County Durham and Darlington NHS FT

QUALITY ACCOUNTS

2024 - 2025

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 2024/25. It also sets out our priorities for the coming year 2025/26. 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 2025/26.

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

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

I am delighted to introduce to you our Quality Account and Quality Report for County Durham and Darlington NHS Foundation Trust for 2024/25.

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 improve the responsiveness of our urgent and emergency care services and reduce waiting list backlogs over the last year. 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. We also surveyed our members during the year to ensure that our priorities remained relevant to them.

During 2024/25 we:

- Saw improvements in respect of all our quality priorities other than pressure ulcer prevention. In particular, we:
    - Sustained reductions in inpatient falls per 1,000 bed days in our acute settings;
    - Consolidated staffing, clinical governance and safety within our maternity services, and fulfilled all of the requirements of the national maternity incentive scheme;
    - Introduced and embedded new ways of learning, through system improvement plans. Although we have further to go to meet our ambitions, the roll out of these plans – which focus on spreading and sustaining improvement over time – has underpinned improvements in areas such as falls, infection control, acting on patient deterioration and sepsis.
    - Delivered improvements in the experience of, and support for: patients with learning disabilities and autism, which were commended during a visit to the Trust by the regional learning disabilities network; patients with cancer, and children and young people with mental health needs whilst in our care.
- Became a national pilot site for 'Martha's Rule' building on our Call for Concern initiative which allows relatives, carers or others to raise concerns regarding deterioration of a loved one in our care.
- Reduced waiting times in our A&E departments and improved the responsiveness of our urgent and emergency care services which were inspected and rated 'Good' by the Care Quality Commission.
- 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.

- Reduced waiting list backlogs, and had no patients waiting over 65 weeks by the year end.

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. This is an area where we are developing our datasets to enable us to understand and tackle lapses in care, through earlier intervention, education and robust management.
- Meet our zero tolerance for cases of MRSA, having reported five 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. In the second half of 2024/25, we launched a major campaign to reinvigorate and audit compliance with fundamental controls at ward and team level.
- 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.
- Embed 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 minimise long waits in the department.

We have ongoing Trust-wide quality improvement work in each of these areas, captured within our plans for 2025/26.

As we move into 2025/26 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, to transform our breast surgery services in line with the recommendations of a recent peer review, and further reviews from the national Getting It Right First Time programme and the Royal College of Surgeons.

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
28th June 2025

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 2024/25 Quality Priorities

Safety	Experience	Effectiveness
Quality Strategy Priorities / Retained priorities from 2023/24 – set out in this section.		
Reduce the harm from inpatient falls, focusing on identification and learning from lapses in care (↑)	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 (↑)	Optimising patients for cancer treatment through prehabilitation. **(↑)**
Maintain zero tolerance of Grade 3 & Grade 4 pressure ulcers (↓)	Increasing the understanding the communication needs of Veterans in relation to cancer (↑)	Maintain and improve the Macmillan Information and Support Centre quality standards **(↑)**
Implement actions, in line with Ockenden and CQC recommendations to sustain safety in maternity services. (↑)	Introduce and develop a psycho-oncology service for cancer patients (↑)	Maintain a positive learning culture across all services that support cancer patients (↑)
	Improve the membership and involvement of the Cancer Experts by Experience (CEBE) group **(↑)**	
Further embed safe practice for invasive procedures: LocSSIPs (↑)	Mixed sex breaches: revision of Trust Policy and associated communications supported by audit / data collection to inform any required remediation plan. (↑)	
Further embed prompt recognition and action on signs of patient deterioration (↑)	End of life care: conclude and roll out the palliative care strategy, ensuring appropriate access to private rooms for dignity as far as possible. (↑)	
Improve the timeliness of assessment and treatment for patients with suspected sepsis (↑)	Continued improvement of nutrition including assessment and provision for specific needs (↑)	
Continue to progress the roll out of the Trust's patient safety strategy. (↑)	Provide a positive experience for those in our care with additional needs; improving Mental Health Act compliance	

Mandated measures for monitoring Further details set out in Part 2C of this report ('Reporting on core indicators')		
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

Key to RAG-ratings:

	On track to deliver improvements expected of the life of the Quality Matters strategy		Improvements 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.

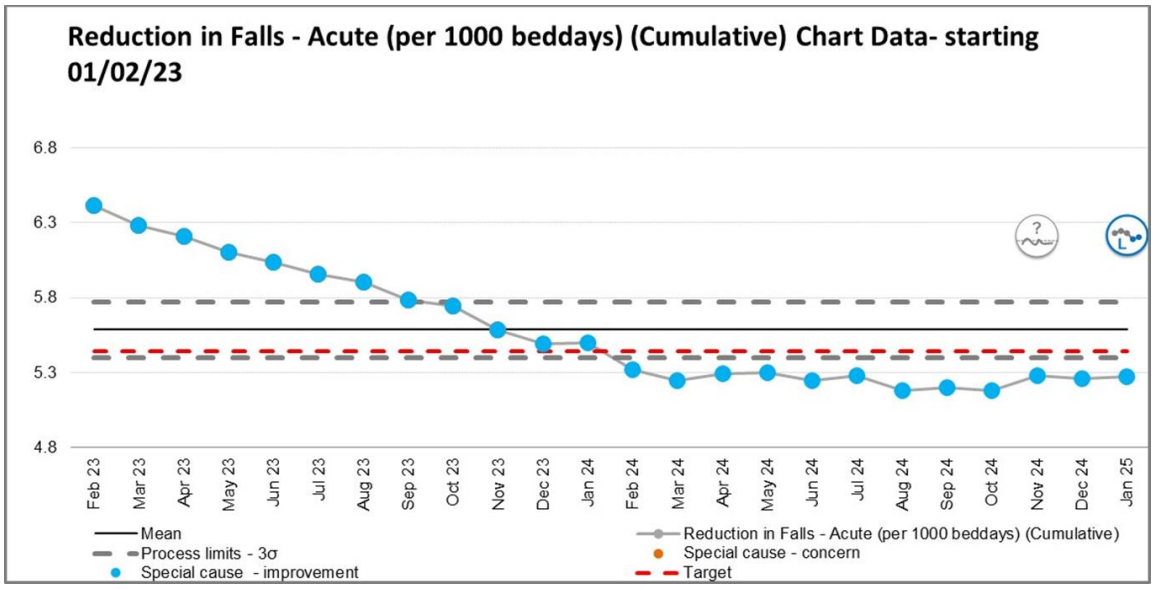
We deliberately set ourselves stretching objectives – to drive meaningful and long-term quality improvement - and, whilst we continue to see significant improvement and success in achieving some of our goals, it is acknowledged that, for some, we have not fulfilled our ambition. Where this is the case, 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 Priorities

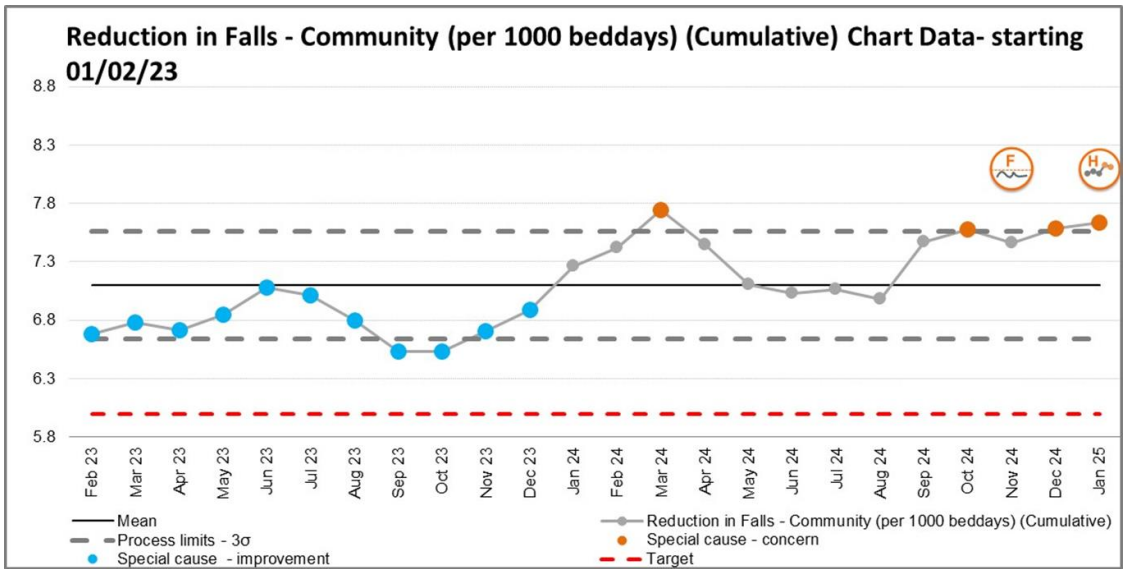
Reducing harm from inpatient falls

Broadly on track (↑)

Over the last two years there has been a sustained reduction in the number of falls – based on a rolling 12 month average - within our acute hospital sites, as illustrated in the chart below. The blue dots indicate that the improvement is as a result of interventions taken by the Trust (a 'special cause improvement').



The trend across the community hospitals has seen an increase in falls over the last two years and has been inconsistent in the last 12 months. Particular increases were noted during winter 2024/25 as the chart below demonstrates.



The data, together with the learning identified from the falls rapid review process, is used to inform quality improvement work across the Trust. Our Falls Team have focused their resources on the development and roll out of bespoke quality improvement plans, for our community hospitals, working with the Trust's Quality Improvement Sister.

It is important to note that we have extended the number of beds in use in our community hospitals and widened the admission criteria in recent years, which can increase the risk of patient falls where, for example, it results in higher numbers of patients needing rehabilitation. We are therefore using the learning from interventions put in place on our acute sites to inform the quality improvement plans in our community hospitals.

Following any fall with significant harm, such as a fractured hip or head injury the Falls Team undertake an 'After Action Review' to fully understand the learning, both positive and negative, associated with the fall. The team have supported clinical staff in the completion of 65 such reviews in 2024/25. The final reports are shared with the patient, or their family, where they have indicated they would like to receive a copy or in incidents where duty of candour applies. In five cases the patient was considered to have died as a result of injuries sustained from the fall and as such have been reported to the Integrated Care Board (ICB) via StEIS.

In addition to local actions, the learning identified from the reviews has informed the development of a Falls System Improvement Plan (SIP) to underpin quality improvement across all clinical areas. Whilst the Falls Team support the clinical teams in delivering quality improvement projects and education, the improvement demonstrated on our acute sites is down to the hard work of the clinical teams embedding the improvements.

One key example of an improvement initiative is an analysis of the time of day that falls have occurred alongside consideration of the factors that may be influencing any higher risk times of day. Understanding these factors allows us to make changes at ward and team level to reduce risk.

Our Falls Intranet page has been updated enabling staff across the Trust to access a wealth of information, resources and evidence based guidance on:

- Preventing Deconditioning
- Falls Prevention
- Reconditioning
- Post-Fall care

Key falls improvement initiatives across the 2024-25 year were:

- Adding a flag to the systems used by the Emergency Department, to flag patients at the risk of falling to staff.
- Hosting a "Falls Awareness Stand" for World Patient Safety Day.

- Dedicated support for two wards tailored to their specific needs.
- Expansion of data collection and analysis through the National Audit of Inpatient Falls
- Analysis of falls in Bathrooms/ Falls while using the Toilet; A number of patients falling, and coming to harm, whilst in the bathroom, toileting or using the commode at the bedside were identified through a thematic review and further actions added to the Falls SIP to promote safety in bathrooms and toileting patients.
- Commencing the refresh of the Regional Falls Strategy (2025-2028)
- Trialling falls sensors on three wards
- The "Call for a Fall" project; an initiative between the falls team, Early Detection, Resuscitation and Mortality Matron and the Moving and Handling Team to seek to develop a falls response team to support post-fall care in inpatient settings across our Acute hospitals at Durham and Darlington.
- The Sunflower Project; a project in Emergency Department at DMH to reduce falls rates utilising visual cues for all patients at risk of falls that are admitted to the department.
- Our Safe Mobility Network**;** building a network of staff members with a particular interest in falls prevention, post-fall care and safe mobility.

The Trusts Falls Committee continues to meet quarterly, to monitor trends, share good practice, and agree further actions where necessary. The work of this Committee is overseen by the Trust's Patient Safety Committee. Trends, action plans and outcomes are scrutinised by the Executive Quality Committee, including progress of the new falls prevention system improvement plan.

We have assessed this objective as broadly on track because the majority of falls occur in our acute sites where we have sustained improvement. Whilst there is clear improvement work required to achieve similar reductions in our community hospitals, we have learned much from the work in our acute hospitals which, once rolled out to community hospitals, should assist us in achieving a similar result.

Reducing harm from healthcare associated infections (HCAIs)

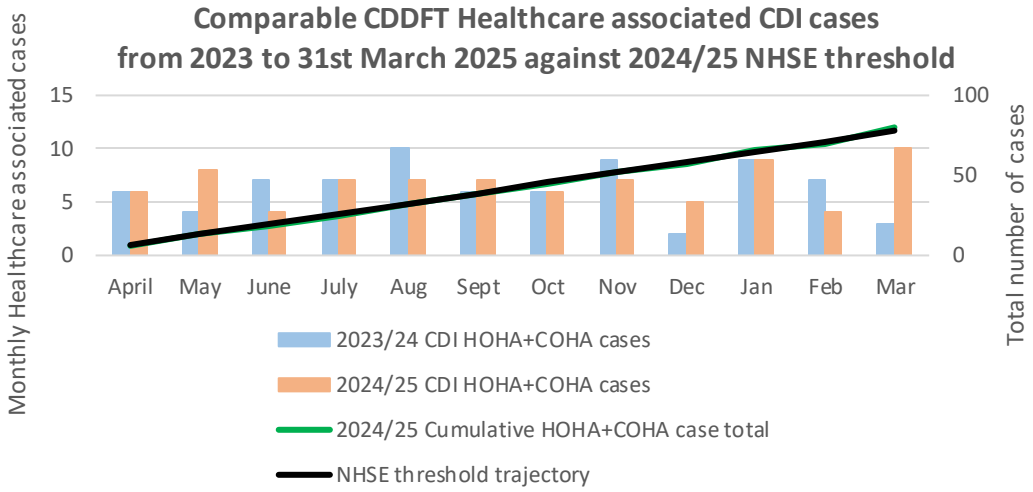
Not on track (↓)

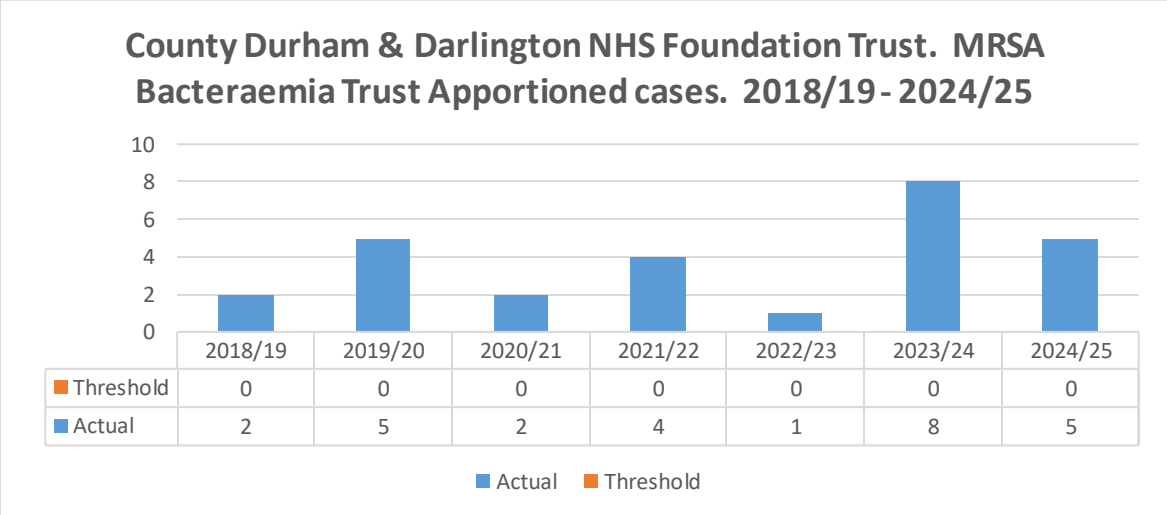
Our 2024/25 ambition was to have no reports cases of MRSA blood stream infections (BSI) and to maintain infection rates within the thresholds mandated by NHS England, and internally. We did not achieve our ambition, reporting five cases of MRSA BSI's and exceeding the NHSE national and MSSA locally set thresholds, with the exception of E.coli BSI.

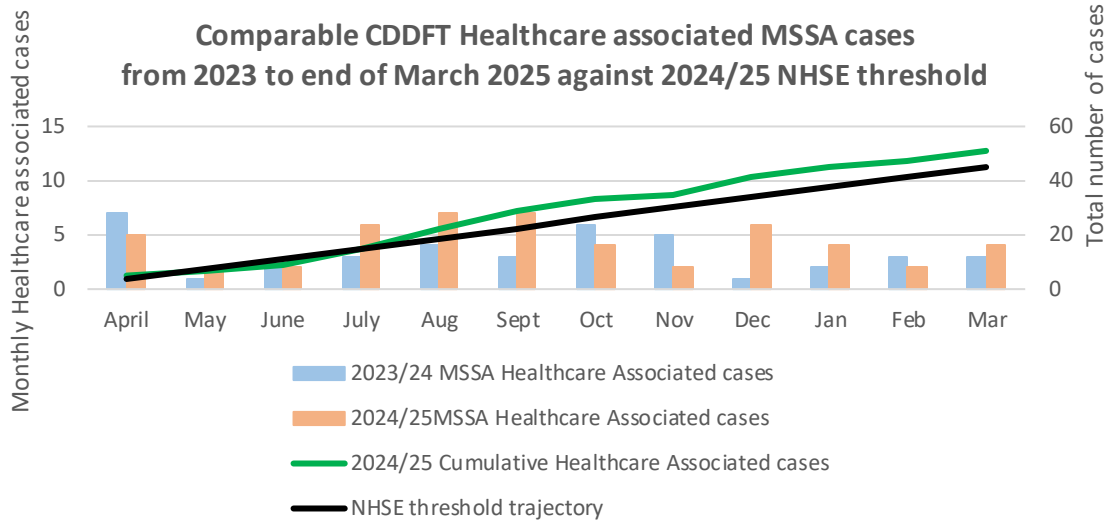
The outcomes for each healthcare associated infection are detailed in the table below. It is important to understand that NHS England allocates thresholds to trusts based on historical performance, to encourage continuous improvement. This can be challenging, particularly in the context of increasing activity as seen within both the region and nationally, nonetheless our ambition is to continuously improve patient safety by reducing infection rates and, therefore, hold the ambition of being within allocated thresholds.

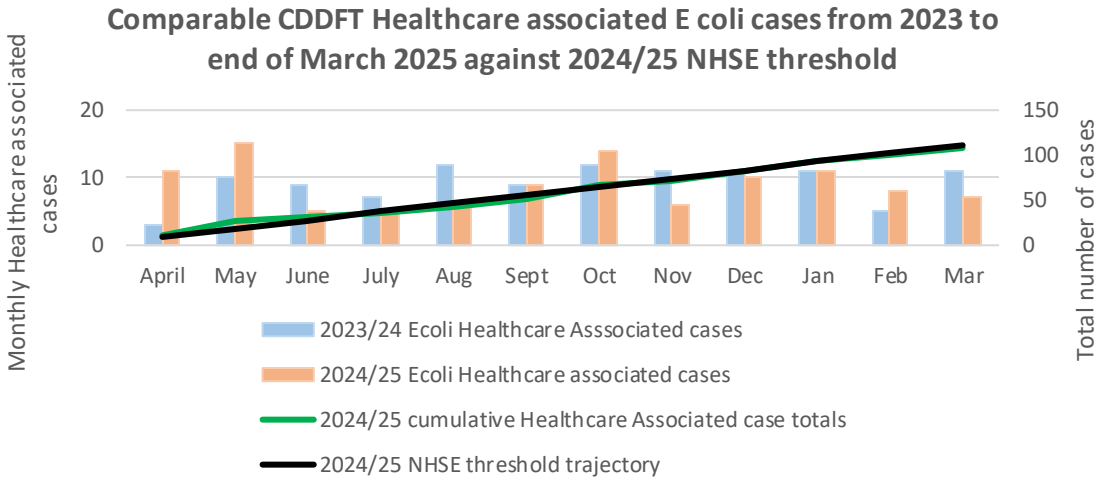
All HCAIs are subject to a rapid review by the clinical teams, supported by the Infection Prevention and Control (IPC) team, to identify any areas of good practice and any areas noted for improvement. The IPC team provides support to the relevant clinical team as required and is able to identify and track themes to share organisationally.

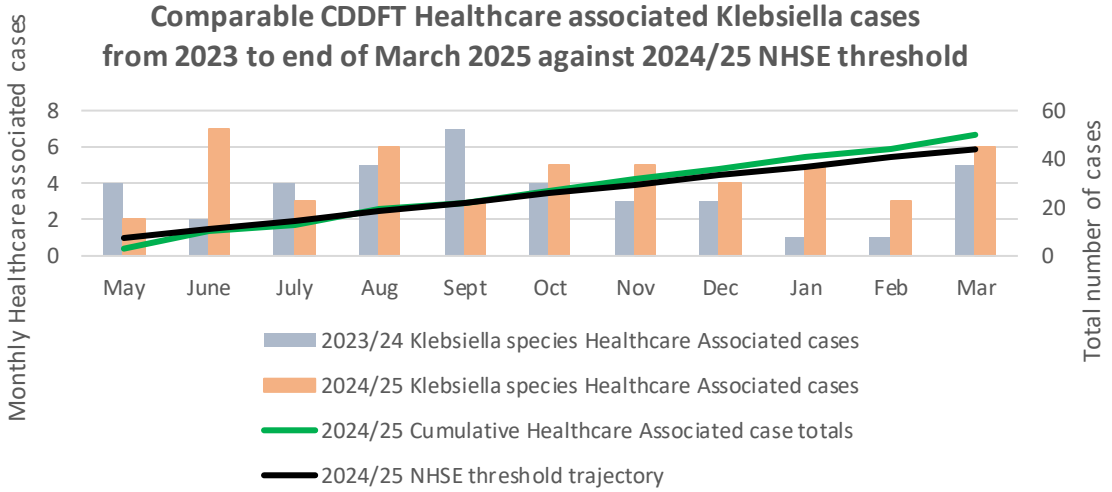
The charts below demonstrate the Trust's position for 2024/25 against nationally mandated and local thresholds.

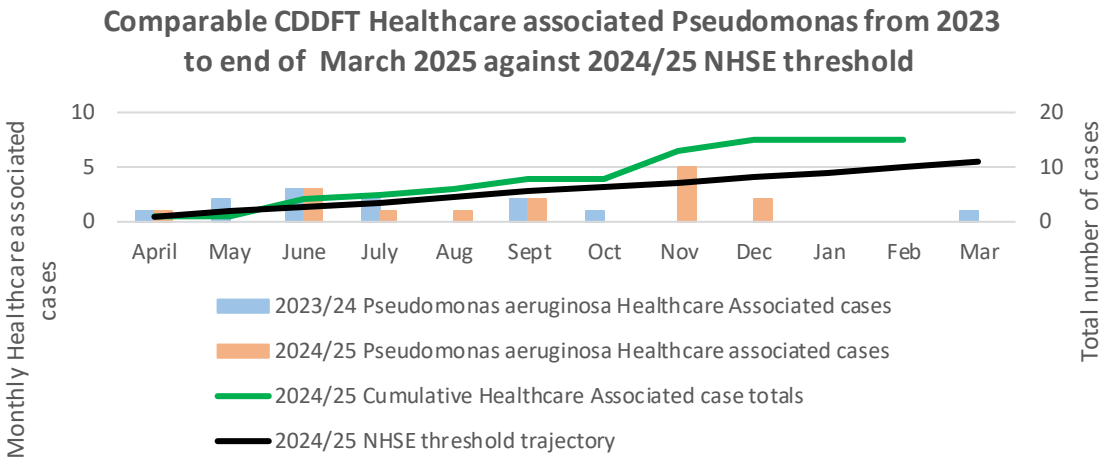





Comparable CDDFT Healthcare associated MSSA cases from 2023 to end of March 2025 against 2024/25 NHSE threshold
Monthly Healthcare associated cases
Total number of cases
15
10
5
0
60
40
20
0
April
May
June
July
Aug
Sept
Oct
Nov
Dec
Jan
Feb
Mar
2023/24 MSSA Healthcare Associated cases
2024/25MSSA Healthcare Associated cases
2024/25 Cumulative Healthcare Associated cases
NHSE threshold trajectory


Comparable CDDFT Healthcare associated E coli cases from 2023 to end of March 2025 against 2024/25 NHSE threshold
Monthly Healthcare associated cases
Total number of cases
20
10
0
150
100
50
0
April
May
June
July
Aug
Sept
Oct
Nov
Dec
Jan
Feb
Mar
2023/24 Ecoli Healthcare Asssociated cases
2024/25 Ecoli Healthcare associated cases
2024/25 cumulative Healthcare Associated case totals
2024/25 NHSE threshold trajectory


Comparable CDDFT Healthcare associated Klebsiella cases from 2023 to end of March 2025 against 2024/25 NHSE threshold
Monthly Healthcare associated cases
Total number of cases
8
6
4
2
0
60
40
20
0
May
June
July
Aug
Sept
Oct
Nov
Dec
Jan
Feb
Mar
2023/24 Klebsiella species Healthcare Associated cases
2024/25 Klebsiella species Healthcare Associated cases
2024/25 Cumulative Healthcare Associated case totals
2024/25 NHSE threshold trajectory

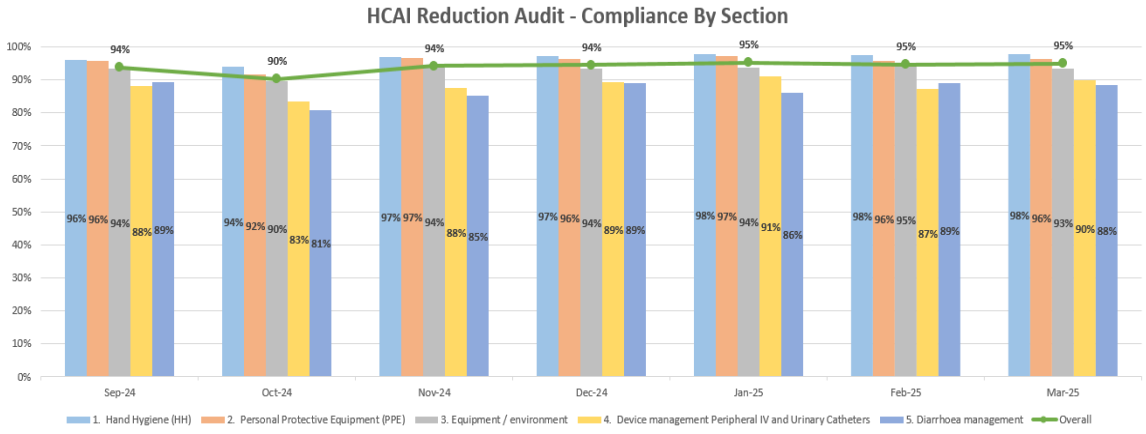


We continued to see persistent outbreaks of Carbapenemase-Producing Enterobacterales (CPE) at CDDFT, with a high prevalence at DMH site. As a result of which we have implemented a number of interventions, including but not limited to:

- 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
- Introduced water light bathing.
- Refurbishment of one ward, including replacement of handwashing facilities and the upgrade of a sluice.

Over the second half of the year, we saw CPE levels reduce at DMH, albeit that we continue to maintain screening and additional control measures in response to some periods of increased incidence and outbreaks.

In September 2024, monthly HCAI reduction audits were introduced to support clinical teams to monitor compliance with IPC practices. The table below demonstrates Trust wide the results of this audit since its inception and the compliance to IPC practices:



Senior nursing and clinical leaders from within our care groups have also led the 'Fight Back Infection' campaign, to embed awareness and understanding in operational teams that reducing HCAIs is 'everyone's business'. We have reinvigorated our network of Infection Control Champions and worked with teams to engender awareness and understanding of, and engagement with the implementation of fundamental controls to manage the spread of

infection. The improvements being seen in the audit scores above, over the second half of the year, reflect the impact of this campaign.

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; and rapid reviews are undertaken for any that occur under our care. These reviews ensure that the learning is established and acted upon promptly for all departments and teams. The reviews are multi-disciplinary and are led by a Tissue Viability Matron. During 2024/25, of the 39 Rapid Review investigations that took place, there were seven Category 3 and 4 pressure ulcer investigations which identified lapses in care. One further Category 4 Pressure Ulcer was escalated as a Patient Safety Incident Investigation. This is an increase on 2023/24, in which three Category 3 or 4 ulcers with lapses in care were identified.

The themes noted where lapses in care were identified included: lack of Waterlow assessments[1], lack of documentation around repositioning of patients to off load pressure and communication failures between professionals. In relation to reviews conducted since August 2024, the absence of Wound Assessment charts and Body Mapping via the inpatient Electronic Patient Record were also contributory factors in the lapses of care identified.

In response to the adverse trend, our Tissue Viability team has focused on providing education and support to front-line clinical teams, with particular emphasis on pressure ulcer prevention and the correct categorisation of ulcers. This has resulted in increased awareness of risk and a positive impact on the completion of Wound assessments, Body Mapping and Care Plans for Pressure Ulcer wounds. We have built on our network of Wound Resource Educational Nurses (WRENS), who work in both the acute and community services with the successful launch of an equivalent role for our Health Care Support Workers. The education delivered by them covers basic skin care and prevention.

The Tissue Viability team has also developed a number of pathways and protocols to support front-line teams in providing to good skin care and correct pressure relief surface selection. Category 2 pressure ulcers are subject to review, using a structured tool. The Tissue Viability team reviews samples of the completed tools and issues are reflected in the education and pathway developments noted above.

