County Durham and Darlington NHS FT

QUALITY ACCOUNTS

2022 - 2023

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 2022/23. It also sets out our priorities for the coming year 2023/24. Early in 2022/23 we re-wrote and launched our quality strategy, "Quality Matters". We agreed quality priorities with our stakeholders which reflected both our emerging strategic objectives, together with those objectives from 2021/22 which had not been achieved and where further work was needed.

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 2022/23 Quality Priorities
Part 2B	2023/24 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 our 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 2023/24.

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.

I am delighted to introduce to you our Quality Account and Quality Report for County Durham and Darlington NHS Foundation Trust for 2022/23

Once again I am able to take great pride in reflecting upon the compassion and dedication shown by our staff, volunteers and partners for the way in which they come together, to care for all our patients – whether receiving acute, planned or emergency based care – to maintain cancer services and to 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 the ongoing Covid-19 pandemic for much of the year, exacerbated by high levels of influenza during the winter and the ongoing impacts of national pay disputes.

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'.

Our priorities were taken mainly from our four-year quality strategy, "Quality Matters", which we consulted on and agreed with all our stakeholders. Where we had not achieved our objectives from previous years, we also rolled these forwards.

Quality Matters 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.

2022/23 also saw the roll out of our Electronic Patient Record System, which provides a huge, and exciting, opportunity to drive quality improvement through technology and which is already supporting us in better understanding and improving our quality.

During 2022/23:

- We achieved the objectives which we had set ourselves for learning from excellence and mortality reduction;
- We implemented the substantial majority of the actions we set out to implement;
- We saw increases in the number of falls, and falls with harm, linked to patient acuity. However, the majority of the 49 rapid reviews were carried out found no lapses in care. We have reinvigorated our Falls Strategy and Falls Team under the leadership of a Patient Safety Matron.
- We had one / no Grade 3 or 4 pressure ulcers against our zero tolerance (awaiting investigation outcome);
- We have one MRSA bacteraemia against our zero tolerance and exceeded our nationally set threshold for C-Diff cases by two. However, were within the thresholds for all Gram Negative Bloodstream Infections;
- We strengthened our procedures for detecting and acting on patient deterioration, reinvigorated the use of local safety standards for invasive procedures (LocSSIPs) and rolled out new or updated sepsis screening tools in urgent care, community services and maternity services. We aim to go further, however, with respect to training in the deteriorating patient and life support; in ensuring high levels of compliance with LocSSIPs; and in minimising the time for antibiotics to be administered to patients with a suspicion of sepsis;
- We established a Maternity Quality Improvement Programme, which empowered staff in the service to drive improvements in: the use of digital systems; antenatal screening; and engaging, development and deploying our workforce. A range of projects were implemented to improve quality and safety with more in the pipeline;

- Working with partners in the local authority and voluntary sectors were able to introduce effective multi-agency arrangements to support safe, timely and effective discharge when patients are ready to leave hospital;
- We continued to develop and consult on our end of life care strategy and saw significant improvement in how we recognise when patients are reaching the end of their lives and support them, and their families with what is to come. However, estate constraints meant that we were not always able to provide side rooms for such patients.
- We refreshed and re-launched training for staff in looking after patients with dementia and with learning disabilities or autism, and consolidated the support that our LD nurses and lead dementia nurse provided to front-line services. Working with Tees, Esk and Wear Valleys NHSFT and other partners, we have implemented effective joint working arrangements to develop and implement care plans for patients with mental health needs whilst in our hospitals
- We have rolled out quality improvement projects to support the nutrition and hydration of patients but need to embed the use of the nutritional needs assessment in our new EPR system.

Over the last quarter, we have improved our A&E waiting times' performance and significantly reduced long waits in the department and the numbers of patients waiting over 12 hours for a bed. Ambulance handover times now average within 30 minutes and we are sustaining these improvements. We are taking further actions for 2023/24, such as expanding Same Day Emergency Care at Durham, to consolidate these improvements.

We have rated ourselves as amber for most quality priorities, which reflects the fact that we set ourselves ambitious and stretching targets and that 2022/23 was only the first year of our quality strategy.

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 and have added new quality goals related to the launch and roll out of our bespoke Patient Safety Strategy, Patient Safety Matters.

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 2022/23 Quality Priorities

The following section of the report sets out our performance with respect to each of the quality priorities we set for 2022/23. Wherever available, historical data is included so that our performance can be seen over time.

Summary of 2022/23 Quality Priorities

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		
Meet Maternity Standards including Ockenden recommendations		
Embed local safety standards 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: update the palliative care strategy and ensure appropriate access to private rooms for dignity	Improve access to paediatric specialist services
	Continued improvement of nutrition including assessment and provision for specific needs	Increasing excellence reporting
		Learning from Deaths (including 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	Summary Hospital Mortality Indicator (SHMI) Patient Reported Outcome Measures (PROMS)

	Ambition achieved		Some but not all elements achieved / improvement on prior year		Ambition not met

We deliberately set ourselves stretching objectives – to drive meaningful and long-term quality improvement - 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 2023/24.

Patient Safety

Reducing harm from inpatient falls

Actions planned have been implemented and the majority of falls subject to rapid review have not involved lapses in care; however, we have seen an increase in the number of falls per 1,000 bed days and in falls with harm.

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. Colleagues from therapies and pharmacy are now involved in the rapid review process to ensure a more multi-disciplinary approach.

The Falls Team has continued to provide targeted support, particularly 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.

In January 2023, a new post of Patient Safety Matron was implemented within the Patient Safety team, and the post-holder is also the Trust Falls Lead. As a result, the service is undergoing a refresh, including a review of the falls policy and ensuring a multi-disciplinary approach to the falls review process with an emphasis on quality improvement and shared learning. The Falls Team has been further supported by the appointment of an additional Charge Nurse which has enabled outreach support to clinical areas for education targeted by findings from the review of incidents.

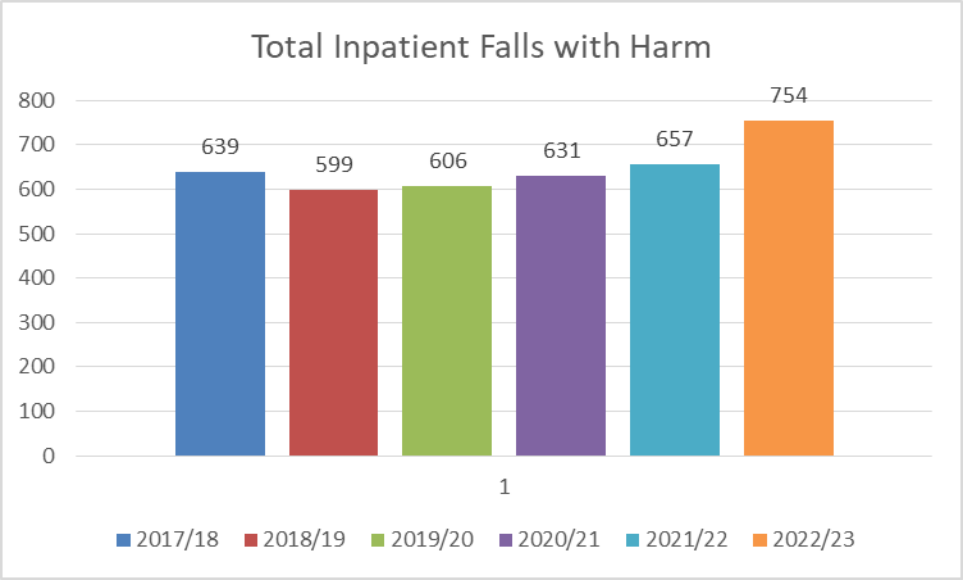
Number of Falls and Falls per 1,000 bed days

There has been an increase in the number of falls overall across the Trust, reflective of the continued system pressures and high bed occupancy. The number of falls per 1000 bed days (relating number of falls to activity) has slightly increased in acute but more significantly in community services.

	2022/23	2021/22	2020/21
Acute sites	6.5	6.4	6.8
Community sites	6.8	5.9	8.0

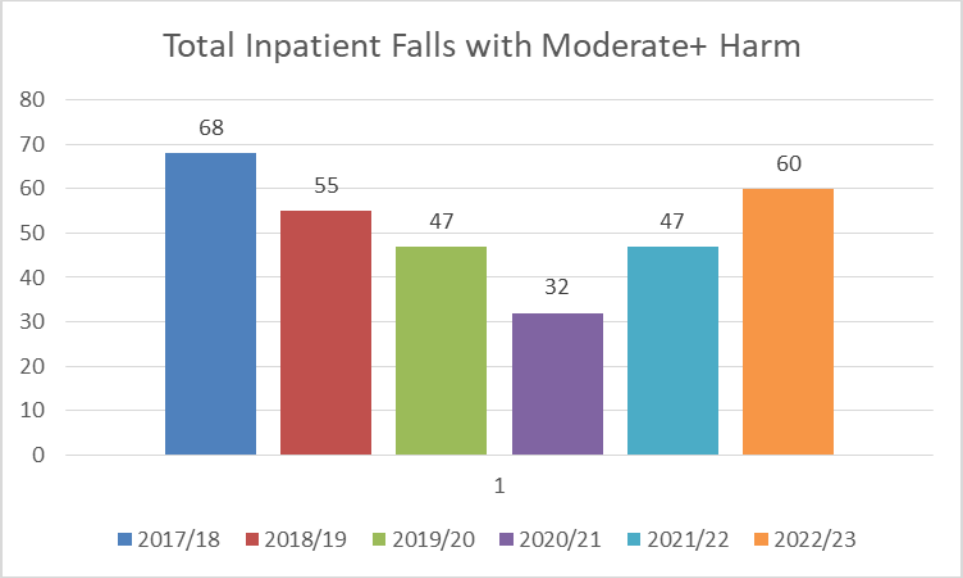
The trend in falls is influenced by patient acuity and comorbidities. Our approach therefore focuses on seeking to identify and learn from lapses in care.

Number of falls with harm



We have built questionnaires into our Incident Reporting system to allow all falls to be assessed for lapses in care and improvement targets have been set based on falls with lapses in care. Our ward based documentation has been updated to the latest falls care bundle, which is supported by ongoing, face to face, education provided by the Falls team to all wards and teams The Trust also recently appointed a Quality Improvement Senior Sister, who, along with the Patient Safety Matron, are focusing on falls as a first priority and supporting improvement projects on wards in acute and community settings.

Number of falls with moderate/severe harm



The number of falls resulting in moderate or greater harm increased from 46 reported in 2021/22 to 60 reported in 2022/23, which is in line with the overall trend for falls with harm.

We completed 49 rapid reviews of falls with moderate or greater harm between April 2022 and March 2023. All reported falls which result in a fractured neck of femur, or a subdural bleed, or are otherwise identified as being of significant concern. Where lapses in care which contributed to the fall have been identified, these are reported to our commissioners as Serious Incidents. There were nine serious incidents reported in 2022/23. However, in most cases, the outcome of the rapid review was that the fall could not be predicted /prevented and did not, therefore, involve lapses in care.

Reducing harm from health care associated infections (HCAIs)

Ambition partly met

The Trust reported one MRSA case, against its zero tolerance, in 2022/23 and exceeded its nationally mandated threshold for C-Diff. Infection rates reduced, however, for all reportable organisms except C-Diff and the Trust met its thresholds for Pseudomonas, Klebsiella and E.Coli.

In the period we have reported one MRSA bacteraemia (exceeding our zero tolerance) and 61 C-Diff cases against our full-year threshold of 59. All cases are reviewed and learning implemented. All providers in the North East, except one, have reported MRSA cases. The trend in C-Diff is replicated in the region and nationally.

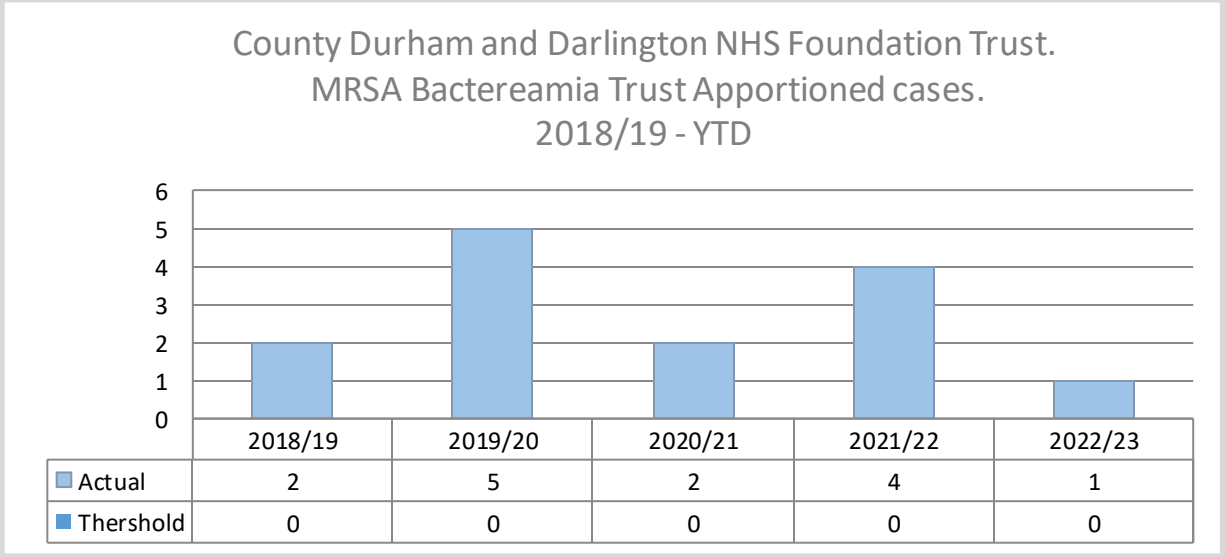
The Trust is above its internally set trajectory for MSSA infections but below national trajectories for Klebsiella, Pseudomonas and e-coli. We have implemented a programme of back to basics audits to reinforce compliance with good infection control practice in all areas. Initially the audits were undertaken every month; however, they have since been adapted to allow the Infection Prevention and Control (IPC) team to provided more intensive support to those areas with challenges, so that most areas are now audited every quarter.

All HCAIs are subject to a Post Infection Review (PIR) by the IPC team to identify any areas of non-compliance with best practice, which enables the IPC team to support the relevant clinical team, and to identify and track themes, enabling targeted support in response to lessons learned.

The charts below demonstrate the Trust's position for 2022/23 against mandatory and local thresholds.

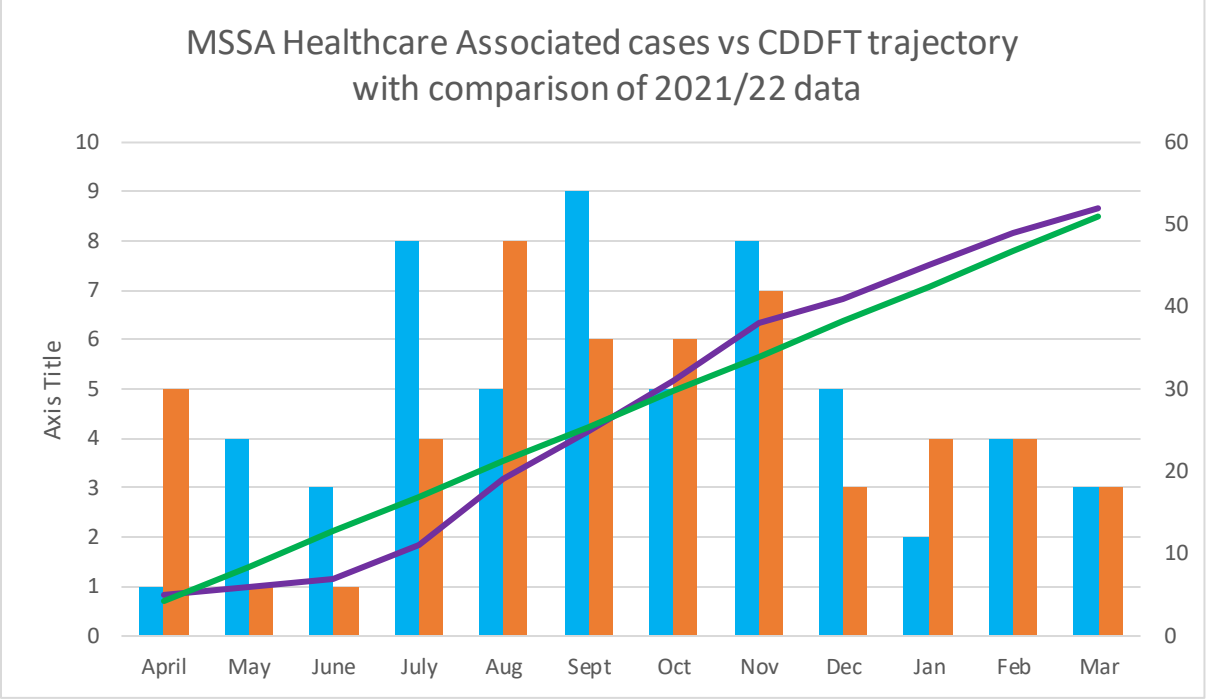
MRSA Bacteraemia

CDDFT reported one case of MRSA Bacteraemia against NHSE threshold of zero avoidable infections. This is a 75% reduction on the previous financial year.



MSSA Bacteraemia

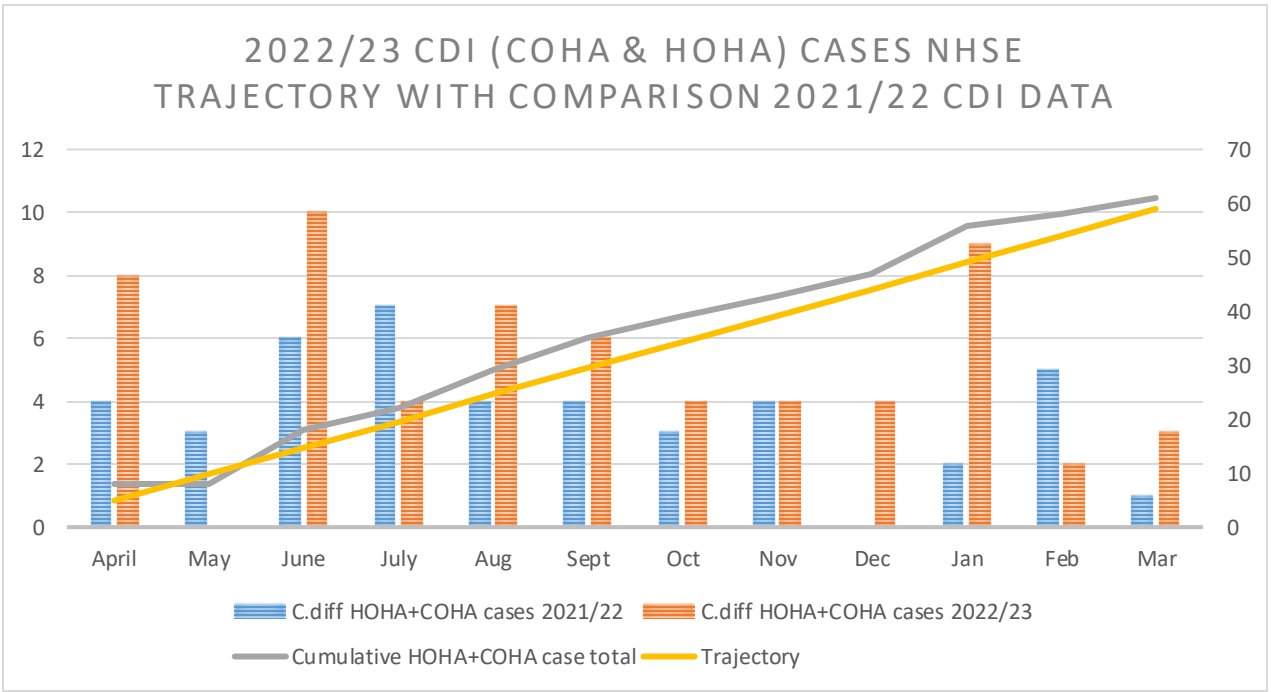
A stretching self-imposed threshold of 51 cases of MSSA was agreed through the Trust's Infection Control Committee. During 2022/23 CDDFT reported 52 Healthcare Associated MSSA cases. This was a **9%** reduction on the previous financial year.



Clostridioides difficile Infection (C-Diff)

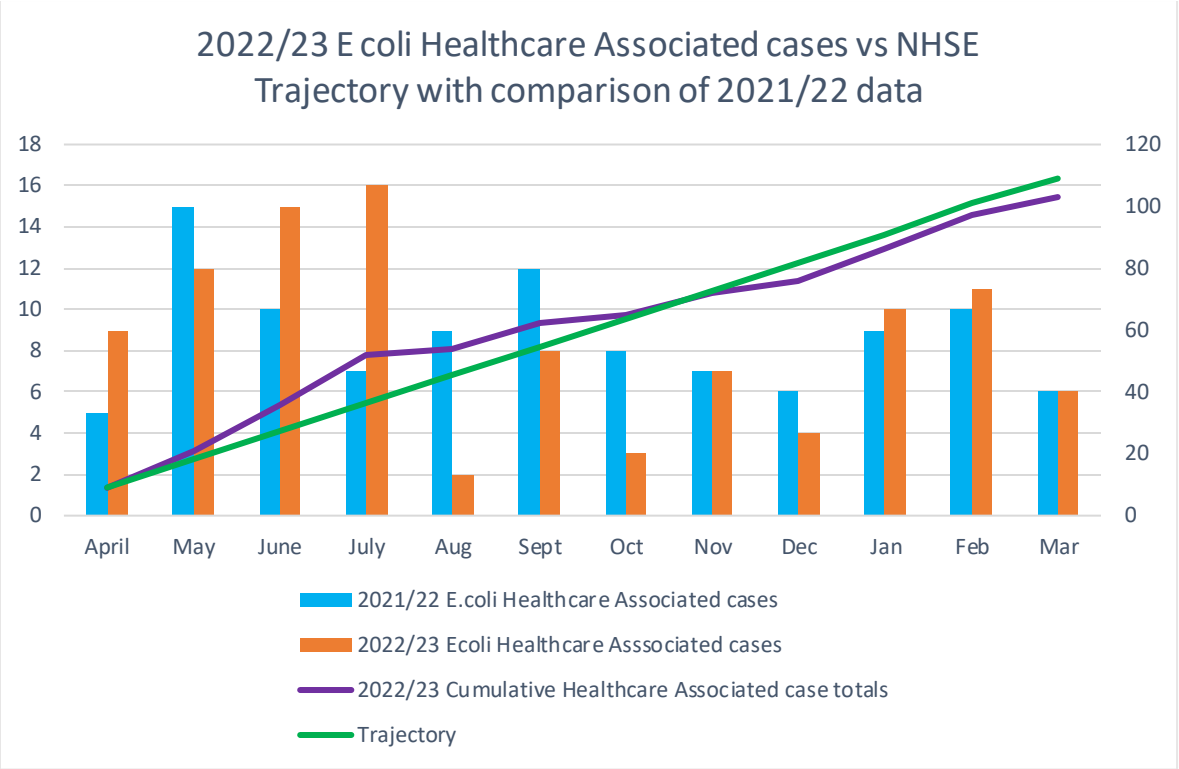
In 2022/23, the Trust reported 61 cases. Whilst this was a **42% increase** from the previous financial year, it was two more than the threshold set for the Trust by NHS England which recognised rises in C-Diff cases nationally. Of the 61 cases, 40 were hospital onset healthcare associated (HOHA) infections and 21 were community onset healthcare associated infections (COHA).

There is no definitive research to explain the increase in C-Diff cases seen nationally following the Covid-19 pandemic. However, the trend has been seen across the North East region, with most providers seeing increases.



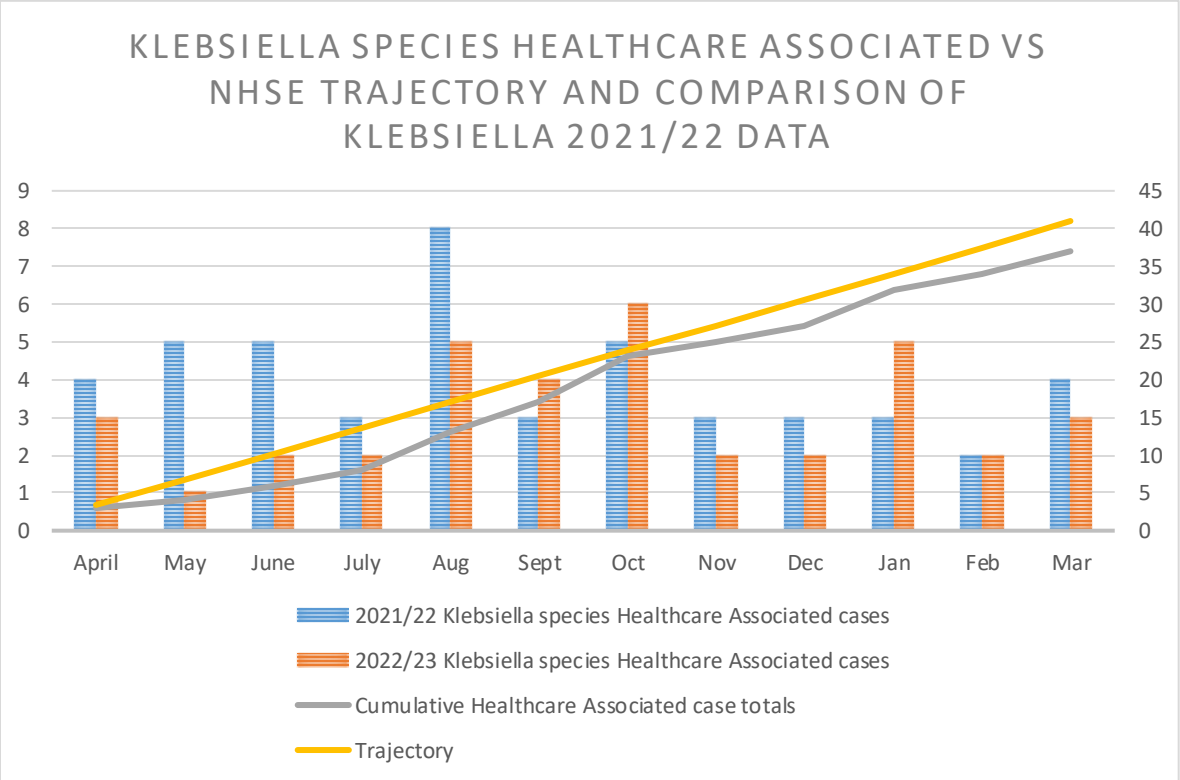
E coli

In 2022/23 CDDFT reported 104 Healthcare Associated E.coli cases against NHSE annual threshold of 109. This was a **1% reduction** on the previous financial year.



