Health and Housing Scrutiny Committee Meeting – 7th January 2026

Item 4 – Quality Strategy and Quality Accounts Update

1. Introduction

The Trust's Quality Strategy – Quality Matters, runs to 31st March 2026. The tables below summarise the aims of the strategy, for each key objective (split by patient safety, patient experience, clinical effectiveness and underlying enablers), the progress made and current position, and further actions being taken. The table notes where there is regular reporting to the Board's Quality Committee or Finance and Performance Committee, and the commentary draws on the evidence in these reports.

The Trust will be refreshing its strategy for the period from 1st April 2026, and the tables include recommendations for work to be carried forward within that new strategy.

As has been articulated in Board meetings, Quality Matters included some objectives relating to improvement in clinical services but should not be considered a clinical services strategy. There is separate work taking place, to review clinical services supported by a Board Advisor, Hugo Mascie Taylor.

Before considering progress on individual objectives, however, it is important to set out the current context and challenges being faced by the Trust. These relate to the well-publicised fallings in the Trust's Breast Service and subsequent, wider, failings in governance – particularly clinical governance – set out in the report on the external governance review pertaining to the Breast Service by Mary Aubrey, which the Trust published in November 2025. The link below will enable any Committee seeking the full detail to read the report and the Trust's response.

[Link]

2. Context and challenges

Assurance in respect of the Breast Surgery Service

We have taken significant action to develop a safe service and to ensure that patients referred and accepted into our breast service receive care within the national expected guidelines.

To enable these changes, it has been necessary to reduce, as a temporary measure, the number of patients that we see on a weekly basis. We are sorry to you as our patients for the impact this has had. We are very grateful to our neighbouring Trusts within the North East and North Cumbria for the support they have given the Trust in managing our patients we cannot see safely.

The reduction in our capacity has impacted the timeliness of care provision not only to County Durham and Darlington patients but also to the wider North East and North Cumbria population and therefore patients may not be seen and treated in the timescales that they were prior to our actions in March of this year. We are sorry for these delays; we are working closely across the region to collaborate on a model of care that is safe but also sustainable in providing timely care.

Changes to the service are as follows:

- Improvement actions began during the latter half of 2024, with an intensive programme of work to make improvements to the breast services from March 2025.
- We have stopped all insourcing and outsourcing arrangements within our breast service.
- Two new oncoplastic Breast Surgeons started in Spring 2025 along with an experienced Oncoplastic Breast Surgeon from Newcastle Hospitals NHS Foundation Trust who is leading improvements to the service and chairing the multi-disciplinary team. Subsequently, a Breast Radiologist from Newcastle's Breast Screening team is also supporting the team.
- The service now provided at CDDFT reflects national guidelines and patients receive the same treatment options as patients being treated in other hospitals in our region. This includes, when appropriate, immediate free-flap reconstruction with a plastic surgeon or oncoplastic breast surgery, which is a specialised approach to treat breast cancer while also reshaping the breast to improve cosmetic outcomes.
- Surgical care is currently being delivered by our newly appointed surgeons whilst we ensure that other members of the team have the appropriate skills and training to provide the level of care that we expect.
- Our Breast assessment clinics are now run in line with modern accepted standards, and patient appointments are longer to enable this and to offer compassionate care.
- Changes have been made to how patients are assessed in these clinics. Mammograms are now reviewed by two Radiologists independently of each other and in line with practice within the screening units. Improvements to the mammography equipment have been made to help identify microcalcifications (these are very small calcium deposits which can be a sign of early cancer), and our Ultrasound scanners have been replaced and now providing much better image quality.
- Consultant Radiographers from across the region are supporting diagnostic clinics meaning that there is support to allow image guided core biopsies instead of clinical biopsies (biopsies undertaken freehand). The practice of using fine needle aspirations (FNA) has ceased except in the exceptional circumstances where the guidelines allow it.

