



DARLINGTON

Borough Council

Health and Housing Scrutiny Committee Agenda

3.00 pm Friday, 29 May 2026

Council Chamber, Town Hall, Darlington, DL1 5QT

Members of the Public are welcome to attend this Meeting.

1. Introduction/Attendance at Meeting
2. Declarations of Interest
3. County Durham and Darlington NHS Foundation Trust - Draft Quality Account 2025/26 –
Report of the Assistant Director Law and Governance
(Pages 3 - 130)

Amy Wennington
Assistant Director Law and Governance

Wednesday, 20 May 2026

**Town Hall
Darlington.**

Membership

Councillors Anderson, Beckett, Crudass, Holroyd, Johnson, Layton, M Nicholson, Pease, Mrs Scott and Vacancy

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

**SPECIAL HEALTH AND HOUSING SCRUTINY COMMITTEE
29 MAY 2026**

COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST QUALITY ACCOUNT 2025-26

SUMMARY REPORT

Purpose of the Report

1. To consider information included in the County Durham and Darlington NHS Foundation Trust's (CDDFT) Quality Account 2025-26 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 Account. This enabled Members to have a better understanding and knowledge of performance when submitting a commentary on the Quality Account at the end of the Municipal Year.
3. The draft Quality Account for CDDFT is attached at appendix 1.

Recommendation

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 Account for 2025-26.

**Amy Wennington
Assistant Director Law and Governance**

Background Papers

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

Hannah Miller: Extension 5801.

Council Plan	The report contributes to the Council Plan in a number of ways through the involvement of Members in contributing to the delivery of the Plan.
Addressing inequalities	There are no issues relating to diversity which this report needs to address.
Tackling Climate Change	There are no issues which this report needs to address.
Efficient and effective use of resources	This report has no impact on the Council's Efficiency Programme.

Health and Wellbeing	This report has implications to address Health and Well Being of residents of Darlington, through scrutinising the services provided by the NHS Trusts.
S17 Crime and Disorder	This report has no implications for Crime and Disorder.
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
Impact on Looked After Children and Care Leavers	This report has no impact on Looked After Children or Care Leavers

MAIN REPORT

Information and Analysis

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.

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County Durham
and Darlington
NHS Foundation Trust

Quality Account 2025/6



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PART 1 – Introduction

Statement on quality from the Chief Executive

This Quality Account aims to provide a transparent summary of quality of care, the areas we wanted to improve upon during 25/26, and the priorities we will take forward into the year ahead. It reflects both the dedication of our staff and the realities of the challenges we continue to face. Having joined the Trust in September 2025, I have met countless colleagues who want to make improvements, and I have seen a lot of good care. I am also aware that we need to re-establish quality as our organising principle, and to be much more focused on outcomes and experience. Across many services, colleagues have worked hard to improve safety, strengthen quality, and respond to the concerns that matter most to patients and families. There are areas where we can see clear improvement in outcomes, and there are also areas where performance has not improved quickly enough or consistently enough, and there are areas where we have normalised standards that are not acceptable. Being open about both is essential if we are to maintain trust and keep improving.



There are examples of improvement across the organisation. We have seen encouraging progress in areas such as aspects of urgent and emergency care, sepsis treatment timeliness, maternity safety actions, support for patients with additional needs, and the development of more psychologically informed cancer services. These examples show what is possible when teams focus on learning, partnership and practical change. At the same time, there are areas where the experience or outcomes for patients are still not where they should be. Health care associated infections, recognition and response to deterioration, discharge processes, flow through the hospital, and elements of our safety and learning culture remain significant concerns. In those areas, the impact on patients can be serious, and it is right that we acknowledge that more needs to change.

We must also specifically acknowledge the issues identified in breast services. For the women affected, the impact has been profound, and we recognise that this continues for many of them long after the original events. While steps have been taken to improve care, strengthen oversight and develop better support, including improvements in outcomes for some patients and the introduction of more targeted psychological support, we know that this does not remove the distress and lasting consequences experienced by those affected. Our responsibility is not only to improve services for the future, but also to continue listening, responding with compassion, and ensuring that the voices of women affected shape the way services develop.

Looking ahead to 2026/27, our key priorities are clear: to improve patient flow and reduce corridor care; strengthen how we recognise and respond to deterioration; reduce harm from infection; improve the quality and safety of discharge; embed stronger governance, learning and accountability; and to have a relentless focus on improving fundamental standards and the experience of patients. Listening to what our patients want, and their experience will help us celebrate success and guide on the things that are most meaningful to patients. We know there is more to do, but we are committed to doing that work with honesty, urgency and a continued focus on better outcomes and better experiences for the people we serve.

Steve Russell

Chief Executive Officer,

**Co Durham and Darlington NHS
Foundation Trust**

County Durham and Darlington NHS



Foundation Trust in numbers 2025/26



What is a Quality Account?

Quality accounts are annual reports to the public from providers of NHS healthcare that detail information about the quality of services they deliver. They are designed to assure patients, service users, carers, the public and commissioners (purchasers of healthcare), that healthcare providers are regularly scrutinising each and every one of the services they provide to local communities and are concentrating on those areas that require the most improvement or attention.

Quality accounts are both retrospective and forward-looking. They look back on the previous year's information regarding quality of service, explaining where an organisation is doing well and where improvement is needed. They also look forward, explaining the areas that have been identified as priorities for improvement over the coming financial year.

The account includes additional information required by NHS England for quality reports, due to Co Durham and Darlington being a Foundation Trust.

PART 2 – Quality Priorities

This section of the Quality Account describes the progress made against priority areas for improvement in the quality of health services identified for 2025/26. This section also details the Quality priority areas for 2026/27.

In addition, this section outlines the quality improvement projects that have been completed in 2025/26, the ongoing patient safety improvement work and the Trust's continued focus on patient and staff experience.

Progress against the Priorities in 2025/26

The Quality Account for 2024/5 outlined the Trust's proposed Quality priorities for the year ahead (2025/26). These Priorities were identified as a result of engagement with patients, the public, staff, members, governors and external stakeholders.

The Priorities for 2025/26 are listed below:

Priority	
1.	Reduce the harm from inpatient falls in community hospitals, focusing on identification and learning from lapses in care
2.	Reduce incidence of, and harm, from Health Care Associated Infections
3.	Maintain zero tolerance of Grade 3 & Grade 4 pressure ulcers
4.	Implement actions from the Maternity Safety Support Programme to sustain safety in maternity services
5.	Embed safe practice for invasive procedures: LocSSIPs
6.	Further embed prompt recognition and action on signs of patient deterioration
7.	Improve the timeliness of assessment and treatment for patients with suspected sepsis
8.	Continue to progress the roll out of the Trust's patient safety strategy
9.	Provide a positive experience for those in our care with additional needs including patients with dementia, learning disabilities, autism and mental health support needs
10.	Ensure a positive patient experience through the discharge process
11.	Increasing the understanding the communication needs of Veterans in relation to cancer
12.	Introduce and develop a psycho-oncology service for cancer patients
13.	Improve the membership and involvement of the Cancer Experts by Experience (CEBE) group
14.	Mixed sex breaches: roll out of revised trust policy
15.	End of life care: conclude and roll out the palliative care strategy, ensuring appropriate access to private rooms for dignity as far as possible
16.	Continued improvement of nutrition including assessment and provision for specific needs
17.	Reduce waiting times in A&E covering: Time to assess, Time to treat, Total time in the department
18.	Optimising patients for cancer treatment through prehabilitation
19.	Maintain and improve the Macmillan Information and Support Centre quality standards
20.	Maintain a positive learning culture across all services that support cancer patients
21.	Transform Breast Surgery

Trust performance

Progress against each of our Priorities is described alongside key metrics identified for each priority area.

Priority 1: Reduce the harm from inpatient falls in community hospitals, focusing on identification and learning from lapses in care:

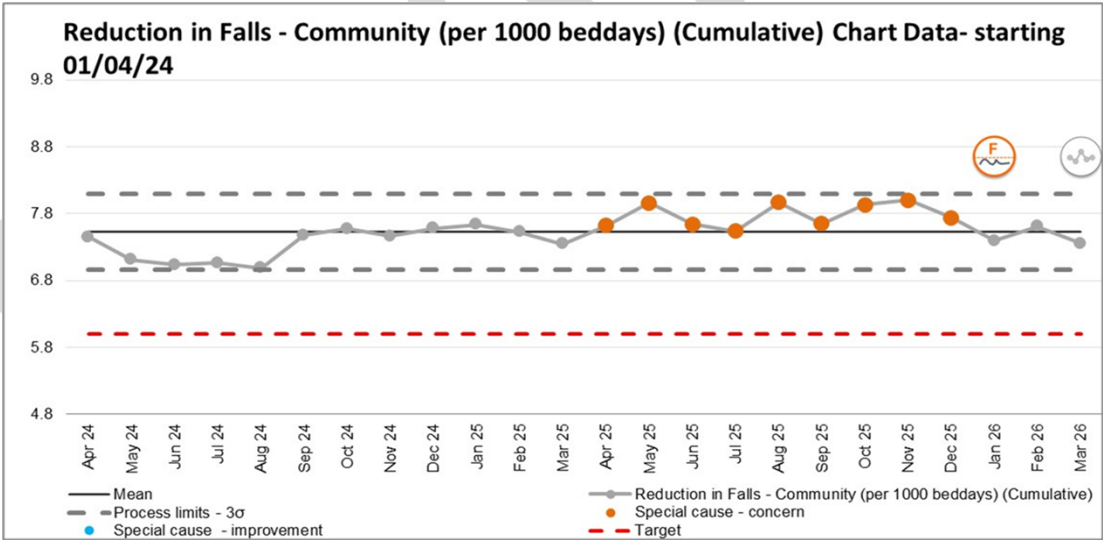
What did we say we would do?

Performance Measure 2025/26	Progress
Reduction in the incidence of falls with lapses in care that contribute to the patient’s fall.	↔
Key: ↑ better than expected; ↔ as expected; ↓ worse than expected	

Progress Update:

Falls continue to be one of the highest-reported categories of patient safety incidents across the Trust. While acute settings have demonstrated a sustained reduction in harm over recent years, this improvement has not yet been mirrored within community hospitals, where patients continue to experience avoidable harm from falls. Addressing this variation remained a key quality priority during 2025/26.

Our aim for 2025/26 was to drive a substantive reduction in inpatient falls within community hospitals, aligning progress with improvements achieved in acute sites. Specific goals included strengthening learning from incidents through rapid reviews, developing community-specific actions within the Falls System Improvement Plan, implementing the regional Falls and Fracture Prevention Strategy, updating enhanced care guidance, embedding deconditioning prevention, and revisiting the thematic review of bathroom falls.



Falls per 1000 bed days on community sites

Although improvement actions are in place, the overall rate of falls in community hospitals has not yet shifted in a meaningful sustained way and there is not yet consistent improvement. Whilst this will not be a 2026/27 Quality Account priority ongoing monitoring will continue with data and improvement actions being scrutinised within the falls group.

Progress was achieved across several areas despite operational pressures. The Falls Team strengthened the rapid review process in collaboration with the Moving and Handling Team, improving insight into safe mobility and post-fall care. Learning from reviews was supported by time-of-fall mapping and informed quality improvement projects such as the introduction of floor-level night lighting in community and rehabilitation hospitals.

Multiple community hospital quality improvement initiatives proceeded, including decaffeinated drinks trials and zonal nursing. The trial of decaffeinated afternoon and evening drinks within community hospitals is based on research that finds caffeine can stimulate the bladder resulting in increased trips to the toilet overnight, thus disturbing sleep and increasing risk of falls. Results were favorable with reduced falls, positive patient feedback and is with no impact on costs.

The Enhanced Therapeutic Observations and Care (ETOC) Policy has been updated and submitted for approval. There has been staff engagement via a questionnaire and input from our Patient Safety Partner (PSP). CDDFT also joined ‘Cohort 4’ of the regional NHS England ETOC programme. This enables support and guidance as we develop our work further to ensure more therapeutic support for our patients, and clearer guidelines for our staff in managing falls prevention and associated interventions. Risk assessments and supportive tools have been revised, and digital integration work is ongoing to develop and embed enhanced care documentation into the EPR.

Preventing deconditioning in frail patients is now an integral component of staff training. Strategies are incorporated into e-learning (Fallsafe/Carefall) and developing face-to-face modules, with additional content on safe mobility and post-fall care planned with the Moving and Handling Team.

A patient safety thematic review of falls in bathrooms was completed in 2025/26; this review made several recommendations to maintain patient safety and dignity within bathroom and toilet facilities. Several actions—such as replacing sharp-edged metal bins—have been implemented and a snapshot audit is underway of facilities to establish compliance. The thematic review will be repeated 2026/27.

Progress continued developing the inclusive regional strategy, although timelines were affected by staffing capacity issues. The stakeholder group has been strengthened, with a key regional meeting occurring in March 2026. Wider engagement is underway with local authorities and voluntary organisations.

In summary, the Trust made partial but meaningful progress in reducing falls harm in community hospitals. While some of the more complex strategic pieces have been slower to conclude, operational improvements, strengthened rapid review processes, environmental modifications, updated policies, and enhanced staff training were successfully delivered.

Priority 2: Reduce incidence of, and harm, from Health Care Associated Infections:

What did we say we would do?

Performance Measure 2025/26	Progress
To reduce all infections and thereby remain within national / locally set thresholds for all mandatory reporting HCAI to reduce the risk of associated patient harm.	↓
Key: ↑ better than expected; ↔ as expected; ↓ worse than expected	

Progress Update:

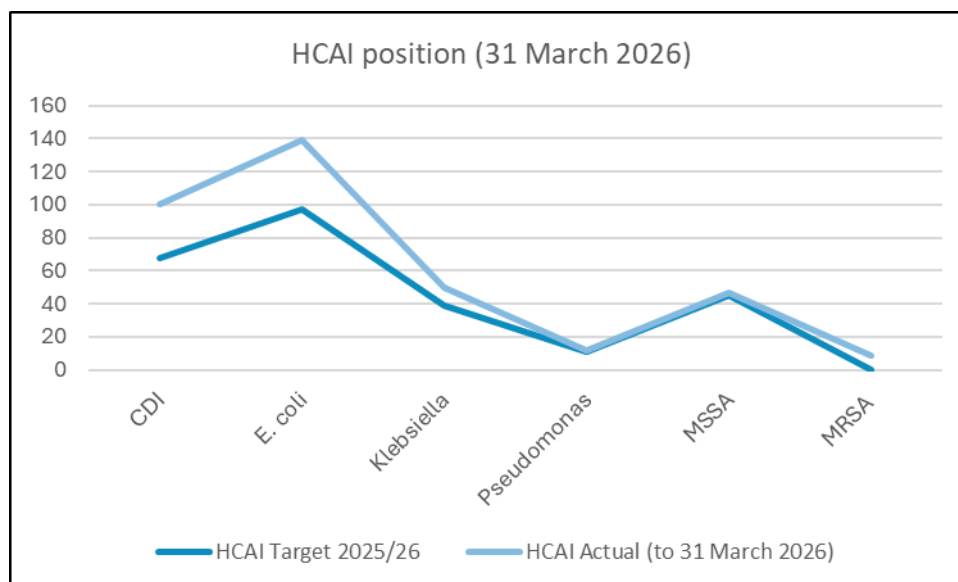
Healthcare associated infections (HCAIs) have exceeded the national annual threshold for all mandatory reportable organisms i.e.

- Clostridioides difficile Infections (CDI).
- MRSA Blood Stream Infections (BSI).
- Gram-negative BSI:
- Klebsiella.
- Pseudomonas.
- E coli.

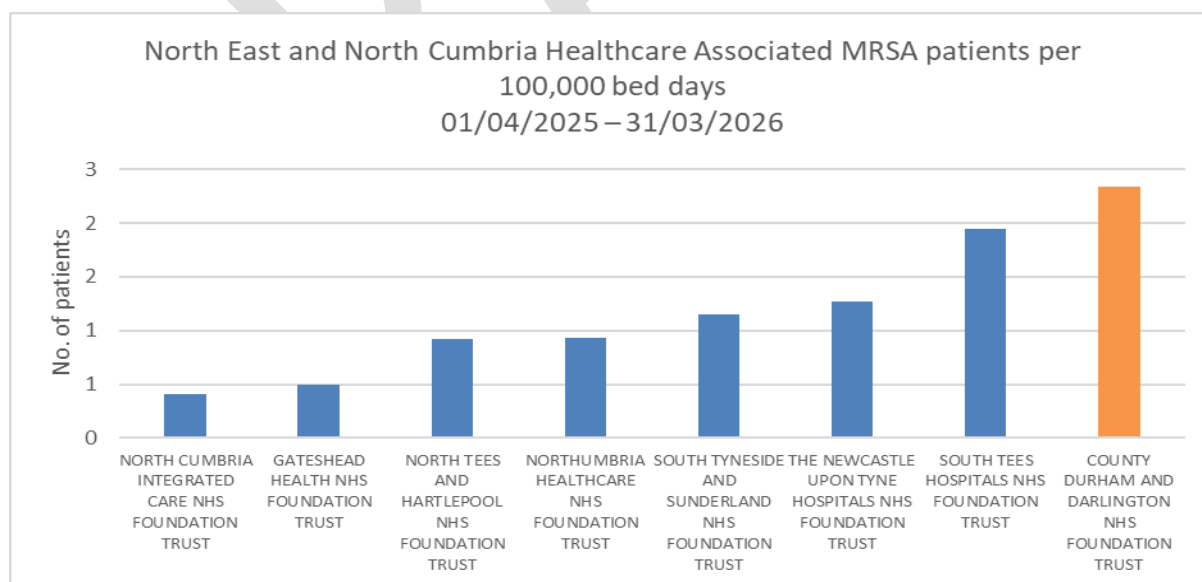
	HCAI Upper Threshold	HCAI Actual (to 31 March 2026)	Variance
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	2025/26		
CDI	68	100	+32
E. coli	97	139	+42
Klebsiella	39	50	+11
Pseudomonas	11	12	+1
MSSA	45	47	+2
MRSA	0	9	+9

HCAI position (to 28 February 2026)

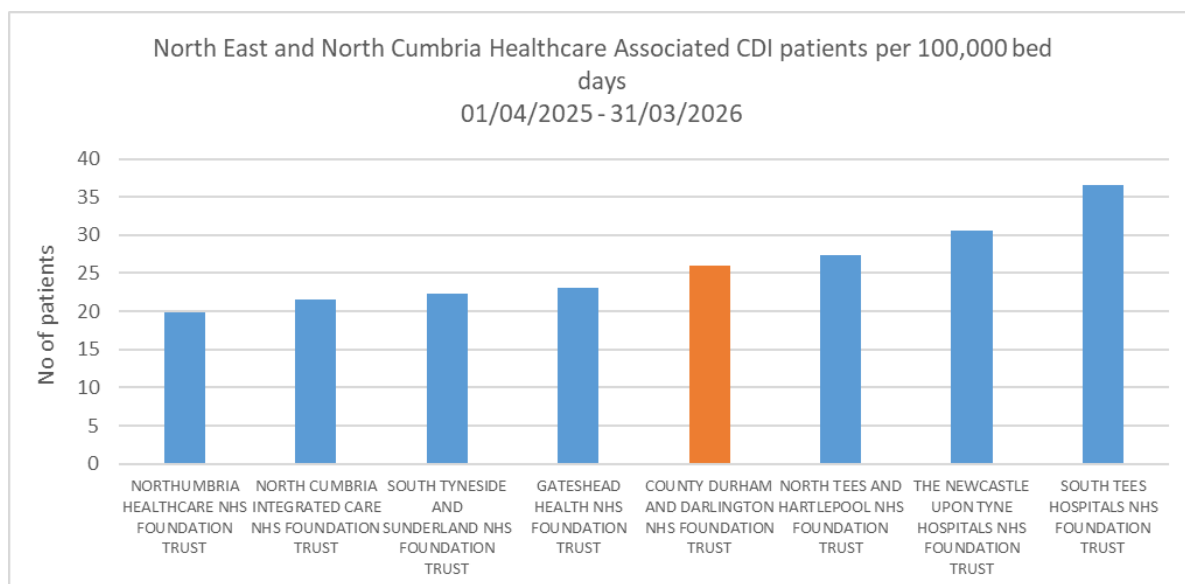


The Trust has exceeded the HCAI position from the previous year and have the highest incidence of MRSA BSI and CDI within the North East and North Cumbria.



Since December 2025, Infection Prevention and Control Nurses (IPCNs) have been able to add MRSA decolonisation directly to the Electronic Patient Record (EPR), resulting in improved compliance with decolonisation prescribed within six hours of a positive result, rising from 40% to 76%.

CDDFT has surpassed the national threshold for Clostridioides difficile infection (CDI) and is currently ranked as having the fourth highest incidence per 100,000 bed days within the NENC ICB.



Common themes identified from CDI patient safety review meetings include gaps in the management of diarrhoea, failure to act promptly at onset (such as timely sampling), delays in transporting samples to the laboratory (with a transport review underway), inaccurate documentation of the Bristol Stool Chart, delays in isolation and Ulysses reporting, and opportunities to improve patient prompts for reporting diarrhoea. Notably, no recurring or significant issues were found in antimicrobial prescribing during these reviews. The CDI case review process has also been evaluated and revised, resulting in enhanced multidisciplinary oversight.

The Trust HCAI reduction System Improvement Plan (SIP) has been amended with the development of a 2026 refreshed HCAI reduction action plan. Reduction of HCAI will remain a key patient safety priority supported by the Executive team. As a result of the deteriorating position, the Executive team are highlighting with all staff groups, that compliance to IPC practices is everyone's responsibility. The HCAI action plan focused on improvement of clinical practice, estates and cleaning.

Due to failure to meet our targets in 25/26 and ongoing concern with HCAIs, HCAI reduction will remain a priority area for 26/27

Priority 3: Maintain zero tolerance of Category 3 & Category 4 pressure ulcers:

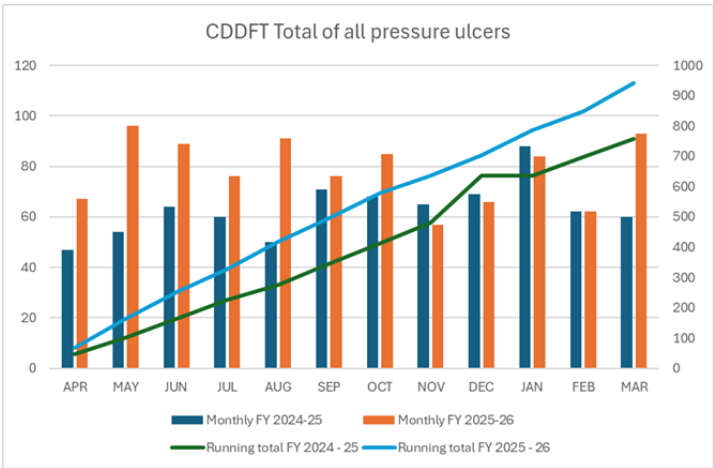
What did we say we would do?

Performance Measure 2025/26	Progress
To achieve the first year pressure ulcer reduction targets for all pressure ulcers with learning identified	↓
Key: ↑ better than expected; ↔ as expected; ↓ worse than expected	

Progress Update:

There have been a higher number of Pressure Ulcers recorded during the 2025/26 year in comparison to the previous 12 month period. The tissue viability specialist nurses continue to work proactively with the clinical teams to support with both pressure ulcer prevention and management however there have been concerns raised regarding the reporting and counting of pressure ulcers (PU) on Ulysses, particularly around the possibility of double counting. In response, a review of the process is currently underway to ensure staff have clear guidance and that the extraction of PU data accurately reflects the true numbers and categories. This work

aims to provide clarity and consistency, thereby supporting improved assurance and more reliable reporting across the Trust.



The Tissue Viability Team have embedded checks on compliance with essential pressure ulcer prevention measures, including risk assessment, documentation and appropriate equipment. A monthly wound assessment audit is also undertaken monthly by TVN team and shared Trustwide

Acute departments have now adopted the Rapid Review process used in Community Services for newly acquired Category 3 and 4 PUs, enabling wards to promptly review care and implement improvements instead of relying solely on the TV Matron.

All patients identified with a Category 3 or 4 PU are clinically reviewed by the Tissue Viability Team for initial assessment and guidance. In addition to this a Wound Photography SOP has been implemented in 2025/26 allowing Tissue Viability Nurses to take wound photography in acute and community services to support wound assessment and evaluation of the improvement or deterioration of the wound. A wound assessment SOP has been approved to guide inpatient care and standardise wound documentation, specifying expectations and requirements for assessing and reassessing wounds.

The Wound Dressing Formulary was revised and implemented in June 2025 through close collaboration with Procurement, ensuring all products are both clinically and cost effective, and readily accessible where required. Updates regarding the anticipated Northern Wound Formulary are pending; its adoption would enable the North East and Cumbria regions to standardise wound dressing protocols, thereby enhancing consistency in patient care.

The Tissue Viability Educational programme has been delivered and will continue to grow throughout 26/27 with introduction of HCA TV Link Nurses. A quarterly random sample of Category 2 incident questionnaires are reviewed by TV to provide assurance any learning actions and good practice is being identified.

Quarterly reports provided by the TV team to individual care groups to identify PU data, themes, attendance at TV training.

Whilst prevention of pressure ulcers will not be included as a priority in 26/27 a focus on fundamentals of care is one of our priorities with metrics included relating to pressure ulcers.

Priority 4: Implement actions from the Maternity Safety Support Programme to sustain safety in maternity services:

What did we say we would do?

Performance Measure 2025/26	Progress
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- High staffing fill rates and maintenance of performance on other staffing related indicators and overall resilience.
- Implementation of actions from the Maternity Safety Support Programme.
- Restarting our Homebirth service.
- Meeting Maternity Incentive Scheme Safety Actions
- Fully embedding MEOWS framework
- Full compliance with the BSOTS triage tool



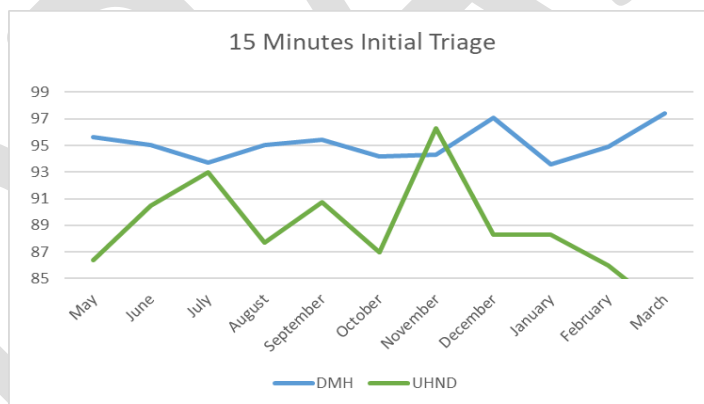
Key: ↑ better than expected; ↔ as expected; ↓ worse than expected

Progress Update:

Safe staffing levels are maintained across all teams, and any rota gaps are managed proactively, resulting in compliance at UHND and DMH. We have recruited to nominal role, with improved acuity seen, as both sites have achieved over 85% of the national target.

Ongoing work is in place to safely transition to, and embed, the national MEOWS framework. Whilst this was not achieved in the period the delays were due to awaiting digital scope and build within all systems (Badgernet and EPR) to ensure the safety of birthing people is maintained wherever they are cared for both in and out of hospital. Despite not transitioning to the national MEOWS, however, we have had success in the year in ensuring raised MEOWS, using our current tool, reliably triggers escalation to the emergency response team and this is now well embedded in the maternity units. It is anticipated that transition to the national MEOWS will complete within 2026/27.

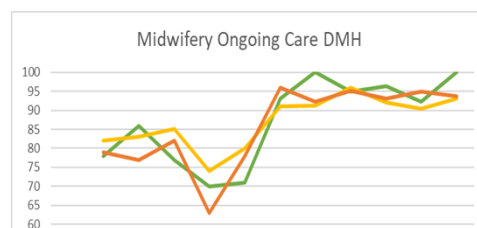
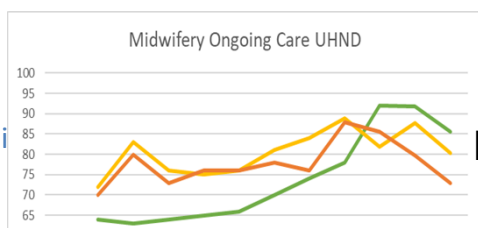
In 2025/26 Maternity Services safely moved the existing triage tool to the nationally recommended tool, BSOTS, to further support delivery of safe pregnancy assessment. BSOTS is in place on both the Durham and Darlington sites with monthly audit monitoring established to confirm compliance with local and regional standards.



The target threshold for BSOTS is initial assessment by a midwife within 15 minutes of arrival to PAU using symptom specific algorithms to allocate clinical priority. The graph above demonstrates compliance with this 15 minute threshold since the launch of BSOTS in April 2025 for the remainder of the 2025/26 year. DMH remain consistently above 90% whereas UHND continues to fluctuate with a notable decline from January to March with current data sitting at 82.1%

Midwifery

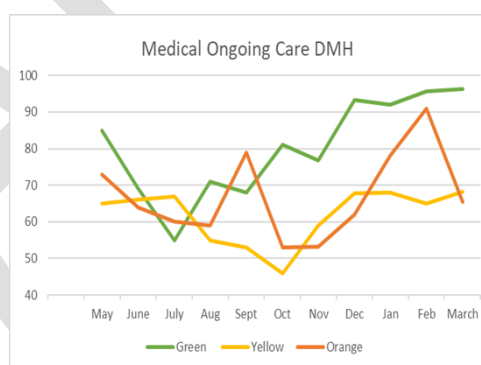
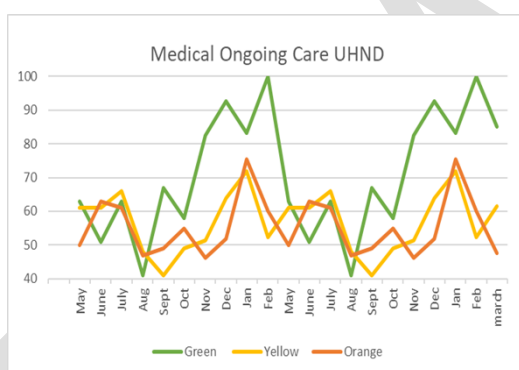
- ◆ **ORANGE** For ongoing care within 15 minutes
- ◆ **YELLOW** For ongoing care within 1 hour
- ◆ **GREEN** For ongoing care within 4 hours



CDDFT performs well in providing midwifery ongoing care; following the launch in April 2025 DMH has maintained performance over 80% (the regional target) since October 2025 and subsequently maintained 90% compliance. UHND showed slower but steady improvement, reaching 80% in January 2026 before experiencing a slight decline from February to March. Ongoing monthly monitoring will be carried out to ensure that improvement action can be implemented against any sustained decrease in performance and ensure patient safety is maintained. Ongoing review of the data via badger net is also required to identify instances where documentation has been entered incorrectly, as this can adversely affect data outcomes even though in reality care has been given within the correct timeframes.

Medical

- ❖ **ORANGE** Within 15 minutes if clinical concerns. 30 Minutes if no concerns
- ❖ **YELLOW** Within 2 hours
- ❖ **GREEN** Within 4 hours if requested.



As the data within the graphs demonstrates, there are ongoing challenges to ensure senior review is achieved within the appropriate timeframe set out within the BSOTS model; this challenge is reflected both regionally and nationally. Gaps in middle grade rosters also influence performance. Locally there is a large difference between sites with UHND underperforming against DMH.

Both sites currently support additional tier 1 level medical staff (F1/F2) at pressure to support flow and early assessment; it is clear from the data that patients triaged as yellow and orange, who often require senior review tier 2 (Registrar / SAS Doctors) and above, are more challenging to achieve. The service is currently reviewing the opportunity to replace the tier 1 provision with a tier 2 commitment.

The aspiration to reinstate the Homebirth service for women and birthing people in County Durham and Darlington was unfortunately not realised in 2025/26. However, recruitment processes are in progress with the appointment of two Homebirth Teams leaders. A Homebirth bespoke model has been finalised with a target of 5th May 2026 to launch the two Homebirth teams.

In relation to implementing and embedding the agreed recommendations from the MSSP; this has now changed to the MatNeolst with a targeted approach. The service has made considerable progress with the recommendations and is on target to address any outstanding recommendations; therefore, maternity will not be included in the 2026/27 priorities and oversight will continue through Trust Governance.

Priority 5: Embed safe practice for invasive procedures: LocSSIPs:

What did we say we would do?

Performance Measure 2025/26	Progress
- Standard audit reports produced at regular intervals for active LocSSIPs and reported into governance structures, which evidence a high level of compliance with requirements. - Progress towards the development of a suite of electronic LocSSIPs in EPR, supported by appropriate training for staff.	↓ ↓
Key: ↑ better than expected; ↔ as expected; ↓ worse than expected	

Progress Update:

The Locally Standardised Safety Intervention Procedures (LocSSIP) Task and Finish Group was originally convened in 2025 and continued its work until February 2026. The Group was paused due to the clinical lead moving on; however, it will be re-established early in 2026/27 as a new clinical lead has been identified, who will work in close collaboration with each of the care group directors.

During its operational period, the multidisciplinary Group undertook a comprehensive review of all existing LocSSIPs to ensure that each was updated, validated, and formally ratified for the 2025/26 cycle. As part of this work, an electronic, centralised LocSSIP repository was developed and shared Trust-wide to support improved visibility and accessibility.

The Group also oversaw ongoing audits of LocSSIP use across relevant clinical areas. These audits reviewed compliance levels, utilisation patterns, and the effectiveness of related safety measures. Findings from these audits informed the Group's recommendations for future improvement and digital integration. Despite the completion of regular audit reports, our progress has been assessed as worse than expected. This is because audit findings are not consistently reported through Care Group and Trust Governance structures, and the audit process is far from being fully embedded across the Organisation.

It was agreed that the transition of LocSSIPs from paper-based formats to electronic versions within the Electronic Patient Record (EPR) should form a key digital development project. The Surgical WHO Checklist was selected as the first component for digital transformation and underwent successful build and testing, achieving a positive proof of concept in late 2025. Appropriate hardware, in the form of Tablet devices, has been procured for the Theatre environment and full implementation of the WHO checklist developed within the EPR will commence in early 2026/27.

LocSSIPs will not be reported as a stand-alone priority in 2026/27 however our priority around governance systems will focus on getting information to teams at the right level and part of our digital priority is to continue the work around building LocSSIPs into our electronic patient record.

Priority 6: Further embed prompt recognition and action on signs of patient deterioration:

What did we say we would do?

Performance Measure 2025/26	Progress
We will see improved compliance rates with training – the Trust standard being 85% - and improvements with observation and escalation audits.	↔

- Substantial progress in implementing the actions in our Deteriorating Patient System Improvement Plan. ↓
- Positive evaluation of the Patients Wellness Questionnaire alongside evidence of its effectiveness. ↔

Key: ↑ better than expected; ↔ as expected; ↓ worse than expected

Progress Update:

Throughout 2025/26 there has been an increasing concern relating to the recognition and management of patient deterioration in clinical areas including the recording and escalation of physiological observations. This has sadly translated into patient harm and has been identified as a contributory factor in Cardiac Arrests. This has been identified in real time at Medical Emergency Team (MET) Calls, through the mortality review process and also through incidents and complaints.