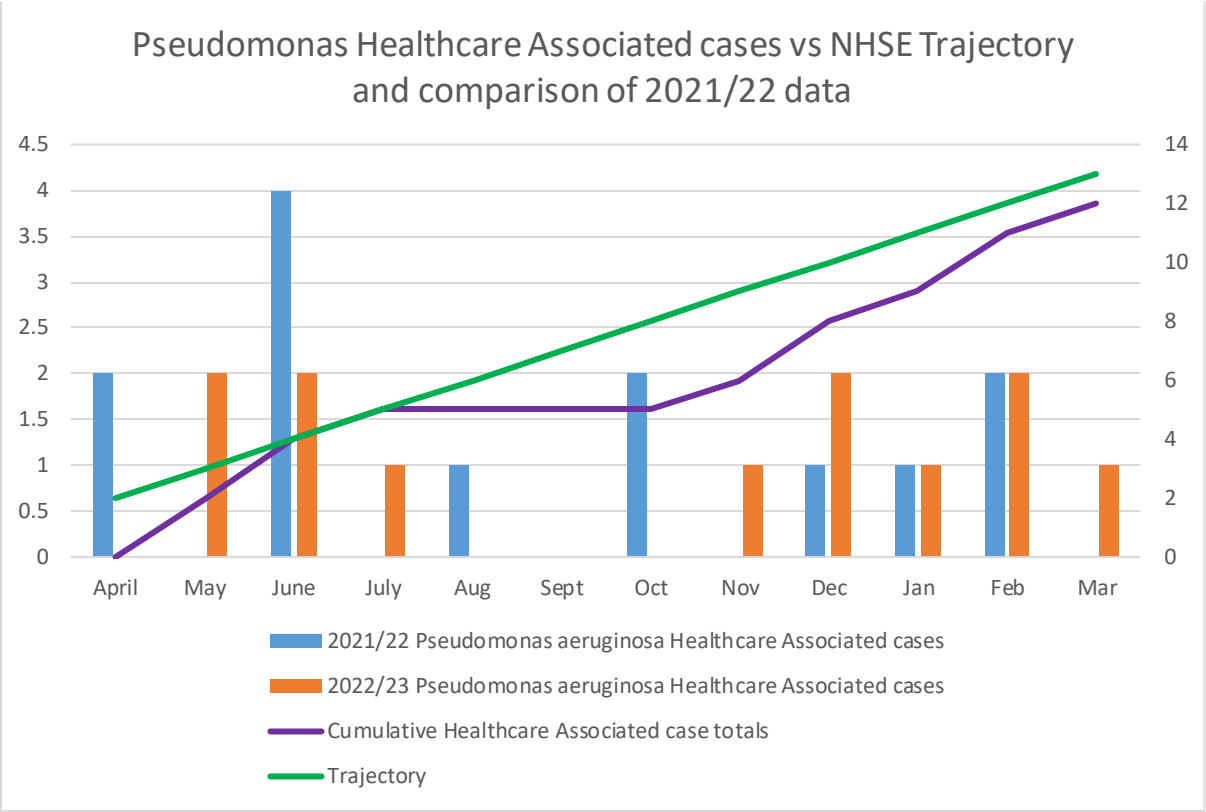
Klebsiella sp

In 2022/23, the Trust reported 38 Healthcare Associated Klebsiella against NHSE threshold of 41. This was a **22% reduction** on the previous financial year.



Pseudomonas

In 2022/23 CDDFT reported 12 healthcare associated pseudomonas cases against NHSE trajectory of **13**. This was a **14% reduction** on the previous financial year.



Reducing harm from category 3 and 4 pressure ulcers

Ambition partly met

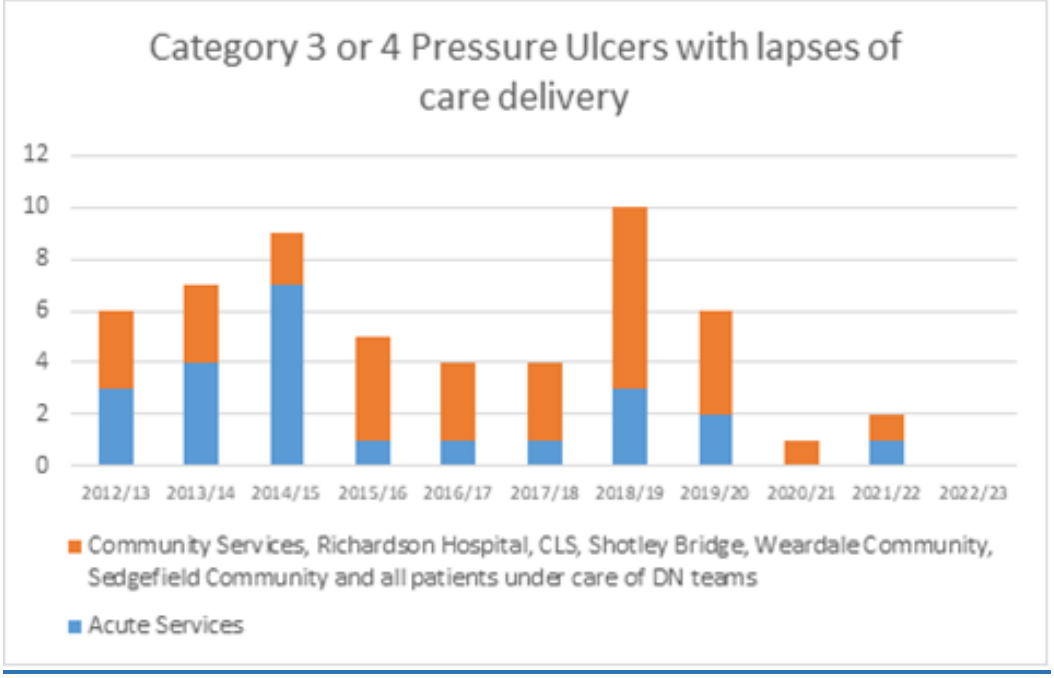
There have been no Category 3 or 4 pressure ulcers with lapses in care reported during year; however, there is one such case still under investigation.

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. At the time of writing there is one high grade pressure ulcer with a potential lapse in care that is the subject of an ongoing investigation by our Tissue Viability team. Otherwise there are no Grade 3 or 4 pressure ulcers with lapses in care reported during the year. Pending the outcome of the investigation were are reporting that we have partly met our objective [Drafting Note – if there is no confirmed lapse in care prior to the final document being issued we will report that our ambition has been met]

Our rapid reviews of all Grade 3 and 4 ulcers which occur in our care ensure that incident reviews are timely, and that learning takes place promptly for all departments and teams. The reviews are multi-disciplinary and are led by a Tissue Viability Matron. Incident reports for Grade 2 ulcers are accompanied by questionnaires designed to assess compliance with Trust policies and to identify lapses in care. The outcomes are validated – on a sample basis – by our specialist Tissue Viability teams with any thematic learning disseminated.

The Tissue Viability team has focused on providing education and support to front-line teams, with particular emphasis on pressure ulcer prevention and the correct categorisation of pressure ulcers. We have a number of Wound Resource Educational Nurses (WRENS), who work in both Community and Acute Tissue Viability services and are hoping to introduce an equivalent role for our HCA staff, which would cover basics skin care and prevention.

The below table shows the long-term trend for Category 3 and 4 pressure ulcers in the Trust, subject to the outcome of the investigation noted above.



Maternity Standards including Ockenden recommendations

Ambition partly met

We have made good progress in implementing our action plans in relation to the Ockenden report and made further quality and safety improvements to our service through a dedicated Maternity Quality Improvement Framework. There is work ongoing to recruit, engage and develop staff in line with service needs and a range of further quality improvements being implemented early in 2023-24.

The Trust implemented a Maternity Quality Improvement Framework, to empower staff within the service to deliver improvements with Executive support and hep from relevant specialists in corporate directorates. This included many of the improvement actions contained in our action plan response to the Ockenden report. MQIF had five work-streams covering: digital systems, workforce, continuity of carer, antenatal and newborn screening and quality and safety.

In line with the national directive we suspended the roll out of Continuity of Carer and implemented a model to sustain acute and community services following extensive consultation with staff. The model includes retaining a small number of teams to provide continuity of carer where there are clear benefits to women and birthing people in the local population and our staffing is sufficiently resilient.

Successes and challenges:

Our key quality improvement initiatives for the maternity service are summarised below, together with successes in the year and areas of ongoing focus and challenge.

- Our maternity service has undergone a full programme of Digital Transformation; including the introduction of a digital solution for maternity record keeping and a patient portal, Badgernet, in addition to the integration of a full system electronic organisational electronic patient record:
    - As part of this integration the service has improved the quality of core datasets and submissions, being an exemplar for data validation within the region;
    - Our digital systems have facilitated live communication and record sharing not only between professionals and families but across Trusts regionally; and
    - They also include risk assessments and decision support functionality to aid staff in providing clinical care and responding to particular presentations and conditions.

- Midwifery Continuity of Carer was introduced in a planned way following full consultation with staff. By early 2022, some 64% of women and birthing people were covered by Continuity of Carer and the approach saw improvements in public health metrics including smoking and breastfeeding, and in clinical outcomes with higher rates of vaginal deliveries and decreased intervention, and significant feedback regarding family satisfaction. In additional the safeguarding teams noted improvements to care and outcomes of vulnerable families receiving continuity of care. Unfortunately, due to a national shortage of midwives and the findings of the Ockenden Inquiry, there was a national improvement to pause the Continuity of Carer programme during the year. In keeping with most maternity services, the Trust was experiencing its staffing pressures and needed to re-evaluate the model of care. Following an extensive programme of staff engagement and consultation we implemented a new model of care proposed by staff - a 'hybrid' approach. This model allows 4 teams to increase caseloads to 1:70 and provide one planned shift a week into the acute service which enables the skills of midwives to be maintained and also for staff to retain an element of the transformational model of care.

- Public Health and Inequalities: in 2022/2023 the service worked collaboratively with the commissioners and local authorities to build on the public health and inequalities offer for Durham and Darlington. This has included the successful opening of the first family hub in Bishop Auckland integrating the continuity of carer team with teams from other services to provide multi-professional support and care for families through a central point of access. This collaborative work has led to the jointly-funded appointment of a Health Inequalities Matron for a three year period, to develop our understanding of the inequalities across our region and help reshape services to address them.

- Workforce: As is well documented, there is a national shortage of midwives, with a current national vacancy rate of around 10%. Retention is also a challenge, partly driven by the impact of national transformation programmes, some of which have far-reaching impacts on work / life balance. We continue to experience such pressures in our own service but have responded proactively through a wide range of developments to recruit, retain and support our staff including:
    - Commissioning an independent assessment of our safe staffing arrangements by the national 'Birth Rate Plus' team, which is ongoing at the time of writing.
    - Investing in a proactive and widely-marketed external recruitment programme and in international recruitment, with 10 internationally-qualified midwives joining us in the summer of 2023.
    - Further developing our successful preceptorship programme in line with national standards for newly qualified midwives.
    - Maintaining our 'Blossom' scheme to support and welcome new midwives.
    - Appointing a Recruitment and Retention Midwife to provided dedicated leadership to all of the work above.
    - Recruitment of specialist midwifery roles covering, for example: digital systems, foetal wellbeing and screening.
    - Developing a 'Maternity Matters' engagement strategy and rolling out a staff engagement programme include protected 'time out' sessions for teams to come together to work on developments and challenges.

  We measure the demands on our service, including patient acuity, six times every day, and proactively monitor rosters and adjust staffing across our maternity service to match staffing to demand.

  Our Homebirth service has been suspended during 2022-23 because of the staffing pressures in the service. We are committed to restoring the service, with an enhanced model of care, as staffing levels allow and we are actively exploring options to do so.

- Estate: Estates constraints have impacted on the maternity service during 2022-23. The Birthing Pool at Darlington has been out of use, pending works to enhance the water quality on the site. We anticipate being able to bring the pool back into use during the coming summer. In addition, necessary changes made during the Covid-19 have resulted in early pregnancy and antenatal

outpatient services being co-located in Durham. Recognising the impact on the patient experience we hope to be able to provide services from separate areas within the Maternity Service footprint at UHND in the near future. We are also looking to upgrade bathroom facilities on our wards at DMH, which are outdated.

More positively, our new bereavement facility for families with pregnancy loss will be formally opened in Durham in summer 2023 and a similar facility is planned for Darlington.

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	2022/23	2021/22
Maternity 12 week bookings	90%	88.8%	88.6%	88.7%	90.5%	89.2%	84.1%
Maternity breast feeding at delivery	60%	64.4%	67.1%	64.9%	66.3%	65.7%	62.6%
Maternity smoking at delivery	22.4%	14.8%	13.6%	12.4%	14.8%	13.9%	12.3%

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

We have established a system to monitor, and obtain assurance that, LocSSIPs are further actions necessary to embed compliance.

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 have been working to implement robust monitoring, auditing and governance procedures to provide assurance that our new LocSSIPs policy is followed.

Our goal for the year was to implement a robust system to monitor, and obtain assurance, that LocSSIPs are correctly followed in practice, that the correct versions are in use and that ownership is clear and transparent. We have; introduced a CDDFT LocSSIP policy and Standard Operating Procedure; updated the CDDFT internet and intranet sites to improve document management and ensure that correct versions are available; and completed an audit of the use of each LocSSIP document in place with results feedback to Clinical Directors, Clinical Leads, Executive and Non-Executive Directors. A Task and Finish group has been established, under the leadership of a Care Group Director to implement improvement actions identified through the audits undertaken.

Following the roll out of our Electronic Patient Record System (EPR), a development programme has begun which will eventually see all LocSSIPs migrated into the system, thereby removing paper copies form the process, enhancing audit functionality and improving compliance.

Embedding prompt recognition and action on signs of patient deterioration

We have made significant improvements in areas such as acute kidney injury and have introduced functionality in our electronic patient record system to help staff identify and act on signs of patient deterioration. We need to embed the use of this functionality and to continue to step back up training in recognising deterioration and providing life support.

One of the key ambitions in the Trust's quality strategy 'Quality Matters' 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 for cardiac arrest prevention and specialist hospital at night and Acute Kidney Injury (AKI) teams, we have continued 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 alongside our regional and national peers we have faced very high demands on our Emergency Departments, and associated long waits, which poses a potential risk to prompt and rapid response to signs of patient deterioration.

In 2022-23 we set out to reinvigorate our resuscitation and deteriorating patient training programmes (from a reduced programme during the active pandemic). Training compliance was monitored monthly and improved for all staff groups and teams. We did not, however, meet our 85% compliance target and will therefore maintain this goal for 2023-24. We have increased class sizes for face to face training with respect to recognition and treatment of deterioration and are gradually recovering after the pandemic.

Our AKI and renal in-reach services have been subject to an interim evaluation, which demonstrated clear benefits identified in terms of: length of stay; improved specialist support to nursing staff and junior doctors; patients' experience, and adherence to NICE guidance and evidence-based standards. Further evidence is needed but the service is also expected to have contributed to reductions in mortality and in preventing unnecessary admissions to critical care.

We have introduced an acute competency development pathway for registered nurses in our Acute Medical Units (AMUs) with further training in managing the deteriorating patient and to impart essential skills such as arterial blood gas interpretation, taking blood cultures and basic rhythm recognition.

The introduction of "Call for Concern", a support service which allows anyone concerned about a patient's condition to call a member of our Acute Intervention Team, has also evaluated well based on an initial review, and we are committed to publicising the service more widely. The Acute Intervention Team work with the ward-based team to review the patient's condition and there are examples where contact from relatives or friends has made a difference to the care of a patient and / or improved communication with the family.

The roll out of Cerner, our electronic patient record system, has prompted changes in some areas and departments in their response to the deteriorating patient. All in-patient areas and Emergency Departments can input vital signs in real time using a handheld electronic device, which also enables escalation to clinicians as events occur. Our focus for the coming year is on embedding the use of this functionality. Treatment Escalation Plans have been captured in our EPR system, as have pain scoring, risk assessment, care planning and staff alerts for patient deterioration. We are also embedding the completion of patient risk assessments and response to alerts.

Improving the management of patients with Sepsis

Ambition partly met

New screening tools have been implemented in paediatrics, maternity, urgent care and community services and a nurse-led sepsis pathway has been implemented to reduce reliance on medical staff and increase the timeliness of interventions including antibiotics. Despite these actions, we continue to experience challenges in providing antibiotics within one hour when our A&E Departments are under pressure.

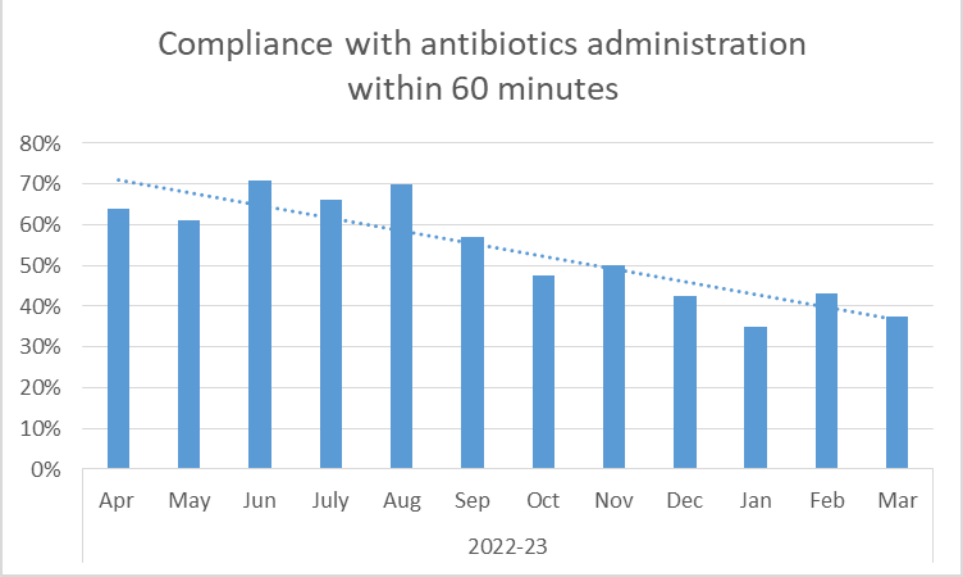
Our aim was to improve the percentage of patients receiving antibiotics within 1 hour of diagnosis in the Emergency Department and to improve both staff awareness and processes to improve the prompt recognition of, and response to sepsis. As a result of recent technological improvements and process innovations at CDDFT, 100% of patients who fit the regionally agreed criteria are screened for sepsis.

The regional sepsis screening tool is now integrated within our nursing observations system. Sepsis screening occurs every time a set of observations are recorded within this system. If a patient is confirmed as a positive sepsis screen, decision support within the system will ask staff to complete the 'Sepsis Six' treatment and inform the medical team for urgent review. All patients within CDDFT are therefore automatically screened for sepsis. A Maternity and Paediatric Sepsis Screening Tool was also recently revised and launched Trust-wide.

A Patient Group Direction (PGD) has been developed which is now available for use within the EPR system for staff who have completed the Nurse-led Sepsis training for Sepsis of Unknown Origin.

Antibiotic Compliance

We continue to monitor compliance with administering antibiotics within one hour of sepsis diagnosis. Unfortunately performance has dropped, which is considered to be associated with operational pressures restricting the availability of medical staff and suitable clinical space to administer antibiotics. We will continue to prioritise this Patient Safety objective in the year head, with further development of a nurse led sepsis pathway and, potentially, additional patient group directions.



Sepsis Education

A Sepsis Study Day is held four times a year and has recently been reinstated following the pandemic. A new programme has been designed which includes simulation training for all ward-based staff to help improve staff awareness of Sepsis and support prompt recognition and response.

Sepsis based simulation training and education for the senior nursing staff in DMH Emergency Department has been in place since July 2021 and has been delivered to 44 members of staff. Ongoing sessions are planned throughout 2023 to extend the training to encompass senior staff working in A&E at UHND and more junior staff.

Prior to implementation of the PGD referred to above, the ED team received bespoke training and were required to complete competencies allowing them to administer IV Tazocin and IV fluids using a PGD. This included high-fidelity simulation scenarios and theory based knowledge from various specialities. Staff were expected to complete e-learning training to ensure that they had basic knowledge of sepsis prior to attending simulation training. All staff involved were required to obtain a clinical skills qualification and be able to order chest x-rays, enabling them to be able to take an in-depth clinical history and give clear evidence of a possible source of infection which would assist their decision making and any request for a medical clinician to review. This pathway supports nursing staff to recognise, respond and refer patients whilst waiting for a senior clinician to review patients resulting in more timely treatment, improved patient outcomes and a decrease in patient mortality. By initiating this change it is envisaged that more antibiotics will be given within the recommend sixty minute guideline endorsed by NICE (2017).

In addition, planned "10@10" sessions supported by consultant microbiologists in both DMH and UHND Emergency Departments support staff education on the overuse of Tazocin and the use of frailty antibiotics along with education for the correct antibiotic prescribing for community acquired pneumonia (CAP) based on the patient's risk score.

Community based Sepsis Tool

Urgent Treatment Centres (UTC) within the Trust document care on SystmOne, which is different to the EPR system used within our hospitals. Recently it was recognised that Sepsis guidance within SystmOne was based on a different tool. Development work has therefore been undertaken to ensure that SystmOne uses the regionally recognised and approved screening tool. Staff within UTCs and community based teams were involved with this change and education was required to ensure that the system worked correctly and was user friendly to staff; this work is now fully completed.

Community teams have established a sepsis pathway called 'Is my patient unwell'. This pathway helps community staff to establish whether a patient meets the sepsis criteria and whether they require emergency treatment, taking account of their early warning score and the sepsis regional tool. In addition to the typical sepsis screening process, this tool also includes 'soft signs' which assist staff in being confident to raise concerns to clinical teams. The tool is now well embedded and enables teams to be able to make a rapid informed clinical decision in the community and gives a structured SBAR tool to escalate patients to GP's and paramedics if required.

E-Learning for Registered Nurses

Sepsis e-learning is available for all registered nurses within the trust via the e-learning for health (e-LFH) programme. Information has been made available for all staff to register via a weekly communications bulletin. The Cardiac Arrest Prevention website provides a range of information and prompts staff to access educational sessions, the sepsis regional tool, NICE guidelines and the UK sepsis trust manual.

Sepsis Poster and leaflets for Patients and Relatives

Sepsis posters, with a QR code and leaflets attached, have been designed to meet NICE quality standards. Posters are displayed in the Emergency Departments, Same Day Emergency Care Services and Urgent Care Centres. The QR code is linked to the Trust's internet site enabling patients and relatives to download relevant information supporting awareness of signs and symptoms of sepsis and signposting to help if required.

Patient Experience

Improving the care of patients with additional needs - Dementia

In summary, good progress has been made with respect to specific training and specialist nursing support for patients with Dementia. Our ongoing aim is to recruit more Dementia Champions, increase the coverage of our training and embed practice developments.

Our aim is to provide appropriate care for patients with cognitive impairment and ensure that patients with an impairment such as dementia and their families have a positive experience of throughout their care.

We continue to communicate key learning messages to staff through our quarterly Dementia Newsletter and through our network of Dementia Link Nurses, or Champions. We have recently restarted face to face briefings for the Dementia Champions from our Lead Dementia Nurse.

One of our aims for 2022-23 was to increase the level of awareness and understanding of dementia among our staff by increasing the take up of Dementia-related training, which continues to be accessed through the Trust's e-learning portal. The training targets for 2022-2023 were achieved. Over 90% of staff completed the required training in dementia awareness, with more than 95% completing Tier 1 training. September 2022 saw the re-introduction of face to face training such as sensory deprivation training, which has been completed by 142 staff, and enhanced care training has been completed by 112 staff.

Patient-led assessments of the clinical environment (PLACE) re-commenced in September 2022, which includes an assessment of how far the environment is Dementia-friendly. The assessments result in local actions, led by ward managers, and upgrades to the environment, which are built into lifecycle maintenance programmes.

The Trust has also signed up to the Dementia Friendly Hospital Charter.

The National Audit of Dementia commenced in September 2022, with the Trust participating in the fifth round of the audit. Data collection ended in March 2023 and the report is expected to be released in Summer 2023.

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

Improving care of patients with additional needs - Learning Disabilities and Autism

We have made specialist training available to all staff and continue to provide specialist nursing support and guidance to front-line teams in caring for and supporting patients with learning disabilities an autism. We are collecting feedback from patients and making changes to our information as a result. Next steps will including offering enhanced training modules and working towards a seven day specialist support service.

Our aim was to provide high quality care and support for patients with a learning disability or autism, and to ensure that they and their families and carers have a positive experience when using our services.

Throughout 2022/23 we have offered Tier 1 e-learning for all staff in CDDFT to access and we have been invited to be part of a pilot for the delivery of further, enhanced training modules, led by the North East and North Cumbria (NENC) Integrated Care Board.

We have also worked with colleagues from Tees, Esk and Wear Valleys NHS FT (TEWV), to establish how we can expand our acute liaison service to provide a seven day service, to ensure that patients'

reasonable adjustments are met and support patients with learning disabilities and autism presenting to our A&E Departments.

We have continued to follow our "Policy for care of patients with a Learning Disability and/or people with Autism" and our Learning Disability guarantee, which is unique to CDDFT, to ensure that patients receive individualised support and care under the guidance of our specialist Learning Disability nursing team, during and on discharge from acute admission.

We actively promote the role of the Acute Liaison Nurse for Learning Disabilities throughout the nursing service in the Trust, providing ongoing training and education whilst in the ward environment. In addition, we have continued to work with service users, carers, and their families to understand and learn from their experiences in order to continuously improve our care.

Our specialist LD nurses receive alerts from the patient administration system when a patient with a diagnosis of a Learning Disability is admitted onto a ward allowing them monitor acute admissions and to provide guidance and support to front-line teams. The LD nurses complete discharge reviews and work with community staff to help support patients with Learning Disabilities and/or Autism in being cared for at home, minimising unnecessary attendances at A&E.

In the last quarter of 2022/23 we launched an 'easy-read' Friends and Family test so that we can collect feedback from patients with a learning disability. We have learned that patients do not always understand the information that we give them, which has led us to consider how we present the information and what further improvements we could make.

We have a continuous audit process in place to monitor compliance with our policy in respect of Do Not Attempt Cardio-pulmonary Resuscitation orders, which provides evidence that it is being followed appropriately for patients with Learning Disabilities and Autism.

Improving the care of patients with additional needs – Mental Health Support

Following the Covid-19 pandemic we have seen an increase in patients attending our A&E departments, and requiring admission to our hospitals with both physical and mental health needs, particularly among children and young people. Accordingly we have needed to introduce new policies and procedures, based on joint working with our mental health trust and local authority colleagues so that we are able to respond to all the patient's needs and provide for their safety, and the safety of others through joint care planning.

We have established a Partnership Alliance Group with colleagues from TEWV, our local authorities and Cumbria, Northumbria, Tyne and Wear FT to jointly oversee the development of services which respond to patients with dual needs in our care, and to consolidate relationships between those leading it. There is an Operational Group sitting underneath the Alliance to deal with operational issues. Through this group we have established arrangements to agree care management plans for patients with dual needs, including any support or supervision needed on our sites from TEWV staff.