Maternity Standards including Ockenden recommendations

The Maternity Service has implemented the 'must do' actions and further recommendations from the CQC inspections in March 2023 and January 2024, and continues to be part of the national Maternity Safety Support Programme (MSSP). Improvement actions taken have focused on:

- Safe staffing, with proactive management of rota gaps.
- Further embedding the triage model in the PAUs, in readiness for moving to the nationally recommended BSOTS framework in May 2025
- Embedding changes and improvements in governance
- Ensuring that are up to date with mandatory training, appraisal and timely return to work interviews following sickness.
- Ensuring full completion of equipment, environmental and medicines checks.
- Continued work to improve frequency of observations and escalation of high MEOWS scores whilst we await the national MEOWS framework.

[1] A Waterlow assessment is a tool to assess the risk of a patient developing pressure ulcers.

Staffing has continued to be a challenge throughout 2024-25, on the Durham site and in the Community particularly. Vacancies have significantly reduced; however, throughout the year a number of staff have been within their supernumerary training periods and, as many of our midwives have been newly qualified, we have needed to manage the skill mix carefully. The investments we made in strengthening midwifery leadership roles and strengthening escalation protocols have enabled us to manage these pressures and to meet the requirements of the national maternity incentive scheme for midwifery staffing, including sustaining supernumerary status for our labour ward coordinators and levels of one to one care.

In 2024-25 a project was launched to support the wellbeing of the maternity teams – 'CHEER'. To date the funding has been utilised to improve staff rest areas, pizza nights, fruit baskets, a Christmas shopping trip and International Day of the Midwife celebrations. We are currently consulting staff across the perinatal team as to what they would like to do together in the coming year. The service is also benefitting from further support for culture development from our Workforce and OD team and external organisations.

In November 2024, the Trust was subject to a regional (LMNS) peer review visit seeking assurance with respect to the essential actions from the national Ockenden inquiry. The visit was very positive with the visiting team recognising the significant improvement from the previous year. Areas of good practice were identified as follows:

- The Trust showed a real togetherness and willingness to work together with some 'shining' team members.
- Leadership, especially in midwifery, has significantly increased, however there is a requirement for the trust to review and communicate the key leadership roles.
- The involvement of the Maternity and Neonatal Voices Partnership Lead in safety and governance meetings ensures a focus on patient safety and staff support.
- Many of the quality improvement initiatives addressing health inequalities are supported by the Trust's active collaboration with Public Health Teams.
- The Trust actively utilise the Learning Disability Diamond Standards, a set of standards that aim to improve the quality of care for people with learning disabilities.
- The use of return to practice midwives, in dedicated roles, to assist newly qualified and international employees.
- A dedicated information analyst to assist with the continuous efforts to implement the Saving Babies Lives Care Bundle in accordance with NENC audits.

The impact of this work can be evidenced through the service's fulfilment of all elements of the Saving Babies Lives Care Bundle and the achievement of compliance with all 10 safety actions within the national Maternity Incentive Scheme; demonstrating substantial progression from the previous year when only six of ten safety actions were met.

Areas for improvement identified by the LMNS peer review included:

- Further work on the senior management structure, particularly the key perinatal leadership role.
- The need to upgrade the estate, particularly for neonatal care at UHND.
- Medicines management.
- Strengthening and further embedding the Patient Safety Incident Response Framework.
- Strengthening the project management of quality improvements, including by adding timeline data.

We are shortly to receive the diagnostic report from our Maternity Safety Support Programme advisers, which will drive the further improvements needed to enable us to sustain high quality maternity services and these will form our quality improvement priorities for 2025/26.

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

Partially met (↑)

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 in order to protect the patient. Having migrated responsibility for the development, issue and adherence to LocSSIPs to local teams, we have implemented monitoring, auditing and governance procedures to provide assurance that our new LocSSIPs policy is followed.

Our goal for the year was to continue 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.

This has largely been achieved, in that the Trust has now resolved previous issues with LocSSIPs being considerably out of date. The current position is that all but two LocSSIPs are within date, and both are currently progressing through the process for renewal.

The process for updating LocSSIPs is now more robustly embedded, with roles and responsibilities clearly defined. This has ensured that during 2024-25 our LocSSIPs Working Group has been able to keep ahead of expiration dates of LocSSIPs, with leads now contacted 6 months in advance of expiry to advise them to begin the process of reviewing and renewing LocSSIPs.

The Clinical Director-led working group previously established has continued during 2024-25 to build on the work already completed, and has the following objectives:

- Ensure that general access to LocSSIPs via the internet / intranet is controlled. This has been achieved and better version control is now in place, with the ability to print less frequently used LocSSIPs off at the point of use and reducing the risk that out of date versions remain in circulation.
- Continue to audit LocSSIPs documentation and adherence to practice. This has also been achieved with audits of compliance of individual LocSSIPs. Around two third of areas had been audited by the year end and we plan to enhance this programme of audits as set out in our priorities for 2025/26.
- Develop LocSSIPs as electronic forms in our EPR to assist staff in adhering to the requirements. Work has begun on exploring the feasibility of migrating all LocSSIPs into the Electronic Patient Record (EPR) system, thereby removing paper copies from the process, enhancing audit functionality and improving compliance. However this remains an ongoing piece of work and the LocSSIPs working group will look to progress feasibility of this across the coming year.

Embedding prompt recognition and action on signs of patient deterioration

Partially met (↑)

The Cardiac Arrest Prevention Team continue to work closely with the Trust Sepsis Lead, Acute Intervention (AI) Team and Digital Health Team (DHT) to provide joined up working in relation to all aspects of the deteriorating patient. Deteriorating Patient and Resuscitation (DPR). Induction training is attended by the DHT to train staff in how to use our clinical systems to aid recognition of key warning signs of patient deterioration.

During the year, we consolidated all ongoing improvement actions into a single Deteriorating Patient SIP. Key improvements are outlined below, together with areas of focus for further improvement.

In 2024-25 a template was developed within our electronic patient record (EPR) system to support the documentation of the clinical response to a patient with a raised early warning score. The 'raised EWS' note type is designed to be used to prompt the user to use a structured approach when reviewing a deteriorating patient, including matters to be considered and information to be captured. We audit compliance with these requirements through ward assurance dashboards.

County Durham and Darlington Foundation Trust were successful in having three hospital's included within the NHS England Martha's Rule pilot scheme in 2024-25. Martha's Rule includes three components:

1. Patients will be asked at least daily, about how they are feeling and if they are getting better or worse. This information will be acted upon in a structured way.
2. All staff will be able to ask for a review from a separate care team if they are concerned a patient is deteriorating and they are not being listened to.
3. Patients, families and carers will also have access to the same rapid review from a separate care team if they feel their concerns are not being responded to.

Parts 2 and 3 of Martha's Rule are incorporated within the Trusts 'Call for Concern' service. Call for Concern was implemented in March 2021 at the DMH, UHND and BAH sites. The service offers patients, families, carers and staff the opportunity to request a rapid review from an expert team if they feel their concerns are not being listened to or acknowledge in the first instance by the parent teams. The service is promoted throughout the hospitals via posters and leaflets, and the information is also available on the trust internet page. The service is planned for extension into the community hospitals, with a pilot at Chester-Le-Street planned for March 2025.

In order to meet Part 1 of Martha's Rule, a pilot of the Patient Wellness Questionnaire has commenced on our Acute Medical Units. This questionnaire aims to ensure that patients are asked at least once daily how they are feeling, and if this is better or worse than when they were previously asked. This will then correspond to structured actions depending on the total score.

Despite the improvements noted above, we have further work to do to embed full compliance with review and escalation protocols for patients with high EWS and have identified further actions from patient safety incident investigations which inform the SIP in place.

Improving the management of patients with sepsis

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 and blood cultures. Additionally our aspiration was to continue to improve our EPR functionality and training to help support the early recognition of sepsis.

Since the roll out of our EPR 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 from staff and continuous testing, we have modified messaging and workflows within the system to be more intuitive and support staff in understanding when action is needed.

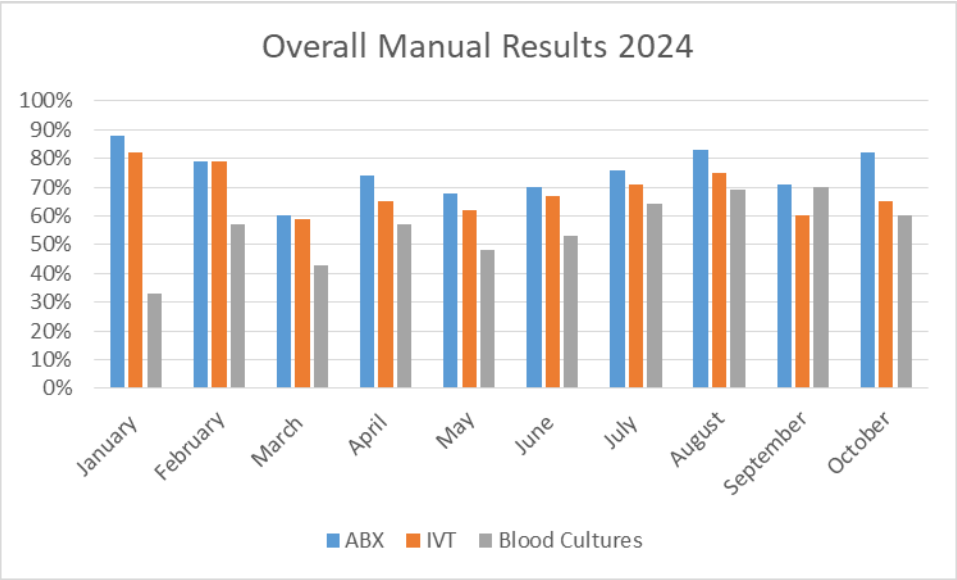
Throughout 2024-25 we have been monitoring compliance with the correct screening of patients for sepsis, and continued education has been provided to areas such as the Emergency Department. Since April 2024 there has been a significant improvement with screening compliance, underpinned by the training 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 but these do not yet account for a number of variables in the way that treatment can be delivered. A manual audit was commenced following these findings which has been undertaken by the Lead Sepsis Nurse which found that the data point being used to identify and confirm Sepsis for the Trust compliance data is currently the data point when the Nurse has confirmed Sepsis rather than when a formal diagnosis has been confirmed or added by the Clinician. The latter data point will provide a more accurate sample. 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. It also doesn't take into account some circumstances where sepsis is not present despite a raised EWS.

The results of the manual audit are noted below from January – October 2024. The sample size was 60 patients across both DMH and UHND, taken from the patients included within the sepsis treatment compliance data. The audit covered provision of antibiotics within one hour, intravenous treatment and blood cultures.

Overall Manual Results	ABX	IVT	Blood Cultures
January	88%	82%	33%
February	79%	79%	57%
March	60%	59%	43%
April	74%	65%	57%
May	68%	62%	48%
June	70%	67%	53%
July	76%	71%	64%
August	83%	75%	69%
September	71%	60%	70%
October	82%	65%	60%



Updated NICE Guidelines

In March 2024 NICE updated their guidelines to ensure that antibiotics are only given to those at the greatest risk of severe sepsis. The aim w to help reduce the risk of antibiotic resistance and give health care professionals more time to treat those who are less severely ill.

The guideline sets out criteria, linked to EWS, to be used to differentiate high risk, severely ill patients who should receive broad-spectrum antibiotics within one hour and others graded as moderate risk, where treatment should be provided within 1 to 3 hours.

Based on these new guidelines the ED sepsis audit process has been reviewed to enable us to check compliance with the taking of blood cultures and provision of antibiotic treatments based on whether the patient is on a one hour or three hour pathway.

Compliance with treatment is recognised to remain low in certain areas such as blood cultures. However there has been an improvement in this through education and visual tools such as blood culture posters and trust screen savers 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 with a separate programme also available, which is designed for ward based nurses. Both of these courses include classroom based teaching and simulation teaching.

The Acute Intervention Team provides “at the elbow” teaching in relation to the deteriorating patient and sepsis, Monday to Friday when not supporting deteriorating patients or attending to emergency calls.

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.

A video has been recorded for all staff, relatives and patients on raising awareness of sepsis, Call 4 Concern and Martha's Rule. This covers the signs and symptoms of sepsis, the 'Sepsis 6 bundle' and the correct sepsis workflow on our clinical system. The video also covers Call 4 Concern and the new Martha's rule which focuses on patients, relatives and carers to call for help/advice if they are concerned about a patient's condition. The video is available to view on the staff intranet via the cardiac arrest prevention team page and the trust internet site. It is also played to staff at the sepsis education days.

Patient Safety Incident Response Framework

In 2024/25 we have continued to embed improved methods of continuous improvement through our System Improvement Plans (SIPs). There are now eight System Improvement Plans in active use on the Trust's Intranet, which are discussed in more detail in the Patient Safety section of the 2024-25 Quality Account.

In addition to the original Patient Safety Partner who has been in positon with the Trust for some time now, one additional Patient Safety Partner has been recruited, with a third identified and recruitment currently being discussed. This will help to strengthen the input into all aspects of patient safety and experience from our service users, and these new appointments will allow additional patient input into both investigations and complaint responses.

Feedback has been obtained informally from some families who have had the support of a Family Liaison Officer (FLO) as part of a Patient Safety Incident Investigation (PSII). In connection with the North East and North Cumbria region Patient Safety Patient and Family engagement Community of Practice network, the leads for FLO's at CDDFT are currently considering the most effective and appropriate ways to evaluate the effectiveness of the service. The FLO service continues to be supported throughout the Trust, with the recruitment of additional FLO's during 2024/25 and further training courses planned for 2025/26.

Patient Experience Priorities

Improving the care of patients with additional needs - Dementia

Broadly on track (↑)

The aims of the Trust are to provide appropriate care for all patients with cognitive impairment, and to ensure that patients with an impairment such as dementia/delirium and their families have a positive experience of their care throughout the patient's journey. There is continued good progress with respect to Dementia-specific training and specialist nursing support for patients with Dementia. Our network of Dementia and Learning Disabilities champions continues to increase, and we have established joint pathways for patients with Mental Health needs with Tees, Esk & Wear Valley NHS Mental Health Trust (TEWV). Throughout 2024-25 the focus of our ongoing efforts has been to: recruit more Dementia and Learning Disabilities Champions; increase the coverage of our training; embed practice developments; and, incrementally, to make our environments more Dementia-friendly.

Key learning messages have been shared throughout the Trust through both our quarterly Dementia Newsletter and our network of Dementia and Learning Disabilities champions. The quarterly Face to face meetings of the network have been well attended, allowing key messages to be shared, development opportunities to be explored and support provided. A

group has been established to develop innovation in practice to support patients with dementia and their carers, including championing reasonable adjustments, dementia friendly environments and hospital passports. Utilising the 'Take 5' platform in the Trust, '5 Minute Education for Busy People', has enabled the promotion of hospital passports across the in all clinical areas. Engaging and working with carers there has also been a refresh of the Carer's Passport during 2024-25.

We have continued to work closely with a range of partners, through local, regional and national working groups to share learning and best practice with respect to services for those with Dementia and to work on joint pathways; for example, work in partnership with Darlington's dementia friendly communities group on a project to show case dementia, led to a 'dementias got talent 'show raising £8,000 to support dementia projects within Darlington.

We are no longer able to participate in the National Audit of Dementia, but have developed local tools to allow us to monitor compliance with key interventions and support ongoing improvements.

Patient-led assessments of the clinical environment (PLACE) took place between September, October and November 2024. The Trust benchmarked slightly below the national average with respect to Dementia; however there was evidence of improvement since the 2023 assessments, in line with the actions taken. Weardale Community Hospital demonstrated a significant improvement, scoring above the national average, as did Richardson Community Hospital. University Hospital North Durham increased their score in the audits from the previous year however remain slightly below the national average. Improvement work continues with both short and long term actions identified, with the longer term actions in the main to be addressed through estates works within lifecycle programmes.

Bespoke training has been provided to clinical teams where requested, covering for example, changes in the brain, recognising the difference between Dementia and Delirium and the link to mental capacity assessments and Deprivation of Liberty Safeguards. The introduction of training in "Positive Approaches to Care" has been well received with two registered trainers delivering these workshops. The focus is on delivering care to reduce the effects of potential trauma not only for the patient but staff. A number of our security and portering teams have attended the training and reported positive results when utilising the skills acquired from the workshop.

Over 90% of staff completed training in dementia awareness during 2024/25, with over 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.

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

In November 2024 the North East and Cumbria Learning Disability Network visited CDDFT, enabling the Trust to share the work which are undertaking to provide good care for patients with learning disabilities (LD) and / or autism. The visit covered:

- Specific processes for admissions and delayed discharges.
- The implementation of the 'Diamond' standards, a national framework to support the care of patients with LD, in our maternity services.
- Our learning disabilities mortality review programme.
- The roles within CDDFT's Learning Disability and Autism Team and current capacity.

- Three wards/departments attended the visit to discuss, share and celebrate the amazing work they are doing to provide reasonable adjustments to Patients with a Learning Disability.
- CDDFT's Learning Disability and Champions.
- Mandatory Learning Disability and Autism awareness training.

The North East and Cumbria Learning Disability Network are hoping to complete annual visits to acute trusts and are very keen that the Learning Disability Network continues to work collaboratively with CDDFT, and other Trusts, to undertake improvement work across the region. The Trust's network visit was a very positive experience with the leads reporting being impressed with many of the arrangements in place and the awareness of our staff and care of patients with LD and autism.

Hospital passports

As outlined above, a great deal of work has been undertaken to embed the use of Hospital Passports. These valuable documents include patient information including: communication preferences; medical history; medications; what the patient likes and does not like and how they will tell staff if they are in pain. The hospital passport is designed to help healthcare professionals to understand a Patient's needs and wants and to support delivery of safe, effective, person centred care. We are working with one of our Patient Safety Partners on developing a hospital passport communications campaign both for CDDFT staff and the public to gain awareness of the hospital passport.

Training

In line with national requirements, CDDFT have introduced the Oliver McGowan Mandatory Training on Learning Disability and Autism. The Oliver McGowan training is structured into two tiers:

- Tier 1 -The Oliver McGowan e-learning package mandatory for all CDDFT Staff.
- Tier 2 – options as to how to take forward tier 2 are currently being appraised.

As the options for Tier 2 are evaluated in the interim, the Learning Disability and Autism team have continued to deliver Learning Disability Diamond Standards training on as part of both the nursing preceptorship and the midwifery mandatory training programmes, also delivering bespoke training to wards and departments where requested.

Learning Disability and Autism Champions

Learning Disability and Autism champions from wards and departments across CDDFT meeting annually, with quarterly newsletters shared to provide the champions key messages and learning events to enable them to cascade the information they receive to their ward and departments with the overall aim to improve care for Patients with a Learning Disability and/or Autism. Themes discussed in our champions meeting in 2024-25 are hospital passports, key Learning Disability pathways, reasonable adjustments and innovative ideas to development opportunities.

Learning from lives and deaths- people with a Learning Disability and Autistic people (LeDeR)

The LeDeR process has been reviewed and relaunched. The Learning Disability and Autism Team are continuing to work in close collaboration with the ICB team and will continue to be involved in the reviews, ensuring that learning is identified, shared and responded to appropriately. The Learning Disability and Autism Team will also be involved in LeDeR Panels to enable us to understand the key messages of learning from reviews.

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

Broadly on track (↑)

During the past year, we have worked with Tees, Esk and Wear Valleys NHS FT (TEWV) to implement and improve care pathways for all patients attending with physical health issues and, at the same time, mental health needs. Work has taken place on optimising pathways for patients with mental health needs attending our A&Es; for example. However, the greatest area of need and focus has continued to be on children and young people, who need mental health support or treatment whilst in our care for physical illness or injury.

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. We have also commenced a working group with TEWV, in response to shared learning from patient safety incidents and coronial processes encompassing both Trusts; this group has developed a collaborative System Improvement Plan and links directly to the governance within Mental Health Operational Group and Mental Health Alliance Board evolving priorities. This has also led to wider stakeholder engagement with has been pivotal to achieving improved pathways and outcomes for patients.

Ongoing improvements include:

- Review of 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.
- Registered nurses identified as Mental Health Champions on our Paediatric Wards, and in the Paediatric Assessment Area (PAA) at UHND and Paediatric ED at DMH.
- Events held to review the experience of children and young people and their families' experience of admission to hospital, opportunities for innovative ways to capture feedback explored; to engage and obtain a robust understanding of their experience.
- Removal of unnecessary ligature points have been removed from the ward areas and the PAA.
- Continued to support the development of pathways and actions, in response to the national benchmarking and gap analysis, improving ways of working for staff and experiences for patients and their families.
- Development and implementation of a policy, in collaboration with the multi-disciplinary team, for the care of patients with mental health needs.
- Training and support for our staff from TEWV colleagues
- Evaluation of our joint arrangements against sources of good practice and published reports from the Care Quality Commission; identifying and enacting associated improvements.
- Launch of 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.
- Exploring and evaluating services from relevant voluntary sector organisation to identify how they might support children/young people and their families during admissions.
- Revision of current arrangements and the digital process to ensure that we always comply with the Mental Health Act on the infrequent occasions that patients need to be sectioned in our care.
- Safety planning and working to provide personalised care, to prevent inappropriate hospital admission and ensure a trauma informed approach to care for CYP who are

known to the organisation and multi-agency teams has been completed, demonstrating positive outcomes, where implemented.

- The Mental Health Operational Group has prioritised learning from case studies and also the importance of transition within its agenda.
- Trauma informed practice groups have commenced and are making good progress across all ages. This is the foundation for the work which will progress regarding restraint.
- Development of a System Improvement Plan for Mental Capacity Act compliance, incorporating learning from incidents, the ICB Patient Safety Alert and promoting education and skills of practitioners.

Data suggests that CYP admissions to the inpatient wards are reduced due to the interventions implemented across the services. Our priority for 2025/26 is to develop similar levels of support and intervention for adults with mental health issues to that now in place for children and young people.

Ensuring a positive patient experience through the discharge process

Together with Durham County Council and Darlington Borough Council we have continued to develop our integrated approach to complex discharge under the definitions of national Pathways 1, 2 and 3. A Transfer of Care Hub Manager has been appointed, who now has responsibility for both the Hospital Social Workers and the hospital Discharge Management Team that form the Transfer of Care Hub (ToCH). By being co-located on the two main acute sites, the ToCH team are able to identify rapidly between them who is best placed to support the ward and patient / family achieve a safe discharge to the most appropriate place for their continued recovery.

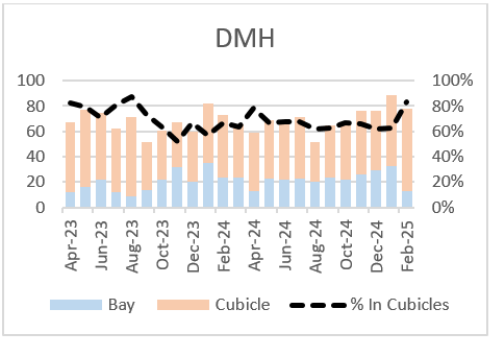
The number of Trusted Assessments undertaken by health staff has increased significantly; this has the benefit of releasing social worker resource to the most complex of cases and of shortening the time by up to two days that a patient is in a hospital bed after they are medically ready for discharge.

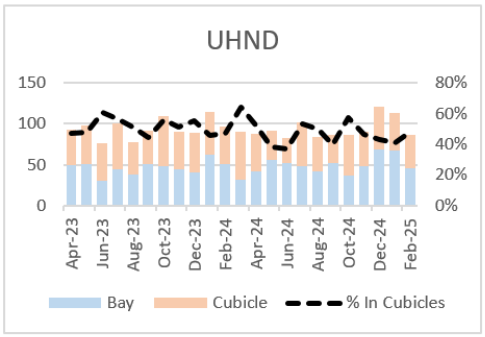
The numbers of patients Not Meeting the Criteria to Reside in an NHS acute bed in our hospitals continues to be among the lowest in the region. This is a result of integrated and collaborative working by all partners including Care Home and Domiciliary Care providers.

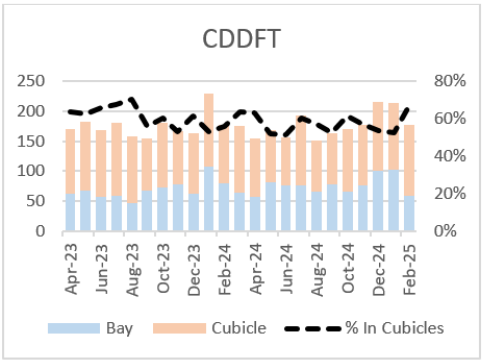
End of Life and Palliative Care

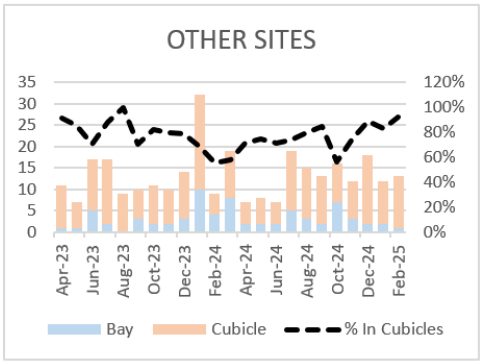
The Trust's End of Life Care was rated as 'Outstanding' in the most recent CQC report and the results of National Audit of Care at End of Life (NACEL) 2023/24 demonstrated continuing good practice in end of life care within the Trust.

Access to single rooms for patients who are dying continues to be a challenge particularly at UHND where more than 50% of patients die in four bedded bays because of fewer side rooms being available within the estate. Availability is better at DMH (88%). We are introducing processes to escalate challenges for wards in identifying single rooms for end of life care patients through our daily site management arrangements and calls to ensure that the needs of end of life care patients are appropriately prioritised alongside other calls on single rooms, and met where possible.

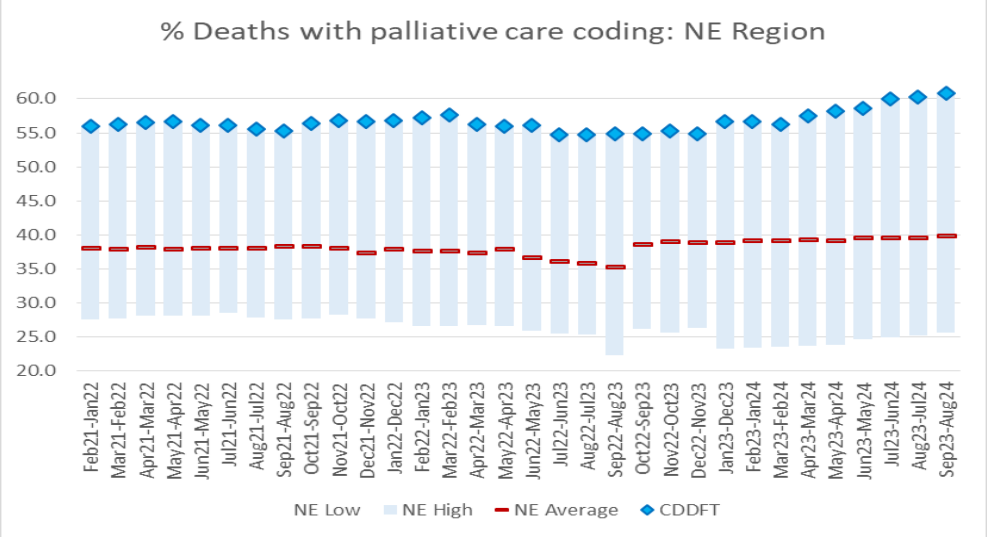








The Trust continues to have the highest proportion of deaths with palliative care coding within the region, as a result of which more than 50% of patients who die in acute hospitals receive input from the specialist palliative care team.

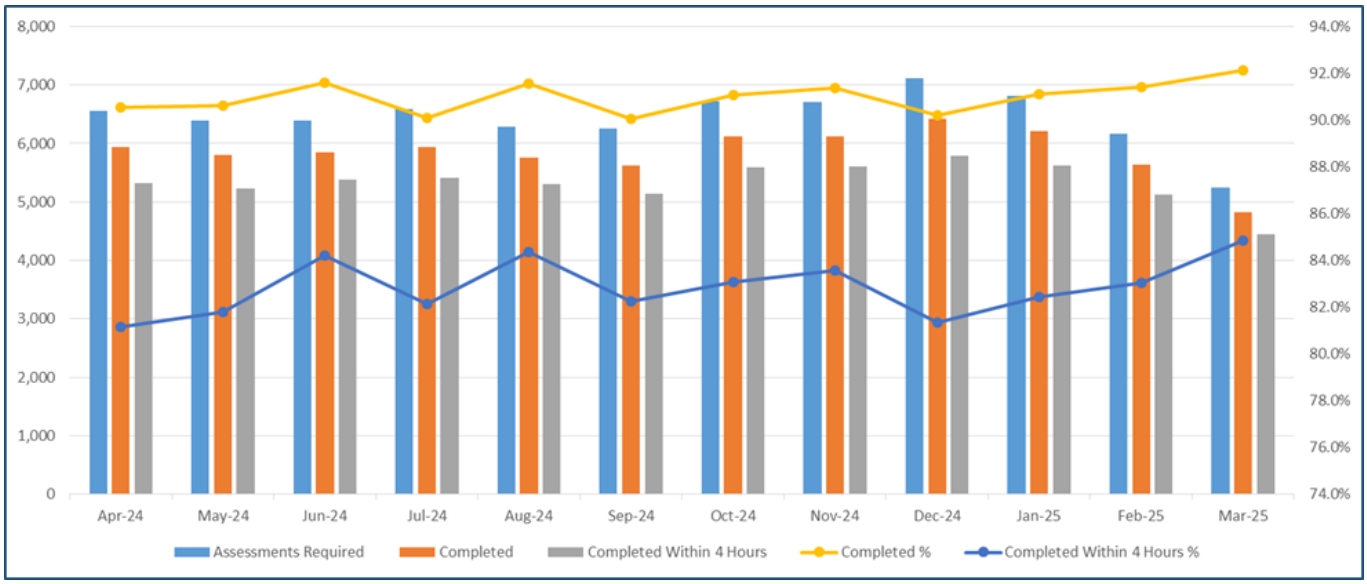


Improving the nutritional support offered to our patients whilst in our care

Partially met (↑)

Compliance data in relation to nutrition assessments is shown in the table and graph below. It can be seen that there is a gradual improvement in practices across the Trust. It is acknowledged that this data is for adult areas only.

