audit for the same reason.

Recommendation

The Committee receives the report as evidence of ongoing commitment to improve quality outcomes for patients under our care.

Joanne Todd
Associate Director of Nursing (Patient Safety & Governance)
October 2020

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QUALITY ACCOUNTS

2019 - 2020

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QUALITY REPORT

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 "Safe, compassionate and joined up care" 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 2019/2020 period. It also outlines those we have agreed for the coming year (2020/2021).

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 the priorities identified with Stakeholders.

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

I am delighted to introduce to you our Quality Account and Quality Report for County Durham and Darlington NHS Foundation Trust for 2019/20.

It is only fitting that I begin this introduction by acknowledging the achievements set out in this document and our ability to support our patients and local populations with safe, compassionate and joined-up care, have only been possible thanks to the tremendous commitment and dedication of our 7,000 strong workforce, alongside our volunteers, partners, Governors and our local communities.

It has been no ordinary year to report upon. On 30th January 2020, a national level 4 major incident was declared as the NHS responded to the COVID-19 pandemic and we therefore spent the final quarter of the financial year 2019/20 in unprecedented territory.

Locally in County Durham and Darlington, this saw the organisation move at pace to change services, first in preparation for the forecasted number of patients with COVID-19 and then transitioning to the management and treatment of those patients.

The response to and impact of COVID-19 will continue for many months to come. However, at this point I would like to reflect on some of the achievements, successes and challenges the Trust faced prior to the pandemic and which are reported within this document.

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

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

2019/20 saw the Trust achieve a 'Good' rating from the CQC, with end of life services being rated 'outstanding', while also becoming one of the most improved Trust's nationally in the NHS Staff Survey.

The CQC visited the Trust's two main hospital sites, University Hospital of North Durham and Darlington Memorial Hospital between 2nd and 4th July and carried out an assessment of end of life care, urgent and emergency care and surgery. The inspection highlighted the Trust's improving and the delivery of high quality patient services, with a clear commitment to continuous improvement.

We were extremely pleased to receive the 'Good' rating which recognised the tremendous effort and commitment of our workforce in continually driving through improvements in services for our patients and local populations.

The CQC also commented positively on the Trust's engagement work and collaboration with partners across the health system. We have established a robust annual programme of engagement with our stakeholders, colleagues and partners, in order to set ourselves a number of quality priorities to continue this improvement in relation to patient safety, clinical outcomes and the experience of those who need our care.

Our quality accounts report on performance within these priority areas and against a range of metrics and targets. In addition to performance reported within this document, there are also a few highlights I would like to draw out when reflecting on the year.

Highlights include the development a tele-skin service which enables GPs to send referrals of patients with suspected skin cancer alongside photos. This enables consultant dermatologists to give a rapid diagnosis. Approximately 13% of patients have received almost immediate re-assurance that their condition can be managed by the GP, with consultant guidance; and a further 9% have been re-assured they do not have cancer and can wait to be seen in a routine clinic appointment. This service has been short-listed for an Innovation Award by the HSJ.
The Trust has also received a Bronze Employer Recognition Award for its commitment to the armed forces. In November 2019, the Trust demonstrated its commitment by signing the Armed Forces Covenant in

partnership with Darlington Borough Council. It has also joined the “Step into Health” programme, which helps members of the armed forces make the transition to civilian employment in the armed forces, and has applied for a Silver Employer Recognition Award.
We celebrated 365 days without a single reported case of MRSA bacteraemia
We also saw a fantastic response to the Trust’s quality improvement plan with a bespoke training programme being designed and delivered to over 300 support staff with the tools, techniques, training and support needed to deliver quality improvements and for this to become embedded across the organisation.

I would like to take this 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 2019/2020

Last year we set 20 priorities. These have been set under the following headings:

- Safety
- Patient Experience
- Clinical Effectiveness

Performance results at a glance

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

		2018/2019	2019/2020 Ambition	2019/2020 Position	
Falls	Patient falls – reduce falls/1000 bed days community hospital	**6.0** ☑	8.0	**5.8**	☑
	Patient falls – reduce falls/1000 bed days acute hospital	**5.5** ☑	5.6	**5.8**	☒
	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 ☑	Introduce dementia strategy and produce an action plan to monitor	Complete	☑
Healthcare Associated Infection (HCAI)	Meticillin Resistant Staphylococcus aureus (MRSA) post 48 hour bacteraemia	2 ⊖	0	6	☒
	Clostridium *difficile* post 72 hour	19 ⊖	45	49 Unable to rate this year due to change in metrics	
Pressure Ulcers	To have no avoidable grade 3 or above pressure ulcers within acute or community services	10 ☒	0	6	⊖
Venous thromboembolism (VTE)	Maintain venous thromboembolism assessment compliance at or above 95%	96.1% ☑	95%	96%	☑
Discharge	Discharge summaries	92.2% ⊖	95%	89.5%	☒
Incidents	Rate of patient safety incidents reported via National Reporting and	Reporting to within 50% ⊖	Reporting to within 75%	National average no longer produced	

		2018/2019	2019/2020 Ambition	2019/2020 Position	
	Learning System (NRLS)				
	Rate of patient safety incidents resulting in severe injury or death from National Reporting and Learning System (NRLS)	Mar18-Sep18 data 0.1% (local) ☑	Within national average	Mar19-Sep19 Data 0.1% (local)	☑
Sepsis	To improve management of patients identified with sepsis	Improvement demonstrated ☑	Ensure patients are screened appropriately	Screening built into electronic systems with triggers for alerts	☑
Local Safety Standards for Invasive Procedures (LocSSIPs)	To deliver a programme of work to review LocSSIPs across the Trust	Progressing as plan ☑	Introduce by 2019/2020	Audit programme of implementation underway	☑
PATIENT EXPERIENCE					
Nutrition and Hydration	Move nutrition assessment to Nervecentre To audit against new indicators	Complete ☑ Programme continues ⊖	Complete To continue to refine	Complete Metrics captured in Quality Matters audit	☑ ☑
End of Life Care	Death in usual Place of Residence increasing	52% ☑	47%	52.3%	☑
Patient personal needs	Responsiveness to patients personal needs	**2018** 69.3% ☑	Within national average 67.2%	**2019** 70.4%	☑
Percentage of staff who would recommend the organisation as a place for friends & family to receive treatment		2018 58% ☒	Within national average 71%	2019 61.3%	⊖
Percentage of staff experience harassment, bullying or abuse from staff in the last 12 months	To achieve average national performance against staff survey	**2018** Managers 12.1% ☑ **Colleagues** 16.6% ☑	Within national average 11.8% 18.0%	**2019** Managers 10/9% **Colleagues** 16.7%	☑ ☑
Percentage of staff believing that the Trust provides equal opportunities for		**2018** 89.6% ☑	Within national average 85.6%	**2019** 90.2%	☑

		2018/2019	2019/2020 Ambition	2019/2020 Position	
career progression or promotion					
Friend and family test	To increase Friends and Family response rates	14.4% ☒	Over 20% in Emergency Department	17.2% (Apr19-Feb20)	⊖
		26.2% ☒	Over 30% inpatient areas	28.8% (Apr19-Feb20)	⊖
CLINICAL EFFECTIVENESS					
Reduction in risk mortality indices	To monitor mortality indices (HSMR and SHMI) on a monthly basis – indices as expected	YTD 2018/2019 (Jan 18 - Dec 18) SHMI: 109.93 ☑ HSMR within expected parameters	To remain within expected parameters for mortality indices	YTD 2018/2019 (Jan 19 - Dec 19) SHMI 115 HSMR within expected parameters	⊖ ☑
			To introduce Learning from Deaths national policy	Policy introduced	☑
Reduction in readmission to hospital (within 28 days)	To reduce emergency readmissions (provisional data results)	**0-15 years** 12.4% ☒	12%	**0-15 years** 11.3%	⊖
		16 years and over 13.5% ⊖		**16 years and over** 12.9%	⊖
		Total 13.3% ⊖		**Total 12.6%**	⊖
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%	2.9% ☑	<5%	6.7%	☒
	- Left without being seen no more than 5%	2.9% ☑		5.3%	☒
	Timeliness indicators: - 95% to be treated/ Admitted/discharged within 4 hours	89.5% (including Urgent Care Centre appointments) 91.5%) ☒	95%	79.5%	☒
	- Time to initial assessment no more than 15 minutes	32mins ☒	15mins	67mins (95th centile)	☒
	- Time to treatment decision no more than 60 minutes	60 mins ☑	60mins	94mins (Median)	☒

		2018/2019	2019/2020 Ambition	2019/2020 Position	
Patient Reported Outcome Measure (PROM) *EQ-5D Index*	To gain better understanding of patient's view of their care and outcomes	2017/18 (Provisional)	National average	2018/19 (provisional)	
	- Hip	0.468 ✓	0.475	0.406	✗
	- Knee	0.344 ✓	0.349	0.390	✓
	- Hernia	0.090 ✓	0.089	N/A	
Maternity Standards (new indicator following stakeholder event)	To monitor compliance with key indicators:				
	- Breastfeeding intention	59.4% ⊖	60%	57.3%	✗
	- Smoking in pregnancy	16.6% ✓	22.4%	16.9%	✓
	- 12 week booking	90.3% ✓	90%	90.8%	✓
	- Complete gap analysis against "Saving Babies lives" NHS England document	Implementation underway ✓	Implementation	Gap analysis complete and implementation continues	✓
Paediatric care (new indicator following stakeholder event)	Improved paediatric pathways for urgent/ emergency care	Year 2 improvement demonstrated ✓	Demonstrate improved pathway	Improvement demonstrated	✓
Excellence Reporting (new indicator following stakeholder event)	To ensure that CDDFT continues to embed learning from excellence into standard culture and practice through Excellence Reporting.	N/A	✓	Embedded and monthly reports produced and shared	✓

Introduction to 2020/2021 priorities

Key priorities for 2020/2021 have been agreed through consultation with staff, governors, Healthwatch, 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 2020/2021 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 and the introduction of the dedicated falls team 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 continue the introduction of the Trust Falls Strategy, covering a 3 year period. - To agree a plan of year 3 actions. - To monitor implementation of year 3 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.	- The dementia screening tool has been incorporated into the electronic nerve centre, and removes the need for paper base assessment. - Data migrated from nerve centre to formulate the national reporting criteria. This generates the statistics for measuring compliance with undertaking the dementia assessment. - The finding from the 2018/2019 NAD report find an overall improvement, however there remains room for further improvement and this will be continued during 2020/21. - The action plans have been merged and are now complete but further improvements will be expected during 2020/21 - Participate in a 5 year research project of dementia services within the Durham area to continue during 2020/21. Participation to continue. - Share the findings of a good practice audit tool for assessing patient care and services for those living with dementia.
Healthcare Associated Infection	National and Board priority. Further improvement on current performance.	- Achieve reduction in MRSA bacteraemia against a threshold of zero. - No more than 44 (see new reporting mechanism) cases of

MRSA bacteraemia[1,2] **Clostridium *difficile***[1,2] ***(Continuation and mandatory)***		hospital acquired Clostridium *difficile.* - Both of these will be reported onto the Mandatory Enhanced Surveillance System and monitored via Infection Control Committee.
Pressure ulcers[1] ***(Continuation)***	To have zero tolerance for grade 3 and 4 pressure ulcers	- Monitor implementation of new reporting metrics - Review of all identified grade 3 or 4 pressure ulcers - Continued education programme
Discharge summaries[1] **(Continuation)**	To improve timeliness of discharge summary completion. Train 2020 intake of new junior doctors	- Data collected via electronic discharge letter system and monitored via monthly performance reviews and Board reporting. - Care Groups undertake consultant level audits
Rate of patient safety incidents resulting in severe injury or death [1,2] **(Continuation and mandatory)**	To increase reporting to 75th percentile against reference group.	- Cascade lessons learned from serious incidents. - Continue to embed Trustwide work to embed and improve reporting of near miss and no harm incidents.
Improve management of patients identified with sepsis[3] **(Continuation)**	To maintain improvement in relation to management of patients with sepsis	- Maintain an audit programme to monitor management of patients with sepsis. - Hold multi-professional study days. - Hold a trustwide audit and monitor sepsis mortality
EXPERIENCE		
Nutrition and Hydration in Hospital[1] **(Continuation)**	To promote optimal nutrition and hydration for all patients.	- Continue to provide support and tailored training where audit reports indicate - Continue to work closely with catering on hospital menu development and nutritional analysis - Reinvigorate staff from all areas - Recognised nutrition subgroups
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*	- Work with CCGs to develop new palliative care strategy for 2020 to 2025 - Focus intensively on recognition of dying in hospital to enhance care - Explore solutions to the relative lack of single rooms - Work with the Medical Examiner system to explore new ways to feedback to bereaved relatives - Continue quality improvement work with out of hours work

	are important to me, including my carer(s)"	- Appoint a new palliative care consultant to provide support to Care Homes
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 year's results. - Quarterly Reports to Integrated Quality Assurance 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. To maintain high scores and remain above the national average	- 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 and bullying and within the Disability and Race Equality Standard.
Friends and Family Test[1] **(Continuation)**	To increase Friends and family response rates	- During 2020/21 we will increase or maintain Friends and Family response rates. All areas participating will receive monthly feedback - We will roll out the new electronic version of Friends & Family test fro September 2020
EFFECTIVENESS		
Hospital Standardised Mortality Ratio (HSMR)[1] **Standardised Hospital Mortality Index (SHMI)[1,2]**	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 within expected levels. - Results will be captured using nationally recognised methods and reported via

(Continuation and mandatory)	To continue to ensure the organisation reviews deaths and implements any learning into clinical practice.	Mortality Reduction Committee. We will continue to benchmark both locally and nationally with organisations of a similar size and type. Updates will be submitted to Trust Board via the performance scorecard. - Trust mortality review process, allocation of priority reviews to central review team for completion will continue to ensure any learning, positive and negative, is embedded in patient care. - Adhere to "Learning from Deaths" policy. - Provide Care Groups with learning from deaths reviews to identify themes for learning - Triangulate mortality reviews and patient safety incidents to establish learning
Reduction in 28 day readmissions to hospital[1,2] (Continuation and mandatory)	To implement effective and safe discharges.	- Monitoring through monthly performance reviews and Board reporting.
To reduce length of time to assess and treat patients in Accident and Emergency department[1,2] Continuation and mandatory)	Safe and timely access to urgent and emergency care.	- Daily performance update against the national 95% standard. - Monitor through monthly performance reviews and Board. - IMS Transformation Programme. - Review of escalation procedures.
Patient reported outcome measures[1,2] (Continuation and mandatory)	To improve response rate.	- To aim to be within national average for improved health gain. - NHS England have removed groin hernia and varicose vein from mandatory data collection, hip and knee will continue.
Maternity standards (new indicator following stakeholder event)	To monitor compliance with key indicators.	- Continue 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 (new indicator following stakeholder event)	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

Review of performance against priorities 2019/2020

The following section of the report focuses on our performance and outcomes against the priorities we set for 2019/2020. 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.

Changes to Services

In May 2018, the Trust agreed with the Council of Governors that it would include a high-level commentary in its Quality Report, setting out its assessment of the impact of significant service change taking place, or impacting within, the reporting year.

Over the course of the year, the Trust, working through the County Durham Integrated Care Board, with partners in primary care and social care introduced a number changes to its adult community services which have benefited patients, including:

- Wrap around service and crisis support for patients on long-term pathways;
- Piloting of a digital care pathway for patients in care homes, which allows patient observations to be monitored remotely, and which triggers early intervention by district nursing staff in response to any issues highlighted, which significantly reduced unnecessary hospital admissions;
- Establishment of a ‘virtual ward’ through which patients on the adult community services caseload, continue to be monitored as part of that caseload during any acute hospital admission. This allows the community service to track the patient’s progress and plan for timely supported discharge.
- Introducing a single point of access for musculo-skeletal services.
- Increasing out of hours cover from senior nursing staff in the community.
- Investing in community-based stroke rehabilitation services, to equalise services across the county and allow more patients to access rehabilitation closer to home.

In addition, we also introduced a ‘tele-dermatology’ app, which enables GPs to submit photographs with referrals for assessment by our Dermatology teams, who are then able to triage referrals to ensure that urgent cancer cases are prioritised and patients with less concerning issues can receive earlier reassurance.

The most significant service change taking place in 2019/20 was the transfer of vascular services from University Hospital North Durham to Sunderland Royal Hospital. The change was made following a proposal by the regional specialist commissioners, based on the outcome of a review by the national vascular network and extensive engagement and consultation through the County Durham Health and Wellbeing Overview and Scrutiny Committee (OSC). The national network review recommended the transfer, to achieve patient benefits from the concentration of resources in three regional hubs and co-

location of vascular services with other services with potentially close dependencies; in particular, renal services. The transition was well-managed and there have been no major incidents or issues occurring.

The Trust's commissioners commenced consultations with the County Durham Health and Wellbeing OSC during 2018/19, on proposals regarding Ward 6 at Bishop Auckland and acute stroke rehabilitation services provided from that site. In addition, the Trust has contributed to a programme of engagement and consultation led by the (then) North Durham CCG on the future of hospital-based services at Shotley Bridge. In all three cases, engagement and consultation were ongoing at 31 March 2020.

In our 2018/19 Quality Report, we noted that the Ophthalmology service was in the process of reviewing its clinical strategy, including the future of the out of hours' ophthalmology service for Darlington Memorial Hospital, which had been withdrawn in April 2017. Whilst the numbers of patients affected were small, the impact on the experience of those patients, including the need to travel significant distances or to wait to receive treatment could not be dismissed. This service was reinstated during the period of the COVID-19 pandemic response, and is to be formally re-established in the early part of 2020/21.
Finally, the Trust made a number of service changes in March 2020/21, on the grounds of urgency and safety, to enable it to stand up capacity at UHND, DMH and BAH to manage the impact of the COVID-19 outbreak. These changes included the standing down of routine elective surgery, in many cases, in line with national directives and the transfer of some services to outlying sites, to create capacity on our acute sites and to protect the services in question for the time being. We worked closely with partners in the independent sector, and maximised the use of BAH, to maintain some day-case services and, more importantly, to treat urgency cancer referrals. Now that we are over the peak of the pandemic, the Trust has developed plans to restart services. Where these include consequential changes to optimise the use of our capacity – given the impact of infection control measures and social distancing – we are engaging and consulting with our stakeholders including the County Durham Health and Wellbeing OSC, and the Darlington Health and Wellbeing OSC.

PATIENT SAFETY

Patient Falls

☑	Reduce falls/1000 bed days community hospitals. Trust ambition achieved

☒	Reduce falls/1000 bed days acute hospital. Improvement not demonstrated

Our Aim
Our aim is for full commitment and focus on continued improvement in all areas of the organisation to identify high risk patients and put in place falls prevention strategies. This will be realised with the work identified for year three of the multi-agency falls strategy. Data is captured in the monthly incident report and as part of the Board performance monitoring data with discussion at the Trust Falls Meeting.

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 1,000 bed days for community settings. Whilst we have achieved this within community hospital settings there has been some slippage within acute care during 2029/20. The baseline aim to reduce falls as part of the three year strategy does show an overall reduction of 7% over the last 2 years, the 10% year on year reduction has not been achieved this year. It has been disappointing not to have made a further reduction in falls Trust wide but against a background of increasing cognitive behavioural challenges for patients and rising age of population we continue to prevent falls in all setting.

During 2019/20 there were 22 falls reported as serious incidents. Of these, two have been requested to be delogged as on investigation one was a pathological fracture and the other was a general deterioration of the bone. Eighteen were fractured neck of femurs and two were head injuries. This is a decrease from previous years.

Sensory training is available for all staff to aid them to understand how vulnerable patients are and are susceptible to falls.

The Royal College of Physician (RCOP) inpatient fracture neck of femur audit has commenced and the Trust is fully engaged with data collection for this.

The red zimmer frame project has shown positive outcomes in terms of patients being able to recognise their zimmer frame and improve safety during mobilising.

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 priority focus for Year 3 of the Falls Prevention Strategy is to continue collaborating with other agencies aligned to the Falls Strategy. These are Clinical Commissioning Groups, North East Ambulance Service, Durham County Council and Darlington Borough Council. Early prevention work will focus on health and wellbeing of the patient.

Full implementation of red zimmer frames as appropriate across the Trust

Participation in National Falls Audit

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
This action plan was shared with all matrons and department leads, ward sisters in 2017, as the national audit of dementia (NAD) 4th round took place 2018, to utilise resources effectively the intention is to use the evidence from the NAD 4th round monitor for improvement.

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. There has been an overall improvement, however there remains the opportunity/the need to improve further and this will remain the focus during 2020/21.

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. Training is delivered to junior

	doctors twice yearly and a basic awareness programme to all staff regardless of their role. ➢ The focus for this coming year is to focus on front line staff more in depth training
Compliance with training and good practice is encouraged and supported.	➢ Feedback to Trust dementia lead via Learning & Development and monitoring via Training Priorities Group ➢ Use of national Audit data and processes.

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:

- Formal monitoring against the elements of the strategy as identified above with clear escalation for support if there is any lapse in implementation, specifically those highlighted below:

Evaluate the impact of the dementia strategy	Analysing outcome of National Dementia Audit
Review the model of dementia care across the country	Commence initial work.
Implement Enhanced Care team @ UHND	Active recruitment continues.
Evaluate impact and potential expansion to other sites	Evaluating effectiveness of the team now to present back to senior leaders in the Trust
Finalise inputs on Nervecentre MCA Care plan/ Dementia switch off from ISOFT, Consider extra question on consent	Nervecentre now fully operational with Dementia Screen. Demonstrated positive effect on performance.
Deliver Dementia Training Year 2	Performance is it on target
Deliver Dementia Training Year 3	
Campaign to improve knowledge of Delirium	Need to consider other work.

The Learning Disability Improvement Standards for NHS Trusts

As part of developing these improvement standards, NHS Improvement identified some services that provide care to people with learning disabilities, autism or both, and others that provide care only to those with learning disabilities. We use the term 'people with learning disabilities, autism or both' in these standards, but advise discretionary interpretation of the term to compliment the particular service against which the standards are being applied.

Trusts are expected to publish their performance against these standards in their annual quality accounts: to demonstrate to the population they serve how they measure quality of services and whether quality is improving. Each standard has its own improvement measures.

Standard 1

Standard 1	All trusts must ensure that they meet their Equality Act Duties to people with learning disabilities, autism or both, and that the wider human rights of these people are respected and protected, as required by the Human Rights Act.		
Improvement measure	**What this means in practice**	**Compliance Statement**	**Compliance**
Trusts must demonstrate they have made reasonable adjustments to care pathways to ensure people with learning disabilities, autism or both can access highly personalised care and achieve equality of outcomes.	This typically includes things like using modified communication, flexible appointment systems and modified triage assessments, and ensuring due regard to the content of hospital passports.	The trust has an established LD service to support patient, relatives and staff to facilitate reasonable adjustment.	
Trusts must have mechanisms to identify and flag patients with learning disabilities, autism or both from the point of admission through to discharge; and where appropriate, share this information as people move through departments and between services.	This might be done using electronic flags in patient administration systems and ensuring the necessary reasonable adjustments are recorded in a person's summary care record.	With the consent of the patient we are able to flag patients with a learning disability facilitate care and support needs.	
Trusts must have processes to investigate the death of a person with learning disabilities, autism or both while using their services, and to learn lessons from the findings of these investigations.	Both local investigations and full engagement with the national LeDeR programme. Also, acting to address findings of investigations.	The trust actively supports the LeDeR process	
Trusts must demonstrate that they vigilantly monitor any restrictions or deprivations of liberty associated with the delivery of care and treatment to people with learning disabilities, autism or both.	Trusts have arrangements to ensure any restrictions and deprivations of liberty are correctly and lawfully authorised, with checks that these are always necessary and proportionate. Trusts are transparent about what they do and why, and are open to challenge.	The Trust have very clear systems to monitor the application of Deprivation of Liberties	
Trusts must have measures to promote anti-discriminatory practice in relation to people with learning disabilities, autism or both.	Trusts have effective safeguarding arrangements to ensure that diagnostic overshadowing and value judgements about a person's quality of life do not detract from their care. Trusts compare outcomes and experiences of people with learning disabilities, autism or both with those of non-disabled peers.	There have been 2 incidents this year where patients care may have been compromised as a result of diagnostic overshadowing. This indicates that whilst there has been significant change with understanding of LD there is still work to be done.	

Standard 2

Standard 2	Every trust must ensure all people with learning disabilities, autism or both and their families and carers are empowered to be partners in the care they receive.		
Improvement measure	**What this means in practice**	**Compliance Statement**	**Compliance**
Trusts must demonstrate processes that ensure they work and engage with people receiving care, their families and carers, as set out in the NHS Constitution.	Trusts involve people, families and carers in all aspects of planning and evaluating care and treatment, and use their feedback and experiences to Trusts tell people if their care has raised safety concerns and what will be done to prevent recurrences.	In the vast majority of cases this would apply however, based on the outcome of two serious incidents this has been questioned and indicates that work is still required to provide a level of understanding to staff within the organisation.	
Trusts must demonstrate that their services are 'values-led'; for example, in service design/improvement, handling of complaints, investigations, training and development, and recruitment.	Trusts make clear the attitudes, behaviours and communication they expect Trusts support people whose complaints and concerns are being looked into. Trusts involve people with learning disabilities in staff recruitment.	The Trust advocates clear values and beliefs	
Trusts must demonstrate that they co-design relevant services with people with learning disabilities, autism or both and their families and carers.	This includes involvement of people, families and carers in reviewing services/pathways that affect them and planning improvements. Some organisations ensure that people with learning disabilities, autism or both are fully involved in strategic decision-making and designing approaches to continuous learning.	We are actively involved in the North East LD Network and use patient and relative experience to inform service delivery. However, to achieve co-production we want to work on as part of the wider patient engagement strategy and the development of patient panels	
Trusts must demonstrate that they learn from complaints, investigations and mortality reviews, and that they engage with and involve people, families and carers throughout these processes.	This might include, for example, adopting NHS England's initiative 'Ask Listen Do'. In line with the LeDeR reviews, trusts should invite the input of people and families affected, to maximise learning from untoward events.	The Trust have clear process for learning from complaints, incidents and LeDeR review . Patient families and carers would be supported to receive the feedback	
Trusts must be able to demonstrate they empower people with learning disabilities, autism or both and their families and carers to exercise their rights.	This might include commissioning people with learning disabilities, autism or both to independently review services, and paying them for any work they do. Trusts actively inform people of their rights, in a manner that is meaningful to them.	This links in with the action above and the development of patient panels. We are part of the North East LD network and use this as a forum to share work	

Standard 3

Standard 3	All trusts must have the skills and capacity to meet the needs of people with learning disabilities, autism or both by providing safe and sustainable staffing, with effective leadership at all levels.		
Improvement measure	**What this means in practice**	**Compliance Statement**	**Compliance**
Based on analysis of the needs of the local population, trusts must ensure staff have the specialist knowledge and skills to meet the unique needs of people with learning disabilities, autism or both who access and use their services, as well as those who support them.	Trusts understand patterns of local need among people with learning disabilities, autism or both, and use this knowledge to determine what skills are required and then recruit the right staff in the right numbers.	We work with Project Choice Apprenticeship Scheme which enables those with a Learning Disability to undertake an apprenticeship with us, thus gaining employment experience, training and development etc. with a view to them gaining long term employment within the NHS.	
Staff must be trained and then routinely updated in how to deliver care to people with learning disabilities, autism or both who use their services, in a way that takes account of their rights, unique needs and health vulnerabilities; adjustments to how services are delivered are tailored to each person's individual needs.	This is likely to include ensuring staff have been trained in: learning disabilities and autism awareness; health issues associated with learning disabilities; supporting people with challenging needs; safeguarding; human rights and mental capacity and best interests.	There is training programme for Learning Disabilities delivered in the trust. As part of the wider safeguarding framework we are also looking at how we can develop the training for Autism.	
Trusts must have workforce plans that manage and mitigate the impact of the growing, cross-system shortage of qualified practitioners with a professional specialism in learning disabilities.	This might include supporting new, emerging roles such as advanced practitioners, apprenticeships, consultant allied health professionals and nurses, clinical academic roles and non-medical prescribers, and employing experts by experience/peer workers.	We have a dedicated workforce to support LD linked to our colleagues in mental health services. We are also looking to support women in pregnancy and have increased Safeguarding Midwives in the effort to improve communications between maternity and LD services.	
Trusts must demonstrate clinical and practice leadership and consideration of the needs of people with learning disabilities, autism or both, within local strategies to ensure safe and sustainable staffing.	This includes trusts having a designated lead for learning disabilities, as well as providing induction, mentorship, supervision and appraisal that explore how people with learning disabilities, autism or both are being supported.	Learning Disabilities and Autism are key factors in the Safeguarding Framework 2019-21. Executive leadership for LD is the responsibility of the Executive Director of Nursing. This is supported on a operational basis by Associate Director of Nursing and Lead Nurse for Learning Disability.	

Next Steps

- Continue on the work to develop patient panels to ensure that we can demonstrate co-production.
- Continue the education and training around reasonable adjustment in relation to Learning Disabilities.
- Widen scope of training as part of the Safeguarding Framework to look at autism in more general terms rather than just in Learning Disabilities.

Healthcare Associated Infections

MRSA bacteraemia

Clostridium *difficile*

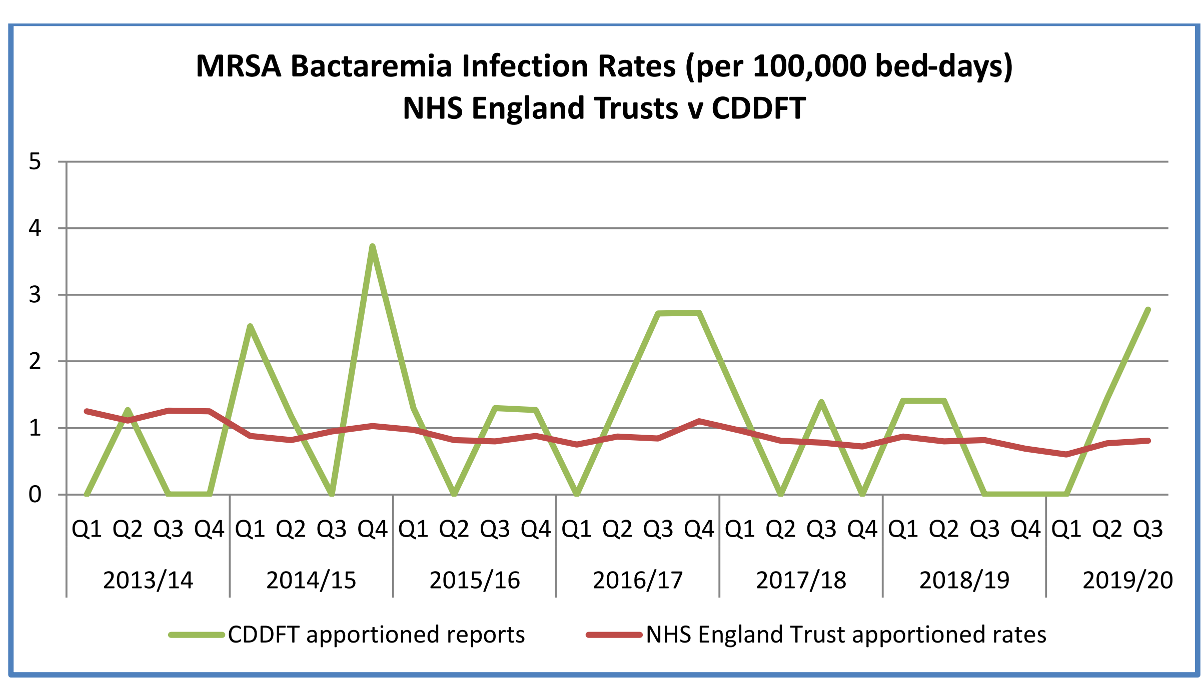
	Unable to rate due to new national metrics

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

Progress
CDDFT has reported 6 cases of MRSA Bacteraemia during the 2019/20 period which puts the Trust above its annual threshold of zero avoidable infections. Post infection review has been carried out for all cases. The findings of the post infection review have been shared at many forums within the organisation

Graphs below indicate the trust end of year position performance against trajectory from 2013/14



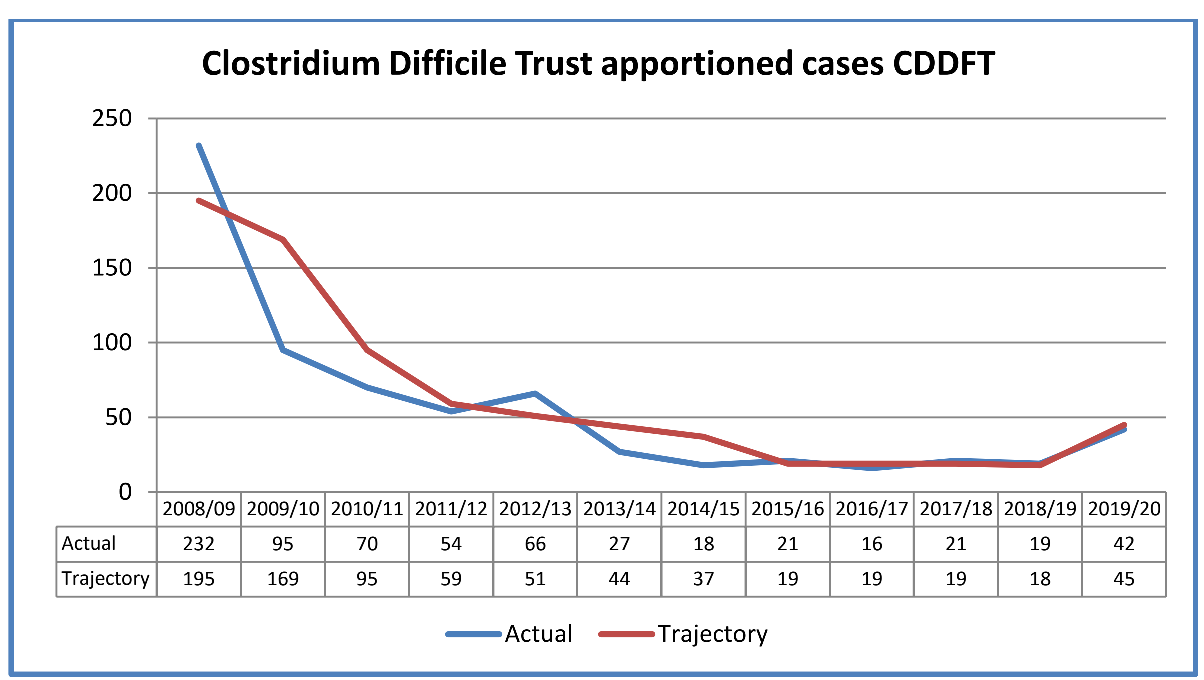
Actions for improvement

- Focus on MRSA Screening and decolonisation
- Focus on monitoring and audit of intravenous line care

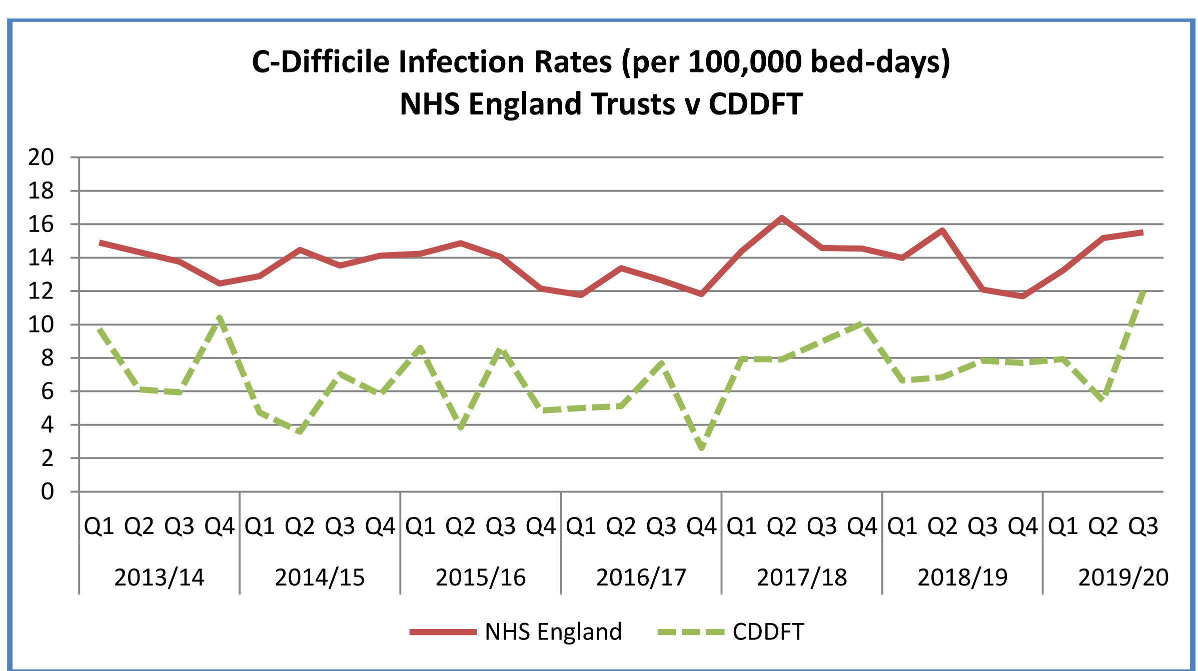
Clostridium *difficile*

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.