We have also:

- Developed and rolled out a policy for the care of patients with mental health needs
- Accessed training and support for staff from TEWV colleagues
- Assessed our joint arrangements against sources of good practice and published reports from the Care Quality Commission and identified and enacted related improvements.
- Review the physical environment for wards at higher risk, considering the actions required to mitigate risk including physical measures such as the removal of unnecessary ligature points and management measures such as supervision.

All of this work is ongoing.

Ambition partly met

Ensuring a positive patient experience through the discharge process

Discharge processes generally result in a positive patient experience and we have implemented effective learning processes from Section 42 Safeguarding Referrals. The Trust works well with a wide range of partners, taking a multi-agency approach to discharge planning, with a number of further improvements being planned.

Throughout the year we have been updating our approach to include learning from all previous Work As One and 'Perfect Week' exercises, building on our Next Step Home approach. We work closely with local authority partners to support early discharge using trusted assessment and time to think beds.

We have seen positive feedback (4 of the Top 5 questions for the Trust in the 2021 CQC national inpatient survey, where we were above average concerned discharge – see below) and have seen fewer Section 42 safeguarding concerns raised in recent months. The Trust's Safeguarding teams have introduced thematic working groups with Discharge Facilitators / Coordinators to embed all learning arising from sub-optimal discharge reports submitted via our Local Authority colleagues. Although only two quarters-worth of data has been reviewed thus far a number of actions were identified and implemented. We have already received positive feedback from a Care Provider who commented on the encouraging changes made by the Trust following concerns previously raised in relation to a client's discharge.

Top five scores for CDDFT:

Survey Section	Question	CDDFT Result (0-10)	Trust Average (0-10)
Leaving hospital	Q46: After leaving hospital, did you get enough support from health or social care services to you recover or manage your condition?	7.0	6.5
Leaving hospital	Q42: Before you left hospital, did you know what would happen next with your care?	7.2	6.8
Leaving hospital	Q37: Did hospital staff discuss with you whether you would need any additional equipment in your home, or any changes to your home, after leaving the hospital?	8.9	8.7
Leaving hospital	Q44: Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?	8.6	8.5

System leadership

This year, we recruited to the position of System Wide Discharge Co-coordinator, a nationally mandated post to provide system support to the discharge process, including implementing of a transfer of care hub (ToCH) which is currently in development.

The County Durham and Darlington ToCH will operated as a system-level coordination centre for local health and social care joining-up all relevant services to support safe, timely and effective discharge wherever they live within our localities. The hub will take responsible for developing timely, person-centred 'step-down' or 'step-up' plans for people based on the principle of 'no place like home'.

Discharge and Choice Policy

We are updating our Discharge & Choice Policy to align our approach to nationally-mandated pathways and best practice.

Early Discharge Planning

The Discharge Management Team provides guidance and support to help ward teams make the necessary referrals to ensure the correct agencies are involved in relation to discharge.

Multi-disciplinary Working

Multi-disciplinary working is fundamental to effective discharge planning and to improving discharge pathways. We have introduced daily interagency calls which includes all partners involved in discharge. The calls focus on finding solutions to any challenges preventing a patient from being discharged when they are ready to leave hospital. The multi-disciplinary approach to discharge planning for patients able to return home or who need temporary placements is proving effective, as we are seeing a reduction in the number of people remaining in hospital for more than seven days after they are medically-optimised, and particularly for those waiting more than 21 days.

All wards now have a directory of services available to support discharges across Durham, Darlington and North Yorkshire. 'Home group' assist this new initiative by supporting those with low level mental health needs with housing and financial problems pre and post discharge. We have already seen improvements in reducing the need for patients to re-attend because such additional needs have not been met.

Housing and Related Services

Effective referral systems are now in place, particularly in relation to hospital discharges, as a result of housing representatives being core participants in the daily interagency calls. A great deal of work has been undertaken to implement a system-wide approach to supporting the homeless with successful outcomes for some very complex cases, including collaborating with the third sector.

Home First / Discharge to Assess

Whilst the focus is on 'Home First' for patient discharges from hospital, capacity and availability within re-ablement and domiciliary care have been a challenge. The development of 'Step Down' facilities and services has enabled patients to be discharged from hospital into a more suitable care environment, once they no longer need hospital-based care but are waiting to access domiciliary care.

All social assessments are now carried out in the community rather than in hospital settings, helping patients to leave hospital sooner once they are ready to do so.

Improved Discharge to Care Homes

Care Home Select (CHS), a brokerage/trusted assessor service for care homes, has worked closely with the Trust and social services to reduce the time in hospital for those requiring more permanent placements particularly for those who are approaching end of life

The Trust has representatives on a number of care home groups/forums which focus on improving discharge pathways

In addition our community nursing service receive daily lists of admissions and discharges from care homes to facilitate communications and appropriate follow up care which continues to work well.

Monitoring and responding to system demand and capacity

Daily medically-optimised patient lists are used to track patients, enabling those involved in discharge to be able to identify and action the next steps required in the discharge process. There is further work to do to ensure that our systems are fully up to date and guidance is being produced for ward-based staff to assist with this.

Ambition partly met

End of Life and Palliative Care

In summary, our draft strategy is being consulted upon, and we are demonstrating real improvement in earlier recognition of when patients are close to the end of their lives. However, access to side rooms for privacy and dignity remains a challenge, especially given estates restraints at UHND.

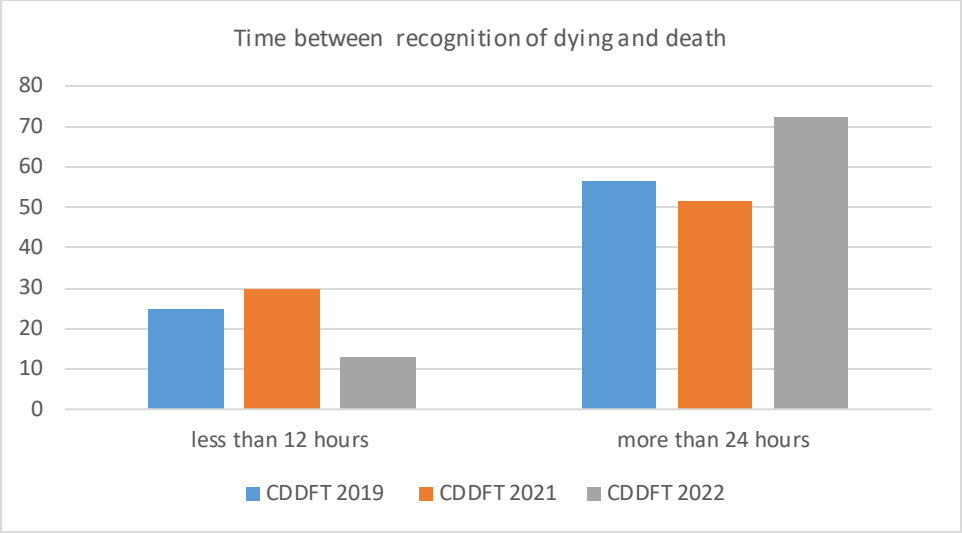
The Trust's End of Life Care was rated as 'Outstanding' in the most recent CQC report. Throughout the year we continued to engage with partners and stakeholders to refresh the palliative care strategy to 2025; however, unfortunately, delays were encountered by pandemic priorities.

Our End of Life Care Strategy has been updated and is out for consultation.

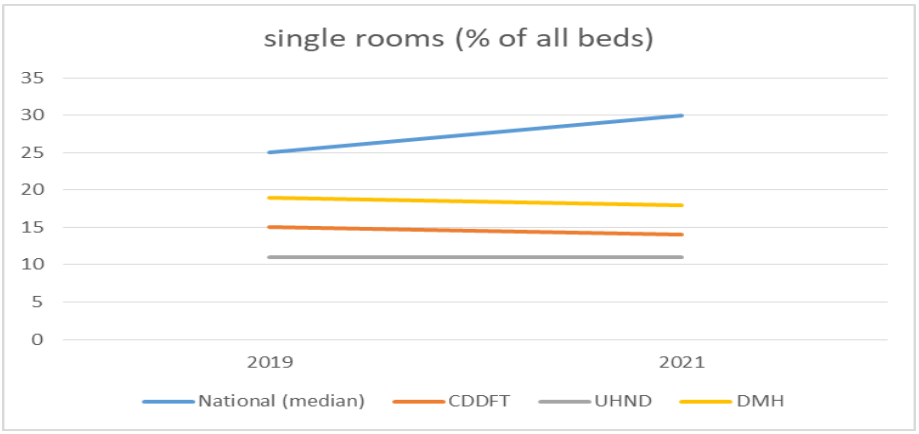
The results of National Audit of Care at End of Life (NACEL) 2022/23 and quality survey data demonstrated continuing good practice in end of life care within the Trust.

Figure notes: NC743 = UHND, NC742 = DMH, quality survey results apply to both acute hospitals

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. Results from NACEL (table 2) show a marked improvement in recognition of patients approaching the end of their lives. Early recognition allows us to discuss what is coming with patients and their loved ones, and to prepare them for it. The results that our interventions of the last few years are beginning to work.

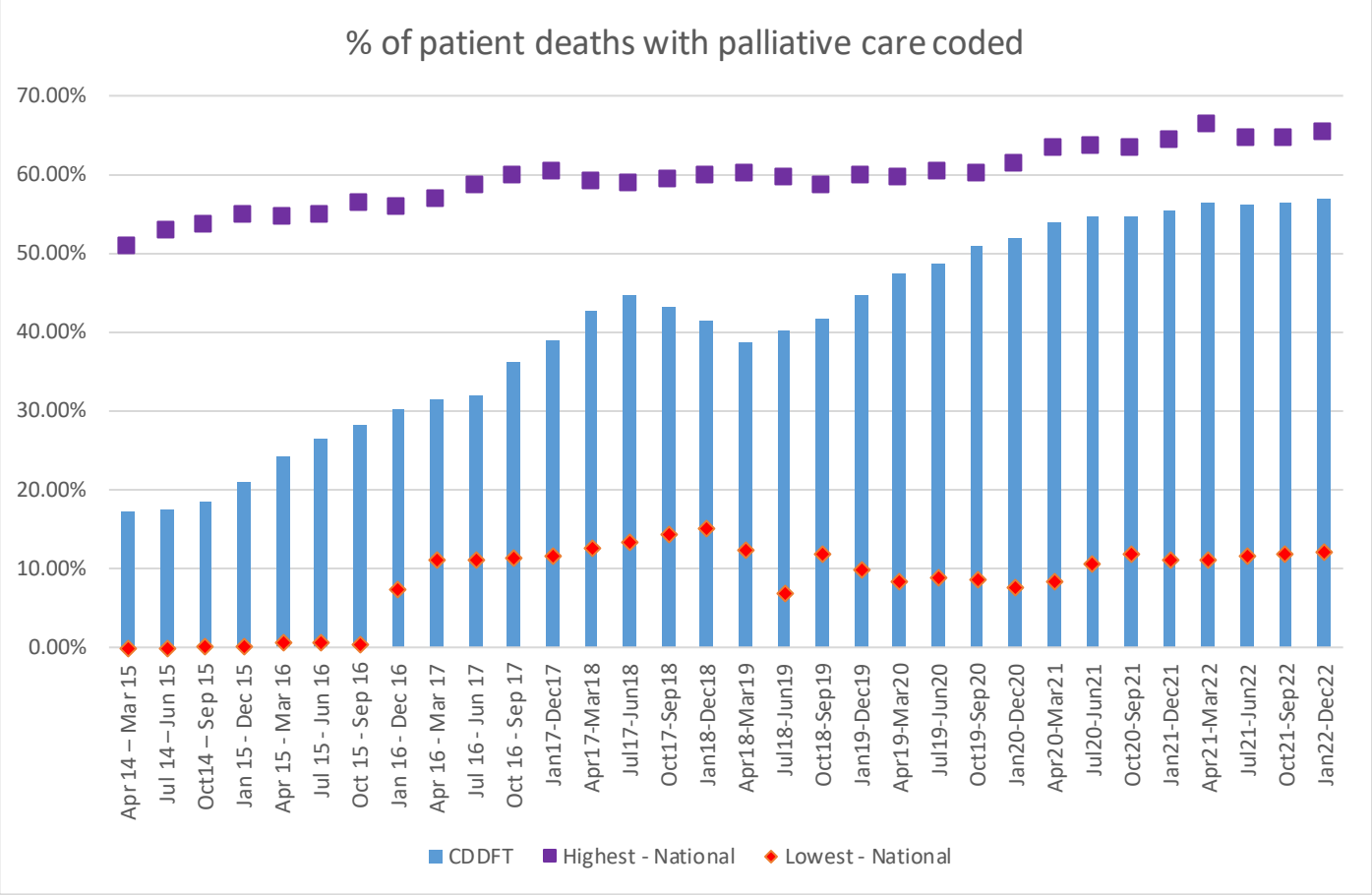


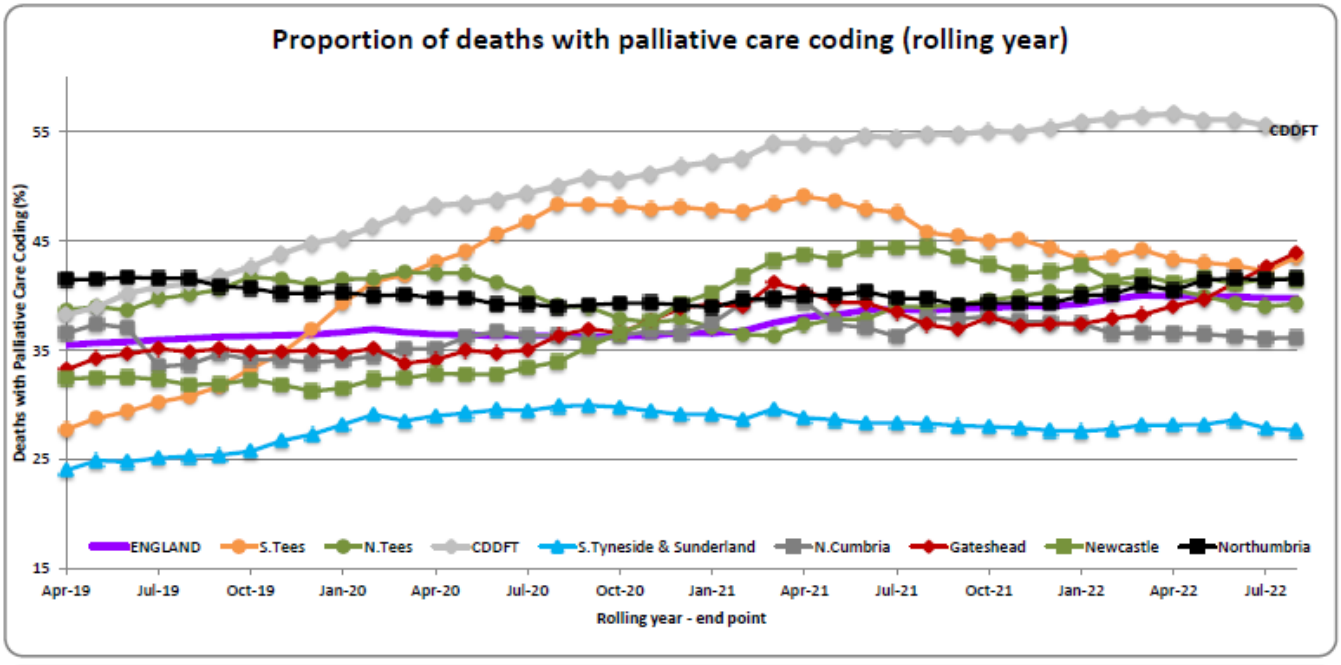
Access to single rooms for patients who are dying is relatively good at DMH (88%) but remains more of a challenge at Durham, where more than 50% of patients die in four bedded bays because of fewer side rooms being available within the estate. The proportion of single rooms continues to decline compared to the national average. Where possible and appropriate, we make use of community hospitals where and are reviewing opportunities to increase side rooms across the Trust's estate, including incremental increases as we extend existing wards, or develop new ones. Education is provided to staff on ways to maintain the privacy and dignity of end of life care patients within the wider hospital footprint where side rooms are not available.



The Trust continues to have the highest proportion of deaths with palliative care coding within the region, as a result of which more than 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)





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

The Dietetics Service has proactively supported front-line staff through a range of initiatives and we have introduced specific campaigns to monitor and maintain hydration. Nutritional needs assessments improved over the first half of the year; however, new processes in our EPR system require further time to embed.

During 2022/23 we aimed to develop a strategy, building on work previously undertaken, to further improve the care delivered to our patients, and to develop and embed nutritional needs assessment and care planning within the Trust's electronic patient record system.

Over the past 12 months we have: implemented annual calibration of weighing scales across the organisation; launched nutrition screening and care planning for adult services via the electronic patient record; and continued to meet NICE guidance through our Nutrition Steering Committee. In addition, as a result of feedback from service users, and learning from incidents and complaints, our Dietitians have extended their scope of practice to undertake enteral tube related procedures. This has resulted in admission avoidance, and more timely discharges, and has supported troubleshooting at ward level. We plan to further develop this service.

Our Dietetics teams have supported wards in maintaining and improving compliance with completion of MUST assessments within four hours of admission. On our medical wards, compliance ranged from 88% to 96% between April and September, with most wards regularly scoring over 90%. There has been a dip since the implementation of the Trust's new EPR system, as has been noted for all risk assessments, however, intensive education and training is being provided on wards to help embed understanding and use of the new system functionality.

In addition to the above:

- We are updating our Nutrition Policy to set out more explicit procedures to protect mealtimes; and
- We have continued to offer role-specific nutrition training for nursing staff.

We are also rolling out the use of "traffic light" jugs to support better hydration among patients. Patients start the day with a red jug, which is replaced with an amber and then a green jug. The traffic-lighting alerts staff to when jugs have not been replaced for some time, putting to a potential lack of hydration. We have also rolled out a 'Drip or Drink' campaign on our wards to encourage staff to consider whether patients who are taking on little hydration should be placed on a drip.

Clinical Effectiveness

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

Recent months have seen improved performance on waiting times, fewer long waits for beds and overall, and strong performance in respect of ambulance handover times. We need to sustain these improvements and to increase the percentage of patients assessed within 15 minutes of arrival.

The Trust has, for the last quarter, seen and treated / admitted around 70 to 73% of patients attending A&E within four hours. This is, generally, slightly above the national average and broadly in line with the region, albeit one or two per cent below on occasion.

At the height of winter, due to respiratory viruses and other demands, the Trust experienced pressure, and patients experienced longer waits and high numbers of 12 hour waits for a bed, following a decision to admit them. However, over the last quarter of 2022/23 we achieved significant reductions in patients waiting over 12 hours in the department and in patients waiting 12 hours or more for a bed, from a decision to admit, as well as in ambulance handover delays. The changes reflect some reduction in demand but also a range of process improvements. The next priority is to maintain and improve performance around the time to assessment and time to treatment indicators.

It is worth noting that the 2023/24 planning target is for Trusts to see and treat / admit at least 76% of patients in four hours by March 2024. We are assured that, given our starting position and with the developments planned for the coming year, such as expansion of Same Day Emergency Care at UHND, we can meet this expectation.

The Trust was asked to present, regionally, on the improvements made in respect of ambulance handover times and 12 hour waits for beds.

Around 62% of patients were assessed within 15 minutes of arrival in the department, in February and March 2023.

In order to deliver the improvements described above we have; doubled the size of the ambulance handover bay at our Darlington hospital, increased the resilience of our bed base (with further increases in capacity planned for early in 2023/24) and recruited additional paediatric specialist nurses to meet the Royal College of Paediatrics and Child Health (RCPCH) recommendations for our A&E at Darlington. We have also fully embedded our Same Day Emergency Care service (as an alternative to A&E for suitable patients) at Darlington and increased the number of patients using it. Additional staff have been assigned into our waiting rooms to monitor patients and undertake safety checklists and checklists to ensure patients receive food and drink whilst waiting and there is in-reach into the departments from acute care physicians when patients require medical review but there is a delay in a medical bed becoming available.

We continue to be well supported by our local authorities to address challenges with access to beds in the community or domiciliary care, supporting timely patient discharge.

We have agreed, and are rolling out, additional investments in middle grade and junior doctors in our A&E Departments and are working on investing in seven day services to ensure all patients receive a medical review every day. Implementation is expected to be incremental, however, given dependence on funding and the recruitment market this will take some time.

Paediatric Care

We have sustained a 24/7 front of hours Paediatric Assessment serviced at UHND and increased specialist staffing, including in the Emergency Department at Darlington. Recruitment of staff for our inpatient wards continues and continue to embed joint working with TEWV for young people with mental health needs.

Over the past 12 months we have continued to make improvements towards our stated goals including; sustaining 24/7 opening for the front of house Paediatric Assessment Area at Durham, recruiting additional specialist nursing staff in line with our aim to meet the RCPCH standards for the Paediatric A&E area at Darlington and made further investments in specialist paediatric and neonatal staff.

Ward based staffing is also increasing to ensure a 1:4 nursing ratio given the acuity and needs of our patients, having seen increased presentations of respiratory viruses and mental health needs. We have established a Partnership Alliance Group, and an operational group with Tees, Esk and Wear Valleys NHSFT (TEWV) and local authority partners to jointly plan and coordinate care for children and young people with mental health needs. The operational group looks after care planning and mitigation of risks.

As part of our commitment to care for young people, and through our work with TEWV, we have reviewed our ligature risk assessments for paediatric wards and are implementing the actions identified, as well as working with the support of the regional Paediatrics Network with respect to the changes we are making to our services.

Excellence Reporting

Excellence reporting has continued to increase year on year and exceeds levels seen at the majority of our peer organisations. The membership of the Learning from Excellence Group continues to increase.

Our objective for 2022/23 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 and work-streams.

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 through a range of communication channels such as Facebook Live Briefings and Directors’ Briefings. The number of members in the group has recently increased, which has seen the remit of the group evolve to incorporate Appreciative Inquiry in line with the new Patient Safety Strategy and patient stories provided by the Patient Experience Team.

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. 381 - 536 reports received per month.

Learning from Deaths (in particular the roll out of Medical Examiners reviews)

All national mortality indicators are in line with statistical parameters. Learning from death reviews continue to find less than 1% of cases which were potentially avoidable and the medical examiner service is fully established in our main hospitals.

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 has remained within the "as expected" range for the last twelve months.

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

During the year we have developed our mortality review approach, and supporting processes, through a range of projects including:

- A project focused on ensuring that patient care is accurately captured with coding, being led by the Quality Improvement Senior Sister.
- Reviewing a sample of deaths for patients who had a prolonged stay within the Emergency Department and died during the same admission. This work will replace the previous reviews completed on coded low risk of death groups.
- Lowering the threshold for mortality review for deaths in our vulnerable groups (such as patients with a known Learning Disability or Mental Health condition).

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.

	2022/23	2021/22	2020/21
Mortality Reviews Completed	438	696	702
Total Patient Deaths recorded	2316	2,207	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 by NHS Digital 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 Variable Life Adjusted Display alerts, this data is not available until six months after the patient has died.

Transition to SJR plus

CDDFT is transitioning to a data collection method known as Structured Judgement Review Plus (SJR+). The SJR+ method enables the Trust to have a better understanding of the quality of care provided than the current data capture approach.

After a successful pilot of SJR+ it was agreed this was the preferred method to support learning from deaths in CDDFT. Training for the central review team is underway and NHS England's Making Data Count team are supporting the trust with the Mortality Dashboard. The aim is for SJR+ to be fully implemented in 2023.

Current CDDFT Mortality RAG Rating

Measure / source of assurance	RAG
Summary Hospital Mortality Indicator (SHMI) – currently 109.69 (within expected range)	
Hospital Standardised Mortality Ratio (HSMR) – 88.52 and within expected range	
Copeland's Risk Adjusted Barometer (CRAB) Annual review data has shown improvements in Surgical Mortality but considered a prompt for further review in medicine relating to global triggers. A review has been completed but not found any cause for concern.	
Completed mortality reviews –currently on track with the mortality review process.	
North East Quality Observatory (NEQOS) Independent Review Monitoring of our VLAD's continue and a sample of VLADS with a less than 20% risk of dying are included in our priority reviews.	

Current CDDFT Mortality RAG Rating

The Medical Examiner Service is now fully operational at Bishop Auckland, Darlington Memorial Hospital and University Hospital of North Durham at CDDFT. We are working towards scrutiny of community deaths by the statutory deadline of October 2023; however, reviews of community deaths will mainly be undertaken by primary care colleagues

Part 2B - Priorities for 2023/24

The Trust refreshed its Quality Strategy during 2022 following consultation with staff and patients and a wide range of external stakeholders. Priorities for 2023/24 reflect both the priorities in this strategy and further priorities (described as "retained" priorities) where further work is required to meet 2022/23 objectives.

Safety	Experience	Effectiveness
Quality Strategy Priorities / Retained priorities for 2023/24: work ongoing		
Reduce the harm from inpatient falls, focusing on identification and learning from lapses in care	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		
Implement actions, in line with Ockenden and other recommendations to sustain safety in maternity services.		
Embed safe practice for invasive procedures: LocSSIPs		
Embed prompt recognition and action on signs of patient deterioration		
Improve the timeliness of administration of antibiotics for patients with suspected sepsis	End of life care: conclude and roll out the palliative care strategy, ensuring appropriate access to private rooms for dignity as far as possible.	Improving access to paediatric specialist services
Meet first year milestones for the roll out of the Trust's patient safety strategy.	Continued improvement of nutrition including assessment and provision for specific needs	
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 / Retained Priorities from 2022/23 – Work ongoing:

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. Minimising harm from falls remains is one of priorities within the Trust's Quality Matters Strategy.

Goals

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

How will we do this?

We will:

- Complete rapid reviews and implement learning from falls with moderate or greater harm with lapses in care, throughout the Trust.
- Increase the population of minor or no harm falls reviewed to identify lapses in care, to identify and act on themes for learning.
- Continue to focus education on key areas such as completing lying and standing blood pressures appropriately and ensuring falls assessment documentation is completed in a timely.
- Look to maximise the benefit of quality improvement initiatives such as 'Zonal Nursing'
- Review the after action review documents to move in line with the new Patient Safety Incident Response Framework.
- Work in partnership with other NHS trusts and organisations to promote safe mobilisation.

Measures of success

Reduction in incidence of falls with lapses in care that contribute to the patient's fall.

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

Why we chose this priority

Minimising harm from HCAIs remains is one of priorities within the Trust's Quality Matters Strategy.

Goals

To minimise the potential risk of patient harm from avoidable HCAI. We aim to be within the national thresholds set for mandatory and local reporting of the below organisms:

- C-Diff
- MRSA
- MSSA
- Gram-negative bloodstream infections:
    - Klebsiella
    - Pseudomonas
    - E coli

To date 2023/24 national thresholds have not been set.

