County Durham and Darlington NHS FT

QUALITY ACCOUNTS

2021 - 2022

Contents

WELCOME AND INTRODUCTION

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

- Darlington Memorial Hospital; and
- University Hospital of North Durham.

In addition, we provide a range of planned and sub-acute hospital care at Bishop Auckland Hospital.

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

- Shotley Bridge
- Chester le Street
- Weardale
- Sedgefield
- Barnard Castle (the Richardson Hospital)

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

Our mission "Safe, compassionate and joined up care" represents our commitment to put the patient at the centre of everything we do.

A guide to the structure of this report

The following report summarises our performance and improvements against the quality priorities we set ourselves for 2021/22. It also sets out our priorities for the coming year 2022/23. Our priorities for 2021/22 were set in the midst of the Covid-19 pandemic, at a time of uncertainty with respect to how long the NHS would need to treat patients with Covid-19 and how significant its continuing impact would be; as such, they represented interim objectives including continued work on priorities from 2020/21, pending the re-write of our quality strategy, "Quality Matters". There were no specific objectives relating to Covid-19 but there were implicit expectations with respect to patient safety, experience and clinical outcomes with respect to the virus and we have therefore included commentary in response to these in Section 3. Our Quality Strategy for 2022/23 to 2025/26 is in the final stages of consultation. Our quality priorities for 2022/23 therefore reflect our emerging strategic objectives and the residual work needed to achieve our 2021/22 objectives.

The Quality Accounts are set out in three parts:

Part 1:	Statement from the Chief Executive of County Durham & Darlington NHS Foundation Trust.
Part 2A	Review of 2021/22 Quality Priorities
Part 2B	2022/23 Quality Priorities
Part 2C	Statements of Assurance from the board
Part 3:	A review of our overall quality performance against our locally agreed and national priorities.
Annex:	Statements from the commissioners, Local Healthwatch organisations and Overview & Scrutiny Committees.

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

What are Quality Accounts?

Quality Accounts are annual reports to the public from the providers of NHS healthcare about the quality of the services they deliver. This quality report incorporates all the requirements of the quality accounts regulations as well as the priorities which we have identified with our stakeholders.

We set ourselves stretching objectives and, whilst we continue to see significant improvement and success in achieving some of our goals, it is acknowledged that, for some, we have not fulfilled our ambition. Where this is the case, we are committed to taking the further actions necessary to achieve them in 2022/23.

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

Part 1: Statement from the Chief Executive of County Durham & Darlington NHS Foundation Trust.

Draft – wording may be amended as the final version is produced.

I am delighted to introduce to you our Quality Account and Quality Report for County Durham and Darlington NHS Foundation Trust for 2021/22.

For the second year running it is with great pride that I am able to reflect upon the compassion, dedication and fortitude shown by our staff, volunteers and partners for the way in which they come together, not only to care for all our patients through further waves of Covid-19 but also to maintain cancer services and restore high levels of elective and diagnostic services which are successfully reducing long waiting lists. The performance against our quality priorities set out in this Quality Account, should be seen in the context of agile and ongoing innovation to support patients with new needs as we emerge from the pandemic: for example, through waiting well initiatives, long-Covid clinics, a widening range of virtual services and 'virtual wards' based in the community.

Our priorities for 2021/22 were set in the midst of the Covid-19 pandemic, at a time of uncertainty with respect to how long the NHS would need to treat patients with Covid-19 and how significant its continuing impact would be; as such, they represented interim objectives including continued work on priorities from 2020/21, pending the re-write of our quality strategy, "Quality Matters". There were no specific objectives relating to Covid-19 but there were implicit expectations with respect to patient safety, experience and clinical outcomes with respect to the virus and we have therefore included commentary in response to these in Section 3. Our Quality Strategy for 2022/23 to 2025/26 is in the final stages of consultation. Our quality priorities for 2022/23 therefore reflect our emerging strategic objectives and the residual work needed to achieve our 2021/22 objectives.

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

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

We have now refreshed and are in the final stages of consultation on our four-year quality strategy - "Quality Matters" – which includes Board-sponsored actions which aim to increase capacity and time to care; foster and sustain our safe and supportive culture for staff and build skills and capability to enable quality improvements to be made at all levels in the Trust. The roll out of our Electronic Patient Record system – during 2022/23 – provides a huge, and exciting, opportunity to drive quality improvement through technology and we have reflected just some of the specific areas where we hope to benefit in our forward priorities. You will also see further plans to invest in urgent and emergency care services to help bring about the improves that, together with our partners in the local health economy, we have been working towards.

During 2021/22:

- We achieved the objectives which we had set ourselves for improving dementia care, paediatric services and mortality reduction.
- We implemented the substantial majority of the actions we set out to implement.
- We saw reductions in falls per 1,000 bed days and falls with moderate or greater harm resulting from lapses in care
- We met national infection control thresholds for Clostridium Difficile and hospital-acquired e-coli but have more to do to meet our zero tolerance for MRSA and to meet our aspirations with respect to pseudomonas and klebsiella.
- Whilst continuing to see very low levels of serious pressure ulcers, we found one Grade 3 and one Grade 3 ulcer with lapses in care, and were unable to perform in line with our zero tolerance.
- We were unable to meet the target of 95% of electronic discharge letters being issued within 24 hours, in part due to pandemic pressures.
- We saw improvements with respect to end of life care and nutrition, but have further to go to update and roll out our local strategies.

- We strengthened our maternity services with the appointment of fetal medicine consultants and midwives, roll out of the initial stages of our continuity of carer programme and the implementation of immediate and essential actions from the Ockenden report. We continue to strengthen the resilience of midwifery staffing and look forward to a review of staffing by the national Birth Rate Plus in the coming months.
- We continue to benchmark well for excellence reporting but have seen a reduction in reporting in the year and have therefore reinvigorated the reporting arrangements.

Due to capacity constraints, the need to maintain all services and the impact of waves of Covid-19 resulting in prolonged periods with more than 100 inpatients with Covid-19, we have not made the improvements in A&E waiting times which we set out to achieve but are investing in increases in staffing, same day emergency care facilities and additional beds, as well as optimising urgent care pathways, in order to target improvements in 2022/23. With the support of our Integrated Care System, we have bid nationally for funds to significantly expand the A&E at UHND and await the outcome of that bid.

As we move into 2022/23 we will continue to focus on, and target improvements, in those areas where we have not achieved our ambitions. Our new Quality Strategy provides a cohesive framework in which we can identify and make quality improvements across a range of priorities. For 2022/23 we have identified key priorities from this strategy, alongside others where, we did not achieve our stretching ambitions in 2021/22 and aim to complete the residual work in the coming year.

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

Sue Jacques
Chief Executive
30th June 2022

Part 2a: Review of 2021/22 Quality Priorities

The following section of the report sets out our performance with respect to each of the quality priorities we set for 2021/22. Wherever available, historical data is included so that our performance can be seen over time.

Summary of 2021/22 Quality Priorities

Safety	Experience	Effectiveness
Local Quality Priorities for 2021/22 (Section 2a)		
Reduce the harm from inpatient falls	Nutrition and Hydration in Hospital	Mortality Reduction
Improve the care of patients with dementia	End of life and palliative care	Maternity Standards
Reduce harm from Health Care Associated Infections		Paediatric Care
Reduce harm from category 3 & 4 pressure ulcers		Excellence Reporting
Improve the timeliness of discharge summaries		
Improve management of patients identified with Sepsis		
Mandated measures for monitoring (Section 3)		
Rate of Patient Safety Incidents resulting in severe injury or death Time spent in the Emergency Department	Percentage of staff who would recommend the provider to friends and family Responsiveness to patients personal needs	Summary Hospital Mortality Index (SHMI) Patient Reported Outcome Measures

	Ambition achieved		Some but not all elements achieved		Ambition not met

Patient Safety

Reducing harm from inpatient falls

Ambition partly met

Our aim

To reduce harm from falls in an increasingly at-risk population

Our progress

The Trust Falls Strategy was reviewed and updated with input from a wide range of stakeholders, making this a county-wide strategy and one which supports the aim of reducing admissions due to falls outside of the Trust. The strategy is aligned with, and feeds into, our new Quality Matters strategy 2022/23 – 2025/26.

In updating our strategy, we have chosen not to set a blanket target to 'reduce falls' as we need to understand the needs of each of the patient groups we care for and to target our support effectively. To make sustained, positive progress in reducing falls, and in particular falls with harm, we are focusing on establishing those falls attributable to the organisation (lapses in care) and those not attributable to care. We have developed a questionnaire to supplement the falls reporting process, the responses to which enable the Falls Team to pinpoint where support and further learning is required most.

Reviewing the actions from the 2021/22 Quality Accounts the team has continued to provide targeted support, particularly in to our international nursing recruits and those returning to practice, as well as to those wards showing an increase in incidents or are reporting concerns.

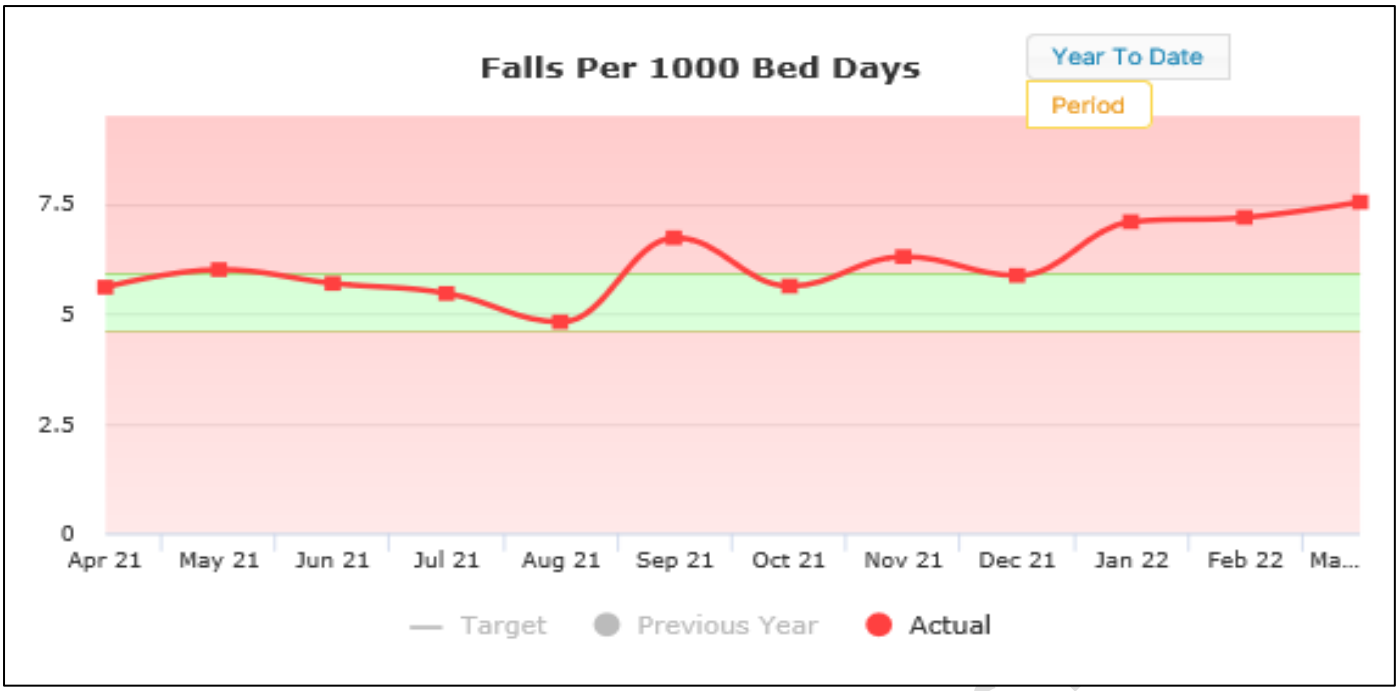
Number of Falls and Falls per 1,000 bed days

The absolute number of falls across the Trust has increased in the year 2021/22, which is reflective of the significantly increased patient flow the Trust experienced compared to 2020/21. The incidence of inpatient falls per 1000 bed days – which relates the number of falls to activity – reduced in 2021/22 compared to the prior year:

	2021/22	2020/21
Acute sites	6.4	6.8
Community sites	5.9	8.0

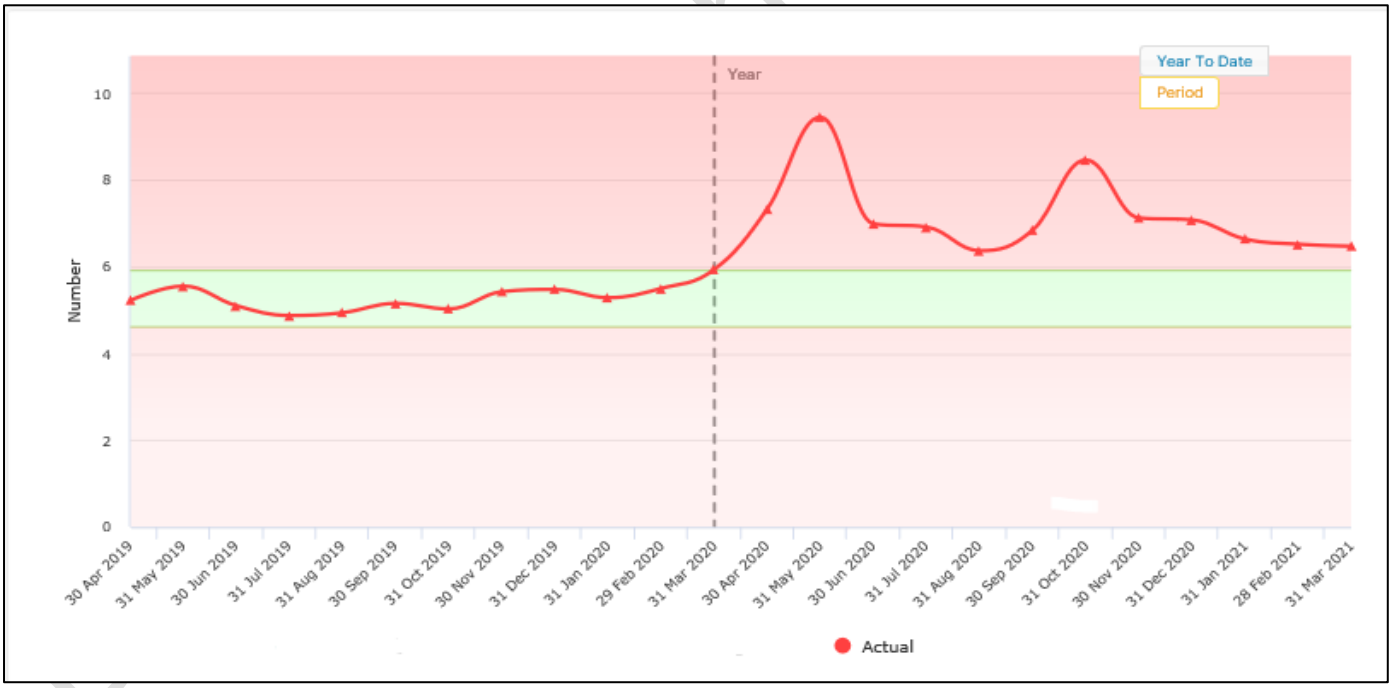
Trend graph – Falls per 1,000 bed days in 2021/22

In the graphs overleaf, the 'green' zone represents normal variation based on pre-pandemic (2019/20) levels. The Trust was able to restore the trend in line with normal variation for much of the year. However, over the last three months we have seen an increase triggered by demand-led – including Covid-19 driven – pressures, which lead to increased movement of patients and staff and a potentially greater risk of falls.



Trend graph – 2019-2021 falls per 1,000 days

The graph below shows the 2019/20 and 2020/21 trends, with the green zone again representing normal pre-pandemic levels. The improved trend in 2021/22, is apparent from a comparison of the 2020/21 trend shown below, with trend in the chart above.



Number of falls with moderate/severe harm

The number of falls resulting in moderate or greater harm increased from 31 reported in 2020/21 to 46 reported in 2021/22. However, those involving lapses in care reduced as outlined below.

All reported falls which result in a fractured neck of femur, or a subdural bleed, or are otherwise identified as being of significant concern were investigated as serious incidents (SI's). Some 26 SI' investigations were completed during the period April 2020 to July 2021, of which nine identified lapses in care against

Trust policy and 17 identified no lapses in care. The SI process took significant time to facilitate, was very time consuming for staff, and learning was only identified at the end of the process which prompted a review of our investigation process. The Trust has therefore adopted a Rapid Review process, involving visits to wards/departments where a fall has occurred within 5 working days, to complete a shorter and more focused review with immediate learning being generated and acted upon sooner. Feedback from both ward staff and the Falls Team has been positive. Since July 2021 and the introduction of the Rapid Review process, 16 rapid reviews for falls incidents have completed of which four identified lapses in care against Trust policy and 12 identified no lapses in care. As such the rate of moderate / severe falls identified due to lapses in care can be seen to be falling; 34.6% in 2020/21 to 25% in 2021/22.

Improving the care of patients with Dementia

Our aim

Building on the work already undertaken in previous years, our aim is to provide appropriate care for patients with cognitive impairment and ensure that patients with dementia and their families have a positive experience of care provided by the Trust.

Our progress

We have begun to re-establish the role of the Dementia Lead Nurse – following the pandemic - and have re-launched John's Campaign. Both initiatives were both shared with colleagues at meetings of our senior nurses and AHP leadership teams, and through our Sisters Away Days during the summer of 2021. To further improve awareness and information sharing we have re-introduced a Trust wide quarterly dementia newsletter and have begun strengthening the role of the dementia link nurse. Our original intention was to produce the Dementia Newsletter monthly however due to a reduction in the information received from different agencies it was agreed a quarterly newsletter would be more appropriate. We have a number of dementia champions are also looking to restart face to face engagement to supplement communication via the newsletter.

We have developed a Dementia-friendly Hospital and Environment Programme drawing on current research and we continue to seek out opportunities and funding to improve the hospital environment. This work is underpinned by the dementia friendly environment audit, which helps us to develop identify and share areas of good practice and is aligned to the development of frailty services. Audit findings are shared with ward managers and matrons to inform action plans.

We have re-launched the carer passport and "This is me" documentation and, during June 2021, undertook the optional case note audit within the national audit of dementia. These audit results, available in spring 2022, will inform future action plans and development schemes. CDDFT will be participating in the 5th round of the national audit of dementia in 2022-2023.

Dementia training is now available via the Trust's e-learning portal. The training target for 2021-22 was achieved, the team are looking to continue to achieve and maintain targets throughout 2022-2023. We will be re-introducing face to face training opportunities; for example, sensory training and becoming a dementia friend.

We continue to work with stakeholders, regional and national working groups to promote dementia services and understanding/awareness and to ensure the needs of those with dementia are taken into consideration, when developing services and changes in clinical practice.

Ambition partly met

Reducing harm from health care associated infections

Our aim

To reduce harm from health care associated infections, in particular by aspiring to:

- a zero tolerance of MRSA bacteraemia
- meet the following thresholds set by NHS England and Improvement:
  - No more than 45 cases of healthcare associated Clostridioides *Difficile* Infections (CDI)
  - No more than 113 healthcare associated cases E coli
  - No more than 38 cases of healthcare associated *Klebsiella sp.*
  - No more than 11 cases of healthcare associated *Pseudomonas ag*

Our progress

During 2021/22 we updated our blood culture policy in line with national guidance and provided face to face IPC training through 'topic of the month' sessions for front-line staff, both actions were identified as measures of success in our last Quality Accounts.

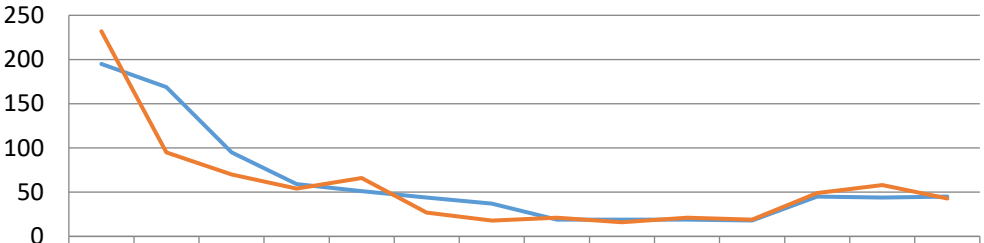
MRSA

Unfortunately there were four cases of MRSA Bacteraemia during the 2021/22 placing the Trust above its threshold of zero avoidable infections. Post infection reviews were carried out on all cases and findings shared across the organisation.

Clostridium difficile

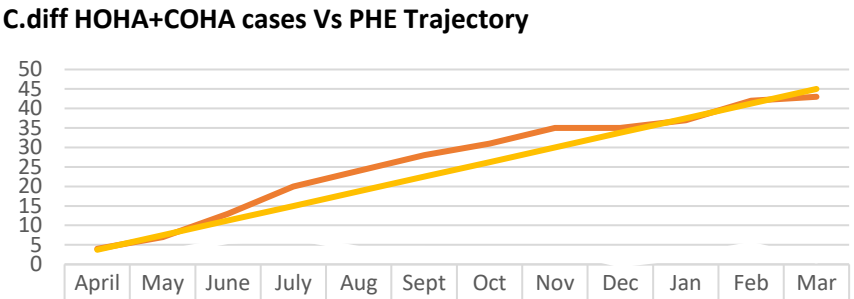
To date the Trust reported 43 trust apportioned Clostridium *Difficile* cases against NHSE/I threshold of 45. The chart below shows the Trust's performance from 2008/9 which shows significant reduction over time. The increase in both the threshold and the actual performance that can be seen from 2019/20 reflects a change to the national definition of trust apportioned cases.

Clostridium difficile Trust Apportioned cases
County Durham & Darlington NHS Foundation trust
2009/10 - 2021/22



	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Threshold	195	169	95	59	51	44	37	19	19	19	18	45	44	45
Actual	232	95	70	54	66	27	18	21	16	21	19	49	58	43

CDDFT CDI trajectory graph 2021/2022



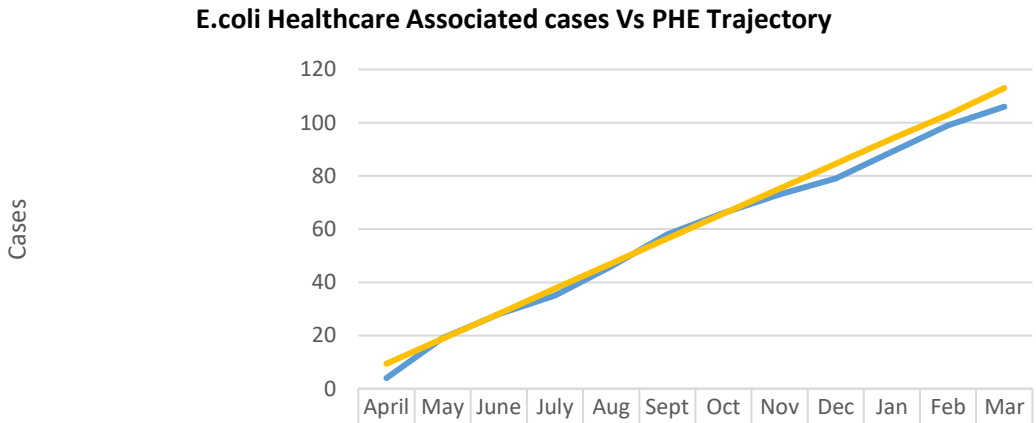
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
C.diff HOHA+COHA cases	4	3	6	7	4	4	3	4	0	2	5	1
Cumulative HOHA+COHA case total	4	7	13	20	24	28	31	35	35	37	42	43
Trajectory	3.75	7.5	11.25	15	18.75	22.5	26.25	30	33.75	37.5	41.25	45

There are still lessons to be learned within the Trust and we aim to ensure that these are embedded in practice in the coming year. Post Infection Reviews (PIR) highlighted key themes including delays in sampling, isolation, inappropriate antibiotic prescribing and inconsistent use of the diarrhoea assessment tool which will be addressed in the work planned for the coming year.

It should be noted that, relative to levels of activity and when considered in the national context, the Trust continues to have lower than average rates of Clostridioides *Difficile* per 1,000 bed days.

E coli

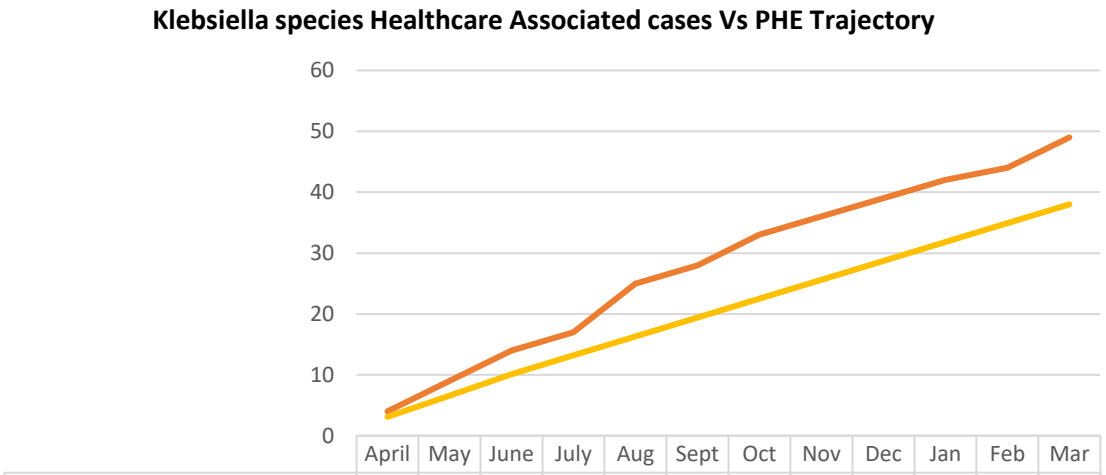
CDDFT reported 106 Trust apportioned E coli cases against the NHSE/I threshold of 113. The chart below shows the E Coli associated cases against the PHE trajectory.