Compliance with deteriorating patient and resuscitation role specific training has been closely monitored and remedial action taken to improve areas of low compliance; it should however be noted that getting accurate data for these metrics remains challenging.

Care Group/ Corporate	Advanced Trauma Life Support (ATLS) - 4 Years	ALS/ ILS - 4 Years	Deteriorating Patient & Resuscitation - 2 Years	Deteriorating Patient & Resuscitation for Senior Medical Staff - 2 Years	EPALS/PILS - 4 Years	HCA Acute Illness Management - 2 Years	Immediate Life Support ILS - 1 Year	Paediatric Immediate Life Support pILS - 1 Year	Level 2 - Adult Basic Life Support - 2 Years	Level 3 - Newborn Immediate Life Support - 4 Years
439 FT Board	78.79%	89.90%	88.33%	79.16%	93.80%	82.73%	70.00%	76.31%	82.66%	70.63%
439 Chief Executive CD Service			100.00%							
439 Medical Director Corp Division			92.86%	50.00%		50.00%				100.00%
439 Nursing & Quality Corp Division		100.00%	91.49%		92.00%	72.22%	100.00%	84.00%		
439 Workforce & Organisation Dev			100.00%	100.00%		100.00%			100.00%	
439 Clinical Specialist Services CG		88.24%	84.34%	75.00%		90.00%	23.53%		78.70%	
439 Community Services CG		100.00%	87.86%	80.00%		78.79%	75.00%		90.10%	
439 Family Health CG			88.17%	60.61%	93.84%	80.23%		86.30%	70.51%	70.42%
439 Medicine CG		83.93%	89.36%	73.40%		81.31%	66.46%		80.00%	
439 Surgery CG	87.50%	96.69%	87.38%	86.19%	97.97%	85.22%	73.03%	87.16%	91.80%	
439 Urgent & Emergency Care CG	76.00%	89.47%	91.62%	79.25%	91.94%	84.34%	75.00%	65.81%	86.67%	

End of Year Resuscitation Training Compliance

To address the challenges associated with deteriorating patients, the Trust has strengthened initiatives focused on early recognition, timely escalation, and effective management of patient deterioration throughout 2025/26.

- Deteriorating Patient and Resuscitation (DPR) Education: Back-to-Basics
- Mobile Technology: Functionality and Support Strategies
- Marthas Rule and Patient Wellbeing Questionnaire (PWQ)
- Acute Intervention Team Enhanced at the elbow education

Deteriorating Patient and Resuscitation (DPR) Education: Back-to-Basics

During 2025/26 the programme has refocused on foundational Deteriorating Patient and Resuscitation (DPR) principles, delivered through structured classroom sessions led by the Cardiac Arrest Prevention Team.

Teaching session content has been thoroughly reviewed, resulting in the production of standardised educational materials designed to reinforce essential skills in patient observation, escalation, fluid management, and sepsis recognition. The current DPR induction process for new staff has also been reviewed, with a particular focus on understanding compliance against the existing process.

Mobile Technology: Functionality and Support Strategies

The Trust has a mobile-first approach for nursing, midwifery, and healthcare assistant workflows across all specialties. Handheld, mobile devices have proven effective in facilitating bedside entry of observation data and enabling rapid escalation when a patient becomes unwell providing alerts to nursing and medical staff. Their use also improves sepsis screening compliance, which is tracked by whether it occurs within 15 minutes of a trigger event. Mobile devices have enabled the delivery of vital signs and Martha's Rule questionnaires (PWQ) directly at the patient's bedside.

Compliance with Observation frequency in line with policy:

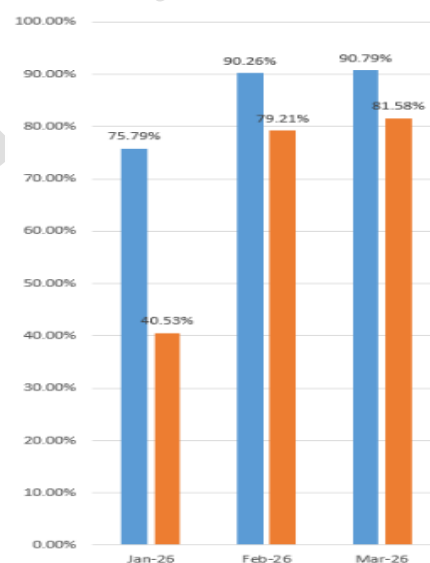
Measure	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
EWS FREQUENCY COMPLIANCE - YES	140,241	143,594	135,128	138,779	135,812	138,914	151,694	146,295	146,566	156,908	141,070	151,227
EWS FREQUENCY COMPLIANCE - NO	12,260	11,966	11,897	11,442	11,585	11,779	13,237	13,309	13,508	14,013	11,574	12,045
Compliance %	92.0%	92.3%	91.9%	92.4%	92.1%	92.2%	92.0%	91.7%	91.6%	91.8%	92.4%	92.6%

Compliance with Observation frequency in line with policy for an early warning score of 6 or above:

Measure	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
EWS FREQUENCY COMPLIANCE - YES	4,833	4,538	4,145	4,234	4,157	4,586	5,440	5,432	6,034	6,209	5,100	5,034
EWS FREQUENCY COMPLIANCE - NO	1,244	1,120	1,238	989	1,146	1,178	1,479	1,416	1,653	1,691	1,282	1,224
Compliance %	79.5%	80.2%	77.0%	81.1%	78.4%	79.6%	78.6%	79.3%	78.5%	78.6%	79.9%	80.4%

There have been challenges in ensuring that staff responsible for receiving escalation alerts consistently log in to the mobile devices. In response, the Digital Health Team offers daily support to all wards, ensuring that at least one nurse or midwife in charge and one doctor is logged in. Compliance with logging in to receive alerts has been closely monitored throughout 2025/26, and improvements are evident.

Organisational levels of compliance are measured against one nurse/midwife in charge and one junior doctor on the ward and logged in to receive the escalation alerts. The data below shows improvements over a three-month period following a Trust wide focus.



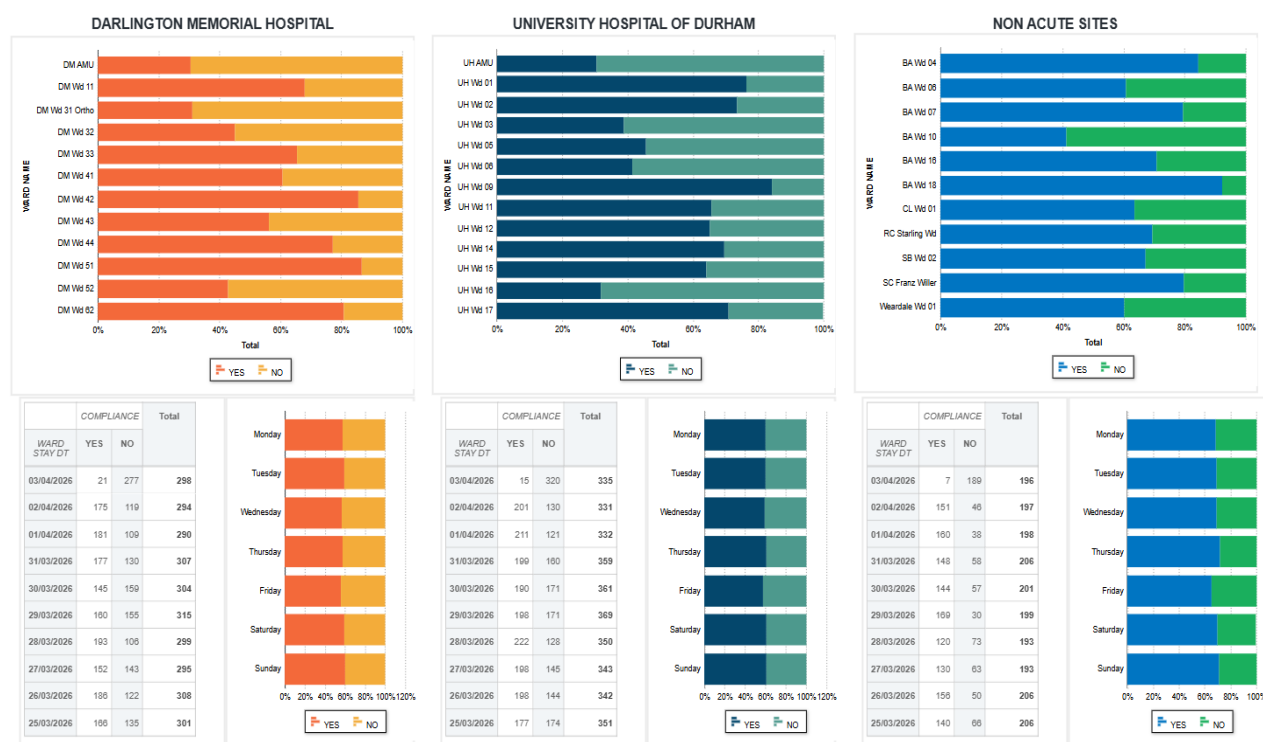
Marthas Rule and Patient Wellbeing Questionnaire (PWQ)

Martha's Rule has been implemented at CDDFT alongside NHS England as part of a national pilot program. The Patient Wellness Questionnaire has been introduced in all adult inpatient areas, within both acute and community hospitals, during 2025/26. Daily compliance checks of completion of the questionnaire are conducted, and additional training or support has been provided to wards where necessary. Each month, audits of samples with high scores have been undertaken to ensure that appropriate escalation occurred, aiding in the early identification and management of patients whose health is worsening. The Acute Intervention Team have offered ad hoc training throughout the Trust to support deteriorating patients; the PWQ is also incorporated within the enhanced at the elbow support delivered by the AI Team. Formal education about Martha's Rule is included in deteriorating patient training, Junior Doctor induction, and preceptorship programs.

	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
DMH	66%	64%	63%	60%	59%	59%
UHND	62%	62%	62%	60%	60%	62%
BAH	71%	81%	79%	78%	75%	74%
Community	66%	74%	78%	75%	75%	72%

Compliance of completion of PWQ, once in 25 hours by site

Dashboards have been created to enable oversight of PWQ recording and scores across the Organisation.



Compliance with Recording PWQ



Example of One Day Snapshot (31st March 2026)

Whilst the PWQ has been well received there remains significant scope for improvement in embedding and enhancing the use of the tool.

In 2025/26 Call for Concern was extended to include all community hospitals for all adult inpatients.

Acute Intervention Team Enhanced at the elbow education

In November 2025 the Acute Intervention Team commenced enhanced at the elbow education. Supported by the senior leadership across the wider patient safety team the AI Team worked daily alongside staff on wards, delivering education to staff whilst assisting in the delivery of patient care. 12 wards have to date received this enhanced support with the education covering:

- Recording of Observation in line with policy including correct frequency
- Correct recording of respiratory rate and AVPU
- Escalation of unwell patients
- Fluid Balance
- Patient Well Being Questionnaire

Due to ongoing patient safety risks around the detection and response to deterioration this will remain a priority area in 26/27.

Priority 7: Improve the timeliness of assessment and treatment for patients with suspected sepsis:

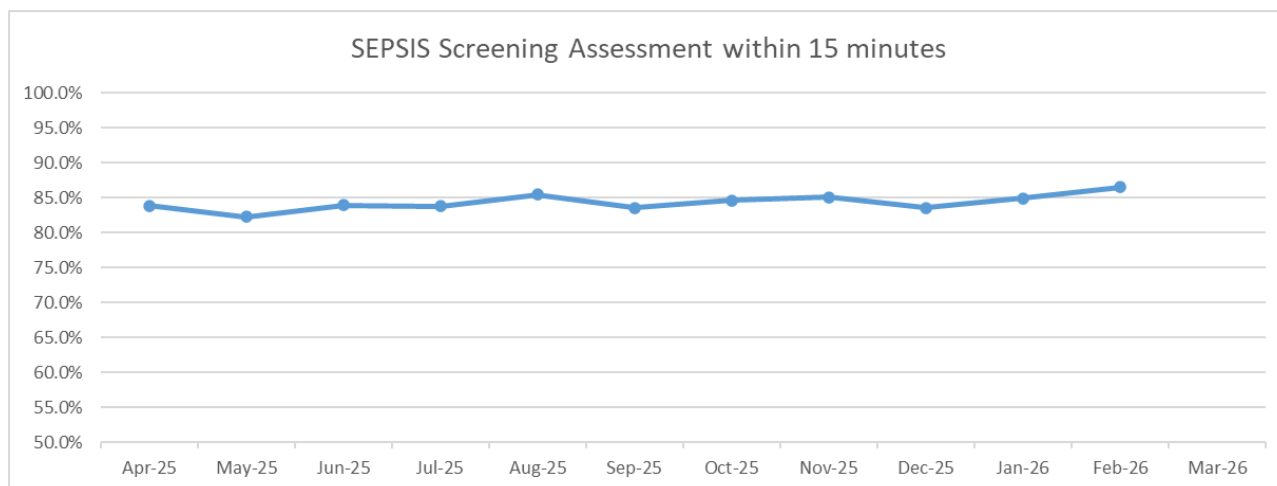
What did we say we would do?

Performance Measure 2025/26	Progress
Improved compliance rates with the percentage of patients receiving antibiotics within one and three hours of diagnosis in both A&E and back of house wards	↑
Improvements in IV treatment	↔
Significant improvements on 2024/25 performance for the taking of blood cultures	↓
Key: ↑ better than expected; ↔ as expected; ↓ worse than expected	

Progress Update:

Sepsis remains a Trust quality priority due to the significant impact on patient safety, mortality and clinical outcome. Focus throughout the year has continued to be on early sepsis screening and prompt treatment where sepsis is confirmed. Compliance with sepsis screening assessment has remained relatively static at or around 85% for the year.

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Sepsis Screening within 15 minutes	83.9%	82.3%	83.9%	83.8%	85.5%	83.6%	84.6%	85.1%	83.6%	84.9%	86.5%	

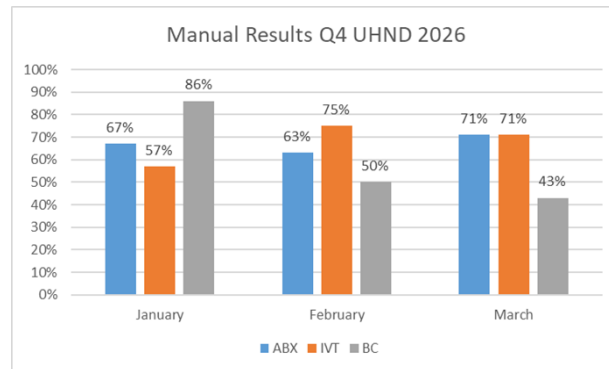
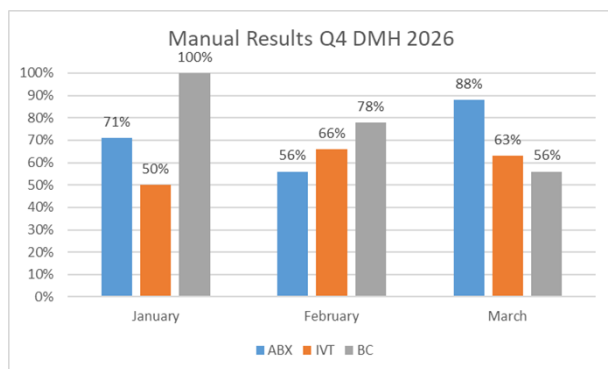


The Trust currently use handheld mobile devices at the patient's bedside to analyse and document physiological observations in real time. In some cases, a sepsis screen is triggered automatically by the mobile application from Medanets. Registered professionals such as staff nurses or midwives will then complete a sepsis screening tool promptly by the patient's bedside. The tool is designed to not be triggered each time a sepsis screen could be generated, and the suppression is driven by the outcome of the first sepsis screen. For example, a negative sepsis screen will suppress any further screens for twenty four hours in the application.

Registered professionals are educated and shown how to use the system to support their clinical judgement which could mean performing a sepsis screen during the suppression period. To support this the application allows the sepsis screen to be manually selected from an 'ad hoc' folder of assessments.

To support the use of the 'ad hoc' sepsis screen the Trust have requested to improve the sepsis workflow digital build by reducing the amount of time the system 'looks back' for a lactate level. Currently, as part of the sepsis screen, the digital tool searches the electronic patient record for a lactate level in the laboratory results; if it locates one which has been received within the last five days it will use it as part of the sepsis screen. The Trust have agreed to reduce this look back to twelve hours to make an 'ad hoc' assessment more relevant to the patient's condition at that time.

Case notes audits undertaken of patients with confirmed sepsis have continued to identify an improvement opportunity in relation to timely IV antibiotics and drawing of blood cultures.



Becton and Dickinson (BD) have provided blood culture education at Darlington Memorial Hospital. Alongside this, a clinical trial is underway to test new blood culture needles, aimed at shortening the time between infection and treatment. The evidence relating to these needles suggest that they improve pathogen detection, lower contamination rates, and support more effective antibiotic use. Microbiology within the Trust is considering a transition to these needles, with a business case currently being submitted. If approved, staff in the Emergency Department and Acute Medical Units throughout the Trust will receive training on blood cultures.

Early identification and management of sepsis continues to be a high priority for the Trust, as sepsis is a frequent cause of patient deterioration and early identification and treatment is known to improve outcomes and mortality. In recognition of this, the focus on sepsis will be incorporated into the broader deteriorating patient priority for 2026/27, ensuring that prompt diagnosis and effective treatment remain central to patient safety and quality care.

Priority 8: Continue to progress the roll out of the Trust's patient safety strategy:

What did we say we would do?

Performance Measure 2025/26	Progress
Increased engagement with the System Improvement Plans, monitored monthly by the Patient Safety Team, with monthly oversight also by specialties and Care Groups, and quarterly oversight by Executive Quality Committee.	↓
Feedback from patients and families on how satisfied they were with responses received.	↓
Improvements in the promptness of learning responses being completed, as well as the engagement of staff at various levels in using the learning tools.	↓
Regular meetings between the Patient Safety, Patient Experience and Legal teams to allow consideration of the best methods to respond to concerns raised, and also to identify themes that are common across incidents, complaints and litigations or Coroner cases.	↑
Key: ↑ better than expected; ↔ as expected; ↓ worse than expected	

Progress Update:

A comprehensive training programme has been introduced in Q4 of 2025/26, focusing on 'Patient Safety, Complaints Handling and Duty of Candour'. This initiative is designed to ensure that all staff involved in the management of complaints and incidents—regardless of their professional background—are equipped with the necessary knowledge and skills. The training aims to deepen staff understanding of learning responses linked to patient safety events, helping them to recognise the importance of transparency and accountability in their practice. Additionally, the programme emphasises the Duty of Candour, reinforcing that this principle is about taking responsibility, acting ethically, and offering a sincere apology to patients or families at the earliest opportunity when things go wrong.

While significant progress has been made, further work remains to be done to assist teams in grasping the systems-based methodology underpinning the Patient Safety Incident Response Framework (PSIRF) and to

strengthen governance processes. There continues to be a tendency to revert to previous Serious Incident (SI) frameworks and Root Cause Analysis (RCA) processes, rather than fully embracing the new PSIRF approach. Ongoing support, guidance, and education will be essential to ensure a cultural shift towards adopting best practice in patient safety investigations and learning responses, ultimately leading to improved outcomes for patients and staff alike.

The patient safety and experience team provides ongoing in-person support to wards and teams whenever feasible. This includes assistance with learning responses, participation in swarm huddles, and guidance on managing Ulysses. Although resources are available on a dedicated intranet page, a review is needed to make them easier to access in 2026/27.

System improvement plans continue to be developed. There are now Trust-wide SIPs for:

1. Data Quality
2. Deteriorating Patient
3. Falls Prevention
4. Health Care Associated Infections
5. Improving Patient Safety & Experience by Improving Flow
6. Maternity
7. Mental Capacity Act
8. Pathology
9. Pharmacy
10. Tissue Viability

Promotion of the system improvement plans, and how to use the information to support timeliness of incident responses to aligned incidents has been included in the comprehensive training package on 'Patient Safety, Complaints Handling and Duty of Candour' that has been rolled out during Q4 of 2025/26. A monthly forum to support SIP owners was established; support was variable, and, due to changes in the team a suitable chair needs to be identified, and the group re-established through 2026/27. Engagement with SIPs, as is referenced on other occasions within the 2025/26 Quality Accounts, has been poor. Consequently, the current SIPs will undergo a full review, and their governance will be re-established, beginning with specialty governance. This approach is essential to ensure that front line staff are actively involved, thereby supporting meaningful improvement activity and driving positive change.

We are proud to collaborate with our dedicated Patient Safety Partners, who actively participate in various programs and important meetings related to patient safety, such as the Patient Safety Committee (now Patient Safety Group), Quality Committee (now Patient Safety and Experience Group and Clinical Effectiveness Group), and the weekly Senior Clinical Leaders Patient Safety Forum. They have also assisted with proofreading and provided feedback on Patient Safety Incident Investigation reports. At present, we have six Patient Safety Partners, and we recently appointed a substantive Lead Patient Safety Partner.

Throughout 2025/26, we have maintained our commitment to integrating patient experience with patient safety processes. This has involved the introduction of daily reviews of all new complaints, with a focus on promptly identifying and reporting any that constitute patient safety incidents. Additionally, a fortnightly triangulation meeting has been established to ensure that patient safety responses are appropriately aligned with inquests and mortality reviews.

Whilst our procedures for involving patients and families in Patient Safety Incident Investigations (PSII) are robust—supported by dedicated family liaison officers—we recognise the need to further enhance our approach by actively engaging patients and families in all learning responses. It is essential that we move beyond procedural compliance and strive to involve patients and their families in a meaningful way. By developing strategies that build genuine partnership and co-production in investigations and subsequent learning, we can ensure that their perspectives inform and enrich our improvement activities, ultimately driving safer and more compassionate care across the Organisation.

Timely completion of patient safety incident investigations (PSIIs) has been challenging. This type of investigation is reserved for complex safety incidents and requires a significant time resource to complete. We have recently appointed two senior members of staff to PSII investigator roles. Once trained these individuals will lead all of the PSIIs in the Organisation, increasing timeliness and quality of reviews.

Due to ongoing concerns with our safety and learning culture, addressing this will remain a priority in 2026/27.

Priority 9: Provide a positive experience for those in our care with additional needs including patients with dementia, learning disabilities, autism and mental health support needs:

What did we say we would do?

Performance Measure 2025/26	Progress
- Meeting our 85% compliance targets for dementia awareness and related training - Improvement in PLACE assessment results for dementia-friendly environments - Ongoing improvement in feedback from service users - ESR figures for training. - The monthly Learning Disability and Autism Team’s monthly data collection and report. - Increased effective use and understanding of hospital passports.	↔ ↔ ↔ ↔ ↔ ↔
Key: ↑ better than expected; ↔ as expected; ↓ worse than expected	

Progress Update:

Dementia

Our aim was to provide appropriate care for patients with cognitive impairment ensuring that patients with an impairment such as dementia/delirium and that their families have a positive experience of their care throughout the patient journey throughout 2025/26.

There is continued positive progress with respect to dementia-specific training; the monthly Positive approaches to care workshops have been well received by those attending the sessions, feedback and evaluation of the workshops has been positive. Sensory training, which forms part of the monthly preceptorship program, along with dementia friends sessions and eLearning; have contributed to enhancing best practice.

Our network of Dementia and Learning Disabilities champions is growing alongside joint care pathways with Tees, Esk & Wear Valley NHS Mental Health Trust (TEWV), supported by joint training for staff. We remain focused on recruiting and supporting champions, keeping our contact list current, expanding training coverage, embedding practice improvements, and making trust environments more Dementia-friendly—ongoing priorities for our organisation.

We continue to communicate with staff via our quarterly Dementia Newsletter and through our network of Dementia and Learning Disabilities Champions. The four annual face-to-face meetings are well attended, providing opportunities for development, information sharing, and support. The task group remains active in encouraging and supporting innovation in practice, both patients and their carers.

Championing reasonable adjustments has led to the implementation of an EPR ‘flag’ system. Initiatives to create dementia-friendly environments and hospital passports—including the 5-slide approach to highlight these passports—have seen updates. Hospital passports, such as “This Is Me” and the Learning Disabilities Passport, are available on the public website for easy access. Posters promoting the hospital passports have been produced and distributed throughout the trust. In collaboration with carers and staff, and by incorporating their feedback, the Carers Passport has been developed and is now a double-sided A4 document.

We have continued to work closely with a range of partners, through local, regional and national working groups, to share learning and best practice with respect to services for those with Dementia. This has also

enabled work on joint pathways and access to sign posting to information and support groups. Working in partnership on a project to show case dementia, with Darlington's dementia friendly communities group led to a 'dementias got talent' show raising £8,000 which has gone to support dementia projects within Darlington. Fifteen local support groups have benefited from the funding which has provided days out, equipment, games and social opportunities such as an afternoon tea dance.

The Trust did not participate in the 6th round of the National Audit of Dementia in September 2024 and at present there are no further opportunities for a national dementia audit, as contract has ended. However, in 2025 internal audit tools, based on the national tool, have been developed, should the trust decided to undertake an audit in the future. The national audit process has been agreed and is undergoing restructure; it is envisaged that by 2027, this national audit will be available to participate in.

Patient-led assessments of the clinical environment (PLACE) took place between September, October and November 2025, and found evidence of improvement from actions implemented in response to the 2024 assessment findings. Despite this, the Trust overall score remained below the national average and there remain improvement opportunities. Short and long-term actions plans have been developed with the longer-term action plans to be addressed through estates works.

Bespoke training has been provided to wards and teams where requested, covering for example, changes in the brain, recognising the difference between dementia and delirium and the link to mental capacity assessments and Deprivation of Liberty Safeguards. The focus is on delivering care to reduce the effects of potential trauma, not only for the patient but staff. Our security and portering teams continue to attend the training which has allowed the staff to have a positive experience when utilising the skills acquired from the PACs workshop.

For 2025/2026 over 90% of staff completed the required eLearning modules training tiers 1 and 2.

Learning Disabilities and Autism

During 2024/25 we continued to support staff by delivering training in several ways; we delivered training on the preceptorship programme, the maternity programme, and delivered bespoke training to departments when requested. Agreement with the Executive Board saw the implementation of the "Oliver McGowan" training tier 1 being approved as essential training for all staff on Electronic Staff Record (ESR). Funding was also secured from the Integrated Care Board (ICB) to allow identified staff groups to complete tier 2 of the Oliver McGowan training.

The collection of service user and carer feedback has been a challenge for the learning disability and autism team due to staff resources, but this is still captured generically by wards and departments; an easy read friends and family questionnaire has been developed and is available for use.

Exploring opportunities within the wider team to ensure specialist knowledge and skills are available to support the organisation in caring for patients with learning disabilities and autism has presented a challenge. Tees Esk and Wear Valleys (TEWV) have been in a process of reconfiguration which subsequently left the position of Acute Liaison Nurse for Learning Disabilities vacant for a period of more than 12 months with occasional seconded cover. Due to the loss of funding for a Specialist Nurse within the team, and retirement, has left the team depleted. A decision was made, and implemented, for the safeguarding team to serve as a point of contact, so wards and departments could continue to receive advice and support when needed.

We continue to review all deaths of patients with a learning disability and autism with an initial review by a member of staff within the learning disability team followed by a review from the central mortality review team. All deaths of patients with a learning disability and/or autism are referred to the national LeDeR programme and we continue to have a place on the reviewing panel.

We have completed work on the promotion of hospital passports which included road shows, communications, distribution of posters, a library accessible via the intranet and internet and an audit to gain a baseline of knowledge followed by another planned audit to measure the success of the campaign.

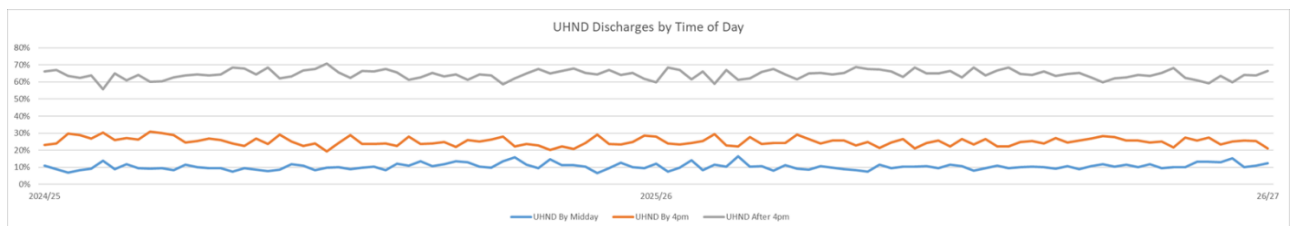
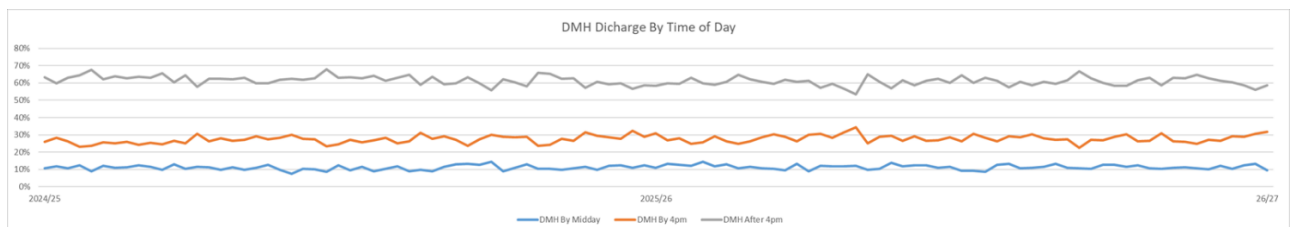
Priority 10: Ensure a positive patient experience through the discharge process:

What did we say we would do?

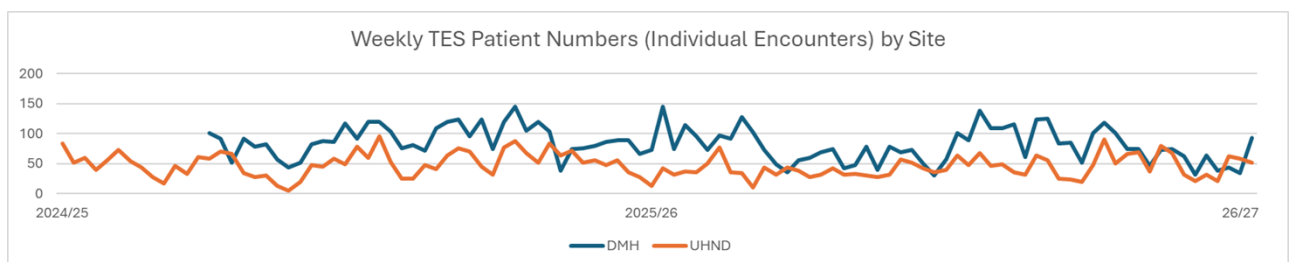
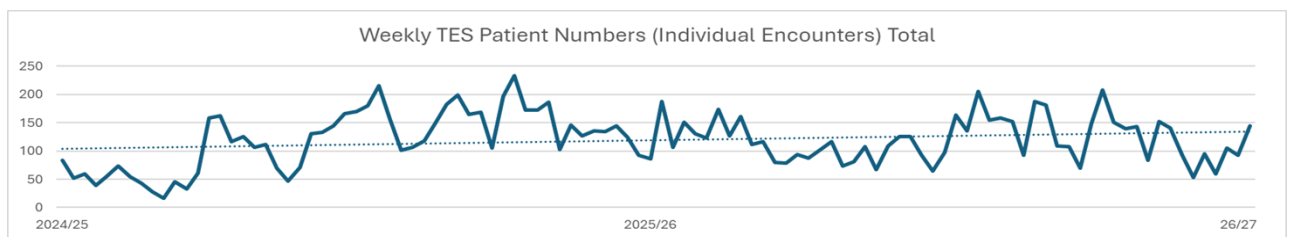
Performance Measure 2025/26	Progress
- Our discharge time will be earlier in the day - Reduced use of Temporary Escalation Spaces across the Trust - Improved patient satisfaction through post-discharge surveys - A reduction in incidents and adverse events related to discharge, measured through Section 42 referral trends, internal reporting and primary care incidents reported through the national reporting system.	↓ ↓ ↓ ↓
Key: ↑ better than expected; ↔ as expected; ↓ worse than expected	

Progress Update:

Despite ongoing efforts throughout 2025/26, we have continued to face significant challenges in improving the discharge process. Discharge times have not shown any meaningful progress, remaining static and failing to meet earlier targets.



The persistent reliance on temporary escalation spaces has resulted in a suboptimal experience for patients, with many reporting dissatisfaction either on the ward or in formal complaints to the Organisation.



Analysis of Friends and Family Feedback from January to March 2026 for comments specifically relating to patient feedback on discharge experiences identified key themes related to communication, delays, involvement, and emotional impact.

- **Poor and inconsistent communication:** Many patients reported confusion about discharge timing and conflicting information, especially from doctors, leading to anxiety and the need to chase updates.
- **Delays causing distress:** Patients frequently experienced long waits for discharge letters, medications, transport, and final reviews, which negatively affected their mental wellbeing and dignity.
- **Lack of patient involvement:** Discharge decisions were often made without patient consultation, with patients feeling uninformed about reasons for discharge or continued hospitalisation.
- **Anxiety about readiness:** Some patients felt unsafe or unprepared for discharge due to concerns about pain, mobility, medication understanding, and lack of home support, sometimes leading to readmissions.
- **Variable discharge planning quality:** Positive experiences involved clear explanations, aligned instructions, and arranged follow-up, while negatives included vague aftercare advice, unexplained medication changes, and inadequate paperwork.
- **Staff roles influence experience:** Nurses and healthcare assistants were praised for kindness and reassurance, whereas doctors were often seen as providing rushed explanations, changing plans without discussion, and limiting patient questions.
- **Dignity and experience impact:** Discharge processes sometimes compromised patient dignity, with corridor waits, privacy issues, and patients feeling "parked" once medically fit.

In addition, primary care and local hospices have repeatedly raised concerns regarding both the quality and timeliness of discharge letters, as well as issues surrounding discharge medications. These ongoing problems highlight the need for renewed focus and targeted interventions to ensure a better discharge experience for all patients.

The table below shows the numbers of Section 42 incidents, a safeguarding concern raised under Section 42 of the Care Act 2014, for CDDFT in 2024/25 and 2025/26.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2024/25	5	4	9	7	18	7	9	20	7	11	11	5	113
2025/26	6	14	9	8	6	12	13	10	9	14	8	4	113

Themes from the Section 42 incidents are:

Theme	24/25	25/26	Total
Medication / prescribing	30	35	65
Pressure damage / skin integrity	26	25	51
Falls / missed injury	49	46	95
Equipment / oxygen / lines	2	0	2
Capacity / MCA / DoLS / mental health	0	1	1
Nutrition / swallowing	0	0	0
Personal care / dignity	0	0	0
Communication / handover / documentation	0	2	2
Discharge planning / referrals	2	4	6
Staffing / capacity	0	0	0
Other	4	0	4

Due to the failure to make significant progress on this priority and ongoing safety concerns discharge processes will be included in a wider priority around flow and corridor care for 2026/27.

