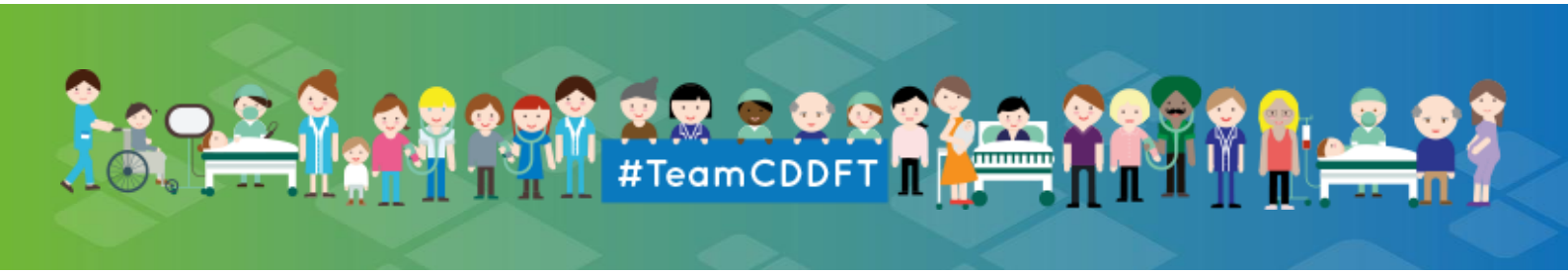


County Durham and Darlington NHS FT

QUALITY ACCOUNTS

2023 - 2024

DRAFT FOR STAKEHOLDER COMMENT

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 2023/24. It also sets out our priorities for the coming year 2024/25. Early in 2022/23 we launched our quality strategy (2022/23 - 2025/26), "Quality Matters" which supports the achievement of the Trust's vision, **Right First Time, Every Time**, and is underpinned by our core values.

We agreed quality priorities with our stakeholders which reflected both our strategic objectives, together with those objectives 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 2023/24 Quality Priorities
Part 2B	2024/25 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 yet fulfilled our ambition. Where this is the case, we are committed to taking the further actions necessary to achieve them in 2024/25.

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

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

[Draft wording – to be finalised and approved by the CEO in the final version for Board approval]

I am delighted to introduce to you our Quality Account and Quality Report for County Durham and Darlington NHS Foundation Trust for 2023/24

Once again I 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 challenging increases in activity and in the acuity of patients.

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.

During 2023/24 we:

- Implemented all of the actions we planned in order to strengthen staffing and improve our paediatric services;
- Reduced falls per 1,000 bed days overall, and in are acute settings as a result of a number of Trust-wide and local quality improvement projects.
- Strengthened our maternity services following a CQC inspection in March 2023 which rated the services on our acute sites as 'inadequate' for the safe and well-led key questions. We took action to address the issues reported by CQC, strengthening leadership, staffing, governance and clinical processes, and were pleased that CQC recognised the improvements when re-inspecting the service in January 2024, increasing the ratings for both key questions to 'requires improvement'.
- Improved systems and processes for recognising and acting on patient deterioration, to embed local safety standards for invasive procedures and the screening and treatment for patients with sepsis.
- Continued to develop training packages and support for staff to care for patients with dementia, LD and autism and – working with partner agencies – improved training, care pathways and the safety of the environments in which we care for children and young people with physical and mental ill-health.
- Consolidated our End of Life care service rated outstanding by CQC.
- Further strengthened multi-agency arrangements to support timely discharge of patients to appropriate settings.
- Used our EPR system to improve, and achieve high rates of, compliance with completion of patient risk assessments and timely recording of patient observations, including assessments supporting nutrition and hydration.
- Consolidated our acute kidney injury nursing specialist service and rolled out quality improvement initiatives focusing on patient hydration.

- Improved our performance on A&E waiting times, achieving the national target to see and treat more than 76% of patients within four years by the year end, reduced ambulance handover delays and implemented a range of further improvements.
- Reduced waiting list backlogs, with no patients waiting over 65 weeks by the year end and met national targets with respect to reducing backlogs for cancer patients and exceeded national targets for faster cancer diagnosis.

We have more to do, however, to ensure that we sustain the improvements outlined above and, in particular to:

- Meet our zero tolerance for Category 3 and 4 pressure ulcers.
- Meet our zero tolerance for cases of MRSA, having reported eight cases in the year making us a regional outlier, and to meet nationally-mandated thresholds for other healthcare associated infections designed to show year on year improvement.
- Ensure timely escalation and action on signs of patient deterioration.
- Ensure that IV treatment and the taking of blood cultures for patients with suspected sepsis is timely.
- Check and ensure compliance with the use of local safety standards for invasive procedures.
- Ensure that nutrition assessments are always completed in line with policy
- Improve the end to end flow of patients from admission to discharge, in order to sustain and further improve A&E waiting times improvements.

We have ongoing Trust-wide quality improvement work in each of these areas, captured within our plans for 2024/25.

As we move into 2024/25 we will continue to focus on, and target improvements, in those areas where we have not achieved our ambitions. We will also continue to work with our NHS partners, including the regional clinical networks, to improve services for patients; for example, we have recently welcomed a review of our breast surgery services led by the Northern Cancer Alliance and await their recommendations.

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 2023

Part 2a: Review of 2023/24 Quality Priorities

The following section of the report sets out our performance with respect to each of the quality priorities we set for 2023/24. Wherever available, historical data is included so that our performance can be seen over time.

Summary of 2023/24 Quality Priorities

Safety	Experience	Effectiveness
Quality Strategy Priorities		
Reduce the harm from inpatient falls (↑)	Provide a positive experience for those in our care 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 (↑)	
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)

Key to RAG-ratings:

	On track to deliver improvements expected of the life of the Quality Matters strategy		Improvement have been made; however, there remains some further work needed during the four-year strategy to meet the objective.
	Broadly on track, with some consolidation of improvements needed.		Off track with remedial work needed

The up and down arrows indicate whether there has been improvement (upward arrow) or deterioration (downward arrow) on prior years.

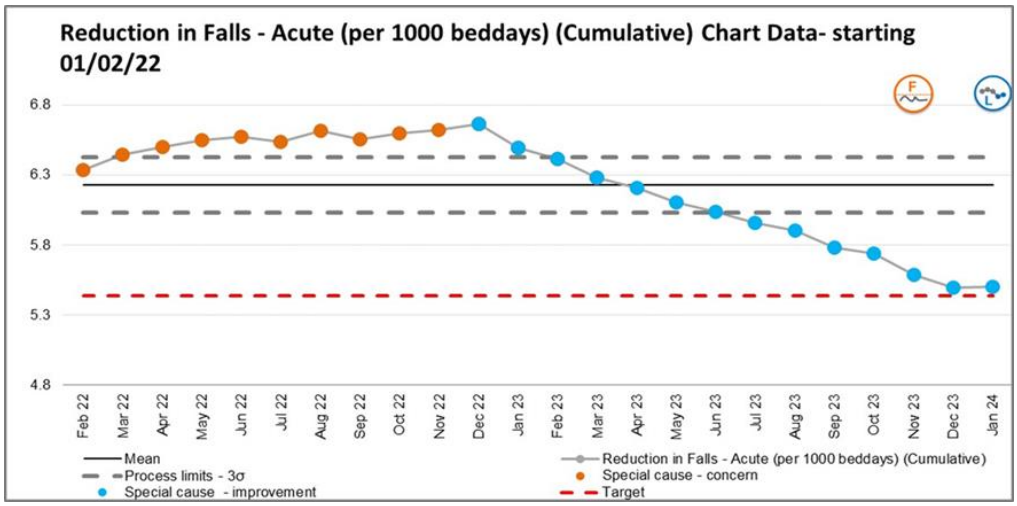
We deliberately set ourselves stretching objectives – to drive meaningful and long-term quality improvement - and, whilst we continue to see significant improvement and success in achieving some of our goals, it is acknowledged that, for some, we have not fulfilled our ambition. Where this is the case, we are committed to taking the further actions necessary to achieve them in 2024/25, with further detail of our plans set out in Part 2B of this document.

Patient Safety

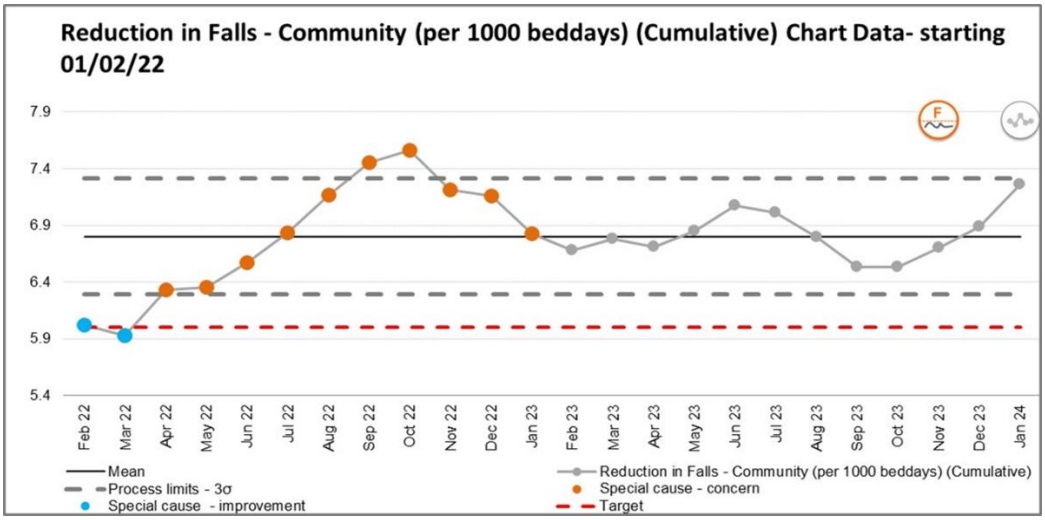
Reducing harm from inpatient falls

Broadly on track (↑)

This year has seen a sustained and significant reduction in falls related to activity across our acute hospitals. The chart below shows the trend in the rolling 12 month average number of falls per 1,000 bed days.



The trend in community hospitals is more flat, with an increase over the winter period noted. It is important to note that our community hospitals take a wider range of patients than previously – many with greater acuity or confusion – and operate, often with higher numbers of beds open.



The Falls Team has continued to use a rapid review tool to guide local actions and wider quality improvement projects to develop practice and knowledge in relation to falls prevention.

The team has undertaken 48 rapid reviews where a patient has suffered moderate or greater harm as a result of the fall. All fractures, head injuries and deaths are subject to a rapid review. If there are wider concerns, or learning identified that is not associated with the fall, then a Level 1 Patient Safety Incident Investigation (PSII) may be considered. In 2023/24 there was one Level 1 investigation undertaken into harm as a direct result of a fall.

The Patient Safety Matron (Falls Lead) and Falls Charge Nurse continue to work closely with all inpatient areas to support learning from incidents and assist staff in undertaking quality improvement projects focused on falls prevention and treatment. This year, the Falls Team has recorded 204 separate quality improvement / educational interventions with frontline staff.

These interventions have included;

- Consolidating our use of functionality in our Electronic Patient Record (EPR) to drive falls risk assessments, care planning and "intentional rounding", an activity which involves increased monitoring of a patient or bay by nursing staff. As part of this work we have re-designed the way in which the system captures intentional roundings based on feedback from ward staff and findings from rapid reviews;
- Developing and rolling out simulation-based training covering multiple falls-based scenarios;
- Helping wards to develop falls information boards; with mapping exercises for slips, trips and falls, and to develop key performance indicators in respect of falls;
- Celebrating success and examples of good practice including issuing excellence reports where notable practice has been observed;
- Undertaking visits to community hospitals to provide support, education and advice;
- Developing and sharing printed resources (screen shots) to prompt correct recording of falls prevention within EPR;
- Development of a network of over 100 'safe mobility champions' to share and promote good practice to reduce the risk of falls in walls and teams;
- 'See Yellow, Think Falls' project in emergency departments;
- Partnership working with community physiotherapy teams;
- Partnership working with back care team in relation to safe recovery of patients from the floor following a fall;
- Helping to implement the recommendations of a National Patient Safety Alert highlighting the risk of entrapment and falls from medical beds, bed rails, bed grab handles and lateral turning devices.
- Presenting on falls risks and improvement actions widely within the Trust and our local communities, including:
    - The 'MELISSA Bus' for International Patient Safety Day (**MELISSA** is a mobile training and simulation **bus** based in the North of England);
    - The 24th International Conference on Falls & Postural Stability - British Geriatric Society
    - A regional 'IMPACT' event - Care Homes Collaboration Event with Community Partners
    - CDDFT's International Nurses Day, Matron's Forum and Sister's Away Days.
    - Induction training days for internationally-qualified nurses and junior doctors.

Our Falls Committee has meet every quarter, to monitor trends, share good practice and agree further actions where necessary. The work of this Committee is overseen by the Trust's Safety Committee. Trends, action plans and outcomes are scrutinised by the Board's Integrated Quality and Assurance Committee.

An example Falls Information Board

Reducing harm from healthcare associated infections (HCAIs)

Not on track

Our 2023/24 ambition was to have no reports cases of MRSA and to maintain infection rates within the thresholds mandated by NHS England, or internally. We did not achieve our ambition, reporting eight cases of MRSA and breaching all of the nationally-set thresholds.

We have reported the outcomes for each healthcare-acquired infection below. It is important to understand that NHS England allocates thresholds to trusts based on historical performance, to encourage continuous improvement. Over the long-term we have reduced infection rates and the thresholds set are therefore challenging, particularly in the context of increasing activity and the regional and national trends noted below. Nonetheless, our ambition is to continuously reduce our infection rates and, therefore, to meet the thresholds set.

Trusts are able to compare infection rates per 100,000 bed days. Using this measure, the Trust is an outlier with respect to our rate of MRSA infections; however, our C-Diff rates are in line with the regional average, and better (lower) than the national average. Nationally, C-Diff rates are increasing. Our rates for other types of healthcare associated infections – MSSA, pseudomonas, klebsiella and E coli are the second lowest in the region.

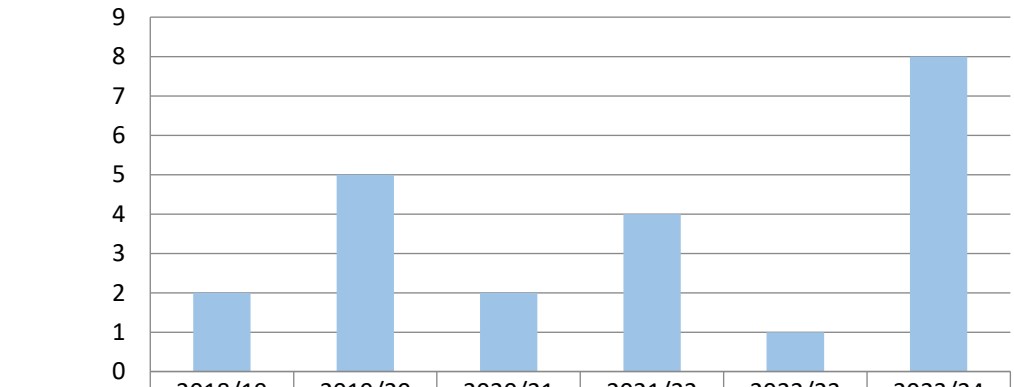
All HCAIs are subject to a rapid review commenced by the Infection Prevention and Control (IPC) team to identify any areas of good practice and any remedial or improvement actions. The IPC team then supports the relevant clinical team as required and is able to identify and track themes to share organisationally.

The charts below demonstrate the Trust's position for 2023/24 against nationally-mandated and local thresholds.

MRSA Bacteraemia

We reported 8 cases of MRSA Bacteraemia against NHSE threshold of zero avoidable infections. Arresting this trend has been a key focus for the Trust's Infection Control and Quality Committees.

County Durham and Darlington NHS Foundation Trust.
MRSA Bacteraemia Trust Apportioned cases.
2018/19 - 2023/24

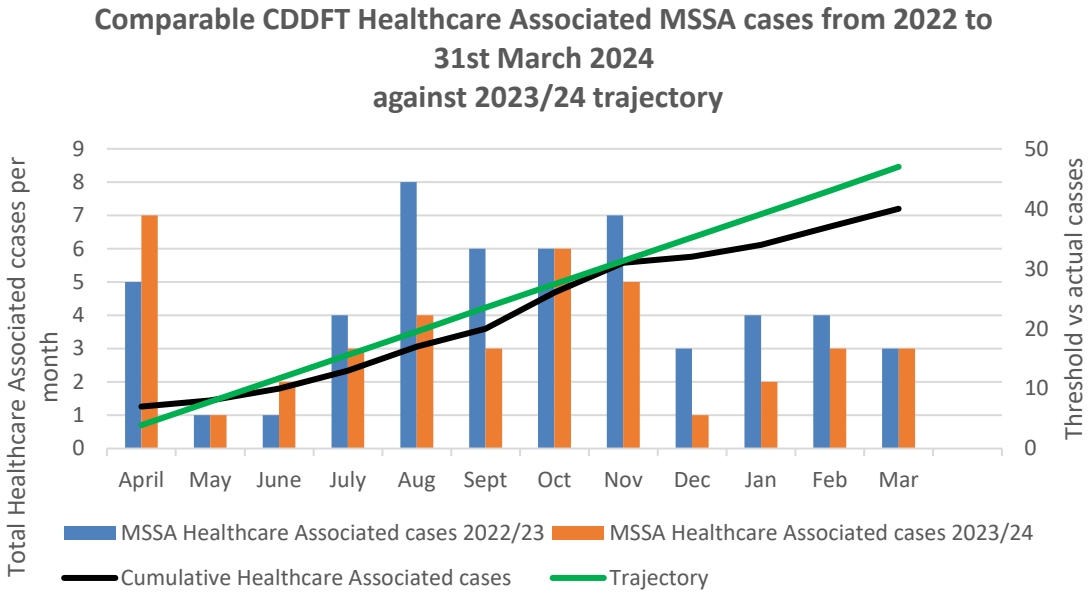


	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Actual	2	5	2	4	1	8
Thershold	0	0	0	0	0	0

Key themes from the cases reported concerned the need to improve cannulation, and reduce catheter-associated urinary tract infections, as well as the need to reinforce practice for screening and de-colonisation. Key messages have been issued to clinical and nursing leads and training provided, with further actions included in the IPC work programme for 2024/25.

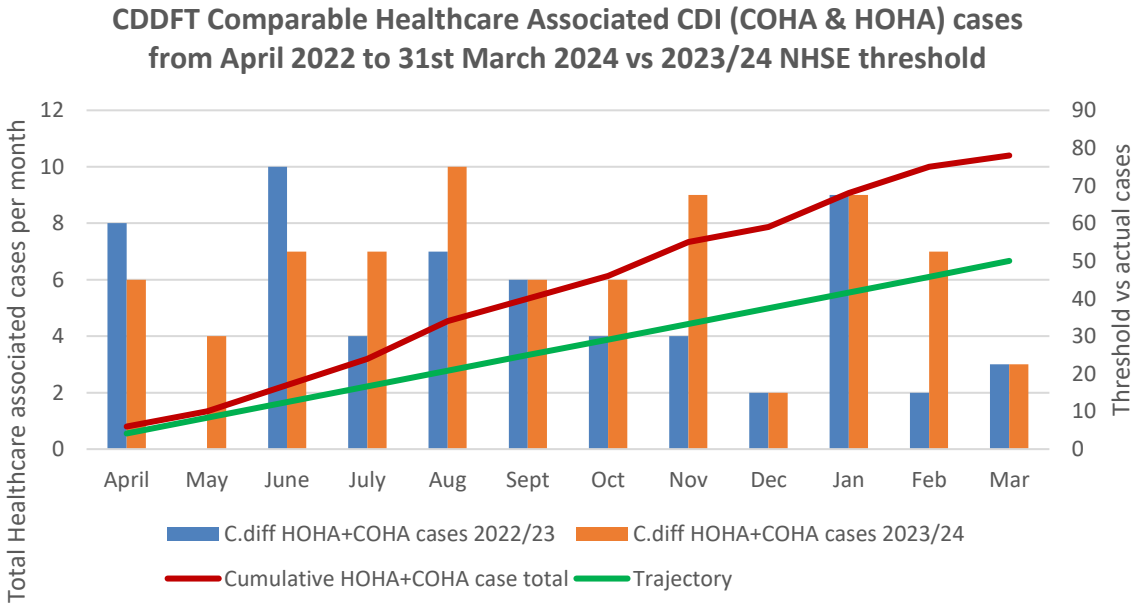
MSSA Bacteraemia

A stretching self-imposed threshold of 47 cases of MSSA was agreed through the Trust's Infection Control Committee. We reported 40 Healthcare Associated MSSA cases. This was a 23% reduction on the previous financial year.



Clostridioides difficile Infection (C-Diff)

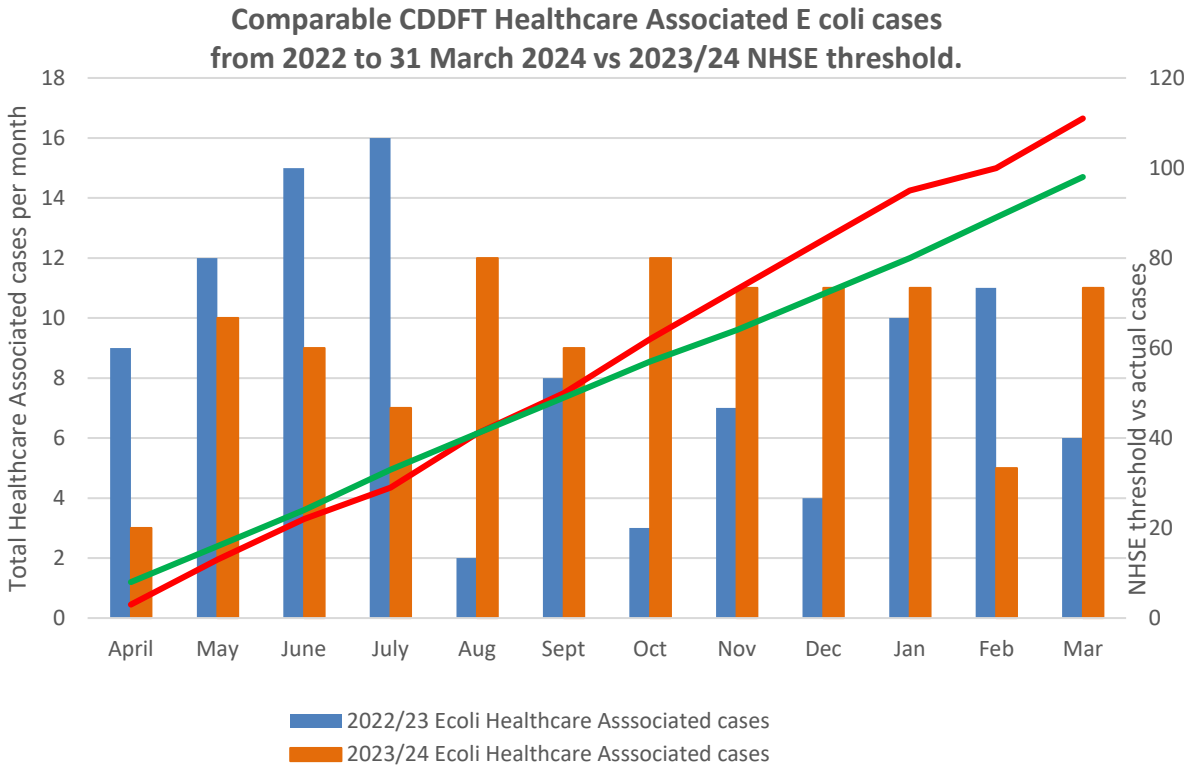
We reported 78 cases, which is a 28% increase from the previous financial year and above the NHS England threshold of 50 cases. Of the 78 cases, 48 were hospital onset healthcare associated (HOHA) infections and 30 were community onset healthcare associated infections (COHA). The increasing trend in C-Diff is a national picture which is replicated in the region. Reinforcement of measures to mitigate the risk of patients developing C-Diff has, however, been a second priority for our Infection Control and Quality Committees.



Key actions taken have been to reinforce compliance with hand hygiene, commode cleanliness and with detection of the infection through stool sampling and isolation of patients. In addition, monitoring data has been shared with clinical teams to support good practice in the prescribing and administration of antibiotics. Further actions are include in our IPC work programme for 2024/25.