To minimise the risk of transmission to patients/staff/visiting personnel from respiratory viruses inclusive of Covid-19.

How will we do this?

We will implement specific plans for each type of infection as outlined below.

Clostridioides Difficile Infections (C-Diff)

We will:

- Focus on early recognition of suspected/infective diarrhoea and appropriate patient management.
- Continue with our Antimicrobial stewardship programme.
- Hold weekly multi-disciplinary C-Diff meetings.
- Share learning in a timely manner to drive improvement.
- Work with partners to monitor cleanliness standards.

MRSA:

We will:

- Review the Trust's MRSA policy and ensure it is aligned to best practice.
- Audit compliance with the policy.
- Focus on MRSA screening and decolonisation.
- Continue to investigate cases and share findings with the organisation.

MSSA:

We will:

- Continue to investigate cases and share any learning across the organisation to support individual areas with any educational requirements.

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.
- Share information on sources of infection and themes from good practice and from lessons learned Trust-wide.
- Undertake prevalence audits for patients with a urinary catheter to ensure best practice is delivered.

Covid-19:

We will:

- Continue to monitor changes in national guidance and incorporate them into our local protocol/policy.
- Continue to monitor prevalence rates and tailor mandatory IPC precautions in line with prevalence.
- Monitor and investigate local periods of increased incidents (PII) and outbreaks.

Measures of success

To remain within nationally set thresholds for all mandatory reporting healthcare associated infections and internal reduction strategies.

Reducing harm from Category 3 and 4 pressure ulcers

Why we chose this priority

Minimising harm from pressure ulcers remains is one of priorities within the Trust's Quality Matters Strategy.

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 for all Category 2 pressure ulcers, with findings reported to Care Group Governance meetings for action and learning.
- Develop an equivalent of the WREN for our HCA staff, to cover basics skin care and prevention.
- Develop an Acute Tissue Viability referral criteria to appropriately signpost staff.
- Develop a skin care pathway to promote the most appropriate cleansing and use of products.
- Develop and introduce a Haematoma Pathway.
- Work with colleagues in Procurement to align the Acute Dressings formulary with community thus providing more consistency with dressing choice and treatment.

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.

Meeting Maternity Standards, including Ockenden Recommendations

Why did we choose this priority?

Safety in maternity services remains a high priority nationally with the publication of the second Ockenden Inquiry Report in April 2022, the Maternity Transformation agenda, and ongoing focus on the Saving Babies Lives care bundle. It remains one of the key priorities in our Quality Matters strategy.

Goals

We aim to further increase the resilience of our maternity services and to implement all of the actions required following national reviews, alongside local quality improvement initiatives, so that we continue to provide high-quality, evidenced based care. In doing so, we aim to consolidate our workforce, ensuring that care is always provided by skilled, knowledgeable, engaged, fulfilled and compassionate professionals.

How will we do this?

We will:

- Implement our 'maternity matters' staff engagement strategy, which focuses on team wellbeing, culture and ways of working in support of high quality care.

- Evaluate the effectiveness of the governance framework within the maternity service and make identified improvements.
- Continue to sustain and strengthen the workforce through recruitment and retention.
- Review models of care to ensure that we maintain safe staffing and quality across all modes of delivery, including home birth.
- Create and implement a strategy to deliver against 'The Three year delivery plan for maternity and neonatal services'.
- Engage and work collaboratively with the ICB and local maternity and neonatal system.

Measures of success

These will comprise:

- Realising the benefits of the 'maternity matters strategy'
- Delivery of the actions following the workforce review to enhance our maternity service and increasing our staff retention rates;
- Restarting our homebirth service;
- Improving our estate and facilities for women, birthing people and their families;
- Full implementation of actions national reports and our local quality improvement programmes; and
- Continued improvement of the outcomes of those women who are in receipt of Continuity of Carer an report these at board level.

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

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. Our work to embed safe practice, which commenced in 2022, continues. Our audit of the 38 LocSSIPs in place in CDDFT shows us that there is still work to do to implement robust monitoring, auditing and governance procedures to provide assurance that our new LocSSIPs policy is followed. This is one of the safety priorities within the Trust's Quality Strategy.

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.
- Continue to audit LocSSIP documentation and adherence to practice.
- Develop LocSSIPs as electronic forms in our EPR system to assist staff in adhering to the requirements.
- Introduce robust monitoring and governance processes.
- Establish a Clinical Director-led working group to build on the work already completed, working towards the stated goals.

Measures of success

- Standard audit reports produced at regular intervals for in-use LocSSIPs and reported into governance structures.
- 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.
- Data reports for any electronic LocSSIP provided by the information team and shared into the governance structures.

Embedding prompt recognition and action on signs of patient deterioration

Why we chose this priority

A key ambition in the Trust's quality strategy 'Quality Matters' 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, we have continued 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.

Goals

To improve 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.
- Audit early warning scores and escalation to ensure that Trust procedures are being followed.
- Publicise more widely our "Call for Concern" service.
- Embed completion of patient risk assessments in the Trust's new EPR system.

Measures of success

We will see improved compliance rates with training (target is 85% completion) and improvements with observation and escalation audits.

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:

- Continue multi-professional study days which include assessments based on simulation exercises.
- Continue planned Sepsis audits and monitor sepsis mortality.
- Increase uptake of the Sepsis based simulation training and education for Band 6 and band 7 sisters in CDDFT Emergency Departments
- Introduce '10@10 sessions' attended by Consultant Microbiologists and CDDFT Emergency Department staff – an educational session focusing on the overuse of Tazocin, the use of frailty antibiotics and provide education for the correct antibiotics for community acquired pneumonia (CAP) based on CURB65 scores
- Further develop the nurse-led sepsis pathway and evaluate the potential for further patient group directions to support improvement in antibiotic administration.

Measures of success

We will see improved compliance rates with the percentage of patients receiving antibiotics within 1 hour of diagnosis in the Emergency Department

Year one implementation of the patient safety strategy

Why we chose this priority

For many years the Trust has pursued a Safety II approach, endeavouring to prevent incidents from ever occurring through direction of resource, quality improvement work and pro-active projects to minimise the potential for harm. This has seen tangible improvements in patient safety over the last decade however there remains more that can be achieved. The Trust Patient Safety Strategy defines how the Trust will continue to staff to deliver safe, reliable, and effective care with the aspiration of zero avoidable physical or psychological harm to our patients.

Goals

We aim to:

- Create a detailed, shared implementation plan, detailing how we will implement and deliver identified actions from the strategy;
- Transition the Trust from serious incident report to reporting in line with the national Patient Safety Incident Response Framework (PSIRF);
- Collaborate with Care Groups to define patient safety priorities which will be identified from Care Group service clinical strategies; and
- Work with Information Services to develop a suite of quality insight and improvement measures.

How will we do this?

We will:

- Embed safety as everyone's business
- Implement governance structures to support the roll out of the strategy

Measures of success

- PSIRF will be rolled out and embedded in the Trust;
- We will see good engagement with Care Groups and those directly involved in improving patient safety;
- We will see reduced timelines for incident closure; and
- Extract richer learning from patient safety incidents.

Patient Experience

Quality Strategy Aims / Retained Priorities from 2022/23 – Work ongoing:

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

i) Patients with dementia

Why did we choose this priority?

To continue to build on our work already undertaken, 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/cognitive impairment, especially those who require extra support and reasonable adjustments making towards their care. We are aware 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 dementia/cognitive impairment to ensure that the environment in which we provide care is the most suitable.

Goals

To embrace opportunities which will 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 environment and evidence based care/practice.
- By restarting face to face meetings with Dementia Champions - four meetings planned throughout 2023, with the first one being in April 2023.
- Working with stakeholders, local, regional and national working groups to promote dementia services and ensuring the needs of those with dementia are taken into consideration when developing services and changes in clinical practice.
- Increasing the number of Dementia Champions.

Measures of success

Meeting our 85% compliance targets for dementia awareness and related training.
Improvement in PLACE assessment results for dementia-friendly environments.
The balance of feedback from service users and carers is positive and improves year on year.

ii) Patients with Learning Disabilities and / 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 can still 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.

We recognise the requirement and need to keep learning disabilities and autism high on our agenda in providing a positive experience for our patients.

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 under the supervision and support of our learning disability team.

To continue with face to face visits from the learning disability team to patients within our care for a period of more than 48 hours.

To complete a review of all patients with a learning disability or autism that have a hospital stay of more than 5 days to ensure a clear plan of care is followed.

To develop a plan on how to deliver an achievable training programme of "The Oliver McGowan Mandatory Training on Learning Disability and Autism" under the guidance of the Secretary of State' Code of Practice, due to be approved during 2023.

How will we do this?

By:

- Seeking opportunities to further develop a learning disability and autism friendly service, using valuable feedback from patients, families, and carers on their experience of a hospital stay.
- Using patients' experiences as stories for education and learning opportunities. We will work with service users and their families to understand and learn from their experiences to continuously improve our care.
- Continuing to follow our learning disability guarantee, which is unique to CDDFT, to ensure that our patients with a learning disability and / or autism receive individualised support and care under the guidance and support of our learning disability team at all stages of their patient journey.
- Designing and delivering an achievable training programme of "The Oliver McGowan Mandatory Training on Learning Disability and Autism"

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.
- Demonstrating effective discharge follow up contacts and visits for people with a learning disability or autism to reduce readmissions.
- Learning from the Trust's mortality reviews and LeDeR programme.

iii) Patients with Mental Health support needs

Why did we choose this priority?

Following the Covid-19 pandemic we have seen an increase in patients attending our A&E departments, and requiring admission to our hospitals with both physical and mental health needs, particularly among children and young people. Accordingly we have needed to introduce new policies and procedures, based on joint working with our mental health trust and local authority colleagues so that we are able to respond to all the patient's needs and provide for their safety, and the safety of others through joint care planning.

Goals

We aim to:

- Embed the understanding of our policies and procedures for looking after patients with both physical and mental health needs among staff through training and on-the-ward support.
- Ensure that robust care management plans are in place for patients with these needs.
- Ensure that our policies and procedures remain evidence-based.
- Maintain effective partnership working with TEWV and local authority colleagues focusing on the needs of the patient.
- Ensure that risks in the environment are minimised as far as possible whilst meeting the needs of patients with acute, physical health conditions.

How will we do this?

By:

- Continue to work through our Partnership and Alliance and Operational Group to strengthen provision for patients with dual needs, including as appropriate consideration of joint posts, training and adaptations to policies and procedures.
- Jointly evaluate the workings of both groups and implement any agreed improvements.
- Monitor and audit our adherence to policies and procedures.
- Evaluate the training and support provided to staff and implement any agreed improvements.
- Where possible, removing risks in the environment

Measures of success

- Staff understand and are able to implement our policies and procedures
- Policies and procedures meet evidence-based good practice
- There are effective management plans in place for all patients with dual needs
- The Partnership Alliance evaluates well
- Training provided to staff evaluates well and / or is improved
- Up to date environmental and ligature risk assessments with action taken to remove risks where possible

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 which were established during 2021/22, focusing on *the High Impact Change Model (HICM) for Managing Transfer of Care* to reflect changes in hospital discharge policy, the 10 point plan and “SAFER” guidance, recognising the importance on the ‘end to end’ pathway for patients.

- Bring forward discharges (on average) to earlier in the day, ensuring ‘home first’ wherever possible;
- 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:

- Work closely with local authority partners to support early discharge using trusted assessment and time to think beds;
- Continue to develop the roles of our Discharge Champions and Facilitators;
- Implement a transfer of care hub (ToCH);
- Review and issue a revised Discharge and Choice Policy;
- Implement a database and performance dashboard for discharge tracking;
- Monitor the timeliness of discharge and delays in discharge, and achieving improvements in both;
- Embed improvements from thematic work regarding Section 42 safeguarding concerns;
- Facilitate earlier discharges in the day i.e. to aim for all discharges by 6pm;
- Improve the times to turnaround tertiary transfers i.e. time of referral and time of transfer;
- Share and learn from patient stories – positive and negative – with respect to discharge.

Measures of success

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

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 and increase single room availability across the Trust.

How will we do this?

We will:

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

Measures of success

These will comprise:

- Palliative Care Strategy launched.
- Further improvement in recognition of the dying.
- 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?

Good nutrition is recognised as pivotal in each part of a patient journey within the Trust. This ranges from those receiving care in a community setting to acute hospital setting; those receiving artificial nutrition to those with no dietary requirements. It also encompasses those whose relatives/ carers are using CDDFT commercial food outlets and staff within the Trust.

Goals

To ensure that patients receive adequate nutrition and hydration by embedding the use of EPR functionality and ensure high levels of compliance in completing nutritional needs (MUST) assessments and associated care plans and by providing effective Dietetics support to front-line teams.

How will we do this?

- We will bring forward business cases for the following:
    - Nutrition Support Team – to increase compliance with NICE Guidelines on Adult Nutrition Support.
    - Catering Dietitian – to meet recommendations from the Hospital Food Review (2020) and NHS England National standards for healthcare food and drink
    - Children's ward Dietitians – to meet service need and demand, and to establish working group to progress nutrition screening in children and young people using inpatient services at CDDFT
- Re-launch the Trust's Nutrition Policy
- Work closely with digital nursing team and senior nursing, midwifery and AHP leadership team to embed the use of EPR in completing MUST assessments and associated care plans.
- Continue to learn from patient and family feedback including compliments, complaints and incidents relating to nutrition ensuring that all professional stakeholders are aware

Measures of success

These will comprise:

- Submission of business cases
- Updated Nutrition Policy with launch of strategy
- Established working group for children's nutrition screening tool (dependent on outcome of business case)
- Nutrition Steering Committee continues in current functionality
- A significant increase in recorded nutrition assessment compliance

Clinical Effectiveness

Quality Strategy Aims / Retained Priorities from 2022/23 – Work ongoing:

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

Why did we choose this priority?

Levels of demand on our A&E services continue to be high, and capacity constraints relating to the size of our department at UHND and our bed base, have, over the past 12 months meant that we have experienced delays providing treatment and / or in admitting patients. Significant improvements have been made, however there is still work to be done.

Goals

To further optimise our clinical pathways, move towards a 7-day clinical service, working with partners, for urgent and emergency care and expand our Same Day Emergency Care services and Same Day Urgent Care – to release pressure in the A&E department at UHND during 2023/24.

With the support of the North East and North Cumbria Integrated Care System, to continue 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, funding for which has already been allocated.
- Increase medical staffing to support discharge and patient flow, as part of the seven day services business case.
- Increase the Trust's bed base in line with the capital programme.
- Implement full front of house Same Day Emergency Care at UHND.
- Progress work on a new Emergency Care Centre at UHND.

Measures of success

These will comprise:

- Improvements in waiting times with respect to assessment, treatment and the total time in the department when measured against national performance targets:
    - Time to initial assessment – the percentage of patients within 15 minutes
    - Time to treatment – less than 60 minutes
    - The number, and percentage, of patients spending more than 12 hours in A&E
    - The average time spent in A&E for admitted and non-admitted patients
    - 12 hour waits for beds
    - Treatment and / or admission within four hours
    - Ambulance handover times under 30 minutes.

Paediatric Care

Why did we choose this priority?

The Trust has seen a continual rise in children and young people with mental health issues, which is in keeping with the national picture, following the pandemic. There is a need for a proactive multi-disciplinary response and approach, to ensure that these patients receive holistic care and support and that they, and those around them, are kept safe.

The growing demands on the service, allied to workforce shortages, make it challenging for the Trust to obtain all the staff it needs and there is a desire to develop our own staff into higher roles.

How will we do this?

We will:

- Continue to develop partnership working with local authorities and mental health trusts to build frameworks for children and young people presenting to the trust in a mental health crisis.
- Ensure our staff have the skills and support to care for the children and young people in a mental health crisis.
- Work in partnership with local Higher Education providers to support the re-introduction of the specialist practice qualifications.

Measures of success

- Maintain robust multi – agency frameworks for children and young people in mental health crisis and ensure staff are supported appropriately through education packages.
- Clinical educators being recruited into post.
- Staff able to apply to join Higher Education programmes to gain specialist practice qualifications.

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 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.

Each of the Trust's five Care Groups' operational performance is reviewed monthly with the Executive Director of Operations, the Deputy Director of Operations and the Head of Planning and Performance.

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 ICB and Local A&E Delivery Board (LADB)

Participation in Clinical Audit

Background

Clinical Audit is a quality improvement (QI) cycle (Figure 1) that seeks to improve patient care and outcomes through a systematic review of care against explicit criteria. The results are used to identify opportunities for improvement and to agree the specific actions or changes required. Further audits determine the efficacy of the changes and support continuous improvement. In short:

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

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

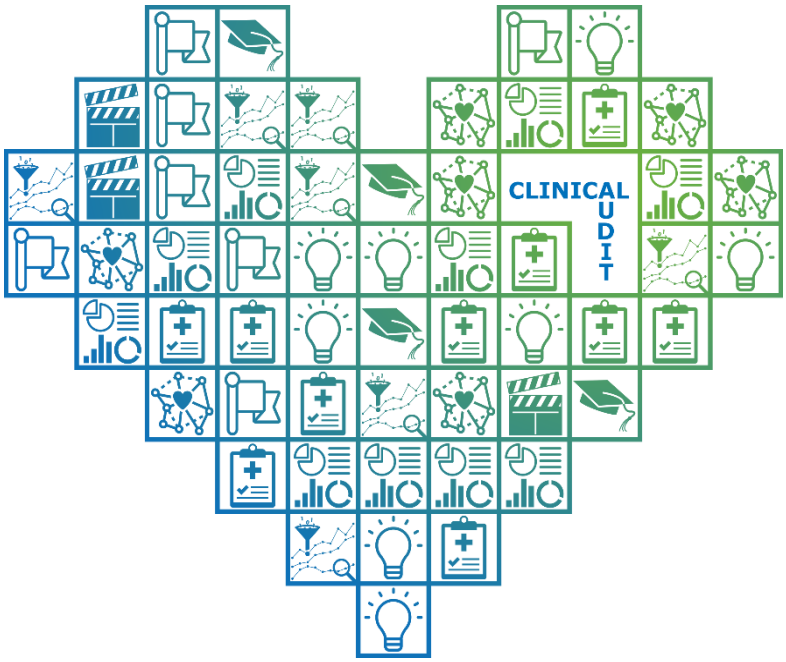
All National Audit reports are reviewed by the Lead Clinician and the Clinical Audit Team, a specific action plan is developed for each audit and approved by both the Speciality and Care Group Clinical Audit Leads. Action plans are monitored by the Clinical Audit team and the Care Group Governance Facilitators.

Participation in Clinical Audit

During 2022/2023 **51** national clinical audits and **7** national confidential enquiry covered NHS services that County Durham & Darlington NHS Foundation Trust provides.

During 2022/2023 County Durham & Darlington NHS Foundation Trust participated in **94** % of national clinical audits and **100** % of national confidential enquiries of which it was eligible to participate in.

The reports of **16 National Clinical Audits** and **18 Local Clinical Audits** were reviewed by the provider in **2022/23** and County Durham & Darlington NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:



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

An excellent example of the effectiveness of local audits can be seen in the Local Safety Standards for Invasive Procedures (LocSSIP) audit programme. LocSSIPs are designed to ensure patient safety and eliminate never events by providing a structured set of checks before, during and after a procedure. The comprehensive audit programme covered all LocSSIPs in use across their respective areas and looked at over 1,500 records in total. The audit identified both areas of good practice and opportunities for improvement which will be investigated in early 2023/24. Each LocSSIP will continue to be audited on a two yearly cycle, to monitor their use and the effectiveness of the improvements made.

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 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. Through 2022/23 the Trust has developed a new clinical audit strategy that is due to be published in the first half of 2023/24 and covers clinical audit activity until the end of 2025/26.

The strategy focuses on 7 domains that build on one another to create an effective and efficient clinical audit programme and develop an open and honest culture throughout the Trust. The domains are.

Education/Training

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

Reporting Accurate and Actionable Information

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

Action Plans

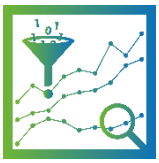
- Development of smarter and sharper action plans.
- Focusing on fewer higher quality actions that address what really matters.
- Identifying and minimise risk, waste and inefficiencies.

Assurance

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

Communication & Engagement

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



Data Collection & Insights

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

New Ways of Working & Process Improvements

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

This strategy represents a step change in the way the Trust approaches clinical audit and will lead to continuous improvement of clinical services in line with the Trusts quality strategy and the strategies developed by individual services. The strategy champions the idea of clinical audit as a quality improvement process that provides valuable insight into the standard of care our patients receive, acting as a catalyst for change and encouraging us to consider how the Trust can do better for our patients and colleagues.

The national clinical audits and national confidential enquiries that County Durham & Darlington NHS Foundation Trust was eligible to participate, participated in and for which data collection was completed during 2022/2023 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	✓	27%
Elective Surgery (National PROMs Programme)	N/A	✓	Ongoing
Emergency Medicine QIPs	Pain in Children	✓	100%
	Assessing for cognitive impairment in older people	Audit Starts May 2023	
	Mental health self-harm	✓	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)	✓	100%
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 (MBRRACE-UK)	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	✓	25%
	Crohn's disease	✓	22%
	Endometriosis	✓	Ongoing
	Testicular Torsion	✓	Ongoing
National Adult Diabetes Audit (NDA)	National Diabetes Foot Care Audit	✓	Ongoing
	National Diabetes Inpatient Safety Audit (NDISA)	✓	100%
	National Core Diabetes Audit	✓	100%
	National Diabetes in Pregnancy Audit	✓	Ongoing

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	✓	91%
	Pulmonary Rehabilitation Organisational and Clinical Audit	✓	100%
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	✓	100%
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)	✓	Ongoing
	National Heart Failure Audit	✓	Ongoing
National Child Mortality Database	N/A	✓	100%
National Early Inflammatory Arthritis Audit (NEIAA)	N/A	✓	Ongoing
National Emergency Laparotomy Audit (NELA)	N/A	✓	Ongoing
National Joint Registry	10 work-streams that all report within Annual report: Primary hip, knee, shoulder, elbow and ankle replacement, Revision hip, knee, shoulder, elbow and ankle replacement.	✓	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
National Obesity Audit	N/A	✓	Utilises existing datasets
Respiratory Audits	Smoking Cessation Audit- Maternity and Mental Health Services	✓	100%
	National Outpatient Management of Pulmonary Embolisms Audit	✓	Ongoing
	Adult Respiratory Support Audit	✗	N/A
Sentinel Stroke National Audit Programme (SSNAP)	N/A	✓	100%
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	N/A	✓	100%
Society for Acute Medicine Benchmarking Audit (SAMBA)	N/A	✓	100%
Trauma Audit & Research Network (TARN)	N/A	✓	100%
National Ophthalmology (NOD)	Age-related Macular Degeneration Audit (AMD)	✓	100%
	Adult Cataract Surgery	✓	100%
Epilepsy12 - 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	✓	100%
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
National Audit of Cardiovascular Disease Prevention (Primary Care)	N/A
Cleft Registry and Audit NEtwork (CRANE)	N/A
Medical and Surgical Clinical Outcome Review Programme	Prison Healthcare Study
National Cardiac Audit Programme (NCAP)	National Adult Cardiac Surgery Audit
Mental Health Clinical Outcome Review Programme	Real-time surveillance of patient suicide
	Suicide (and homicide) by people under mental health care
	Suicide by middle-aged men (Topic closed 2022/22)
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
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

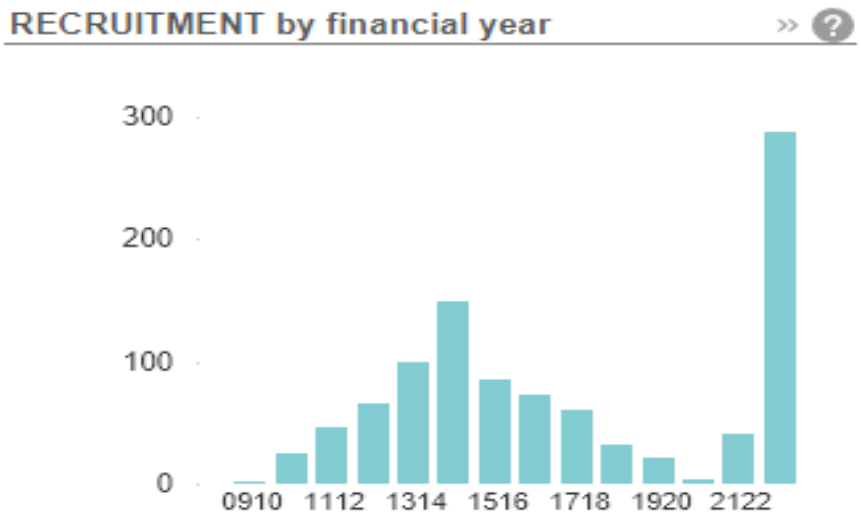
Research and Innovation continues to be a priority within CDDFT, with a ward to board ethos. We have developed a blueprint strategy for the future, which has received excellent feedback from both internal and external stakeholders, and will inform further developments.

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 increase engagement in clinical research across the Trust.

The number of patients receiving relevant health services provided or sub-contracted by County Durham & Darlington NHS Foundation Trust in 2022/23 to date, that were recruited during that period to participate in research approved by a Research Ethics Committee, was 3,259 participants.

The Trust recruited to 85 National Institute Health Research Portfolio studies, and had 67 active Principal Investigators in 2022-23.

One of the key successes in 2022-23 was to hugely increase our Commercial trial recruitment, as shown in the graph below which shows Commercial trial recruitment from 2009/10 to 2022/23



CDDFT have played an integral part in helping local innovators attract prime funding and progress innovations locally and within the trust. CDDFT has also been successful in attracting over £1m of funding to help researchers and Innovators take projects forward.

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

- We are the second highest recruiters nationally to the RESULT HIP study (Anaesthetics)
- The iGBS3 study (Children's): CDDFT is the third highest recruiter in the region
- The HARMONIE commercial trial in RSV infection (Children's): we are the highest recruiting site in the region
- CDDFT have recruited 1,399 babies to the INGRID-2 heel prick study (Reproductive Health)

Goals agreed with commissioners

County Durham and Darlington income in 2022/23 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework because the scheme was suspended. We are aware that the suspension will come to an end for 2023/2024.

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 2022/23.

Care Quality Commission Ratings

The last full inspection of the Trust took place 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, we 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 – or 'should do' actions - included in CQC's reports. 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.

CQC Maternity Services Inspection

The Trust's Maternity services were inspected by the CQC, as part of their maternity services inspection programme during the year. Site visits were undertaken on 28th and 29th March and the draft report is understood to be in preparation (drafting note – this wording will be updated should the final report be published before the issue of the Quality Accounts).