Priority 11: Increasing the understanding of the communication needs of Veterans in relation to cancer:

What did we say we would do?

Performance Measure 2025/26	Progress
- The number of services and organisations the final report is shared with. - The number of people asked if they have ever served in the British Armed Forces by the Macmillan Information and Support Centre team. - Positive feedback on the veterans' support leaflet from clinical teams and patients.	↔ ↑ ↔
Key: ↑ better than expected; ↔ as expected; ↓ worse than expected	

Progress Update:

Resources were codesigned with veterans and include leaflets, pull-up banners, videos focused on early detection and screening as well as support available for veterans with cancer, and an A-Z directory of organisations supporting military personnel. This information, along with the videos, has been shared on the CDDFT website and the NCA's 'My Wellbeing Space' webpages.

The Macmillan Information Centre team now routinely ask visitors whether they have ever served in the British Armed Forces, enabling them to provide tailored advice; additionally, a method for identifying veterans on EPR for all Trust patients is currently being explored.

The final project report and presentations have been disseminated to local, regional, and national organisations with an interest in the initiative, including the Clatterbridge Cancer Centre, a presentation at the TEWV Veterans event attended by several local organisations, and the Northumbria Veterans Network. Feedback gathered from veterans at the conclusion of the project was overwhelmingly positive, with many expressing that they felt valued, listened to, and involved.

Priority 12: Introduce and develop a psycho-oncology service for cancer patients:

What did we say we would do?

Performance Measure 2025/26	Progress
- Presentation of a business case to Trust Executives to ensure people affected by cancer in County Durham and Darlington have access to appropriate and timely psycho-social support. - Delivery of a cancer psychology service will have commenced, including provision of support to identified patients and to clinical teams supporting them to deliver psychologically informed services, aligned to the regional Improving Mental Wellbeing strategy and objectives.	↔ ↔
Key: ↑ better than expected; ↔ as expected; ↓ worse than expected	

Progress Update:

In the period of April 2025 – January 2026 substantial progress has been made toward establishing a substantive psycho-oncology service within CDDFT, with clear evidence of early delivery, measurable impact, and learning. This has been achieved with 0.6 WTE qualified member of staff beginning in April 2025 and 0.5 Band 4 Assistant psychologist beginning June 2026

Service engagement

Internal scoping

From May through to August internal listening events were offered to all tumour site specialties to understand existing pathways, workforce capability and the psychological need and presentations staff were identifying.

Key learning:

- Staff managing high unmet psychological presentations across all tumour pathways,
- No internal psychological support, limited external support
- Workforce knowledge gaps in managing complex psychological distress/some risk

Requirements:

- There was strong demand from all tumour sites for a dedicated, internal psychology service to which staff can escalate psychologically complex patients who require specialist input beyond nurse level capacity. There was also an identified requirement for the provision of clear feedback so that learning can be included in further MDT actions.

There was a consistent request for consultation advice to support staff in managing patients' psychological needs.

External scoping

External stakeholder contact remains in progress with local charities, regional partners and 3rd party organisations to ensure alignment with established local services and regional cancer and mental wellbeing strategies. Work is also ongoing to gather patient input.

Strategy and service development

A three-year strategic plan has been developed, with an associated business case, outlining a substantive cancer psychology service model with phased introduction over 3 years.

Early implementation activity

While awaiting approval of the substantive model, early implementation activity has progressed to reduce immediate unmet need with the resource currently available. This has included:

1. Establishing targeted therapy support for patients identified as part of the Breast Service Review as having been psychologically impacted
2. Implementation of weekly psychology consultation clinics for staff to access quick specialist advice on managing patients with complex psychological needs
3. Developing a signposting pathway to provide staff with a wider knowledge of services to which they can sign post their patients
4. Introduction of Specialist CNS' psychological supervision sessions in two priority clinical areas: Breast and Colorectal
5. Securing external funding to support a 12-month Band 8a post (recruitment underway; job advert under review).

Activity outcomes and measurable impact

1. Targeted Therapy Clinic Breast Review patient
 - 8 patients referred via Breast review pathway.
 - All patients accepted
 - 6 patients assessed
 - 3 patients currently receiving active therapy
 - 3 patients waiting to be fully assessed
 - 1 case assessed - treatment temporarily on hold as clinic now at full capacity
 - Average wait time -patients receive a first appointment offer within an average of 7.5 days from referral.

Clinical complexity data: all referrals scored above clinical threshold for psychological concern. Two indicate high levels of trauma-related distress. Overall, depression ranged from moderate to moderate severe, and anxiety was demonstrated at a severe level.

Learning: The psychometric profile confirms that referrals are appropriately identifying patients with severe and complex psychological distress. To date the clinic provides rapid access to care. However, demand has rapidly reached full clinic capacity, evidencing unmet need and supporting the case for substantive service expansion

2. Consultation Clinics (Staff support model)

- 51 consultation clinics offered (approx. 3 per week)
- 6 requests for support: (1 out of about 13 clinic slots booked - uptake increasing as awareness grows)
- Principal users - Nurses, secondary users - Doctors.
- Psychological concerns clustered around: trauma, anxiety and general psychological harm.

Feedback was undertaken through a post consultation question 100% of staff using consultation clinic indicate it gave direction on dealing with the issue of concern

Learning: The listening events highlighted the need for advice in managing complex patients however consultation clinic uptake is increasing it has not yet matched the capacity offered. This highlights the importance of ongoing, awareness raising and that time needed is needed for new services to become embedded and used

3. Sign posting service

- 6 requests for support
- All requests answered within 1 day.

4. Specialist Psychological Supervision for CNS

- 10 specialist supervision sessions delivered (5 per tumour site)

Attendance has been good: Breast CNS team 100%; Colorectal team 70 % (1 staff member withdrew/ 2 declined the offer)

Evaluation feedback indicates that the supervision was perceived as highly beneficial across all questionnaire domains: improving the quality of clinical care provided, enhancing clinical insight, confidence, and self-awareness, supporting staff to cope with work-related stress, helping clinicians identify areas for skill development, providing a safe and respectful space for sharing concerns. No negative feedback was reported.

Priority 13: Improve the membership and involvement of the Cancer Experts by Experience (CEBE) group:

What did we say we would do?

Performance Measure 2025/26	Progress
Increased membership of CEBE, including the reader review panel	↓
Evidence of involvement of existing members in updating the Terms of Reference and setting objectives for the group in 2025/26	↔
Evidence of integration of CEBE feedback into decision making regarding aspects cancer care delivery.	↔
Key: ↑ better than expected; ↔ as expected; ↓ worse than expected	

Progress Update:

The CEBE group has maintained its current structure, continuing to meet four times a year under the ongoing leadership of the existing chair and vice chair. Early in 2025, the group's Terms of Reference were reviewed and updated to ensure they remain relevant and fit for purpose. Efforts to expand the group's membership have included promotion through Clinical Nurse Specialists, Macmillan Cancer Information and Support Centres, social media, Northern Cancer Voices, and Healthwatch.

Although there has been a notable interest in joining CEBE, actual conversion from expressions of interest to regular attendance and active engagement with the group's activities has remained low. To address this, a survey was distributed among existing members to identify factors that might enhance participation and attendance. Three responses were received, each offering unique suggestions for boosting membership.

The Lead Cancer Nurse has continued to keep the leadership and executive teams informed by regularly sharing feedback from the CEBE group. Additionally, both the chair and vice chair have played an active role in representing the patient perspective on several CDDFT quality panels. New or updated cancer information has also been distributed to the CEBE reader and reviewer panel. In response to requests for feedback, several comments have been submitted, and two Macmillan Information Centre volunteers have agreed to review the newly developed breast cancer leaflets.

Priority 14: Mixed sex breaches: roll out of revised trust policy:

What did we say we would do?

Performance Measure 2025/26	Progress
- An increase in incident reporting of breaches - Discussion at every site/bed calls - Evidence of reporting through, and discussion at, Trust Governance Meetings	↔ ↔ ↓
Key: ↑ better than expected; ↔ as expected; ↓ worse than expected	

Progress Update:

The Delivering Same Sex Accommodation policy has undergone a comprehensive review, including legal considerations in relation to the UK Supreme Court ruling, and was ratified in Q4 2025-26. It reflects thorough discussions and consensus with the EPRR team to strengthen the reporting mechanisms for any mixed sex breach (MSB).

After a period of non-reporting, this process will facilitate compliance with the national requirement for reporting to the Trust Board, which will resume in March 2026.

MSB has also been evaluated in relation to corridor care and treatment escalation, both of which remain key priorities for the Organisation.

Priority 15: End of life care: conclude and roll out the palliative care strategy, ensuring appropriate access to private rooms for dignity as far as possible:

What did we say we would do?

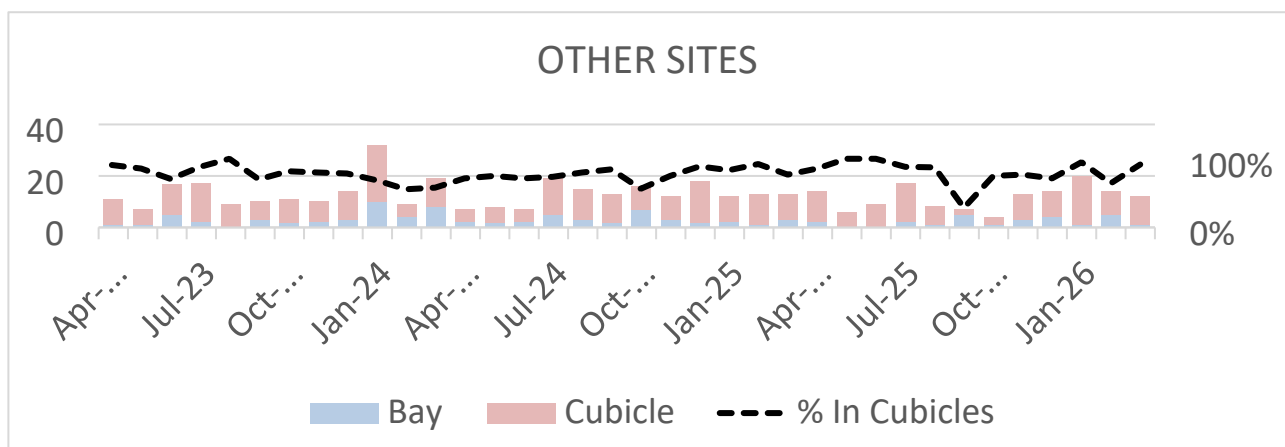
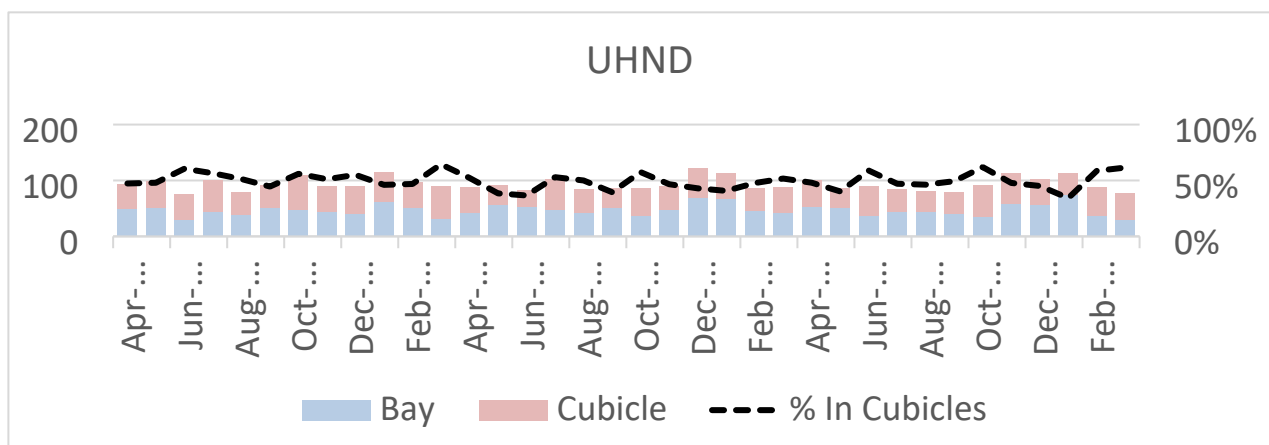
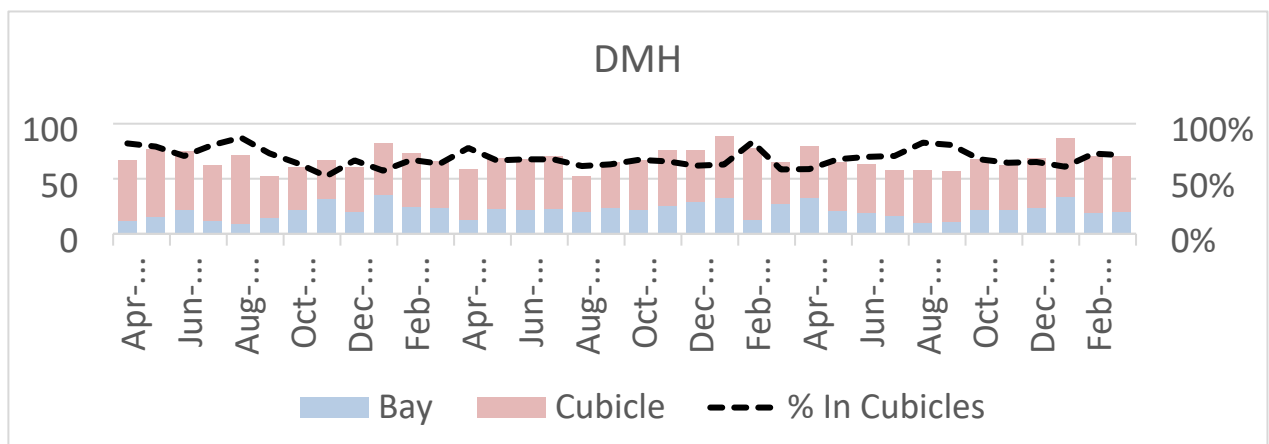
Performance Measure 2025/26	Progress
- Improvement in time prior to death that dying is recognised (nationally audited measure) - Increase the number of patients registered for palliative care within primary care. - Reduce the number of patients dying in multiple occupancy rooms and associated reductions in distress reported by families	↓ ↑ ↓
Key: ↑ better than expected; ↔ as expected; ↓ worse than expected	

Progress Update:

Little progress has been made on the ambition to improve earlier recognition of dying in hospital in the last year. Data from the national audit of care at end of life (NACEL) shows no overall change or improvement, and a reduction in time between recognition and death in Darlington Memorial Hospital. The palliative care service is working with information services to create a real-time continuous measure generated from the electronic patient record. The Specialist Palliative Care Service continues to support education of doctors at all grades and has initiated simulation sessions for resident doctors which includes recognition of dying.

The proportion of patients in County Durham where palliative care need has been recognised has increased from 0.9% to 1.1% over the last year. The average level of recognition across the Northeast Region remains stable at 0.7%.

Very sadly the proportion of patients able to access a single room when dying in hospital in county Durham has not improved over the last year. Only 50 or 60% of patients have the comfort and dignity of a single room in their last days of life in our hospitals. This objective has been challenging to achieve due to pressure on capacity, limited availability of side rooms and conflicting need for rooms for infection control reasons. Our 26/27 priority around improving flow may help to address this shortfall.



Priority 16: Continued improvement of nutrition including assessment and provision for specific needs:

What did we say we would do?

Performance Measure 2025/26	Progress
• Progress against the SIP	⬆
• Continued gradual improvement in compliance of MUST (nutrition screening)	↔

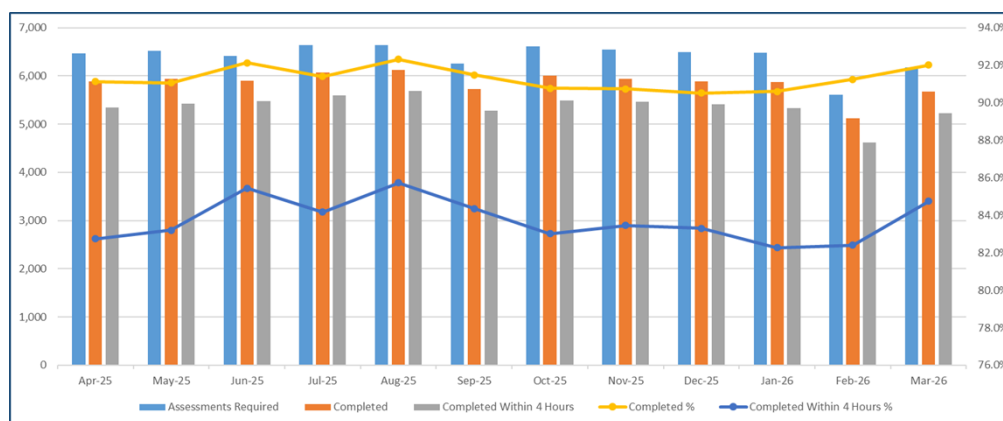
Key: ↑ better than expected; ↔ as expected; ↓ worse than expected

Progress Update:

The Nutrition and Swallowing SIP has been formally approved through the Trust governance process. Ongoing monitoring of incidents related to nutrition continues, with any emerging themes are addressed by the relevant working groups, including Nutrition, Hydration & Improvement and Enteral & Parenteral Nutrition.

Over the past year, compliance with nutrition screening in adult hospital wards has remained relatively steady. Dietetic clinical supervision sessions have identified a possible issue regarding the reliance on estimated or reported weights rather than actual measurements, which is thought to be contributing to static nutrition screening compliance. This observation will inform the focus for the coming year.

Measure	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Assessments Required	6,460	6,521	6,410	6,641	6,637	6,261	6,614	6,542	6,497	6,475	5,605	6,171
Completed	5,887	5,938	5,905	6,070	6,127	5,728	6,003	5,936	5,881	5,866	5,114	5,678
Completed Within 4 Hours	5,345	5,425	5,477	5,589	5,690	5,281	5,490	5,460	5,412	5,327	4,619	5,230
Completed %	91.1%	91.1%	92.1%	91.4%	92.3%	91.5%	90.8%	90.7%	90.5%	90.6%	91.2%	92.0%
Completed Within 4 Hours %	82.7%	83.2%	85.4%	84.2%	85.7%	84.3%	83.0%	83.5%	83.3%	82.3%	82.4%	84.8%



Ward-level initiatives are actively encouraged, such as Richardson Community Hospital's weekly efforts centred on nutritional drinks, and examples of good practice are being shared across the wider Trust wards.

Priority 17: Reduce waiting times in A&E covering: Time to assess, Time to treat, Total time in the department:

What did we say we would do?

Performance Measure 2025/26	Progress
- Improvements in waiting times with respect to assessment, treatment and the total time in the Emergency Departments when measured against national performance targets. - Time to initial assessment – the percentage of patients within 15 minutes. - The number, and percentage, of patients spending more than 12 hours in A&E. - Treatment and / or admission within 4 hours. - Average ambulance handover time within 15 minutes;	↑ ↔ ↔ ↔ ↔
Key:	↑ better than expected; ↔ as expected; ↓ worse than expected

Progress Update:

The establishment of the Frailty Assessment Unit/SDEC has significantly improved clinical pathways, allowing patients to access specialist care earlier in the patient journey. This change has led to better patient experiences and outcomes, with positive effects observed at DMH earlier in the year. There has been focused

improvement work to support, wherever possible, patients being streamed away from the Emergency Department to be seen, treated, and discharged on the same day.

At UHND, the UTC is now located next to the ED, offering a continuous 24/7 service supported by Durham Dales Health Federation. However, capital funding has not been secured to advance the Emergency Care Centre plans at UHND.

Urgent and Emergency Care Standards:

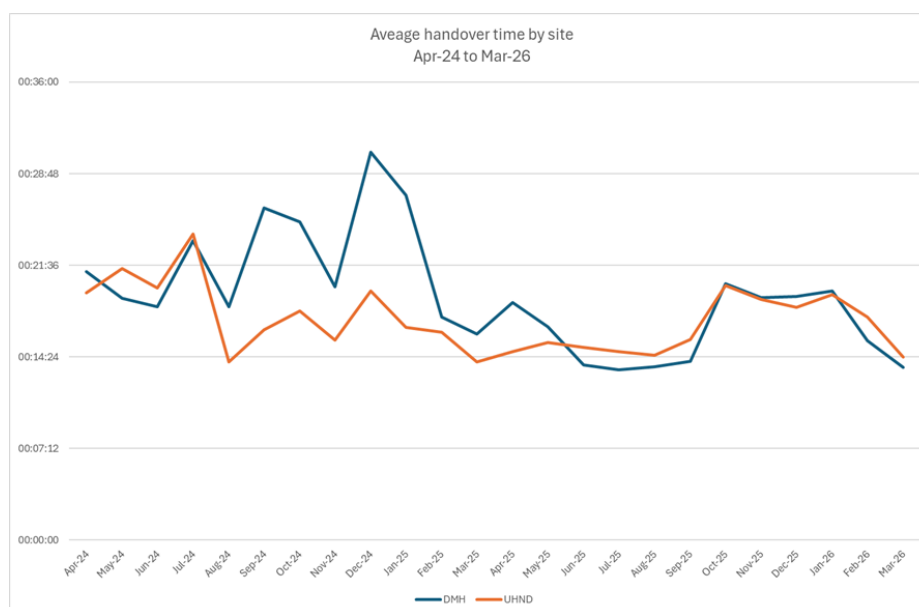
4-hour performance: performance has been ahead of plan throughout 2025/26 with reportable 4 hour waits at 79.1% in March 2026 against a plan of 78%; March 2026 performance was lower than March 2025, however. Compared to the previous year, performance has improved on average. Performance was improved at the Emergency Departments in most months compared to the previous year.

Month	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
DMH ED attends	5,807	6,003	5,811	6,043	5,606	5,774	5,886	5,841	5,820	5,853	5,139	5,948
DMH ED 4 Hour Waits	2,210	2,305	1,991	2,065	2,223	2,256	2,460	2,474	2,452	2,566	2,088	2,229
DMH % Seen in 4 Hrs	61.9%	61.6%	65.7%	65.8%	60.3%	60.9%	58.2%	57.6%	57.9%	56.2%	59.4%	62.5%
UHND ED attends	7,139	7,233	7,340	7,173	6,786	6,853	7,524	7,268	7,037	7,095	6,310	7,297
UHND ED 4 Hours wait	2,983	3,010	2,729	2,691	2,615	2,647	3,156	3,164	3,130	3,338	2,781	2,902
UHND % Seen in 4 Hrs	58.2%	58.4%	62.8%	62.5%	61.5%	61.4%	58.1%	56.5%	55.5%	53.0%	55.9%	60.2%
Total ED attends - Type 1	12,946	13,236	13,151	13,216	12,392	12,627	13,410	13,109	12,857	12,948	11,449	13,245
Urgent Care Centre - Type 3 (Walk-Ins)	4,225	4,259	4,450	4,271	4,198	3,999	4,086	3,921	4,059	3,631	3,338	3,934
Urgent Care Centre - Type 3 (Booked Appointments)	8,010	7,722	7,246	7,291	7,401	7,130	7,391	7,428	7,877	7,389	6,427	7,388
Trust Over 4 hour waits	5,193	5,315	4,720	4,756	4,838	4,903	5,616	5,638	5,582	5,904	4,869	5,131
ED Only Activity % under 4 hour waits	59.9%	59.8%	64.1%	64.0%	61.0%	61.2%	58.1%	57.0%	56.6%	54.4%	57.5%	61.3%
Reportable % under 4 hour waits (including UCC Booked from Jan '2020)	79.4%	78.9%	81.0%	80.8%	79.8%	79.4%	77.4%	76.9%	77.5%	75.4%	77.0%	79.1%
Annual plan	74.9%	75.9%	74.4%	74.5%	77.8%	75.9%	76.8%	74.5%	74.8%	74.3%	74.0%	78.0%

12 hours performance: DMH performance has significantly improved year on year. However, the position has deteriorated in Q3 and Q4 at UHND.

Measure	Month:	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
DMH ED attends		5,807	6,003	5,811	6,043	5,606	5,774	5,886	5,841	5,820	5,853	5,139	5,948
DMH ED Patients spending more than 12 hours in department		704	655	519	429	482	419	717	748	771	828	599	450
% DMH ED Patients spending more than 12 hours in department		12.1%	10.9%	8.9%	7.1%	8.6%	7.3%	12.2%	12.8%	13.2%	14.1%	11.7%	7.6%
UHND ED attends		7,139	7,233	7,340	7,173	6,786	6,853	7,524	7,268	7,037	7,095	6,310	7,297
UHND ED Patients spending more than 12 hours in department		555	688	460	586	456	770	1,017	874	896	1,201	884	603
% UHND ED Patients spending more than 12 hours in department		7.8%	9.5%	6.3%	8.2%	6.7%	11.2%	13.5%	12.0%	12.7%	16.9%	14.0%	8.3%
Trust ED attends		12,946	13,236	13,151	13,216	12,392	12,627	13,410	13,109	12,857	12,948	11,449	13,245
Trust ED Patients spending more than 12 hours in department		1,259	1,343	979	1,015	938	1,189	1,734	1,622	1,667	2,029	1,483	1,053
% Trust ED Patients spending more than 12 hours in department		9.7%	10.1%	7.4%	7.7%	7.6%	9.4%	12.9%	12.4%	13.0%	15.7%	13.0%	8.0%

Ambulance handover times: average handover times have shown a marked improvement in comparison with 2024/25 and compare well with regional Trusts.



Performance compares well with regional Trusts, with DMH averaging the 2nd best handover times, and UHND the 4th best handover times.

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Rank
Darlington Memorial A&E	00:18:40	00:16:45	00:13:47	00:13:22	00:13:37	00:14:04	00:20:08	00:19:03	00:19:10	00:19:35	00:15:39	00:13:33	2
James Cook A&E	00:24:26	00:22:14	00:22:48	00:22:18	00:14:31	00:25:09	00:24:32	00:23:55	00:26:18	00:29:20	00:25:23	00:14:24	8
North Tees Hospital A&E	00:16:40	00:16:10	00:16:37	00:15:58	00:13:29	00:17:22	00:17:28	00:17:18	00:19:45	00:22:28	00:17:58	00:14:54	3
Nsec A&E	00:21:31	00:17:07	00:16:33	00:15:22	00:23:14	00:17:22	00:23:13	00:18:29	00:19:48	00:20:50	00:18:13	00:21:57	5
Queen Elizabeth Emrg Hub	00:14:12	00:14:00	00:13:47	00:13:45	00:17:01	00:14:04	00:14:26	00:14:15	00:14:52	00:15:44	00:14:07	00:16:13	1
RVIA&E	00:25:35	00:25:01	00:25:37	00:23:48	00:16:21	00:20:33	00:21:55	00:20:59	00:22:27	00:21:54	00:23:32	00:14:23	6
South Tyneside Hosp A&E	00:25:04	00:21:28	00:22:55	00:20:25	00:25:06	00:22:11	00:23:00	00:27:34	00:30:05	00:26:51	00:20:51	00:21:07	9
Sunderland Royal A&E	00:25:20	00:20:00	00:23:45	00:18:45	00:23:51	00:21:14	00:23:40	00:25:05	00:25:15	00:28:33	00:21:32	00:17:44	7
Uhnd A&E	00:14:49	00:15:32	00:15:08	00:14:48	00:22:27	00:15:46	00:20:00	00:18:54	00:18:18	00:19:18	00:17:31	00:15:54	4

The capacity to reduce waiting times exceeding 45 minutes has been negatively impacted during certain periods in the winter, due to a substantial number of patients awaiting admission. Reporting on handovers in excess of 45 minutes was introduced in year and has been included in the 2026/27 as an explicit measure with all provider trusts expected to prevent waits of this length throughout the year. Whilst space in AHA is limited the ED team flex up to create additional capacity to sustain short handover times so far as possible thus prioritising patients waiting outside the hospital requiring urgent medical assistance.

Efforts to streamline discharge, eliminate delays of 24 hours, and implement Clinical Operational Standards supported by the Getting It Right First Time Frailty and Falls Urgent and Emergency Care programme, have continued to advance, building on previous Organisational initiatives aimed at improving flow.

The time to initial assessment within 15 minutes for patients has been 85.5% on average across the year and consistently above 83% on a monthly basis. The percentage of patients waiting 12 hours for a bed is 10.6%, with rates varying from 7.4% in June 2025 to 15.7% in January 2026.

Despite this work, achieving effective patient flow remains a challenge, and this is having a negative effect on the amount of time patients spend in the Emergency Department. Due to the adverse impact on both patient safety and experience, improving flow and eliminating corridor care will be established as key priorities for 2026/27.

Priority 18: Optimising patients for cancer treatment through prehabilitation:

What did we say we would do?

Performance Measure 2025/26

Progress

- The evidence provided from the Durham University research collaboration and the publication of its findings. 
- The use of digital analytics and patient experience feedback allowing us to demonstrate if there has been an increased uptake in use of the digital prehabilitation programme (both self-directed and facilitated). 
- Approval that the programme can be move from a 'pilot' to a substantive service which is available to more patients in County Durham and Darlington. 

Key:  better than expected;  as expected;  worse than expected

Progress Update:

The current funding arrangements for both the Cancer Treatment Outcome Programme (CTOP) and the Waiting Well (WW) initiative in Durham are due to conclude on 31/03/2026. To date, substantive or long-term funding has not been secured, and we are still awaiting confirmation regarding the extension of temporary funding from both the regional Waiting Well team and the Northern Cancer Alliance (NCA).

The research collaboration with Durham University officially commenced in August 2025. However, progress has been hampered by several delays, largely attributable to mandatory procedures and approval processes required by both the Trust and the University. Recruitment of study participants is actively ongoing.

The digital prehabilitation programme remains central to the universal offer available to all cancer patients. Despite concerted attempts to enhance uptake—including modifications to delivery methods and scheduling—engagement with the facilitated version has remained disappointingly low. As a result, the programme is now solely delivered as a self-led option, allowing patients to access resources independently.

Priority 19: Maintain and improve the Macmillan Information and Support Centre quality standards:

What did we say we would do?

Performance Measure 2025/26	Progress
• By seeking patient feedback regarding the services and environments	
• Improvements to the Macmillan centre at DMH to ensure the MQEM can be achieved in future	
• Standards will be achieved to acquire the MVQS	

Key:  better than expected;  as expected;  worse than expected

Progress Update:

Macmillan Quality Environment Mark (MQEM)

A grant was secured to facilitate enhancements at three centres: DMH, BAH, and UHND. These improvements were implemented during the summer of 2025 and have resulted in notable advancements in storage capacity, privacy, and overall ambience. As a result, patients at these centres can expect an improved experience, with greater comfort and enhanced confidentiality during their visits.

Complementary Therapy Service

The Complementary Therapy Service continues to provide free treatments to cancer patients, aiming to support their physical and emotional wellbeing throughout their journey. These therapies are offered in partnership with local hospices, ensuring that care is accessible in a comfortable and supportive environment. The service relies on ongoing fundraising efforts to maintain and expand its offerings, enabling more individuals to benefit from these valuable interventions at no cost.

MVQS (Macmillan Volunteer Quality Mark) and increasing volunteer numbers in all centres

The team successfully achieved the Macmillan Volunteer Quality Mark (MVQS) in March 2025, reflecting their ongoing commitment to high standards in volunteer engagement and support. We continue to warmly welcome new volunteers who bring fresh enthusiasm and skills to the centres, helping to enhance the range of services and support available to patients and their families. However, despite these efforts, a number of existing volunteers have left the team due to personal circumstances, which has meant that overall volunteer numbers have remained stable rather than increasing. The dedication and flexibility of the current team is greatly valued, and we remain focused on fostering a supportive environment that encourages both retention and recruitment of volunteers to ensure service continuity across all centres.

Outreach

Volunteers continue to make regular visits to chemotherapy wards, where they provide invaluable support to both patients and staff. The team also collaborates closely with Joining the Dots to deliver the HOPE programme. This partnership enables the centres to offer a comprehensive range of support, focusing on both emotional and practical aspects of cancer care.

Health and Wellbeing

Continue to provide Holistic Needs Assessments (HNAs) to pre-chemotherapy patients and others as appropriate, offering guidance and support regarding wellbeing throughout treatment. The delivery of HOPE and Look Good Feel Better (LGFB) workshops have been maintained, both of which are well attended and receive excellent feedback. The centres remain open to patients and families seeking health and wellbeing support, with no appointment required.

Priority 20: Maintain a positive learning culture across all services that support cancer patients:

What did we say we would do?

Performance Measure 2024/25	Progress
• ACCEND part of all cancer education.	↑
• Increase the use of self-assessment competency frameworks across the clinical and non-clinical cancer workforce.	↓
• Increase the use of GMCA e-portfolio to record CPD and competency achievement.	↓
• SACT standardisation and sustainable education.	↔
• Macmillan & NHS England education grants.	↔
• All Cancer CNS teams and senior SACT nurses trained in Advanced Comms and Level 2 Psychology.	↔
• Sage and Thyme embedded as essential communication training for all levels of staff.	↔
• 'Train the trainer' Advanced Comms training successfully completed to enable rollout of Advanced Communication training for B6 and above staff within the trust.	↔
• Successful collaboration with Learning & Development and local universities to develop different levels of communication training for all staff within the Trust.	↓
Key:	↑ better than expected; ↔ as expected; ↓ worse than expected

Progress Update:

Aspirant Cancer Career and Education Development programme (ACCEND) is now integrated as a key component of all cancer education, with ongoing work to refine specific elements and ensure that learning is aligned to relevant competencies. The self-assessment competency frameworks developed through ACCEND have been shared across both clinical and non-clinical cancer workforces, providing teams with access to self-assessment tools. However, monitoring of compliance has not yet been implemented, representing an area that requires improvement.

The use of e-portfolios to record Continuing Professional Development (CPD) and competency achievements has increased, with these resources now shared amongst teams. Despite this, uptake has been limited, and

greater engagement from matrons is needed, especially as e-portfolios now offer line manager capabilities that can be utilised for appraisals. In terms of Systemic Anti-Cancer Therapy (SACT) standardisation and sustainable education, there has been collaboration with the Lead SACT Nurse to establish regular education sessions on both sites, supported by nominated education link nurses. Additionally, training videos covering topics such as line care are being filmed to make these resources available for all trust staff outside of normal working hours. An away day is also being planned to facilitate the implementation of both ACCEND and SACT updates.

The SACT Community of Practice (CoP) is now operating on a regional basis. NHS England education grants have been successfully obtained for Cancer Clinical Nurse Specialists (CNS) and SACT nurses, with specific funding allocated for further training of the Breast Cancer CNS team. Cancer CNS teams and senior SACT nurses have received training in Advanced Communications and Level 2 Psychology, with only a few staff who were unable to attend scheduled dates in 2025 remaining to be trained.