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
E.coli Healthcare Associated cases	4	15	9	7	9	12	8	7	6	10	10	7
Cumulative Healthcare Associated case totals	4	19	28	35	46	58	66	73	79	89	99	106
Trajectory	9.4	18.8	28.2	37.6	47	56.4	65.8	75.2	84.6	94	103	113

Klebsiella sp

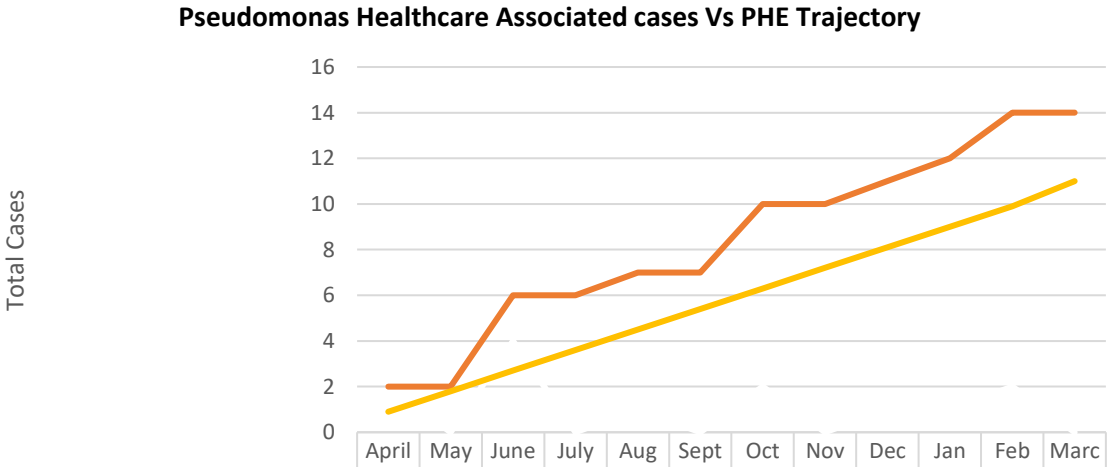
CDDFT reported 49 Trust apportioned Klebsiella cases against NHSE/I threshold of 38. The chart below shows the Klebsiella associated cases against the PHE trajectory.



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Klebsiella species Healthcare Associated cases	4	5	5	3	8	3	5	3	3	3	2	4
Cumulative Healthcare Associated case totals	4	9	14	17	25	28	33	36	39	42	44	49
Trajectory	3.1	6.6	10.1	13.2	16.3	19.4	22.5	25.6	28.7	31.8	34.9	38

Pseudomonas

To date CDDFT reported 12 Trust apportioned Pseudomonas cases against NHSE/I threshold of 11. The chart below shows the Pseudomonas associated cases against the PHE trajectory.



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Marc
Pseudomonas aeruginosa Healthcare Associated cases	2	0	4	0	1	0	2	0	1	1	2	0
Cumulative Healthcare Associated case totals	2	2	6	6	7	7	10	10	11	12	14	14
Trajectory	0.9	1.8	2.7	3.6	4.5	5.4	6.3	7.2	8.1	9	9.9	11

Reducing harm from category 3 and 4 pressure ulcers

Ambition not met

Our aim

We have a zero tolerance for pressure ulcers resulting from lapses in care and our aim is to have no Category 3 or 4 pressure ulcers involving such lapses

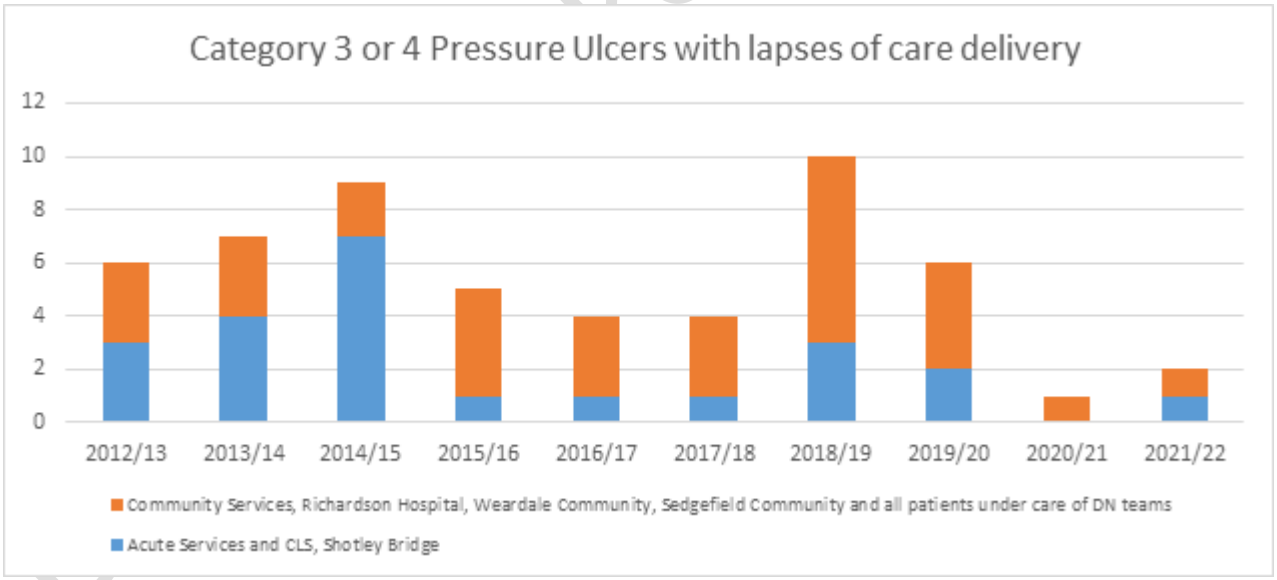
Our progress

We undertake rapid reviews of all Grade 3 and 4 ulcers occurring in our care to ensure incident reviews are timely, and that learning takes place in real time across all domains. The reviews are multi-disciplinary and are led by Tissue Viability nurses. Incident reports for Grade 2 ulcers are accompanied by questionnaires designed to assess compliance with Trust policies and identified lapses in care, which are validated – on a sample basis – by our specialist Tissue Viability teams and any thematic learning is disseminated.

We aimed to increase the number of Wound Resource Educational Nurses (WRENs) across the organisation in 2021/22 but have been unable to do so because of the pandemic. We have, however, maintained the complement of WRENs in place from 2020/21 and the team have reconfigured their work programme to include local audit involvement and more localised ownership of the WREN programme. Our aim remains to expand the number of WRENs and widen their work to encompass a multi-disciplinary team approach working with physiotherapists and Occupational Therapists in the coming year.

In 2021/22 the Trust reported one category 4 pressure ulcer and one category 3 pressure ulcer involving lapses in care.

- The Category 4 case was reviewed and an action plan put in place. Learning points were identified for both our third party wheelchair provider and our District Nurses service.
- The Category 3 case occurred within the hospital environment, and a six month action plan was put in pace. Subsequent audits show improvements, and additional pressure-ulcer specific training has been provided.



Ambition not met

Improving the timeliness of discharge summaries sent to GP

Our aim

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

Our progress

During 2021/22, due to Covid-19 pressures there has been reduced focus on this specific ambition. Performance remained above 90% up until September, dropping to the lowest level of performance in December of 84.28%. The average or the year was 89.4%.

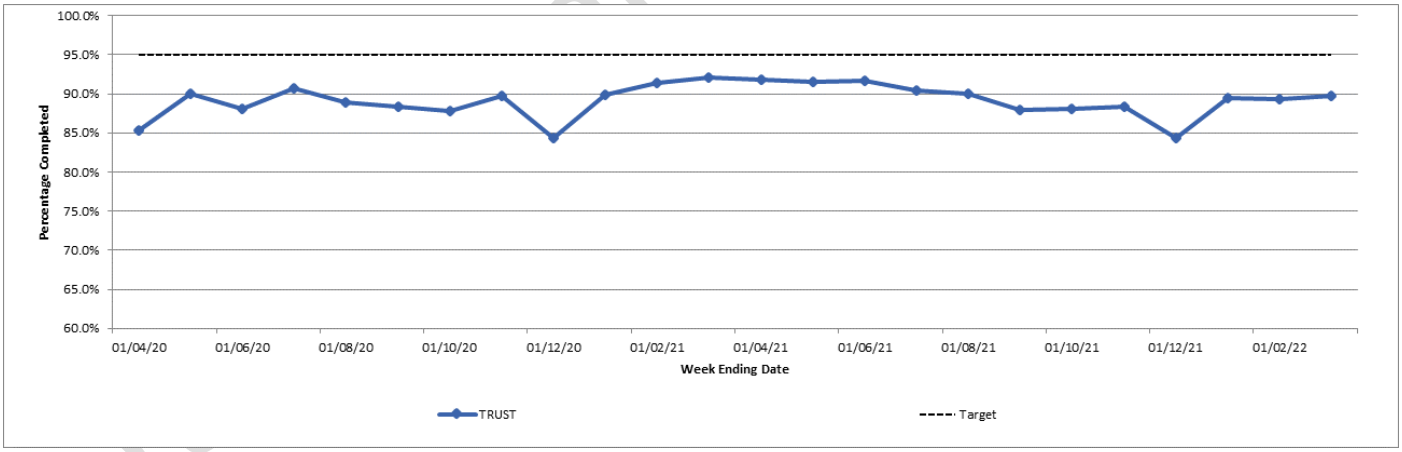
A significant amount of work has however been progressed in relation to overall discharge planning, including the development of real-time reporting of COVID and vaccination statuses and embedding the latest discharge policy guidance.

Each Care Group has a responsible lead manager to whom a weekly dataset is sent to enable them to identify variation and manage performance at specialty, consultant and ward level. Progress continues to be regularly reported to the Operational Performance and Assurance Committee and to the Trust Board.

Our current "Work As One" improvement initiative (which has run from mid-December 2021 and is ongoing) focuses closely on all aspects of discharge including timeliness of communication to GPs. The Electronic Patient Record system (EPR), which we will roll out in 2022/23 will auto-populate the discharge summary with information captured on admission and during the patient's stay, helping to improve the quality and completeness of information and to expedite the process of issuing summaries.

A renewed focus on the timeliness of discharge summaries is to be incorporated into this work in 2022/23.

Discharge Summaries dispatched within 24 hours



	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Trust	85.30%	90.00%	88.10%	90.70%	88.90%	88.40%	87.80%	89.80%	84.30%	89.90%	91.40%	92.10%	91.80%	91.50%	91.70%	90.50%	90.00%	87.90%	88.10%	88.30%	84.30%	89.50%	89.40%	89.70%
Target	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%

Improving the management of patients with Sepsis

Ambition partly met

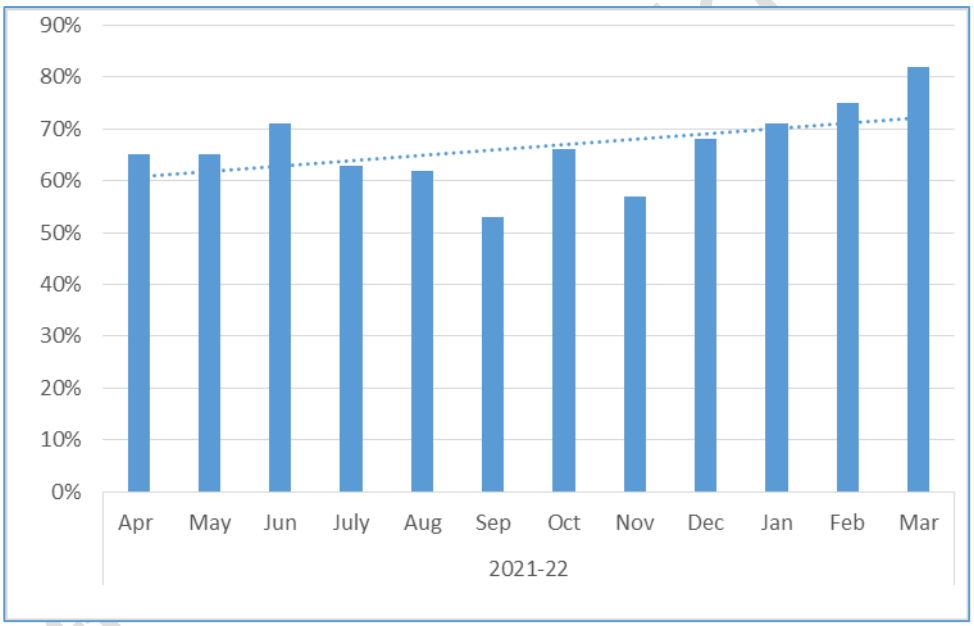
Our aim

To improve the percentage of patients receiving antibiotics within 1 hour of diagnosis in the Emergency Department and to improve both staff awareness and processes to improve the prompt recognition of, and response to sepsis.

Our progress

The regional sepsis screening tool is now integrated within our nursing observations system – Nervecentre - for inpatients and our A&E system – Symphony - for patients attending our A&E departments. All patients within CDDFT are therefore automatically screened for sepsis. The Sepsis bundle within Nervecentre enables the bundle to be completed electronically for inpatients screened as positive. The Maternity Sepsis Screening Tool was recently revised and launched Trust-wide. Three simulation study days (against our aspiration of four) were delivered in the year to help improve staff awareness of Sepsis and support prompt recognition and response. A Patient Group Direction (PGD) has also been developed, which is currently in the pilot phase, for Sepsis of Unknown Origin. A Trust Sepsis Lead Nurse has been in post since June 2021.

Audits continue in the A&E Departments; however the time to administration of antibiotics has not improved in 2021/22. We have fluctuated between 53% and 82%, with improved performance towards the year end.



The results reflect, in part, constraints with respect to the availability of staffing and physical space when the departments are experiencing high demand. Our for the year ahead is therefore to continue improvement work on the rapid delivery of antibiotics to patients within our A&E Departments, which will be supported by the roll out of the PGD to relevant nursing staff.

Patient Experience

Improving the nutritional support offered to our patients whilst in our care

Our aim
During 2021/22 we aimed to develop a strategy building on the work already undertaken to further improve the care delivered to our patients.

Our progress
Four success measures were identified last year:

- The Nutrition Steering Committee has been re-established and has good engagement;
- A business case for Nutritional Support team is in the final phase prior to submission;
- An annual calibration programme for weighing scales has been completed; and
- The development and launch of a new Nutrition Strategy.

Unfortunately the strategy was not completed or launched as planned and therefore remains a focus for the team in the coming year.

The Trust's Nutrition Steering Committee has been re-invigorated, and is chaired by the Executive Director for Nursing and Allied Health Professions with multi-disciplinary input. Clear reporting structures are in place for this committee and the two sub-groups that report into it.

Obtaining an accurate weight for a patient is an essential part of nutrition planning and is one the key elements of the screening process. As well as enabling monitoring of the patients nutritional status it also ensures that medication and other treatments can be accurately prescribed. Following on from the work undertaken in 2020/21 by Dietetics and Medical Engineering to standardise weighing scales across all areas of the organisation, the annual calibration programme has commenced. This project has ensured that all areas have access to scales that meet nationally set standards and that staff can be confident that they have been calibrated and therefore accurate.

Role-specific nurse training for nutrition has been revised and offered both face to face and via our digital platform.

End of Life and Palliative Care

Our aim

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

Our progress

In the most recent CQC report End of Life Care in the Trust is rated as 'Outstanding'.

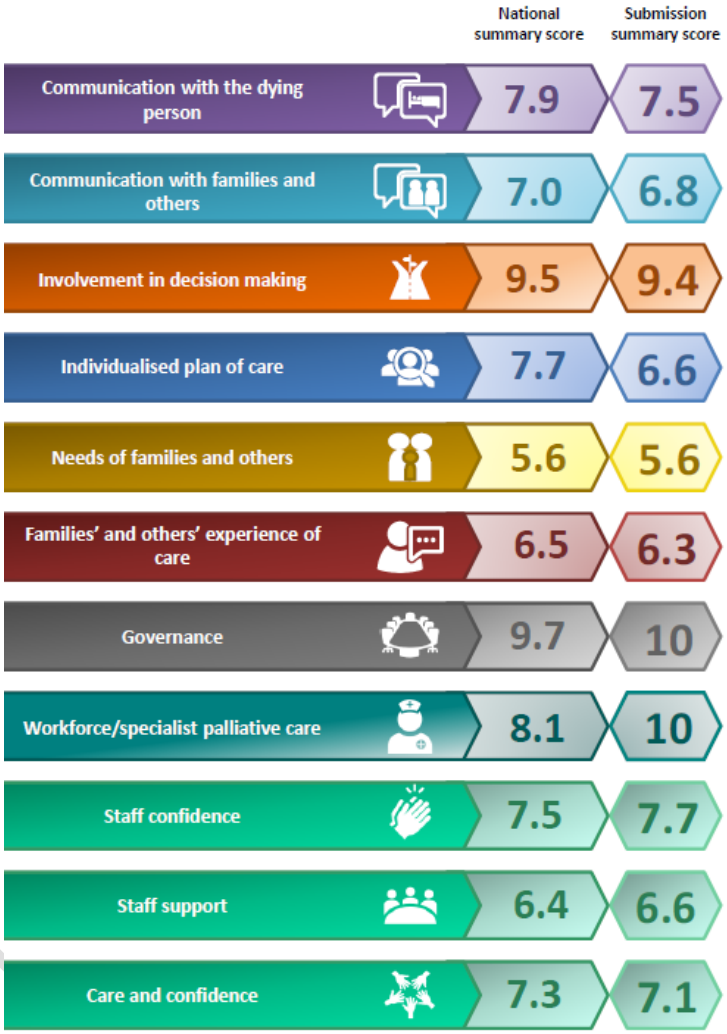
Key actions planned for 2021/22

Throughout the year we continued to engage with partners and stakeholders to refresh the palliative care strategy to 2025; however, unfortunately, delays were encountered by pandemic priorities. We have continued to promote recognition of patients who are dying in hospital – which supports compassionate, responsive and effective care planning for this group of patients – with this topic now included in Trust-wide training programmes. Local audit results shows that recognition of dying from Covid-19 was very good (90% of all deaths). Access to single rooms for patients who are dying is relatively good at DMH (88%) but remains more of a challenge at Durham due to fewer side rooms being available within the estate. A review

of the care after death documentation was undertaken, and a checklist was developed that will remain with the case notes and has rolled out across the Trust.

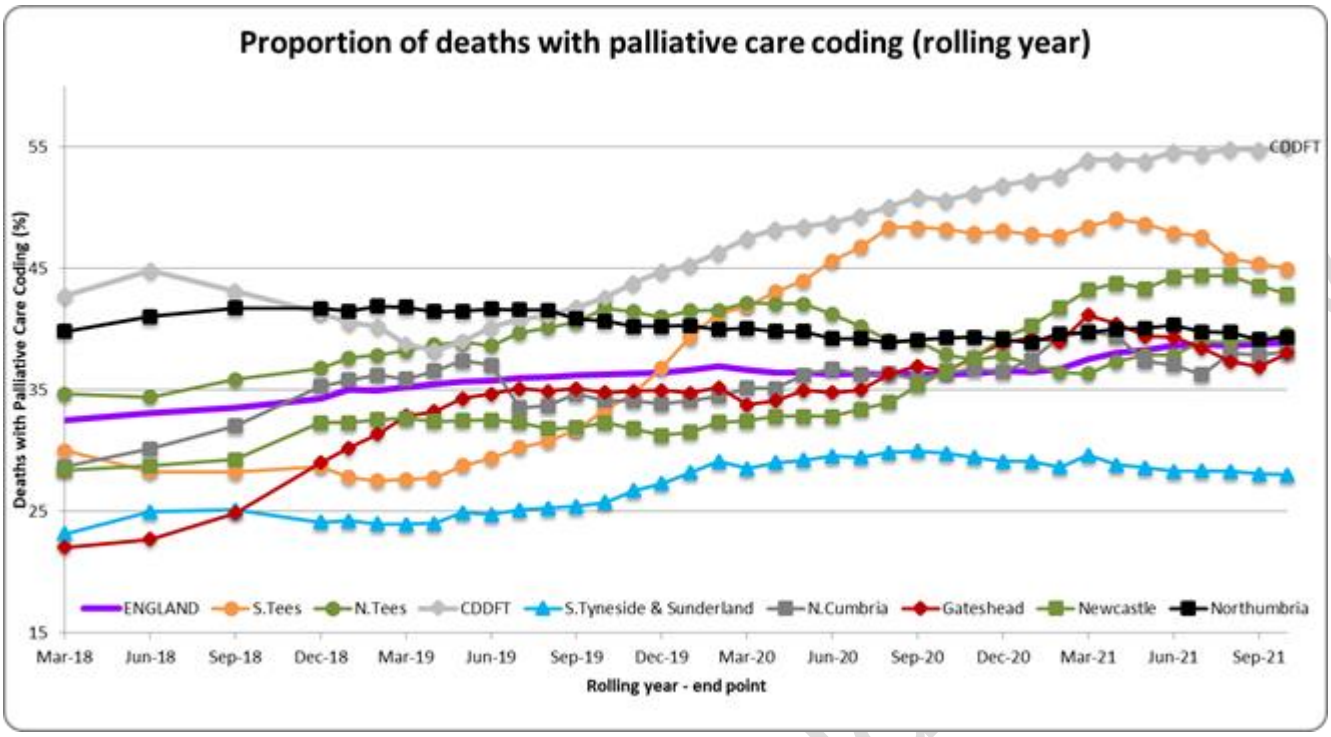
Other actions from the most recent National Audit

The results of National Audit of Care at End of Life (NACEL) 2021 and quality survey data demonstrated continuing good practice in end of life care within the Trust. These results are taken from the NACEL headline report and we await the full version being published. Until the full report is published, we are only able to undertake limited analysis and have therefore focused on a number of immediate actions looking to include key areas for improvement into our training programmes. The team are also exploring opportunities to improve documentation and compliance through the EPR system to be implemented in Autumn 2022.



The chart overleaf demonstrates that the Trust continues to have the highest proportion of deaths with palliative care coding within the region, with over 50% of patients who die in acute hospitals receiving input from the specialist palliative care team.

Palliative Care Coding (proportion of people who died who received input from specialist palliative care)



Clinical Effectiveness

Mortality

Ambition met

Our aim

To continue to strengthen our mortality review process and implement the Medical Examiner role, whilst seeking to improve our SHMI position, through education on record-keeping and coding.

Our progress

The Trust uses three main measures to understand its position in relation to mortality: the Hospital Standardised Mortality Ratio (HSMR); the Summary Hospital Mortality Index (SHMI) and Crude Mortality. CDDFT's HSMR has been below the national 100 standard throughout the 12 month period and sits within the "as expected" range when looked at nationally.

CDDFT's SHMI increased to 116.82 in April 2021, and remained above statistical limits for much of the year but decreased to 109.78 – within statistical limits - in February 2022. The original increase in SHMI was felt to be due to the fact that COVID-19 cases were being removed from the dataset, resulting in a mismatch between the observed and expected ratio. This was a theme seen nationally.

We carried out detailed investigations to understand our SHMI trend including utilising external experts and additional data from Copeland's Risk Adjusted Barometer. Other indications of mortality, and the results of the extensive programme of mortality reviews in the Trust, did not suggest the Trust was an outlier for excess deaths.

External input was provided by the North East Quality Observatory Service (NEQOS) whose Lead presented to the CDDFT Trust Board on the impact of Covid-19 on SHMI (and its reliability) in the North East. NEQOS commended CDDFT on the number and depth of learning from deaths reviews completed by the Trust and advised that more assurance should be taken from the Trust's own reviews and alternative measures which they commended as being in line with good practice.

The Mortality Committee, Clinical Effectiveness Committee and the Board continue to monitor trends closely every quarter including learning and actions.

Over the longer-term investigations have suggested a number of reasons for the Trust's reported SHMI position and were have taken steps to improve it position via the following:

- Appointment of three clinical champions, who are already contributing to the improved Trust position, by providing training and education to medical staff on wards on the depth of recording and coding required in notes and discharge letters.
- Continuing to complete mortality reviews for all deaths coded to low risk diagnosis groups.
- Making use of crude mortality, which is an unadjusted measure that reports the percentage of deaths in an organisation. Crude mortality is used together to understand the current position and identify quality improvement opportunities. The Trust's rolling 12 month crude mortality has fallen from 5.08% in April 2021 to 4.6% in September 2021. This is as expected with the number of Covid-19 related deaths.