Measure	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Assessments Required	6,555	6,399	6,388	6,593	6,282	6,249	6,726	6,704	7,112	6,812	6,167	5,240
Completed	5,934	5,799	5,852	5,940	5,752	5,628	6,125	6,126	6,415	6,206	5,638	4,827
Completed Within 4 Hours	5,320	5,235	5,380	5,415	5,300	5,140	5,589	5,603	5,785	5,616	5,122	4,447
Completed %	**90.5%**	**90.6%**	**91.6%**	**90.1%**	**91.6%**	**90.1%**	**91.1%**	**91.4%**	**90.2%**	**91.1%**	**91.4%**	**92.1%**
Completed Within 4 Hours %	**81.2%**	**81.8%**	**84.2%**	**82.1%**	**84.4%**	**82.3%**	**83.1%**	**83.6%**	**81.3%**	**82.4%**	**83.1%**	**84.9%**



Over the past 12 months we have:

- We have continued to monitor and highlight areas of good practice and areas that require further support via our Professional Leads and matrons groups. The former includes senior nurses, midwives and Allied Health Practitioners.
- Dietetic services have continued to provide bespoke training and support to areas where ward managers have requested assistance following learning from service user feedback or have concerns.
- The Nutrition and Hydration Improvement Group has been utilised to drive positive changes, share ideas and good practice regarding ward level nutrition. Parenteral and Enteral Nutrition Group has continued to work on improvements regarding artificial nutrition support.
- We are working towards digitalising enteral tube feeding training and nutrition screening (MUST) and towards achieving compliance with national standards and guidelines regarding nutrition.
- Dietetics have reviewed their capacity within paediatric dietetics and developed business case for SCBU and children's wards dietetics and have developed plans for a catering services Dietitian and nutrition support team

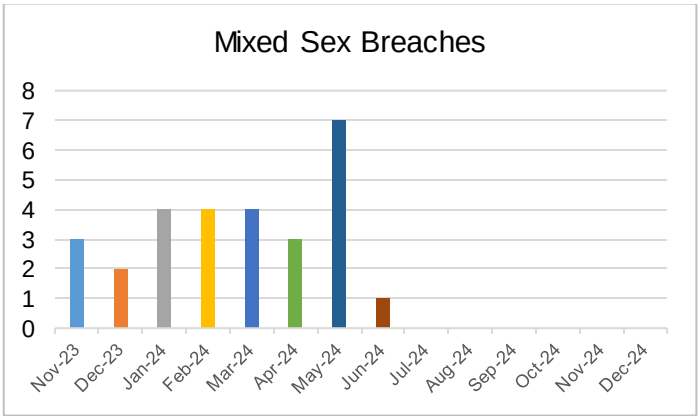
Delivering Same Sex Accommodation / Minimising Mixed Sex Breaches

Broadly on track (↑)

In 2024-25 the Trust has seen a reduction in mixed sex breaches. In 2024 a report reviewing Delivering Same Sex Accommodation (DSSA) and the management of Mixed Sex Accommodation breaches was presented to our Quality Committee. This highlighted the need for an update to the Trust policy and strengthening the approach for DSSA, including robust incident reporting, escalation and oversight of breaches, and improved assurance arrangements.

Education and communications were delivered to improve understanding of incident reporting and ensure that there is sufficient detail in the information reported through Ulysses to facilitate clear oversight of justified or unjustified Mixed Sex Accommodation Breaches.

Mixed Sex Accommodation Breaches are a standing agenda item on the twice daily organisational site meetings to ensure that any actual or potential breaches are highlighted and where possible mitigated. The chart below demonstrates the improvements seen in 2024, with no breaches occurring in the last five months of the year.



The updated policy is shortly to be rolled out, building on the changes put in place. The NHS Policy on Same Sex Accommodation is being reviewed in the light of the recent Supreme Court judgment on the legal definition of the term 'woman'. We will take account of any changes to national NHS guidance as we update and roll out our policy.

Ensuring a positive patient experience through user engagement – Elderly Care and End of Life Care

Broadly on track (↑)

The Trust has worked closely with key local and partners, such as the Carers Association and our established relationships with GP practices, local charity's and council run services such as Home Group to engage in discussions and consultations with staff, patients, their families, and various stakeholders throughout the year. Through these partnerships, valuable insights and feedback have been gathered on the services the Trust provides.

This feedback has been instrumental in identifying both strengths and areas for improvement within our elderly and end-of-life services. By ensuring that these partnerships are maintained and strengthened, we continue to develop a patient-centred approach that focuses on the holistic needs of our elderly and end-of-life patients.

A positive outcome of this collaboration are the improvements in the Trusts comprehensive geriatric assessments allowing us to gain a broad history from our patients at the front door enabling us to signpost them to our partnership services early in their admission to either avoid admission entirely or support with complex discharges working collaboratively to provide patients and their family's with quality care and discharge at the earliest opportunity.

Cancer Services

Broadly on track (↑)

We set out a range of priorities and activities to maintain a positive experience for patients with cancer for 2024/25, and provide updates below.

The Trusts Cancer Outcomes Services Dataset performance remains consistently high. We strive to maintain the required 80% standard for staging completion and work with our Cancer Nurse Specialists to ensure the attendance at diagnosis is recorded, Holistic Needs Assessments are completed and treatment summaries are shared with patients and GPs.

[DN – data requested for the 80% above]

Improvement work between Cancer Services and the Radiology department has resulted in a marked improvement in the late cancellations and DNAs for CT / MRI scans, with a cohort of patients receiving calls and support to attend appointments from our Macmillan Team.

Proactive wellbeing calls are made to patients daily with up to 60 calls made per day and the service has received extremely positive patient experience feedback.

Increasing the understanding the communication needs of Veterans in relation to cancer

A Stakeholder engagement event, attended by over 30 people, was held in May 2024. Attendees were from organisations working with veterans such as Help for Heroes, East Durham Veterans and Blind Life Durham as well as representatives from secondary care, primary care, Healthwatch and the community sector. A "veterans workshop" followed the initial event in November 2024 for veterans to comment on existing resources, and to co-design an information leaflet for veterans and plan production of videos sharing messages by veterans for veterans about screening, early detection and accessing support. This event was attended by approximately 30 people.

In addition, training on the 'Psychology of Veterans' was provided by Click Therapies to over 20 CDDFT and primary care staff working with veterans. The leaflets have now been created and printed, with the final edits of the videos due to be completed in June. Veterans were asked to provide feedback on involvement with the project with the positive comments received suggesting veterans are not often asked for their views about healthcare services. A final project report has been shared across the region via the Northern Cancer Alliance and an information area for veterans added to CDDFT's 'Cancer Information and Support' web pages.

Introduce and develop a psycho-oncology service for cancer patients

With the support of the Northern Cancer Alliance and the North East and North Cumbria ICB, a Consultant Psychologist was recruited and started in post in April 2025. Recruitment is currently underway for an Assistant Psychologist to support the consultant, who will have until December 2025 to complete a business case for the service.

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

CEBE membership has remained relatively static, as some members are inactive but others have joined as new members. The group has an appointed chair and deputy chair who set the meeting agenda and lead group meetings. Feedback from CEBE meetings is shared with lead

cancer nurse to inform delivery and improvement of service provision for cancer patients. Members of the CEBE group have taken part in and supported the Trust's Clinical Quality Panels and the CEBE reviewer panel is regularly asked to comment on new patient information and resources to ensure it is easy to understand, doesn't contact medical jargon and is clear/concise.

Cancer patient experience feedback mechanisms and governance

CDDFT has continued to deliver a programme of 5 for 5 surveys which enables the Trust to capture real time information about patients' experience in any areas of specific interest. Results of 5 for 5 surveys are shared by Lead Cancer Nurse with the Patient Experience team and with care groups/tumour teams for action. An area identified that could benefit from improvement from the most recent Cancer Patient Experience Survey is inpatient experience. We have worked with CEBE and Joining the Dots to create a draft questionnaire, which is in the process of being approved by the reviewer panel. Information about existing 5 for 5 Surveys, including results of past surveys, has been transferred to the new CDDFT website (this can be found on our Cancer Information and Support web pages).

Clinical Effectiveness Priorities

Partially met (↑)

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

We continue to see an improvement in key performance areas such as ambulance handover 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, and can create pressure in ensuring patients are in the department for the shortest time possible.

In respect of the A&E four hour waiting times standard, the Trust has exceeded plan in each month of the year and is expected to achieve the national ambition, which was for at least 78% of patients to be seen, treated or discharged within four hours of attendance to our Emergency Departments and Urgent Treatment Centres by March 2025. Some 79.7% of patients were seen and admitted, or treated within four hours in March 2025.

The Trust also saw sustained improvement, compared to the prior year in the percentage of patients classified as 'Type 1 Attendances' seen and treated, or admitted, within four hours. These are noted as 'ED Only' in the chart below.

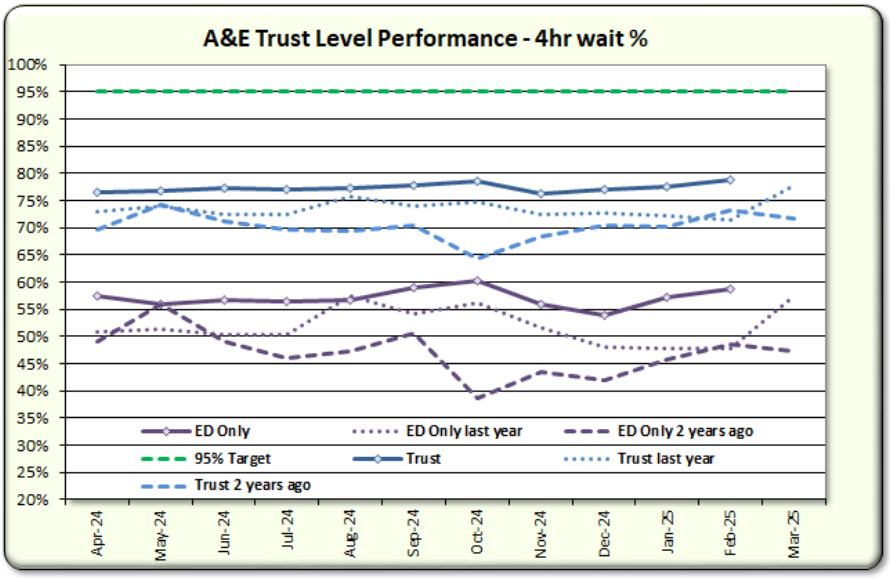


FIGURE 1 – A&E TRUST LEVEL PERFORMANCE

The charts overleaf show our performance on a range of other indicators, pointing to improvements in the number of ambulance handovers completed within the 15 minute target time, but challenges in respect of the number of patients spending more than 12 hours in the department in total.

The improvements seen for most metrics have been achieved through a sustained 'Improving Patient Safety and Experience by Improving Patient Flow' quality improvement programme which includes a number of rapid quality improvement initiatives undertaken over the winter period. Latterly, these have helped to reduce the number of patients spending over 12 hours in the department, month on month, to a level which is now well within the national average.

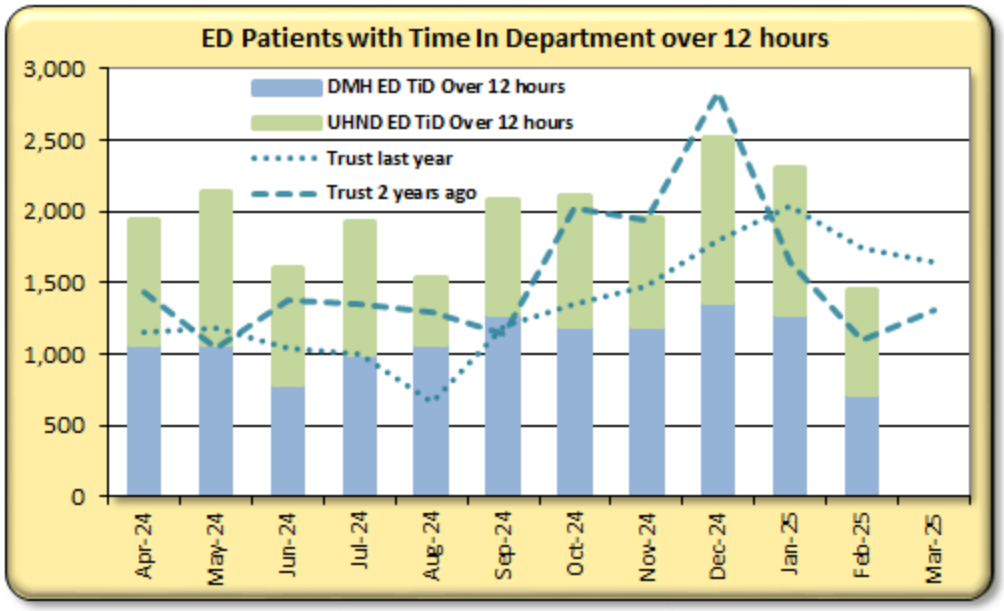


Figure 2 - ED Patient Time in Department over 12 Hours

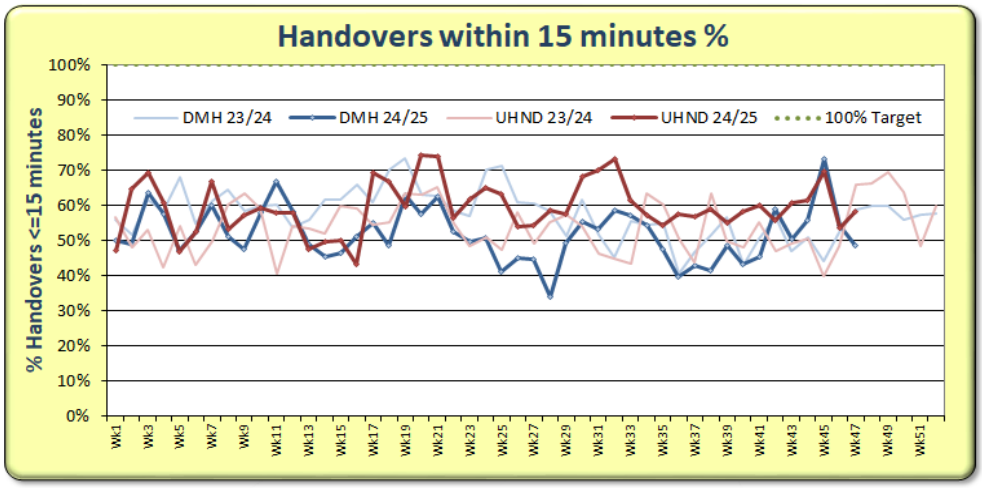


Figure 3 - Ambulance Handovers within 15 minutes by %

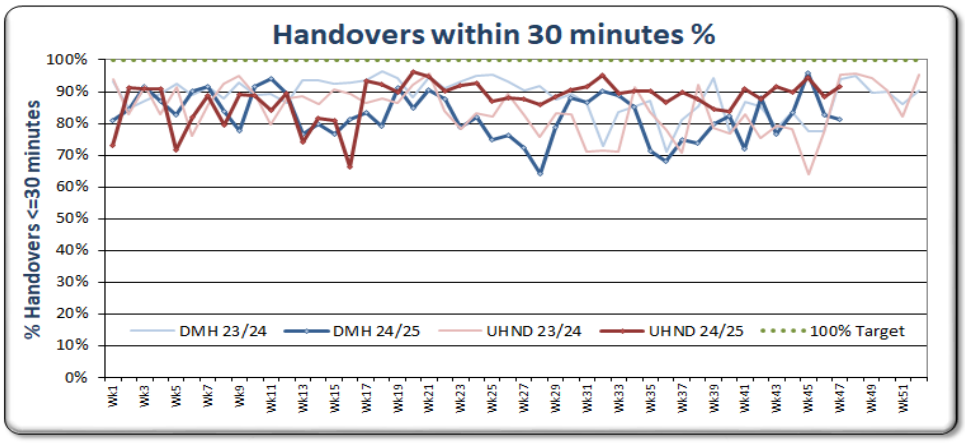


Figure 4 - Handover ambulances meeting standard (both sites)

Despite meeting or bettering national averages in most areas the Trust acknowledges the ongoing need to improve both the experience of patients experiencing long waits and the

effectiveness of the care pathways that enable the delivery of timely treatment and patient flow.

Work continues to look at new opportunities following the successful implementation of Same Day Emergency Care (SDEC) services across the Trust; the colocation of the Urgent Treatment Centre at UHND during afternoon and evening 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 with the aim of achieving 24/7 co-location of urgent care at UHND and increasing direct ambulance conveyance to SDEC.

The Improving Patient Flow programme includes work-streams focused on timely patient review, flow between departments, discharge and supporting processes and will remain a priority for our senior leadership team so that we can sustain and further improve performance in waiting times and mitigate the need to place some patients in temporary escalation spaces at times of significant pressure.

Optimising patients for cancer treatment through prehabilitation

Prehabilitation is an element of rehabilitation where your journey to recovery starts before surgery has even begun through physical, nutritional and psychological support. It supports patients with steps that they can take to help prepare for their upcoming surgery.

Patients are now being signposted to the self-directed digital prehabilitation programme during the triage process. Cancer Nurse Specialists and Cancer Care co-ordinators (CCC's) are also actively encouraged to provide patients with information on how to access the course during their initial consultation.

Facilitated delivery of the digital programme was trialled over a six month period but 'take up' was low. This has now been paused pending a review which will involve collaboration with patient representatives.

We are continuously gathering evidence to demonstrate the impact of prehabilitation interventions on patient outcomes with the aim of building a robust business case to secure substantive funding for the service. The latest length of stay data shows a 1 standard bed day and 1.1 critical care bed day saving for colorectal cancer patients who engaged in prehab and an improvement or maintenance in all six validated patient reported (PROMS) and physiological outcome measures (Co. Durham programme – all pilot tumour groups).

Maintain and improve the Macmillan Information and Support Centre quality standards (MacMillan Quality Environment Mark – MQEM)

MQEM – In March 2024 the BAH and UHND Macmillan Centres were assessed by the Macmillan Environmental Team and were awarded the MQEM status again. DMH was not included in this assessment due to deficits in its layout. As a result an improvement grant application was submitted requesting funding to make the necessary changes to the DMH centre to bring it up to the MQEM standard and also to make small improvements at BAH and UHND. This application was successful and will be actioned in 2025.

Volunteers – The service continues to have an extremely reliable team of volunteers who support both the Macmillan Centres and the Chemotherapy Units, they provide not only face to face support to patients, they also provide valuable administrative support with data collection, social media and reminder appointment phone calls.

Complementary Therapy Service – The service provider for this service sadly went out of business in August 2024; however, another provider for the South of the trust was quickly found and the service resumed in October 2024. Fundraising has been ongoing during 2024 which will enable the service to continue for the foreseeable future.

Health and Wellbeing – The service supports Look Good Feel Better workshops, Wig and headwear services, Prosthesis and Bra Clinics, HOPE workshops and Cancer Awareness routinely.

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

The following actions have been taken in support of this objective during the year:

- Induction and competency documents created for all job roles within cancer services, including cancer care coordinators (CCC) and cancer nurse specialists (CNS), to Foundation, Specialist, and Leadership levels.
- Support with recruitment within the Cancer CNS and CCC teams, helping to embed induction and competency.
- Sage & Thyme training – which builds skills for supportive conversations with patients and relatives who are worried and distressed were funded for a second year by Training and Development. Some, 93 people were trained in 2024/25 and course feedback was excellent with 100% of participants stating that they would recommend it to a colleague.
- The national Aspirant Cancer Career and Education Development programme (ACCEND) has been integrated as part of all Cancer Education sessions for students and preceptees and in Trust study days, and new starter education plans. The Trust's educator is part of a regional community of practice.
- Through the Northern Cancer Alliance there is funding for Cancer CNS and Systematic Anti-Cancer Treatment (SACT) staff to record CPD and competency achievement.
- Further, specific training has been supported through access to wider grant funding.

Breast Surgery Review Programme

Following reviews of the Trust's breast surgery service by the Northern Cancer Alliance, the national GIRFT programme and the Royal College of surgeons we are undertaking a full service review – as publicised in April 2025 – alongside transforming and modernising the surgery we provide.

We have already:

- Recruited two new consultants with expertise in oncoplastic surgery, increasing the range of treatment options available on site;
- Acquired modern 'Faxitron' machines to support diagnostics in theatres; and
- Strengthened the leadership, administration and operation of our multi-disciplinary patient reviews with the support of a visiting specialist consultant.

We are also strengthening the clinical governance arrangements for the service and working with partners in the region to ensure sustainable access to the specialist diagnostic services needed to match capacity to demand for the service.

Our priority, alongside the transformation programme, is to understand the experience of patients using our service. Should the ongoing work identify any particular concerns with patient care, patients are being contacted and fully supported, including providing access to further assessment or treatment.

Part 2B - Priorities for 2025/26

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 2025/26 reflect both the ongoing priorities in this strategy and further priorities (described as "retained" priorities) where further work is required to meet 2024/25 objectives.

Safety	Experience	Effectiveness
Quality Strategy Priorities / Retained priorities from 2024/25: work ongoing		
Reduce the harm from inpatient falls in community hospitals, focusing on identification and learning from lapses in care	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	Optimising patients for cancer treatment through prehabilitation.
Maintain zero tolerance of Grade 3 & Grade 4 pressure ulcers	Increasing the understanding the communication needs of Veterans in relation to cancer	Maintain and improve the Macmillan Information and Support Centre quality standards
Implement actions from the Maternity Safety Support Programme to sustain safety in maternity services.	Introduce and develop a psycho-oncology service for cancer patients	Maintain a positive learning culture across all services that support cancer patients
	Improve the membership and involvement of the Cancer Experts by Experience (CEBE) group	Transform Breast Surgery
Embed safe practice for invasive procedures: LocSSIPs	Mixed sex breaches: roll out of revised trust policy.	
Further embed prompt recognition and action on signs of patient deterioration	End of life care: conclude and roll out the palliative care strategy, ensuring appropriate access to private rooms for dignity as far as possible.	
Improve the timeliness of assessment and treatment for patients with suspected sepsis	Continued improvement of nutrition including assessment and provision for specific needs	
Continue to progress the roll out of the Trust's patient safety strategy.		

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 2024/25 – Work ongoing:

Reducing harm from inpatient falls in community hospitals

Why we chose this priority

Falls continue to be one of the highest reported categories of incidents across the trust, and patients continue to suffer harm as a consequence of them. However falls in community hospitals are not seeing the sustained reduction that we have seen in our acute settings.

Goals

Our goal, therefore, is to drive a substantive reduction in falls in community hospitals aligned to that seen in acute settings in the last two years.

How will we do this?

We will:

- Continue our supported rapid review process to ensure learning from falls results in specific and measurable actions
- Monitor and develop our quality improvement work through the Falls System Improvement Plan, with bespoke interventions for community hospitals
- Work with other health and social care partners and voluntary sector networks to finalise and implement an inclusive Falls and Fracture Prevention Strategy 2024-27.
- Review and update the policy and guidance relating to the provision of enhanced care
- Continue to educate staff about the importance of preventing deconditioning in our frail elderly patients
- Revisit the thematic review of falls in bathrooms to evaluate the effectiveness of the actions taken following the review

Measures of success

Reduction in the 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 one of the key priorities within the Trust's Quality Matters Strategy. There has been an increase in HCAIs over the last year and therefore we need to reduce the risk of patient harm from any potentially avoidable infection.

Goals

To minimise the potential risk of patient harm from avoidable HCAIs we will aim to be within the national thresholds set for the mandatory reporting of:

- Clostridioides Difficile Infections (CDI);
- MRSA BSI;
- Gram-negative BSI:
- Klebsiella;
- Pseudomonas;
- E coli.

As there has no national threshold to date for MSSA BSI, locally there will be a continued aim to reduce the incidence by 5% from the end of 2024/25 thereby agreeing a set threshold of 49 cases.

How will we do this?

We will:

- Continue to promote optimum IPC practice, building on the success of our fight back infection campaign, and continuation of the IPC champions, to embed ownership and improvement of IPC practices across all of our clinical areas.
- Share learning from CDI rapid reviews to promote best practice for diarrhoea management and antimicrobial stewardship, discussing complex CDI patients in MDT CDI meetings.
- Work with clinical teams to promote cleaning being performed in line with policy to reduce the risk of environmental contamination.
- Promote timely review of the need for invasive peripheral IV cannula and urinary catheters to reduce associated device related infection risks for BSI whilst promoting best practice for device care.

Measures of success

To reduce all infections and thereby remain within national / locally set thresholds for all mandatory reporting HCAI to reduce the risk of associated patient harm.

Reducing harm from Category 3 and 4 pressure ulcers

Why we chose this priority

Minimising harm from pressure ulcers remains is one of the key 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; Rapid Reviews now take place fortnightly rather than monthly to capture learning at the earliest opportunity.
- Embed, and refine, the rapid review process to ensure it remains fit for purpose and identifies all possible learning to inform and improve our patient care.
- Ensure all patients identified with Category 3 and above pressure ulcers whilst in our care have a clinical review by the Tissue Viability Nursing Team
- Launch the Photography SOP which will allow Tissue Viability Nurses to take wound photography in acute services to support wound assessment and evaluation of the improvement or deterioration of the wound.
- Undertake quarterly thematic reviews for all Category 2 pressure ulcers, reporting findings into Care Group Governance meetings for action and learning.
- Gain approval for joint Acute and Community Dressings formulary to promote continuity in patient care
- Continue to provide education and support with wound assessment, body mapping, pressure ulcer prevention and wound care planning

Measures of success

For patients within our care to have no Category 3 or 4 pressure ulcers with lapses in care delivery identified.

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 are focussed on fully implementing the quality improvement programme implemented following CQC and Ockenden peer review visits in 2024, with a key focus being receipt of the findings of our Maternity Safety Support Programme (MSSP) Advisers and acting upon the recommendations.

Goals

- To remain 100% compliant with the safety actions in the national maternity incentive scheme (MIS) and saving babies lives (SBL) care bundle.
- To ensure safe staffing levels across all of the teams and proactively manage any gaps in the rota.
- To safely transition to, and embed, the national MEOWS framework.
- To implement and evaluate the effectiveness of BSOTS in PAU; moving from the current triage tool to the nationally recommended tool to further support delivery of safe pregnancy assessment.
- Reinstate of a Homebirth service for women and birthing people in County Durham and Darlington.
- To implement and embed the agreed recommendations from the MSSP.

How will we do this?

We will:

- Continue to implement our “maternity matters” staff engagement strategy and project CHEER.
- Develop a workforce strategy (inclusive of recruitment and retention) to maximise workforce and recruit to remaining vacancies in both acute and community services, ensuring that there is a resilient staffing model.
- Bi annually review our safe staffing levels and models of care against workforce planning models.
- Augment our quality and governance structure against the standards articulated in the Three Year Delivery Plan for Maternity and Neonatal Services
- Continue to monitor compliance with MIS safety actions and SBL to achieve full compliance
- Manage quality improvement via the maternity and neonatal service improvement plan. Communicate back to staff so that everyone is engaged with the changes we still need to make.
- Integrate further actions from the MSSP into the above improvement programmes and implement them.

Measures of success

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

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 maintain the effective systems of tracking and assurance now in place to ensure LocSSIPs remain current and up to date; continuing to monitor and improve compliance with the correct use of LocSSIPs.

How will we do this?

We will:

- Continue to audit LocSSIPs documentation and adherence to practice.
- Introduce observational audits to assess whether LocSSIPs are being used as intended in practice, and that they are not treated as compliance checklists.

- Progress the feasibility of developing LocSSIPs as electronic forms within the EPR system to further enhance patient safety and assist staff in adhering to the requirements.

Measures of success

- Standard audit reports produced at regular intervals for active LocSSIPs and reported into governance structures, which evidence a high level of compliance with requirements.
- Progress towards the development of a suite of electronic LocSSIPs in EPR, supported by appropriate training to staff.

Embedding prompt recognition and action on signs of patient deterioration

Why we chose this priority

Whilst we have made some substantial improvements in how we recognise and act upon patient deterioration, 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 upon earlier.

Goals

- To further improve compliance with training with respect to patient deterioration and resuscitation
- To further reduce incidents involving delayed recognition or action on patient deterioration in line with our 'highly reliable organisation' ambition.
- Continue to increase compliance with the use of handheld devices for recording patient observations to ensure the clinical teams are prompted by the decision support to assist their decision making and escalation.
- Implement and embed Patient Wellness Questionnaire, an evidence based tool proven to give earlier indications that a patient may be deteriorating, across all inpatient as part of our Martha's rule improvement activity.
- Extend the Call for Concern service into the community hospitals.

How will we do this?

We will:

- Closely monitor compliance with relevant training programmes.
- Promote Trust-wide learning and education in response to any incidents, with harm or near misses, involving delayed recognition or action on deterioration.
- Audit early warning scores and escalation to ensure that Trust procedures are being followed.
- Use digital technology to support clinical teams in utilising the patient wellness questionnaire.
- Expand publicity of our "Call for Concern" (Martha's Rule) service and roll out to community hospitals.
- Continue to embed our System Improvement Plan for Patient Deterioration which aims to address key themes and actions from recent Patient Safety Investigations.
- Continue to promote 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.
- Substantial progress in implementing the actions in our Deteriorating Patient System Improvement Plan.
- Positive evaluation of the Patients Wellness Questionnaire alongside evidence of its effectiveness.

Improving the management and treatment of patients with sepsis

Why we chose this priority

To ensure that patients within our care with sepsis are rapidly identified and receive timely treatment. Audits undertaken in 2024/25 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 reliably monitor compliance with provision of antibiotics using the system.