Sage and Thyme has been embedded as foundation level communication training for all staff, with sessions now taking place every other month and the licence fee covered by CPD funding. In total, 118 staff were trained during 2025/26. The ‘Train the Trainer’ Advanced Communications training has been successfully completed, and work is underway with Teesside University to develop an ‘Enhanced Communications’ course for Band 4 and Band 5 nurses and Allied Health Professionals (AHPs). Furthermore, insights gained from the Train the Trainer course will be used to develop an Advanced Communication Skills Training (ACST) course for the Band 6 and Band 7 Cancer CNS workforce.

Priority 21: Transform Breast Surgery:

What did we say we would do?

Performance Measure 2024/25	Progress
- A sustainable demand and capacity model - Full implementation of reviewers’ recommendations - Compliance with evidence-based best practice with respect to treatment options - Specialty-specific clinical governance arrangements being implemented and embedded.	↓ ↔ ↔ ↔
Key: ↑ better than expected ; ↔ as expected ; ↓ worse than expected	

Progress Update:

In 2025/26, we identified and established the full extent of significant and longstanding failings within our breast service. These issues had persisted over a sustained period of time, and, through comprehensive internal reviews and independent external assessments, it became clear that the quality and safety of care provided to patients had been adversely affected.

In November 2025, our newly appointed Chief Executive and Interim Chair publicly acknowledged the findings of the Independent Governance (“Aubrey”) Report and offered a sincere and unreserved apology to all patients and families affected, and to staff whose concerns had not been listened to or acted upon. They accepted full responsibility for the failures identified and the harm caused, expressing deep regret for the distress experienced and the loss of trust resulting from these failings.

Our response to the Aubrey Report began with the following apology from the Interim Chair and Chief Executive:

“To the patients and their families that we failed – we are sorry, and we accept responsibility. We acknowledge that the failures identified mean that some women under our care were not treated compassionately, experienced delayed diagnoses, underwent unnecessary surgery, and were not offered the full range of treatment options. We unreservedly accept the distress and loss of trust this has caused. The Aubrey Report lays bare the extent of our failings over more than a decade. We accept full responsibility for what has

happened and are determined—working with our staff and our patients—to create a better CDDFT that delivers safe, compassionate, evidence-based care.”

The Trust committed to transparency, learning, and meaningful action. Initial steps were taken immediately, and a comprehensive programme of work was put in place to address the failures set out in the report. Our priorities included supporting those affected, improving breast services, restoring trust, and embedding a culture of openness, compassion, and accountability at every level of the organisation. Patients and families impacted were encouraged to contact a dedicated support team for assistance, and the Trust committed to reporting openly on progress and welcoming feedback from patients, staff, and stakeholders.

Recognising these failings enabled us to address their root causes and implement the changes necessary to restore confidence in the service and ensure consistently high standards of care.

Service Recovery and Capacity Management

Significant action has been taken to establish a safe and sustainable breast service that meets national expected guidelines. To enable these improvements, it was necessary to reduce, on a temporary basis, the number of patients seen each week. We sincerely apologise to patients for the impact this has had.

We are extremely grateful to our neighbouring Trusts across the North East and North Cumbria for their support in caring for patients we were unable to see safely. This temporary reduction in capacity has affected timeliness of care for patients in County Durham and Darlington, as well as the wider regional population, meaning some patients have not been seen or treated within previous timescales. We are sorry for these delays. We have worked closely with regional partners to develop a model of care that is both safe and sustainable, while restoring timely access to treatment.

Key Changes to the Breast Service

- Improvement actions commenced in the latter half of 2024, with an intensive programme of work implemented from March 2025.
- All insourcing and outsourcing arrangements within the breast service have ceased.
- Two new oncoplastic breast surgeons were appointed in Spring 2025, alongside an experienced oncoplastic breast surgeon from Newcastle Hospitals NHS Foundation Trust, who is leading improvements to the service and chairing the multidisciplinary team (MDT). A breast radiologist from Newcastle’s Breast Screening Team is also providing ongoing support.
- The service now fully aligns with national guidelines, ensuring patients are offered the same treatment options as in other regional centres. This includes, where clinically appropriate, immediate free-flap reconstruction with input from plastic surgeons, or oncoplastic breast surgery to achieve optimal clinical and cosmetic outcomes.
- Surgical care is currently delivered by the newly appointed surgeons while further team members complete the necessary training and skill development to meet expected standards of care.
- Breast assessment clinics are now delivered in line with modern best practice, with longer appointment times to allow for comprehensive and compassionate patient care.
- Diagnostic processes have been strengthened. Mammograms are now independently reviewed by two radiologists, in line with screening unit standards. Mammography equipment has been upgraded to support detection of microcalcifications, and ultrasound scanners have been replaced to significantly improve image quality.
- Consultant radiographers from across the region are supporting diagnostic clinics, enabling routine use of image-guided core biopsies. Fine needle aspiration (FNA) is no longer used except in rare circumstances permitted by national guidance.
- All treatment decisions are made through a single, robust multidisciplinary team meeting, attended consistently by surgeons, oncologists, radiologists, pathologists, and breast care nurses, with a designated chair and coordinator.
- Patients with benign (non-cancerous) breast lumps are now offered minimally invasive treatment rather than unnecessary surgery. This service is currently provided at Newcastle Hospitals, with CDDFT staff undergoing training to deliver this locally at Durham and Darlington.

- Additional equipment has been introduced to reduce the need for re-operations. Faxitron machines allow immediate examination of excised tissue to confirm complete lesion removal, and KliniTrays improve the accuracy of pathological assessment. Improvements have also been made to implant use to ensure practice complies with guidance and minimises infection risk.
- Enhanced breast-specific governance arrangements are now in place. Audits, guideline compliance, complaints, and morbidity and mortality data are reviewed monthly. Real-time data collection supports monitoring of key quality indicators, including mastectomy rates, re-excision rates, immediate reconstruction rates, and complications.

An audit has been undertaken for surgery March 2025 - March 2026, which evidences significant improvement from the 2019 GIRFT visit:

Metric	National Average	CDDFT 2019 GIRFT visit	CDDFT 2025/2026
Breast conserving surgery	65%	53%	72%
Re-excision	17%	25%	12%
Immediate reconstruction	30%	14%	33%

Reflections on 2025/26 and Setting Priorities for 2026/27

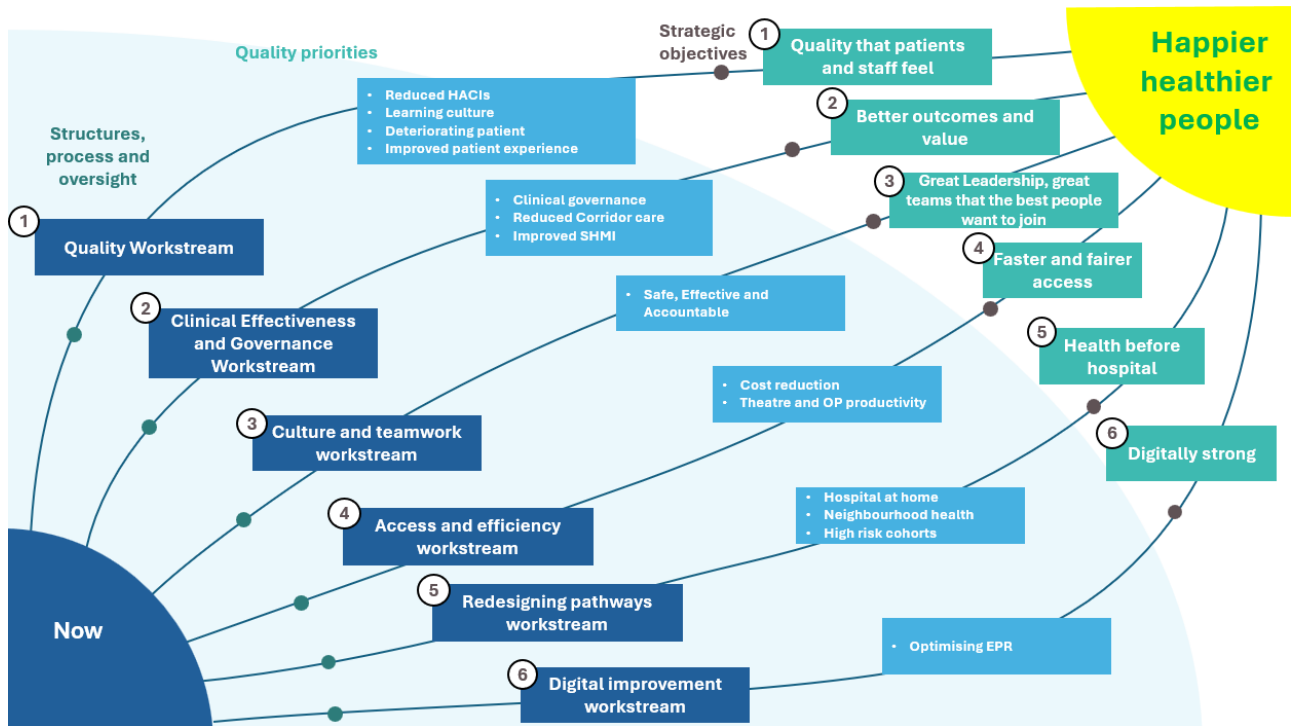
2025/26 has been a particularly challenging year for the Trust; for our patients, their families and our staff. We have faced significant difficulties within our Breast Services, and the findings from the Aubrey report have highlighted substantial issues in Trust governance, including a culture that has too often prioritised finance and performance over quality. In addition to this, the Trust received two section 29a warning notices from the Care Quality Commission (CQC) following both a well-led inspection in December 2025 and an inspection of surgery in November 2025, emphasising the need for urgent improvement. It is important to note that these were issues we had already recognised ourselves and understood the necessity for urgent resolution.

In response to these challenges, there have already been considerable changes in Board leadership, aimed at moving the Trust forward and ensuring that quality remains at the heart of our work. In November, ‘Safe, Effective, Accountable’—the Trust’s formal response to the Aubrey report, was published. This outlined the steps the Trust committed to take in addressing the report’s findings and recommendations. The plan centres on strengthening clinical governance, enhancing transparency, and embedding a culture of safety and accountability across the Organisation. Our commitment to these actions is intended to drive meaningful change and restore confidence among patients, staff, and the wider community.

Historically, our Quality Accounts have listed around twenty priorities each year, which has arguably diluted our efforts and did not always address the most pressing issues. Recognising the need for focused action, the priorities for 2026/27 have been redefined to concentrate on the areas with the greatest potential and need for urgent improvement to optimise the quality of care for our patients and their families.

Our priorities have reduced from 21 to 9 and are now closely aligned with our strategic objectives, the actions outlined in both the Aubrey report and CQC inspection findings from 2025, our patient safety incident response plan, and, importantly, the feedback from our patients—whether through complaints, concerns, or other channels—where we recognise we must do better.

Priorities deliberately include a focus on systems, processes and accountability so that during 2026 we build the foundations necessary to stabilise the Trust start working towards our strategic objectives.



By focusing on what truly matters, we are committed to delivering meaningful improvements in quality, safety, and patient experience throughout 2026/27.

The priorities have been discussed and agreed within meetings with clinicians via Patient Safety and Experience Group and Clinical Effectiveness Group as well as among Board members at Quality Committee and Board meetings.

2026/27 Priorities – Building Foundations to Allow us to Stabilise.



Priority 1 – 2026/27: Reduce incidence of, and harm from, healthcare associated infections (HCAs)

Priority 1:	Reduce incidence of, and harm from, healthcare associated infections (HCAs)
Why we chose this as a priority and what it means for patients:	Healthcare associated infections cause avoidable harm, prolong admission and increase mortality risk. Current HCAI data identifies an urgent need to improve reliability of infection prevention and control practice, particularly for <i>Clostridioides difficile</i> infection (CDI) and MRSA bacteraemia. At the end of 2025/26, CDDFT's CDI incidence was above the National threshold, and the Trust is among the highest incidence rates in the NENC ICB. The Trust also has the highest MRSA bacteraemia incidence in the NENC ICB, with high associated harm (including reported 28 day mortality). Reviews have highlighted key improvement opportunities in diarrhoea management including prompt acting at onset, timely sampling, timely isolation and timely specimen transport to the laboratory alongside consistent documentation (including Bristol Stool Chart). Ward level clustering of CDI cases indicates potential environmental, workforce or practice-related risks, requiring targeted improvement. Improving HCAI rates will reduce harm, improve patient outcomes and support safe and effective antimicrobial use.
What we are planning to do:	• Deliver the refreshed HCAI Reduction Improvement Action Plan, with clear focus on clinical practice, cleaning and estates, with sustained Executive leadership and the Executive led reduction meeting cycle. • Improve reliability of suspected/confirmed CDI management: act at onset of diarrhoea, timely sampling, isolate suspected/confirmed cases promptly, improve Bristol Stool Chart completion/maintenance, and reduce delays in specimen transport to the laboratory (including review of transport processes).

	- Strengthen learning and improvement: collate and share learning from HCAI reviews via IPC bulletins, education and training, BRICCS programme and Safety Huddles (including use of infographics). - Working to strengthen clinical care standards, including a focus on reviewing the current waterless bathing protocol to include better risk assessments
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How Will We Measure Success		
Performance Measures:	Proposed Measure	Target
	CDI and MRSA bacteraemia incidence (mandatory HCAI reporting) and progress against threshold/trajectory. CDI pathway reliability: isolation within 2 hours; sample obtained; Bristol Stool Chart completed; specimen transport to lab within 4 hours. MRSA: decolonisation prescribed within 6 hours of result. Antimicrobial stewardship: AWARe antibiotic use; IV antibiotic use. Governance: ICC/AMT attendance and representation.	CDI Q1 – <15 cases Q2 – <15 cases Q3 – <15 cases Q4 – <15 cases MRSA bacteraemia Q1 – 0 Q2 – 0 Q3 – 0 Q4 – 0
How will we ensure that progress is being made?		
Whilst delivery of the above actions is within Care Groups in Wards and Departments, the responsibility for monitoring implementation and progress with described metrics will sit with the HCAI Reduction Group with oversight from the Patient Safety and Experience Group chaired by the Chief Nursing Officer. Patient Safety and Experience Group will escalate to Quality Committee if we are at risk of not meeting targets		

Priority 2 – 2026/27: To improve patient safety and experience by reducing corridor care (Temporary Escalation Spaces) and improving patient flow.

Priority 2:	To improve patient safety and experience by reducing corridor care (TES) and improving patient flow
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Why we chose this as a priority and what it means for patients:	Corridor care (known locally as Temporary Escalation Spaces, TES) is a significant patient safety risk and can compromise privacy, dignity and timely access to assessment and treatment. The GIRFT Corridor Care Improvement Guide (March 2026) sets out clear expectations for reducing and ultimately eliminating corridor care through stronger operational standards, defined limits and escalation, consistent reporting, learning from breaches, and system-wide work to improve patient flow. Our current position highlights gaps including undefined TES limits, inconsistent reporting, and variable embedding of SAFER principles. Addressing these will reduce avoidable harm, improve experience, and strengthen accountability and learning when pressure on capacity leads to corridor care. Addressing this priority would mean that we work towards eliminating corridor care. This quality priority will help us progress towards our strategic objective of 'Quality of Care that Patients and Staff can feel'
What we are planning to do:	• Implement improvement actions aligned to GIRFT Corridor Care Improvement Guide • Create a new task and finish group to oversee progress with implementing GIRFT guidance along with wider work around embedding of clinical operational standards and flow pathways in and out of the hospital. • Strengthen supported clinical decision making, effective use of EDD, criteria led discharge with the medical workforce • Implement actions for known discharge improvement opportunities (discharge process, letters, medication etc) • Explore mitigable deaths within 14 days of admission and relationship to advanced care planning in community and whilst an inpatient prior to discharge. • Establishing the 'Realistic Medicine' concept within the Trust

How Will We Measure Success	
Proposed Measure	Target
Quarter 1	
Establish an Improving Flow task and finish group with defined ToR	ToR agreed by Clinical Effectiveness Group
Define corridor care limits for each site / clinical area	
Risk assess areas, find alternatives and close red areas completely	
Establish baseline and reporting relevant metrics: • ED corridor care episodes (>45 minutes, midnight–midnight) • Inpatient corridor care snapshot at 08:00 (adult G&A, outside bed space >45 minutes) • Overall number of TES patients on wards • Ambulance handover breaches • 24 hour ED waits • Length of Stay • Discharges before midday • Section 42 incidents	Baseline and reporting mechanism established

• Friends and family tests raising concerns with discharge process. • Deaths in hospital less than 14 days after admission	
Quarter 2 - 4	
Systems for oversight and escalation embedded	Q2 – Improving flow group established, meetings taking place Q3 – Improvement plan agreed with actions on track
Reduction of patients in temporary escalation spaces in both ED and in-patient areas - ED TES - Patients in TES space at midnight - Overall number of patients in TES spaces	Q2 – 20% Reduction on Baseline Q3 – 40% Reduction on Baseline Q4 – 50% Reduction on Baseline
Zero tolerance for 24 hour ED waits	Q2-4 – No 24 hour ED waits
Minimise delays to ambulance handover (over 15 minutes)	Q4 – target of 32.31% at end of year
Zero tolerance for ambulance handover over 45 minutes	Q2-4 – No handover delays over 45 minutes
Reduction in the number of discharge ready patients in hospital	Q2 - 10% reduction on baseline Q3 - 20% reduction on baseline Q4 - 30% reduction on baseline
Increase discharges before midday	Q2 – 15% of discharges before midday Q3 – 25% of discharges before midday Q4 – 33% of Discharges occur before midday
Decrease incidents and concerns around discharge process - Section 42 incident numbers - Number of complaints relating to discharge process from F&F	Q2 – 20% Reduction on Baseline Q3 – 40% Reduction on Baseline Q4 – 50% Reduction on Baseline
Increase the number of discharges letters sent within 24 hours	Q2 - Q3 – 90% sent within 24 hours Q4 – 95% sent within 24 hours
Decrease deaths in hospital less than 14 days after admission through improvements in advanced care planning	Q2 – 2% Reduction on Baseline Q3 – 4% Reduction on Baseline Q4 – 5% Reduction on Baseline
How will we ensure that progress is being made?	
Whilst delivery of the above actions is within Care Groups and in Wards and Departments, the responsibility for monitoring implementation and progress with described metrics will sit with the newly formed Improving Flow task and finish group reporting to Clinical Effectiveness Group chaired by the Chief Medical Officer. Clinical Effectiveness group will escalate to Quality Committee if we are at risk of not meeting targets.	

Priority 3 – 2026/27: To improve patient safety by strengthening the recognition, management and escalation of deterioration and acutely unwell patients.

Priority 3:	To improve patient safety by strengthening the recognition, management and escalation of deterioration and acutely unwell patients
Why we chose this as a priority and what it means for patients:	Incident reviews, mortality reviews and complaints raised by patients and families have identified a theme of delayed recognition of deterioration, inconsistent escalation, and delays to time-critical treatment (including sepsis). Strengthening our processes will support earlier intervention, safer escalation and better outcomes for patients who become acutely unwell. Addressing this priority means patients with high NEWS / MEOWS / POPS scores and suspected sepsis will be identified and treated promptly, with appropriate senior clinical review and a clear treatment plan implemented. This quality priority will help us progress towards our strategic objectives of 'Better Outcomes' and 'Quality that patients and staff can feel'
What we are planning to do:	• Reinforce and standardise completion of observations and escalation actions in line with Trust policy for patients who are acutely unwell (including NEWS > 6). • Improve information available to specialties by including data on completion of observations, timeliness of sepsis treatment and care aware log in in Integrated Quality and Performance Reports so that specialty areas are aware of their performance against key metrics and can identify areas for improvement. • Use learning from PSIs, mortality reviews, incident investigations and complaints to target education, simulation, audit and feedback at ward/service level. • Improve recognition and response to high NEWS / MEOWS / POPS and sepsis alerts by ensuring staff log on to Zebra devices and act on alerts in a timely way (links to EPR priority) • Continue to promote Martha's rule initiative, including patient wellness questionnaire. • Review escalation processes available for Acute Intervention Team so that they work more closely with critical care when appropriate to do so. • Improve recognition of patients approaching the end of life (see priority 4) • Embed a culture of learning from incidents at ward/service level as part of work around clinical governance (see priority 8)

How Will We Measure Success	
Proposed Measure	Target
Quarter 1	
Review and develop strategy to support the timely completion of observations and appropriate escalation	Updated strategy presented to Mortality Group
Review how learning from deteriorating patient audits is shared at ward level	

Establish IQPR dashboard including deteriorating patient metrics	Dashboard available to specialties
As described in EPR priority, progress work around communication devices	See EPR priority
Review AI team processes around links with critical care	Proposals made +/- policy updated
Establish baseline metrics for: • Incomplete observations • Care aware log in • Sepsis metrics • Completion of wellness questionnaire	Baseline defined
Quarter 2 - 4	
Systems for oversight and escalation embedded	Q2 – Monitoring of success of strategy via Mortality Group
Improvement in incomplete observations, care aware login, sepsis metrics	Q2 – 10% improvement on baseline Q3 – 20% improvement on baseline Q4 – 30% improvement on baseline
Improve use of patient wellness questionnaire	Q2 – 10% improvement on baseline Q3 – 20% improvement on baseline Q4 – 30% improvement on baseline
How will we ensure that progress is being made?	
Whilst delivery of the above actions is within Care Groups in Wards / Services, the responsibility for monitoring implementation and progress with described metrics will sit with the Mortality Group with oversight from the Patient Safety and Experience Group chaired by the Chief Nursing Officer. Patient Safety and Experience Group will escalate to Quality Committee if we are at risk of not meeting targets	

Priority 4 – 2026/27: To improve mortality outcomes by addressing higher than expected SHMI and strengthening learning from deaths

Priority 4:	To improve mortality outcomes by addressing higher than expected SHMI and strengthening learning from deaths
Why we chose this as a priority and what it means for patients:	Our Standardised Hospital Mortality Index (SHMI) is higher than expected. We need to be confident we are exploring all opportunities for improvement, learning consistently from deaths, and acting quickly where there are themes or unwarranted variation. We also need to identify and resolve issues with clinical coding that may make data unreliable and obscure where the risks are. Addressing this priority would mean that deaths will be reviewed reliably, with meaningful learning identified. Areas of concern will be identified at specialty level, and we will strengthen our understanding of data quality (including diagnostic coding), so that improvement activity is targeted and measurable. This quality priority will help us progress towards our strategic objective of 'Better Outcomes'

What we are planning to do:	• Review the Terms of Reference for Mortality Group to increase the clinical focus and incorporate discussion of metrics related to the deteriorating patient and resuscitation. • Improve information sharing between Medical Examiner Service and mortality review process so that we ensure that all sources of learning are utilized in a joined-up manner. • Increase the number of doctors completing structured mortality reviews, reinforcing the purpose of completing these and delivery of the appropriate training. • Introduce/strengthen specialty-level mortality review, ensuring that this links in with the wider mortality review and patient safety processes and that themes and patterns are identified. • Given the known issue with deteriorating patients, review a sample of deaths where the patient had a NEWS > 5 in the 48 hours before death to assess recognition, escalation, and response. • Review a sample of patients who die within 30 days of discharge to identify opportunities to strengthen discharge planning, follow-up and safety-netting. • Strengthen coding team to reduce uncoded and partly coded episodes. • Make changes to EPR to improve the quality of information available to coding team, reduce presenting complaints that are symptoms or signs and increase depth of coding. • Use learning to prioritise improvement workstreams, share learning across services, and evidence impact through repeat review and outcome monitoring.
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How Will We Measure Success	
Proposed Measure	Target
Quarter 1	
Review of the Terms of Reference and structure of mortality group	ToR agreed
Undertake an analysis of data collected by ME service to understand how this data can be used to identify learning and link to mortality process	Complete analysis and proposals made to mortality group
Develop strategy to increase the number of doctors undertaking mortality reviews	Strategy supported through mortality group
Develop business case to support a robust coding team	Case presented and supported
Define expectations for specialties regarding conduct of and information capture from mortality reviews	Expectations developed and circulated
Review a sample of cases with raised NEWS before death	Review complete and presented to mortality group
Review a sample of patients who die within 30 days of discharge	
Develop proposals to address coding issues including improving data quality on EPR and resourcing of coding team	Proposals presented to mortality group
Establish baseline metrics for • Proportion of mortality reviews completed by doctors • Specialties sharing mortality reviews with central team	Baseline identified (data already available on coding metrics)

• Percentage of invalid primary diagnosis coding • Depth of coding in non-elective patients	
Quarter 2 - 4	
Systems for oversight and escalation embedded	Q2 - New structure of mortality review group in use Q2 – Data from ME feeding to mortality review group Q2 – Strategy developed to address any issues identified from review of cases
Increased number of mortality reviews completed by doctors	Q2 – 20% of reviews by doctors Q3 – 40% of reviews by doctors Q4 – 50% of reviews by doctors
Increased number of specialties sharing mortality review data with mortality team	Q2 – 10% increase in specialties sharing Q3 – 20% increase in specialties sharing Q4 – 40% increase in specialties sharing
Decrease percentage of episodes with invalid primary code and diagnosis as sign or symptom, and increase depth of non-elective coding	Q2 – 20% improvement towards regional benchmark Q3 - 40% improvement towards regional benchmark Q4 – In line with regional average
How will we ensure that progress is being made?	
Whilst delivery of the above actions is within Care Groups in Wards / Services, the responsibility for monitoring implementation and progress with described metrics will sit with Mortality Review Group reporting to Clinical Effectiveness group chaired by the Chief Medical Officer. Clinical Effectiveness Group will escalate to Integrated Quality and Performance Committee if we are at risk of not meeting targets.	

Priority 5 –2026/27: To improve patient experience by strengthening fundamental care and responding to feedback quickly and consistently.

Priority 5:	To improve patient experience by strengthening fundamental care and responding to feedback quickly and consistently
Why we chose this as a priority and what it means for patients:	High numbers of complaints, feedback to Executive Directors from patients, dissatisfaction reflected through the Friends and Family Test (FFT), and concerns raised via system partners, social media and the press tell us we can make significant improvements in the experience patients and families have when they use our services. Addressing this priority would mean that we improve on delivering fundamentals of care and that when concerns are raised, they are listened to and acted on in a timely manner. This quality priority will help us progress towards our strategic objective of ‘Quality that patients and staff feel’
What we are planning to do:	• Improve and assure adherence to fundamental care standards (for example: personal care, nutrition and hydration, pain management, comfort, dignity, communication and timely response to call bells). • Increase senior nursing presence in clinical areas to provide visible leadership, coaching and support, and to address issues promptly. • Roll out real-time patient feedback trust-wide to provide immediate feedback and enable swift local action where issues are identified. • Define roles, responsibilities and expectations with regards to complaint management and provide education where needed. • Include complaints data in IQPR dashboard to allow specialties to monitor and manage performance in this area.

	- Strengthen processes to manage patient and family concerns at local level, including clear escalation routes, same-day resolution where possible, and learning capture before concerns become formal complaints. - Deliver a “You said, we did” campaign so patients and families can see how their feedback directly leads to improvements. - Establish a Patient Council and a new Patient Experience Group to ensure patient experience has the focus, governance and improvement capacity it deserves within the Trust. - Integrate the ‘Experience of Waiting’ questionnaire into the Trust’s patient feedback processes and use the findings to support targeted improvement initiatives.
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How Will We Measure Success	
Proposed Measure	Target
Quarter 1	
Establish a Patient Experience group	ToR agreed and meeting dates planned
Establish a Patient Council	
Establish IQPR dashboard	Dashboard available to specialties
Define roles and responsibilities with regards to complaint management	Roles and responsibilities defined
Review and refine information available to staff around managing complaints	Policy reviewed and easily accessible on PSET web pages
Establish baseline metrics for - Hospital acquired pressure sores - Incidents and complaints related to fundamentals of care - Number of formal complaints - Percentage of complaints resolved by early resolution - Percentage of complaints overdue - Friends and family test – response rate and percentage positive	
Quarter 2 - 4	
Systems for oversight and escalation embedded	Q2 – Patient experience group and Patient Council established with good attendance Q2 – IQPR dashboard embedded in practice
Progress roll out of real time patient feedback	Q2 – Completed in 30% of wards Q3 – Completed in 60% of wards Q4 – Completed in 100% of wards
Improvement in measures related to fundamentals of care - Pressure sores	Q2 – 30% reduction Q3 – 40% reduction Q4 – 50% reduction

- Incidents and complaints related to fundamentals of care	
Reduction in the number of formal complaints	Q2 – 30% reduction Q3 – 40% reduction Q4 – 50% reduction
Increase in the percentage of complaints managed by early resolution	Q2 – 30% increase Q3 – 40% increase Q4 – 50% increase
Eliminate overdue complaints	Q2 – less than 25% of complaints overdue Q3 – less than 10% of complaints overdue Q4 – less than 5% of complaints overdue
Friends and family - Response rate - Percentage positive	Q2 – 30% increase Q3 – 40% increase Q4 – 50% increase
How will we ensure that progress is being made?	
Whilst delivery of the above actions is within Care Groups in Wards / Services, the responsibility for monitoring implementation and progress with described metrics will be shared between patient safety group (fundamentals of care actions) and patient experience group (remaining actions) with oversight from the Patient Safety and Experience Group chaired by the Chief Nursing Officer Patient Safety and Experience Group will escalate to Quality Committee if we are at risk of not meeting targets	

Priority 6 –2026/27: To strengthen our learning culture and embed learning from incidents, complaints and reviews into meaningful improvement.

Priority 6:	To strengthen our learning culture and embed learning from incidents, complaints and reviews into meaningful improvement
Why we chose this as a priority and what it means for patients:	We know from recurrent incidents and repeated themes in complaints and mortality reviews that we are not consistently embedding learning into day-to-day practice. Too often, actions are agreed but not completed, not sustained, or not tested for impact, leading to avoidable repeat events and a poor experience for patients and families. Addressing this priority would mean that learning will be translated into practical changes on wards and in services, staff will be supported to speak up and report, and we will close the loop by sharing what has changed (“you said, we did” for safety and quality) and demonstrating that improvements are working. This quality priority will help us progress towards our strategic objectives of ‘Better Outcomes’ and ‘Quality that patients and staff can feel’.
What we are planning to do:	• Embed ward to board governance processes (see priority 8) • Define roles and responsibilities with regards to incident review and embedding of learning • Review patient safety guidance to ensure that processes are clearly defined in a way that supports staff to proactively manage safety incidents. • Continue to ensure that all staff receive training in incidents, risk and duty of candour, including principles of being fair guidance. • Include reporting of open incidents, complaints and actions in IQPR dashboard to improve ownership and monitoring at specialty level. • Improve feedback loops, ensuring staff who report incidents and teams involved in reviews receive timely feedback on outcomes and changes made. • Transition to Patient Safety Incident Investigations being undertaken by PSII investigators so that reports are timelier, recommendations are more consistent and expectations of specialties are clearer.

	• Refine Patient Safety Group to ensure that it effectively serves its role of identifying emerging safety themes and has oversight of progress on safety priorities. • Develop PSII panel to include oversight of actions from PSII in its function. • Introduce a mechanism to feedback to specialties on the quality of incident reviews and action planning from reviews tabled at patient safety group and PSII panels. • Publish a monthly learning summary (Trust and care group) highlighting themes, actions taken, and “you said, we did” examples for safety, quality and patient experience. • Strengthen safety huddles to ensure that they include whole MDT. • Build capability: targeted training/coaching in human factors and quality improvement for clinical leaders, investigators and ward teams, with support to spread and scale what works.
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How Will We Measure Success	
Proposed Measure	Target
Quarter 1	
Define roles and responsibilities for governance, escalation and risk management	Responsibilities defined and shared
Review of patient safety guidance and patient safety web pages	Guidance and web pages simplified
Establish a IQPR dashboard	Dashboard available to specialties
Establish mechanism for feedback on quality of reviews and actions	Mechanism defined
Complete training of PSII investigators	Training complete
Review Patient Safety Group ToR and agenda	Updated ToR approved
Review PSII panel ToR	
Define template for monthly learning summary	Template defined
Establish baseline metrics for Percentage of staff trained in incidents, complaints and DoC Time taken to complete PSII Open incidents Overdue actions	Baseline defined
Quarter 2 - 4	
Systems for oversight and escalation embedded	Q2 - Patient safety group and PSII panel working to new ToR Q2 – IQPR dashboard embedded in practice
Increase the number of PSII conducted by PSII investigators	Q2 – 50% of PSII completed by PSII investigators Q3 – 100% of PSII completed by PSII investigators
Percentage of PSII completed within 6 months of incident	Q2 – 50% completed within 6 months Q3 – 70% completed within 6 months Q4 – 80% completed within 6 months
Reduce the number of open incidents and actions	Q2 – 20% improvement on baseline Q3 – 40% improvement on baseline Q4 – 60% improvement on baseline

Increase the number of staff trained in incidents, complaints and DoC	Q2 – 70% of staff trained Q3 – 80% of staff trained Q4 – 90% of staff trained
Monthly learning summary embedded	Q2 – Summary produced and circulated every month
How will we ensure that progress is being made?	
Whilst delivery of the above actions is within Care Groups in Wards / Services, the responsibility for monitoring implementation and progress with described metrics will sit with the Patient Safety Group reporting to Patient Safety and Experience Group chaired by the Chief Nursing Officer. Patient Safety and Experience Group will escalate to Quality Committee if we are at risk of not meeting targets	

Priority 7 – 2026/27: To optimise EPR and digital workflows to improve patient safety and staff experience.

Priori ty 7:	To optimise EPR and digital workflows to improve patient safety and staff experience
Why we chose this as a priority and what it means for patients:	There are multiple safety benefits that we can harness within the EPR including clearer documentation, safer medicines processes, more reliable escalation, improved tracking of patients and results, and better visibility of risk. We also know that some current digital workflows create friction for staff and reduce the time available for direct patient care. Addressing this priority would mean designing and implementing EPR changes that make it easier to do the right thing first time, improve compliance with key safety processes, and improve staff experience by reducing duplication, improving communication and providing fit-for-purpose tools at the point of care. This quality priority will help us progress towards our strategic objective of ‘Digitally Strong’
What we are planning to do	• Implement electronic outcome forms to reduce the risk of patients being lost to follow up. • Launch new doctor M pages in EPR, supported by associated education and ensure accountability for non-adherence. • Build LocSSIPs in EPR (carried over from 2025/26 actions) and ensure benefits realisation is defined and tracked. • Implement the new ward boards developed by Medanets and ensure ward teams are supported to use them reliably as part of daily safety and flow processes. • Develop clear project plans to implement daytime tasking and closed-loop scanning, including training, go-live support and post-implementation assurance. • Implement Zebra as a single communication device, enabling voice communication, messaging and receipt of high NEWS alerts and sepsis alerts. • Make system changes to promote better use of message centre, reducing the risk of results not being actioned. • Develop nursing and AHP M Page documentation in EPR in line with the medical documentation, ensuring consistent structure, risk visibility and handover readiness across professions. • Define and agree other EPR development priorities, with clear development timelines and governance to ensure delivery to plan. • Strengthen our approach to utilising the product development pipeline from TPP • In Q4, re-assess staff satisfaction with EPR and digital workflows to confirm improvements and identify next priorities.