With respect to the learning from deaths reviews completed by the Trust, for the overwhelming majority of patients the quality of care was rated as good or better with lapses in care leading to poor or very poor ratings being found in less than one per cent of cases.

	2021/22	2020/21
Mortality Reviews Completed	390	702
Total Patient Deaths recorded	2,188	2,399

In regard to the above, it must be noted that Mortality data is provided by NHS Digital, and "Priority Deaths" uploaded to the Trust's database by our Information Department the following month. These are allocated for review by the middle of that month. It can therefore take anywhere between 4-8 weeks (sometimes longer) for the central review team to complete. There are also some occasions when some deaths reviewed can be added much later than when death occurred - for example following a complaint, which may be raised many months after the patient's death. In addition, for some of the current cohort of deaths under review, such as those who have a less than 10% SHMI risk of death, this data is not available until six months after the patient has died. Therefore there is at least an 8 month wait before these reviews can be concluded. This sample made up around 40% of the deaths we reviewed last year. Taking all of these factors into account, there is therefore an inherent time lag in the completion of reviews which explains the – currently – lower number of reviews for 2021/22.

Current CDDFT Mortality RAG Rating

Measure / source of assurance	RAG
Summary Hospital Mortality Indicator (SHMI) – currently 109.8 (within expected range)	
Hospital Standardised Mortality Ratio (HSMR) – 93 and within expected range	
Copeland's Risk Adjusted Barometer (CRAB)	
Completed mortality reviews – 1,179 deaths reviewed from 2020/21, of which 10 (<1%) had evidence of lapses in care. There is a time lag in deaths being available for review. To January 2022, 182 reviews had been completed in 2021/22 with similar trends.	
North East Quality Observatory (NEQOS) Independent Review	

Despite all of the ongoing work there remain some challenges re: capturing all comorbidities necessary for an accurate assessment of the risk of mortality; however, the EPR system being rolled out in 2022/23 will better support this. EPR will enable immediate access to notes that are legible and accessible to all, in addition to optimising work flows in Sepsis and AKI. Monitoring will continue through thematic analysis of case reviews, monitoring in Mortality reduction committee and mortality indicator data.

Eight Medical Examiners and five Medical Examiner Officers have now been appointed and pre-screening is now in place for 100% of deaths at DMH. We are working towards pre-screening of all deaths at UHND during 2022/23.

Maternity Standards

Our aim
To continue to progress the plans developed in 2020/21 in reference to the Ockenden Report (December 2020) and implementation of the Continuity of Carer initiative.

Our progress

Key actions from 2021/22

In response to our goals for 2021/21:

- Fetal Medicine Consultants are now in place at both acute sites and a Fetal Wellbeing Lead Nurse has been appointed;
- The role of the Head of Midwifery has been upgraded in line with Ockenden recommendations and reports to the Director of Nursing (in his capacity as Executive Maternity Safety Champion).
- There are bi-monthly meetings with the Maternity Safety Champions, supplemented by site visits and channels for regular meetings with staff; staffing ratios meet “birth rate” plus standards (based on establishments); and
- We have rolled out our ‘Infinity (Continuity of Carer) programme to three teams in full, with three others completing shadowing and shortly to go live. National leads have visited the Trust and commended the approach. We are taking stock of staffing across all our acute and community midwifery services to ensure that it remains safe prior to moving to each planned stage of the programme, which has now been recommended as the right following the second report from the Ockenden Inquiry.
- Staffing ratios meet “birth rate” plus standards (based on establishments). The Trust aims to staff its acute sites in line with the recommended staffing ratios for tertiary centres given the needs of the women it looks after. In practice, staffing has needed to be kept under continual review due to sickness absence, maternity leave and the impact of the pandemic (in common with other Trusts). We have secured national funding to recruit beyond current vacancies to support resilience.

Other actions:

Our Community and Continuity of Care Teams have worked tirelessly over the pandemic to ensure that all women receive their first appointment with Maternity Services in a timely manner. Booking appointments remain in place over a virtual platform providing flexibility for booking of care quickly and in a timely manner.

Difficulties have been encountered throughout the pandemic particularly where women have sometimes been unable to present as promptly as we would prefer. In response we have introduced direct referral to Community and Continuity Teams, with booking appointments evaluating well when completed in this way. All women are given a face to face “Early Birds” appointment to receive all the key Health Promotion advice in line with the Public Health Agenda, and also completion of their booking bloods with adherence to National Screening standards.

The Infant Feeding Team have maintained our UNICEF accreditation and are currently preparing for UNICEF GOLD accreditation. The Infant Feeding Team continues to grow and develop: our Band y

Specialist Midwife will from May become a job share opportunity, allowing us to retain the skills of an experienced midwife, whilst developing a new specialist in this area. New appointments also include a Band 6 Midwife and B2 Team support officer. The Team continues to provide support with complex feeding issues, plans, Frenulotomy, and Antenatal and Postnatal bespoke feeding support.

Face to Face training for Infant Feeding has been modified due to constraints surrounding Covid-19. Whilst training was delivered via MS Teams plans are in place to return to the face to face format. The Team continues to support women with all aspects of Infant Feeding support and can point to excellent qualitative data and user feedback via the Maternity Voice Partnership.

We continue to make great improvements in reducing smoking during pregnancy among those who use our services. Our Community Midwifery teams are proactive in undertaking carbon monoxide monitoring and in making early referrals to smoking cessation services. Work is currently underway to reinvigorate Antenatal Clinic contacts with Stop Smoking Services with two dedicated roles being appointed to.

The Trust has continued to monitor the following maternity standards and has made good progress against all three, as shown below. All targets were met in the fourth quarter.

	Target	**Q1**	**Q2**	**Q3**	**Q4**	**2021/22**	2020/21	2019/20
Maternity 12 week bookings	90%	76.8%	84.5 %	88.3%	90.4%	84.1%	92.4%	90.8%
Maternity breast feeding at delivery	60%	57.9%	61.8 %	66.7%	64.8%	62.6%	58%	59.4%
Maternity smoking at delivery	22.4%	10.4%	11.9 %	14.0%	13.0%	12.3%	14.9%	16.9%

Paediatric Care

Our aim

We aimed to provide expanded access to Paediatric Assessment services and further develop partnerships with other providers

Our planned measures of success were:

- For the UHND Paediatric Assessment Area to operates a 24/7 model;
- For Multi-agency pathways of care to be in place for children and young people with mental health problems; and
- To continue to develop pathways and relationships across primary and secondary care.

Our progress

Having operated a 12/24 model, the Paediatric Assessment Area at UHND moved to a 24/7 model of operation from October 2021. Children are now able to access this age-appropriate environment 24 hours per day, which has improved streaming from ED and means that children are not accommodated in a waiting room with adults, resulting in a much better patient experience.

A dedicated paediatric emergency unit opened at Darlington Memorial Hospital in September 2021. It includes a triage room, treatment rooms that have been decorated with colourful murals, and a paediatric resuscitation room. The unit also features a sensory room that has been designed for those infants, children or young people who are particularly anxious or sensitive to noise and lights who could benefit from a very relaxing calming space. This provides a more age-appropriate, relaxing and calm environment that is separate from the adult emergency department. We have also increased our complement of

children's nurses in A&E at DMH and established training in paediatric competencies for all nursing staff working that area.

In response to the significant increase in young people requiring hospital admission due to the physical effects of an eating disorder, we have worked alongside Tees, Esk and Wear Valley NHS Foundation Trust (TEWV) to develop a care pathway, which involves a specialist Eating Disorders Nurse being present on the daily ward round on both inpatient paediatric wards to provide a seamless and holistic approach to care and timely discharge, followed by an intensive support package in the community.

We introduced an evidence based admission pathway for young people underpinned by the national Management of Really Sick Patients with Anorexia Nervosa (MARSiPAN) guidelines. A partnership Dietician post, hosted by TEWV, has been created to support the development of meal plans and provide support throughout the care pathway, both at home and in hospital. We have developed an Operational Mental Health Group with representation from CDDFT and TEWV to support the development of integrated care pathways.

Excellence Reporting

Our aim

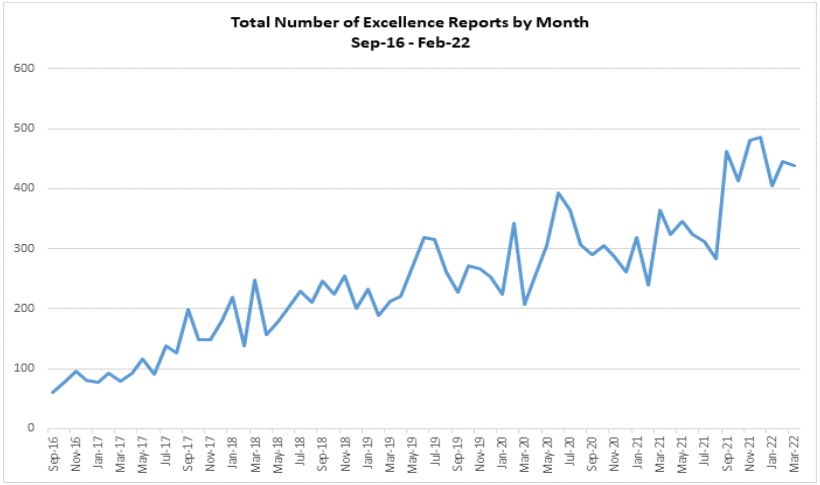
Our objective for 2021/22 was to continue to embed learning from excellence into standard culture and practice through Excellence Reporting and effective collaboration with colleagues across the organisation to triangulate activities / work streams.

Our progress

The Trust continues to promote the reporting of excellence, to both celebrate and learn from it, in the organisation via: a quarterly Trust wide bulletin; "Walls of Awesomeness" on some of our main corridors; and various other communication channels such as Facebook Live Briefings and Directors' Briefings. The number of members in the group has recently increased, and the remit of the group has evolved somewhat, incorporating some Appreciative Inquiry in line with the new Patient Safety Strategy and some patient stories from the Patient Experience Team Compliments into the bulletin.

The Trust's excellence reporting process compares favourably with Trusts nationally, is well embedded and we consistently see high numbers of excellence reports being submitted, i.e. 250-330 reports received per month.

From June 2021 staff excellence reports and a proportion of patient generated compliments were reported collectively, the improvement noted in the graph below is therefore misleading. On further investigation, the amalgamation of staff to staff excellence reports and patient compliments was identified and interrogation of the data actually showed a decrease in staff to staff excellence reports. Through the latter part of the year the team have been working on reinvigorating the staff to staff excellence reporting system. The compliments received from patients/families will soon have their own platform on the Ulysses system, therefore separating again these two strands of reporting. The group are continuing to look at ways to develop the initiative further throughout the coming year.



Part 2B - Priorities for 2022/23

The Trust has refreshed its Quality Strategy following consultation with staff and patients and a wide range of external stakeholders. Priorities for 2022/23 reflect both the priorities in this strategy and further priorities (described as “retained” priorities) where further work is required to meet 2021/22 objectives.

Safety	Experience	Effectiveness
Quality Strategy Priorities		
Reduce the harm from inpatient falls	Provide a positive experience for those in our care whose with additional needs including patients with dementia, learning disabilities, autism and mental health support needs	Reduce waiting times in A&E covering: Time to assess, Time to treat, Total time in the department
Reduce incidence of, and harm, from Health Care Associated Infections	Ensure a positive patient experience through the discharge process	
Maintain zero tolerance of Grade 3 & Grade 4 pressure ulcers		
Maternity Standards including Ockenden recommendations		
Embed safe practice for invasive procedures: LocSSIPs		
Embed prompt recognition and action on signs of patient deterioration		
Retained priorities for 2022/23: work ongoing		
Improve the timeliness of administration of antibiotics for patients with suspected sepsis	End of life care: palliative care strategy, ensuring appropriate access to private rooms for dignity	Improving access to paediatric specialist services
	Continued improvement of nutrition including assessment and provision for specific needs	Increasing excellence reporting
		Learning from Deaths (in particular the roll out of Medical Examiners reviews)
Mandated measures for monitoring		
Rate of Patient Safety Incidents resulting in severe injury or death Time spent in the Emergency Department	Percentage of staff who would recommend the provider to friends and family Responsiveness to patients personal needs	SHMI Patient Reported Outcome Measures

Patient Safety

Quality Strategy Aims:

Reducing harm from inpatient falls

Why we chose this priority

This continues to be a priority for the organisation, with falls being one of the highest reported incidents across the Trust.

Goals

To reduce harm from falls in an increasingly at-risk population

How will we do this?

We will:

- Use our electronic systems to support staff in improving lying and standing blood pressure documentation and escalation;
- Work with EPR leads to ensure all falls assessments are captured;
- Introduce a Falls Prevention Advocate role, related meetings and plan actions ;
- Work with all partner organisations to develop a falls pathway to support patients at whichever point they enter the system;
- Develop a toolkit of interventions for Ward managers to choose from to aid in falls prevention;
- Create a Falls Leaflet to support access to the Falls Team and community-based support; and
- Further development of the Rapid Review process with a view to increasing ward staff ownership.

Measures of success

We will be able to identify falls with lapses in care, and set meaningful baselines from which we will see a reduction in 2022/23 compared to 2021/22.

Reducing the incidence of, and harm from, Healthcare Associated Infections

Why we chose this priority

This remains a high priority for the organisation and continuation of this priority will support the work ongoing within the team.

Goals

Our goals are to:

1. Meet our zero tolerance for MRSA bacteraemia.
2. Achieve thresholds to be set by NHS England and Improvement for Clostridium Difficile and Gram Negative Blood Stream Infections.

How will we do this?

MRSA:

We will:

- Focus on MRSA Screening and decolonisation;
- Review and update the Trust MRSA policy; and

- Continue to investigate cases and share findings with the organisation.

Clostridium Difficile Infections (CDI)

We will:

- Focus on early identification and isolation
- Continue with our Antimicrobial stewardship programme, including engagement with the Senior Responsible Officer through Integrated Care System;
- Share learning in a timely manner to drive improvement; and
- Review and update our CDI policy in line with NICE guidelines.

Gram Negative Blood Stream Infections (GNBSI)

We will:

- Continue to monitor practices for both acute and community onset infections and ensure that joint reviews are undertaken to focus on improvement across the health economy;
- Continue to comply with UK Health Security Agency (UKHSA) guidance;
- Actively participate in the UKHSA data collection covering GNBSIs;
- Continue to audit healthcare practices which include:
    - Monitoring and improving Visual Infusion Phlebitis (VIP) Scoring, through the introduction of a trust wide WASP framework;
    - Participating and leading elements of the newly established CDDFT Asepsis group; and
- Improve the resilience and responsiveness of the IPC team and restructure to support a 7-day IPC service

Measures of success

These will comprise:

- An updated CDI policy;
- An updated MRSA policy;
- An updated policy for Principles of Infection Control and Guidance on Isolation;
- Reinstatement of formal face to face IPC training building on the 'topic of the month' approach in 2021/22 - this started from 1st April 2022;
- Joint working on Infection Prevention and Control strategies within the Antimicrobial stewardship programme;
- Continued development of an improved IPC service.

Reducing harm from category 3 and 4 pressure ulcers

Why we chose this priority

Reducing harm from pressure ulcers continues to be a patient safety priority for the organisation.

Goals

For patients within our care to have no category 3 or 4 pressure ulcers that have been identified as having lapses in care delivery.

How will we do this?

We will:

- Continue to develop our learning in real time across all domains;
- Embed, and refine, the rapid review process;

- Ensure all patients identified with category 3 and above pressure ulcers whilst in our care have a formal review.
- Undertake Quarterly thematic reviews are undertaken on all category 2 pressure ulcers, with findings reported to Care Group Governance meetings for action and learning.

Measures of success

- For patients within our care to have no category 3 or 4 pressure ulcers that have been identified as having lapses in care delivery.
- An increase in the number of Wound Resource Educational Nurses (WRENs) across the organisation.
- A revised educational programme including local audit, an increase localised ownership of the WREN programme and a multi-disciplinary team approach, working with Physiotherapists and Occupational Therapists.

Meeting Maternity Standards, including Ockenden Recommendations

Why did we choose this priority?

Maternity safety remains a high priority nationally with the publication of the second Ockenden Inquiry Report in April 2022, and the implementation of the "Continuity of Carer" initiative as part of the Maternity Transformation agenda, together with numerous work streams that remain on going around the Saving Babies Lives care bundle.

Goals

To continue to progress the plans developed in 2021/22 and implement all recommendations from the Ockenden reports applicable to the Trust.

How will we do this?

We will:

- Complete the gap analysis against the latest Ockenden recommendations now underway;
- Receive and act on an independent assessment of staffing against the Birth Rate Plus standards;
- Continue to implement our Continuity of Carer strategy, ensuring that staffing across the whole of the maternity service remains safe and that risk is balanced, in line with national position following publication of the second Ockenden Inquiry report; and
- Develop the workforce through recruitment and retention work that remains ongoing.

Measures of success

These will comprise:

- Development and implementation of an action plan following the completion of the gap analysis noted above.
- A full workforce review presented to our Board of Directors every six months, which addresses any recommendations from the external review against Birth Rate Plus standards.
- Progressing our Continuity of Carer strategy, based on risk assessment and management of safe staffing across the service as a whole.
- Continued improvement of the outcomes of those women who are in receipt of Continuity of Carer an report these at board level.
- Increasing retention rates for staff working in our Maternity Services.

Embedding safe practice for invasive procedures, inside and outside of theatres

Why did we choose this priority?

The use of local patient safety standards for invasive procedures (LocSSIPs) ensures that all necessary safety checks are undertaken before, during and after a procedure to protect the patient. Having migrated responsibility for the development, issue and adherence to LocSSIPs to local teams, we need to implement robust monitoring, auditing and governance procedures to provide assurance that our new LocSSIPs policy is followed.

Goals

To provide a system of assurance and compliance monitoring that LocSSIPs are correctly followed, that tracking processes are maintained and that ownership is clear and transparent.

How will we do this?

We will:

- Ensure that general access to LocSSIPs via the internet / intranet is controlled;
- Audit the currency of LocSSIP documentation and adherence to it practice, establishing a two year audit programme, focusing on higher risk areas in 2021/22;
- Develop LocSSIPs as electronic forms in our EPR system to assist staff in adhering to the requirements; and
- Introduce robust monitoring and governance processes.

Measures of success

- Full audit of in-use LocSSIPs completed in line with the two year plan.
- Robust monitoring and reporting processes established at Trust and Care Group level.
- Development of a suite of electronic LocSSIPs in EPR, supported by appropriate training to staff.

Embedding prompt recognition and action on signs of patient deterioration

Why did we choose this priority?

One of the key ambitions in the Trust's Quality Matters strategy is to maintain and continuously improve our safety practices, as a 'Highly Reliable' organisation. Whilst we have made some substantial improvements in how we recognise and act on deterioration through our arrangements cardiac arrest prevention, hospital at night and Acute Kidney injury, we continue to see some incidents resulting in moderate or greater harm to patients where the signs of deterioration could have been recognised and acted on sooner.

In addition, during the pandemic, the Trust necessarily agreed to a reduction in the frequency of training programmes related to patient deterioration to maintain staff on the front-line and now needs to refresh this training.

Goals

To reinvigorate compliance with training with respect to patient deterioration and resuscitation and further reduce incidents involving delayed recognition or action on patient deterioration in line with our 'highly reliable organisation' ambition.

How will we do this?

We will:

- Reinstate frequency requirements and closely monitor compliance with relevant training programmes;

- Promote wide learning and education in response to any incidents of harm or significant near misses involving delayed recognition or action on deterioration; and
- Celebrate successful interventions and improvements in early recognition and action on patient deterioration under the banner of our 'Highly Reliable Organisation' activities.

Measures of success

We will see a reduction in incidents with moderate or greater harm involving delayed recognition or action on signs of deterioration, improved compliance rates with training and substantive examples of sharing of learning and success.

Retained Priorities from 2021/22 – Work ongoing:

Improving the management of patients with sepsis

Why we chose this priority

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

Goals

- To improve the percentage of patients receiving antibiotics within 1 hour of diagnosis in the Emergency Department
- To improve staff awareness and processes to ensure prompt recognition and response.

How will we do this?

We will:

- Hold multi-professional study days which include assessments based on simulation exercises.
- Continue planned Sepsis audits and monitor sepsis mortality.
- Deliver planned education to clinical staff and improve the quality of care for patients with sepsis.
- Review the current regional screening tool for adults and how this will align to the Electronic Patient Record (EPR) in our EPR system now under development.
- Enhance our current Sepsis e-resources for staff.
- Roll out a Patient Group Direction to allow senior nurses to administer antibiotic therapy to patients with sepsis of unknown origin.

Measures of success

- Four multi professional study days held per year
- A substantive improvement in the percentage of patients triggering for sepsis who are administered antibiotics in the first hour in our A&E departments, measured through ongoing audits.

Patient Experience

Quality Strategy Aims:

Providing a positive experience in our care for those with additional needs

Improving care of patients with dementia

Why did we choose this priority?

To continue to build on our work to ensure that our patient environments are dementia-friendly and that our staff have high levels of awareness and understanding of how to support patients with dementia.

Goals

To embrace opportunities to enhance and provide appropriate care for patients with cognitive impairment such as dementia and to ensure that they, and their families, have a positive experience in our care.

How will we do this?

By focusing on opportunities to further develop, a dementia friendly hospital and evidence based care/practice

Measures of success

These will comprise:

- Wider Trust understanding supported by increased completion of Dementia related staff training programmes.
- Further development of the role of the Dementia link nurses
- Delivery of dementia audit programme and development / delivery of associated action plans.

Improving care of patients with Learning Disabilities or Autism

Why did we choose this priority?

We recognise that people with a learning disability or autism require extra support and reasonable adjustments making towards their care. We know that we can do more to ensure that all of our staff are able to fully understand and respond proactively to the needs of patients with learning disabilities or autism and to ensure that the environment in which we provide care is always the most suitable.

Goals

To embrace opportunities to enhance and provide appropriate care and support for patients with a learning disability or autism and to ensure that they and their families will have a positive experience in our care.

How will we do this?

By seeking opportunities to further develop, a learning disability and autism friendly service. We follow our learning disability guarantee, which is unique to CDDFT, to ensure that our patients with a learning disability and autism receive individualised support and care under the guidance and support of our learning disability team. We will work with service users and their families to understand and learn from their experiences to continuously improve our care.

Measures of success

- Completion of Learning Disability and Autism related staff training programmes resulting in wider and deeper understanding of how to support patients with learning disabilities or autism across the Trust.
- Further development of the role of the Learning Disabilities Liaison Nurses.
- Delivery of a Learning Disability and Autism Guarantee.
- Monitoring of A&E attendances and working with community staff to help them support patients with learning disabilities or autism to provide help at home and reduce the need for A&E attendances.
- Monitoring the effectiveness of our discharge follow up visits for people with a learning disability or autism to reduce readmissions.
- Learning from the Trust's mortality reviews and LeDeR programme.

Ensuring a positive patient experience through the discharge process

Why did we choose this priority?

Discharging a patient from our care requires often detailed planning, communication with families and carers and – often – detailed coordination between different teams and with partner agencies. Delays in discharge and issues in communication, can lead to a poor patient experience and increase anxiety for our patients and those looking after them. The vast majority of patients are discharged with no issues; however, we know that this is not always the case and, in aspiring to be a highly reliable organisation we want every discharge to be safe, timely and well-communicated to families and those responsible for onward care.

Goals

To build on arrangements for discharge established over the winter of 2021/22 as part of our "Work As One" initiative, to:

- Bring forward discharges (on average) to earlier in the day;
- Ensure that patients have a positive experience through the discharge process; and
- Minimise incidents and adverse events relating to the discharge process.

How will we do this?

We will:

- Continue to develop the roles of our Discharge Champions and Facilitators
- Monitor the timeliness of discharge and delays in discharge, targeting improvements in both
- Share and learn from patient stories – positive and negative – with respect to discharge
- Continue to work with partner agencies to review and learn from any adverse events occurring on discharge and disseminate learning to all teams

Measures of success

We will our discharge curve brought forward to earlier in the day, improved patient satisfaction through post-discharge surveys and a reduction in incidents and adverse events related to discharge.

Retained Priorities from 2021/22 – Work ongoing:

End of life and palliative care

Why did we chose this priority

The Trust continues to strive to implement the overarching aim of the national strategy: *"I can make the last stage of my life as good as possible because everyone works together confidently, honestly and*

consistently to help me and the people who are important to me, including my carer(s)" This builds on the improvements that have already taken place.

Goals

To further deliver on the national strategy in line with a refreshed local strategy.

How will we do this?

We will:

- Work with stakeholders to develop and roll out a new palliative care strategy to 2025;
- Focus intensively on recognition of dying in hospital to enhance care; and
- Explore solutions to the relative lack of single rooms: Ensuring appropriate access to private rooms for dignity.

Measures of success

These will comprise:

- Checklist developed and implemented for care after death documentation.
- Palliative Care Strategy launched.
- Solutions proposed to the relative lack of single rooms.

Improving the nutritional support offered to our patients whilst in our care

Why did we choose this priority?

In 2015, Jane Cummins Chief Nursing Officer stated *"The link between nutrition and hydration and a person's health is a fundamental part of any stage of life, but all the more so for the sick or vulnerable. Person-focussed, quality compassionate care involves looking at what matters to a person as a whole, not only concentrating on their specific medical condition*."