From a trajectory of 45 cases, the year-end number of *Clostridium difficile* cases (both community onset and hospital onset) was 49. Benchmarking data below demonstrates that although the set threshold has been exceeded the Trusts performance in terms of rate per 100,000 bed days, remains consistently low when compared with regional data.



	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Actual	232	95	70	54	66	27	18	21	16	21	19	42
Trajectory	195	169	95	59	51	44	37	19	19	19	18	45



Actions for Improvements

- Focus on early identification and isolation
- Continue with Antimicrobial stewardship programme
- Continue to monitor practices for both acute and community onset and ensure that joint reviews are undertaken to focus on improvement across the health economy

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:
A comprehensive action plan is being developed for 2020/2021 for all hospital acquired infection improvement goals.

NHSI document "Clostridium difficile infection objectives for NHS organisations in 2018/19, guidance on sanction implementation and notification of changes to case attribution definitions from 2019" outlined changes to the CDI reporting algorithm for the financial year 2019/20 these are:

- Reducing the number of days to identify hospital onset healthcare associated cases from ≥3 to ≥2 days following admission

- Adding a prior healthcare exposure element for community onset cases.

Cases reported to the healthcare associated infection data capture system continue to be assigned as follows:

- Healthcare onset healthcare associated: cases detected three or more days after admission
- Community onset healthcare associated: cases detected within two days of admission where the patient has been an inpatient in the trust reporting the case in the previous four weeks
- Community onset indeterminate association: cases detected within two days of admission where the patient has been an inpatient in the Trust reporting the case in the previous 12 weeks but not the most recent four weeks
- Community onset community associated: case detected within two days of admission where the patient has not been an inpatient in the trust reporting the case in the previous 12 weeks.

All patients with CDI cases have an electronic alert placed on their records. The infection control team can track patients as soon as they are admitted and ensure robust management plans are in place.

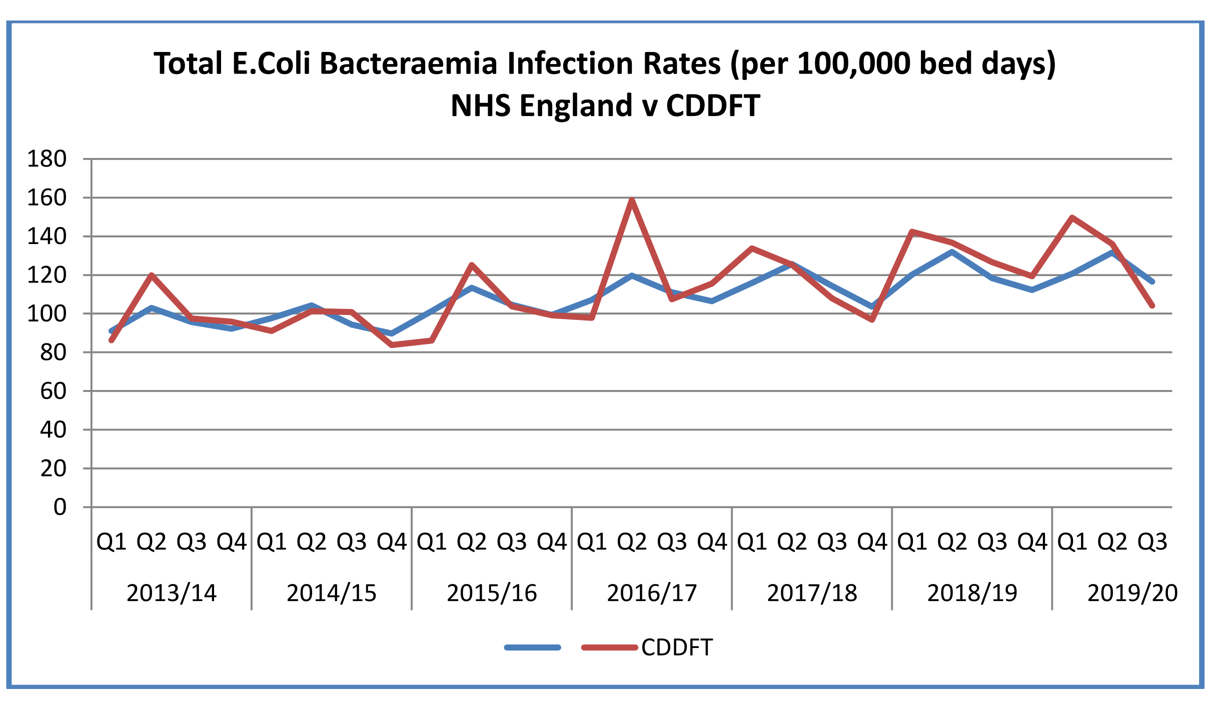
For this year we have re considered the current process and made some changes to ensure a robust review of all cases is carried out in collaboration with infection control representation from both acute and CCG, antimicrobial pharmacy and consultant microbiologists/ Infection control doctors. Whilst there has not been a national directive on reduction targets this year due to COVID-19 pandemic, we aim to reduce by a further case and have a local threshold of 44 cases during 2020/21

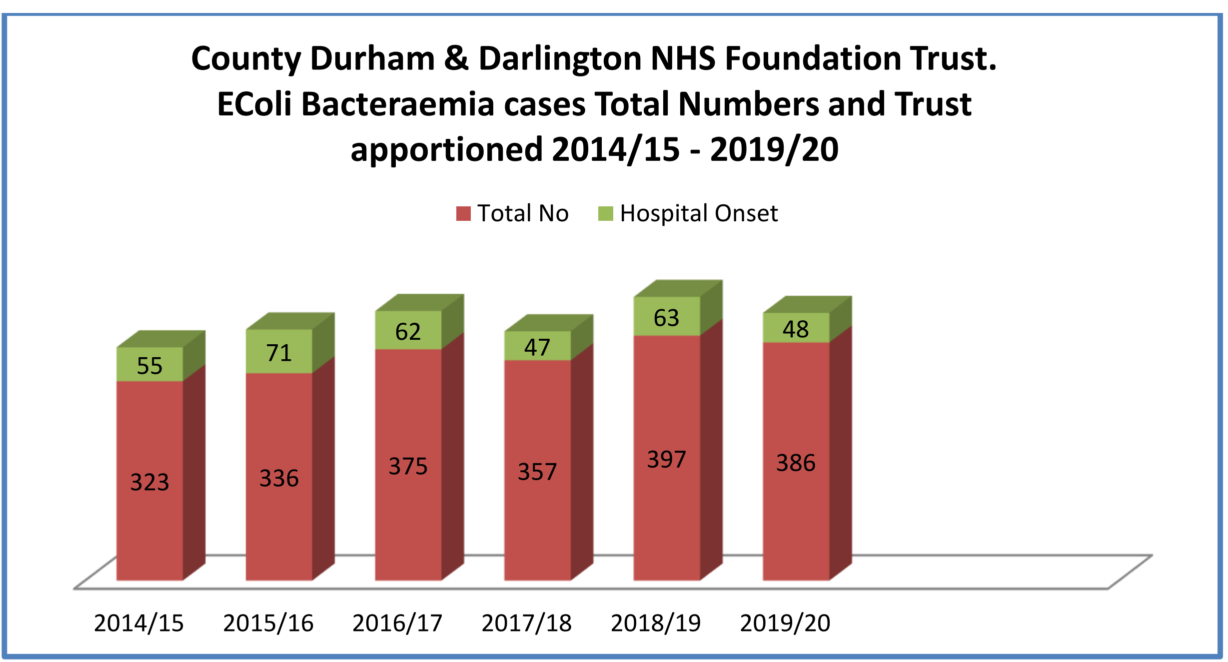
E-Coli Bacteraemia

What is Escherichia coli? *Escherichia coli* (abbreviated as *E. coli*) is a Gram-Negative bacteria found in the environment, foods, and intestines of people and animals. Although most strains of *E. coli* are harmless, others can make you sick. Some kinds of *E. coli* can cause diarrhoea, while others may cause urinary tract infections, respiratory illness pneumonia, blood stream infections and other illnesses. In May 2017 the Secretary of State for Health launched an ambition to reduce healthcare associated Gram-negative bloodstream infections by 50% by 2021 and reduce inappropriate antimicrobial prescribing by 50% by 2021.The initial focus is on reducing E.coli Blood stream infections by 10%

It is known that 75% of E coli bacteraemia are community onset so we are working closely with CCG colleagues on a whole health economy action plan.

From 1st June 2011 the Trust has reported all E coli bacteraemia cases. For the 2019/20 period the Trust reported a total of 387 cases of E coli bacteraemia and 48 hospital onset cases. This is a decrease in total numbers in both the overall and the hospital onset figures.





Pressure Ulcers

☒	Trust ambition not achieved

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

Progress
We have recently implemented the new NHSi guidelines within the organisation and consolidated our previous learning incorporating the new guides into all education.
All patients identified with grade 3 and above pressure ulcers whilst in our care have formal review. 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.

Although there has been an increase within community of Category 3/4, review of these cases has found that sometimes the patient has chronic illness and makes choices on the interventions offered.

Acute Services Hospitals – DMH, UHND, CLS, Shotley Bridge	**Category 2 with lapses in care**	**Category 3/4 with lapses in care**
2012/13	34	3
2013/14	16	4
2014/15	13	7
2015/16	2	1
2016/17	4	1
2017/2018	0	1
2018/2019	5	3
2019/2020	10	2

Community Services Richardson Hospital, Weardale Community, Sedgefield Community and all patients under care of DN teams	**Category 2 with lapses in care**	**Category 3/4 with lapses in care**
2012/13	23	3
2013/14	2	3

2014/15	2	2
2015/16	0	4
2016/17	2	3
2017/2018	0	3
2018/2019	0	7
2019/2020	8	4

This will remain a primary priority for 2020/2021 as we continue with improvement measures to achieve our aspiration of zero avoidable pressure ulcers.

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:

- Promote existing resources on ward areas on wound definitions especially on pressure damage.
- Raise awareness on the availability of the new Trust policy on Pressure Prevention and Moisture Damage.
- Promote the acronym – ASSKING to help staff think about avoiding skin damage
  - Assessment
  - Skin Care
  - Surface
  - Keep Moving
  - Incontinence
  - Nutrition
  - Giving patient information on prevention.
- Ensure high standards of pressure prevention equipment are available
- Develop and deliver evidence based educational programme
- Develop and support our Wound Resource Educational Nurse (WREN)
- Audit clinical practice and set action plans to improve practice where needed.
- Provide a supportive and accessible service to all patients and staff.

Discharge Summaries

☒	Trust ambition not achieved

Our aim

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

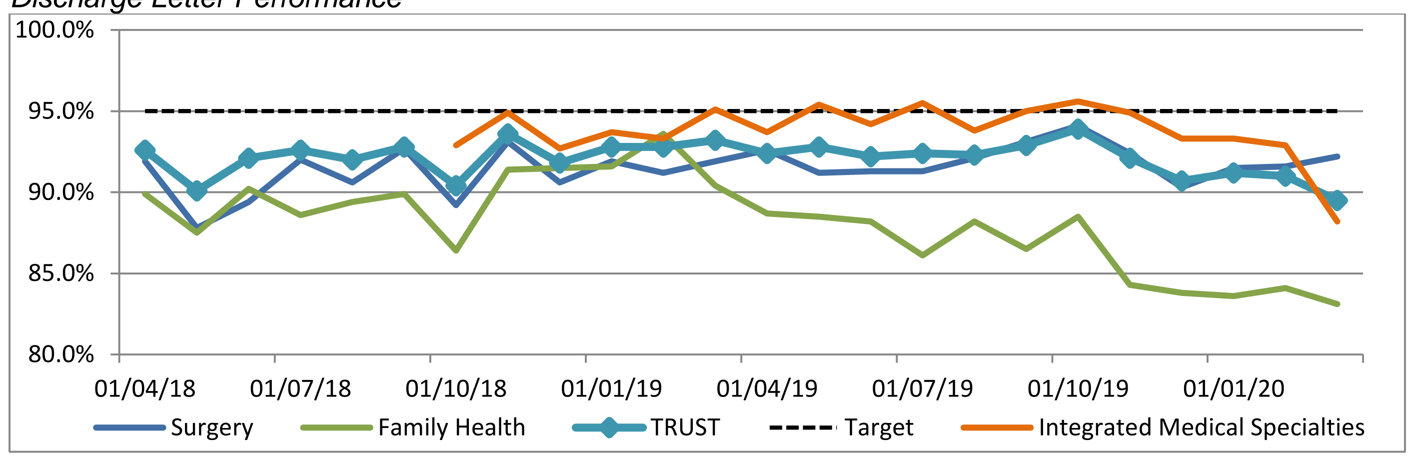
Progress

This remains a high priority for GPs and the Trust. Timely discharge information enables GPs to provide effective and safe follow-up care for patients after a hospital stay.

Surgery and Medicine (IMS) usually exceed 90%, whilst IMS increasingly frequently achieves the 95% target. This contributes to Trust-wide performance which is typically in excess of 90%. Work is taking place with Family Health, consisting mainly of paediatrics and gynaecology, to improve their position and learn from what has helped the other Care Groups raise performance. IMS performance has dipped in March due to the pressures occasioned by COVID-19.

Care Groups emphasise the importance of this target during the induction process for junior doctors, and through governance meetings.

Discharge Letter Performance



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Surgery	92.6%	91.2%	91.3%	91.3%	92.1%	93.1%	94.1%	92.4%	90.3%	91.5%	91.6%	92.2%
IMS	93.7%	95.4%	94.2%	95.5%	93.8%	95.0%	95.6%	94.9%	93.3%	93.3%	92.9%	88.2%
Family Health	88.7%	88.5%	88.2%	86.1%	88.2%	86.5%	88.5%	84.3%	83.8%	83.6%	84.1%	83.1%
TRUST	**92.4%**	**92.8%**	**92.2%**	**92.4%**	**92.3%**	**92.9%**	**93.9%**	**92.1%**	**90.7%**	**91.2%**	**91.0%**	**89.5%**

Each Care Group has a responsible lead manager to whom a weekly dataset is sent to enable them to identify variation and manage performance at specialty, consultant and ward level. The performance of each Care Group is monitored in monthly Performance Reviews and quarterly Executive-led reviews. Progress is also reported to the Integrated Quality and Assurance Committee and to the Trust Board.

Next steps

Current reporting arrangements will continue and the Trust will continue to re-emphasise to all front-line staff its clinical importance. Family Health, in particular, are conducting a "deep dive" exercise to try to raise performance to the level of the other Care Groups.

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

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.

Never Events

Disappointingly, the Trust reported three 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.

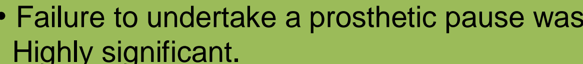
Mis-selection of high strength midazolam during conscious sedation

- Gastroscopy procedure with sedation drawn up without diluting the extra strength Midazolam 10mg/2ml (which should be diluted in 8mls of Sodium Chloride making it 10mg/10mls).

- Safety alert issued to remind staff of the national shortage of Midazolam Injection 5mg in 5mL and 50mg in 50mL and to direct on the below required actions:
- **Actions required for areas that usually stock midazolam 5mg/5mL and 50mg/50mL injection:**
- Ensure that all staff members are made aware that midazolam **10mg/2mL (high strength)** injection may be supplied by pharmacy
- Ensure that midazolam **10mg/2mL (high strength)** injection is entered on a separate page of the controlled drug register and highlight that it is 'high strength'
- Avoid ordering midazolam until ward stocks are low to ensure only one strength of midazolam is available in a clinical area (to avoid confusion)
- Pharmacy will attach red "check strength" labels to all midazolam injection packs during the shortage
- Where smaller doses are required, ensure that the injection is appropriately diluted with sodium chloride 0.9% or water for injection
- As is standard practice, please ensure that **flumazenil** injection is readily available in all areas where midazolam is used

Wrong Implant

Wrong short gamma intramedullary nail



- Failure to undertake a prosthetic pause was Highly significant.

- The choice of prostheses changed after the Fracture was reduced and the alternative Prostheses was on the trolley shelf.

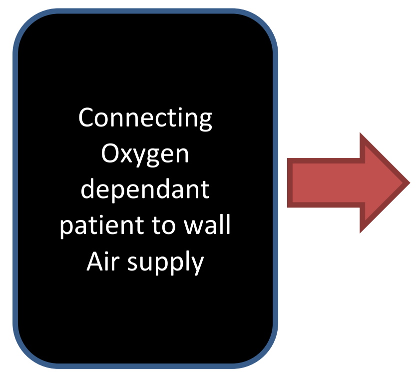
- The Team care assistant was still sent to obtain it.

- Locating the correct prosthesis was confusing for Team care assistant sent to the cabinet.

- When asked to check the prostheses the surgeon Appears to have declined the request.

- Concerns were expressed regarding the capacity Of staff rotating from Gynaecology theatres and Part time staff members.

- The team was not familiar with each other.



- Ambulance staff should not initiate treatment using piped medical gases unless under the supervision of Emergency Department staff
- Between patients an area that is not cleared and ready for the next patient presents a risk
- Ambulance staff attached patient to medical piped air in order to continue the treatment commenced during transfer from ambulance stretcher oxygen cylinder
- Ambulance staff unfamiliar with medical piped air and attached to flowmeter present in wall outlet. This was from the previous patient, who was receiving medical air, but the bay had not yet been cleared
- Failure to handover to ED staff due to staff in monitoring being required to provide medical care to extremely sick patients within the same location

The Never Events that have occurred and learning identified (as shown in the tables above) have been shared Trust wide via bulletins, posters and at educational sessions and through communications and presentations. The identified learning has been shared with local NHS organisations when staff involved in the incident have been employed with an external organisation, to ensure multi agency learning.

Regulation 28
The Trust received one Regulation 28 letters of the Coroner's Investigation Regulation during 2019/20.

The Coroner raised concern that:

Existing patient record systems fail to ensure that important and urgent information is brought, in a timely way, to the attention of those who need it.

In response to this, the root cause analysis report was reviewed and it was concluded that a misleading choice of words had been used as follows:

"The matron advised that nursing staff primarily utilise Nervecentre (an electronic patient record) accessed by a hand held device as the main source of information during a shift rather than the patient's paper health record".

This was in relation to documentation. The report suggested that multidisciplinary staff used different care records to record patient assessments. In reality, detailed patient care records are multi-disciplinary and in paper format within the Trust. Both nursing and physiotherapy records, along with medical entries are recorded contemporaneously within the paper record. In relation to the patient the physiotherapist had recorded within the paper record, placed mobility advice above the bed and handed over this advice verbally to the nursing staff.

To address this issue physiotherapists now record in the mobility gallery in Nervecentre if they identify change in mobility or change in interventions required. This does not replace the detailed paper record but ensures that all staff are aware of this whether accessing paper records or Nervecentre.

The Coroner also raised concern that "vulnerable patients are obliged to share walking aids on hospital wards"

On review, that Trust concluded that during traditional working hours walking aids are provided by physiotherapists following assessment of the patient, but to ensure that patients do not need to share mobility equipment a buffer stock of walking aids has been introduced for out of hours use.

Serious Incidents
The Trust reported 70 serious incidents during 2019/2020 (four of which were de-logged or in the process of requesting de-log). 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.

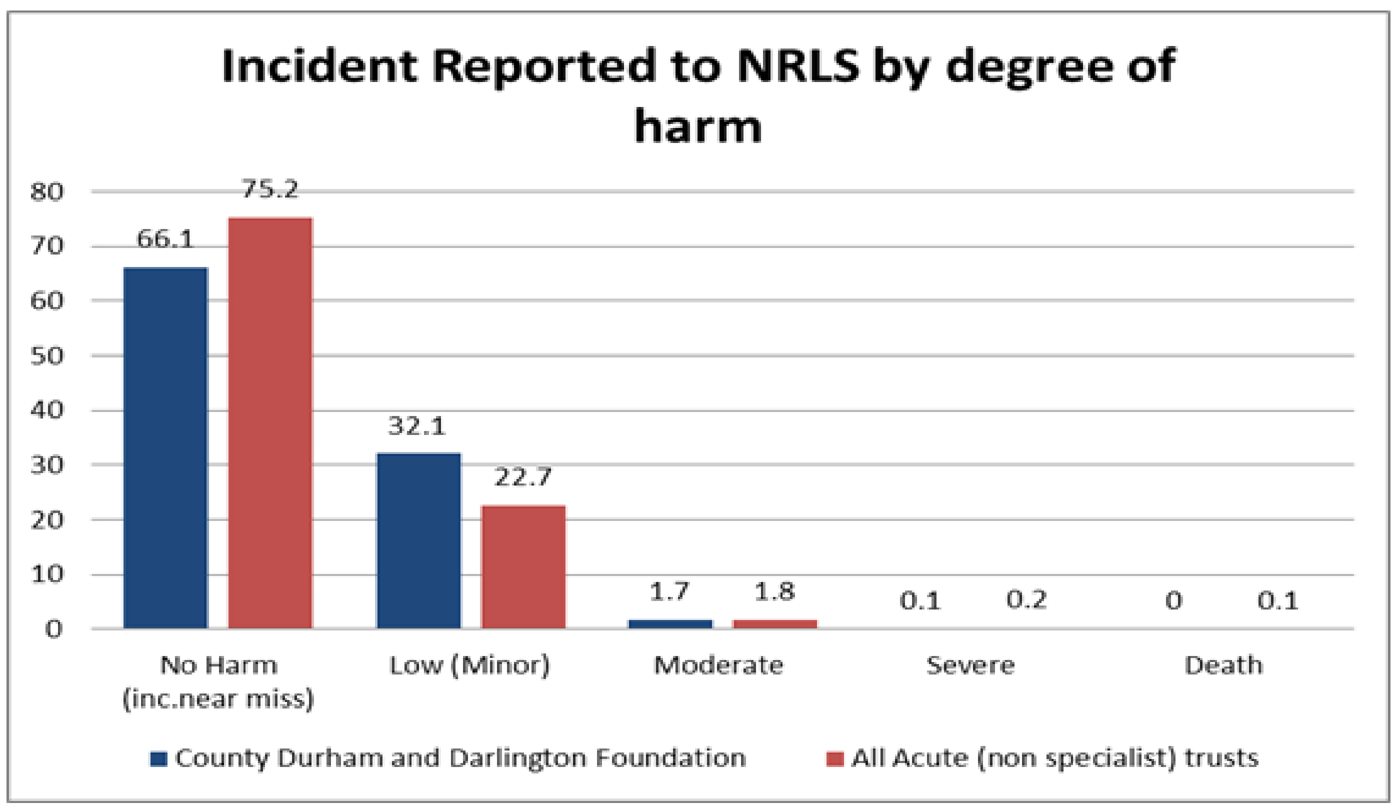
Period	Apr16 Sept16	Oct 16 Mar17	Apr 17 Sept 17	Oct 17 Mar 18	Apr 18 Sep 18	Oct 18 Mar 19	Apr 19 Sep 19
Patient safety incidents	5238	5527	5334	5324	6703	7382	6706
CDDFT %age reporting Rate (1000 bed days)	35.17	37.66	36.75	35.64	47.24	49.63	47.17
CDDFT %age severe injury & death	0.3	0.2	0.4	0.1	0.1	0.1	0.05
National %age reporting rate (1000 bed days)	40.02	40.12	* Not available	* Not available	* Not available	43.31	49.8
National %age severe injury & death	0.4	0.3	* Not available	* Not available	0.2	0.2	0.07

*From April 2018 the release of the organisation patient safety incident data workbook (official statistics) the NRLS organisation level summary report no longer include national average statistics.

Our aim
- To continue to aim for an increase in near miss and no harm incident reporting
- 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 *(Apr – Sep 2019 NRLS Data)*



Harm rating

The reporting period for April – September 2019 shows a decrease in reporting rate on the last period. The national average reporting rate for Acute (non-specialist) is 49.8 and ours is slightly lower at 47.17. However the reporting period for Oct 18 – Mar 19 showed a significant increase in our reporting rate of 49.63 compared to Oct 17 – Mar 18, which showed 35.64. Therefore the organisation has maintained a good reporting culture, although will continue to increase reporting to continue to improve our trend.

CDDFT have seen a 1% increase of incidents reported between the Apr and Sep 18 and Apr – Sep 19 (an increase of 3 incidents).

CDDFT has an improved reporting delay rate from 33 days to 22 days; which is in line with the national average of 22 days. This is due to the integrated working with external reporters to ensure they report incidents to CDDFT from other organisations soon after the incident has occurred to allow CDDFT to investigate.

Further work has been undertaken by the Patient Safety team throughout 2019/20 on the analysis of the reporting of no harm and near miss incidents and identified that the incidents aren't always graded appropriately during the management process.

Within 2019/20 the patient safety team have continued the "learning from near misses" campaign and has seen a further increase in 37% increase in near miss incidents being reported (between April to December 2018 and April to December 2019). Pilot work has been undertaken within CDD community services in reviewing themes identified within their near miss no harm incidents and service improvement work has been undertaken as a result of the analysis. This campaign will continue in 2020/21 to further improve learning from lower harm incidents to prevent serious incidents occurring.

In 2019/20 the Patient Safety Champion role was launched in the organisation to support the communication of learning from incidents to front line staff at all levels of the organisations by working in collaboration with Patient Safety Team and Care Group Facilitators. There are currently 70 Patient Safety Champions in the Trust from a wide range of specialties and staff groups within both community and acute sites.

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 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 2019/20
- To explore the standardisation of lessons learnt documentation alongside the Patient Safety Champions
- To continue to share learning and service improvements from incident themes to mitigate the potential risk in c service areas.

Improve management of patients identified with sepsis

☑	Trust ambition achieved

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

Progress
The regional sepsis screening tool is 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. Following the pilot of the one hours bundle, it was evaluated by clinicians involved that this did not provide additional support to the overall management of patients with sepsis. Therefore is no longer a priority areas of focus for 2020/21.

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 closely monitor timeliness of sepsis one hour care bundle delivery to patients with sepsis.

Deliver planned education to clinical staff and improve the quality of care for patients with sepsis.

Complete Trust wide audit and monitor sepsis mortality.

MATERNITY STANDARDS

Maternity Standards: Breastfeeding

☒	Trust ambition not achieved

Our Aim
To improve breastfeeding initiation rates – Target 60%.
This data collected is CSC breastfeeding intention in relation to this indicator.

Progress
Year to date performance 2019/2020 – 57.3%.

Next Steps
County Durham & Darlington NHS Foundation Trust is taking the following actions (outlined below) to improve this number and/or rate, and so the quality of its services:

- The Infant Feeding Team has been under reconfiguration. The team has strengthened with the addition of a Band 6 midwife supporting the Midwives and Maternity Care assistants with education and training.

- Preparation for UNICEF UK Baby Friendly Accreditation re-assessment is progressing; this will take place late 2020/early 2021.

- Alongside the UNICEF UK re-assessment we are working towards achieving the UNICEF UK Gold Award which recognises sustainment of standards, within this award all senior manager and managers expected to support proportionate responsibility and accountability and help to foster an organisation that protects and promotes the Baby Friendly Standards.

- The Infant Feeding Team are involved in the Maternity Neonatal Collaborative project in supporting high risk mothers to obtain breastmilk for their babies. This includes Colostrum harvesting from 36 weeks of pregnancy. This successful initiative has seen a significant decrease in admissions to our NNU, keeping mothers and babies together thus further reinforcing the path to successful breastfeeding.

- Many other mothers who have previously formula fed are Colostrum harvesting by choice. This also reduces the need for formula supplementation for high risk babies.

- The Infant Feeding Training Curriculum has been revised to recognise further developments in infant feeding and all staff are expected to attend an annual 4 hour update followed by practical assessments.

- The development of a Specialist Infant Feeding Clinic to provide information and support to mothers with complex needs is under discussion with a priority to promote the value of breastfeeding.

- The Frenulotomy service remains in place and provides support and if required Tongue Tie division to provide Mothers and Infants a supportive feeding environment and Specialist Input following the procedure.

Maternity Standards: Smoking in Pregnancy

	Trust ambition achieved

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

Progress
2019/2020 performance – 16.9%.

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:

- There has been a change to Carbon Monoxide (CO) monitoring in antenatal women, all women have CO monitoring done on every contact and the policy has been updated to reflect that.

- Introduction of CO monitors on the Maternity Wards to enabling monitoring of women on Antenatal or Postnatal Wards.

- The Trust is involved with the Local Maternity Systems Reducing Smoking in Pregnancy Project. This includes additional Very Brief Awareness training for staff and development of a Regional Tobacco Dependency in Pregnancy Pathway.

- A reduction in threshold is currently being agreed to improve results further.

- NRT available for all women admitted to the acute sites, with this being provided to them on admission. Work continues to secure a wider range to be made available.

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
2018/2019 Performance 90.8%.

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 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 GP's and Health Visitors.
- 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.
- The development of an online booking template is being explored.
- An early birds style Pre Assessment Clinic is now in place to ensure women are seen at the earliest opportunity and receive key pieces of Health advice.

Saving Babies Lives v.2

☑	Trust ambition achieved to continue implementation

- **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 and 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.
- **Element 5 -** reducing preterm births

Gap Analysis

Element	Achieved Yes/No	Planned Actions
Element 1	Yes	• Post-delivery CO monitoring of all women.
Element 2	Yes	• Risk assessment at booking with early administration of aspirin where required • 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. • Repeat fetal campaign bi-annually to capture all new pregnancies
Element 4	Partial	• Central CTG monitoring & archiving system including Dawes-Redman capacity • Appoint staff to support practice development within CTG teaching. • MDT involvement with MatNeoSIP with regional approach to physiological CTG
Element 5	Partial	• Explore access to TVCS and capacity for a clinician to lead a preterm birth pathway for women at risk of preterm birth. Successful pilot achieved on one acute site to be extended to second acute site for full compliance.