- Decisions about treatment are now made by a single multi-disciplinary team which is regularly attended by all members of the team including surgeons, oncologists, radiologists, pathologists and breast care nurses with an assigned chair and consistent coordinator, leading to a more functional and robust meeting.
- Where patients have a benign (non-cancerous) lump they are offered minimally invasive treatment, instead of unnecessary surgery. This is currently taking place at Newcastle Hospitals but staff at CDDFT are training to provide this within the Breast Service at Durham and Darlington.
- We have put additional equipment in place to reduce unnecessary further operations. Faxitron machines at each hospital mean we can examine tissue that is removed during surgery to immediately check that the breast lesion has been fully removed. This reduces the need for women to have further operations (re-excisions). KliniTrays are used to improve the accuracy of the pathologist's assessment of whether all cancer cells have been removed. Improvements to how implants are used have been put in place to ensure care is in line with guidance and helps to minimise infection.
- Breast governance specific arrangements are now in place to review audits, guideline implementation, complaints and morbidity and mortality data on a monthly basis. Data is routinely collected in real time to inform audit key quality indicators such as mastectomy rates, re-excision rates, immediate reconstruction rates and complications.

These changes have already improved outcomes for the patients we have provided care to. We have audited our outcomes against national expectations for symptomatic units between March 2025 and October 2025 which show that:

- 69.5% of women had breast conserving surgery. This compares to 53% for the year ending June 2024. 69.5% is better than the GIRFT expected rate of 65%.
- 21.4% of women had an immediate reconstruction. This compares to 14% for the year ending June 2024, and is moving closer to the GIRFT expected standard of 30%
- The re-excision (re-operation) rate was 13.4%. This compared to 26% for the year ending June 2024 and is better than the GIRFT standard of 17%.

Governance Issues and Response

The Aubrey Report highlights gaps and weaknesses in leadership, corporate governance, clinical governance, organisational culture, management of and support for doctors and management of insourced and outsourced services, all of which enabled issues with the Breast Service to persist for several years. These were not confined to the Breast Surgery specialty, or the General Surgery directorate in which they operated, but were more pervasive, requiring action to prevent similar issues with the service. The Trust's response sets out five programmes of work, with actions phased as follows, to tackle the underlying issues:

- Completed actions;
- Three to six months;
- Six to twelve months; and
- Twelve to 18 months.

Programmes of work	Executive Lead	Non-Executive Lead	Our commitment
Leadership and corporate governance	Chief Executive	Chair	Patients will be cared for in a Trust that is well led and governed, and operating effectively to achieve long-term success. Staff will see and work with leaders who are determined in pursuing safe, sustainable high-quality services.
Clinical governance	Medical Director Executive Director of Nursing	Chair of Integrated Quality and Assurance Committee	Our clinical services will be safer and more effective through stronger clinical governance, closer collaboration, better use of data and by truly listening to our patients and staff. Risks to services will be recognised and escalated promptly and acted upon.
Culture	Chief Executive	Chair of People and Culture Committee	Our culture will be open, transparent and compassionate for patients and staff. We will be responsive to staff and patient views, and staff will be empowered to deliver and improve high-quality services
Management of, and support for, doctors	Medical Director Director of Workforce & OD	Chair of People and Culture Committee	Medical staff will be more open and collaborative, supported by effective training, supervision and appraisals; services to patients will be clinically led and job plans aligned to service needs.
Financial governance and contract management	Executive Finance Director	Chair of Finance and Performance Committee Chair of Audit Committee	To best meet the needs of patients, staff and the taxpayer we will ensure the highest standards of financial governance, bringing clinical work back in house wherever possible and ensuring any contracted-out services meet the high-quality standards we will set for ourselves.

The Trust is under new leadership and has made a number of appointments to strengthen the Board. Highly experienced Board advisers have been appointed to support the transformational change required. The response document set out a range of completed actions, which were further consolidated in December, with the establishment of a People and Culture Committee reporting to the Board and the recruitment of five new Non-Executive Directors who will commence in post during January 2026.

Committee members are encouraged to read the full response, which can be found using the link in the introduction above.

The Aubrey Report led to the Trust agreeing a range of regulatory undertakings with NHS England in order to implement the above programmes of work and to address the wider need to strengthen leadership capacity and capability.