Eating and drinking are essential for maintenance of nutrition and hydration but are also important for pleasure and social interactions. The ability to eat and drink hinges on a complex and coordinated system, resulting in significant potential for things to go wrong.

Goals

To develop a strategy building on the work already undertaken to further improve the nutritional care delivered to our patients. We will continue to strive to work across professional disciplines to drive good nutrition practices across the organisation

How will we do this?

- Progression of Nutrition Support Team business case to increase Trust compliance with NICE CG32 (2017) recommendations
- Development of a Catering Dietitian business case to support recommendations from Hospital Food Review (2020);
- Revising the Trust's Nutrition and Hydration Policy;
- Developing and implementing the Nutrition Strategy;
- Supporting the implementation of nutrition screening through our forthcoming EPR system; and
- Working with EPR colleagues to support achievement of the 95% target for MUST assessments to be completed for new admissions to each ward.

Measures of success

These will comprise:

- Submission of Nutrition Support Team business case
- Submission of Catering Dietitian business case
- Nutrition screening tool (MUST) compliance and usability of screening tool via EPR
- Updated Nutrition and Hydration Policy with launch of strategy
- Consistently achieving the 95% target for MUST assessments

Clinical Effectiveness

Quality Strategy Aims:

Reducing waiting times in A&E: Time to assess, Time to treat, Total time in the department

Why did we choose this priority?

Given current levels of demand on our A&E services, and capacity constraints relating to the size our department at UHND and our bed base, we can experience delays providing treatment and / or in admitting patients. There is evidence that long waits in accessing treatment can affect patient outcomes and – of themselves – long waits are a poor patient experience.

Goals

To further optimise our clinical pathways, working with partners, for urgent and emergency care and expand our same day emergency care services – to take some pressure off the A&E department at UHND during 2021/22.

With the support of the North East and North Cumbria Integrated Care System, to secure capital funding and cover to move forward with our plans for a new Emergency Care Centre at UHND.

To expand and optimise medical staffing for our A&E departments and to enhance our nursing staffing is in line national safe nursing care standards.

How will we do this?

We will:

- Recruit additional junior doctors, funding for which has already been allocated.
- Recruit additional middle grade doctors, following approval of a business case currently in process.
- Piloting the safe nursing care standards in our A&E at UHND and adapting our nursing staffing accordingly.
- Opening an expanded front of house SDEC facility at UHND from late summer 2022
- Working with commissioners and primary care to agree and implement the optimum model for urgent care at the UHND site
- Increasing our bed base at both UHND and DMH, over of the course of the year, to improve flow out of our A&E departments.
- Working to secure funding and capital approvals to commence work on a new Emergency Care Centre at UHND.

Measures of success

These will comprise:

- Substantive increases in medical staffing
- Nursing staffing aligned to the recommendations from the pilot exercise
- The new SDEC facility at UHND open and being able to treat and discharge patients, which are currently using our A&E department but do not need A&E care and / or admission.

- Agreeing and rolling out a model of urgent care at UHND that supports the A&E department.
- Improvements in waiting times with respect to assessment, treatment and the total time in the department.

Retained Priorities from 2021/22 – Work ongoing:

Paediatric Care

Why did we choose this priority?

The Trust has selected this priority to build on the work already undertaken and to strengthen partnerships across mental health, local authorities and primary care. This is particularly important as the Trust, as has been seen nationally, have seen an increase in children and young people with mental health issues which can only be addressed as a whole health economy

Goals

To provide expanded access to Paediatric Assessment services and further develop partnerships with other providers

How will we do this?

We will:

- Sustain the operating hours of Paediatric Assessment Area (PAA) at UHND to 24/7
- Review the provision of front of house paediatric assessment at Darlington Memorial Hospital
- Further develop partnership working with local authorities and mental health trusts to develop pathways of care for children and young people with mental health problems

Measures of success

- UHND Paediatric Assessment Area operates a sustainable 24/7 model; and
- Multi-agency pathways of care are in place for children and young people with mental health problems

Excellence Reporting

Why did we choose this priority?

The Trust has selected this priority to continue to embed learning from excellence within the Trust, in line with the direction of the new national Patient Safety Strategy.

Goals

To continue to embed learning from excellence into our organisational culture and practice through Excellence Reporting, Appreciative Inquiry and patient stories from compliments received.

How will we do this?

We will:

- Promote the use of the excellence reporting system;
- Share and promote stories of learning from excellence;
- Share Appreciative Inquiry cases;
- Share patient stories from compliments received;

- Continue to collaborate with group members from across the organisation, including Workforce Experience Team in order to maximise the effectiveness of the group and work stream and triangulate with other organisational activities.

Measures of success

These will comprise:

- Continued or increased levels of excellence reporting
- Examples of sharing of excellence and resulting learning across the Trust
- Examples of effective collaboration across the organisation and triangulation of activity

Learning from Deaths

Why did we chose this priority?

To progress work-streams in support of the local and national learning from deaths agenda, in order to maximise the effectiveness with which we identify and act on learning from the work of our medical examiners and mortality reviews.

Goals

We will continue to strengthen our mortality review process and implement the Medical Examiner role, whilst seeking to maintain improvements in our SHMI position, through education on record-keeping and coding.

How will we do this?

We will:

- Continue to adhere to the recommendations of the CQC's report 'Learning, candour and accountability', and the National Quality Board's National Guidance on Learning from Deaths for Trusts March 2017.
- Provide care groups with quarterly learning from deaths reports identifying themes of learning as commenced in 2019/20.
- Continue to work with Regional and Primary Care colleagues to ensure joint learning.
- Ensure triangulation between mortality review and patient safety and incident reporting established in 2021-22 continues.
- Embed Trust-wide implementation of the Medical Examiner Service, including pre-screening of all deaths.
- Utilise the EPR system which enables immediate access to notes that are legible and accessible to all, in addition to optimising work flows in Sepsis and AKI.

Measures of success

These will comprise:

- Quarterly learning reports shared.
- Full Medical examiner service in place.
- Maintaining SHMI within statistically 'normal' limits.

Part 2C Statements of Assurance from the Board

Review of Services

Review of the performance of the Trust's services is undertaken by the Trust Board and its Operational Performance and Assurance sub-committee (OPAC). Both receive a monthly Integrated Quality and Performance Report (IQPR) covering performance against the key national and local standards and measures. This process has continued throughout the year.

Additionally, in normal times, each of the Trust's five Care Groups' operational performance is reviewed monthly with the Director of Performance and any significant risks escalated to Executive Directors. During Covid-19 surges, this process was suspended when appropriate to do so, and performance has been covered every month in Senior Leadership Team meetings and any exceptional performance escalated through the Command Structure that was stood in response to the pandemic.

Externally, the Trust has continued to work closely with:

- Other regional Trusts, including participation in regional hub planning.
- The independent sector, which has provided some elective and diagnostic activity
- Partners in the CCG and Local A&E Delivery Board (LADB)

Participation in Clinical Audit

Background

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 and quarterly reports to the Clinical Effectiveness Committee. Assurance is provided to the Board through the Integrated Quality and Assurance Committee which scrutinises quarterly reports from the Clinical Audit Team.

All National Audit reports are reviewed by the Lead Clinician and the Clinical Audit Team, and 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 Care Group Governance Facilitators.

Participation in Clinical Audit

During 2021/22 there were **47** national clinical audits and **7** national confidential enquiries applicable to the NHS services that County Durham & Darlington NHS Foundation Trust provides. Of the **47** national clinical audits there was no participation due to impact of Covid-19 for **2** national clinical audits (as a result of suspension, delay, or no data collection due to re-deployment of staff related to the care of patients with Covid-19). These two audits have been excluded from the calculation of the percentage participated below.

During 2021/22 County Durham & Darlington NHS Foundation Trust participated in **96**% of the national clinical audits, and **100** % of the national confidential enquiries which it was eligible to participate in.

The reports of **37 National Clinical Audits** and **48 Local Clinical Audits** were reviewed by the provider in **2021/22** and County Durham & Darlington NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Actions typically include the 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) programs 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 structures outlined above are essential to achieving this. 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 as follows.

Communication & Engagement

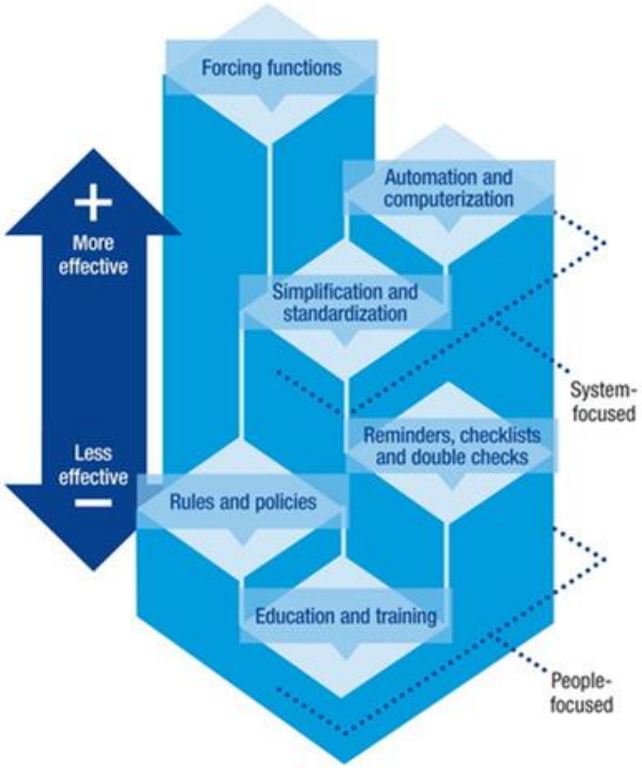
- Promoting clinical audit through excellence reporting.
- Enhancing access to clinical audit training and online resources.
- Actively engaging with other QI initiatives throughout the Trust.
- Supporting junior doctors with access to a library of routine audits.

Measuring Success

- Developing a high level overview of the performance of the clinical audit programme.
- Encouraging audits that indicate the effectiveness of previous interventions.
- Feedback from staff on the clinical audit process.

Supporting Effective Change

- Support and training with root cause analysis and the use of human factors techniques.
- Investigate and remove barriers to accessing QI processes and implementing change.
- Support and training on appropriate, efficient and effective interventions.
- Adopting a holistic approach to QI, making use of both people and system focused changes/ interventions to ensure the delivery of high quality and effective patient care.
- Emphasising the importance of smaller achievable changes where appropriate, that which can be owned by individuals or teams. Particularly for Junior Doctors on short rotations who have limited time to complete QI activities.



KEEP, A. B. J. CLINICAL AUDIT DOES NOT WORK, IS QUALITY IMPROVEMENT ANY BETTER? HTTPS://DOI.ORG/10.12968/HMED.2018.79.9.508 79, 508–510 (2018).

The national clinical audits and national confidential enquiries that County Durham & Darlington NHS Foundation Trust was eligible to participate in, participated in and for which data collection was completed during 2021/2022 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 Audits Applicable to County Durham & Darlington NHS Foundation Trust

National Program	Topic	Participation	% cases submitted
Case Mix Programme (CMP)	N/A	✓	100%
Child Health Clinical Outcome Review Programme	Transition from child to adult health services	✓	Ongoing
Elective Surgery (National PROMs Programme)	N/A	✓	Hip (76%) Knee (53%)
Emergency Medicine QIPs	Infection Prevention and Control	✓	Ongoing
	Pain in Children	✓	Ongoing
Falls and Fragility Fracture Audit Programme (FFFAP)	National Audit of Inpatient Falls	✓	100%
	National Hip Fracture Database	✓	100%
	Fracture Liaison Service Database (FLS-DB)	✓	55%
Gastro-intestinal Cancer Audit Programme (GICAP)	National Bowel Cancer Audit	✓	100%
	National Oesophago-Gastric Cancer Audit (NOGCA)	✓	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	Maternal mortality surveillance and confidential enquiry (confidential enquiry includes morbidity data)	✓	Ongoing
	Perinatal confidential enquiries	✓	Ongoing
	Perinatal mortality surveillance	✓	Ongoing
Medical and Surgical Clinical Outcome Review Programme	Community acquired pneumonia	Data Collection Scheduled for 2022	
	Crohn's disease	Data Collection Started April 2022	
	Epilepsy Study	✓	67%
National Adult Diabetes Audit (NDA)	National Diabetes Foot Care Audit	✓	Ongoing
	National Diabetes Inpatient Safety Audit (NDISA)	✓	Ongoing
	National Core Diabetes Audit	✓	Ongoing
	National Diabetes in Pregnancy Audit	✓	Ongoing
	NDA Integrated Specialist Survey	✓	N/A

National Program	Topic	Participation	% cases submitted
National Asthma and COPD Audit Programme (NACAP)	Adult Asthma Secondary Care	✓	100%
	Chronic Obstructive Pulmonary Disease Secondary Care	✓	100%
	Paediatric Asthma Secondary Care	✓	Ongoing
	Pulmonary Rehabilitation Organisational and Clinical Audit	✓	Ongoing
National Audit of Breast Cancer in Older Patients (NABCOP)	N/A	✓	100%
National Audit of Cardiac Rehabilitation	N/A	✓	Ongoing
National Audit of Care at the End of Life (NACEL)	N/A	✓	100%
National Audit of Dementia	Spotlight Audit for Memory Assessment Services	✓	100%
National Bariatric Surgery Register	N/A	✓	94%
National Cardiac Arrest Audit (NCAA)	N/A	✓	100%
National Cardiac Audit Programme (NCAP)	Myocardial Ischaemia National Audit Project (MINAP)	✓	Ongoing
	National Audit of Cardiac Rhythm Management (CRM)	✓	100%?
	National Heart Failure Audit	✓	Ongoing
National Comparative Audit of Blood Transfusion	2021 Audit of Blood Transfusion against NICE Guidelines	✓	Postponed due to Covid-19
National Emergency Laparotomy Audit (NELA)	N/A	✓	DMH 96% UNHD 98%
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.	✓	100%
National Lung Cancer Audit	N/A	✓	Utilises existing datasets

National Program	Topic	Participation	% cases submitted
National Maternity and Perinatal Audit (NMPA)	N/A	✓	100%
National Neonatal Audit Programme (NNAP)	N/A	✓	Ongoing
Respiratory Audits	Smoking Cessation Audit- Maternity and Mental Health Services	✓	100%
	National Outpatient Management of Pulmonary Embolisms Audit	✓	Ongoing
Sentinel Stroke National Audit Programme (SSNAP)	N/A	✓	100%
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	N/A	✓	Ongoing
Society for Acute Medicine Benchmarking Audit (SAMBA)	N/A	✓	Ongoing
Trauma Audit & Research Network (TARN)	N/A	✓	100%
National Ophthalmology (NOD)	Age-related Macular Degeneration Audit (AMD)	✓	100%
	Adult Cataract Surgery	✗	N/A
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	✓	100%
Perioperative Quality Improvement Programme (PQIP)	N/A	✗	N/A
Inflammatory Bowel Disease Audit	N/A	✗	Staff re-deployed due to Covid-19
UK Parkinson's Audit	N/A	✗	Postponed due to Covid-19
National Paediatric Diabetes Audit (NPDA)	N/A	✓	100%

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

National Program	Topic
Breast and Cosmetic Implant Registry	N/A
British Spinal Registry	N/A
Cleft Registry and Audit NEtwork (CRANE)	N/A
Medical and Surgical Clinical Outcome Review Programme	Physical Health in Mental Health Hospitals
National Cardiac Audit Programme (NCAP)	National Adult Cardiac Surgery Audit
Management of the Lower Ureter in Nephroureterectomy	Management of the Lower Ureter in Nephroureterectomy
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 2021/22)
Muscle Invasive Bladder Cancer at Transurethral REsection of Bladder Audit (MITRE)	Muscle Invasive Bladder Cancer at Transurethral REsection of Bladder Audit (MITRE)
National Audit of Pulmonary Hypertension	N/A
National Clinical Audit of Psychosis (NCAP)	N/`A
Transurethral REsection and Single instillation intra-vesical chemotherapy Evaluation in bladder Cancer Treatment (RESECT) Improving quality in TURBT surgery.	N/A
National Prostate Cancer Audit (NPCA)	N/A
National Vascular Registry	N/A
Neurosurgical National Audit Programme	N/A
Out of hospital cardiac outcomes (OHCAO)	N/A
Paediatric Intensive Care Audit Network (PICANet)	N/A
Prescribing Observatory for Mental Health	Prescribing for depression in adult mental health services
	Prescribing for substance misuse: alcohol detoxification in adult mental health inpatient services
	Prescribing of antipsychotic medication in adult mental health services, including high dose, combined and PRN
	Use of clozapine
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)

Participation in Clinical Research

Research and Innovation continues to be a priority within CDDFT, with a ward to board ethos. We have developed a blueprint for the future, which has received excellent feedback from both internal and external stakeholders – this will sit alongside the existing strategy and will inform further developments.

Our focus is to ensure research and innovation is core business. The next steps will be to strengthen our multi-disciplinary research agenda and to work closely with the quality improvement team and patient safety.

The number of patients receiving relevant health services provided or sub-contracted by County Durham & Darlington NHS Foundation Trust in 2021/22 to date, that were recruited during that period to participate in research approved by a Research Ethics Committee was 3,236 participants.

This recruitment number was higher than 2020/21 despite a shift from Covid-19 to non-Covid-19 studies. The Trust recruited to 53 National Institute Health Research Portfolio studies with most paused studies due to Covid-19 now re-opened. The Trust had 67 active Principal Investigators in 2021-22.

The Trust is part of the Durham Tees Valley Research Alliance (DTVRA) alongside North Tees & Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust. This last year has seen our department deliver a number of Urgent Public Health Covid-19 studies as well as re-open all of our non-Covid trials that had been previously paused during the pandemic. One of the key successes was to deliver the NOVAVAX Covid vaccine trial from the hub at Hartlepool Hospital. We over recruited to this trial enrolling 532 participants against a target of 350.

In this past year we have submitted data on 1,342 patients for the CCP ISARIC Covid-19 data collection study. Overall, 1,446 participants from the Trust have contributed data to Covid-19 and infection studies.

Other highlights from some of the research trials open at CDDFT:

- The White9 Study (Orthopaedics) UHND is the top national recruiter opening in August 2021;
- The ROCKETS Study (Obstetrics and Gynaecology) UHND is consistently top national recruiter;
- The ENRICH-AF study (Cardiology) UHND – a top 10 recruiter globally;
- The GENOMICC Study (Covid-19) UHND is in the top 10 recruiters;
- For CONSCOP2 (a trial of contrast-enhanced colonoscopy), the Trust is the second highest recruiting site in UK;
- The GI Research Team at DMH recruited the first UK patient to the MESSINA trial, a commercial trial giving a new treatment to patients with Eosinophilic Oesophagitis; and
- The PERSPECTIVES Study (Gastroenterology): 1,176 patients were recruited this year into a locally-led study by one of our Clinical Nurse Specialists.

Goals agreed with commissioners

County Durham and Darlington income in 2020/21 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework because the scheme was suspended due to the Covid-19 pandemic.

CQC Registration

County Durham & Darlington NHS Foundation Trust is required to register with the Care Quality Commission; the Trust's current registration status is 'registered without conditions.

The Care Quality Commission has not taken enforcement action against County Durham and Darlington NHS Foundation Trust during 2021/22.

Care Quality Commission Ratings

The Trust was last inspected between June 2019 and September 2019, with the final report being issued in December 2019. Three key services were inspected in June 2019 at both DMH and UHND: Surgery, End of

Life Care and Urgent and Emergency Care. In addition, Trust-wide reviews of "Well-Led" arrangements and our Use of Resources were undertaken. The Trust received an overall Good rating, which was replicated for the significant majority of its services. Our current ratings are those set out in CQC's report, published in December 2019, and combine the outcomes of the latest inspection with ratings for those services not inspected, which were brought forward from the comprehensive inspection reported in September 2015 and the further inspection reported in March 2018.

Overall ratings by Domain are set out below:

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

Use of Resources Assessment	Good

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

Darlington Memorial Hospital (DMH)

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

Ratings for Darlington Memorial Hospital

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

University Hospital North Durham (UHND)

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

Ratings for University Hospital of North Durham

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

Community Services

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

Ratings for community health services

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

Implementation of actions from the 2019 inspection

We have implemented all of the Must Do actions agreed with CQC. Whilst we have improved our medical staffing and arrangements for children accessing our A&E departments to have access to specialist children's nurses, continue to further strengthen and improve the resilience of our arrangements in both areas. As outlined earlier in this document: we are recruiting additional medical staff to our A&E Departments; we have opened a 24 hour Paediatric Assessment Area – co-located with the A&E department at UHND; and, at DMH we have recruited more specialist nurses to staff the children's A&E area, working alongside general nurses

who are approved to work with children in A&E, following assessment by senior nurses from our A&E and Paediatrics Services based on a rigorous competency framework.

In addition to the above, we have implemented the substantial majority of improvement recommendations included in CQC's reports, subject to a minority which could not be implemented because of the way in which the Covid-19 pandemic changed our operations and management arrangements.

We are now are actively working on enhancements to services and key processes as we seek to consolidate our Good rating and embed further outstanding practices; as we strive to continuously improve services for our patients.

Data Quality

County Durham and Darlington NHS Foundation Trust submitted records during 2021/22 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

- which included the patients valid NHS number was:
  - 99.5% for Admitted Patient Care
  - 99.7% for Outpatient Care
  - 97.6% for Accident and Emergency Care

- which included the patient's valid General Medical Practice Code was:
  - 99.7% for Admitted Patient Care
  - 99.5% for Outpatient Care
  - 99.5% for Accident and Emergency Care

Data Security and Protection Toolkit Annual Return

The Trust can report that, in line with NHS Digital compliance requirements it will be aiming to publish its Data Security and Protection Toolkit annual return, and predict a publication status prior to 30th June 2022 of 'standards met' but are aiming towards 'standards exceeded' if Cyber Essentials Plus certification is achieved.

Clinical Coding Error Rate

County Durham and Darlington NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2021/22 by the Audit Commission.

Learning from Deaths

During 2021/2022, 2,188 patients died in the Trust, a quarterly breakdown is provided below:

- 429 in the first quarter;
- 569 in the second quarter;
- 607 in the third quarter; and
- 560 in the fourth quarter.

By 31 March 2022, 390 case record reviews and eight investigations had been carried out in relation to 2188 of the deaths included above.

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

- 149 in the first quarter;
- 121 in the second quarter;
- 85 in the third quarter; and

- 35 in the fourth quarter.

Four (0.18%) of the patient deaths during the reporting period were judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of:

- 1 representing 0.2% for the first quarter;
- 1 representing 0.2% for the second quarter;
- 1 representing 0.2% for the third quarter; and
- 1 representing 0.2% for the fourth quarter.

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

The key learning themes identified from the reviews completed in 2021/2022 have been in relation to ensuring the physiological observation policy is followed, repeating blood tests and documentation. Learning identified through case record review overall has related to: escalation planning and decision making, and recognition that a patient is reaching the end of their life and communication with family. Treatment of Sepsis and Acute Kidney Injury are also an ongoing theme for quality improvement.

Actions that County Durham and Darlington NHS Foundation Trust has taken in relation to the learning identified from those deaths in 2021/22 form part of comprehensive SMART action plans monitored through the Trust governance processes. Since March 2021, the Trust has operated 'Call for Concern', which allows patients and relatives to alert clinical teams to concerns, in response to learning from mortality reviews.

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

Some 452 Case Record Reviews and 4 investigations were completed after 31st March 2021 which related to patient deaths which took place before the start of the reporting period.

Eight deaths, representing 0.3% of the deaths before the reporting period were judged to be more likely than not to have been due to the problems in the care provided to the patient. These numbers have been estimated using the PRISM 2 mortality review methodology or through County Durham and Darlington NHS Foundation Trust Serious Incident Reporting Process.

Staff who 'Speak Up' (Including Whistle-blowers)

The Trust has a number of channels through which staff can speak up, and raise concerns regarding quality of care, bullying, harassment and patient safety, in particular:

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

The Trust's Freedom to Speak Up Guardian is a registered nurse who has previously worked in senior nursing management roles. Their appointment has been publicised through the Trust's intranet site,

screensavers, staff bulletins and staff meetings and also through wider staff engagement events using Facebook. In previous years, the Guardian has undertaken a wide-ranging programme of visits to wards and departments; this was not possible for much of the last two years due to the pandemic. However, such visits are now programmed in and taking place.