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. We are pleased with the improvement seen with regards to this indicator and are working with Commissioners to agree the threshold for 2019/2010 to reset the challenge for further improvement.

Element 2 – Identification & surveillance of pregnancies with fetal growth restriction.

All Community Midwives have received GROW training including assessments of measuring Symphysis Fundal Height and completion of online learning. There are also regular updates provided.

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, presented through Clinical Governance and educational days..

Element 3 – Raising awareness amongst pregnant women of the importance of detecting & reporting reduced foetal 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 foetal movements.

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

Trust embarked on a media campaign in June 2018, to highlight and educate on the importance of foetal movements. This was shared on all social media platforms and local intranet. A single telephone number for triage and assessment was put in place to ease access to advice for all women. A local radio station supported the campaign and also supported a roadshow across the region in which maternity staff and user representatives were involved. Posters are in place on Lifts in both acute hospitals as visual aids and a branded theme was used. This was partly funded by SANDS and our own charitable funds. We perform well when measured against the standards for raising awareness of reduced foetal movement

Element 4 – Effective fetal monitoring in labour.

All Obstetric and Midwifery staff to complete K2 training package. A mandatory test has been added to this package that all midwives complete on an annual basis as part of their essential training.

Fresh eyes have become hourly review, fresh ears now implemented hourly for all low risk labours including home births.

As part of the electronic patient record (EPR) project, implement a Central CTG monitoring & archiving system including Dawes-Redman capacity (an assessment tool for antenatal CTG to assess whether the tracing is normal). The Business Case was on hold until the procurement exercise for the Trust EPR was complete. Our local Business Case has now been updated and sits with procurement prior to Care Group approval.

Purchase of 10 CTG monitors equipped with recognised antenatal analysis (Dawes/Redman)

Version two of the Saving Babies' Lives Care Bundle (SBLCBv2), has been produced to build on the achievements of version one and was launched in March 2019. It aims to provide detailed information for providers and commissioners of maternity care on how to reduce perinatal mortality across England. A fifth element has been introduced within the bundle which is focused on the reduction of preterm birth. The maternity service has developed a strategy to reach compliance by developing a preterm birth clinic in the South of the county. This practice is to be shared Trustwide, a clinical lead has been identified.

Paediatric Care

☑	Trust ambition achieved to provide specialist children's assessment area UHND

Children and young people attending hospital for unscheduled care, should be provided with a safe, dedicated area away from adult care areas. The RCPCH standards for Emergency care document guide, Facing the Future - standards for children and young people in emergency care settings, sets out 70 standards, which provide the benchmark for the development and delivery of emergency care for children. At its heart, Facing the Future is about the rights of children and young people - to be involved in decisions about their care, and be treated by the right people, at the right time, in the right place. The first step in meeting those standards is focused on the development of a separate children's assessment area at UHND.

An area has been identified in UHND adjacent to the main Emergency Department, that could be used to provide a separate, yet co located assessment area. The Paediatric and Emergency care clinical teams would work into this area, providing an integrated approach to care for children and families.
The specialist skills of both teams would support a safer and more effective care pathway.
Facing the future outlines 70 standards for providing Emergency Care for Children, covering

- an integrated urgent and emergency care system
- environment in emergency care settings
- workforce and training
- management of the sick or injured child
- safeguarding in emergency care settings
- mental health
- children with complex medical needs
- major incidents involving children and young people
- safe transfers
- death of a child
- information system and data analysis
- research for paediatric emergency care.

The development of a separate and specialist emergency care setting for children and young people at UHND, is the first step in meeting the standards. Benchmarking and audit of the service will be undertaken over a 2 year developmental period as the service embeds and matures. There will be standards that we can achieve early in the process and those which will require significantly new ways of working and resource allocation. However both the Emergency medicine team and the Paediatric team are committed to improving the standard of care for children and young people who present to CDDFT with an unscheduled care need.

Excellence Reporting

☑	Trust ambition achieved

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.

Next steps

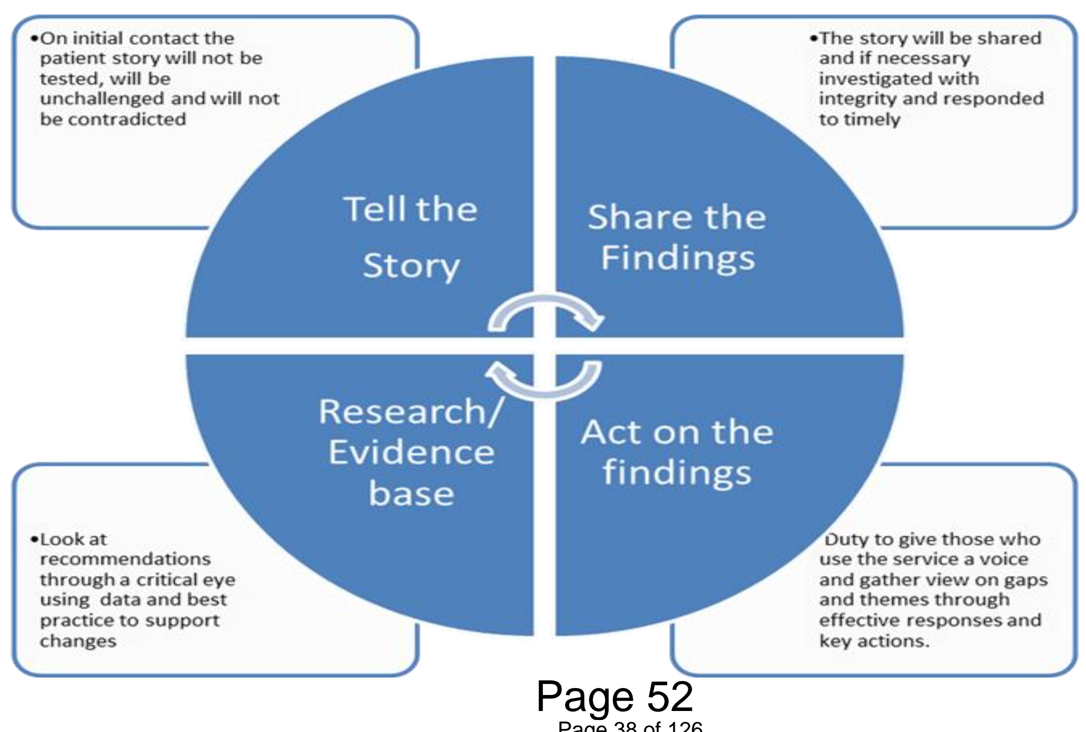
County Durham & Darlington NHS Foundation Trust intends to take the following actions (outlined below) to improve this number and/or rate, and so the quality of its services. The following actions will continue to be embedded

- 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.
- Care Groups receive monthly reports into governance meetings.
- The learning from excellence group has developed a trust wide bulletin.
- This is shared at ECL prior to full Trust circulation.

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 aimed 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.

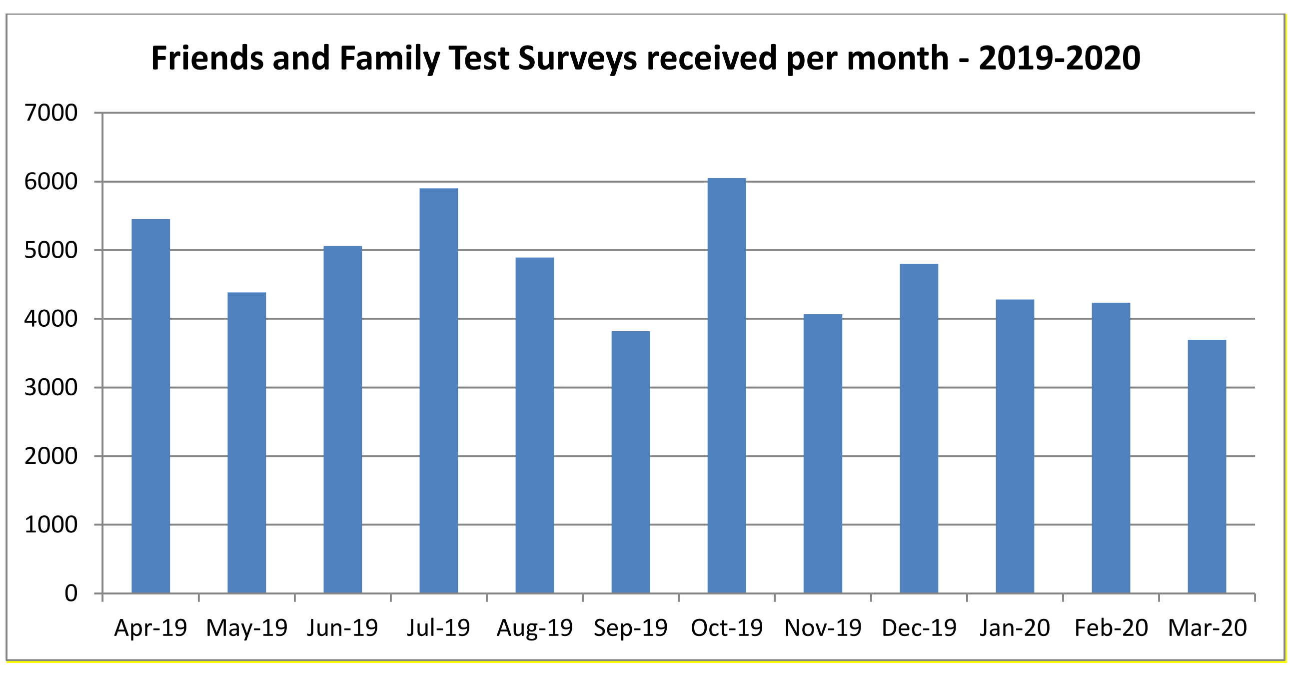
The Trust will continue to raise staff awareness and continue to capture data advising Care Groups of their compliance rates and of areas where actions are required for improvement.

Friends and Family Test (FFT) for patient feedback

Throughout 2019-20 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.

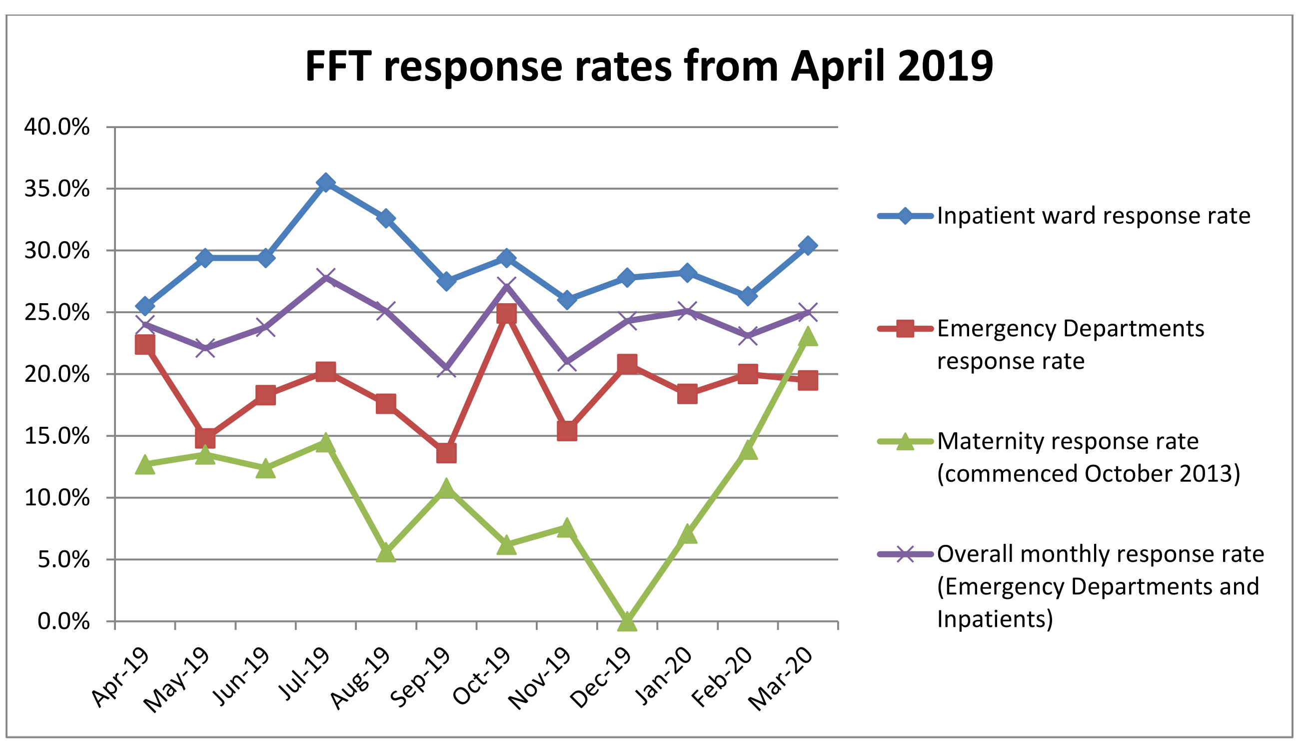


The table below demonstrates the Trust’s response rates for 2019-20 for Emergency Department/Urgent Care Centres, Inpatient / Day case areas and Maternity, showing the response rates since adopting a new internal process.

In April, July, October, December 2019 and February 2020 the 20% response rate was achieved for the Emergency Departments. Returns in the other months did not achieve the 20%, the threshold has only been missed by a narrow margin.

The response rates for Maternity have continued to fluctuate across the year, with response rates dropping despite increasing efforts within the speciality to improve returns rates.

July and August 2019 saw the best response rates for Inpatients. Whilst we have not achieved the 40% threshold for returns we believe that we have sustained the improvements made. The significance of positive engagement with this process has been encouraged via meetings with senior nurse and midwifery teams as well as sisters, charge nurses and ward managers. Where negative comments emerged these are shared back to the individual wards and departments when the forms are collated. Most importantly the outcome of the returns indicates high satisfaction rates with the services.



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:

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

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

The following chart shows the Trust-wide recommendation score from April 2019 for Emergency Department / Urgent Care Centres, Inpatient / Day cases and Maternity Services:

Month	Inpatient		A&E		Maternity	
	% Rec	% Not	% Rec	% Not	% Rec	% Not
April 2019	96%	1%	93%	1%	98%	1%
May 2019	97%	1%	93%	1%	99%	1%
June 2019	97%	1%	93%	1%	99%	0%
July 2019	97%	1%	91%	1%	98%	0%
August 2019	98%	1%	93%	1%	100%	0%
September 2019	97%	1%	93%	1%	98%	0%
October 2019	97%	1%	91%	2%	93%	2%
November 2019	97%	1%	91%	2%	100%	0%
December 2019	98%	1%	91%	1%	Data was not available for Dec 19	
January 2020	98%	1%	94%	1%	99%	1%
February 2020	97%	1%	93%	1%	98%	1%
March 2020	96%	1%	92%	2%	99%	0%

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 is demonstrated below:

Training

Training sessions and presentations were provided by the Patient Experience Team in order to promote the importance of patient/carer feedback within CDDFT. A particular success this year was the work undertaken with the PHSO in providing development to staff within the team, development for senior staff within the organisation on effective complaints response and the delivery board development.

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.

National Patient Survey (NPS) Reports

Inpatients Survey 2018 - Reported June 2019
For County Durham & Darlington NHS Foundation Trust, 575 service users responded to the survey and the Trust's response rate was 49%.

The Trust scored in the top 20% of Trusts on eight questions and the bottom 20% of Trust's on two questions.

Top 20% of Trusts on eight questions which were:

1. In your opinion, had the specialist you saw in hospital been given all the necessary information about your condition or illness from the person who referred you?
2. While in hospital, did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?
3. Did you get enough help from staff to eat your meals?
4. Did you have confidence and trust in any other clinical staff treating you (eg physiotherapists, speech therapists, psychologists)
5. Beforehand, did a member of staff answer your questions about the operation or procedure in a way you could understand?
6. Did a member of staff tell you about medication side effects to watch for when you went home?
7. Did a member of staff tell you about any danger signals you should watch for after you went home?
8. Was the care and support you expected available when you needed it?

Bottom 20% of Trusts on two questions which were:

1. Was your admission date changed by the hospital?
2. Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?

At point of issuing this report we are awaiting the publication of the 2019 report to compare if actions plan have resulted in improved outcomes.

National Maternity Survey 2019 – Reported January 2020
For County Durham & Darlington NHS Foundation Trust, there was a 39% response rate, the average Mean Rating score: across all questions was 80% which is higher than in 2018.

Of the 19 indicator, 19 were about the same or better as other organisations for women accessing the services and there were 2 indicators that were better.

- Having confidence and trust in the staff caring from them during labour
- Receiving the information that they needed after birth

Whilst within normal parameters the survey would suggest that there are areas for improvement in relation to:

- Discharge from hospital being delayed
- Partner involved in care being able to stay with them as much as they wanted

Overall, the result of the survey demonstrate that women received a good service from maternity services within the Trust, received relevant information to support them pre and post-natal and were attended to by skilled and professional workforce that promotes confidence in the care they received.

Urgent and Emergency Care Survey 2018-19 – Reported December 2019
For County Durham & Darlington NHS Foundation Trust 296 responded who had used type 1 services and 105 responded for those who used type 3 service at the Trust.

Of the 35 indicators 33 were about the same as other organisations for patients using type 1 services. There were 2 indicators that were better in relation to test results prior to leaving the department, and being provided with a full explanation of the results.

In relation to those using type 3 services 27 were about the same as other organisations, however, 1 was worse than other organisations. This was in relation to opportunity for family/friends or carers being able to talk to a healthcare professional. There are some suggestions for areas for improvement which specifically relate to waiting time in the urgent care centres. A recommendation from this survey would be to look at how we provide information about:

- Medication side effects
- Resuming usual activities
- Home and family situations
- Improve waiting time signage
- Improve opportunities to facilitate discussion with family and carers

Children & Young People's Patient Experience Survey 2018 – Reported October 2019.
For County Durham & Darlington NHS Foundation Trust, 307 service users responded to the survey and the Trust's response rate was 27%.

The Trust scored in the top 20% of Trusts on four questions and the bottom 20% of Trusts on five questions.

Top 20% of Trusts on four questions which were:
1) Did the hospital change your child's admission date at all?
2) Was your child given enough privacy when receiving care and treatment?
3) When you left hospital, did you know what was going to happen next with your child's care?
4) Before the operations or procedures, did hospital staff explain to you what would be done?

Bottom 20% of Trusts on five questions which were:
1) How would you rate the facilities for parents or carers staying overnight?
2) During any operations or procedures, did staff play with your child or do anything to distract them?
3) Did hospital staff play with you or do any activities with you while you were in hospital (8-11 only)?
4) Did hospital staff talk with you about how there were going to care for you?
5) If you felt pain while you were at the hospital, do you think staff did everything they could to help you?

These results have been shared with the care group to share the areas of good practice and support the development of the areas for improvement.

The above issues form part of the National Survey action plan which is monitored and reviewed at the Executive Patient Safety and Experience Committee.

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 to 5 key questions and compares our survey results against the National Inpatient Survey results for 2018 (reported 2019).

Patient Experience Indicator Questions	National In-patient 2018 results	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	↑↓
Did you feel involved enough in decisions about your care and treatment?	75%	81%	87%	79%	81%	78%	↓
Were you given enough privacy when discussing your condition or treatment?	84%	83%	87%	88%	85%	88%	↑

Did you find a member of staff to discuss any worries or fears that you had?	58%	81%	83%	84%	84%	87%	↑
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?	51%	61%	66%	66%	67%	66%	↓
Did hospital staff tell you who you should contact if you were worried about your condition or treatment after you left hospital?	77%	75%	75%	81%	74%	83%	↑

It was decided in the light of National Inpatient surveys taking place on a regular basis the Post Discharge Survey was duplicating work. It was felt time and resources could be better used by concentrating on patient contact such as asking patients to relay Patient Stories or their experience in forums that gave staff a real picture of the effect this had on the patient and families.

We also aim to focus on the results of the national survey results highlighting areas of improvement that are within the national perimeters but are at the lower centile.

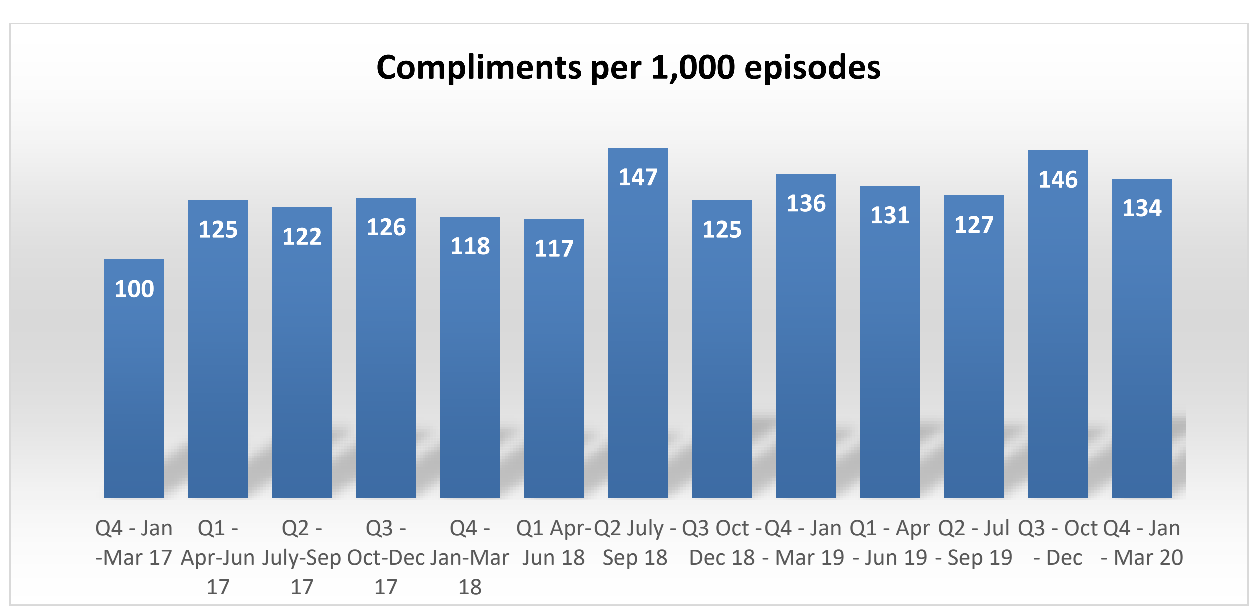
Themes for 2019-20 are identified below:

Theme	Q4 17-18	Q1 18-19	Q2 18-19	Q3 18-19	Q4 18-19	Q1 19-20	Q2 19-20
Food	1	4	4	4	2	2	2
Medication	3	2					
Treatment and care	8	9	8	7	5	8	7
Response to buzzers / for help					1	1	1
Communication	12	5	6	6	3	4	1
Feeling safe			1		1	1	
Attitude	3	3	3	2	2	3	5
Personal care	2	1	1			1	2
Discharge	2	2	2	2	3	1	4
Noise at night / disturbance	1	3	2	2	1	2	
Transfer between wards	3		2	3		1	
Cleanliness			3	3	1		
More information / choice							
Environment/TV/entertainment	2		3		3		2
Confidentiality	1			2		1	2
Privacy & Dignity	4			1	2	2	
Staffing	5	3	5	2	1	2	
Parking		2					

Compliments

The below table and chart highlight the number of compliments received for 2018/19 in comparison to previous years. A quarterly report is available to all staff via the Trust intranet. Patients and carers are also encouraged to share their comments on the Trust's website, as well as NHS Choices.

Quarter	2013-14	2014-15	2015-16	2016-17	2017/2018	2018/19	2019-20
1	5297	5288	6058	4761	4409	4226	4774
2	5782	5473	7406	4953	4339	5260	4661
3	4523	6123	6078	5355	4628	4733	5266
4	4863	6228	3902	4093	4195	5181	4465
Total	20,465	23,112	23,444	19,162	17,571	19,400	19, 166



Working in Partnership with Healthwatch

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.

Healthwatch members are an intrinsic aspect of the governance process in complaints by supporting a peer review process. Whereby current anonymised complaint reports and responses are reviewed to ensure a fair and balanced response is provided to patients. Feedback is shared at Integrated Quality and Assurance Committee.

Learning from Experience

Individual action plans are developed in response to partly and founded complaints and shared with the complainant. Examples of 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.

The Trust also recognises that patient stories are a powerful tool for engaging staff and patients. The Patient Experience Team promote patient stories as an effective way of making sure that the patient's voice is heard at the highest level, and that improvement of services is centred on the needs of the patient.

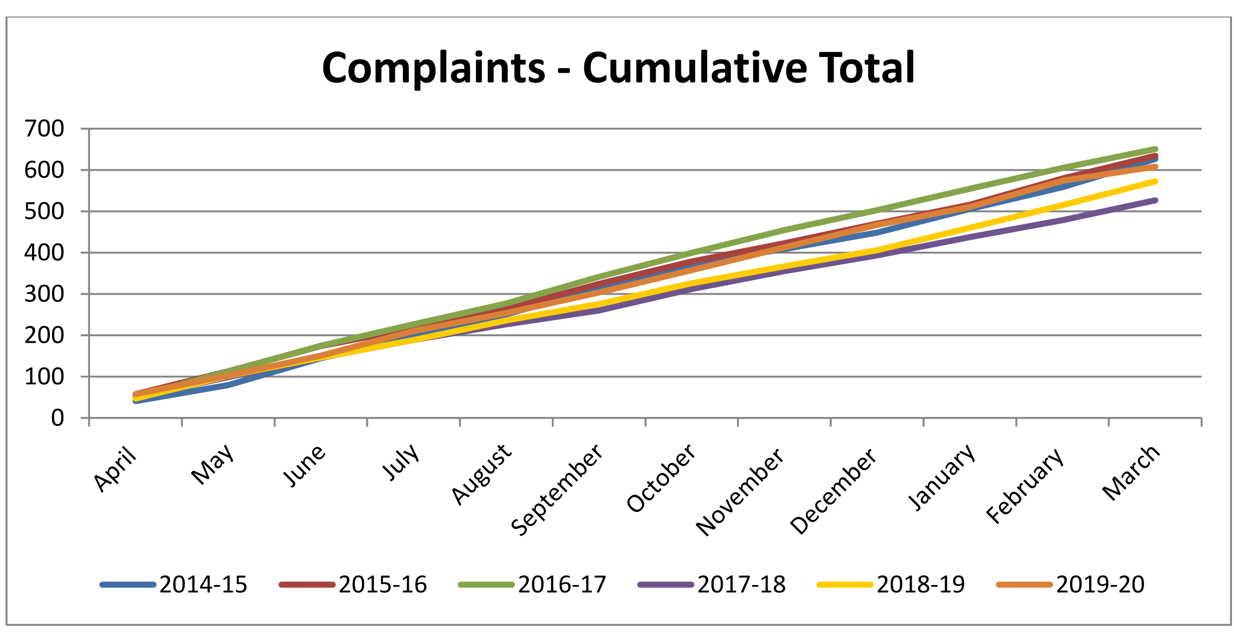
An individual story is not in itself representative of all patient experiences. However, each story is valid as that is how that individual person experienced healthcare. Collectively stories can help build a picture of what it is like to receive healthcare and how we can improve locally and trust wide.

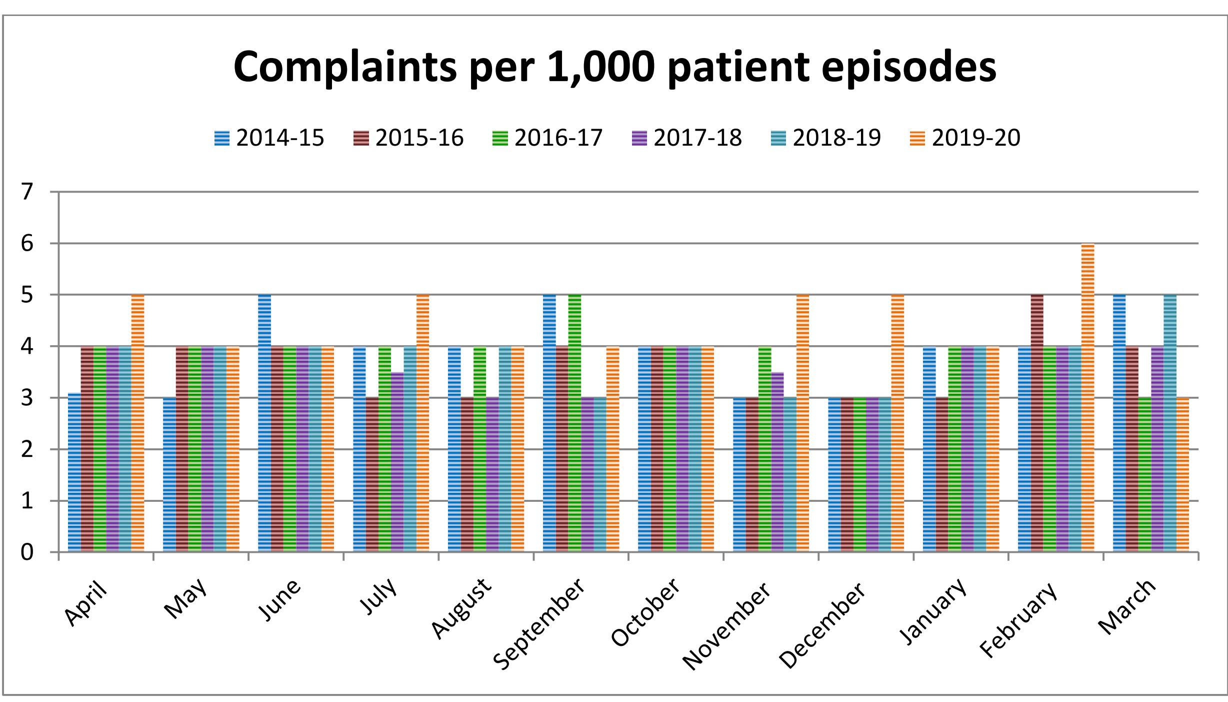
The patient story needs to be seen in context of the wider of the Patient Experience & Community Engagement Strategy. A Patient Story is shared quarterly at the Integrated Quality and Assurance Committee. Appropriate actions where required are highlighted and monitored. We are exploring various ways of sharing stories across the organisation moving forward. Where possible we encourage service users to attend strategic meetings and share their experiences, which has been very powerful and constructive.

Complaints

As well as proactive patient feedback the Trust also receive formal complaints and informal concerns via the patient experience team. The Trust follows the NHS complaints procedure and accepts complaints either verbally or in writing. If complaints are founded or partially founded the complainant receives an action plan to address the issues identified as well as a response. Complainants are offered a meeting and or a written response and are encouraged to participate in action planning to turn 'complaints into contributions'.

The below charts show the number of formal complaints received Trust-wide throughout 2019-20 as well as number of complaints per 1000 patient episodes in comparison to previous years.

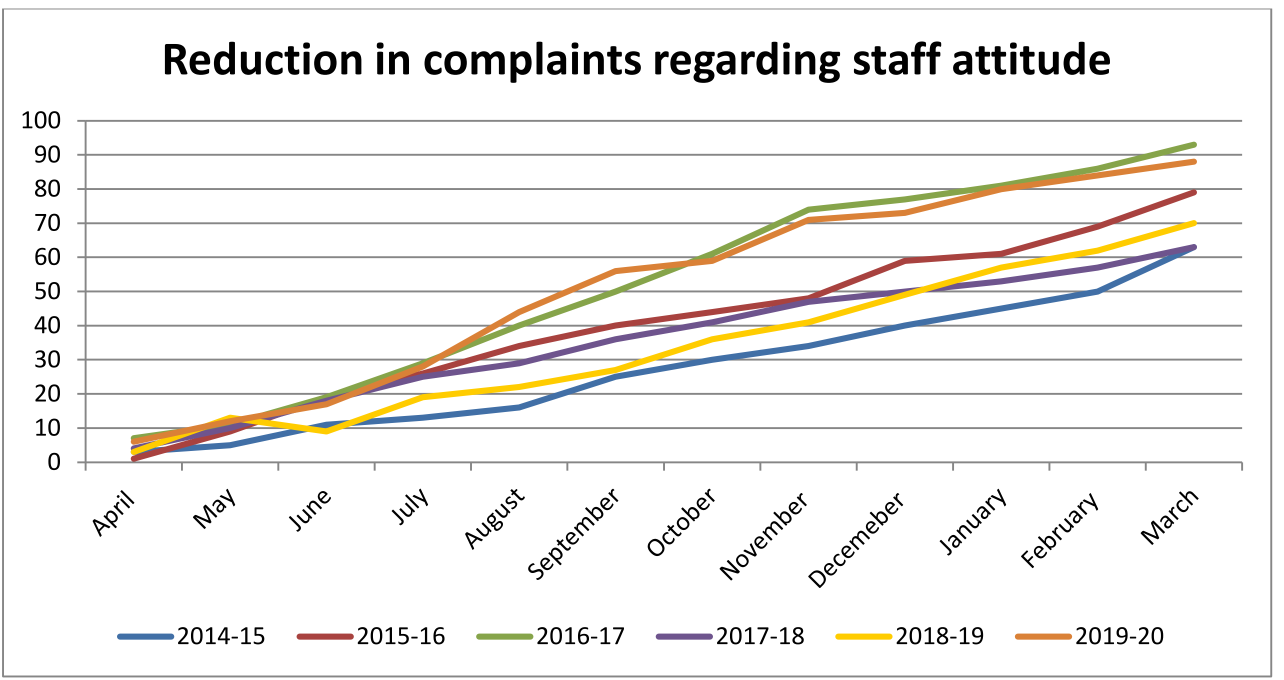




Complaints Monitoring

The Trust continues to monitor complaints in relation to staff attitude. Our aim is to remain below the threshold set in the 2012-13 Quality Accounts of 70 per year.