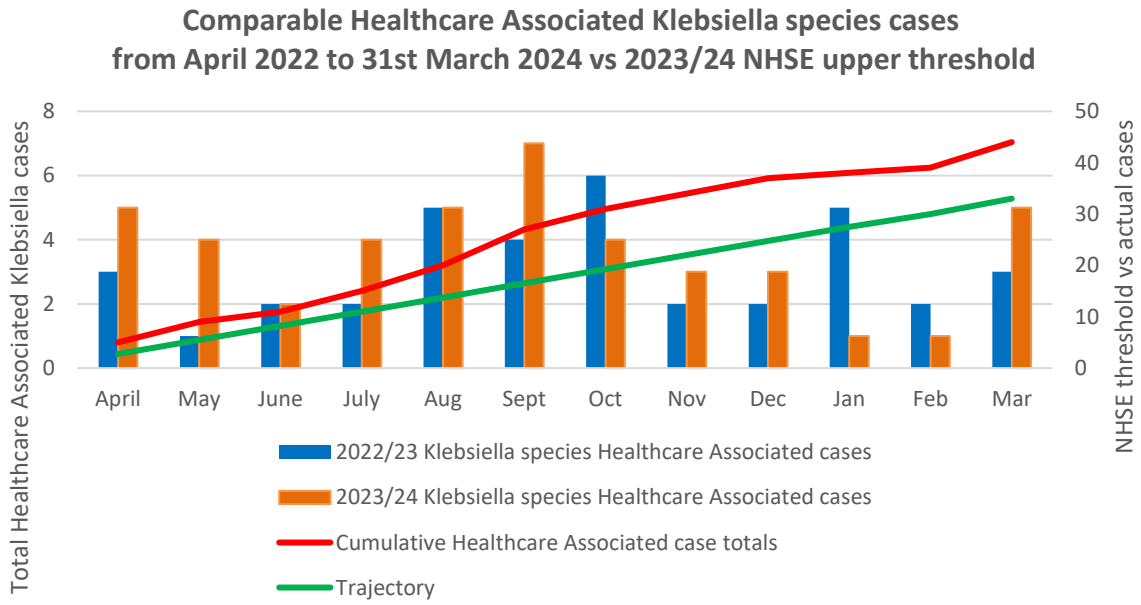
E coli

In 2023/24 CDDFT reported 111 Healthcare Associated E.coli cases against NHSE annual threshold of 98. This was a 6.7% increase on the previous financial year.



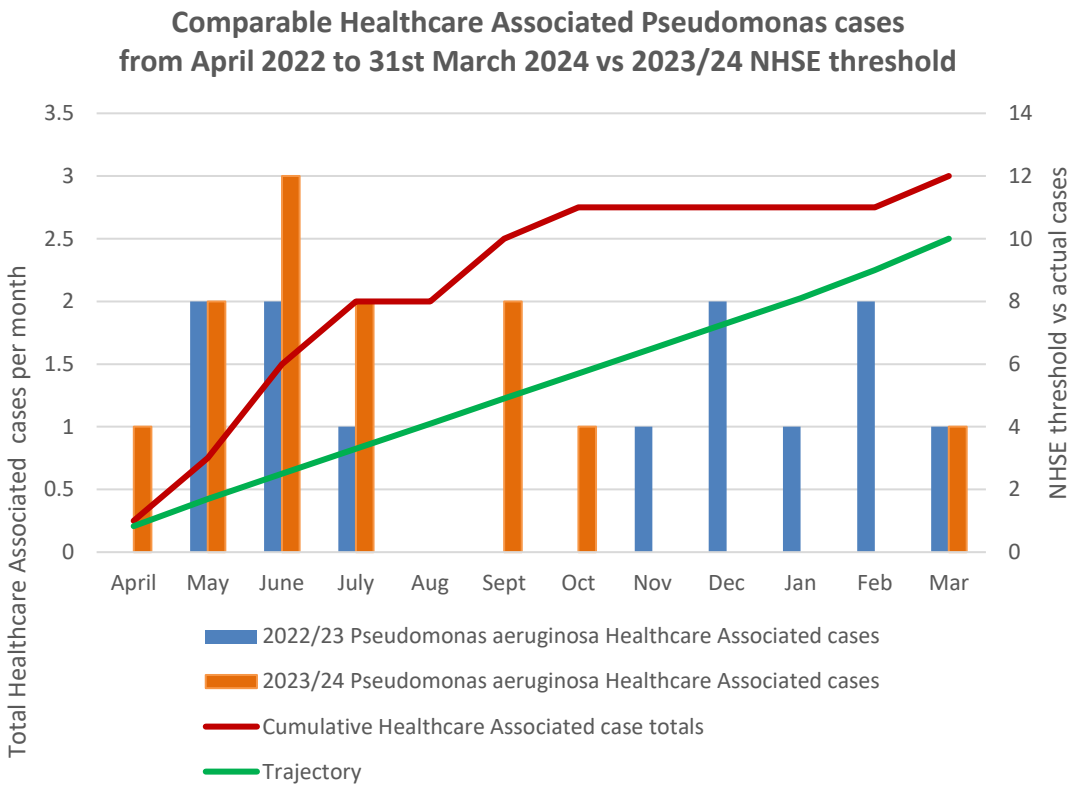
Klebsiella sp

In2023/24, the Trust reported 44 Healthcare Associated Klebsiella against NHSE threshold of 41. This was a 16% increase on the previous financial year.



Pseudomonas

In 2023/24 CDDFT reported 12 healthcare associated pseudomonas cases against NHSE trajectory of 10. Although this is 2 cases above the threshold, this is in line with the 12 cases reported in 2022/23.



Other matters and overall actions

The monitoring of Covid-19 continued during 2023/24 and confirmed cases reported in line with national guidance. We saw a 37% reduction in the declaration of Covid-19 outbreaks and a reduction seen in all reporting categories. The success of the vaccination programme and development of immunity for those previously infected which will have continued to the overall reduction.

We completed the upgrade of the water infrastructure at DMH, which was being undertaken in response to the presence of legionella in the water supply. Restrictions previously in place, such as the closure of the birthing pool, to keep patients and staff safe, have been lifted.

We have seen outbreaks of Carbapenamase-Producing Enterobacterales at DMH, as a result of which we have:

- Taken advice from the UK Health Security Agency and other experts
- Deep cleaned bays and a whole ward
- Decontaminated drains
- Introduced an enhanced screening regime
- Commenced replacement of handwashing facilities and the upgrade of a sluice.

A two-year refresh of the clinical environments at DMH is taking place with a budget of around £2m.

In the light of the adverse trends noted above in infection rates our Medical and Nursing Directors are writing to all staff to re-emphasise the importance of effective infection control and we are, from June 2024, reinvigorating two-weekly meetings of our healthcare associated infection reduction group, which will be chaired by a Deputy Medical Director.

Reducing harm from Category 3 and 4 pressure ulcers

The Trust has a zero tolerance for Category 3 and 4 pressure ulcers involving lapses in care. During 2023/24 we reported one Category 4 pressure ulcer and two Category 3 pressure ulcers investigated which have identified lapses in care.

The Category 4 pressure ulcer (PU) occurred in a community hospital and was a complex case with the patient suffering multiple comorbidities. The review panel and Community Hospitals Matron reviewed the incident including the patient records and agreed that there were no lapses in care that would have prevented the wound from developing due to patient preference. It was noted, however, that there were formal risk assessments were not always documented.

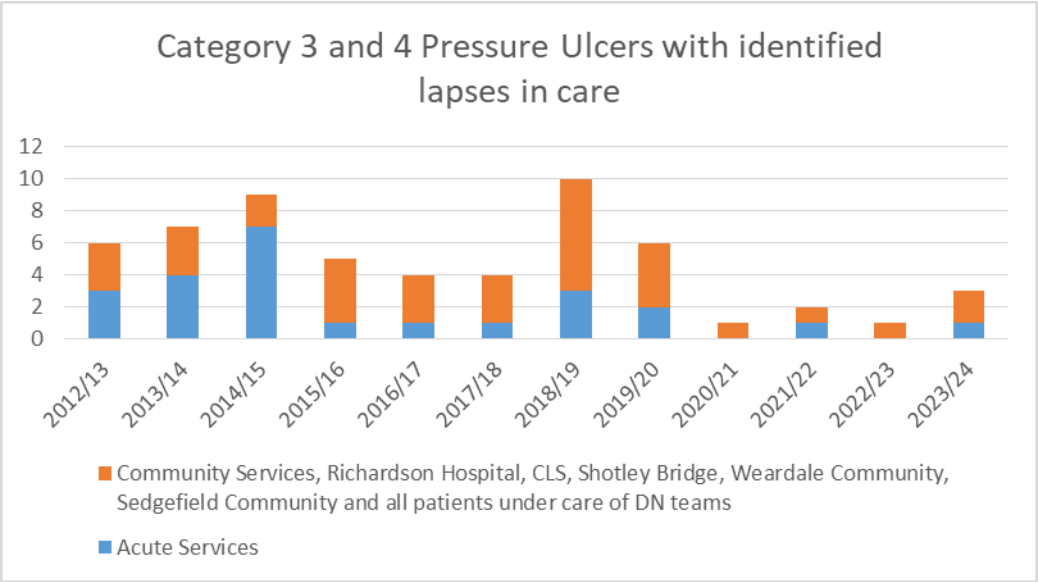
We identified that an absence of formal documented risk assessments and skin inspections, and communication failure between specialities were all contributory factors in respect of the two Category 3 Pressure Ulcers.

Pressure Ulcer (PU) prevention remains a high priority for our health professionals in all settings. While PU incidence is expected to rise given the ageing population in the UK and Europe, they can occur in people of any age. We therefore work hard to ensure that all our practitioners know about the causes and consequences of PUs and are aware of up-to-date guidance on the prevention and management in patients who have developed a PU or who are at risk of developing a PU.

We undertake rapid reviews of all Grade 3 and 4 ulcers which occur in our care. These 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 (TV) Team with any thematic learning disseminated. Our care groups are provided with quarterly reports detailing findings and actions taken.

The TV team continues to focus on providing education and support to front-line teams, with particular emphasis on PU prevention and the correct categorisation of ulcers. We have a network of Wound Resource Educational Nurses (WRENS), that work in both our acute and community services and we have been successful in launching an equivalent role for our HCA staff, which covers basic skin care and prevention. Over the last year a number of pathways and protocols have been developed by the TV team to support nursing staff in relation to good skin care and correct pressure relief surface selection. We have also seen the introduction of a Haematoma pathway and Acute TV referral criteria. The TV Team's intranet page now provides a multitude of resources and links to support wound care and prevention in practice.

The below graph shows the long-term trend for Category 3 and 4 pressure ulcers in the Trust:


Category 3 and 4 Pressure Ulcers with identified lapses in care
12
10
8
6
4
2
0
2012/13
2013/14
2014/15
2015/16
2016/17
2017/18
2018/19
2019/20
2020/21
2021/22
2022/23
2023/24
Community Services, Richardson Hospital, CLS, Shotley Bridge, Weardale Community, Sedgefield Community and all patients under care of DN teams
Acute Services

Maternity Standards including Ockenden recommendations

In March 2023, CQC undertook a focused inspection of the safe and well-led key questions for the maternity services delivered in our acute hospitals. Following the inspection the CQC issued the Trust with a Section 29A Warning Notice, requiring improvements to the quality of care in the areas inspected. These included:

- Improving staffing and ensuring resilience in staffing rotas.
- Implementing an evidence-based triage process for those attending our Pregnancy Assessment Units.
- Reducing delays to inductions of labour.
- Improving antenatal and new-born screening, risk assessments, recording and escalation of maternal observations and foetal heart monitoring.
- Increasing access to NICE-recommended equipment for foetal heart monitoring.
- Strengthening clinical governance, including: learning from incidents, improving clinical audit processes, and enhancing the reliability of benchmarking and reporting.
- Greater involvement of service users in learning when things go wrong.
- Ensuring compliance with essential training requirements.

The final CQC rating for both the safe and well-led key questions, for both our acute maternity units was "Inadequate". Actions to improve care in the areas covered in the warning notice were implemented immediately, and additional actions from the final report thereafter. Continuous monitoring and audit programmes were put in place to ensure that improvements were embedded and additional equipment sourced and deployed where necessary. We have also strengthened our relationship with the Local Maternity and Neonatal System, in particular within the aspect of neonatal care.

Support was received from midwifery specialists from the North East and North Cumbria Integrated Care Board to help us identify and implement improvements.

CQC undertook an unannounced inspection at the end of January 2024 to assess whether the improvements required had been implemented. CQC noted in their press release which accompanied the publishing of the re-inspection findings that *"staff had clearly worked hard since our previous inspection to improve the quality of care they were delivering to people, and they know where further improvements are needed so people receive the high standard of care they deserve…."*

The table below summarises the improvement in service and hospital ratings following the publication of the re-inspection findings.

	DMH MATERNITY	UHND MATERNITY
Safe	Requires improvement ● ↑	Requires improvement ● ↑
Well Led	Requires improvement ● ↑	Requires improvement ● ↑

The remaining 'Must Do' actions identified from the CQC re-inspection findings are:

- Consolidating improvements staffing;
- Further embedding the triage model in the PAUs;
- Embedding changes and improvements in governance;
- Consolidating improvements in compliance with mandatory training; and
- Ensuring full completion of equipment, environmental and medicines checks.

These actions will be taken forward by our new Director of Midwifery, who commenced in post in February 2024. We have strengthened the leadership structure for the service, ensuring that we have a Head of Midwifery for each site and appointing a dedicated Quality and Governance Matron.

The key challenge for our services, with respect to CQC, implementation of essential Ockenden actions and the Maternity Incentive scheme, remains staffing. The accepted model for midwifery staffing is known as Birth Rate Plus. Our maternity service was reviewed independently by the national Birth Rate Plus team during 2023, following which we have implemented dedicated acute and community midwifery teams. The staffing model in our acute units now follows Birth Rate Plus recommendations and the Trust Board agreed to enhanced staffing levels (over and above Birth Rate plus recommendations) for our community services to enable our teams to continue to support families locally.

Birth Rate Plus required substantial increases to the staffing in our acute units, which has partly been achieved through recruitment of graduate and internationally-qualified midwives and the voluntary transfer of a number of midwives based in the community to our acute sites. Our fill rates have increased over the last quarter of 2023/24 and, alongside the enhanced leadership, have led to improved resilience in rotas, reduced delays to induction of labour and fewer staffing incidents. Our labour ward coordinators are able to remain supernumerary for the majority of shifts. Nonetheless, we continue to run with a number of vacancies on each site. We are therefore proactively recruiting for experienced midwives and have already made offers to undergraduate midwives for the September 2024 in-take. We have also agreed to establish further specialist roles in our midwifery teams and are recruiting specialist midwives for Bereavement Support and Diabetes.

Staffing within our community services teams also remains challenged, with recruitment taking place to fill vacancies. Our Home Birth service remains suspended, until such time as we have sufficient, fully trained staff to provide it safely. We fully understand the impact of this suspension on patient choice and the distress which may be caused and are committed to reinstating the service as soon as we can safely provide it.

In February 2024, we opened a Bereavement Suite at UHND for families suffering pregnancy loss was opened in February 2024. We now plan to develop a similar facility for DMH.

We implemented our “maternity matters” staff engagement strategy, which focuses on team wellbeing, culture and ways of working in support of high quality care. Staff engagement has been delivered via:

- Face to Face meetings
- Regular bulletins vis email
- Maternity Bitesize, a weekly meeting which is recorded in Teams for those unable to attend which has delivered a variety of topics.

In November 2023, the Trust was subject to a regional peer review visit seeking assurance with respect to the essential actions from the national Ockenden inquiry. The visit flagged improvements needed to our neonatal transitional care, and the configuration of our neonatal unit at Durham. Interim improvements were enacted immediately and longer-term improvements will be implemented in 2024/25. Neonatal transitional care supports resident mothers as primary care providers for their babies where their care requirements are in excess of normal new-born care, but not sufficient to require admission to a neonatal unit.

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

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 implemented robust monitoring, auditing and governance procedures to provide assurance that our new LocSSIPs policy is followed.

Our goal for the year was to continue 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. Early in the year we audited compliance with LocSSIPs across our services and found variable compliance, including a number of requirements needing further embedding. A Task and Finish Group was therefore set up and the following actions completed:

- We introduced a CDDFT LocSSIPs Policy and Standard Operating Procedure;
- We updated our internet and intranet sites to improve document management and ensure that correct versions are available,
- We completed an audit of the use of each LocSSIP document and shared the results for action in each relevant department.

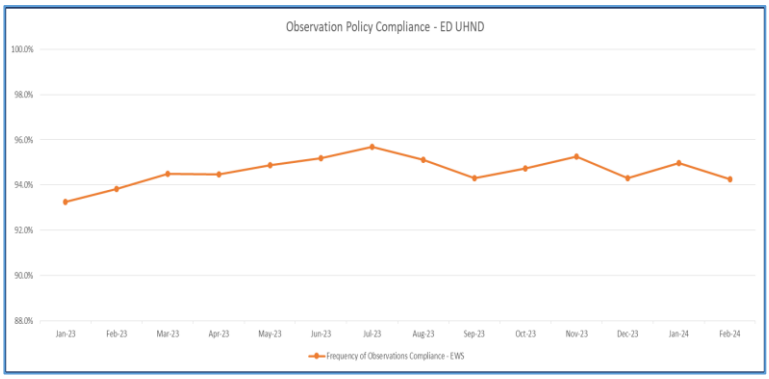
The LocSSIPs Task and Finish group has: continued to support the development of new LocSSIPs; ensures trainings is delivered within the Trust; and reviews audit results and action plans; and provides service improvement recommendations where required. A re-audit is planned for Quarter 1, 2024/25 to determine whether the expected improvements have been made.

In 2024/25 the LocSSIPs Task and Finish group will focus on the further development of migrating all LocSSIPs into our EPR system, thereby removing paper copies from the process, enhancing audit functionality and improving compliance.

Embedding prompt recognition and action on signs of patient deterioration

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, '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.

During 2023/24 we introduced functionality in our electronic patient record system to help staff identify and act on signs of patient deterioration and we sought to embed this practice in 2023-24. Using this functionality ward managers and staff at all levels are able to monitor completion of patient risk assessments and the taking of observations in real-time and we have seen continuous improvement in compliance over the course of the year. The chart below shows over 90% compliance for taking observations in our A&E Department at UHND, for example.



It is important, however, that the system design and functionality meets the needs of our clinical teams. Further work is planned for 2024-24 exploring the use of a system called Vocera to act as a communication device for Clinicians, replacing the need for a mobile phone and enabling 'one device to serve all' meaning that teams will only need to rely on one handheld device in their pocket for alerting, escalation, responding and communicating patients of concern.

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. The deteriorating patient education programme ensures that all registered Nurses, AHP's and Healthcare Assistants receive deteriorating patient training every two years. We are meeting the target for over 85% of staff to be trained through this programme. Education is completed with the Consultants alongside specialist palliative care training on a two year rolling programme. Further progress is required to ensure that the compliance with this training is above the 85% standard as the current compliance rate is 72%. The Cardiac Arrest Prevention (CAP) team (who deliver this education programme) have increased their capacity to deliver resuscitation training courses following a period of reduced programmes in 2020 – 2022 due to the pandemic.

The introduction of "Call for Concern, C4C", 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. On receipt of a call, the Acute Intervention Team works 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. In 2023-24 a scoping exercise has been completed and a business case written to explore how can implement the C4C service across the community hospitals as well as the acute sites.

Recently the introduction of 'Martha's rule' has welcomed expressions of interest from NHS Trusts to NHS England to act as pilot sites. In essence, Martha's Rule provides for patients and those close to them to request a second review if they are concerned, which is catered for by C4C. Although we already have C4C in place, we have nonetheless submitted our interest, as we want to focus on ensuring that we understand any concerns or worries voiced by the patient or their relative on a daily basis as part of our on-going care and treatment.

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.

Improving the management of patients with sepsis

Partially met (↑)

Our aim for the year was to improve the recognition and management of sepsis Trust-wide and, in particular, the provision of timely treatment including antibiotics.

Training in, and optimisation of, our EPR system to support recognition of sepsis

Since the inception of our new EPR system in October 2022, all areas have received 'at the elbow' training on the use of handheld devices to enter patient observations. This enables high national early warning scores (NEWS) and sepsis alerts to be escalated to the correct clinician. For inpatients areas - during day time hours (09.00 to 17.00hrs) a Doctor and Nurse in Charge will receive these alerts; out of hours the Hospital at Night team will automatically receive the tasks helping to ensure prompt review and treatment of the patient.

Acting on feedback to staff we have also modified messaging and workflows within the system to be more intuitive and support staff in understanding when action is needed.

We have been monitoring compliance with correct screening patients for sepsis and continued education has been provided to areas such as the Emergency Department. Since April 2023 there has been a significant improvement with screening compliance, underpinned by the training and system simplifications noted above.

Antibiotic Compliance and Blood Cultures.

We continue to monitor compliance with administering antibiotics within one hour of sepsis diagnosis, following evidence of delayed treatment being observed in previous years from incidents, healthcare acquired infections and national mortality alerts

Reports have been built within the EPR system but these do not yet account for a number of variables in the way that treatment can be delivered. A manual audit has therefore been undertaken by the Lead Sepsis Nurse, which found that the system report was counting the time elapsed from suspicion of sepsis noted by a nurse, rather than a diagnosis confirmed by a clinician. The report also failed to take into account where antibiotics had been given, as a matter of urgency, to acute unwell patients in monitoring or resuscitation bays and situations where patients were already on antibiotics and, as a result.

The results of the manual audit are noted below. The sample size was 60 patients across both DMH and UHND, taken from the patients included within the sepsis treatment compliance data. It covered provision of antibiotics within one hour, intravenous treatment and blood cultures.

Overall	Antibiotic	IVT	Blood Cultures
Manual Audit	83%	72%	33%

We intend to use the detailed findings from the manual audit to improve the EPR system report so that we are able to obtain more frequent, automated monitoring information.

Compliance with taking of blood cultures remains low. To try and improve this, our microbiologists have been providing education within the Emergency Department as part of daily "10 at 10" (ten minutes at 10 a.m.) training sessions to raise awareness of the appropriate indications for taking blood cultures. Blood culture posters and Trust screen savers have also been designed to remind clinicians of the importance of this.

Education and awareness raising

A sepsis study day is held four times a year for ED nurses. A separate programme has also been designed for ward based nurses. Both of these include classroom based teaching and simulation teaching.

The Acute Intervention Team provides at the elbow teaching around the deteriorating patient and sepsis. It is expected that they deliver teaching between the hours of 9-5, Monday-Friday, however deteriorating patients and emergency calls will always take priority of this.

To keep staff members informed of any important information that needs to be communicated, posters are displayed on all toilet doors throughout the trust. These are brief and useful reminders for staff, derived from patient safety topics.

Sepsis e-learning is available for all registered nurses within the trust. 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 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

Our aim is to provide appropriate care for patients with cognitive impairment and to ensure that patients with an impairment such as dementia and their families have a positive experience of their care throughout the patient journey. In summary, good progress has been made with respect to: Dementia-specific training; specialist nursing support for patients with Dementia; reinvigorating our network of Dementia champions and establishing joint pathways for patients with Mental Health needs with Tees, Esk & Wear Valley NHS Mental Health Trust (TEWV). The focus of our ongoing efforts is to: recruit more Dementia Champions; increase the coverage of our training; embed practice developments; and – incrementally – to make our environments more Dementia-friendly

We continue to communicate key learning messages to staff through our quarterly Dementia Newsletter and through our network of Dementia Champions. We have recently restarted face to face briefings for the Dementia Champions from our Lead Dementia Nurse, which are four times per year, in which information is shared, development opportunities discussed and supported. We have 85 champions who now cover not only Dementia but also Learning Disabilities.

We work closely a range of partners, through local, regional and national working groups to share learning and best practice with respect to services for those with Dementia and to work on joint pathways such as those with TEWV where appropriate.

The Trust has reviewed the results of the fifth round of the National Audit of Dementia published in the summer of 2023 and has implemented action plans where scope for improvement was identified.

Patient-led assessments of the clinical environment (PLACE) took place between September, October and November 2023, and found evidence of improvement and actions undertaken from the 2022 action plan. We scored just below the national average score for the Trust's dementia-friendly environment in the PLACE 2023 inspections. DMH and BAH both scored above the average but there is improvement work needed at UHND and in community hospitals. Short-term actions have been captured in the action plans from the visits. Longer-term actions will be addressed incrementally through estates works.

Over 90% of staff completed the required training in dementia awareness during 2023/24, with more than 95% completing Tier 1 training. Sensory awareness training was delivered to our international nurse recruits and forms part of the nursing preceptorship programme and induction training for health care support workers. Bespoke training has been provided to wards and teams where requested, covering for example, changes in the brain, recognising the difference between dementia and delirium and the link to mental capacity assessments and Deprivation of Liberty Safeguards.