Goals

- To continue to improve the percentage of patients receiving antibiotics within 1 hour and 3 hours 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.
- To improve the sepsis care plans in our EPR to make them more user friendly, therefore increasing compliance
- To review and update our electronic sepsis screening tool to ensure it is as effective as possible in identifying patients with sepsis

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 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.
- Develop nurses Trust-wide by educating them in taking blood cultures to enable patients to have more timely treatment and to meet national standards for timings of sepsis management.
- Collaborate with digital and clinical teams to ensure sepsis screening tools within our electronic systems are updated to ensure best practice for screening patients.

Measures of success

We will see improved compliance rates with the percentage of patients receiving antibiotics within one and three hour of diagnosis in both the Emergency Department and back of house wards, improvements in IV treatment and significant improvements on 2024/25 performance for the taking of blood cultures.

Patient Safety Incident Response Framework

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

One of the key ways we will aim to achieve this is 2025/26 is through stronger links between the Patient Safety, Patient Experience and Legal teams within CDDFT. This development work has already begun, and we will continue to triangulate between patient/family complaints, patient safety incidents and Coroner cases to ensure that we provide comprehensive and compassionate responses to patients and families, and that we maximize the opportunities for learning and improvement. We will:

- Continue to develop the engagement of staff across the organisation with our System Improvement Plans.
- Improve the compassionate engagement and involvement of those affected by patient safety incidents.
- Continue to use resources to maximise improvement and respond proportionately and effectively to themes and issues.

How will we do this?

- Implement a monthly meeting with all owners of System Improvement Plans to ensure that they address all aspects of national priorities for safety, and to continue to promote awareness of them to staff within clinical areas.
- Utilise the Patient Safety Partners to provide input into investigation responses sent to patients/families, ensuring that concerns are taken seriously and ensure that the patient voices is present, and heard, within our patient safety forums.
- A rolling programme of engagement from the Patient Safety Team with staff in clinical areas to ensure understanding of the various systems based approaches to learning, focusing on complex contributory factors and emphasising the focus on fair and just approaches.
- Develop stronger triangulation between Patient Safety, Patient Experience and Legal teams within CDDFT, which will allow more effective identification of learning and themes, regardless of whether they are identified by staff or by patients/families.

Measures of success

These will include:

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

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

There is still the need to develop high-levels of understanding and awareness of how to care for 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 there remain 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 2024/25 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.

Measure of success:

Meeting our 85% compliance targets for dementia awareness and related training and an improvement in PLACE assessment results for dementia-friendly environments. Ongoing improvement in feedback from service users.

Patients with Learning Disabilities and / or Autism

Why we chose this priority

To continue to ensure that our staff have the knowledge and understanding of how to support Patients with a Learning Disability and/or Autism effectively. To ensure we are delivering high quality and effective care to Patients with a Learning Disability and/or Autism and to help reduce any health inequalities they may experience.

Goals:

- Delivery of a Learning Disability and Autism awareness training programme comprising e-learning, face to face training, and bespoke departmental training.
- To explore alternative strategies for collect service user and carer feedback, including development of an easy-read friends and family tests to review patient experience to enable us to gather feedback.
- Exploring opportunities within the wider team to ensure specialist knowledge and skills are available to support the Organisation in caring for patients with Learning Disabilities and Autism.
- Completion of initial CDDFT mortality reviews on deaths of patients with a Learning Disability and/or Autism and liaison with LeDeR to enable us to learn from deaths of individuals with a Learning Disability and/or Autism.
- To increase the knowledge and understanding with regards to hospital passport for both staff and the public.

How will we do this?

- Monitoring the delivery of training within three months of the Oliver McGowan e-learning package being made mandatory for all CDDFT staff.
- Monitoring Learning Disability and Autism Awareness through face-to face attendance and feedback.
- Monitoring and learning from patient and carer feedback.
-
- Continuously review the specialist provision for the Learning Disability and Autism Service
- Liaising with CDDFT's mortality team and LeDeR reviewers regarding deaths of individuals with a Learning Disability and/or Autism in CDDFT, and attending LeDeR panel meetings.
- To carry out a hospital passport communications campaign to support both staff and the wider population to increase their knowledge and understanding on hospital passports. To update CDDFT's internet and intranet to include information regarding hospital passports.
- Completion of mortality reviews with a clear pathway of sharing the learning with all relevant parties.

Measure of success:

- ESR figures for training.
- The monthly Learning Disability and Autism Team's monthly data collection and report.
- Increased effective use and understanding of hospital passports.

Patients with Mental Health support needs

Why we chose this priority

The care of patients of all ages with mental health support needs has remains a priority, with the aim of achieving parity of esteem for our patients. This continues to be the priority within the recent national reports including Lord Dari's report (2024). The learning and priorities from this have been reviewed and will continue to feature within the work plan for the Mental Health Operational Group.

The mental health of our children and young people is also a key priority in the NHS Children's Transformation Programme. Improving our engagement with children, young people, patients and their families & carers in a meaningful way, will ensure that we have a better and accurate understanding of their experience, their journey through our pathways and their outcomes. This will support achieving personalised care planning and appropriate holistic support for all of our patients with mental health support needs.

Goals

- To maintain effective partnership working with TEWV, local authority and multi-agency colleagues focusing on the individualised needs of the patient, including those with complex needs.
- To continue to build and strengthen our alliance with TEWV, and build relationships with other regional providers whose patients may use our services
- To achieve true parity of esteem for all patients who are presenting to hospital with mental and physical ill health
- To ensure that patients' care is personalised; they receive the appropriate support in a collaborative manner to ensure that they are cared for in the most appropriate environment and that safe discharge plans are made successfully, preventing unnecessary prolonged admission.
- To embed nurse-led care of children and young people with mental health needs, which is collaborative and involves all relevant professionals from the outset and to listen to children and young people using the service.
- To use our patients feedback to enhance and improve our care of patients with mental health support needs.
- To support seamless transition to adult services.
- To ensure our compliance with the Mental Health Act is optimised.

How will we do this?

- Through patient experience events hosted jointly with our TEWV and local authority colleagues; facilitating co-production and understanding of lived experience, to ensure appropriate pathway development.
- Through continued agreement of bespoke care pathways for children and young people and adults, 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; and ensure there is evaluation of sessions to continuously to improve our provision.
- 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.
- Using colleagues from TEWVFT to support the Trust by providing an education package to support the understanding and development of skills and knowledge regarding Mental Health Act.
- Working with the Digital Team, to look at a digital solution, which will support the recording of patients who are detained and record-keeping around the reading of rights.
- Prioritising reasonable adjustment and embedding the use of Health Passports to support providing holistic individualised care.

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.
- An effective and productive Partnership Alliance.
- Positive evaluation of the training provided to staff.
- We will continue to see a sustained improvement in our compliance with the Mental Health Act.
- Reduction in length of stay and readmission in patients with mental health support needs.

Ensuring a positive patient experience through the discharge process

Why we chose this priority

The need for effective discharge continues to be a priority. The increasing pressures on the emergency departments, the high acuity of patients and high numbers of admissions has resulted in the maximising all available bed capacity, and patients in Temporary Escalation Spaces becoming almost a daily occurrence; this is a position that the Trust does not want to become normalised. Therefore focus in 2025/26 will look to enhance all opportunities available to support safe, early, effective discharge.

Goals

To:

- Bring forward discharges (on average) to earlier in the day, ensuring 'home first' wherever possible;
- Fully embed the 'SAFER' principles across all inpatient areas
- To achieve improved performance against the Planned Discharged Date
- To improve the discharge processes that underpin all Discharge Pathways i.e. discharge medicines, discharge letters, ambulance booking
- To complete the integration of the Transfer of Care Hub staff from partner organisations
- Ensure that patients have a positive experience through the discharge process
- Minimise incidents and adverse events relating to the discharge process.

How will we do this?

We will:

- Build on and sustain the improvements across the Organisation with the continued engagement in our 'Improving Patient Safety and Experience by Improving Patient Flow' quality improvement programme relating to discharge planning and timely discharge on the day patients leave hospital.
- Re-invigorate and embed the 'SAFER' principles across inpatient areas
- Ensure local and wider learning from concerns reported by local authorities or primary care colleagues.
- Use patient surveys to understand patients' own experience on discharge and make improvements.

Measures of success

- Our discharge time will be earlier in the day
- Reduced use of Temporary Escalation Spaces across the Trust
- Improved patient satisfaction through post-discharge surveys
- A reduction in incidents and adverse events related to discharge, measured through Section 42 referral trends, internal reporting and primary care incidents reported through SIRMs.

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)”

Goals

- To improve earlier recognition of death in hospital
- To explore ways to improve access to palliative care for patient groups who have previously had less equitable access
- To support acute hospital wards to provide comfort and dignity to patients who are dying and their families

How will we do this?

We will:

- Focus intensively on earlier recognition of dying in hospital in all palliative care teaching and model
- 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 ensuring appropriate access to private rooms for dignity.

Measures of success

- Improvement in time prior to death that dying is recognised (nationally audited measure)
- Increase the number of patients registered for palliative care within primary care
- Reduce the number of patients dying in multiple occupancy rooms and associated reductions in distress reported by families

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 work to improve and embed good nutritional care through weekly weighing of patients, completion of MUST assessments and relevant onward referrals to dietetics
- To share good nutrition practices at ward level across the organisation regardless of clinical area or care group
- To continue to monitor incident trends relating to nutrition

How will we do this?

- Develop and launch a Trust-wide System Improvement Plan (SIP) incorporating nutrition and swallowing for areas including eating and drinking, artificial enteral nutrition support and parenteral nutrition support
- Continue to learn from positive and negative feedback in relation to nutrition practices with incident forms, comments and complaints
- Continue to strive to improve nutrition practices across all areas of the Trust including working collaboratively with all care groups and disciplines

Measures of success

- Progress against the SIP
- Continued gradual improvement in compliance of MUST (nutrition screening)

Cancer Services

Why we chose this priority

The NHS Long Term Plan (LTP) was published in January 2019; and set out stretching ambitions and commitments to improve cancer outcomes and services in England over the following ten years. The ambitions will be delivered in a way that:

- improves quality of life outcomes;
- improves patient experience outcomes;
- reduces variation; and
- reduces inequalities

Goals

- To maintain delivery on the Long Term Plan (2019)
- To adapt to deliver outcomes aligned with the NHS 10 year Health Plan when it is published across the whole cancer pathway.

How will we do this?

- Continuing to utilise our Navigators and Cancer Care Coordinators to provide patient support; enabling any barriers to diagnostics/treatment to be identified and patients supported throughout their pathway.
- We will maximise our Macmillan volunteer team by delivering patient wellbeing calls prior to MRI and CT scans to improve the patient experience and reduce the number of DNAs and late cancellations.
- We will utilise our cancer care coordinators to provide proactive calls to all patients prior to starting a SACT regime to support non-clinical needs to assist attendance and adherence to treatment.

- We will endeavour to ensure any changes to service delivery are co-produced, or have patient consultation, through the use of our Cancer Experts by Experience.

Measures of success

- Improved COSD performance outcomes where navigators and coordinators have pathway involvement and reports are published monthly.
- Maintenance and extension of the wellbeing calls, with audits of the impact evidencing an improvement in experience and efficiencies
- Increased patient involvement in improvements service change/development
- Continued improvement in our National Cancer Patient Experience audit results

Increasing the understanding the communication needs of Veterans in relation to cancer

Why we chose this priority

There is still more to be done to meet the needs of Veterans in understanding and engaging with our services.

Goals

- To share the resources created as a result of the project undertaken in 2024-25 with other Trusts across the region as well as with partners and services working with veterans, encouraging ex-service personnel to engage with screening, early diagnosis and access support services
- To begin identifying whether people affected by cancer are veterans.

How will we do this?

- We will share the final project report with relevant services, partners and the Northern Cancer Alliance
- We will ask people visiting or contacting the Macmillan Information and Support centres whether they are military veterans.

Measures of success

- The number of services and organisations the final report is shared with
- The number of people asked if they have ever served in the British Armed Forces by the Macmillan Information and Support Centre team
- Positive feedback on the veterans' support leaflet from clinical teams and patients.

Introduce and develop a psycho-oncology service for cancer patients

Why we chose this priority

Psychosocial support remains the key priority nationally to support the improvement of Quality of Life for Cancer patients in direct response to the national Quality of Life survey results. CDDFT does not currently provide a cancer psychology service but the evidence base, patient experience feedback and feedback from the clinical teams demonstrates it is needed. A consultant psychologist has recently been appointed within cancer services and recruitment is under way to supplement this post with an Assistant Psychologist.

Goals

- To develop a substantive psycho-oncology service to support people affected by cancer with complex psychological needs which arise either as a result of their diagnosis or treatment, or are an exacerbation of an existing mental health condition.

How will we do this?

- Developing pathways and processes to integrate the service into CDDFT
- Creating a business case detailing a substantive model for cancer psychology service at CDDFT.

Measures of success

- Presentation of a business case to Trust Executives to ensure people affected by cancer in County Durham and Darlington have access to appropriate and timely psycho-social support.
- Delivery of a cancer psychology service will have commenced, including provision of support to identified patients and to clinical teams supporting them to deliver psychologically informed services, aligned to the regional Improving Mental Wellbeing strategy and objectives.

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

Why we chose this priority

Patient involvement and co-design remain at the heart of the cancer services strategy. CDDFT's Cancer Experts by Experience Group (CEBE), formed in 2023 after the previous Patient and Carer group dissolved the during Covid-19 pandemic, enables people with lived experience of cancer to inform, influence and improve services. Understanding what matters the most to people affected by cancer allows CDDFT to develop and deliver services to support local population needs.

Goals

- We will continue to promote CEBE membership through our patient facing services and through partner organisations working with people affected by cancer
- We will continue to offer different levels of membership including a reviewer panel option enabling people affected by cancer who may not wish to attend core group meetings to comment on and contribute to the development of new promotional resources.
- We will ensure clear communication pathways are developed between CDDFT and the CEBE to ensure patient experience is placed at the heart of our service delivery and development.
- We will invite healthcare professionals to attend as guests at CEBE meetings to support patient engagement with cancer service teams and providers

How will we do this?

- Promoting CEBE through our Macmillan Information and Support Centres, clinical teams, social media, the Trust website (Cancer Information and Support pages),

HOPE courses and through partner organisations such as Healthwatch and Northern Cancer Voices.

- We will support the CEBE group to review its Terms of Reference early in 2025, continue to provide administrative support to the group and feedback any issues identified by the CEBE group through the Lead Cancer Nurse, care groups and Patient Experience team.
- Share cancer service updates, improvement plans and new projects with the group to ensure members are fully updated and that CDDFT is able to benefit from their expertise and experience.

Measures of success

- Increased membership of CEBE, including the reader review panel
- Evidence of involvement of existing members in updating the Terms of Reference and setting objectives for the group in 2025/26
- Evidence of integration of CEBE feedback into decision making regarding aspects cancer care delivery.

Cancer patient experience feedback mechanisms and governance

Why we chose this priority

Cancer patient experience feedback continues to be of utmost importance as it enables us to understand how well our services are meeting the needs of service users and improve and enhance them in response to the feedback. In response to a national Cancer Improvement Collaborative in 2019, CDDFT developed a local rolling programme of patient experience surveys (called '5 for 5'). These surveys aim to explore the key themes highlighted by the National Cancer Patient Experience Survey (NCPES) results and also other areas identified within the Trust. Whilst the NCPES is valuable, and allows patients experience to be compared across teams and between Trusts, the NCPES results are not received until 10 months after the surveys have been distributed; the 5 for 5 surveys allow the Trust to obtain patient experience in a timely manner to enables prompt improvement action where it is identified as being required.

Goals

- To ensure patient feedback is heard and considered by teams working with people affected by cancer
- To ensure that feedback informs service development and delivery.

How will we do this?

- We will continue to deliver 5 for 5 surveys in response to areas highlighted by the NCPES or by the Trust's cancer delivery teams
- We will share the survey results with the patient experience team and service leads so that rapid action can be taken on any key findings
- We will publish the results of all surveys on CDDFT's 'Cancer Information and Support' web pages
- We will share the results of the annual NCPES surveys with all relevant departments and service and inform all tumour teams and service leads of NCPES patient response rates, supporting with the assimilation of the yearly results to maximise clinical team engagement and action planning.

Measures of success

- Clinical engagement and action plan development following publication of CPES results
- Continued reporting of cancer results from 5 for 5 surveys conducted with patients and staff experience through CCDFT's web pages.

Delivering Same Sex Accommodation / Minimising Mixed Sex Breaches

Why we chose this priority

Delivering same sex accommodation is a statutory priority and whilst we have reduced the number of breaches, they can still occur at times of pressure.

Goals

- To maintain rigorous oversight of DSSA and provide assurance regarding monitoring and oversight of Mixed Sex Accommodation incidents
- To minimise unjustified breaches and mitigate risk when justified breaches occur
- The fully implement and embed the new policy.

How will we do this?

- Through education across all of the clinical teams
- With a clear communications plan to raise staff awareness
- Through reinforcing the need to incident report any breaches
- Ensuring there are robust pathways for escalation of any impending, or actual, breaches

Measures of success

- An increase in incident reporting of breaches
- Discussion at every site/bed calls
- Evidence of reporting through, and discussion at, Trust Governance Meetings

Clinical Effectiveness
Quality Strategy Aims / Retained Priorities from 2024/24 – 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 priority was chosen in line with national priorities for improving Urgent and Emergency Care. Levels of demand on our Urgent and Emergency Care services continue to be high, and capacity constraints relating to the size of our department at the UHND site combined with our bed base have, over the past 12 months, meant that we have experienced some delays in providing treatment and / or in admitting patients. The previous pressure points remain, becoming at times even more acutely pressurised, despite the significant improvements made in 2024/25

Goals

- To further optimise clinical pathways; the continued movement towards a seven-day clinical service, and relocation and co-location of all of our SDEC services and robust 24/7 UTC provision to release pressure in the Emergency Department at UHND during 2025/26.
- To progress with our plans for a new Emergency Care Centre at UHND, with the support of the North East and North Cumbria Integrated Care Board, as and when funding becomes available.
- To achieve our planned maintenance and improvement in the emergency care standards (4 hours and 12 hours in department)

How will we do this?

- Through full roll out and embedding of improvements within our 'Improving Patient Safety and Patient Experience by Improving Flow' programme.
- Optimisation of the SDEC and urgent treatment pathways
- Seeking funding for the new Emergency Care Centre.
- Continuing to engender a culture of collective responsibility for patient flow between teams and professions at all stages of the patient's care.
- Completion of ongoing improvement sprints.
- Daily monitoring, validation and review of all patients, ensuring minimisation of performance against 4-hour, 12 hour trolley breaches, patients spending 12 hours and 24 hours in the department

Measures of success

These will comprise of:

- Improvements in waiting times with respect to assessment, treatment and the total time in the Emergency Departments when measured against national performance targets;
    - Time to initial assessment – the percentage of patients within 15 minutes;
    - Time to treatment – less than 60 minutes;
    - The number, and percentage, of patients spending more than 12 hours in ED;
    - The average time spent in ED for admitted and non-admitted patients;

- 12 hour waits for beds;
- Treatment and / or admission within 4 hours;
- Average ambulance handover time within15 minutes;

Optimising patients for cancer treatment through prehabilitation

Why we chose this priority

Cancer prehabilitation is included in the national cancer plan outcomes for 2025/26. As a community based programme designed to improve cancer outcomes, reduce treatment variation, address health inequalities, improve health behaviours and patient experience, CTOP is aligned with all 3 shifts identified within the new 10 year Health Plan; sickness to prevention, hospital to community, analogue to digital.

Goals

- To sustain the existing delivery model and further develop CTOP to provide community based equitable, multi-modal prehabilitation to more cancer patients across County Durham and Darlington

How will we do this?

- The Durham University research project will enable us to learn more about the barriers and facilitators to participation in cancer prehabilitation. This will inform our ongoing service development work.
- We will work with patient representatives to review, and make changes to, the facilitated delivery of the digital prehabilitation programme with the aim of increasing accessibility and uptake across CDDFT.
- We will continue to gather evidence through data collection to clearly demonstrate within the business case the benefits of prehab to patients and the organisation.
- Continue to share our findings regionally and nationally.

Measures of success

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

Maintain and improve the Macmillan Information and Support Centre quality standards

Why we chose this priority

Whilst we made improvements in 2024-25 this remains a priority for us as an Organisation moving into 2025-26.

Goals

- MQEM

    - To ensure the Improvement Grant is used to facilitate improvements in all three centres, to provide an improved space for supporting patients and their loved ones.

- Complementary Therapy Service
    - To continue to offer a free service for cancer patients, utilising local charities to deliver the service
    - To pursue charitable ventures to ensure the service is viable.

- MVQS (Macmillan Volunteer Quality Mark) and increasing volunteer numbers in all centres
    - To continue to nurture a quality team of volunteers who support the centre and the people who seek support.

- Outreach
    - To promote the service in all areas of the hospital so that all patients, families and staff feel supported.

- Health and Wellbeing
    - To continue to deliver services that improve patient health and wellbeing during treatment and supporting a positive recovery.

- To celebrate and achieve the highest standard of quality awards for our Macmillan environments and teams and offer beneficial services for cancer patients.

How will we do this?

- We will ensure the environmental updating is completed in a timely manner.
- We will achieve the Volunteer accreditation overseen by Macmillan Volunteering Quality Mark (MVQS).
- We will increase the volunteer workforce where needed.
- We will continue to offer complementary therapies.
- We will continue to offer health and wellbeing services

Measures of success

- By seeking patient feedback regarding the services and environments.
- Improvements to the Macmillan centre at DMH to ensure the MEQM can be achieved in future.
- Standards will be achieved to acquire the MVQS.

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

Why we chose this priority

The quality of care delivery is in part underpinned by appropriate and relevant training for all staff. This also contributes to effective recruitment and retention of posts and ensures an equitable standard of care across teams.

Goals

- Embed a culture of continuous learning across all staff groups within cancer services and the wider workforce delivering care to patients with cancer.
- Improve communication training within the Trust as there is no standard provision within the Trust nor available regionally or nationally.

How will we do this?

We will:

- Continue to embed induction and competency frameworks, aligned to ACCEND, for new starters within the clinical and non-clinical cancer workforce. To achieve competence within the frameworks staff members will be exploring their learning needs and completing training and education.
- Continue to deliver cancer education throughout the trust and to primary care partners, including bespoke training on ED, wards and district nursing teams. This helps to increase cancer knowledge of staff who work with people affected by cancer, ensuring better informed care.
- Promote the ACCEND learning hub and optimise opportunities to increase cancer education in the wider trust workforce, aligning to a national cancer education programme and resources.
- Continue to grow pre-registration student placements within Cancer Nursing teams, helping to grow the future cancer workforce and spread knowledge of caring for cancer patients at an early stage of a nurse's career.
- Collaborate with Charity sector partners (including Macmillan Cancer Care) and NHS England/ ICB to provide financial support for training and education of our Cancer CNS teams and SACT nurses.
- Collaborate with Learning & Development and local universities to look at development and delivery of communication training within the trust for all staff groups.
- Continue to deliver Sage and Thyme foundation level communication training within the trust, helping to build staff confidence in dealing with distressed or upset people.
- Complete Advanced Communication 'Train the Trainer' training.
- Ensure all Cancer CNS and senior SACT nurses are trained in Advanced Communication and Level 2 Psychology, so up to date with an essential component of their training. This will include clinical supervision and be aided by the new Consultant Psychologist within Oncology.
- Review ways in which education is delivered across site within SACT, and attempt to develop standardisation in practice across the SACT teams and within the region.

Measures of success

These will comprise of:

- ACCEND as part of all cancer education.
- Increased use of self-assessment competency frameworks across the clinical and non-clinical cancer workforce.
- Increased use of GMCA e-portfolio to record CPD and competency achievement.
- SACT standardisation and sustainable education.
- Macmillan & NHS England education grants.
- All Cancer CNS teams and senior SACT nurses trained in Advanced Communications and Level 2 Psychology.
- Sage and Thyme embedded as essential communication training for all levels of staff.
- 'Train the trainer' Advanced Communications training successfully completed to enable rollout of Advanced Communication training for B6 and above staff within the trust.

- Successful collaboration with Learning & Development and local universities to develop different levels of communication training for all staff within the Trust.

Transform Breast Surgery Service

Why we chose this priority

Third party service reviews have identified areas in which our service and clinical practice need to be brought up to date to align it with national best practice, and to ensure that all of our patients are offered a full range of treatment options aligned to their needs.

Goals

- To provide a breast surgery service which is aligned to best practice
- To offer a full range of treatment options appropriate to patient need
- To implement a sustainable delivery model with sufficient capacity to meet demand
- To implement effective, service-led, clinical governance for Breast Surgery
- To understand the experience of patients using the service, including in the recent past and, where necessary to ensure that patients are contacted and appropriately supported.

How will we do this?

- There is a Breast Surgery Response Programme in place, which is overseeing the implementation of the recommendations from the external reports. Effective implementation of these recommendations will enable us to achieve the majority of the objectives detailed within our goals.
- We have commissioned an independent assessment of our governance processes, which will inform and support improvements in clinical governance both in breast services and the wider Organisation.

Measures of success

These will comprise:

- A sustainable demand and capacity model
- Full implementation of reviewers' recommendations
- Compliance with evidence-based best practice with respect to treatment options
- Specialty-specific clinical governance arrangements being implemented and embedded.

Link to mandatory quality indicators and further developments in 2025/26

We will continue to undertake work, as set out in Section 3, to minimise waiting list backlogs in accordance with the 2025/26 Operational Planning Guidance. As this is a national priority, it is not recorded as local priorities in this section, but remain key areas of focus in terms of ensuring the effectiveness of our services.

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 six 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

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.

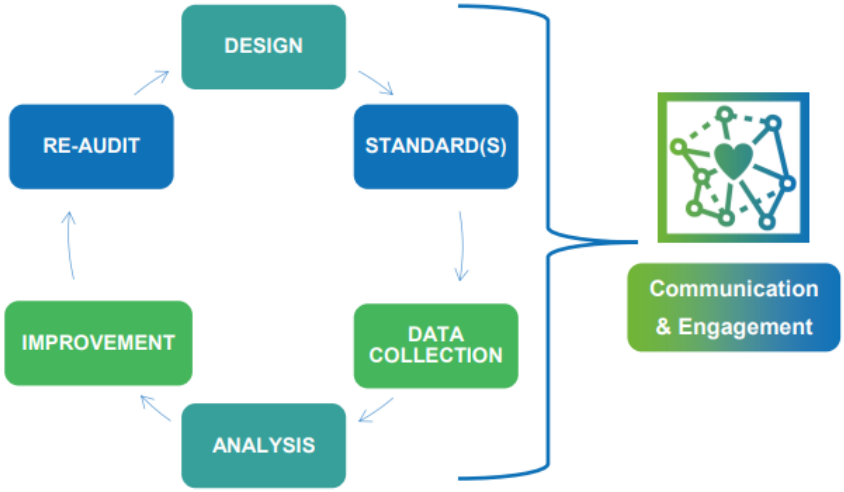


Figure 5: CDDFT Clinical Audit Cycle

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

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

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

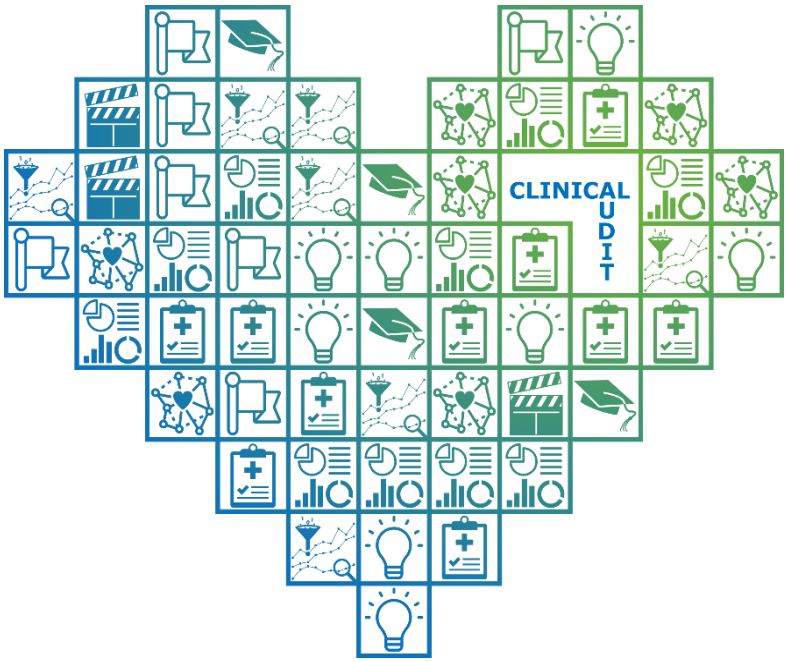
National Audit reports are reviewed by the Lead Clinician and the Clinical Audit Team, a specific action plan is developed for each audit and approved by both the Speciality and Care Group Clinical Audit Leads. Action plans are monitored by the Clinical Audit team and the Care Group Governance Facilitators.

Participation in Clinical Audit

During 2024/2025 **55** national clinical audits and **4** national confidential enquiry covered NHS services that County Durham & Darlington NHS Foundation Trust provides.

During 2024/2025 County Durham & Darlington NHS Foundation Trust participated in **96 %** of national clinical audits and **100** % of national confidential enquiries of which it was eligible to participate in.

The reports of **15 National Clinical Audits** were reviewed and **207** Local Audits were successfully completed by the Trust in **2024/25**. 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 clinical audit strategy covering the development of the Trusts clinical audit programme until the end of 2025/26.

The strategy focuses on seven domains that build on one another to create an effective and efficient clinical audit programme and develop an open and honest culture throughout the Trust. During 2024/2025 significant progress has been made in achieving the objectives within the strategy. The domains and examples of the progress achieved are described below.

Education/Training

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

Reporting Accurate and Actionable Information

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

Action Plans

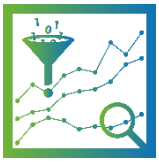
- Development of smarter and sharper action plans.
- Focusing on fewer higher quality actions that address what really matters.
- Identifying and minimise risk, waste and inefficiencies.