This has been monitored closely at Integrated Quality and Assurance Committees and Executives. Throughout 2019-20 we have received 88 complaints regarding attitude of staff as a primary cause of concern, which is an increase on 2018-19, this represents a slight increase from the previous year but remains within the threshold of the tolerance that we set ourselves. Due to the nature of these concerns this is something that we continue to monitor.



Nutrition in hospital

☑	Trust ambition achieved

Nutrition

Our aim
To ensure that inpatients are adequately screened for under nutrition and that they have onward referral as appropriate. To ensure that inpatients are regularly monitored for their risk of under nutrition 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 Trust-wide role and in 2019/20 the following areas have become business as usual.

- Nutritional Assessment (MUST) in Nerve Centre.
- End of life nutritional care pathway.
- Revision of Nutrition policy
- Parenteral Nutrition policy
- Nutrition Subgroups (Parenteral and Enteral Nutrition Group and Nutrition, Hydration Improvement Team) to review parenteral and enteral nutrition, nutritional screening, nutrition and hydration.
- Registered Nurse Nutrition Training offered monthly by Nutrition Nurse Specialist incorporating WASP framework for nasogastric and basic gastrostomy care
- Nasal retention device policy
- Dietetic and nutrition nursing support to the push PEG service
- Revision and re-write of gastrostomy policy
- Further roll out of metrics capture via Quality Matters audit
- Extended scope WASP frameworks for Dietitians in the areas of gastrostomy care
- Working group standardising weighing scales 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.

The service will in 2020/2021 continue to work to review the documentation in Nerve Centre in line with Perfect Ward results. We will provide greater focus on recording weight and effective nutrition care planning.

We will:

- Continue to provide support and tailored training where ward areas are highlighted as not achieving Perfect Ward standards
- Continue to work closely together with catering services on hospital menu development and nutritional analysis. We will continue to try to recruit to a catering Dietitian post for the Trust to provide greater support between ward nursing staff and catering services.
- Work to increase awareness of nutrition Trust-wide by re-invigorating ward staff from all disciplines.
- Reorganise the nutrition subgroups into the following: Parenteral and Enteral nutrition, Catering, Nutrition nursing. This will be done with a view to focussing on specific issues and hope to increase engagement. It is anticipated that the catering and nutrition nursing group will work in close collaboration

Patient Led Assessments of the Care Environment

2019 PLACE Assessments

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

These assessments were introduced in April 2013 to replace the former Patient Environment Action Team (PEAT) assessments which had been undertaken from 2000 – 2012 inclusive.
The PLACE collection has been substantially reviewed and refined since publication of the 2018 results. 2019 scores therefore establish a new baseline and cannot be compared with figures from earlier years.

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 aim of PLACE assessments is to provide a snapshot of how an organisation is performing against a range of non-clinical activities which impact on the patient experience of care, which include Cleanliness; the Condition, Appearance and Maintenance of healthcare premises; the extent to which the environment supports the delivery of care with Privacy and Dignity; how well the needs of patients with dementia are met; how well the needs of patients with a disability are met and the quality and availability of Food and Beverages.

The table below details the dates on which the PLACE assessments were undertaken.

Site	Assessment Date
Weardale	5th November
Chester-Le-Street	27th September
Shotley Bridge	24th September
Richardson	18th October
Sedgefield	8th November
Bishop Auckland	25th October
DMH	8th October
DMH	11th October
DMH – Food – (evening meal)	14th October
UHND	1st October
UHND	3rd October
UHND – Food – (evening meal)	7th October

The teams consisted of Facilities and Clinical staff and Patient assessors who made up the 50% requirement within each team.

Following completion of the site assessments, the information was inputted onto the central website hosted by the NHS Digital for analysis and publication by the required June deadline.

Action plans were produced by ward/department. These will be tracked by CDDS Facilities Management to ensure actions are progressed.

The charts below show the 2019 results.

National Average & Trust Score	Cleanliness	Condition Appearance and Maintenance	Privacy, Dignity and Wellbeing	Food & Hydration Overall Score	Ward Food Score	Organisation Food Score	Dementia	Disability
National Average 2019	**98.6%**	**96.4%**	**86.1%**	**92.2%**	**92.6%**	**91.9%**	**80.7%**	**82.5%**
County Durham & Darlington NHS Foundation Trust – 2019	99.45%	98.54%	85.32%	97.45%	97.74%	97.09%	78.56%	80.66%

CDDFT by site	Cleanliness	Condition Appearance and Maintenance	Privacy, Dignity and Wellbeing	Food & Hydration Overall Score	Ward Food Score	Organisation Food Score	Dementia	Disability
Bishop Auckland Hospital	100%	99.28%	91.98%	98.61%	100%	97.22%	87.5%	85.27%
Chester Le Street Community Hospital	100%	99.39%	95.06%	98.61%	100%	97.22%	87.65%	85.74%
Darlington Memorial Hospital	98.75%	98.87%	82.63%	97.60%	97.73%	97.22%	77.14%	78.71%
Richardson Hospital	99.71%	99.33%	90.20%	97.67%	100%	95.19%	77.17%	79.61%
Sedgefield Community Hospital	99.83%	99.15%	91.53%	95.79%	96.43%	95.19%	65.65%	69.12%
Shotley Bridge Community Hospital	100%	100%	86.84%	96.48%	97.78%	95.19%	77.66%	79.79%
University Hospital North Durham	98.98%	98.08%	85.73%	97.08%	97.04%	97.22%	78.09%	81.74%
Weardale Community Hospital	100%	95.19%	76.74%	97.31%	100%	94.63%	76.54%	78.64%

Scores highlighted in **green** indicate above the national average score.
Scores highlighted in **orange** 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, there are now several pieces of legislation governing food safety, including the requirement to have a food safety management system based on Hazard Analysis Critical Control Point (HACCP) principles.

Food Safety Officers (authorised by the Council) inspect food premises to assess compliance with food hygiene legislation which includes, Food Hygiene and Safety, Structure, Cleaning and Confidence in Management and Control Systems to ensure food is being prepared in a safe, clean environment and all relevant records are being maintained.

All main kitchens must be inspected at regular intervals by Environmental Health Officers (EHO). The frequency of these inspections depends on the type of business. A star rating system is used of which 1 is the lowest and 5 is the highest. The table below illustrates dates of the last inspection for food premises within CDDFT along with the star rating.

Environmental Health Officer inspections	Last Inspection	Star Rating
Darlington Memorial Hospital	February 2019	✡✡✡✡✡
University Hospital North Durham	October 2018	✡✡✡✡✡
Bishop Auckland Hospital	February 2019	✡✡✡✡✡
Chester le Street Hospital	September 2018	✡✡✡✡✡
Shotley Bridge Hospital	July 2018	✡✡✡✡✡
Sedgefield Community Hospital	February 2019	✡✡✡✡✡
Weardale Community Hospital	June 2018	✡✡✡✡✡
Richardson Community Hospital	October 2019	✡✡✡✡✡

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.

Since August 2017 the catering department is 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 following table illustrates the external accreditation held by Facilities:

Accreditation	Service	Last Audit	Next Audit/ Inspection
STS (Support Training Solutions)	Catering DMH	22 & 23rd January 2020	June 2020

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
We have triangulated data from the National audit of bereaved relatives, the VOICES survey, complaints, incidents and numerical national data. We continue to improve palliative care for patients and families; End of life Care in the trust in now rated as 'Outstanding' in the most recent CQC report.

Summary of Findings from National Audit if Care of Dying Patient and Bereaved Relative Survey (VOICES)

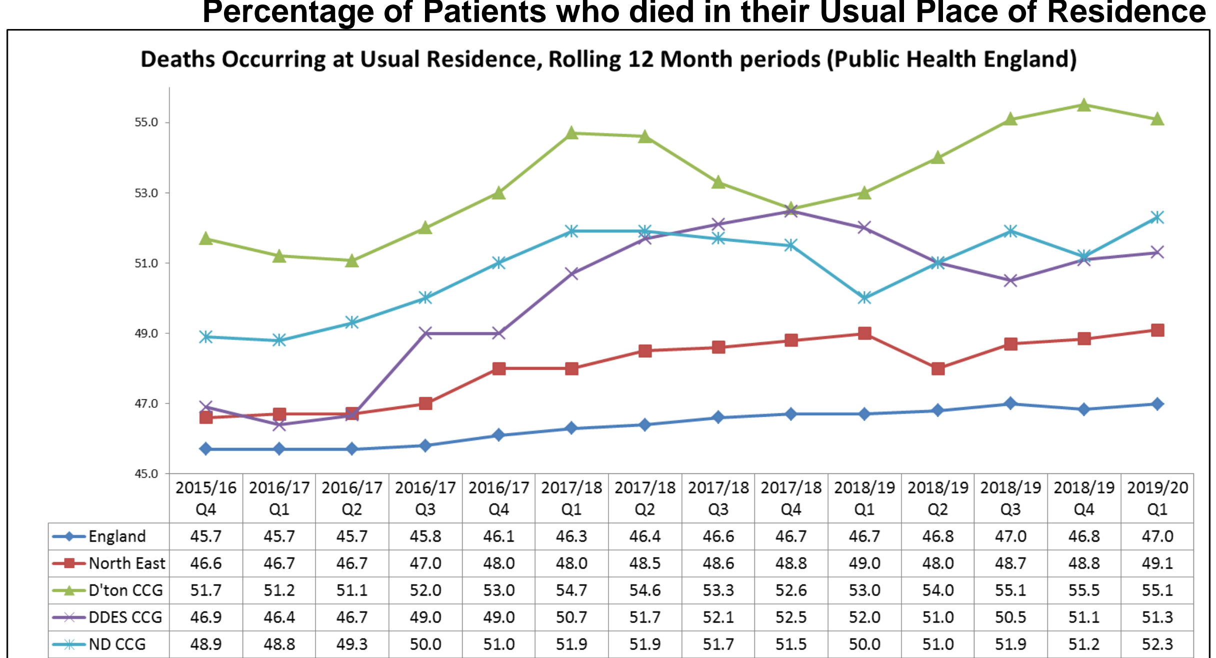
- Lots of people rate care as excellent and are very appreciative of the love care and attention they receive. With the exception of 'support to eat and drink', the results of the quality survey of bereaved relatives are above the national averages for all domains of care provided to both the patient and families.
- The Community Nursing Service received excellent feedback
- The out of hours service does not always meet the needs of patients who are dying at home – this is the area that scored lowest and is most in need of improvement

- A smaller number of carers experience care that is not adequate – especially in hospital. The Acute Hospitals have 0.36WTE nurses per 100 beds in the Specialist palliative care team compared to a national mean of 1.52 and median of 0.93.
- There are insufficient single rooms in the acute hospitals, creating a lack of privacy and dignity for dying patients and their families. In CDDFT acute hospitals only 15% of our beds are single occupancy rooms, compared to a national mean of 25% for acute hospitals.
- Relatives expressed distress at lack of recognition and communication of dying especially in hospitals. The mean time from recognition of dying to death in our sample was 50hrs and the national mean was 89hrs.

Death in Usual Place of Residence

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. (see graph below)

Percentage of Patients who died in their Usual Place of Residence



	2015/16 Q4	2016/17 Q1	2016/17 Q2	2016/17 Q3	2016/17 Q4	2017/18 Q1	2017/18 Q2	2017/18 Q3	2017/18 Q4	2018/19 Q1	2018/19 Q2	2018/19 Q3	2018/19 Q4	2019/20 Q1
England	45.7	45.7	45.7	45.8	46.1	46.3	46.4	46.6	46.7	46.7	46.8	47.0	46.8	47.0
North East	46.6	46.7	46.7	47.0	48.0	48.0	48.5	48.6	48.8	49.0	48.0	48.7	48.8	49.1
D'ton CCG	51.7	51.2	51.1	52.0	53.0	54.7	54.6	53.3	52.6	53.0	54.0	55.1	55.5	55.1
DDES CCG	46.9	46.4	46.7	49.0	49.0	50.7	51.7	52.1	52.5	52.0	51.0	50.5	51.1	51.3
ND CCG	48.9	48.8	49.3	50.0	51.0	51.9	51.9	51.7	51.5	50.0	51.0	51.9	51.2	52.3

Source: Public Health England

Action this year

We have used the areas identified above to improve our palliative care teaching and are ahead of target to deliver palliative care training to all clinicians.

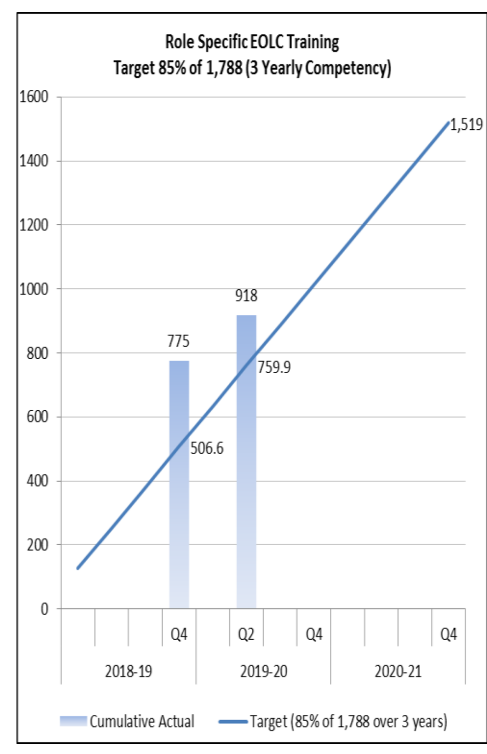
We continue to improve the use of advance care planning though increased use of NEAS special patient notifications and Emergency Health Care Plans. We have worked with CCG and NEAS to agree a comprehensive approach to personalised care planning.

The community service has improved the provision of experienced community nurse out of hours.

In the acute hospitals we have bought new beds for families of dying patients and increased focus on other elements of support

We have changed signage to ensure everyone working on hospital ward recognises rooms and which patients are dying.

The unscheduled care and palliative care services are doing work that identifies variation and identify improvements.



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:

- work with the CCGs to develop a new palliative care strategy for 2020 to 2025.
- focus intensively on recognition of dying in hospital so that we recognise more people earlier and improve care for them and support for their families.
- explore solutions to the relative lack of single rooms in our acute hospitals and the distress this causes.
- work with the new Medical Examiner System to explore new ways to improve feedback from bereaved relatives.
- continue our quality improvement work with the out of hours and palliative care services.
- appoint a new palliative care consultant and use this resource to improve palliative care support to care homes.

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

	Trust ambition not achieved but improvements made

Our aim
To increase the weighted score of staff who would recommend the provider to friends and family 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” compliments the Quality strategy.

Questions	2019		2018		Trust improvement/ deterioration
	Trust	National Average	Trust	National Average	
Q21c. Staff recommending the organisation as a place to work	57.8%	64%	47.8%	62.3%	Significant improvement in Trust score. Below the national average
Q21d. Staff recommending the organisation as a place for family and friends to receive treatment	61.3%	71%	58%	70%	Significant improvement in Trust score. Below the national average

As can be seen from the table there has been a significant improvement in the Trust’s score from 2018 to 2019 in relation to staff recommending the organisation as a place to work. However we remain below the national average with regard to this question. In respect of staff recommending the organisation as a place for family and friends to receive treatment there has been a significant improvement in the Trust score however we remain below the national average. This means that although significant improvements have been made we have not met our ambition to achieve the national average with regard to staff recommending the organisation to friends and family either as a place to work or receive treatment.

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

☑	Trust ambition achieved

The Trust continues to meet its ambition with regard to the percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months. However work will continue to improve this further.

There are two questions relating to this ambition in the new style staff survey report and the results are outlined in the table below:

Questions	2019		2018		Trust improvement/ deterioration
	Trust	National Average	Trust	National Average	
Q13b. Staff reporting experiencing harassment, bullying or abuse from managers in the last 12 months	10.9%	11.8%	12.1%	12.2%	Significant improvement in the Trust score and better than the national average. (the lower the score the better)
Q13c. Staff reporting harassment, bullying or abuse from colleagues in the past 12 months	16.7%	18.0%.	16.6%	18.3%	There has been no statistically significant change in the Trust score and remain better than the national average. (The lower the score the better).

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

☑	Trust ambition achieved

The Trust continues to meet its ambition with regard to the percentage of staff believing that there are equal opportunities for progression and the staff survey results are identified below:

Questions	2019		2018		Trust improvement/ deterioration
	Trust	National Average	Trust	National Average	
Q14. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	90.2%	85.6%	89.6%	85.5%	Trust score improved and higher than national average (higher the score the better)

The Trust score for 2019 has improved on 2018 and has also increased the gap between the Trust score and the national average. Further analysis of the results show that the % of white staff believing that the trust provides equal opportunities for progression has remained at 90% in 2019 which is better than the national average of 87.4% for 2019. The % of black and minority ethnic staff believing there is equal opportunity for career progression in 2019 is 85.7% which is significantly better than the national average of 72.9%.

Progress

Work has continued to focus on staff engagement which has been recognised as an area for improvement through the national staff survey and local quarterly Staff Friends and Family Test. Interventions this year have aimed to support us identify why this is and develop an ongoing dialogue around engagement whilst working towards our longer term goal of enhancing the experience of our people. Key programmes and work streams that have been undertaken and introduced include:

Moving to Good
Specific engagement interventions have taken place as part of the NHS Improvement/England (NHSI/E) 'Moving to Good' programme. The 'Engagement Enablers' described below have been developed and delivered to enhance meaningful-conversation and support engagement with our colleagues to improve workforce experience and retain and attract the best people.

- 'Walk in my Shoes' Workshops – aimed at everyone within the organisation, have looked at what engagement is, why we do it, what each person's experience is and an award winning idea we can all use for increasing enjoyment at work and actively participating in building a great workforce experience.
- 'Engaging Managers/Leaders' Workshops – aimed at those in a formal leadership position have explored their individual engagement and how to enhance the workforce experience of colleagues. It looks at and gathers information around their experience of work, what staff engagement is and how, why and when we do it. It also introduces learning for managers in how to engage with their teams.
- 'Café Conversations' – are an informal space to have meaningful conversations about what matters to our people and promote engagement in the national Staff Survey.
- Recruitment to a Change team – from across the organisation in order to support this activity. The team have looked at how we progress this work and using 'self as instrument', agreeing to complete a leadership behaviours survey looking at their own strengths and development areas as a guide to modelling collective leadership – a key part of the 'Moving To Good' work – and ensuring the workforce experience team aren't alone in driving this work forward.

The engagement sessions have captured the views and experiences of a cross section of our people and the data collected has been mapped against the five cultural indicators of vision and values, goals and performance, support and compassion, learning and innovation and teamwork. Using the 'Moving to Good' methodology, the information from the engagement sessions is being analysed for emerging themes which will be used to inform the 'design' part of the process, the development of ongoing organisational culture, leadership interventions and the Staff Matter action plan for 2020/21.

Our learning has been shared at the North East Leadership Academy's Organisational Development Network through a presentation as best practice in June 2019 and at the North East & North Cumbria Community of Practice HFE Event in November 2019.

Staff Matter
The people strategy document Staff Matter sets out the strategic workforce priorities CDDFT have agreed for the period 2017- 2020 (reviewed annually). Each Care Group and Corporate area produced a staff matter action plan for 2019/2020 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 Staff Matter strategy is undergoing a complete refresh both in terms of content and reporting process and will take account of feedback from both the staff survey and our engagement activities. The new strategy will be launched on 1 April 2020.

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 final two cohorts completed the programme during 2019/20 bringing the total number of senior managers attending the programme to 189. A full review of the SLP programme and consideration of the next steps is being undertaken during quarter four of this financial year.

Leadership Conference
2019/20 saw the annual leadership conference combined with the Highly Reliable Organisation conferences. The aims of the sessions are to challenge our thinking around how we operate as leaders at both Trust and individual level. This year's conference took place in June with Paul Redmond being the keynote speaker on the topic of Generational Diversity.

Senior Managers and Heads of Departments (SMHODs)
Senior Manager and Heads of Department monthly meetings with the Chief Executive and Directors are an opportunity for open, frank two way discussions on important topical issues. Monthly sessions will be scheduled for 2020/21.

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 will be reviewed and refreshed as part of the wider review of Leadership and Management Development within the Trust.

Developing Managers as Leaders
The Great Line Management Fundamentals 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, managing staff absence and interview skills. 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. This programme has been fully refreshed during 2019/20 and will be reviewed for 2021.

The Trust have been working with the North East Leadership Academy (NELA) to enhance our local leadership learning offer and provide an opportunity to work across systems, in partnership with local organisations. The Workforce Experience Team has a trained facilitator for the programme and will be piloting Mary Seacole during quarter four. Evaluation information from the pilot will be used to inform our future offer and support our culture, talent and engagement focus, deepening leadership learning into the organisation with a view of strengthening a collective leadership approach.

Talent Management
The Trust has taken an inclusive approach to talent management which focuses on the identification of individuals' strengths in order to further develop the capability of teams across the Trust. It also recognises that not everyone is seeking career progression, but that should not preclude them from development opportunities.

Within CDDFT, we have aligned talent management to our annual appraisal and role review framework, which acts as an umbrella framework for all staff groups both clinical and non-clinical. This process includes a 'talent conversation' for all staff and ensures both staff and managers discuss the performance, potential, ambition and readiness for progression of all staff across the Trust. These four elements form the basis of a structured approach to the development of staff for personal and career development at an individual basis, and to ensure the Trust is able to meet its workforce planning needs for future critical roles by having robust and managed succession planning.

Staff from both the Learning and Development Team and Workforce Experience Team delivered a Talent Management training session for the Executive Directors and following this the talent management process and associated paperwork was validated by attendees. A pilot/mock Talent Review Board will take place during quarter four prior to arranging the first Talent Review Board for Directors. Directors, will nominate staff (identified through the appraisal process against performance, potential, ambition/aspiration and readiness) to be reviewed as their potential successors in the talent pipeline.

Under the umbrella of “grow your own” further work has been undertaken during 2019/20 utilising 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. The number of apprenticeships currently in place within the trust is 274, which includes 36 young apprentices. The apprenticeships range from level 2 to level 7 across a broad spectrum of professional areas.

In addition a member of the Workforce Experience Team sits on the Regional Talent Management Network which looks at cross system working and sharing experience.

Personal Resilience

Given the unprecedented change facing the NHS, staff development sessions promoting personal resilience strategies have continued throughout 2019/20. The percentage of staff feeling unwell due to workplace stress has increased since 2015 and in order to address this issue a personal resilience module for staff members to consider implementing suitable coping mechanisms during times of stress has been successfully delivered and a “Managing Stress in Others” workshop for managers has been delivered to support managers in recognising and dealing with stress in others to support their teams.

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 more are planned for 2020/21. In addition the “Board to ward” walk arounds where the executive team along with Non-Executive Directors carry out Trust wide visits to discuss any issues and provide support to staff.

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’s people strategy Staff Matter. Progress is monitored via the quarterly Staff Matter action plan updates.

In addition to the Trust wide actions under the umbrella of “Moving to Good” 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. Requests for support are taken to a panel which is made up of staff who work in HR and Workforce Experience. Each case is examined and the most appropriate resource is allocated depending on need. Examples include diagnostic work with teams followed up by interventions designed to improve team working.

Equalities, Diversity and Inclusion (ED&I)

The following is a summary of the EDI activity which has taken place across 2019/20. These interventions, projects and new initiatives have built on work already carried out to improve workforce equality, diversity and inclusion across all of the protected characteristics.

Building Leadership for Inclusion (BLFI)

The BLFI pilot officially ended 31 March 2019. During the first quarter of the financial year 2019/2020 the Trust were asked to showcase the work undertaken as part of the project at two “sharing the Learning” events organised by the National Leadership Academy. These took place in London on 4 June and Leeds on 11 June. Following the events the Trust were contacted by NHSE/I and asked if we would be happy to produce a case study of our work which will feature as an example of good practice in their review of the “Developing People, Improving Care” strategy. The case study is also being used by the National Leadership Academy as part of their report on the BLFI pilot. In January 2020 the trust were asked to share their work at the

regional Inclusion conference which took place at St James Park Newcastle on the 22 January 2020. Work is continuing and we are now a Leadership Learning Organisation as part of the national network.

EDI Strategic Group
The ED&I Strategic Group have been established and their remit is to drive the EDI agenda and establish priorities for the coming year. The Group is chaired by the Family Health Care Group Clinical Director and its membership consists of the Director of Nursing, Associate Director of Nursing (Patient Experience), the Head of Communications and Charity, Workforce Experience business Partner and the Workforce Experience Officer for ED&I.

EDI Engagement Group – This group continues to develop and will be responsible for actively driving the EDI agenda across the wider organisation into all ward, service areas and departments through EDI activity which generates meaningful engagement.

Both of these groups are evolving in line with our work undertaken over the past two years through the Building Leadership for Inclusion programme. These are Trust wide organisational groups with a key aim of embedding the EDI activity and responsibility in ensuring that this work is the responsibility of all within the organisation. Over the last year we have worked more closely with Care Groups and Corporate areas to ensure that this work is considered as part of the core business of the organisation.

EDI Intranet Sites
Work continues to update content and information to the equality & diversity Intranet site to support the policy documents, as well as providing staff and managers with supporting information around equality, diversity and inclusion.

Disability Confident Standard
A review of the Disability Confident Standard took place earlier this year looking at how we attract and support disabled people during our advertising and recruitment process and how we continue to support and develop our disabled workforce. Following the review CDDFT has been awarded the standard for a further three years.

Disability Employment Pledge
As a Trust we continue in our aim to support and employ more staff with a learning disability through our continued commitment of signing up to the NHS Learning Disability Employment Pledge which we have been have been awarded at Level 2.

NHS Project Choice
Other work around this agenda includes our continued involvement with the NHS 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 is tailored to the needs of the young people which enable them to meet and develop their individual skills

Staff Network Groups
Work has continued to support our Facebook staff network groups to encourage involvement of staff in the EDI agenda. A fourth staff network group was launched in July 2019 – the Equality Staff Network group which is open to all CDDFT staff, meetings have taken place monthly since its launch for two hours over the lunch period. Meetings have taken place in multiple sites across CDDFT and at each session a guest speaker has presented on a variety of key EDI topics during the first part of the session, the rest of the session has been an open forum for staff to discuss any issues or topics they wish to raise. Once staff join the group they will receive copies of any presentations/ resources from each Equality Staff Network Group even if they are unable to attend the session. Members of the group are encouraged to share this information with their colleagues and teams.

NHS Rainbow Badges
The NHS Rainbow badge was launched on the 1st October 2019 promoting support for LGBT+ staff through the Rainbow Badge initiative. Since its launch over 300 staff have engaged with the programme.

External Stakeholders
We continue to work with external partners – Darlington & Durham Pride, Health watch, NELA (particularly through the promotion of the Stepping Up and Ready Now leadership programmes aimed at BAME NHS staff) and Durham County Council to raise the profile of CDDFT as an employer of choice.

Workforce Disability Equality Standard (WDES)
Over May to August 2019 work was carried out to complete the first CDDFT 2019 Workforce Disability Equality Standard (WDES) report. The WDES is mandated by the NHS Standard Contract and applies to all NHS Trusts and Foundation Trusts from April 2019. The WDES is a data-based standard that uses a series of measures (Metrics) to improve the experiences of Disabled staff in the NHS. Overall the CDDFT 2019 report was positive but revealed some areas where CDDFT could make improvement and these have been included in our overall EDI action plan

Workforce Race Equality Standard (WRES)
Over May to August work was carried out to complete the CDDFT 2019 Workforce Race Equality Standard (WRES) report. The WRES uses indicators (measures) of an organisation's workforce, including a Board membership indicator to gauge the current state of 'workforce race equality'. CDDFT uses the WRES to track progress in identifying and helping to eliminate discrimination in the treatment of Black, Asian, or Visible Minority Ethnic staff. Overall the 2019 report was positive compared to the 2018 report; however there are still some areas where improvement is still needed.

Equality Delivery System 2 (EDS2)
We completed our 2019 EDS2 report which focuses on the following four objectives:
1. Better health outcomes for all
2. Improved patient access and experience
3. Empowered, engaged and well-supported staff
4. Inclusive leadership at all levels

Against each objective are a set of 18 outcomes and the Trust gathered a portfolio of evidence for our staff, patients, stakeholders and local communities to review and grade our performance against each outcome.

The grading helps the Trust understand where it is underdeveloped, developing, achieving or excelling.

- Excelling – **Purple**
- Achieving – **Green**
- Developing – **Amber**
- Undeveloped – **Red**

As an organisation across all four goals and eighteen outcomes required within the EDS2 reporting criteria we have graded ourselves as achieving. More evidence across all nine protected characteristics is needed to demonstrate that EDI is fully embedded across all services and the wider organisation to meet the criteria for excelling.

EDI Staff Surveys
To enhance the data and information contained in the EDS2, WRES and WDES we issued three separate equality staff surveys. These surveys concentrated on the following staff:

- Full Equality Staff Survey to all CDDFT staff based on questions and data required for the EDS2 report and to inform our action planning
- Staff Disability Survey sent to all staff who have identified as having a disability on our ESR system – information from this survey feed directly into our WDES report and inform our action planning around supporting staff with disabilities
- Staff Ethnicity Survey sent to all staff who have identified as being from an ethnic minority background on our ESR system – information from this survey feeds directly into our WRES report and inform our action planning around supporting staff from a BAME background

Regional EDI Delivery Group
The Great Place to Work Delivery Board in June 2019 expanded the membership number of work streams involved to six - Recruitment, Occupational Health, Statutory & Mandatory training, Health and Wellbeing, Flexibility of Employment and Equality, Diversity & Inclusion. This group has meet monthly since July 2019 focusing on establishing and delivering key objectives in the short term up to March 2020 and setting a more ambitious and detailed set of planning objectives covering up to 2025.

Next Steps

County Durham & Darlington NHS Foundation Trust intends to take the following actions to improve staff experience and the quality of its services, thereby improving results. However as these activities were developed prior to Covid19 these are likely to change to reflect the priorities coming from the circumstances we now find ourselves in. However there will be continued emphasis on engagement, health and wellbeing and Inclusion.

Moving to Good
As part of the ongoing NHS Improvement (NHSI) Culture & Leadership Programme around understanding the perspective of our people and the culture at CDDFT, further engagement sessions have been scheduled during 2020 in order to continue dialogue around what it is like to work here and how can we improve the Workforce Experience. The activity forms a part of the NHSI methodology, the information from the engagement activity is being continually populated against the five cultural indicators of an engaged organisation for emerging themes which will inform ongoing interventions. Work will continue to develop the change Team.

Leadership and Management Development
The leadership and management development offering will be reviewed and refreshed for 2020/2021 to ensure it meets current and future leadership and management development needs.

Leadership Conference
The sixth Leadership Conference will take place in September 2020 and will once again be combined with the Becoming a Highly Reliable Organisation conference. A keynote speaker for this conference is currently being sourced.

Talent Management

- Representation will continue in the Regional Talent Management Network meetings. These are held quarterly with a view to share learning and ensuring our Talent Management processes are suitable for cross-system working.
- As part of the wider work being undertaken by the Regional Talent Board, the Trust will be participating in the roll out of the organisation talent readiness tool.
- The Trust will evaluate the Talent Review Board pilot and rollout the first Talent Review board

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

Coaching

- Building on the work undertaken during 2019/20 we will continue to establish a multi-disciplinary coaching network
- Representation at the Regional Coaching network will continue in order to aid cross system working and the sharing of good practice
- The Trust will look to align the coaching offer with talent management

Building Leadership for Inclusion
Work will continue to ensure this becomes part of the mainstream Equalities, Diversity and Inclusion offer. The Trust will continue to work with the National Leadership Academy on this agenda.

Appraisal
The monitoring of appraisal completion and quality audits will continue throughout 2020/2021 to in order to evaluate the appraisal process and quality of the appraisal conversations.

Equalities, Diversity and Inclusion

- ***Staff Network Groups***
  We will continue to support and develop the four staff network groups and offer members access to important EDI information and resources. As part of the regional Great Place to Work EDI Delivery group members of the Trust's network groups will be offered the opportunity to develop skills in leading/ chairing a network group via a project funding through funding received from NELA.

- ***NHS Rainbow Badges***
  This initiative will be expanded to offer support to staff and patients. We will also continue to promote this to encourage more staff to become volunteers

- ***Everyday Language Solutions (ELS)***
  We will continue to work with Care Groups to improve the patient experience of using our interpretation and translation services by promoting staff training offered by ELS.
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- ***Staff Friends and Family Test (SFFT) –*** staff engagement will continue to be measured via the quarterly and year-end SFFT reports. Results will be used to further inform Staff Matter action plans.

- ***#100 Faces***
  We will continue to identify key celebration/ EDI dates across 2020/21 and link these into the #100 Faces project to expand membership of the campaign

- ***Continued engagement with staff around the ED&I Agenda***
  We will continue to improve and develop our CDDFT EDI Intranet and Internet sites. Equality Staff surveys have proved very successful this year so we will continue to collect staff EDI feedback via survey monkey questionnaires and look at key themes and feedback identified from staff responses.

- ***Targeted EDI projects***
  We will continue to work with internal partners to research and develop resources for staff around EDI topics i.e. menopause, BAME staff development opportunities, mental health support, Transgender support etc.

- ***EDI Strategic Group***
  The continued development and influence of this strategic group in driving the EDI agenda across CDDFT.