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

The Trust's specialist learning disabilities (LD) and autism nurses continue to offer a 'guarantee' that is unique in the region, working with partner agencies to facilitate safe and effective discharge and provide ongoing support following discharge to reduce the risk of readmission. The Information Department, wards and partner agencies are all asked to alert the team to relevant patient admissions so that all patients with LD and / or autism can be supported whilst in hospital and after they leave.

Our specialist LD nurses continue to work closely with wards and departments, families and care providers so that they can continuously monitor the effectiveness of our services and respond to changing demands. As part of this work, they have offered bespoke training to wards and departments. Policy is being embedded into day to day practice as is evident from the patient records inspected during the learning disability team patient reviews.

With respect to further developments in the year:

- The Trust has committed to reviewing all deaths for those with learning disabilities as part of our mortality review programme and participated in panels for both Teesside and Co Durham; and
- The team have seen significant improvements in completion of DNACPR forms for LD patients in 2023/24 and continues to monitor completion closely.

The main area in which improvements need to be consolidated relates to training. We planned to introduce mandatory training in LD and autism during 2023/24, with the Government's preferred training package being the Oliver McGowan programme. Roll out was dependent on the receipt of on Governance guidance with respect to training expectations which has not yet been issued. Rather than risk further delay, we have committed to making the programme mandatory for all staff from May 2024. The regional clinical network continues to develop its own Diamonds training programme and this will be evaluated as a potential alternative, depending on the expectations of the Government in due course.

In the interim, the team has continued to deliver training on as part of both the nursing preceptorship and the midwifery mandatory training programmes.

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

As in the previous year we have seen a continued need for children and young people accessing our service due to mental health needs.

This also remains a theme from safeguarding referrals, for children who are accessing CDDFT services and whilst this will not capture all of the admissions, it provides a relevant understanding of some of the high risk admissions.

Our Partnership Mental Health Alliance Board and the Operational Mental Health Group has continued to strengthen the collaborative work to meet the needs of the population we serve. Working jointly with our partners, we have been able to manage children and young people presenting with a mental health crisis and support them in the community as an alternative to admission to hospital. This has been achieved by joint care planning and early intervention in the acute setting to prevent admission to hospital.

As we embed the work undertaken last year:

- We are reviewing the continuing multi-disciplinary and multi-agency care pathway for children and young people, from the Emergency Department to the ward, with the aim of providing consistent and high quality care provision to children/young people and their families.
- We have appointed registered nurses as Mental Health Champions on our Paediatric Wards, and in the Paediatric Assessment Area (PAA) and Paediatric A&E at DMH.
- Events have taken place to review the experience of children and young people and their families' experience of admission to hospital, and we continue to look at innovative ways to capture feedback; engage and obtain a robust understanding of their experience.
- All unnecessary ligature points have been removed from the ward areas and the PAA.
- We have jointly appointed a Mental Health Project Manager, who is employed by both CDDFT and TEWV, to facilitate continued partnership and joined up working, with consistent and shared goals.
- We have developed and rolled out a policy, in collaboration with the multi-disciplinary team for the care of patients with mental health needs. The policy has been approved through governance processes and is now ratified and available for staff.
- We have accessed training and support for our staff from TEWV colleagues
- We have evaluated our joint arrangements against sources of good practice and published reports from the Care Quality Commission and identified and enacted related improvements.
- We have commenced a review of the physical environment for all 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.

- We have launched a project to improve quality of care, incorporating positive approaches to care; training and education which prioritises a trauma-informed approach for all staff across the organisation is currently underway.
- Services from relevant voluntary sector organisations are being evaluated to identify how they might support children/young people and their families during admissions. One of our challenges is in ensuring that we always comply with the Mental Health Act on the infrequent occasions that patients need to be sectioned in our care and we are revising our arrangements to achieve this.

Ensuring a positive patient experience through the discharge process

We work closely with partners across the system to coordinate complex discharges. During the year, we have agreed a policy and developed the concept of a transfer of care hub for step down care. We are working on a job description for shared post with Durham County Council to act as a System Wide Discharge Coordinator for step down care.

Daily inter-agency calls continue to be well represented and to provide a forum focused on finding solutions to any challenges preventing a patient from being discharged when they are ready to leave hospital. These calls are now supplemented by individual multidisciplinary meetings that are called to discuss specific cases in more detail and develop bespoke action plans. There is also now a more regular and direct communication route for North Yorkshire patients through the County Council.

Overall, the number of people remaining in hospital for more than seven days, over 14 days and over 21 days continues to be amongst the very best in the North East and Yorkshire region, and we continue to benchmark well re: bed days “lost” due to patients remaining in an NHS bed after they are medically optimised. This is a reflection on the system as a whole and the vital role played by social care and the providers of care home beds and domiciliary care.

Using fixed-term funding we are working with ‘Home group’ to access support for those patients with low level mental health needs with housing and financial problems pre and post discharge. Their responsiveness is excellent and, after initially focusing on patients leaving UHND, they have been able to extend their service to support County Durham residents on all hospital sites. By meeting the need for support, we have seen a reduction in readmissions.

All assessments of someone’s longer term social care needs are carried out in the community setting and this, together with the development of trusted assessments has helped to minimise patients remaining in hospital awaiting ‘assessment of need’. There have, however, still been some delays as a result of capacity not meeting demand at peak times

Internally, we continue to work with ward staff to ensure that accurate information on patients awaiting discharge and the reasons for any delay are captured. This enables us to use daily ‘discharge-ready’ lists to track patients, and to plan, prepare for and enact their discharge.

During the third and fourth quarters of 2023/24 we were able to access support from the national NHS Discharge Fund to expand the capacity of our Discharge Management Team, enabling a physical presence on all three main hospital sites, as well on Saturdays and Bank Holidays. The team have also started undertaking Trusted Assessments, which enable discharge without the need for social worker involvement.

Further, ongoing developments include:

- Reinvigorating the implementation of NHS England’s SAFER approach to managing patient flow, which promotes timely senior reviews to support discharge decision-making, ensuring that all patients have an estimated discharge date and associated discharge criteria and seeking to discharge higher numbers of patients earlier in the day.
- Implementing the Optica electronic discharge management tool. Further work is needed to implement this alongside our EPR system; however it is expected to support the allocation and management of tasks needed to discharge individual patients.

End of Life and Palliative Care

Broadly on track (↑)

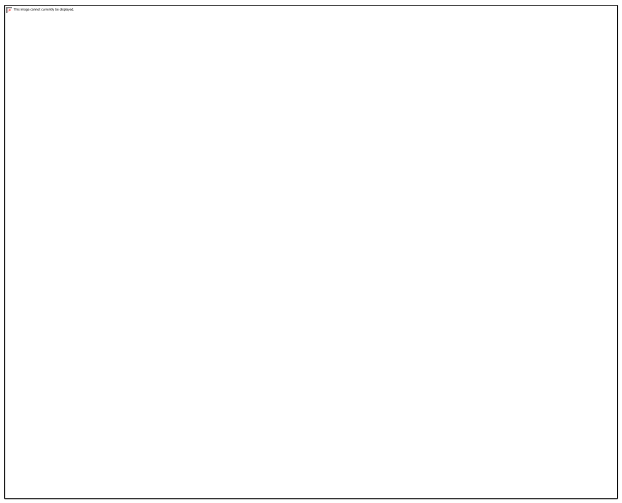
The Trust's End of Life Care was rated as 'Outstanding' in the most recent CQC report and the results of National Audit of Care at End of Life (NACEL) 2022/23 and quality survey data demonstrated continuing good practice in end of life care within the Trust.

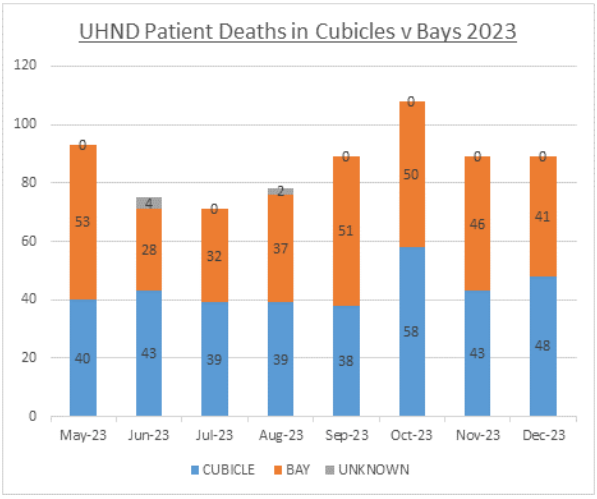
Figure notes: NC743 = UHND, NC742 = DMH, quality survey results apply to both acute hospitals

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.

The Patient Flow teams on the Acute sites do all they can to provide access to privacy for dying patients and, where possible and appropriate, we make use of community hospitals.

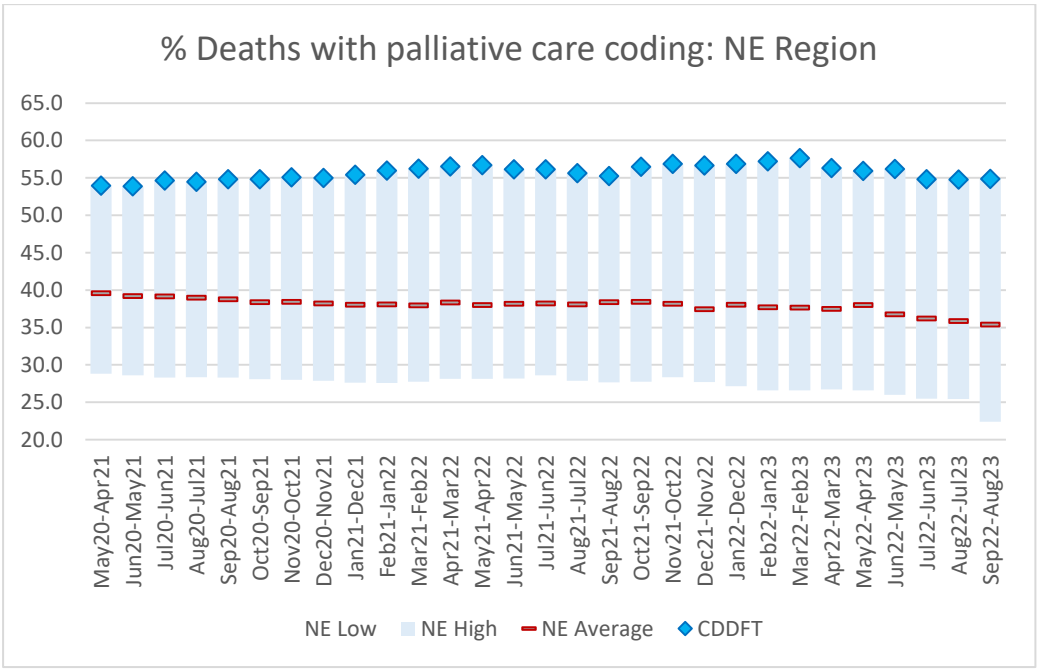
Education is provided to staff on ways to maintain the privacy and dignity of end of life care patients within the wider hospital footprint where side rooms are not available.

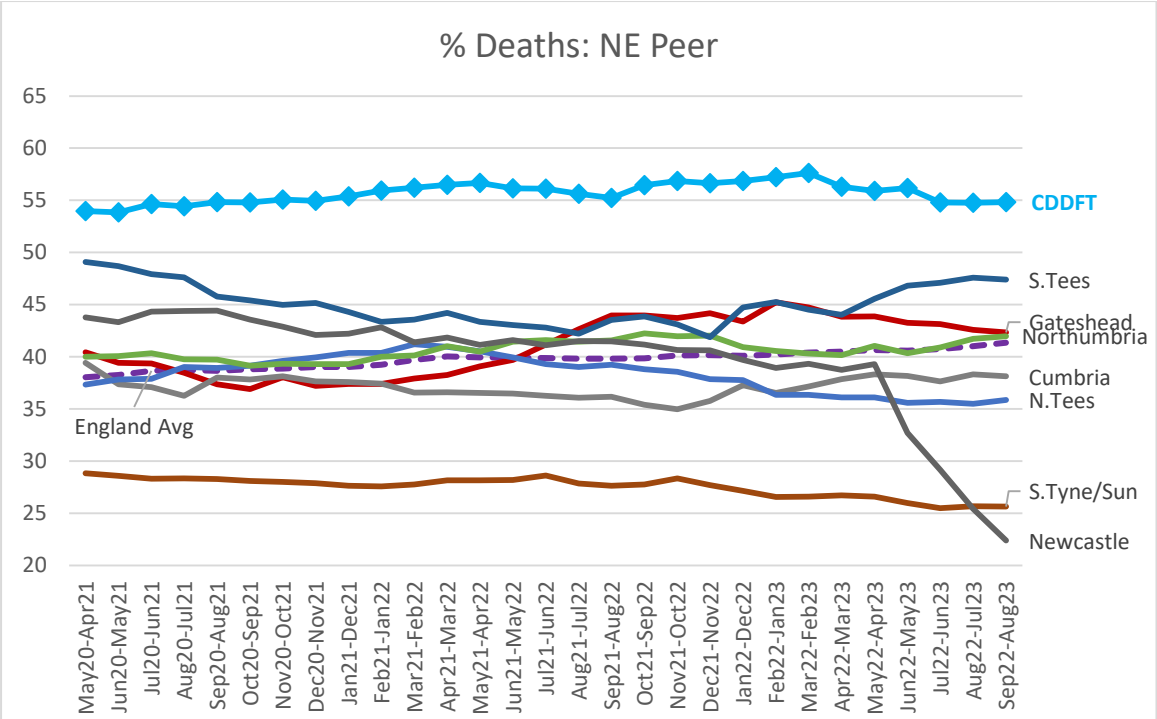




The Trust continues to have the highest proportion of deaths with palliative care coding within the region, as a result of which more than 50% of patients who die in acute hospitals receive input from the specialist palliative care team.

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

Partially met (↑)

We have continued embed compliance with nutrition screening in the hospital settings, with month on month improvements as shown in the table below.

Measure	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Assessments Required	6,324	6,506	6,429	6,441	6,430	6,211	6,573	6,681	6,833	7,259	6,737	6,885
Completed	2,803	3,036	2,967	3,519	4,357	4,672	5,473	5,561	5,959	6,448	6,032	6,186
Completed Within 4 Hours	2,048	2,220	2,127	2,426	3,219	3,627	4,495	4,641	5,202	5,636	5,418	5,583
Completed %	**44.3%**	**46.7%**	**46.2%**	**54.6%**	**67.8%**	**75.2%**	**83.3%**	**83.2%**	**87.2%**	**88.8%**	**89.5%**	**89.8%**
Completed Within 4 Hours %	**32.4%**	**34.1%**	**33.1%**	**37.7%**	**50.1%**	**58.4%**	**68.4%**	**69.5%**	**76.1%**	**77.6%**	**80.4%**	**81.1%**

Over the past 12 months we have:

- seen improvements in compliance with MUST assessments - as of January 2024, some **89%** of patients had received a MUST assessment and **76%** of those had been assessed within four hours of admission as per policy;
- increased the use of handgrip measurements for patients under the care of the Dietitian;
- re-invigorated the Nutrition and Hydration Improvement Group;
- promoted fluid balance and hydration through our use of 'Traffic Light" jugs and our 'Drip or Drink' campaigns;
- continued to learn from service user feedback and implemented changes; and
- worked towards achieving compliance with new National standards and guidelines for nutrition.

The 'Drip or Drink' campaign acts as a reminder to staff to consider their patients' hydration levels and to ensure that those requiring a drip are placed on one promptly. The 'Traffic Light' jug system visually alerts staff when a patient's fluid in-take is slow. The first jug of the day is red, the second amber, and the third green; therefore a patient with a red jug well into the day would flag as potentially needing support.

We have also audited the use of a nutrition assessment tool in paediatrics and estimated the amount of dietetic time required to provide care to those identified as high risk. A business case has been submitted for resources aligned to this assessment.

Nutrition training was re-evaluated during the year, and now takes up less time to deliver freeing staff time to care for patients. Enteral tube training is in the final stages of being digitalised into “bite size” sessions with accompanying WASP competency frameworks.

The main area for improvement is now the timeliness of nutrition screening assessments.

Clinical Effectiveness

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

This year has seen continued improved in key performance areas such as ambulance handovers times, ambulance clearance times, and 12 hour trolley waits, while experiencing unprecedented levels of demand and volumes of ambulance conveyances. We have also needed to manage flow to mitigate the risk of the spread of infection, ensuring that patients are screened, isolated and cohorted to mitigate against the risk of infection, particularly when we have had outbreaks of CPE at DMH. This introduces challenges when, for example, the demand for side rooms is high.

The Trust achieved exceeded the national target, which was for at least 76% of patients to be seen and treated within four hours of attendance to our A&E departments and urgent treatment centres, in March 2024, achieving 77.7%. Generally, we improved performance on overall waiting times across the year compared to 2022/23 and achieved similar improvements in reducing ambulance handover delays and long waits, and with respect to waiting times for Type 1 (A&E) only attendances. In times of surge, however, and particularly during the last winter, we have seen some deterioration in performance and we have further to go to meet the national average with respect to waiting times for Type 1 attendances.

Improvements implemented during the year included the colocation of Medical Same Day Emergency Care and ED at UHND in October 2023; the colocation of the Urgent Treatment Centre at UHND during daytime hours; the introduction of new streaming pathways to reduce the number of patients attending the Emergency Departments; and cross-site collaboration between Clinical Leads to ensure a consistent, best-practice approach to patient care is applied. There is on-going work to further improve colocation outside of daytime hours, and to introduce direct ambulance conveyance to Same Day Emergency Care.

Most importantly, we know that, as demand continues to increase, we need to optimise the end to end flow our patients through our hospitals in order to sustain, and make further improvements in waiting times and, moreover, to minimise those times where patients suffer long waits overall, or for beds, in our departments.

Improving Paediatric and Neonatal Services

Ward based staffing has been increased following a robust establishment review using a triangulated approach as recommended by NICE and the National Quality Board. As staffing has stabilised at UHND beds have been reopened in line with safe staffing guidance. Over the past 12 months we also have welcomed Internationally Educated Nurses to our paediatric workforce.

Our Special Care Baby Units have also undertaken an evidence-based workforce assessment, to ensure that the units are working to the British Association of Perinatal Medicine (BAPM) nursing safe staffing standards. Accordingly our neonatal transitional care model is now under review to ensure it meets the BAPM standards.

In the coming year the model of care within the Paediatric Assessment Unit at UHND will be reviewed in line with the principles of safe staffing, to ensure we continue to meet the needs of the young people and their families at UHND.

Our community paediatric nursing teams have been restructured into one team with a Band 7 Team Leader to strengthen the leadership in the team and allow the acute Ward Manager to focus upon inpatient issues.

Over the past 12 months our collaborative working with TEWV has strengthened and we are currently reviewing our admission pathways for children and young people with mental health needs. Registered nurses have been identified in inpatient wards, in the Paediatric Assessment Area at UHND and the Paediatric A&E department at DMH to work with TEWV as mental health champions in line with the National Children & Young People's Transformation Project and the NHS Long Term Plan. We are also working with children and young people and their families to understand their experience in hospital following admission with a mental health crisis. Our work with TEWV has also reduced the need for the children to be admitted in crisis by early intervention in paediatric ED.

We have also:

- Reviewed our governance structure to ensure all services in the care group have a clear reporting structure;
- Developed a "one stop shop" for young people cared for at Aycliffe Secure Centre, ensuring the care required is offered in familiar surroundings without the need to travel to hospital for an outpatient appointment;
- Completed ligature risk assessments in all inpatient paediatric areas;
- Developed multi-disciplinary care plans for children and young people requiring inpatient care in a mental health crisis; and
- Visited Alder Hey Children's Hospital to learn from measures which they have instituted for children and young people with mental health needs.

Part 2B - Priorities for 2024/25

The Trust refreshed its Quality Strategy (Quality Matters) during 2022 following consultation with staff and patients and a wide range of external stakeholders. Quality Matters is our quality strategy for the period 2022/23 – 2025/26. Our priorities for 2024/25 reflect both the ongoing priorities in this strategy and further priorities (described as "retained" priorities) where further work is required to meet 2023/24 objectives.

Safety	Experience	Effectiveness
Quality Strategy Priorities / Retained priorities from 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	At the present time we expect to include priorities relating to cancer service and elderly care, including acting on any third party recommendations but are still in dialogue with the teams on the precise actions and measures.
Maintain zero tolerance of Grade 3 & Grade 4 pressure ulcers		
Implement actions, in line with Ockenden and CQC recommendations to sustain safety in maternity services.		
Further embed safe practice for invasive procedures: LocSSIPs		
Further embed prompt recognition and action on signs of patient deterioration		
Improve the timeliness of assessment and treatment 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.	
Continue to progress 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	Summary Hospital Mortality Indicator (SHMI) Patient Reported Outcome Measures

Patient Safety
Quality Strategy Aims / Retained Priorities from 2023/24 – Work ongoing:

Reducing harm from inpatient falls

Why we chose this priority

Falls remain one of the highest reported categories of incidents across the Trust. Despite meeting six of the seven goals set out in 2023/24 and partially meeting the final goal, minimising harm from falls remains is one of priorities within the Trust's Quality Matters Strategy.

Goals

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

How will we do this?

We will:

- To undertake rapid reviews for multiple falls, along with a selection of 'no harm' falls in high risk areas.
- To support education pertaining to, and evaluation, of the updated bed rails policy.
- To update the falls information intranet page to provide a comprehensive and easily accessible contemporaneous resource for clinical staff.
- To work in partnership with the wider health and social care and voluntary sector networks to agree an inclusive Falls and Fracture Prevention Strategy 2024-27.
- To incorporate the risk of deconditioning and consideration of the use of full capacity protocol into the rapid review template

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 (HCAIs)

Why we chose this priority

Minimising harm from HCAIs remains is one of priorities within the Trust's Quality Matters Strategy and we have seen increases in HCAIs over the last year and need to arrest the trend.

Goals

To minimise the potential risk of patient harm from avoidable HCAIs. 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; and
    - E coli.

To date 2024/25 national thresholds have not been set although we have been informed of changes to the definitions and timing to categorise a healthcare associated infection. As a result it is anticipated that there will be acknowledgement of an increase in healthcare associated infections which is expected to be reflected in revised annual thresholds when issued.

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.
- Undertake a rapid review of all healthcare associated C-Diff cases collaboratively with the clinical teams for timely review of best practice and any lessons learnt for clinical teams to action as appropriate.
- Hold weekly multi-disciplinary C-Diff meetings for complex C-Diff cases.
- 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.
- Support Trust wide focused work to improve peripheral IV device management.
- 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 GNBSI and share information with clinical teams to support continuous improvement across the health economy.
- Share information on sources of infection and themes from good practice and 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. .
- Continue work with colleagues in Procurement to align the acute dressings formulary with that for the community to provide more consistency with dressing choice and treatment.
- Complete and gain approval of a mattress selection guide for community services-(currently being updated).

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 and CQC Recommendations

Why we chose this priority

Safety in maternity services remains a high priority nationally with the publication of the "Three Year Delivery Plan for Maternity and Neonatal Services". Locally, we need to fully implement the quality improvement programme put in place following the CQC and Ockenden peer review visits in 2023 and are being supported by NHS England, through the national Maternity Safety Support Programme.

Ongoing focus on the Saving Babies Lives Care Bundle also remains a specific priority.

Goals

We aim to demonstrate a continuous quality improvement against the actions noted in the CQC report to regain a "Good "rating and to meet all exit criteria for the Maternity Safety Support Programme over the course of 2024/25.

How will we do this?

We will:

- Continue to implement our "maternity matters" staff engagement strategy.

- Embed our enhanced leadership structure and recruit further specialist roles to support the retention and resilience of our workforce.
- Using all available recruitment channels, seek to fill remaining vacancies in our acute and community services and establish resilient staffing models.
- Progress towards reinstatement of our Homebirth service.
- Bi annually review our safe staffing levels and models of care against workforce planning models.
- Develop our quality and governance structure to deliver the “Three Year Delivery Plan for Maternity and Neonatal Services
- Strive to meet all Safety Actions as outlined in the national Maternity and Perinatal Incentive Scheme.

Measures of success

These will comprise:

- Increased staffing fill rates and improvement in other related staffing indicators and overall resilience.
- Implementation of all actions from the most recent CQC inspection.
- Fulfilment of the exit criteria from the Maternity Safety Support Programme.
- Restarting our Homebirth service.
- Meeting Maternity Incentive Scheme Year 6 Safety Actions

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

Why we chose 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. Fully embedding compliance with the 47 LocSSIPs in place within the Trust is one of the safety priorities within our Quality Strategy.