Assurance

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

Communication & Engagement

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



Data Collection & Insights

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

New Ways of Working & Process Improvements

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

Progress Achieved

- Clinical Audit training sessions have been delivered to 187 staff members with additional training sessions planned throughout 2025.
- Clinical Audit sessions are now part of the registered doctor training programme.
- Clinical audit activity is reported through the Trusts Quality & Performance framework.
- A clinical audit dashboard has been developed to provide a single source of information relating to clinical audit activity for all staff to make use of, this is in the early stages of deployment.

- Clinical audit reports showing the progress of audits and outstanding actions are published to care groups and specialties weekly and quarterly reports to our Quality Committee and the Board's Integrated Quality and Assurance Committee contain the latest progress and outcomes for all major national audits, and headlines from local audits.
- Improvements to the process for requesting, approving and monitoring clinical audits are underway.
- Communication posters on display across the Trust for staff to request support from the clinical audit team.
- Development of better links with Health Informatics to enable more efficient access to clinical data.
- Development of awards for high quality clinical audits, with 7 audits awarded this in 2024/2025, an example is shown below in figure 2.

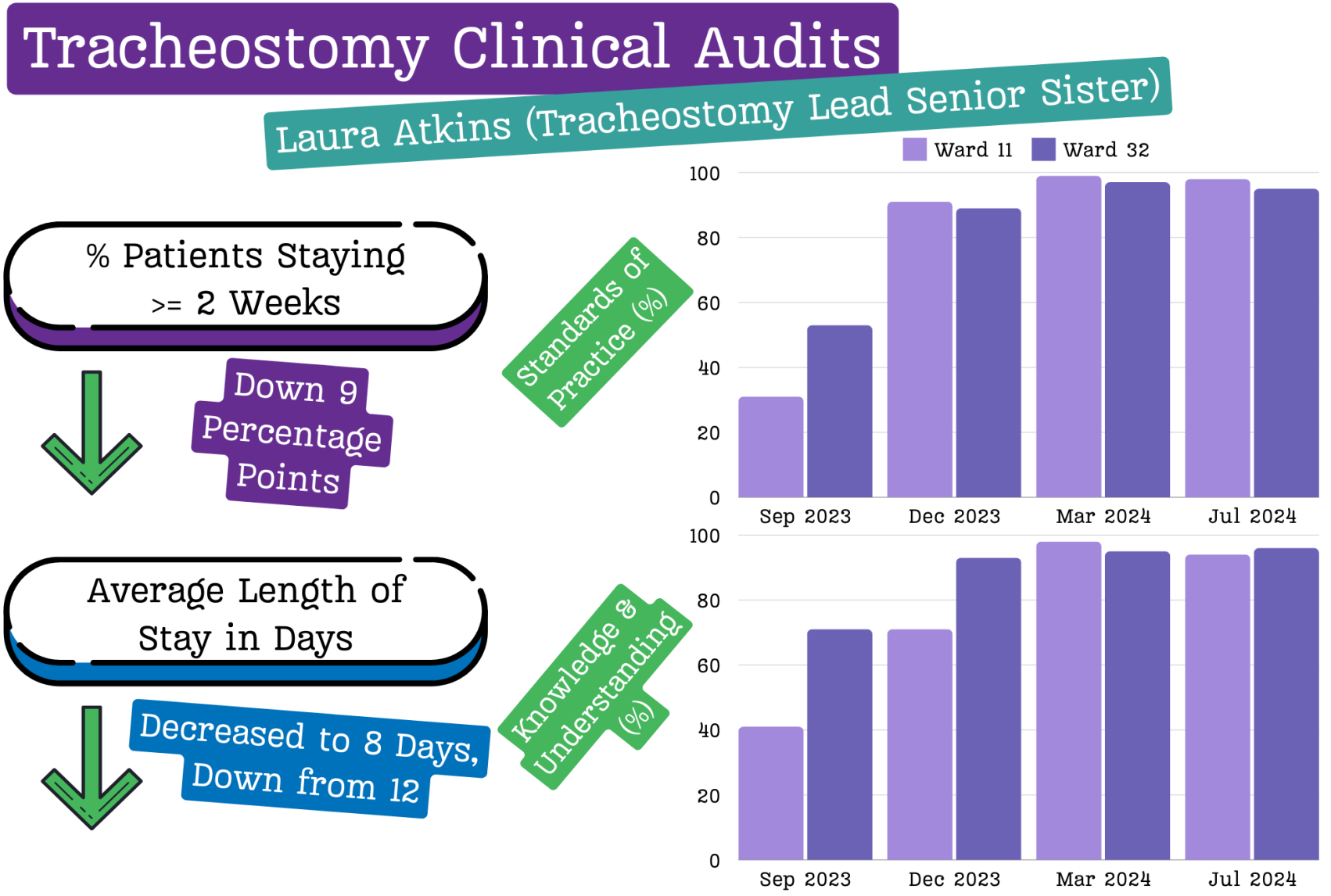


Figure 6: Poster produced showcasing an example of a high-quality clinical audit conducted at CDDFT

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 2024/25 are contained within the table below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry:

National Program	Topic	Participation	% cases submitted
Case Mix Programme (CMP)	N/A	✓	100%
Emergency Medicine QIPs	Mental Health (Self-Harm)	✓	25%
	Time Critical Medications (TCM)	✓	13%
	Care of Older People (COP)	✓	53%
Falls and Fragility Fracture Audit Programme (FFFAP)	National Audit of Inpatient Falls	✓	100%
	National Hip Fracture Database	✓	100%
	Fracture Liaison Service Database (FLS-DB)	✓	100%
LeDeR - learning from lives and deaths of people with a learning disability and autistic people	N/A	✓	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	Rehabilitation following critical illness	✓	100%
	Blood Sodium	✓	Ongoing
	Emergency procedures in children and young people	✓	Ongoing
	Acute limb Ischaemia	✓	Ongoing

National Program	Topic	Participation	% cases submitted
National Adult Diabetes Audit (NDA)	National Diabetes Foot Care Audit	✓	Ongoing
	National Diabetes Inpatient Safety Audit (NDISA)	✓	Ongoing
	National Core Diabetes Audit	✓	Ongoing
	National Pregnancy in Diabetes Audit (NPID)	✓	Ongoing
	Diabetes Prevention Programme (DPP) Audit	✓	Ongoing
	Transition (Adolescents and Young Adults) and Young Type 2 Audit	✓	Ongoing
	Gestational Diabetes Audit	✓	Ongoing
National Asthma and COPD Audit Programme (NACAP)	COPD Secondary Care	✓	Ongoing
	Pulmonary Rehabilitation	✓	100%
	Adult Asthma Secondary Care	✓	Ongoing
	Children and Young People's Asthma Secondary Care	✓	100%
National Audit of Cardiac Rehabilitation	N/A	✓	Ongoing
National Audit of Care at the End of Life (NACEL)	N/A	✓	Ongoing
National Bariatric Surgery Register	N/A	✓	Ongoing
National Cardiac Arrest Audit (NCAA)	N/A	✓	Ongoing
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 Program	Topic	Participation	% cases submitted
National Comparative Audit of Blood Transfusion:	National Comparative Audit of NICE Quality Standard QS138	✓	Ongoing
	National Comparative Audit of Bedside Transfusion Practice	✓	Ongoing
National Child Mortality Database	N/A	✓	100%
National Early Inflammatory Arthritis Audit (NEIAA)	N/A	✗	N/A
National Emergency Laparotomy Audit (NELA)	Laparotomy	✓	Ongoing
National Joint Registry	10 work-streams that all report within Annual report: Primary hip, knee, shoulder, elbow and ankle replacement, Revision hip, knee, shoulder, elbow and ankle replacement.	✓	100%
National Maternity and Perinatal Audit (NMPA)	N/A	✓	100%
National Neonatal Audit Programme (NNAP)	N/A	✓	100%
National Obesity Audit	N/A	✓	Utilises existing datasets
Sentinel Stroke National Audit Programme (SSNAP)	N/A	✓	90%+
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	N/A	✓	Ongoing
Society for Acute Medicine Benchmarking Audit (SAMBA)	N/A	✓	100%
National Major Trauma Registry	N/A	✓	Ongoing
National Ophthalmology (NOD)	Age-related Macular Degeneration Audit (AMD)	✓	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%

National Program	Topic	Participation	% cases submitted
Perioperative Quality Improvement Programme (PQIP)	N/A	✗	N/A
National Paediatric Diabetes Audit (NPDA)	N/A	✓	Ongoing
National Cancer Audit Collaborating Centre (NATCAN)	National Audit of Metastatic Breast Cancer (NAoMe)	✓	Utilises existing datasets
	National Audit of Primary Breast Cancer (NAoPri)	✓	Utilises existing datasets
	National Bowel Cancer Audit (NBOCA)	✓	Utilises existing datasets
	National Lung Cancer Audit (NLCA)1	✓	Utilises existing datasets
	National Non-Hodgkin Lymphoma Audit (NNHLA)	✓	Utilises existing datasets
	National Oesophago-Gastric Cancer Audit (NOGCA)	✓	Utilises existing datasets
	National Ovarian Cancer Audit (NOCA)	✓	Utilises existing datasets
	National Pancreatic Cancer Audit (NPaCA)	✓	Utilises existing datasets

1 – Case notes were supplied for review where available.

National Audits **Not** Applicable to County Durham & Darlington NHS Foundation Trust were as follows:

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

National Program	Topic
National Cardiac Audit Programme (NCAP)	National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)
	National Congenital Heart Disease Audit (NCHDA)
	National Adult Cardiac Surgery Audit
	UK Transcatheter Aortic Valve Implantation (TAVI) Registry
	Left Atrial Appendage Occlusion (LAAO) Registry
	Patent Foramen Ovale Closure (PFOC) Registry
	Transcatheter Mitral and Tricuspid Valve (TMTV) Registry

Participation in Clinical Research

[DN – acronyms to be checked with Research and Updated]

Performance

We are currently managing 83 active studies, including 40 recruiting portfolio-adopted studies, down from 47 last quarter. Our studies span 14 specialties across DMH, UHND, BAH, and CLS, with new Mental Health studies following closure of the CALM dental study.

Recruitment

Recruitment is strongest in Reproductive Health, Gastrointestinal (GI), and Critical Care, though overall recruitment remains below previous years and regional trends. CDDFT is ranked eighth out of 13 regional trusts. High-recruiting studies include INGR1D2 (Type 1 Diabetes), WHiTE14 (Orthopaedics), OSCAR (Urology), UK-ROX (Critical Care), NAIAD (AI in Colonoscopy), and COLO-COHORT (Colorectal Cancer).

Study Setup

26% of studies met the under-40-day setup target, a drop from 60% last year, reflecting reduced RRDN support. We are preparing to bring the setup process back in-house to improve performance.

NMAHP Strategy Progress

A team is actively delivering the strategy, developing Research Champion roles, and creating a funding information hub. Communication is via podcasts, bulletins, and social media posts.

Durham University Partnership

There are 26 research ideas under review and 5 live collaborations: Cancer Prehabilitation, Stroke Rehabilitation, Improving Discharge Processes, Imposter Syndrome, and Alternative Energy Sources. Two funding bids are awaiting outcomes. 'Bridging the Gap' training has been delivered to support research development.

Innovation

Seven active innovation projects, 10 closed. Three projects are under intellectual property review. No new income or grants this quarter, but ongoing advice and support provided to innovators, including copyright and IP guidance.

Goals agreed with commissioners

County Durham and Darlington income in 2024/25 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework.

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.

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, CQC have undertaken inspections 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 in January 2024. The Trust's urgent and emergency care services were inspected in 2024, with the inspection reports published in January 2025.

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)

The hospital is rated 'Good' and all services are rated "Good", except End of Life care which is rated Outstanding and Maternity, which is rated Requires Improvement.

Actions following the most recent inspections have been implemented.

University Hospital North Durham (UHND)

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

Actions following the most recent inspections have been implemented.

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.

CQC Inspection of Urgency and Emergency Care Services 2024

The CQC inspected urgent and emergency care at both UHND and DMH. Both sites were rated 'Good' overall and for each of the following key questions:

- Are services safe?

- Are services effective?
- Are services responsive?
- Are services well-led?

The inspection did not seek to assess whether services were caring. There were no requirement notices or other actions required.

Data Quality

County Durham and Darlington NHS Foundation Trust submitted records during 2024/25 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data (up to and including M10).

The percentage of records in the published data:

which included the patient's valid NHS number was:
99.8% for Admitted Patient Care;
99.9% for Outpatient Care; and
98.1% 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
99.1% 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 7, 2024/25 Data Security and Protection Toolkit annual return, on the 30th June 2025.

The new version of the NHSE DSP Cyber Assurance Framework (CAF) aligned Toolkit is totally new and cannot be viewed as a comparison for previous years. At present the Trust is still gathering evidence for prior to a validation audit and cannot provide an indication of the expected outcome.

For the NHSE DSP Toolkit version 6, 2023/24 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 2024/25 by the Audit Commission.

Learning from Deaths

During 2024/25, 2,101 patients died in the Trust, a quarterly breakdown is provided below:

- 480 in the first quarter;
- 506 in the second quarter;
- 562 in the third quarter; and
- 557 in the fourth quarter.

In July 2023 we made the transition to implement the national patient safety investigation response framework (PSIRF). Therefore the term investigation included here makes reference to Patient Safety Incident Investigations (PSII's) only, or a mortality review being undertaken.

In 2024-25 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:

- 150 in the first quarter;
- 115 in the second quarter;

- 101 in the third quarter; and
- 63 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:

- 0 representing 0% for the first quarter;
- 1 representing 0.2%% for the second quarter;
- 0 representing 0% for the third quarter; and
- 0 representing 0 % for the fourth quarter.

These numbers have been generated using the Structured Judgement Plus mortality review methodology or through County Durham and Darlington NHS Foundation Trust's STEIS Reporting Process which is where PSII's are reported.

The key learning themes identified from the reviews completed in 2024/25 were long waits and capacity issues in ED; decision-making/focus of care; and recognition of limitation of care; advanced care planning, including DNACPR/EHCP; delays/missed medications, observations and escalation of deterioration and documentation

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 2024/25 forms part of the system improvement plans implemented trust-wide. The purpose of the System Improvement Plans (SIP) is to document and incorporate incident-based learning and provide an overarching plan for improvement allowing a focus on the "bigger picture and to identify any new themes. Each system improvement plan has its own individual governance structure to ensure it is being overseen and managed by those with the most expertise in that area to manage its progress and gain assurance that it is meeting the patient safety and experience problems or challenges that it was implemented to improve.

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

The FTSU Guardian continues to promote the principles of speaking up, listening and the importance of following up concerns or ideas from colleagues across the organisation by means of face to face sessions including participating in Trust Induction, the Nursing Preceptorship programme, meet and greet events for 1st and 2nd year medical students, team meetings including Care Group Senior Leaders meetings and unannounced visits to departments and services across the footprint of the organisation. Agency staff are of a particular interest to the Guardian and she is working with the Resourcing Business Manager to reach out to this staff group to share that their voice is important and how they can be heard. There is currently no mandatory commitment for Agency services to provide a comprehensive overview of FTSU and the Guardian aims to redress this for those who chose to support CDDFT through agency shifts. The team of FTSU Champions has increased to 11, and we are very proud to have a resident doctor join the team. There are three more colleagues that have expressed an interest in undertaking this voluntary role with an expectation that the Guardian will have completed their recruitment by April 2025.

The Guardian has undertaken specific pieces of work for the Chief Executive, to explore the experiences of staff working in Maternity Services, was recently invited and engaged with a Regional Network Peer review and, more recently, provided a report exploring the impact of Temporary Escalation Spaces on staff across the organisation. This is a current standing agenda item for discussion, action and feedback for and from Senior Leaders and Executives on a weekly basis.

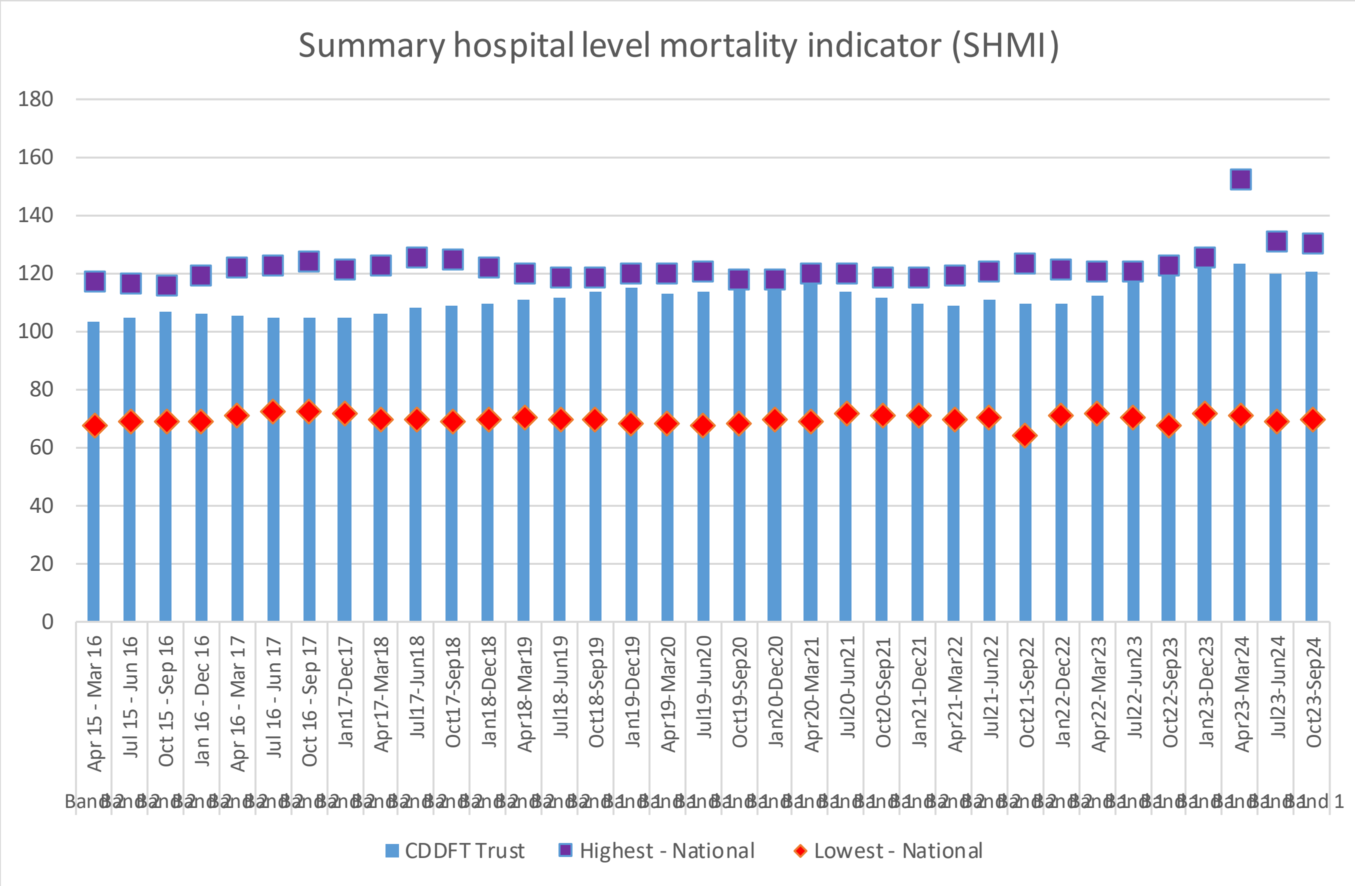
The Guardian has been invited to a Perioperative Practitioners Regional Conferences and has committed to being a key note speaker for future events.

Reporting against core indicators

This information is required under the Quality Accounts regulations. In some cases, however, the requirements have been superseded by subsequent changes to NHS policy and this is explained where relevant.

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 Trust is an outlier for SHMI. Having taken external advice from the North East Quality Observatory, and undergone a further review of our learning from deaths review process, there are known issues with the depth and completeness of coding of non-elective care episodes, resulting from loss of staff, in prior years, in our clinical coding team and the completeness of information captured in patient records. Whilst new coding staff have been recruited there is a run-in period before they are fully proficient and, whilst medical staff have received additional training on the information to be captured in our EPR system, neither issue was fully mitigated within the periods covered by the latest SHMI data.

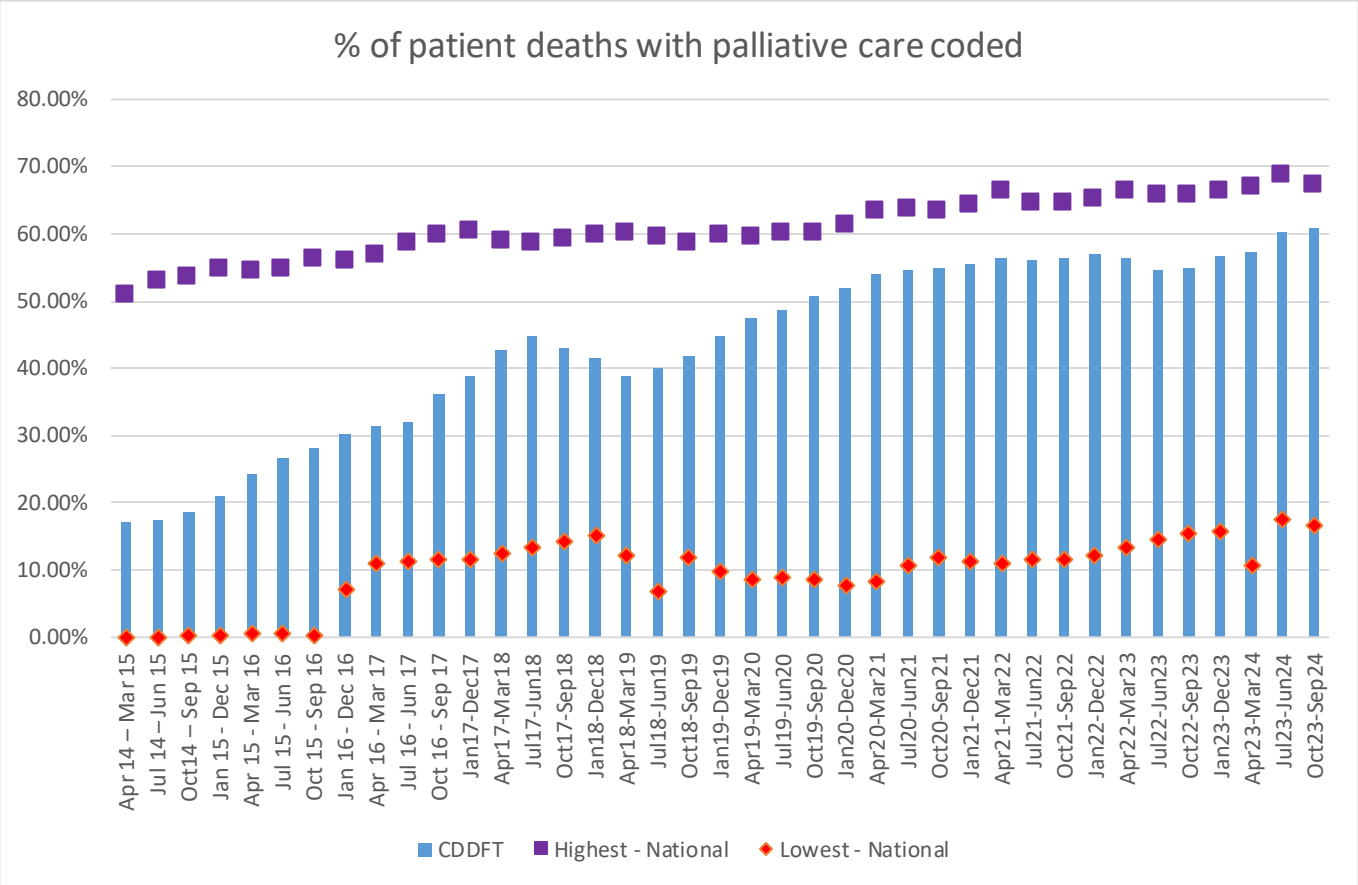
In order to ensure that there is no issue with the underlying quality of care, rather than data quality, mortality reviews continue to be performed for all priority deaths and we follow up all concerns raised by the Medical Examiners. Less than 1% of deaths were deemed to have evidence of preventability from the reviews performed for 2023/24 and 2024/25.

Other sources of assurance are positive:

- The Hospital Standardised Mortality Ratio is within statistical limits;
- There has been no significant fluctuation in crude mortality rates.

- 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 issues flagged by the Medical Examiner Service, which examines all deaths not requiring referral to the Coroner in our acute hospitals, pointing to a consistent underlying issue with the quality of the Trust's care.

Percentage of deaths with palliative care coded



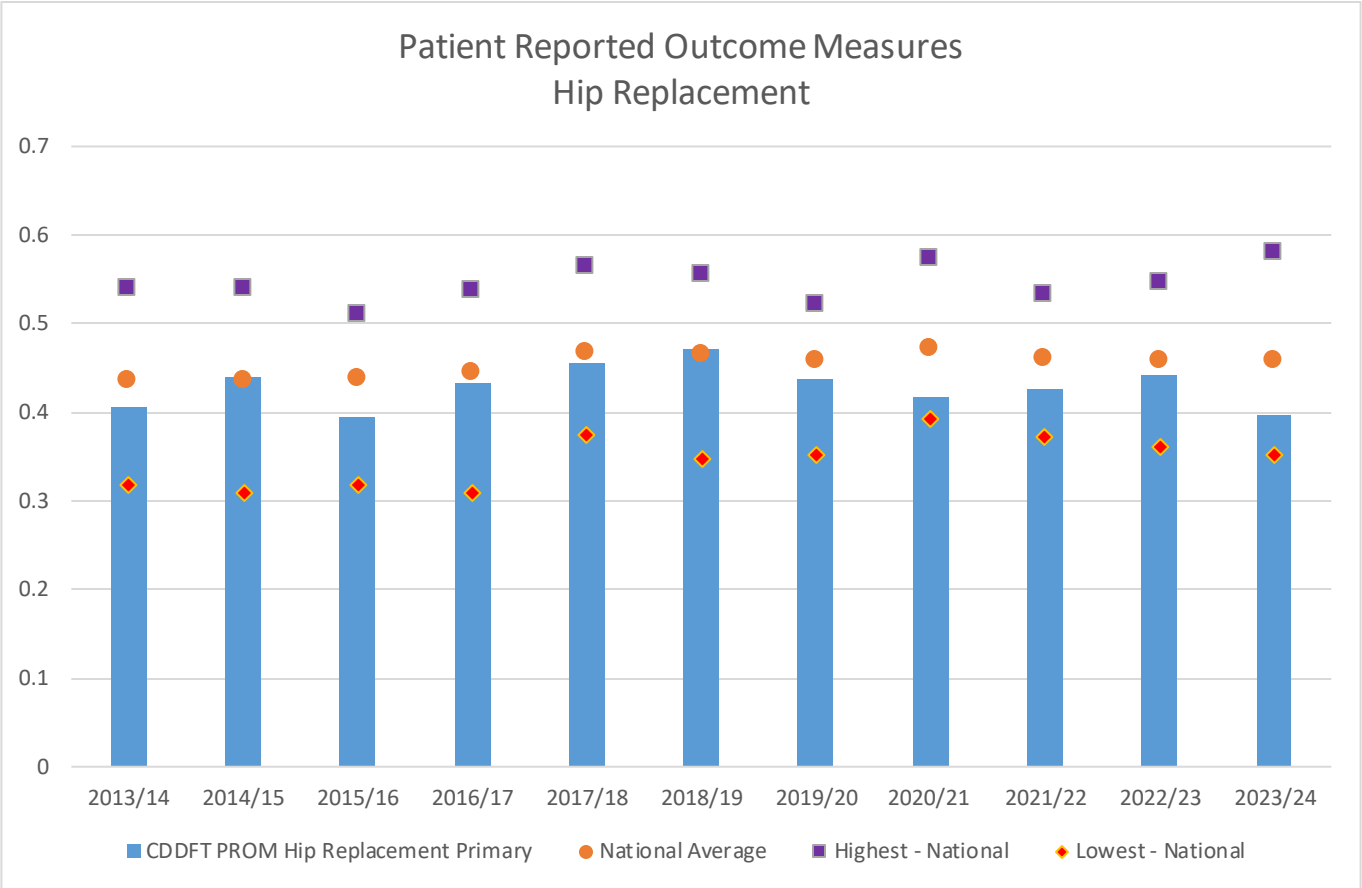
Data source: NHS Digital

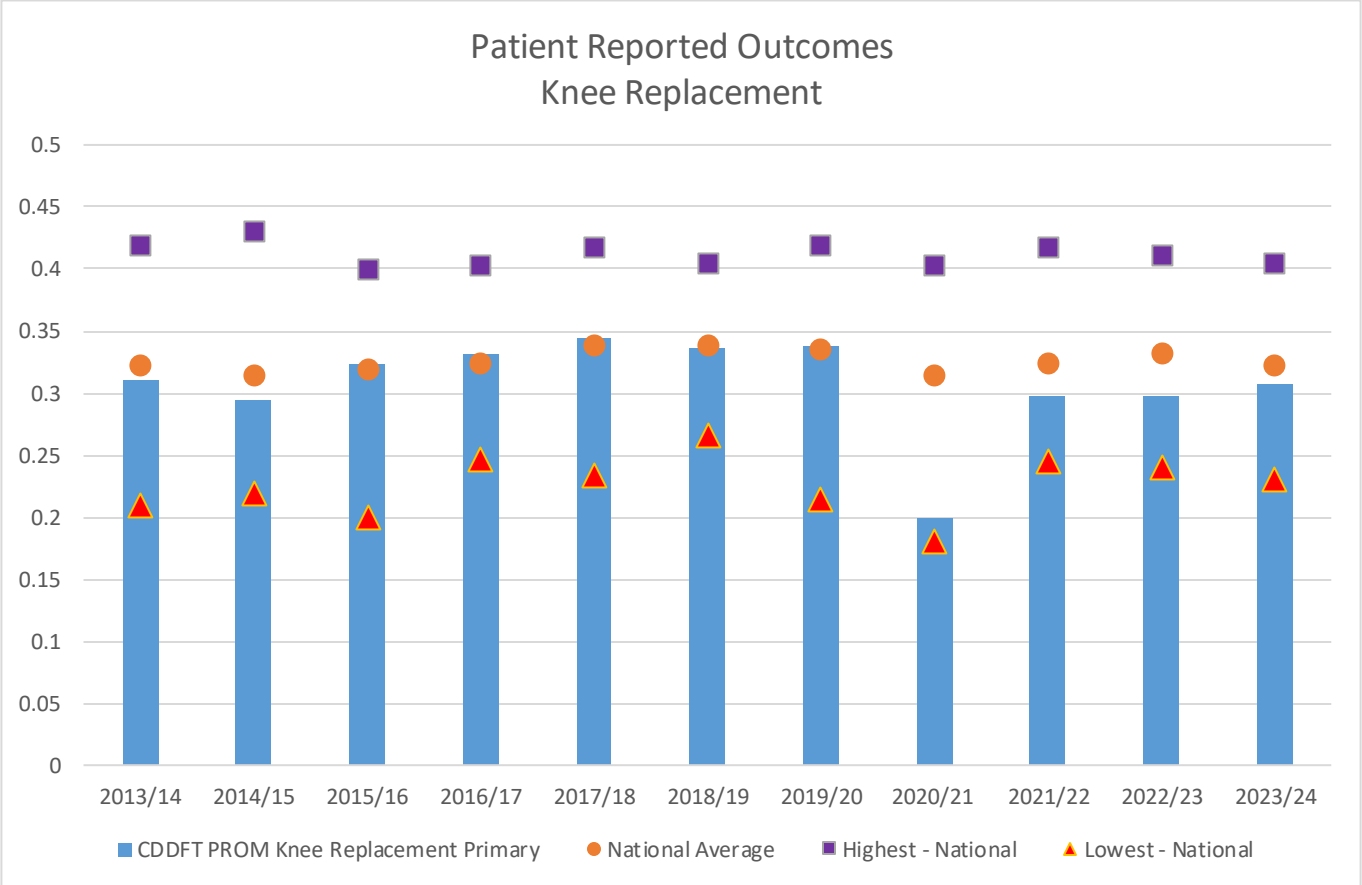
The County Durham and Darlington NHS Trust considers that this data is as described for the following reasons: this data is regularly reviewed at the Trust End of Life Steering Group

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.