- ***EDI Strategy***
  The current ED&I strategy will be refreshed and launched in April 2020.

- ***Regional EDI Delivery Group***
  Continue to represent CDDFT as part of the regional EDI Delivery Group and to continue to take an active role in delivery of key group objectives.

Arrangements for Staff to Speak Up

The Trust has essentially three channels through which staff can speak up, and raise concerns regarding quality of care, bullying, harassment and patient safety:

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

The Trust's Freedom to Speak Up Guardian is a qualified nurse by background and a former staff advocate for the Royal College of Nursing. The role has been regularly-publicised through the Trust's intranet site, staff

bulletins, staff meetings and visits to wards and teams. Training is provided to all staff on how to raise concerns and bespoke training provided to the Board, Executive, senior leaders and senior nurses on how to support the creation of a culture of speaking up in their departments.

Positive feedback from staff who have used the Guardian is quoted in communications to encourage others to feel confident in raising matters with her. The Freedom to Speak Up Guardian actively participates in national and regional networks in order to identify and implement good practice within the Trust, covering. This has included providing feedback to those raising concerns on the actions taken by the Trust, progress and outcomes, as well as continuing to liaise with the member of staff for several months after the conclusion of the matter, in order to identify – at the earliest opportunity – any detriment which might have occurred. The Guardian is supported by Freedom to Speak Up Champions, who provide a confidential sounding board for staff considering raising a concern, and signpost them to the Guardian. We continue to look for suitable candidates to expand our network of champions.

The Freedom to Speak Up Guardian is supported by the Senior Associate Director of Assurance and Compliance and by a Non-Executive Director on the Board. The Board has agreed a Freedom to Speak Up Strategy for 2019/20 to 2021/22, which aims to embed a culture in which staff feel able to speak up, and in which the Trust universally listens to, looks into and learns from concerns raised. A bespoke survey of over 800 staff was undertaken to evaluate the strength of current arrangements, and identify priority areas for improvement in 2020/21. The clear majority of respondents said that they were willing to speak up and would have confidence in the Trust's response; however, we want to ensure that all staff can share the same level of confidence and this will key objective for planned work in the coming year.

CLINICAL EFFECTIVENESS

Reduction in Hospital Standardised Mortality Ratio (HSMR) and Standardised Hospital Mortality Indicator (SHMI)

☑	Trust ambition achieved - HSMR

⊖	Trust ambition not achieved but improvements made - SHMI

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 NHS Digital.

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
To be comparable to the national average and regional peers for mortality rates, and aim to be lower than comparable to 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 NHS Digital.
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 been slightly above the national 100 standard, peaking in the 12 month period up to Mar19 at 105.3 before beginning to fall to 100 in Nov 19. Weekend HSMR is generally higher than weekday admissions, with the same peak in Mar19 before a gradual fall.

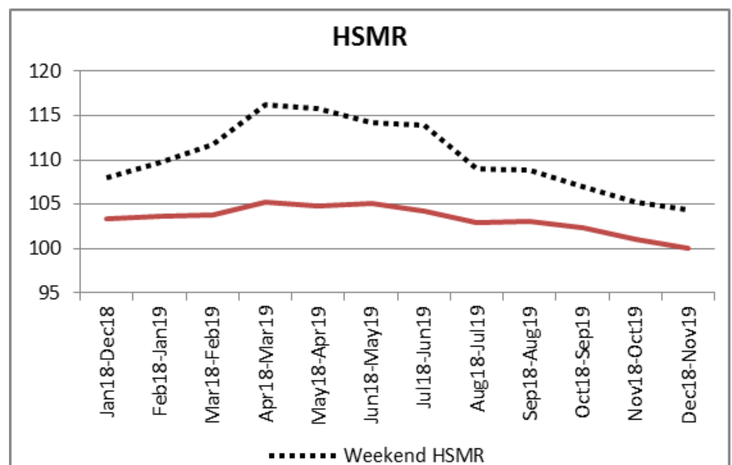


Figure 1 – HSMR 12 month rolling data timeline

The funnel plot for this time period displays expected number of deaths versus HSMR (Figure 2) and shows that the Trust sits between the upper and lower control limits, with Trust HSMR in the ‘as expected’ range.

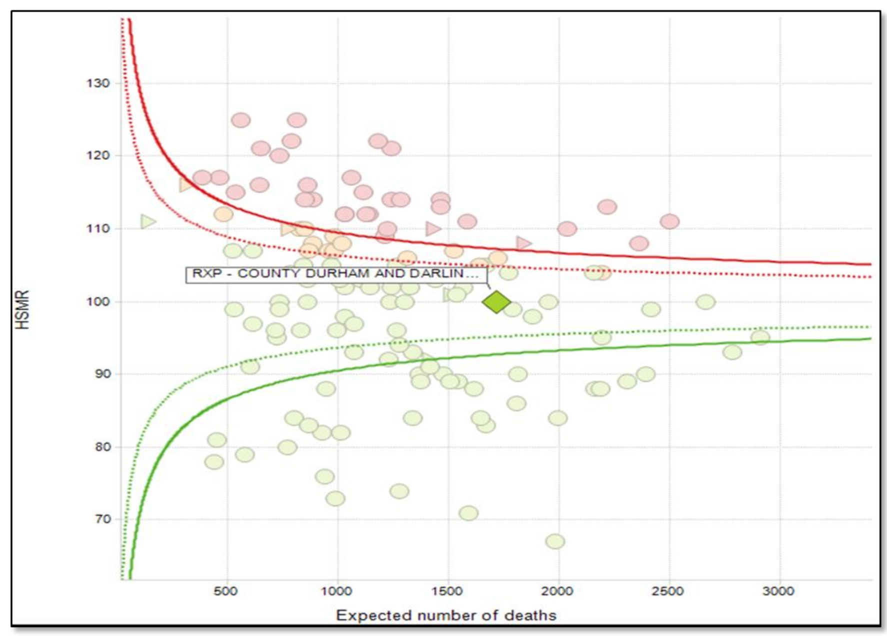


Figure 2 - Funnel plot showing expected number of deaths and HSMR (Dec18-Nov19))

SHMI
The SHMI 12mth rolling data (Figure 3) shows a steady increase from 109.9 in Dec18 to 113.6 in Nov19. The Trust became a national outlier in Aug19, with SHMI in band 1;'higher than expected'.

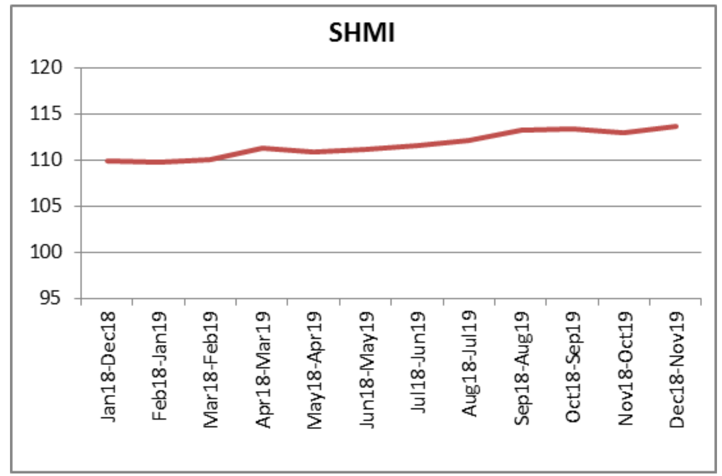


Figure 3 – SHMI 12mth rolling data timeline

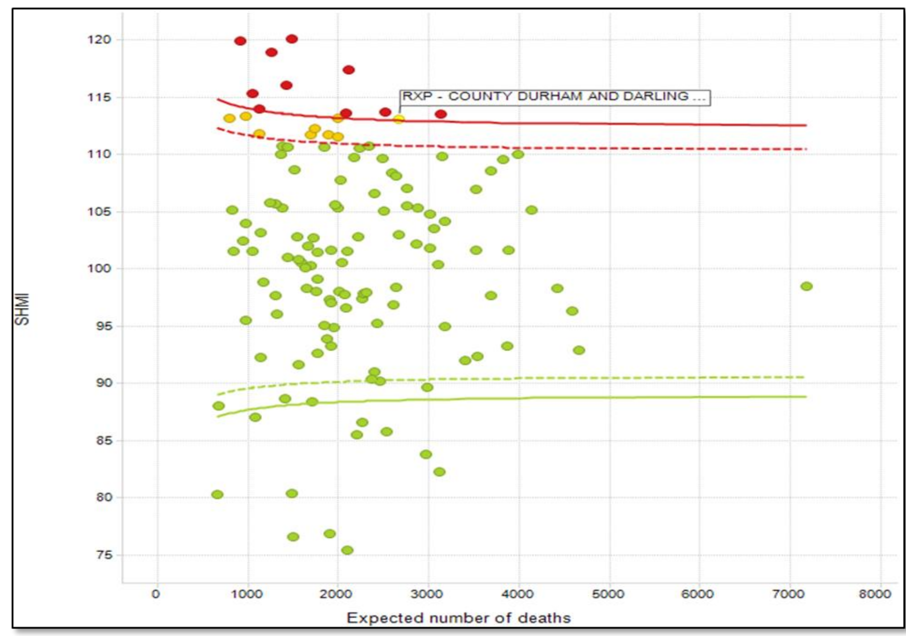


Figure 4 - Funnel plot showing expected number of deaths and SHMI for period Dec18-Nov19

Crude Mortality

The Trust's rolling 12mth crude mortality has gradually fallen from 4.6% in Dec18 and has stabilised at 4.2% for the last 6 months

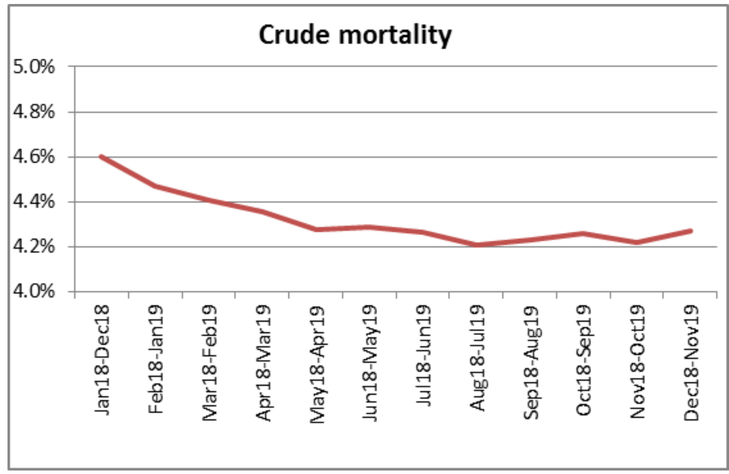


Figure 5 – Rolling 12mth Crude Mortality timeline

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 other deaths. The outcome of these reviews is presented on the Trust Mortality review Dashboard at the Trust board quarterly. Mortality reviews completed outside the central review team, for example from surgical M&M meetings, are now captured and reflected within the Trust Dashboard. Maternity and paediatrics have a separate mortality review process that fulfils statutory requirements in these areas. This work is co-ordinated the Associate Director for Mortality and Deputy Medical Director for Safety and Governance. All data is reported into the Trust's Mortality Reduction Committee.

Whilst undertaking mortality reviews are essential it is equally important the information and learning gained from the reviews is translated into the care delivered in CDDFT.

Learning from mortality reviews is discussed at the central team monthly meetings and also disseminated within the relevant committees to which the learning relates for example escalation planning discussed within Resuscitation and Deteriorating Patient Committee.

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, facilitated by discussion of learning at the Trusts Clinical Effectiveness Committee. The new Care Group Director within Community services will support and enable us to further work with primary care colleagues to share learning. Regionally there are projects looking at the management of sepsis, acute kidney injury and the deteriorating patient that have been generated from the regional mortality work.

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:

- Ensure that mortality remains a strong focus for the Trust, by;
- Continuing to adhere to the recommendations of the CQC's report 'Learning, candour and accountability', and the National Quality Board's National Guidance on Learning from Deaths for Trusts March 2017.
- The Trust will continue to build on the mortality review process within the organisation.
- Provide care groups with quarterly learning from deaths reports identifying themes of learning as commenced in 2019/20.
- Continue to work with Regional and Primary Care colleagues to ensure joint learning.
- Ensure the triangulation between mortality review and patient safety and incident reporting establish in 2019/20 continues.
- A Lead Medical Examiner has been appointed and a phased implementation is being planned, including the recruitment of more Medical Examiners to enable the Trust to provide a full service.

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.

Progress

At 7.3%, the re-admission rate in 2019-20 is identical with that of the previous year. The highest re-admission rate (8%) was in March 2020: a technical fall due to the decline in emergency and elective admissions in the second half of that month as a result of the covid-19 outbreak.

The largest percentage of re-admissions were non-elective patients who had been discharged from the UHND A&E Short Stay and MAU. The largest percentage of elective patients who were re-admitted had also previously been discharged from the short-stay surgical assessment units.

The vast majority of re-admissions took place shortly after discharge: 12.97% within the first 24 hours following discharge, 41.01% within the first week.

Next Steps

Whole system non-elective care is the responsibility of the Local A&E Delivery Board (LADB) chaired by the Trust's Chief Executive.

One of LADB's key priorities is to reduce emergency admissions and re-admissions by improving alternative urgent and emergency care services and pathways. Initiatives have included #nextstephome, Perfect Quarters, introduction of a Patient Choice policy to minimise delays caused by patients choosing a Care Home, use of Red and Green days to focus Ward staff on what actions need taking each day to move the patient towards discharge. All these initiatives aim to embody and embed good practice, such as criteria-led discharge and home to assess.

In addition, building on existing Intermediate Care provision, developments in the Community Care Group, such as the locality-based Teams Around Patients (TAPS), also aim to reduce the incidence of admissions and re-admissions. They have made good progress in reducing emergency admissions from Care Homes. This work will continue in 2020-21 and will be supported by work to improve the management of patients exhibiting frailty.

Towards the end of the year the Trust developed a GP immediate advice facility to use when the GP is considering sending a patient to A&E or for a direct admission. It is too early yet to properly assess its impact.

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

☒	Trust ambition not achieved

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 in the Emergency Department (ED).
- ➢ Ambulance crews hand over the care of patients to CDDFT staff within 15 minutes of arrival.

Progress

Type 1 A&E activity grew at an unprecedented rate for much of the year. By November, attendances were running 10.5% ahead of 2018 levels, including growth in DMH activity from North Yorkshire. However, this trend was reversed in mid-March following the national lock-down occasioned by the COVID-19 outbreak.

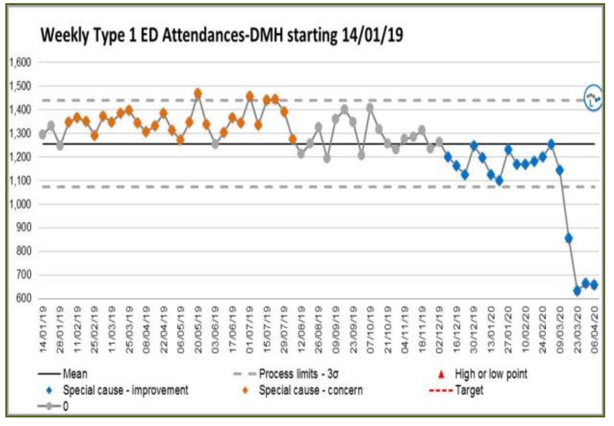
During the final full week in March, compared to the equivalent week in February, Type 1 attendances fell by 44% at UHND and 47% at DMH. Similarly large falls occurred in Urgent Care and emergency

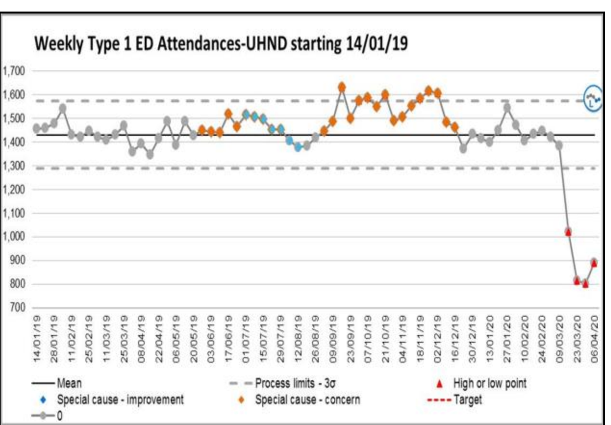
admissions. This mirrors the national trend and is continuing. In the seven days ending 14th April compared to the same period up to the 23rd Feb:

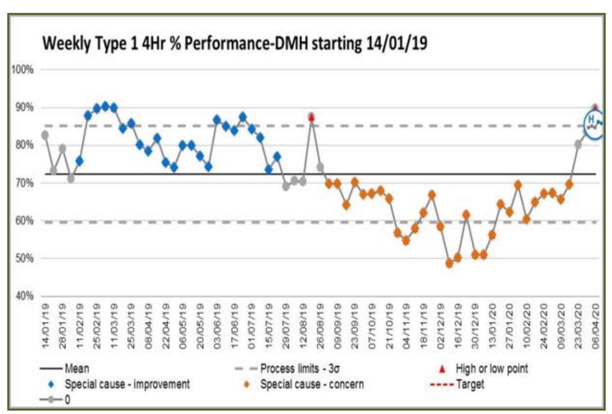
- ED attends fell by 43%
- Ambulance attends fell by 30%
- Ambulance handovers >30 minutes fell by 83%
- 4hr performance (all types) improved by 31% to 93.3%.
- Bed occupancy fell by 28%.

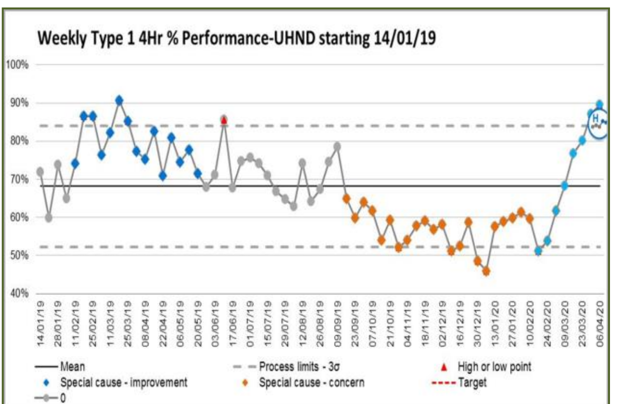
As a result, ED performance against the four hour waiting time standard has been transformed.

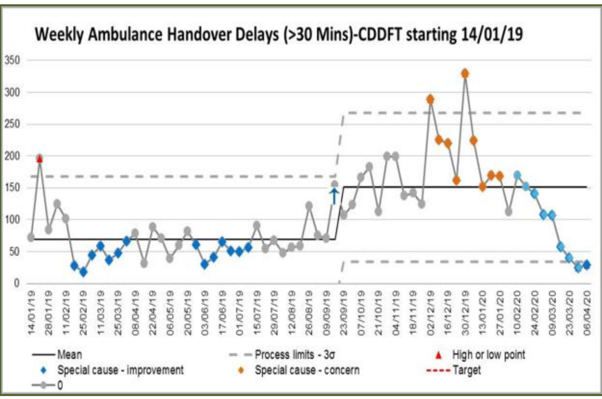
	4hr performance - week ending						
	02-Mar	09-Mar	16-Mar	23-Mar	30-Mar	06-Apr	13-Apr
DMH	67.36%	65.62%	69.59%	80.13%	83.46%	89.68%	98.11%
UHND	61.74%	68.30%	76.69%	80.12%	87.16%	89.56%	88.84%
Trust (all types)	81.05%	83.36%	83.60%	86.39%	88.88%	92.26%	93.52%







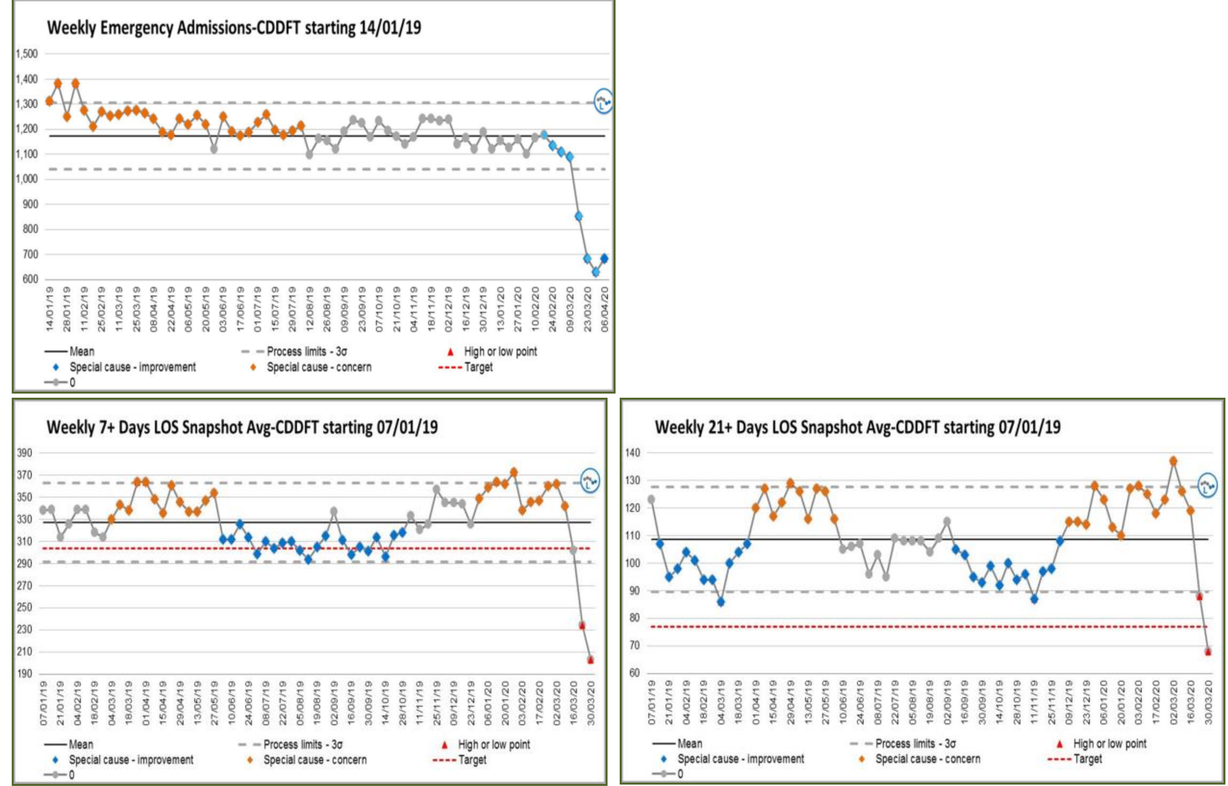




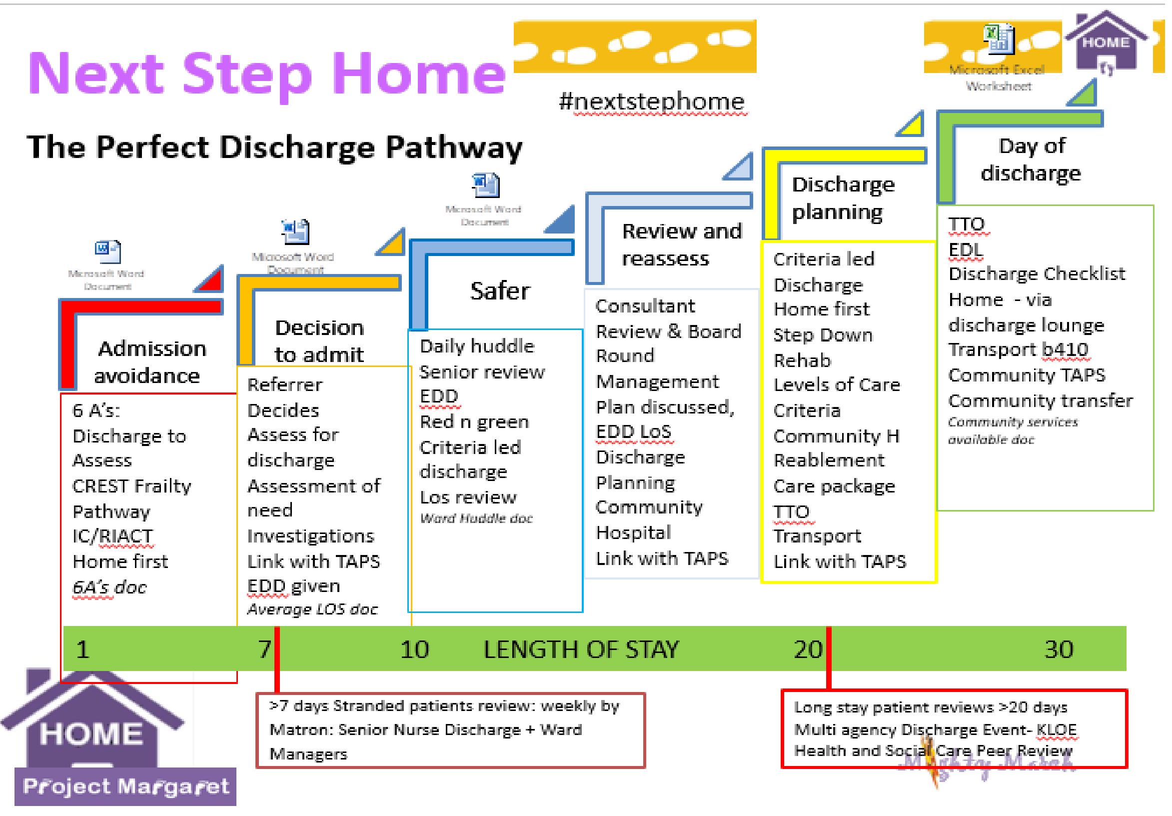
The Trust aims for optimal use of bed stock and has low long-stay patient numbers. It has minimal delayed transfers of care but its limited core bed stock (the lowest per head of population in the region) means that in normal circumstances it routinely operates with bed occupancy levels higher than the national 85% recommended level. This restricts the timely transfer of patients from the Acute Medical and Surgical Assessment units to base wards causing queues in ED of patients who are awaiting an assessment. This in

turn adversely affects ED waiting times. However, the COVID-19 outbreak has brought about a reversal of normal trends. Bed occupancy in the 6 weeks prior to the final week in March averaged 83.38%, but in the final week of the financial year it fell to 61.69%. This was caused by:

- Emergency admissions in the final week of March fell by 33% compared to the 6-week average.
- As part of the response to COVID-19, the Trust began to open up additional escalation beds at both the acute and community hospital sites. This created capacity to assess and treat patients in a more timely manner, thus reducing the number of long-stay patients.



Throughout the year the Trust has implemented the #nextstephome initiative. This involves embedding a range of good practice initiatives focussed on all parts of the pathway, from admission prevention to timely and safe discharge.



For the quarter leading up to winter this range of initiatives has been distilled into a Perfect Quarter, which has focussed on some key priority areas.

- Supporting Patient Choice Policy: aims to help patients who need to be discharged into a Care Home find a suitable home in a timely manner.
- Perfect Discharge Pathway: information/posters on each ward help staff understand what community support is available to patients being discharged.
- Red and Green Days and ticket home. '**Red days**' are defined as those days that fail to contribute to a patient's discharge from hospital. **Green** days are those on which a patient receives an intervention that supports a successful discharge.

In October, LADB sponsored a whole system Summit to agree priorities for how all partners can help improve urgent and emergency care. The priorities identified were:

- Improved access to community based services.
- Streaming & Navigation: identify and diverting patients attending ED that are suitable for care elsewhere.
- Improve and expand Same Day Emergency Care (SDEC) which is also a mandatory national requirement.
- Develop protocols for timely and safe discharge into community and social care.
- Improve responsiveness of surge & escalation process.

Delayed transfers of care (DTOCs)

As in previous years, the vast majority of delayed transfers of care were the responsibility of the NHS (1355) compared to Social Care (178). These numbers include 258 delays caused by patients or relatives. The largest number of NHS-responsible delays (409) relate to waits for step-down care. Other NHS delays related to: assessment delays (228), housing problems (178), Nursing home placement delays (152), Care packages at home (65), community equipment delays (51), and residential home delays (45). Social Care delays related to: Care packages at home (85), assessment delays (50), residential home delays (7), nursing home delays (5).

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 the plan to continue to drive improvements, the trust participated in national audits. The last national audit was conducted in May 2018 and the results were reported in September 2018. From 2019 onwards the priority 7 Day Standards has been assessed as part of the Trust's Board Assurance Framework and there is no longer a national audit. However, in order to continue to provide an assurance to the Board an 80 case note review was undertaken internally in November 2019.The results were that

- 100% patients with high dependence care needs receiving twice daily review.
- 91% of patients were seen within 14 hours of admission to hospital by a consultant a significant improvement from 2017 when it was 80% and maintaining the very level of 92% achieved in 2018.
- The Trust also continues to have appropriate access to diagnostic tests
- The Trust has access full access to specialist, consultant directed interventions.

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

☑	Trust ambition achieved

What are they? PROMs measure quality from the patient perspective by using questionnaires. In 2018 the national requirement for collection of PROMs changed in NHS Trusts. Previous to this, the outcomes of four clinical procedures were collected – hip replacements, knee replacements, hernia and varicose veins. This requirement from NHS England has now changed in that NHS Trusts are measured against outcomes following Total Knee and Total Hip replacement surgeries only. 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 and 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

Is to continue to have good response rates for our patients who have had total hip and knee replacements. To enable this, during 2018 /19 data analysis indicates that PROMS continues to improve on a yearly basis and in particular hip surgery is now considered as a good outlier.

The Questionnaire which was initially sent out 6 months prior to surgery is now given on the day of surgery as during 2018/19 due to unforeseen cancellation of operations, some patients were receiving PROMS questionnaire 2 without having had their procedures which had a consequence on our recorded performance and patient experience. With the implementation of this there we have seen improvement on the previous issues regarding the completed questionnaires where patients had cancelled operations. We are also anticipating that questionnaire 2 will see improved outcomes once distributed.

Further work is ongoing with NHS Digital in regards to co-morbidities.

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 2019/20 County Durham & Darlington NHS Foundation Trust provided and/or sub-contracted 94 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 2019/2020 represents 97 per cent of the total income generated from the provision of relevant health services by the County Durham & Darlington NHS Foundation Trust for 2019/20.

Review of Services

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

Operational review of the Trust's services is undertaken by the Trust Board and its IQAC sub-committee, which receive a monthly Integrated Operational Performance report covering the key national and local performance metrics.

Strategic reviews are provided periodically to the Board and its sub-committees on important developments. These have included:

- Bed Reconfiguration programme
- Urgent and Emergency Care whole system improvement
- Orthopaedic service transformation

Participation in Clinical Audits and National Confidential Enquiries

During 2019/2020 52 national clinical audits and 5 national confidential enquiries covered NHS services that County Durham & Darlington NHS Foundation Trust provides.

During 2019/2020 County Durham & Darlington NHS Foundation Trust participated in 98% 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 and for which data collection was completed during 2019/2020 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 19– Mar 20	% cases submitted
Women's and Children's Health				
Maternal, infant and newborn programme (MBRRACE-UK)* (Also known as Maternal, Newborn and Infant Clinical Outcome review Programme)	✓	✓	On-going	100%
Neonatal intensive and special care(NNAP) -	✓	✓	✓	100%
National Maternity and Perinatal Audit (	✓	✓	✓	100%
National Audit of Seizures and Epilepsies in Children and Young People – Epilepsy 12 (RCPCH)	✓	✓	✓ Cohort 1 submitted Dec19	N/A
Paediatric intensive care (PICANet)	X			
Care of Children in Emergency Departments) (Royal College of Emergency Medicine)	✓	✓	✓	*100%

* Sample required by the Royal College of Emergency Medicine has been submitted unless there were not enough patients that met the inclusion criteria over the audit period 1/8/19- 31/1/20.

National Audit/ National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 19 – Mar 20	% cases submitted
Acute Care				
Adult critical care (Case Mix Programme) –	✓	✓	On-going data collection. Final quarter to be submitted May 20	100% Apr – Dec 19
National emergency laparotomy audit (NELA)	✓	✓	✓	*DMH 93% UHND 93%
Hip, knee ankle, shoulder elbow replacements (National Joint Registry)	✓	✓	On-going	95%
Major Trauma Audit (Trauma and Audit Research Network TARN)	✓	✓	On-going. Data still being collected	Jan 2018-Jul 2019 UHND 94% DMH 100+%
Society for Acute Medicine's Benchmarking Audit - SAMBA (Society for Acute Medicine)	✓	✓	✓	**100%

* Case ascertainment required is >85% of expected cases between 1/12/18and 30/11/2019

** All patients admitted to Darlington Memorial Hospital and University Hospital's Acute Medical Units on the 27th June 2019. All patients included in new Winter SAMBA

National Audit/ National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 19– Mar 20	% cases submitted
Long Term Conditions				
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) Adult Asthma - Secondary Care Audit. Paediatric Asthma - Secondary Care Audit. Chronic Obstructive Pulmonary Disease (COPD) - Secondary Care Audit Pulmonary Rehabilitation – Organisational and Clinical Audit	 ✓ ✓ ✓ ✓	 ✓ ✓ ✓ ✓	 Ongoing data collection Ongoing data collection Ongoing data collection Ongoing data collection	 N/A First years submission still to be made N/A 100% 100% All patients that consented.
National Audit of Pulmonary Hypertension (NHS Digital)	X			
UK Cystic Fibrosis Registry (Cystic Fibrosis Registry)	X			
British Thoracic Society (BTS) – National Smoking Cessation Audit	✓	✓	✓	*100%
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	✓	X	X	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 Inpatient Audit. (NaDIA)	✓	✓	✓	100%
NaDIA Harms	✓	✓	✓	100%
National Diabetes Footcare Audit (NDFA)	✓	✓	✓	100%
Inflammatory Bowel Disease (IBD) Programme (IBD Registry) National Clinical Audit of Biological Therapies	 ✓	 ✓	 on-going data collection	 N/A

All admissions included at DMH and UHND until the required sample of 20 current smokers achieved.