Goals

To implement an effective 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 LocSSIPs documentation and adherence to practice.
- Develop LocSSIPs as electronic forms in our EPR system to assist staff in adhering to the requirements.
- Maintain our 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, which evidence a high level of compliance with requirements.
- 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 LocSSIPs 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 response to all relevant triggers, in the Trust's new EPR system.
- Roll out our System Improvement Plan for Patient Deterioration which aims to address key themes and actions from recent Patient Safety Investigations.
- Introduce technology throughout the organisation to ensure 'one handheld device for all purposes'.

Measures of success

- We will see improved compliance rates with training – the Trust standard being 85% - and improvements with observation and escalation audits.
- Implementation of the hand-held device technology trust wide.
- Substantial progress in implementing the action in our Deteriorating Patient System Improvement Plan.

Improving the management and treatment 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. Audits undertaken in 2023/24 identify a need for further improvement in IV treatment and the taking of blood cultures and we are not yet at the point where we can monitor compliance with provision of antibiotics reliably using the system.

Goals

- To continue to improve the percentage of patients receiving antibiotics within 1 hour of diagnosis in the Emergency Department.
- To ensure that blood cultures are taken in a patient with a positive sepsis screen.
- 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.
- Continue to develop our '10@10 training sessions' attended by Consultant Microbiologists and CDDFT Emergency Department staff – an educational session focusing on the importance of appropriate indications for taking blood cultures.
- Develop a Blood Culture Task and Finish Group.
- Trial the use of sepsis boxes.
- Continue to educate patients and relatives on the recognition of the signs and symptoms of sepsis by organising a public engagement event.
- Further develop system reporting or audit procedures to allow us to measure performance more frequently.

Measures of success

We will see improved compliance rates with the percentage of patients receiving antibiotics within one hour of diagnosis in the Emergency Department and back of house ward areas, improvements in IV treatment and significant improvements on 2023/24 performance for the taking of blood cultures.

Year one implementation of the patient safety strategy

Why we chose this priority

In 2023/24 we published our Patient Safety strategy, outlining the key areas of focus for the Trust for the next 3 years aligned to the National Patient Safety Strategy three pillars of Insight, Involvement and Improvement. This strategy seeks to develop our safety culture and processes and underpins the achievement of our safety priorities.

Goals

In 2024/25 we aim to:

- Further embed continuous improvement through our System Improvement Plans;
- Expand the number of Patient Safety Partners at CDDFT; and
- Evaluate the effectiveness of our Family Liaison Officer Service with those families involved in investigations.

How will we do this?

We will:

- Develop and roll out System Improvement Plans in relation to identified safety themes and support our care groups in using rapid learning tools.
- Recruit further Patient Safety Partners.
- Learn from the evaluation of the Family Liaison Officer role to strengthen the service and recruit additional FLOs.

Measures of success

These will include:

- Further embedding of the use of System Improvement Plans and rapid learning from incidents.
- Additional Family Liaison Officers in place.
- Ability to build on Family Liaison Officer service-based on evaluation.
- Establishing a team of Patient Safety Partners in Place.

Patient Experience

Quality Strategy Aims / Retained Priorities from 2023/24 – Work ongoing:

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

Patients with Dementia

Why we chose this priority

To develop high-levels of understanding and awareness of how to care patients with dementia among our staff and to develop our patient environments in line with guidelines and standards for dementia-friendliness. Despite improvements made in recent years, national audit results point to areas where we can make further improvements on behalf of our patients.

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.
- Develop consistently high levels of understanding and awareness of dementia among our staff.
- To make short-term improvements for dementia-friendly patient environments and ensure that longer-term improvements are considered in our estates and capital plans.

How will we do this?

- By implementing short-term actions to improve patient environments in line with action plans from the 2023/24 PLACE visits and to promote consideration of longer-term changes in estates and capital plans.
- To promote good practice through our network of Dementia Champions with a minimum of four face to face meetings with the Lead Dementia Nurse during the year.
- 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 and LD Champions.

Measures of success

Meeting our 85% compliance targets for dementia awareness and related training and 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.

Patients with Learning Disabilities and / or Autism

Why we chose this priority

We want to ensure that our staff understand the needs of, and are able to care for patients with LD and Autism effectively, by providing training and maximising the support available from our specialist LD and Autism team. In doing so, we want to develop our services in line with the feedback we have started to collect from service users on their expectations of our services.

Goals:

- Development and roll out of revised training programme in conjunction with the North East and Cumbria clinical network, ensuring that all staff have completed the training within 12 months of the roll out date, allowing for long-term sick leave, special and maternity leave.
- Continued delivery of training as part the nursing preceptorship programme and the maternity programme.
- To substantiate increases in capacity in the LD and Autism team currently funded on a fixed-term basis.
- To complete five day reviews of our patients so that we can evidence a clear plan of care and treatment is in place.
- Completion of mortality reviews to learn from the deaths of all patients with a learning disability and will also continue membership of the LeDeR review groups within our localities.

How will we do this?

- Delivery of a training programme comprising e-learning, face to face training, and bespoke departmental training.
- Completion of data and conversations with family members and carers within EPR on reasonable adjustments and support required.
- Completion of five day reviews to evidence a clear plan of care and treatment.
- Completion of easy-read friends and family tests to review patient experience.
- Securing funding for a full time substantive specialist nurse position.
- Completion of mortality reviews on deaths of patients with a learning disability.

Measure of success:

- All staff – other than those on long-term leave – to be trained within 12 months of the launch of the programme.
- Positive friends and family test results reported to the Board.
- Improvements in service user feedback as we implement changes in response to their expectations.
- Completion of mortality reviews with a clear pathway of learning.

Patients with Mental Health support needs

Why we chose this priority

The mental health of our children and young people is a key priority in the NHS Children's Transformation Programme. There is relevant work to complete with adult mental health services too, to ensure that we are addressing national and local themes for young people are at the point of transition.

Improving our engagement with children, young people and their families in a meaningful way, will ensure that we have a better and accurate understanding of their experience, their journey through our pathways and outcomes. Accordingly we have needed to introduce new policies and procedures, based on joint working with our mental health trust and multi-agency partners so that we are able to respond to our patients' holistic needs and provide for their safety, and the safety of others through personalising their care and joined up working and care planning.

Goals

We aim to:

- Listen to the experience of children with physical and mental health needs who access our services
- Embed nurse-led care of children and young people with mental health needs.

- Seamless transition to adult services.
- Ensure our policies and guidelines remain evidence-based.
- Complete effective risk assessments of the children and young people to maintain safety.
- Maintain effective partnership working with TEWV and local authority colleagues focusing on the needs of the patient.
- Optimise multi-agency working with partners to ensure seamless care provision in the right place.
- Ensure care is given to children and young people when they are admitted to CDDFT.

How will we do this?

By:

- Patient experience events hosted jointly with our TEWV and local authority colleagues
- Continued agreement of bespoke care pathways for children and young people who are admitted with mental ill health.
- Increasing our training provision, to provide staff with an understanding of mental ill health and to develop the use of positive care approaches and trauma informed practice. This will, in turn, help to ensure that the needs of children and young people in our care are appropriately understood and their care is personalised, and to ensure we are meeting our statutory responsibilities.
- Continued work through our Partnership and Alliance Boards and Operational Group to strengthen relationships and service provision for patients with dual needs, including as appropriate consideration of joint posts, training and adaptations to policies and procedures.
- Jointly evaluating the workings of both groups and implementing any agreed improvements.
- Monitoring and auditing our adherence to policies and procedures.
- Evaluating the training and support provided to staff and implementing any agreed improvements.

Measures of success

- Policies and procedures will meet evidence-based good practice.
- There will be effective management plans in place for all patients with dual needs.
- The Partnership Alliance will evaluate well.
- Training provided to staff evaluates well and / or is improved.
- Ongoing update of environmental and ligature risk assessments with action taken to remove risks where possible

Ensuring a positive patient experience through the discharge process

Why we chose this priority

Discharging a patient from our care often requires detailed planning, communication with families and carers and – often – detailed coordination between different teams and partner agencies. Delays in discharge and / or 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. In particular to:

- 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:

- Reinforce integrated working with local authorities as shown by the joint appointment of the system lead post, as well as the pooled funding of the Discharge Management Team and Discharge to Assess therapists.
- Progress the full Transfer of Care Hub model.
- Promote and embed the reissued Discharge policy
- Maximise the implementation of the Optica discharge management tool, embedding its use on our wards.
- Make best use of the available daily data on discharge delays, with clear escalation routes established within social care

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 we chose this priority

We continue 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 ensuring everyone dying has good access to palliative care

How will we do this?

We will:

- Focus intensively on recognition of dying in hospital in all palliative care teaching.
- Continue to explore ways to ensure more people have access to palliative care when they are dying.
- 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:

- Maintaining or improving the proportion of people who are dying seen by palliative care specialists.
- Continuing to explore ways of improving privacy for patients dying in hospital.

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

Why we chose 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 an 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 continue to ensure that patients receive adequate nutrition and hydration. We will continue to work to embed the use of EPR functionality and ensure high levels of compliance in completing nutritional needs (MUST) assessments and associated care plans. Where patients screened using MUST trigger a dietetic referral, assessment and appropriate care plans will be put in place.

How will we do this?

- Reviewing and, as necessary, enhancing capacity in the Dietetics team to explore ways to provide ward-based paediatric dietetics.
- Developing and rolling out plans for compliance with the NHS Food and Drink Strategy.
- Working with internal and external stakeholders to embed good nutrition practices Trust-wide.
- Continuing to learn from positive and negative feedback in relation to nutrition practices with Ulysses incident forms.
- Continuing to strive for high levels of compliance with nutrition screening and care planning.

Measures of success

We will define a standard for, and achieve and maintain high levels of compliance with, completion of MUST assessments in line with policy and be able to demonstrate learning from feedback and incidents, and progress towards compliance with the NHS Food and Drink Strategy.

Clinical Effectiveness
Quality Strategy Aims / Retained Priorities from 2023/24 – Work ongoing:

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

Why we chose this priority

This choice was made in line with national priorities for improving urgent and emergency care. 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 some delays providing treatment and / or in admitting patients. The previous pressure points remain, and even more acutely pressurised, despite the significant improvements made in 2023/24.

Goals

Our goals include further optimisation of clinical pathways, the continued movement towards a seven-day clinical service, and relocation and colocation of all of our Same Day Emergency Care services and robust 24/7 UTC provision to release pressure in the A&E department at UHND during 2024/25.

With the support of the North East and North Cumbria Integrated Care Board, we will seek to move forward with our plans for a new Emergency Care Centre at UHND.

We will also seek 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:

- Continue to recruit for seven day services;
- Increase the Trust's bed base in line with the planning guidance;
- Implement full collocated Same Day Emergency Care;
- Seek funding for, and progress work towards, a new Emergency Care Centre at UHND;
- Explore the introduction of a sustainable Rapid Assessment and Treatment Model in both A&E Departments;
- Explore an extension of our See and Treat facilities overnight;
- Look to increase the level pharmacy support to our A&E Departments; and
- Roll out end to end improvements in patient flow in line with good practice imported from across the NHS.

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 4 hours; and
    - Ambulance handover times under 15 minutes.

At the present time we expect to include priorities relating to cancer service and elderly care, including acting on any third party recommendations but are still in dialogue with the teams on the precise actions and measures.

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 Director of Quality, 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.

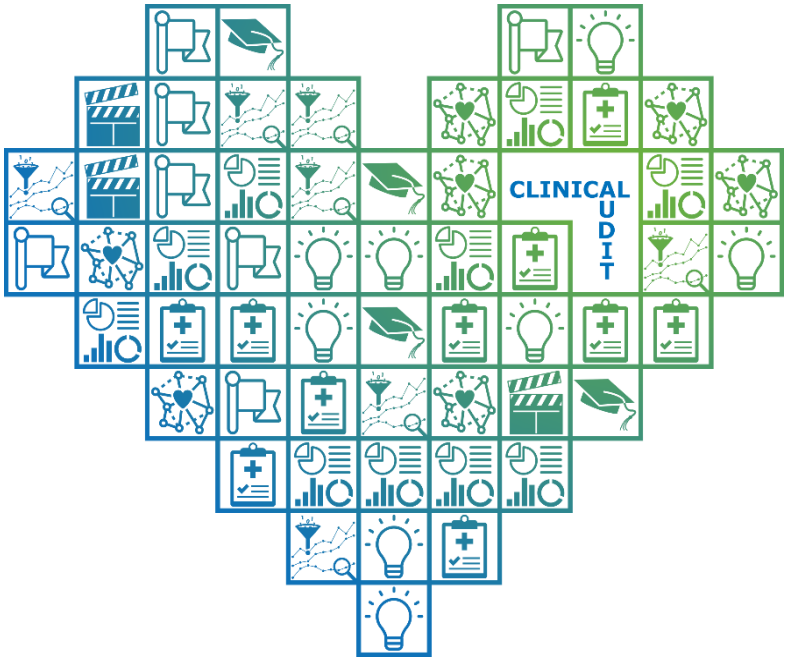
All National Audit reports are reviewed by the Lead Clinician and the Clinical Audit Team, a specific action plan is developed for each audit and approved by both the Speciality and Care Group Clinical Audit Leads. Action plans are monitored by the Clinical Audit team and the Care Group Governance Facilitators.

Participation in Clinical Audit

During 2023/2024 **49** national clinical audits and **4** national confidential enquiry covered NHS services that County Durham & Darlington NHS Foundation Trust provides.

During 2023/2024 County Durham & Darlington NHS Foundation Trust participated in **90 %** of national clinical audits and **100** % of national confidential enquiries of which it was eligible to participate in.

The reports of 11 **National Clinical Audits** and 35 **Local Clinical Audits** were reviewed by the provider in **2024/25** 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.

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

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

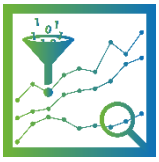
- Development of smarter and sharper action plans.
- Focusing on fewer higher quality actions that address what really matters.
- Identifying and minimise risk, waste and inefficiencies.

Assurance

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

Communication & Engagement

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

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 in which County Durham & Darlington NHS Foundation Trust was eligible to participate, participated in and for which data collection was completed during 2023/2024 are contained within the table below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry:

National Program	Topic	Participation	% cases submitted
Case Mix Programme (CMP)	N/A	✓	100%
Elective Surgery (National PROMs Programme)	N/A	✓	Ongoing
Emergency Medicine QIPs	Mental Health (Self-Harm) Year 1	✗	Not applicable
	Assessing for cognitive impairment in older people	✓	100%
	Care of Older People Year 1	✗	Not applicable
Falls and Fragility Fracture Audit Programme (FFFAP)	National Audit of Inpatient Falls	✓	100%

National Program	Topic	Participation	% cases submitted
	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	✓	Ongoing
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	End of Life Care	✓	31%[1]
	Juvenile idiopathic arthritis study: Clinician questionnaire	✓	0%[1]
	Endometriosis	✓	18%[1]
	ICU Rehabilitation	✓	Ongoing
National Adult Diabetes Audit (NDA)	National Diabetes Foot Care Audit	✓	Ongoing
	National Diabetes Inpatient Safety Audit (NDISA)	✓	Ongoing
	National Core Diabetes Audit	✓	Ongoing
	National Diabetes in Pregnancy Audit	✓	Ongoing

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	✓	100%
	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	✗	N/A
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
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%[2]
National Ophthalmology (NOD)	Age-related Macular Degeneration Audit (AMD)	✓	100%
	Adult Cataract Surgery	✓	100%
Epilepsy 12 - National Audit of Seizures and Epilepsies for Children and Young People	Epilepsy12 has separate work-streams/data collection for: Clinical Audit, Organisational Audit	✓	100%
Perioperative Quality Improvement Programme (PQIP)	N/A	✗	N/A
Inflammatory Bowel Disease Audit	N/A	✗	N/A
National Paediatric Diabetes Audit (NPDA)	N/A	✓	100%
Epilepsy 12 - National Audit of Seizures and Epilepsies for Children and Young People	Epilepsy12 has separate work-streams/data collection for: Clinical Audit, Organisational Audit	✓	100%

1 – Case notes were supplied for review where available.
2 – The national audit provider ended support due to IT security issues. This audit will begin again in 2024/2025 under a new provider.

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

Our research department has maintained a robust portfolio over the past year, with 74 ongoing studies across four sites: DMH, UHND, BAH, and CLS, covering a wide spectrum of medical disciplines. These efforts span diverse areas including Anaesthesia, Perioperative Medicine, Cancer, Cardiovascular Disease, Children's Health, Critical Care, Dermatology, Diabetes, and Ear, Nose, and Throat specialties.

We're proud to have achieved recognition as the second-highest acute commercial recruiter regionally, underscoring our commitment to research excellence. Notable achievements include being the top

recruiter regionally in significant studies such as MCM5 in Postmenopausal Bleeding Patients and several others.

Active engagement within the Trust and with the local community has been a priority, with initiatives including participation in Trust recruitment days and networking events with academic institutions and health providers. We're exploring international collaborations to enhance research capabilities and ensure a robust pipeline of new studies.

Efforts led by R&I Director Dr Julie Cox have expanded patient and carer involvement, promoting a patient-centric approach. Plans are underway to reintroduce the annual report and disseminate research findings effectively. Strategic partnerships with Durham University have been established to leverage academic resources for patient care.

Recruitment remains incresing in the areas highlighted Green whil decline is shown in Red. An overall increase of nearly 30%. Reproductive Health has been one of our stronger recruiting areas with Peadiatrics and GI following behind.

Goals agreed with commissioners

County Durham and Darlington income in 2023/24 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework [Wording to be confirmed]

Care Quality Commission 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 issued a Section 29A Warning Notice following its inspection of the safe and well-led key questions for our acute maternity services in March 2023, requiring the Trust to take action to implement significant improvements in maternity services by 7th September 2023. The notice covered eight areas:

- Staffing levels;
- Delays in induction of labour;
- Governance, including learning from incidents;
- Timely clinical audit and use of audit and benchmarking data;
- Triage of women and birthing people attending our Pregnancy Assessment Units;
- Maternal and neonatal observations;
- Foetal heart monitoring; and
- Antenatal and new-born screening.

We took the necessary actions by the deadline, reporting each month to our CQC relationship management team. The final inspection report included some further actions under requirements notices which were also completed. CQC undertook a re-inspection, covering the safe and well-led key questions for maternity services on both acute sites in January 2024, which included seeking evidence that we had implemented the actions. The inspection confirmed that the actions required within the Warning Notice had been taken and improvements made. No further warning notice has been issued and no formal enforcement action is being taken.

The final reports from the January 2024 inspection – issued in March 2024 - noted, however, that further work was needed to embed improvements in triage, staffing, governance and mandatory training and also identified three further 'Must Do' actions concerning safe storage of medicines, controlled drug registers and checks on equipment and the clinical environment. The report included requirements notices in respect of these actions. In April 2024, we submitted a formal action plan to CQC and have begun to implement these further actions.

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. Subsequently, as outlined above and on page 18 of this report, CQC undertook an inspection of the maternity services at UHND and DMH on our acute sites – as part of the national maternity services inspection programme – in March 2023 and a further, follow-up inspection in January 2024.

Following the above inspections, overall ratings for the Trust by Domain are set out below:

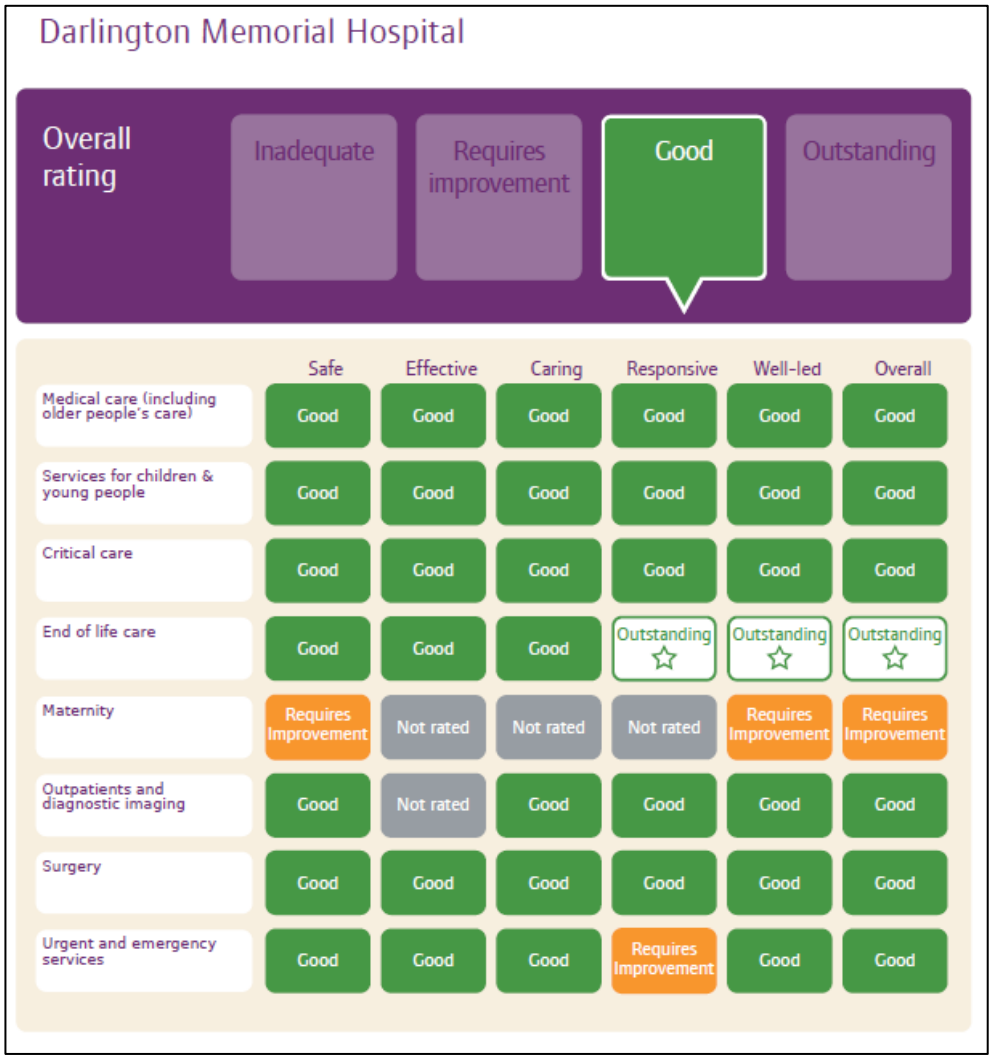
Are services safe?	Requires Improvement (RI)
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good
Overall rating for quality	**Good**

Use of Resources Assessment	Good

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

Darlington Memorial Hospital (DMH)

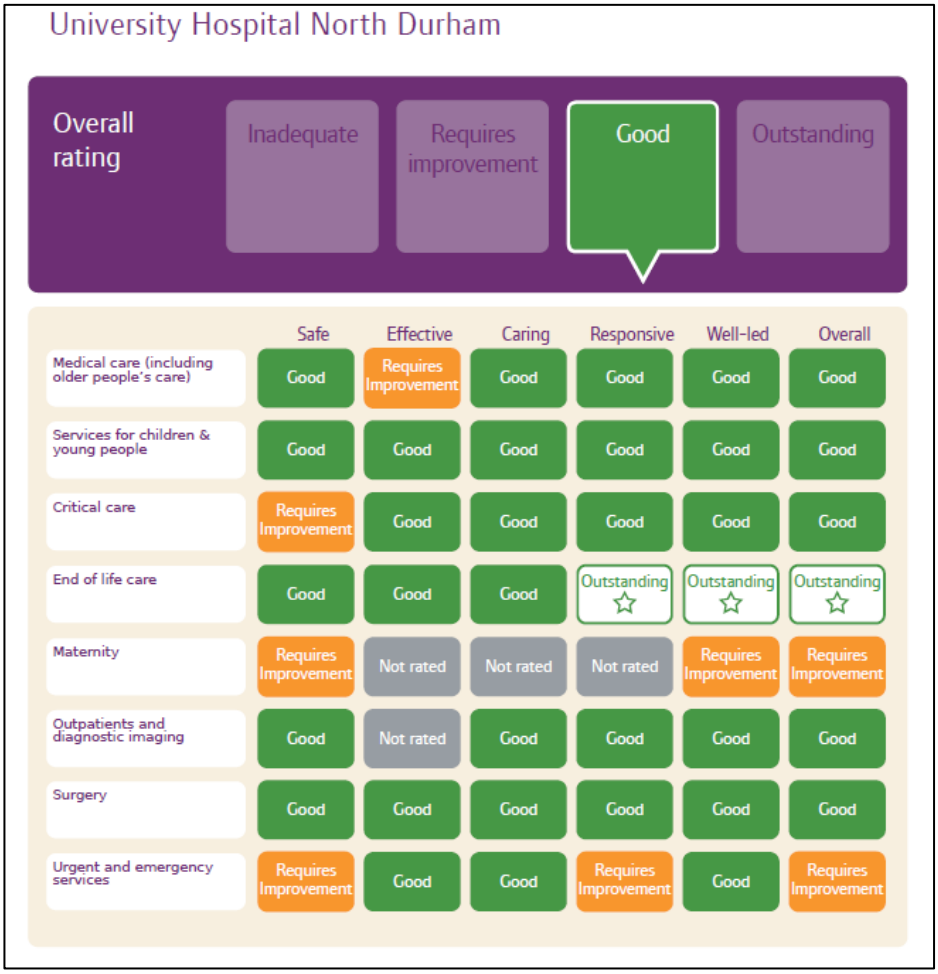
All services are rated “Good”, except End of Life care which is rated Outstanding and Maternity, which is rated Requires Improvement.