Ongoing CQC inspections

CQC have completed fieldwork for inspections of the Trust's Surgery and Community-based services, and a full review of the Trust's well-led arrangements. Findings for Surgery and the well-led inspection are consistent with the themes in the Aubrey report and have led to Section 29 Warning Notices being issued to require significant improvements over the next quarter in:

- Governance and risk management arrangements – aligned to issues raised within the Aubrey Report relating to risks not being escalated and acted upon appropriately, and inconsistent specialty governance.
- Clinical audit – aligned to issues raised within the Aubrey Report with respect to completion and oversight of audits and follow through on improvement actions.
- Closedown of, and learning from, incidents including duty of candour.
- Similarly, closedown of, and learning from complaints.
- Embedding compliance with respect to recognition and action re: the deteriorating patient.

The last three issues were captured in the Trust's risk registers with action plans in place. In effect, CQC have judged that the Trust needs to accelerate actions within its response to the Aubrey Report or within risk registers, so that 'significant improvements' are evident by April 2026.

Overarching improvement plan

Actions are already underway in all areas, as set out in the Trust's response to the Aubrey report and in response to CQC feedback. All of the actions from the Aubrey Report, feedback from CQC and the regulatory undertakings agreed with NHS England are now being pulled together into a single improvement plan, progress against which will be reported at each Trust public board meeting.

3. Quality Strategy / Accounts – Progress

Introduction

A subjective RAG-rating has been used to assess progress as follows:

Objective achieved / largely achieved – improvements need to be sustained		Further work needed to consolidate and sustain improvements made	
Some improvements, but not yet achieved and further work, which will take time, is in progress		More significant remedial action is needed and is in progress	

In keeping with the challenges outlined above, we will be reviewing each area rated red or amber, to understand why previous approaches have failed to

Patient Safety Priorities

Objective	Aims / Progress	Current position	Supporting report	RAG rating	Further actions
Restoring our focus on being 'highly reliable'	We aimed to embed a safety culture resulting in no recurring never events, reduced Regulation 28 Notices and improved system learning. Key actions have included the roll out of the Trust's Patient Safety Strategy and System Improvement Plans.	Despite actions taken, the Board's Quality Committee has been advised of delays in completion of incident investigations and actions, challenges in securing engagement in completing system improvement plans, and examples of recurring never events (involving wrong site surgery or retained objects). A recent internal audit could provide only limited assurance with respect to learning from never events.	Patient Safety & Experience Report to the Board's Quality Committee	**Red**	• Recruitment of increased patient safety partners • Releasing matron capacity tied up in flow to focus on safety and quality • Recruitment of two patient safety investigators. • **This objective will be carried forward to the new strategy**
Reducing falls and harm from falls	Through targeted education and improvement plans, we aimed to reduce the incident of falls and associated harm. The Falls team has supported wards and community hospitals with interventions – such as 'zonal nursing' – resulting in reduced numbers and severity of falls.	Over the strategy period falls in the acute sector (per 1,000 bed days) have reduced to around 5.3, which is within prior benchmarks. Falls per 1,000 bed days in community hospitals have increased; however, this reflects a change in the mix of patients at community sites and remains within SPC limits.	Quarterly Falls Report to Quality Committee.	**Yellow**	• Ongoing targeted education and improvement support. • Continued monitoring and auditing of performance at ward / team level
Minimising pressure ulcers and associated harm	We aimed to implement audits of compliance with tissue viability protocols and to expand education through champion networks, both of which have been achieved.	It is difficult to measure comparable performance as the previous 'zero tolerance' for ulcers with lapses in care was found to be an unreliable measure. However, compliance audits are now in place allowing improvement trajectories to be set. The latest quarter's audit results range from 89% compliance to 91%.	Quarterly Tissue Viability Report to Quality Committee	**Amber**	• Agreement of improvement trajectories. • **This objective will be carried forwards in the new strategy**