Data Quality

County Durham and Darlington NHS Foundation Trust submitted records during 2022/23 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 patient's valid NHS number was:
  99.4% for Admitted Patient Care;
  99.4% for Outpatient Care; and
  98.4% for Accident and Emergency Care.

- which included the patient's valid General Medical Practice Code was:
  99.8% for Admitted Patient Care;
  99.8% for Outpatient Care; and
  99.7% 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 version 5, 2022/23, Data Security and Protection Toolkit annual return, on the 30th June 2023 aiming to achieve 'standards met'.

For the year 2021/22 the Trust submitted 'standards met'.

Clinical Coding Error Rate

County Durham and Darlington NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2022/23 by the Audit Commission.

Learning from Deaths

During 2022/2023, 2,316 patients died in the Trust, a quarterly breakdown is provided below:

- 521 in the first quarter;
- 520 in the second quarter;
- 662 in the third quarter; and
- 615 in the fourth quarter.

By 31 March 2023, 390 case record reviews and eight investigations had been carried out in relation to 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:

- 125 in the first quarter;
- 116 in the second quarter;
- 105 in the third quarter; and
- 71 in the fourth quarter.

Three (0.1%) 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
- 0 representing 0 % for the fourth quarter.

These numbers have been generated 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 2022/23 were recognition of dying, patient hydration, long waits in the emergency departments and timely recognition of Sepsis. Use of antivirals in patients with Covid-19 was also highlighted which resulted in a quality improvement project. Recognition of the deteriorating patient has been identified largely through unexpected death reviews. This needs to be a focused area for improvement into 2023-24. A national CQUIN requirement will support this work.

Actions that County Durham and Darlington NHS Foundation Trust has taken in relation to the learning identified from those deaths in 2022/23 form part of comprehensive SMART action plans monitored through the Trust governance processes.

Some 452 Case Record Reviews and 4 investigations were completed after 31st March 2021 which related to patient deaths that 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 and Freedom to Speak Up Champions, of which there are currently five. Any referrals made formally to the Guardian / Champions 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. Her appointment has been publicised through the Trust's intranet site, screensavers, staff bulletins, posters and staff meetings and also through wider staff engagement events using Facebook. The Guardian has undertaken a wide-ranging programme of visits to wards and departments.

The Trust promotes the National Guardian's Office's training modules "Speak Up", "Listen Up" and "Follow 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. She is a member of the Peer Support North East & Cumbria Regional Network of Guardians. The six champions are expected to role model the values and behaviours associated with speaking up as well being able to provide information on options available. The Champion role can also be utilised to reduce detrimental responses to speaking up through promotion and role modelling.

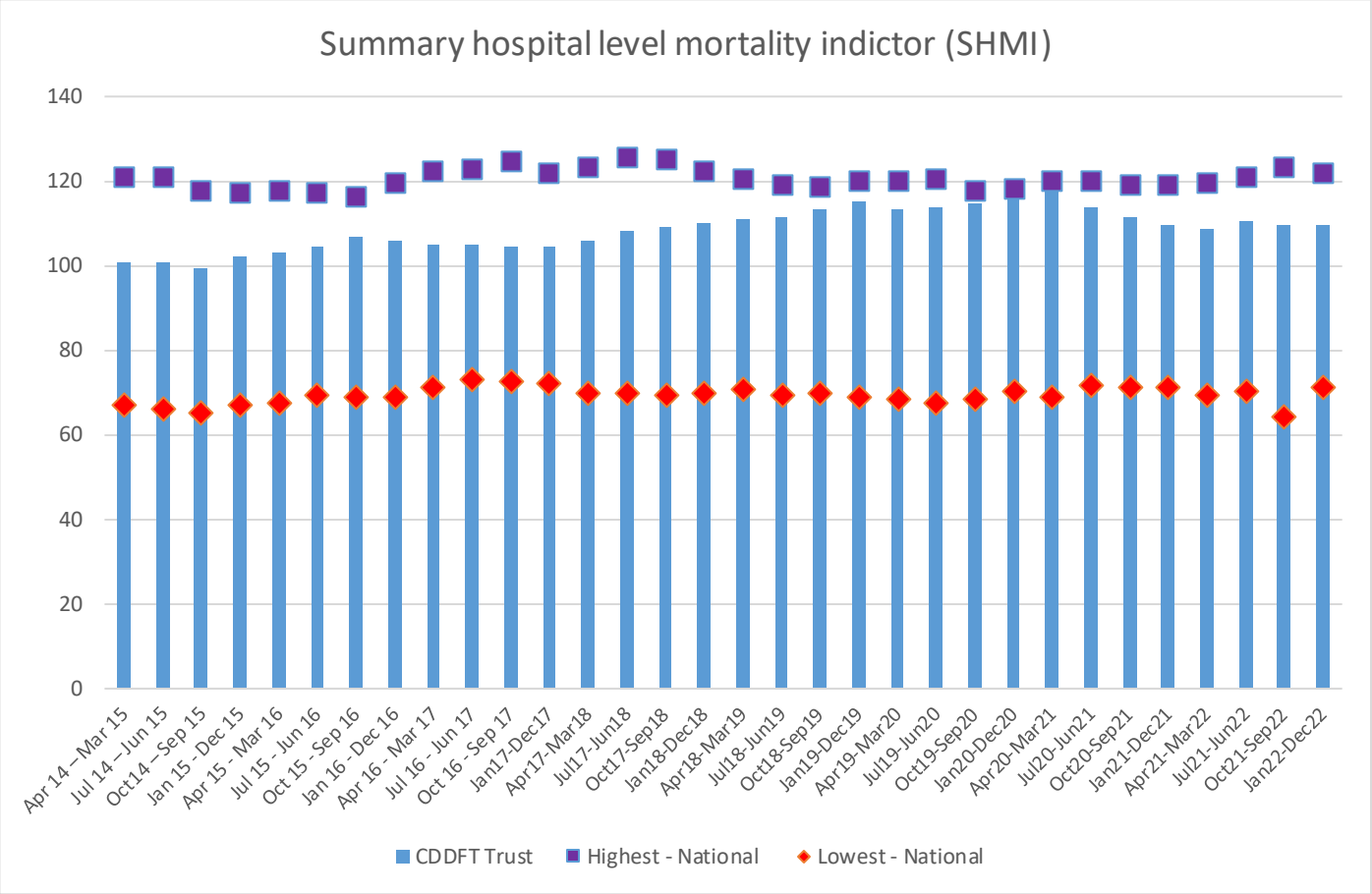
All Champions have been provided with the National Guardian's Office guidance to provide clarity on their remit including: requiring a detailed knowledge of the Speaking Up Policy, escalation routes and useful contacts. Champions are not expected to handle any cases. The outcome of having a champion network is that workers are reminded of the importance of speaking up, they can be signposted to the FTSUG or feel more empowered to take action themselves. The champion role can also be utilised to collate themes for wider learning opportunities.

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 is being refreshed for 2023-24.

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

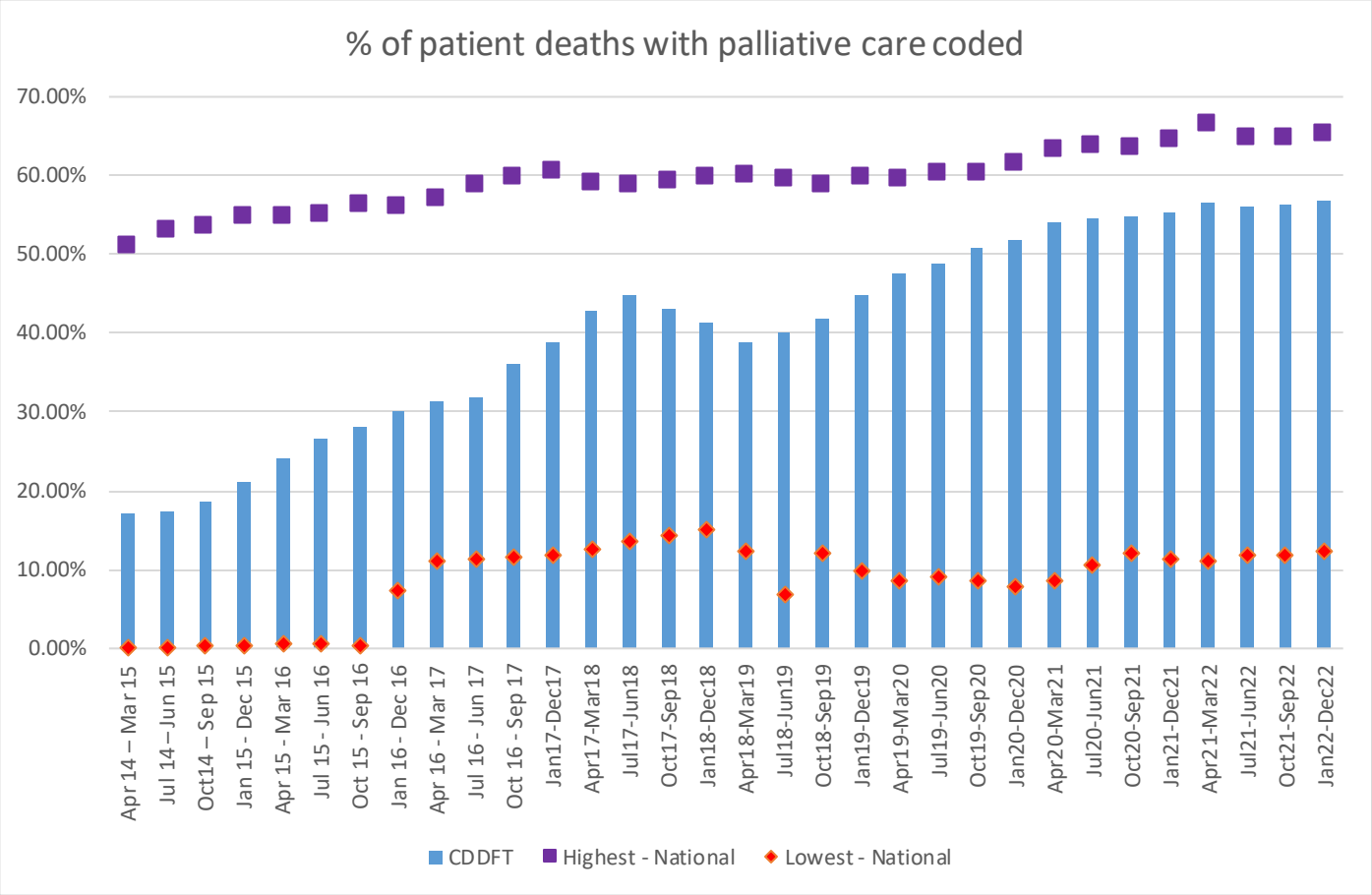
The County Durham and Darlington NHS Trust intends to take the following actions to improve the indicator and so the quality of services by continuing to ensure that mortality remains a strong focus for the Trust. Over the past twelve months our SHMI position has remained within the expected range. We will continue to improve our position via the following:

- A project focused on ensuring that patient care is accurately captured with coding, being led by the Quality Improvement Senior Sister.
- Reviewing a sample of deaths for patients that had a prolonged stay within the Emergency Department and died during the same admission. This work will replace the previous reviews completed on coded low risk of death groups.

We will also 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.

We will continue to focus on sharing learning and hope to achieve this through the adoption of "SJRplus" and the reporting dashboard which enables floor to board reporting focused on the narrative and context of care as well standard mortality indicators.

Percentage of deaths with palliative care coded



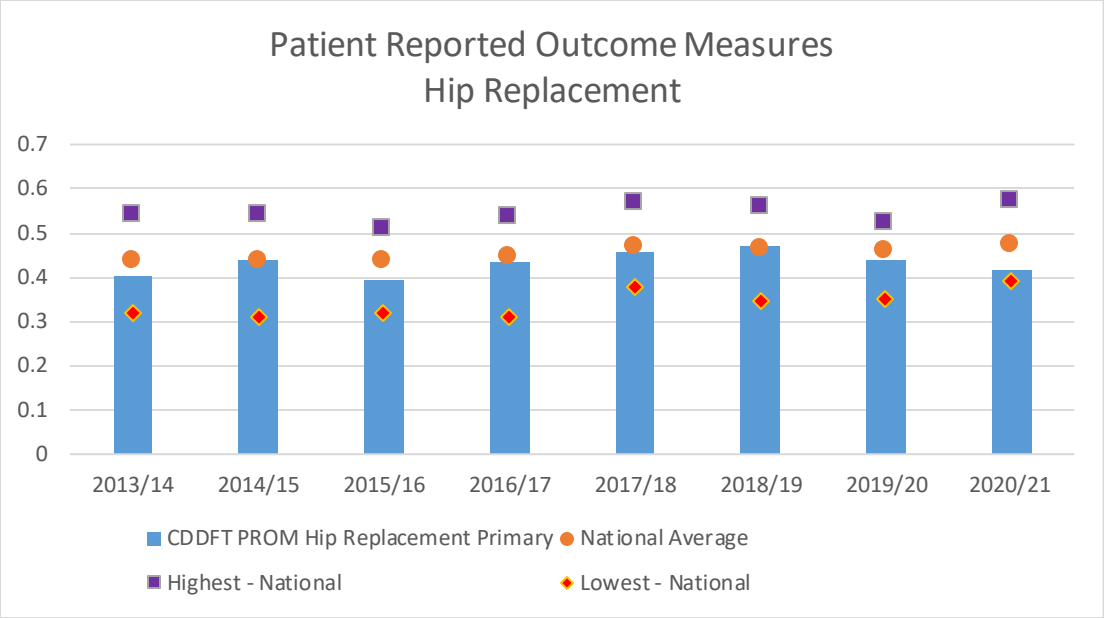
Data source: NHS Digital

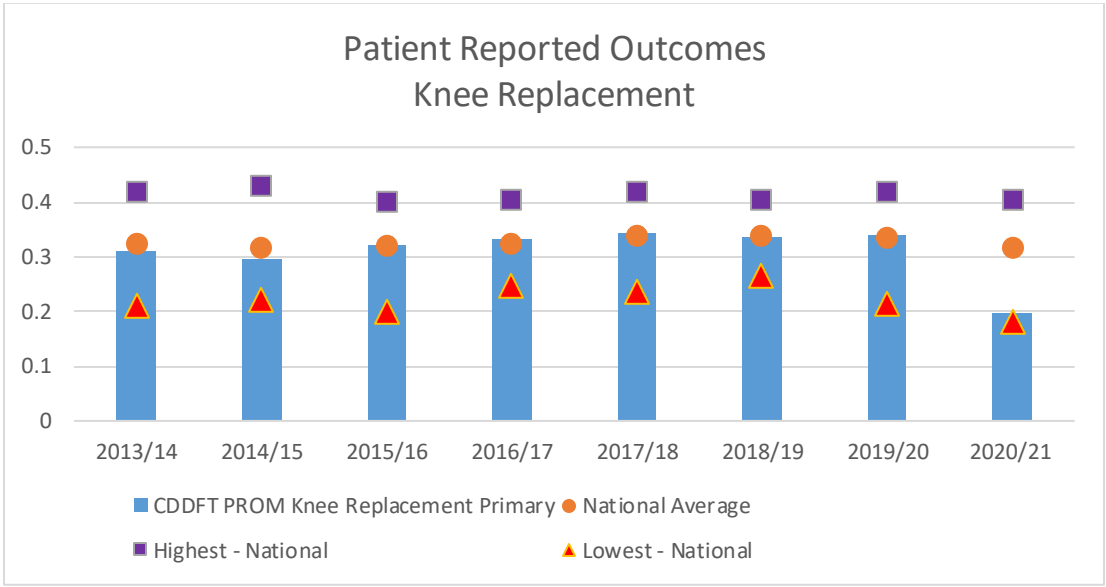
The County Durham and Darlington NHS Trust considers that this data is as described for the following reasons: this data is regularly reviewed at the Trust End of Life Steering Group

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 charts above are those submitted in our last Quality Accounts, NHS Digital PROMS advise that; '*in 2021 significant changes were made to the processing of Hospital Episode Statistics (HES) data and its associated data fields which are used to link the PROMs-HES data. Redevelopment of an update linkage process between these data are still outstanding with no definitive date for completion this present time. This has unfortunately resulted in a pause in the current publication reporting series for PROMS at this time. We will endeavour to update this linkage process and resume publication of this series as soon as we are able but unfortunately are unable to provide a timeframe for this. We will provide further updates as soon as this is known.*'

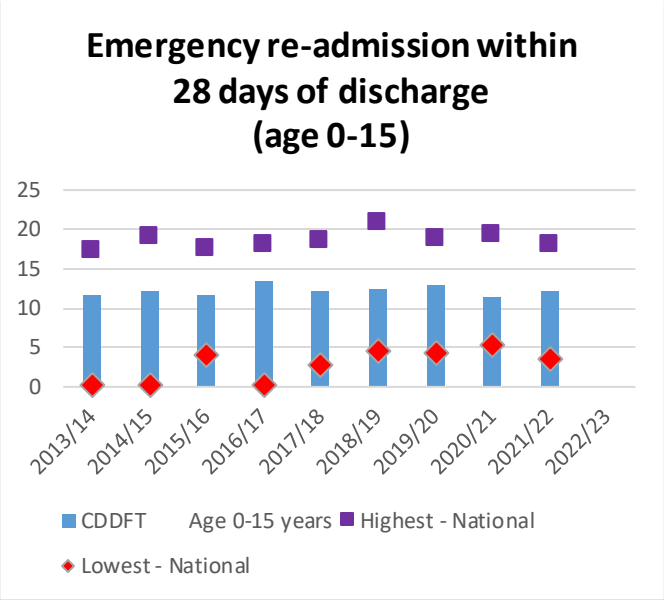
The Orthopaedics team have, in addition to the national picture shown above, been working on an internal process for PROMS compliance. Ward teams are engaged in the process, which it is hoped, will result in an increase in our data moving forward. Contact has been made with the PROMS team to ensure all the collection and delivery names and points are up to date

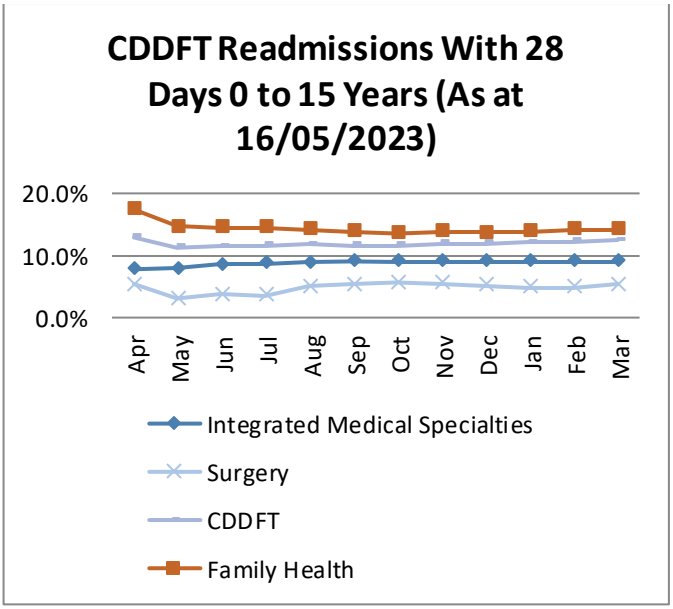
In addition, County Durham and Darlington NHS Trust have now implemented a scheme to support our elective recovery programme which has helped increase the number of theatre lists which can be run for

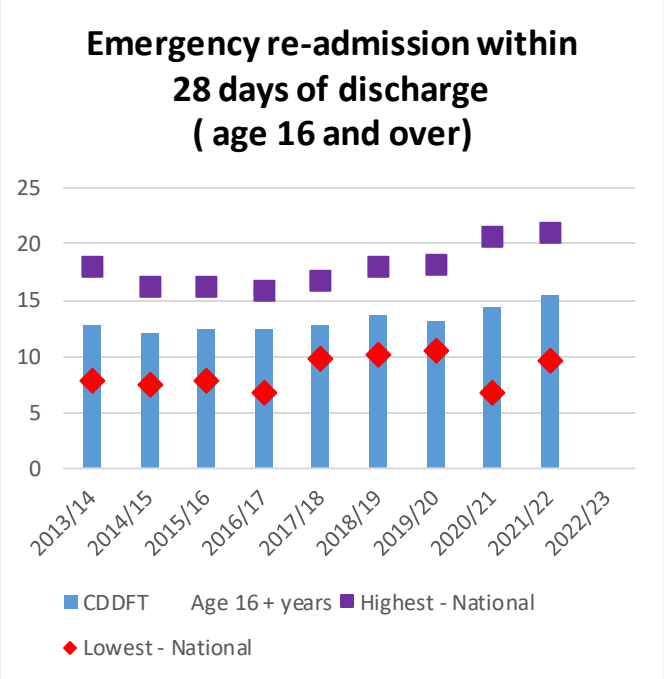
elective orthopaedic surgery. An obvious benefit of this will be an expected increase in PROMS questionnaires completion. Orthopaedics elective beds are now available at Darlington and Durham as well as the full elective ward at Bishop Auckland. We continue to have a slightly reduced theatre programme for elective orthopaedic surgery due to the reduction in trained Orthopaedics theatre staff as well as the need to prioritise Trauma activity but the number of elective sessions has increased over the last 6 months. The Orthopaedic and Day Surgery teams in conjunction with the pre assessment team have implemented a weekly meeting whereby elective surgery is discussed and PROMS questionnaire compliance is monitored.

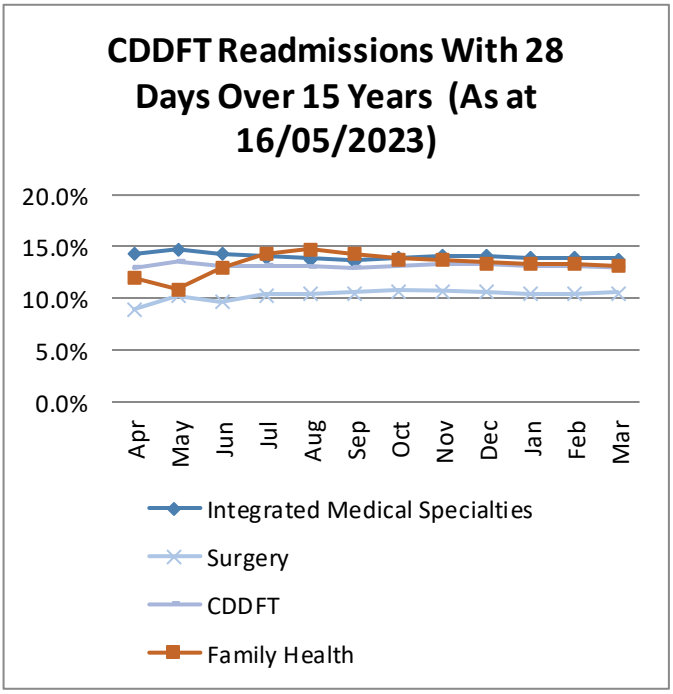
Patients re-admitted to a hospital within 28 days of being discharged

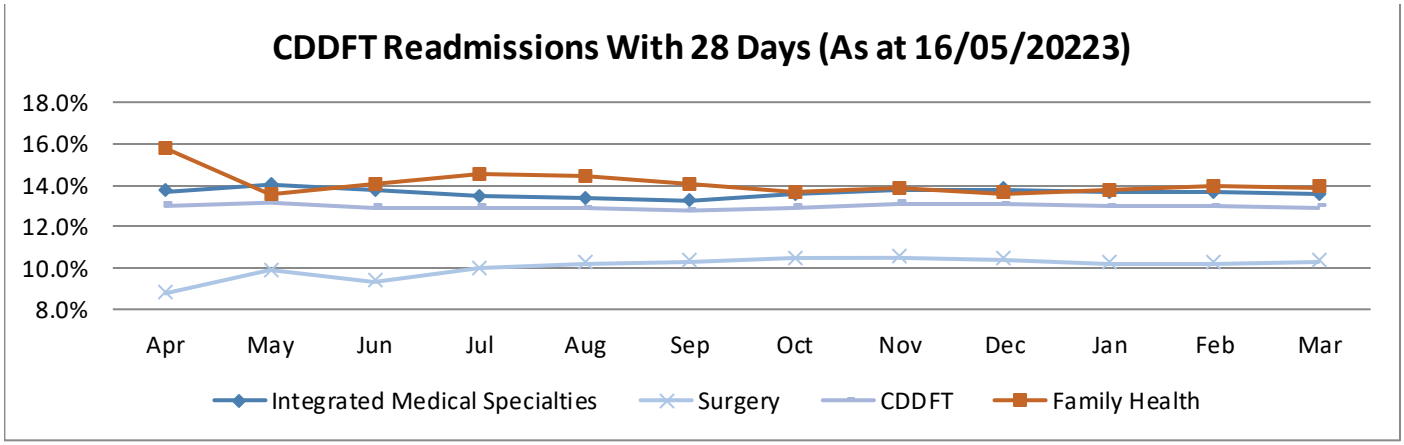
Timely and safe discharges or transfers of care remain a priority for CDDFT.