University Hospital North Durham (UHND)

All services are rated Good overall, except for End of Life Care (Outstanding) and both Maternity Services and Urgent and Emergency Care (both rated 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.



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

CQC Maternity Services Inspection

The scope, findings and actions arising from this inspection are summarised in the section on our CQC registration on page 53 and the section on maternity services on page 19.

Data Quality

County Durham and Darlington NHS Foundation Trust submitted records during 2023/24 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:
  99.8% for Admitted Patient Care;
  99.4% for Outpatient Care; and
  99.1% for Accident and Emergency Care.

- which included the patient's valid General Medical Practice Code was:
  99.9% for Admitted Patient Care;
  100% 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 England compliance requirements it will be aiming to publish its version 6, 2023/24, Data Security and Protection Toolkit annual return, on the 30th June 2024. We are currently working towards 'standards met' however, this version is not a 'like for like comparison' and at present the Trust is gathering evidence for audit April 2024 so cannot give any indication what the final outcome will be.

For the year 2022/23 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 2023/24 by the Audit Commission.

Learning from Deaths

During 2023/2024, 2,102 patients died in the Trust, a quarterly breakdown is provided below:

- 517 in the first quarter;
- 488 in the second quarter;
- 511 in the third quarter; and
- 586 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. [numbers and periods to be checked as not aligned]

In July 2023 we made the transition to implement the national patient safety investigation framework. Therefore the term investigation included here makes reference to Level 1 Patient Safety Incident Investigations only or a mortality review being undertaken.

In 2023-24 seven deaths were 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:

- 217 in the first quarter;
- 157 in the second quarter;
- 133 in the third quarter; and
- 71 in the fourth quarter.

Three (0.2%) 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;
- 0 representing 0% for the third quarter; and
- 1 representing 0.2 % 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 STEIS Reporting Process which is where Level 1 investigations are reported.

The key learning themes identified from the reviews completed in 2023/24 were: recognition of dying; patient hydration; long waits in the emergency departments and timely recognition of sepsis. Recognition of the deteriorating patient has been identified largely through unexpected death reviews. This has been a focused area for improvement in 2023-24 and we are contributing to the national CQUIN audit in this area. The results demonstrated that we are within the expected threshold. We will continue to be part of the CQUIN for the next 12 months.

Further work has been focused on escalation and observation audits and the corporate nursing teams have been completing education daily on this subject.

Our response to learning from incidents and patient safety investigations in 2023/24 forms part of comprehensive SMART action plans monitored through the Trust's governance processes.

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 Patient Safety Incident Investigation 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. Any referrals made formally to the Guardian / Champions are logged and overseen by the Guardian 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 role 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 FTSUG has recently participated in a Regional Network Peer Review, coordinated by the NENC ICB, which has involved both case reviews and a site visit by the ICB's Freedom to Speak Up Guardian. The report of the peer review findings, including any areas for improvement, is awaited.

The FTSUG provides verbal and written reports to both the Executive Board and CDDFT Group Audit Committee and also prepares progress reports in respect of her personal objectives as outlined in her yearly appraisal. There is an expectation that the organisation will complete a Reflection and Planning Tool every 2 years and conversely the Guardian holds the organisation to account by seeking updates and progress reports from the Board. The Board completed the self-reflection tool early in 2023 and considered it alongside the Guardian's own gap analysis. The resulting actions were captured in a Freedom to Speak Up Strategy entitled "Safe Conversations for Better Care – For Everyone, Everyday".

Further important developments during the year:

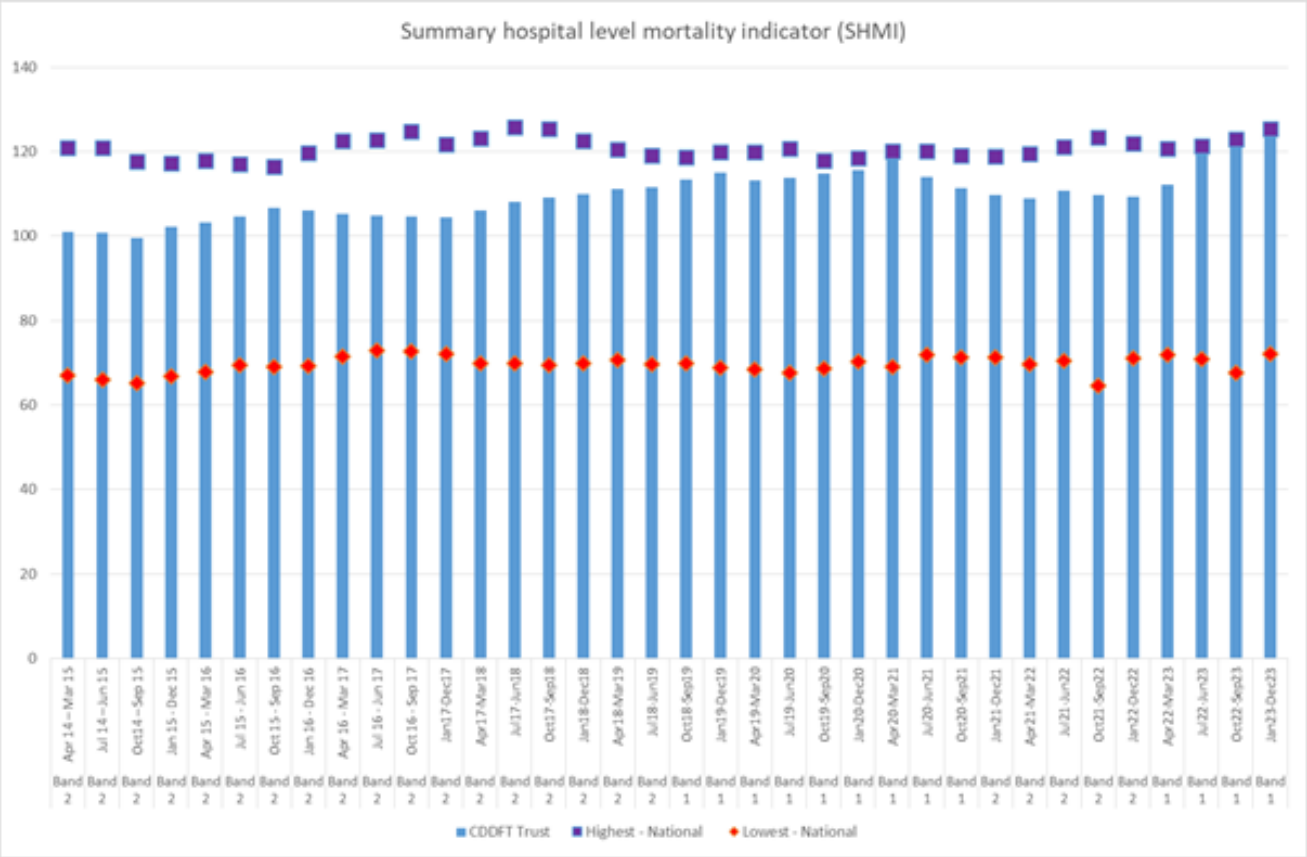
- The Board sanctioned an increase in the Guardian's capacity to three days per week and the number of FSTU Champions has now increased to 10 covering a number of sites.
- The Guardian has continued her programme of proactive 'meet and greet' visits to clinical areas and teams to publicise her role and allow staff to 'put a face to a name'. She has worked closely with Workforce Experience and regularly contributed to nursing induction and junior doctor teaching sessions. She has undertaken numerous visits to acute settings and the community hospitals. The growth in FTSU Champions testifies to the impact of this work.
- The Guardian has continued to develop the content of her Board Reports to include more information on trend analysis, themes, staff groups and the professional levels of those raising concerns.
- She has worked with Communications on particular campaigns and materials to publicise her role, including the distribution of further posters, straplines and screensavers
- We developed easy-read versions of both the Freedom to Speak Up Policy, and the above strategy, both of which were issued to all staff via the staff bulletin.

- The Guardian has been an active member of the Regional FTSU Guardians' network, which has expanded to include North Yorkshire and Humberside giving rise to greater opportunities to share and learn from peers and receives good support from her colleagues. She has identified and implemented good practice to import from other providers through this process.
- The Guardian has a dedicated page on the staff intranet, the content of which continues to be refreshed and developed.

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's Mortality Reduction Committee

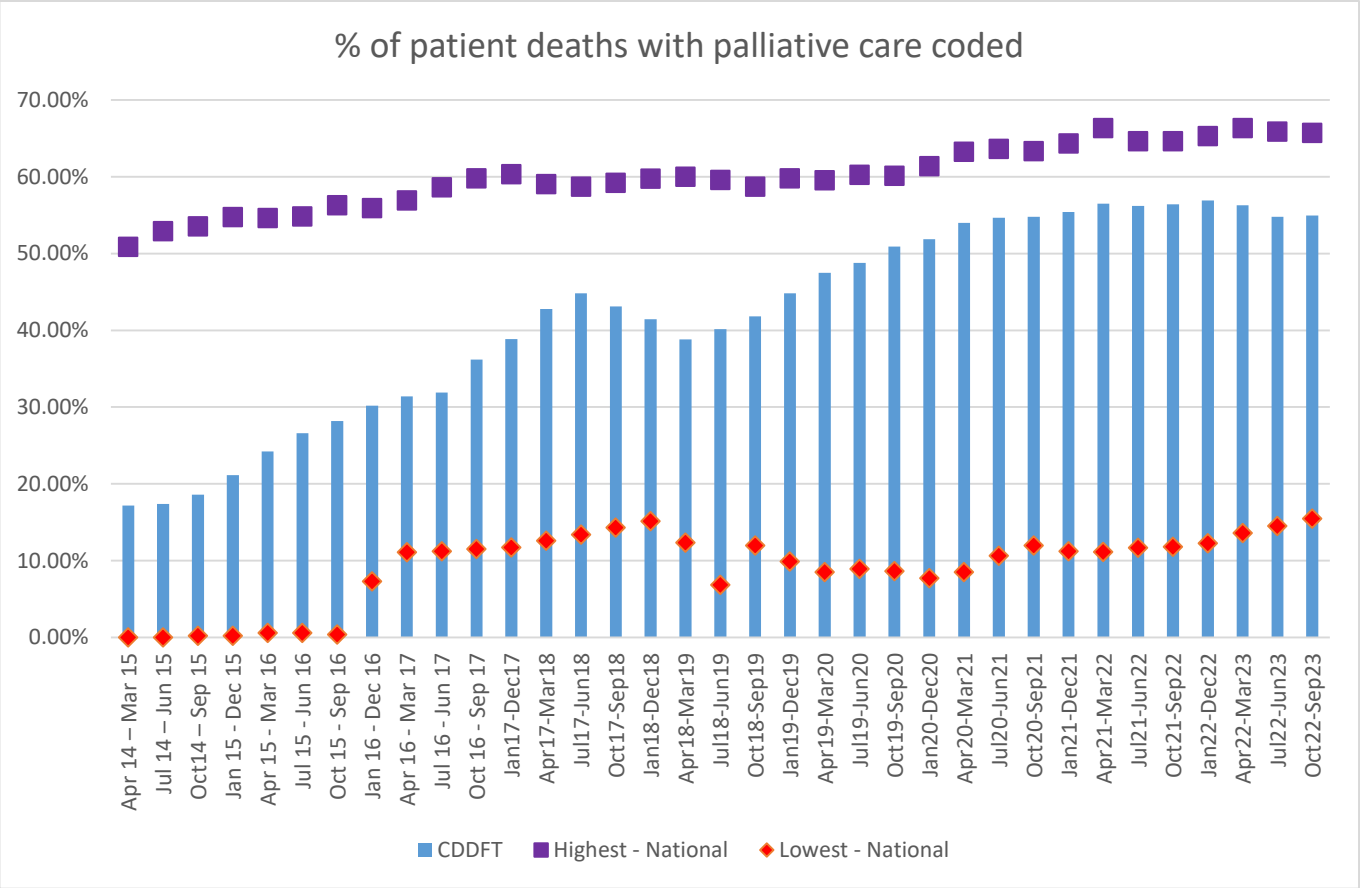
The County Durham and Darlington NHS Trust has commissioned a further external review of our learning from deaths process, to improve the indicator and so the quality of services by continuing to ensure that mortality remains a strong focus for the Trust.

As the Trust is an outlier for SHMI it has already taken external advice from the North East Quality Observatory, and a range of further work to enable it to determine whether there is any underlying issue with the quality of care. These reviews have identified that depth and completeness of coding, which has been affected by both capacity constraints in our clinical coding team and the completeness of information captured in patient records, is considered to be a key contributory factor.

All other sources of assurance are positive:

- The Hospital Standardised Mortality Ratio is within statistical limits;
- The Trust does more learning from deaths reviews than most others in the region and does not find widespread issues with the quality of care (less than 1% of reviews in 2022/23 found care to be poor).
- The Trust uses a tool known as the Copeland' Risk Adjusted Barometer (CRAB) to assess mortality and risk factors for both surgery and medicine. This data shows surgical mortality to be well within expectations and also shows a long-term improvement in medical care.
- There have been no significant issues flagged by the Medical Examiner Service, which examines all deaths not requiring referral to the Coroner in our acute hospitals.

Percentage of deaths with palliative care coded



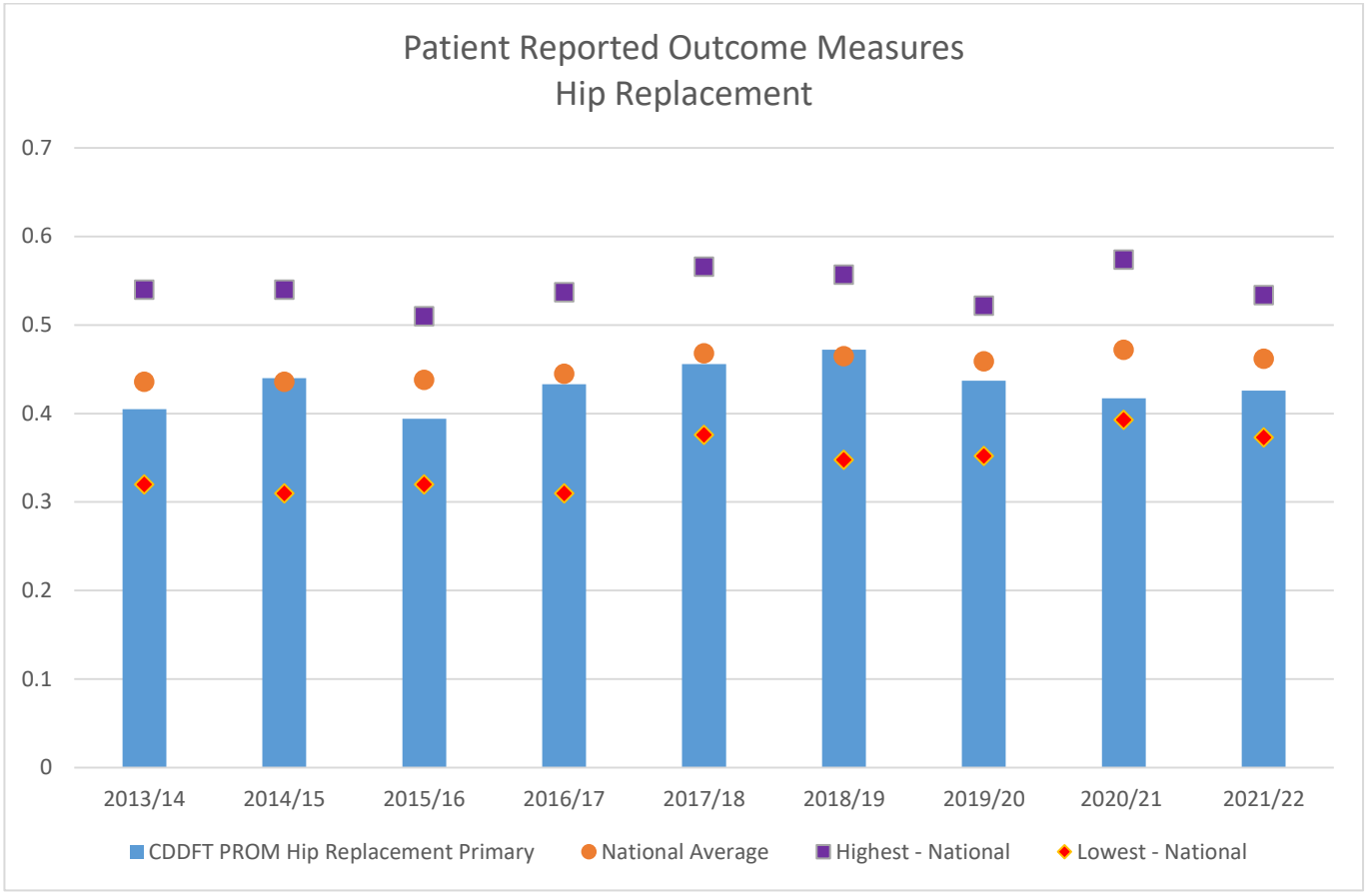
Data source: NHS Digital

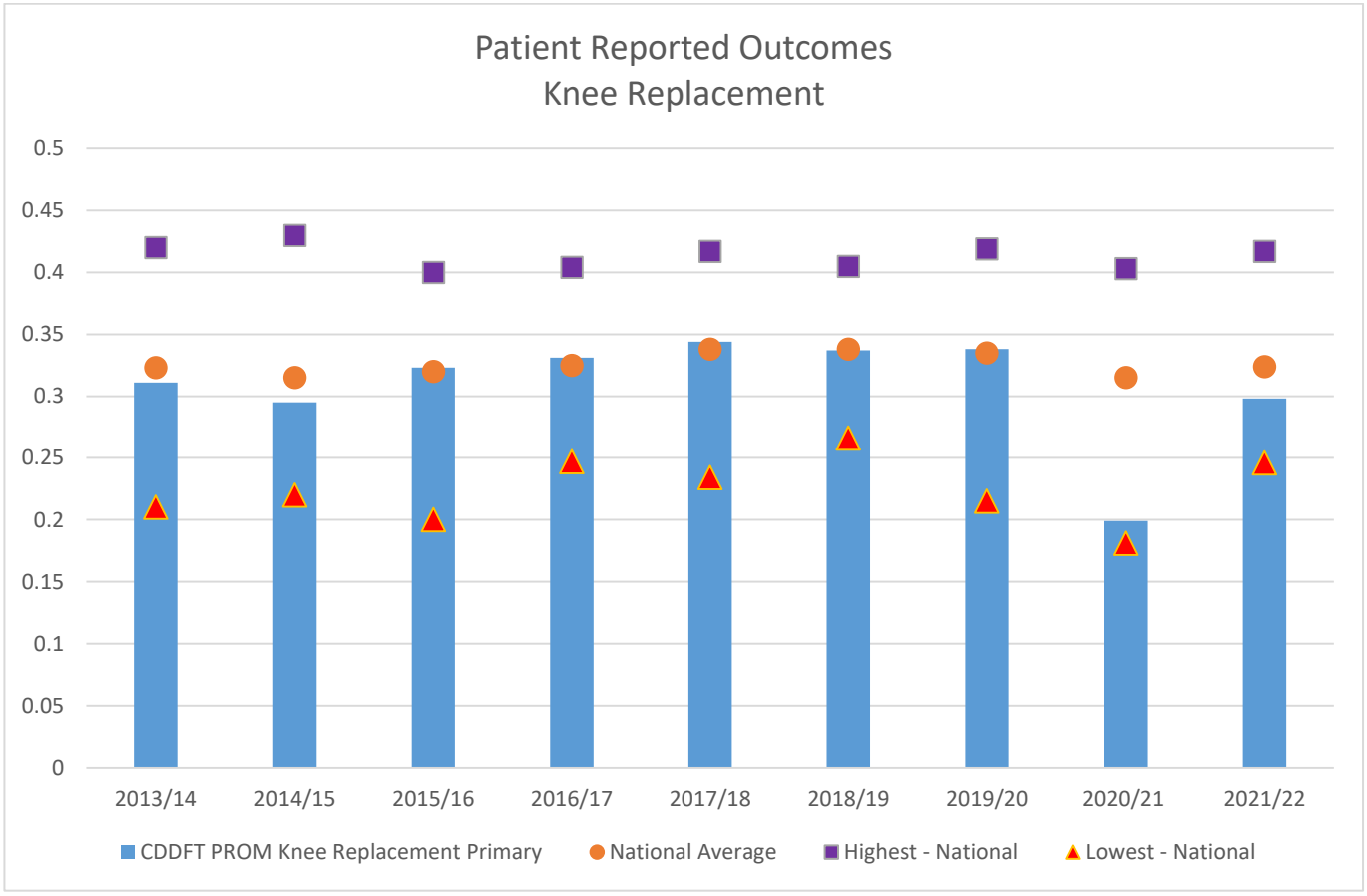
The County Durham and Darlington NHS Trust considers that this data is as described for the following reasons: this data is regularly reviewed at the Trust End of Life Steering Group

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 previous 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.'*

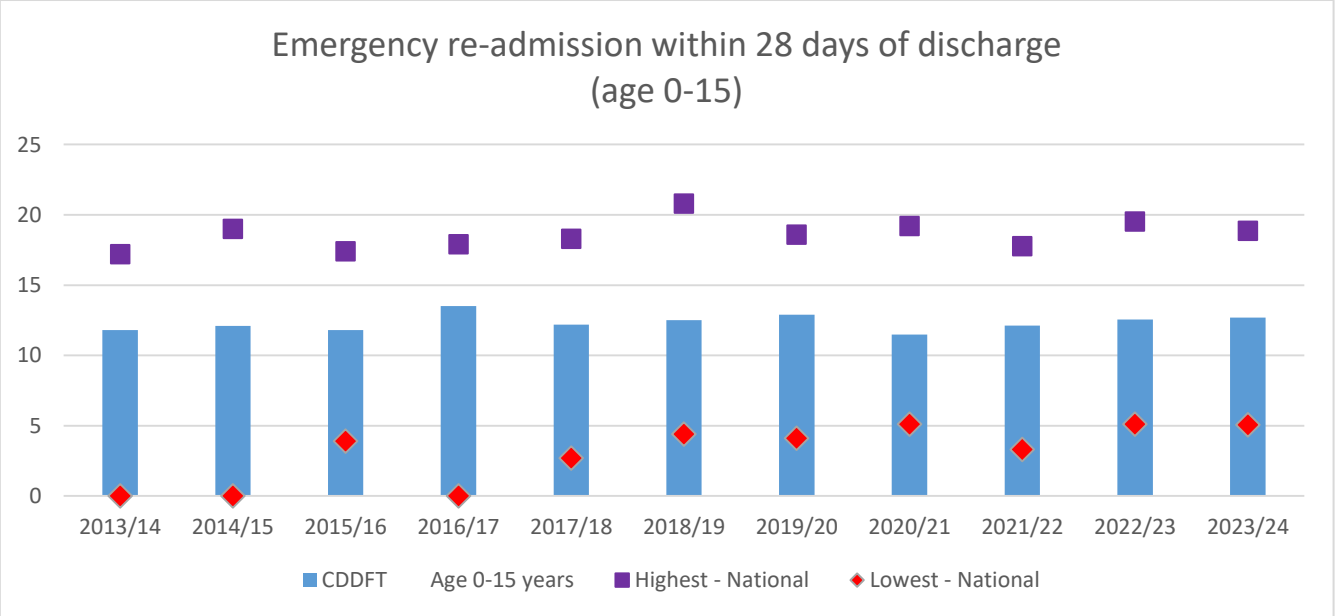
We have implemented a scheme to support our elective recovery programme which has helped increase the number of theatre lists which can be run for elective orthopaedic surgery. In addition and insources model of service was introduced to further support elective recovery. An obvious benefit of this will be an expected increase in PROMS questionnaires completion.