Objective	Aims / Progress	Current position	Supporting report	RAG rating	Further actions
Reducing healthcare associated infections and related harm	The aims of the strategy were to reduce cases of C-Diff and CPE, eliminate cases of MRSA, expand IPC capacity and effect ongoing auditing and improvement activity	There is now a seven day IPC service and there are no remaining CPE outbreaks at DMH. Audits across seven core dimensions of IPC take place monthly, with results showing improvement over time (generally over 90% for the last six months). However, the Trust is a regional outlier for high numbers of C-Diff and MRSA cases and above trajectory for all mandatory-reportable infections. Audits show pockets of poor compliance, hence mystery shopper audits and a protocol for professional conversations have also been implemented.	Bi-monthly Infection Prevention and Control Report to Board Quality Committee	**Red**	• Ongoing audits, targeted education and improvement activity • Investigation and learning from cases of infection **This objective will be carried forwards in the new strategy**
Embedding safe practice in invasive procedures	The aims of the strategy were to ensure that all LocSSIPs required by NatSSIPs 2 were in place and to embed adherence to their use. We also planned to migrate LocSSIPs into the EPR system.	There have been improvements in document management and version control, and in ensuring that documents are in date. A Task and Finish (T&F) Group is in place and has undertaken campaigns to promote LocSSIPs and their use. However, a recent compliance audit of all LocSSIPs in use found that an incorrect LocSSIP version had been used in 55% of cases, there was some missing data in 32% of completed LocSSIPs and, in over 20% of cases, LocSSIPs were not present. LocSSIPs have not yet been migrated into EPR.	Quarterly Task and Finish Group and clinical audit reports to Board Quality Committee.	**Red**	• New clinical lead for the T&F Group to be identified. • Care Group Directors to lead on actions to drive up compliance with existing LocSSIPs in their services. • Benchmarking with neighbouring trusts, and comparison to NatSSIPs 2, to ensure all required protocols are in place. • Rolling out observational, as well as compliance audits. • Developing LocSSIPs in EPR. • **This objective will be carried forwards in the new strategy**

Objective	Aims / Progress	Current position	Supporting report	RAG rating	Further actions
Improving recognition and action on patient deterioration	The aims of the strategy were to: reduce incidents associated with deterioration through education and training; meet NICE guidance for sepsis screening and treatment and to embed the Trust's AKI pathway.	The AKI pathway is now well-established and there is good compliance (over 90%) with taking of observations and completion of risk assessments. Call for Concern (meeting two of the Martha's Rule requirements) is embedded. However, recent reports to the Board's Quality Committee have highlighted issues with repeat observations for patients with High Early Warning Scores, escalation of out of range observations, training and other related issues. Sepsis screening rates are high, but audits identify continuing challenges in timely taking of blood cultures and provision of antibiotics.	Patient Safety & Experience Report to Board Quality Committee and specific updates on patient deterioration	**Red**	• All of the actions in the monthly reports on observations and deterioration. These include dedicated support and training from the Acute Intervention and Cardiac Arrest teams and monitoring and improvement of adherence to observation and escalation protocols. • **This objective will be carried forwards in the new strategy. Whilst significant improvements, as required by CQC are being targeted by March 2026, more time will be needed to full embed changes required.**
Improving safety in maternity services	The aims of the strategy were to embed improvements in governance, triage process and sustainable staffing, as well as to meet the requirements of all 10 Safety Actions in the MIS.	Staffing reports show high fill rates at DMH and increasing fill at UHND. 1 to 1 care and supernumerary coordinator status is being maintained. The Trust is set to declare compliance with the 10 MIS Safety Actions for the second year.	Maternity Updates to Board Quality Committee and Board (monthly)	**Green**	• Continued auditing to ensure that actions from CQC inspections, Ockenden peer reviews and other reports are embedded and sustained.
Ensuring prompt and effective patient follow up	The aim of the strategy was to prevent further incidents of loss to follow up, particularly in Ophthalmology.	Prior to the roll out of EPR, the object was rated as achieved. IQAC has been advised of ongoing work to check entries on 'missing to follow up' lists to ensure that EPR is updated correctly and to trigger follow up, where necessary.	Periodic update on Missing to Follow Up reviews to Board Quality Committee.	**Amber**	• Follow through of ongoing work on missing to follow up lists • Remedial actions for any action loss to follow up identified. • **This objective will be carried forwards in the new strategy if work has not concluded by March 2026.**