Proposed Measure	Target
Quarter 1	

Complete pilot of electronic outcome forms	Pilot complete and outcome reviewed
Complete build and testing of new doctors MPage	Testing complete
Launch electronic WHO checklist in theatres	WHO checklist in use
Complete pilot of Zebra as multi-modal communication device	Pilot complete and outcome reviewed, timeline for further roll out agreed
Develop proposals to improve use of message centre (worklist and landing page)	Proposals developed and discussed at DCOAG
Define and agree other EPR priorities with clear development timelines • Nursing/AHP MPages • Wider LocSSIP build • Daytime tasking/shared jobs list • Closed loop scanning Discharge workflow	Development timelines approved through DCOAG
Quarter 2 - 4	
Complete roll out of electronic outcome forms	Q2 – 25% of outpatient clinics using Q3 - 50% of outpatient clinics using Q4 – all outpatient clinics using
Increase adoption and sustained use of new MPages and templates	Q2 – 20% of medical staff using new templates Q3 – 40% of medical staff using new templates Q4 – 60% of medical staff using new templates
Roll out of Ward boards	Q2 – Ward boards live in priority areas Q3 – Ward boards live in all areas
Communication device roll out	Q2/Q3 – Progress on schedule with agreed timeline Q4 – roll out complete
Progress with other priorities	Q2 – 80% milestones delivered on time Q3 – 90% milestones delivered on time Q4 – 95% milestones delivered on time
Measure staff satisfaction	Q4 – Complete staff satisfaction pulse on EPR/digital
How will we ensure that progress is being made?	
The responsibility for monitoring implementation of the above actions and progress with described metrics will sit with Digital Clinical Operational Advisory Group reporting to Digital Strategy Group chaired by the deputy Chief Executive Clinical Effectiveness group will escalate to Quality Committee if we are at risk of not meeting targets	

Priority 8 –2026/27: To strengthen clinical governance and clinical effectiveness from shop floor to board.

Priority 8:	To strengthen clinical governance and clinical effectiveness from shop floor to board
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Why we chose this as a priority and what it means for patients:	We know from our internal review of Breast Service and the Aubrey report that we have weaknesses in clinical governance and clinical effectiveness, and that we must fully embed robust governance from the shop floor to the board. This includes clear structures, consistent review of quality and outcomes, and strong escalation and accountability where standards are not met. Addressing this priority would mean that patients can be confident that care is delivered in line with evidence-based standards, variation is identified and addressed, and learning is translated into improvement, with visible clinical leadership and curiosity at every level. This quality priority will help us progress towards our strategic objective of 'Better Outcomes'
What we are planning to do:	• Ensure care group governance structures are clearly defined and embedded, with specialty governance established and aligned to Trust governance systems. • Implement a standardised governance template and agenda at specialty and care group level, ensuring consistent reporting so that issues and learning feed upwards from specialty to care group and board and there is oversight and challenge at every step. • Define roles and responsibilities with regard to governance, escalation and risk management, strengthening clinical engagement at all levels by setting clear expectations for attendance, leadership and ownership. • Strengthen professional standards and embed accountability, including clear expectations for behaviour and practice, timely feedback and escalation, and supportive action where standards are not met. • Improve information available to specialties by producing an Integrated Quality and Performance Report to ward level so that specialty areas are aware of their performance against key metrics and can identify areas for improvement. • Improve systems for oversight of service assessments against NICE, GIRFT and other national standards via restructuring of Clinical Standards Group. • Establish a clear process for clinical standards group or patient safety group to escalate when there are concerns about a service so that a detailed review can be triggered with executive oversight. • Streamline the process for guideline and policy approval to make it easier to progress quality improvement and make services more responsive. • Implement enhanced reporting to the Board's Integrated Quality and Assurance Committee on the outcomes of core national audits. • Ensure that there is a clear process for escalation of quality and safety concerns for any member of staff to use. • Build and embed a culture of clinical curiosity at every level, encouraging constructive challenge, reflective practice and learning. • Strengthen the quality panel process to include reviewers from neighbouring Trusts, observations in clinical areas and feedback from patients and local system partners. • Strengthen risk management processes, defining risk tolerances and empowering specialties to interact with risk registers. • Strengthen ward to board walk around process to ensure it both supports services and assists with identification of issues.

How Will We Measure Success	
Proposed Measure	Target
Quarter 1	

Define roles and responsibilities for governance, escalation and risk management	Responsibilities defined and shared
Establish a IQPR dashboard	Dashboard available to specialties
Review functions and structure of Clinical Standards Group	Terms of reference agreed
Define an escalation process for specialties where there are concerns	Process defined and approved
Define new process for guideline and policy approval	
Define and publicise a process for escalation of quality and safety concerns	
Review and refine quality panel process	
Define and embed a clear process around risk management	
Review ward to board walk around process	
Establish baseline metrics for: - Number of specialties using standardised governance agenda - Overdue audits and open actions from audits	Metrics established
Quarter 2-4	
Systems for oversight and escalation embedded	Clinical Standards meeting established with good attendance and working to new agenda. New process for guideline and policy approval embedded. Evidence of staff using defined escalation process Evidence of effective risk management
Increase maturity and consistency of specialty and care group governance meetings	Q2 – 70% of specialties using standard agenda and producing required outputs. Q3 – 80% of specialties using standard agenda and producing required outputs. Q4 – 100% of specialties using standard agenda and producing required outputs
Increase delivery of clinical audit / benchmarking	Q2 – 70% of audit plans on schedule Q3 – 90% of audits plans on schedule Q4 – 90% of audit plans on schedule
Improve timely implementation of actions with evidence checks for priority actions	Q2 – 60% of action plans on time, with evidence of completion Q3 – 70% of action plans on time, with evidence of completion Q4 – 80% of action plans on time, with evidence of completion
Compliance with PSEG and CEG Terms of Reference	Q2 – Audit of Q1 and Q2 compliance and identification and implementation of improvement actions Q4 – Actions concluded and reaudit demonstrating improvement on Q2 audit
How will we ensure that progress is being made?	
The responsibility for monitoring implementation of the above actions and progress with described metrics will sit with the Clinical Standards Group reporting to Clinical Effectiveness Group chaired by the Chief Medical Officer. Clinical Effectiveness group will escalate to Quality Committee if we are at risk of not meeting targets	

Priority 9 –2026/27: To Ensure that the Trust is implementing required changes in response to the Aubrey Report

Priority 9:	To Ensure that the Trust is implementing required changes in response to the Aubrey Report
Why we chose this as a priority and what it means for patients:	The Aubrey report, commissioned in response to failings in the Breast Service, highlighted a significant number of areas for improvement. In November 2025 the Trust published 'Safe, Effective and Accountable'. Our response to the independent reviews of breast services leadership and governance. Whilst it is not necessary to duplicate all of the targets from this response in quality priorities embedding the learning from the Aubrey report is a key priority for us in 26/27. Addressing this priority would mean that we have made significant improvements in our structures and systems, ensuring that they are robust enough to detect issues with fragile services and professional standards at an early stage. This quality priority will help us progress towards many of our strategic objectives.
What we are planning to do:	• Ensure that there is a clear governance and escalation process around programmes of work identified in Safe, Effective and Accountable, reviewing that the oversight arrangements described in the document remain appropriate in view of redesigned meeting structures. • Map actions from action plan to relevant reporting structures, reviewing actions to ensure that they will address the planned changes described in the document. • Monitor progress with actions via a dual approach – reporting to relevant executive led groups and oversight of the whole action plan by the deputy Chief Executive.

How Will We Measure Success	
Proposed Measure	Target
Quarter 1	
Confirm reporting for programmes of work to executive groups • Leadership and corporate governance • Clinical Governance • Culture • Management and support for doctors Financial governance and contract management	Structure defined
Review action plans via this structure to ensure that they remain appropriate	Evidence of review at meetings
Continue to progress actions described in Safe, Effective and Accountable action plan	Q1 – 80% of actions on track
Quarter 2-4	
Continued progress with Safe, Effective and Accountable action plan	Q2 – 85% actions on track Q3 – 90% actions on track Q4 – 100% actions on track
How will we ensure that progress is being made?	
The responsibility for monitoring implementation of the above will fall to the groups identified to oversee progress with various aspects of the Safe, Effective and Accountable action plan, with each group reporting through an executive led group. Overall progress with the action plan will also be overseen by the deputy Chief Executive who will be responsible for reporting progress to Board	

Quality Improvements during 2024/25

There are many examples of quality improvement (QI) initiatives that have been successfully delivered throughout the year resulting in improved quality of care for the people who use services. Examples of some of the work the Trust has done are given in the sections below:

Quality Improvement Project

Implementation of the *Love and Nuts* Survey

Love  and Nuts 

Background

The Quality Improvement initiative was developed in response to low engagement in the Surgical Care Group Staff Survey, where only a small proportion of staff participated. Despite the limited response rate, the findings highlighted concerns regarding staff willingness to recommend the Organisation as a place to work or receive care.

The care group matrons aimed to identify what staff value in their roles, and which areas of their work environment need improvement. Initial themes included management, communication, training, pay, parking, respect, and workplace culture.

To support this, a more accessible and low-burden method of gathering staff experience was introduced. The Love and Nuts survey was designed to capture what matters most to staff by asking them to identify five things they value in their workplace and three aspects that cause frustration. This informal approach

encouraged open and honest engagement and created a safe environment for staff to share both positive experiences and areas of concern.

Your role-

Love

&

Nuts

5 things that you **love** about your workplace:

-
-
-
-
-

3 things that drive you **nuts** about your workplace:

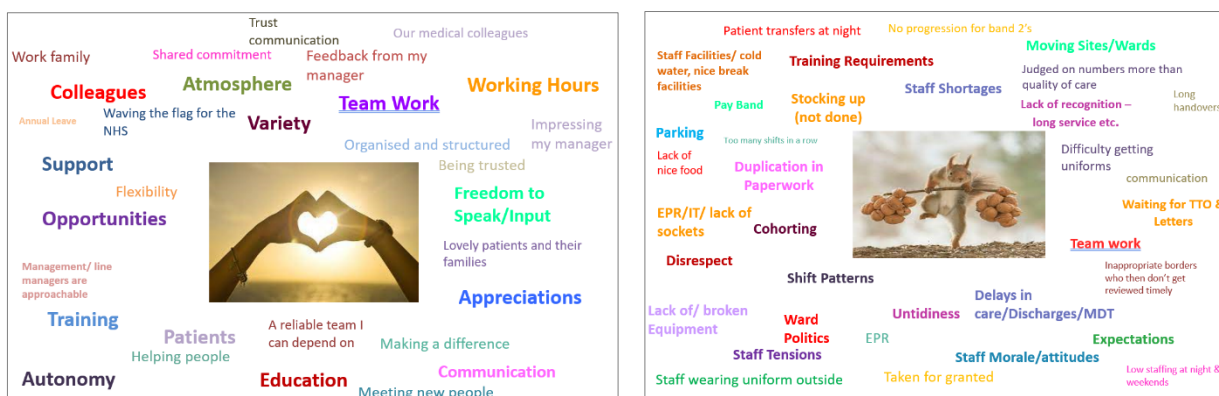
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What did we do?

The Love and Nuts survey was implemented across wards and departments as a simple paper-based tool. Staff were invited to provide feedback on what they appreciate about their workplace and what negatively affects their day-to-day experience. Staff were also asked to identify their staff group to ensure representation across all roles.

The approach generated rich qualitative insight into factors that influence morale, job satisfaction and team culture. It also highlighted recurrent issues affecting staff experience, including operational pressures, communication challenges, equipment concerns, staffing levels, shift patterns and environmental factors.

The findings were used to support open discussion within teams, promote shared ownership of improvement and recognise positive contributions. Staff expressed a clear preference for the simplicity of the paper format, which supported higher levels of engagement.



What has been the impact?

The feedback gathered through the initiative demonstrated that several basic staff needs were not being consistently met. Addressing these needs became a priority, as staff indicated that improvements in these areas would significantly enhance their sense of safety, wellbeing and job satisfaction.

A range of actions have since been implemented or initiated, including:

- Additional parking capacity and improved food provision
- Development of a task and finish group to address IT challenges, EPR issues and duplication of paperwork
- Work to embed the zonal nursing model to support safer cohorting.
- Identification of training needs and collaboration with Training and Development
- Improved communication and planning around staff movement between wards
- Escalation and resolution of equipment issues through established quality audit processes

- Recruitment activity to address staffing shortages, including successful HCA recruitment.
- Improvements to staff facilities, including replacement of broken furniture and provision of water supplies.
- Engagement with clinical leads to improve discharge processes and reduce delays in care.

The initiative has strengthened the link between staff experience and patient care by ensuring staff feel heard, valued and supported. It has also reinforced a culture of listening, compassion and continuous improvement across the Surgical Care Group.

Love  and Nuts 

Quality Improvement Project

DESTINATION HEALTH @ CDDFT *Improving access, experience and outcomes through healthcare travel.*

BACKGROUND Access to healthcare does not begin at the hospital door. Travel and transport are recognised barriers to healthcare access, disproportionately affecting people living in deprivation, rural communities, inclusion health groups and those with disabilities. These barriers contribute to missed appointments, delayed care, poorer outcomes, and widening health inequalities. In 2021, a Poverty Proofing© assessment across CDDFT identified healthcare travel as a key contributor to avoidable inequality. Despite this, travel is often overlooked within patient pathways, outpatient transformation and performance planning.

PROJECT SUMMARY A Trust-wide evaluation of healthcare travel across elective and outpatient pathways, building on Poverty Proofing© recommendations and national guidance. Methods included:

- Review of national policy, standards and NHS England guidance
- Mapping current CDDFT processes for Patient Transport Services (NEPTS) and the Healthcare Travel Cost Scheme (HTCS)
- Benchmarking HTCS delivery against national provider requirements
- Analysis of outpatient performance, deprivation (Core20) and DNA data
- Financial modelling of missed appointments and HTCS uptake
- Engagement with frontline staff, finance, patient experience, and voluntary/community organisations
- Development of practical improvement actions and a proposed strategic framework for healthcare travel

KEY FINDINGS

Healthcare travel is not embedded in patient pathways, missing opportunities to improve access, experience, sustainability and performance.

- The system is complex and poorly understood by both patients and staff, disadvantaging Core20 and inclusion groups.
- CDDFT meets only 2 of 10 national HTCS provider requirements; awareness and promotion are very limited.
- Only ~1.2% of eligible patients claim HTCS, despite an estimated 16% eligibility within the Trust population.
- Core20 patients account for 38% of all missed appointments, with DNA rates 1.4× higher than the average for the Trust.
- Modelling shows that supporting travel costs for 5,000 patients could save ~£836,750, by reducing DNAs alone.
- CDDFT is a national outlier for low remote consultation use, increasing avoidable travel and carbon impact.
- Limited data exists on how patients actually travel, restricting service planning and sustainability work.

ADDING VALUE This work demonstrated that considering healthcare travel is an equity and efficiency opportunity with potential impacts including:

- Improved attendance, access and patient experience
- Reduced health inequalities for Core20 and inclusion groups
- Better outpatient productivity and clinic utilisation, which could reduce demand on unplanned attendances from unmet need
- Financial savings through reduced DNAs (IQEW opportunity)
- Alignment with outpatient transformation, digital strategy and Green Plan
- Reduced stress for patients, families and staff
- Clearer governance and legal compliance with HTCS requirements

4 PRIORITY ACTIONS

To deliver the greatest equity-efficiency benefit, CDDFT should focus on:

1. Raising staff awareness so access and travel are routinely considered in care pathways
2. Improving patient signposting and health-literate information on travel, transport and support
3. Deciding a clear strategic approach to the HTCS, including governance and promotion
4. Expanding telehealth capability to reduce unnecessary journeys and widen access

PROGRESS

- Staff awareness material developed to promote a “Think Travel” approach within clinical staff & outpatient booking teams, prompting consideration of nearest appropriate site, reasonable adjustments for Core20 / disabled patients and whether travel is necessary at all
- Improved travel information included in appointment letters
- Travel & transport website landing page in redesign giving standardised, health literate and accessible information.
- Outpatient travel survey completed

BUT THERE IS STILL MORE TO DO INCLUDING:

- Strengthening promotion of the Healthcare Travel Cost Scheme including understanding financial impact/operational implications
- Access to a virtual telehealth platform
- Establishing clearer governance and ownership for a Trust Travel & Access Strategy that encompasses all the relevant stakeholder groups

Quality Improvement Project

IMPROVING ACCESS TO HEALTHCARE: LEARNING FROM PATIENT EXPERIENCES OF OUTPATIENT TRAVEL

BACKGROUND: Travel to healthcare appointments is a critical but often under-recognised determinant of access, safety, equity and patient experience. Within CDDFT, travel and parking issues are recurring themes in complaints and patient feedback, yet Trust-wide intelligence on how patients travel to outpatient appointments and the impact on attendance, equity and experience was limited. This project aimed to address that gap and inform Trust outpatient transformation, health inequalities action and sustainability priorities.

WHAT DID WE DO?

- Designed and delivered a Trust-wide outpatient travel survey across acute and community sites over a four-week period (Nov-Dec 2025)
- Collected 413 patient, carer and guardian responses, using both paper and digital formats to maximise accessibility.
- Applied a quality improvement lens, analysing findings through patient safety, patient experience, equity (Core20 & inclusion/plus groups), efficiency, and sustainability.
- Mapped travel distance and hospital attended, identifying patterns of long-distance travel and potential mismatches between appointment location and patient geography.
- Explored opportunities to reduce unnecessary travel, including virtual appointments, improved travel information, and alternative transport options such as Park & Ride.
- Used patient voice and quantitative data to identify actionable system-level improvements.

WHAT WAS THE IMPACT?

Improved understanding of patient risk and experience

- Travel and parking were shown to be core determinants of safety and access, not peripheral issues.
- 42% of respondents reported being late for or missing appointments due to travel, rising to 70% at UHND.
- Parking pressure created a critical “last-mile” risk, leading to missed or shortened consultations, increased anxiety, and unsafe drop-off or walking practices, particularly for older adults, disabled patients, parents with infants, and oncology patients.

Clear evidence of health inequalities

- Patients from Core20, disabled and benefit-receiving groups experienced greater transport barriers, higher reliance on public transport, and greater financial burden.
- Intersectional groups (disability + low income) reported the highest cumulative impact, reinforcing the need for reasonable adjustments and equity-aware booking decisions.

Actionable system-wide improvement opportunities

- Identified opportunities to reduce avoidable travel through clearer appointment communication, consideration of nearest suitable site, and expansion of virtual care where clinically appropriate.
- Highlighted quick-win improvements such as clearer messaging that Blue Badge parking is free, better wayfinding, managed drop-off zones, and improved travel information on appointment letters and the Trust website.
- Provided a foundation for engagement with local authority and transport partners on buses and Park & Ride.

Contribution to sustainability goals

- Modelling suggests ~38 tonnes CO₂e reduction per year if only a small proportion of outpatient journeys shifted from car to bus or Park & Ride, supporting Trust and NHS Net Zero ambitions. This work reframes travel from an estates issue to a quality, safety and equity priority. It has generated Trust-wide recommendations which can be taken forward to improve attendance, patient experience, equity, clinic efficiency and sustainability. The findings support the

development of a coordinated, Trust-wide Travel and Access Strategy and a “Think Travel” approach embedded within outpatient booking and service design.

Quality Improvement Project

Reducing in-patient falls by introducing decaffeinated afternoon drinks

Background

The Starling Ward at Richardson Community Hospital observed an elevated incidence of patient falls, particularly during nighttime hours. A considerable portion of these incidents occurred as patients were mobilising to the bathroom. Research indicates that caffeine functions as both a brain and bladder stimulant, increasing urinary frequency and thereby contributing to nocturnal bathroom visits. Other NHS Trusts have implemented trials substituting caffeinated beverages with decaffeinated alternatives, reporting subsequent reductions in overnight toileting and related falls.

To address these concerns, The Starling Ward initiated a Quality Improvement project to assess if providing decaffeinated beverages after 3pm would decrease falls, boost patient comfort, and improve overall safety. The project began in June 2025 and was led by the ward manager.

What We Did

The ward introduced decaffeinated tea and coffee from 3 pm onwards as the default option. Staff were encouraged to explain the health benefits to patients, supporting informed choice and engagement, and posters were displayed across the ward to inform patients and relatives of the opt-out approach. Patients were able to request a caffeinated option if they preferred. The team ensured decaffeinated drinks were limited to afternoons only to minimise withdrawal risks.



What Was the Impact?

- **Improved safety** – Falls decreased during the first months of the trial, particularly overnight. Between June and August 2024, the ward recorded **18 patient falls**, with **10 (56%) occurring overnight (18:00–06:00)** and a falls per 1,000 bed days ranking of **4th place**. Following the introduction of **afternoon decaffeinated drinks in June 2025**, falls reduced to **13** over the same three-month period, representing a **28% reduction**, with **overnight falls decreasing from 10 to 6 (40% reduction)** and now

accounting for **46% of total falls**. Concurrently, the ward's falls per 1,000 bed days ranking improved from **4th to 10th** place, indicating an overall improvement in falls performance compared with other wards. This indicates that falls reduced not only in absolute terms, but also relative to other wards, strengthening the case that this intervention contributed meaningfully to improvement.

- **Improved patient experience** – Most patients reported no noticeable difference in taste between caffeinated and decaffeinated drinks.
- **Enhanced patient care** – Patients felt supported in reducing night-time bathroom trips and appreciated the proactive approach.
- **Increased staff satisfaction** – Staff reported feeling more confident and positive due to the reduction in falls.
- **Positive patient feedback** – Several patients expressed intentions to continue drinking decaf at home.
- **Financial/resource benefits** – The initiative was cost-effective, with minimal price difference between caffeinated and decaffeinated stock.

While this is a small data set the timing, direction of change, and improvement in benchmarking strongly suggest the intervention had a positive impact.

Following the successful implementation of the initiative on Starling Ward, it has now been extended to all in-patient wards within our community hospitals. We are also piloting this initiative across several wards at our acute sites. Additionally, the time period has been expanded, and all afternoon beverages are now served decaffeinated by default.

Quality Improvement Project

Timely administration of critical medication in the Emergency Department

Background

Time Critical Medications (TCM) represent a significant and ongoing patient safety risk within the Emergency Departments, where delays or omissions can rapidly result in harm, increased morbidity, prolonged hospital stays and avoidable cost. Despite national safety alerts since 2010, and clear definitions that delays of more than 30 minutes in scheduled TCM can lead to adverse outcomes, consistent and reliable management of these medicines in ED remains variable. This risk is heightened by increasing ED attendances and extended waiting times, particularly for patients with long-term conditions whose usual medication regimens must be maintained during their ED stay.

The Royal College of Emergency Medicine (RCEM) National Time Critical Medication Quality Improvement Programme (QIP) seeks to address this risk at a national level by embedding safer medication practices across ED pathways. The programme focuses on high-risk medications using the **MISSED** framework (Movement disorders, Immunosuppressants, Sugar/insulin, Steroids, Epilepsy,



DOACs/anticoagulants), reinforcing the core principle that missed time-critical medication causes patient harm. The QIP adopts a phased approach, reviewing the full patient journey from arrival to departure. In Year 1, the programme prioritises people with Parkinson's disease prescribed oral levodopa and patients with diabetes requiring subcutaneous insulin, groups in whom even short medication delays are associated with increased complications, longer lengths of stay, higher readmission rates and significant financial impact. Participation in this QIP supports the Trust's objectives around patient safety, medicines optimisation, harm reduction and assurance against known national risks in urgent and emergency care and brings together several improvements over a period of time.

What We Did

To support delivery of the RCEM Time Critical Medication (TCM) Quality Improvement Programme and mitigate the known patient safety risks associated with delayed or omitted TCM in the Emergency Department, a phased programme of actions has been implemented and planned across clinical practice, staff education, patient awareness and system partners.

1. Medication Access and Clinical Safety

- Parkinson's medication resource box implemented at both sites
- FirstNet TCM icon added to support early identification of patients on TCM (went live **2 Feb 2026**)

2. Workforce Education and Clinical Leadership

- Time Critical Medication link nurses established across both sites (Jan 2025)
- Parkinson's-specific and Insulin-specific TCM teaching delivered at both sites

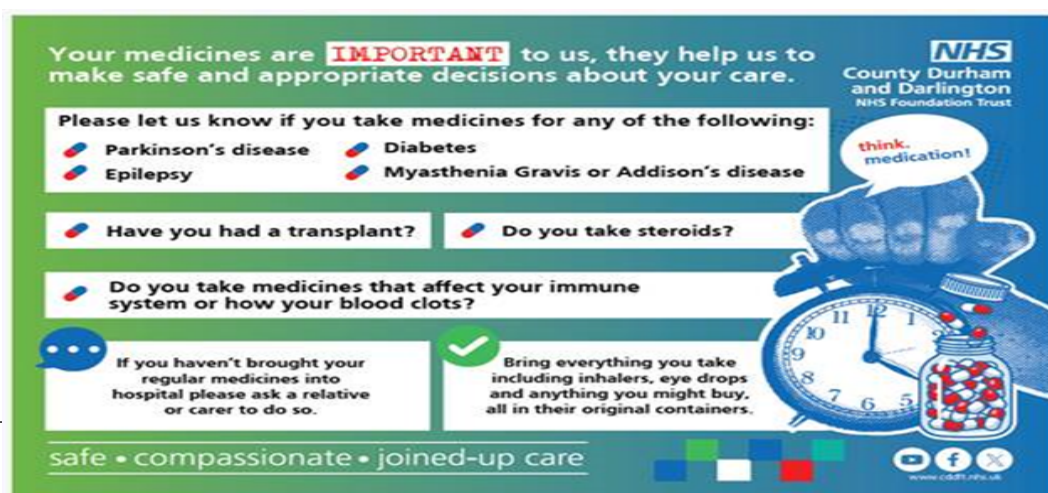
3. Patient Awareness and Shared Responsibility

- RCEM patient-facing posters displayed in ED to encourage and empower patients to liaise with staff about their medications
- Localised TCM posters and ED television screensavers live at both sites (from 16 May 2025)
- Trust external website updated to request that patients bring usual medications to ED (31 Mar 2025)
- Outpatient areas displaying posters requesting patients bring in their own medication (from Sep 2025)

4. Pre-Hospital and System Partner Engagement

- Engagement with North East Ambulance Service (NEAS) and Yorkshire Ambulance Service (YAS) displaying TCM posters (from Feb 2025)
- YAS incorporating TCM education and awareness into practice (Feb 2025)
- YAS working towards "Bring Your Own Medication" / green bag approach (Dec 2025)
- Private ambulance providers engaged to display TCM posters (Aug 2025)
- Ambulance handover process updated to include explicit Time Critical Medication question (Jul 2025)

This programme demonstrates a coordinated, system-wide approach to improving Time Critical Medication safety in the Emergency Department, aligned with RCEM national priorities. Delivery to date shows strong progress in education, patient engagement and medicines access, with further digital and pathway enhancements planned through 2026. Ongoing monitoring will be provided through ED governance and medicines safety structures.



Quality Improvement Project

Reducing pre analytical errors in pathology



Background

The pre-analytical phase of the laboratory testing pathway is widely recognised as a vulnerable point for error and remains a significant contributor to inaccuracies, delays, and inefficiencies in laboratory services. The pre-analytical phase in the laboratory refers to the period from the initial test requisition to the moment a specimen is ready for analysis in the laboratory. Errors at this stage can arise from issues such as incorrect or poorly printed barcodes, incomplete or inaccurate electronic patient record (EPR) requests, and sample labelling problems. These issues can compromise patient safety, delay clinical decision-making, and place additional operational pressures on Pathology services.

The continued need to re-label and re-process samples has several important consequences:

- **Delayed results:** Re-printing and re-labelling samples inevitably delays analysis, leading to slower availability of results for clinicians.
- **Impact on patient care:** Delayed laboratory results can postpone diagnosis, treatment initiation, and discharge decisions, potentially prolonging hospital stays and increasing patient anxiety.
- **Increased clinical risk:** Time-critical tests (e.g. blood gases, coagulation studies, infection markers) are particularly affected, raising the risk of adverse outcomes or suboptimal clinical decisions.
- **Repeat sampling:** In some cases, patients may require repeat blood sampling, causing discomfort, dissatisfaction, and loss of confidence in care processes.
- **Increased workload and cost:** Significant laboratory staff time is diverted to non-value-adding activities such as re-labelling, manual checks, and error investigation, reducing capacity for core diagnostic work.
- **System pressure:** Ongoing pre-analytical errors contribute to inefficiencies across the wider diagnostic pathway, exacerbating pressures on staff, services and patient flow.

In response to ongoing concerns, the Pathology service has been systematically monitoring pre-analytical errors, including sample rejections and EPR-related issues, over the past 6 months.

What we did

- Monthly monitoring of pre-analytical errors, sample rejections, and EPR issues has been established, with reports produced and shared with care groups to promote transparency and awareness.
- Targeted engagement and education have been delivered by Pathology teams across wards, departments, GP practices, and prison healthcare settings. These visits focused on correct

sample labelling, barcode printing standards, and the downstream impact of errors on patient care and laboratory workload.

- Ongoing feedback has been provided to clinical areas to support local improvement, reinforce best practice and close the feedback loop.

Results and Current Position

Overall, sustained improvement across all monitored pre-analytical error types has not yet been achieved. However, a notable and encouraging improvement has been observed in relation to poorly printed barcodes.

Over the past three consecutive months, there has been a sustained reduction in barcode printing errors, which is attributed to the education and engagement delivered by the Pathology teams. Incidents of poorly printed barcodes have reduced from approximately **4,000 per month to 1,500 per month**. This equates to Pathology now re-printing around **half the number of samples** previously required.

Reason for Error	Sep-25	Oct-25	Nov-25	Dec-25	Jan- 26	Feb-26
1- Barcode Poorly Printed	4303	3213	2367	1703	1973	1331

Summary

In summary, targeted education and engagement have delivered a clear and sustained improvement in the quality of barcode printing, demonstrating that focused intervention can be effective. While pre-analytical errors continue to occur, the progress achieved provides a strong foundation on which to build. Maintaining momentum through continued system improvement, staff education, and shared ownership with clinical areas offers a clear opportunity to achieve further and sustained reductions, with associated benefits for laboratory efficiency, turnaround times, and patient care.

Quality Improvement Project

'Take 5'

Background

The "Take 5" initiative, pioneered at Royal Perth Hospital and adapted for County Durham and Darlington NHS Foundation Trust (CDDFT), addresses the critical need for rapid, high-impact learning to reduce repeated patient safety incidents. By delivering 5-minute, high-quality, and visually engaging content, this system directly tackles the challenge of a time-pressured workforce.

What we did

A team from the Trust arranged a virtual meeting with the leads of the "Take 5" initiative at Royal Perth Hospital via Microsoft Teams, allowing them to share their valuable insights and experiences regarding the concept. With express permission from Royal Perth Hospital, County Durham and Darlington NHS Foundation Trust (CDDFT) subsequently launched the initiative. The rollout was led by two dedicated ward managers based at community hospitals. The "Take 5" concept consists of five slides designed to be read in no more than five minutes. The structure is as follows:

- **The Hook:** A dramatic statistic, a brief story, or a "Did you know?" scenario highlighting a safety incident.



- **The Issue (1–2 mins):** Bold statements outlining what went wrong and why it presents a risk.
- **The Action (2 mins):** Three to five clear, bullet-pointed, actionable steps to change practice.
- Resources (30 seconds):** Direct links to full guidelines, policies, or relevant eLearning modules.



Any member of the Trust is permitted to create a Take 5. Upon completion of quality and content reviews, these are published on a dedicated intranet page accessible to all Trust staff.

Five minute education for busy people

Take 5 is an educational initiative inspired by the Royal Perth Hospital model. Take 5 is designed to provide quick, high-quality learning in a concise five-minute format, accessible through a single click on our intranet. Each Take 5 module will consist of up to five slides, featuring three key takeaways and a focus on visuals over text, ensuring it is both impactful and digestible for our busy colleagues.

This initiative underscores our commitment to embedding patient safety and quality improvement into the heart of our organisational culture.

Take 5 latest releases

Click on the titles below to read more on the highlighted topics

Latest Releases

Bare Below the Elbows and Hand Hygiene	Commode Cleaning	Clozapine Acute Trust Training
Discharge	CPE	Lithium Acute Trust Training
Diarrhoea Management	Clean Between	Apprenticeships
Reasonable Adjustment Digital Flags		

Current Take 5's

All of our current 'Take 5's can be found within the relevant topic boxes below

Contact

Take 5

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Feedback, suggestions, requests

If you have any feedback, questions or suggestions for a future Take 5 topic, please email cdofitake5@nhs.net

Take 5 adopted with credit and thanks to Royal Perth Hospital, Australia.

Current Position

Currently, there are **67** 'Take 5' resources available for staff, covering both clinical and non-clinical topics. The initiative has gained significant momentum, with employees from all professional backgrounds discussing their use and independently creating new editions to effectively communicate important messages to colleagues.

Quality Improvement Project

Reducing In-patient Reducing Falls following stroke

Background

Falls are a recognised risk for patients following stroke, with approximately 7% occurring within the first week of admission. In early 2024, Ward 2 experienced an unexpected increase in inpatient falls, prompting immediate action to reduce harm and improve patient safety.

What We Did

A coordinated quality improvement approach was introduced, led by the Ward 2 multidisciplinary team. Key actions included:

- Analysis of falls data using ward floor maps to identify patterns and target interventions.
- Changes to night-shift supervision, with staff positioned closer to patient bays.
- Environmental improvements, including replacement of metal bins with safer alternatives.
- Introduction of highly visible falls-prevention cues (yellow sunflower bundle, signage, lanyards).
- Implementation of post-fall “swarm” huddles to support real-time learning.
- Designation of a Falls Monitor on each shift to lead prevention activity and ensure documentation.
- Enhanced training with the Falls Prevention Team, including EPR documentation and post-fall care.
- Clear guidance for agency staff via a dedicated ward falls folder.

What was the impact?

Reduction in inpatient falls: Following a peak in April 2024 (17 falls), sustained reductions were seen, with falls decreasing to 3 per month by May 2025.

Improved patient safety and experience: Fewer falls and reduced risk of harm.

Stronger safety culture: Improved real-time learning, staff engagement, and shared responsibility for prevention.

Increased staff confidence: Clear roles, visual cues, and targeted training improved consistency and compliance with the Falls Policy.

More reliable documentation: Improved quality and completeness of EPR and incident reporting.

Overall, this work demonstrates that targeted environmental changes, visible safety measures, and structured staff support can significantly reduce inpatient falls and improve patient safety.