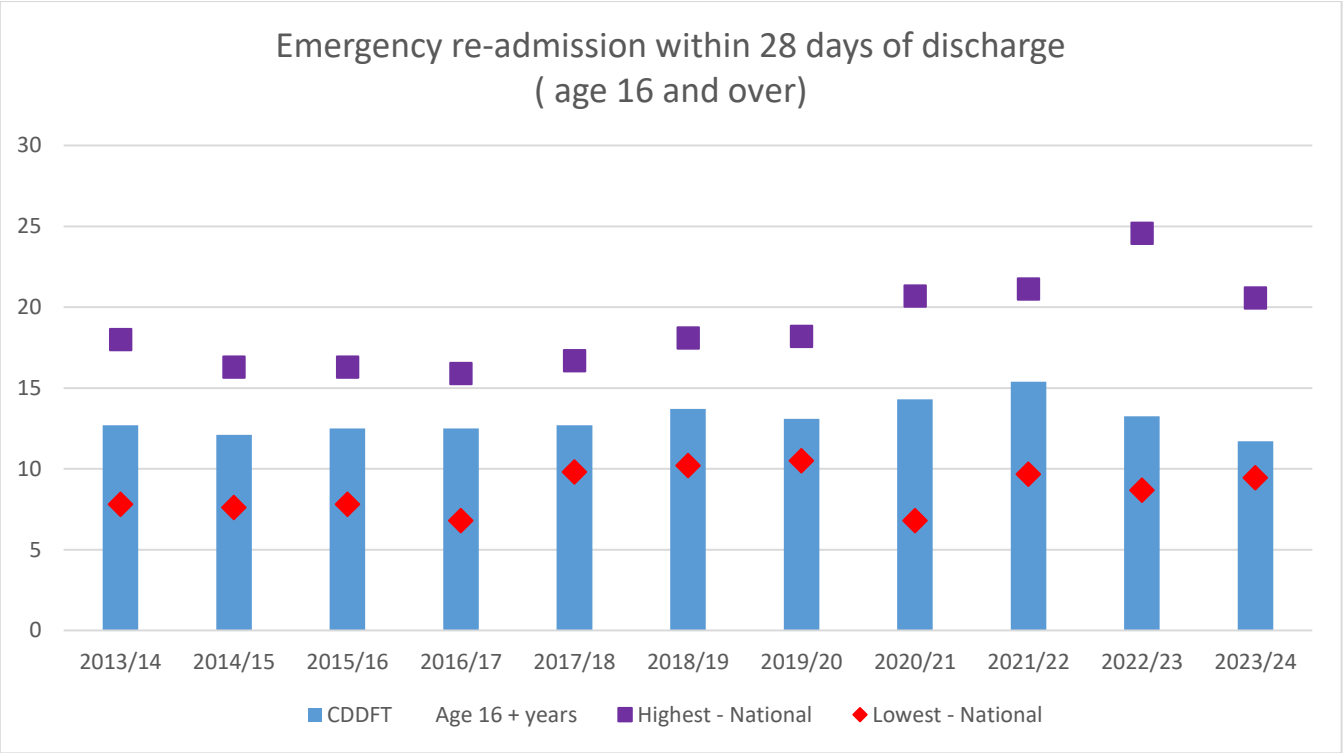
Orthopaedics' elective beds remain available at Darlington and Durham as well as the full elective ward at Bishop Auckland. As reported in last year's Quality Accounts, we have seen a reduction in trained Orthopaedics theatre staff which negatively impacts available Theatre time.

The team has in addition to the national picture shown above, introduced an internal process for PROMS compliance. Patients are provided with a PROMS questionnaire upon admission to the Day Surgery Unit and returned to staff upon completion, and prior to discharge. Review of PROMS data is undertaken at Directorate Meetings

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:

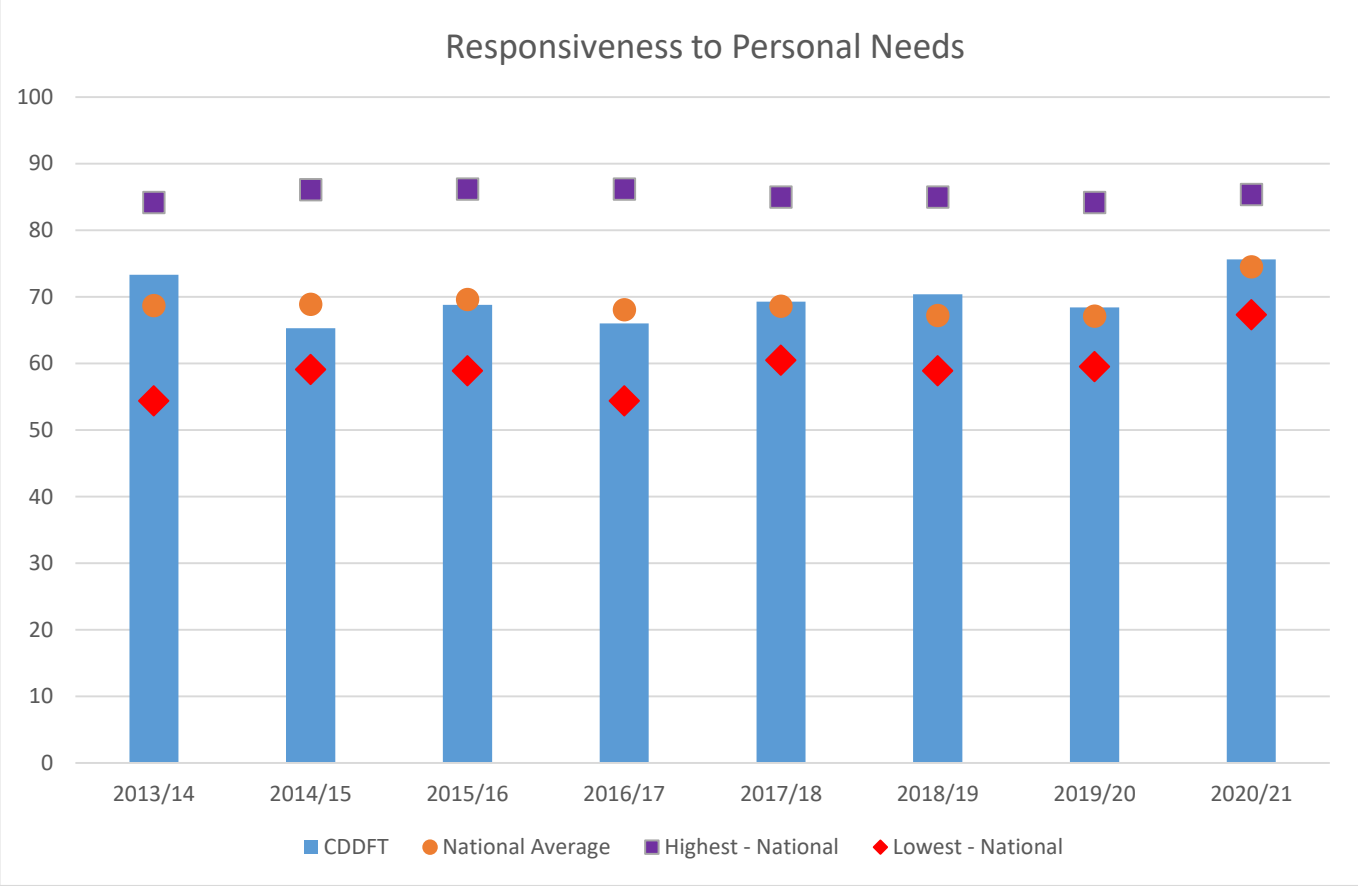
A number of actions have been taken in support of this measure:

- Introduction of a community-based urgent crisis response service. Patients, over 90% of the time, receive a response within two hours to support them at home. Work is underway to develop quality markers for this service.
- 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

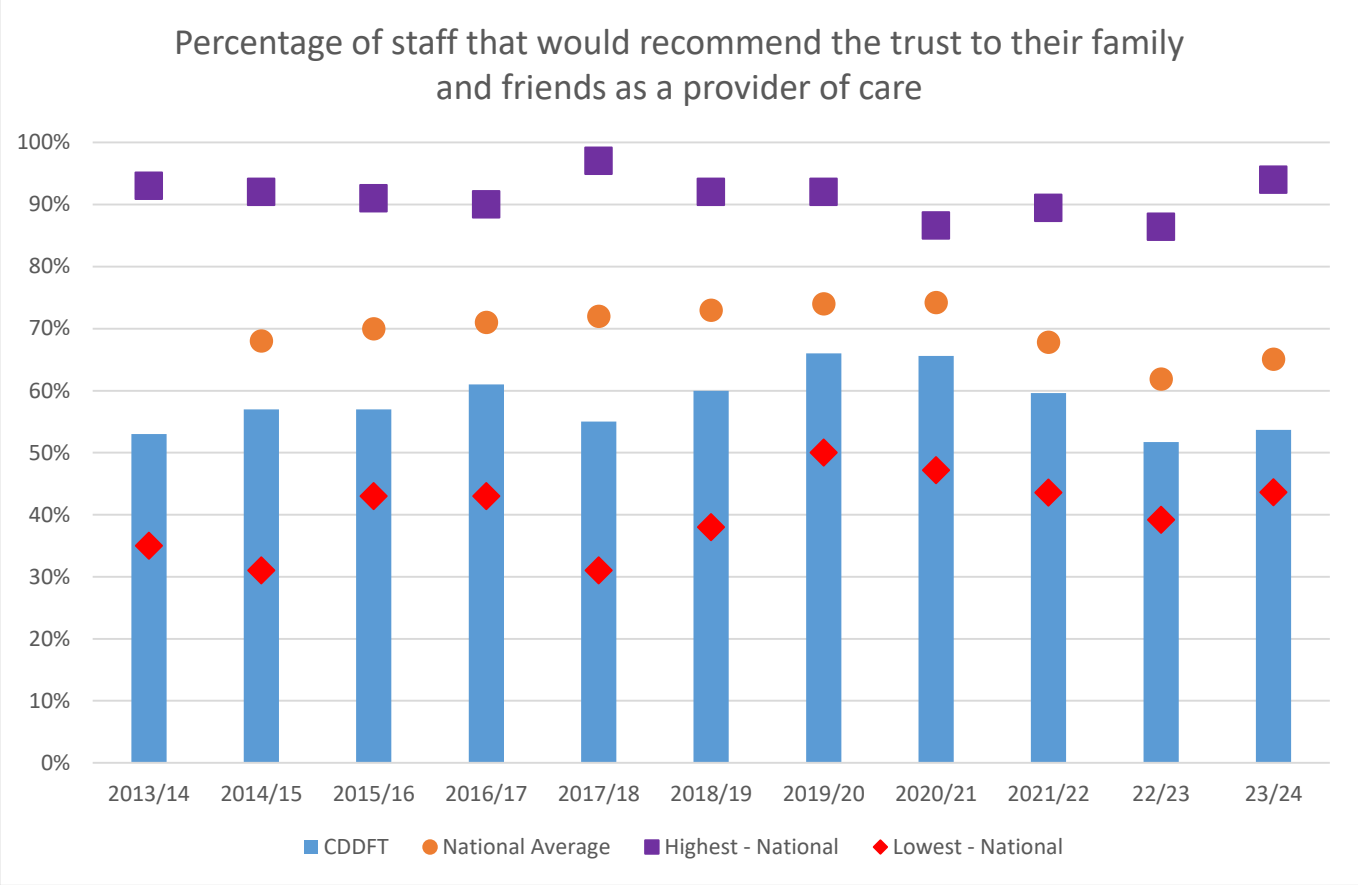


Data source: NHS Digital

The charts above are those submitted in our previous 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 2023

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 recommending the organisation as a place for family and friends to receive treatment'* from NHS Staff Survey for the last three years is shown below. The national average score is also shown.

We note that the question has been amended slightly for the 2023 staff survey and now asks *'If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation'*, however the tracking used by the survey remains consistent year on year. It is also of note that the score from staff does not match the patient Friends and Family Test results for the Trust which typically shown between 96% and 98% of patients having a positive experience whilst in our care.

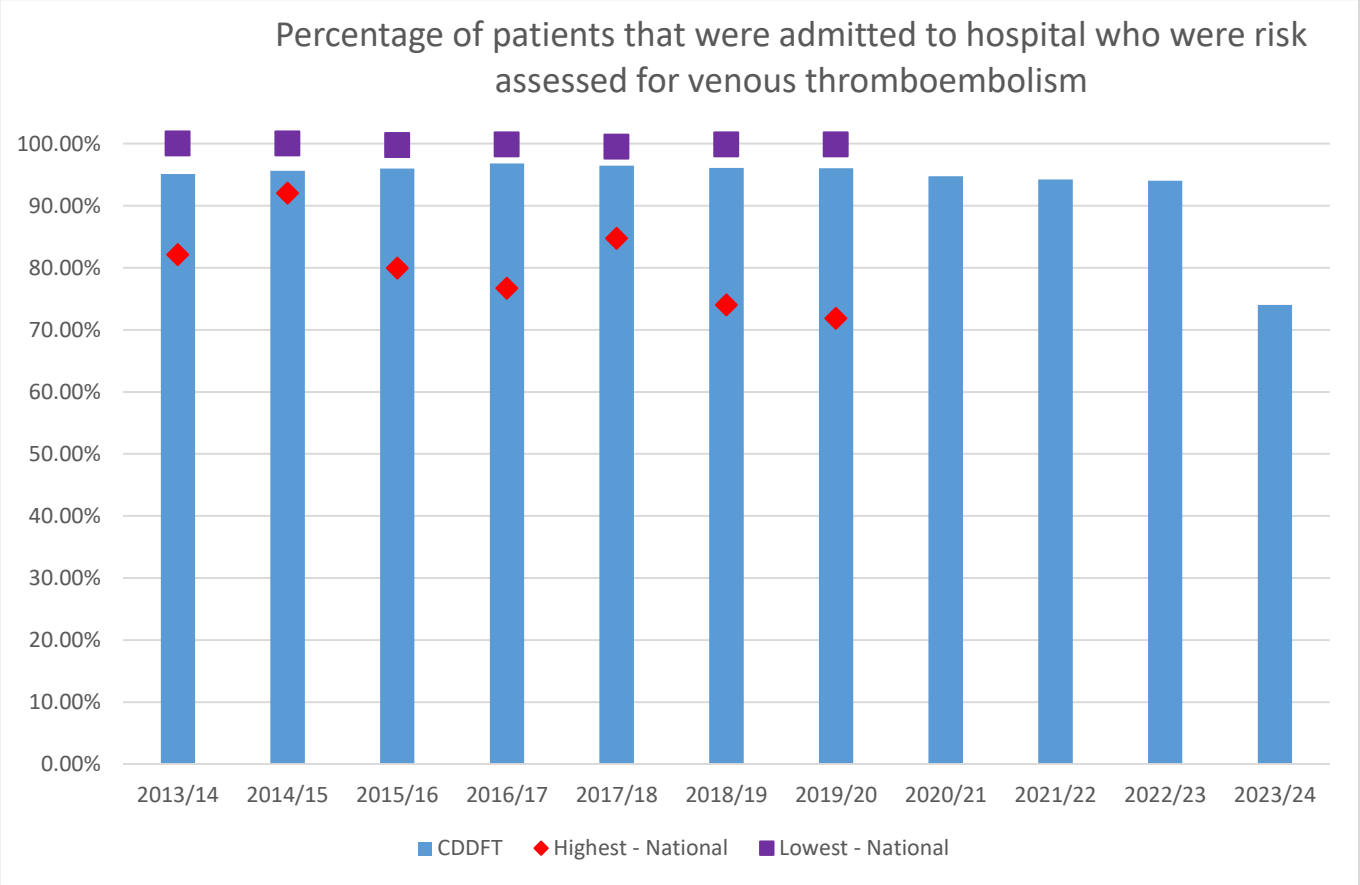
Question	2023		2022		2021		Trust Improvement / Deterioration
	Trust	National Average	Trust	National Average	Trust	National Average	
Q25d. If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	**53.70%**	**63.30%**	**51.70%**	**61.90%**	**59.60%**	**66.90%**	The Trust score has seen an improvement compared to 2022, but remains lower than 2021. The Trust reflects the national trend, showing improvement for 2023 following a period of deterioration nationally 2020-2021.

County Durham & Darlington NHS Foundation Trust continues 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 empower 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.

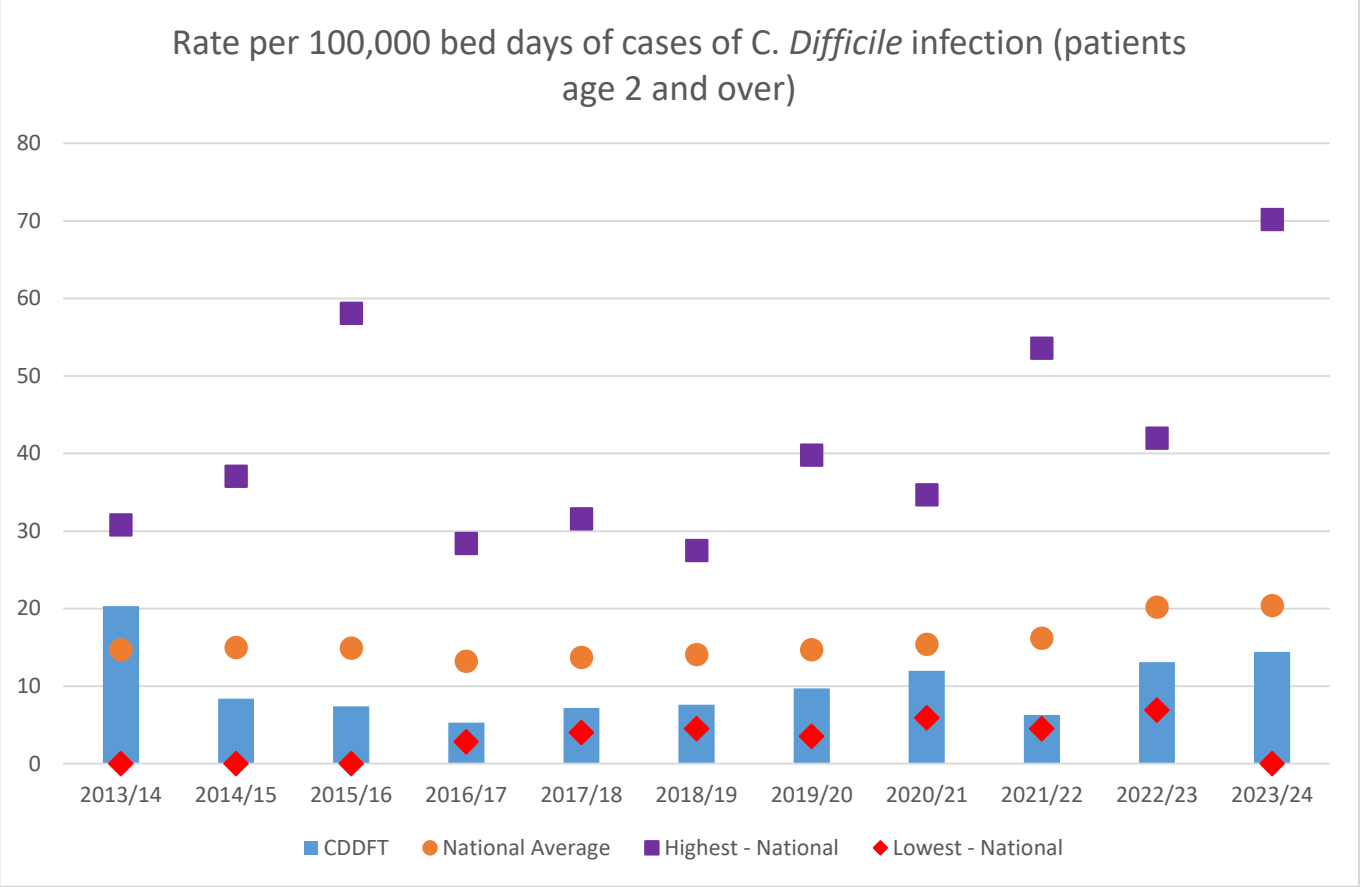


Data source: NHS Digital.

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. We continue with our priority of ensuring that clinical teams at County Durham and Darlington NHS Trust are completing this assessment correctly and to establish formal reporting metrics. Ongoing compliance monitoring to ensure that current performance is maintained, and that NICE guidelines are met, and to improve the quality of service takes place through our clinical governance structures and each service is monitored against an improvement trajectory through their monthly Quality and Performance Review meeting with the Executive Director of Operations and Director of Quality.

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



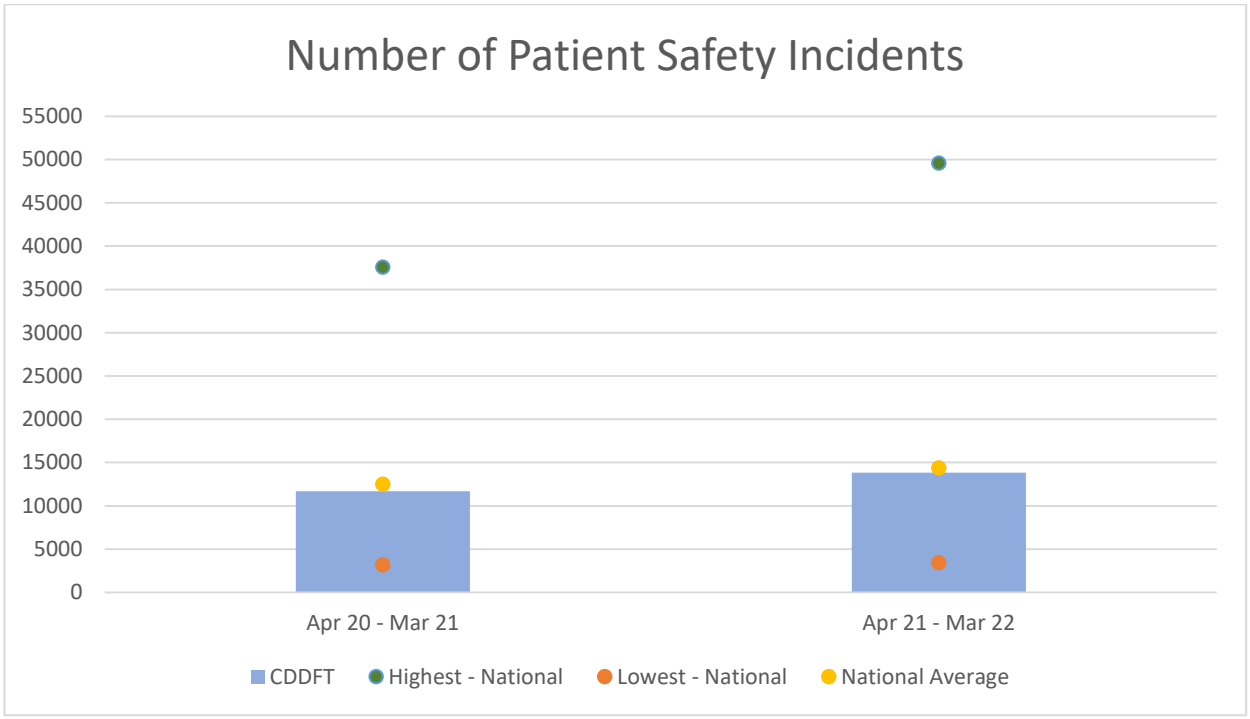
Data source: NHS Digital

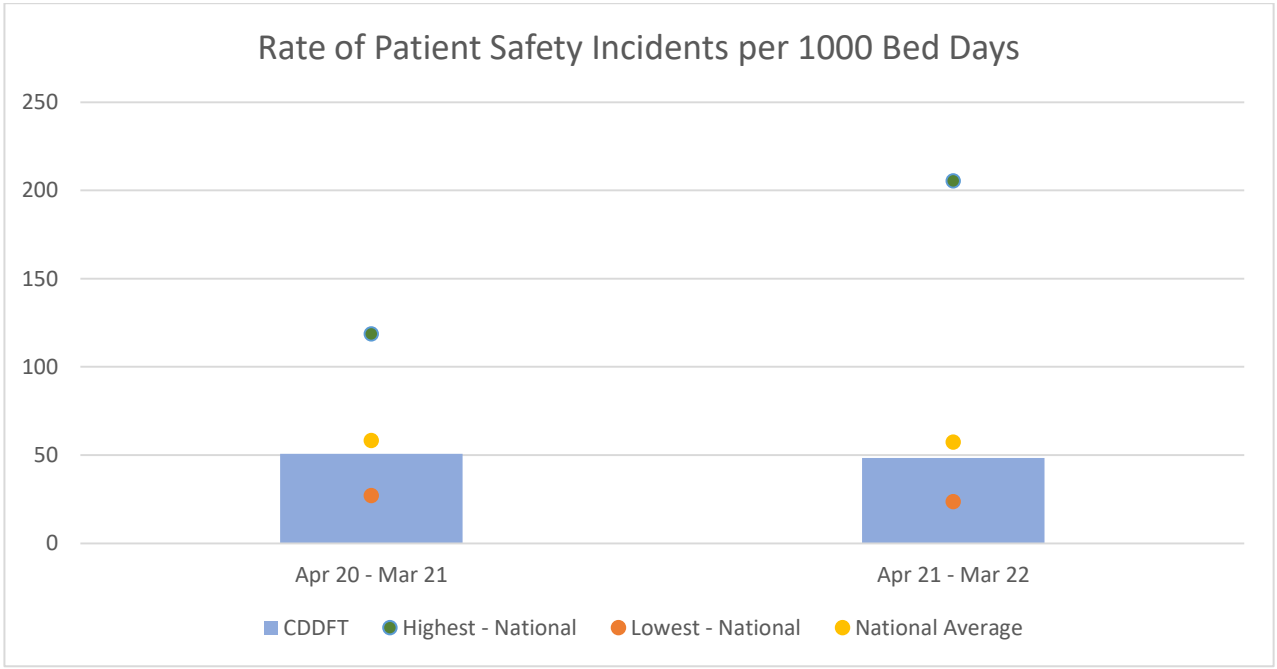
The County Durham and Darlington NHS Trust considers that this data is as described for the following reasons: the Trust monitors this data regularly via its Infection Control and Executive Quality Committees. Despite a significant increase in the number of C-Diff cases in the past two years, the national trend has been similar and the Trust remains below the national average. The Trust's nationally set threshold was 50 cases; however the Trust reported 78 cases in the year. The increasing trend in C-Diff is also replicated in the region.