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

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:

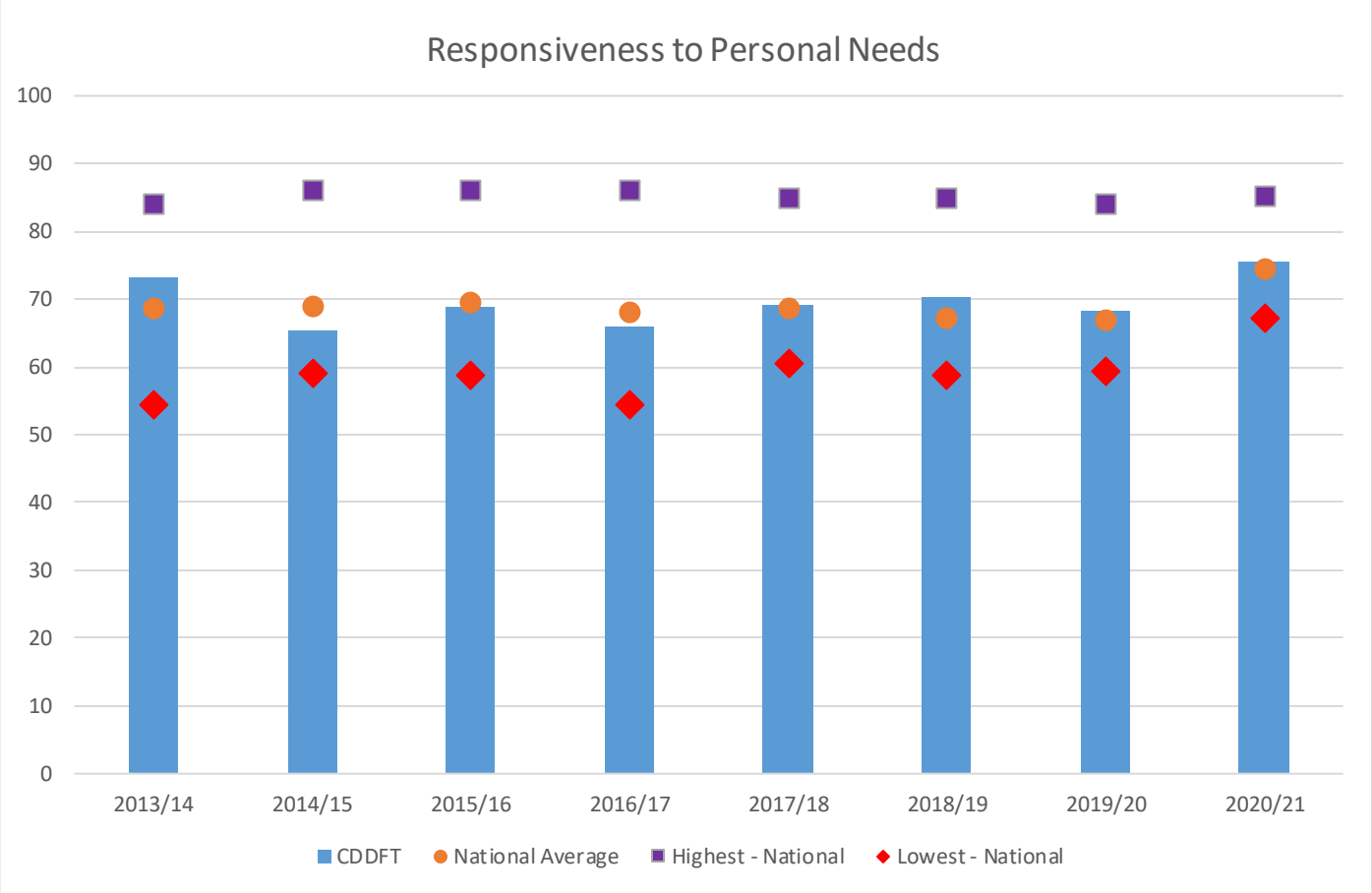
A number of actions have been taken in support of this measure:

- Introduction of community-based urgent crisis response service. 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.
- There has been increased bed capacity in all community hospitals and in 'time to think' beds for those patients who are not quite ready to go home, but do not require an acute bed. Some may need an additional period of rehabilitation.
- Primary Care Colleagues have access to clinical Advice and Guidance, 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

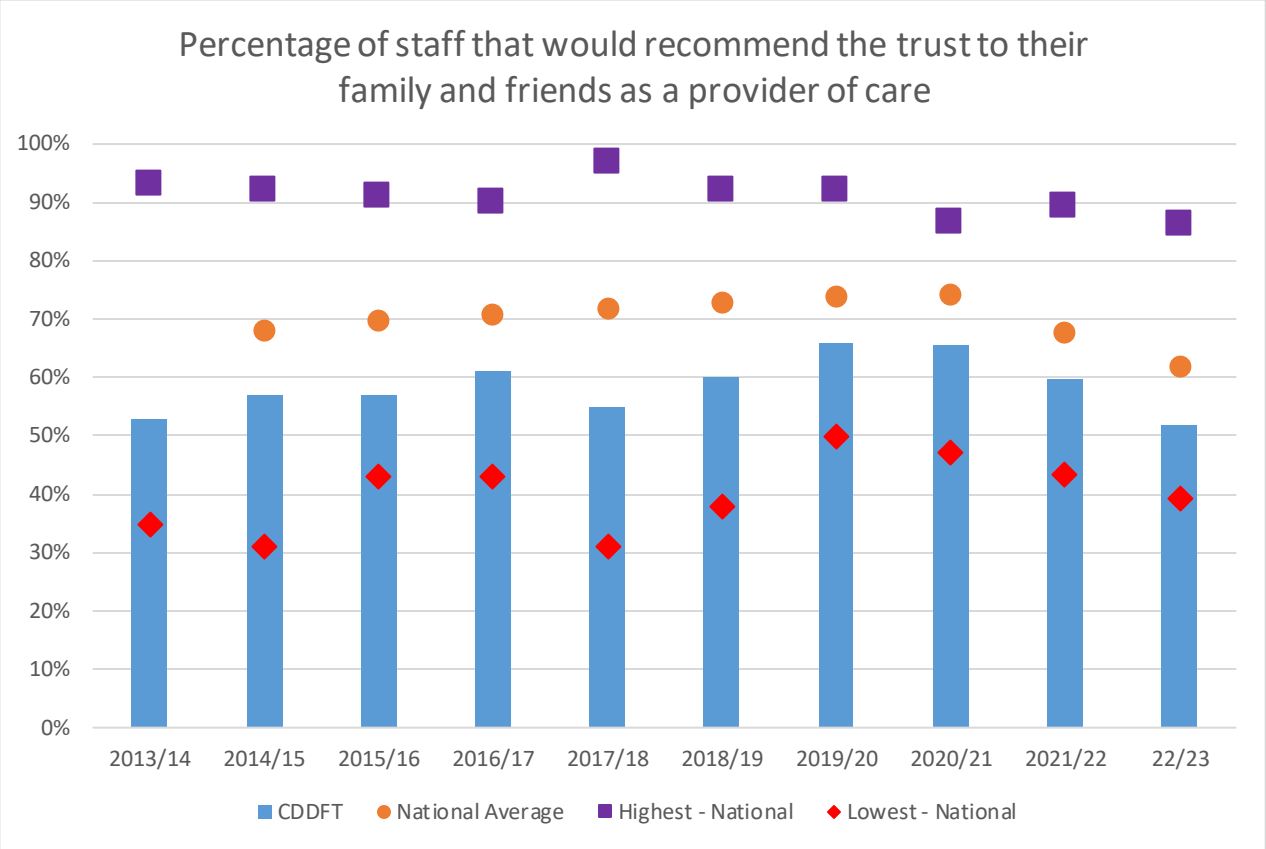


Data source: NHS Digital

The charts above are those submitted in our last Quality Accounts, NHS outcomes Framework (for the responiveness of patietns needs) advises us; '*following the merger of NHS Digital and NHS England on 1st February 2023 we are revieing the future presentation of the NHS Outcomes Framework indicators. As part of this review, the annual publication which was due to be released in March 2023 has been delayed. Further announcemnents about this dataset will be made (on this page) in due course.'*

The County Durham and Darlington NHS Trust continues to take the following actions to improve the indicator and so the quality of services by: analysing patient feedback, particularly from our own surveys, 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.

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



Data source: NHS Staff Survey 2022

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

The Trust's weighted score for the percentage of staff who would recommend it to friends and family as a place receive treatment, from NHS Staff Survey for the last two years is shown below. The national average score is also shown.

Questions	2022		2021		Trust improvement/ deterioration
	Trust	**National Average**	**Trust**	**National Average**	
Q21d. Staff recommending the organisation as a place for family and friends to receive treatment	51.7%	61.9%	59.6%	66.9%	The trust score has seen a significant deterioration compared to 2021. The score for this question has, however, also deteriorated nationally

County Durham & Darlington NHS Foundation Trust intends to take the following actions to improve staff experience and the quality of its services, thereby improving results:

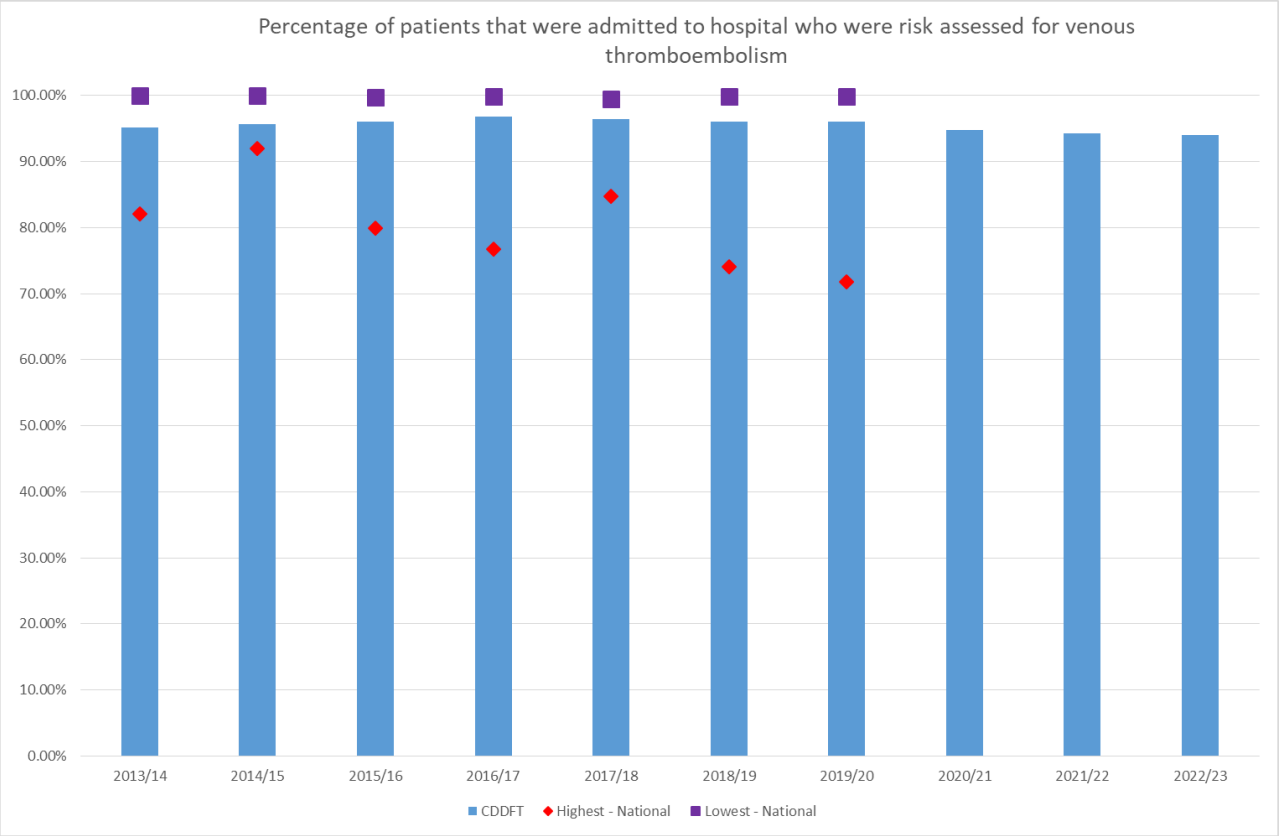
- Piloting a new approach to staff engagement which links both the workforce and the patient experience. There is good evidence that staff morale and engagement is enhanced by positive patient feedback and by implementing improvements in patient care in response to feedback. Learning from others in the region, we will collect patient feedback for a number of wards and share it with ward-based teams to support engagement and empowering them to make change.

The approach will be evaluated and, if successful, will be rolled out across the rest of the Trust. We have already refreshed our Friends and Family Test results posters and we are displaying them prominently in staff areas on our wards.

- Developing a ward quality dashboard, so that teams can celebrate success and improvement. We know from the staff survey undertaken in developing the quality strategy that staff felt they needed more information on how they are doing.
- Equipping local managers with support from both Workforce Experience and Patient Experience, and through skills development courses, such as our Engaging Managers course, to elicit feedback from staff on local issues and areas for improvement.
- Sharing work taking place as part of our Quality Matters strategy, resulting improvements in care and celebrating individual and Trust success.

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.

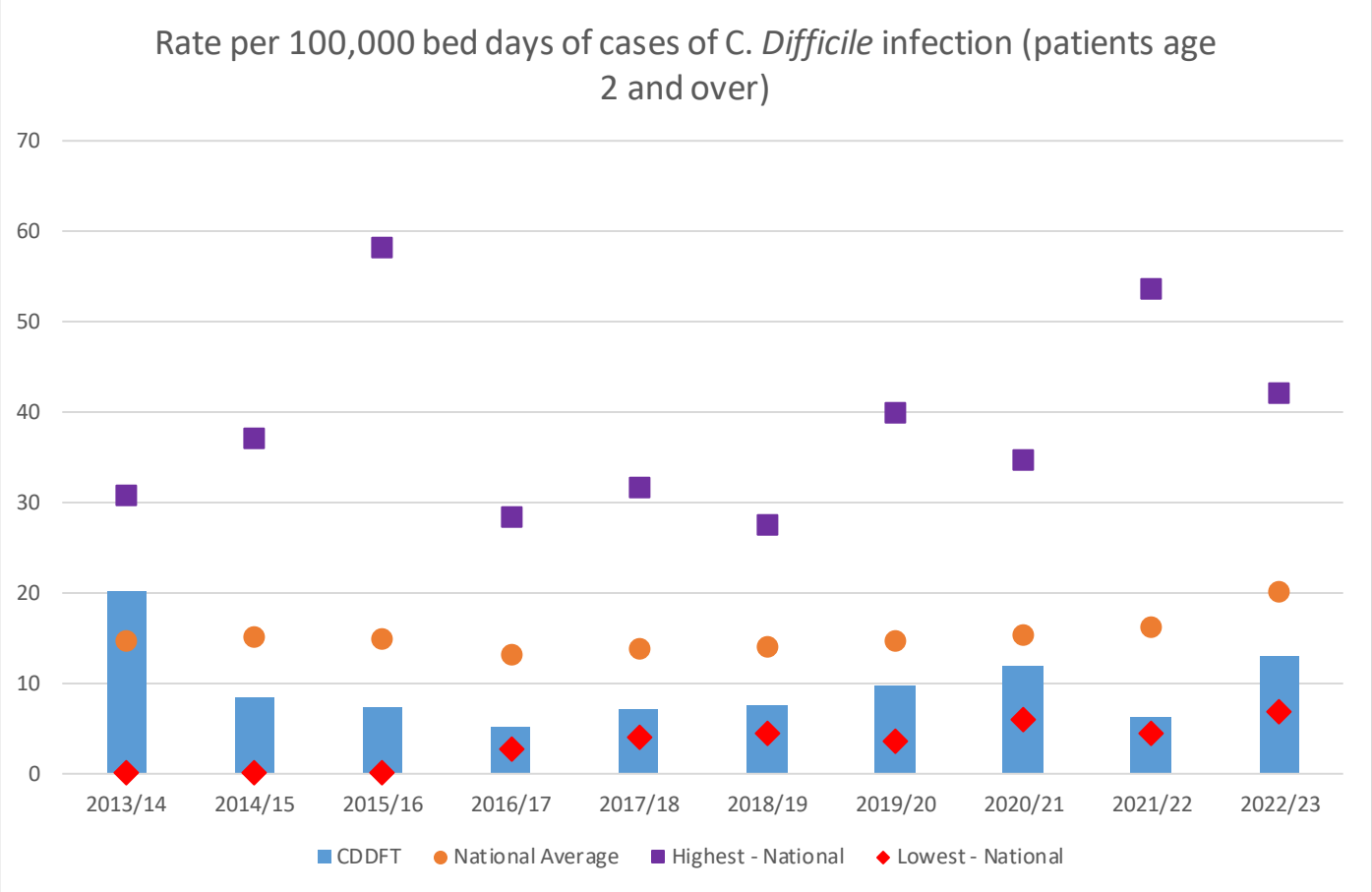


Data source: NHS Digital.

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.

Since October 2022 VTE assessment is documented within the electronic patient record. Our priority for this year and next is to ensure that clinical teams at County Durham and Darlington NHS Trust are completing this assessment correctly and to establish formal reporting metrics. Continuation of compliance monitoring to ensure that current performance is maintained, and NICE guidelines are met, and to improve the quality of service will be managed through the usual governance framework.

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

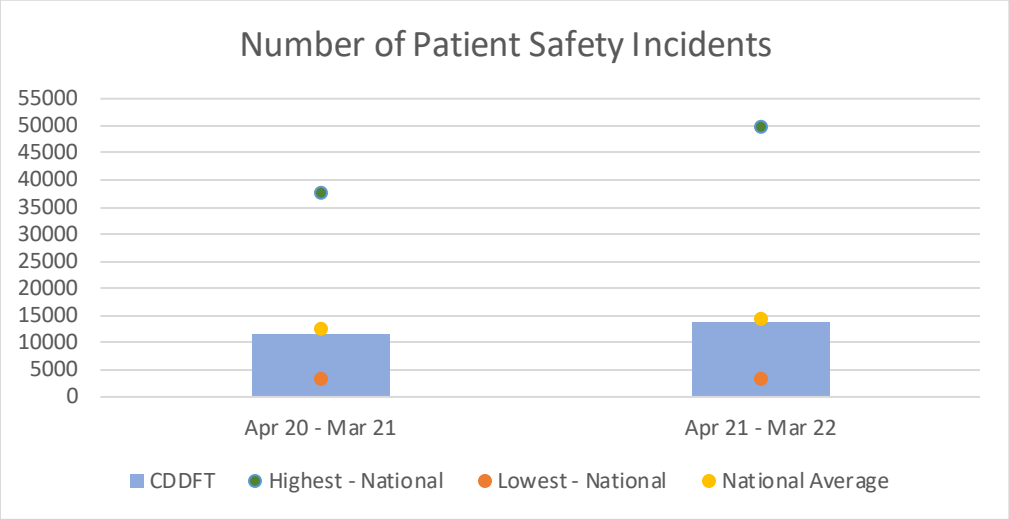


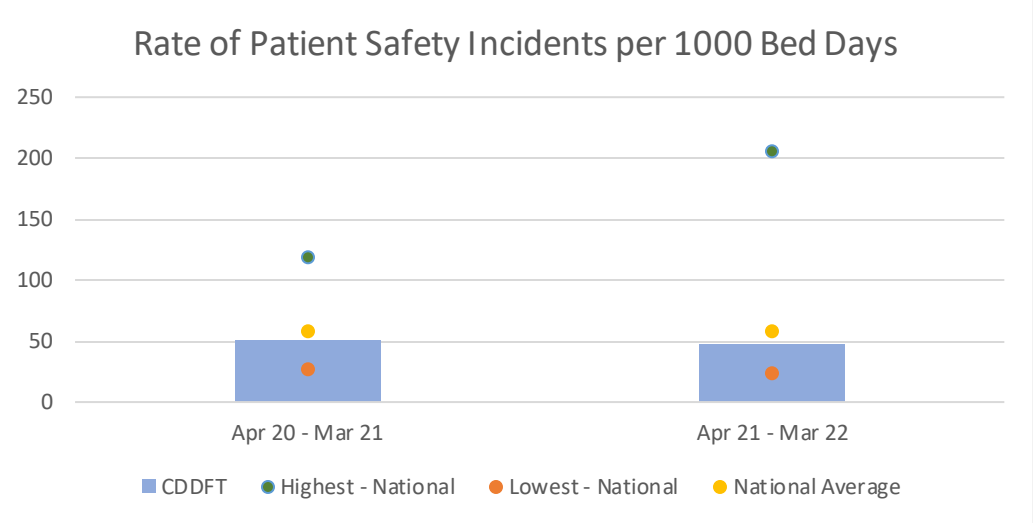
Data source: NHS Digital

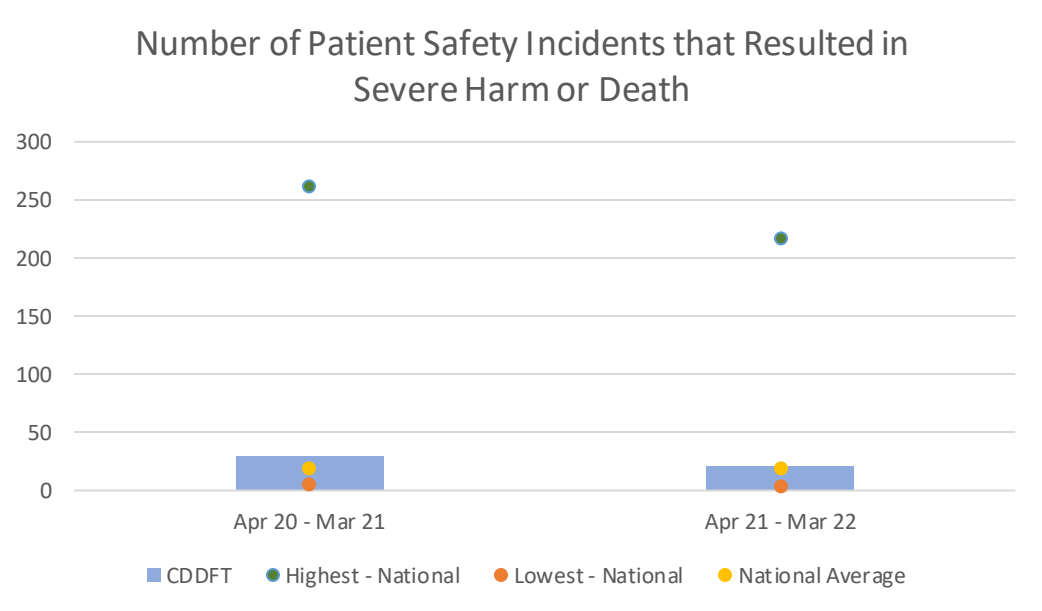
The County Durham and Darlington NHS Trust considers that this data is as described for the following reasons: the Trust monitors this data regularly via its Infection Control and Executive Patient Safety and Experience Committees. Despite a significant increase in the number of C-Diff cases from 2021/22, the national trend has been similar and the Trust remains below the national average. The Trust exceeded its nationally set threshold by two cases.

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 as well as learning from individual case reviews and back to basics audits undertaken every quarter.

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







Data source: National Reporting and Learning System (NRLS).

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.

Since April 2020, NRLS has moved to annual rather than six monthly reporting. As a result, unlike previous years, only the previous two years has been presented in the charts above to ensure appropriate data comparison. In addition, due to the national move from NRLS to Learn from Patient Safety Event Service (LFPSE) in mid-2023, some trusts that have migrated to the new system may not be included in the dataset which may impact the national figures.

The County Durham and Darlington NHS Foundation Trust intends to take the following actions to improve the indicator:

- Encouraging reporting of no harm and low harm incidents and near misses among staff during 2022/23, which resulted in an increase in reporting that will not yet be fully reflected in the NRLS data.
- Implementing a bespoke Patient Safety Strategy – Patient Safety Matters - which builds on the principles in Patient Safety Incident Reporting Framework.

Family and Friends Test and other forms of patient feedback and engagement

Throughout the pandemic responses for the Family and Friends Test were low due to posters being removed from the wall with QR codes and paper forms removed for infection prevention and control reasons. During 2022 we have reintroduced paper cards, refreshed/replaced posters and worked with wards and departments to increase the number of responses we receive to not only drive service improvement but celebrate our successes.

In response to our priorities identified in the 2022-2023 Accounts; our FFT posters were redesigned and displayed at the entrances of all ward and patient areas, ward and departments now have personalised paper cards to be given to patients on discharge or when leaving the department which include an option to scan a QR code, visit the website or manually fill in the paper cards. These initiatives have resulted in an increase in the amount of responses received and we hope this will continue to gain momentum in the coming year.

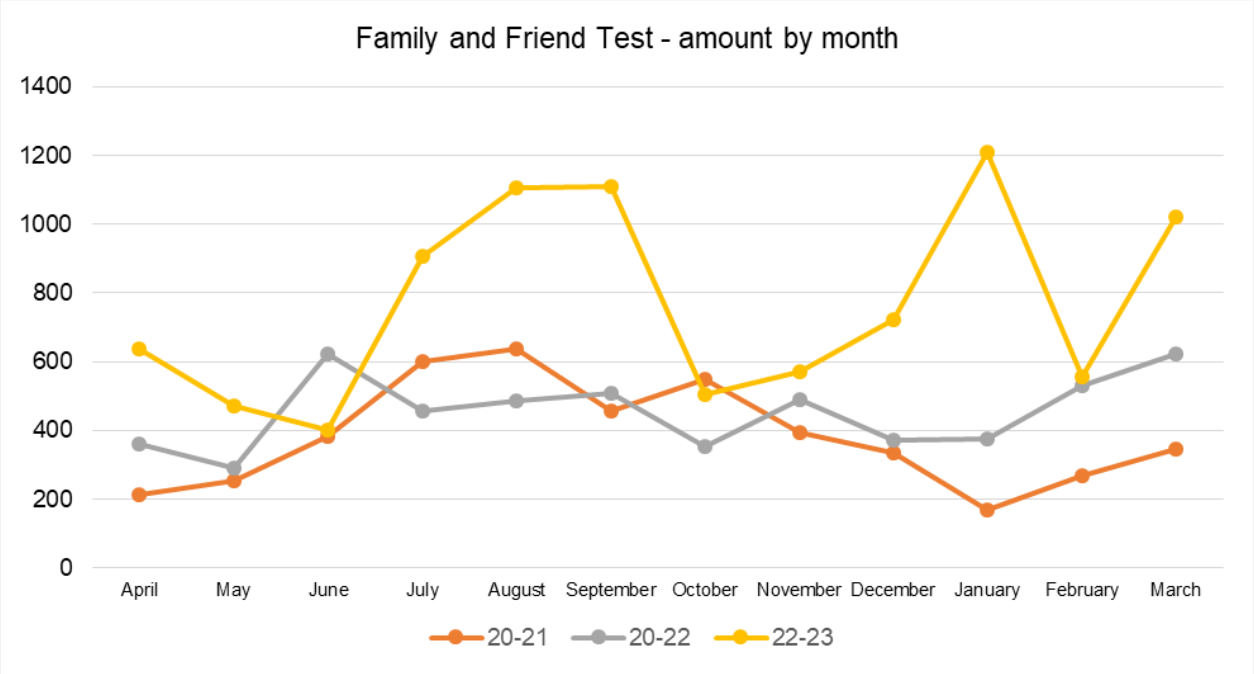
We also the Rehabilitation after Critical Illness Team (RaCI) and Rehabilitation Teams, in evaluating service improvement. The evaluation results were very positive, responders were very happy with the services and were unable to identify any areas in which they thought the services could be improved, at this stage. The evaluation was a ringing endorsement of these services with teams able to celebrate their successes.

Our 'you said, we did' campaign has identified a number of service improvements during 2022/23. Improvements have been made to our Wig Service and through the introduction of volunteers to Ward 33 which allows ward staff more time to care. Volunteers provide wide ranging support to patients including support with eating and drinking.

There has been positive work carried out with parents who remember their lost babies in the Little Angels garden at UHND. Parents have been a key part of our consultation group and supported the project to relocate the baby memorial garden on that site. Parents have had significant input into the look and style of the garden and helped the Trust consider a project plan for the relocation to be carried out empathetically. As a result of this work we have now introduced a Trustees of the Garden Group for future management of the area.

We had hoped to introduce a text messaging service in the year, however an evaluation identified that set-up and ongoing costs were too prohibitive at this time. Following the introduction of EPR, the new electronic paper record, we are now exploring ways that this initiative could be delivered through the EPR system functionality.

The graphs below show local and national comparisons to the responses received.