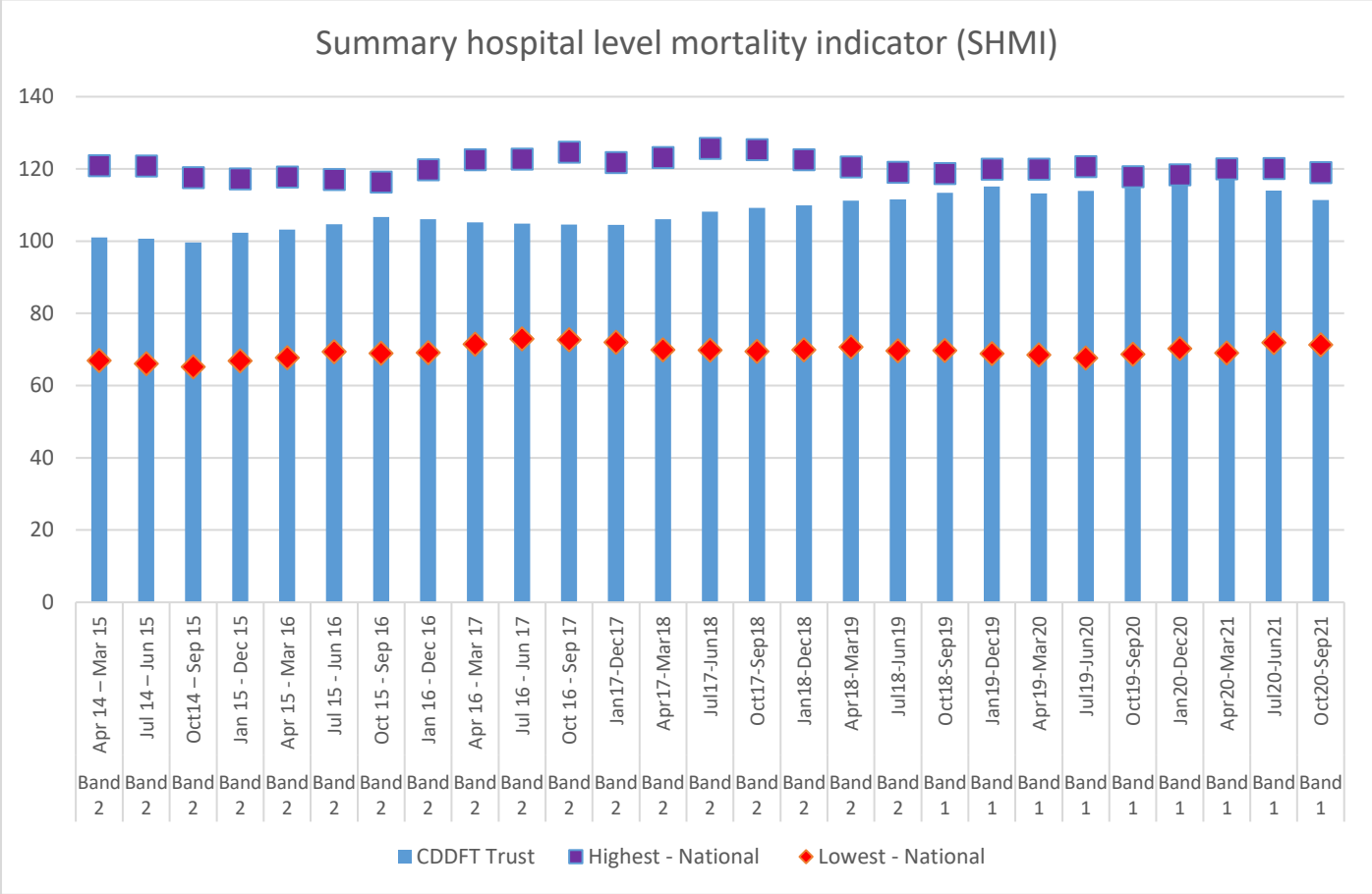
The Trust promotes the National Guardian's Office's training modules "Speak Up" and "Listen Up" to all staff and managers respectively, through its e-learning platform and monitors uptake.

The Freedom to Speak Up Guardian actively participates in national and regional networks in order to identify and implement good practice within the Trust. The Guardian is supported by two Freedom to Speak Up Champions, who provide a confidential sounding board for staff considering raising a concern, and signpost them to the Guardian. The Guardian reports to the Chief Executive and the Trust Board on her work, trends and benchmarking.

The Freedom to Speak Up Guardian is supported by the Senior Associate Director of Assurance and Compliance and by a Non-Executive Director. The Board has agreed a Freedom to Speak Up Strategy for, which aims to embed a culture in which staff feel able to speak up, and in which the Trust universally listens to, looks into and learns from concerns raised. This ran to 31st March 2022 and is being refreshed.

Reporting against core indicators

Domain 1 – Preventing people from dying prematurely
SHMI and Palliative Care Coding



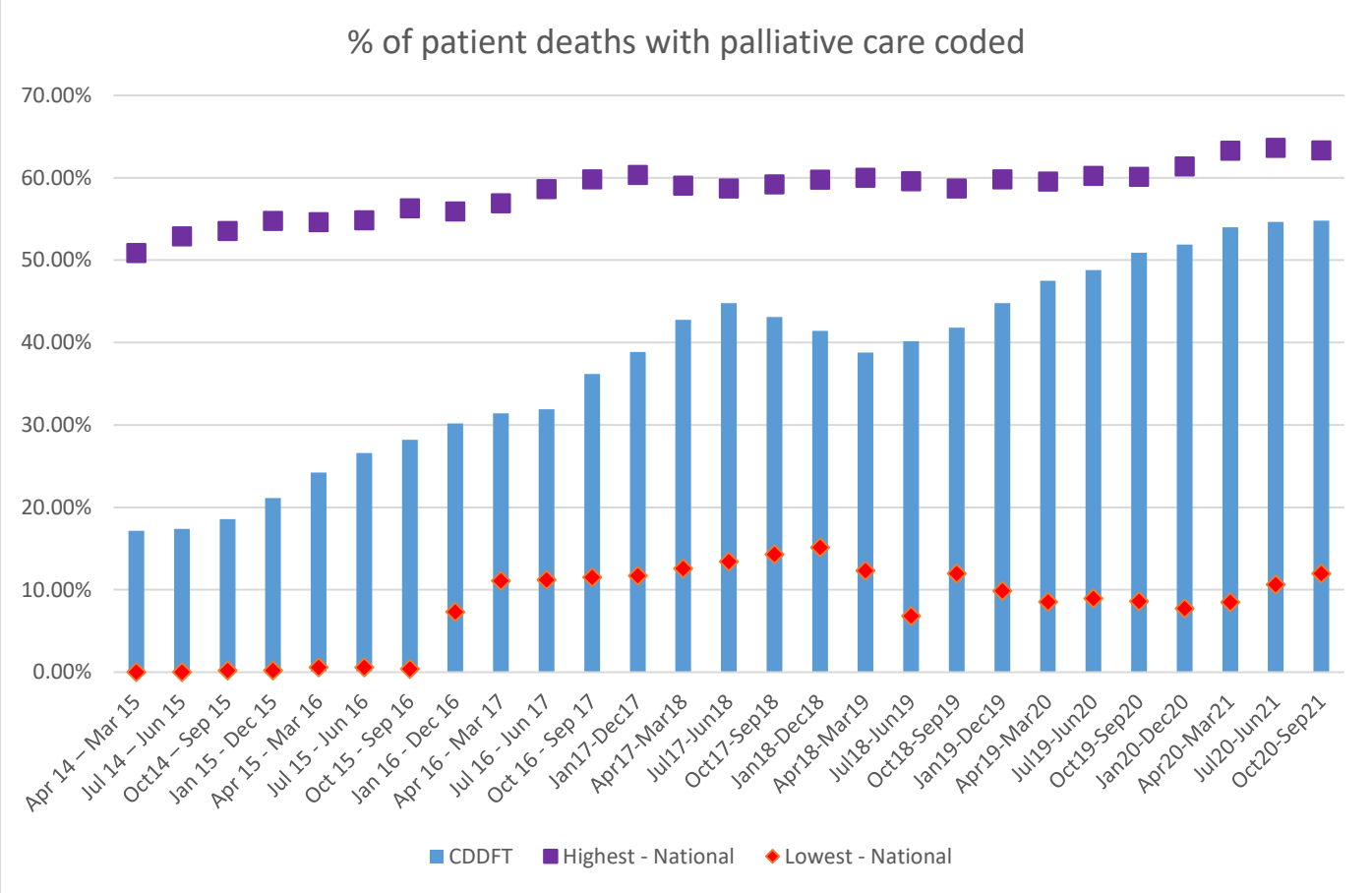
Data source: NHS Digital

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 Mortality Reduction Committee

The County Durham and Darlington NHS Trust intends to take the following actions to improve the indicator and so the quality of services by continuing to ensure that mortality remains a strong focus for the Trust. The Trust will continue to build on the mortality review process within the organisation and provide care groups with quarterly learning from deaths reports identifying themes of learning. Work will continue with Regional and Primary Care colleagues to ensure joint learning. The Trust has appointed a lead Medical Examiner and continues to recruit more Medical Examiners to enable the Trust to provide a full service. This year the Trust will also implement a new EPR system which will enable immediate access to notes that are legible and accessible to all, in addition to optimising work flows in Sepsis and AKI. Monitoring will continue through thematic analysis of case reviews, and reporting of Mortality indicators and the results of learning from deaths reviews to the Mortality Committee.

As outlined in Part 2A, the Trust has appointed three clinical champions providing education and training in recording of comorbidities in notes and discharge letters, so that patient episodes are accurately coded to the correct diagnosis group, and has also appointed AKI nurses to support our wards in recognising and acting on signs of AKI. The Trust carried out detailed investigations to understand its SHMI trend including utilising external experts and additional data from Copeland's Risk Adjusted Barometer. The external view of CDDFT's SHMI position was provided by NEQOS who commended the Trust on the number and depth of learning from deaths reviews completed and advised that more assurance should be taken from the Trust's own reviews and alternative measures which NEQOS stated was in line with good practice. As a result of this work CDDFT's SHMI is now within the expected range.

Percentage of deaths with palliative care coded



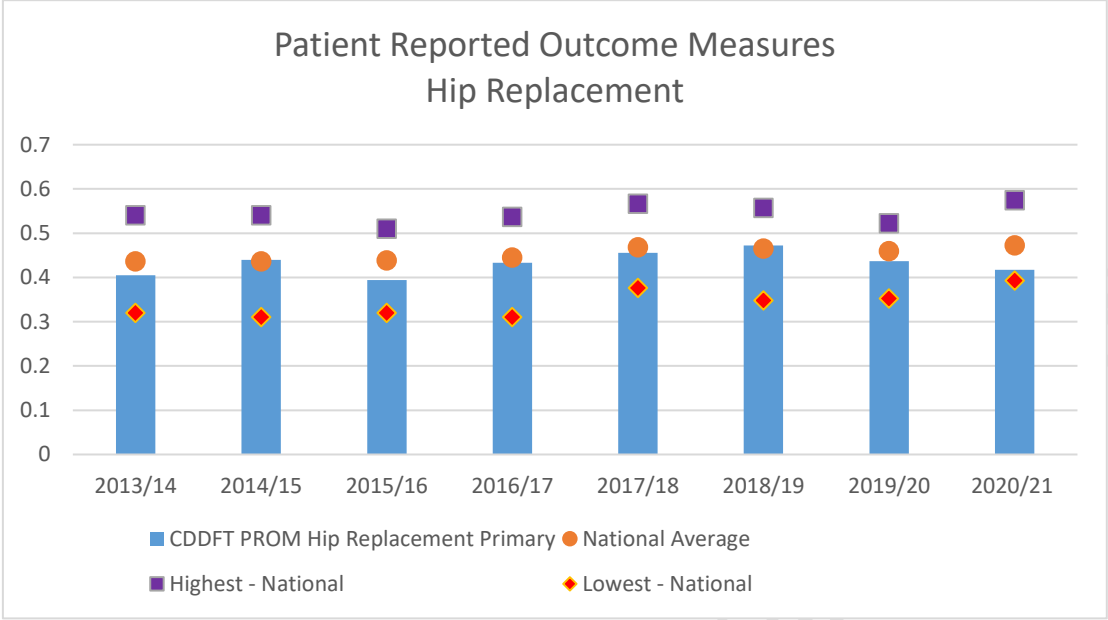
Data source: NHS Digital

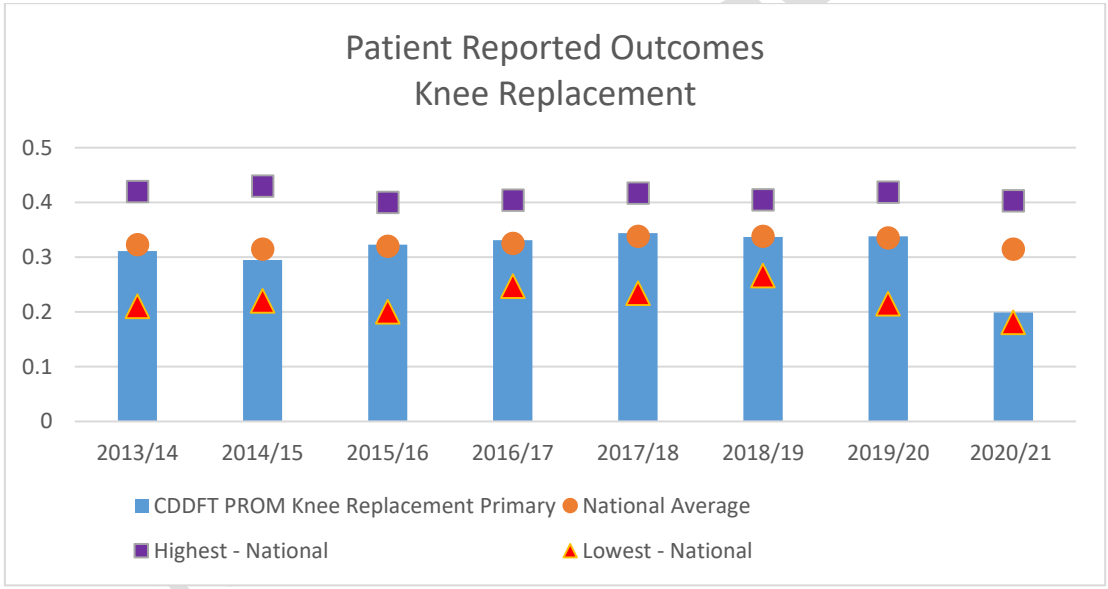
The County Durham and Darlington NHS Trust considers that this data is as described for the following reasons: this data is regularly reviewed at the Trust End of Life Steering Group

The County Durham and Darlington NHS Trust intends to take the following actions to improve the percentage and so the quality of services by: continuing to work with stakeholders to develop and implement the five year palliative care strategy which was delayed due to pandemic priorities; continuing our focus on the recognition of dying in hospital so that people can be identified at an early stage of the process and improve the care and support to them and their families; exploring solutions to the relative lack of single rooms (which is good in DMH (88%) but remains more of a challenge at Durham) and exploring changes to documentation within the new Electronic Patient Record (EPR).

Domain 3 – Helping people to recover from episodes of ill health or following injury

Patient Reported Outcome Measures (PROMS)





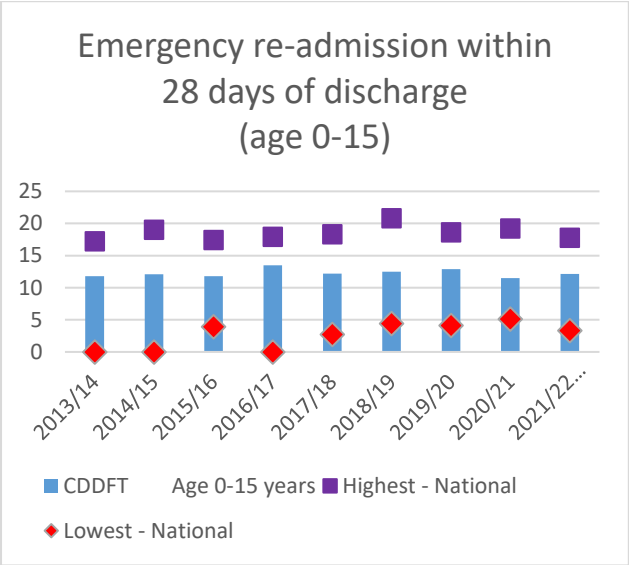
Data source: NHS Digital

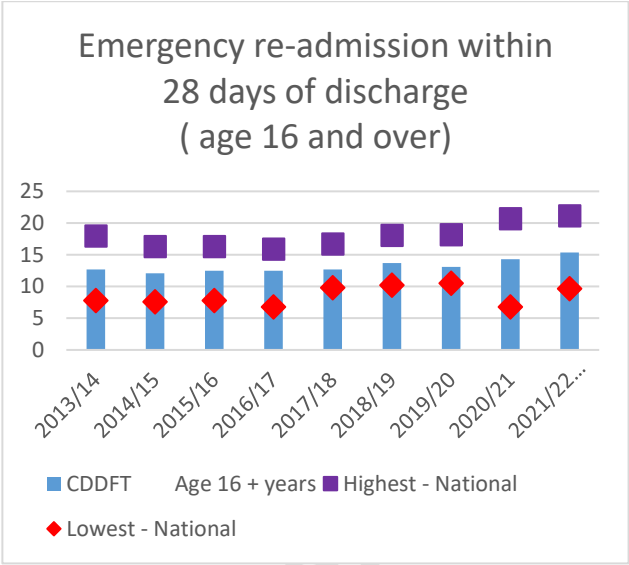
The County Durham and Darlington NHS Trust considers that this data is as described for the following reasons: the data is collected by a dedicated team and is reviewed by the Surgery Care group.

The County Durham and Darlington NHS Trust intends to take the following actions to improve the percentage and so the quality of services by: implementing recovery plans for planned, elective Orthopaedic surgery and theatre staffing to be monitored by Executive Directors. Planned Orthopaedic surgery, like all planned surgery, has been significantly hampered by the Covid-19 pandemic. Ward bed availability and infection control policies have resulted in a significant decrease in elective surgery as witnessed in the results above. The Trust has also had to contend with a reduction of trained Orthopaedic Theatre staff and therefore a reduction in available Theatre sessions, a product of retirements, Covid-19 shielding and the need to train newly qualified staff. The impact is particularly stark for knee arthroplasty.

Patients re-admitted to a hospital within 28 days of being discharged

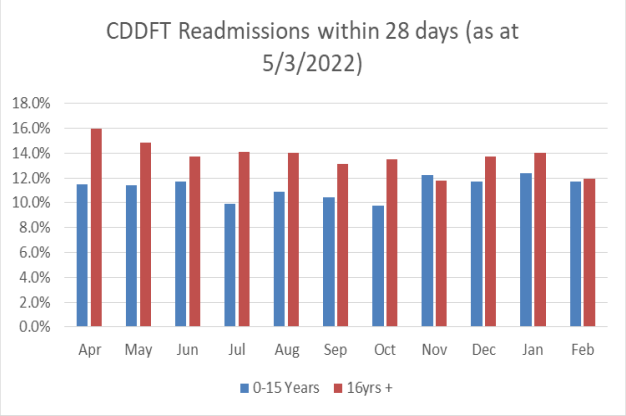
Timely and safe discharges or transfers of care remain a priority for CDDFT.





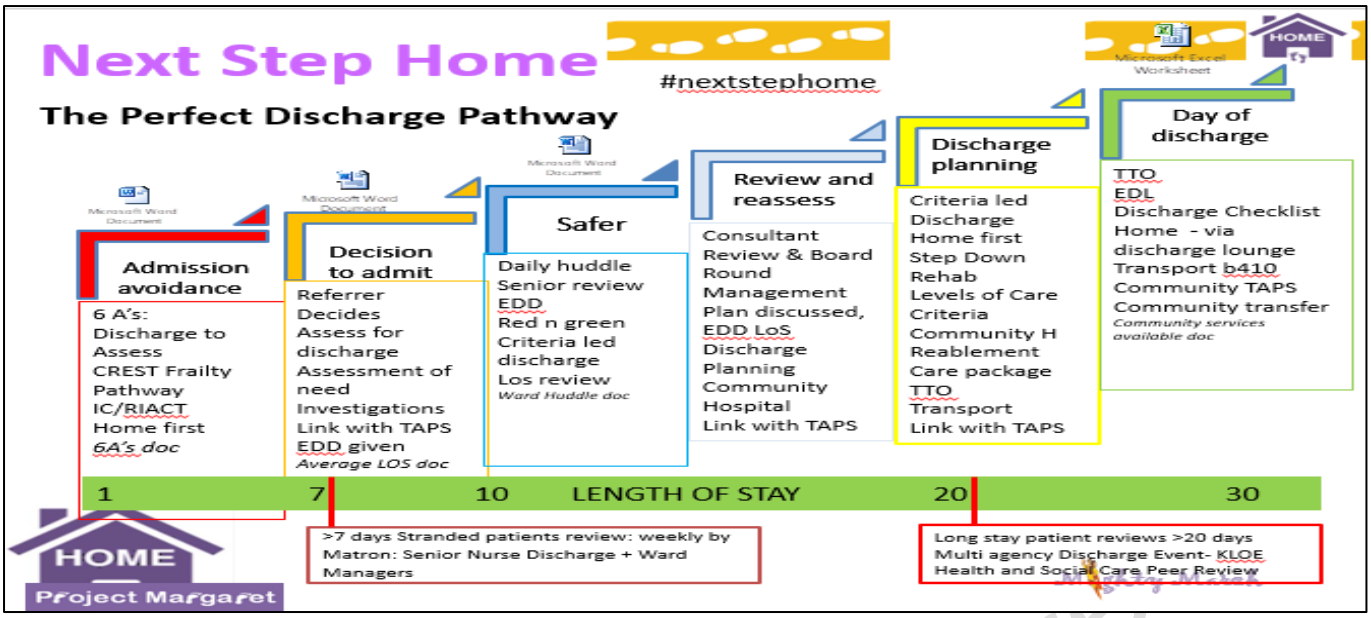
There remains a lower re-admission rate amongst 0-15 year olds.

The re-admission rate peaked at 16% in April and has reduced throughout the year.



This data is collated and submitted as per national guidelines and is regularly reviewed.

The Trust has continued to implement Discharge Guidance via an internal Discharge Working Group, reporting ultimately to the Local A&E Delivery Board, and through the Trust's Next Step Home initiative:



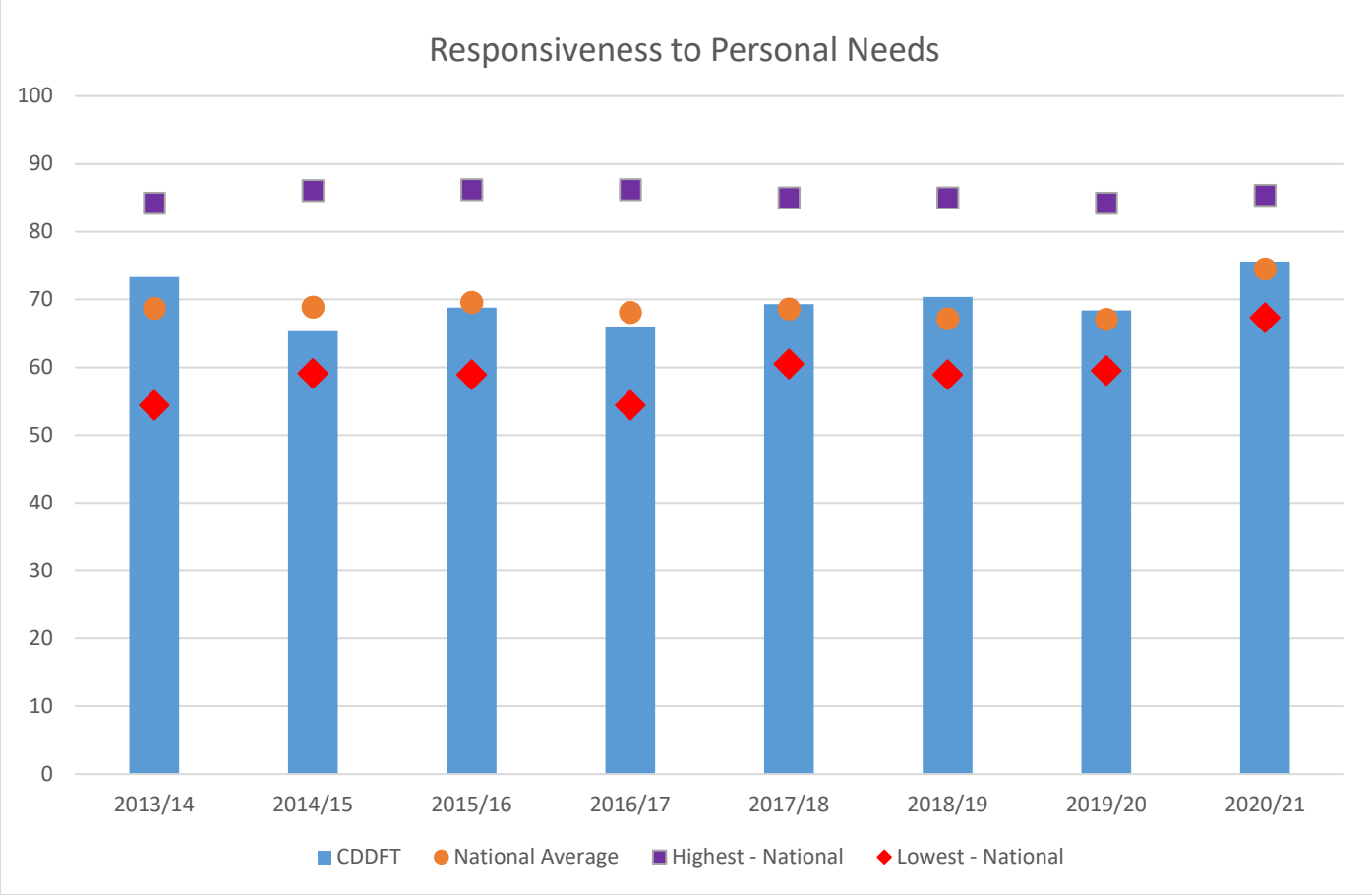
A number of actions have been taken in support of this measure:

- Introduction of community-based urgent crisis response services. Patients, over 90% of the time, receive a response with two hours to support them at home. Work is underway to develop quality markers for this service.
- Investment has been made into adult therapies who are instrumental to support discharge and timely transfers of care.
- There has been increased bed capacity in all community hospitals for those patients who are not quite ready to go home, but do not require an acute bed. They may need an additional period of rehabilitation.
- Primary Care Colleagues have access to a Clinical Advice Line, which enables them to access consultant advice without the need for a re-admission or an out-patient appointment.
- All rapid access services providing alternatives to admission have been reviewed and promoted to partners.