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

Patient Reported Outcome Measures (PROMS)





Data source: NHS Digital

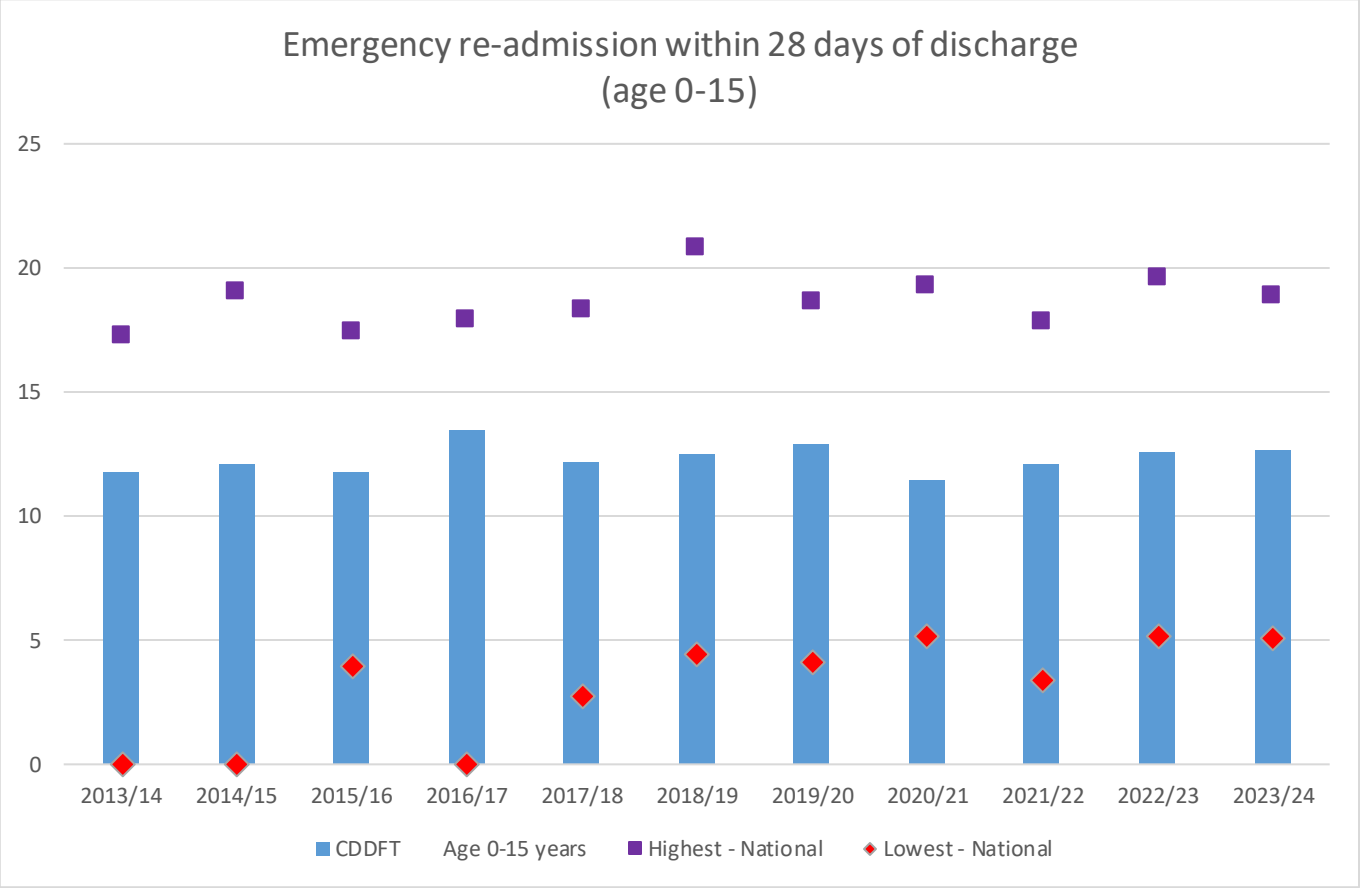
The County Durham and Darlington NHS Trust considers that this data is as described for the following reasons: PROMS data is reviewed in directorate meetings.

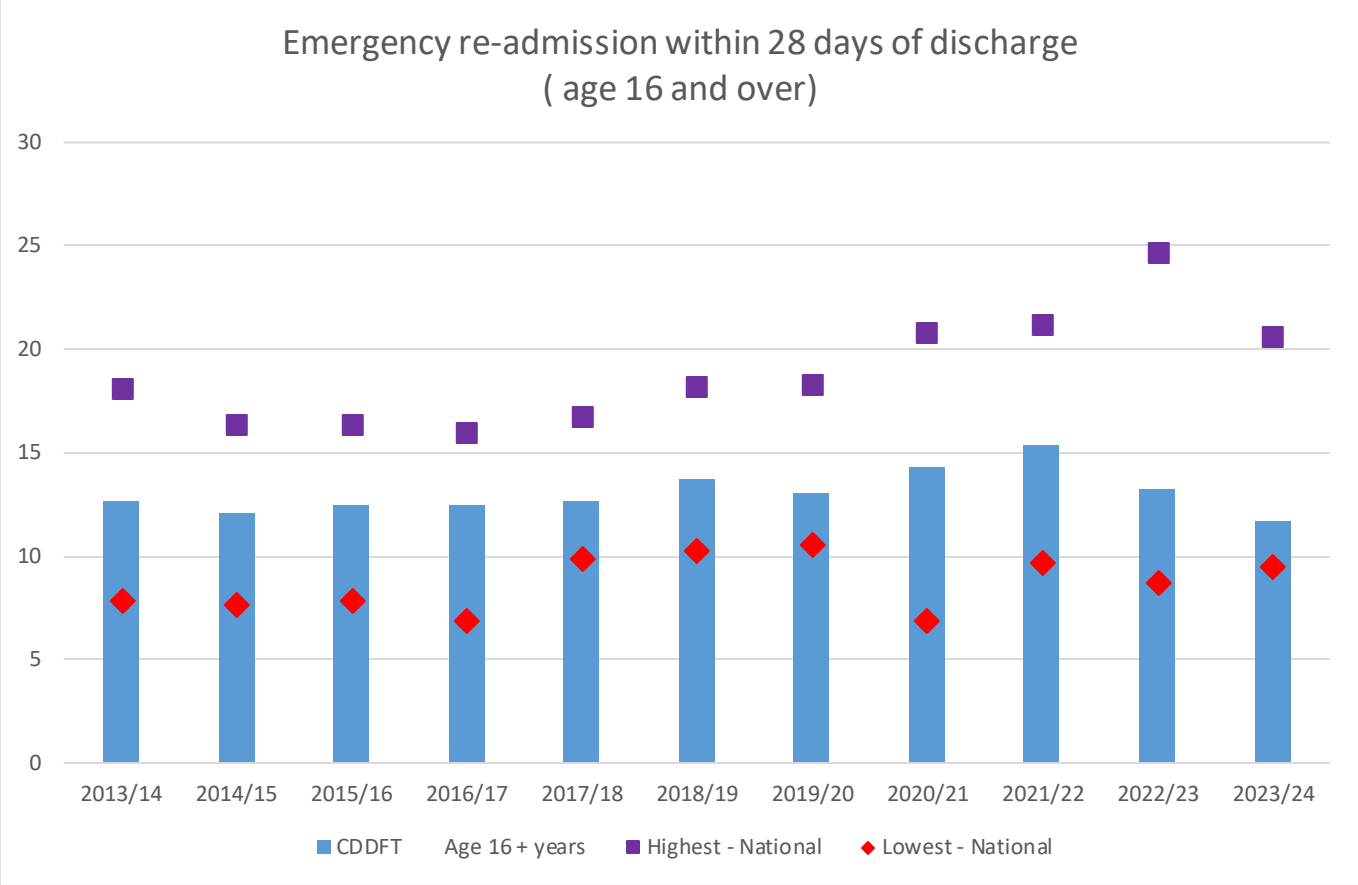
We have implemented a scheme to support our elective recovery programme which has helped increase the number of theatre lists which can be run for elective orthopaedic surgery. In addition and insources model of service was introduced to further support elective recovery. An obvious benefit of this will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

BAH

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.

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





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

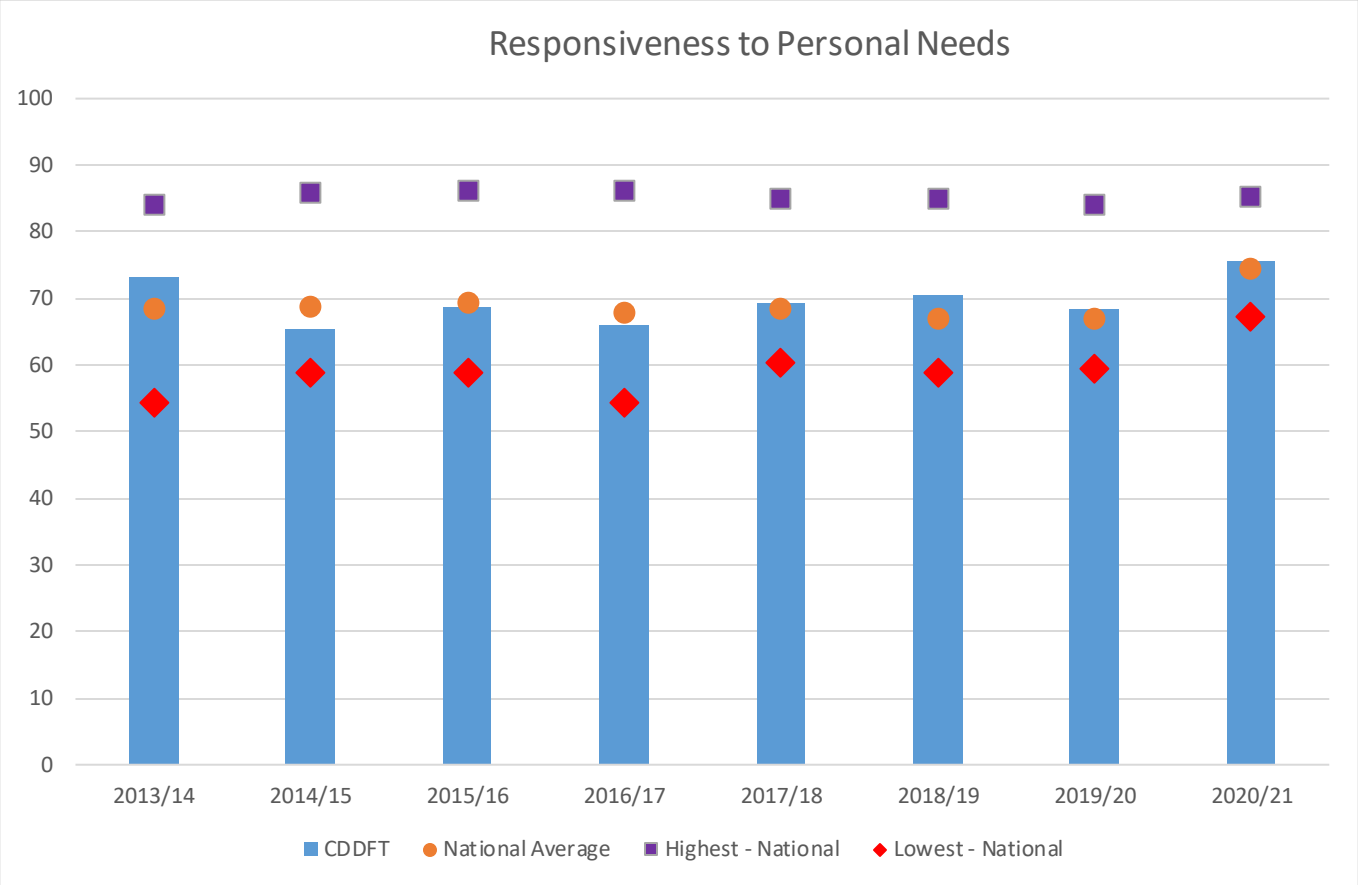
A number initiatives are in place in support of this measure:

- Introduction of a community-based urgent crisis response service. Patients, in general, 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. The data is only available to 2021.

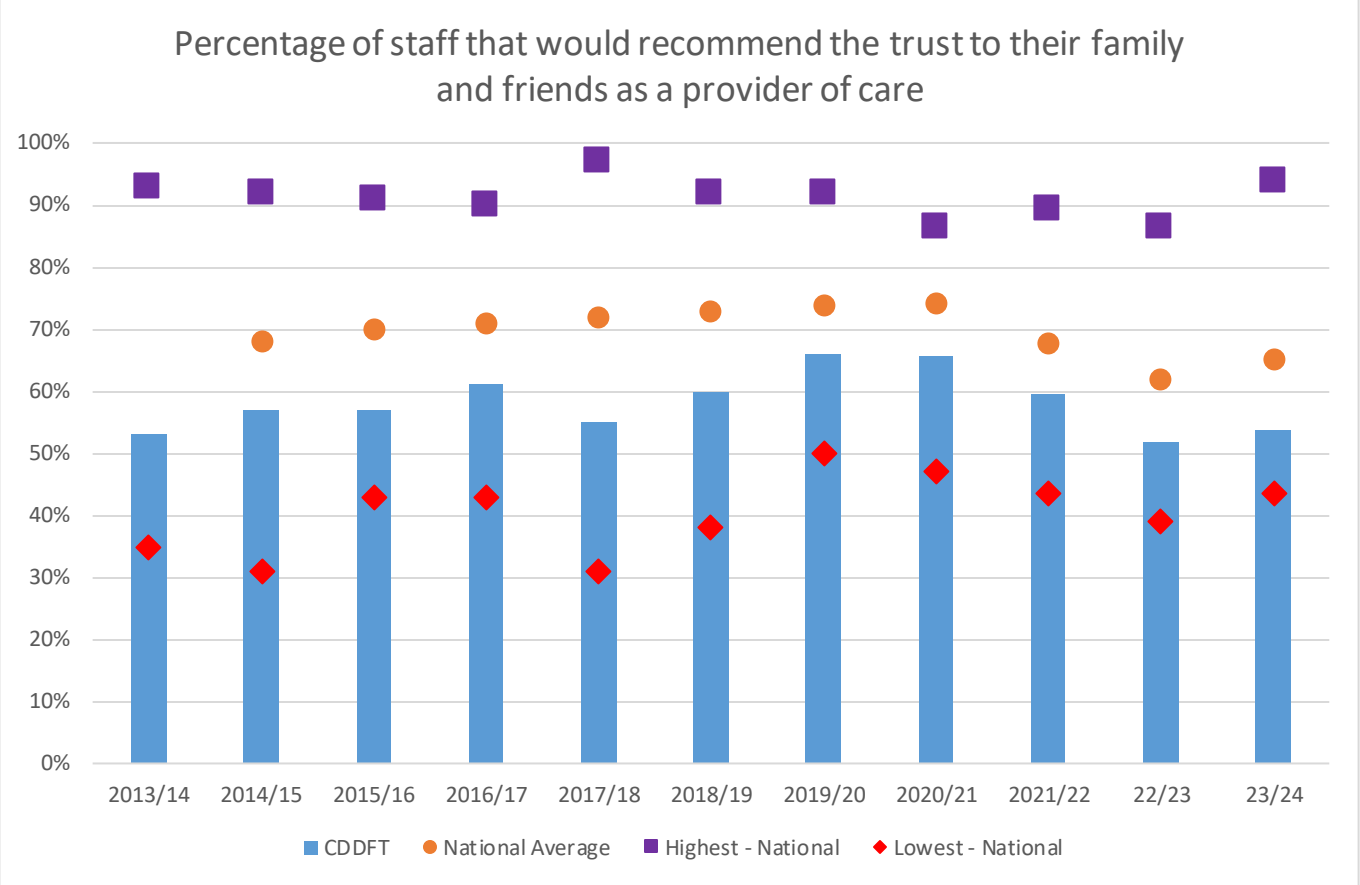


Data source: NHS Digital

The charts above are those submitted in our previous Quality Accounts, NHS outcomes Framework (for the responiveness of patients 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 announcements 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 trust-wide and local surveys, 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

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

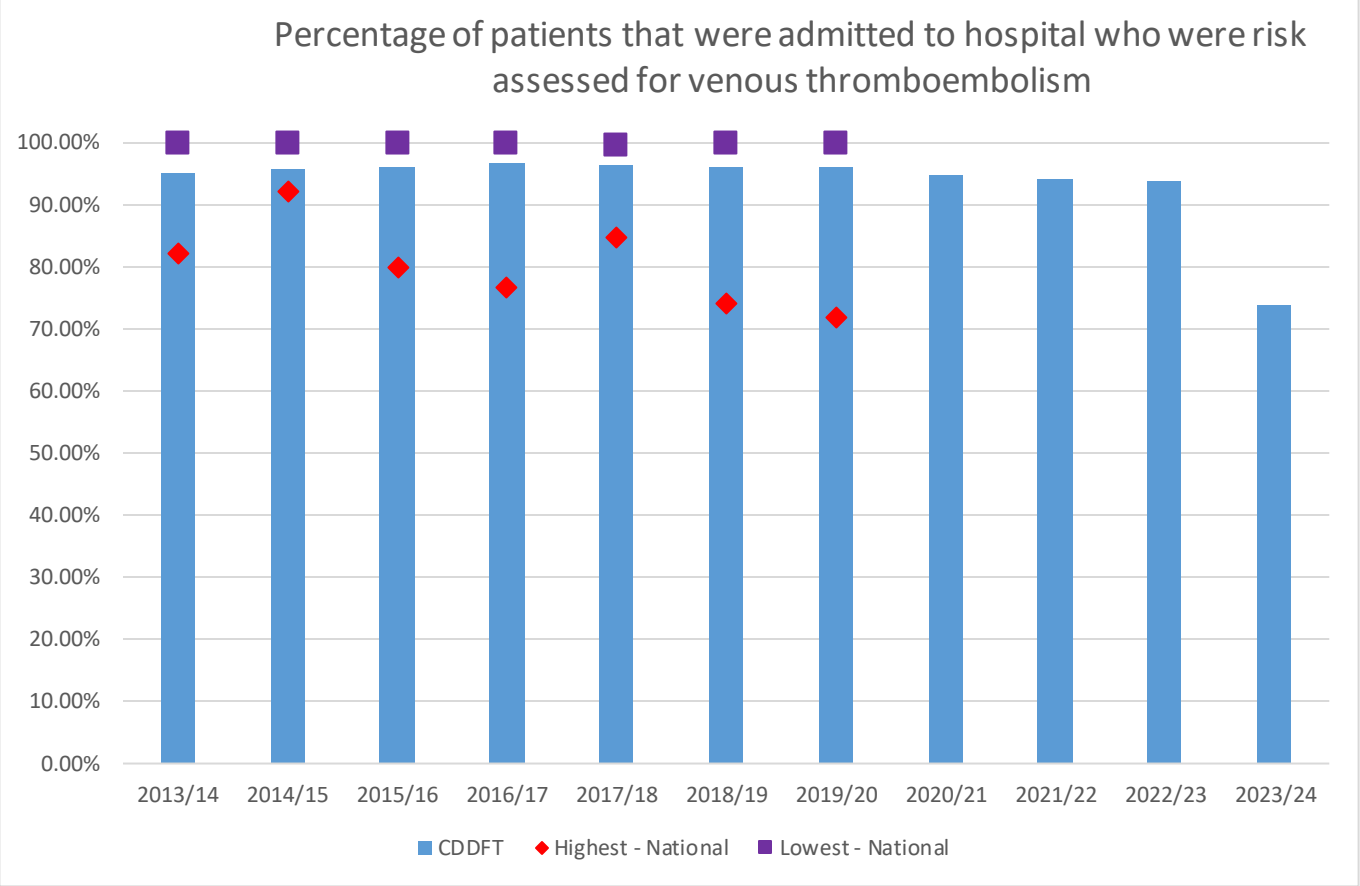
It is of note that the score from staff does not match the patient Friends and Family Test results for the Trust which typically shown between 96% and 98% of patients having a positive experience whilst in our care.

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:

- Developing a ward accreditation framework, to provide wards and teams with data from audits, patient surveys and other quality metrics, so that they can evidence and be credited for the quality of service provided.
- Spreading a culture of quality improvement, through a quality improvement network and hub, and training of aspirant nursing and clinical leaders in quality improvement and innovation.
- 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.



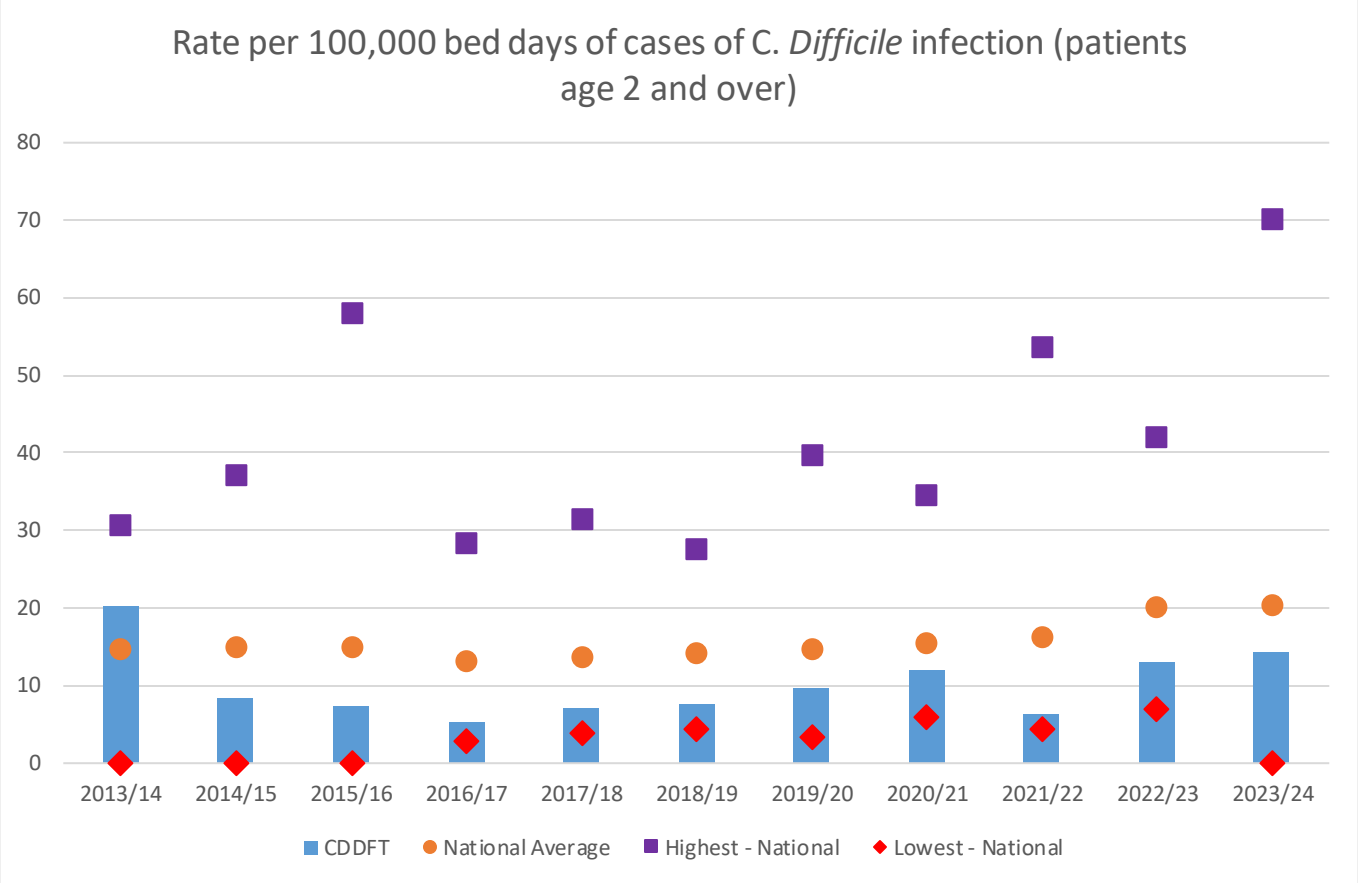
Data source: NHS Digital.

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 through our Quality and Performance Dashboards. 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. The system allows us to assess compliance for all assessments more reliably than before, which contributes to the fall off in completion suggested by the above dataset. County Durham and Darlington NHS FT is taking the following actions to improve the quality of care:

- A clinically-led Task and Finish Group has been set up to lead on actions to drive up compliance with VTE assessments including education, training in the system and, where necessary, system changes.