Part 3 Other Information

This section of the Quality Account includes an overview of the quality of care provided during 2022/23 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 recently launched 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

Quality Improvement

In October 2022, the Trust appointed a Quality Improvement Senior Sister. This new role facilitates and provides support to clinical teams looking to develop QI initiatives. The QI Senior Sister is working towards building a culture of continuous care quality improvement in the Trust giving everyone, at every level, the opportunity to participate in positive change.

Incident Reporting and Investigation

The reporting and investigation of incidents and 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 2022/23 reported 50 such incidents; this is a decrease compared to 57 reported in 2021/22. All of these incidents have had an investigation completed 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 2023-24. In previous Quality Accounts we have described how the Trust piloted a rapid review process for falls resulting in fracture neck of femurs and how the pilot had enabled 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. Having been deemed a success, the pilot, and learning outcomes, were included within the Trust's three years Falls strategy and rapid reviews are now embedded practice.

The original pilot completed 16 falls rapid reviews. For 2022/23 that number has increased to 49 falls rapid reviews completed.

This year has also seen the development of the Trust's Patient Safety Strategy for 2023-2026 which underpins the core objective in our "Quality Matters" strategy of "Keeping You Safe" when you use our services. Having pursued a Safety II approach of endeavouring to prevent incidents from ever occurring through direction of resource, quality improvement work and pro-active projects to minimise the potential for harm, the approach delivered tangible improvements in patient safety; however, there remains more that can be achieved.

Our Patient Safety Strategy outlines how we will continue to maximise the safety of our patients; involve staff, and provide meaningful and full engagement of patients and their families; use data to direct our efforts; and ensure we learn from any patient safety incidents.

Patient safety is everyone's business. By providing a safe and just culture, in which our staff are empowered to learn from incidents and act on safety risks, and by working in partnership with our patients and their families we can, together, deliver safe and reliable care which aims for zero avoidable physical or psychological harm to our patients.

Key priorities we set out in the Patient Safety Strategy include:

- Early Detection - Since 2013 the Trust has seen a 56% reduction in cardiac arrests per thousand admissions. This has been achieved through consistently reviewing, and learning from, both cardiac arrest and medical emergency calls. The strategy sets out our aim to; continue to review all Cardiac Arrests and MET Calls to maximise the potential for learning, work with the AI team to monitor for any areas of 'soft intelligence' relating to the deteriorating patient where patient safety gains could be made and remain vigilant for emerging themes to ensure swift intervention is taken to prevent patient harm occurring
- Learning from Deaths - Since 2017, CDDFT has had a robust Learning from Deaths Process and the process and policy has continuously evolved to ensure that the selection of patients reviewed maximises the potential for learning. The implementation of the ME Service further consolidates the learning from deaths processes to ensure that no stone is left unturned in the quest for learning. The strategy sets out our aim to; maintain flexibility in relation to the deaths reviewed to ensure that all areas for potential learning are explored, continue to expand the ME Service to ensure robust surveillance of patients who die whilst in the care of CDDFT and maximise the opportunities for learning and ensure that action is taken against any themes identified through the learning from deaths process.
- Learning from Excellence - We established Learning from Excellence (LfE) in 2016 and since then over 22,500 excellence reports have been made, the numbers increasing year on year. The new Learning from Patient Safety Events (LFPSE) reporting system, which replaces the current National Reporting and Learning System (NRLS) in autumn 2023, takes learning from excellence one step further. The system will integrate these events, capturing them alongside the adverse incidents, and also enabling patients and their families to report instances of excellence as well as adverse patient safety incidents. The strategy sets out our aim to; continue to promote the reporting of excellence, reinvigorate the Learning from Excellence working group, which faltered during the

Covid-19 pandemic, and focus on exploring how the learning from good practice can be disseminated into the clinical areas to ensure that it supports the delivery of high quality, safe care.

- Learning form Patient Safety incidents - The Trust's annual patient safety incident response plan (PSIRP) sets out how the Trust learns from patient safety incidents reported by staff and patients, their families and carers as part of our work to continually improve the quality and safety of the care we provide. The strategy sets out our aim to; ensure our annual PSIRP supports the robust investigation of adverse incidents and provides a clear structure to staff as to what level of investigation is required and ensure the learning from PSII's and other incident examinations is disseminated in the most effective manner into the clinical areas to minimise the risk of future incidents of a similar nature occurring.

National Patient Safety Developments

As noted above our local patient safety strategy and priorities are informed by the National Patient Safety Strategy. We continue to progress with the transition to the National Patient Safety Strategy through the following:

- The Falls rapid review process is now standardised practice.
- Patient safety incident investigations are now using the new PSIRF templates.
- We have begun to use learning teams to identify and undertake quality improvement work organisationally following a theme identified from incident reporting;
- We have made greater use 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 September 2023.

Never Events

The Trust have reported zero never events in 2022/23. A never event is defined as an incident that should not occur if correct procedures and policies are in place.

Local Patient Safety Initiatives

In 2022/23, a regional patient safety group was formed to share key priorities and ideas on matters relating to patient safety. Throughout 2022-23 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.

Associate Directors of Nursing Patient Safety Forum

The Associate Directors of Nursing Patient Safety Forum is a recently introduced forum which is responsible for monitoring any emerging patient safety issues, as well as providing senior leadership direction to manage outstanding issues in relation to incident management, Duty of Candour and Patient safety incident investigation safety actions. The forum will also ensure that investigations spanning safety, experience and / or legal are managed in the most appropriate manner to provide the best experience, in a timely manner, for the patient or their family.

Maternity Quality Improvement Forum (MQIF)

Senior leadership in maternity services and patient safety recognised the need to ensure long term, embedded changes in practice following reviews of incident action plans. Whilst short term improvements were being made, consistently translating short term actions into long term, embedded changes was less successful.

The Maternity Quality Improvement Framework (MQIF) was established with initial work streams were built on the themes observed within national learning and recommendations from high profile reports, alongside themes from local maternity patient safety incidents and safety related risks on the services risk register. The drive of each work stream was to utilise the themes to inform quality improvement

work, with ongoing monitoring, to really embed learning across the service. The initial work streams agreed upon, and approved by the executive led oversight meeting were:

- Continuity of Carer
- Workforce
- Digital
- Screening
- Quality and Safety (to incorporate other areas for learning not covered in the previous four work streams)

There have been a number of key successes within MQIF, and the framework enabled the service to drive change forwards at an increased pace, improving safety for women and babies in our care. The incidents overall in maternity services, whilst continuing to show a good reporting culture, are beginning to reduce to a level previously associated with being 'normal' within maternity services.

Patient Experience

Patient Experience

The Patient Experience and Engagement Strategy is being revised for 2023 to 2025. The objectives and work-streams have been defined and are underway 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.

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 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

The Patient Experience Team have worked with a number of complainants to capture their stories in detail, using the video testimony of the families involved, which are then shared with nursing and clinical teams, to promulgate learning and with our Integrated Quality and Assurance Committee (IQAC), for assurance and reflection. IQAC has, on several occasions, recommended that the stories – which can be particularly powerful – are shared with, and videos watched by – all Board members and has sought update on actions taken.

Learning objectives and actions are developed with the families concerned. We are now starting to invite complainants into the Trust to under-take walk-arounds to allow them to see the changes made as a result of their feedback.

One particularly powerful example of this approach is 'Andrew's Story' as noted below, with the patient involvement aspects led by the Patient Experience and Learning and Disabilities Teams. The Trust was acknowledged in NHS England's Action from Learning Report 2021/22 for this piece of work:

When Andrew was admitted to hospital with a urinary tract infection (UTI), he did not recover as expected and staff were not asking why. Andrew's family did not feel they were listened to and their concerns were ignored. Changes in Andrew's behaviour were attributed to him having dementia, and further questions were not asked. Unfortunately, this meant two pathological hip breaks went undiagnosed for several weeks.

Andrew had Down's syndrome and sadly died in early 2020 at the age of 51. County Durham Clinical Commissioning Group (CCG) and County Durham and Darlington NHS Foundation Trust (CDDFT) approached Mixit, a local drama group in the North East, who were asked to produce a film to portray Andrew's experiences. The film has been shared widely as a learning tool. Its purpose is to emphasise that reasonable adjustments should be made for people with a learning disability and that nothing should be assumed as a result of someone having a learning disability. The film was made with the consent and support of Andrew's family, who want to share his story in the hope of changing attitudes towards people with a learning disability in health and care settings. Andrew was non-verbal, but the film gives him a voice. The viewer is urged to see the person, not their learning disability, and to adapt their behaviour, ask the right questions, look the right way and, ultimately, 'See Me'.

Stories such as Andrew's encourage everyone working in health and social care, as well as the public, to challenge preconceived ideas they may have around what is best for a person with a learning disability, and instead listen to that person.

There is an ongoing plan to share Andrews's story at CDDFT from ward to board via social media, patient experience forum and also in the care groups.

Major Service Re-Design

We have undertaken extensive public engagement activity, with commissioners, with respect to the plans to replace Shotley Bridge Community Hospital with a new facility in the same locality. This has included:

- Seven formal public engagement events
- An ongoing reference group, working with local councillors
- Use of existing partnerships, to elicit the views of younger service users
- Ongoing engagement, with a dedicated Communications Lead in place for the project.

The services to be provided from the facility have been extensively discussed and finalised through the engagement process – including accounting to the public for the absence of endoscopy and theatres in the new facility. The full equality impact assessment for the facility was shared with the Board, as well as the details of the public engagement activity and outcomes, as part of the outline business case for the site, in December 2022.

Developing opportunities for feedback – harder to reach groups

The patient experience team has developed an 'easy read' version of the Friends and Family Test, to help those with learning disabilities and other relevant conditions provide feedback on their experience in our care. This augments existing patient experience feedback measures, including the main Friends and Family Test, compliments, local (post-discharge) and national surveys.

Involving patients in service evaluation

Both the implementation of the Trust's Acute Kidney Injury Service and the 'Call for Concern' initiative - which allows patients' carers, relatives or friends to contact the Acute Intervention Team should they be concerned about the deterioration of a loved one - have been subject to interim evaluations reported to the Board, and to the Clinical Effectiveness Committee respectively. Both have collected and used patient feedback as part of these initial evaluations and will do so more extensively in the final evaluation stage.

Cancer services

There is a rolling programme of cancer patient experience feedback surveys (the "5 for 5" survey) running throughout 2022/23. The survey looks at different elements of the patient's experience, including access to the service, each time it is undertaken and was used post pandemic to take patient views on access to chemotherapy services which supported the decision to reinstate services at UHND.

Service Level activity

Examples of service-led engagement, involvement and related improvement activity are summarised in the table below, this is not be an exhaustive list.

Integrated Medical Specialties	A key service change introduced in the last two years has been the development of the acute frailty model. The service has undertaken a patient survey to support the evaluation of the change covering: • Awareness of the service • How far patients and families considered their concerns were listened to • How well-informed they were with respect to the survey and their condition • How far patients, carers and families felt involved in their care and treatment • The value placed on the service. The feedback was strongly positive.
Community Services	The service is organised into Teams Around Patients working closely with the GP practices responsible for patients. This approach enables primary care services to represent the views of their patients and, at macro-level, service users' experience is considered as part of the Co Durham Integrated Care Partnership. The service works with many service users in care homes and there is a joint forum held with care home leads. As part of these discussions, feedback on the Trust's services is considered. One of the most recent service developments is the establishment of community-based Long Covid clinics. We has recently set up a Friends & Family Test to allow it to receive feedback from patients about the service. There is also regular attendance at a Countywide Patient Reference Group which is a patient and carer group meeting hosted by the ICB to provide updates on the service.
Surgery	The Care Group has considered patient feedback, obtained through complaints, and local surveys and made a number of changes, examples of which include the following: • The Ophthalmology pathway was revised following feedback from a patient and their family to ensure that patient journey is streamlined and a holistic approach is taken. The out of hours' service was also reinstated following a temporary suspension in response to patient and Governor feedback.

	• Clinical Decisions Unit UHND- patient feedback always referred to the long wait for senior review, hence the on call rota was changed to introduce 1st & 2nd on call consultant in 2020. • Clinical Decisions Unit UHND - The patient feedback has highlighted that location of the waiting room is not ideal and there is a lack of confidentiality. Work is taking place to adapt the current space to address these issues. In the meantime the service has turned one of the examination bays into a comfortable seating area with a T.V. so the patient feels more included in their care/ journey. • Families provided feedback that they felt "shut off" when doors were closed on the side room when their family member was approaching the end of their life. The service now asks the family if they would like the doors open or closed. Previously there was the assumption that families preferred the privacy; families are now always asked and assumptions are not made. • Clinical Decisions Unit DMH - patients raised concern regarding the waiting time to be seen by ENT, leading to a review of the pathway which is ongoing, with proposals expected to be taken through specialty and care group governance in the near future. • The recently, and significantly, expanded Rehabilitation after Critical Illness used patient feedback as part of an interim service evaluation.
Family Health	The Maternity Service works closely with the Maternity Voices Partnership, with the Chair of the MVP attending the Family Health Quality Governance Meetings. The Service has developed its response to the national maternity survey results, for 2021/22 in partnership with the MVP and agreed additional actions as part of their feedback. There is ongoing work between the MVP, Infinity Teams and Healthwatch on health inequalities and the MVP has been used to engage with service users with respect to the temporary suspension of the both the home birth service and birthing pool at DMH. CDDFT is working with Children's North East (CNE) to help poverty proof paediatric services recognising that our services must be accessible to citizens from all socio-economic backgrounds. The process of Poverty Proofing© Health Settings is delivered in partnership with CNE and will provide us with insights into the challenges that individuals face in accessing, attending or engaging with our services. The focus is on engaging with families (particularly those experiencing poverty) to identify barriers to engagement in health services and working together to overcome these barriers, eliminate inequalities and improve accessibility.

National Patient Survey Reports

There were three National Surveys carried out 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.

NHS Adult Inpatient Survey

The survey was administered by the Coordination Centre for Mixed Methods (CCMM) at Ipsos. A total of 166,318 patients were invited to participate in the survey across 134 acute and specialist NHS trusts. Completed responses were received from 62,235 patients, an adjusted response rate of 39%. Patients were eligible to participate in the survey if they were aged 16 years or over, had spent at least one night in hospital, and were not admitted to maternity or psychiatric units.

The Trust scored better than average for 17 of the 23 questions and, for the 10 sections, the Trust appeared in the Top 5 on six occasions.

Actions agreed

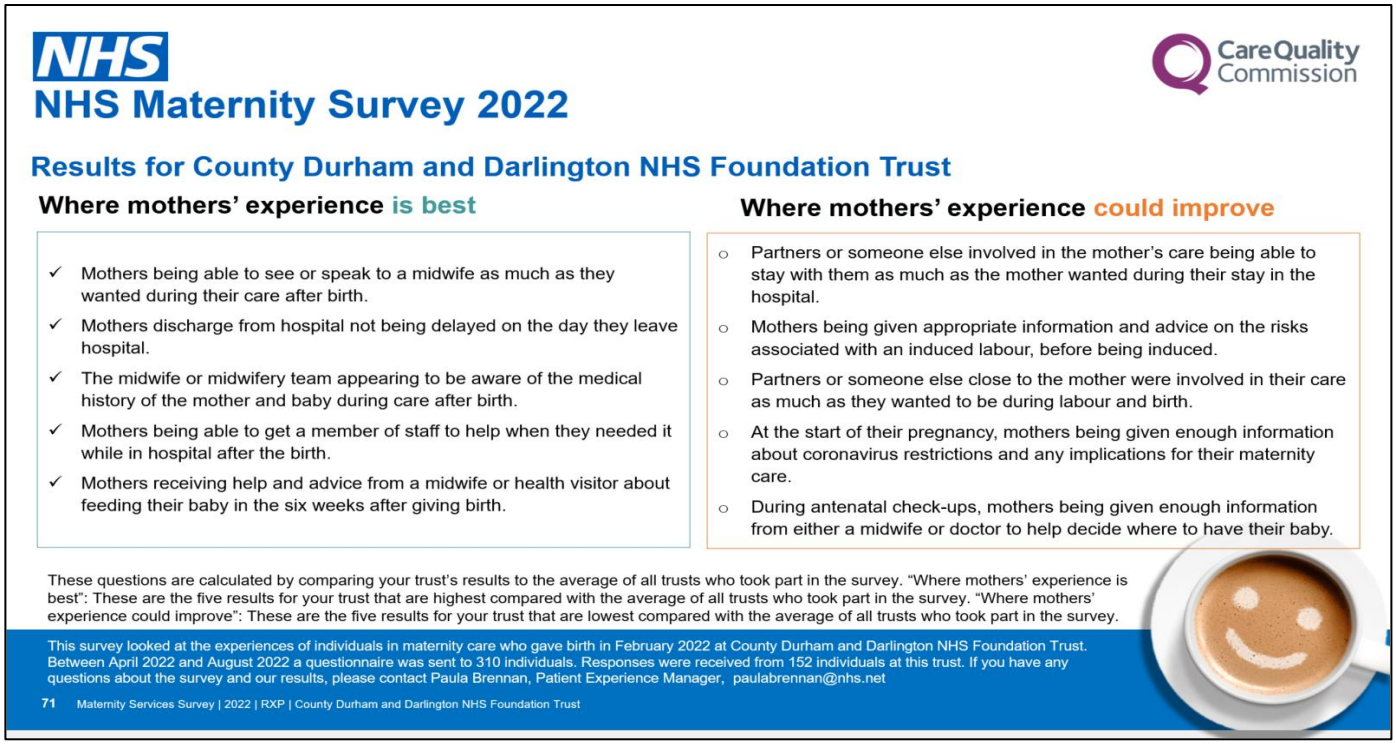
After analysis of the report there are a number of actions for consideration. We developed, and have been rolling out, an action plan covering:

- Identify those providers consistently in the 'Best 20%' from patient surveys and engage them to elicit learning
- Celebrate the successes internally from the report.
- Share the results externally, supported by the Communications Team.
- Work with wards/departments to understand obstacles with providing food outside of set meal times to understand if this can be improved.
- Work with wards/departments to raise awareness around privacy and conversations at the bedside.
- Prioritise improvements to the platforms available for patients to engage and provide feedback on the service and their experience.
- Monitor the progress quarterly through the Post Discharge Survey

CQC National Maternity Survey 2022 - Headline Summary Report

All NHS Trusts providing maternity services are required by CQC to participate in the survey. All women receiving maternity services in February 2022 were selected for the survey. There were 310 women were included in the survey and 152 responded (49%). The Patient Perspective average response rate for all 31 Trusts it surveyed was 48%. The response rate comprised three per cent of the women who delivered in our care in 2022. The average Mean Rating Score was 76.1%, slightly lower than in 2021.

We scored in the top 20% of Trusts on 7 questions and in the bottom 20% of Trusts on 14 questions out of a total of 59 questions. No questions showed at least 10% improvement on the 2021 score, and for 1 question the score was worse by 10% or more.



Action Plan co-produced with the Maternity Voices Partnership

One of the key themes from the feedback related to Induction of Labour. We are therefore undertaking a specific Induction of Labour Quality Improvement Project under the direction of the MQIF Quality and Safety Group

Challenges identified

- Lack of consistent counselling
- Variation in preferred methods cross site
- Anticipated delays
- Suitability of outpatient Induction of Labour.
- Unacceptable delays with Induction of Labour process, especially with high risk cases.
- Poor patient experience.

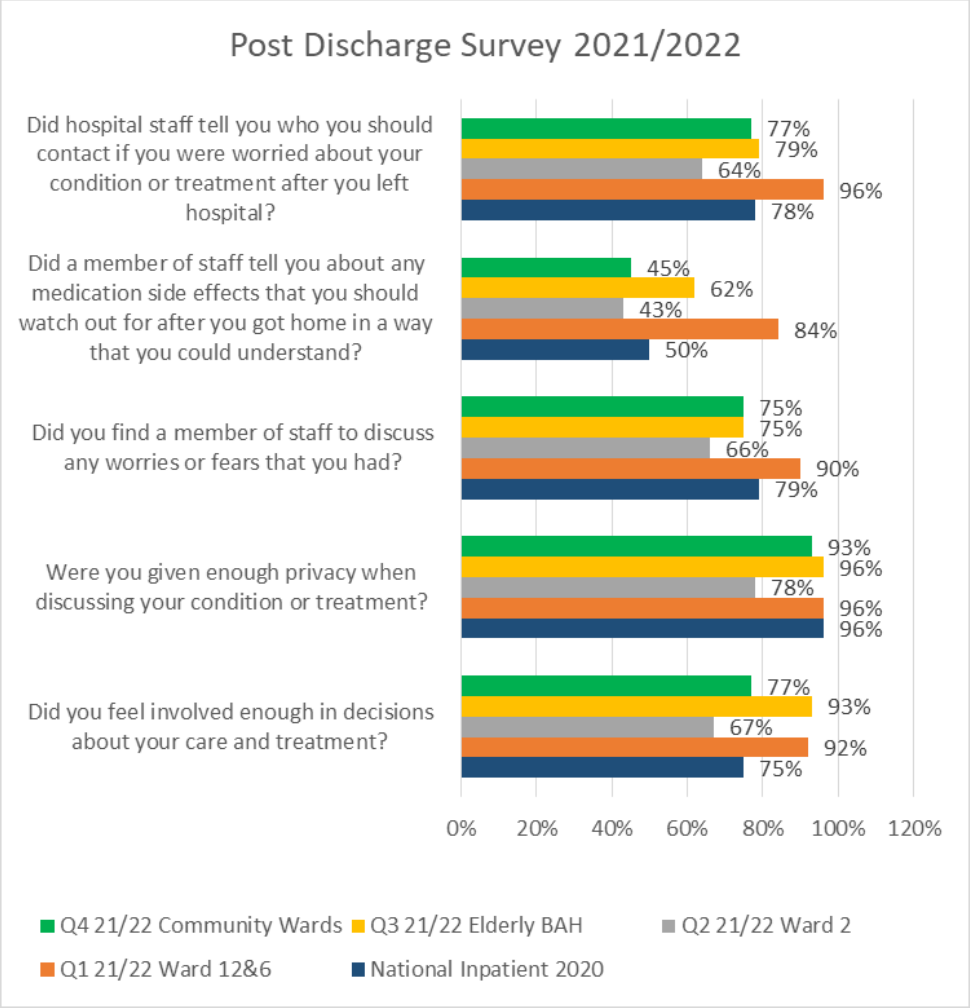
Solutions Agreed

- We have co-produced an audit tool, with the Maternity Voices Partnership, which we will use to understand more about specific women experiences.
- Separate pathway from main acute work by Induction of Labour Midwives (core team of MW who will work cross site)
- Use the IOL pro forma on BadgerNet to document IOL: reason, timeframe. Timeframe will guide the on call team if workload demands are high.
- Use the same form to document Bishop Score and Counselling provided including any anticipated delays.
- Induction of Labour leaflet on BadgerNet to be used consistently by all teams
- The service and the Communications team are to develop a video regarding Induction of Labour. This can also be signposted to the patients at the time of discussion.

Post Discharge Survey

The Trust's Post Discharge Survey was refreshed during 2021 and now runs over a quarterly cycle and 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.

The data shown is full year 2021/22. To date only Q1 and Q2 data are available for 2022/23, hence we are not able to show the full year 2022/23 data at this stage.



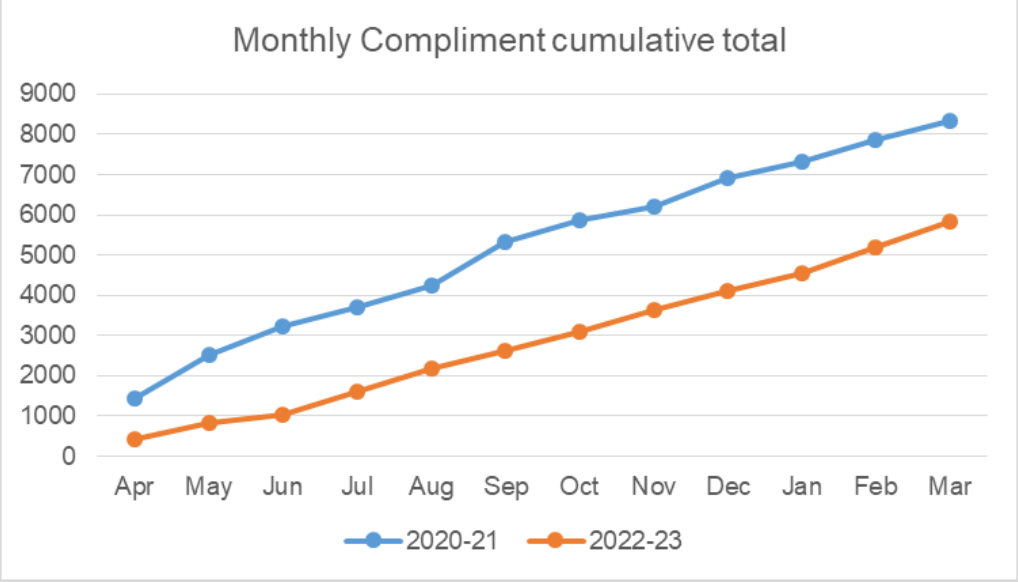
Survey results are shared with the relevant wards and local improvement plans are developed and implemented.

Carried over from the previous Quality Account 2021-2022 is ensuring a positive patient experience throughout the discharge process. The Patient Experience Team have continued to work collaboratively with Discharge Leads in the Trust to understand, agree and support the implementation of actions to drive service improvement.

Compliments

We continue to improve the way in which compliments are collated for CDDFT staff. The chart below shows that the cumulative total for compliments received for 2022-2023 remains quite low in comparison to the total for 2020/21.

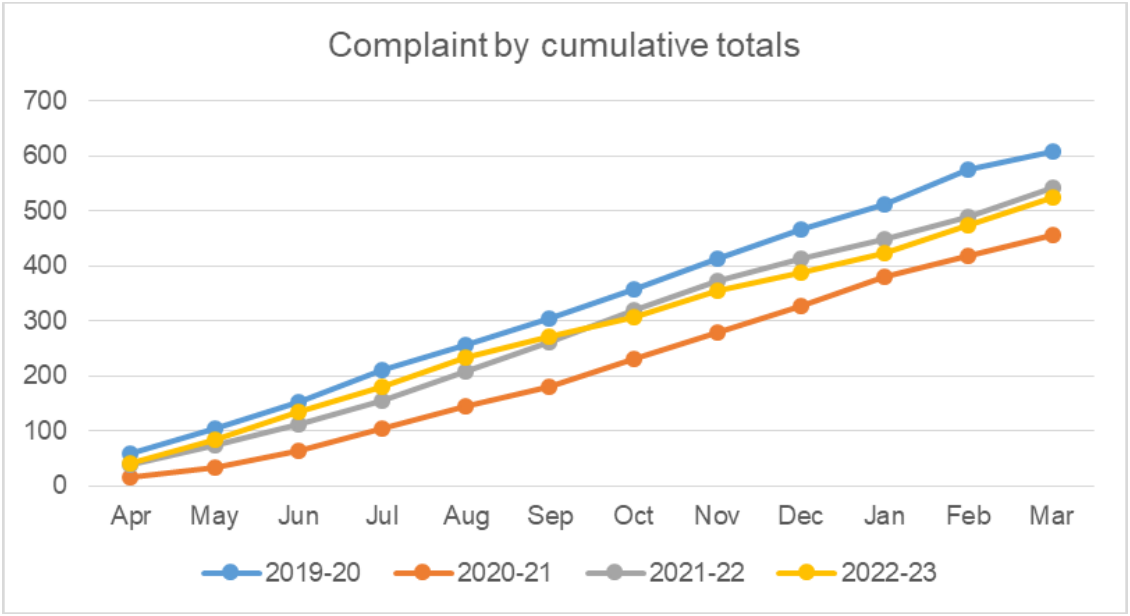
A new module for Ulysses will be implemented in the new financial year and the compliments process will be relaunched and reinvigorated.