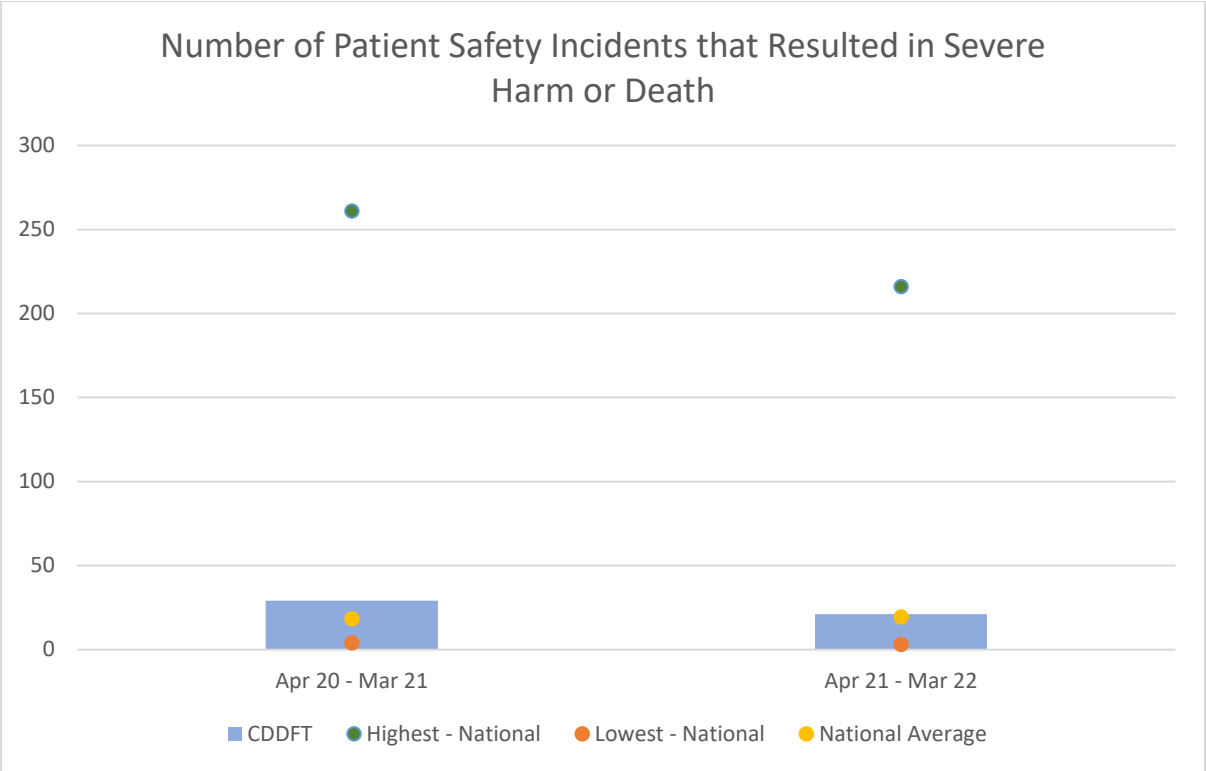
The County Durham and Darlington NHS Trust intends to take the following actions to improve the indicator and so the quality of services by:

- Focusing on early recognition of suspected / infective diarrhoea and appropriate patient management.
- Continuing with our Antimicrobial stewardship programme.
- Undertaking a rapid review of all healthcare associated C-Diff cases collaboratively with the clinical teams for timely review of best practice and any lessons learnt for action as appropriate.
- Holding weekly multi-disciplinary C-Diff meetings for complex C-Diff cases.
- Sharing learning in a timely manner to drive improvement.
- Monitoring of cleanliness standards.

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 has taken the following actions to improve the indicator:

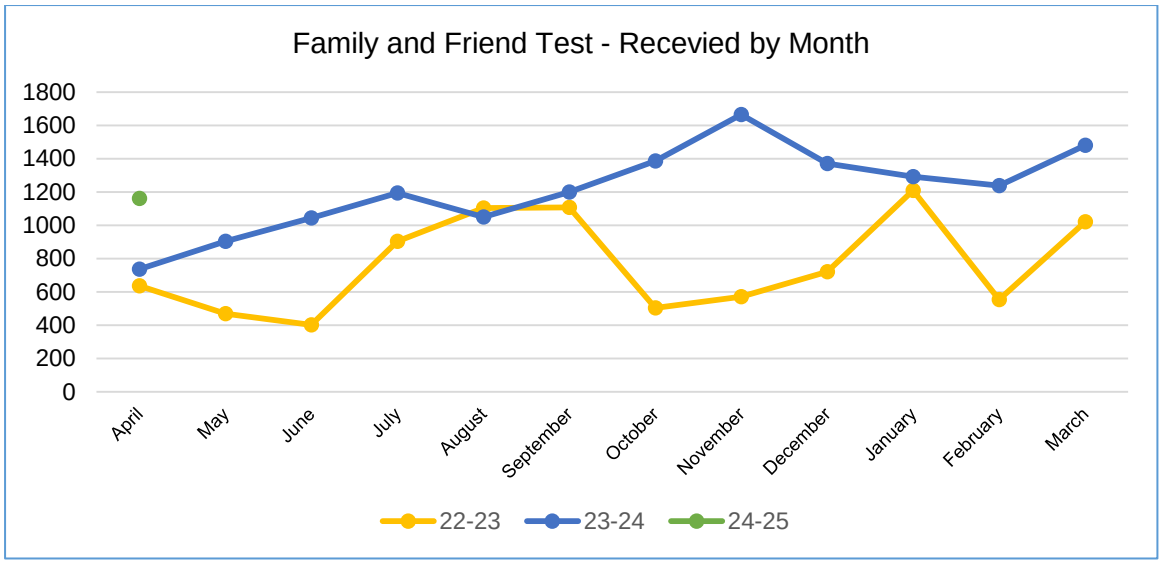
- Encouraging reporting of no harm and low harm incidents and near misses among staff during, resulting in an increase in reporting.
- Implementing our bespoke Patient Safety Strategy – Patient Safety Matters - which builds on the principles in Patient Safety Incident Reporting Framework.

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

Friends and Family Test

The Friends and Family Test has undertaken throughout 2023/24 and improvements to how we capture feedback from our patients and how we use this data / information to drive service improvement.

There are now over 200 areas each with personalised feedback cards which are handed to patients when they visit. Feedback cards are collated and recorded by the Patient Experience Team who have seen a significant increase in the amount of responses compared to 2022/23. A further, significant, increase has also been noted for April 2024 as shown in the chart below.



Each month Wards and Departments receive both quantitative and qualitative feedback in the form of a poster to be displayed on their noticeboards to patients and staff. The posters promote the, overall, positive experience of patients together with a sample of compliments.

Friend and Family Easy read

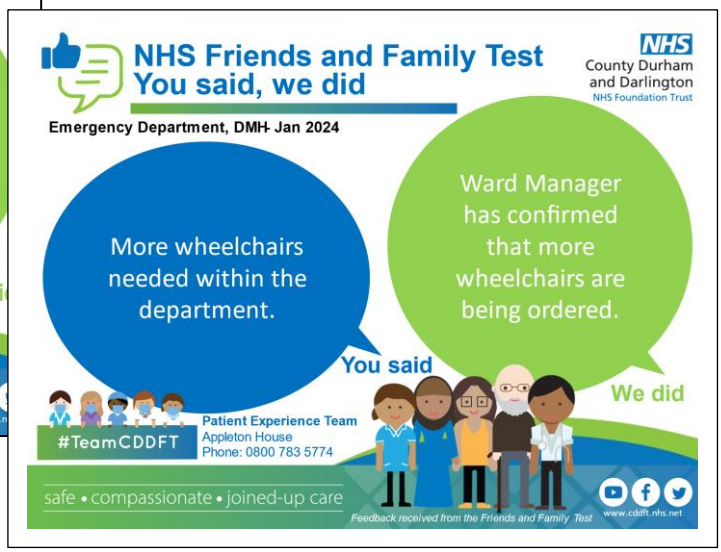
We also introduced an easy read Friends and Family Test card which is offered to our Patients with learning disabilities support by our Learning Disabilities Nursing Team.

Friend and Family Interpreting Service

Looking at ways to improve the health inequalities agenda, every patient who has the services of an interpreter is to be offered an opportunity to complete the Friends and Family Test as part of their appointment with the support of this interpreter.

'You said we did'

We continue to utilise the feedback from our patients and service users to drive service improvement through the 'you said, we did' initiative. Wards and departments are offered feedback and required to agree local actions and improvements. Examples are shown below.



Part 3 Other Information

This section of the Quality Account includes an overview of the quality of care provided during 2023/24 that has not already been reviewed in this report, covering aspects of Patient Safety, the Patient Experience and Clinical Effectiveness. There is also a review of performance against indicators included in the NHS Oversight Framework

The Trust launched its Quality Strategy (Quality Matters) in 2022/23, to cover the four years to 2025/26. A number of Trust priorities can be seen to overlap with national planning guidance.

Patient Safety

Quality Improvement

The Senior Sister for Quality Improvement has supported a number of projects this year. These include:

- '4AT' which is an assessment used to assess delirium.
- 'Drip or Drink' and the hydration traffic light jug campaign which are both linked to improving hydration in hospitals. The Drip or Drink campaign has been trademarked and is now being used in other hospitals. This initiative has also prompted improvements as to how we approach both nutrition and hydration in the emergency departments and as a result has now seen the introduction of a hostess trolley across both sites. Further work is planned to ensure both departments can provide warm meals.
- The traffic light jug campaign is operational across a large number of our wards and teams and has been very successful so far, as it encourages patients and staff to focus on maintaining sufficient hydration through the day. Early analysis of the impact of this initiative showed a reduction in falls and urinary tract infections.

In 2024-25, the Senior Sister for QI is going to support improvement work with falls in the community hospitals and the ACT NOW campaign which is an initiative developed to support rapid assessment and planning for the deteriorating patient.

Incident Reporting and Investigation

Incident reporting and investigations have undergone national review resulting in a change in the national patient safety strategy and systems used. In 2023-24 CDDFT transitioned across to the new Patient Safety Incident Response Framework (replacing the Serious Incident Framework) and to the national Learning From Patient Safety Events (LFPSE) platform, which replaced the National Reporting and Learning System. As other NHS Organisations are following different timelines for implementation we have not been able to include comparative data in this report. NHS England is considering how they will produce national data and are looking to release these in the coming months but annual reports remain paused.

The emphasis of the new approach is on rapid and systemic learning, focusing on themes rather than individual incidents. There are therefore fewer individual patient safety incident investigations under the new approach and the numbers cannot be compared with the number of serious incidents in prior years.

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 incident investigations 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.

The reporting and investigation of incidents and subsequent learning is integral to maintaining patient safety and improving our quality of care. Between 1st April 2023 and 31st March 2024, 2.5% of incidents were reported as resulting in moderate harm or worse, which is slightly higher than in 2022-23.

Falls, and falls resulting in harm continue to be one of the highest reported incidents. The work of our Falls Team, and the improvements arising have been set out on page 11of this report.

In 2023 our primary focus was to embed the new Patient Safety Incident Response Framework (PSIRF). One of the key aims of the new framework is to ensure rapid learning, achieved at the sharp end where effective change can occur. This is why many patient safety investigations are taking the form of an 'After Action Review' (or known locally as 'level 2') which means that the review will occur quite quickly after the incident has occurred using the SEIPS model to understand contributing factors. A good example of where these reviews have worked well is in the falls work.

Another integral element of PSIRF is engaging patients and families early in the investigation process. In 2023 we introduced the role of Family Liaison Officers (FLO) across CDDFT. These are staff who have received specialist training that will act as the conduit between the investigation and the patient/family. We have twenty five active FLO's currently and have a further twenty four people undertaking the training in 2024-25.

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.

Never Events

The Trust have unfortunately reported one never event in 2023-24. The event falls into the category of 'wrong site surgery' involving a dermatology procedure. The event was deemed to be a no harm incident and an investigation has taken place.

Our focus in 2024-25 is to develop system improvement plans, these will be based on learning identified through investigations and align to the national patient safety priorities. The aim of the plan is to enable focus on completing the improvements rather than producing singular and potentially repetitive action plans for every individual patient safety event.

Patient Experience

Patient Experience

Our Patient Experience and Engagement strategy was introduced in 2022 and included multiple objectives over three work streams: Patient Experience, Engagement and the Volunteer Service. We have summarised our progress against key objectives below:

Patient Experience:

1. **Take every opportunity to gather and analyse feedback and insights to drive service improvement.**

√ We introduced paper cards to all ward areas to increase the level of feedback.
√ We introduced an easy read feedback method.
√ We introduced drawing feedback sheets for young children.

2. **Take every opportunity to gather and analyse feedback and insights to drive service improvement.**

√ We introduced several service specific feedback surveys to evaluate services throughout CDDFT, including the Looked After Children team, the Anorectal Physiology Service and diagnostic spirometry service.
√ We introduced an external platform for patients and service users to raise concerns and compliments.

Engagement

1. **Take every opportunity to gather and analyse feedback and insights to drive service improvement.**

√ We expanded our use of patient stories covering both positive and negative experiences, to celebrate success and drive service improvement.

√ We reintroduced the post discharge survey quarterly, using this insight to identify service improvement and celebrate success.

2. **Take every opportunity to gather and analyse feedback and insights to drive service improvement.**

√ We restarted our Patient Experience Network Group in June 2023; the group meets quarterly with a membership of internal, external and patient representatives.

√ Work continues to reintroduce the Patient Council and we will embark a social media campaign throughout 2024 to drive engagement.

Volunteer Service

1. **Increase the number of active volunteers for CDDFT.**

√ We now have 110 active volunteers here at CDDFT.

2. **Introduce a diverse team of volunteers.**

√ Working in collaboration with our colleagues at the Durham Refugee Monitoring Service, we now several refugees who are currently actively volunteering within our services.

3. **Progress the volunteer to career pathway for CDDFT.**

√ During 2023 we successfully embedded the Volunteer to Career program enrolling 12 candidates, 6 of whom secured employment. We are looking to embed the approach in the Trust's workforce plans moving forwards.

4. **Support the introduction of volunteers to the workforce to allow time to care.**

√ We introduced Volunteer to Career candidates in ward helper roles to support areas who needed additional support. Feedback from staff and volunteers has been positive.

5. **Develop the role profiles for volunteers at CDDFT.**

√ We devised and rolled out the ward helper role for our volunteer to career candidates. Further role profiles will be introduced as the program expands in the coming year.

University Hospital of North Durham, Baby Memorial Garden

Plans to improve and expand the Emergency Services in University Hospital of North Durham were approved and work started to the building and surrounding areas. This resulted in moving the Baby Memorial Garden becoming a priority.

Social media and Newspaper communications began to engage with the parents who had arranged for plaques to be placed in the garden over many years. This proved difficult as due to the sensitivity of the bereavement there was no formal list of parents to reach out to and contact was through external methods. Open engagement sessions were held and advertised through media and we were able to reach out to approximately 80 parents who have worked CDDFT to successfully and empathetically move the Baby Memorial Garden to its new location on the Woodland Walk. The garden will have an opening ceremony in the coming months and the trustees of the garden will be introduced to ensure constant engagement with parents using the garden.

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.

National Inpatient Survey 2022

(These surveys run at least 12 months behind this is the most up-to-date results)

This survey looked at the experiences of 63,224 people, across 133 NHS trusts, who stayed at least one night in hospital as an inpatient during November 2022. Questions included in the survey followed people's journeys from admission to hospital, treatment and discharge.

Between January and April 2023, 1,250 people at each participating NHS trust were invited to take part. The survey was broken down into 11 sections and the rating for CDDFT are shown below.

• Admission to hospital	6.3/10	about the same as other Trusts.
• The hospital and ward	7.8/10	about the same as other Trusts.
• Doctors	8.9/10	about the same as other Trusts.
• Nurses	8.5/10	about the same as other Trusts.
• Care and Treatment	8.1/10	about the same as other Trusts.
• Leaving Hospital	7.1/10	about the same as other Trusts.
• Feedback on Care	1.0/10	about the same as other Trusts.
• Respect and Dignity	9.2/10	about the same as other Trusts.
• Overall Experience	8.0/10	about the same as other Trusts.

Actions identified:

Feedback on care – reintroduction of Friend and Family Test to gather feedback, the impact of this initiative being stood down over the pandemic took its toll but we are confident that 2023 results will see a much-improved score in the latter part of 2024.

Leaving Hospital - A recent evaluation of the discharge process working in collaboration with HealthWatch County Durham identified areas of improvement. We introduced a Discharge Support Team provided by Durham County carers, documentation has been evaluated and a review of the medication delays have been considered.

Overall Experience – Whilst there could always be improvements with overall experience it was important to celebrate our successes with staff, and the reintroduction of the post discharge survey has allowed this to be monitored closely quarterly and resolve needed improvements that are identified timely.

CQC National Maternity Survey 2023

The survey was administered by the Coordination Centre for Mixed Methods (CCMM) at Ipsos. A total of 63,271 people who used maternity services were invited to participate in the survey across 121 NHS trusts.

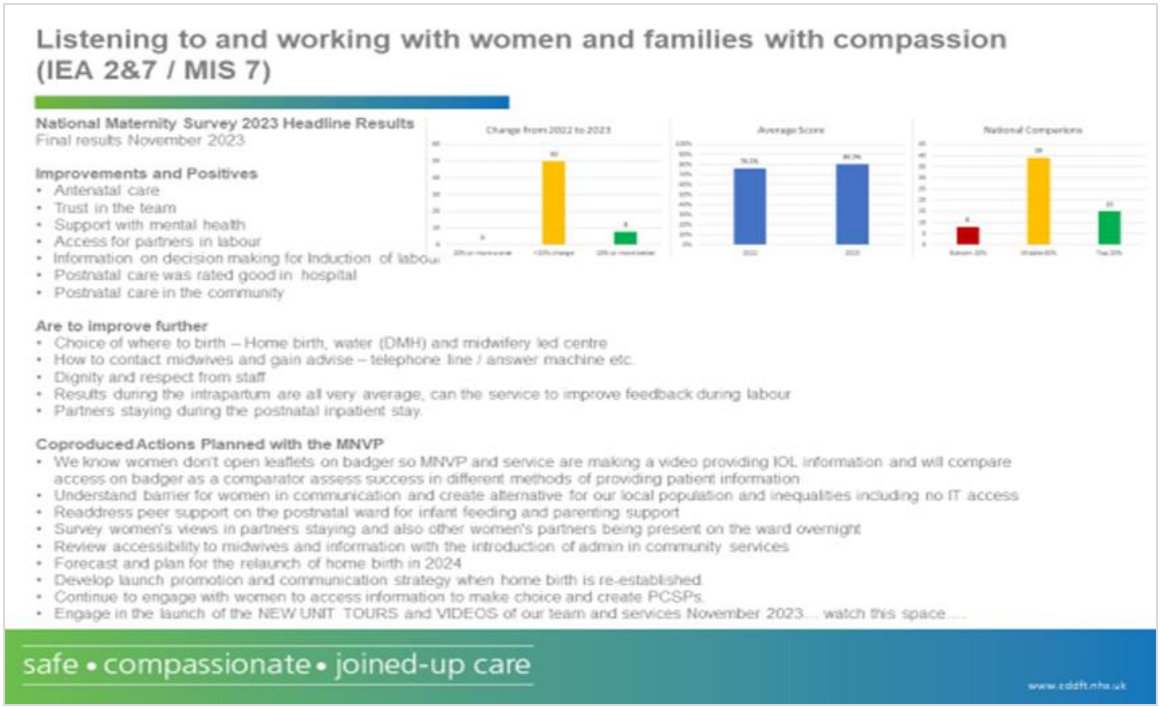
The survey for CDDFT noted that maternity service users' experience was best in the following areas:

- √ Maternity service users being able to get support or advice about feeding their baby during evenings, nights, or weekends, if they needed this.
- √ Maternity service users discharge from hospital not being delayed on the day they leave hospital.
- √ Maternity service users being able to see or speak to a midwife as much as they wanted during their care after birth.
- √ Midwives providing service users with relevant information, during their pregnancy, about feeding their baby.
- √ Maternity service users receiving help and advice from a midwife or health visitor about feeding their baby in the six weeks after giving birth.

The following areas were flagged where maternity service users' experience could improve.

- √ Partners or someone else involved in the service user's care being able to stay with them as much as the service user wanted during their stay in the hospital.
- √ During antenatal check-ups, maternity service users being given enough information from either a midwife or doctor to help decide where to have their baby.
- √ Maternity service users being offered a choice about where to have their baby during their antenatal care.
- √ During pregnancy, maternity service users receiving the help they needed when they contacted a midwifery team.
- √ Maternity service users feeling that if they raised a concern during their antenatal care it was taken seriously.

Our maternity services leaders worked with the local Maternity and Neonatal Voices Partnership to co-produce an action plan as shown overleaf.



Urgent and Emergency Care

Type 1 – Emergency Departments

The Urgent and Emergency Care team, recently met with Patient Experience during October 2023 to consider the findings of the most recent National Survey. Details of the findings and actions identified are shown below.

Type 1: Action Planning

Bottom five scores (compared with national average)

Question	Rating		Action to date
Section 2: Waiting	**CDDFT**	**Average**	
Q7. How long did you wait before you first spoke to a nurse or doctor?	3.9	5.0	The ED Senior Team created a 4 hour action plan with the aim of reducing waits and improving responsiveness. This plan is almost complete and has resulted in improvements across sites for the same period last year. Ambulance handovers have seen DMH and UHND achieve sustainably the best in the region. Effective streaming is essential to ensure the patient is seen in the right place, first time. A Quality Improvement work streams was initiated in summer 23 and is progressing to reduce delays in ED and improve responsiveness. Assessment time in ED DMH has improved enabling more patients to be fully assessed in 15 minutes.
Q8. Sometimes, people will first talk to a doctor or nurse and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?	4.2	5.4	As above Capacity in the ED is challenging at times of high attendance and UEC is working with IMS and Surgery to improve flow releasing ED cubicles for patients to be examined in. ED flex to utilise all available accessible areas to see ambulatory stream of patients, aiding discharge where possible. Patients are kept informed of waiting times for four different streams of care via an electronic board displayed in the waiting room where health care staff record patient observations and are available to speak to or raise any concerns to, if required.