National Audit/ National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 19 – Mar 20	% cases submitted
Mental Health Conditions				
Prescribing in mental health services (POMH)	X			

National Clinical Audit of Psychosis (NCAP)	X			
Mental Health programme: National Confidential Inquiry into Suicide and Homicide for people with mental illness(NCISH)	X			
Mental Health – Care in Emergency Departments) (Royal College of Emergency Medicine)	✓	✓	✓	*100%
Mental Health Care Pathway – CYP Urgent & Emergency Mental Health Care and Intensive Care (National Collaborating Centre for Mental Health	X			

* Sample required by the Royal College of Emergency Medicine has been submitted unless there were not enough patients that met the inclusion criteria over the audit period 1/8/19- 31/1/20.

National Audit/ National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 19– Mar 20	% cases submitted
Older People				
Falls and Fragility Fractures Audit Programme (FFFAP):				
Fracture Liaison Service Database (FLS-DB)	✓	✓	✓	58% of expected fragility fractures to Dec 19
Hip fracture (National Hip Fracture Database)	✓	✓	✓	100% Validated
Inpatient falls (RCoP)	✓	✓	On-going	100%
Sentinel Stroke National Audit Programme (SSNAP)	✓	✓	On-going 19/20 final 4 months data to be submitted by 6/5/2020	>80% (A) case ascertainment Oct-Dec 2019
National Audit of Dementia Royal College of Psychiatrists	✓	✓	✓	*100%
Assessing Cognitive Impairment in Older People/Care in Emergency Departments (Royal College of Emergency Medicine)	✓	✓	✓	**100%
UK Parkinson's Audit – (Parkinsons UK)	✓	✓	✓	***100%

* A minimum of 25 patients for each hospital site was required.

** Sample required by the Royal College of Emergency Medicine has been submitted unless there were not enough patients that met the inclusion criteria over the audit period 1/8/19- 31/1/20.

*** The required sample for each of the services involved was submitted.

National Audit/ National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 19 – Mar 20	% cases submitted
Heart				
Acute Coronary Syndrome or Acute Myocardial Infarction & other ACS (MINAP)	✓	✓	On-going	Data to be submitted 25/05/2020
National Adult Cardiac Surgery Audit (Adult Cardiac Surgery)	X			

Cardiac Arrhythmia (HRM)	✓	✓	On-going	100%
Heart failure (Heart Failure Audit)	✓	✓	On-going	Data to be submitted 08/06/2020
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.	X			
National Audit of Cardiac Rehabilitation (University of York)	✓	✓	✓	N/A
National Audit of Percutaneous Coronary Interventions(PCI)	X			
National Congenital Heart Disease (CHD)	X			

National Audit/ National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 19 – Mar 20	% cases submitted
Cancer				
Lung cancer (National Lung Cancer Audit)	✓	✓	✓	100%
Bowel cancer (National Bowel Cancer Audit Programme)	✓	✓	**✓	100%
National Gastro-Intestinal Audit Programme (National O-G Cancer Audit)	✓	✓	***✓	100%
National Prostate Cancer Audit.	X	X		
National Audit of Breast Cancer in Older Patients (NABCOP)	✓	✓	On-going monthly data submissions	100%

* Data collection deadline in 2019/2020 for patients covering period Jan – Dec 2018
** Data collection deadline in 2019/2020 for patients covering period 1st Apr 2018 – 31st Mar 2019
*** Data collection deadline in 2019/2020 for patients covering period 1st Apr 2018 – 31st Mar 2019

National Audit/ National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 19 – Mar 20	% cases submitted
Other				
Elective surgery (National PROMs Programme)	✓	✓	N/A	N/A
National Ophthalmology Audit (NOD)	✓	✓	✓	98.3%
National Bariatric Surgery Registry (NBSR)	✓	✓	Prospective Ongoing data collection	100%
Endocrine and Thyroid Audit (British Association of Endocrine and Thyroid Surgeons (BAETS))	✓	✓	On-going data collection	N/A
Serious Hazards of Transfusion (SHOT) :UK national haemovigilance scheme	✓	✓	No incidents for CDDFT	N/A
National Audit of Care at the End of Life (NACEL)	✓	✓	✓	100%
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	✓	✓	N/A	N/A
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) Antibiotic	✓	✓	N/A	N/A

Consumption - Public Health England				
Surgical Site Infection Surveillance Service (SSISS) - Public Health England	✓	✓	✓	100%
Perioperative Quality Improvement Programme (PQIP) - (Royal College of Anaesthetists)	✓	DMH ✓	✓	70%
National Audit of Anxiety and Depression	X			
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: Female stress urinary incontinence	X			

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National Audit/ National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 19 – Mar 20	% cases submitted
Other				
Blood transfusion and Transplant				
2018/19 Audit of Maternal Anaemia (National Comparative Audit of Blood Transfusion)	✓	✓	✓	100%
Re-audit of medical use of blood (National Comparative Audit of Blood Transfusion	✓	✓	✓	100%
National Confidential Enquiries – Medical and Surgical Clinical Outcome Review Programme				
Out of Hospital Cardiac Arrest	✓	✓	✓	63%
Pulmonary Embolism	✓	✓	✓	89%
Acute Bowel Obstruction	✓	✓	✓	100%
Long Term Ventilation	✓	✓	✓	N/A Organisational Questionnaire only applicable to CDDFT
Dysphagia in Parkinson's Disease	✓	✓	On-going	N/A

- The reports of *30 national clinical audits were reviewed by the provider in 2019 and County Durham & Darlington NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

* For the National Cardiac Arrest Audit (NCAA) 18/19, National Bariatric Surgery 18/19, National Ophthalmology Audit 18/19, British Thoracic Society (BTS) Non Invasive Ventilation (NIV) DMH, Endocrine and Thyroid National Audit (BAETS) there was compliance with standards.

National Clinical Audits reviewed in 2019/2020	Action
National Audit of Dementia 2018/19	Assessments of Delirium: • Embedded and promote the practice with medical and nursing staff to use the identified and agreed tools, when people with dementia and or delirium are admitted as an emergency and follow up assessment on ward areas. • Cognitive testing using a validated structured tool is used on admission and again prior to discharge that both are recorded and shared within the discharge letter • Causes of cognitive impairment is summarised and recorded, as well as shared in the discharge letter. • Persistent behavioural psychological symptoms such as aggression wandering shouting are recorded and shared within the discharge letter. Personal information collected to support care : • Embedded and promote the practice with medical and nursing staff to identify and record factors that can cause distress in our patients and those factors that can aid in calming the patient. Dementia Awareness training: • Leads responsible for County Durham and Darlington NHS foundation trust staff, will promote, facilitate & highlight to their staff their compliance/engagement with the appropriate levels of training identified on ESR for their role and monitor compliance. Trust/Health Boards involvement in dementia care: • To develop the current process of routine monitoring to facilitate the scrutiny & sharing of data which clearly identifies the proportion of people with dementia who experience 1. A fall during their admission 2. readmitted within 30 days of discharge 3. complaints analysed by age Overall Improvement in care in general hospitals: • The trust as a whole will work towards implementing the recommendations by 20:09:2020, including. 1. Other dementia friendly initiatives 2. Publish progress made on implementing dementia recommendations in annual trust statement on dementia. Theme 1: Assessment • Staff to continue to develop their practice in recording information from their assessments. This

	area has the potential to improve, as other areas of the action plan are achieved. Theme 3: Information and Communication. • There is clear on going communication with families and carers of people with dementia. 1. A record of discussions will be recorded in the patients notes 2. Provision for reasonable adjustments will be documented and consistently implemented. 3. Information will be shared with the MDT 4. To explore and pilot the potential use of a visual marker i.e. Forget-me-Knott symbol. Theme 4: Nutrition. • Ensure that the nutrition & hydration needs of patients with dementia are included in nurse shift handovers. • Promote the availability of snacks and finger food to those patients with dementia and their family/carer. Theme 6: Discharge. • Discharge Coordination: Ensure that patient documentation reflects the discussions that Place of discharge & support needs have been discussed with the person with dementia and the person's carer/relative. • Discharge Planning: Ensure discharge planning is initiated within 24 hours of admission and documented. Support needs and plan are documented in the discharge plan and summary of discharge Record the referral to social worker of the need for assessment due to proposed changes in need. Documented in patient's notes capacity assessment undertaken , consent documented • Carer involvement: Relatives receive more than 24 hours' notice of discharge and time family informed of discharge date and time is documented.
Royal College of Emergency Medicine – Vital Signs in Adults 2018 (Darlington Memorial Hospital).	Add on level of compliance with Royal College of Emergency Medicine standards on the Weekly Report. Look into HCA staffing levels. Nursing staff to ensure that there is a written record of senior decision maker has recognised the abnormal vital signs if present. Nursing staff to ensure that there is a written record of senior decision maker has acted upon abnormal vital signs if present in all cases.
Royal College of Emergency Medicine – Vital Signs in Adults 2018 (University Hospital of North Durham).	To push staff to record respiratory rate, oxygen saturation, pulse, blood pressure, GCS or AVPU score, temperature measured and recorded within 15 mins for patients triaged to the majors or resuscitation areas.

	To push staff to record the repeat set of vital signs in the notes within 60 minutes of the first set of abnormal vital signs. Educate staff to ensure that there is evidence that the clinician recognised the abnormal vital signs if present. Educate staff to ensure that there is documented evidence that abnormal vital signs (if present) were acted upon in all cases.
Royal College of Emergency Medicine – VTE risk in lower limb immobilisation 2018 (Darlington Memorial Hospital).	Investigate the possible inclusion of a tick box on Symphony when patients fitted with a new leg cast or boot have their risk of VTE and bleeding assessed during their visit to the Emergency Department. Complete work on patient information leaflet proposal for next Emergency Department DMH Governance meeting in October 2019. Pharmacological thromboprophylaxis is given in Orthopaedics the next following day. Not applicable to Emergency Department DMH.
Royal College of Emergency Medicine – VTE risk in lower limb immobilisation 2018. (University Hospital of North Durham).	Liaise with orthopaedics to review current practice in relation to the RCEM's definition of compliance and see if we need to change to this. Implement the new Trust VTE Patient Information Leaflet. Re-audit in 1 years' time.
Royal College of Emergency Medicine – Feverish Children 2018. (University Hospital of North Durham).	To embed rapid assessment in Paediatric Assessment Area (PAA) protocols. Education of the PAA staff re RCEM Fundamental standard for respiratory rate measurement and recorded within 15 mins of arrival. To embed rapid assessment in Paediatric Assessment Area (PAA) protocols. Education of the PAA staff re RCEM Fundamental standard for oxygen saturation measured and recorded within 15 mins of arrival. To embed rapid assessment in Paediatric Assessment Area (PAA) protocols. Education of the PAA staff re RCEM Fundamental standard for pulse measured and recorded within 15 mins of arrival. To embed rapid assessment in Paediatric Assessment Area (PAA) protocols. Education of the PAA staff re RCEM Fundamental standard for Systolic blood pressure/capillary refill measured and recorded within 15 mins of arrival. To embed rapid assessment in Paediatric Assessment Area (PAA) protocols. Education of the PAA staff re RCEM Fundamental standard for GCS score (or AVPU) measured and recorded within 15 mins of arrival. To embed rapid assessment in Paediatric Assessment Area (PAA) protocols. Education of the PAA staff re RCEM Fundamental standard for Temperature measured and recorded within 15 mins of arrival. Review Triage Protocols. Educate PAA and ED staff re: timely review (under 4 hrs) (by an EM or paediatric consultant , ST4+ or equivalent non-training doctor) children presenting to ED's with

	febrile illness who are <1 yr OR have no apparent source of infection with red features as per NICE feverish illness guidance OR are assessed to be at intermediate or high risk of sepsis (2 or more amber features, or one red feature) . Educate PAA/ED staff on the use of NICE Sepsis Risk Stratification Tool and the recording of investigations for children assessed at high risk of sepsis.
National Diabetes Audit (Adult) 17/18.	Monthly monitoring of live dashboards for all eight care processes across all 3 CCG's at Diabetes Governance Board to significantly improve compliance with NICE Guidance. Improve coding to ensure the data is both accurate and comprehensive. Improve documentation of Urine Albumin. Improve documentation of Serum Creatinine. The majority of Type 2 patients are now being cared for in primary care thereby stream lining secondary care specialist clinics. Resources released to be used to make improvements to meet treatment outcomes national benchmarks.
National Diabetes in Pregnancy Audit 2017 and 2018 Darlington Memorial Hospital.	• Educational session on preconception care delivered to primary care physicians. • Further educational sessions planned. • Previous draft letter sent to CCG's raising awareness about the importance of preconception care and the need for timely referral. • As part of the community diabetes project, DSN's/Consultants to raise awareness about the importance of preconception care • Extensive support/input from Diabetes Team in these clinics and increased use of technology to Improve control.
National Diabetes in Pregnancy Audit 2017 and 2018 University Hospital of North Durham.	• Educational session on preconception care delivered to primary care physicians. • Further educational sessions planned. • Previous draft letter sent to CCG's raising awareness about the importance of preconception care and the need for timely referral. • As part of the community diabetes project, DSN's/Consultants to raise awareness about the importance of preconception care. • Develop a Preconceptual service including Lead Obstetrician and Diabetologist (MatNeo Project) • To discuss with Obstetric and Paediatric Teams at SAGE meeting the need undertake a breakdown of neonatal admission indicators and compare performance of both acute sites.
National Diabetes Inpatient Day Audit 2018 Darlington Memorial Hospital. (Hospital characteristics only)	To appoint more Specialist Diabetes Dietitians. Matter to be raised at the Diabetes Governance Meeting. Appoint more podiatrists. To determine level of electronic prescribing within CDDFT and could the present level be better categorised as full rather than partial. Also, determine if total electronic prescribing could be achieved.

	To determine why DMH does not use remote blood glucose monitoring and explore widening the use within DMH.
National Diabetes Inpatient Day Audit 2018 University Hospital of North Durham. (Hospital characteristics only)	One additional Diabetes Inpatient Specialist Nurse required for UHND. Service managers from Medicine and Podiatry to liaise to increase enhanced support from Podiatry for the Diabetes Inpatient Service.
MINAP 17/18	Creation of a Cardiac dedicated ward. Strict admissions policy. Creation of an ACS register to ensure compliance with NICE guidance and to improve the accuracy of data for MINAP. Create a template for myocardial injury. Identify a pathway for DMH STEMI patients and incorporate into ACS register to improve the reliability of MINAP data.
National Heart Failure Audit 17/18	Audit of the 15% of DMH patients that did not receive and echocardiogram to be undertaken to determine why not performed. Audit of the 23% of UHND patients that did not receive discharge planning to be undertaken to determine reasons for the UHND lower result. Audit of the 33% of UHND patients that were not referred HF Nurse for follow up to be undertaken to determine reasons for the UHND lower result.
National Diabetes Footcare Audit 15-18.	To continue education of Primary Care Physicians about pathway and early referral to the MDT. N.B. The data submitted for the period 15/18 only covered Tier 3 patients attending the MDFT acute clinics and therefore does not provide a true reflection of all those patients assessed and treated by the CDDFT Diabetic service. To provide a more accurate picture patients attending in the community are now also included. It is likely that it will take until the 2020/21 results for this to be shown in future reports.
National Emergency Laparotomy Audit (NELA) Dec 17-Nov 18 (Trustwide).	Look into funding of more critical care beds. Cancel elective admissions over emergency cases.
Sentinel Stroke Audit Programme (SSNAP) 18/19	Domain 1 Scanning: • As a direct admissions ward, NEAS telephone handover was deemed as clock start, therefore patient not on the stroke unit at this point. SSNAP clock start changed to when patient actually arrives on stroke unit. • Continue to monitor 1hr scan performance / clock start • Internal monitoring by monthly performance reports • Continue to work with radiology team to validate monthly scan data for accuracy. Domain 2 Stroke Unit: • Ensure stroke unit BCP is followed. • Medical team and Nurse Practitioners to escalate to Senior Management team and submit a

	safeguard incident if no bed capacity on the ward to accept new patients. • Internal monitoring by monthly performance reports. Domain 3 Thrombolysis: • Internal monitoring by monthly performance reports and SSNAP audit reports. • Review / reflect on those cases NOT thrombolysed and identify if there are any trends in assessment. Domain 5 Occupational Therapy, Domain 6 Physiotherapy , Domain 7 Speech and Language Therapy and Domain 8 MDT Working: • North Durham and Durham Dales Easington and Sedgefield CCGs submitting business case for a combined stroke unit within UHND which will provide an opportunity to enhance a Community Specialist Stroke Rehabilitation service rather than an Early Supported Discharge Model. Domain 9 Standards by Discharge: • Internal monitoring by monthly performance reports and SSNAP audit reports. • Continue to review stroke care pathway.
Serious Hazards of Transfusion (SHOT) :UK national haemovigilance scheme 2018	Update laboratory MHP Protocol - currently under review - change request added to the laboratory MHP protocol (LP/PA/TR48) to add this statement. Identified that Laboratory Novoseven and Beriplex SOPs uses trade name throughout text – document to be revised – change requests raised. Implementation of Group Check Policy is in progress by T3 team, issues have been encountered with LIMS solution, being tested in v5.34 in conjunction with Software upgrade. As discussed at August T3, group felt not feasible to look up all patients at registration (plus Sp-ICE is not complete antibody history record, can only view data from hospitals that share, and only data from NHSBT referrals, not antibody identification performed by hospitals = not a complete record). Agreed minimum look up should be all Haemoglobinopathy patients, and antenatals with antibodies. SOP LP/PA/TR125 to be updated to reflect this (change request raised) and disseminate to staff for action. To include dosage guidance within the requesting blood components policy. Paediatric guidelines to be reviewed and incorporated into paediatric policy. Paediatric transfusion policy to be created.
National Lung Cancer Audit 2018 (Reporting on 2017)	Increase surgical input for difficult tissue sampling at DGH level e.g. VATS - Biopsy Lung; Radio labelled nodule excision of small lesions. Will depend upon proper resources made available at Regional Thoracic Surgical Centre. Split the NCLA 2017 data for north/south to study the difference in practice if outcomes different and change practice for improvement.

	Build on MDT process, with planning MDT to be more effective to complete staging/diagnostic process in a timely fashion. To action rapid assessment and early referral for treatment and surgery. Maximise Cardiothoracic Surgical Presence in local MDT if needed. Explore the possibility of keyhole/robotic surgery to improve re-section rates in patients with borderline fitness. New Lung CNS is expected to be appointed by the end of July 2019. Will improve the capability of the service and help bring the performance up to the required standard.
National Asthma and COPD Audit Programme (NACAP) – COPD Secondary Care 17/18 Darlington Memorial Hospital	Education & Training on prescribing oxygen and stipulation of oxygen target range. EPMA progress, linking with IT to add information and review system. Await results of the BTS smoking cessation audit as this will provide performance and further root cause information on smoking cessation.
National Asthma and COPD Audit Programme (NACAP) – COPD Secondary Care 17/18 University Hospital of North Durham	Flag up to AMU Team (Sisters, Consultants, and Clerking Doctors) that all patients prescribed oxygen should have their oxygen target range stipulated. Ensure oxygen target range is stipulated on EPMA. Email to Clinical Lead Emergency Department UHND informing that the NACAP COPD Secondary Care audit has flagged up that as a QI Priority all patients requiring NIV on presentation receive it within 2 hrs. ? Are they experiencing any departmental barriers to starting NIV. Flag up to AMU Team Flag up to AMU Team (Sisters, Consultants, and Clerking Doctors) that DECAF scores should be recorded for UHND patients admitted with ?COPD. N.B. 96.7% of COPD patients have their smoking status recorded. 14.2% of current smokers at UHND did not have recorded whether they had been prescribed smoking cessation pharmacotherapy during the admission. 42.1% were offered but declined. Feedback to AMU the UHND result and the need to always record Smoking cessation pharmacotherapy prescribed to current smokers during admission. Posters for AMU.
British Thoracic Society (BTS) Adult Community Acquired Pneumonia 18/19 Darlington Memorial Hospital.	Ask Radiology to undertake a snap shot audit of 20 Community Acquired Pneumonia (CAP) patients Chest X-Ray (CXR) requests over the audit. Re-audit notes to determine whether the quality of data collection adequate. Highlight at Governance day 7th November 2019 re findings and ask Emergency Dept. /AMU to look at process for obtaining a CXR prior to the patient receiving the first dose of antibiotic. Write to Emergency Department Lead about concern that of those patients who had a CXR and were reviewed before antibiotics were given, 35% of patients had their first dose of antibiotics more than 4 hrs after CXR (National 17 %). Respiratory Clinical Director to liaise with Junior doctors re: the current process for requesting blood cultures when CAP diagnosed.

	Radiology to audit a subset of 30-50 notes, looking at the dates of the initial audit CXR and if there had been a follow up CXR within 6 weeks of this date.
British Thoracic Society (BTS) Adult Community Acquired Pneumonia 18/19 University Hospital of North Durham.	Message to Junior Doctors to improve the antibiotic treatment of patients with CURB scores 3-5. Message to Junior Doctors to improve the percentage of patients that have blood cultures taken within the first 24 hours.
National Neonatal Audit Programme (NNAP) 2018	Education to staff for steroids distribution Benchmark with DMH staff/ward To add audit question on the proforma tool for development and use of Pre-term labour Proformas. Education to staff on magnesium sulphate Data validation check Look into starting local priority audit Key messages with doctors and staff Posters in wards/staff room To add audit question on the proforma tool Campaign “Talk to my Mom” Laminate small poster on Incubator to be used by staff for prompt, once complete taken off. Key messages with doctors and staff Benchmark with DMH staff/ward To add audit question on the proforma tool Cards given to parents on admission with information on ward round & to add any questions they may have Education to staff on ROP Benchmark with UHND staff/ward Education to staff on 2 years follow up To look at systems i.e. ecdm & ecamis for record and appointment check for 2 year follow up. Data validation check. Yellow star fields are sometimes missed/not complete & system does not make these fields mandatory where as if you save & close or move forward/backward in the page the system lets you do it. To become mandatory in the system where a pop up window prompts you to complete the yellow star fields before proceeding further. Also Reminder function at the bottom of the page prompts staff what is not complete, but does not show the entire yellow star missing items or other relevant elements so you have to trawl through the tabs to double check.
National Paediatric Diabetes Audit 2017/18	All outpatient clinics will have at least one Paediatric diabetic specialist nurse (PDSN) in attendance. 1.54 wte additional PDSNs will be recruited by May 2019 PDSNs will be trained to undertake Venepuncture so that young people attending clinic can have their bloods obtained in a timely one stop appointment Foot examination, the process for planning and delivering foot exams will be further analysed. Data validation will be carried out and the undertaking foot health checks by PDSNs/health care assistant will be explored with podiatry services. Eye screening completion rate 79.9% of which 6.2% was abnormal. In order to appreciate the total potential

	abnormal eye screens we need to increase the screening rate to at least 90%. Data validation using twinkle database will be undertaken The importance of eye screening will be included in the structured education programme in order to increase screening uptake. To increase the rate of appointment attended and the overall take up rate. We have secured funding for additional dietetic resource 0.5 wte. Ensure ring and remind service for outpatient dietetic appointments are in place. Explore strategies to improve engagement (and therefore attendance rate with dietetic service). To include more parallel clinics where possible. Add to annual clinic review check list the following; Flu vaccine recommendation “Sick day rules” advice Blood ketone testing Raise awareness of the sick day guidelines available on the intranet paediatric guidance Data validation using twinkle database will be undertaken. The non-ketotic inpatient pathway and integrated DKA pathway available in the intranet paediatric guidance, will be highlighted in junior doctor training sessions, ward key message and discussed at Paediatric SAGE meeting. Increase Paediatric Diabetes Specialist Nurse (PDSN) support by employing 1.54 wte. Increase Psychology support by employing 0.5 wte. Increase dietetic support by employing 0.5 wte. We will standardise the education program for C&YP and their families through a structured and validated curriculum, managed by a senior PDSN with specialist education skills. Senior PDSN has completed the SEREN education course
National Audit of Care at the End of Life (NACEL) Round 1 2018	Guidelines will be developed to support clinical staff in how to approach these conversations and how to document hydration and nutrition requirements of dying patients. Guidelines will be developed to support clinicians in what should be said and documented in relation to common sedative side effects of medications used at end of life. Care plans on Nervecentre have been developed to support end of life care. Implementation May 2019 Evaluation of Nervecentre end of life care plans

	The possibility of developing a proforma to support End of Life (EOL) care needs further consideration but this should wait until the Nervecentre EOL care plans are imbedded in practice and the effect of these has been evaluated. If a decision is made that a proforma should be used it will require a dedicated resource and this would require a business case to be developed Development of end of life observations on Nervecentre is in discussion and will require a capital investment. The specialist palliative care team are working with the special projects team to investigate the best approach to this and develop a business case. The palliative Care service will work with the new Medical Examiner to create a process for rapid feedback and support for staff. This will help us to target education and training.

Confidential Enquiries

County Durham and Darlington NHS Foundation Trust has participated/is still participating in 5 enquiries during the course of 2019/2020. The Trust has submitted/is submitting either patient or organisational data for all studies which were deemed relevant.

Confidential Enquiries reviewed in 2019/2020	Action
NCEPOD – ‘ Failure to Function’ – Heart Failure	Produce a guideline for the clinical management if acute heart failure. Develop the pharmacists’ role in the treatment of acute heart failure. Strengthen HF MDT and review documentation. Review and improve discharge documentation. Ensure adequate staffing so all appropriate patients are followed up by Specialist Heart Failure Team after discharge.

The reports of 20 local clinical audits were reviewed by provider in 2019/2020 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 2019/2020	Action
On-going audit of decision to delivery times in Caesarean Section	Education of medical staff through local teaching and risk management meetings to document appropriate primary indications. Education of medical staff through local teaching and risk management meetings to document appropriate use of FBS/instrumental delivery except in true contraindications.
Clinical Coding of ENT Operative Procedures	Discuss clinical coding errors with Clinical Coding Department to reduce errors.
Management of Deep Vein Thrombosis and Pulmonary Embolism in stroke patients	Poster highlighting RCP guidelines on intermittent pneumatic compression (IPC) devices.

	Transfer clerking pro-forma highlighting VTE review on admission with patient education. Poster with instructions for VTE re-assessment. Weekly MDT to review patient mobility status with tick-box for VTE re-assessment on MDT sheet.
Audit of Cyclopentolate 1% administration	Sticker adapted with all information attached and staff to remember to sign all notes.
Evaluating if the Clinical Record keeping and NHS Safeguarding Information Recording Policies are being adhered to within the Orthoptic Department	To give feedback to staff to ensure they understand what parental responsibility means and to remind them to record this.
Management of blood pressure in the acute phase of intracerebral haemorrhage	Standardise blood pressure monitoring in ICH to bring in line with thrombolysis care Proposed plan: ▪ Blood pressure would be recorded: ▪ Every fifteen minutes for the first 2 hours ▪ Every 30 minutes for the remainder of the first 6 hours ▪ Every hour for the remainder of the first 24 hours Educate staff regarding BP monitoring in the acute stroke unit. Standardise methods of blood pressure lowering amongst ICH patients (labetalol and/or GTN infusion).
Audit to evaluate the effectiveness of femoral / fascia iliac regional catheters / infusions for pain relief in patients with fractured neck or shaft of femurs.	Acute pain service needs investment to allow nurses to cover seven day service - leads will ensure escalated to matron and that acute pain nurse hours are considered for every new surgical business case. Acute pain service needs investment to allow funding of and to provide a regional block service in the new theatres project at DMH block room leads will ensure escalated to matron and that acute pain consultant and nurse hours are considered for every new surgical business case
Movement in operation theatres of orthopaedic emergencies.	Raise awareness among staff to adhere to NICE guidance.
Audit of using the right continuation sheets for ENT.	To let doctors know during induction to use speciality specific continuation sheets. To inform ward manager to let nurses and other staff to use the specialty specific continuation sheets.
Audit on the Appropriateness and Accuracy of Information Provided on Deep Venous Thrombosis Ultrasound (US) Requests	Education of doctors in weekly teaching session and making DVT ultrasound (US) request checklist available in wards as a reminder.
Paediatric Appendicectomy Audit	Creation of an all-day Emergency Surgical List. Early Review by Experienced Surgical Decision Maker (Senior Registrar or Consultant). Do not delay time with pre-operative ultrasound scan (US). Prescribe IV Antibiotics once Clinical Diagnosis of Appendicitis made – especially if overnight delay. Ensure Correct Potassium Supplementation in Post-Operative IV Maintenance Fluid.
Nasogastric NG Tube Compliance in Intensive Care 2019	Combine NG pathway and LOCSSIP into one document. 'Tick box' for reasons for insertion on documentation.
Neuroprotection in preterm deliveries, less than 34 weeks	Reminder to staff. IR1 to be completed for any iSoft notes missing to highlight issues.

	Preterm Grab Bag to be used.
Clock variations	Radio controlled wall clocks being ordered to replace basic battery powered ones as these lose time as soon as they have been corrected Discuss with engineering. Some clocks only they can adjust and will do so within 2 weeks of clocks going forward and back, if these are found out of time in the interim we will let them know and they will adjust as soon as possible Information gained from engineering about how staff can adjust clocks on other monitors/machines. This has been circulated to all anaesthetists and anaesthetic nurses so if they come across clocks which are incorrect they can put them right.
Management of patients with epilepsy during pregnancy	Introduction of the epilepsy pathway in hand held notes to be used by all health care professionals involved in care. Ensure referral to epilepsy ANC early to ensure appropriate antenatal care.
An audit to determine the compliance of staff to document the risks of radiation exposure are provided to patients	Posters explaining risks to be displayed in waiting rooms and clinics. Radiograph justification forms have been amended to include OPG's (Orthopantomogram) and prompts that risks have been discussed and documented.
Management of Atrial Fibrillation in the Acute Medical Unit (AMU)	Educate junior doctors about the importance of calculating CHA2DS2-VAS and HAS-BLED score and document.
Audit of epidural chart completions and compliance to policy	The pain team will disseminate these audit findings to ward managers and acute pain link nurses and reiterate importance of 100 % compliance with documentation of signed evidence that the spinal information leaflet was provided. It will be reiterated to ward managers and pain link nurses that within the trust that any surgical nurse caring for patients with spinals must attend spinal training and updates provided by Acute Pain Service. The pain team will disseminate these audit findings to ward managers and acute pain link nurses and reiterate importance of 100 % compliance with recording of observations 1 hourly for 6 hours, then 4 hourly for total 24 hr post spinal. Particularly attention will be given to recording of observations during the night.
Major Post Partum Haemorrhage (PPH) Audit UHND	Add Massive Obstetric Haemhorrage protocol deactivation with date and time to the PPH proforma. Staff reminded of risk factors for PPH with a laminated poster on labour ward.
Management of supracondylar fractures in children. BOAST 11 Audit of practice 2019	Incorporate documentation message into departmental induction to improve knowledge of guidelines. Educate the department post-op X-rays at less than 10 days requested at first clinic wire site check. Educate the department that wire removal date booked at this follow up X-ray appointment.

Research & Innovation

The number of patients receiving relevant health services provided or sub-contracted by County Durham & Darlington NHS Foundation Trust in 2019/2020 that were recruited during that period to participate in research approved by a Research Ethics Committee was 1,401 participants. The table below shows the areas research has taken place within CDDFT.

Managing Specialty	Pts
Gastroenterology	717
Cancer	109
Stroke	98
Anaesthesia, Perioperative Medicine and Pain Management	81
Renal Disorders	77
Cardiovascular Disease	71
Reproductive Health and Childbirth	61
Dermatology	41
Infection	40
Children	34
Surgery	18
Musculoskeletal Disorders	13
Diabetes	6
Ear, Nose and Throat	6
Mental Health	6
Trauma and Emergency Care	6
Critical Care	5
Respiratory Disorders	4
Haematology	3
Neurological Disorders	3
Health Services Research	1
Hepatology	1
Total	**1,401**

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 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 2019/20 County Durham & Darlington NHS Foundation Trust was involved in conducting National Institute for Health Research (NIHR) Portfolio clinical research studies in urology.

Work has continued against the Research & Innovation Strategy 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 72 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 for the second year running. In 2019/2020 we aim to continue to develop more Chief Investigators within CDDFT therefore the number of Investigator Initiated studies in line with national priorities.

Further developments from collaboration agreements with North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust, we have established the Durham Tees Valley Research Alliance. This collaborative project between the three organisations hopes to establish the Durham Tees Valley as a destination for clinical research and innovation; offering advantages to publicly funded researchers and commercial partners. This will give greater patient access to research opportunities and streamline the research service across the region.

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

CQUIN schemes are in place covering CDDFT services provided for its main NHS commissioners: the Clinical Commissioning Groups, Specialist Commissioners and Public Health. The aim is to focus attention on making improvements in priority areas and services. This year there is also a CQUIN relating to the Armed Forces Covenant.

The 2019-20 CQUINs are.