Quality Improvement Project

Sisters Hour

Background

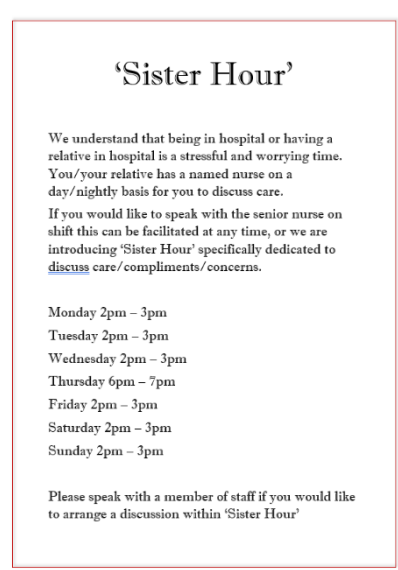
The sister's hour was introduced in response to recurring concerns about communication from patients and relatives. When families were asked why they didn't raise issues or speak to staff, their common answers were that staff appeared busy, they didn't want to be a bother, or they had already spoken to the allocated nurse.

The idea originated from a hospital in Cornwall, where a matrons relative had visited and discovered "sister's hour"—a designated time set up to address any concerns. At that hospital, there was a posted schedule on the ward when relatives or patients could book a session to talk with the sister. Routine updates were still handled by the nurse assigned to the patient's care.

What We Did

The Matrons relative spoke with the sister at the hospital in Cornwall, received some information, and brought back their poster and details. The concept was then shared with the Ward Manager of Ward 16, who decided to implement it herself. Initially, posters were created, however their message was

unclear due to colour choices. The Ward Manager subsequently developed her own posters and leaflets are given to patients upon admission. An appointment book is available seven days a week with either band 7 or band 6 staff available to speak to relatives; the Ward Manager ensures afternoon and evening slots are open. Recently, band 6 staff held a phone meeting for a relative who lived some distance away. A log of all conversations on the unit is maintained by the Ward Manager.



What was the impact?

The results have been fewer complaints as concerns are being addressed promptly. Some staff are concerned about time, but we stress that meeting patients and relatives in person is more efficient, and a far better patient experience, than handling formal complaints.

Other Quality Improvement Projects

Improvement Management Programme Projects

The Trust runs an Improvement Management Programme (IMP), a structured development course that strengthens how staff lead and deliver improvement. IMP builds practical skills in identifying issues, understanding root causes, and testing changes in a systematic, evidence-based way so that services become safer, more effective, and more consistent. As part of the programme, each participant completes their own Quality Improvement (QI) project, applying the tools and methods they learn to a real challenge in their area.

Recent projects have included:

- Improving patient flow and reducing delays in the discharge process at Bishop Auckland Hospital.
- Enhancing the Children's Occupational Therapy social care assessment process.
- Maintaining and strengthening public membership.
- Improving the timely administration of IV antibiotics for neonates at risk of sepsis within the transitional care service.
- Ensuring that 1-hourly nursing rounds are consistently completed.
- Developing a comprehensive resource hub; improving room availability.
- Developing a safe and effective service to increase the uptake and delivery of COVID-19 and winter flu vaccinations for hospital inpatients with a length of stay over 14 days.

Ward 2 'Scan Me' Wall

On Ward 2, a dedicated Healthcare Assistant (HCA) took the initiative to create a 'Scan Me' wall, designed to encourage patients and visitors to share their experiences through the Friends and Family Test. By scanning the displayed QR code, individuals can quickly and easily leave feedback, enabling the ward team to identify

areas for improvement and respond promptly to concerns or suggestions. This proactive approach has helped foster a culture of open communication, ensuring that patient and visitor voices are heard and acted upon to enhance the quality of care.



Patient Safety

Patient safety remains a core priority for the Trust. Our work this year has focused on strengthening learning systems, improving timeliness and quality of patient safety investigations, further embedding and reinforcing the Patient Safety Incident Response Framework (PSIRF), and improving the culture, tools and data used to support safe care.

Early in 2025/26, we merged the patient safety and patient experience teams into a single, unified team. The purpose of this integration was to facilitate triangulation of themes, support the early identification of patient safety incidents that come to the Trust's attention through complaints and concerns raised by patients and their families, and enhance patient and family involvement in patient safety learning responses.

While notable progress has been made following the integration of the patient safety and patient experience teams, there is still work to be done in fully uniting them as a cohesive unit. The process of embedding this unified approach will be a continued focus throughout 2026/27 as we strive to enhance collaboration and maximize the benefits of this merger.

Strengthening Patient Safety Incident Response (PSIRF)

The organisation continues to strengthen the PSIRF foundations, although timeliness of completing investigations has proven to be a significant challenge. This creates risk in relation to rapid identification and implementation of learning; in response to this we have successfully recruited two Band 8a lead Investigators to ensure timely, meaningful and quality investigations without needing to balance competing operational pressures.

Family Liaison Officers have continued to be a valuable role, with 50 specially trained staff continuing to ensure those affected by patient safety incidents are involved in learning and strengthening communication throughout the investigation.

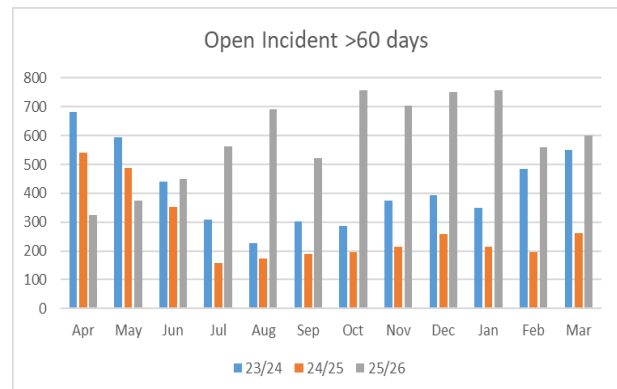
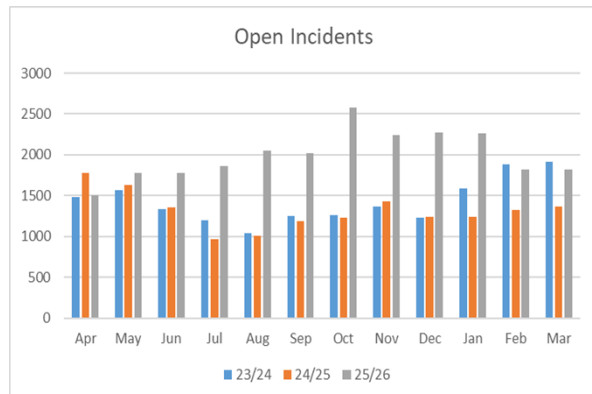
The weekly 'Senior Clinical Leaders' meeting ensures that incidents of moderate or greater harm, or concerning lower-harm incidents, are assigned appropriate investigation types per the Patient Safety Incident Response Plan and that there is awareness across the wider organisation. The Lead Patient Safety Partner attends these meetings.

Incident Reporting and Learning Culture

Timely reporting of patient safety incidents is essential for enabling rapid learning and preventing recurrence; delays in reporting can result in missed opportunities for improvement and increase risks to patient safety. By building a proactive reporting culture and ensuring staff are well-informed, we can better identify trends, address root causes, and implement effective solutions to enhance care quality.

Although there has been some progress, the incident reporting culture within the Trust is not yet at the level we aspire to. During 2025/26, we launched a poster campaign to raise awareness and encourage staff to report incidents but recognised that more robust action was needed. Toward the end of the year, we expanded our efforts through extensive education sessions delivered across the Organisation, aiming to embed the importance of timely and accurate reporting into everyday practice.

Timely incident management has deteriorated this year, with slower responses and a growing number of open incidents, including several that have remained unresolved for over 60 days. These delays result in missed opportunities for learning and increase the risk of repeated patient safety incidents. Embedding learning from incidents is a key priority for 2026/27, and renewed efforts are underway with Care Groups and Specialties to improve response times.



Timeliness of responding to incidents

Patient Safety Reviews Dependent on External Reviewers *Breast Services Lookback*

An external expert desktop review of patients who have had surgical procedures within the Breast Service at CDDFT has been prompted due to concerns raised through the following routes:

- Concerns raised within the current service in relation to the historical care of patients who have re-presented.
- Northern Cancer Alliance review
- Invited Royal College of Surgeons review (focusing on cases that NCA rated as 'red')
- Calls to the helpline from patients who have received care.
- Concerns raised by a neighbouring radiology service.

The 'lookback' is currently focused on patients who had surgery within the service between 1st January 2023 up to and including 21st February 2025, however, patients who have concerns about their care can initiate a review regardless of whether their care was in this timeframe. Work is ongoing to refine the scope, which has been influenced by engagement with other Trusts who have undertaken large scale lookbacks, and analysis of current data. We are actively engaging with stakeholders to determine whether the current timeframe of the lookback provides sufficient assurance.

Recruitment of additional expert reviewers is underway to support timely case reviews, with learning from individual reviews contributing to transformation workstreams.

Audiology

Following national concerns identified through the NHS Paediatric Hearing Services Improvement (PHSI) programme, CDDFT has undertaken a comprehensive retrospective review of newborn hearing screening referrals between 2019 and 2023. A total of 398 cases were identified, with 397 remaining in scope following validation. An External Subject Matter Expert review has confirmed that the majority of cases present no or

low clinical risk. A cohort of 112 children required recall for further assessment, all of whom have been subject to a structured, risk-based prioritisation process and appropriate clinical follow-up. Incident reporting and Duty of Candour processes were applied in line with statutory requirements, and system-wide oversight is maintained through regular Strategic Incident Management Team meetings led by the ICB.

The service has completed all outstanding recall appointments and has received validated harm levels, which are being managed in accordance with the Patient Safety Incident Response Framework (PSIRF). Targeted interventions have been implemented to strengthen service processes, governance arrangements, and staff training. Learning has been embedded to enhance paediatric audiology oversight, improve pathway reliability, and reduce the risk of recurrence.

Quality Improvement (QI) – Capability and Culture

Patient safety isn't just about reacting to incidents after they happen, it's also about preventing them in the first place. Safety II, a modern approach promoted by the NHS, focuses on understanding what goes right in everyday care and using those insights to stop problems before they occur. In simple terms, Safety II encourages staff to look for opportunities to improve systems and processes, learn from positive outcomes, and take proactive steps to make care safer for everyone. By acting on these improvement opportunities, we can ensure that risks are addressed early, making patient care more reliable and resilient.

Integrated within the patient safety and experience team, is a Quality Improvement Sister who plays a pivotal role in supporting wards and departments to improve systems and processes, proactively addressing emerging risks and contributing to safer, higher-quality patient care. By providing expert advice and guidance, the Sister empowers staff across the organisation who wish to undertake their own quality improvement projects.

While the Quality Improvement Sister currently works part-time, which naturally places some limitations on the breadth and scale of support that can be provided, throughout 2026/27 the Trust will continue to explore how this function within the patient safety and experience team can be enhanced. This is part of our commitment to continuously drive improvements in the quality of care delivered to our patients and to maximise the impact of quality improvement initiatives across the organisation.

Key Improvement Projects have Included:

- Trial of decaffeinated afternoon and evening drinks within community hospitals.
- The Sunflower bundle aimed at increasing visibility of patients at-risk of falls, particularly relating to falls in bathrooms and toilet facilities.

Patient Experience – an update on performance during 2025/26

Throughout 2025/26, we dedicated considerable time to ensuring data accuracy and reliable reporting of complaints and concerns. We completely redesigned the complaints process, made patient feedback channels more accessible, increased our use of real-time data, and strengthened learning from patient experiences.

How we listen to Patients and Carers

The Trust gathers feedback through a broad and developing range of channels including:

- Friends and Family Test (FFT), with increased digital capture and commencement of real-time feedback mechanism
- Formal complaints
- Informal enquiries

- Compliments
- National Surveys (Maternity Surveys, National Inpatient Survey, National Urgent and Emergency Care Survey)
- Patient stories

This multi-layered insight, which we will continue to build on and develop in 2026/27 ensures that CDDFT's understanding of patient experience is representative and responsive.

Whilst we have taken initial steps to improve our patient experience function within the trust, we acknowledge that these measures are only the beginning. We recognise that there remains a considerable journey ahead to fully harness patient feedback and ensure that we consistently meet the needs of our patients and their families, especially when concerns are raised. Our ongoing commitment is to develop and refine our approach, so that every voice is heard and acted upon in a meaningful way.

Key Improvement Actions Initiated during 2025/26

Major Policy & Process Improvements

- Full revision of the Complaints and Concerns Policy (POL/COMP/0003) to align with PHSO 2022 standards.
- Updated SOPs and development of improved system workflow.
- Terminology update to align to PHSO standards.

Action to Improve Responsiveness

- Initial steps taken to improved Investigating Officer (IO) contact with complainants, reinforced through a comprehensive training package.
- Improvements to the Ulysses Complaints Management System to help IOs address complaints efficiently.

Engagement & Patient Voice

- Recruitment of a substantive Patient Safety and Experience Partner.
- Increase Patient voice within Trust Quality Meetings
- Plans for a Patient Council to commence during 2026/27.

Learning from Patient Stories

- Patient Stories began to develop over 2025/26 through both videos and presentations.
- Learning from the Patient Stories integrated into training and improvement plans.

Volunteers

- 15 new volunteers were recruited in 2025/26, 13 of whom are now dedicated to speaking to patients across the Trust to collect Friends and Family feedback.
- 124 applications are currently being processed; 64 of these have met to discuss the roles and proceed to security checks and 60 are in process of arranging initial meeting.

Changes to the Friends & Family Test (FFT)

In September 2026, we transitioned from paper-based Friends and Family Test (FFT) to a digital format, with full implementation achieved by October 2026. A trial conducted in the Emergency Department across both acute sites in July 2026 yielded highly positive results, utilising face-to-face feedback via the FFT form and immediately addressing patient and family comments during conversations. This proactive approach enabled prompt resolution of several issues at their source. Additionally, we have enhanced the FFT by adding new questions designed to gain deeper insight into how patients rate the quality of care they receive and how involved they feel in decision making about their treatment. These changes aim to ensure that patient feedback more accurately reflects individual experiences and supports continuous improvement.

However, since this transition, we have observed a significant drop in the number of responses collected. To address this, the increase in volunteers—13 dedicated FFT volunteers recruited to gather direct feedback

from patients on the wards and within departments—should help boost response rates. We are also continuing to work closely with all wards, services, and departments across the Trust to encourage them to actively promote the FFT with their patients, providing multiple tools such as laminated QR codes and posters for patients and families to access the form themselves. All feedback collected is shared monthly with the care group governance team, with emerging themes identified to drive ongoing service improvements.

Realtime Patient Feedback

In February 2026 the Trust commenced a pilot of Real Time Patient Feedback. Utilising a questionnaire already in use at both Northumbria and Newcastle Teaching Hospitals, it aims to establish feedback from at least half of the patients on a ward twice a month. The pilot focused on three wards initially, one at DMH, one at UHND and one at BAH and results so far are positive. Data is being shared immediately with the wards involved to enable them to remedy any issues raised by patients.



In the pilot wards Patients consistently report being treated with kindness and dignity, and free-text feedback frequently describes care as ‘*excellent*’, ‘*attentive*’, and ‘*supportive*’. This will be rolled out Organisation wide throughout 2026/27.

Staff Experience – an update on performance during 2025/26

This section of the Quality Account details the approach taken by the Trust to regularly measure and understand the experiences on the Trust’s workforce. This gives us data and intelligence to inform the Trust’s commitment to being the best place to work and train.

The results of the Staff Survey have been widely shared with all managers and staff and shared on the Trust intranet to promote transparency of the responses on an anonymized basis. This information is used to identify the key priorities for the Trust. In Quarter 3 2025 we established the People and Culture Committee, and this is further supported by the creation of a supporting Strategic Workforce Group which will provide a more focused operational and strategic approach to addressing key workforce issues and outcomes including how we measure staff experience.

It should be noted that the staff survey is just one of the many ways in which we engage regularly with our workforce. We have increased the number of mechanisms to enable increased staff engagement which now include: a Quarterly Staff Survey, an Equity, Diversity and Inclusion Survey, Staff Network Groups, our Trust

Facebook page and Team Talk live briefings held by the Chief Executive and the Executive Team alongside frequent walk-arounds by Board Members and senior leaders, all of which feed into our ongoing activity and commitment to improvement. With the appointment of our new Chief Executive and a number of changes in the Executive team, our Team Talks are held weekly to engage all staff and managers directly, share key important information and provide the opportunity to ask and submit questions to the Executive leadership team.

During 2025/26 we have continued our staff engagement and workforce fulfilment culture work, through the ongoing implementation of our Values into Action #KindnessMatters campaign and training programme. This has been demonstrated through Trust-wide attendance at our all staff workshops and was further embedded with our leadership offer: A Kinder Manager/Leader throughout 2025/26. This will be reviewed in relation to its impact together with our revised culture improvement programme.

We recognise the importance of leadership and line management in supporting workforce fulfilment and engagement. Our leadership development approach aims to nurture compassionate, collective and inclusive leadership. We continue to refine our leadership programmes for our senior leaders as well as our programmes for line managers development. These offers sit alongside our formal qualifications offered through our Apprenticeship and CPD funded development opportunities. We also offer managers standalone programmes in key areas to support their practical and policy skills development. 2025 has seen the introduction of a new peer support offer for leaders through a monthly Leadership Community of Practice online event.

Professional coaching for our staff and managers has been a key feature of our work over the last few years and included increasing the capacity of our internal network of coaches through supporting colleagues to undertake formal ILM Level 5 coaching qualifications. 2025/26 has seen this work progress further with the offer of Coaching Skills for Managers training being offered to our managers and leaders as well as a bespoke programme being offered to support our preceptors, mentors and supervisors to further embed this within our cultural approach to learning and development.

In addition, performance metrics and actions relating to Equity, Diversity and Inclusion have been incorporated into a single Equity, Diversity and Inclusion Dashboard , bringing together all our work under one performance plan aligning the Workforce Race Equality Standard, Workforce Disability Equality Standard and Equality Delivery System, Pay gap reporting, High Impact Actions Equality, Diversity and Inclusion Survey actions and Staff Network Group objectives.

NHS staff survey

The NHS staff survey is conducted annually. From 2021/22 the survey questions align to the seven elements of the NHS ‘People Promise’, retaining two previous themes of engagement and morale. All indicators are based on a score out of 10 for specific questions with the indicator score being the average of those. The response rate to the 2025/26 survey among trust staff was 40% (2024/25: 42%). Scores for each indicator together with that of the survey benchmarking group (Acute and Combined Acute and Community Trusts) are presented below.

Results by Theme 2023 to 2025

The benchmarking group for CDDFT is that of Acute and Combined Acute and Community Trusts.

Indicators (‘People Promise’ elements and themes)	2025		2024		2023	
	Trust Score	Benchmarking Group Score	Trust Score	Benchmarking Group Score	Trust Score	Benchmarking Group Score

We are compassionate and inclusive	7.17	7.28	7.18	7.21	7.24	7.24
We are recognised and rewarded	5.80	5.87	5.82	5.92	5.94	5.94
We each have a voice that counts	6.49	6.60	6.63	6.67	6.66	6.70
We are safe and healthy	5.98	6.07	6.04	6.09	6.03	6.06
We are always learning	5.53	5.57	5.68	5.64	5.63	5.61
We work flexibly	6.15	6.22	6.24	6.24	6.16	6.20
We are a team	6.67	6.75	6.68	6.74	6.74	6.75
Staff Engagement	6.51	6.74	6.7	6.84	6.74	6.91
Morale	5.74	5.84	5.86	5.93	5.85	5.91

The Trust scored lower than the benchmarking group score across all seven People Promise themes and Staff Engagement and Morale and all scores are lower than 2024 scores. The Trust's Culture Plan will progress improvement across all areas during 2026/27 this will sit alongside the Trust's Integrated Action Plan that addresses actions from a number of sources including the Aubrey report, CQC report etc. This will support local level actions taken each Care Group and Directorate via People Matter Action Plans – as described in Staff Experience and Engagement section above.

NHS Annual Staff Survey Areas of Improvement and Deterioration from 2024 to 2025

Positive trends 2025

Top 5 scored questions	CDDFT 2025	Benchmark Group Average
q23a. Received appraisal in the past 12 months	93%	86%
q31b. Disability: organisation made reasonable adjustment(s) to enable me to carry out work	80%	74%
q13d. Last experience of physical violence reported	76%	72%
q11b. In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities	37%	41%
q15. Organisation acts fairly: career progression	56%	53%

Most improved scored questions	CDDFT 2025	CDDFT 2024
q13d. Last experience of physical violence reported	77%	72%
q10b. Don't work any additional paid hours per week for this organisation, over and above contracted hours	66%	61%
q5c. Relationships at work are unstrained	44%	42%
q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	52%	50%
q22. I can eat nutritious and affordable food at work	55%	53%

Key areas for Development 2025

Bottom 5 scores vs Organisation Average	CDDFT 2025	Benchmark Group Average
q25d. If friend/relative needed treatment would be happy with standard of care provided by organisation	50%	61%
q25c. Would recommend organisation as place to work	49%	58%
q25a. Care of patients/service users is organisation's top priority	65%	72%
q4b. Satisfied with extent organisation values my work	38%	42%
q11a. Organisation takes positive action on health and well-being	47%	53%

Most declined scores	CDDFT 2025	CDDFT 2024
q24e. Able to access the right learning and development opportunities when I need to	58%	64%
q3h. Have adequate materials, supplies and equipment to do my work	50%	56%
q24b. There are opportunities for me to develop my career in this organisation	48%	53%
q11a. Organisation takes positive action on health and well-being	47%	53%
q24c. Have opportunities to improve my knowledge and skills	67%	72%

Future priorities and targets

The 2025 NHS Staff Survey results and accompanying staff comments present a consistent picture which requires significant improvement. While teamwork and local leadership remain strengths, sustained operational pressures are impacting staff experience in areas such as wellbeing, engagement and morale.

The workforce priorities for 2026 aim to address these challenges by focusing on:

- staff wellbeing and safe working environments
- leadership capability and visibility
- development and career progression
- operational infrastructure affecting the working environment
- reward and recognition
- Values and behaviours

These priorities aim to ensure that the organisation continues to improve staff experience while supporting the delivery of safe, high-quality patient care.

These will be measured through the People and Culture Committee over the coming months to ensure that we have a positive approach to an improved staff experience.

Equity, Diversity & Inclusion (EDI) Activity 2025/26

EDI Staff Network Groups

We are actively seeking to expand both the membership of our staff networks, the extent to which our staff engage with them and their influence on our policies, procedures and approach. Our staff networks set their own objectives which include the creation of a reasonable adjustments guidance document for managers, promoting LGBTQ+ allyship through the NHS rainbow badge, and increasing cultural awareness through dedicated events. Our networks provide us with an excellent platform for feedback and inclusion from staff

members with protected characteristics. We currently have staff network groups for LGBTQ+, Unity and Ethnic Diversity, Disability and Long-term Conditions and Faith. These groups have both regular meetings and regular communication via email.

We also maintain an Equality Staff Network, which consists of staff that have expressed an interest in our Equality, Diversity & Inclusion work and are valuable allies working to share and promote equity within the workplace as well as in challenging stigma and bias. Our staff networks have seen an increase in combined membership of 306 staff with a further 247 staff subscribing to our Equality staff network newsletter, which provides updates on each network and EDI activity.

Throughout 2025/26 our staff network groups have supported in sharing a variety of staff stories and reflections to assist with awareness and creating resources to educate staff through lived experiences. These stories are incorporated into a number of celebrations dates and campaigns such as Disability History month and South Asian Heritage month. In addition, we utilise these opportunities to further promote and draw awareness to our staff network groups and their activity.

A staff network group chair development programme has also been established in 2025/26 providing an opportunity to develop staff network group leadership through the development of its chairs. The programme forms part of the ongoing support to develop and enhance our staff network groups.

Organisational policies

We have a range of organisational policies to support equity, diversity and inclusion as outlined below. A number of these policies were updated and reviewed in 2025 with the support of key stakeholders, our staff network groups and in line with the latest legislation and best practice:

- Equality, Diversity and Human Rights Policy.
- Disability and Long-term Health Condition Policy.
- Interpreting and Translation Policy.
- Religious Observance by Employees Policy.
- Menopause Policy.
- Dignity at Work Policy.
- Staff Network Group Policy.

Equality, Diversity & Inclusion Staff Surveys

The 2025 Equality Staff Survey was circulated to all CDDFT and SCL staff throughout June 2025. A total of 79 staff responded. We continue to work closely with all our staff network groups to formulate supplementary questions to include in our annual Equality, Diversity & Inclusion internal staff survey. All of the data and staff responses are used to inform our national reports and to influence our future Equality, Diversity & Inclusion action planning process.

EDI Staff Engagement

Staff engagement remains at the heart of our overarching Equality, Diversity & Inclusion strategy, to ensure that we elicit and respond to staff feedback and maintain a compassionate and inclusive culture. We engage with staff through several mechanisms including: trust wide communications; social media and awareness raising events, such as those celebrating particular days or months; for example, Black History month; and the delivery of monthly Equality, Diversity & Inclusion themed live events via a closed Facebook Group for staff and podcasting. We continue to offer staff a variety of methods to provide us with ideas and feedback on what they would like us to focus on in the future, so that we can build upon our staff engagement programme.

We continue to build on our work around the 'lived experience' of all our staff with a wide range of staff stories being shared from underrepresented groups across the Trust. These stories help to raise understanding of the barriers individuals face at work and provide a learning platform for good practice. Our

“Inspiring Inclusion” campaign underpins much of this work with a focus on promoting inclusion, psychological safety and staff disclosure of equality and diversity monitoring information.

Building on the success in 2023 and 2024, our Unity and Ethnic Diversity staff network group held a Cultural celebration event in November 2025. This event provided a platform to showcase both the cultural diversity and range of life experience in our workplace. This event was highly successful with a wide range of staff members attending alongside supporting functions providing information stalls at the event to promote health and wellbeing, training and development and the Trust’s Violence Prevention and Reduction work.

EDI Education and training

We continue to support and develop our Equality, Diversity & Inclusion (EDI) training offer by including positive Equality, Diversity & Inclusion messages in all management and leadership programmes offered internally. This includes, for example: a focus on unconscious bias and eliminating discrimination in our recruitment training (Right People Right Job); supporting reasonable adjustments in Managing Absence training; and, more generally, ensuring inclusive and compassionate leadership approaches are threaded through every part of our offer.

A number of training and awareness programmes have been delivered throughout 2025 on a range of Equality, Diversity & Inclusion issues including Reasonable Adjustments, Religious Observance and Cultural Awareness. New training programmes were launched in 2025/26 on Managing a Neurodiverse team for managers and a Neurodiversity Awareness training programme for staff.

We continue to offer training to all staff on dealing with bullying and negative behaviours which includes a strong focus on treating colleagues with respect in line with the principles of “Civility Saves Lives” and additional information on micro-aggressions experienced by staff with protected characteristics. This training programme also focuses on building confidence in challenging behaviours informally where possible as well as more formal routes for managing situations. Equality, Diversity & Inclusion representatives also actively participate in the Trust’s Violence Prevention and Reduction Group.

Education on mental health issues has continued to be a key focus in 2024, 2025 and into 2026 and will continue to remain a priority as mental health issues continue to be one of the highest causes of sickness absence within the Trust. Training is offered to all staff on Mental Health Awareness and managers are offered training entitled Mental Health at Work for Managers. In addition, we continue to offer Mental Health First Aid training and training in Building Personal Resilience.

EDI Recruitment and Talent Management

Recruitment and career progression continues to be an area for improvement within our Equality, Diversity & Inclusion strategy. We have successfully embedded changes to our recruitment processes through our past work on our ‘Overhauling Recruitment’ initiative. We continue to monitor and improve our inclusivity within not only the recruitment process, but the ongoing experience of our workforce.

One of the key areas highlighted within our most recent Workforce Race Equality Standard report was the disparity within leadership roles in the Trust between staff from White British backgrounds and those with BAME ethnicity. We continue to work with colleagues in our Unity and Ethnic Diversity staff network group to understand any inherent bias, and barriers to progression and to actively promote training and development to ensure that our leadership development and talent management processes support progression into leadership roles for these staff.

Tackling inequality and removing barriers in respect of equality, diversity and human rights through both our employment practices and the services we provide remains a key focus for the Trust.

EDI Reporting

The Trust is committed to making the NHS a better and fairer place for all our staff and service users, through the implementation of our Equality, Diversity and Inclusion (EDI) Framework that sits within our People

Matter Strategy. This strategy, alongside current workforce data, supports with the Trust with establishing annual EDI priorities which, in turn, inform an EDI Dashboard action plan.

The EDI Dashboard action plan is also informed by three improvement framework tools contained in three National reports covering the: Equality Delivery System (EDS); Workforce Race Equality Standard (WRES); and the Workforce Disability Equality Standard (WDES). This is alongside other measures, such as our Disability Confident Scheme commitment, the Gender Pay Gap Report and workforce metrics, and: the results from: the 2025 NHS Staff Survey, our quarterly Pulse surveys; internal staff equality surveys; and views and suggestions from our staff network groups. Action plans are taken forward under the banner of ‘People Matter’ - the Trust’s people strategy and the supporting frameworks of continuous improvement and re-evaluation based on staff feedback.

Through the use of the NHS national reports and staff surveys the Trust is able to comply with the Public Sector Equality Duty, and indeed to go further in order to improve our workforce experience in line with our People Matter strategy.

Equality Delivery System (EDS National Report)

The EDS has three domains:

- Domain 1: Commissioned or Provided Services;
- Domain 2: Workforce Health and Wellbeing; and
- Domain 3: Inclusive Leadership.

There are 11 outcomes, across the three domains as a whole. Having gathered a portfolio of evidence for our staff, patients, stakeholders and local communities we have self-assessed our performance against each domain. The Standard asks organisations to rank their arrangements as: underdeveloped activity, developing activity, achieving activity or excelling activity. Our self-assessed rating is described in table 19 below:

EDS 2025 Self-Assessment Rating

Domain	Rating
Domain 1: Commissioned or Provided Services	Achieving
Domain 2: Workforce Health and Wellbeing	Developing Activity
Domain 3: Inclusive Leadership	Developing Activity
EDSD 25 Overall Rating	Developing Activity

Our continued work and focus on inclusion will allow us to build further evidence across all nine protected characteristics to allow us to demonstrate that Equality, Diversity and Inclusion is fully embedded across all services and the wider organisation, and to help us move towards “excelling” for all objectives and outcomes.

Equity, Diversity and Inclusion forms one of the three key frameworks in our People Matter strategy 2023-2026, helping to ensure that equity, diversity and inclusion is embedded throughout all people activity within the Trust. Our EDI plans are heavily informed by the datasets used to compile our annual Equality Delivery System report, our Workforce Race Equality Standard and Workforce Disability Equality Standard reports, as well as our Staff Network and Staff Survey feedback. All findings support the development of an underpinning EDI Dashboard action plan, with specific local actions being part of locally developed People Matter Action Plans.

Workforce Race Equality Standard (WRES National Report 2025/26)

The Workforce Race Equality Standard was first mandated in July 2015 to ensure that employees from Black, Asian and Minority Ethnic (BAME) backgrounds had equal access to career opportunities and received fair treatment in the workplace.

It is a data-based standard that uses a series of measures to improve the experiences and opportunities of BAME staff working for the NHS. CDDFT uses the Workforce Race Equality Standard report to track progress in identifying and helping to eliminate discrimination and unfair treatment of our BAME staff.

From our most recent Workforce Race Equality Standard report, we focused on the following for 2025/26:

- Increase membership and attendance of the BAME staff network group and formulate effective mechanisms to translate feedback into activity.
- Creating and sharing a supporting campaign to reduce violence and bullying as well as discrimination experienced in the workplace for BAME staff, utilising current working groups and staff networks, and in support of existing campaigns, resources, and processes.
- Improving cultural awareness through staff stories and experiences showcasing cultural awareness and cultural differences, with a focus on reducing negative behaviours experienced by staff.
- Increase staff engagement and membership and with our Unity and Ethnic Diversity staff network group and supporting activities.
- Improve staff non-disclosure rates in relation to protected characteristics on ESR by utilising the established Inspiring Inclusion campaign.
- Review Trust recruitment and induction materials and documentation to better promote and showcase the Trust's inclusivity offerings to new and potential staff members. This work will be carried out alongside the overarching People Matter activity.
- Utilise available workforce data to identify trends alongside feedback and support from network group members.

We review workforce datasets throughout the year to monitor the progress of our Workforce Race Equality Standard action plans and gain further insights into specific focus areas.

Of the 12 voting members on the Board, one has mixed BAME and White - British Ethnicity, and the remainder have White-British Ethnicity recorded on ESR.

Workforce Disability Equality Standard (WDES National Report 2025/26)

The Workforce Disability Equality Standard is mandated by the NHS Standard Contract and has applied to all NHS Trusts since April 2019.

It is a data-based standard that uses a series of measures to improve the experiences of disabled staff working for the NHS, however unlike the Workforce Race Equality Standard this report also includes a section which asks for narrative evidence of actions taken around engagement with staff.

Data in this report was collected from: the NHS Staff Survey 2024 results; our staff network groups and our Equality staff survey results 2025.

In 2025/26 we identified the following areas of focus:

- Supporting current Trust campaigns to tackle harassment, bullying, and abuse from patients and colleagues with focus on minority groups.
- Utilise staff stories and resources to educate colleagues about the lived experience of disability and to challenge stigma, bias, and micro-aggressions/incivilities.
- Promote and embed targeted campaigns that support disability inclusion in the workplace, including Inspiring Inclusion, Disability Confident Leader, and related guidance and resources.
- Build and establish more resources to support with Neurodiversity inclusion in the workplace utilising lived experience and expertise.
- Focus on supporting staff and managers in providing reasonable adjustments for colleagues with disabilities or long-term health conditions. This will include issuing additional guidance for managers and promoting staff stories and existing resources.

PART 3 – Performance and Statements of Assurance

This section of the Quality Account provides details of the Trust's performance against core indicators and sets out a series of statements of assurance from the Board on

NHS England Oversight Framework

NHS England (NHSE) is an independent regulator of NHS Trusts. It requires that minimum standards are maintained, and these are described in the Operating Framework as the most significant priorities. During 2024/25 the principal oversight document issued by NHS England was the Oversight Framework.

The Quality Account includes those indicators which were reported as part of NHSE's oversight for the whole year i.e. those indicators that appear in both the Risk Assessment Framework and the Oversight Framework. The table below summarises the performance during 2025/26 against the relevant indicators and performance thresholds.