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



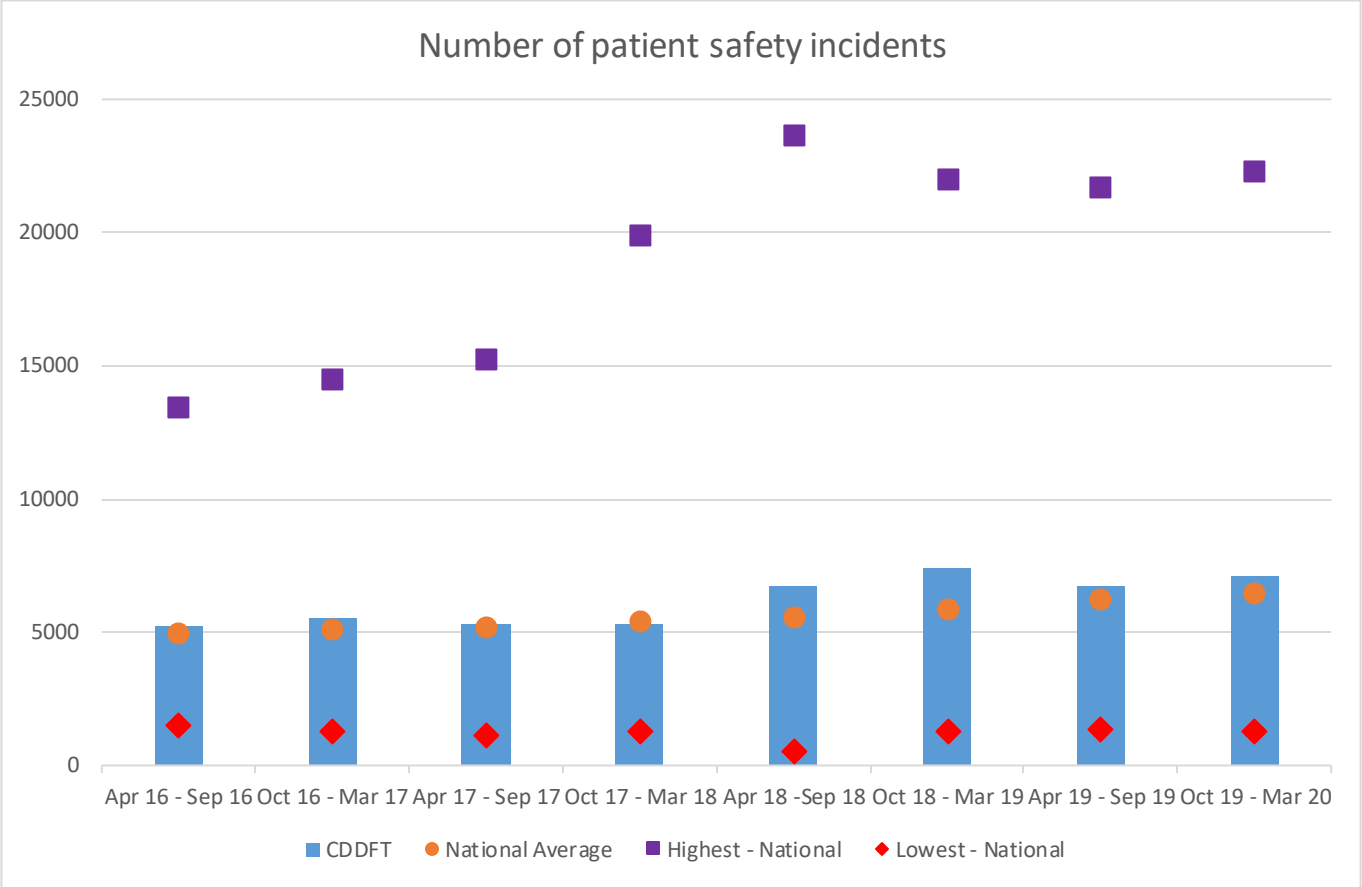
Data source: NHS Digital

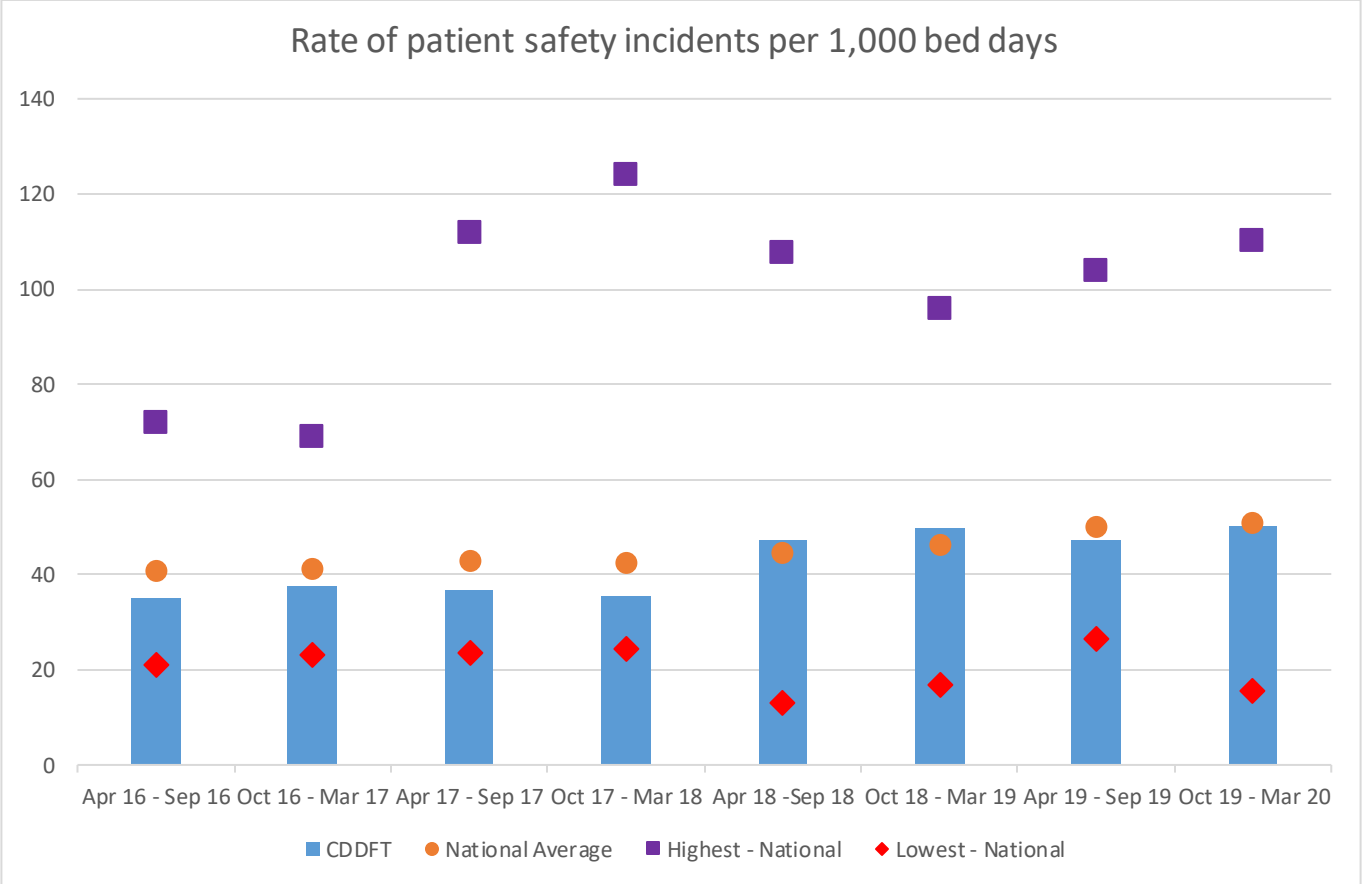
The County Durham and Darlington NHS Trust considers that this data is as described for the following reasons: the Trust monitors this data regularly via its Infection Control and Executive Quality Committees. Despite a significant increase in the number of C-Diff cases in the past two years, the national trend has been similar and the Trust remains below the national average. The Trust's nationally set threshold was 78 cases; however the Trust reported 80 cases in the year. The increasing trend in C-Diff is also replicated in the region.

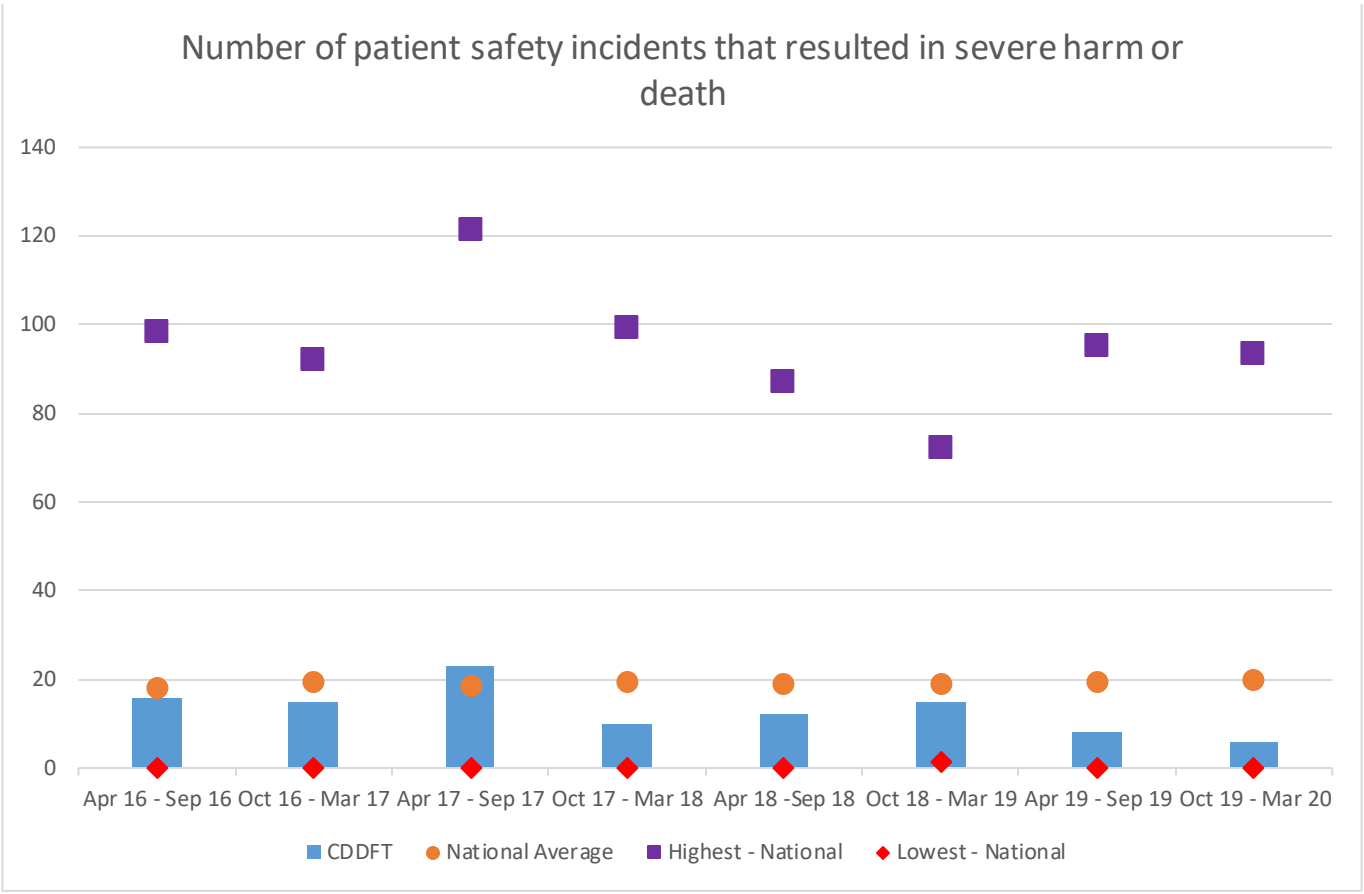
The County Durham and Darlington NHS Trust intends to take the following actions to improve the indicator and so the quality of services, through our Trust-wide 'Fight Back Infection' campaign:

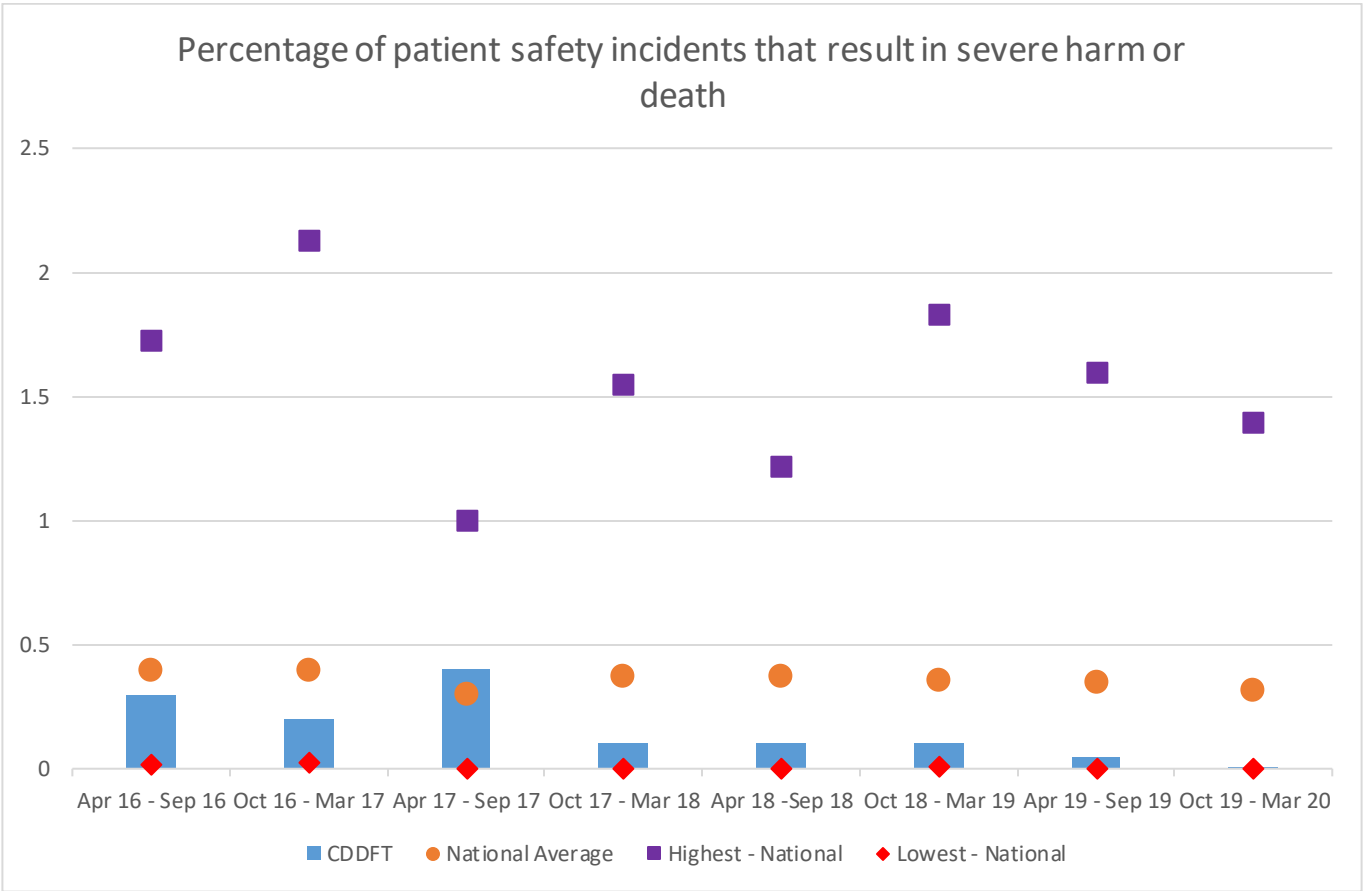
- Focusing on early recognition of suspected / infective diarrhoea and appropriate patient management.
- Continuing with our Antimicrobial stewardship programme.
- Undertaking a rapid review of all healthcare associated C-Diff cases collaboratively with the clinical teams for timely review of best practice 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: NHS Digital

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

Since April 2020, the NHS moved to PSIRF, and has since moved to the Learning from Patient Safety Events national platform, resulting in the data being superseded as a measure of our effectiveness in learning from patient safety incidents.

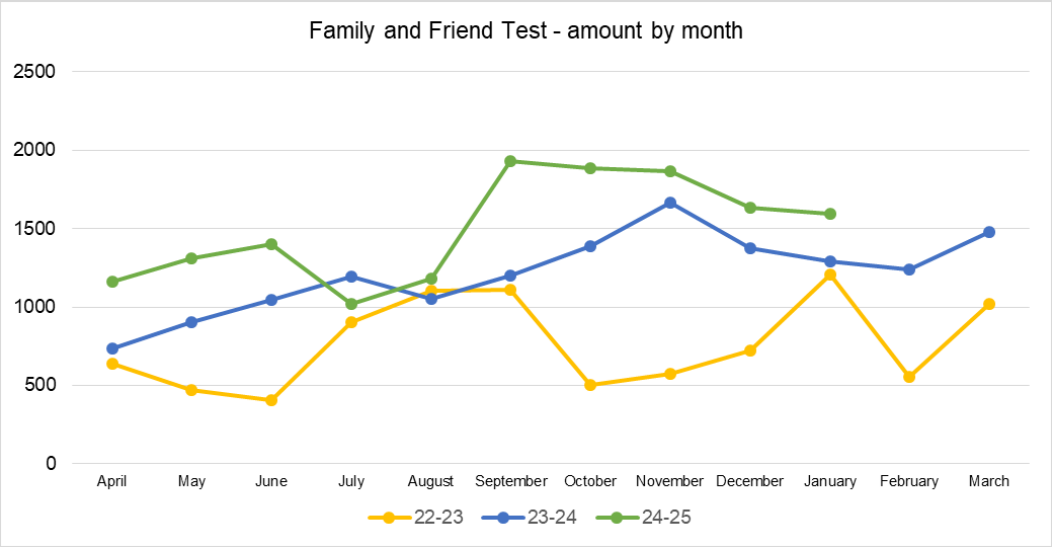
The County Durham and Darlington NHS Foundation Trust has taken the following actions to improve the indicator:

- 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. Further information on the roll out of this strategy is set out in Part 2A of this quality account, and at the start of Part 3.

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

Friends and Family Test

2024/25 has seen the number of response increase and this is reflected on the below chart.



The Patient Experience have carried out ward walkabouts to engage with ward staff to understand the barriers to collecting feedback from our patients, family members and service users. To ensure people are able to respond to feedback in a way they would like, we have replenished supplies of paper cards, which can be handed out for patients to complete and have ensured each ward has a poster including an appropriate QR code should patients and family members want to use a mobile device. We have included a page on the new CDDFT Trust Website should patients, family members or service users wish to use this method.

There are some wards and departments utilising our volunteers to liaise with people and offer to support with the Friend and Family Test survey should they need it. This has supported an increase in numbers especially in our Emergency Department in Darlington Memorial Hospital.

We revised the Friend and Family Test card in the latter part of 2024 and have asked if people would like to be a member of a CDDFT Patient Council. This has enabled the Patient Experience Team to capture public interest, to date we have 445 members and this grows each month. In Quarter 1 of 2025 we will engage with the group to understand how best to capitalise on their interest to obtain patient views generally, and to support co-design within services.

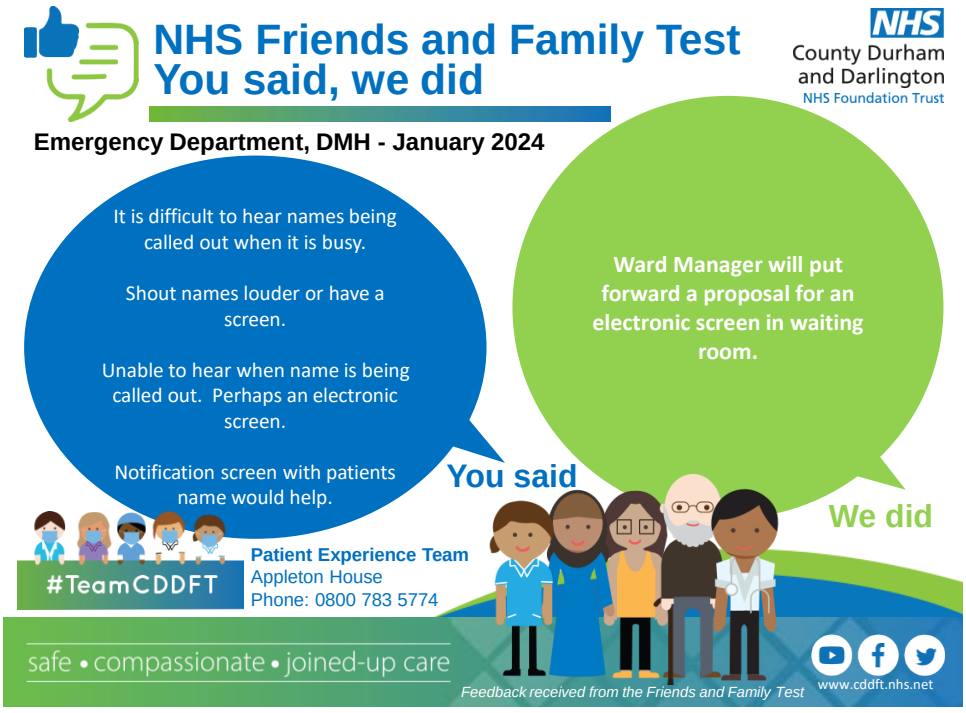
The “Formfinity” system is being introduced in April 2025, this is a new text messaging service which is part of the Patient Experience Portal introduced in 2024. This will allow the Patient Experience Team to select wards and departments throughout the Trust and share the Friend and Family Test survey by text message. A pilot project will first be run in the Emergency Departments on both acute sites.

Friend and Family Easy read
Our Learning Disabilities Team liaise with patients, families members and carers offering an opportunity to give feedback on the experience they have had when care and treatment has been offered. The feedback we have received to date has been positive and no areas of service improvements have been identified or required.

Friend and Family Interpreting Service
From April 2025, patients and family members who require the additional support of an interpreter will be offered an opportunity to complete a Fried and Family Test card as part of their appointment. The interpreter which is supporting will translate the questions and capture the responses and share them with the Trust. This will, in turn enable us to access feedback from a wider range of patient backgrounds and needs. This service will be offered for patients where English is not their first language and also patients who require the support of a British Sign Language interpreter.

In Quarter 22 of 2025/26 we will be rolling out Friend and Family Test cards in the top 5 languages/interpreters which we use. There will be 5 separate paper cards written in the top 5 languages and posters in the appropriate languages with a QR code to complete the survey online placed around the CDDFT sites, both acute and community.

<u>'You said we did'</u>
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. An examples is shown below.



Other Patient Experience Feedback and Engagement
2024 has seen an increase in service specific engagement with patients. There are over 40 separate engagement projects capturing service specific feedback. For example, Maternity Services have engaged with patients to capture feedback on immunisation, and Intensive Care have sought and acted on patient feedback for the RaCI (Rehabilitation after Critical Illness) team, and Podiatry Services have recently begun capturing feedback. All the individual responses are used to shape or services and enhance the experience of our patients, family members and service users.

Part 3 Other Information

This section of the Quality Account includes an overview of the quality of care provided during 2024/25 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

Quality Improvement (QI) has remained a key focus for CDDFT. To this end, a rolling programme of induction training to preceptees, student nurses and foundation doctors is provided to ensure a supported the workforce, helping them to identify and engage in QI projects. Further training can then be undertaken within the Trust's "IMP" programme, should individuals request this.

A Trust 'Quality Hub' intranet page is in development to promote QI projects. The intranet page will sign post staff to relevant sources of support, enable previous QI projects to be shared and be a repository of QI information, tools and documents. The site is currently accessible; however, further improvement to the site is planned to continue in 2025.

Examples of projects undertaken in 2024/25 included the continued roll out of the traffic light jug system across the Trust. The Traffic light jug system is aimed at improving hydration and hydration awareness amongst our patients and staff, by jugs labelled red, amber and green to provide a visual cue to the nursing staff with respect to a patient's fluid intake.

The Royal College of Emergency Medicine, Time critical medication quality improvement project is now under way and will remain a priority within QI for the next 2 years as more time critical medications are added to the audit cycles. This is a collaborative project between ED, clinical audit, pharmacy and QI whereby the administration of six specific, time critical medications will be audited to identify current ED performance against clinical standards. Participating EDs can see how they perform compared to the national mean average and PDSA cycles for quality improvement can be mapped against the data collected. Improvement work-streams already, as part of this project, include bespoke teaching sessions within the ED department, a Parkinson's medication resource box for prompt access to Parkinson's medications and improved patient communication and awareness. It is anticipated that a number of other work-streams will be developed from this.

Following a thematic review, falls in bathrooms were identified as an area for improvement. This has led to the development of the Sunflower bundle which is currently being trialled on a number of areas. The Sunflower bundle includes visual cues including a 'door hanger' to identify when people are at increased risk of falls are in the bathroom. Initial data shows that there is a positive increase in awareness and understanding of falls risk. The results of the trial will be shared widely and adapted or implemented as required.

There is now a pipeline of quality improvement projects, which will be completed according to priority and capacity, during 2025/26.

Incident Reporting and Investigation

During 2024/25 CDDFT has continued to develop and strengthen the implementation of PSIRF (Patient Safety Incident Response Framework) within the organisation.

The Trust's annual Patient Safety Incident Response Plan (PSIRP), which sets out how the Trust learns from patient safety incidents, was reviewed and updated in line with what we have already learnt since the implementation of PSIRF. This ensures that our PSIRP continues to supports the robust investigation of adverse incidents, with appropriate focus on the safety priorities of the organisation. It also guides the organisation's decisions on what type of review/investigation is required for differing patient safety events.

In 2024/25 CDDFT commenced 29 Patient Safety Incident Investigations (PSII's) and 10 Thematic Reviews. There are fewer investigations at this level than there would have been at the level of Serious Incident reviews under the previous Serious Incident Framework. Other individual incidents which warranted review during this period will have had more rapid learning responses completed (through a variety of approaches such as swarm huddles or after action reviews. This emphasises the focus now placed on exploration of wider themes of systemic learning, as well as more rapid and effective responses to individual incidents where required.

Referrals also continued to be made to the Maternity and Newborn Safety Investigations Branch (MNSI) during 2024/25 where the relevant criteria was met. There were 8 MNSI referrals made during 2024/25 (including one duplicate which were automatically rejected). Seven of these referrals were accepted (one of which was also agreed to require a PSII which is being completed simultaneously). The other rejected MNSI referral was reviewed within the Maternity specialty.

Considerable work has taken place during 2024/25 to improve the understanding and application of learning responses, and to promote the responsibility and ownership of these within clinical areas. The Patient Safety Team have responded to feedback from clinical departments and as a result have provided more user friendly templates, plus support packs and flowcharts to aid understanding around both the process of learning from patient safety events and the arrangements in place for governance. Numerous education and awareness sessions have also been held, with the majority of these taking place in clinical areas – giving the Patient Safety Team a stronger visual presence in wards and departments, and providing staff with the support they need to effectively respond and learn from patient safety events.

The reporting and investigation of incidents and subsequent learning remains integral to CDDFT's focus on maintaining and improving safe, effective and quality care. Between 1st April 2024 and 31st March 2025, 1.5% of patient safety incidents were reported as resulting in moderate harm or worse, which is lower than in 2023-24 (where it was 2.5%).

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 within this report.

Falls, and other types of incidents which are highly reported within the organisation (such as Healthcare Associated Infections, Medication, Tissue Viability, Pathology and Maternity incidents) are addressed through individual learning responses, PSII's and thematic reviews where appropriate, as well as through the development of System Improvement Plans, which was one of the Trust's key safety focuses in 2024/25.

The System Improvement Plans are based on learning identified through investigations and thematic work, and align to national and local patient safety priorities. The aim of the plans is to drive a focus on completing the improvements rather than producing singular and potentially repetitive action plans for every individual patient safety event. There are now eight System Improvement Plans in active use on the Trust's Intranet, which can be accessed by all staff. These cover: Data Quality, the Deteriorating Patient, Falls Prevention, Health Care Associated Infections, Improving Patient Safety & Experience by Improving Flow, Medications, Pathology, and Tissue Viability. A further two plans are in development for: Maternity Services and the Mental Capacity Act. Staff are able to align incidents on the Ulysses incident reporting system to specific areas within the individual System Improvement Plans, which allows issues to be addressed at a wider organisational and systematic level. System Improvement Plan owners then liaise with the action owners for specific areas within their plans and produce bi-monthly progress updates, which are monitored through the Trust's Executive Quality Committee.

The Trust's support of PSIRF has been maintained throughout 2024/25 by ensuring the funding and resources required for training of additional lead investigators for PSII's and Family Liaison Officers (FLO). This has ensured we maintain a healthy resource of trained investigators (currently we have 65 in the Trust), as well as FLO's (of which we have 37 active FLO's, with a further two training courses currently planned).

CDDFT is committed to continuing to provide a safe and just culture, in which we work collaboratively across our organisation (and with others where needed) to learn from incidents and act to improve safety. By working with all those affected by patient safety events (including patients, families and staff) we will

continue to aim to prevent avoidable physical or psychological harm to our patients. One of the key ways we will aim to achieve this is 2025/26 is through stronger links between the Patient Safety, Patient Experience and Legal teams within CDDFT. This development work has already begun, and we will continue to triangulate between patient/family complaints, patient safety incidents and Coroner cases to ensure that we provide comprehensive and compassionate responses to patients and families, and that we maximize the opportunities for learning and improvement.

Never Events

The Trust have reported four Never Events in 2024-25. These are described below:

- An incident of an incorrect syringe (not an insulin syringe) being used to draw up insulin. This did not result in any harm to the patient, and a PSII has taken place identifying learning leading to key actions as follows: Paediatric prescriptions are required to be completed on the Electronic Patient Record (EPR); DKA Guidelines have been made more easily accessible; second check processes have been strengthened and a standard operating procedure developed that outlines correct steps for preparing an insulin infusion.
- Two incidents of retained vaginal packs in Maternity (although one had occurred in the previous reporting year it was identified as a Never Event during 2024-25). PSII's are underway with some immediate learning already implemented including; the use of a digital tool within Badgernet for indwelling surgical packs that would offer a count process outside of the theatre environment, additional simulation added to role specific training, and the standard operating procedure reviewed to ensure robust management and understanding that a patient wearing a purple wrist band indicates that a pack is in situ.
- One incident of wrong site surgery within Community Podiatry whereby the lateral rather than the medial side of the nail (as had been consented) was removed. A PSII is underway to identify learning and actions.

Digital Systems

The Trust continues to use various digital systems including Oracle Cerner Electronic Patient Record (EPR) as our majority patient record. The system continues includes safety measures, such as prompts and alerts, to support safe care at the point of delivery and to allow safety to be audited afterwards. Data is being utilised in real time to monitor compliance with risk assessments, patient flow or other metrics required by the Trust or wider. Patient safety remains a high priority alongside the utilisation of digital systems therefore upgrades have been performed during 2024/25 to ensure the systems are safe and effective.

At present there are 17 risks in the Trust's risk database relating to the EPR system, covering items such as clinical documentation to results endorsing. The Digital Health Team remains a dedicated service across the Trust providing at the elbow support, education and face to face training packages where required. System improvements and enhancements suggested by clinicians across the Trust are reviewed and where appropriate developed into our system for use. All EPR or digital system users are encouraged to provide feedback in person or via digital means to ensure the digital systems work for those who need to use them.

The Digital Health Team has focused on embedding a range of digital solutions to support the delivery of care directly, on inpatient wards and in maternity services for example, and indirectly by enabling rapid communication between clinical colleagues. An upgrade of the digital dictation system was undertaken with Digital Health Team support and training meaning users across the Trust can be supported in real time on the floor.

Our focus over the next year will remain on the education and training ensuring all users of the digital systems. Those using the EPR system will have refresher training and support ongoing to utilise all aspects of the system they require.

Patient Experience

Our Patient Experience and Engagement strategy is now entering its final year and all objectives have been reached and work has begun to draft the new strategy.

Patient Experience:

1. **Take every opportunity to gather and analyse feedback and insights to drive service improvement.**
2. **Take every opportunity to gather and analyse feedback and insights to drive service improvement.**
3. **Celebrate our successes at every opportunity.**

- ✓ We have introduced access to record concerns and compliments via the new Trust website.
- ✓ We have approximately 40 ongoing service specific patient experience services ongoing to help improve and shape our services here at CDDFT.
- ✓ We use the 'you said we did' incentive to drive service improvement from comment son Friend and Family Test responses.
- ✓ We have introduced Friend and Family Test monthly posters for wards and departments. This includes a quantitative poster with amount of responses and a qualitative poster showing positive comments from patients, family members and service users.
- ✓ We have introduced monthly compliment posters for staff to celebrate success.