Domain 4 – Ensuring people have a positive experience of care

Responsiveness to the personal needs of patients

This is based on the average score of five domains from the National Inpatient Survey, which measures the experiences of people admitted to NHS Hospitals

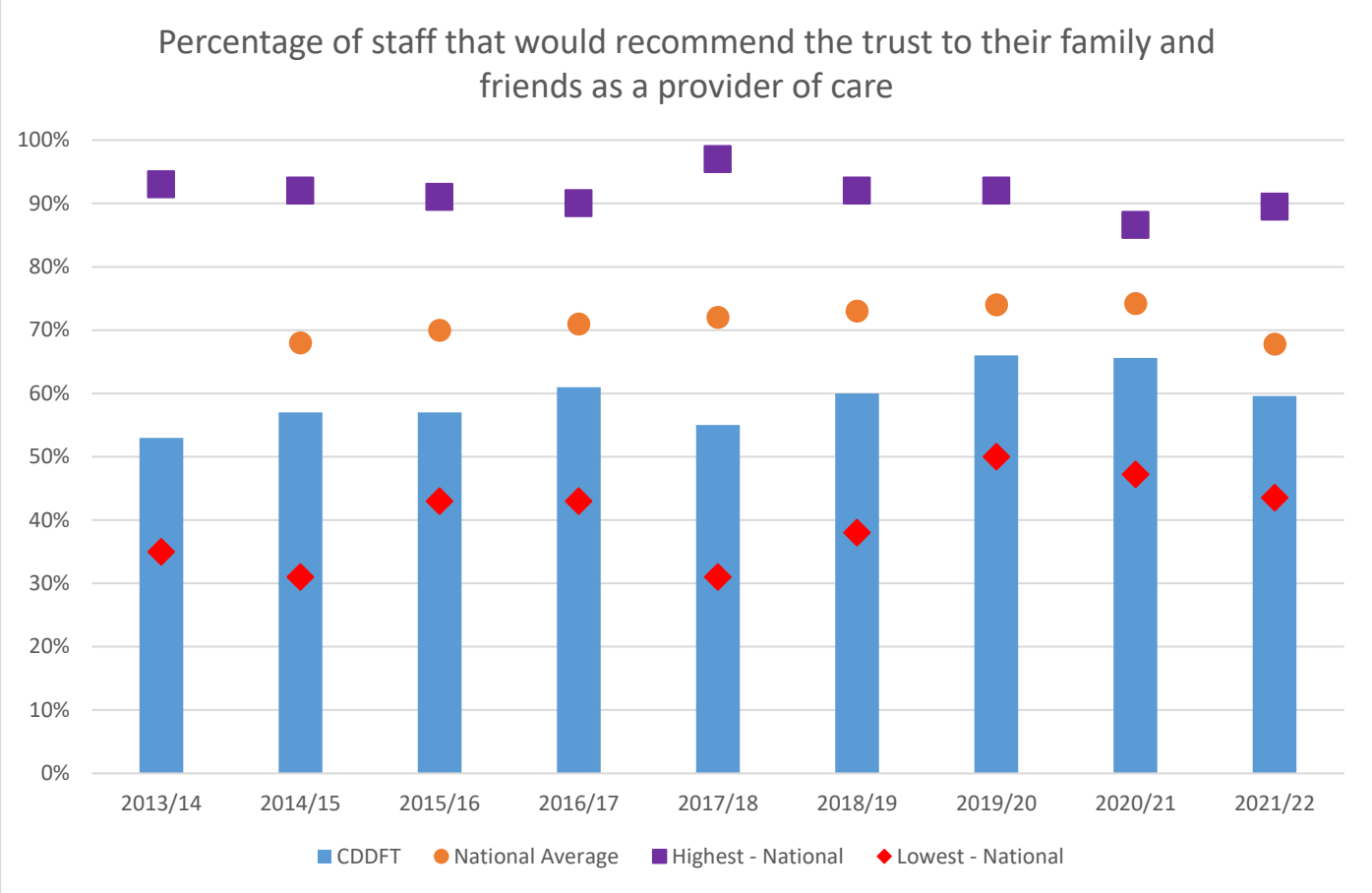


Data source: NHS Digital

The County Durham and Darlington NHS Trust considers that this data is as described for the following reasons: the data is submitted as per national guidelines. This data is reviewed and is line with local and national survey results.

The County Durham and Darlington NHS Trust has taken the following actions to improve the indicator and so the quality of services by: analysing patient feedback, particularly from our own post-discharge survey, for the five key questions underpinning this indicator, triangulating it with other sources of patient experience feedback and sharing it with wards and teams to support local improvement work.

Staff who would recommend the Trust to their family and friends as a provider of care



Data source: NHS Digital

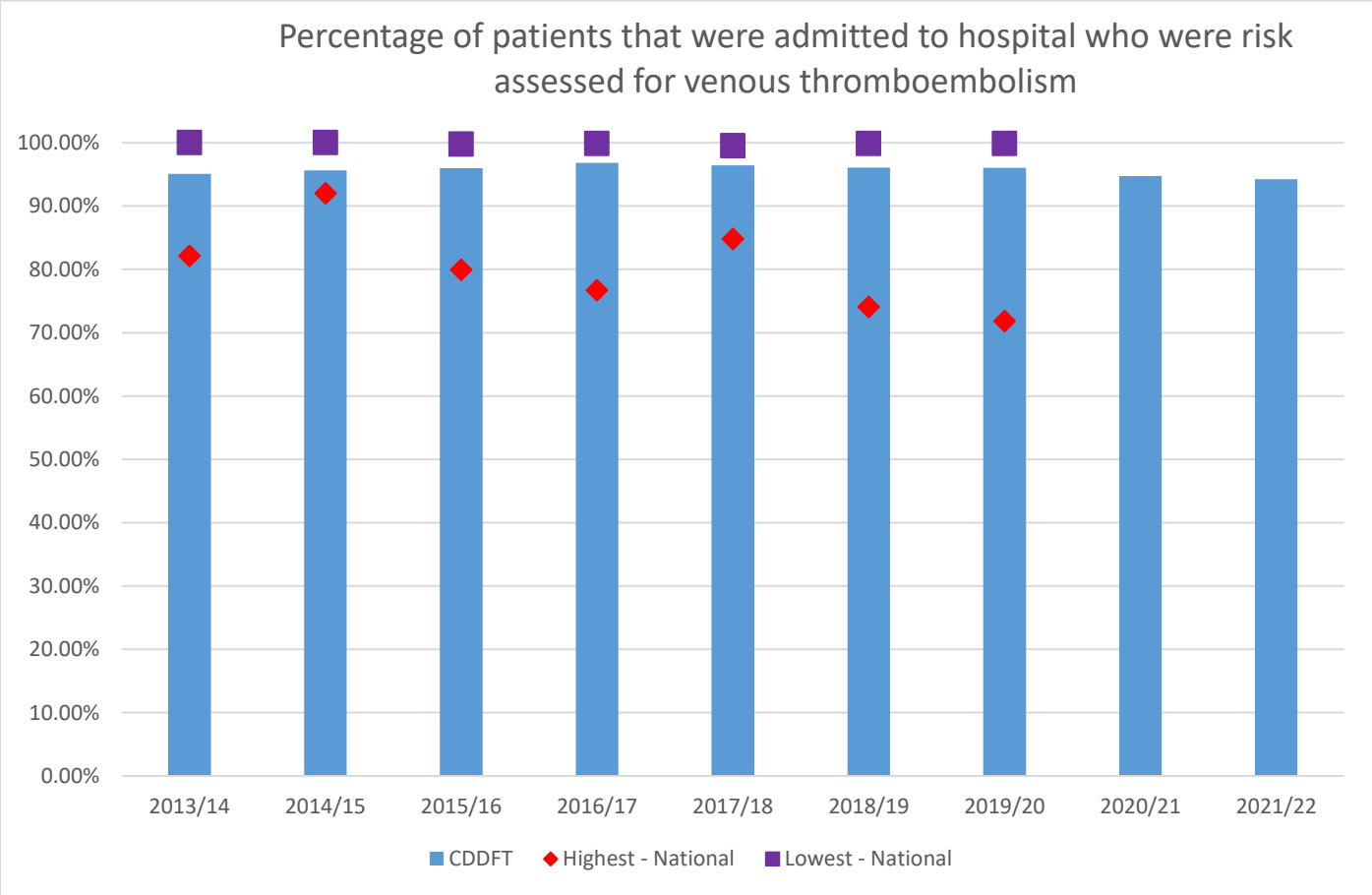
The County Durham and Darlington NHS Trust considers that this data is as described for the following reasons: the data shown is drawn from staff survey results and is reviewed by the Trust as part of the review of National Staff Survey results.

The County Durham and Darlington NHS Trust intends to take the following actions to improve the percentage and so the quality of services by:

- Continuing to promote the excellent care that the organisation provides through mechanisms such as staff bulletins and FaceBook live, hosted by Executive Directors, that highlight new innovations and accolades the organisation has achieved as well as recognising staff contributions to excellent care through Excellence awards and #TeamCDDFT Star Awards amongst other initiatives.
- The promotion of excellence reporting and celebrating successful quality and safety improvements as outlined in Section 2A.
- The roll out of a refreshed Quality Matters Strategy which – at its heart – is designed to provide staff with more capacity and time to care and build skills and capability to continuously improve the quality of care.

Domain 5 – Treating and caring for people in a safe environment and protecting them from avoidable harm.

Percentage of patients that were admitted to hospital who were risk assessed for venous thromboembolism.

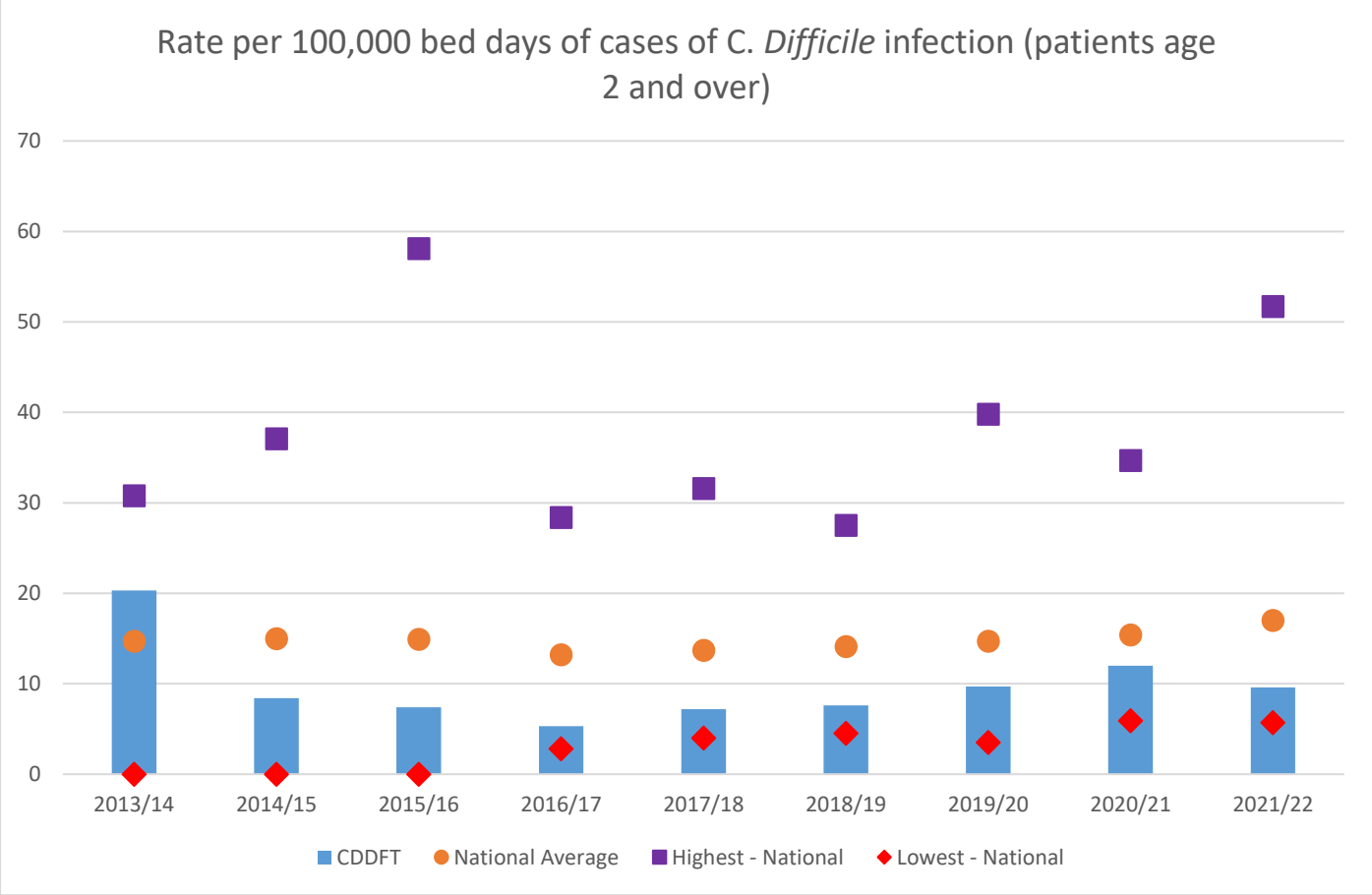


Data source: NHS Digital.

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 and performance was in line with previous years. Nationally data collection was suspended from 2020/21 therefore there is no benchmarking (lowest and highest) in the chart above.

The County Durham and Darlington NHS Trust intends to take the following actions to improve the percentage and so the quality of services by: establishing a VTE working group, led by the Deputy Medical Director for Governance, which will develop actions and support the continuation of compliance monitoring to ensure that current performance is maintained, NICE guidelines are met and improve the quality of service.

Rate per 100,000 bed days of trust apportioned C. Difficile infection that have occurred within the Trust amongst patients aged 2 or over

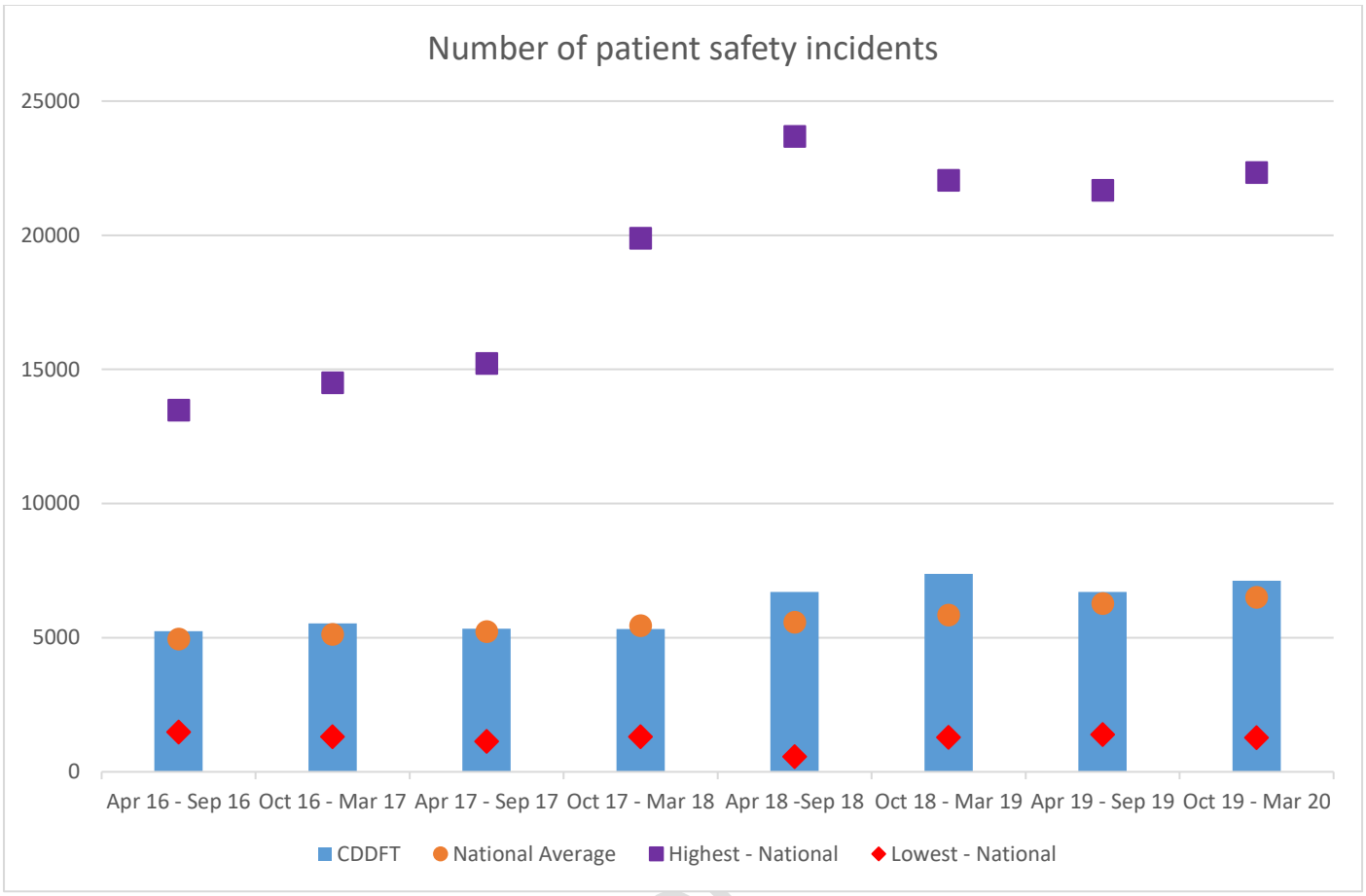


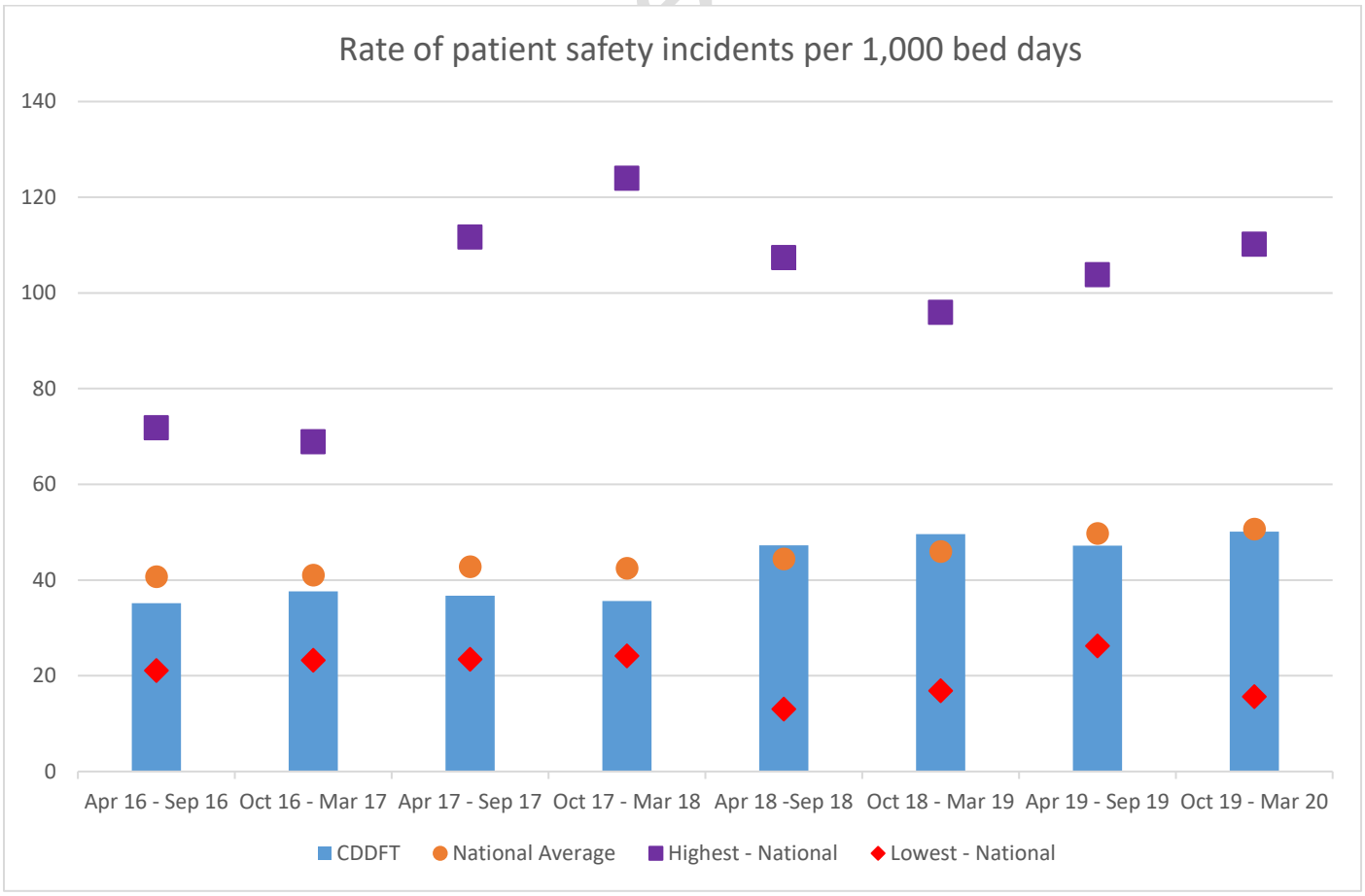
Data source: NHS Digital

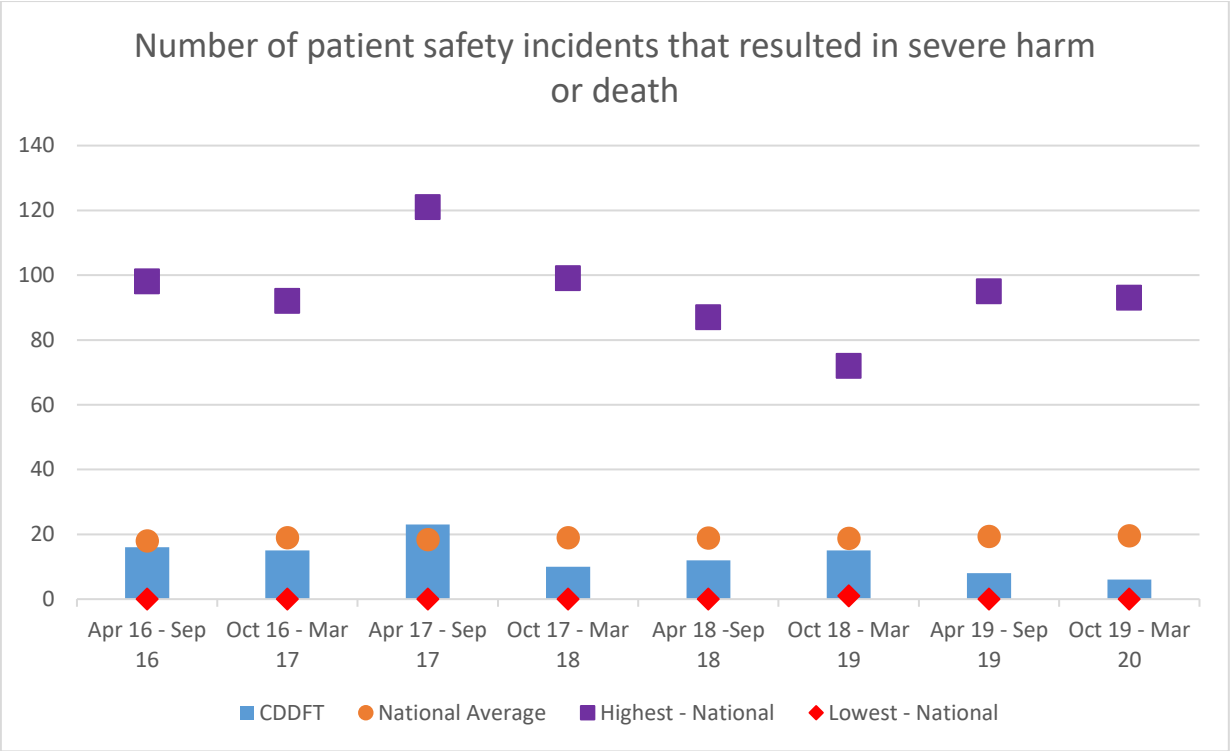
The County Durham and Darlington NHS Trust considers that this data is as described for the following reasons: the Trust monitors this data regularly via its Infection Control and Executive Patient Safety and Experience Committees. It is noted that, whilst the rate increased in 202/21, the rate dropped to pre 2019/20 levels for 2021/22, remaining well below the National Average. The Trust performed better than its full-year threshold for 2021/22 as set by NHSE/I.