Patient Experience Priorities

Objective	Aims / Progress	Current position	Supporting report	RAG rating	Further actions
Improving our understanding of patients' experience in our care	We aimed to increase our use of patient stories and patient representatives, to learn from trusts that fare well in national surveys, to provide 'customer care' training to staff and see reductions in complaints, particularly those relating to staff attitudes.	We will shortly have recruited four patient safety partners and have used patient representatives in work on the Breast Service and in quality panels. The Board's Quality Committee makes use of patient stories and seeks to follow through on learning identified. However, we have seen increases in complaints, and delayed responses and learning and we continue to need to improve how we learn from national surveys, including good practice elsewhere.	Monthly Patient Safety and Experience Report to Board Quality Committee Patient Surveys reported to the Board's Quality Committee.	**Amber**	• Ongoing work within the Patient Experience team to strengthen learning from patient surveys, and to routinely collect qualitative patient feedback, which is then shared with front-line teams and used to drive improvements. • Better use of patient stories for learning at all levels in the Trust. • Improving responsiveness to complaints (engagement with complainants and timeliness) and learning from complaints. • **This objective will be carried forwards in the new strategy**
Implementing NICE guidance on shared care	We aimed to implement and audit compliance with the NICE guideline in line with the ICS-wide personalised care programme.	Whilst individual areas have reviewed adherence to the guideline and MacMillan have provided some independent validation that principles such as 'What Matters to Me' are acted upon, we have not undertaken a systematic survey / audit of compliance and need to do so.	**Assurance gap – survey required**	**Amber**	• Full survey of position and action plan (Quarter 4, 2025/26)
Supporting patients with additional needs (Mental Health, LD and Autism)	Through the following actions, the aim of the strategy was to improve recognition and fulfilment of additional needs and thereby provide a better experience for patients with wider needs: • Roll out of training programmes • Targeted education and champion networks • Developing appropriate joint care pathways and plans with partners • Learning from service users and their carers	A service level agreement, and supporting arrangements, are in place with TEWV leading to the development of joint care plans, which has proved successful especially in Paediatrics. A review from the regional LD Network in Autumn of 2024 commended the Trust for its specialist LD services and for recognition / provision for reasonable adjustments in clinical areas visited. A network of LD and Dementia Champions is in place. Training programmes such as the Oliver McGowan training have been mandated and rolled out and we are developing training on personalised approaches to care and Trauma-Informed Practice.	Periodic reporting to Board Quality Committee – cycle needs to be formalised.	**Yellow**	• Consolidation of improvements through ongoing work programmes • Learning from patient stories where reasonable adjustments have not been made, to ensure good practice seen by the LD network can be embedded in all areas.

Objective	Aims / Progress	Current position	Supporting report	RAG rating	Further actions
Improving how we listen to patients and families	The aim of the strategy was to increase patient engagement activity and to embed engagement in support of service development and co-design in services.	Patient engagement activity is well-established in some areas such as maternity and cancer services and arrangements are in place to use patient representatives to support activity such as quality panels. Over 400 volunteers have been recruited for Patient Councils or similar forums, but these are not yet in place and patient engagement is not well embedded in a number of services.	Monthly Patient Safety and Experience Report to Board Quality Committee.	**Amber**	• Establish trust-wide engagement forums / patient councils • Implement membership strategy • Develop patient engagement activity across all services and demonstrate resulting service improvements. • **This objective will be carried forwards in the new strategy**
Improving experience on discharge	The aim of the strategy was to improve the experience of patients on discharge, by providing more timely discharge, with good communication to the patient, their family and onward agencies, measured through patient feedback and a reduction in Section 42 Referrals around discharge.	We have been unable to materially improve the timeliness of discharge during the day, with many patients still going home in the evening. Improved arrangements are in place (including the Trusted Assessor model) which have helped to minimise unnecessary delays in hospital. Whilst we have, at times, seen reductions in Section 42 referrals and incidents reported by primary care, the picture is variable and there are gaps and quality issues with discharge communications issued to GP practices.	Monthly Quality Report to Board Quality Committee	**Amber**	• Work with the external GIRFT Further Faster programme on planning and supporting more timely discharge (on the day of discharge) • Ongoing learning from themes from S42 referrals and incidents flagged by primary care • Address issues with complete transmission and quality of discharge letters • **This objective will be carried forwards in the new strategy**
Nutrition and Hydration	Whilst not included within our strategy, we added aims with respect to nutrition and hydration to our quality account priorities in previous years.	Over the life of the strategy, we have embedded our AKI service and increased compliance with completion of nutritional risk assessments for patients to around 90% or more. There remain some areas of risk, which are subject to ongoing work, relating to placement of nasogastric tubes and compliance with fluid balance monitoring	Quarterly Quality Accounts updates to Board Quality Committee	**Amber**	• Improvement plan with respect to fluid balance (captured in risk register) • Work led by Dietetics on safety protocol for nasogastric tubes (clinical audit in progress).
Cancer Services – Experience Objectives	Whilst not included within our strategy, we added aims with respect to nutrition and respect to the experience of patients with cancer to our Quality Accounts in 2024/25 and brought forward key objectives to 2025/26. These related to improving engagement with veterans, providing access to a Psycho-oncology service and learning from patients' experiences.	We have shared resources developed to support veterans in engaging with cancer services with partner organisations and across the region and have started to track levels of engagement. We have appointed a Psychologist to pilot and lead the development of a Psycho-oncology service (over several years). We continue to seek views from our Cancer Experts by Experience Group and have developed action plans to respond to the 2024 national survey.	National Cancer Patient by Experience Survey 2024 – results reported to Board Quality Committee with Action Plan to follow	**Yellow**	• Action plans by tumour group / service to be developed, quality-assured and shared with the Board Quality Committee for the National Cancer Patient Experience Survey.