Quarterly performance against NHS England Oversight Framework

Indicator		Target/ Threshold	2025/26 Quarterly performance			
			Q1	Q2	Q3	Q4
Referral to treatment	Incomplete pathways waiting less than 18 weeks from point of referral to treatment	92%	68.5% (Jun)	70.1% (Sep)	67.5% (Dec)	66.8% (Mar)
	Incomplete pathways waiting over 78 weeks for elective care	0	0 (Jun)	0 (Sep)	0 (Dec)	0 (Mar)
	Incomplete pathways waiting over 65 weeks for elective care	0	0 (Jun)	1 (Sep)	14 (Dec)	1 (Mar)
A&E	Maximum waiting time of four hours from arrival to admission/ transfer/ discharge	78%	79.8%	80%	77.3%	77.2%
Ambulance handovers	Waiting less than 30 minutes between arrival and handover	95%	90.2%	93.3%	87.8%	90.9%
Cancer	Diagnosis or ruling out of Cancer within 28 days of referral	80%	68.4%	62.7%	56.2%	62.6%
	Commence treatment within 31 days of a decision to treat date	96%	91.6%	93%	93.1%	89.9%
	Commence treatment within 62 days of being referred	85%	70.8%	75.6%	67.4%	70.4%
Clostridium (C.) difficile	Meeting the Clostridium (C.) difficile objective (numbers reported are cumulative, quarterly)	<= 60 cases	25	31	25	19
Diagnostics	Maximum 6-week wait for diagnostic procedures	95%	88.2% (Jun)	83.6% (Sep)	85.5% (Dec)	90.5% (Mar)
Improving access to psychological therapies (IAPT)	Referrals to the IAPT programme will be treated within 6 weeks of referral	75%				
	Referrals to the IAPT programme will be treated within 18 weeks of referral	95%				
	People completing treatment who move to recovery	50%				
SHMI	Reported in arrears Quarter relates to period in which results published	As expected	125.6	126.6	127.2	127.8
			Higher than expected	Higher than expected	Higher than expected	Higher than expected

Reporting against core indicators

This section of the Quality Account provides comparisons of quality standards common to all providers.

The standards are set by the Department of Health and the information and data used is from the NHS Information Centre. All data can be found at: <https://indicators.ic.nhs.uk/webview>.

The standards that are benchmarked are:

- Summary hospital-level mortality indicator (SHMI)
- Patient reported outcome measures
- Emergency readmissions within 28 days
- Responsiveness to the needs of patients
- Staff who would recommend the Trust to family or friends
- Venous thromboembolism risk assessment
- C.difficile
- Patient safety incidents

Summary Hospital-level Mortality Indicator (SHMI)

Performance against the summary hospital-level mortality indicator (SHMI) core quality indicators

Measure	December 2023 – November 2024					December 2024 – November 2025				
	Trust Value	National Average	National Min	National Max	Status	Trust Value	National Average	National Min	National Max	Status
The value and banding of the summary hospital-level mortality indicator ('SHMI')	1.21 Band 1 - Higher than Expected	1.00	0.70	1.28	↓	1.27 Band 1 - Higher than Expected	1.00	0.71	1.31	↓
% of patient deaths with palliative care coded at either diagnosis or specialty level	62	44	17	66	↑	64	44.0	17	69	↑
Key: ↑ better than expected; ↔ as expected; ↓ worse than expected										

The County Durham and Darlington NHS Trust considers that this data is as described for the following reasons: this data is regularly reviewed by the Trust's Mortality Reduction Committee.

The Trust SHMI is higher than expected; the primary priority for the Trust is exploring all opportunities for improvement, learning consistently from deaths, and acting quickly where there are themes and unwarranted variation. Whilst there are some known issues with documentation, and therefore coding, with a 17.7% invalid primary diagnosis code against a national average of 3.6% that may be obscuring where the risks are the focus remains identifying any potential harm.

The Trust provide Palliative Care services on both acute sites over seven days a week and outreach services to a subacute site and five community hospitals. The percentage of deaths coded with palliative care codes is 64%, above the national average. This is a reflection of the good work the Trust Palliative Care Service provide.

The Trust has taken the following actions to investigate SHMI, and improve the quality of its services, by following a comprehensive process for monitoring mortality.

- Deaths within the Trust are all reviewed by a clinical reviewer to understand if there were any improvements or learning identified for a patients care.

- The Trust participates in a regional group that shares best practice with regards to hospital mortality and monitoring.
- The Trust have an active team of Medical Examiners who support the bereavement process of our patients.
- The Trust to continue to apply the SJR+ methodology consistently, aligned with PSIRF principles.
- SHMI and Coding review from multiple stakeholders such as Digital Leads, Clinicians, Clinical Coders and the Information Department to review current challenges, issues or ideas on improvements.

Concerns in relation to Trust SHMI have informed the decision to include this as a 2026/27 priority: *To improve mortality outcomes by addressing higher than expected SHMI and strengthening learning from deaths.*

Patient Reported Outcome Measures (PROMS)

PROMS core quality indicators

Measure:	April 2023 – March 2024					April 2024 – March 2025				
EQ-5D index	Trust Value	National Average	National Min	National Max	Status	Trust Value	National Average	National Min	National Max	Status
case mix adjusted health gain										
Groin hernia surgery*		Data no longer collected					Data no longer collected			
Varicose vein surgery*										
Hip replacement surgery (primary)	0.397	0.458	0.352	0.581	↔	0.405	0.451	0.267	0.543	↔
Knee replacement surgery (primary)	0.308	0.323	0.231	0.405	↔	0.334	0.32	0.231	0.496	↔
Key:	ñ corresponds to patient experience of “significant health gain” ↔ corresponds to patient experience of “no significant health gain”									

The County Durham and Darlington NHS Trust considers that this data is as described for the following reasons: PROMS data is reviewed in directorate meetings.

Emergency readmissions to hospital within 28 days

Performance on emergency readmissions to hospital within 28 days of discharge

Measure	April 2023 – March 2024					April 2024 – March 2025				
	Trust Value	National Average	National Min	National Max	Status	Trust Value	National Average	National Min	National Max	Status
Patients aged 0-15	12.9	12.0	4.2	24.2	↑	7.4	12.03	4.4	20.2	↑
Patients aged 16 or over	13.02	14.18	7.78	21.7	↑	13.5	14.07	7.9	22.2	↑
Key:	↑ better than expected; ↔ as expected; ↓ worse than expected									

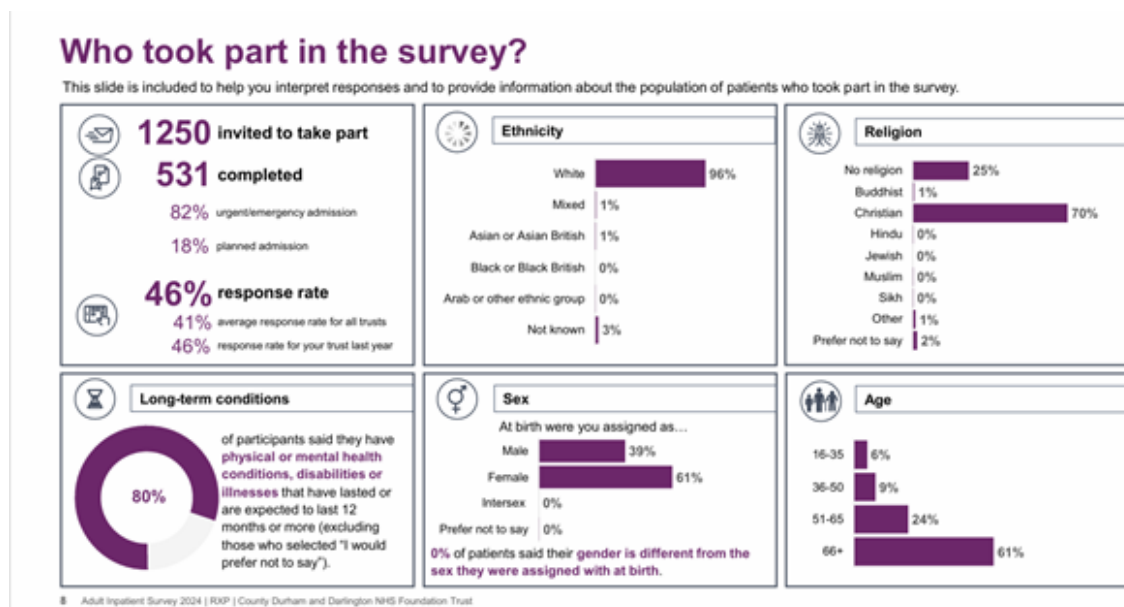
The County Durham and Darlington NHS Trust considers that this data is as described for the following reasons: This data is collated and submitted as per national guidelines and is regularly reviewed.

The Trust has taken the following actions to review emergency readmissions to hospitals within 28 days, and improve the quality of its services, by:

- Wards across the Trust have dedicated Discharge Facilitators who help ensure all provisions are in place prior to discharge.
- The introduction of the Frailty Hospital at Home Service in 2025 provides experienced clinicians with a specialist interest in older peoples medicine a service, to provide care in a persons preferred place of care such as their home. The Frailty Hospital at Home Team help reduce inpatient admission bed days, prevent re-admissions to inpatient beds for care and provide treatment at home. A strong emphasis on advanced care planning is undertaken to ensure patients are cared for correctly in their last months, weeks or days of their lives.
- The Digital systems such as EPR provide staff with checklists and assessments to ensure discharges are thought out and multidisciplinary teams are involved where required.
- Paediatric Services can provide reviews and assessments within their locally based Paediatric Assessment Units where appropriate reducing inpatient admissions to the children's wards.
- Across the inpatient adult wards huddles have been established to improve communication and plans for the whole multidisciplinary teams where a focus is on 'home today'. The ward list is thoroughly reviewed and targeted discharge dates are updated. Discharge Management Teams are then digitally able to track and review patients who are ready for home but unable to progress for a number of reasons.

Responsiveness to the personal needs of patients

Performance on responsiveness to the personal needs of patients



The 2024 National Adult Inpatient Survey were published by CQC on 9 September 2025. Out of 1250 patients invited to take part, 531 responded. The results indicated that, compared to benchmarks, the Trust performed 'about the same' on 41 questions and scored somewhat better than expected on 4 questions.

In comparison with the 2023 results the Trust saw a significant improvement in 5 individual questions, no difference to 32 and significantly worse scores to 1 question - "How clean was the hospital room or ward that you were in?".

Where patient experience is best:

- Support from health or social care services
- Leaving hospital; given enough notice
- Information about medicine to take home
- Leaving hospital; involved in decision making
- Individual needs; taking into account dietary needs

Where patients experience could improve:

- Explaining change of wards; reasons for changing wards in a way they can understand
- Wait to get a bed
- Cleanliness
- Information while on a virtual ward
- Sleeping; preventing sleeping due to noise of staff

The results position CDDFT as a steady performer in patient experience with no significant deficits identified in the survey reporting. Across all core domains (admission, ward environment, staff interactions, discharge and overall experience), CDDFT scored “About the same” as most other NHS trusts nationally. This indicates stable, consistent performance relative to peers, with no areas flagged as significantly worse than average.

Venous thromboembolism (VTE) risk assessment

Performance on VTE risk assessment: %

	2022/23	2023/24	2024/25	2025/26
Measure:	% of admitted patients risk-assessed for VTE			
Target:	95.0%	95.0%	95.0%	95.0%
Trust Value:	94.0%	74.0%	86.8%	85.1%
National Average:	No Data	No Data	90.24%	91.26%
National Min:	No Data	No Data	14.3%	14.9%
National Max:	No Data	No Data	99.4%	99.4%
Status:	↔	↓	↓	↓
Key:	↑ better than expected; ↔ as expected; ↓ worse than expected			

The County Durham and Darlington NHS Trust considers that this data is as described for the following reasons: the Trust has continued to monitor this data internally through our Quality and Performance Dashboards. National data collections recommenced in 2024/25 following suspension due to the Covid-19 pandemic therefore there is no benchmarking data available for the intervening years.

Since October 2022 VTE assessment is documented within the electronic patient record. The system allows us to assess compliance for all assessments more reliably than before, which contributes to the fall off in completion suggested by the above dataset. County Durham and Darlington NHS FT is taking the following actions to improve the quality of care:

- A clinically led Task and Finish Group has been set up to lead on actions to drive up compliance with VTE assessment.

Staff who would be happy with the standard of care provided by this Trust to family or friends

Performance on Staff who would be happy with the standard of care provided to family or friends

Measure	2024/25					2025/26				
	Trust Value	National Average	National Min	National Max	Status	Trust Value	National Average	National Min	National Max	Status
% of staff employed by, or under contract to the Trust who would be happy with the standard of care provided to family or friends	53.7%	61.5%	39.68%	89.6%	↓	49.8%	60.8%	34.7%	88.4%	↓
Key:	↑ better than expected; ↔ as expected; ↓ worse than expected									

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

The 2025 results shows a decline in the percentage of Trust staff who would recommend our services however the Trust remain higher than the lowest scoring organisation. As detailed earlier in the 2025/26 Quality Accounts the Trust has experienced significant change of senior leaders across the last year which has had an impact on the Organisation overall. We continue to have a highly motivated and caring workforce who remain committed to delivering high quality care.

The Trust has taken the following actions to review the data in relation to the measure of staff who would be happy with the standard of care provided by this Trust to family or friends, and improve the quality of its services, by focusing on the following themes:

Everyday systems and facilities

Issues with IT systems, buildings, parking and access to basic facilities can add unnecessary stress to busy shifts have been highlighted and explored for improvements.

Patient safety and dignity

Colleagues spoke about the emotional impact of working in pressured environments, including corridor care and overcrowding. Detailed work is ongoing to improve safety and dignity of all patients and staff and also forms one of our 2026/27 Quality Accounts Priorities.

Leadership and visibility

Staff value supportive local managers but want to see clearer action and stronger connection between senior leaders and frontline experience. Regular and frequent ward visits and department walk rounds have been introduced and ongoing over the last six months.

Workload and staffing pressures

Many described ongoing pressure, burnout and the impact of staffing levels on wellbeing and patient care. Staffing reviews and evaluations have been performed to ensure SafeCare Live is accurate and utilised to support clinical care.

Pay, progression and development

Concerns about fairness, career progression and access to development opportunities were also raised.

Standards and behaviours

Some colleagues raised concerns about behaviours and the confidence to speak up.

C. difficile

Performance on C. difficile

Measure	2024/25					2025/26				
	Trust Value	National Average	National Min	National Max	Status	Trust Value	National Average	National Min	National Max	Status
Trust apportioned rate of C. difficile infection for patients aged two years and over per 100,000 bed days	14.3	20.9	0.0	70.2	↓	14.9	23.3	1.8	81.0	↓
Key: ↑ better than expected; ↔ as expected; ↓ worse than expected										

The County Durham and Darlington NHS Trust considers that this data is as described for the following reasons: the Trust monitors this data regularly via its Infection Control and Quality Committees. Despite a significant increase in the number of C-Diff cases in the past two years, the national trend has been similar and the Trust remains below the national average. The Trust's nationally set threshold was 60 cases; however the Trust reported 100 cases in the year. The increasing trend in C-Diff is also replicated in the region.

Patient Safety Incidents

The table below presents the Trust's performance on patient safety incidents. The Trust considers that this data is as described for the following reasons:

- The Trust encourages all staff to highlight when and where incidents have occurred. The Trust recognises that in line with Learn From Patient Safety Events (LFPSE) guidance, organisations cannot learn and improve if they do not know what the problems are.
- The Trust continues to ensure that staff are engaged in the process and receive feedback on incidents reported at ward and/or department level.

The Trust has taken the following actions to improve patient safety, and the quality of its services, by:

- Delivering training sessions to all staff in leadership roles, overseeing incident learning responses.

Performance on patient safety incidents:

Measure	April 2024 – March 2025	April 2025 – March 2026
Number of incidents	26886	31131
Rate per 1000 admissions	180.9	196.1

Learning from Deaths

Profile

The Trust has had an established mortality review process and is a member of North East Trust Collaborative Mortality Review Group since 2013. Mortality reviews are triangulated with other mortality and patient safety data.

Information, good practice and learning is shared at a bi-monthly meeting of partner trusts. Internally progress and learning are shared with Clinical Leaders at Mortality Group and reports are provided for Care Group Governance meetings. A quarterly report presented at Quality Committee then Trust Board.

Cases reviewed

	Quarter 1 (April – June)	Quarter 2 (Jul – Sept)	Quarter 3 (Oct – Dec)	Quarter 4 (Jan – Mar)	Total (2025/26)
Patient Deaths	516	451	542	553	2067
Mortality reviews complete	108	134	136	72	450
Cases with an incident raised	30	26	17	3	76
Patient deaths were judged to be more likely than not due to problems in the care provided	0	1 (0.2%)	1 (0.2%)	0	2 (0.13%)

During the reporting period, two (0.13%) of patient deaths were judged to be more likely than not due to problems in the care provided. These figures have been generated using the Structured Judgement Review Plus (SJR+) methodology.

The key learning themes identified from the reviews completed during 2025/26 included observation, recognition, and escalation of patient deterioration; decision-making, including the focus of care and recognition of limitations of treatment; and fluid balance monitoring and management.

After 31 March 2025, 224 case record reviews and four investigations were completed which related to deaths which took place before the start of the reporting period. A further 27 cases had an incident raised on Ulysses due to issues identified in the care provided, including those where poor care was identified.

The key learning themes identified from the reviews completed during 2025/26 included observations, recognition, and escalation of patient deterioration; decision-making, including the focus of care and recognition of limitations of treatment; and fluid balance monitoring and management.

Statements of assurance from the Board

Services and reviews

The Trust works to deliver high-quality care by conducting specialty reviews through multi-disciplinary quality panels. These panels were introduced in September 2024 to evaluate services with clinical and management leads, assessing outcomes and patient experience, identifying strengths, areas for improvement, and knowledge gaps.

The panels review data and information relevant to the service including adherence to National Institute for Health and Care Excellence (NICE) guidelines, participation in local and national audits, outcomes metrics such as waiting times and health status, as well as patient feedback including complaints and compliments. Their role is to assess whether services are Safe, Effective, Caring, Responsive, and Well-led.

During 2025/26, the specialties and services that were reviewed included:

- Urgent and Emergency Care
 - Emergency Care
 - Urgent Treatment Centres
 -
- Community Services
 - Community Nursing
 - Community Hospitals
 - End of Life Care
- Diagnostics
 - Pharmacy
 - Radiology
 - Pathology

External reviews from the Royal College of Surgeons Breast service review and the Royal College of Radiologists review of radiology were received in year.

Freedom to Speak Up

The Freedom to Speak Up Guardian holds a stand-alone post with ringfenced time allocated to undertake the duties as outlined by the National Guardians Office (NGO). Registered with the NGO, the FTSU Guardian engages with NGO annual update training and actively participates in the monthly Regional Guardians Network meetings and “Keep in touch” meeting. These provide learning and development, peer support and an opportunity to influence the national FTSU agenda. In addition, the FTSU Guardian is supported by both an Executive and Non-Executive Director lead, and the Senior Associate Director of Assurance & Compliance, updates are submitted to the Quality Assurance Committee, and the Board. The Guardian has contact with the Board of Governors and meets annually to deliver training alongside national and local updates.

Trust staff can confidentially contact the Freedom to Speak Up (FTSU) Guardian by text, email, or phone about any work-related concerns. The Guardian provides impartial advice and support for escalating or managing issues and promotes both individual and organizational learning. Staff are also encouraged to raise concerns with their line managers to build effective working relationships.

The Guardian follows the FTSU process, remaining impartial and practicing effective listening to ensure structure and consistency in handling each case.

Freedom to Speak Up Guardians help:

- Protect patient safety and the quality of care
- Improve the experience of workers
- Promote learning and improvement

By ensuring that:

- Workers are supported in speaking up
- Barriers to speaking up are addressed
- A positive culture of speaking up is fostered
- Issues raised are used as opportunities for learning and improvement

A People & Culture Committee was established in Q3, and the FTSUG will work with stakeholders to share information and ensure concerns are addressed. FTSUG capacity is under review for possible expansion. The number of FTSU Champions has grown to 18, with more expected soon. The Trust’s services and large geography remain well covered.

The FTSUG is attending upcoming Staff Roadshows across the geographical footprint to capture staff voice and encourage a conversation with Executives to share their lived experience of what it’s like to work for the Trust.

Freedom to Speak Up activity in 2025/26:

2025/26	Number of Speak Up Cases	During
Quarter 1	29	
Quarter 2	35	
Quarter 3	61	
Quarter 4	93	
Total	218	
Total number of anonymous cases = 5 (all 5 have since opened up with the FTSUG)		

2025/26 the Aubrey report, relating to the Breast service review, highlighted key cultural issues within the

Trust relating to staff feeling they had the ability to speak up. We committed in our response to the report, 'Safe, Effective, Accountable Care', to, working with the Freedom to Speak Up Guardian, embedding speaking up metrics in all care group and corporate directorate reviews, making it explicit that raising concerns is expected, protected and valued.

Staff reporting incidents

The Learn from Patient Safety Events Service (LFPSE) recognise that organisations that report more incidents usually have better and more effective safety cultures. During April 2025 to March 2026, a total of 31,131 (26,886 in 2024/25) incidents were reported by staff. Representing an increase of 4,245 reported incidents since the previous year.

Once reported, each incident is investigated and remedial action taken where necessary. To further encourage reporting, staff receive feedback on incidents reported which is provided electronically through the Trust's incident reporting system. The Trust is focused on, and taking action to improve, the length of time patient safety incidents are open for to improve timeliness of learning responses.

The top five types of incidents reported in the Trust during 2025/26 are indicated in the table below.

Top five incident types reported by staff during 2025/26 by cause group:

Themes	Number Reported	% of Total Reported
Tissue Viability	3782	13.45%
Access, admission and transfer	2695	9.58%
Maternal/Baby Incident	2318	8.24%
Slips, Trips and Falls	2288	8.14%
Medication Incidents	1926	6.85%

Top 3 Themes using AI to analyse the free text details of incident:

Themes	Number Reported	% of Total Reported
Moisture / Pressure / Skin Damage	5967	20.3%
Medication / Medicines Safety	3696	13.1%
Falls (including unwitnessed)	2590	9.2%

Complaints

The Trust values the contributions patients and their carers have made to its patient surveys, complaints and compliments. The table below presents a summary of the principal complaint performance indicators monitored across the Trust. Please note that there were concerns regarding data and reporting accuracy for information submitted prior to April 2025. However, since April 2025, there has been greater confidence in the accuracy and reliability of both the data and reporting processes.

Key complaints performance indicators

Measure	Target	2025/26 Outturn	2024/25 Outturn	2023/24 Outturn
New complaints received (formal and informal)	no target	2704	2485	1608
Acknowledge all complaints within 3 days of receipt	100%	99.4%	100%	91%
Complaints closed	no target	3000	2655	2543
Complaints closed within timescale agreed with complainant	95%	1494	1429	1416
		55%	58%*	88%

Percentage of well – founded complaints	no target	Data not available*	60%	68%
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*Complaints process updated in January 2024; closure timeframe shortened.

The total number of new complaints received in 2025/26 is 2704 which represents an increase of 219 (9%) from the total received in the previous year. The main themes resulting from complaints are detailed in the table below:

Main themes resulting from complaints

Themes	New complaints received	Percentage of total new complaints received
Clinical Treatment	1199	41%
Appointments	620	21%
Customer Care	566	19%

The Trust acknowledges that prompt resolution of concerns is generally preferable. Accordingly, during the second half of 2025/26, efforts have been concentrated on encouraging and assisting clinical teams to address patient or family issues as they occur, thereby minimising escalation to formal complaints whenever feasible.

During 2025/26, the Parliamentary and Health Service Ombudsman (PHSO) notified the Trust of its intention to investigate 23 complaints.

Patient Safety Incidents

During the year, the Trust continued to embed the NHS England Patient Safety Incident Response Framework (PSIRF) which replaced the Serious Incident Framework (2015). The PSIRF advocates a coordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

Whilst progress has been made there is still significant work to do, particularly in relation to specialty teams taking responsibility for initiating swift learning responses to maximise learning potential.

Our current Patient Safety Incident Response Plan identifies 12 key patient safety priorities:

- Loss of patients to follow up / missed test results.
- Quality of In-patient documentation, discharge information, handover and communication.
- Healthcare Associated Infections.
- VTE assessment and prophylaxis.
- Identification and response to the deteriorating patient.
- Availability and administration of time critical medication and insulin safety.
- Maternity Services.
- Mental Health Crisis.
- Flow of patients from ED / Impact of Full Capacity Protocol.
- Falls.
- Tissue Viability
- Mental Capacity and Safeguarding (including the safe use of chemical restraint).

In accordance with NHS England guidance, we review our plan every two years, whilst this review is not due until later in 2026 the plan is currently under review to refine priorities. In addition to these priorities, the Trust

will also investigate the nationally mandated patient safety incidents in accordance with NHS England guidance.

Never Events

Never Events are serious, largely preventable patient safety incidents that should not have occurred if the available preventative measures had been implemented. During the year 2025/26, the Trust reported two never events, the details of this case are included in the table below:

Never Events reported in 2025/26

Never Event	Number reported	Comment
Wrong site injected	1	Reported in October 2025, 2025/5738 (349210) and investigation is underway.
Surgical/invasive procedure incident meeting SI criteria - NG Tube	1	Reported in June 2025, 2025/3741 (335147), and investigation is complete and awaiting final approval.
Two Aquacel packs unintentionally retained within wound following operation for planned evacuation of left iliac fossa haematoma	1	Reported in March 2026, 2026/1383 (366859) and investigation is underway.

The cases were investigated as After-Action Reviews (AAR) as patient safety incident investigations (PSII) are no longer mandatory under PSIRF and the most proportionate response can be selected.

Duty of Candour

The statutory duty of candour became effective from November 2014 and all Trusts are required to comply with the duty of candour after becoming aware of a notifiable safety incident.

A notifiable safety incident is defined as 'any unintended incident that occurred in respect of a patient during the provision of a regulated activity that, in the reasonable opinion of the healthcare professional, could result in or appears to have resulted in:

- Death
- Severe harm, moderate harm or prolonged psychological harm to the patient.

The Trust is required to be open and honest by verbally notifying patients of such incidents as soon as reasonably practicable and to follow up this verbal notification with a written notification, including an apology. The duty of candour has been included in training for all staff responsible for managing learning responses during quarter 4 of 2025/26, with plans to continue this into early 2026/27. This addresses difficulties staff have had understanding that these responses must be completed within ten working days and highlights the importance of apologising whenever an incident occurs.

The Trust utilises the existing incident reporting system (Ulysses) to record and manage all notifiable safety incidents to ensure that the requirements of the duty of candour are adhered to. Monitoring of compliance is reported on a monthly basis through Quality and Performance Review meetings and to the Quality Committee.

Data quality

Good quality data and information underpin the effective delivery of patient care and is essential if improvements in quality of care are to be made. Improving data quality, including the quality of ethnicity and other equality data, improves patient care and increases value for money.

Data created, maintained, and used by the Trust must be of the highest quality so that:

- Decision making about an individual patient and their care is of maximum benefit
- The Trust can better measure and report on service provision
- The public and patients can assess the quality of the Trust's services

Our data quality: The patient's NHS number

A 2008 National Patient Safety Agency report found that the largest single source of nationally reported patient safety incidents related to the misidentification of patients.

The NHS Number is a unique, key data item that is used to identify and link patient records, so it is crucial that is available when needed. The percentage of patient records that included the patient's valid NHS number for the period 2025/26 in the latest published data (up to and including M10) was as follows:

	Co Durham and Darlington (CDDFT)	National average
Admitted Patient Care	99.8%	99.7%
Outpatient Care	99.9%	99.7%
Accident and Emergency Care	99.1%	98.6%

Which included the patient's valid General Medical Practice Code was:

	Co Durham and Darlington (CDDFT)
Admitted Patient Care	99.9%
Outpatient Care	100%
Accident and Emergency Care	99.7%

Clinical coding of admitted patients

Clinical coding translates the medical terminology, as written by the clinician to describe a patient's diagnosis and treatment, into standard recognised codes. The accuracy of this coding is a key indicator of the accuracy of the patient record.

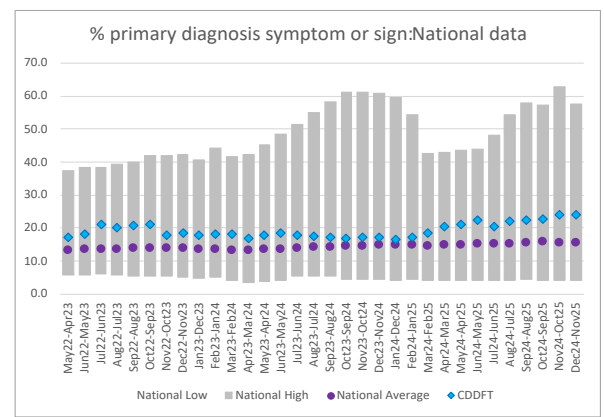
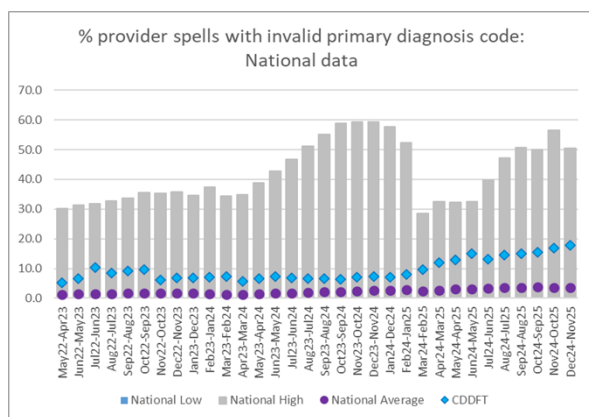
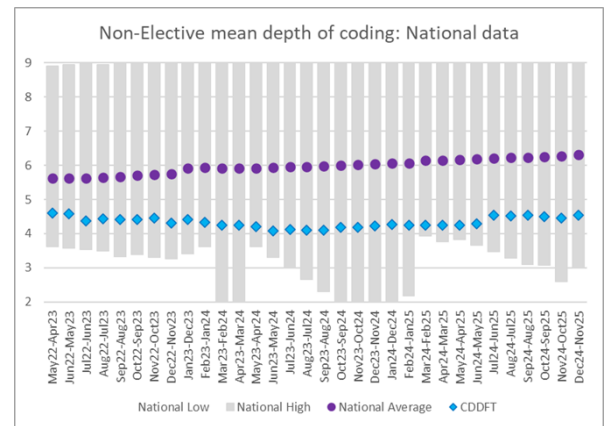
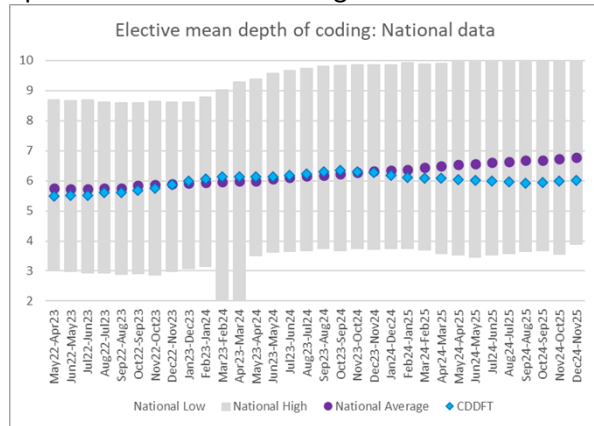
Clinical codes can be used to identify specific groups of anonymised patients (for example, those who have had a stroke, or those who have had a hip replacement operation) so that indicators of quality can be produced to help inform the improvement process.

Since the introduction of the electronic patient record (EPR) system in October 2022, CDDFT has encountered significant challenges within its clinical coding department. The transition has resulted in an inability to submit fully coded data to the Secondary User Service (SUS), impacting on the quality and completeness of information available for national reporting and analysis.

These issues are multi-factorial and currently undergoing review. One consequence is that the code R69.X (Unknown and unspecified causes of morbidity) is externally assigned to all uncoded activity, which provides no detailed clinical coding for these admissions. Most of the uncoded data consists of records from emergency medicine.

The primary factors driving these challenges include ongoing resource constraints within the clinical coding team and suboptimal documentation standards across clinical areas. As a result, coding processes now take

approximately 25% longer than before, further delaying data submission and reducing coding depth. Addressing these concerns is essential for improving data quality and supporting effective clinical and operational decision-making.



Actions to improve data quality

In the last 12 months we have supported our ongoing data quality initiatives by:

- Supported one of the Deputy Chief Clinical Information Officers in attending training to gain the necessary skills to build new pages in the EPR. The outcome of this will be simplification of medical documentation, supporting Doctors in documenting in a more intuitive manner, within structured data fields (documented once used many times) and consequently improving the quality of clinical information.
- Begun development of e-Outcome forms to improve the quality of information recorded in the EPR from outpatient attendances.
- Implementing targeted work to enhance the completeness and timeliness of discharge letters, ensuring that accurate and comprehensive information is promptly communicated to primary care and other stakeholders.

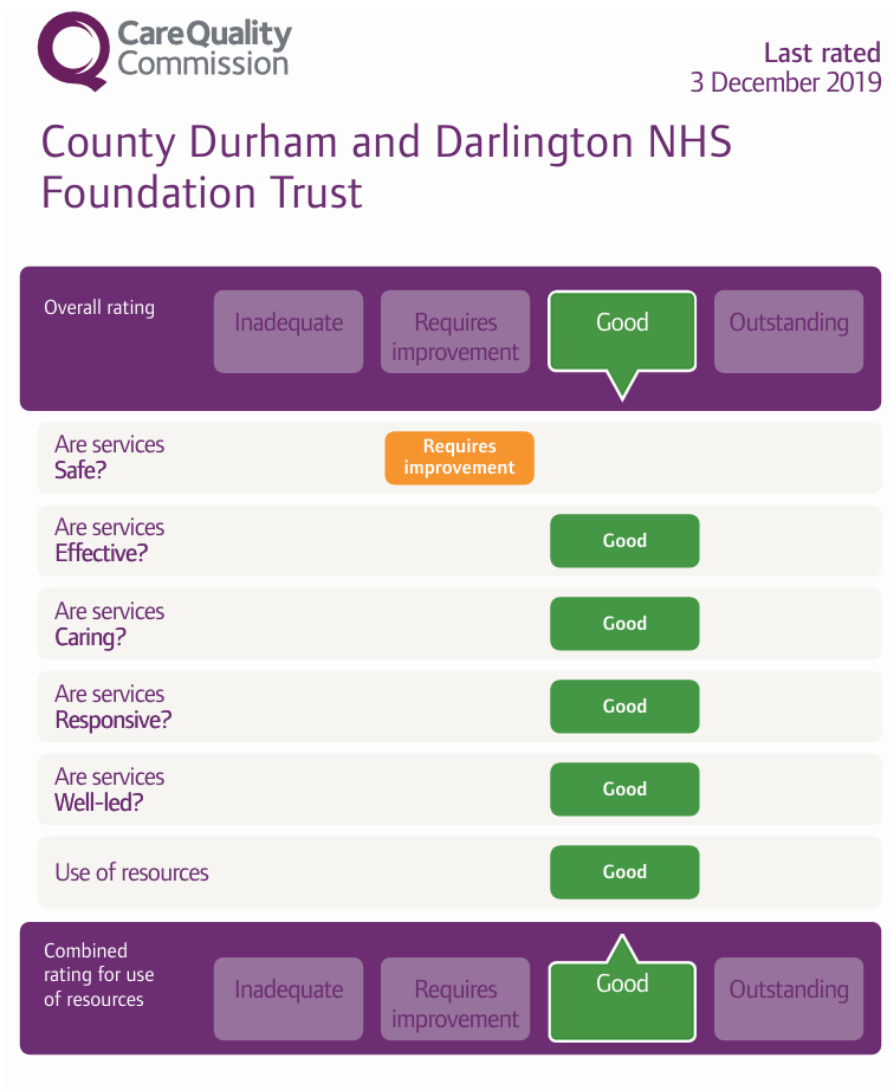
The Trust will continue to support and improve our data quality by:

- Continuing to adhere to national information standards
- Throughout 2026/27, we will implement the new pages in EPR developed by the Deputy Chief Clinical Information Officer (CCIO), actively monitor adherence to the updated documentation process, and provide remedial education to support any instances of non-compliance.
- Engage with clinical leaders on the development and reporting of outcome measures from coded data, using this as an opportunity to address any underlying data quality issues

Statements from the Care Quality Commission (CQC)

Co Durham and Darlington NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is fully registered with no conditions. The CQC issued the Trust with two Section 29a Warning notices in 2025has not taken enforcement action against the Trust during 2024/25.