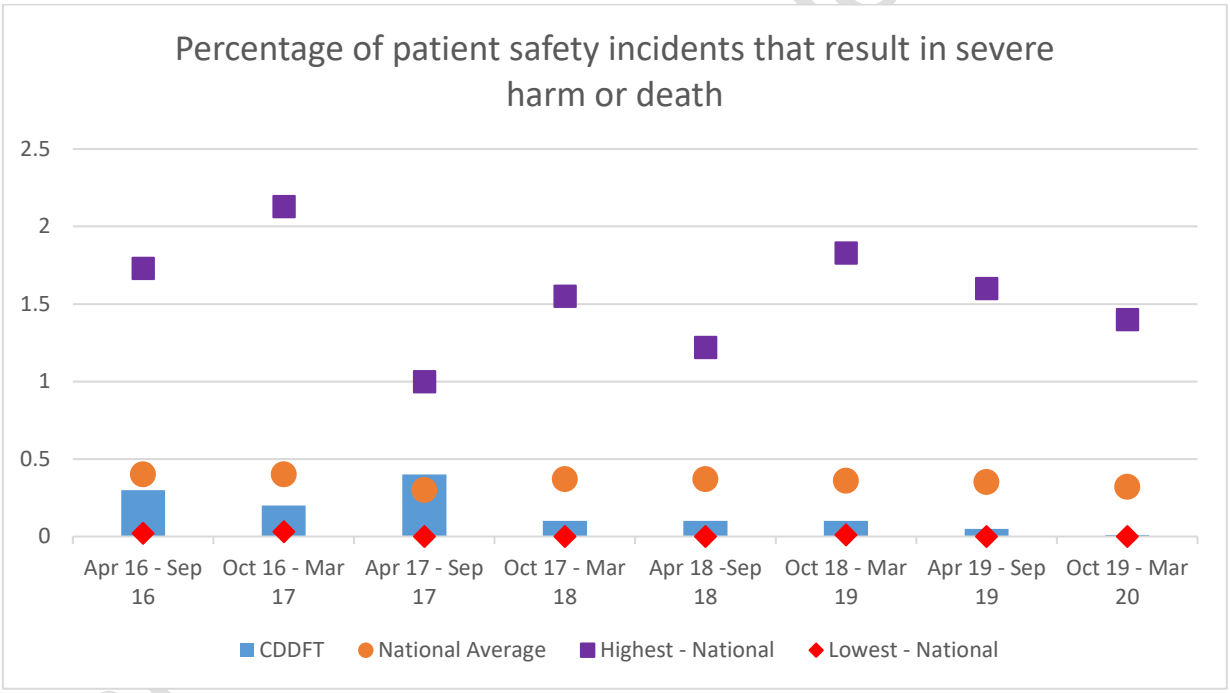
The County Durham and Darlington NHS Trust intends to take the following actions to improve the indicator and so the quality of services by: focusing on early identification and isolation; continuing to build on its antimicrobial stewardship programme; and through wider engagement via the Integrated Care System. The individual case review process is carried out in collaboration with infection control representatives from both acute care and CCGs, antimicrobial pharmacy colleagues and consultant microbiologists/ infection control doctors. These joint reviews will continue and will focus on improvement across the health economy.

Patient Safety Incidents and the percentage that resulted in severe harm or death.









Data source: National Reporting and Learning System

The County Durham and Darlington NHS Trust considers that this data is as described for the following reasons: the data is validated by the Patient Safety Team and agreed at Safety Committee and at Executive level before it is uploaded to NRLS.

The County Durham and Darlington NHS Trust intends to take the following actions to improve the indicator and so the quality of services by undertaking a full review of the National Patient Safety Strategy objectives as well as implementing the key principles identified in the Patient Safety Incident Reporting Framework.

Friends and Family Test

The Friends and Family Test data submission has now been reintroduced after it was suspended in 2020, however there has been a noted dramatic reduction in the amount of responses we capture at CDDFT. Pre pandemic, we recorded in the region of 5,000 responses monthly; however we have struggled some months to capture 500 since the electronic form was introduced. Whilst it is not known for certain, this could have been impacted by the removal of posters due to infection control reasons throughout the pandemic, or lack of footfall due to visiting restrictions.

The focus for 2022 is to improve our electronic responses for the Friend and Family Test. Some work has already been carried out as detailed below:

- Improved posters have been printed and placed in heavy footfall areas and in wards and departments, with a QR code which takes you direct to the short survey.
- We have reintroduced paper cards to compliment the electronic form, allowing all patients to have a voice.
- We have introduced patient surveys to evaluate the patient experience in areas where service improvement has been undertaken.

Work currently being considered for the future is:

- Enhancing the evaluation process for service improvements, involving patients with the planning stages rather than post evaluation only; and
- Using text messages and/or email to offer people to complete the family and friends tests when it is convenient for them.

Part 3 Other Information

This section of the Quality Account includes an overview of the quality of care provided during 2021/22 that has not already been reviewed in this report. This will include elements from Patient Safety, Patient Experience and Clinical Effectiveness. There is also a review of performance against indicators included in the NHS Oversight Framework

The Trust has recently revised its Quality Strategy, a four year forward view. A number of Trust priorities can be seen to overlap with National planning guidance. In this section of the Quality Accounts we will also be reporting on those priorities not specifically detailed in the Trust Quality Strategy but which are included here as we would expect to complete the necessary actions within the next 12 months.

Patient Safety

Health Care Associated Infections: Minimising the risk of Covid-19 transmission in our hospitals

The Trust has followed infection prevention and control guidance from the UK Health Security Agency, to mitigate the risk of transmission of Covid-19 throughout 2021/22 with key controls including:

- Provision of Personal Protective Equipment (PPE) to all staff, including fit testing for respirator masks and provision of training and advice on how to use the equipment correctly. The IPC team carried out monthly audits of compliance with PPE and other infection control measures.
- Implementing requirements for social distancing in all clinical and non-clinical areas and mandating the use of face masks for non-clinical staff accessing hospital walkways and common areas.
- Increased cleaning in clinical areas.
- Signage at our entrances, to designate walkways, in common areas and at lifts, to reinforce the need for social distancing.
- Mask and sanitiser stations at all our entrances.
- Deploying staff in our Outpatient clinics to greet staff and reinforce Covid-19 safety procedures.

- Implementing social distancing in our waiting rooms.
- Regular walk-arounds to all clinical areas from the Medical and Nursing Directors and their deputies, and by the Infection Control Team.
- Segregated pathways for patients with, and with suspicion of, Covid-19.
- Strict protocols for cohorting of patients in contact with others developing the virus.
- Daily meetings chaired by the Director of Nursing or a deputy to investigate any case of nosocomial transmission and all outbreaks.
- Rapid review of Covid-19 safety arrangements and compliance by the infection control team (patient areas) or health and safety teams (general or staff areas) in response to any outbreaks.
- Containment measures for any outbreak, ensuring that areas affected were safe to reopen.
- Involvement of Infection Control professionals in daily command and control calls including any decisions impacting on segregation of pathways and the management of any demand pressures needing re-designation of beds or changes to the management of contacts.
- Rigorous testing and screening of patients prior to admission and at intervals specified by Public Health England thereafter, monitored weekly and reported to Gold Command.
- Implementation of a Covid-19 Workplace Safety Policy, following Government, HSE and Public Health England guidance through a network of Covid-19 local safety champions supported by frequent walk-arounds by the Health and Safety Team and underpinned by a Trust-wide risk assessment and local risk assessments.

The Board, and Gold Command, sought assurance on the implementation and effectiveness of the above arrangements through:

- Audits of compliance with Covid-19 safety practices at ward level, as part of monthly Perfect Ward areas, with high levels of compliance observed throughout the year.
- Safety monitoring officer checks, on PPE compliance and other procedures on wards. The officers revisit wards and carry out further audits in response to any issues found.
- Collating evidence of compliance against NHS England and Improvement's Infection Prevention and Control Assurance Framework, and reporting to the Integrated Quality and Assurance Committee and the Board.
- Review of reports on testing compliance by Gold Command.

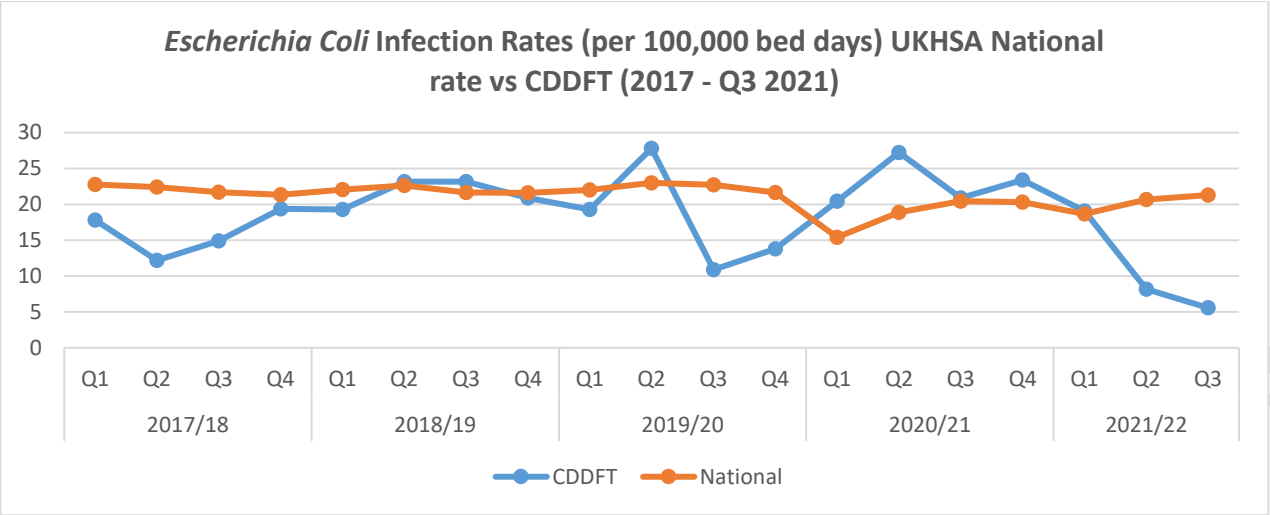
The Trust invited NHSE/I's Lead Infection Control officer to visit all three of its main sites. Observations and suggestions were acted upon and further enhancements to controls implemented.

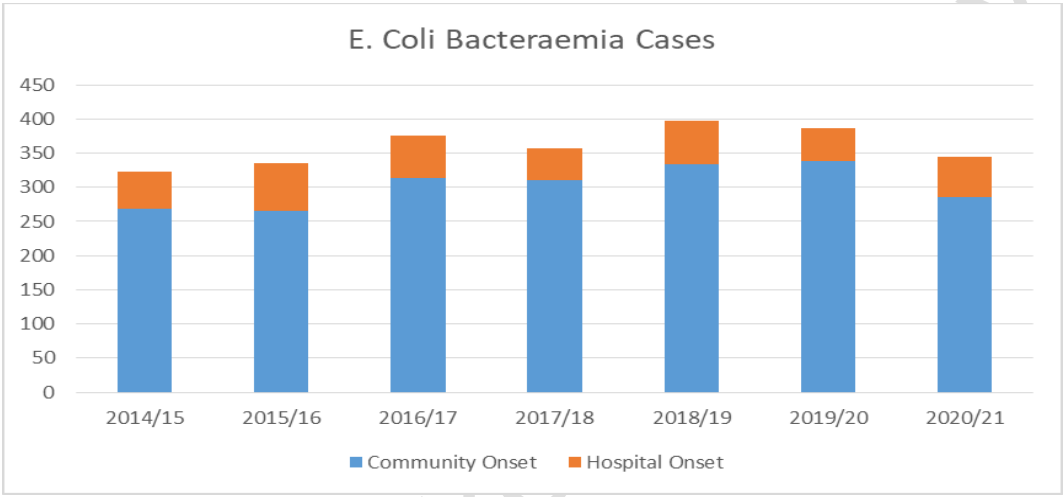
E-Coli Bacteraemia

What is Escherichia coli? *Escherichia coli* (abbreviated as *E. coli*) is a Gram-Negative bacteria found in the environment, foods, and intestines of people and animals. In May 2017 the Secretary of State for Health launched an ambition to reduce healthcare associated Gram-negative bloodstream infections by 50% by 2021 and reduce inappropriate antimicrobial prescribing by 50% by 2021.The initial focus is on reducing E.coli Blood stream infections by 10%

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

From 1st June 2011 the Trust has reported all E coli bacteraemia cases. For the 2021/22 period the Trust reported a total of 324 cases of E coli bacteraemia of which 105 were hospital onset cases.





Incident Reporting and Investigation

The reporting and investigation of incidents and the subsequent learning is integral to maintaining patient safety and improving the quality of care that the Trust provides. The latest NRLS benchmarking report show that the Trust has a reporting rate of 50.7 incidents per 1000 bed days against a national average of 57.0 per 1000 bed days. In addition to this, 1% of incidents reported were moderate harm or above compared to 2% nationally.

The Trust is required to report Serious Incidents as defined with the National Patient Safety Framework and in 2021/22 reported 57 such incidents; this is a reduction on the 62 reported in 2020/21. All of these incidents have had a full root cause analysis review and themes for learning have been identified and shared.

Falls resulting in harm remain the highest reported incidents and reducing harm from falls continues to be quality priority for 2022/23. In 2021/22, CDDFT piloted a rapid review process for falls resulting in fracture neck of femurs. This pilot has allowed the Falls Lead to carry out a rapid review of a fall within five days to identify any immediate learning and to assess whether the fall required ongoing serious investigation. This pilot has been successful and the learning outcomes have been included within the Trust's three years Falls strategy.

The pilot has undertaken 16 falls rapid reviews that have been excluded from the Serious Incident investigation figures for 2021/22 and will continue to exclude alongside the new national patient safety investigation threshold from 2022/23.

Never Events

Disappointingly, the Trust reported two never events during the period. A never event is defined as an incident that should not occur if correct procedures and policies are in place.

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

Never Event 1: wrong site surgery. Key learning included updating the Plastics and Dermatological LocSSIP to set out a standard process for marking site and a requirement to pause immediately before injection to check that the correct site is to be injected. We have also strengthened the booking procedures for the Plastics Dressing Clinic theatre list.

Never Event 2: retained foreign object post-operation. The Trust had a similar incident during 2017, and the patient safety investigation established that mitigations put in place following the previous incident had not been in operation and, had they been, they may well have prevented the object from being retained. The investigation concluded that there had been a failure to embed learning from a previous never event and the immediate actions identified were re-established and will continue to be monitored to ensure they are embedded. The Board's Integrated Quality and Assurance Committee has scrutinised the learning from this never event in detail, and was advised that actions required following the previous never event had been taken but had – due to disruption during the pandemic – lapsed and would be reinstated with additional, on-going monitoring put in place to prevent any future lapse.

Local Patient Safety Initiatives

In 2021/22 the Patient Safety Champion role was relaunched in the organisation to support the communication of learning from incidents to front line staff at all levels working in collaboration with Patient Safety Team and Care Group Facilitators. Throughout 2021/22 the Patient Safety Champions continued to meet and share learning and experiences from a wide range of specialties and staff groups within both community and acute sites.

National Patient Safety Developments

The Patient Safety team undertook a full review of the National Patient Safety Strategy within 2021/22 and identified key actions to be taken to ensure relevant process and systems are in place in CDDFT to meet these principles and standards. The Patient Safety Team have led a number of pilots and initiatives, examples of which are outlined below:

- Pilot of Rapid Review process for thematic incidents – specifically falls/pressure ulcers;
- Pilot of the New Patient Safety Investigation Process for two incidents that would have currently meet the Serious Incident criteria within the Patient Safety Incident Review Framework;
- The use of learning teams to identify and undertake quality improvement work organisationally following a theme identified from incident reporting;
- Pilot of immediate debriefs following an incident to determine the ongoing patient safety investigation required.

The Patient Safety Team will continue to align the Patient Safety priorities for the Trust to the National Patient Safety Strategy for full implementation by April 2023.

Patient Experience

Patient Experience

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

Our vision for services is “Right First Time, Every Time” and our mission - ‘safe compassionate joined up care’ - puts patients at the centre of all we do. The engagement of our patients, members, staff and public is key to understanding how we are performing against our vision and mission and how we need to develop and evaluate our services to ensure that the care we are providing is meeting the needs of our patients. The strategy sets out how we will increase engagement and involvement within our local communities which will promote trust in our services, support reputational management and help position us as the provider of choice.

The strategy has been reviewed and revised for 2022/23 and, whilst continuing to be underpinned by the principles of Dignity for All, “Think Like a Patient”, sets out our aims and aspirations to raise the agenda of patient and public involvement and engagement and also embed the new PHSO NHS Complaints Framework.

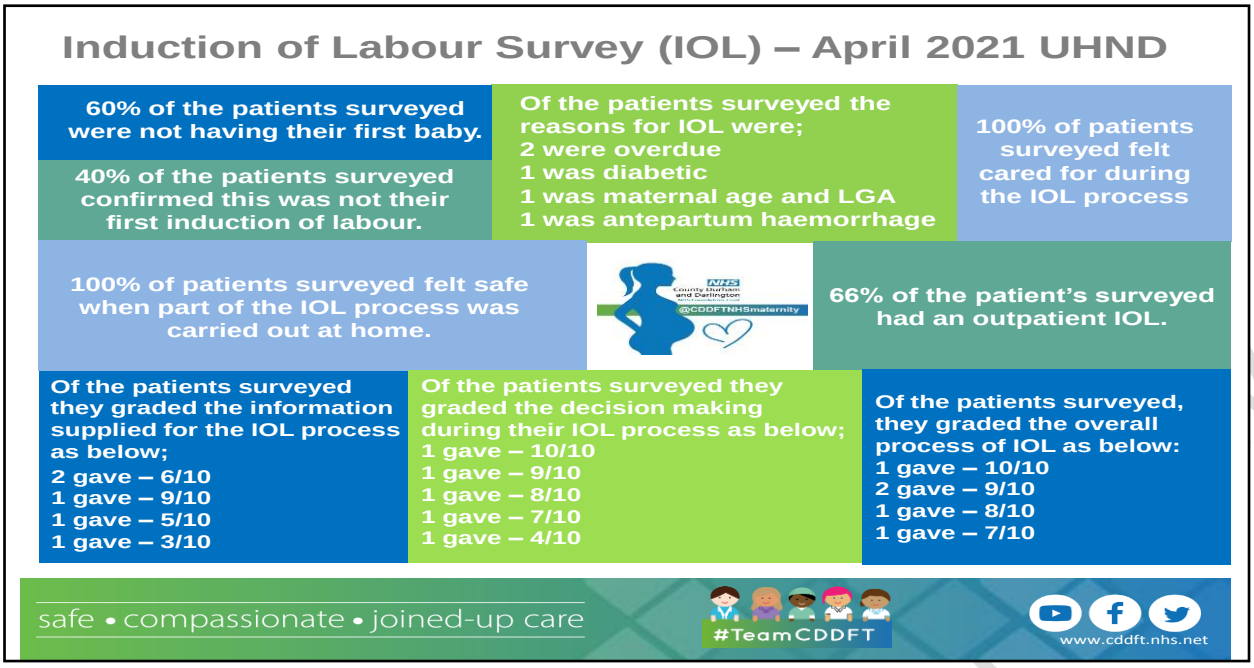
The Trust will continue to raise staff awareness and continue to capture data advising Care Groups of their compliance rates and of areas of complaints learning where actions are required for improvement.

Patient and Public Involvement

During 2021 the Patient Experience Team have worked on numerous patient and public involvement projects with various departments throughout the Trust, focusing on post service improvement evaluations for the services noted below:

- Obstetrics joint epilepsy nurse led clinic
- Wellbeing for 4 the time being – SALT and Occupational Therapy/Physiotherapy
- Rehabilitation after Critical Illness Team
- Home Enteral Feeding
- Respiratory – Cognitive Behavioural Therapy
- Acute Frailty Team
- Pathology
- Induction of Labour

The findings are presented in a poster format and an example is shown below.



The introduction of pre service improvement evaluation will be the focus of our 2022/23 work to allow our patients, public and carers to assist in shaping our services at CDDFT.

National Patient Survey Reports

There were three National Surveys carried out during 2021 by our service provider Patient Perspective and these results are benchmarked to their clients rather than nationally. A summary of the results is set out below.

CQC National Maternity Survey 2021 - Headline Summary report

- Some 307 mothers were included in the survey.
- A total of 173 responses were received, a response rate of 56.9%
- The average score was 77.4, about the same as the Patient Perspective (PP) average of 77.5.
- The Trust was better by 10% or more than the PP average on 2 questions.
- The Trust was worse by 10% or more than the PP average on 1 question.
- The Trust was about the same as the PP average on the remaining 55 questions.

Children and Young Peoples Patient Experience Survey 2020

- Overall 990 questionnaires were emailed, with 265 responses, a response rate of 28%.
- The Trust scored in the top 20% of Trusts on 6 questions and the bottom 20% of Trusts on 7 questions.
- There was an improvement of 10% or more on 2 questions. Results were worse by 10% or more for 4 questions.

NHS Children and Young People's Patient Experience Survey Benchmark Headline Report 2020

The survey was administered by the Survey Coordination Centre for Existing Methods (SCCEM) at Picker Institute. The average result is based on Trusts who use Patient Perspective to carry out the surveys for them.

A total of 113,943 patients were invited to participate in the survey across 125 acute and specialist NHS trusts. Completed responses were received from 27,374 parents and children and young people, an adjusted response rate of 24.2%.

Patients were eligible to participate in the survey if they had been admitted to hospital, were aged between 15 days and 15 years old and had been discharged between 1 November 2020 and 31 January 2021.

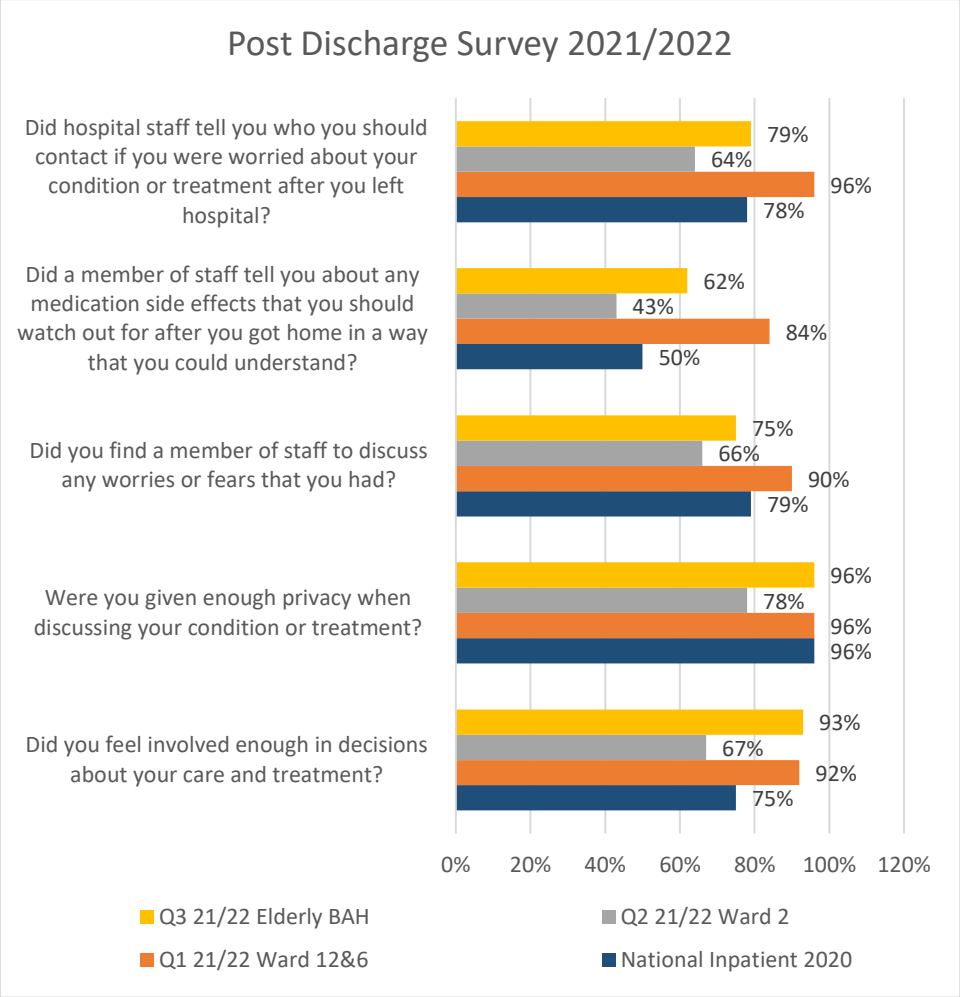
For CDDFT there was a sample of 1,137 people invited to take part and 265 completed the response, this was made up of 177 urgent/emergency admissions and 88 planned admissions. This was a response rate of 24% in comparison with 25% for the previous survey.