Engagement

1. **Implement visible and engaging ways to share patient feedback (positive and learning points) with wards and teams, and their service users.**
2. **Introduce a diverse Patient Council and reinvigorate the Patient Experience Network Group. Collate, report and share good practice examples of local patient engagement to engender greater use and consistency of service user engagement in services.**
3. **Capture and report positive service user engagement and outcomes increasing visibility to the Board.**

- ✓ We produced professionally produced patient story video to share learning and actions to drive our service improvement work around reasonable adjustments.
- ✓ We now offer people who complete a Family and Friend Test card to be part of the patient council. We now have approximately 445 members and increasing. We will liaise with this group of people to work with co-production projects.
- ✓ We have improved the process for capturing and sharing compliments reported by patients and family members.
- ✓ We include a section of positive feedback each month in the board report.

Volunteer Service

1. **Increase the number of active volunteers for CDDFT.**
2. **Introduce a diverse team of volunteers.**
3. **Progress the volunteer to career pathway for CDDFT.**
4. **Support the introduction of volunteers to the workforce to allow time to care.**
5. **Develop the role profiles for volunteer at CDDFT.**

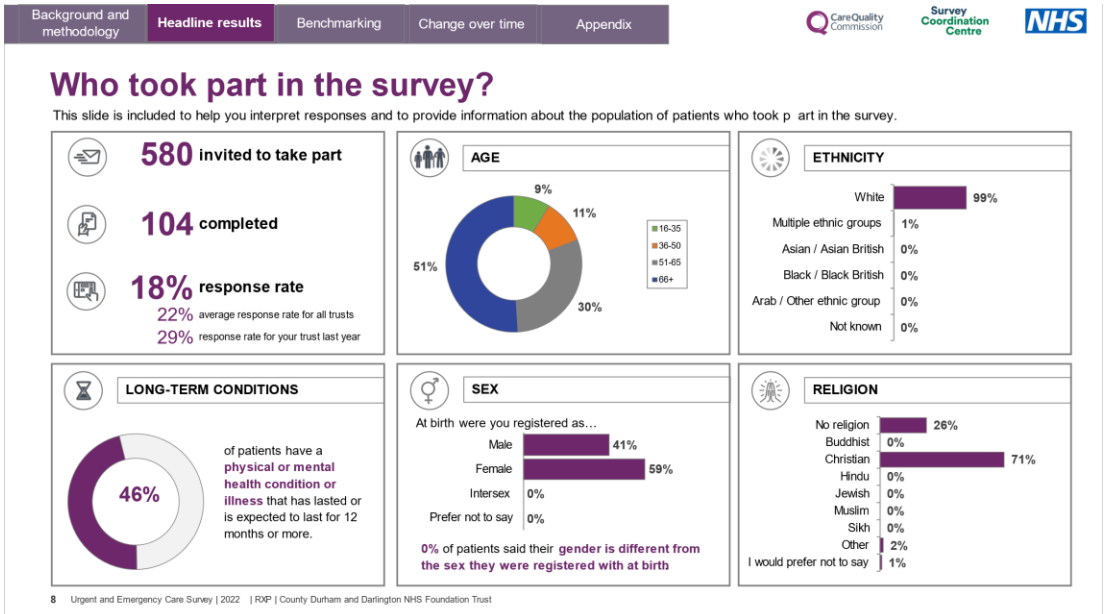
- ✓ We aimed to have 100 active volunteers we currently have 130 volunteers.
- ✓ We have successfully recruited a diverse team of volunteers.
- ✓ The volunteer to career pathway was a great success, we had 12 candidates and 7 people were able to go onto gain employment or start health and social care education.
- ✓ We have a number of role profiles within CDDFT including, administration, healthcare assistants and portering.

University Hospital of North Durham, Baby Memorial Garden

In 2024 the Baby Memorial Garden was relocated with the support of some of the bereft parents. A tree from the old garden was used to carve a monument in the garden and all plaques were moved sympathetically.

National Patient Survey Reports
Urgent and Emergency Care Survey
2022/2024 Response Report - Type 3 – Urgent Treatment Centres
Who took part in the survey?

The below shows the comparative data from the responses from 2022 to 2024.



Looking at the response data there have been more people invited to the survey and the update for 2024 has increased significantly with CDDFT at 33% response rate higher than the average rate for all trusts. It is interested that 82% of responders all have long term conditions, a significant rise on 2022 when it was 46%. There are no significant points from the other demographic data other then there were minimal responses from ethinicities other than White British.

Response Analysis

The 2024 survey is not directly comparable to the 2022 survey because the question set varied in some areas; where possible the sections have been aligned. The below section of the report looks at each section of the survey, capturing the highest and lowest rate and the rate for CDDFT for both 2022 and 2024.

Section 1 – Waiting

Question	National High 2024	National Low 2024	National average 2024	CDDFT 2022	CDDFT 2024
After your first assessment did the health professional tell you what would happen next?	9.9	8.4	9.4	N/A*	9.4
Were you informed how long you would have to wait to be examined or treated?	6.9	1.9	3.9	N/A*	3.7
Were you kept updated on how long your wait would be?	6.6	1.6	4.0	3.0	3.3
While you were waiting were you able to get help with your condition or symptoms from a member of staff?	7.1	2.7	4.7	N/A*	5.1

* This is a new question for 2024 survey

Section 2 – Interactions with Health Professionals

Question	National High 2024	National Low 2024	National average 2024	CDDFT 2022	CDDFT 2024
Did you have enough time to discuss your condition and treatment with the health professional?	9.7	7.2	8.7	9.4	9.0
While you were in the Urgent Treatment Centre, did a health professional explain your condition and treatment in a way you could understand?	9.6	6.7	8.5	9.0	8.7
Did the health professional listen to what you had to say?	9.8	7.8	9.0	9.4	9.2
If you had any anxieties or fears about your condition or treatment, did a health professional discuss them with you?	8.4	5.5	7.1	7.9	7.3

Section 3 - Privacy

Question	National High 2024	National Low 2024	National average 2024	CDDFT 2022	CDDFT 2024
Were you given enough privacy when discussing your condition with the receptionist?	8.0	6.0	7.1	7.9	7.5
Were you given enough privacy when being examined or treated	9.8	7.8	9.3	N/A*	9.5

* This is a new question for 2024 survey

CDDFT scored above average for both 2022 and 2024.

Section 4 – Your care and treatment

Question	National High 2024	National Low 2024	National average 2024	CDDFT 2022	CDDFT 2024
Were you involved as much as you wanted to be in decisions about your care and treatment?	9.5	6.9	8.3	8.6	8.5
Do you think the staff helped you control your pain?	7.8	4.4	6.3	7.4	6.2

Section 5 – Communication about tests

Question	National High 2024	National Low 2024	National average 2024	CDDFT 2022	CDDFT 2024
If you had any tests, did a member of staff explain why you needed them in a way you could understand?	9.7	6.7	8.6	8.1	8.9
Before you left the Urgent Treatment Centre, did a member of staff explain the results in a way you could understand?	9.5	6.2	8.3	7.9	8.6

Section 6 – Hospital environment and facilities

Question	National High 2024	National Low 2024	National average 2024	CDDFT 2022	CDDFT 2024
While you were in the Urgent Treatment Centre, did you feel safe around patients or visitors?	10.0	7.1	8.6	9.8	9.1
While you were at the Urgent Treatment Centre, were you able to get food and drinks?	8.1	1.4	5.9	6.8	6.5

Section 7 – Information to support recovery at home

Question	National High 2024	National Low 2024	National average 2024	CDDFT 2022	CDDFT 2024
Thinking about any new medication you were to take at home, were you given any of the following?	6.1	3.4	4.8	N/A*	4.8
Before you left the Urgent Treatment Centre, did health professionals give you information on how to care for your condition at home?	9.5	5.5	8.2	9.1	8.2

To what extent did you understand the information you were given on how to care for your condition at home?	9.6	7.7	9.0	8.1	9.1
From the information you were given by health professionals did you feel able to care for your condition at home?	9.4	7.5	8.8	N/A*	8.5

* This is a new question for 2024 survey

Section 8 – Support and care after leaving the Urgent Treatment Centre

Question	National High 2024	National Low 2024	National average 2024	CDDFT 2022	CDDFT 2024
Did a member of staff tell you to contact if you were worried about your condition or treatment after you left the Urgent Treatment Centre?	9.6	6.0	8.2	9.1	8.3
Did a member of staff discuss with you whether you may need further health or social care services after leaving the Urgent Treatment Centre?	9.7	6.0	8.0	N/A*	9.2

* This is a new question for 2024 survey

Section 9 – Respect and Dignity

Question	National High 2024	National Low 2024	National average 2024	CDDFT 2022	CDDFT 2024
Overall, did you feel you were treated with respect and dignity while you were in the Urgent Treatment Centre?	9.9	7.6	9.0	9.4	9.2

Section 10 – Overall experience

Question	National High 2024	National Low 2024	National average 2024	CDDFT 2022	CDDFT 2024
Overall, how was your experience while you were in the Urgent Treatment Centre?	9.4	6.6	8.3	9.4	8.5

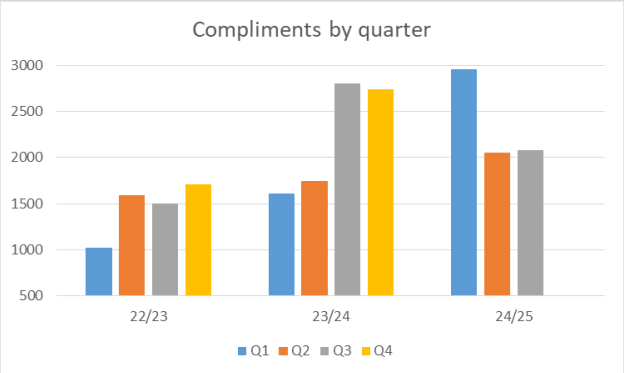
The table below notes the actions we have taken in respect to the issues highlighted.

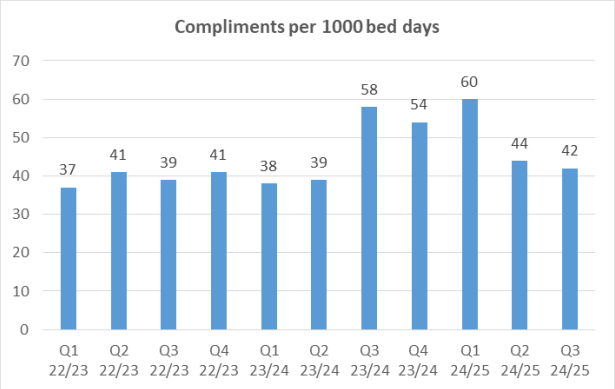
Section	Issue	Action	Update	Status
All	Share the content of the report	1. To share with UEC triumvirate. 2. To share with UTC staff. 3. To include in Board Report, Quality Committee and IQAC updates. 4. To include in UEC care group report. 5. To produce a public release on the results	1. Report shared on 2/12/24. 2. The report has been shared with the staff on 24/12/24.	Complete
All	Meet with UEC to look at the results together and consider the actions identified and formalise an action plan.	1. To arrange a meeting with the team.	1. Meeting took place on 11/12/24.	Complete
1.	Results show a below average score and a reduction from the 2022 results regarding communication.	1. Non co-located UTCs to inform patients of waiting time in their waiting areas. 2. Reception to inform at check in		Complete

Section	Issue	Action	Update	Status
		3. Nurse in charge to inform waiting area if any significant delays		
2.	Whilst all results are above national average they have reduced since the 2022 results.	1. Ensure patient understands treatment plan and has opportunity to ask questions.		Complete
3.	Result show a reduction regarding privacy when checking into the urgent treatment centre with the receptionist.	1. Patients to be given option to discuss in private.		Complete
4.	Both questions rates have reduced from 2022 to 2024, and control of pain is below national average.	1. Identify where possible, potential for patients in pain at point of triage		Complete
5.	Both questions rates have improved from 2022 to 2024.	1. Share this positive result with staff to celebrate their success and reaffirm this importance of clear communication to our patients.	The report has been shared with the staff.	Complete
6.	Both areas are above national average but patients' ability to get food and drinks has decreased.	1. Provide information leaflets as appropriate and ensure patient understands treatment plan.		Complete
7.	Results show a reduction in rates regarding patients caring for themselves once they are at home.	1. Ensure patient understands treatment plan and has opportunity to ask questions. 2. Ensure patient understands what to do should their condition worsen		Complete
8.	Reduction in rate regarding safety netting information.	1. To consider reaffirming the importance of safety netting information being given on discharge.		Complete
9.	A reduction in 2022 results however still above national average.	1. Patients to be given option to discuss in private.		Complete
10.	Overall experience result has dropped since 2022.	1. Increase and encourage Friends & Family feedback. Patients given clip board with patient survey on to complete after their consultation. This is reviewed monthly and action taken on any areas identify for improvement 2. Monitor Friend and Family Test results to identify themes and trends to consider for service improvement.		Complete Ongoing

Compliments

Compliments continue to be reported from our patients for our staff. During 2024 we further improved the ways in which we collect 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 received quarterly over a three year period and the number of complaints per 1000 bed days.

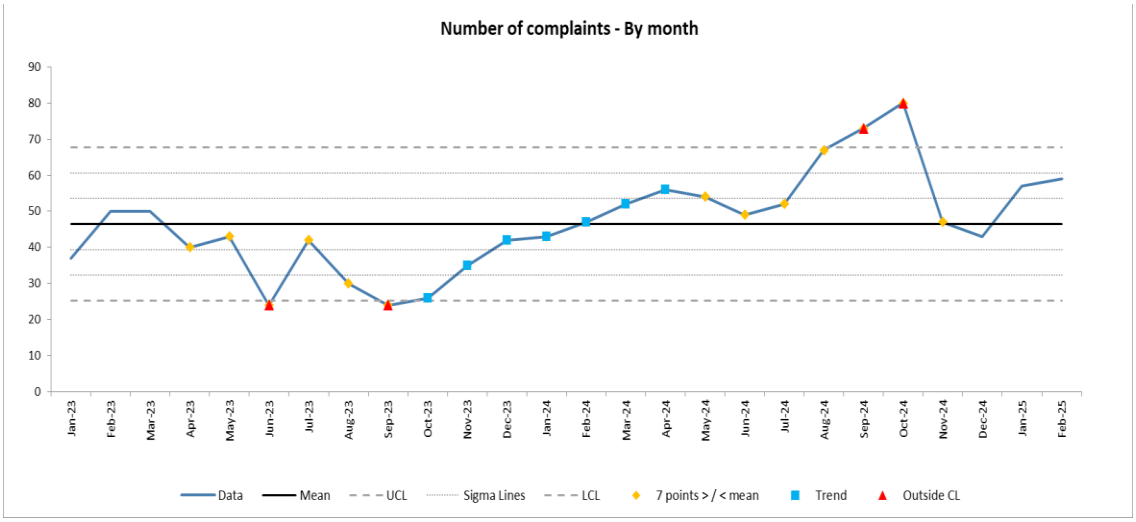




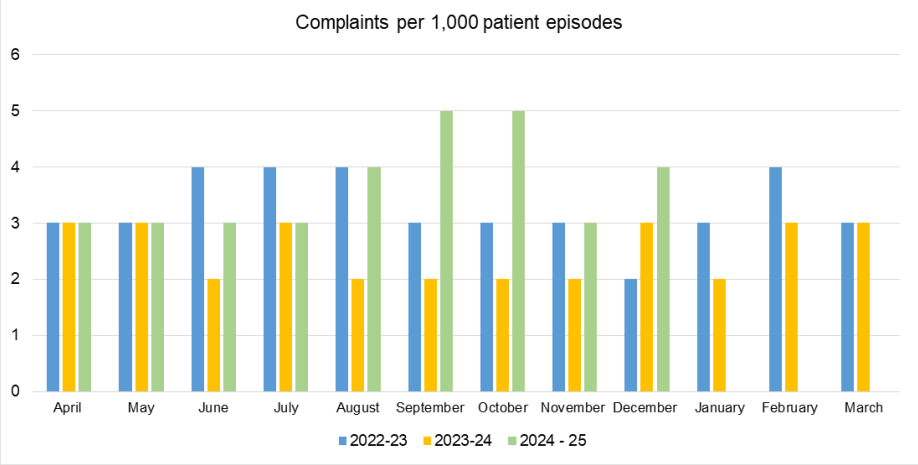
Complaints

The Trust implemented a new process in December 2023 which introduced investigating officers for complaints. The aim was to respond to complaints more quickly and to ensure that responses were always empathetic. The process has been implemented over a year now and approximately 50% of complaints are now resolved within 35 working days, an improvement on prior years. A new web module has been introduce to offer support for investigating officers to manage their cases and a training session was introduced in 2025.

The below chart shows the number of complaints month on month from January 2023 to February 2025 for comparison.

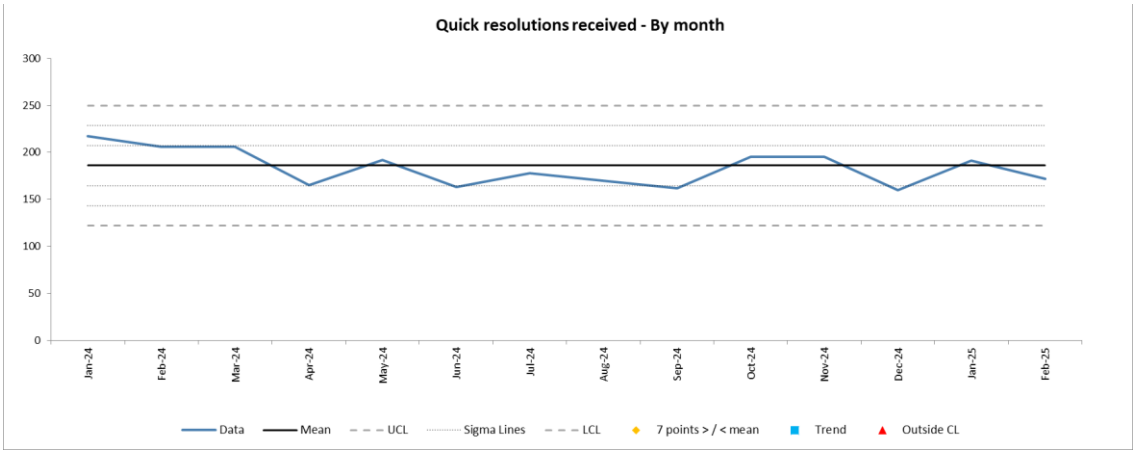


The below chart shows the number of complaint received per 1000 bed days over a three year comparison.

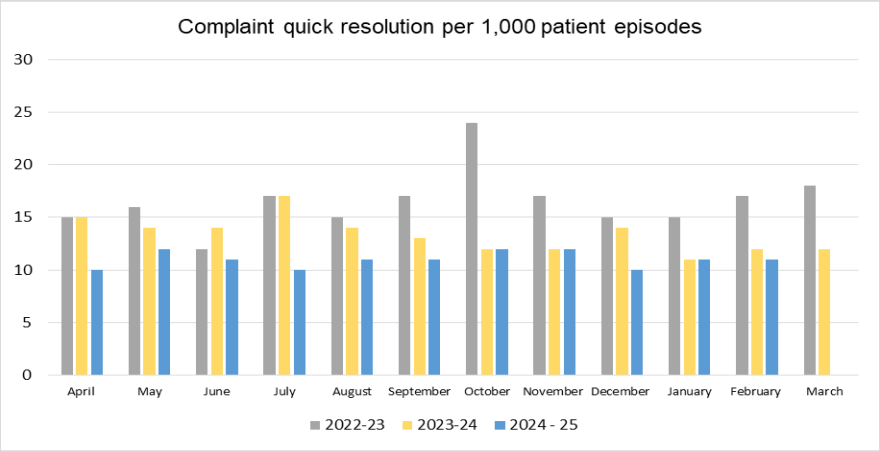


Quick Resolution Complaints

The below chart shows the number of quick resolution complaints month on month from January 2023 to February 2025 for comparison.



The below chart shows the number of complaint quick resolution cases received per 1000 bed days over a three year comparison.



Learning from Experience

During 2024 the learning from 3 complaint cases, working with patients and families, has been used to produce three patient story videos. These videos focus predominantly around making reasonable adjustments for patients. The learning from the cases have been used to inform a Trust-wide System Improvement Plan (SIP).

[DN – need to check these are publicly available and will work given the quality accounts are published in several forms]

The links for each of the videos are below:

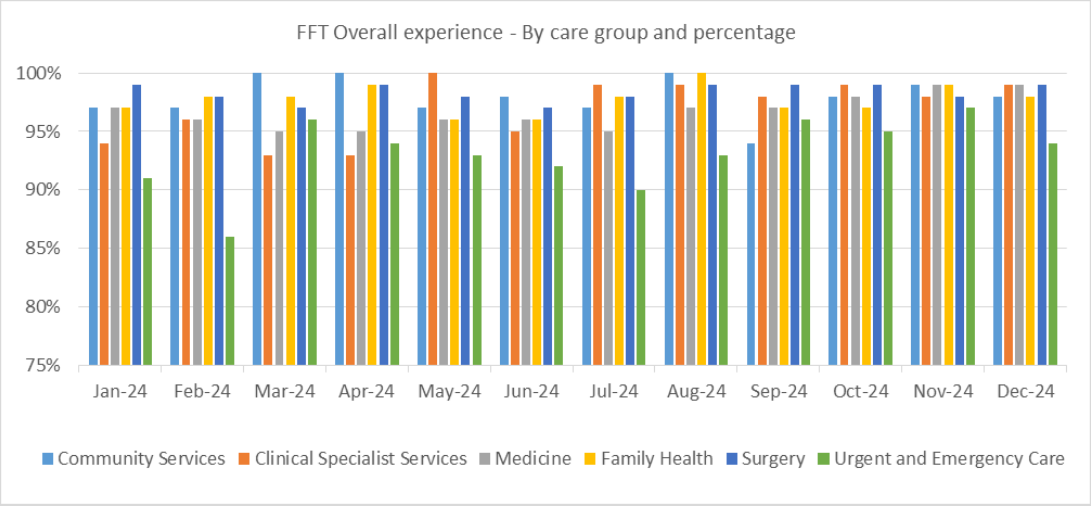
- Ian's Story - CDDFT Patient Stories Leanne
- Jim's Story - JIM
- Simon's Story - CDDFT Patient Stories Bridget

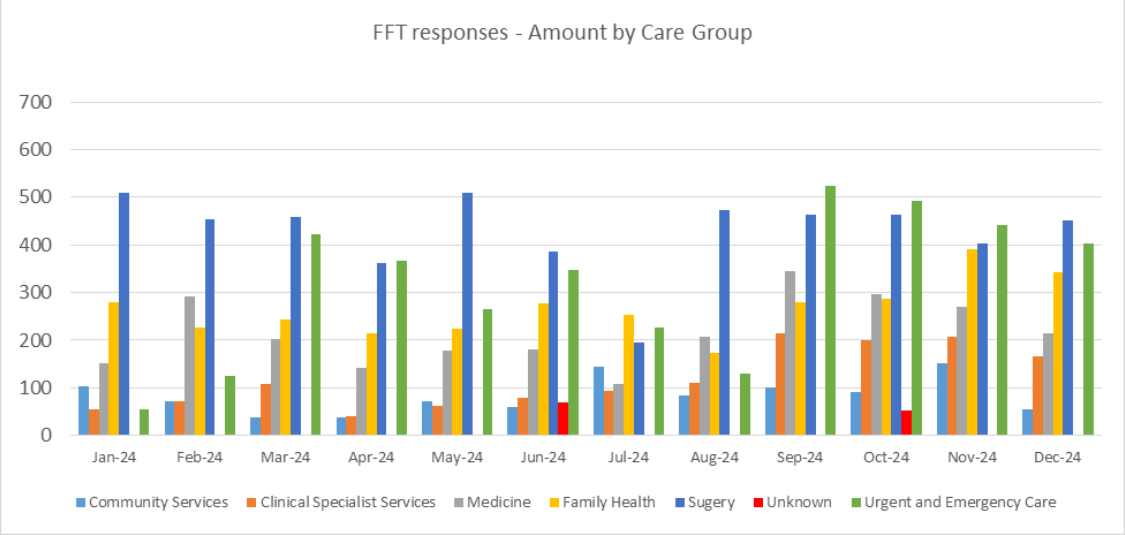
Actions and Learning Associated with the Patient Story Videos

1. Staff learning disability training has been agreed and actioned to be mandatory for all staff – Tier 1 Oliver McGowan
2. The training package was shared with the families and they have been involved in finalising this prior to being rolled out to Trust staff.
3. These patient stories will be utilised within both the learning disability training and complaint investigation training, and also added to the Trust website in the public Patient Experience domain.
4. Two of the contributors to the videos attended Medicine away days and told their stories to the attendees.
5. A review of the service provision to patient groups who are identified as having additional needs and service improvement for health passports within the Trust, to ensure personalised care.
6. A review on how reasonable adjustments for patients, including the use of our digital systems.
7. A full review of how we support carers within the Trust, including the use of the carers' passport.

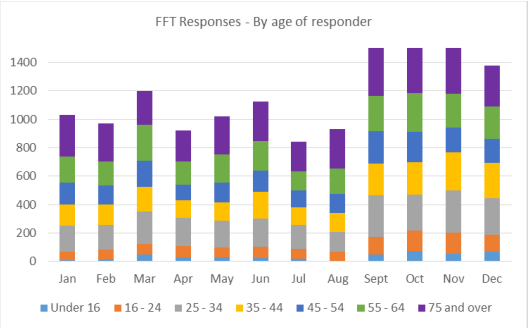
Friend and Family Test

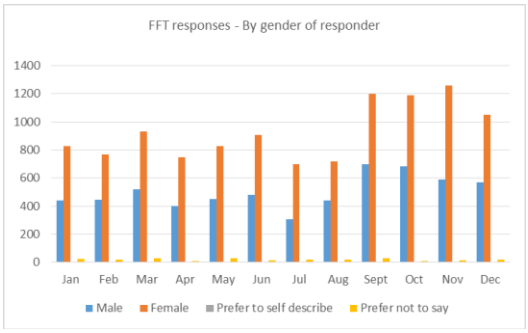
Responses from the Friend and Family Test have increased during 2024. The below charts show the overall experience and number of responses month on month.

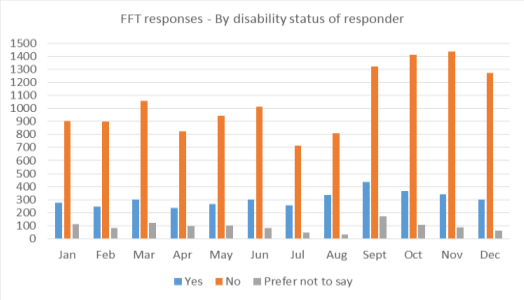


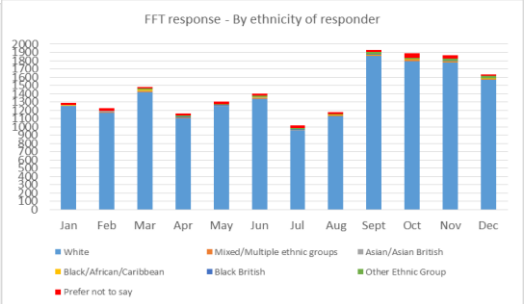


The below charts show a breakdown of demographic data collected from the response. Work will commence in 2025 to improve the response and we aim to collect a much wider range of data from a more diverse range of patients.









Clinical Effectiveness

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

Please see the detailed commentary in Section 2A, page 32.

Performance Summary

Elective Recovery

During the 2024/25 operating year, the operational planning guidance was in place to support continued delivery of recovery. These ambitions were grouped under 4 headings; Urgent and Emergency Care, Elective Care, Diagnostics, and Cancer. These ambitions in detail were:

Urgent and Emergency Care

- To achieve 78% against the 4 hour standard for transfer, admission, or discharge. The Trust met this ambition at the year-end, with 79.7% of patients seen and treated, or admitted in March 2025.

Elective Care

- To eliminate waits in excess of 65 weeks for patients with an incomplete open RTT pathway by 30 September 2024. This ambition was revised in year to 22 December. The Trust achieved this in December 2024 and has been close to maintaining this performance in the subsequent months, with no more than 1 breach reported at each corresponding month-end.
- To deliver or exceed Value weighted activity of 107% of the baseline across the operating year. On average this has been achieved.
- To increase the proportion of OP attends that attract tariff to 46%. This has been achieved in each month in the year.

Diagnostics

- To achieve 95% against the 6-week diagnostic standard by March 2025. The Trust did not achieve this target at the year but exceeded the national average. The main area of pressure relates to non-obstetric ultrasound.

Cancer

- To achieve 70% against the 62-day treatment standard by March 2025. The Trust is expecting to deliver against this ambition at the year-end. [DN – need final validated data for March]
- To achieve 77% against the 28-day diagnostic standard by March 2025. The Trust delivered against this ambition at the year-end.

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

[DN – to added at the end of the process once received]

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

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

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

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

- the content of the quality report meets the requirements set out in the NHS foundation trust annual reporting manual 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 2024 to June 2025
    - papers relating to quality reported to the board over the period April 2024 to June 2025
    - feedback from commissioners dated XXX
    - feedback from governors dated XXX
    - feedback from local HealthWatch organisations dated XXX
    - feedback from overview and scrutiny committees dated XXX and XXX
    - the Trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated XXX (2023/24 report) Please note, the annual report for 2024/25 is currently in development.
    - the national patient survey XXXX
    - the NHS national staff survey XXXX
    - the Head of Internal Audit's annual opinion of the Trust's control environment dated XXXX
    - CQC inspection reports dated 11th April 2024 and XX January 2025.
- the quality report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the quality report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the quality report has been prepared in accordance with NHS England's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

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

By order of the board

Chairman

Chief Executive

GLOSSARY OF TERMS

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

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

AHP – Allied Healthcare Professional

AKI – Acute Kidney Injury

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

BAH – Bishop Auckland Hospital

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

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

CDDFT –County Durham and Darlington NHS Foundation Trust

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

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.

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.

ICB – Integrated Care Board - a statutory NHS organisation which is responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in a geographical area.

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

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

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

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 - localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or other device), resulting from sustained pressure (including pressure associated with shear)

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

PSIRF - Patient Safety Incident Response Framework - the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

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

TEWVFT – Tees, Esk & Wear Valley NHS Foundation Trust

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