There were three inspections by the CQC in 2025/26; Surgery, Community Services and Well Led. The Trust has received the draft reports and is currently undertaking factual accuracy checks. The final reports are expected to have a negative impact on the ratings for Surgery and Well Led.



Participation in clinical research

This section of the Quality Account describes the Trust's participation in clinical and academic research studies.

The Trust recruited 4,118 participants in 73 studies across 15 specialties. One major colorectal study contributed many participants, while the remainder were distributed among smaller studies in MSK, Cancer, Reproductive Health, Stroke, Critical Care, Surgery, and Dermatology.

Managing Specialty	Number of Studies	Total Recruitment
Anaesthesia, Perioperative Medicine and Pain Management	5	45
Cancer	8	117
Cardiovascular	3	13
Children	4	9
Critical Care	6	64
Dermatology	7	38
Diabetes, Metabolic and Endocrine	2	15
Gastroenterology and Hepatology	9	3,454
Musculoskeletal and Orthopaedics	6	117
Renal	1	4
Reproductive Health and Childbirth	3	100
Respiratory	1	2
Stroke	6	57
Surgery	6	62
Trauma and Emergency Care	2	78
Total	69	4,175

In the most recent reporting period CDDFT opened 33.3% of non-commercial studies within 60 days of HRA approval (3 of 9 studies), an improvement on the previous period's 27.8% (5 of 18). Commercial performance cannot be compared meaningfully for 2025/26 as no commercial studies were assessed (0 of 0), whereas the 2024/25 year saw 50% (1 of 2) opened on time.

The Nursing Midwifery and Allied Health Professional (NMAHP) & Clinical Research Practitioner (CRP) Research Strategy continues to progress well, with improved visibility of research through Trust communications, leadership forums, and the Annual General Meeting. This is showing strengthened engagement, with new activity in Ophthalmology, and the number of NMAHP Principal Investigators (PI) increasing to 13, alongside one NMAHP Chief Investigator (CI). Student placements, internships and early-career engagement also continue to build research capacity. Despite operational pressures throughout the year, R&I is steadily developing a stronger, more embedded NMAHP research culture.

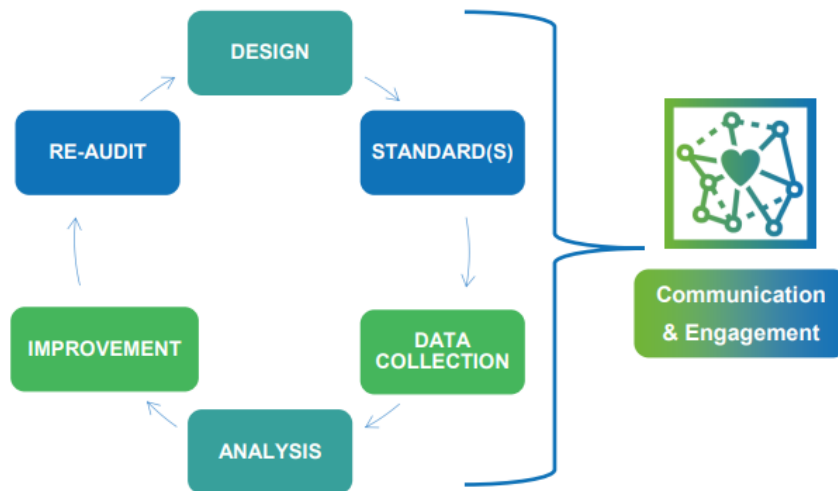
During Quarter 4 of 2025/26, our collaboration with Durham University has continued to mature, with eight live joint projects active across non-medical specialties and steady progress on major shared funding applications, with £425,430 awarded and £4,107,688 submitted earlier in 2025 now awaiting feedback. These activities reflect a growing and increasingly embedded partnership, supporting clinical-academic development and expanding research opportunities for Clinicians, NMAHP and CRP staff.

Throughout the year, innovation has been consistent, with 8 to 14 active projects each quarter and ongoing progress in early-stage ideas, enhanced governance, and increased Trust-wide participation. Improved processes and collaboration via the regional Innovation Forum have helped drive these efforts. The service continues to offer guidance, visibility, and support across organisations, ensuring preparedness for upcoming innovation initiatives.

Confirmed funding for CDDFT from Research Development Network (RDN) in 2026/27 totals £1,100,605. This is made up of £1,025,973 in Hospital Funding, grant allocations of £31,621 for Health Informatics to increase support for research activity, £29,998 for enhanced research delivery capacity (including the ability to undertake home visits), and £13,013 for Pharmacy Capacity.

Participation in clinical audit

Clinical Audit is a quality improvement (QI) cycle (Figure 1) that seeks to improve patient care and outcomes through a systematic review of care against explicit criteria.



CDDFT Clinical Audit Cycle

The results are used to identify opportunities for improvement and to agree the specific actions or changes required. Further audits determine the efficacy of the changes and support continuous improvement. In short:

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

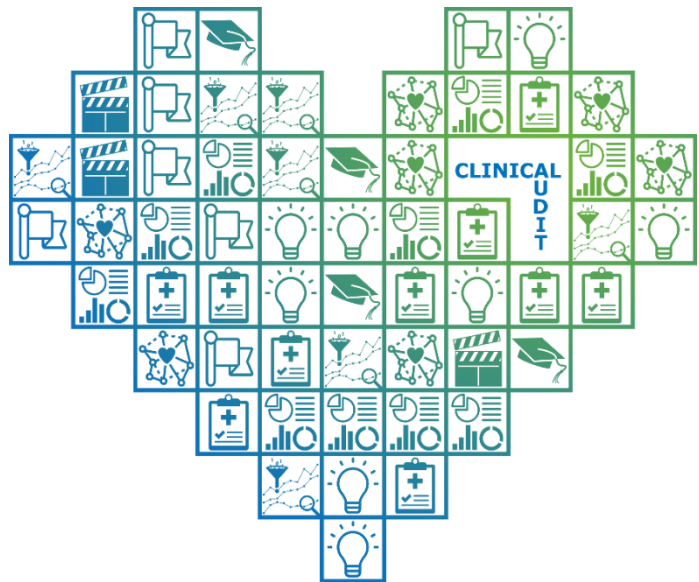
Clinical audit is embedded within the operating rhythm of the Trust and is included as a substantive item on the agenda in monthly Care Group Governance meetings. Assurance is provided to the Board through the Integrated Quality and Assurance Committee which reviews quarterly reports from the Clinical Audit Team.

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

During 2025/2026 **55** national clinical audits and **2** national confidential enquiry covered NHS services that County Durham & Darlington NHS Foundation Trust provides.

During 2025/2026 County Durham & Darlington NHS Foundation Trust participated in **95 %** of national clinical audits and **100 %** of national confidential enquiries of which it was eligible to participate in.

The reports of **22 National Clinical Audits** were reviewed and **93** Local Audits were successfully completed by the provider in **2025/26**. County Durham & Darlington NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:



Actions typically include: education and training of staff; review of patient pathways; the alignment of local processes to national guidelines; changes to current systems and processes; and the introduction of new systems and processes where necessary to support staff in delivering excellent patient care.

For Quality Improvement (QI) programmes such as Clinical Audit to be effective they need to be embedded within the culture of the Trust, easily accessible and supported by senior leadership. The Clinical Audit Team is dedicated to promoting Clinical Audit as a QI tool, refining the audit process and supporting staff through engagement and access to training. In June 2023 the Trust published its new clinical audit strategy covering the development of the Trusts clinical audit programme until the end of 2025/26.

The strategy focuses on seven domains that build on one another to create an effective and efficient clinical audit programme and develop an open and honest culture throughout the Trust. During 2025/2026 significant progress has been made in achieving the objectives within the strategy. The domains and examples of the progress achieved are described below.



Education/Training

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



Reporting Accurate and Actionable Information

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



Action Plans

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



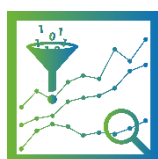
Assurance

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



Communication & Engagement

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



Data Collection & Insights

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



New Ways of Working & Process Improvements

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

Progress Achieved

The internal clinical audit monitoring platform has been updated to:

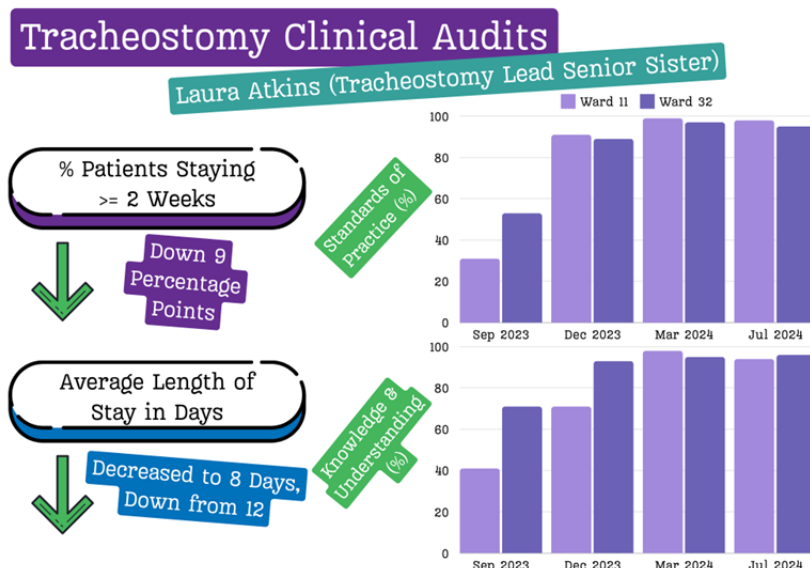
- Strengthen audit approvals to improve the quality of registered audits and to provide governance oversight and increased ownership.
- Improve the reporting of risk and recording of robust action plans
- Provide staff with comprehensive help text and guidance.
- Strength reporting and monitoring for assurance purposes.
- Automated notifications have been implemented.
- A robust escalation process has been implemented to tackle issues with specific audit projects.
- Additional action types have been added to enable the separate monitoring of actions relating to the administration of audits and those related to improvements because of the audits.

Clinical Audit training was provided to 251 staff members throughout 2025/26, with further sessions scheduled for 2026/27.

The clinical audit dashboard, first introduced in 2024/25, has been updated to leverage the increased robustness of the audit platform to provide enhanced functionality. Additionally, all reporting from the clinical audit system has been updated to make use of the changes.

The Trust received two runner up awards in the Clinical Audit Heroes Awards 2025, hosted by HQIP, in the Efficiencies category for 'Clinical Audit Awareness Week' and for an audit investigating Tracheostomy

standards of practice by the Tracheostomy Lead Nurse. This is the first time the Trust has submitted an audit for consideration.



Poster produced showcasing an example of a high-quality clinical audit conducted at CDDFT

Summary of Reviews of National Clinical Audit Reports undertaken in 2025/26

National Audit of Care at the End of Life (NACEL) – 2024/25

Encouraging improvements have been made compared to previous years for key areas that have been a focus for development and improvement, in particular in relation to time from recognition of dying to death and discussion and documentation of hydration and nutrition options. A number of actions have been completed looking at improving recording of end of life care documentation within the Trusts Electronic Patient Record system and teaching about recognition of dying is included in all palliative care education events.

National Heart Failure Audit (NHFA) – 2024/25

The National Heart Failure Audit shows that care for patients admitted with heart failure across UHND and DMH is largely meeting, and in several areas exceeding, national standards. Most patients received cardiology-led care and specialist heart failure input, with strong performance in prescribing ACEi/ARB/ARNI and beta blockers for patients with HFrEF, and discharge planning exceeding national targets at Darlington Memorial Hospital. Opportunities for improvement were identified in the optimisation and documentation of mineralocorticoid receptor antagonist and SGLT2 inhibitor prescribing, and in discharge management planning and referral recording at UHND. Actions agreed through cardiology governance focus on earlier consideration of therapies during admission, improved documentation of clinical exceptions and ensuring all patients have a documented discharge management plan and appropriate referral, with the aim of further improving compliance, data quality and continuity of care.

Transfusion Audits Summary – 2024/25

County Durham and Darlington NHS Foundation Trust undertook several transfusion audits in 2024/25, confirming strong overall compliance with national safety standards and guidelines across both UHND and DMH. The Serious Hazards of Transfusion (SHOT) Audit evidenced good performance in transfusion safety, information technology, staff training, safety culture, hemovigilance, and governance. Partial compliance was noted in documentation of transfusions at discharge and paediatric/neonatal training, prompting actions to enhance electronic patient records, reinforce staff training, and ensure mandatory transfusion education is embedded in induction and refresher programmes.

The National Comparative Audit of Bedside Transfusion Practice demonstrated that patient identification and bedside checking processes are reliably undertaken, with DMH excelling in safety-critical checks. Areas for improvement at UHND included timely recording of patient observations during transfusion, consistency in final administration checks, and completion of staff competency assessments. Measures introduced include targeted training, safety reminders, better bedside electronic equipment, and plans to optimise the electronic patient record with prompts for transfusion practice.

In the 2024 National Comparative Audit of NICE Quality Standard QS138, the Trust contributed a full sample, performing well in pre-operative iron supplementation and use of tranexamic acid, both exceeding national averages. Clinical reassessment and haemoglobin checking after transfusion also showed high compliance. However, providing written and verbal information to transfused patients and consistent documentation of clinical justification for transfusion above restrictive thresholds remain areas for improvement. Actions implemented focus on procedure reviews, reinforcing documentation, and ongoing education, with regular audit and quality improvement cycles established to drive progress and ensure best practice in patient blood management.

Maternity Services Audit Summary - 2024/25

A comprehensive series of audits across County Durham and Darlington NHS Foundation Trust's maternity services in 2024/25 demonstrates strong compliance with national standards and a consistent focus on quality improvement. The Consultant Presence Audit at UHND (Q3 2024) showed near-total adherence to Royal College of Obstetricians and Gynaecologists guidelines, with consultants present for virtually all high-risk scenarios. Partial compliance was noted only in cases of clinical deterioration managed overnight, prompting strengthened documentation and ongoing quarterly audits to ensure safe, senior-led care.

Saving Babies' Lives Care Bundle audits reveal significant progress in multiple areas. Element 6 (Pre-existing Diabetes, Q4 2024/25) saw compliance rates rise to over 80%, with most women receiving recommended continuous glucose monitoring and third-trimester HbA1c checks. Improvements were driven by embedding routine testing in community midwifery, better documentation, multidisciplinary oversight, and staff education.

The Q2 2024/25 executive summary confirmed ongoing implementation of all six elements of the Saving Babies' Lives Care Bundle, with smoking cessation rates surpassing national targets and robust multidisciplinary care pathways for fetal growth surveillance, reduced fetal movement, fetal monitoring, preterm birth, and diabetes management. Efforts to increase tobacco dependency advisor capacity, strengthen digital pathways, and enhance data collection are ongoing to further reduce perinatal mortality and achieve full compliance with SBLCBv3 by March 2025.

Element 2 (Fetal Growth, Q4 2024/25) audits demonstrated high compliance with risk assessment, surveillance, and management of fetal growth restriction. Over 97% of women received aspirin risk assessment at booking, and more than 91% were recommended vitamin D, both exceeding targets. Uterine artery Doppler assessments were well implemented for high-risk pregnancies, with ongoing training, data accuracy initiatives, and multidisciplinary collaboration supporting early detection and optimal management.

The Band 7 Labour Ward Coordinator Supernumerary Status Audit confirmed that coordinators at both UHND and DMH consistently start shifts with protected supernumerary status, as per CNST Safety Action 5. Short-term loss of this status is rare, well-managed, and within national guidelines. Continued workforce review, additional coordinator appointments, and formalisation of supernumerary status in the HealthRoster system are planned to further enhance assurance of safe, senior-led care.

Across all maternity audits, a shared emphasis is placed on regular monitoring, robust documentation, staff education, and data-driven quality improvement. These coordinated actions aim to ensure safe, effective, and senior-led care for mothers and babies, driving sustained progress towards national compliance targets and improved perinatal outcomes.

Participation in the AlliGator international prospective cohort study has provided valuable assurance and learning regarding the management of acute appendicitis across County Durham and Darlington NHS Foundation Trust. Findings demonstrate strong performance in several key areas, including a high laparoscopic appendectomy rate exceeding international benchmarks, appropriate use of imaging, low negative appendectomy rates, and timely access to surgery for most patients. Areas identified for improvement included inconsistent documentation of appendicitis risk scores, variation in time to theatre within 24 hours, lower uptake of ambulatory laparoscopic appendectomy for uncomplicated cases, and opportunities to strengthen early imaging pathways, particularly ultrasound use. Actions have been completed to address these areas, including dissemination of clear clinical guidance, educational sessions across emergency, surgical and paediatric teams, improved imaging algorithms, enhanced training for radiology staff, and reinforcement of timely surgery and pathological specimen assessment. These actions are intended to reduce variation, optimise emergency surgical pathways, and improve patient outcomes, contributing to safer and more efficient care.

National Respiratory Audit Programme Summary - 2023/24

The 2023/24 clinical audits for COPD, adult asthma, and children's asthma across County Durham & Darlington NHS Foundation Trust highlighted persistent gaps in care delivery. For adults, only 10% of asthma patients had peak flow measured within one hour of arrival, and fewer than half received all recommended discharge bundle elements. COPD patients saw just 18% treated with non-invasive ventilation within two hours and only 4% referred to pulmonary rehabilitation on discharge. In children, only 36% received all elements of good discharge planning, and timely steroid administration was achieved in 28%. Action plans have focused on raising staff awareness, improving documentation, and increasing clinical presence in emergency departments. The Trust will continue to monitor progress through re-audit and participation in national improvement programmes, aiming to enhance compliance with national standards and improve patient outcomes for respiratory care.

The national clinical audits and national confidential enquiries in which County Durham & Darlington NHS Foundation Trust was eligible to participate and for which data collection was completed during 2025/2026 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 Program	Topic	Participation	% cases submitted
Case Mix Programme (CMP)	N/A	✓	100%
Emergency Medicine QIPs	Mental Health (Self-Harm)	✓	<10%
	Time Critical Medications (TCM)	✓	<10%
	Care of Older People (COP)	✓	<10%
Falls and Fragility Fracture Audit Programme (FFFAP)	National Audit of Inpatient Falls	✓	100%
	National Hip Fracture Database	✓	100%
	Fracture Liaison Service Database (FLS-DB)	✓	100%
LeDeR - learning from lives and deaths of people with a learning disability and autistic people	N/A	✓	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Maternal mortality surveillance and confidential enquiry (confidential enquiry includes morbidity data)	✓	100%
	Perinatal confidential enquiries	✓	100%
	Perinatal mortality surveillance	✓	100%
Medical and Surgical Clinical Outcome Review	Rib Fractures Trust Wide	✓	Data Collection Ongoing (100% of

Programme			case notes submitted)
	Acute Illness in people with a learning disability	✓	40% (100% of case notes submitted)
National Adult Diabetes Audit (NDA)	National Diabetes Foot Care Audit	✓	Ongoing
	National Diabetes Inpatient Safety Audit (NDISA)	✓	100%
	National Core Diabetes Audit	✓	100%
	National Pregnancy in Diabetes Audit (NPID)	✓	100%
	Transition (Adolescents and Young Adults) and Young Type 2 Audit	✓	Utilises existing datasets
	Gestational Diabetes Audit	✓	Utilises existing datasets
National Asthma and COPD Audit Programme (NAP)	COPD Secondary Care	✓	Ongoing
	Pulmonary Rehabilitation	✓	100%
	Adult Asthma Secondary Care	✓	Ongoing
	Children and Young People's Asthma Secondary Care	✓	Ongoing
National Audit of Cardiac Rehabilitation	N/A	✗	N/A
National Audit of Care at the End of Life (NACEL)	N/A	✓	100%
National Bariatric Surgery Register	N/A	✓	Ongoing
National Cardiac Arrest Audit (NCAA)	N/A	✓	TBC
National Cardiac Audit Programme (NCAP)	Myocardial Ischaemia National Audit Project (MINAP)	✓	TBC
	National Audit of Cardiac Rhythm Management (CRM)	✓	TBC
	National Heart Failure Audit	✓	TBC
National Comparative Audit of Blood Transfusion:	National Comparative Audit of NICE Quality Standard QS138	✓	100%
	National Comparative Audit of Bedside Transfusion Practice	✓	100%
National Child Mortality Database	N/A	✓	100%
National Early Inflammatory Arthritis Audit (NEIAA)	N/A	✓	N/A
National Emergency Laparotomy Audit (NELA)	Laparotomy	✓	Ongoing
National Joint Registry	10 work-streams that all report within Annual report: Primary hip, knee, shoulder, elbow and ankle replacement, Revision hip, knee, shoulder, elbow and ankle replacement.	✓	Utilises existing datasets
National Maternity and Perinatal Audit (NMPA)	N/A	✓	100%
National Neonatal Audit Programme (NNAP)	N/A	✓	100%
National Obesity Audit	N/A	✓	Utilises existing datasets

National Program	Topic	Participation	% cases submitted
Sentinel Stroke National Audit Programme (SSNAP)	N/A	✓	90%+
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	N/A	✓	100%

Society for Acute Medicine Benchmarking Audit (SAMBA)	N/A	✓	100%
National Major Trauma Registry	N/A	✓	Ongoing
National Ophthalmology (NOD)	Age-related Macular Degeneration Audit (AMD)	✓	Utilises existing datasets
	Adult Cataract Surgery	✓	Utilises existing datasets
Epilepsy 12 - National Audit of Seizures and Epilepsies for Children and Young People	Epilepsy12 has separate work-streams/data collection for: Clinical Audit, Organisational Audit	✓	Ongoing
Perioperative Quality Improvement Programme (PQIP)	N/A	✗	N/A
National Paediatric Diabetes Audit (NPDA)	N/A	✓	Utilises existing datasets
National Cancer Audit Collaborating Centre (NATCAN)	National Audit of Metastatic Breast Cancer (NAoMe)	✓	Utilises existing datasets
	National Audit of Primary Breast Cancer (NAoPri)	✓	Utilises existing datasets
	National Bowel Cancer Audit (NBOCA)	✓	Utilises existing datasets
	National Lung Cancer Audit (NLCA)1	✓	Utilises existing datasets
	National Non-Hodgkin Lymphoma Audit (NNHLA)	✓	Utilises existing datasets
	National Oesophago-Gastric Cancer Audit (NOGCA)	✓	Utilises existing datasets
	National Ovarian Cancer Audit (NOCA)	✓	Utilises existing datasets
	National Pancreatic Cancer Audit (NPaCA)	✓	Utilises existing datasets
	Breast and Cosmetic Implant Registry	✗	N/A

National Audits **Not** Applicable to County Durham & Darlington NHS Foundation Trust

National Program	Topic
National Cancer Audit Collaborating Centre (NATCAN)	National Kidney Cancer Audit (NKCA)
	National Prostate Cancer

	Audit (NPCA)
BAUS Data & Audit Programme	BAUS Penile Fracture Audit
	BAUS I-DUNC (Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard of Care Practices)
	Environmental Lessons Learned and Applied to the bladder cancer care pathway audit (ELLA)
Breast and Cosmetic Implant Registry	N/A
National Audit of Cardiovascular Disease Prevention (Primary Care)	N/A
British Hernia Society Registry	N/A
Cleft Registry and Audit Network (CRANE)	N/A
Mental Health Clinical Outcome Review Programme	Real-time surveillance of patient suicide
	Suicide (and homicide) by people under mental health care
	Suicide by middle-aged men (Topic closed 2022/22)
National Audit of Pulmonary Hypertension	N/A
National Clinical Audit of Psychosis (NCAP)	N/A
National Prostate Cancer Audit (NPCA)	N/A
National Vascular Registry	N/A
Out of hospital cardiac outcomes (OHCAO)	N/A
Paediatric Intensive Care Audit Network (PICANet)	N/A
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS)	Oncology & Reconstruction
	Trauma
	Orthognathic Surgery
	Non-melanoma skin cancers
Prescribing Observatory for Mental Health (POMH)	Oral and Dentoalveolar Surgery
	Rapid tranquillisation in the context of the pharmacological management of acutely disturbed behaviour
	The use of melatonin
	The use of opioids in mental health service
Renal Audits	National Acute Kidney Injury Audit
	UK Renal Registry Chronic Kidney Disease Audit
UK Cystic Fibrosis Registry	N/A
National Cardiac Audit Programme (NCAP)	National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)
	National Congenital Heart Disease Audit (NCHDA)
	National Adult Cardiac Surgery Audit
	UK Transcatheter Aortic Valve Implantation (TAVI) Registry
	Left Atrial Appendage Occlusion (LAAO) Registry
	Patent Foramen Ovale Closure (PFOC) Registry
	Transcatheter Mitral and Tricuspid Valve (TMTV) Registry

PART 4 - Listening to the views of stakeholders to inform the Quality Account

There is a high expectation that the Trust listens to the views of a wide range of stakeholders and that the Board of Directors would give careful consideration to these views when determining the quality improvement priorities.

The Trust wishes to acknowledge the views of all those involved and is grateful for their time and contribution. This has included voluntary groups across Co Durham and Darlington, Primary Care, feedback from patients via on-going patient surveys, and public and staff members.

Annex 1: Statements from stakeholders

Statement on behalf of the Council of Governors

The Quality Account was circulated via email on the 16 May 2025 to key stakeholders. This formal response was received on the 23 June 2025.

Council of Governors' response to Co Durham and Darlington NHS Foundation Trust Quality Account 2025/26

TO ADD

Frank White

Lead Governor

Statement on behalf of the Health and Wellbeing Overview and Scrutiny Committee, Durham County Council

The Quality Account was circulated via email on the 15 May 2026 to key stakeholders.
This formal response was received on the XXXXXXXX.

Statement on behalf of the Health and Wellbeing Overview and Scrutiny Committee, Darlington Borough Council

The Quality Account was circulated via email on the 15 May 2026 to key stakeholders.
This formal response was received on the XXXXXXXX.

Statement on behalf of Healthwatch Darlington

Annex 2: Statement of Directors' Responsibilities for the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year. NHS Improvement has issued guidance to NHS Foundation Trust boards on the form and content of annual quality reports (which incorporate the above legal requirements), and on the arrangements that NHS Foundation Trust boards should put in place to support the data quality for the preparation of the quality report. In preparing the quality report, directors are required to take steps to satisfy themselves that:

- The content of the quality report meets the requirements set out in the NHS foundation trust annual reporting manual 2023/24 and supporting guidance from NHSE on Quality Accounts 2023/24
- The content of the quality report is not inconsistent with internal and external sources of information including:
 - o board minutes and papers for the period April 2025 to June 2026
 - o papers relating to quality reported to the board over the period April 2025 to June 2026
 - o feedback from commissioners dated XXXXX
 - o feedback from governors dated XXXX
 - o feedback from local HealthWatch organisations dated XXXX and XXXX
 - o feedback from overview and scrutiny committees dated XXXX and XXXX
 - o the national inpatient survey results for 2024, published September 2025.
 - o the NHS national staff survey 2025.
 - o the Head of Internal Audit's provisional annual opinion of the Trust's control environment dated XXXX. The Trust has agreed an extended accounts submission timetable with NHSE for 2025/26 and the final annual opinion will not be issued until the submission date.
 - o CQC inspection reports dated 11th April 2024 and 14th January 2025.
- The quality report presents a balanced picture of the NHS foundation trust's performance over the period covered
- The performance information reported in the quality report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- The quality report has been prepared in accordance with NHS England's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations), as well as the standards to support data quality for the preparation of the quality report. The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the Board

Mr Steve Russell, Chief Executive Officer

Mrs Alison Marshall, Interim Chair

Annex 3: Glossary of terms

Glossary	
Acute Care	Hospital care for patients with urgent or severe illness, typically provided in emergency departments, acute wards, or specialist units.
Antimicrobial Stewardship	A coordinated approach to promoting the appropriate use of antibiotics to reduce harm, prevent resistance, and improve patient outcomes.
Care Quality Commission (CQC)	The independent regulator of health and social care services in England, responsible for monitoring, inspecting and rating services.
Clinical Governance	The system through which NHS organisations are accountable for continuously improving service quality, safeguarding high standards of care, and creating an environment where excellence can flourish.
Corridor Care	Care delivered to patients in non-clinical areas such as corridors or waiting spaces due to lack of appropriate bed capacity. This is recognised as a patient safety risk.
Duty of Candour	A statutory requirement for healthcare organisations to be open and honest with patients and families when something goes wrong that causes harm.
Electronic Patient Record (EPR)	A digital system used to record, store and access patient clinical information across healthcare services.
Friends and Family Test (FFT)	A national feedback tool that asks patients whether they would recommend the service they received to others.
Healthcare Associated Infection (HCAI)	An infection acquired as a result of healthcare treatment or contact with healthcare services.
Integrated Care Board (ICB)	An NHS statutory organisation responsible for planning and commissioning healthcare services across a defined geographical area.
Learning Culture	An organisational culture where staff are encouraged to report incidents, share concerns, learn from mistakes, and continuously improve care.
Learning from Deaths	A national programme requiring NHS trusts to review deaths to identify learning, improve care, and prevent avoidable harm.
Mortality Review	A structured review of a patient's death to identify whether care could have been improved and to capture learning.
Patient Safety Incident	An unintended or unexpected event that could have or did lead to harm for a patient.
Patient Safety Incident Response Framework (PSIRF)	The NHS framework that guides how organisations respond to patient safety incidents with a focus on learning and improvement rather than blame.
Quality Improvement (QI)	A systematic approach to improving healthcare services through testing changes, measuring impact, and embedding successful improvements.

Serious Incident	A patient safety incident that results in significant harm and requires a comprehensive investigation.
System Improvement Plan (SIP)	A coordinated plan of actions designed to address systemic issues affecting quality or safety.
Temporary Escalation Spaces (TES)	Areas used to care for patients during periods of high demand when standard bed capacity is exceeded.

Annex 4: Abbreviations

Abbreviations	
A&E	Accident and Emergency
ACCEND	Aspirant Cancer Career and Education Development
ACST	Advanced Communication Skills Training
AI Team	Acute Intervention Team
AHP	Allied Health Professional
AMT	Antimicrobial Management Team
AVPU	Alert, Voice, Pain, Unresponsive
BAH	Bishop Auckland Hospital
BRICCS	Building Reliability in Infection Control and Cleaning Standards
BSI	Bloodstream Infection
BSOTS	Birmingham Symptom-specific Obstetric Triage System
CDDFT	County Durham and Darlington NHS Foundation Trust
CEBE	Cancer Experts by Experience
CDI	Clostridioides difficile Infection
CNS	Clinical Nurse Specialist
COP	Care of Older People
CPD	Continuing Professional Development
CQC	Care Quality Commission
DCOAG	Digital Clinical Operational Advisory Group
DMH	Darlington Memorial Hospital
DNA	Did Not Attend
DoC	Duty of Candour
DoLS	Deprivation of Liberty Safeguards
DPR	Deteriorating Patient and Resuscitation
ED	Emergency Department
EPR	Electronic Patient Record
ESR	Electronic Staff Record
ETOC	Enhanced Therapeutic Observations and Care
FFT	Friends and Family Test
G&A	General and Acute
GIRFT	Getting It Right First Time
HCA	Healthcare Assistant
HCAI	Healthcare Associated Infection

HNAs	Holistic Needs Assessments
HTCS	Healthcare Travel Cost Scheme
ICB	Integrated Care Board
ICC	Infection Control Committee
IPCN	Infection Prevention and Control Nurse
IQPR	Integrated Quality and Performance Report
IV	Intravenous
LeDeR	Learning from Lives and Deaths of People with a Learning Disability and Autistic People
LGFB	Look Good Feel Better
LocSSIP	Local Safety Standards for Invasive Procedures
MCA	Mental Capacity Act
MDT	Multidisciplinary Team
ME	Medical Examiner
MEOWS	Modified Early Obstetric Warning Score
MET	Medical Emergency Team
MRSA	Methicillin-Resistant Staphylococcus aureus
MSSA	Methicillin-Sensitive Staphylococcus aureus
MUST	Malnutrition Universal Screening Tool
MVQS	Macmillan Volunteer Quality Mark
MQEM	Macmillan Quality Environment Mark
NACEL	National Audit of Care at End of Life
NCA	Northern Cancer Alliance
NEAS	North East Ambulance Service
NENC ICB	North East and North Cumbria Integrated Care Board
NEWS	National Early Warning Score
NEPTS	North East Patient Transport Service
NHS	National Health Service
PAU	Pregnancy Assessment Unit
PLACE	Patient-Led Assessments of the Care Environment
POPS	Paediatric Observation Priority Score
PSII	Patient Safety Incident Investigation
PSIRF	Patient Safety Incident Response Framework
PSP	Patient Safety Partner
PU	Pressure Ulcer
PWQ	Patient Wellness Questionnaire
QI	Quality Improvement
QIP	Quality Improvement Programme
RCEM	Royal College of Emergency Medicine
SACT	Systemic Anti-Cancer Therapy
SAFER	Senior review, All patients, Flow, Early discharge, Review
SDEC	Same Day Emergency Care
SHMI	Standardised Hospital Mortality Index
SI	Serious Incident

SIP	System Improvement Plan
SJR+	Structured Judgement Review Plus
SOP	Standard Operating Procedure
TCM	Time Critical Medication
TES	Temporary Escalation Spaces
ToR	Terms of Reference
TV	Tissue Viability
TVN	Tissue Viability Nurse
UHND	University Hospital of North Durham
UTC	Urgent Treatment Centre
WHO	World Health Organisation
YAS	Yorkshire Ambulance Service

Annex 5: Feedback form



We value your views on our Quality Account.

Your feedback helps shape our priorities and directly informs the development of the 2025/26 Quality Account.



Please use the QR code or the link below to access the short **feedback form** and share your thoughts.

CDDFT Quality Account
Feedback Form 2025/26



[CDDFT Quality Account Feedback Form 2025/26 – Fill in form](#)

Alternative formats

If you would like a copy of this information in large print or other format, please call the Patient Safety and Experience Team on:

0800 783 5774 or email: cddft.patientexperience@nhs.net



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