In comparison to other trusts CDDFT was somewhat better in 1 question, about the same in in 28, somewhat worse in 6 and worse than expected in 2.

In comparison with CDDFT's previous report in 2018 we were significantly better in 4 questions no different in 50 and significantly worse in 3.

Post Discharge Survey

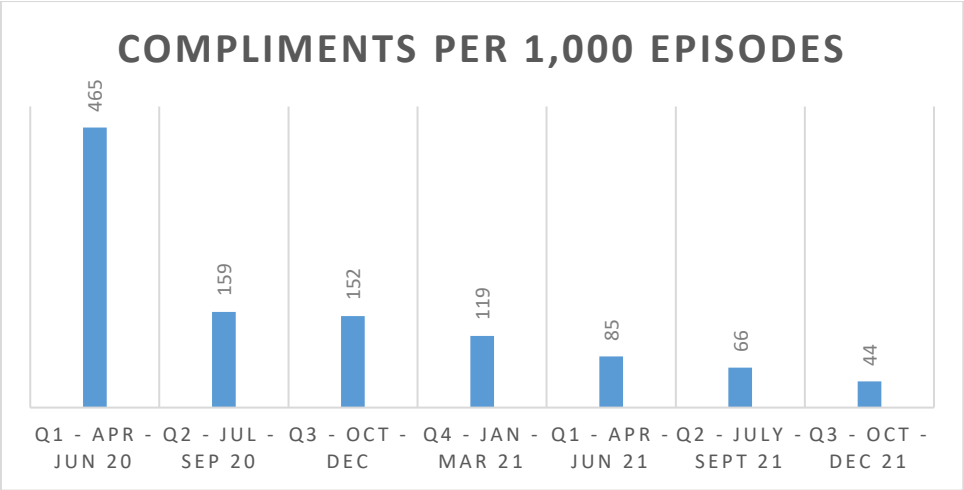
The Post Discharge Survey was redeveloped during 2021 and now runs as a quarterly cycle. This survey is aligned to the national survey. The table below shows the Trust quarterly results for 2021-2022 in comparison to the National Survey results from 2020.



Survey results are shared with the relevant wards and local improvement plans developed and implemented.

Compliments

The chart and table below show the quarterly trend of compliments received per 1,000 patient episodes. As it clearly shows there has been a reduction of compliments made throughout the pandemic.



Complaints

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

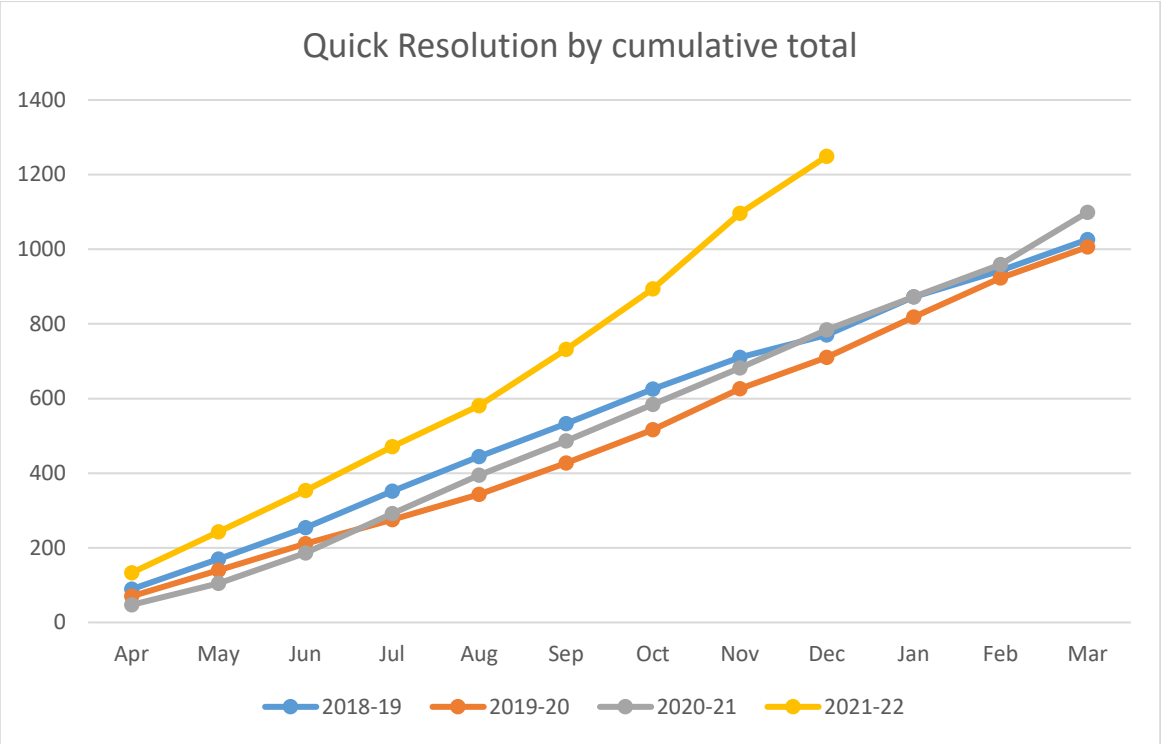
The charts below show the number of formal complaints received trust-wide throughout 2021-22 as a cumulative total and in comparison to previous years back to 2018-19. And also complaints in comparison to 1000 patient bed days.

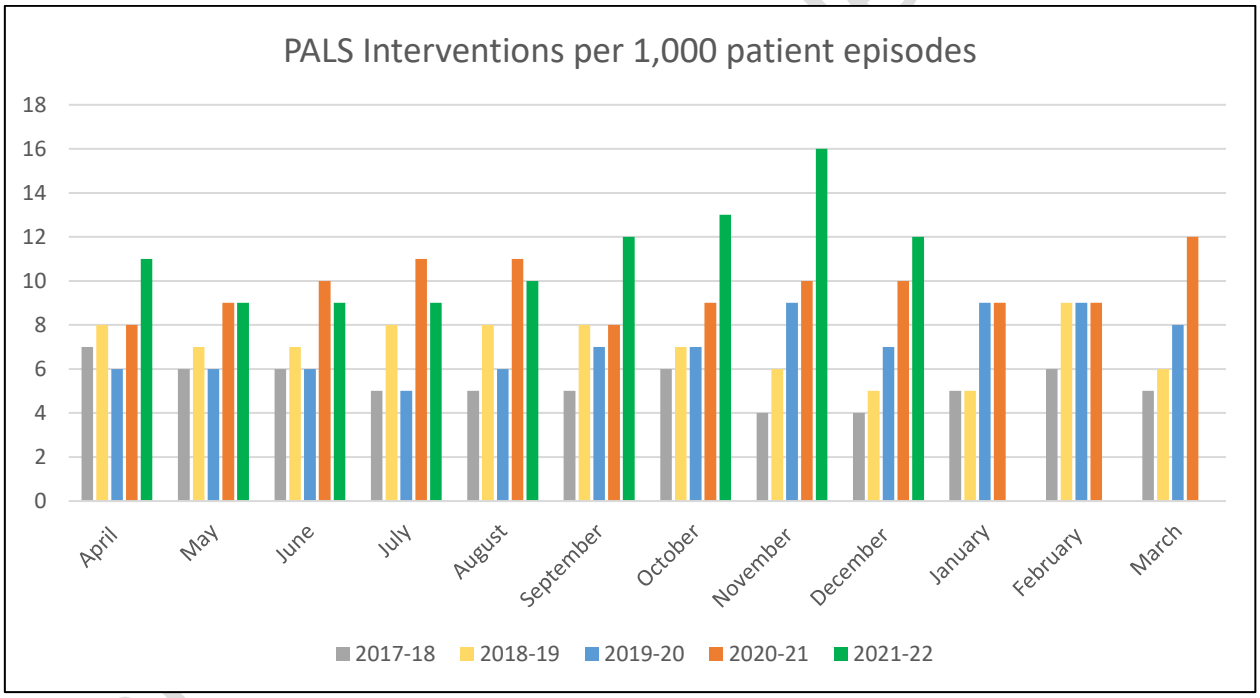
[Drafting Note: Charts are being validated and will be included in the final published document]

Quick Resolution Complaints (Formally PALS)

As part of the PHSO National Standard pilot going forward PALS will be reported as "quick resolution complaints" rather than PALS. Whilst these are categorised as a complaint they will be processed in the same timeframes for patients.

The below charts show the number of quick complaints received trust-wide throughout 2021-22 as a cumulative total and in comparison to previous years back to 2018-19. And also complaints in comparison to 1000 patient bed days. The trend is under investigation but is considered to relate to the promotion of local resolution of complaints by our Integrated Medical Services care group and pandemic-related impacts including lack of visiting (and therefore informal channels for communication) and increased waiting times for appointments.





Working in Partnership with Healthwatch

With the recent implementation of the Trust's Patient Experience Network Group, working partnerships with our Healthwatch colleagues have been reinstated and now active once again.

Working in collaboration will be a priority during 2022 and will included asking Healthwatch to resume their reviews of a sample of anonymised complaint letters and responses on our behalf, which provides a valuable, independent and patient-centred perspective on the quality of our complaints responses. We also review the yearly agenda for Healthwatch County Durham and Healthwatch Darlington and plan how we can align the patient experience agenda to produce reports written in collaboration with robust actions plans for areas of improvement. Any action plans will be presented for assurance at the Patient Experience Network Group on a quarterly basis once these have been approved through internal governance processes.

Learning from Experience

The Patient Experience Team produced their first interactive patient story in 2020 and this was well received. A second patient story video was produced in November 2021 and presented across the Trust in December 2021. We will look to share patient stories evidencing excellent practice in the same format throughout 2022.

The Patient Experience Team continues to work in partnership with the Trust's Care Groups to learn from the issues identified in all formal and quick resolution complaints, and to obtain assurance from actions and to celebrate the excellence identified through Patient Experience.

Looking after the experience of patients and families during Covid-19

During 2021/22 the Trust gradually eased visiting restrictions in line with national guidance, allowing a level controlled visiting to general wards and the support of partners to be provided during pregnancy, and parents to remain with children. We continued to use iPads to facilitate virtual visiting in line with the guidance.

Relatives were also able to leave non-valuable belongings, such as a change of clothes, with our hospital receptions for rapid delivery to the patient by a member of the portering team.

We have complied with national duty of candour requirements, and appointed an advocate to contact the families of anyone who died following infection with Covid-19 acquired in hospital. This service has been well received with families expressing gratitude for the fact that we had remembered their loved one and for our openness.

Clinical Effectiveness

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

We aim to assess and treat all patients in A&E in a timely and safe manner. The national standard requires 95% of patients to be treated and transferred or discharged within 4 hours of arrival in the Emergency Department (ED).

During the early part of the year, when Covid-19 inpatient numbers subsided and lockdowns led to reduced overall ED activity, performance against the four hour standard improved and was closer to 90%. As activity started to return, performance dropped off resulting in average performance, over the year, of 74.25%. The Each wave of Covid-19 had a high impact on our performance, not only because Covid-19 patients require additional beds but because of the inherent issues in managing patients with the virus: the need to await test results and then isolate patients appropriately, closure of bays due to patient contacts or outbreaks and the need to flex the number of Covid-19 beds up or down (which sometimes results in some ring-fenced beds necessarily remaining empty as they cannot be used for non-Covid-19 patients). Pre pandemic, the Trust had plans to increase its capacity for same day emergency care – taking some patients out of the A&E queue who could be treated and discharged on the same day, to increase the footprint of the A&E department and to increase the number of beds, in response to capacity limitations. A number of these changes were delayed, magnifying the impact of Covid-19 pressures. It is also important to note that, pre-pandemic, we reduced the amount of elective activity undertaken in winter to free up more beds to cope with non-elective pressures; however, given the growth in waiting lists during the pandemic, we were – rightly – unable to do so in 2021/22.

The pressures noted above were seen across the country and the Trust was not a national outlier. The North East region performed well overall; however, comparatively greater patient demand was a reality in County Durham and in South Tyneside and Sunderland which – together with the capacity limitations noted above – limited our ability to perform as well as some others in our region.

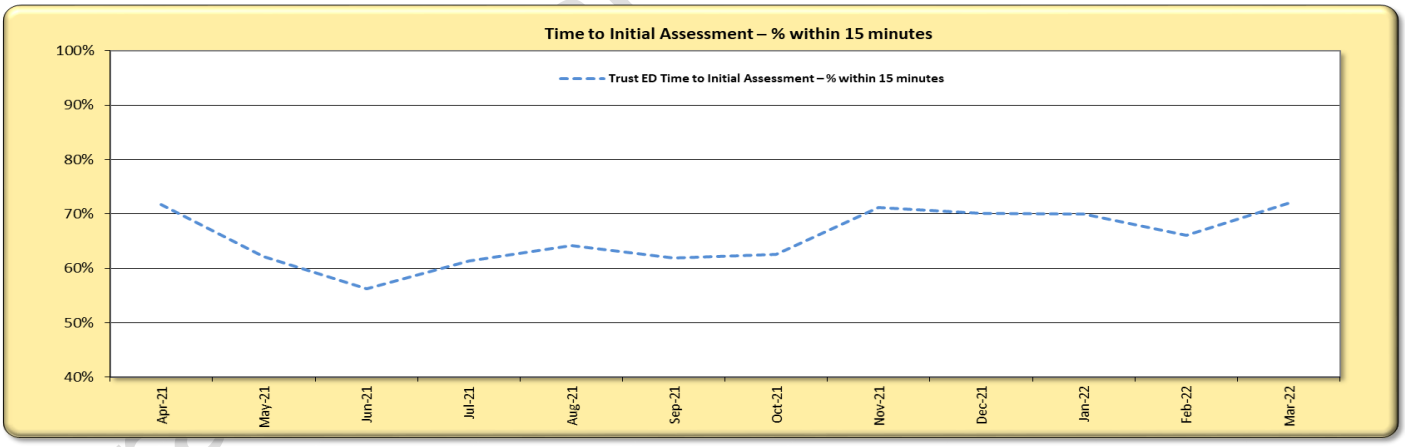
Month/Quarter	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
DMH ED attends	5,514	5,617	5,871	5,624	5,571	5,569	5,588	5,217	5,148	5,257	4,883	6,056
DMH ED 4 Hour Waits	729	1,073	1,363	1,796	1,947	2,344	2,520	2,277	2,396	2,311	2,224	2,089
DMH % Seen in 4 Hrs	86.78%	80.90%	76.78%	68.07%	65.05%	57.91%	54.90%	56.35%	53.46%	56.04%	54.45%	65.51%
UHND ED attends	6,728	7,280	7,420	7,040	6,773	6,704	6,901	6,618	6,218	6,406	6,047	7,041
UHND ED 4 Hours wait	1,372	2,035	2,420	3,087	3,104	3,449	3,894	3,867	3,359	3,381	3,484	2,871
UHND % Seen in 4 Hrs	79.61%	72.05%	67.39%	56.15%	54.17%	48.55%	43.57%	41.57%	45.98%	47.22%	42.38%	59.22%
Total ED attends - Type 1	12,242	12,897	13,291	12,664	12,344	12,273	12,489	11,835	11,366	11,663	10,930	13,097
Urgent Care Centre - Type 3 (Walk-Ins)	3,080	3,868	4,187	4,469	4,250	4,965	4,982	4,513	4,133	3,604	3,482	4,437
Urgent Care Centre - Type 3 (Booked Appointments)	2,225	2,544	2,271	2,013	2,790	3,093	3,081	2,927	3,101	3,073	3,178	3,330
Trust Over 4 hour waits	2,101	3,108	3,783	4,883	5,051	5,793	6,414	6,144	5,755	5,692	5,708	4,960
ED Only Activity % under 4 hour waits	82.84%	75.90%	71.54%	61.44%	59.08%	52.80%	48.64%	48.09%	49.37%	51.20%	47.78%	62.13%
Reportable % under 4 hour waits (including UCC Booked from Jan '2020)	88.03%	83.90%	80.84%	74.50%	73.94%	71.51%	68.79%	68.12%	69.06%	68.96%	67.55%	76.23%

New A&E clinical standards have been reported in shadow form in 2021/22, with focus placed on the time patients spend in the Department. The volume of patients waiting over 12 hours has gradually increased throughout the year, with higher volumes of patients spending more than 12 hours in the department during the winter period, as a result of the factors outlined above.

Standard Month:	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Trust ED Patients spending more than 12 hours in ED	78	151	248	404	666	938	1,211	1,097	991	1,000	1,081	727
% Trust ED Patients spending more than 12 hours in ED	0.6%	1.2%	1.9%	3.2%	5.4%	7.6%	9.7%	9.3%	8.7%	8.6%	9.9%	5.6%

A further indication of the pressures we have experienced is the number of patients who have breached the 12 hour 'trolley' wait for a base ward bed following a decision to admit. Breaches started to occur in September and have done throughout the winter period, only starting to reside in the last two months of the year.

The time to initial assessment has also varied, aligned to operational pressures and the impact of Covid-19 surges.



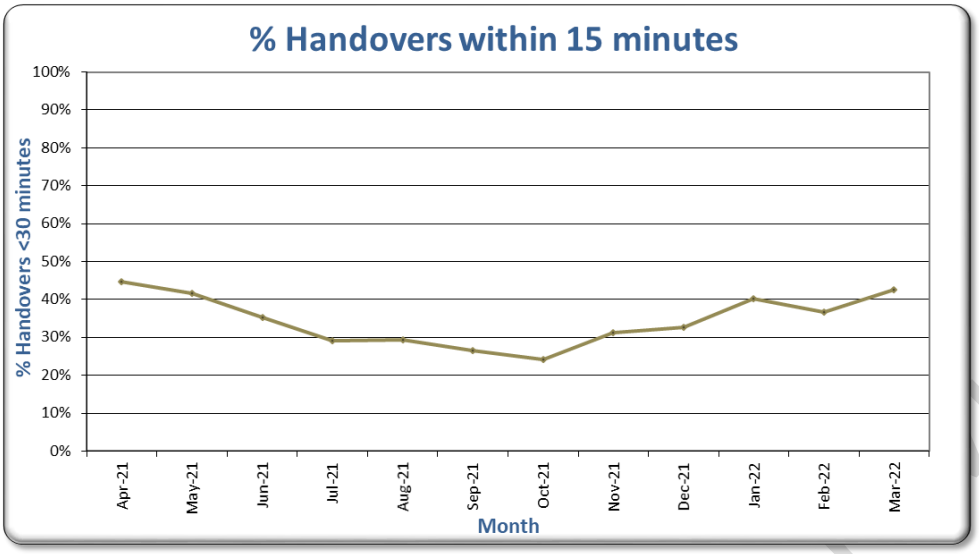
As outlined in Section 2B, reducing waiting times in our A&E Departments is a high quality improvement priority for the Trust with a number of actions planned to increase our physical and staffing capacity and to optimise our clinical pathways.

Ambulance handovers

With respect to ambulance handovers, we aim for crews to handover the care of patients to CDDFT staff within 15 minutes of arrival. The Trust actively captures all ambulance arrivals, pro-actively utilising the handover screens in the Emergency Departments to record the timing of handovers, over 90% of the time.

The number of handovers completed within 15 minutes has varied throughout the year with lower levels experienced in September and October just ahead of the winter pressures period. Lower levels of

performance is congruent with Covid-19 surges and increased activity. The Trust's performance is not significantly out of line with the region.



The Trust also monitors the total arrival to clear times and improvement can be seen from November onwards, aiming to achieve arrival to clear times within 30 minutes.

	Average Arrival to Clear Times (Minutes)											
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Darlington Memorial A&E	35.1	37.5	38.1	49.0	50.9	54.2	55.3	50.0	43.3	45.1	40.1	37.8
UHND A&E	33.9	36.5	40.0	43.1	44.8	54.0	54.3	45.6	43.3	35.2	37.9	33.1

The improvements reflect a number of actions taken to improve handover performance.

- Securing temporary additional workforce from CIPHER Medical to staff ambulance handover bays until such as time to reach full recruitment.
- Escalation processes strengthened
- Embedding of a new ambulance handover SOP produced by the North East Ambulance Service

There is a long term plan for a new ED build at UHND and in the interim, a number of estate works are now underway to impact in 2022/23.

Optimising treatments for Covid-19

Throughout the pandemic, we sought to deploy up to date treatments based on research and emerging evidence regionally, nationally and internationally.

We have contributed actively to research into Covid-19 as outlined in "Participating in Clinical Research" earlier in this section and supported colleagues in the region in setting up and operating a limited Covid-19 Medicines Delivery Unit to ensure that prescribed anti-viral treatments could be dispensed and transported to vulnerable patients in the community.

We also supported public vaccination programmes through our own vaccination sites, and working in primary care sites. We vaccinated over 25,000 members of the public in addition to vaccinating our own staff and staff from partner organisations.

Performance Summary

Recovery and restoration

During this second year of Covid-19, several pieces of guidance were issued aiming to restore and recover elective activity.

In relation to the requirements, we performed as follows:

- Restore Cancer referrals: Patients have been encouraged to come forward with their concerns. Referrals now exceed pre Covid-19 levels.
- Increase activity to over 89% of 2019/20 activity levels: 99% was achieved for October 2021 to March 2022.
- Eliminate waits of over 104 weeks by March 2022: There were three patients waiting over 104 weeks at 31st March 2022 two of which were due to patient choice.
- Hold or reduce the number of patients waiting over 52 weeks: The number has continued to reduce month on month.
- Stabilise waiting lists around the level seen at the end of September 2021: Waiting lists have grown incrementally throughout the year.
- Increase the use of Advice and Guidance: These requests continue to significantly exceed pre Covid-19 levels.
- Increase the use of Patient Initiated Follow-Up (PIFU) pathways, instead of providing automatic follow-up out-patient appointments: Plans for safe and appropriate PIFU have been developed for a number of specialties and this will widen to all specialties in 2022/23.
- To reduce the 62 day Cancer backlog: A local target of a reduction to less than 132 patients was set and this was exceeded. Performance against the NHS Constitution cancer standards has improved month on month through the year.
- Increase access to Diagnostics: Monthly performance has been consistently high to the national standard of 99% to seen within 6 weeks all year, achieving the standard in February 2022.

Annex 1 – Statements from Commissioners, local Healthwatch organisations and overview and scrutiny committees

To be added when received.

Annex 2: Statement of directors' responsibilities for the Quality Report

REQUIRES UPDATING PRIOR TO PUBLICATION

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 2019/20 and supporting guidance Detailed requirements for quality reports 2019/20
- the content of the quality report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2020 to June 2021
    - papers relating to quality reported to the board over the period April 2020 to June 2021
    - feedback from commissioners dated 25/06/2021
    - feedback from governors dated 02/06/2021, 09/06/2021, 11/06/2021
    - feedback from local Healthwatch organisations dated 18/06/2021
    - feedback from overview and scrutiny committees dated 24/06/2021 and 25/06/2021
    - the Trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 21/05/2021
    - the national patient survey 02/07/2020
    - the national staff survey 05/2020
    - the Head of Internal Audit's annual opinion of the Trust's control environment dated 01/06/2021
    - CQC inspection report dated 03/12/2019
- 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 Improvement'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

Chairman

Chief Executive

GLOSSARY OF TERMS

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

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

AKI – Acute Kidney Injury

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

BAH – Bishop Auckland Hospital

BAME – Black, Asian and minority ethnic

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

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

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

CDDFT –County Durham and Darlington NHS Foundation Trust

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

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

CoG - Council of Governors.

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

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

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

DMH – Darlington Memorial Hospital

ED – Emergency Department

FFT – Friends and Family Test

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

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

Frenulotomy Service – This is a service providing treatment for babies with tongue tie

GP –General Practitioner

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

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

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

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

Integrated Care System - new partnerships between the organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups

MDT – Multi Disciplinary Team A multidisciplinary team (MDT) is a group of health and care staff who are members of different organisations and professions (e.g. GPs, social workers, nurses), that work together to make decisions regarding the treatment of individual patients and service users

MRSA - Methicillin-Resistant Staphylococcus Aureus - bacterium responsible for several difficult to treat infections.

MUST - Malnutrition Universal Screening Tool

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

NCEPOD - National Confidential Enquiry into Patient Outcome and Death

NEQOS - North East Quality Observatory System

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

NEWS – National Early Warning Score - tool which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes.

NHS – Abbreviation used to refer to National Health Service

NHSI/E NHS Improvement/England– the national body which awards the Trust its provider licence and regulates the Trust against it.

NHSFT –NHS Foundation Trust

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

NHS Providers – a national association representing Trusts and Foundation Trusts

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

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

NRLS - National Reporting and Learning System

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

OSC - Overview and Scrutiny Committee

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

PPI - Patient and Public Involvement

PPE – Personal and Protective Equipment. This is term that is used to describe equipment that staff are provided with to keep themselves and others safe in the work place including masks, aprons, gloves etc.

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

PRISM2 – This is methodology used for mortality review

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

Provider Sector – Trusts and Foundation Trusts

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

SALT – Speech and Language Therapy

Secondary care – care provided in hospitals.

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

SystmOne – electronic patient record used in primary care and community services

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

UHND - University Hospital of North Durham

UTI - Urinary Tract Infection

VTE - Venous Thromboembolism