CCG ACUTE CQUINs
CCG1. Antimicrobial Resistance AMR: • Lower Urinary Tract Infections in Older People: 90% of antibiotic prescriptions in older people meet NICE guidance • Antibiotic Prophylaxis in Colorectal Surgery: 90% of antibiotic surgical prophylaxis prescriptions for elective colorectal surgery being a single dose and prescribed in accordance with local antibiotic guidelines.
CCG2. Staff Flu Vaccinations: 80% uptake of flu vaccinations by frontline clinical staff.
CCG 3. Alcohol and Tobacco: • Screening: 80% of in-patients screened for smoking and alcohol. • Tobacco Brief Advice: 90% of identified smokers given brief advice • Alcohol Brief Advice: 90% of patients identified as drinking above low risk levels, given brief advice or offered a specialist referral.
CCG7. Three High Impact Actions to Prevent Hospital Falls: 80% of older inpatients receiving three key falls prevention actions (Lying and standing blood pressure recorded; no hypnotics or antipsychotics or anxiolytics given during stay OR rationale documented; mobility assessment documented within 24 hours of admission.
CCG11. Same Day Emergency Care • Pulmonary Embolus: 75% of patients managed in the same day setting • Tachycardia with Atrial Fibrillation: 75% of patients managed in the same day setting • Community Acquired Pneumonia: Patients managed in the same day setting.
CCG COMMUNITY CQUINs
CCG2. Staff Flu Vaccinations: 80% uptake of flu vaccinations by frontline clinical staff.
CCG 3. Alcohol and Tobacco • Screening: 80% of in-patients screened for smoking and alcohol. • Tobacco Brief Advice: 90% of identified smokers given brief advice • Alcohol Brief Advice: 90% of patients identified as drinking above low risk levels, given brief advice or offered a specialist referral.
CCG7. Three High Impact Actions to Prevent Hospital Falls: 80% of older inpatients receiving three key falls prevention actions (Lying and standing blood pressure recorded; no hypnotics or antipsychotics or anxiolytics given during stay OR rationale documented; mobility assessment documented within 24 hours of admission.
CCG9. Six Month Reviews for Stroke Survivors: 55% of eligible stroke survivors receive a six month follow up within 4-8 months of their stroke.

SPECIALIST COMMISSIONER CQUINs
Medicines Optimisation
ARMED FORCES HEALTH CQUIN
Armed Forces Covenant: sign and implement. In November the Trust held a joint signing ceremony with Darlington Borough Council to commit (or in the case of the Council to re-commit) to implementing the Covenant. It was subsequently successful in achieving the Bronze employer award to recognise its commitment and has signed up to the "Step into Health" initiative, which aims to help armed forces personnel make the transition to civilian life with a job in the NHS. The Trust has recently made an application for a Silver employer recognition award.
PUBLIC HEALTH CQUIN
Train Bowel Screening staff in the use of Making Every Contact Count (MECC)
Dental Pathway & referral management: develop and use agreed pathways
Dental Dashboard: improved reporting of dental activity

In March, following the COVID-19 outbreak, NHS England issued new guidance to Trusts and commissioners to the effect that a report on quarter 4 CQUIN performance was no longer required. This enabled maximum attention to be devoted to coping with the impact of COVID-19.

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.

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 2018/2019.

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

Care Quality Commission Ratings

The Trust was inspected between June 2019 and September 2019, with the final report being issued in December 2019. Three key services were inspected in June 2019 at both DMH and UHND: Surgery, End of Life Care and Urgent and Emergency Care. In addition, Trust-wide reviews of “Well-Led” arrangements and our Use of Resources were undertaken. The Trust received an overall Good rating, which was replicated for the significant majority of its services. We were delighted with this outcome, following two previous ‘Requires Improvement’ ratings; it validated the many improvements we have made, in services and in the wider organisation, and the excellent work undertaken by our staff, day in day out.

CQC’s report, published in December 2019, 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 and the further inspection reported in March 2018.

Overall ratings by Domain are set out below:

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

Use of Resources Assessment	Good

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

Darlington Memorial Hospital (DMH)

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

Ratings for Darlington Memorial Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good ↑ Oct 2019	Good →← Oct 2019	Good →← Oct 2019	Requires improvement →← Oct 2019	Good →← Oct 2019	Good ↑ Oct 2019
Medical care (including older people's care)	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018
Surgery	Good ↑ Oct 2019	Good →← Oct 2019	Good →← Oct 2019	Good →← Oct 2019	Good ↑ Oct 2019	Good ↑ Oct 2019
Critical care	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Maternity	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018
Services for children and young people	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
End of life care	Good ↑ Oct 2019	Good ↑ Oct 2019	Good →← Oct 2019	Outstanding ↑ Oct 2019	Outstanding ↑↑ Oct 2019	Outstanding ↑↑ Oct 2019
Outpatients and Diagnostic Imaging	Good Sept 2015	N/A	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015

University Hospital North Durham (UNHD)

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

Ratings for University Hospital of North Durham	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement →← Oct 2019	Good →← Oct 2019	Good →← Oct 2019	Requires improvement →← Oct 2019	Good →← Oct 2019	Requires improvement →← Oct 2019
Medical care (including older people's care)	Good Mar 2018	Requires improvement Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018
Surgery	Good ↑ Oct 2019	Good →← Oct 2019	Good →← Oct 2019	Good ↑ Oct 2019	Good ↑ Oct 2019	Good ↑ Oct 2019
Critical care	Requires improvement Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Maternity	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018
Services for children and young people	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
End of life care	Good ↑ Oct 2019	Good ↑ Oct 2019	Good →← Oct 2019	Outstanding ↑ Oct 2019	Outstanding ↑↑ Oct 2019	Outstanding ↑↑ Oct 2019
Outpatients and Diagnostic Imaging	Good Sept 2015	N/A	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015

Community Services

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

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

Key improvements since the 2017 inspection (reported in March 2018).

The Outstanding rating for the End of Life Care service recognises significant improvements in medical staffing, out of hours services, and leadership, and in the use of data on incidents, complaints and from audits to review and continually improve the service.

The Good rating for Surgery has been achieved following major improvements in safety practice, governance and leadership, which have seen a substantial reduction in the number of never events reported by the Care Group over the last few years.

Despite Urgent and Emergency Care at UHND retaining its 'Requires Improvements' rating, both at UHND and at DMH (which saw its rating improved to 'Good'), the Trust made significant improvements in safety practise, particularly with respect to medicines management and storage, compared to the previous inspection.

We were pleased that CQC saw and quoted many examples of outstanding practice, and rated the Caring Domain "Good" in all areas. The number of Must Do actions more than halved compared to the inspection reported in March 2018 and the number of outstanding practices saw a five-fold increase.

Key areas for improvement from the 2019 inspection and actions being taken

The overall rating of 'Requires Improvement' for the Safe Domain reflects the 2015 rating for Critical Care at UHND and the findings of the 2019 inspection for Urgent and Emergency Care. The actions agreed with CQC in 2015 regarding Critical Care – which involved providing critical care outreach and increased pharmacy support - have been fully implemented, but the rating will not be reviewed until the service is re-inspected.

The main areas for improvement from the most recent inspection concern the safety of urgent and emergency care services at UHND and the responsiveness of emergency care services on both main sites. With respect to the Safe Domain, key actions include making further progress in recruiting medical staff and in providing specially-staffed services for children attending A&E. Plans are in place, but currently on hold due to the Covid-19 incident response, to extend the opening hours of our Paediatric Assessment Unit at UHND, which is staffed by Paediatric specialists. In addition, we continue to pursue a wide range of initiatives to strengthen medical staffing including: international recruitment; use of specialist agencies; using the CESR training scheme to develop our own consultants and development of advanced nursing practitioner roles. CQC assess the responsiveness of our A&E services, primarily, in relation to A&E waiting times. The Trust is constrained – both in terms of the physical size of its A&E Departments, and staffing – in its ability to sustain what were (until the start of the Covid-19 pandemic) very high levels of demand. A comprehensive plan has been agreed with our system partners including short-term improvement actions and medium and long-term actions to improve staffing and A&E facilities, which is designed to facilitate significant improvements in performance over the next two years.

The following 'Must Do' actions were set out in CQC's report. An update on the status of each action is provided:

Action	Status
1. The Trust's Fit and Proper Persons Test should cover all statutory requirements	• The Trust's Fit and Proper Test Procedure has been amended and now covers all requirements. Previous gaps have been remediated.
2. Increase the coverage of training in the Mental Capacity Act and Deprivation of Liberty Safeguards	• The Trust trains all staff in Safeguarding Adults and in the core requirements of the MCA and DOLS. Additional training is provided to specialist staff and the Trust was meeting targets set prior to the suspension of mandatory training put in place in response to national guidance as part of the Covid-19 response.
3. Ensure compliance with training targets for the above	• See above.
4. Ensure consistent compliance with policy for syringe driver checks	• The policy has been reviewed, updated and republished and audits are planned to measure and improve compliance over time.

Action	Status
5. Ensure consistent compliance with policy for pain assessments / action (end of life care)	• The policy has been reviewed, updated and republished and audits are planned to measure and improve compliance over time.
6. Ensure safe and secure storage of medicines in all areas	• This was a specific issue related to pain assessments which has been addressed as part of the work outlined above.
7. Continue to strengthen paediatric nursing and medical staffing in A&E Departments	• Plans to expand the hours of opening of the Paediatric Assessment Unit at UHND will address the first part of this action, and the recruitment plans outlined above will address the second. Further work is being undertaken to increase access to paediatric nursing specialists for children attending the A&E Department at DMH. This may be within the Department, or through rapid transfer to back of house Paediatric Assessment Unit.
8. Ensure consistent compliance for Oxygen prescribing with British Thoracic Society (BTS) recommendations	• We have introduced new functionality in our Electronic Prescription Management and Administration System, together with periodic audits, which have resulted in much improved compliance with the BTS recommendations.
9. Ensure the availability of paediatrics-trained clinicians for children streamed away from the A&E Department	• See the commentary under 7 above.

Conclusion

We are clearly delighted with the recognition that the Good ratings provide, for both the Trust and all but one of its services. We have, however, have worked hard to implement the further improvements required by CQC and we are now are actively working on enhancements to services and key processes as we seek to consolidate our Good rating and embed further outstanding practices; as we strive to continuously improve services for our patients.

Data Quality

County Durham & Darlington NHS Foundation Trust submitted records during 2019/2020 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 M13
- which included the patients valid NHS number was:
  99.6% for Admitted Patient Care
  99.6% for Outpatient Care
  96.9% for Accident and Emergency Care
- which included the patient's valid General Medical Practice Code was:
  99.8% for Admitted Patient Care
  99.9% for Outpatient Care
  99.7% for Accident and Emergency Care

CDDFT have submitted a return for the Data Security and Protection Toolkit V1 2019/2020 and published 'standards met' status.

County Durham & Darlington NHS Foundation Trust was not subject to the Payment By Results clinical coding audit during 2019/2020 by the Audit Commission, however, internal audit carried out by our accredited audit yielded the following accuracy scores:-

Coded Data	% Correct	Level of Attainment
Primary Diagnosis	**98.50**	**Advisory**
Secondary Diagnosis	**98.92**	**Advisory**
Primary Procedure	**98.26**	**Advisory**
Secondary Procedure	**96.94**	**Advisory**

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. The sample size had a combined denominator of 200 Finished Consultant Episodes

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

- Monthly spot samples of discharges, comparing transfer and discharge times within the notes to the system recorded times.
- Monthly data quality group with corporate and care group representation feeding up to the Information Quality Assurance agenda with SIAO meeting.

- 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.

- Coding team to be aligned with Care Group specific specialty structured to aid better team working, coverage and skill mix and experience. Specialty specific workshops will be carried to facilitate this new way of working.

- Co-morbidity validation reporting at record level shared within clinical teams for validation and recode if documented Co-morbidity clinically signed off. Approximately 300-350 validation records created and distributed every month.

- In depth NHS Number status review process being carried out as mobilisation preparation for EPR implementation. This will move into contact and activity records during the mobilisation phase.
- Review of Community services data quality following initiation of Community Dataset transmissions to the National portal.

Cyber-Security and Data Protection

The Trust remain committed to achieving and maintaining the highest standards of data security and protection and continue to invest in world class monitoring software, technical controls and counter measures in order to protect the availability, integrity, confidentiality and resilience of all of its data assets.

The Trust continue to actively engage with NHS digital and its partner organisations in a continuous program of Cyber-Security improvement and have recently successfully completed work acting as a pilot adopter organisation for the review and implementation of a Unified Cyber Risk Framework.

This work has reinforced that the Trust's cyber-security strategy is fit for purpose as it continues to develop in line with an ever changing threat landscape and business need; while maintaining the principles of good governance, process management, user education and awareness coupled with highly focussed reporting and vigilance at its core.

The flexibility of this strategy allows the Trust to ensure it can deliver a highly effective means of maintaining protection and mitigation against threats whilst still providing secure, efficient and usable systems to our staff and partners.

The Trust can also report that in line with NHS digital compliance requirements it has submitted and published its Data Security and Protection Toolkit annual return, successfully achieving the publication status of 'Standards Met' for 2019/2020.

Learning from Deaths

During 2019/2020, 1975 of County 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:

474 in the first quarter;
460 in the second quarter;
495 in the third quarter;
546 in the fourth quarter.

By 31/03/19, 458 case record reviews and four investigations have been carried out in relation to 1975 of the deaths included above.

In four 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:

160 in the first quarter;
134 in the second quarter;
123 in the third quarter;
41 in the fourth quarter.

Four, representing 0.20% 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:

2 representing 0.4% for the first quarter;
1 representing 0.22% for the second quarter;
1 representing 0.20% for the third quarter;
0 representing 0% for the fourth quarter.

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

The key learning themes identified through those deaths identified in 2019/2020 have been in relation to adherence to policy, ensuring all observations are documented within Nervecentre and documentation. Learning identified through case record review overall has included escalation planning and decision making, recognition that a patient is reaching the end of their life and senior reviews.

Actions that County Durham and Darlington NHS Foundation Trust has taken in relation to the learning identified from those deaths in 2019/2020 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.

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

285 case record reviews and two investigations were completed after 1st April 2019 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 0.36% of the patient deaths during 2018/2019, were judged to be more likely than not to have been due to problems in the care provided to the patient.

PART 3 ADDITIONAL INFORMATION

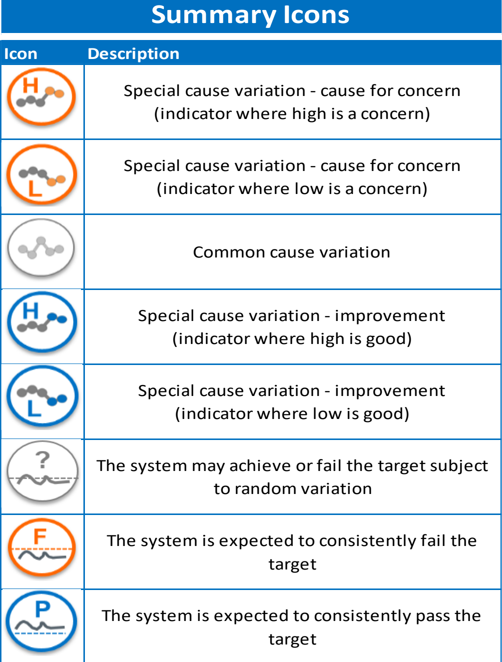
Financial Review

For 2019/20, the group annual accounts showed a **surplus** of **£11.486m**. From a regulatory perspective the Group Annual Accounts position is adjusted to remove the impact of the Charity consolidation and also the impact of the impairment included within the accounts. The table below highlights the adjusted surplus and reconciles the reported position against the Trusts NHSE/I control total for the 2019/20 financial year.

Performance Framework

The Trust has begun a review of the way it monitors and manages performance, commencing with reports to the Board. The Integrated Operational Performance Report to the Board is more streamlined and integrated. In line with the latest NHE/I recommendations from the “Making Data Count” initiative it makes extensive use of Statistical Process Control charts (SPCC). Work continues to cascade this form of reporting to other Board sub-committees and Care Groups. It has the advantages of: helping ask the right questions, providing clear messages, helping focus on the right issues and responding proportionately, improving governance and assurance.

Reports still use the Trust touchstone framework: Best Experience, Best Outcome, Best Efficiency and Best Employer. These align to the CQC key lines of enquiry.



Summary Icons

Icon	Description
H	Special cause variation - cause for concern (indicator where high is a concern)
L	Special cause variation - cause for concern (indicator where low is a concern)
	Common cause variation
H	Special cause variation - improvement (indicator where high is good)
L	Special cause variation - improvement (indicator where low is good)
?	The system may achieve or fail the target subject to random variation
F	The system is expected to consistently fail the target
P	The system is expected to consistently pass the target

NHS Constitutional Standards

Performance Measure	RO	Last Period		This Period		Variation Indicator	Target Indicator	Target	Target Type
Referral To Treatment % Within 18wks	CL	Feb-20	86.06%	Mar-20	82.04%	L	?	92.20%	NHSI Traj
Referral To Treatment Total Incompletes	CL	Feb-20	24,132	Mar-20	22,524	H	F	20,336	NHSI Traj
A&E % Seen Within 4 Hours (Type 1 and 3)	CL	Feb-20	78.60%	Mar-20	83.11%	L	?	89.56%	NHSI Traj
A&E Attendances (Type 1 and 3)	CL	Feb-20	20,165	Mar-20	16,434	H	?	17,561	NHSI Traj
A&E % Seen Within 4 Hours (Inc All UCC)	CL	Feb-20	78.60%	Mar-20	83.11%	L	?	89.56%	NHSI Traj
Cancer 2WW to Treatment Within 62 Days	CL	Jan-20	79.02%	Feb-20	83.42%		?	85.00%	National
DM01 Diagnostics % Within 6 Weeks	CL	Feb-20	99.20%	Mar-20	96.17%	L	?	99.00%	National

Best Experience

Performance Measure	RO	Last Period		This Period		Variation Indicator	Target Indicator	Target	Target Type
Non Elective / ED Access / Bed Management									
A&E % Seen Within 4 Hours - DMH (Type 1)	CL	Feb-20	65.54%	Mar-20	70.04%		-	-	-
A&E % Seen Within 4 Hours - UHND (Type 1)	CL	Feb-20	56.05%	Mar-20	70.45%		-	-	-
Ambulance handovers >15-30mins	CL	Feb-20	971	Mar-20	891			714	NHSI Traj
Ambulance handovers >30-60mins	CL	Feb-20	341	Mar-20	243			117	NHSI Traj
Ambulance handovers >60mins	CL	Feb-20	234	Mar-20	106			17	NHSI Traj
Ambulance Handovers - no. >120 minutes	CL	Feb-20	48	Mar-20	23	-		0	National
A&E Type 1 - Time to treatment (median)	CL	Feb-20	106	Mar-20	77			60	National
12 Hour Trolley Waits	CL	Feb-20	1	Mar-20	0	-		0	National
Community Bed Occupancy	CL	Feb-20	89.64%	Feb-20	89.64%			90.0%	Local
Delayed Transfers of Care	CL	Jan-20	0.8%	Feb-20	0.9%			<1%	Local
Long Stay Patients 7+ Days LoS	CL	Feb-20	348	Mar-20	305			301	Ambition
Long Stay Patients 14+ Days LoS	CL	Feb-20	199	Mar-20	177			159	Ambition
Long Stay Patients 21+ Days LoS	CL	Feb-20	124	Mar-20	115			77	Ambition

Performance Measure	RO	Last Period		This Period		Variation Indicator	Target Indicator	Target	Target Type
Elective, Theatres & Critical Care									
Cancelled Operations - Breaches of 28 Days	CL	Feb-20	0	Mar-20	1			0	Local
Urgent Operations cancelled for 2nd time	CL	Feb-20	0	Mar-20	0	-		0	Local
DNA % Rate	CL	Feb-20	8.15%	Mar-20	9.21%			6.96%	National Median
First to Follow Up Ratio	CL	Feb-20	1 : 1.78	Mar-20	1 : 1.82		-	-	-
Referral To Treatment % Within 18wks	CL	Feb-20	86.06%	Mar-20	82.04%			92.20%	NHSI Traj
Referral To Treatment Total Incompletes	CL	Feb-20	24,132	Mar-20	22,524			20336	NHSI Traj
Referral to Treatment 52 Week Breaches	CL	Feb-20	0	Mar-20	0			0	National
Referral to Treatment 18 Weeks Backlog	CL	Feb-20	3,364	Mar-20	4,045			-	National
Cancer 2WW	CL	Jan-20	91.06%	Feb-20	91.34%			93.00%	National
Cancer 2WW Breast Symptoms	CL	Jan-20	85.26%	Feb-20	75.41%			93.00%	National
Cancer 31 Days Diagnosis to Treatment	CL	Jan-20	98.76%	Feb-20	99.28%			96.00%	National
Cancer 2WW to Treatment Within 62 Days	CL	Jan-20	79.02%	Feb-20	83.42%			85.00%	National
Cancer 62 Days Consultant Upgrade	CL	Jan-20	80.00%	Feb-20	75.00%			85.00%	National

Performance Measure	RO	Last Period		This Period		Variation Indicator	Target Indicator	Target	Target Type
Admitted Care/ Friends and Family									
Discharge summaries within 24 hours	NS	Feb-20	91.0%	Mar-20	89.5%			95.0%	Local
Friends and Family Test - recommended rate Inpatients	NS	Feb-20	97.3%	Mar-20	96.2%		-	-	-
Friends and Family Test - recommended rate A&E	NS	Feb-20	92.8%	Mar-20	91.6%		-	-	-
Friends and Family Test - recommended rate Maternity	NS	Feb-20	100.0%	Mar-20	98.8%		-	-	-
Friends and Family Test - recommended rate Community	NS	Jan-20	98.52%	Feb-20	99.19%		-	-	-
% staff who would recommend the trust to Friends & Family needing care or treatment	MS	Q2 18/19	66.15%	Q2 19/20	74.24%			-	Local
Mixed Sex Accommodation Breaches	NS	Feb-20	0	Mar-20	0			0	National

Performance Measure	RO	Last Period		This Period		Variation Indicator	Target Indicator	Target	Target Type
Best Practice									
VTE	CL	Jan-20	95.72%	Feb-20	95.70%			95.0%	National
Sepsis Screening AE (Quarterly)	NS	Q2 19/20	100.0%	Q3 19/20	100.0%			100.0%	National
Sepsis Screening IP (Quarterly)	NS	Q2 19/20	100.0%	Q3 19/20	100.0%			100.0%	National
Dementia - eligible admissions screened	NS	Jan-20	90.28%	Feb-20	88.09%			90.0%	National
Dementia - AMTS compliance	NS	Jan-20	72.73%	Feb-20	69.57%			90.0%	National
Dementia - onward referrals	NS	Jan-20	100.0%	Feb-20	100.0%			90.0%	National

Best Outcome

Performance Measure	RO	Last Period		This Period		Variation Indicator	Target Indicator	Target	Target Type
Infection Control/ Incident Reporting/ Mortality/ Harm Free Care									
Clostridium difficile cases cumulative*	NS	Feb-20	44	Mar-20	49	-		45 PA	National
MRSA Bacteraemia cumulative*	NS	Feb-20	5	Mar-20	5	-	-	0	National
MSSA cumulative*	NS	Feb-20	34	Mar-20	35	-	-	-	-
Ecoli cumulative*	NS	Feb-20	357	Mar-20	385	-	-	-	-
Never events	NS	Feb-20	0	Mar-20	0			0	National
Serious Incidents reported <2 working days	NS	Feb-20	7	Mar-20	4		-	-	Local
Total number of incidents reported (Monitoring trends)	NS	Feb-20	1,651	Mar-20	1,360		-	-	Local
Serious Incident RCAs submitted within 60 working days	NS	Nov-19	60.00%	Dec-19	66.66%		-	-	Local
Compliments	NS	Dec-19	1,672	Jan-20	1,912		-	-	Local
Crude Mortality (rolling 12 months)	NS	Oct-19	4.22%	Nov-19	4.27%		-	-	-
HSMR (rolling 12 months)	NS	Oct-19	101.12	Nov-19	100.01		-	-	-
SHMI (rolling 12 months)	NS	Oct-19	112.99	Nov-19	113.62		-	-	-
Reduction in Falls - Acute (per 1000 beddays) (Cumulative)	NS	Feb-20	5.7	Mar-20	5.8			5.4	Local
Reduction in Falls - Community (per 1000 beddays) (Cumulative)	NS	Feb-20	5.7	Mar-20	5.8			6.0	Local
Grade 3 & 4 newly acquired avoidable pressure ulcers - Acute	NS	Nov-19	0	Dec-19	1			0	Monitoring
Grade 3 & 4 newly acquired avoidable pressure ulcers - Community	NS	Nov-19	0	Dec-19	1			0	Monitoring
Grade 2 newly acquired avoidable pressure ulcers - Acute	NS	Nov-19	2	Dec-19	1			0	Monitoring
Grade 2 newly acquired avoidable pressure ulcers - Community	NS	Nov-19	0	Dec-19	0			0	Monitoring

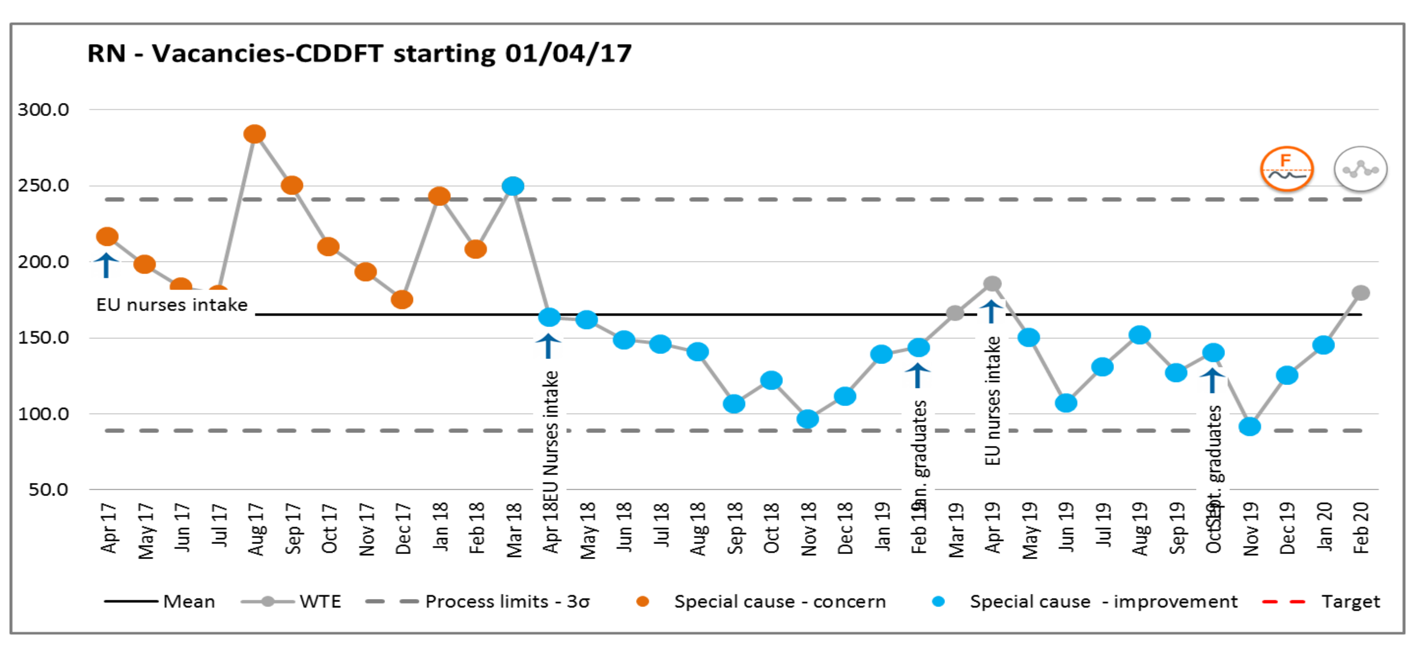
Best Employer

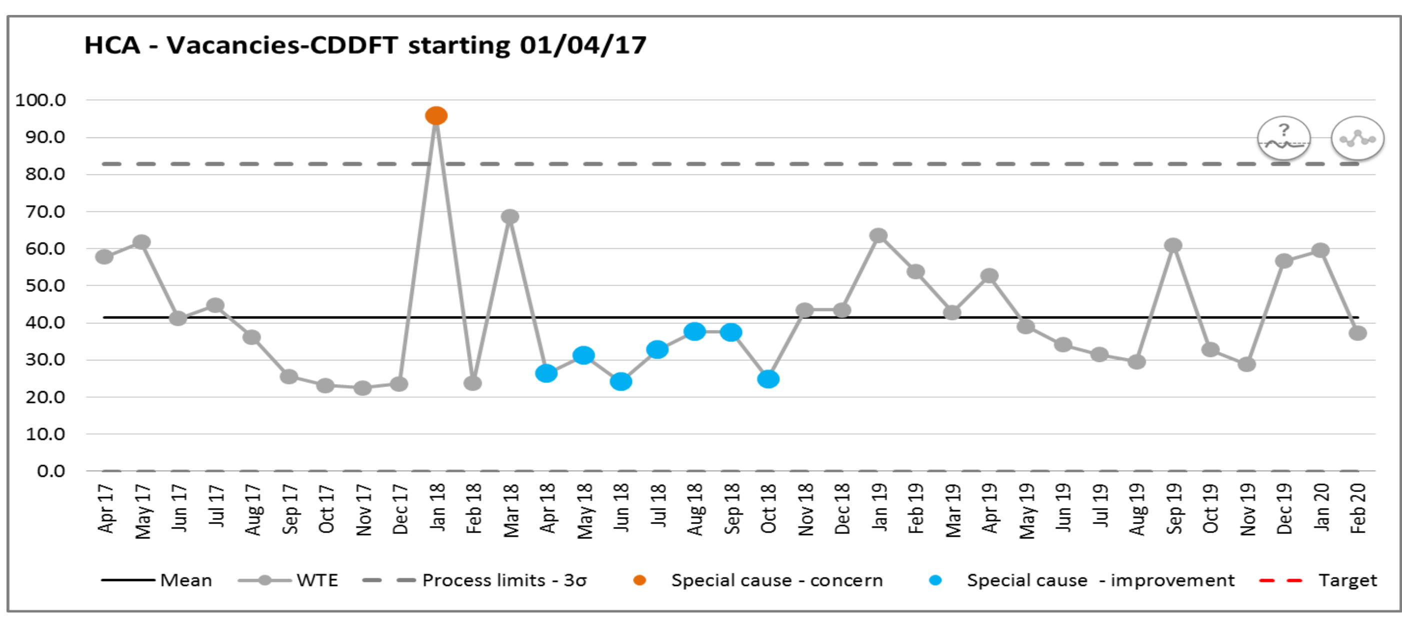
Feb-20	Care Hours Per Patient Day (CHPPD)					Day			Night		
Ward name	Cumulative count over the month of patients at 23:59 each day	Registered Nurses/ Midwives	Non-registered Nurses/ Midwives	Non-registered Nursing Associates	Overall	Average fill rate - Registered Nurses/ Midwives (%)	Average fill rate - Non-registered Nurses/ Midwives (care staff) (%)	Average fill rate - Non-Registered Nursing Associates (%)	Average fill rate - Registered Nurses/ Midwives (%)	Average fill rate - Non-registered Nurses/ Midwives (care staff) (%)	Average fill rate - Non-Registered Nursing Associates (%)
Ward 4 Stroke Rehab Unit BAGH (0248)	757	2.4	2.7	0.0	5.1	87.2%	101.4%	-	81.1%	96.8%	-
Ward 16 BAGH [0249]	810	2.6	4.0	0.0	6.6	88.6%	112.0%	-	86.5%	127.6%	-
Ward 18 BAGH [1409]	131	11.1	6.5	0.0	17.7	91.0%	75.2%	-	70.8%	117.2%	-
Ward 6 BAGH [0243]	596	2.5	4.4	0.0	6.9	75.2%	142.1%	-	69.9%	159.6%	-
Ward 1 C-L-S [0307]	558	3.0	3.4	0.0	6.4	89.5%	154.5%	-	97.1%	134.1%	-
AMU DMH (1203)	683	5.8	3.3	0.1	9.2	100.0%	101.4%	37.4%	97.8%	92.0%	-
CCU DMH [0202]	221	6.5	1.4	0.0	7.9	83.0%	109.6%	-	81.7%	-	-
Critical Care DMH (1619)	236	24.8	2.2	0.0	27.0	100.8%	86.9%	-	90.1%	110.5%	-
Ward 42 DMH [0206]	228	6.5	1.6	0.0	8.1	79.0%	81.9%	-	100.0%	86.2%	-
SCBU DMH [2203]	133	10.8	5.4	0.0	16.2	93.4%	-	-	102.3%	-	-
Ward 21 DMH [2201]	279	14.5	2.8	0.0	17.3	96.0%	89.4%	-	89.6%	82.8%	-
Ward 31 DMH (1204)	583	3.9	4.6	0.4	8.9	116.6%	147.2%	100.0%	103.8%	170.5%	100.0%
Ward 32 DMH (1205)	729	3.4	3.8	0.0	7.2	99.7%	204.9%	-	140.0%	175.4%	-
Orthopaedic Unit DMH (1402)	621	3.2	2.8	0.3	6.3	85.0%	80.1%	100.0%	59.3%	98.9%	100.0%
Ward 41 DMH [0205]	777	2.5	3.2	0.0	5.6	85.2%	111.8%	-	98.3%	119.8%	-
Ward 43 DMH [0207]	839	2.3	2.7	0.0	5.0	80.3%	108.7%	-	79.0%	117.9%	-
Ward 44 DMH [0208]	737	3.7	2.5	0.0	6.2	108.1%	105.7%	-	89.7%	93.0%	-
Ward 51 DMH (0233)	724	2.5	2.4	0.1	5.0	80.0%	103.9%	35.0%	101.1%	101.7%	-
Ward 52 DMH (0211)	876	2.0	4.0	0.0	6.0	55.9%	105.9%	-	77.6%	156.5%	-
Ward 61 DMH [0706]	554	4.0	2.4	0.0	6.4	106.3%	92.8%	-	83.6%	97.2%	-
Ward 62 DMH [0705]	274	5.4	2.5	0.0	7.9	98.7%	104.2%	-	100.0%	-	-
C-Hosp Richardson, Starling Ward (401018)	372	4.2	3.6	0.3	8.0	82.9%	100.7%	70.4%	90.9%	75.7%	100.0%

Best Efficiency

Performance Measure	RO	Last Period		This Period		Variation Indicator	Target Indicator	Target	Target Type
Finance/ Workforce									
Sickness	MS	Jan-20	5.54%	Feb-20	4.95%			<4%	Local
Appraisals	MS	Jan-20	73.7%	Feb-20	79.4%	-	-	95.0%	Local
Essential Training	MS	Jan-20	93.78%	Feb-20	94.85%	-	-	95.0%	Local
Voluntary Turnover	MS	Jan-20	7.48%	Feb-20	7.69%			9.0%	Local
Vacancy rate - nursing qualified	MS	Jan-20	145.29	Feb-20	179.52	-	-	-	-
Vacancy rate - nursing unqualified	MS	Jan-20	59.49	Feb-20	37.30	-	-	-	-
Performance against NHSI Plan excluding PSF, FRF and MRET funding (Cumulative)	DB	Jan-20	£106	Feb-20	£107	N/A		-	National
Cost Reduction (£000s) (cumulative)	DB	Jan-20	£16,211	Feb-20	£20,202	N/A		£16,211	National
Agency use (£000's) (cumulative)	DB	Jan-20	£7,109	Feb-20	£7,860			£14,855	National
Cash Balance	DB	Jan-20	£2,319	Feb-20	£2,319	N/A		-£4,879	Local
Capital Spend (£000's) (cumulative)	DB	Jan-20	£11,556	Feb-20	£11,556	N/A		£21,236	National

Examples of SPC charts showing the trend in nurse & health care assistant vacancies





Performance Risks

Non-elective pressures

The Trust's main operational and performance risk is the ability to provide Urgent and Emergency Care to the standards expected. As detailed previously, ED activity grew at an unprecedented rate from the start of the year until the impact of the COVID-19 virus was felt in mid-March 2020. Although COVID funding is enabling the Trust to open a significant number of additional escalation beds temporarily, sustainable long term success will only come by dealing with the physical capacity constraints in both EDs, supported by whole system actions as agreed at the October 2019 Summit.