We have maintained the good progress noted in our 2024/25 quality accounts with respect to End of Life / Palliative Care and adherence to the current version of national guidance on single sex accommodation.

Clinical Services and Clinical Effectiveness

Objective	Aims / Progress	Current position	Supporting report	RAG rating	Further actions
Improving Urgent and Emergency Care	The aim of the strategy was to introduce and expand same day emergency care; improve pathways for the care of children in A&E; and to improve waiting times, achieving reductions in the numbers of patients spending over 12 hours waiting for admission, or in the department in total. We also aimed to reduce ambulance handover delays and to increase the resilience of our staffing.	Same Day Emergency Care provision is in place on both sites but needs to be further expanded at UHND. Pathways of care for children in A&E are different between the two sites but are appropriately staffed. The resilience of medical staffing rotas has improved and waiting times have also improved, with fewer lengthy handover delays and reductions in the percentage of patients spending over 12 hours in the department. However, the percentage is still well above the level which we would wish to tolerate.	Reporting on A&E services to OPAC and to Board within the IQPR.	**Amber**	• Further development of SDEC services at UHND • Work as part of the GIRFT Further Faster collaborative on flow, discharge and admissions • The FPC has requested a paper to set out 'what would it take' to significantly reduce long waits in our A&E Departments to inform further action planning. • **This objective will be carried forwards in the new strategy**
Reducing long waits for elective care	The aim of the strategy was for the Trust to eliminate waits over 65 weeks, to significantly reduce waits over 52 weeks and to support patients with their wellbeing whilst waiting for a procedure.	We have, essentially, eliminated waits over 65 weeks and made (compared to 2022) significant in-roads into the backlog of patients waiting over 52 weeks. Patients have received wellbeing support whilst waiting. However, the number of over-52 week waits remains too high and there are challenges matching capacity to demand to achieve levels of activity needed to work towards restoration of the RTT waiting times standard.	Elective waiting times reporting in the IQPR.	**Amber**	• Demand and capacity planning, linked to job plans to optimise capacity • Looking to make better use of capacity at Bishop Auckland • Looking to increase PIFU and day case activity where appropriate. • **This objective will be carried forwards in the new strategy**
Improving cancer services	The main aims of the strategy were to adapt services to meet the requirements of the NHS Long-Term Plan and to develop sustainable staffing.	Cancer Services have commenced roll out initiatives such as prehabilitation in line with regional pilots and reviewed pathways in line with best practice guidelines. There remains a need to substantiate cancer care coordinators, and the Breast Service Review has highlighted the need to review the workings of MDTs. At the present time there are pressures on waiting times because of the issues in the Breast Service, demand and capacity pressures in Dermatology and some challenges with pathways in Colorectal, all of which have bespoke action plans.	Cancer Services Report to OPAC.	**Amber**	• Continued development of services to meet the long-term plan objectives • Substantiation of posts for cancer care coordinators • Ongoing work on pathways, working with the Northern Cancer Alliance and regional partners • **This objective will be carried forwards in the new strategy**