Question	Rating		Action to date
Q12. Overall, how long did your visit to A&E last?	4.4	5.2	As above. In addition focussed work programmes are in progress to improve flow out of ED for those patients that require admission. Delays in flow for these patients adversely impacts on the responsiveness of the service for all patients.
Section 4: Care and Treatment	**CDDFT**	**Average**	
Q21. While you were in the Emergency Department, did staff help you with your communication needs? (E.g. any language needs or communication needs related to a disability, sensory loss or impairment).	5.5	6.4	Findings shared with Matrons and GM's to gain an understanding of any specific barriers and to support the identification of improvements, including resources that would improve the quality of communication. ED use a language interpreting service on a regular basis to enable clinical staff to communicate with patients and understand their needs.
Section 7: Leaving the Emergency Department	**CDDFT**	**Average**	
Q45. If you had contact with care and support services after leaving the Emergency Department, did the health or social care staff have information about your visit?	4.2	6.0	Findings shared with Matrons and GM's to gain an understanding of any specific barriers to healthcare information being appropriately shared and to identify solutions. GP discharge letters are monitored and generated for all discharges from the Emergency Department, which is available in primary care to share with the wider primary care teams as necessitated such as district nurses etc.

Type 3 – Action Planning

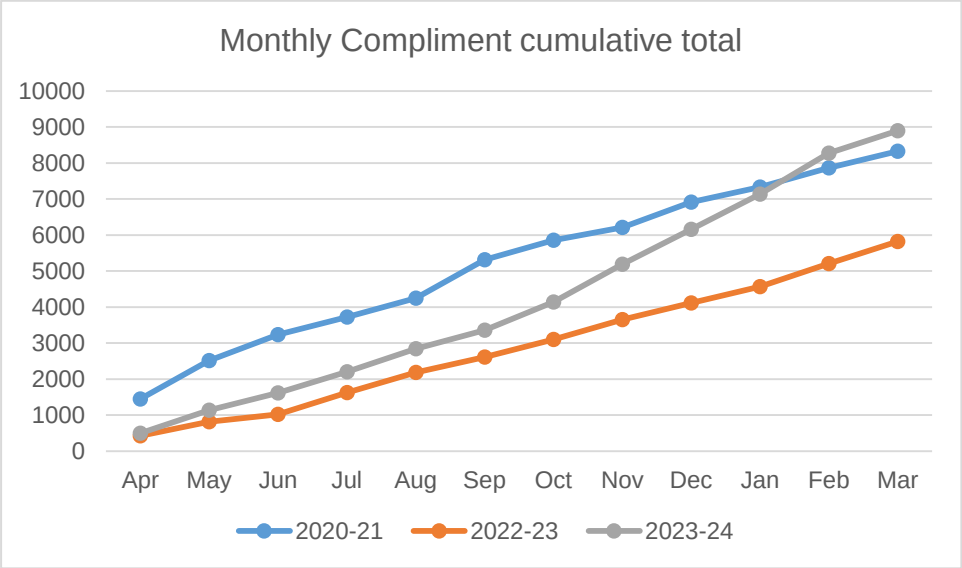
Bottom five scores (compared with national average)

Question	Rating		Action to date
Section 4: Care and Treatment	**CDDFT**	**Average**	
Q28. Do you think the staff did everything they could to help control your pain?	7.4	7.8	Share findings with UTC teams; • Increase in Friends and Family response rates to enable timely service improvements. • Focussed audits to be explored
Section 5: Test	**CDDFT**	**Average**	
Q26. If you had any tests, did a member of staff explain why you needed them in a way you could understand?	8.1	8.8	As above
Q27. Before you left the Urgent Treatment Centre, did a member of staff explain the results of the tests in a way you could understand?	7.9	8.8	As above
Section 6: Environment and Facilities	**CDDFT**	**Average**	
Q30. While you were in the Urgent Treatment Centre, did you feel threatened by other patients or visitors?	9.8	10.0	Trust zero tolerance and security posters are in place. 24/7 security is presence at DMH UTC as it shares the same waiting room as ED.
Section 7: Leaving the Urgent Treatment Centre	**CDDFT**	**Average**	
Q37. Did a member of staff discuss with you whether you may need further health or social care services after leaving the Urgent Treatment Centre? (E.g. services from GP, physiotherapist or community nurse, or assistance from social services or the voluntary sector).	8.0	8.2	Share findings with UTC teams for reflection on potential improvements

Compliments

Compliments continue to be reported from our patients for our staff. During 2023 we improved the ways we collect these compliments and the Patient Experience Team work closely with wards and departments to ensure we collate them appropriately.

The below chart shows the number of compliments cumulative, and shows that the amount of complaints has significantly increased from 2022-23 period. The Trust receives 20 compliments for every 1 complaint raised.



Complaints

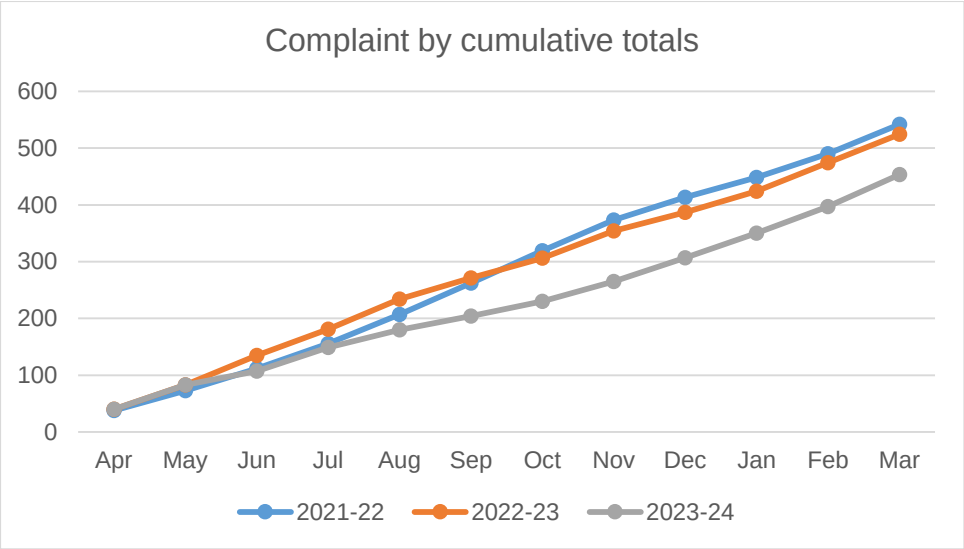
After the implementation of the PHSO Complaint Standard Framework at CDDFT in 2022, the complaint process was evaluated and in December 2023 we overhauled our complaints handling policy. The changes took account of feedback from our complainants and have been designed to increase early engagement with complainants, and to allow them to receive a timely and empathetic response to their concerns.

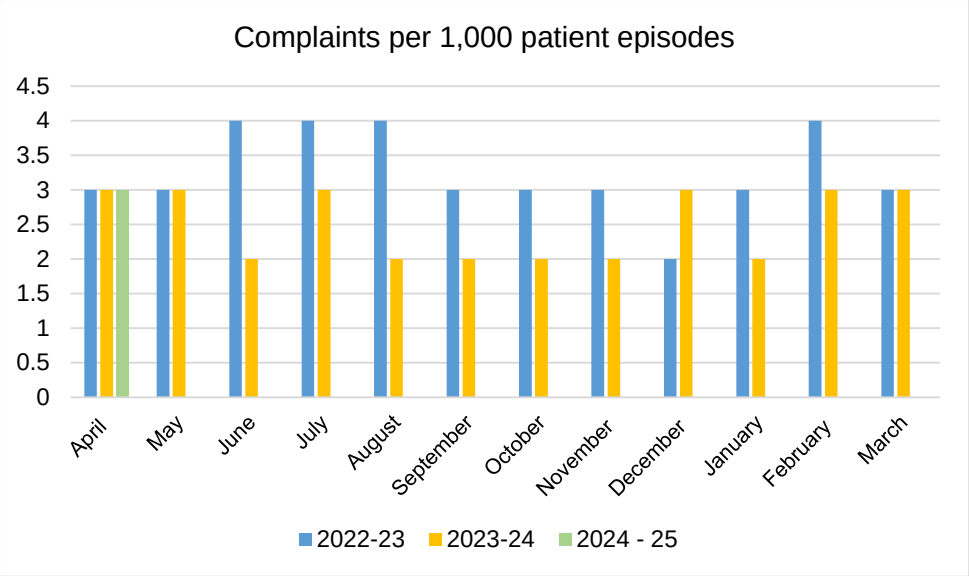
The changes made are shown below.

- √ Investigating Officers are allocated to complaints and they communicate with complainants rather than the Patient Experience Team.
- √ Target timescales have been set for complaints to be responded to within 35 working days, 25 for investigation and 10 for peer review and CEO approval.
- √ Access to a web system to assist investigation officers and ensure robust governance processes.

Whilst still early into the implementation of the new approach, the changes have had a positive effect, complainants have been able to discuss their concerns with the investigators and less responses have been queried, some cases are being resolved as quick resolution cases and the timescales for completion have reduced.

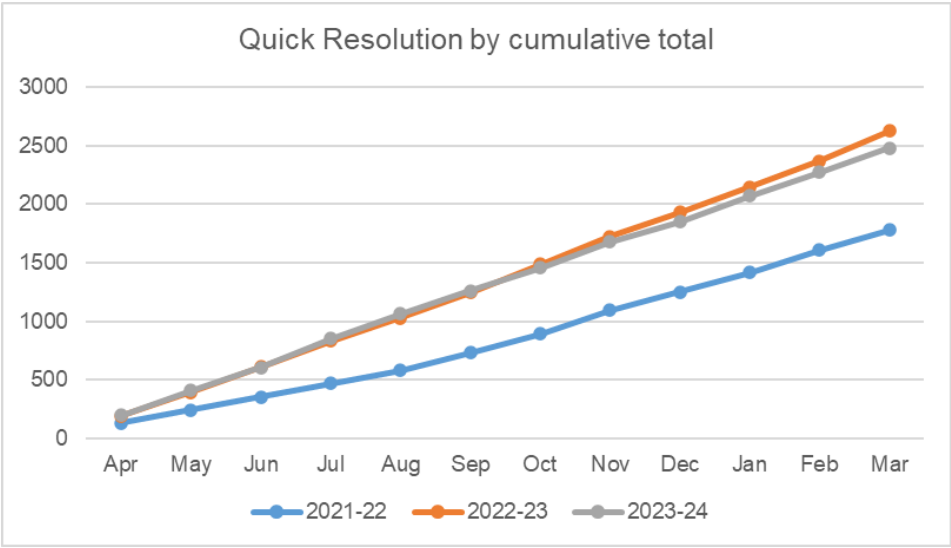
The charts below show the number of formal complaints received Trust-wide throughout 2023-24 as a cumulative total and in comparison, to previous years back to 2021-22. They also show complaints per 1,000 patient bed days so that the link between the number of complaints and activity is clear.

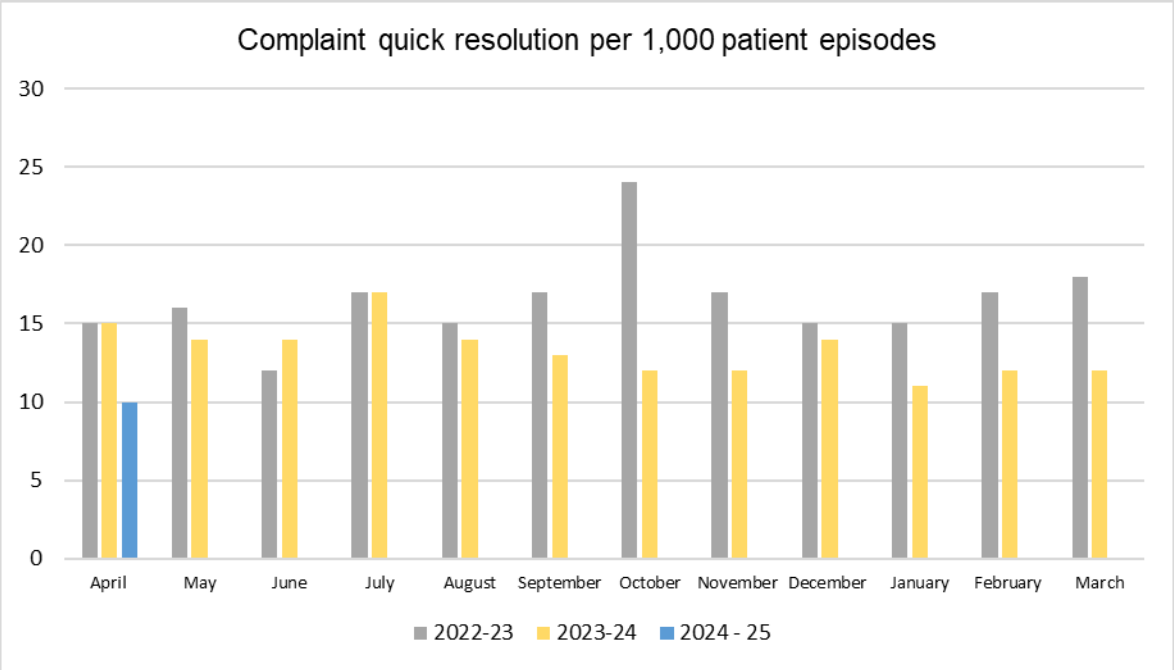




Quick Resolution Complaints

The charts below show the number of quick complaints received trust-wide throughout 2023-24 as a cumulative total and in comparison, to previous years back to 2021-2022, together with the number of quick resolution complaints per 1,000 patient bed days.





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. This is now done from positive experience as well as from complaints.

In response to previous patient stories, we have started Therapy Dog visits to wards and departments, these have proven to be positive.

During one visit the dog visited a patient who was in the last stage of life, Freddy. The family had been made aware it was just a matter of time. It was thought that a therapy dog visit would help the family.

Several weeks later a thank you card came in from Freddy and his partner Evelyn who thanked us for the visit and they truly believe the visit from the dog made Freddy's health improve. This visit happened in November 2023 and Freddy is still enjoying life with his partner, and they are eternally grateful.

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 4 hour standard has been pressured through the year. For the last quarter (Jan – Mar), reported Trust performance was 73.9%, ranging from 71.4% in February to 77.8% in March.

Before the COVID-19 pandemic, the Trust had plans to increase its capacity for Same Day Emergency Care (SDEC), streaming some patients out of the ED queue who could be treated and discharged on the same day. This work has commenced in 2023/24 further development plans in 2024/25.

Increasing the footprint of the EDs and the bed base in response to capacity limitations were also key ambitions. Work is underway at the UHND site ahead of the construction of the new ED.

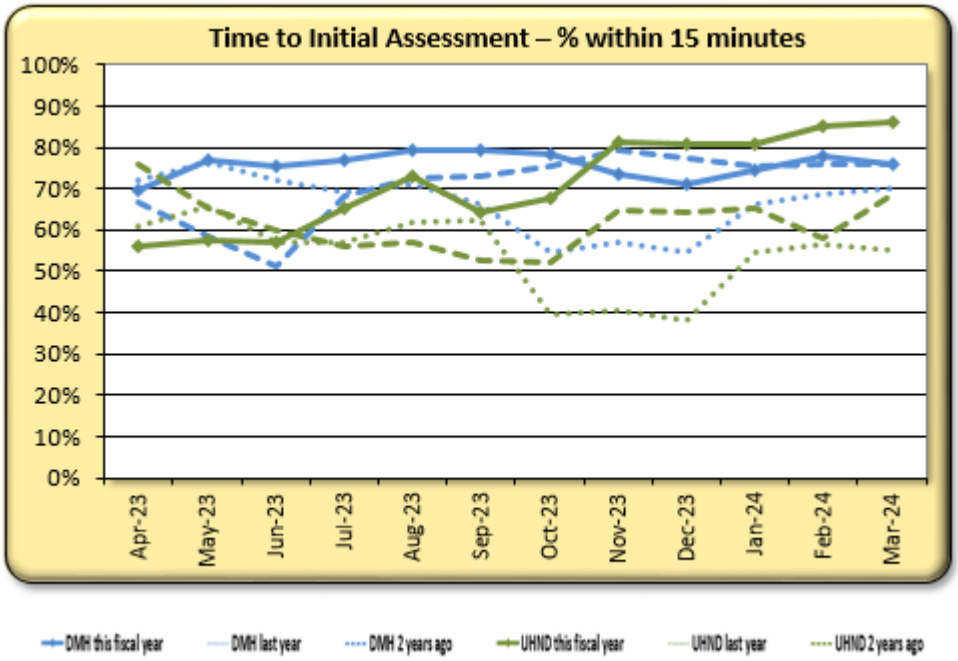
In 2023/24, the North East region performed comparatively well compared to the national position; the year also saw dramatic growth in demand for urgent and emergency services, with attendances at an ED 6.8% higher than the prior year, 12.2% higher at an urgent care facility, and unplanned care attendances resulting in a hospital stay of at least 1 day increasing by 11.6%.

Month/Quarter	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Qtr 1 2023/24	Qtr 2 2023/24	Qtr 3 2023/24	Qtr 4 2023/24	Fiscal Year 2023/24
DMH ED attends	5,649	5,881	5,956	6,077	5,752	5,829	6,307	5,725	5,960	6,152	5,844	6,113	17,486	17,658	17,992	18,109	71,245
DMH ED 4 Hour Waits	2,832	2,976	2,885	2,851	2,442	2,457	2,781	2,820	3,141	3,269	3,032	2,665	8,693	7,750	8,742	8,966	34,151
DMH % Seen in 4 Hrs	49.87%	49.40%	51.56%	53.09%	57.55%	57.85%	55.91%	50.74%	47.30%	46.86%	48.12%	56.40%	50.29%	56.11%	51.41%	50.49%	52.07%
UHND ED attends	6,536	6,988	7,050	7,003	6,550	6,811	6,880	6,864	6,728	6,963	7,039	7,074	20,574	20,364	20,472	21,076	82,486
UHND ED 4 Hours wait	3,170	3,292	3,593	3,636	2,787	3,332	3,006	3,266	3,441	3,561	3,695	2,966	10,055	9,755	9,713	10,222	39,745
UHND % Seen in 4 Hrs	51.50%	52.89%	49.04%	48.08%	57.45%	51.08%	56.31%	52.42%	48.86%	48.86%	47.51%	58.07%	51.13%	52.10%	52.55%	51.50%	51.82%
Total ED attends - Type 1	12,185	12,869	13,006	13,080	12,302	12,640	13,187	12,589	12,688	13,115	12,883	13,187	38,060	38,022	38,464	39,185	153,731
Urgent Care Centre - Type 3 (Walk-Ins)	3,805	4,567	4,379	4,216	3,978	4,156	4,213	4,141	4,385	4,161	4,077	4,651	12,751	12,350	12,739	12,889	50,729
Urgent Care Centre - Type 3 (Booked Appointments)	6,162	6,607	6,100	6,328	5,330	5,376	5,522	5,374	7,128	7,378	6,529	7,490	18,869	17,034	18,024	21,397	75,324
Trust Over 4 hour waits	6,002	6,268	6,478	6,487	5,229	5,789	5,787	6,086	6,582	6,830	6,727	5,631	18,748	17,505	18,455	19,188	73,896
ED Only Activity % under 4 hour waits	50.74%	51.29%	50.19%	50.41%	57.49%	54.20%	56.12%	51.66%	48.12%	47.92%	47.78%	57.30%	50.74%	53.96%	52.02%	51.03%	51.93%
Reportable % under 4 hour waits (including UCC Booked from Jan '2020)	72.91%	73.93%	72.42%	72.54%	75.80%	73.89%	74.75%	72.47%	72.80%	72.30%	71.36%	77.77%	73.09%	74.03%	73.34%	73.88%	73.59%

Additional 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. The proportion spending in excess of 12 hours in the department ranged from 5.4% in August 2023 to 15.6% in January 2024.

Standard Month:	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Trust ED Patients spending more than 12 hours in A&E	1,154	1,184	1,039	999	659	1,190	1,353	1,481	1,802	2,044	1,743	1,650
% Trust ED Patients spending more than 12 hours in A&E	9.5%	9.2%	8.0%	7.6%	5.4%	9.4%	10.3%	11.8%	14.2%	15.6%	13.5%	12.5%

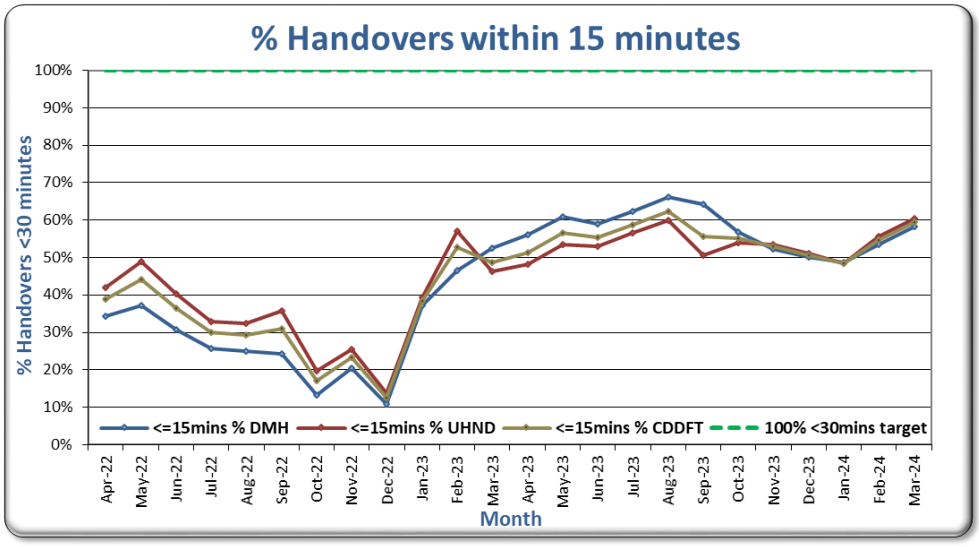
The Trust has achieved significant reductions in the number and proportion of patients waiting over 12 hours in the department and in the number of patients waiting 12 hours or more for a bed from a decision to admit, as well as in ambulance handover delays. The changes are in the context of increasing demand and are reflective if a range of process improvements.



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 January at the peak of the winter pressure 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. Performance has been predictably more pressured in the winter months but recovered well in March.

	Arrival to clearance time (mins)											
Site	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Darlington Memorial A&e	24.7	25.8	25.0	24.3	23.8	24.1	25.5	32.0	32.6	35.6	31.7	26.9
Uni Hsp Of North Durham A&e	29.1	28.9	27.2	27.9	25.9	29.3	33.9	39.0	36.7	36.9	34.0	27.0

Performance Summary

Recovery and restoration

During this operating year, the operational planning guidance was in place to support continued delivery of recovery, which stated a number of performance ambitions. In relation to the ambitions, we performed as follows:

- Increase activity to over 103% of 2019/20 value weighted activity levels: around 117.6% was achieved for April 2023 to March 2024;
- To improve performance against the 4 hour Urgent and Emergency Care standards to at least 76% by March 2024: this was achieved.
- To consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard: this was consistently achieved.
- Eliminate waits of over 65 weeks by March 2024: this was delivered.
- Develop a plan to reduce the number of patients waiting over 52 weeks to zero by March 2025: material progress was made in-year with the number of patients waiting 52 weeks reducing ahead of the submitted annual plan trajectory.
- To deliver diagnostic activity to meet elective and cancer waiting time objectives: this was achieved.
- To deliver diagnostic wait performance of 95%: this was not achieved.
- To reduce the 62 day Cancer backlog to the February 2020 level: A local target of a reduction to fewer than 126 patients by March 2024 on a graduated trajectory was set. This was routinely achieved form May 2023.
- To achieved the interim Faster Diagnosis Standard target of 75%: this was delivered.
- Validate at least 90% of patients with an open pathway at least every 12 weeks: this ambition was introduced in-year and but was not consistently achieved and has been included in the 2024/25 operational planning guidance, so will be given increased focus. Trust performance has routinely been in excess of 80%, which has been as identified as Green and within tolerance in comparison to other providers across the regional.

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

[To be added once received in June]

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

[Wording to be checked and updated in the final version for Board sign off]

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

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

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

- the content of the quality report meets the requirements set out in the NHS foundation trust annual reporting manual 2023/24 and supporting guidance from NHSE on Quality Accounts 2023/24
- the content of the quality report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2023 to June 2024
    - papers relating to quality reported to the board over the period April 2023 to June 2024
    - feedback from commissioners dated XX/06/24
    - feedback from governors dated XX/06/24
    - feedback from local HealthWatch organisations dated XX/06/24
    - feedback from overview and scrutiny committees dated XX/06/24 and XX/06/24
    - the Trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated: in draft (2022-2023 report) Please note, the annual report for 2023-2024 is currently in development.
    - the national patient survey 2023
    - the NHS national staff survey 2023
    - the Head of Internal Audit's annual opinion of the Trust's control environment dated XX/06/24
    - CQC inspection reports dated 3rd December 2019 and XX March 2024.
- the quality report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the quality report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the quality report has been prepared in accordance with NHS England's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the board

Chairman

Chief Executive

GLOSSARY OF TERMS

[To be checked and updated in the final version for Board sign off]

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.

Pressure Ulcer -

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