Elective pressures: 18 weeks RTT

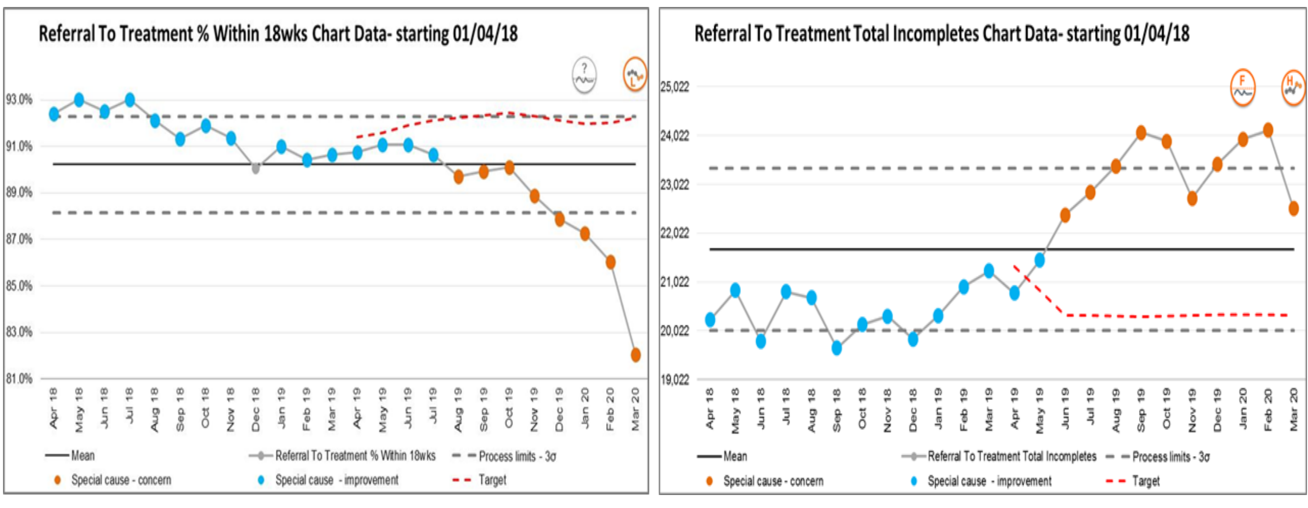
Elective pressures have grown over the latter half of the year, albeit they have been mitigated somewhat by a reduction in referrals. Over the period Apr 19- Feb 20, referrals fell by 1.8% mainly due to a fall of 2.6% in GP referrals.

Referrals Apr 2019-Feb 2020

	2018-19	2019-20	Variance	% variation
GP	89191	86916	-2275	-2.6%
Non-GP	68546	67910	-636	-0.9%
Total	157737	154826	-2911	-1.8%

Following the COVID-19 outbreak, with effect from 19th March 2020 the Trust has no longer been accepting routine referrals. The only exceptions are 2ww referrals (eg: cancer). Consequently, referral volumes fell by 36.6% in March (38.7% from GPs). This contributed to a total fall in referrals for the year of 7.6% including a fall of 5.7% in GP referrals.

The build-up of elective pressures exerted a negative effect on performance against the 18 week RTT standard through much of the year.



The key factors driving these trends have included:

- Growth in non-elective activity, both medical and trauma, resulting in cancellations of surgical sessions to create beds for emergency patients.
- Capacity constraints, including: core bed availability; staffing resources (consultants, theatre and endoscopy nurses and other specialist roles such as breast radiologists, where there are national shortages); changes to Central Sterile Services Department (CSSD) which has created unexpected equipment issues.

Specialty recovery action plans are in place. The actions being taken in the Specialties most affected include:

- **Breast surgery, Orthopaedics and some diagnostics:** targetted recruitment and continued use of Independent sector (IS) support.

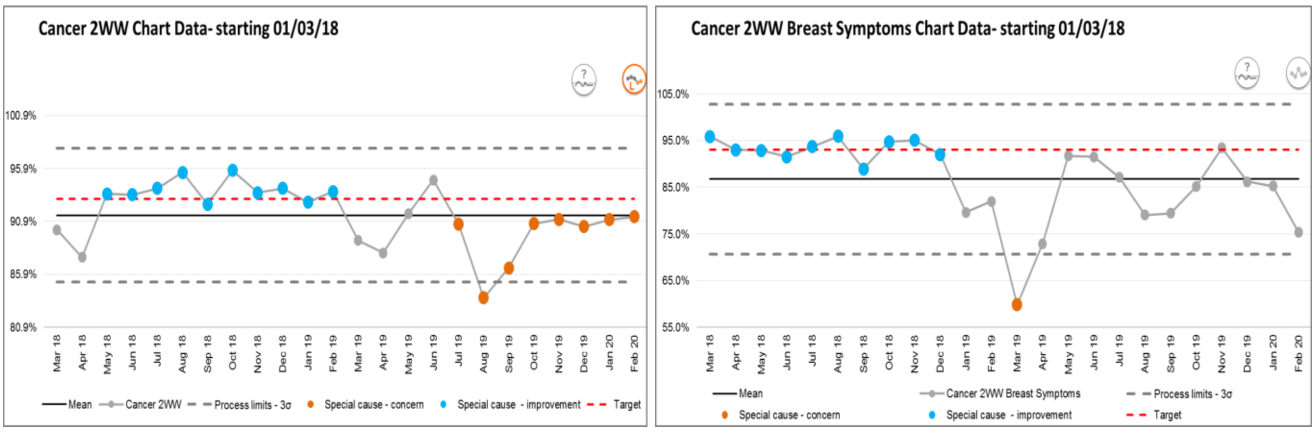
- **Rheumatology:** new physio and pharmacy – led models of care. An additional consultant has recently been appointed.
- **Dermatology and Plastics:** a new tele-skin service for all 2-week wait cancer referrals to dermatology or plastics. All referrals are accompanied by photographs of the lesion and are triaged within one working day by a dermatology consultant. Only 70% of such referrals turn out to need a referral into a two-week wait slot, either dermatology or plastics. The remainder are triaged to more appropriate pathways, including into routine clinics, or 13% back to the GP with advice on Primary Care management.

For patients caught up in the suspension of elective activity due to the COVID-19 crisis, clinicians are being asked to conduct telephone triage to ensure all urgent cases receive prompt attention. For others, it may be appropriate to remain on the list until an out-patient appointment or a procedure can be arranged; for yet others it may be appropriate to discharge them. Care Groups are also being asked to take the opportunity to carefully validate existing lists.
The Trust also continues to provide services designed to enable GPs to manage more patients in Primary Care:

- Advice and Guidance. This nationally mandated service requires Trusts to provide advice and guidance for GPs as an alternative to an out-patient appointment. Each week in 2020 to date GPs have made an average of 138 such requests.
- Bed bureau. This IMS initiative has been established to provide GPs with a senior source of advice in relation to patients whom they are considering sending to A&E or admitting.
- Alternative out-patient models: as an alternative to the traditional out-patient appointment, the Trust is exploring other options such telephone consultations or extending the tele-skin service to other Specialties.

Cancer

The main cancer access standards are: first appointment within two weeks (2ww), first appointment for breast symptomatic 2ww referral, 31 days to start of treatment from decision to treat, and 62 days from 2ww referral to treatment. The Trust routinely meets the 31-day target, but it is becoming more challenging to consistently meet the other standards due to activity pressures described earlier in the report. The Trust is one of the few Trusts nationally to achieve the 62-day standard although performance has weakened as the year has progressed.



Performance to the end of February is:

Indicator	Target	Performance
2ww	93%	91.34%
2ww breast symptomatic	93%	75.41%
31 day diagnosis to treatment	96%	99.28%
2ww to treatment within 62 days	85%	83.42%

Other key performance risks:

Finance: four of the five Care Groups, Community being the exception, have been in financial escalation throughout the year mainly due to difficulties in identifying substantial cost improvement schemes which do

not adversely affect core service provision. Monthly Finance clinics for each Care Group continue to operate with executive input.

Workforce: in common with many Trusts, CDDFT is affected by a shortage of nurses and relies heavily on bank and agency staff. Gaps in the medical workforce are concentrated in specific specialties.

Sickness absence continues to be an issue. The two main reasons continue to be musculo-skeletal and mental health/stress.

Recruitment and health and well-being continue to be key objectives for the Trust in 2020-21.

Priorities for 2019/2020

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	2017/2018	2018/2019	2019/2020 (provisional)
Readmission within 28 days of discharge[1]										
CDDFT Age 0-15 years	10.4	10.3		11.8	12.1	11.8	13.5	12.2	12.5	12.7
National high	14.1	14.9		17.2	19.0	17.4	17.9	18.3	20.8	18.1
National low	0.0	0.0		0.0	0.0	3.9	0.0	2.7	4.4	3.9
CDDFT Age 16 + years	12.0	12.1		12.7	12.1	12.5	12.5	12.7	13.7	13.4
National high	14.1	13.8		18.0	16.3	16.3	15.9	16.7	18.1	20.7
National low	0.0	0.0		7.8	7.6	7.8	6.8	9.8	10.2	10.9
CDDFT MRSA per 100,000 bed days[3]	1.4	1.1	0.9	0.6	1.8	0.7	1.7	0.7	0.8	1.4
North East	2	2	1	1	1	0.8	1.1	0.7	0.5	0.6
England	3	2	1	1	0.8	0.9	0.9	0.8	0.7	0.7
National high	9	9	10	11	3.2	6.5	2.7	5.8	6.8	3.7
National low	0	0	0	0	0	0	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	7.2	7.6	8.9
England	29.7	22.3	17.4	14.7	15	14.9	13.2	13.7	14.1	15.2
National high		71.2	58.2	30.8	37.1	58.11	28.4	31.56	90.0	59.7
National low		0	0	0	0	0	2.8	3.98	0.0	0.0
Patient Reported Outcome measures (PROM) – case mix adjusted health gain[1]	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/2018	2018/2019	2019/2020 (provisional)
CDDFT PROM Groin Hernia	0.100	0.120	0.098	0.081	0.064	0.075	0.072	0.090		
England	0.080	0.090	0.085	0.085	0.084	0.088	0.086	0.089		
National high	0.140	0.120	0.140	0.150	0.140	0.160	0.135	0.137		
National low	0.010	0.030	0.030	0.010	0.010	0.020	0.006	0.029		

CDDFT PROM Hip	0.430	0.380	0.380							
England	0.410	0.410	0.410							
National high	0.480	0.470	0.470							
National low	0.290	0.260	0.320							
CDDFT PROM Hip Replacement Primary				0.405	0.440	0.394	0.433	0.456	0.472	0.406
England				0.436	0.436	0.438	0.445	0.468	0.465	0.475
National high				0.540	0.540	0.510	0.537	0.566	0.557	0.562
National low				0.320	0.310	0.320	0.310	0.376	0.348	0.406
CDDFT PROM Hip Replacement Revision				NA	NA	NA	NA	NA	N/A	N/A
England				0.260	0.277	0.283	0.290	0.289	0.287	0.295
National high				0.350	0.370	0.370	0.362	0.322	0.396	N/A
National low				0.170	0.160	0.220	0.239	0.142	0.206	N/A
CDDFT PROM Knee	0.320	0.290	0.300							
England	0.300	0.300	0.300							
National high	0.370	0.380	0.370							
National low	0.170	0.200	0.180							
CDDFT PROM Knee Replacement Primary				0.311	0.295	0.323	0.331	0.344	0.337	0.390
England				0.323	0.315	0.320	0.325	0.338	0.338	0.349
National high				0.420	0.430	0.400	0.404	0.417	0.405	0.435
National low				0.210	0.220	0.200	0.247	0.234	0.266	0.262
CDDFT PROM Knee Replacement Revision				NA	NA	NA	NA	NA	N/A	N/A
England				0.248	0.261	0.258	0.273	0.292	0.288	0.331
National high				0.370	0.320	0.340	0.296	0.328	0.297	N/A
National low				0.200	0.120	0.190	0.156	0.196	0.196	N/A

	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/2018	2018/19	2019/20
CDDFT VTE assessment Trust				**95.10%**	**95.65%**	**95.99%**	**96.83%**	**96.45%**	**96.10%**	**96.03%**
National Low				**82.10%**	**92.00%**	**79.93%**	**76.68%**	**84.77%**	**74.03%**	**71.84%**
National High				**100.00%**	**100.00%**	**99.76%**	**99.88%**	**99.53%**	**99.86%**	**99.87%**

YEAR	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/2018	2018/19	
CDDFT Responsiveness to personal needs of the patient[1]	71.5	67.9	68.5	73.3	65.3	68.8	66.0	69.3	70.4	
England	67.3	67.4	68.1	68.7	68.9	69.6	68.1	68.6	67.2	
National high	82.6	85	84.4	84.2	86.1	86.2	86.2	85.0	85.0	
National low	56.7	56.5	57.4	54.4	59.1	58.9	54.4	60.5	58.9	

YEAR	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/2018	2018/19	2019/20 provisional
CDDFT Percentage of staff who would recommend the trust to their family or friends[1]	49%	50%	57%	53%	57%	57%	61%	55%	60%	63%
England					68%	70%	71%	72%	73%	73%

National high		94%	94%	93%	92%	91%	90%	97%	92%	92%
National low		35%	40%	35%	31%	43%	43%	31%	38%	20%

	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	65.2	104.5	101.9	
	Jul 12 - Jun 13	115.6	62.6	104.3	101.9	
	Octr 12 - Sep13	118.6	63	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	N/A	Peer was via CHKS
	Apr 14 – Mar 15	121	67	101.0	N/A	Peer was via CHKS
	Jul 14 – Jun 15	120.9	66.1	100.7	N/A	Peer was via CHKS
	Oct14 – Sep 15	117.7	65.2	99.6	N/A	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	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	104.9	105.3	
	Oct 16 - Sep 17	124.7	72.7	104.6	101.9	
	Jan17-Dec17	121.81	72.04	104.5	102.4	
	Apr17-Mar18	123.21	69.94	106.1	103.3	
	Jul17-Jun18	125.72	69.82	108.2	103.4	
	Oct17-Sep18	125.41	69.53	109.2	102.0	
	Jan18-Dec18	122.64	69.93	109.9	102.3	
	Apr18-Mar19	120.58	70.69	111.2	101.3	
	Jul18-Jun19	119.16	69.67	111.6	101.0	
	Oct18-Sep19	118.77	69.79	113.4	101.9	
	Jan19-Dec19	119.99	68.89	115.1	102.8	
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			2 (As Expected)		13 Trusts higher than expected
	Apr17-Mar18			2 (As Expected)		13 Trusts higher than expected
	Jul17-Jun18			2 (As Expected)		15 Trusts higher than expected
	Oct17-Sep18			2 (As Expected)		15 Trusts higher than expected
	Jan18-Dec18			2 (As Expected)		11 Trusts higher than expected
	Apr18-Mar19			2 (As Expected)		13 Trusts higher than expected
	Jul18-Jun19			2 (As Expected)		9 Trusts higher than expected
	Oct18-Sep19			1 (Higher than expected)		8 Trusts higher than expected
	Jan19-Dec19			1 (Higher than expected)		10 Trusts higher than expected
The percentage of patient deaths with palliative care coded	Apr 12 - Mar 13	44.00%	0.10%	12.80%		
	Jul 12 - Jun 13	44.10%	0.00%	14.00%		
	Octr 12 - Sep13	44.90%	0.00%	14.10%		
	Jan - Dec 13	46.90%	1.30%	15.90%		
	Ap 13 - Mar 14	48.50%	0.00%	17.80%		
	Jul 13 - Jun 14	49.00%	0.00%	18.70%		
	Oct 13 - Sep 14	49.40%	0.00%	19.00%		
	Jan – Dec 14	48.30%	0.00%	17.70%		
	Apr 14 – Mar 15	50.85%	0.00%	17.18%		
	Jul 14 – Jun 15	52.90%	0.00%	17.39%		
	Oct14 – Sep 15	53.53%	0.20%	18.59%		
	Jan 15 - Dec 15	54.75%	0.19%	21.12%	26.14%	
	Apr 15 - Mar 16	54.60%	0.58%	24.22%	27.55%	
	Jul 15 - Jun 16	54.83%	0.57%	26.58%	27.84%	
	Oct 15 - Sep 16	56.27%	0.39%	28.19%	28.06%	
	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	60.34%	11.70%	38.86%	29.48%	
	Apr17-Mar18	59.02%	12.58%	42.76%	30.10%	

	Jul17-Jun18	58.70%	13.40%	44.80%	30.53%	
	Oct17-Sep18	59.20%	14.30%	43.12%	31.50%	
	Jan18-Dec18	59.74%	15.14%	41.42%	32.50%	
	Apr18-Mar19	60.00%	12.32%	38.80%	32.98%	
	Jul18-Jun19	59.57%	6.82%	40.15%	33.67%	
	Oct18-Sep19	58.68%	11.96%	41.80%	34.00%	
	Jan19-Dec19	59.80%	9.88%	44.80%	34.86%	

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 since the introduction of the 3 year Falls Strategy but further work is required. 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. We aim to have a 30% reduction overall at the end of 2020/21 when we reach the end of the 3 year strategy.
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 year two of the Falls Strategy and agree priorities for year three.
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 blood stream infections can cause serious illness and this is a mandatory indicator.
Our aim
We aim to have zero patients with avoidable hospital acquired MRSA bacteraemia as set by as set by NHS England guidance.
Our actions

We will continue to hold 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 post infection review 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 **44** identified with *Clostridium difficile* infection that are attributed to the trust. Due to COVID-19 pandemic, improvement goals have not been set for 2020/21 but we have made a local decision to reduce the threshold by one case on 2019/20 aim.

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

All 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 HCAI reduction group, Infection Control Committee and reported to Trust Board. Reported cases will be subject to a comprehensive review to ensure that any remedial actions are addressed.

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 advise any change in practice, 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 patients both within hospital or community settings continue to be 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 equipment 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. 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?

Communication should be timely and of a high standard when patients are discharged back to the care of their own GP. This ensures the GP is aware of the patient's admission and of any prescription or other changes that have taken place or are recommended by the discharging consultant. In addition, if a patient has died in hospital, it is important to advise the GP promptly to avoid any potential distress to relatives should the Practice attempt to contact them, unaware of the patient's decease.

Over the course of the year Trust-wide performance has consistently exceeded 90%, with the medical specialty (IMS) increasingly frequently achieving the target.

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 monthly Performance Review meetings and the Board and its IQAC sub-committee. The 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 those 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 results 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.

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. The indicator relating to nutrition care planning remains an area for improvement. Nutrition care planning has been incorporated into the Registered Nurses mandatory training. This is an area we will continue to monitor closely, providing support to ward areas where required.
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
- Continue to deliver palliative care mandatory training for all staff.
- Support and monitor new out of hours advice service
- Develop and deliver actions from VOICES survey

Measuring and monitoring

- Achieve interim targets for mandatory three year education programme (33% at end of year 1)
- Continuing improvement in palliative care coding
- Continuing improvement in ''death in usual place of residence'' (DIUPR)
- Maintain Achievement of Preferred Place of Death (specialist Palliative Care Service) at over 90%

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

To maintain improvement in results from inpatient surveys and remain within or better than national average for the indicators

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 Integrated Quality Assurance 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, 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, some of which may be entirely appropriate; but they can be an indicator of an unsuccessful discharge. 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 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. The development of Teams Around Patients (TAPs), in particular, will improve the delivery of robust multi-disciplinary care.

Measuring and monitoring

Internally, the Trust monitors re-admissions at operational level via monthly Performance Reviews. At strategic level re-admissions are reported to the Board and to its IQAC sub-committee. At a system level, the LADB monitors both emergency admissions and re-admissions.

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

Why is this a priority?

This is an NHS Constitution right. Patients should be treated in a timely manner. It is also important to prevent overcrowding within ED. If not, cubicles in A&E blocked with patients waiting for an in-patient bed slow the process of care for everyone, creating additional risk and inconvenience for all patients, and leading to ambulance handover delays.

Our aim

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

Our actions

Pressures in Urgent and Emergency Care are an indicator of pressures in the wider health and social care system. The Trust's #nextstephome initiative is the main improvement vehicle. However, in the autumn, the Trust and its key partners held a successful Summit to generate actions to improve the whole system. This is now being implemented.

Measuring and monitoring

The Trust continues to report in line with national requirements. Internally, performance is reported to the Board and its IQAC sub-committee and is monitored operationally via monthly Performance Reviews of the IMS Care Group. Externally, monthly reports are provided to the Local A&E Delivery Board, chaired by the Trust's Chief Executive and to NHS regulatory bodies. .

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 community emergencies as they arise. This creates a risk for patients in the community and for the two local ambulance providers, North East (NEAS) and Yorkshire (YAS) Ambulance services.

Our aim

We aim to take over the care of patients arriving by ambulance within 15 minutes of their arrival at A&E. The Trust subscribes to the regional zero tolerance approach to ambulance handover delays.

Our actions

We continue to work with partners in the local A&E Delivery Board to improve patient flow through ED and to extend the opening times of dedicated handover bays to meet the growing demands and pressures.

Measuring and monitoring

All >30 minute handover delays are reported and any >120 minute delays are individually reviewed. Handover performance is governed by standard national definitions. Internally, performance is reported to the Board and its IQAC sub-committee and is monitored operationally via monthly Performance Reviews of the IMS Care Group. Externally, monthly reports are provided to the Local A&E Delivery Board, chaired by the Trust's Chief Executive

RTT

Why is this a priority?

Patients have a right under the NHS Constitution to be treated within 18 weeks.

Our aim

To provide treatment for patients within 18 weeks of referral 92% of the time.

Our actions

We continue to work with CCG commissioners and social care partners, reviewing and modernising care pathways and increasing the provision of advice and guidance services for GPs to reduce unnecessary referrals and in-patient admissions, and to provide more care closer to home. An innovative development this year is the introduction of a tele-skin service. All potential skin cancer referrals are accompanied by photos of the lesions and are triaged in a virtual clinic within one working day by a consultant. This has improved the use of 2ww cancer out-patient capacity by reducing demand for urgent appointments by 30%.

Measuring and monitoring

This issue is governed by national definitions and reporting arrangements. This is a statutory target which is reviewed in a range of regular forums, including regular reports to the Trust Board and its IQAC sub-committee.

Cancer

Why is this a priority?

Early diagnosis and treatment is important for successful treatment and outcomes for cancer patients. Cancer targets are also NHS Constitution standards.

Our aim

To provide timely treatment for all potential cancer patients.

Our actions

The Trust routinely updates its Cancer Services Action Plan.to ensure its ambitions for cancer care are achieved. This includes the proposed Faster Diagnosis standard which is expected to come into effect from April 2020.

Measuring and monitoring

Cancer activity is governed by national definitions and statutory reporting arrangements and standards. Performance is reviewed in a range of fora, including regular reports to the Trust Board and its IQAC sub-committee.

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

We will continue to 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 continue to embed learning from the gap analysis around compliance with this standard 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 and ensuring that care between primary and secondary settings is streamlined by the provision of increased education and improved accessibility to GPs.

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.

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

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

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

NHS North Durham CCG
Sedgefield Community Hospital
Salters Lane
Sedgefield
Stockton-on-Tees
TS21 3EE

Feedback from Darlington Borough Council Health and Partnerships Scrutiny Committee

County Durham and Darlington NHS Foundation Trust – Draft Quality Account 2018/19

Feedback from Healthwatch Darlington

DURHAM COUNTY COUNCIL ADULTS WELLBEING AND HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Transformation & Partnerships
Durham County Council, County Hall, Durham DH1 5UF
Main Telephone 03000 26 0000

Text Messaging Service 07860 093 073

Feedback from Health and Wellbeing Board

Contact:
Direct Tel: 03000 268 801
email:
Your ref:
Our ref:

Yours sincerely,

Feedback from Healthwatch County Durham

Statement of Directors' Responsibility in Respect of the Quality Report

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

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

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

- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2018 to March 2019;
  - papers relating to quality reported to the board over the period April 2018 to March 2019;
  - feedback from commissioners dated 30th April 2019;
  - views of governors shared at meetings of the Council of Governors Quality and Healthcare Governance Committee during 2018/2019 and the joint Trust Board and Council of Governors meeting held on 22nd May 2019;
  - feedback from local Healthwatch organisations dated 7th May 2019 and 14th May 2019;
  - feedback from Durham County Council Adults Wellbeing and Health Overview and Scrutiny Committee dated 14th May 2019;
  - feedback from Durham County Council Health and Wellbeing Board dated 9th May 2019.
  - feedback from Darlington Borough Council Health and Partnership Scrutiny Committee dated 8th May 2019;
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
  - the 2017 national patient survey;
  - the 2018 national staff survey;
  - the 2018/2019 Head of Internal Audit's annual opinion over the trust's control environment; and
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, confirms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual).

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

By Order of the Board:

NB: Sign and date in any colour ink except black

………24/05/19………………………Date ………………………………………………Chairman

………24/05/19………………………Date ………………………………………………Chief Executive

GLOSSARY OF TERMS

Accident and Emergency (A&E) - hospital department that assesses and treats people with serious injuries and those in need of emergency treatment (also known as Emergency Departments).

Acute – describes a disease or injury of rapid onset, severe symptoms and brief duration. In the context of a hospital, 'acute' describes a facility for the treatment of such diseases and injuries.

Benchmarking – process that helps professionals to take a structured approach to the development of best practice.

BAH - Abbreviation used to refer to Bishop Auckland Hospital

Board of Directors – the powers of a Trust are exercised by the Board of Directors (also known as the Trust Board). In a foundation Trust, the Board of Directors is accountable to governors for the performance of the Trust.

Clinical Care Group / Care Group – one of the Trust's five operating divisions, which include Integrated Medical Specialties, Surgery, Clinical Specialist Services, Community Services and Family Health.

Cavendish Review – An independent review, held in the wake of the Francis enquiry into Mid-Staffordshire Hospitals NHS Trust, which made recommendations with respect to the recruitment development and support of unregistered staff working in health and social care.

CDDFT – Abbreviation used to refer to County Durham and Darlington NHS Foundation Trust

CHP – Abbreviation used to refer to Combined Heat and Power

Clinical Commissioning Groups (CCGs) – Entities which are responsible for commissioning many NHS funded services under the new Health and Social Care Act 2012, established 1 April 2013.

Clostridium difficile (C.Difficile or CDIFF) – a health care associated intestinal infection that mostly affects elderly patients with underlying diseases.

CoG - Abbreviation used to refer to a Council of Governors.

Commissioning for Quality and Innovation (CQUIN) – a payment framework developed to ensure that a proportion of a providers' income is determined by their work towards quality and innovation.

Community based health services – services provided outside of a hospital setting, usually in clinics, surgeries or in the patient's own home.

Community hospitals - local hospitals providing a range of clinical services.

Cost Improvement Programme – an on-going cycle of work to improve processes to enhance quality and improve productivity and efficiency, subject to annual targets within our annual operating plans agreed with NHS Improvement.

DDES – Durham Dales, Easington and Sedgefield Clinical Commissioning Group

DMH – Abbreviation used to refer to Darlington Memorial Hospital

ED – Abbreviation used to refer to Emergency Department

FFT – Abbreviation used to refer to the Friends and Family Test

Foundation Trust (FT) – NHS hospitals that are run as independent public benefit corporations and are controlled and run locally.

Freedom to Speak Up Guardian – a role created following the national 'Freedom to Speak Up' review which examined arrangements in the NHS to support staff raising concerns about care. The role is independent of management and reports to the Chief Executive and the Board. The Guardian's role is to support the development of an environment in which staff are supported in raising concerns, to encourage them to do so, and to monitor the effectiveness with which concerns are looked into and acted upon.

GP – Abbreviation used to refer to a General Practitioner

Healthcare Associated Infection (HCAI) – infections such as MRSA or *Clostridium difficile* that patients or health workers may acquire from a healthcare environment such as a hospital or care home.

Hospital Standardised Mortality Ratio (HSMR) – the number of deaths in a given year as a percentage of those expected.

Health and Wellbeing Boards (HWB) – Boards comprised of health and social care commissioners and the consumer watchdog (Healthwatch), in place to oversee the development and delivery of a joint health and well-being strategy and plans for the geographical areas which they cover.

Infection Control – the practices used to prevent the spread of communicable diseases.

Methicillin-Resistant Staphyloccus Aureus (MRSA) – bacterium responsible for several difficult to treat infections.

MUST - Abbreviation used to refer to Malnutrition Universal Screening Tool

National tariff (tariff) – centrally agreed list of prices for particular procedures; linked to the Payment by Results policy.

NCEPOD - Abbreviation used to refer to National Confidential Enquiry into Patient Outcome and Death

NEQOS - Abbreviation used to refer to the North East Quality Observatory System

NEST – A workplace pensions scheme established by the Government

Never Events - Serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.

NHS – Abbreviation used to refer to National Health Service

NHS Improvement (NHSI) – the national body which awards the Trust its provider licence and regulates the Trust against it.

NHSFT – Abbreviation used to refer to NHS Foundation Trust

NHS Constitution – establishes the principles and values of the NHS. It sets out the rights and responsibilities of public, patients and staff to ensure that the NHS operates fairly and effectively.

NHS Providers – a national association representing Trusts and Foundation Trusts

NICE - Abbreviation used to refer to National Institute for Health and Care Excellence

Non-Executive Directors (NEDs) of foundation Trusts – independent directors appointed by the Governors to sit on the Board of Directors, with no responsibility for the management of the business on a day to day basis. The Chair of the foundation Trust will be a Non-Executive Director.

NRLS - Abbreviation used to refer to National Reporting and Learning System

Operated Healthcare Facility – The provision of a fully operating healthcare facility, including estate, facilities, consumables and equipment, in this case provided under contract by the Trust's subsidiary, SCL.

OSC - Abbreviation used to refer to an Overview and Scrutiny Committee

Patient Advice and Liaison Services (PALS) – services that provide information, advice and support to help patients, families and their carers

PPI - Abbreviation used to refer to Patient and Public Involvement

Primary care – the collective term for family health services that are usually the patient's first point of contact with the NHS; includes general medical and dental practices, community pharmacy and optometry.

PROM - Abbreviation for Patient Recorded Outcome Measure, which is a measure of health improvement reported by a patient following an operation.

Provider Sector – Trusts and Foundation Trusts

Referral to Treatment (RTT) Time – the description for the performance measure relating to how long a patient has to wait for an elective operation following a referral. The performance measure is that 92% of patients must be seen within 18 weeks.

Secondary care – care provided in hospitals.

Summary Hospital-level Mortality Indicator (SHMI) – New indicator which uses standard and transparent methodology for reporting mortality at hospital level.

Provider Sustainability Fund A national fund administered by NHS England which makes funding available to providers in line with the achievement of key financial and performance targets; the aim is to create headroom to enable providers to transform and improve services, including their productivity and efficiency.

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

UHND - Abbreviation used to refer to University Hospital of North Durham

UTI - Abbreviation for Urinary Tract Infection

VTE - Abbreviation for Venous Thromboembolism