Objective	Aims / Progress	Current position	Supporting report	RAG rating	Further actions
Enhancing community services	The aim of the strategy was to expand 'hospital at home' and similar services to enable patients to be treated in their own homes rather than needing to attend hospital.	Community Services have continued to develop care for patients in their own homes, for example through the community respiratory service, OPAT, the crisis response team (performance on which exceeds the national target) and close working between the Palliative Care Team and Care Homes. The Co Durham Care Partnership renewed the Trust's Adult Community Servies contract based on performance during the first contract term and the ability of the Trust to work with partners on improved services.	**Current reporting gap –** assurance being bult into Board Committee work plans	**Yellow**	• Consolidation of existing improvement plans in Community Services
Consolidating other services	The aims of the strategy were to consolidate improvements in Frailty / Elderly Care and work towards seven day services, particularly in Medicine.	The Frailty Service, particularly at DMH, has demonstrated improvements across a range of clinical indicators and is now rolling out a 'Hospital at Home' model. Whilst the Trust has not fully implemented seven day rotas, coverage of weekends has, for most specialties, significantly improved.	**Current reporting gap** – assurance being built into Board Committee work plans	**Yellow**	• Further roll out of frailty hospital at home model • Evaluation of seven day service provision.

Enablers in the Quality Matters Strategy

Increasing capacity and time to care	Developing a Safe and Supportive Culture	Developing capability
The aim was to increase capacity through: • Recruitment to substantive posts; • Streamlining processes; • Implementing our EPR system (which was expected to release time); and • Working with system partners to reduce demand.	The aim was to embed a safe and supportive culture through: • Increased support and visibility from senior leaders • Fostering a culture, based on kindness, wellbeing and success • Maintaining an honest dialogue.	The aim was to increase capability for quality oversight and improvement through: • Developing skills through training • Improving systems and information • Listening to patients, families and carers • Improving our infrastructure for quality improvement.
Amber	**Red**	**Amber**
Action taken We successfully recruited increased numbers of nursing and medical staff, albeit with the issues regarding 'locum consultant' training pathways noted in the Aubrey Report. Ward audit processes were streamlined and ward staff now only complete audits in one month in each quarter, compared to the previous monthly requirement. Audits in intervening months are completed by senior nurses and buddy teams. Work has taken place with partners on alternatives to A&E admission / unscheduled care demand. EPR was rolled out and did reduce time in some areas (e.g. removing the need to double-clerk patients in A&E and then in AMU due to different systems.	**Action taken** Attempts were made to improve the culture through the Civility Saves Lives campaign and latterly the Kindness Matters training and follow up	**Action taken** See 'Patient Experience priorities' above for listening to patients and families. We established a Quality Improvement Approach (IMPS), but it is not a core 'CDDFT way'. A Quality Improvement Network and hub were also established. Over 1,000 IMPS novices have been trained. A quality improvement senior sister was appointed to support small-scale local QI projects e.g. on wards. We have begun to roll out a ward accreditation framework underpinned by a core set of information around quality.
Current position Whilst we have increased capacity, we need to ensure that we use it efficiently, by streamlining meetings and complex structures to make it easier for staff to 'get things done' in their own areas.	**Current position** As is now well documented through the Aubrey Report and Trust Response, a reset of culture and of the behaviours, framework is needed, which will be a significant piece of work.	**Current position** We need to significantly increase patient engagement activity and improve how we listen to patients and families. We need to enhance our ward assurance framework and work with front-line teams to best support their skills development and empowerment to make improvements in their own services.

All of the above enablers will need to be evaluated and considered for carry forward, in some form, in the refresh of the Trust's strategy.

Conclusion

Whilst the Trust has made some improvements over the life of the Quality Matters Strategy, in areas such as maternity, A&E and community services, there are some significant areas of under-achievement where urgent and / or focused action is needed, particularly in respect of patient safety priorities and culture, and there is further work needed in all areas, particularly those RAG-rated amber.

The further work required will need to be evaluated and, as appropriate, taken forwards in the Trust's refreshed strategy, from early 2026/27.