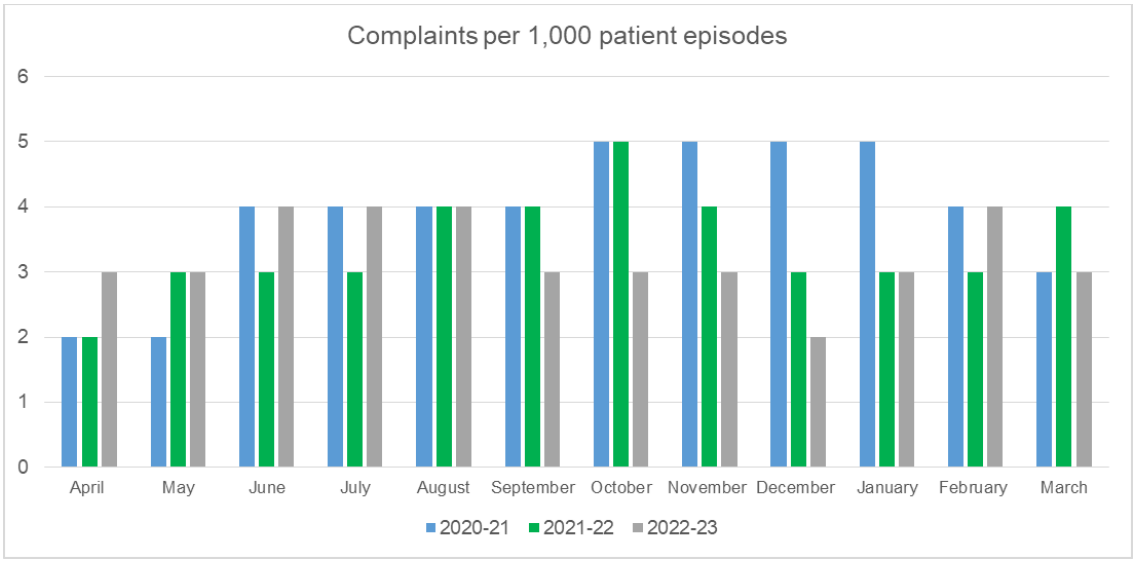


Complaints

As well as seeking to collect and learn from proactive patient feedback the Trust fully investigates, and implements learning from 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'.

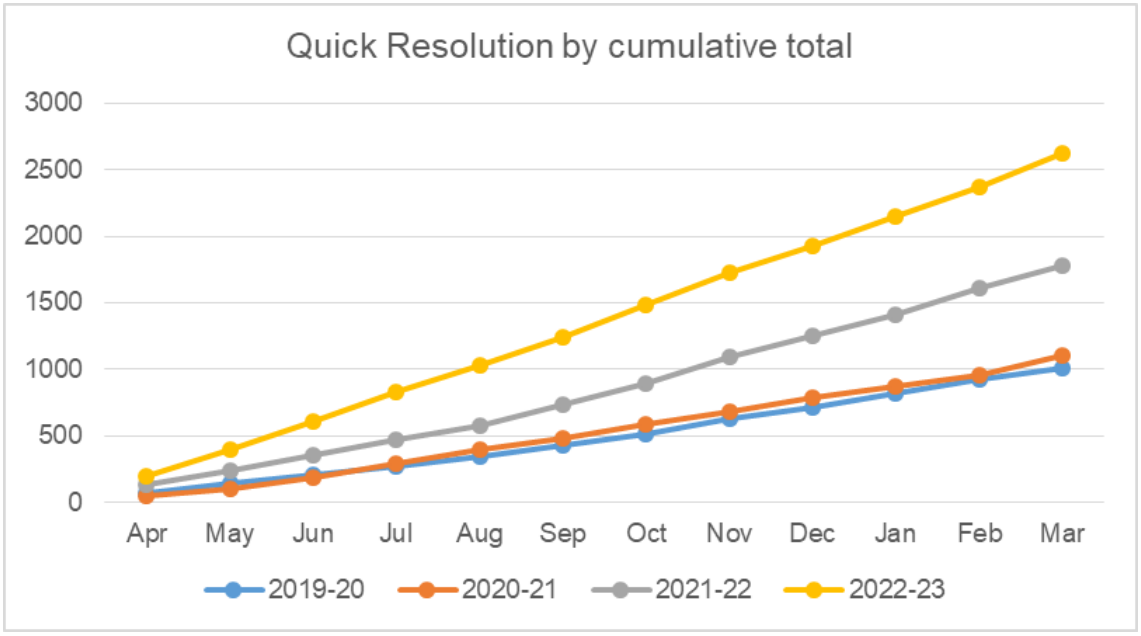
The charts below show the number of formal complaints received Trust-wide throughout 2022-23 as a cumulative total and in comparison to previous years back to 2019-20. It also shows complaints per 1,000 patient bed days so that the link between the number of complaints and activity is clear.





Quick Resolution Complaints

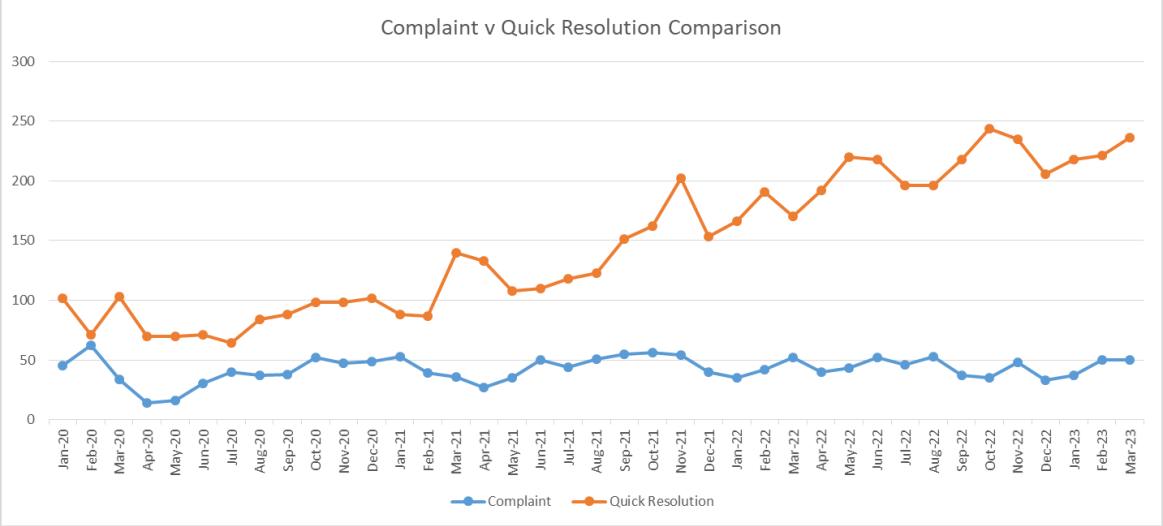
The below charts show the number of quick complaints received trust-wide throughout 2022-23 as a cumulative total and in comparison to previous years back to 2019-20, together with the number of quick resolution complaints per 1,000 patient bed days.



Complaint v quick resolution cases

The Trust participated in a national pilot exercise in 2021 which aimed to standardise the application of the national complaint framework during 2021. One of the changes made as a result of this pilot was the triage of complaints effectively to allow cases, where possible, be handled as a quick resolution case. The approach has been successful as shown in the chart overleaf.

Handling of complaints as quick resolution cases where possible has resulted in an upturn of quick resolution cases. The benefit for the complainant is that the matter is typically resolved in less than 10 days, often with a conversation where possible, whereas a formal complaint can take up to 6 months for a resolution dependent on complexity.



Learning from Experience

We have continued to use feedback from patients, in particular patient stories, to share valuable lessons to the experience of patients in our care. One recent example has resulted in the production of a video which will be used educate staff in handling the most challenging aspects of conversations around ceilings of care, and Do Not Resuscitate Orders with patients and their loved ones. The video draws on the story of a spouse who suffered from a lack of clear communication in connection.

Volunteer Service

The volunteer service at CDDFT was stood down throughout the pandemic. Prior to the pandemic we had over 200 volunteers in post. We currently have 80 volunteers in post. Through a series of recruitment events we are now increasing our volunteer pool towards previous levels focusing on roles which can maximise support to front-line services. We have also enrolled in the 'Volunteer to Career' programme sponsored by Health Education England and Helpforce, receiving £24,000 funding to secure a Band 3 additional member of the team to roll out scheme for the Trust.

The scheme aims to positively impact NHS workforce recruitment needs at a local level through the design of Volunteer to Career initiatives. NHS Organisations are supported with funding to support senior clinicians to work with volunteer service teams to design and develop specific roles to be undertaken by volunteers according to the local workforce recruitment needs.

A key measure of the success of the programme an increase in the number of volunteers who have an interest in pursuing a career in health and care after their volunteering experience. Learning from the programme will be scaled and spread through the development of resources, tools, learning, case studies and evidence-based models/initiatives developed within the projects and shared with other organisations.

During the recent volunteer recruitment sessions held in January 2023 the patient experience team have secured 46 successful applications of which 22 are potential volunteer to career candidates.

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).

Performance against the 4hour standard has remained pressured through the year. For the last quarter, the Trust has seen and treated / admitted around 70 to 73% of patients attending A&E within four hours.

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 its bed base, 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 and the national requirement to recover the long waiter position, we were, rightly, unable to do so in 2022/23.

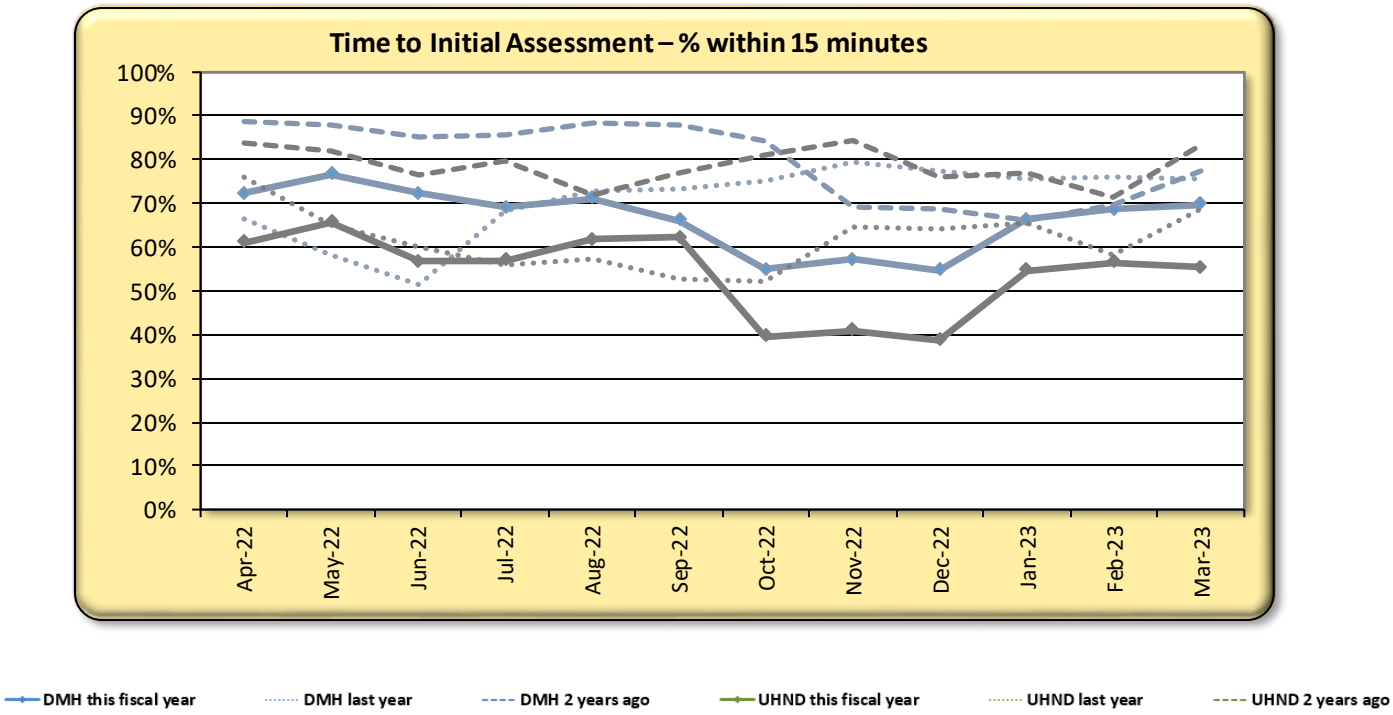
The pressures noted above were seen across the country and the Trust was not a national outlier. The North East region performed comparatively well; however, greater patient demand was a reality in County Durham which, together with the capacity limitations noted above, limited our ability to perform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

Month/Quarter	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Qtr 1 2022/23	Qtr 2 2022/23	Qtr 3 2022/23	Qtr 4 2022/23	Fiscal Year 2022/23
DMH ED attends	5,454	5,841	5,675	5,686	5,264	5,187	5,260	5,423	5,554	5,062	4,911	5,476	16,970	16,137	16,237	15,449	64,793
DMH ED 4 Hour Waits	2,432	2,100	2,564	2,733	2,686	2,564	2,975	3,090	3,250	2,853	2,607	2,921	7,096	7,983	9,315	8,381	32,775
DMH % Seen in 4 Hrs	55.41%	64.05%	54.82%	51.93%	48.97%	50.57%	43.44%	43.02%	41.48%	43.64%	46.92%	46.66%	58.19%	50.53%	42.63%	45.75%	49.42%
UHND ED attends	6,481	6,958	6,802	6,459	6,171	6,255	6,516	6,742	6,643	5,860	6,082	6,805	20,241	18,885	19,901	18,747	77,774
UHND ED 4 Hours wait	3,658	3,528	3,785	3,813	3,347	3,105	4,207	3,747	3,701	2,996	2,994	3,534	10,971	10,265	11,655	9,524	42,415
UHND % Seen in 4 Hrs	43.56%	49.30%	44.35%	40.97%	45.76%	50.36%	35.44%	44.42%	44.29%	48.87%	50.77%	48.07%	45.80%	45.64%	41.44%	49.20%	45.46%
Total ED attends - Type 1	11,935	12,799	12,477	12,145	11,435	11,442	11,776	12,165	12,197	10,922	10,993	12,281	37,211	35,022	36,138	34,196	142,567
Urgent Care Centre - Type 3 (Walk-Ins)	4,365	4,876	5,080	4,921	4,381	3,975	4,473	4,499	5,859	3,841	3,692	3,955	14,321	13,277	14,831	11,488	53,917
Urgent Care Centre - Type 3 (Booked Appointments)	3,683	4,257	4,385	4,424	3,924	3,756	4,128	5,256	6,096	5,262	6,432	6,695	12,325	12,104	15,480	18,389	58,298
Trust Over 4 hour waits	6,090	5,628	6,349	6,546	6,033	5,669	7,182	6,837	6,951	5,849	5,601	6,455	18,067	18,248	20,970	17,905	75,190
ED Only Activity % under 4 hour waits	48.97%	56.03%	49.11%	46.10%	47.24%	50.45%	39.01%	43.80%	43.01%	46.45%	49.05%	47.44%	51.45%	47.90%	41.97%	47.64%	47.26%
Reportable % under 4 hour waits (including UCC Booked from Jan '2020)	69.52%	74.34%	71.06%	69.54%	69.44%	70.43%	64.75%	68.81%	71.22%	70.79%	73.48%	71.85%	71.71%	69.79%	68.44%	72.06%	70.49%

New A&E clinical standards have been reported in shadow form since 2021/22, with focus placed on the time patients spend in the Department. The volume of patients waiting over 12 hours has fluctuated 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 and when the burden of Covid-19 and flu was significant.

Standard Month:	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Trust ED Patients spending more than 12 hours in A&E	1,435	1,042	1,376	1,349	1,297	1,140	1,905	1,878	2,614	1,543	1,056	1,244
% Trust ED Patients spending more than 12 hours in A&E	12.0%	8.1%	11.0%	11.1%	11.3%	10.0%	16.2%	15.4%	21.4%	14.1%	9.6%	10.1%

We have achieved significant reductions in patients waiting over 12 hours in the department and in patients waiting 12 hours or more for a bed, from a decision to admit, as well as in ambulance handover delays. The changes reflect some reduction in demand but also a range of process improvements. Going forward our priority is to maintain and improve performance around the time to assessment and time to treatment indicators.

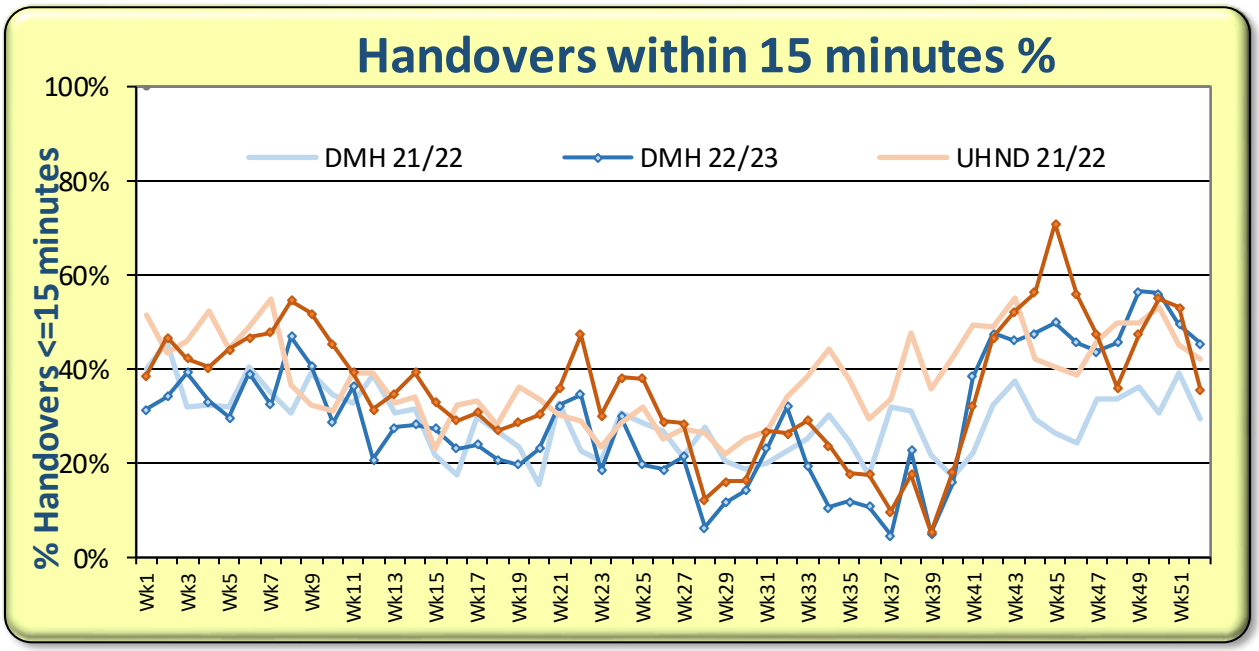


As outlined in Section 2B, reducing waiting times in our A&E Departments is a high quality improvement priority for the Trust with a number of actions planned to increase our physical and staffing capacity and to optimise our clinical pathways.

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 proportion of handovers completed within 15 minutes has varied throughout the year with lower levels experienced in October just ahead of the winter pressures period. Lower levels of performance are congruent with Covid-19 and Flu 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 December onwards, aiming to achieve arrival to clear times within 30 minutes. This improvement results directly from actions taken by the Trust, including an expansion of capacity for handover, particularly at DMH, rather than demand-led factors. It has been sustained in the first two months of 2023/24.

	Average Arrive to Clear Time (Mins)											
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Darlington Memorial A&e	39.5	39.0	44.7	50.9	54.1	57.2	83.6	64.5	143.2	45.0	28.6	27.5
Uni Hsp Of North Durham A&e	38.7	35.9	41.9	47.6	48.8	46.2	75.3	62.3	118.4	49.2	27.8	31.3

The Trust was asked to present, regionally, on the improvements made in respect of ambulance handover times and 12 hour waits for beds. Around 62% of patients were assessed within 15 minutes of arrival in the department, in February and March 2023.

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 2023/24.

Performance Summary

Recovery and restoration

During this third 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:

- Increase activity to over 104% of 2019/20 activity levels: 93.9% was achieved for April 2022 to March 2023;
- Reduce follow up activity to no more than 85% of 2019/20 activity levels: 85.3% was achieved for April 2022 to March 2023;
- Eliminate waits of over 78 weeks by March 2023: this was delivered
- Validate all patients who will be waiting 52 weeks by the end of March 2023 by 20th January 2023: this was delivered
- Hold or reduce the number of patients waiting over 52 weeks, with a plan to eliminate by March 2025: work is underway to achieve the long-term ambition, and 52 week wait volumes have been falling in the latter part of the year
- Increase the use of Advice and Guidance to 16 per 100 referrals: These requests continue to significantly exceed pre Covid-19 levels and meet the stated target
- Increase the use of Patient Initiated Follow-Up (PIFU) pathways to 5%: Plans for safe and appropriate PIFU have been rolled out in several specialties, although only around 2% of patients are moving to a PIFU pathway
- To reduce the 62 day Cancer backlog to the February 2020 level: A local target of a reduction to fewer than 132 patients was set and this has been met at times throughout the year, including at year-end. Performance against the NHS Constitution cancer standards has been strong compared to the regional position throughout the year
- To achieved the interim Faster Diagnosis Standard target of 75%.This is being routinely met
- Increase access to Diagnostics: Monthly performance has been consistently high and improving towards the temporarily relaxed national standard of 95% to seen within 6 weeks
- To increase diagnostic activity to 120% of pre-pandemic levels: Performance of approximately 110% has been achieved
- To reduce 12 hour waits to no more than 2%: this target has not been met and remains pressured
- To eliminate ambulance handovers of 60 minutes or greater: this target has not been met and, although much improved, remains pressured
- To ensure 95% of ambulance handovers take place within 30 minutes: this target has not been met and, although improved, remains pressured
- To ensure 65% of ambulance handovers take place within 15 minutes: this target has not been met and, although improved, remains pressured.

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

On receipt of the statements from Commissioners, local Healthwatch organisations and overview and scrutiny committees, a number of points for clarification and further questions were asked. We can confirm that we have provide further clarification and additional information in response to the requests received.

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

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

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

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

- the content of the quality report meets the requirements set out in the NHS foundation trust annual reporting manual 2022/23 and supporting guidance from NHSE/I on Quality Accounts 2022/23
- 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 2022 to June 2023
    - papers relating to quality reported to the board over the period April 2022 to June 2023
    - feedback from commissioners dated [TBC]
    - feedback from governors dated [TBC], [TBC]and [TBC]
    - feedback from local Healthwatch organisations dated [TBC]
    - feedback from overview and scrutiny committees dated [TBC]and [TBC]
    - the Trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated XXX Please note, the annual report for 2022-2023 is currently in development.
    - the national patient survey 2022
    - the NHS national staff survey 2022
    - the Head of Internal Audit's annual opinion of the Trust's control environment dated [TBC]
    - CQC inspection report dated 3rd December 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

[TBC] 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.

AHP – Allied Healthcare Professional

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.

Booking Bloods – Routine antenatal tests offered to all women

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.

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.

COHA – Community-Onset Healthcare Associated infection

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.

Continuity of Carer - A way of delivering maternity care so that women receive dedicated support from the same midwifery team throughout their pregnancy

Copeland's Risk Adjusted Barometer - A system which uses coded data from the Secondary Users Service (SUS) to measure the occurrence of medical triggers in inpatients as an indicator of morbidity

CQC – Care Quality Commission

Crude Mortality - Mortality from all causes in a given time interval for a given population

DMH – Darlington Memorial Hospital

ED – Emergency Department

e-Coli – Escherichia Coli, a Gram-negative bacterium

EPR – Electronic Patient Record

Fetal – From '*fetus*' - a young human being

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.

HOHA - Hospital-Onset Healthcare Associated infection

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.

Healthwatch – Independent consumer champion for health and social care

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

IPC – Infection Prevention and Control

John's Campaign (Dementia) – The offer of a unique form of support in delivering compassionate and effective patient care, for the right of people with dementia to be supported by their carers in hospital

Klebsiella sp – a Gram-negative bacteria

LADB – County Durham & Darlington Local A&E Delivery Board

LeDeR Programme – Learning Disability Mortality Review commissioned to improve standards of care for people with learning disabilities

LocSSIPs – Local Safety Standards for Invasive Procedures

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

Mortality – Death rate, the ratio of actual deaths to expected deaths

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

Nervecentre – Electronic nursing observation system

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

NHS Digital - An executive non-departmental public body, sponsored by the Department of Health and Social Care which uses information and technology to improve health and care.

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.

Nosocomial Transmission – Infections that develop as a result of a stay in hospital

NRLS - National Reporting and Learning System

Ockenden Report – by Donna Ockenden, chair of the Independent Maternity Review

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

Perfect Ward / Tendable – A quality inspection platform for healthcare settings

PGD – Patient Group Directive, used in prescribing, administration and supply of medication

PHE – Public Health England, now replaced by UKHSA (UK Health Security Agency)

PHSO – Parliamentary and Health Service Ombudsman

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

Pseudomonas ag – a Gram-negative bacteria

RAG Rating – Red, Amber Green rating system used to summarise indicator values e.g. alert, caution, on-track

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

SDEC – Same Day Emergency Care

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.

Tertiary Centre – Provider of specialist healthcare

TEWV – Tees, Esk & Wear Valley NHS Foundation Trust

This is Me Documentation - Intended to provide healthcare professionals with information about the person with dementia as an individual, to enhance the care and support given while the person is in an unfamiliar surrounding

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

UHND - University Hospital of North Durham

UKHSA – UK Health Security Agency, replacement of PHE (Public Health England)

Ulysses system – Incident reporting and management system

UNICEF (UNICEF Gold) – United Nations International Children's Emergency Fund, Gold is awarded to services that achieve full baby friendly accreditation (Gold Baby Friendly Service)

Virtual Ward – A service for treating NHS patients at home

VTE - Venous Thromboembolism

WASP Programme - Competency assessment; witnessed, assimilated, supervised and proficient